

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

DATA INTEGRITY BOARD

CERTIFICATION OF BOARD ACTION

**Title:** "Verification of Eligibility for Minimum Essential Coverage under the Patient Protection and Affordable Care Act through a Department of Defense Health Benefits Plan"

**Identifier:** HHS CMA #1806

**PARTIES TO THE AGREEMENT:**

**Recipient:** Centers for Medicare & Medicaid Services (CMS)

**Source:** Department of Defense (DoD), Defense Manpower Data Center (DMDC)

**PURPOSE OF THE AGREEMENT:**

This Computer Matching Agreement establishes the terms, conditions, and procedures under which the Department of Defense (DoD), Defense Manpower Data Center (DMDC) will provide information or data to CMS. Under the authority of the Patient Protection and Affordable Care Act of 2010 (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152) (collectively, the ACA) and the implementing regulations, CMS, in its capacity as operator of the Federally-facilitated Exchanges (FFE) and the Federal enrollment and eligibility platform, will use DoD's information to verify an Applicant's or Enrollee's eligibility for Minimum Essential Coverage (MEC) through a TRICARE Health Care Program for the purpose of making Eligibility Determinations, including Eligibility Determinations for which HHS is responsible under 45 CFR § 155.302.

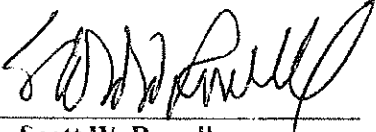
**Conditions of Approval:**

There are no special conditions to approval of this agreement.

**Action:**

As Chairperson of the Data Integrity Board, I hereby certify Board approval of this computer matching agreement.

10/22/18  
Date

  
\_\_\_\_\_  
Scott W. Rowell  
Chair, HHS Data Integrity Board

**COMPUTER MATCHING AGREEMENT  
BETWEEN  
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
AND  
THE DEPARTMENT OF DEFENSE  
DEFENSE MANPOWER DATA CENTER  
FOR VERIFICATION OF ELIGIBILITY FOR MINIMUM ESSENTIAL COVERAGE  
UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT THROUGH  
A DEPARTMENT OF DEFENSE HEALTH BENEFITS PLAN**

**CMS Computer Matching Agreement No. 2018-07  
Department of Health and Human Services No. 1806  
DoD-DMDC No. 18**

**Projected Effective Date: December 1, 2018  
Projected Expiration Date: June 1, 2020**

**I. PURPOSE, LEGAL AUTHORITIES AND DEFINITIONS**

**A. Purposes**

This Computer Matching Agreement (Agreement) establishes the terms, conditions, and procedures under which the Department of Defense (DoD) will provide information or data (data) to Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services (HHS).

Under the authority of the Patient Protection and Affordable Care Act of 2010 (ACA) (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152) (collectively, the ACA) and the implementing regulations, CMS, in its capacity as operator of the Federally-facilitated Exchanges (FFE) and the Federal enrollment and eligibility platform, will use DoD's information to verify an Applicant's or Enrollee's eligibility for Minimum Essential Coverage (MEC) through a TRICARE Health Program for the purpose of making Eligibility Determinations, including Eligibility Determinations for which HHS is responsible under 45 CFR § 155.302. DoD acknowledges that Administering Entities (AE), which include state-based Exchanges (SBE) and Basic Health Programs (BHP), will use DoD data, accessed through the Data Services Hub (Hub), to make Eligibility Determinations.

The Computer Matching and Privacy Protection Act of 1988 (CMPPA) (Public Law 100-503) amended the Privacy Act (5 U.S.C. § 552a) and requires the parties participating in a matching program to execute a written agreement specifying the terms and conditions under which the matching will be conducted. CMS has determined that verifications conducted by CMS, on behalf of AE, using the Hub, and accessing DoD data will constitute a "matching program" as defined in the CMPPA.

The responsible component for CMS is the Center for Consumer Information & Insurance Oversight (CCIIO). CMS will serve as the Recipient Agency. The DoD component responsible for the disclosure is the Defense Manpower Data Center (DMDC). DoD will serve as the Source Agency in this Agreement.

DMDC provides the Defense Health Agency (DHA) with the data used to determine medical eligibility, enrollment and medical claims payment via the Defense Enrollment Eligibility Reporting System (DEERS). DHA establishes health care coverage benefits for active duty services members and their family members and retirees and their family members. The DMDC, via DEERS, will integrate with the Hub to provide services to verify an Applicant's or Enrollee's eligibility for TRICARE health benefits.

By entering into this Agreement, the Parties agree to comply with the terms and conditions set forth herein and the applicable law and implementing regulations. The terms and conditions of this Agreement will be carried out by authorized officers, employees and contractors of CMS and DoD. The terms and conditions under which SBE may receive and use DoD data will be set forth in a separate agreement between CMS and each state-based AE.

## B. Legal Authorities

The following statutes govern or provide legal authority for the uses of data, including disclosures, under this Agreement:

1. This Agreement is executed pursuant to the Privacy Act of 1974 (5 U.S.C. § 552a) as amended by the CMPPA and the regulations and guidance promulgated thereunder, including Office of Management and Budget (OMB) Circular A-108 Federal Agency Responsibilities for Review, Reporting, and Publication under the Privacy Act published at 81 Federal Register (FR) 94424 (Dec. 23, 2016) and OMB guidelines pertaining to computer matching published at 54 FR 25818 (June 19, 1989). The Privacy Act at 5 U.S.C. § 552a(b)(3) authorizes a federal agency to disclose information about an individual that is maintained in a system of records, without the individual's prior written consent, when the disclosure is pursuant to a routine use published in a System of Records Notice (SORN) as required by 5 U.S.C. § 552a(e)(4)(D). The Parties have published routine uses for their applicable systems of records which authorize the disclosures made under this Agreement.
2. Under the ACA, certain individuals are eligible for certain financial assistance in paying for private insurance coverage under a Qualified Health Plan (QHP) when enrollment is through an Exchange. Such assistance includes Advanced Premium Tax Credits (APTC), under 26 U.S.C. § 36B and section 1412 of the ACA, and Cost Sharing Reductions (CSR) under section 1402 of the ACA.
3. Section 36B(c)(2) of the Internal Revenue Code of 1986, as added by section 1401 of the ACA, provides that an individual is ineligible for APTC if that individual is eligible for other "minimum essential coverage" (MEC), as defined in 26 U.S.C. § 5000A(f) other than MEC described in 26 U.S.C. §

5000A(f)(l)(C), such as coverage under TRICARE. Section 1402(f) of the ACA provides that an individual is ineligible for CSR under §§ 1402(c) and (d)(l) if the individual is not also eligible for the premium tax credit for the relevant month.

4. Section 1331 of the ACA authorizes the BHP and section 1331 (e)(l)(C) requires the state administering BHP to verify whether an individual is eligible for other MEC, such as coverage under TRICARE. (See 45 C.F.R. § 155.320(d).)
5. Section 1411 of the ACA requires the Secretary of HHS to establish a program to determine eligibility for an individual to purchase a QHP through an Exchange and to determine eligibility for Insurance Affordability Programs, including APTC and CSR. The system established by HHS under section 1411 to determine eligibility for APTC and CSR requires an Exchange to verify whether an individual is eligible for other MEC, such as coverage through TRICARE, by sending information to HHS for HHS to provide a response. (See 45 CFR § 155.320(b).)
6. Pursuant to sections 1411(c)(4)(B) and 1411(d) of the ACA, the Secretary of HHS has determined that verification of eligibility for the TRICARE coverage described in this Agreement is best made using a computer matching program as described in this Agreement. An Exchange may use this verification service through the Hub to support Eligibility Determinations for APTC and CSR by sending a request to the Hub. CMS facilitates the verification against DoD data, and a response with the result of that verification attempt is sent to the entity that determines eligibility for APTC and CSR. Under 45 CFR §§ 155.302 and 155.305, the Eligibility Determinations for APTC and CSR may be made by an Exchange or HHS. CMS carries out the Exchange-related responsibilities of HHS. (See 76 FR 4703 (Jan. 26, 2011)).
7. Under the authority of sections 1311, 1321, and 1411(a) of the ACA, the Secretary of HHS adopted regulations, 45 CFR § 155.330, which further address the requirements for an Exchange to predetermine eligibility for enrollment in a QHP through an Exchange and for APTC and CSR during the benefit year based on certain types of changes in circumstances.
8. Section 1411(f) of the ACA sets forth the appeals authority.
9. Health plans are only permitted to use or disclose protected health information (PHI), such as eligibility and enrollment information, as permitted or required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Among other things, the HIPAA Privacy Rule (45 CFR § 164.512(k)(6)) permits a health plan that is a government program providing public benefits, such as TRICARE, to disclose eligibility and enrollment information to an agency administering another government program providing public benefits if the disclosure is required or expressly authorized under regulation or statute. 45 CFR § 155.320(b)(2) expressly authorizes the disclosure to HHS of information regarding eligibility for and enrollment in a health plan, which may be considered PHI, for the purposes of verification of applicant eligibility for MEC as part of

the eligibility determination process for APTC or CSR.

### C. Definitions

For the purposes of this Agreement:

1. "ACA" means Patient Protection and Affordable Care Act of 2010 (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152) (collectively, the ACA);
2. "Administering Entity" means a state Medicaid agency, Children's Health Insurance Program (CHIP), a basic health program (BHP), or an Exchange administering an Insurance Affordability Program;
3. "Advanced Premium Tax Credit" or "APTC" has the meaning provided under 45 CFR § 155.20, and means payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the ACA), which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with section 1412 of the ACA. APTC are not considered Federal Tax Information under 26 U.S.C. § 6103;
4. "Applicant" means an individual who is seeking eligibility for him or herself through an application submitted to an Exchange, excluding individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of Part 155 of title 45 of the Code of Federal Regulations, submitted to a BHP program or transmitted to an Exchange by an agency administering an Insurance Affordability Program for at least one of the following (1) enrollment in a QHP through an Exchange; or (2) the BHP;
5. "Authorized Representative" means an individual, person or organization acting, in accordance with 45 CFR § 155.227, on behalf of an Applicant or Enrollee in applying for an Eligibility Determination, including a redetermination, and in carrying out other ongoing communications with the Exchange;
6. "Benefit Year" means the calendar year for which a health plan purchased through an Exchange provides coverage for health benefits;
7. "BHP" means Basic Health Program as established under § 1331 of the ACA;
8. "Breach" is defined by OMB Memorandum M-17-12 Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017), as the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, or any similar occurrence where (1) a person other than an authorized user accesses or potentially accesses personally identifiable information or (2) an authorized user accesses or potentially accesses personally identifiable information for an other than authorized purpose;
9. "CMS" means the Centers for Medicare & Medicaid Services;

10. "Cost Sharing Reductions" or "CSR" is defined at 45 CFR § 155.20 and means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange;
11. "DEERS" means Defense Enrollment Eligibility Reporting System;
12. "DHA" means Defense Health Agency;
13. "DMDC" means the Defense Manpower Data Center;
14. "DoD" means Department of Defense;
15. "Eligibility Determination" means the determination of eligibility for Insurance Affordability Programs, including a redetermination based on a self-reported change pursuant to 45 CFR § 155.330, and the process of appealing a decision on a determination when an appeal is provided pursuant to section 1411(f) of the ACA;
16. "Enrollee" means an individual enrolled in a QHP through an Exchange or enrolled in a BHP;
17. "Exchange" means an American Health Benefit Exchange established under sections 1311(b), 1311(d)(1), and 1321(c)(1) of the ACA, including both SBE and FFE;
18. "Federally Facilitated Exchange" or "FFE" means an Exchange established by HHS and operated by CMS under section 1321(c)(1) of the ACA;
19. "HHS" means the Department of Health and Human Services;
20. "Hub" or "Data Services Hub" is the CMS managed, single data exchange for AE to interface with Federal agency partners. Hub services allow for adherence to Federal and industry standards for security, data transport, data safeguards as well as CMS policy for AE for Eligibility Determination and enrollment services;
21. "Insurance Affordability Programs" include (1) a program that makes coverage in a QHP through an Exchange with APTC; (2) a program that makes available coverage in a QHP through an Exchange with CSR; (3) the Medicaid program established under Title XIX of the Social Security Act; (4) Children's Health Insurance Program (CHIP) established under Title XXI of the Social Security Act; and (5) the BHP established under section 1331 of the ACA;
22. "MEC" or "Minimum Essential Coverage" is defined in I.R.C. § 5000A(f) and includes health insurance coverage offered in the individual market within a state, which includes a QHP offered through an Exchange, an eligible employer-sponsored plan, or government-sponsored coverage such as coverage under Medicare Part A, TRICARE, or a DoD Health Care Program;

23. "Personally Identifiable Information" or "PII" is defined by OMB Circular No. A-130, Managing Information as a Strategic Resource (July 28, 2016), and means information which can be used to distinguish or trace an individual's identity, either alone or when combined with other information that is linked or linkable to a specific individual;
24. "Qualified Health Plan" or "QHP" means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 in title 45 of CFR issued or recognized by the Exchange through which such plan is offered in accordance with the process described in subpart K of part 155 in title 45 of C.F.R.;
25. "Recipient Agency" is defined by the Privacy Act (5 U.S.C. § 552a(a)(9)) and means any agency, or contractor thereof, receiving records contained in a System of Records from a Source Agency for use in a matching program;
26. "Security Incident" means "Incident," which is defined by OMB Memorandum M-17-12 Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017) as an occurrence that (1) actually or imminently jeopardizes, without lawful authority, the integrity, confidentiality, or availability of information or an information system; or (2) constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies;
27. "Source Agency" is defined by the Privacy Act (5 U.S.C. § 552a(a)(11)), and means any agency which discloses records contained in a system of records to be used in a matching program. DoD is the Source Agency in this Agreement;
28. "State-based Exchange" or "SBE" means an Exchange established and operated by a State, and approved by HHS under 45 CFR § 155.105;
29. "System of Records" or "SOR" is defined by the Privacy Act (5 U.S.C. § 552a(a)(5)), and means a group of any records under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual; and
30. "TRICARE" means a DoD government sponsored health program which establishes health care coverage benefits for active duty services members and their family members, retirees and their family members.

## **II. RESPONSIBILITIES OF THE PARTIES**

### **A. CMS Responsibilities**

1. CMS will implement procedures through which an Applicant or Enrollee may request an Eligibility Determination via a single, streamlined application.

2. CMS will implement procedures through which an AE can request information from and match an Applicant's or Enrollee's information with DoD's DEERS system of records through the CMS Hub. CMS will only request data from or request a data match with DoD's records when necessary to make an Eligibility Determination, including an initial determination of eligibility, a determination based on a self-reported change, or a re-verification at the end of the inconsistency period.
3. CMS will receive the DoD response data elements through the Hub and will utilize the information provided by DoD in making Eligibility Determinations.
4. CMS will implement procedures through which a state-based AE can request information from DoD through the Hub to make Eligibility Determinations.
5. CMS will provide Congress and the OMB with notice of this matching program and will publish the required matching notice in the Federal Register.
6. CMS will enter into agreements with state-based AE that bind these entities, including employees, contractors, and agents, to comply with the privacy and security standards and protections for PII, including requirements for these entities and their employees, contractors, and agents to comply with the use and disclosure limitations set forth in section 1411(g) of the ACA, and privacy and security standards that are consistent with the principles outlined under 45 CFR § 155.260, and privacy and security standards that are consistent with the terms and conditions of this Agreement.
7. CMS will ensure the receipt of appropriate consents from Applicants or Enrollees for use of PII collected, used, and disclosed for the purposes and programs outlined in this Agreement.

#### B. DoD Responsibilities

1. DoD will implement procedures to respond to verification requests by CMS to transmit information from DEERS to verify or validate eligibility for TRICARE health benefit programs.
2. DoD will perform deterministic data matching to match the identity of the Applicant or Enrollee's inputs with DoD data records.
3. DoD will provide its data to the Hub, in accordance with Section IV. B. 2. to verify whether the Applicant or Enrollee was eligible for DoD TRICARE benefit programs within the period requested by CMS.

### III. JUSTIFICATION AND ANTICIPATED RESULTS

Pursuant to the Privacy Act's subsection 552a(o)(1)(B) requirement, the justification for the program and the anticipated results, including a specific estimate of any savings, is described below:



## A. Cost Benefit Analysis

As required by § 552a(u)(4) of the Privacy Act, a cost benefit analysis (CBA) is included as Attachment 1 covering this and seven other “Marketplace” matching programs which CMS conducts with other Federal agencies. The CBA demonstrates that monetary costs to operate the eight Marketplace matching programs exceed \$30.5 million, but does not quantify direct governmental cost saving benefits sufficient to offset the costs since the Marketplace matching programs are not intended to avoid or recover improper payments. The CBA, therefore, does not demonstrate that the matching program is likely to be cost-effective.

## B. Other Supporting Justifications

Although the cost benefit analysis does not demonstrate that this matching program is likely to be cost effective, the program is justified for other reasons, as explained in this section. The Data Integrity Board therefore is requested to make a determination, in writing, that a cost benefit analysis reflecting a cost-savings is not required, in accordance with 5 U.S.C. § 552a(u)(4)(B), and to approve the agreement based on the other justifications and mitigating factors stated below and in the CBA.

1. Certain Marketplace matching programs are required and are not discretionary. However, some Marketplace matching programs are based on permissive routine use disclosure authority, not a statutory obligation.
2. The Marketplace matching programs’ eligibility determinations and MEC checks result in improved accuracy of consumer eligibility determinations, which CMS anticipates will continue to produce expedited Eligibility Determinations while minimizing administrative burdens and achieve operational efficiencies.
3. The matching programs provide a significant net benefit to the public by accurately determining eligibility for financial assistance (including the APTC and CSR).
4. An efficient eligibility and enrollment process contributes to greater numbers of consumers enrolling in Marketplace qualified health plans, resulting in a reduction of the uninsured population, therefore improving overall health care delivery.
5. Continuing to use the current matching program structure, which is less costly than any alternative structure, is expected to increase the public’s trust in the participating agencies as stewards of taxpayer dollars.

## C. Specific Estimate of Any Savings

There is no cost savings to conducting the Marketplace matching programs, as opposed to not conducting them. By requiring a single, streamlined application process, the ACA effectively required use of computer matching to make eligibility determinations. Therefore, the optimal result is attained by limiting the cost by using a matching program operational structure and technological process that is more efficient than any alternatives.

The Privacy Act does not require the showing of a favorable ratio for the match to be continued, only that an analysis be done unless statutorily excepted or waived by the DIB.

The intention is to provide Congress with information to help evaluate the cost-effectiveness of statutory matching requirements with a view to revising or eliminating them where appropriate.

#### **IV. DESCRIPTION OF THE DATA TO BE EXCHANGED**

The Privacy Act requires that each CMA describe the records that will be matched and exchanged, including a sample of data elements that will be used, the approximate number of records that will be matched, and the projected starting and completion dates of the program.

##### **A. Systems of Records**

1. The CMS SOR that supports this matching program is the CMS Health Insurance Exchanges System (HIX), CMS System No. 09-70-0560, last published in full at 78 FR. 63211 (Oct. 23, 2013), as amended at 83 FR 6591 (Feb. 14, 2018), located at the Terremark data center in Culpeper, VA. Routine Use 3 supports CMS's disclosures to DoD: "To disclose information about applicants and Relevant individual(s) in order to obtain information from other Federal agencies and State agencies and third party data sources that provide information to CMS, pursuant to agreements with CMS, for purposes of determining the eligibility of applicants to enroll in QHPs through an Exchange, in insurance affordability programs, or for a certification of exemption from the individual responsibility requirement."
2. The DoD SOR that supports this matching program is DMDC 02 DoD, Defense Enrollment Eligibility Reporting Systems (DEERS), published at 81 FR 49210 (July 27, 2016), located at the DISA DECC Columbus in Columbus, OH. Routine Use 7f supports DoD's disclosure to CMS: "Providing to the Centers for Medicaid and Medicare Services, Department of Health and Human Services, for the purpose of verifying individual's healthcare eligibility status, in accordance with the Affordable Care Act. Data provided to CMS will be used to make eligibility determinations for insurance affordability programs, administered by Medicaid, the Children's Health Insurance Program (CHIP), the Basic Health Program (BHP) and the American Health Benefit Exchange."<sup>1</sup>

##### **B. Specified Data Elements**

1. From CMS to DoD. For each Applicant or Enrollee seeking an Eligibility Determination, the Administering Entity will submit a request through CMS by way of the Hub to DMDC that may contain, but is not limited to, the following specified data elements in a fixed record format:
  - a. Transaction ID
  - b. Social Security Number (SSN)
  - c. Input First Name
  - d. Input Middle Name

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<sup>1</sup> At the time of publication of this matching agreement, the DMDC 02 SORN did not list a routine use #6.

- e. Input Surname
  - f. Input Date of Birth
  - g. Input Gender
  - h. Input Requested QHP coverage effective date
  - i. Input Requested QHP coverage end date
2. From DoD to CMS. For each Applicant or Enrollee seeking an Eligibility Determination through an AE, DMDC will provide to the Hub one of several outputs indicating whether an individual has MEC or not. The response will be in a standard fixed record electronic format (e.g., response file) and may contain, but is not limited to, the following specified data elements:
- a. Insurance End Date
  - b. Person SSN Identification
  - c. Response Code
  - d. Response Code Text

C. Number of Records

The following table provides the base estimates for the total number of transactions in FY 2019 and FY 2020, as well as the number of transactions in the estimated highest month within each of those years. These estimates are subject to change as business assumptions or estimates are updated and/or refined.

	FY 2019 Total	FY 2019 Highest Month	FY 2020 Total	FY 2020 Highest Month
Base Estimate	89,491,707	16,748,043	78,777,489	15,094,179

D. Projected Starting and Completion Dates of the Matching Program

Projected Effective Date – December 1, 2018

Projected Expiration Date – June 1, 2020 (June 1, 2021 if renewed 1 year)

V. PROCEDURES FOR INDIVIDUAL NOTICE

- A. CMS will publish notice of the matching program in the Federal Register as required by the Privacy Act (5 U.S.C. § 552a (e)(12)).
- B. At the time of application or when an individual reports a change of circumstances, CMS, or a State-based agency administering an Insurance Affordability Program, will provide a notice to Applicants for enrollment in a QHP or an Insurance Affordability Programs under ACA on the streamlined eligibility application. The agency administering the Insurance Affordability Program, including CMS in its capacity as an FFE, will ensure

provision of a Redetermination or Renewal notice in accordance with applicable law. These notices will inform Applicants that the information they provide may be verified with information in the records of other Federal agencies.

## **VI. VERIFICATION AND OPPORTUNITY TO CONTEST**

The Privacy Act requires that each matching agreement specify procedures for verifying information produced in the matching program and an opportunity to contest findings, as required by 5 U.S.C. § 552a(p).

### **A. Verification and Opportunity to Contest Procedures.**

Before an AE may take any adverse action based on the information received from the match, the individual will be permitted to provide the necessary information or documentation to verify eligibility information. When an AE determines that an individual is ineligible for an Insurance Affordability program based on the information provided by the match, and that information is inconsistent with information provided on the streamlined eligibility application or otherwise by an Applicant or Enrollee, the AE will comply with applicable law and will notify each Applicant, or Enrollee of the match findings and provide the following information: (1) The AE received information that indicates the individual is ineligible for an Insurance Affordability Program; and (2) the Applicant, or Enrollee has a specified number of days from the date of the notice to contest the determination that the Applicant or Enrollee is not eligible for the relevant Insurance Affordability Programs.

### **B. Contesting Findings:**

In the event that information attested to by an individual for matching purposes is inconsistent with information received through electronic verifications obtained by the DoD through the Hub, the DoD must provide notice to the individual that the information they provided did not match information received through electronic verifications as follows:

1. If the AE is an Exchange, an individual seeking to resolve inconsistencies between attestations and the results of electronic verification for the purposes of completing an Eligibility Determination should be provided the opportunity to follow the procedures outlined in 45 CFR § 155.315(f). The AE will provide the proper contact information and instructions to the individual resolving the inconsistency.
2. If the AE is an agency administering a Medicaid or CHIP program, an individual seeking to resolve inconsistencies between attestations and the results of electronic verifications for the purposes of completing an Eligibility Determination should be provided the opportunity to follow the procedures outlined in 42 CFR §§ 435.952, 435.956 and 457.380. The AE will provide the proper contact information and instructions to the individual resolving the inconsistency.
3. Per 42 CFR § 600.345, if the AE is a BHP, it must elect either Exchange verification

procedures at 45 CFR §§ 155.315 and 155.320, or Medicaid verification procedures at 42 CFR § 435.945-956; and will resolve inconsistencies as set forth in Paragraphs VI.B.1. and 2 above.

## **VII. ACCURACY ASSESSMENTS**

DMDC currently estimates that 99% of the information within DEERS is accurate for ACA purposes in cases where (1) an exact applicant match is returned, (2) the applicant has an enrollment status of "verified", and (3) their enrollment period coincides with the start/end dates received from the Hub.

## **VIII. PROCEDURES FOR RETENTION AND TIMELY DESTRUCTION OF IDENTIFIABLE RECORDS**

DoD and CMS will retain data received from the other party via the Hub only for the period of time required to verify an Applicant or Enrollee's eligibility for TRICARE health benefits under this matching program and will then destroy the data by electronic purging, unless DoD or CMS are required to retain the information for enrollment, billing, payment, program audit purposes, or legal evidentiary purposes or where they are required by law to retain the information. The CMS FFE and state-based AE will retain data for such purposes and under the same terms. In case of such retention, DoD and CMS will retire the retained data in accordance with the applicable Federal Records Retention Schedule (see 44 U.S.C. § 3303a). DoD and CMS will not create permanent files or a separate system comprised solely of the data provided by the other party.

## **IX. SECURITY PROCEDURES**

- A. General: CMS and DoD will maintain a level of security that is commensurate with the risk and magnitude of harm that could result from the loss, misuse, disclosure, or modification of the information contained on the system with the highest appropriate sensitivity level.
- B. Legal Compliance: CMS and DoD shall comply with the limitations on use, disclosure, storage, transport, and safeguarding of data under all applicable Federal laws and regulations. These laws and regulations include section 1411(g) of the Affordable Care Act; the Privacy Act of 1974; the E-Government Act of 2002, which includes the Federal Information Security Management Act of 2002 (FISMA), 44 U.S.C. §§ 3541-3549, as amended by the Federal Information Security Modernization Act, 44 U.S.C. §§ 3551- 3558; HIPAA; the Computer Fraud and Abuse Act of 1986; the Clinger-Cohen Act of 1996; and the corresponding implementation regulations for each statute. Additionally, CMS will follow Federal, HHS, and CMS policies including the HHS Information Security and Privacy Policy, as amended, and the CMS Information Security Acceptable Risk Safeguards (ARS) and CMS Minimum Security Requirements.

CMS and DoD will comply with OMB circulars and memoranda, such as OMB Circular A-130, Managing Information as a Strategic Resource, published at 81 FR

49,689 (July 28, 2016); National Institute of Standards and Technology (NIST) directives and publications; and the Federal Acquisition Regulations. These laws, directives, and regulations include requirements for safeguarding Federal information systems and PII used in Federal agency business processes, as well as related reporting requirements. The Parties recognize and will implement the laws, regulations, NIST standards, and OMB directives including those published subsequent to the effective date of this Agreement.

FISMA requirements apply to all Federal contractors, organizations, or entities that possess or use Federal information, or that operate, use, or have access to Federal information systems on behalf of an agency. Both Parties are responsible for oversight and compliance of their contractors and agents.

- C. Loss, Potential Loss, Incident Reporting, and Breach Notification. CMS and DoD will comply with OMB reporting guidelines in the event of a loss, potential loss, Security Incident or Breach of PII (see OMB Memorandum M-17-12, Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017)), and the responsibilities and procedures of its own agency breach response plan. The Party experiencing the incident will notify the other Party's System Security Contact named in this Agreement within one (1) hour of discovering the incident. If the Party experiencing the incident is unable to speak with the other Party's System Security Contact within one (1) hour or if for some reason contacting the System Security Contact is not practicable (e.g., outside of normal business hours), then the following contact information shall be used:
- DMDC Privacy Office: [dodhra.dodc-mb.dmdc.list.privacy-office@mail.mil](mailto:dodhra.dodc-mb.dmdc.list.privacy-office@mail.mil)
  - CMS IT Service Desk: 1(800) 562-1963 or [CMS IT Service Desk@cms.hhs.gov](mailto:CMS_IT_Service_Desk@cms.hhs.gov)

The Party that experienced the loss, potential loss, Security Incident, or Breach will be responsible for following its established procedures, including notifying the proper organizations (e.g., United State Computer Emergency Readiness Team (US-CERT)), conducting a breach and risk analysis, and making a determination of the need for notice and/or remediation to individuals affected by the loss. Parties under this agreement will follow PII breach notification policies and related procedures as required by OMB guidelines and the US-CERT Federal Incident Notification Guidelines. If the Party experiencing the breach determines that the risk of harm requires notification to the affected individuals or other remedies that Party will carry out these remedies without cost to the other Party.

- D. Administrative Safeguards: CMS and DoD will restrict access to the matched data and to any data created by the match to only those authorized users of the Hub, e.g., AE and their employees, agents, officials, contractors, etc., who need it to perform their official duties in connection with the uses of data authorized in this Agreement. Further, CMS and DoD will advise all personnel who will have access to the data matched and to any data created by the match of the confidential nature of the data, the safeguards required to protect the data, and the civil and criminal sanctions for noncompliance contained in the applicable Federal laws.

- E. Physical Safeguards: CMS and DoD will store the data matched and any data created by the match in an area that is physically and technologically secure from access by unauthorized persons at all times. Physical safeguards may include, but are not limited to, door locks, card keys, biometric identifiers, etc. Only authorized personnel will transport the data matched and any data created by the match. CMS and DoD will establish appropriate safeguards for such data, as determined by a risk-based assessment of the circumstances involved.
- F. Technical Safeguards: CMS and DoD will process the data matched and any data created by the match under the immediate supervision and control of authorized personnel to protect the confidentiality of the data in such a way that unauthorized persons cannot retrieve any such data by means of computer, remote terminal, or other means. Systems personnel must enter personal identification numbers when accessing data on a party's systems. DoD and CMS will strictly limit authorization to those electronic data areas necessary for the authorized analyst to perform his or her official duties.
- G. Application of Policies and Procedures: The Parties will adopt policies and procedures to ensure that each party uses the information described in this Agreement that is contained in their respective records or obtained from each other solely as provided in this Agreement. CMS and DoD will comply with their respective policies and procedures and any subsequent revisions.
- H. Compliance. CMS must ensure information systems and data exchanged under this matching agreement are maintained compliant with CMS guidance CMS Acceptable Risk Safeguards and Minimum Acceptable Risk Standards for Exchanges - MARS-E) Exchange Reference Architecture Supplement. The MARS-E suite of documents can be found at: <http://www.cms.gov/ccio/resources/regulations-and-guidance/index.html>, under Minimum Acceptable Risk Standards. To the extent, these documents are revised during the term of this Agreement, CMS must ensure compliance with the revised version.

## **X. RECORDS USAGE, DUPLICATION AND DISCLOSURE**

CMS and DoD will comply with the following limitations on use, duplication, and disclosure of the electronic files and data provided by the other party under this Agreement:

- A. CMS and DoD will only use or disclose the data for the purposes described in this Agreement or allowed by applicable SORN or Federal law.
- B. The matching data provided by DoD under this Agreement will remain the property of DoD and will be retained by CMS and AE to be used for audits to verify the accuracy of matches and to adjudicate appeals.
- C. CMS will restrict access to data solely to officers, employees, contractors of CMS and

AE, their officers, employees, and contractors. Through the Hub CMS may disclose the data received under this Agreement to AE pursuant to separate CMA that authorize such entities to use the data for Eligibility Determinations regarding APTC, CSR, and BHP.

- D. CMS FFE and AE will restrict access to the results of the data match to Applicants and Enrollees, application filers, and Authorized Representatives of such persons; and to individuals or entities who have been authorized by CMS and are bound by regulation or are under agreement with CMS or an AE to assist with Eligibility Determinations and enrollment.

## **XI. COMPTROLLER GENERAL ACCESS**

Pursuant to 5 U.S.C. § 552a(o)(1)(K), the Government Accountability Office (Comptroller General) may have access to all CMS and DMDC records, as necessary, in order to verify compliance with this Agreement.

## **XII. REPORT TO CONGRESS AND OMB**

When both the HHS Data Integrity Board (DIB) and the DoD DIB have approved this Agreement, CMS will submit a report of the matching program to Congress and OMB for review, and will provide a copy of such notification to DoD.

## **XIII. REIMBURSEMENT**

Expenses incurred by this data match will not involve any payments or reimbursement between DoD and CMS. Cost adjustments, however, may be made in the future between the parties DoD and CMS may make such adjustments by means of a reimbursable agreement between the parties.

## **XIV. PERSONS TO CONTACT**

A. The DoD contacts are:

1. Project Coordinator

Brian Stroud  
Defense Enrollment Eligibility Reporting System  
Defense Manpower Data Center  
400 Gigling Rd  
Seaside, CA 93955-6771  
Telephone: 831.583.2500 extension 5575  
E-mail: Brian.K.Stroud4.civ@mail.mil

2. Privacy Issues

Samuel M. Peterson  
Privacy/FOIA Branch Chief



Defense Manpower Data Center  
400 Gigling Rd  
Seaside, CA 93955-6771  
Telephone: (831) 583-2400 x4457  
E-mail: Samuel.M.Peterson2.civ@mail.mil

Tori Rodrigues  
Privacy Analyst  
Defense Manpower Data Center  
PM Support  
400 Gigling Rd  
Seaside, CA 93955-6771  
Telephone: (831) 583-2400 x4482  
E-mail: Victoria.W.Rodrigues.ctr@mail.mil

3. Security Issues

Vickie Galante, CISSP  
Information Assurance Officer  
Defense Manpower Data Center  
400 Gigling Rd  
Seaside, CA 93955-6771  
Telephone: (831) 583-2400 x5447  
Victoria.J.Galante.civ@mail.mil

B. The CMS contacts are:

1. Program Issues

Elizabeth Kane  
Director, Verifications Policy and Operations Division  
Eligibility and Enrollment Policy and Operations Group  
Center for Consumer Information and Insurance Oversight Centers for  
Medicaid and Medicare Services  
Telephone: (301) 492-4418  
E-Mail: Elizabeth.Kane@cms.hhs.gov

2. Privacy and Agreement Issues:

Walter Stone, CMS Privacy Act Officer  
Division of Security, Privacy Policy & Governance  
Information Security & Privacy Group  
Office of Information Technology  
Centers for Medicare & Medicaid Services  
Location: N1-14-56  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Telephone: (410) 786-5357  
E-mail: Walter.Stone@cms.hhs.gov

Barbara Demopulos, Privacy Advisor  
Division of Security, Privacy Policy & Governance  
Information Security & Privacy Group  
Office of Information Technology  
Centers for Medicare & Medicaid Services  
Location: N1-14-40  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Telephone: (410) 786-6340  
E- mail: Barbara.Demopulos@cms.hhs.gov

## **XV. DURATION, MODIFICATION, AND TERMINATION**

- A. **Effective Date:** The Effective Date of this Agreement is December 1, 2018, provided that CMS reported the proposal to re-establish this matching agreement to the Congressional committees of jurisdiction and OMB in accordance with 5 U.S.C. § 552a(o)(2)(A) and (r) and OMB Circular A-108 and, upon completion of their advance review period, CMS published notice of the matching program in the Federal Register for a minimum of thirty days as required by 5 U.S.C. 552a(e)(12).
- B. CMS and DoD may, within three (3) months prior to the expiration of this Agreement, renew this Agreement for a period not to exceed twelve (12) months if CMS and DoD certify the following to the HHS DIB:
1. The matching program will be conducted without change; and
  2. The parties have conducted the matching program in compliance with this Agreement.
- C. **Modification:** The Parties may modify this Agreement at any time by a written modification, mutually agreed to by both Parties. The proposed modified Agreement must be reviewed by HHS DIB counsel in OGC to determine if the change is significant and requires a new agreement.
- D. **Termination:** This Agreement may be terminated at any time upon the mutual written consent of the Parties. Either party may unilaterally terminate this agreement upon written notice to the other party, in which case the termination date shall be effective ninety (90) days after the date of the notice or at a later date specified in the notice provided this date does not exceed the approved duration for the agreement. A copy of this notification should be submitted to the Secretary, HHS DIB.

## **XVI. INTEGRATION CLAUSE**

This Agreement constitutes the entire agreement of the parties with respect to its subject matter and supersedes all other data exchange agreements between the Parties that pertain to the disclosure of data between DoD and CMS for the purposes described in this Agreement. The parties have made no representations, warranties, or promises outside of this Agreement.

**XVII. APPROVALS**


**A. Centers for Medicare & Medicaid Services Program Official**

The authorized program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits his or her respective organization to the terms of this Agreement.

<b>Approved by (Signature of Authorized CMS Approving Official)</b>	
Jeffrey Grant Digitally signed by	
Jeffrey Grant –S	
Date: 2018.05.29 23:05:16 -04'00'	
<b>Jeffrey Grant</b> <b>Deputy Director for Operations</b> <b>Center for Consumer Information &amp; Insurance Oversight</b> <b>Centers for Medicare &amp; Medicaid Services</b>	<b>Date:</b>

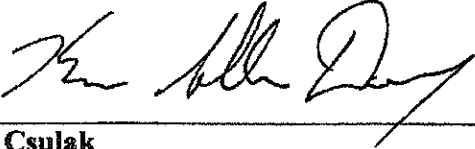
**B. Centers for Medicare & Medicaid Services Program Official**

The authorized program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits the organization to the terms of this Agreement.

Approved by (Signature of Authorized CMS Program Official)	
	
Tim Hill Deputy Director Center for Medicaid and CHIP Services Centers for Medicare & Medicaid Services	Date: 7/18/18

C. Centers for Medicare & Medicaid Services Approving Official

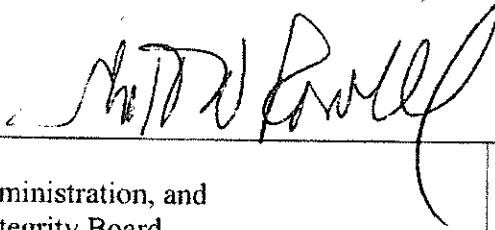
The authorized approving official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits the organization to the t

<b>Approved by (Signature of Authorized CMS Approving Official)</b> 	
<b>For</b> <b>Emery Csulak</b> <b>Information Security and Privacy Group</b> <b>Chief Information Security Officer (CISO)/Senior Official</b> <b>for Privacy</b> <b>Office of Information Technology</b> <b>Centers for Medicare &amp; Medicaid Services</b>	<b>Date:</b>  07/20/2018

D. Data Integrity Board: Department of Health and Human Services

The authorized DIB official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

Approved by (Signature of Authorized HHS DIB Official)



Scott W. Rowell  
Assistant Secretary for Administration, and  
Chairperson, HHS Data Integrity Board  
U.S. Department of Health and Human Services

Date:

10/13/18

E. DMDC Program Official

The authorized program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

Approved By (Signature of Authorized DMDC Approving Official)	
<b>SORRENTO.MICHAEL.V.1</b> <b>399639162</b>	Digitally signed by SORRENTO.MICHAEL.V.1399639162 Date: 2018.10.16 17:22:12 -04'00'
Michael V. Sorrento Director Defense Manpower Data Center Department of Defense	Date:

F. DIB: Department of Defense

The authorized DIB official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

Approved By (Signature of Authorized DoD DIB Official)	
CHUNG.JOO.Y. Digitally signed by 1512306507 CHUNG.JOO.Y.1512306507 Date: 2018.10.22 17:30:27 -04'00'	
Joo Y. Chung Chair Defense Data Integrity Board Department of Defense	Date:



ATTACHMENT 1



**Centers for Medicare and Medicaid Services (CMS)**  
**Marketplace Computer Matching Agreement (CMA)**  
**Cost / Benefit Analysis (CBA)**  
**For the Renewal of Eight Matching Programs in 2018**

Prepared by:

Center of Consumer Information and Insurance Oversight (CCIIO), CMS

Dated January 31, 2018



**COST-BENEFIT ANALYSIS FOR MARKETPLACE MATCHING PROGRAMS  
JANUARY 31, 2018**

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## **COST-BENEFIT ANALYSIS FOR MARKETPLACE MATCHING PROGRAMS JANUARY 31, 2018**

This cost benefit analysis (CBA) provides information about the costs and benefits of conducting the eight Marketplace matching programs, to support re-establishing those matching programs when the current agreements expire in 2018. The CBA demonstrates that monetary costs exceed \$30.5 million, but does not quantify benefits sufficient to offset the costs. However, the CBA describes other benefits (under Key Element 3 and in the “Other Benefits and Mitigating Factors” section following Key Element 4) which justify Data Integrity Board (DIB) approval of the matching programs. As required by the Privacy Act at 5 U.S.C. 552a(u)(4)(B), Section III.B. of this matching agreement requests that the DIB determine, in writing, that a CBA (i.e., cost-effectiveness) is not required to support approval of the agreement and requests that the DIB approve the agreement based on the other stated justifications.

### **I. MATCHING OBJECTIVE**

The objective of the marketplace matching programs is to make initial eligibility determinations, redeterminations and renewals for enrollment in a qualified health plan, insurance affordability programs, and to issue certificates of exemption to individuals who are exempt from the individual mandate to maintain health insurance coverage. For those consumers who request financial assistance, they will be determined eligible for an amount of advanced premium tax credits (APTC) and cost sharing reductions, Medicaid, CHIP or BHP, where applicable. The Exchange and Medicaid/CHIP agencies verify data elements dependent on the eligibility determination they are performing. These may include citizenship or immigration status, household income, access to non-employer-sponsored and/or employer-sponsored minimum essential coverage. Non-employer-sponsored coverage includes coverage through TRICARE, Veteran’s Health Benefits, Medicaid, Medicare, or benefits through service in the Peace Corps. Employer-sponsored coverage for Federal Employee Health Benefits can be verified with the Office of Personnel Management. The matching programs provide a single streamlined process for making accurate and real-time assessments of each applicant’s eligibility and affordable insurance options and ensuring that the consumer can enroll in the correct applicable State health subsidy program<sup>2</sup> or be properly determined to be exempt from needing coverage.

### **MATCHING PROGRAM STRUCTURE**

The Patient Protection and Affordable Care Act, Public Law No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (ACA) requires that each State develop secure electronic interfaces for the exchange of data under a matching program using a single application form for determining eligibility for all State health subsidy programs.

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<sup>2</sup> Section 1413(e) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term “applicable State health subsidy program” means—(1) the program under this title for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402; (2) a State Medicaid program under title XIX of the Social Security Act; (3) a State children’s health insurance program (CHIP) under title XXI of such Act; and (4) a State program under section 1331 establishing qualified basic health plans.

CMS has entered into eight matching agreements with other Federal agencies including Social Security Administration (SSA), Department of Homeland Security (DHS), Internal Revenue Service (IRS), Veterans Health Administration (VHA), Department of Defense (DoD), Office of Personnel Management (OPM), and the Peace Corps. In addition, CMS has developed a matching program that is executed with every State-based Administering Entity (AE)<sup>3</sup> State Medicaid agency and each State-based Marketplace. The Federal Data Services Hub (Hub) was designed to be the centralized platform for the secure electronic interface that connects all State Medicaid agencies, State-based Exchanges and the Federal data sources (TDS or trusted data source).

Without the Hub, each State AE would have to enter into a separate arrangement with each TDS to determine whether applicants for State health subsidy programs are eligible for coverage. If operations related to the matching program were conducted through separate arrangements outside of the Hub, CMS believes the costs to CMS, each TDS, the AEs, and consumers (applicants) would be greater than under the current structure.; Therefore, CMS intends to retain the existing matching program structure when it re-establishes the eight matching agreements, but with changes intended to make the matching programs compatible with the current CMS operations and data flow.

Beginning with the Open Enrollment Period for plan year (PY) 2019, CMS is implementing a program to allow Direct Enrollment (DE) entities (qualified health plan (QHP) issuers and web-brokers) in the Federally-facilitated Exchanges (FFE) and State-based Exchanges on the Federal Platform (SBE-FPs) to integrate an application for Marketplace coverage through the FFE with the standalone eligibility service (SES) to host application and enrollment services on their own website. The SES is a suite of application program interfaces (APIs) that will allow partners to create, update, submit, and ultimately retrieve eligibility results for an application. The Enhanced Direct Enrollment (EDE) pathway will replace the proxy DE pathway that CMS allowed DE entities to use for PY 2018. When using the EDE pathway, a DE entity will provide a full application, enrollment, and post enrollment support experience on its website, and must implement the full EDE application programming interface (API) suite of services.

## **BACKGROUND**

CMS used the following assumptions in development of the cost benefit analysis (CBA):

- Because the ACA mandates use of computer matching and requires a single streamlined application process for consumers, the issue to address in the CBA isn't whether to conduct the matching programs, but how efficiently the matching programs are structured and conducted (i.e., how streamlined the eligibility determination process is for consumers, and whether the structure is less costly than an alternative structure).
- The eight matching programs, when re-established, will use processes currently in place by the source agencies and entities known as the trusted data sources (TDS). The TDSs

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<sup>3</sup> "Administering Entity" or "AE" means a State-based entity administering an Insurance Affordability Program. An AE may be a Medicaid agency, a Children's Health Insurance Program (CHIP), a basic health program (BHP), or a State-based Marketplace (SBM) established under Section 1311 of the ACA.

are IRS, DHS, SSA, OPM, Peace Corps, VHA, DoD, Current Sources of Income, and state based administering entities (AEs). In addition, several contractors provide a variety of support services to the Hub, such as Identity Proofing, trouble shooting, procedure writing, and maintenance support just to name a few.

- Private citizens (as potential beneficiaries) can apply for applicable State health subsidy programs on the basis of the private benefit and cost of applying. The private benefit from applying is the expected value of health insurance coverage (private insurance, Medicaid, CHIP or a Basic Health Plan) obtained through a State-based Exchange or through the Federally-facilitated Exchange in relation to the value of health insurance that could be obtained without the ACA defined American Health Benefit Exchange<sup>4</sup>.
- CMS has internal costs related to the funding of CMS federal staff and associated resources to complete processes and responsibilities related to the matching programs.
- CMS has several internal cost centers that work on the Hub. Within CMS, these centers may be assisted by external contractors. This cost category is organized as an internal cost.
- CMS has external costs in the hiring, maintenance, and associated costs of contractors to perform numerous functions related to the Hub.
- CMS has several external cost factors related to the calculation of cost per transaction between a trusted data source and source agency, and CMS as the recipient agency. The cost of each data transaction is estimated from the prior year's matching program budget and the estimated number of data transactions.
- For the recovery of Improper Payments and Debts (Key Element 4), CMS is not currently utilizing the data match result from the matching programs for payment and debt reconciliations; however, the benefit of the match does provide the potential to implement this capability in the future.
- All annual personnel costs and savings are rounded to the nearest dollar.

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<sup>4</sup> American Health Benefit Exchange is defined @ 1311(b)(1).

## II. COSTS

### A. Key Elements 1 and 2: Personnel Costs and Computer Costs

1. Costs for the recipient and source agencies are primarily personnel costs associated with maintenance and operations supported by information technology resources; therefore, Key Elements 1 and 2 are combined. ***Recipient Agency (CMS) Personnel and Computer Costs - \$30.5 million (Total)***

Costs incurred by CMS for the Hub are estimated to total \$30.5 million (\$30,563,340) per year. That total includes internal costs of CMS staff and resources, and external costs to hire contractors to perform numerous functions related to the Hub, in order to obtain data from the source agencies and make the data available to AEs. It includes a portion of the costs CMS pays for the services described in subsections 1.a. through 1.h. below (not all of those costs have been quantified). It also includes \$9,287,587 for costs CMS reimburses to some of the source federal agencies (TDS).

Cost estimates are based on established definitions and practices for program and policy evaluation.<sup>5</sup> CMS estimated the number of hours for its staff to complete the systems changes based on experience with other systems adjustments of similar magnitude. CMS also collected cost estimates provided by its current contractors for this proposed effort.<sup>6</sup>

#### ***a. Marketplace Security Operations Center (SOC) – \$8.5 million (subtotal)***

The marketplace SOC is responsible for the security operations and maintenance for Healthcare.gov. In total, more than 130 people work in data security; about 100 are contractors and 35-38 are federal employees. One midlevel contractor costs \$150,000 per year and a senior contractor costs \$200,000 per year. On the federal side the most common civil service grade is GS-13, which costs around \$100,000 to \$110,000 per year, not including benefits. The current cost of all Healthcare.gov data security is \$8.5 million per year.<sup>7</sup> The Healthcare.gov data security budget is not itemized by matching program; therefore, the matching program costs to the marketplace SOC are not quantifiable.

<sup>5</sup> E.J. Mishan, *Cost-Benefit Analysis: An Introduction*, New York: Praeger Publishers, 1971. Also see U.S. Office of Management and Budget, OMB Circular No. A-94 Revised, *Guidelines and Discount Rates for Benefit-Cost Analysis of Federal Programs*, October 29, 2002.

<sup>6</sup> For personnel costs, CMS used publicly available wage data from the Bureau of Labor Statistics (BLS: [www.bls.gov/oes/current/oes\\_nat.htm](http://www.bls.gov/oes/current/oes_nat.htm)) for May 2016, which is the most current data available at the time in which this cost benefit analysis was drafted, for Medicare plan and contractor personnel (i.e., third party) rates. To estimate the government staff personnel costs, CMS used the 2017 salary table with locality of pay for the Washington, D.C., Baltimore, MD and Northern Virginia area from the Office of Personnel Management ([www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/DCB\\_h.pdf](http://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/DCB_h.pdf)).

<sup>7</sup> The cost of data security was provided to us by CMS as a lump-sum amount. When we performed independent calculations of federal salaries we used the following information for FY2018.

GS Grade	Hourly Rate	Annual Cost
GS11	\$56.49	\$108,461
GS12	\$67.71	\$130,003
GS13	\$80.52	\$154,598

***b. Exchange Operations Center (XOC) - \$18.4 million (subtotal)***

The Exchange Operations Center (XOC) is an internal group in CMS that manages the Hub contract. XOC’s costs are significant given that the proposed appropriation for exchange operations (not including user fees) in the FY 2018 federal budget was \$18.4 million.<sup>8</sup> At the time of this report we were unable to secure an exact budget amount for the XOC outlay in 2017.

***c. Other CMS Centers - \$1.7 million (subtotal)***

Using information on federal salaries and personnel time devoted to the Hub, we calculated that the direct costs of other CMS centers are \$1,710,400 per year. This information is shown in Table 1:

**Table 1: Direct Costs of Other CMS Centers**

<b>Center</b>	<b>Annual Cost</b>
Eligibility and Enrollment (E&E)	\$658,682
SMIPG (State Policy)	\$278,740
Marketplace Information Technology (MITG/HUB)	\$538,272
Marketplace Information Technology (MITG/STATE)	\$234,707
<b>Total</b>	<b>\$1,710,400</b>

Source: Authors’ calculations based on Federal salaries and benefits applied to personnel time provided by CMS

***d. Hub Support - \$352,940 (subtotal)***

CMS contracts with a support vendor to perform numerous tasks related to the Hub, including writing procedures and standards and general trouble-shooting. Over time, the support contractor’s role has tapered off so they currently have two subcontractors working 25 hours per week and 1 hour per week, respectively, at CMS. The current value of the support contract is approximately \$352,940 per year (\$227 hourly rate with 15 percent overhead, 52 weeks per year).

***e. Hub Operations – Monetary, but not quantified***

CMS contracts with a vendor to provide service-oriented activities for the Hub. We assume that the associated costs are significant given that the original cost of the Hub in

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GS14	\$95.15	\$182,688
GS15	\$111.93	\$214,906

The hourly rate for each GS grade is “fully loaded” (it includes all wages and benefits, such as pay for time not worked). We used 1,920 hours of work time per year to derive the annual cost of each GS grade.

<sup>8</sup> <https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf>, Page 5.

2013<sup>9</sup> was \$55 million. It is likely that the Hub has become more efficient since that time. At the time of this report we were unable to secure an exact budget amount for the Hub operations vendor outlay in 2017.

***f. Marketplace Systems Integrator (MSI) – Monetary, but not quantified***

CMS contracts with a vendor to provide integration support across all FFE systems to include the Hub. We were not able to determine the value of this contract.

***g. Current Sources of Income– Monetary, but not quantified***

The IRS is the primary source of income data to verify eligibility for subsidy programs under the ACA. Despite the importance of these data, they have some limitations. Income reported to the IRS is based on tax filings, therefore; there is a time lag on income verification. Some individuals do not file income tax returns and others have changed their filing status. In contrast, insurance coverage is always prospective. Individuals are asked on their application about their current income, which may not match the retrospective IRS income data.

To overcome the limitations of IRS data, CMS works with a contractor to provide a commercial sources of current income to the FFE and States. While the funding amounts are not publically available they were included in the cost analysis of this project.

***h. Identity-Proofing Services – monetary, but not quantified***

Another consumer credit reporting agency is accessed via the Hub for “remote identity proofing” (RIDP). Even though a person has a form of identification, there needs to be an identity check so SSA knows the person’s identification has been validated. RIDP is typically completed before a person can submit an online application, and while it is not an eligibility requirement it is a way to confirm people are who they say they are.<sup>10</sup> CMS pays a fee per transaction for RIDP, but we did not have access to this information.

***2. Source Federal Agency (TDS) Costs Not Reimbursed by CMS – monetary, but not quantified***

CMS does not reimburse costs incurred by IRS, DoD, and Peace Corps to supply data to the Hub..

(Costs incurred by SSA, DHS, VHA, and OPM are reimbursed by CMS under contracts which charge a total amount per Fiscal Year. The total contract cost for FY2017 is \$9,287,587, which is included in CMS’s costs, in 1.above. That figure is not included here, to avoid double-counting.)

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<sup>9</sup> <https://www.reuters.com/article/usa-healthcare-hiring/insight-it-takes-an-army-tens-of-thousands-of-workers-roll-out-obamacare-idUSL2N0EW28820130621?feedType=RSS&feedName=marketsNews&rpc=43>

<sup>10</sup> T. Shaw and S. Gonzales, “Remote Identity Proofing: Impacts on Access to Health Insurance,” Center on Budget and Policy Priorities, January 7, 2016.



### 3. *State Administering Entity (AE) Costs – monetary, but not quantified*

Any and all personnel and computer costs associated with the matching program with State AE are absorbed by CMS. The costs were not quantifiable.

### 4. *Medicare Drug and Health Plans' Costs*

Any and all personnel and computer costs associated with the matching program with Medicare Drug and Health Plans are absorbed by CMS. The costs were not quantifiable.

### 5. *Client (Applicant) Costs – non-monetary; quantified as \$1.46 billion (\$87.63 per applicant)*

Costs incurred by consumers to shop and then apply for and enroll (or re-enroll) in a qualified health plan each year are time related costs, which are estimated to average 3.965 hours per applicant and \$22.10 per hour, or \$87.63 per applicant per year. Multiplied by the number of enrollees projected for 2018 (approximately 12 million), this totals \$1.46 billion per year. Only approximately 72% of those who start an application actually get marketplace coverage. Time costs for those who shop for but do not apply, and for those who apply but do not enroll, are not counted.

## III. BENEFITS

### A. Key Element 3: Avoidance of Future Improper Payments

#### 1. *Benefits to Agencies – not quantified*

Costs incurred by CMS are Benefits to Agencies:

The Marketplace matching programs' eligibility determinations and eligibility verifications result in improved accuracy of beneficiary eligibility data ensuring that individuals enrolled in Medicaid, are not enrolled in a Qualified Health Plan (QHP). Improved data quality helps ensure that eligibility determinations and other decisions affecting advanced premium tax credits (APTC) affecting are accurate, which helps avoid future improper payments.

The matching programs improve the accuracy of beneficiary eligibility data as follows:

- **Multi-faceted attestation of beneficiary eligibility data.** Using matching data supplied by the eight trusted data sources for attestation in combination with an individual applicant's attestation of his or her personal information is more reliable than relying solely on applicant attestations. Due to the potential and historical presence of identity fraud, the utilization of matching programs minimizes the risk of incorrect personal information being presented and used to make eligibility determinations; therefore, preventing the incorrect dispersal of federal subsidy program benefits.
- **Verification and contest procedures.** The "verification and opportunity to contest findings" requirements specified in the Marketplace matching agreements, which are required by subsection (p) of the Privacy Act (5 USC 552a(p)), also improve data quality, thereby ensuring accurate eligibility determinations and other decisions, and avoiding improper payments. Before an Administering Entity (AE) may take any adverse action based on the information received from the match, the individual must be permitted to provide the necessary information or

documentation to verify eligibility information. When an AE determines that an individual is ineligible for an Insurance Affordability Program based on the information provided through the match, and that information is inconsistent with information provided on the streamlined eligibility application or otherwise by an Applicant or Enrollee, the AE will comply with applicable law and will notify each Applicant, or Enrollee of the match findings and provide the following information: (1) The Administering Entity received information that indicates the individual is ineligible for an Insurance Affordability Program; and (2) the Applicant, or Enrollee has a specified number of days from the date of the notice to contest the determination that the Applicant or Enrollee is not eligible for the relevant Insurance Affordability Programs.

**2. *Benefits to Clients (Applicants who Enroll or Re-Enroll) – quantified as \$45.378 billion***

The approximately 72% of applicants whose eligibility for coverage is determined through these matching programs and who enroll or re-enroll in a qualified health plan will receive a government subsidy (APTC) worth an approximate average of \$3,020 per year per enrollee. Multiplied by the number of enrollees/re-enrollees projected for 2018 (12 million), this subsidy benefit totals \$45.378 billion per year.

**3. *Benefits to the General Public – not quantified***

An efficient application process may contribute to greater numbers of consumers enrolling in qualified health plans. Fewer uninsured patients helps reduce health care costs borne by taxpayers, because patients without insurance coverage might seek treatment in hospital settings for conditions which are less costly to treat in other settings (such as, in a doctor's office) and might delay treatment until their conditions worsen, and require more extensive health care services.

**B. *Key Element 4: Recovery of Improper Payments and Debts – not applicable***

Key Element 4 is not applicable, because data from the Marketplace matching programs is not currently used to identify and recover improper payments and debts, as this is not a primary goal of the matching programs. Annual reconciliation and recovery of improper tax payments are performed by the IRS through a process that is independent of the Marketplace matching programs and other CMS eligibility determination activities. While the Marketplace matching programs could provide for annual and monthly reporting of data by Marketplaces to the IRS and consumers for the purpose of supporting IRS's annual reconciliation, annual and monthly reporting is not currently an activity covered in the IRS-CMS CMA; rather, that information is exchanged between the agencies through Information Exchange Agreements. At most, the data used in the Marketplace matching programs has the future potential benefit of being used in an analytical form, to assist IRS in identifying and/or recovering improper payments and debts.

#### **IV. OTHER BENEFITS AND MITIGATING FACTORS WHICH JUSTIFY THE MATCHING PROGRAMS**

The Marketplace matching programs are required and are not discretionary. The matching programs are an operational dependency of the HUB even if they are not cost-effective.

The current structure of the Marketplace matching programs has been successful for operational needs. It is providing a single streamlined application process for consumers, and is providing accurate adjudication in eligibility determinations and MEC checks, which presumably contribute to increased enrollments in qualified health plans. However, the application process needs to be made more efficient for consumers, because applicants' time costs currently are much larger than the government subsidy per person.

CMS believes the current structure is less duplicative and therefore less costly for CMS, CMS partners, and State AEs, than the alternative structure (requiring each State AE to enter into separate matching arrangements with each TDS). CMS believes separate arrangements would involve:

- More agreements to prepare and administer (there would be one agreement per AE with each TDS, in place of one agreement per AE with CMS, and one agreement per TDS with CMS);
- More TDS data transmissions to effect and secure (there would be one TDS transmission per AE, in place of each single TDS transmission to the Hub);
- More systems to maintain and secure, to store the TDS data (there would be one system per AE, in place of the single, central Hub system); and
- More copies of TDS data to correct when errors are identified (there would be one copy to correct in each AE system, instead of the single copy in the Hub system).

Continuing to use the current matching program structure, which is less costly than the alternative structure and achieves the primary goals of providing a single streamlined application process and accurate eligibility determinations, is expected to increase the public's trust in the participating agencies as stewards of taxpayer dollars.

Modifying the application process when the matching programs are re-established in 2018 to include a phased roll out of enhanced direct enrollment (EDE) will make the application process more efficient for consumers who opt to apply for coverage through third party websites instead of through healthdata.gov. The majority usage of EDE (50%+) by the public, will reduce costs of all Hub programs by at least 20 percent.

#### **V. DETAIL SUPPORTING CMS AND TDS COSTS (FY2018)**

##### **TDS Costs Reimbursed/Not Reimbursed by CMS**

We attempted to determine the cost to each TDS of supplying data to the Hub. However, we were not able to determine these costs except at the Social Security Administration (SSA). Consequently, we analyzed how much CMS paid each TDS for the data transactions.

**Table 2: TDS Costs and Transactions Reimbursed by CMS (FY2018)**

<b>Agency</b>	<b>Contract Cost</b>	<b>Transactions</b>	<b>Cost/Transaction</b>
SSA	\$3,277,205	215,534,872	\$0.01520
DHS	\$3,989,359	8,795,473	\$0.45357
VA	\$2,006,623	90,738,087	N/A
OPM	\$14,400	23,170,916	N/A
Peace Corps	No reimbursement contract	unknown	unknown
IRS	No reimbursement contract	Unknown	unknown
DoD	No reimbursement contract <sup>11</sup>	Unknown	unknown
<b>Total / Total / Average</b>	<b>\$9,287,587</b>	<b>338,239,348</b>	<b>\$0.02746</b>

Source: Authors' calculations applied to data from the Social Security Administration and CMS

*a. Social Security Administration (SSA)*

The SSA is the source of numerous data elements for the Hub: verification of the applicant's name, date of birth, citizenship, Social Security Number (SSN), a binary indicator for incarceration,<sup>12</sup> and Title II income (retirement and disability).

This is accomplished through a reimbursable agreement with CMS valued at \$2,052,087 in FY2017 and estimated at \$3,277,205 in FY2018. The amount is first estimated and then is billed at actual cost on a quarterly basis, so that the total bill at the end of the fiscal year equals SSA's actual cost for that year. For example, the estimated cost for FY2017 was \$2,969,325 versus the actual billed cost of \$2,052,087. If this pattern continues, the actual billed amount in FY2018 will be less than the estimate. Past bills "always" have been less than the estimates, according to a personal communication from SSA.

Because the SSA is a source of numerous data elements for the Hub, it had 215,534,872 transactions in FY2018, the highest volume of transactions from any TDS. This is shown in Table 2 above.

Using the estimated FY2018 cost of the contract, the average cost per transaction with the SSA is about 1.5 cents. We expect that the actual cost per transaction will be less than 1.5 cents when actual FY2018 costs are billed.

We attempted to break down SSA's cost into fixed and variable costs. However, we found that SSA (and other TDSs) does not keep records in that format. Instead, SSA provided a categorical breakdown of the estimated FY2018 cost: \$2,637,758 for systems support, \$637,704 for operations support, and \$1,743 for an annual renewal fee. The last item might be considered as fixed, but it is a very small part of the total cost. Therefore, we considered all of SSA's costs to be variable.

If the SSA were not a Trusted Data Source, CMS believes it would be very difficult to find an alternative data source. For example, self-verification of Social Security Numbers

<sup>11</sup> Although not reimbursed through agreement with CMS, DoD's estimated cost of administering the match is \$605,000.

<sup>12</sup> Individuals in prison are not eligible for ACA benefits.

(SSNs) would invite a high incidence of fraud (e.g., using another person's number). If SSA did not provide information on incarceration, prisons might provide it, but this would be on a voluntary basis. The Department of Justice (DOJ) is also a possible source of information on incarceration, but SSA is not sure how DOJ keeps this information.

***b. Department of Homeland Security (DHS)***

The DHS is the verification source for naturalized and derived citizenship, and immigration status. The total cost of the DHS contract with CMS was \$3,938,359 in FY2018, and there were 8,795,473 transactions. There are standard fees associated with using SAVE. There are up to 3 steps in the SAVE verification process: Step 1 is a real-time "ping" to their system. Consumers who could not be successfully verified may go to Step 2, which takes 3-5 federal working days in which a Status Verifier conducts additional database research on the data entered by the agency representative. Step 3 requires submission of electronic copies of the applicant's immigration documents. Upon receipt of this documentation, a Status Verifier researches the data and documentation and verifies status.

***c. Veterans Health Administration (VHA)***

The VHA contract with CMS is transactions-based, but the formula is not transparent. The cost of the VHA contract was \$2,006,623 in FY2018. There were 90,738,087 transactions, for an average cost of approximately 2.2 cents.

***d. Office of Personnel Management***

OPM charges a flat fee of \$14,400 per year for the development and submission of an Annual Premium Index File which is used to calculate affordability when a consumer is found to be in the monthly enrollment file.

***e. Other Trusted Data Sources***

CMS does not pay the other Trusted Data Sources (IRS, DoD, and Peace Corps). Clearly, these agencies incur costs of providing the data, but we were not able to quantify these subsidies.

## **VI. CONCLUSION**

For the Hub to provide a net benefit, it must provide incremental benefits that exceed the incremental costs of using the Hub. The principal question of this analysis is whether the net benefit would be positive, negative, or neutral and what incentive is provided by each combination. Our analysis finds the estimated net benefit of the Hub in 2017 is \$45.378 billion. This assumes 12 million people using the Hub. Further, we find that the net benefit will be larger as more people use the Hub.

One of the major policy considerations is whether any of the proposed changes to the ACA would impact the costs and benefits of the Hub. Our analysis suggests that the benefits outweigh the costs of the Hub given the increase in private insurance coverage through the ACA.

Policy reforms already signed into law will impact the CBA results. For example, the 2017 tax reform legislation includes a provision that will repeal the individual mandate in 2019. This will have an impact on the demand for health insurance and, as a consequence, on our CBA analysis. The subsequent appendices provide further detail on the marketplace matching program benefits, including an analysis of the planned EDE program and the net benefit analysis and justification of costs.

## **VII. APPENDIX A: DETAILS SUPPORTING OTHER BENEFITS AND MITIGATING FACTORS – THE FUTURE STATE OF EDE AND MARKETPLACE**

CMS has released data on the number of people who have enrolled in plans for 2018 coverage in the 39 state exchanges that use the HealthCare.gov platform. As of December 15, 2017, 8,822,329 people had made plan selections.<sup>13</sup> The total tally of enrollment, including states that use their own platforms, was not available at the time of this report. Many of the state-based marketplaces are still running open enrollment. Charles Gaba of ACASignups.net has run his own operation to verify enrollment levels in state-based marketplaces and estimates that total enrollment will reach at least 11.6 million and possibly 12 million people in 2018.<sup>14</sup>

If we assume marketplace enrollment of 12 million and a conversion ratio of 72 percent (see footnote 20), we can solve for the number of people who begin an application:  $12,000,000/0.72 = 16,666,667$ . If each of these people “spends” \$87.63 in applying, the total time cost of Hub users is \$1.46 billion.<sup>15</sup>

While CMS will place a number of restrictions on the proxy direct enrollment process to “...minimize risk to HealthCare.gov functionality and of eligibility inaccuracies,” it eliminates “...the currently required consumer-facing redirect with Security Assertion Markup Language (SAML) for all individual market enrollment transactions for coverage offered through the Federally-facilitated Exchanges (FfEs) and State-Based Exchanges on the Federal Platform (SBE-FPs) that rely on HealthCare.gov for individual market eligibility and enrollment functions.” This change will shorten the time necessary for consumers to set up accounts on the Exchanges and allow agents, including health insurers and brokers, who are assisting consumers, to collect consumer information on 3<sup>rd</sup> party websites and input that information directly into HealthCare.gov.

Both of these changes have the potential to change the results, and possibly the conclusions, of our cost-benefit analysis presented in the previous sections. The elimination of consumer-facing redirect with SAML will provide an immediate reduction in the shopping enrollment time for all consumers – both those using the traditional exchanges and those using the new direct enrollment process. We currently have no

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<sup>13</sup> Centers for Medicare and Medicaid Services, “Weekly Enrollment Snapshot: Week Seven,” December 21, 2017; available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-21.html>.

<sup>14</sup> Charles Gaba, ACASignups.net; available at <http://acasignups.net/17/12/21/multiple-updates-hey-trump-repeal-116m-qhps-confirmed-likely-120m-when-dust-settles>.

<sup>15</sup> People who start an application but fail to complete it may spend more or less time than those who complete the application. We do not have data to make this adjustment.

estimate of the shopping enrollment time savings because of this change but it is not inconsequential. Even a 10 minute reduction results in a 4% reduction in opportunity cost. However, as noted above, this change applies to both pathways equally and simply reduces the opportunity cost of all consumers regardless of pathway.

Unlike the elimination of the SAML requirement, the ability to input data directly into HealthCare.gov through 3<sup>rd</sup> party websites poses a possible asymmetry. Information gathered by the authors' suggests that 3<sup>rd</sup> party sites may yield a reduction of 30 percent or more in shopping enrollment time compared with using HealthCare.gov.

Using the results presented in the previous sections of this report we simulated the effect of this change on the consumers' opportunity cost. We modeled a 5, 10 and 15 minute reduction in shopping enrollment time due to the elimination of the SAML requirement. In this simulation we do not distinguish between the HealthCare.gov site and 3<sup>rd</sup> party sites because either could be more efficient in terms of the time a consumer spends on the site. Results are shown in Table 6.

**Table 6: Consumer Opportunity Cost by Reductions in Shopping Enrollment Time**

Current Opportunity Cost						\$87.63
	% Reduction in Shopping Enrollment Time Due to Increase in Web Site Efficiency					
	20%	25%	30%	35%	40%	Current State of Affairs
5 min*	\$70.46	\$66.16	\$61.87	\$57.57	\$53.28	\$85.87
10 min*	\$70.81	\$66.60	\$62.39	\$58.19	\$53.98	\$84.12
15 min*	\$71.16	\$67.04	\$62.92	\$58.80	\$54.68	\$82.37

\* Minutes reduced from elimination of SAML requirement

Recall that our model currently estimates a per person opportunity cost of \$87.63 or \$1.46 billion for all Hub users. Following the same approach as before – assuming marketplace enrollment of 12 million and a conversion ratio of 72 percent (see footnote 20) – we calculated the total time cost of Hub users under the time savings shown in Table 6. These results appear in Table 7.

**Table 7: Total Opportunity Cost by Reductions in Shopping Enrollment Time**

Total Current Opportunity Cost (in billions)						\$ 1.46
Total Opportunity Cost due to Web Site Efficiencies (in billions)						
	20%	25%	30%	35%	40%	Current State of Affairs
5 min*	\$ 17.17	\$ 21.47	\$ 25.76	\$ 30.06	\$ 34.35	\$ 1.43
10 min*	\$ 16.82	\$ 21.03	\$ 25.24	\$ 29.44	\$ 33.65	\$ 1.40
15 min*	\$ 16.47	\$ 20.59	\$ 24.71	\$ 28.83	\$ 32.95	\$ 1.37

\* Minutes reduced from elimination of SAML requirement

There are at least two pertinent indirect effects of these changes that could affect our cost-benefit results. Both are related to the effect of differential migration of consumers to 3<sup>rd</sup> party web sites. The first is based on the observation that 3<sup>rd</sup> party web sites might be more efficient, and therefore less costly in terms of shopping enrollment time. This would lower the consumer's opportunity costs. Below we examine both the marginal effect of differential enrollment and the extreme case of total migration to 3<sup>rd</sup> party web sites.

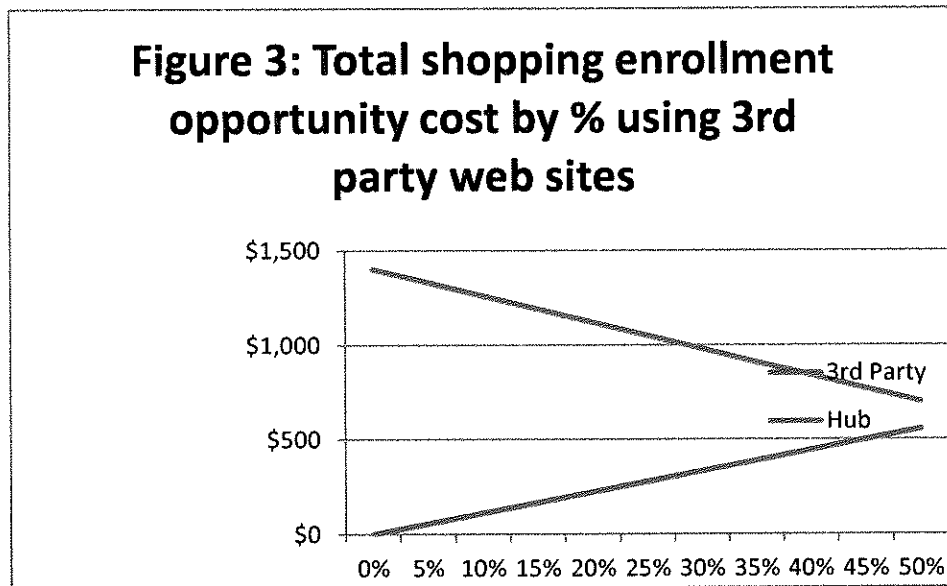
To estimate the total consumer opportunity cost due to differential migration to 3<sup>rd</sup> party web sites, we assumed a 10% reduction in shopping enrollment time due to the removal of the SAML requirement and a subsequent 25% reduction in shopping enrollment time for those using 3<sup>rd</sup> party web sites. We assumed that the exchange sites saw no changes except for the removal of the SAML requirement. We examined various proportions of consumers using 3<sup>rd</sup> party web sites and compared the savings in total opportunity costs. The results are shown in Table 8 and convergence is illustrated in Figure 3.

**Table 8: Total Shopping Enrollment Time Opportunity Cost by % Using 3rd Party Web Sites**

% using 3rd Party Web Site	Shopping Time Opportunity Costs (in millions)			% Reduction in Opportunity Costs
	3rd Party Web Site	Hub	Total	
0%	\$ -	\$ 1,402	\$ 1,402	
5%	\$ 55	\$ 1,332	\$ 1,387	1.0%
10%	\$ 111	\$ 1,262	\$ 1,373	2.1%
15%	\$ 166	\$ 1,192	\$ 1,358	3.1%
20%	\$ 222	\$ 1,122	\$ 1,344	4.2%
25%	\$ 277	\$ 1,052	\$ 1,329	5.2%
30%	\$ 333	\$ 981	\$ 1,314	6.2%
35%	\$ 388	\$ 911	\$ 1,300	7.3%
40%	\$ 444	\$ 841	\$ 1,285	8.3%
45%	\$ 499	\$ 771	\$ 1,271	9.4%
50%	\$ 555	\$ 701	\$ 1,256	10.4%



At 100% use of 3<sup>rd</sup> party web sites the total opportunity costs is reduced by 21% or \$292 million.



The second indirect effect of a decrease in shopping costs is that the *total* cost of private insurance in the ACA marketplaces will decrease. This will increase the demand for marketplace coverage, both under current law and under alternative scenarios considered in a following section of our report. As the migration to less expensive 3<sup>rd</sup> party web sites increases, the second indirect demand effect will be larger. This effect can be modeled with reasonable confidence and will be included in our 10-year analysis of marketplace enrollment under current law and alternative scenarios.

There appears to be a tendency for those at lower income levels to use guides/navigators and to complete enrollment at higher rates than the population as a whole. Sommers and his colleagues report an 87.3 percent rate of enrollment for a sample of low income individuals in three states with 38 percent receiving assistance from a navigator or social worker (see footnote 20). At this time, it is unclear how the latter will affect migration to navigators/brokers and health issuers who use 3<sup>rd</sup> party web sites, but it is clear that higher rates of completion due to lower opportunity costs could have an impact on our base model, especially through increased use of tax credits and CSR payments. Neither of these effects can currently be estimated with any reasonable level of confidence.

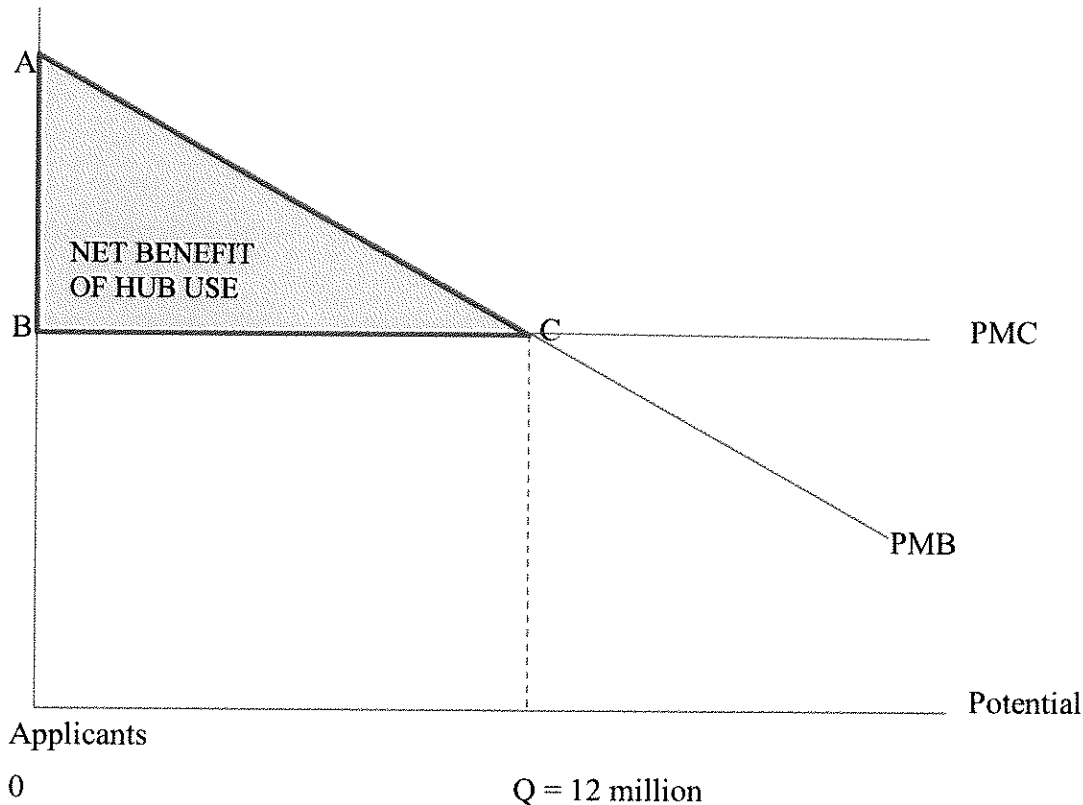
**VIII. APPENDIX B: DETAILS SUPPORTING OTHER BENEFITS AND MITIGATING FACTORS – THE NET BENEFIT OF HUB USE**

In the previous section, we concluded that the social marginal costs of using the Hub exceed the private marginal costs, but not by a large amount. Furthermore, we are not able to quantify the external benefits of using the Hub (i.e., avoidance of future improper payments and recovery of improper payments and debt). This means that the net benefit of Hub use will be determined where the private marginal benefits (PMB) and private marginal costs (PMC) are equal, at an enrollment of 12 million people.

This cost-benefit model resembles Figure 4. Area 0BCQ is the cost of using the Hub for those who get covered, which we estimate as \$87.63 x 12 million people = \$1,051,560,000.

The net benefit of the Hub is area ABC. To account for the time cost of people who start the application process but do not get covered, we will subtract  $\$87.63 \times 4,666,667$  people =  $\$408,940,029$  from the net benefit.

### Marginal Benefits and Costs



**Figure 4: Revised Net Benefit of Hub Use**

The size of the net benefit depends on how the demand for insurance responds to the price of coverage. Inelastic demand (less price-responsiveness) implies that the net benefit is larger, and *vice versa*. According to our calculations, the demand for insurance is relatively inelastic and the net benefit is large. Table 9 shows the net benefit of using the Hub to obtain insurance by income class:

**Table 9: Net Benefit of Hub Use by Income Class**

Income (FPL)	Net Benefit per Person in 2017\$	% of Individuals with 2017 Plan Selection through the Marketplaces in States using HealthCare.gov	Net Benefit in \$1,000,000\$
<100%	\$3,547	3	\$1,277
100% to 200%	\$3,019	56	\$20,290
200% to 300%	\$5,811	22	\$15,342
300% to 400%	\$4,645	9	\$5,017
>400%	\$2,877	10	\$3,452
<b>Total</b>		<b>100</b>	<b>\$45,378</b>

Source: Authors' calculations assuming 12 million people have marketplace coverage

The average net benefit per person of marketplace coverage ranges from \$2,877 (>400% of poverty) to \$5,811 (200% to 300% of poverty). Assuming that 12 million people obtain marketplace coverage, we estimate that the total net benefit in 2017 is \$45.378 billion. This value dwarfs the cost of using the hub and the cost of those who start an application but do not get covered.