COMPUTER MATCHING AGREEMENT
BETWEEN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
SOCIAL SECURITY ADMINISTRATION
FOR
DETERMINING ENROLLMENT OR ELIGIBILITY
FOR
INSURANCE AFFORDABILITY PROGRAMS UNDER
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Centers for Medicare & Medicaid Services No. 2018-12
Department of Health and Human Services No. 1803
The Social Security Administration No. 1097

I. PURPOSE, LEGAL AUTHORITY, DEFINITIONS, AND RESPONSIBILITIES OF THE PARTIES

A. Purpose

This computer matching agreement (agreement) establishes the terms, conditions, safeguards, and procedures under which the Social Security Administration (SSA) will disclose information to the Centers for Medicare & Medicaid Services (CMS) in connection with the administration of Insurance Affordability Programs under the Patient Protection and Affordable Care Act (Public Law (Pub. L.) No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (collectively, ACA) and its implementing regulations. CMS will use SSA data to make initial Eligibility Determinations for eligibility to enroll in a Qualified Health Plan (QHP) through an Exchange established under ACA; eligibility for Insurance Affordability Programs and for certifications of Exemption; and eligibility Redeterminations and Renewal decisions, including appeal determinations, for enrollment in a QHP through an Exchange and Insurance Affordability Programs and for certifications of Exemption. Insurance Affordability Programs include:

1. Advance payments of the premium tax credit (APTC) and cost sharing reductions (CSR),
2. Medicaid,
3. Children's Health Insurance Program (CHIP), and
4. Basic Health Program (BHP).

As set forth in this agreement, SSA will provide CMS with the following information when relevant: (1) Social Security number (SSN) verifications, (2) a death indicator,

(3) a Title II disability indicator, (4) prisoner data, (5) monthly and annual Social Security benefit information under Title II of the Social Security Act (Act) (Title II income), (6) Quarters of Coverage (QC), and (7) confirmation that an allegation of citizenship is consistent with SSA records.

The terms and conditions of this agreement will be carried out by authorized employees and contractors of CMS and SSA.

B. Legal/Statutory Authority

This agreement is executed in compliance with the Privacy Act of 1974 (5 United States Code (U.S.C.) § 552a), as amended; ACA; the Act; the Federal Information Security Management Act (FISMA), as amended by the Federal Information Security Modernization Act of 2014 (Pub. L. 113-283), and the regulations and guidance promulgated thereunder; Office of Management and Budget (OMB) Circular A-130, Managing Information as a Strategic Resource, published at 81 Federal Register (Fed. Reg.) 49,689 (July 28, 2016); and OMB guidelines pertaining to computer matching published at 54 Fed. Reg. 25818 (June 19, 1989).

The following statutes provide legal authority for the uses, including disclosures, under this agreement:

1. Section 1411(a) of ACA requires the Secretary of the Department of Health and Human Services (HHS) to establish a program meeting the requirements of ACA to determine eligibility for enrollment in coverage under a QHP through an Exchange or certain Insurance Affordability Programs, and for certifications of Exemption. Pursuant to section 1311(d)(4)(H) of ACA, an Exchange, subject to section 1411 of ACA, must grant a certification attesting that an individual is exempt from the individual responsibility requirement or penalty imposed by section 5000A of the Internal Revenue Code (IRC). Under section 1411(c) of ACA, the Secretary of HHS shall submit certain identifying information and SSNs to the Commissioner of Social Security for a determination as to whether the information provided is consistent with the information in the records of SSA. Under section 1411(d) of ACA, the Secretary of HHS is directed to establish a system for the verification of other information necessary to make an Eligibility Determination. Section 1411(e)(1) of ACA directs recipients of the information transmitted by the Secretary of HHS to respond to the request(s) for verification in connection with that information. The Secretary of HHS has developed and implemented portions of this program through regulations at 45 C.F.R. Part 155.

2. Section 1413(a) of ACA requires the Secretary of HHS to establish a system under which individuals may apply for enrollment in, and receive an Eligibility Determination for participation in Insurance Affordability Programs or enrollment in a QHP through an Exchange. Section 1413(c) of ACA directs the use of a secure electronic system for transmitting information to determine eligibility for Insurance Affordability Programs and enrollment in a QHP through an Exchange and section 1413(d) of ACA authorizes the Secretary of HHS to enter into agreements to

share data under section 1413. The program established by the Secretary under 1413 of ACA also provides for the Secretary of HHS to transmit information to the Commissioner of Social Security for verification purposes for periodic Redeterminations and Renewals of Eligibility Determinations under certain circumstances. The Secretary of HHS has developed and implemented portions of this program through regulations at 42 C.F.R. §§ 435.948, 435.949, and 457.380.

3. Section 1411(c)(4) of ACA requires HHS (herein after CMS) and SSA to use an online system or a system otherwise involving electronic exchange.

4. Section 205(r)(3) of the Act permits SSA to disclose, on a reimbursable basis, death status indicator information to a Federal agency or State agency that administers a federally-funded benefit other than pursuant to the Act to ensure proper payment of such benefit. Section 7213 of the Intelligence Reform and Terrorism Prevention Act of 2004 provides SSA authority to add a death indicator to verification routines that the agency determines to be appropriate.

5. Sections 202(x)(3)(B)(iv) and 1611(e)(1)(I)(iii) of the Act permit SSA to disclose, on a reimbursable basis, prisoner information to an agency administering a Federal or federally-assisted cash, food, or medical assistance program for eligibility and other administrative purposes under such program.

6. Section 1106(b) of the Act authorizes SSA to disclose SSA information so long as the disclosure is legally authorized and the recipient agency agrees to pay for the information requested in such amount, if any (not exceeding the cost of furnishing the information), as may be determined by the Commissioner of Social Security.

7. Section 1411(f)(1) of ACA requires the Secretary of HHS, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security to establish procedures for re-determining eligibility on a periodic basis in appropriate circumstances.

8. Section 1411(f)(1) of ACA requires the Secretary of HHS to establish procedures for the periodic redetermination of eligibility for enrollment in a QHP through an Exchange, APTC, CSRs, and certifications of Exemption. Under the authority of sections 1311, 1321, and 1411 of ACA, the Secretary of HHS adopted regulations – 45 C.F.R. §§ 155.330 and 155.335 – which further address the requirements for an Exchange to re-determine eligibility for enrollment in a QHP through an Exchange and for APTC and CSRs during the benefit year based on certain types of changes in circumstances, as well as on an annual basis. Pursuant to 45 C.F.R. § 155.620, an Exchange must re-determine an individual's eligibility for a certification of Exemption, except for the certification of Exemption described in 45 C.F.R. § 155.605(g)(2), when it receives new information from the individual. Pursuant to 42 C.F.R. §§ 435.916 and 457.343, State agencies administering Medicaid and CHIP programs must also periodically review eligibility and renew determinations of eligibility for Medicaid and CHIP beneficiaries.

9. Section 1943(b)(3) of the Act (as added by section 2201 of ACA) requires that Medicaid and CHIP agencies utilize the same streamlined enrollment system and secure electronic interface established under section 1413 of ACA to verify data and determine eligibility.

10. Section 1331 of ACA provides the authority for the BHP. Section 1331 provides that an eligible individual in the BHP is one whose income is in a certain range and who is not eligible to enroll in Medicaid for essential health benefits, nor for minimum essential coverage (as defined in section 5000A(f) of the IRC of 1986) nor for affordable employer-sponsored insurance. 42 C.F.R. § 600.300 requires BHPs to establish mechanisms and procedures to maximize coordination with the Exchange, Medicaid, and CHIP. It further requires agencies administering BHPs to establish and maintain processes to make income eligibility determinations using modified adjusted gross income, and to ensure that applications received by the agency result in eligibility assessments or determinations for those other programs. It further requires the agency administering the BHP to participate in the secure exchange of information with agencies administering other Insurance Affordability Programs.

11. The Privacy Act, 5 U.S.C. § 552a(b)(3), authorizes a Federal agency to disclose information about an individual that is maintained by an agency in an agency system of records, without the prior written consent of the individual, when such disclosure is pursuant to a routine use. SSA and CMS have routine uses in their respective systems of records to authorize their disclosures under this agreement.

C. Definitions

1. "ACA" means Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (collectively, ACA);
2. "Advance Payments of the Premium Tax Credit" or "APTC" means payment of the tax credits specified in section 36B of the IRC (as added by section 1401 of ACA), which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of ACA;
3. "Applicant" means an individual seeking enrollment in a QHP through an Exchange, eligibility for himself or herself in an Insurance Affordability Program, or an Exemption; this term includes individuals whose eligibility is determined at the time of a Renewal or Redetermination;
4. "Application Filers" means an Applicant, an adult who is in the Applicant's household (as defined in 42 C.F.R. § 435.603(f)), or family (as defined in 26 C.F.R. § 1.36B-1(d)), an Authorized Representative of an Applicant, or if the

Applicant is a minor or incapacitated, someone acting responsibly for an Applicant, excluding those individuals seeking eligibility for an Exemption;

5. "Authorized User" means an information system user who is provided with access privileges to any data resulting from this match or to any data created as a result of this match;

6. "Basic Health Program" or "BHP" means an optional State program established under section 1331 of ACA;

7. "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 (PII); or (2) an Authorized User accesses or potentially accesses PII for an other than authorized purpose;

8. "Children's Health Insurance Program" or "CHIP" means the State program established under Title XXI of the Act;

9. "CMS" means the Centers for Medicare & Medicaid Services;

10. "Eligibility Determination" means the determination of eligibility for enrollment in a QHP through an Exchange, Insurance Affordability Program, or Exemption, and includes the process of resolving an appeal of an Eligibility Determination;

11. "Exchange" means a State-based Exchange (including a not-for-profit exchange) or a Federally-Facilitated Exchange (FFE) established under sections 1311(b), 1311(d)(1), or 1321(c)(1) of ACA;

12. "Exemption" means an exemption from the requirement or penalty imposed by section 5000A of the IRC; pursuant to section 1311(d)(4)(H) of ACA, an Exchange, subject to section 1411 of ACA, must grant a certification attesting that an individual is exempt from the individual responsibility requirement or penalty imposed by section 5000A of the IRC;

13. "HHS" means the Department of Health and Human Services;

14. "Incident" is defined by OMB M-17-12 (Jan. 3, 2017), and means 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;

15. "Insurance Affordability Program" means a program that is one of the following: (1) a State Medicaid program under Title XIX of the Act; (2) a State CHIP under Title XXI of such Act; (3) a State BHP established under section 1331 of ACA; (4) a program that makes coverage in a QHP through the Exchange with APTC; or (5) a program that makes available coverage in a QHP through the Exchange with cost-sharing reductions;

16. "Matching Program" means any computerized comparison of two or more automated systems of records or a system of records with non-Federal records for the purpose of

establishing or verifying eligibility, or compliance with statutory and regulatory requirements, for payments under Federal benefit programs, or for the purpose of recouping payments or delinquent debts under Federal benefit programs;

17. "Personally Identifiable Information" or "PII" is defined by OMB M-17-12 (January 3, 2017), and means information which can be used to distinguish or trace an individual's identity, such as name, SSN, biometric records, etc., alone, or when combined with other information that is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.;
18. "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 the C.F.R. issued or recognized by each Exchange through which such plan is offered in accordance with the process described in 45 C.F.R. § 155 subpart K;
19. "Quarter of Coverage" or "QC" is the basic unit of Social Security coverage used in determining a worker's insured status. SSA will credit an individual with QCs based on his/her earnings covered under Social Security;
20. "Redetermination" means the process by which an Exchange determines eligibility for enrollment in a QHP and/or for an Insurance Affordability Program or certification of Exemption for an enrollee in one of two circumstances: (1) on an annual basis prior to or during open enrollment; and/or (2) when an individual communicates an update to an Exchange that indicates a change to the individual's circumstances affecting his/her eligibility;
21. "Relevant Individual" means any individual listed by name and SSN on an application for enrollment in a QHP through an Exchange, an Insurance Affordability Program, or for an Exemption whose PII may bear upon a determination of the eligibility of an individual for enrollment in a QHP and/or for an Insurance Affordability Program or certification of Exemption;
22. "Renewal" means the annual process by which the eligibility of Medicaid and CHIP beneficiaries is reviewed for continuation of coverage;
23. "Routine Use" means an exception to the Privacy Act that allows government agencies to disclose record(s) (such as to another agency) in cases in which the use of such record is compatible with the purpose for which it was initially collected;
24. "SSA" means the Social Security Administration;
25. "System of Records" 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.

D. Responsibilities of the Parties

1. CMS's Responsibilities

   a. Pursuant to sections 1411 and 1413 of ACA, CMS will develop procedures to transmit information to SSA.

b. CMS will only request data from SSA's records when necessary to make an Eligibility Determination, or for use in a Redetermination or a Renewal.

c. CMS will provide the required data elements necessary and agreed upon when requesting data from SSA, including but not limited to: first and last name, date of birth, and SSN.

d. CMS will use the information disclosed by SSA for the purposes set forth in this agreement.

e. CMS will ensure its use of the information SSA provides is in accordance with the Privacy Act, 5 U.S.C. § 552a, and Federal law.

f. CMS will provide Congress and OMB with notice of this Matching Program, and notice of any modification of this Matching Program, and will publish the required matching notices in the Federal. Register.

g. CMS will reimburse SSA for the costs associated with SSA's performance of this agreement pursuant to a separately executed interagency agreement.

h. CMS will ensure the SSA-provided monthly and annual Title II benefit income information, and any information regarding detailed QC, will only be displayed when the written consent of the subject individual has been obtained during the application, Eligibility Determination, Redetermination, Renewal, or Exemption determination processes, including any related appeals processes.

i. When both the HHS Data Integrity Board (DIB) and the SSA DIB approve 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 SSA.

2. SSA's Responsibility

SSA will provide the required data necessary and agreed upon when transmitting a service response to CMS for Eligibility Determinations, Redeterminations, and Renewals.

II. JUSTIFICATION AND ANTICIPATED RESULTS

A. Cost Benefit Analysis

As required by § 552a(u)(4) of the Privacy Act, a cost benefit analysis (CBA) is included as Attachment A, 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

Even though the Marketplace matching programs are not intended to be cost-effective, ample justification exists in the CBA sections III (Benefits) and IV (Other Benefits and Mitigating Factors) to justify DIB approval of the matching programs. As required by the Privacy Act at 5 U.S.C. § 552a(u)(4)(B), each party's DIB is requested to determine, in writing, that a CBA for an existing CMA is required. The Act does not require the showing of a favorable ratio for the match to be continued, only that an analysis be done. The intention is to provide Congress with information to help evaluate the effectiveness of statutory matching requirements with a view to revising or eliminating them where appropriate. Therefore, each party's DIB acknowledge that the only quantified benefits are cost savings achieved by using the existing matching program instead of a manual process for eligibility verifications and to approve the agreement based on these other stated justifications:

a. Certain Marketplace matching programs are required and are not discretionary. However, some Marketplace matching programs are based on SSA's permissive routine use disclosure authority, not a statutory obligation.
b. The Marketplace matching programs' eligibility determinations and MEC checks result in improved accuracy of consumer eligibility, which CMS anticipates will continue to produce expedited Eligibility Determinations while minimizing administrative burdens and achieve operational efficiencies.
c. The matching programs provide a significant net benefit to the public by accurately determining eligibility for the advanced payment of the premium tax credit (APTC).
d. 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.
e. 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. However, the execution of the marketplace matching programs is mandated by statute and regulation. 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.

CMS estimates that the cost of operating this computer match with SSA was about $30.5 million ($30,563,340) per year. CMS's analysis suggests that the benefits outweigh the costs given the increase in private insurance coverage through the ACA.

III. RECORDS DESCRIPTION

CMS and SSA have published relevant Systems of Record Notices (SORN) that cover this data matching exchange. CMS and SSA will maintain data obtained through this agreement in accordance with the Privacy Act and SORN requirements.

SSA's SORNs that are applicable to this exchange have routine uses to provide the information covered by this agreement to CMS for use in Eligibility Determinations, Redeterminations, and Renewals. Upon disclosure of information from SSA to CMS, CMS is responsible for ensuring its uses and disclosures of the information comply with the Privacy Act, OMB guidance relevant to Matching Programs, and applicable Federal law.

A. Systems of Records

1. The CMS SORN that supports this data Matching Program is the CMS Health Insurance Exchanges System (HIX), CMS System No. 09-70-0560, as amended, published at 78 Fed. Reg. 8538 (Feb. 6, 2013), 78 Fed. Reg. 32256 (May 29, 2013), and 78 Fed. Reg. 63211 (Oct. 23, 2013). CMS will use a streamlined application to administer the ACA application process and to obtain Applicant information. Consult this SORN for information about CMS's authority to collect and maintain information, categories of individuals covered, and CMS uses of the information.

2. The SSA SORNs listed below have routine use provisions under which SSA will disclose information to CMS for purposes of Eligibility Determinations, Redeterminations, and Renewals.

    a. Master Files of SSN Holders and SSN Applications, 60-0058, 75 Fed. Reg. 82121 (December 29, 2010), as amended 78 Fed. Reg. 40542 (July 5, 2013) and 79 Fed. Reg. 8780 (February 13, 2014);

    b. Prisoner Update Processing System (PUPS), 60-0269, 64 Fed. Reg. 11076 (March 8, 1999), as amended 72 Fed. Reg. 69723 (December 10, 2007) and 78 Fed. Reg. 40542 (July 5, 2013);

    c. Master Beneficiary Record, 60-0090, 71 Fed. Reg. 1826 (January 11, 2006), as amended 72 Fed. Reg. 69723 (December 10, 2007) and 78 Fed. Reg. 40542 (July 5, 2013);

    d. Earnings Recording and Self-Employment Income System, 60-0059, 71 Fed. Reg. 1819 (January 11, 2006), as amended 78 Fed. Reg. 40542 (July 5, 2013).

B. Number of Records Involved

The following table provides the base estimates for the total number of transactions in fiscal year (FY) 2018 and FY 2019, as well as the number of transactions in the estimated highest month within each of those years. These estimates use current business assumptions, as well as historical transaction data. These estimates are subject to change as business assumptions or estimates are updated and/or refined.

	FY 2018 Total	FY 2018 Highest Month	FY 2019 Total	FY 2019 Highest Month
Real-time	178,130,105	38,824,778	177,271,595	38,747,942
Batch	37,404,766	4,515,424	36,917,788	4,534,384

C. Specified Data Elements Used in the Match

Applicants for enrollment in a QHP through an Exchange, Insurance Affordability Program, and certifications for Exemption are only required to provide information strictly necessary to authenticate identity, determine eligibility, and determine the amount of an APTC or CSRs. Accordingly, CMS will request a limited amount of SSA information for purposes of ACA Eligibility Determinations, Redeterminations, and Renewals.

1. For each Applicant and for Relevant Individuals, CMS will submit a request file to SSA that contains the following mandatory specified data elements in a fixed record format: last name, first name, date of birth, SSN, and citizenship indicator.

2. For each Applicant, SSA will provide CMS with a response file in a fixed record format. Depending on CMS's request, SSA's response may include the following data elements: last name, first name, date of birth, death indicator, disability indicator, prisoner information, Title II (annual and monthly) income information, and confirmation of attestations of citizenship status and SSN. SSA may also provide QC data when CMS requests it.

3. For Relevant Individuals, CMS will request a limited amount of SSA information. Based on CMS's request, SSA will verify a Relevant Individual's SSN with a death indicator and may provide a Relevant Individual's QC data or Title II (annual and monthly) income information. CMS will not request citizenship or immigration status data for a Relevant Individual.

4. For Renewals and Redeterminations, CMS will request and SSA will verify SSNs with a death indicator, disclose Title II income information, and provide the disability indicator.

5. For self-reported Redeterminations, CMS will provide SSA with the following: updated or new information reported by the enrollee or enrolled individual, last name, first name, date of birth, and SSN. Depending on CMS's request, SSA's response will include each of the following data elements that are relevant and responsive to CMS's request: last name, first name, date of birth, death indicator, disability indicator, prisoner information, Title II (annual and monthly) income information, and confirmation of new attestations of citizenship status, verification of SSN, and QC data.

6. For Individuals seeking an Exemption, CMS will provide last name, first name, date of birth, citizenship indicator, and SSN to SSA. SSA will provide CMS with a response including: last name, first name, date of birth, confirmation of attestations of citizenship status, verification of SSN, death indicator, disability indicator, prisoner information, and Title II (annual and monthly) income information.

D. Frequency of Data Exchanges

The data exchange under this agreement will begin September 9, 2018 and continue through March 8, 2020, in accordance with schedules set by CMS and SSA. CMS will submit requests electronically in real-time on a daily basis throughout the year.

IV. NOTICE PROCEDURES

A. CMS will publish notice of the Matching Program in the Fed. Reg. as required by the Privacy Act (5 U.S.C. § 552a(e)(12)).

B. At the time of application or change of circumstances, CMS will provide a notice to Applicants for enrollment in a QHP, or an Insurance Affordability Program under ACA, on the OMB-approved streamlined eligibility application. CMS 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.

C. When an Applicant submits an application for an Exemption, CMS will provide individual notice on the Exemption application regarding the collection, use, and disclosure of the Applicant's PII. The Exemption application also will contain a Privacy Act statement describing the purposes for which the information is intended to be used and the authority that authorizes the collection of the information.

V. VERIFICATION PROCEDURES AND OPPORTUNITY TO CONTEST FINDINGS

Information maintained or created by CMS regarding any individual that becomes part of the CMS System of Records can be corrected by contacting CMS. CMS established and will maintain record corrections procedures consistent with the Privacy Act.

CMS established and will maintain procedures to verify information and to provide a means for individuals to contest information prior to an adverse action related to the Eligibility Determination, Renewal, or Redetermination being taken. CMS will ensure provision of the proper contact information and instructions to the individual contesting the contents of the information depending on the source and type of information being contested.

VI. DISPOSITION OF MATCHED ITEMS

A. SSA and CMS will retain the electronic submission and response files received from the other party only for the period of time required to complete a verification necessary for the applicable Eligibility Determination, Redetermination, or Renewal under this Matching Program and will destroy all such files by electronic purging, unless the parties are required to retain the files in order to meet evidentiary requirements, for internal audits, for accuracy checks, and to adjudicate appeals. In case of such retention, the parties will retire the retained files in accordance with the applicable Federal Records Retention Schedule (44 U.S.C. § 3303a). The parties will not create permanent files or a separate system comprised solely of the data provided by the other party.

B. SSA will not collect or maintain PII submitted by CMS for verification, except as provided in Section XI for audit logging purposes. The submission files provided by CMS remain the property of CMS.

C. Neither SSA nor CMS will create a permanent file or separate system consisting of information concerning only those individuals who are involved in this matching program.

VII. SECURITY PROCEDURES

SSA and CMS will comply with the requirements of FISMA, 44 U.S.C. Chapter 35, Subchapter II, as amended by the Federal Information Security Modernization Act of 2014 (Pub. L. No. 113-283); related OMB circulars and memoranda, such as Circular A-130, *Managing Information as a Strategic Resource* (July 28, 2016); National Institute of Standards and Technology (NIST) directives; and the Federal Acquisition Regulations, including any applicable amendments published after the effective date of this agreement. 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. Both agencies recognize, and will implement, the

laws, regulations, NIST standards, and OMB directives including those published subsequent to the effective date of this agreement. Additionally, CMS will follow Federal, HHS, and CMS policies, including the HHS Information Security and Privacy Policy and the CMS Information Security Acceptable Risk Safeguards (ARS) CMS Minimum Security Requirements.

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 agencies are responsible for oversight and compliance of their contractors and agents.

A. Incident Reporting

If either SSA or CMS experiences an incident involving the loss or breach of PII provided by SSA or CMS under the terms of this agreement, they will follow the incident reporting guidelines issued by OMB. In the event of a reportable incident under OMB guidance involving PII, the agency experiencing the incident is responsible for following its established procedures, including notification to the proper organizations (e.g., United States Computer Emergency Readiness Team, the agency's privacy office). In addition, the agency experiencing the incident (e.g., electronic or paper) will notify the other agency's Systems Security Contact named in this agreement. If CMS is unable to speak with the SSA Systems Security Contact within one hour or if for some other reason notifying the SSA Systems Security Contact is not practicable (e.g., it is outside of the normal business hours), CMS will call SSA's National Network Service Center toll free at 1-877-697-4889. If SSA is unable to speak with CMS Systems Security Contact within one hour, SSA will contact CMS IT Service Desk at 1-800-562-1963 or via email at CMS_IT_Service_Desk@cms.hhs.gov.

B. Breach Notification

SSA and CMS will follow PII breach notification policies and related procedures issued by OMB. If the agency that experienced the breach determines that the risk of harm requires notification to affected individuals or other remedies, that agency will carry out these remedies without cost to the other agency.

C. Administrative Safeguards

SSA and CMS will restrict access to the data matched and to any data created by the match to authorized employees and officials who need it to perform their official duties in connection with the uses of the data authorized in this agreement, except as required by Federal law. Further, SSA and CMS will advise all personnel who 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.

D. Physical Safeguards

SSA and CMS 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. Only authorized personnel will transport the data matched and any data created by the match. SSA and CMS will establish appropriate safeguards for such data, as determined by a risk-based assessment of the circumstances involved.

E. Technical Safeguards

SSA and CMS will process the data matched and any data created by the match under the immediate supervision and control of authorized personnel in a manner that will protect the confidentiality of the data, so that unauthorized persons cannot retrieve any data by computer, remote terminal, or other means. Systems personnel must enter personal identification numbers when accessing data on the agencies' systems. SSA and CMS will strictly limit authorization to those electronic data areas necessary for the authorized analyst to perform his or her official duties.

F. Application of Policy and Procedures

SSA and CMS will adopt policies and procedures to ensure that each agency uses the information contained in their respective records or obtained from each other solely as provided in this agreement. SSA and CMS will comply with these guidelines and any subsequent revisions.

G. Onsite Inspection

SSA and CMS have the right to monitor the other party's compliance with FISMA and OMB requirements. Both parties have the right to make onsite inspections for auditing compliance, if necessary, for the duration or any extension of this agreement. If either party elects to complete an onsite inspection, the auditing agency will provide the other advanced written notice of any onsite inspection and the parties will set a mutually agreeable date for such inspection.

H. Compliance

CMS must ensure information systems that process information provided by SSA under this matching agreement are compliant with CMS standards contained in the Minimum Acceptable Risk Standards for Exchanges (MARS-E). The MARS-E suite of documents can be found at: http://www.cms.gov/cciio/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. CMS will implement compliance monitoring procedures to ensure that information provided by SSA under this matching agreement is properly used by CMS or by Authorized Users. Reviews of Authorized Users will be conducted at the

discretion of CMS.

I. Logging

CMS will retain a log of transactions submitted by CMS to SSA for matching under this agreement for audit purposes. The logged information will be retained by CMS and will be made available upon request in order to conduct analysis and investigations of reported Security Incidents involving access or disclosure of information provided by SSA under this matching agreement.

J. Reports of Fraud and Misuse

Each party will report to the other party such incidents of fraud or misuse known to the party that involve information supplied by the other party under this matching agreement.

K. Security Status Sharing

Federal agencies that conduct security assessments of Authorized Users in support of ACA may also share information regarding the operational status of those entities to other Federal agencies that supply information in support of ACA operations.

VIII. RECORDS USAGE, DUPLICATION, AND REDISCLOSURE RESTRICTIONS

CMS and SSA will comply with the following limitations on use of the submission and response files, and data provided by the other agency under this agreement:

This agreement governs SSA disclosures to CMS and CMS disclosures to SSA for the purposes outlined in this agreement. Such disclosures are distinct from CMS disclosures to other parties for purposes of Eligibility Determinations, Renewals, and Redeterminations, which are subject to and solely governed by CMS SORN(s). CMS has responsibility for safeguarding the information described in its SORN(s) and ensuring that its use of such information is in compliance with the Privacy Act, Federal law, and OMB guidance.

A. CMS and SSA will use the data only for purposes described in this agreement.

B. CMS and SSA will not use the data or submission and response files to extract information concerning individuals therein for any purpose not covered by this agreement.

C. The matching response files provided by SSA under this agreement will remain the property of SSA and CMS will retain the matching response files only as described in Section VI of this agreement.

D. CMS and SSA will not duplicate or disseminate the submission and response files, within or outside their respective agencies, without the written consent of the other party, except as required by Federal law or for purposes under this agreement.

E. CMS and SSA will not permit the submission and response files exchanged under this agreement to be stored, transferred, or maintained outside of the United States, its territories or possessions, except to process Internet-based applications from individuals seeking coverage through an Exchange from a foreign location.

F. Any individual who knowingly and willfully uses information obtained pursuant to this agreement in a manner or for a purpose not authorized by 45 C.F.R. § 155.260 and section 1411(g) of ACA are potentially subject to the civil penalty provisions of section 1411(h)(2) of ACA, which carries a fine of up to $25,000.

IX. RECORDS ACCURACY ASSESSMENTS

SSA independently assessed the benefits data to be more than 99 percent accurate when the benefit record is created. Prisoner data, some of which is not independently verified by SSA, does not have the same degree of accuracy as SSA's benefit data. CMS will independently verify prisoner data through applicable CMS verification procedures and the notice and opportunity to contest procedures specified in Section VIII of this agreement before taking any adverse action. The SSA Enumeration System used for SSN matching is 100 percent accurate based on SSA's Office of Quality Review "FY 2015 Enumeration Accuracy Report (April, 2016)."

SSA's citizenship data may be less than 50 percent current. An applicant for an original SSN provides identifying information upon application for that number. However, there is no obligation for the SSN number holder to report a subsequent change in immigration status to SSA unless the number holder files a claim for Social Security benefits. CMS will independently verify citizenship data through applicable CMS verification procedures.

X. COMPTROLLER GENERAL ACCESS

The Government Accountability Office (Comptroller General) may have access to all CMS and SSA data, it deems necessary in order to monitor or verify compliance with this CMA.

XI. REIMBURSEMENT/FUNDING

A. SSA will collect funds from CMS during FY 2018 through the Intra-Governmental Payment and Collection (IPAC) system on a quarterly basis, sufficient to reimburse SSA for the costs it has incurred for performing services through the date of billing. SSA will mail a copy of the IPAC billing and all original supporting documentation to CMS at Accounting Operations, 7500 Security Boulevard, Baltimore, MD 21244, no later than five (5) calendar days following the processing of the IPAC

transaction. At least quarterly, but no later than thirty (30) days after an accountable event, SSA will provide CMS with a performance report (e.g., a billing statement) that details all work performed to date. Additionally, at least quarterly, SSA and CMS will reconcile balances related to revenue and expenses for work performed under this agreement.

B. This agreement does not authorize SSA to incur obligations through the performance of the services described herein. Only the execution of Form SSA-1235, agreement Covering Reimbursable Services, and an executed Inter-Agency Agreement (IAA), authorizes the performance of such services. SSA may incur obligations by performing services under a reimbursable agreement only on a fiscal year basis. Accordingly, attached to, and made a part of this Agreement, are an executed Form SSA-1235 and an executed IAA that provide authorization for SSA to perform services under this agreement in FY 2018. SSA's ability to perform work beyond FY 2018 is subject to the availability of funds.

XII. DURATION OF AGREEMENT, MODIFICATION, AND TERMINATION

A. Duration: The Effective Date of this agreement is September 9, 2018, provided that CMS reported the proposal to re-establish this matching program to the Congressional committees of jurisdiction and OMB in accordance with 5 U.S.C. § 552a(o)(2)(A); and OMB Circular A-108 and CMS published notice of the matching program in the Fed. Reg. in accordance with 5 U.S.C. § 552a(e)(12).

This agreement will be in effect for a period of eighteen (18) months.

The DIBs of CMS and SSA may, within 3 months prior to the expiration of this agreement, renew this agreement for a period not to exceed 12 months if CMS and SSA can certify to their DIBs that:

1. The matching program will be conducted without change; and

2. CMS and SSA have conducted the matching program in compliance with the original agreement.

If either party does not want to continue this program, it must notify the other party of its intention not to continue at least 90 days before the end of the period of the agreement.

B. Modification: The parties may modify this agreement at any time by a written modification, agreed to by both parties and approved by the DIB of each agency.

C. Termination: The parties may terminate this agreement at any time with the consent of both parties. Either party may unilaterally terminate this agreement upon written notice to the other party, in which case the termination shall be effective 90 days after the date of the notice, or at a later date specified in the notice.

SSA may immediately and unilaterally suspend the data flow under this agreement or terminate this agreement if SSA:

1. Determines that CMS has used or disclosed the information in an unauthorized manner;

2. Determines that CMS has violated or failed to follow the terms of this agreement; or

3. Has reason to believe that CMS breached the terms for security of data. If SSA suspends the data flow in accordance with this subsection, SSA will suspend the data until SSA makes a final determination of a breach.

XIII. LIABILITY

A. Each party to this agreement shall be liable for acts and omissions of its own employees.

B. Neither party shall be liable for any injury to another party's personnel or damage to another party's property, unless such injury or damage is compensable under the Federal Tort Claims Act (28 U.S.C. § 1346(b)), or pursuant to other Federal statutory authority.

C. Neither party shall be responsible for any financial loss incurred by the other, whether directly or indirectly, through the use of any data furnished pursuant to this agreement.

XIV. DISPUTE RESOLUTION

In the event of a dispute related to reimbursements under Section XV of this agreement, SSA and CMS will resolve those disputes in accordance with instructions provided in the Treasury Financial Manual (TFM) Volume I, Part 2, Chapter 4700, Appendix 10, *Intragovernmental Transaction Guide.*

XV. DISCLAIMER

SSA is not liable for any damages or loss resulting from errors in information provided to CMS under this agreement. SSA is not liable for damages or loss resulting from the destruction of any materials or data provided by CMS. All information furnished to CMS is subject to the limitations and qualifications, if any, transmitted with such information. The performance or delivery by SSA of the goods and/or services described herein and the timeliness of said delivery are authorized only to the extent that they are consistent with proper performance of the official duties and obligations of SSA and the relative importance of this request to others. If for any reason SSA delays or fails to provide

services, or discontinues the services or any part thereof, SSA is not liable for any damages or loss resulting from such delay or for any such failure or discontinuance.

XVI. PERSONS TO CONTACT

A. SSA Contacts:

Matching Agreement

Kelvin Chapman, Government Information Specialist
Office of the General Counsel
Office of Privacy and Disclosure
6401 Security Boulevard, 617 Altmeyer
Baltimore, MD 21235
Telephone: (410) 965-9312
Fax: (410) 594-0115
Email: Kelvin.Chapman@ssa.gov

Program Policy

Monica Nolan, Team Leader
Medicare Team
Office of Earnings, Enumeration & Medicare Policy
Office of Income Security Programs
6401 Security Boulevard, 2-P-17-B Robert M. Ball Building
Baltimore, MD 21235
Telephone: (410) 965-2075
Email: Monica.Nolan@ssa.gov

Security Systems Issues

Jennifer Ruiz, Director
Office of Information Security
Division of Compliance and Assessments
Suite 3208 Annex
6401 Security Boulevard
Baltimore, MD 21235
Phone: (410) 966-8253
Email: Jennifer.Ruiz@ssa.gov

Computer Systems Issues

Melanie Burns
Division of Medicare Processing & Title II Support
6401 Security Boulevard, 4517 Robert M. Ball Building
Baltimore, MD 21235
Telephone: (410) 966-0444
Fax: (410) 597-1384
Email: Melanie.Burns@ssa.gov

Project Coordinator

Stephanie Brock, Data Exchange Liaison
Senior Data Exchange Liaison
Office of Data Exchange
Federal Agreements Branch
6401 Security Boulevard,
Baltimore, MD 21235
Telephone: (410) 965-7827
Email: Stephanie.Brock@ssa.gov

B. CMS Contacts:

Program Issues

Elizabeth Kane
Acting Director, Verifications Policy & Operations Branch
Eligibility and Enrollment Policy and Operations Group
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
7501 Wisconsin Avenue
Bethesda, MD 20814
Telephone: (301) 492-4418
Fax: (443) 380-5531
Email: Elizabeth.Kane@cms.hhs.gov

Medicaid/CHIP Issues
Greg McGuigan
Acting Director
Data and Systems Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: S2-22-27
Location: S2-23-06
Baltimore, MD 21244-1850
Telephone: (410) 786-5002
Email: greg.mcguigan@cms.hhs.gov

Systems and Security
Darrin V. Lyles
Information Security Officer, CIISG
CMS\OIS\CIISG
Consumer Information and Insurance Systems Group
7500 Security Boulevard
Baltimore, MD 21244
Telephone: (410) 786-4744
Telephone: (443) 979-3169 (Mobile)
Email: Darrin.Lyles@cms.hhs.gov

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) 7 86-5357
Email: Walter. Stone@cms.hhs.gov

Barbara Demopulos, Privacy SME
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

Email: Barbara.demopulos@cms.hhs.gov

XVII. INTEGRATION CLAUSE

This agreement, including the Form SSA-1235 and the executed IAA, constitutes the entire agreement of the parties with respect to its subject matter and supersedes all other data exchange agreements between the parties existing at the time this agreement is executed that pertain to the disclosure of the following specified data elements between SSA and CMS for the purposes described in this agreement: SSN verification, death indicator, Title II disability indicator, confirmation of consistency of citizenship declaration, monthly and annual Title II benefit, QC, and prisoner data. SSA and CMS have made no representations, warranties, or promises outside of this Agreement. This agreement takes precedence over any other documents that may be in conflict with it.

XVIII. SEVERABILITY

If any term or other provision of this agreement is determined to be invalid, illegal, or incapable of being enforced by any rule or law, or public policy, all other terms, conditions, or provisions of this agreement shall nevertheless remain in full force and effect, provided that the Matching Program contemplated hereby is not affected in any manner materially adverse to any party. Upon such determination that any term or other provision is invalid, illegal, or incapable of being enforced, the parties hereto shall negotiate in good faith to modify this agreement so as to effect the original intent of the parties as closely as possible in an acceptable manner to the end that the transactions contemplated hereby are satisfied to the fullest extent possible.

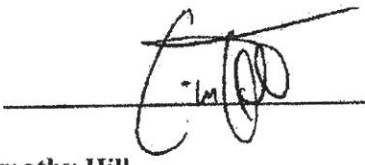
XIX. APPROVALS

A. Centers for Medicare & Medicaid Services Program & Approving Officials

The authorized program and approving officials, whose signatures appear below, accept and expressly agree to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit the organization to the terms of this agreement.

Approved by (Signature of Authorized CMS Program Official)

Approved by (Signature of Authorized CMS Program Official)



Date: 5/3/18

Timothy Hill
Acting Director

Centers for Medicaid and CHIP Services,

Centers for Medicare & Medicaid Services

Approved by (Signature of Authorized CMS Approving Official)

Emery Csulak Date: 6/7/18

Emery Csulak
Director, Information Security and Privacy Group
Chief Information Security Officer (CISO)/Senior Official for Privacy
Office of Information Technology
Centers for Medicare & Medicaid Services

B. DIB: 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, confirms 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)

Alberto Cajas for **Date:** 6/28/2018

Heather Flick
Acting Chairperson
Data Integrity Board
United States Department of Health and Human Services

C. Social Security Administration 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 terms of this Agreement.

Approved By (Signature of Authorized SSA Approving Official)

Norma Followell for

Monica Chyn **Date:** 5-3-18

Monica Chyn
Acting Deputy Executive Director
Office of Privacy and Disclosure
Office of the General Counsel

D. DIB: Social Security Administration Approving Official

The authorized DIB 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 their respective organization to the terms of this Agreement.

Approved By (Signature of Authorized SSA DIB Official)

Mary Ann Zimmerman **Date:** 5/29/18

Mary Ann Zimmerman
Acting Chairperson
Data Integrity Board
Social Security Administration

Attachments:

1. Cost-Benefit Analysis

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 II.B of each 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[1] 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

[1] 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.

program using a single application form for determining eligibility for all State health subsidy programs.

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)[2] 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

[2] "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.

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 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[3].
- 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.

[3] 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.[4] 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.[5]

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

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4 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.

5 For personnel costs, CMS used publicly available wage data from the Bureau of Labor Statistics (BLS: 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).

cost of all Healthcare.gov data security is $8.5 million per year.[6] The Healthcare.gov data security budget is not itemized by matching program; therefore, the matching program costs to the marketplace SOC are not quantifiable.

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.[7] 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

Center	Annual Cost
Eligibility and Enrollment (E&E)	$658,682
SMIPG (State Policy)	$278,740
Marketplace Information Technology (MITG/HUB)	$538,272

6 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
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.

[7] https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf, Page 5.

Marketplace Information Technology (MITG/STATE)	$234,707
Total	**$1,710,400**

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 2013[8] 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.

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[8] 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

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.[9] CMS pays a fee per transaction for RIPD, 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, and has no information about their costs.

(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.)

3. State Administering Agency (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.

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[9] T. Shaw and S. Gonzales, "Remote Identity Proofing: Impacts on Access to Health Insurance," Center on Budget and Policy Priorities, January 7, 2016.

III. BENEFITS

b. 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 MEC checks 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.

c. 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)

Agency	Contract Cost	Transactions	Cost/Transaction
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	Unknown	unknown
Total / Total / Average	**$9,287,587**	**338,239,348**	**$0.02746**

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,[10] 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.

[10] Individuals in prison are not eligible for ACA benefits.

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 (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, yielding an average cost of approximately 45 cents per transaction. This is the highest average cost of transactions with any TDS.

The DHS charges according to a graduated fee schedule for using the database called "SAVE" (Systematic Alien Verification for Entitlements Program). There are up to 3 steps of 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 a 3-5 days for additional database searches. The third step requires manual touch from a DHS Status Verification Officer and requires a G-845 form. Costs are currently 50 cents per use at Steps 1 and 2 and $1.50 per use at Step 3. Automation through DHS's paperless initiative will impact these costs in the future.

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.[11] The total tally of enrollment, including states that use their own platforms, will not be available until March, 2018. 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.[12]

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.[13]

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 3rd 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 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.

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[11] 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.

[12] 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.

[13] 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.

Unlike the elimination of the SAML requirement, the ability to input data directly into HealthCare.gov through 3rd party websites poses a possible asymmetry. Information gathered by the authors' suggests that 3rd 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 3rd 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

* Minutes reduced from elimination of SAML requirement

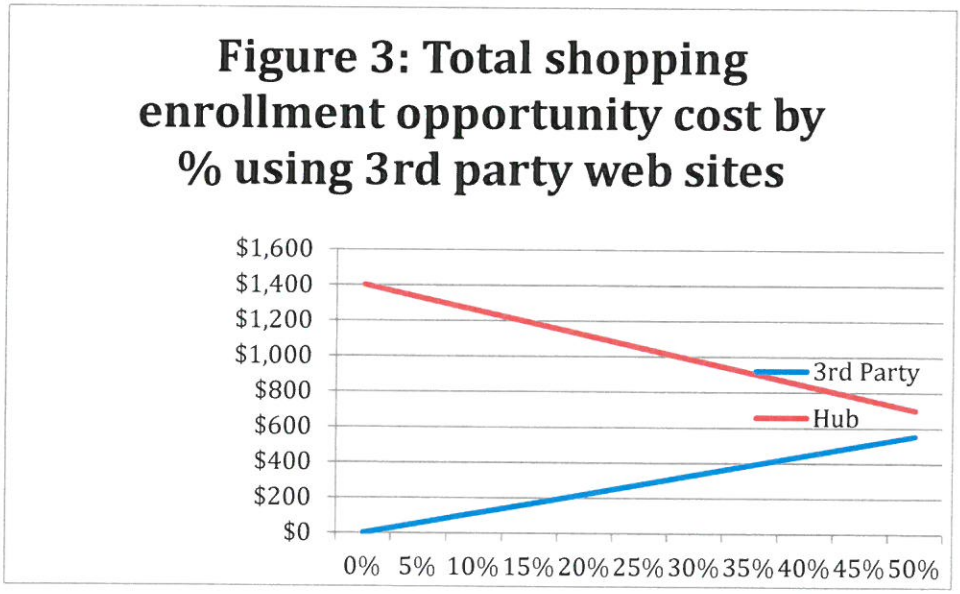
There are at least two pertinent indirect effects of these changes that could affect our cost-benefit results. Both are related to the effect of differential migration of consumers to 3rd party web sites. The first is based on the observation that 3rd party web sites might be more efficient, and therefore 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 3rd party web sites.

To estimate the total consumer opportunity cost due to differential migration to 3rd 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 3rd 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 3rd 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 3rd 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 3rd 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 3rd 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 x 4,666,667 people = $408,940,029 from the net benefit.

Marginal Benefits and Costs

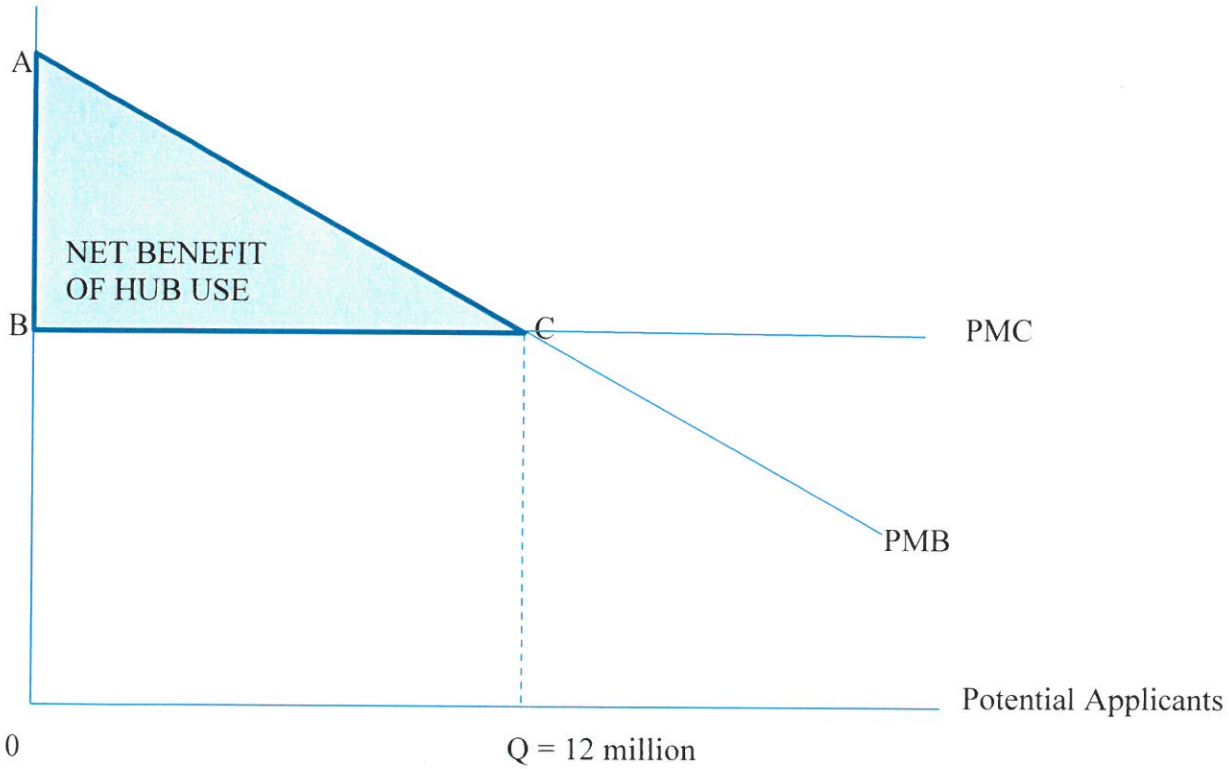


Figure 4: Revised Net Benefit of Hub Use

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
Total		**100**	**$45,378**

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.