

**COMPUTER MATCHING AGREEMENT BETWEEN
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
And
THE OFFICE OF PERSONNEL MANAGEMENT
For
VERIFICATION OF ELIGIBILITY FOR MINIMUM ESSENTIAL COVERAGE
UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
THROUGH AN
OFFICE OF PERSONNEL MANAGEMENT HEALTH BENEFIT PLAN**

CMS Computer Matching Agreement No. 2025-14

Effective Date - June 8, 2026
Expiration Date - December 7, 2027

I. PURPOSE, LEGAL AUTHORITIES, AND DEFINITIONS

A. Purpose

This Computer Matching Agreement (Agreement) establishes the terms, conditions, safeguards, and procedures under which the U.S. Office of Personnel Management (OPM) will provide information to the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS). The terms and conditions of this Agreement will be carried out by authorized officers, employees, and contractors of OPM and CMS. OPM and CMS are each a "Party" and collectively "the Parties."

Under the authority of 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) (collectively, the PPACA) and the implementing regulations, CMS, in its capacity as the Federally-facilitated Exchange, and other Administering Entities (AEs) will use OPM's eligibility information to verify an Applicant's or Enrollee's eligibility for Minimum Essential Coverage (MEC) through an OPM Health Benefits Plan. Eligibility for an OPM Health Benefits Plan which meets affordability standards usually precludes eligibility for financial assistance (including advance payments of the premium tax credit (APTC) or cost sharing reduction (CSR), which are types of insurance affordability programs) for a Qualified Health Plan (QHP) through the Federally-facilitated or State-based Exchanges¹.

¹ Since January 1, 2014, consumers in every state (including the District of Columbia) have had access to health insurance coverage through Health Insurance Exchanges operated by State-based Exchanges (SBEs) or by the Federal government through the Federally-facilitated Exchange. SBEs have adopted various names for their programs (e.g., Kentucky's 'kynect' or California's 'Covered California') but they are still Exchanges as established under sections 1311(b) and 1311(d)(1) or 1321(c)(1) of the PPACA.

The Privacy Act of 1974, as amended (in particular, by the Computer Matching and Privacy Protection Act of 1988 (CMPPA) (Public Law 100-503)), requires the parties participating in a matching program to execute a written agreement specifying the terms and conditions under which the matching program will be conducted. CMS has determined that status verification checks conducted by AEs using the Enterprise Human Resources Integration (EHRI) data source Status File provided to CMS by OPM constitute a "matching program" as defined in the CMPPA.

CMS has entered into matching agreements or other data sharing agreements with the following federal agencies:

- 1) Social Security Administration (SSA),
- 2) Department of Homeland Security (DHS),
- 3) Internal Revenue Service (IRS),
- 4) Veterans Health Administration (VHA),
- 5) Department of Defense (DoD),
- 6) Office of Personnel Management (OPM), and
- 7) the Peace Corps,

due to the change in the title of CMS' agreement with DHS in July 2023. In addition, CMS has developed a matching program that is executed with every State AE, including state Medicaid and CHIP agencies and State-based Exchanges. CMS designed the Federal Data Services Hub (Hub) to be a centralized platform for the secure electronic interface that connects all AEs and trusted data sources.

Without the Hub, each State AE would be required to enter into a separate arrangement with each federal agency to determine whether applicants for state health subsidy programs are eligible for coverage. If the match operations were conducted through separate arrangements outside of the Hub, the costs to CMS, the source federal agencies, the AEs, and consumers (applicants) would be significantly greater than under the current structure.

The responsible component for CMS is the Center for Consumer Information & Insurance Oversight (CCIIO). HHS/CMS is the Recipient Agency, and will be responsible for publishing the Federal Register notice required by 5 U.S.C. § 552a(e)(12). The OPM components responsible for the disclosure of information are the Human Resources Solutions office and the Office of the Chief Information Officer. OPM is the Source Agency in this matching program.

By entering into this Agreement, the Parties agree to comply with the terms and conditions set forth herein and the applicable law and implementing regulations. The terms and conditions of this Agreement will be carried out by Authorized Users.

B. Legal Authorities

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

1. This Agreement is executed pursuant to the Privacy Act of 1974, as amended (5 U.S.C. § 552a) and the regulations and guidance promulgated thereunder, including Office of Management and Budget (OMB) Circular A-108 “Federal Agency Responsibilities for Review, Reporting, and Publication under the Privacy Act” published at 81 FR 94424 (Dec. 23, 2016), and OMB guidance pertaining to computer matching published at 54 FR 25818 (June 19, 1989).
2. Under the PPACA, certain individuals are eligible for certain financial assistance in paying for private insurance coverage under a QHP when enrollment is through an Exchange. Such assistance includes APTC, under 26 U.S.C. § 36B and section 1412 of the Affordable Care Act, and CSRs under section 1402 of the Affordable Care Act.
3. Section 36B(c)(2) of the Internal Revenue Code of 1986 (IRC), as added by section 1401 of the PPACA, provides that an Applicant is ineligible for APTC if he or she is eligible for MEC as defined in 26 U.S.C. § 5000A(f), other than MEC described in 26 U.S.C. § 5000A(f)(1)(C). Section 1402(t)(2) of the PPACA provides that an individual is ineligible for CSRs if the individual is not also eligible for the premium tax credit for the IRC relevant month.
4. Section 1331 of the PPACA authorizes the BHP and requires each state administering a BHP to verify whether an individual is eligible for certain MEC as defined in 26 U.S.C. § 5000A(f), such as coverage under an OPM Health Benefits Plan (see implementing regulations at 45 CFR §155.320(d)).
5. Section 1411 of the PPACA requires the Secretary of HHS to establish a program to determine an individual's eligibility to purchase a QHP through an Exchange and to determine eligibility for APTC and CSRs. The system established by HHS under section 1411(c)(4)(B) and (d) to determine eligibility for APTC and CSRs requires an Exchange to verify whether an individual is eligible for certain eligible employer sponsored plans, such as an OPM Health Benefits Plan (45 CFR § 155.320(d)), requires OPM to provide information to HHS/CMS, which CMS then makes available to the requesting AE through the Hub.
6. Under 45 CFR § 155.302 and 155.305, the eligibility determinations for APTC and CSRs may be made by an Exchange or HHS. CMS carries out the Exchange-related responsibilities of HHS (76 FR 4703 (Jan. 26, 2011)).

7. Under the authority of sections 1311, 1321, and 1411(a) of the PPACA, the Secretary of HHS adopted the regulation at 45 CFR § 155.330, which further addresses the requirements for an Exchange to re-determine an Applicant's eligibility for enrollment in a QHP through an Exchange and for APTC and for APTC and CSRs during the Benefit Year based on certain types of changes in circumstances.
8. 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 published for that system of records. OPM has published a routine use in its applicable system of records notice (SORN) to address the disclosures under this Agreement. CMS does not disclose information in its system of records to OPM as part of this Agreement.

C. Definitions

For the purposes of this Agreement:

1. "Administering Entity" or "AE" means a state Medicaid agency, Children's Health Insurance Program (CHIP), a Basic Health Program (BHP), or an Exchange administering an Insurance Affordability Program;
2. "Advance Payments of the Premium Tax Credit" or "APTC" means payment of the tax credit specified in section 36B of the IRC (as added by section 1401 of the PPACA) that is provided on an advance basis on behalf of an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the PPACA. An individual's APTC eligibility status is not considered "taxpayer return information" as defined under 26 U.S.C. § 6103;
3. "Agent" or "Broker" means a person or entity licensed by the State as an agent, broker, or insurance producer;
4. "Applicant" means an individual seeking an Eligibility Determination for enrollment in a QHP through an Exchange, or for an IAP, or for a certification of Exemption. This term includes individuals whose eligibility is determined at the time of a renewal or redetermination;
5. "Authorized Representative" means an individual, person or organization acting, in accordance with 45 CFR § 155.227, on behalf of an Applicant or Enrollee in applying for an eligibility determination, including a redetermination, and in carrying out other ongoing communications with the Exchange;

6. "Authorized User" means an information system user who is provided with access privileges to any data resulting from this matching program or to any data created as a result of this match. Authorized Users include AEs;
7. "Benefit Year" means the calendar year for which a health plan purchased through an Exchange provides coverage for health benefits;
8. "Breach" is defined in 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 purposes;
9. "CMS" means the Centers for Medicare & Medicaid Services;
10. "Cost-sharing reduction" or "CSR" is defined at 45 CFR § 155.20 and means a reduction in cost sharing of an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Alaskan Native/American Indian enrolled in a QHP through an Exchange, provided in accordance with section 1402 of the PPACA. An individual's CSR eligibility status is not considered "taxpayer return information" as defined under 26 U.S.C. § 6103;
11. "Eligibility Determination" means the determination of eligibility by an AE for enrollment in a QHP through an Exchange, an IAP or for a Certification of Exemption. This includes initial determinations or redeterminations based on a change in the individual's status, and appeals;
12. "Enrollee" means an individual enrolled in a QHP through an Exchange or enrolled in a BHP;
13. "Exchange" (otherwise known as Marketplace) means an FFE or an SBE (including a not-for-profit exchange) established under sections 1311(b) and 1311(d)(1) or 1321(c)(1) of PPACA. For purposes of this Agreement, all references to an Exchange shall refer equally to and include a state agency that is responsible for administering the Insurance Affordability Program under which individuals and small businesses may enroll in Qualified Health Plans in the state;
14. "Federally-facilitated Exchange" or "FFE" means an Exchange established by HHS and operated by CMS under § 1321 of the PPACA;
15. "HHS" means the Department of Health and Human Services;

16. "Hub" or "Data Services Hub" is the CMS managed, single data exchange for AEs to use to interface with Federal agency partners. Hub services allow for adherence to federal and industry standards for security, data transport, and data safeguards as well as CMS policy for AEs for eligibility determination and enrollment services;
17. "Insurance Affordability Programs" include: (1) a program that makes coverage in a QHP through an Exchange with APTC; (2) a program that makes available coverage in a QHP through an Exchange with CSRs; (3) the Medicaid program established under Title XIX of the Social Security Act; (4) the Children's Health Insurance Program (CHIP) established under Title XXI of the Social Security Act; and (5) the BHP established under Section 1331 of the PPACA;
18. "Minimum Essential Coverage" or "MEC" is defined in Internal Revenue Code (IRC) § 5000A(f), and includes health insurance coverage offered in the individual market within a state, which includes a QHP offered through an Exchange, an eligible employer-sponsored plan, or government sponsored coverage such as coverage under Medicare Part A or an OPM Health Benefits Plan;
19. "OPM Health Benefits Plan" means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services and as contracted for or approved by OPM under 5 U.S.C. Chapter 89;
20. "PPACA" means 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), codified at 42 U.S.C. §§ 18001 et seq. (collectively, the PPACA);
21. "Personally Identifiable Information" or "PII" is defined in OMB Memorandum M-17-12 Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017), and means information that can be used to distinguish or trace an individual's identity, either alone or when combined with other information that is linked or linkable to a specific individual;
22. "Qualified Health Plan" or "QHP" is a health plan that has in effect a certification that it meets the standards described in subpart C of Part 156 of Title 45 of the CFR issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of Part 155 in Title 45 of the CFR;

23. "Recipient Agency" is defined by the Privacy Act at 5 U.S.C. § 552a(a)(9) and means any agency, or contractor thereof, receiving records contained in a system of records from a Source Agency for use in a matching program;
24. "Record" is defined in the Privacy Act at 5 U.S.C. § 552a(a)(4) and means any item, collection, or grouping of information about an individual that is maintained by an agency, including but not limited to information about the individual's education, financial transactions, medical history, and criminal or employment history and that contains the individual's name, or the identifying number, symbol, or other identifying particular assigned to the individual;
25. "Security Incident" or "Incident" is defined in OMB Memorandum M-17-12 Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017) as an occurrence that (1) actually or imminently jeopardizes, without lawful authority, the integrity, confidentiality, or availability of information or an information system; or (2) constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies;
26. "Source Agency" as defined by the Privacy Act at 5 U.S.C. § 552a(a)(11), means any agency that discloses records contained in a system of records to be used in a matching program;
27. "State-based Exchange" or "SBE" means an Exchange established and operated by a State, and approved by HHS under 45 CFR § 155.105;
28. "Status File" is a file provided by OPM to CMS that includes data about an individual's Federal Employee's Health Benefit eligibility;
29. "System of Records" or "SOR" is defined by the Privacy Act at 5 U.S.C. § 552a(a)(5) and means a group of any records under the control of any agency from which information about an individual is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

II. RESPONSIBILITIES OF THE PARTIES

A. CMS Responsibilities

1. CMS will develop procedures through which an Applicant or Enrollee may request an eligibility determination via a single, streamlined application.

2. CMS will send requests for updated data to EHRHelp@opm.gov as detailed in Section IV.C and D.
3. AEs administering Insurance Affordability Programs will access the Status File through the Hub. The Hub will use the information contained in the OPM status file to indicate if an Applicant or Enrollee is enrolled in or eligible for an OPM Health Benefits Plan, which is a form of MEC under the PPACA.
4. CMS will receive a Premium Spread Index File from OPM on an annual basis that identifies the lowest premium available to a Federal employee in each of the 32 premium localities.
5. AEs will receive data from the Premium Spread Index File when an individual is identified in the OPM Status file. The AE will use this data to determine whether the lowest cost self-only plan offered to the employee is affordable.
6. CMS has developed and will maintain procedures through which AEs can request and receive information verifying eligibility for MEC from the OPM Status File through the Hub to make eligibility determinations.
7. CMS will enter into agreements with AEs that bind these entities to comply with appropriate privacy and security protections for PII, including requirements for these entities and their employees, contractors, and agents to comply with the use and disclosure requirements set forth in section 1411(g) of the PPACA (42 U.S.C. § 18081), and privacy and security standards that are consistent with the principles outlined under 45 CFR § 155.260, and privacy and security standards that are consistent with NIST Special Publication 800-53, Revision 5 and the terms and conditions of this Agreement.
8. CMS will provide Congress and the OMB with advance notice of this matching program, and upon completion of OMB's review, will publish the matching notice in the Federal Register.
9. CMS will ensure the receipt of appropriate consents from Applicants or Enrollees for use of PII collected, used, and disclosed for the purposes and programs outlined in this Agreement.

B. OPM Responsibilities

1. OPM will provide CMS with data from the OPM system of records OPM/GOVT-1 (General Personnel Records), 77 FR 79694 (Dec. 11, 2012), updated at 80 FR 74815 (Nov. 30, 2015) and at 87 FR 5874 (Feb. 2, 2022). The disclosure to CMS is authorized by Routine Use "rr". See <https://www.federalregister.gov/documents/2012/12/11/2012-29777/privacy-act-of-1974-update-existing-system-of-records>.

2. Upon receiving the updated file requests at EHRhelp@opm.gov, OPM will submit the Status File and Premium Spread Index files to CMS as detailed in Section IV.C and D.

III. JUSTIFICATION AND ANTICIPATED RESULTS

A. Cost Benefit Analysis Requirements

As required by § 552a(u)(4) of the Privacy Act, a cost benefit analysis (CBA) is included as Attachment 1, covering this matching program and seven other "Exchange" matching programs which CMS conducts with other Federal agencies and AEs. The CBA demonstrates that monetary costs to operate all eight Exchange matching programs are approximately \$74.5 million, but does not quantify direct governmental monetary benefits sufficient to estimate whether they offset such costs, because the Exchange 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 (i.e., does not show that the program is likely to pay for itself) and does not produce a favorable benefit-to-cost ratio.

However, other supporting justifications and mitigating factors support approval of this CMA, as described in Section B., below. OMB guidance provides that the Privacy Act "does not require the showing of a favorable ratio for the match to be continued. The intention is to provide Congress with information to help evaluate the cost-effectiveness of statutory matching requirements with a view to revising or eliminating them where appropriate." See OMB guidance pertaining to computer matching, 54 FR 25818 at 25828 (June 19, 1989), titled "Privacy Act of 1974: Final Guidance Interpreting the Provisions of Public Law 100-503, the Computer Matching and Privacy Protection Act of 1988."

B. Other Supporting Justifications

Although the cost benefit analysis does not demonstrate that the Exchange matching programs are likely to be cost-effective, the programs are justified for other reasons, as explained in this section. Each Party's Data Integrity Board (DIB) therefore is requested to waive the requirements of 5 U.S.C. § 552a(u)(4)(A) and determine, in writing, that a cost benefit analysis demonstrating that the matching program is likely to be cost effective is not required, in accordance with 5 U.S.C. § 552a(u)(4)(B) and to approve the agreement based on these other supporting justifications:

1. Certain Exchange matching programs are required (i.e., are based on a statutory obligation), not discretionary to conduct.

2. The Exchange matching programs improve the speed and accuracy of consumer eligibility determinations while minimizing administrative burdens and achieving operational efficiencies.
3. The matching programs benefit the public and consumers by accurately determining consumers' eligibility for financial assistance (including APTC and CSRs).
4. An efficient eligibility and enrollment process provided by the Exchange matching programs contributes to greater numbers of consumers enrolling in Exchange qualified health plans, resulting in a reduction of the uninsured population and improving overall health care delivery.
5. Continuing to use the current matching program structure, which is less costly than any alternative structure, is expected to increase the public's trust in the participating agencies as stewards of taxpayer dollars.

C. Specific Estimate of Any Savings

There are no cost savings to conducting the Exchange matching programs, as opposed to not conducting them. By requiring a single, streamlined application process, the PPACA effectively required use of computer matching to make eligibility determinations. Therefore, the optimal cost-savings result is attained by limiting the costs of conducting the matching program to the extent possible, and by using a matching program operational structure and technological process that is more efficient than any alternatives. CMS' analysis suggests that the benefits of increased enrollment outweigh the costs given the increase in private insurance coverage through the PPACA.

IV. RECORDS DESCRIPTION

The Privacy Act at 5 U.S.C. § 552a(o)(1)(C) requires that each CMA specifically describe the records that will be matched, including each data element that will be used, the approximate number of records that will be matched, and the projected starting and completion dates of the program.

A. Systems of Records (SORs)

CMS

The CMS SORN that supports this matching program is "CMS Health Insurance Exchanges System (HIX)," System No. 09-70-0560, last published in full at 78 FR 63211 (Oct. 23, 2013), and partially amended at 83 FR 6591 (Feb. 14, 2018). Routine Use 3 authorizes CMS' disclosures of OPM data to AEs: "for purposes of determining the eligibility of Applicants to enroll in QHPs through an Exchange,

in IAPs, or for a certification of exemption from the individual responsibility requirement."

OPM

The OPM System of Records that supports this matching program is "General Personnel Records" (OPM\GOVT-1), published at 77 FR 79694 (Dec. 11, 2012) and updated at 80 FR 74815 (Nov. 30, 2015) and at 87 FR 5874 (Feb. 2, 2022). The disclosure of information to CMS will be made in accordance with Routine Use "rr", "To disclose information to CMS to assist in determining whether individuals are eligible for programs under the PPACA".

B. Number of Records

CMS will receive a bulk file from OPM annually for the Premium Spread Index File and monthly for the Status File. The files will contain data elements for all individuals currently covered by or eligible for OPM health coverage. OPM estimates that each file will contain data elements pertaining to approximately two million individuals.

C. Specified Data Elements

From CMS to OPM. CMS will submit requests to OPM at the appropriate email address for updated data. CMS will not share any data with OPM under this Agreement that will be used to support eligibility determinations. However, through the Hub, CMS will provide file transfer acknowledgements confirming that data files provided by OPM have been transmitted successfully. If there is a transport level error during a file transmission, CMS will provide OPM with an automated error response to that effect. If, during the Hub's data validation process, CMS detects an error in a data file received from OPM, CMS will provide OPM with an error file.

From OPM to CMS. Upon receiving the request for updated files, OPM will send CMS an updated Status File that contains a list of and data for active Federal employees. The Status File will include the following specified data elements:

- a. Record type;
- b. Record number;
- c. Unique person ID;
- d. Social Security Number;
- e. Last name;
- f. Middle name;
- g. First name;
- h. Last name suffix;
- i. Sex;
- j. Date of birth;

k. Health Plan Code

Upon receiving the update request, OPM will send to CMS, on an annual basis, a Premium Spread Index File that identifies the lowest premium available to a Federal employee in each of the 32 premium localities. The Premium Spread Index File provides premium data for the current and future calendar year, for both fee-for-service and health maintenance organization health plans, including the following specified data elements:

- a. State;
- b. Plan;
- c. Option;
- d. Enrollment code;
- e. Current total bi-weekly premium;
- f. Future total bi-weekly premium;
- g. Future government pays bi-weekly premium;
- h. Future employee pays bi-weekly premium;
- i. Future change in employee payment bi-weekly premium;
- j. Current total monthly premium;
- k. Future total monthly premium;
- l. Future government pays monthly premium;
- m. Future employee pays monthly premium;
- n. Future change in employee payment monthly premium

D. Frequency of Data Exchanges

The data exchanges under this agreement will begin June 8, 2026 and continue through December 7, 2027, in accordance with schedules set by CMS and OPM. CMS will submit requests for updated files to EHRhelp@opm.gov. CMS will submit requests electronically in real-time and batch processing on a daily basis throughout each year. OPM provides a monthly file that CMS loads into the area where PII can be stored. The requests from states query the OPM database stored on the Hub. A test Premium Spread Index File is provided in late August/early September, and the production Premium Spread Index File is provided in late September/early October.

E. Projected Starting and Completion Dates of the Matching

Program Starting Date – June 8, 2026

Completion Date – December 7, 2027 (December 7, 2028 if renewed for 1 year)

V. NOTICE PROCEDURES

- A. CMS will publish notice of the matching program in the Federal Register as required by the Privacy Act at 5 U.S.C. § 552a(e)(12).

- B. At the time of application or change of circumstances, an AE administering an Insurance Affordability Program will provide individualized (i.e., actual) notice to the Applicants or Enrollees about the OMB-approved streamlined eligibility application.
- C. The AE administering the Insurance Affordability Program will ensure provision of a redetermination notice in accordance with applicable law. These notices will inform Applicants and Enrollees that the information they provide may be verified with information in the records of other Federal agencies.

VI. VERIFICATION PROCEDURES AND OPPORTUNITY TO CONTEST FINDINGS

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

A. Verification Procedures

Before an AE may take any adverse action based on the information received from the matches under this Agreement, the AE will permit the individual to provide the necessary information or documentation to verify eligibility information. When an agency administering an Insurance Affordability Program determines that an Applicant or an Enrollee is ineligible for an Insurance Affordability Program based on the information provided by the match, and that information is inconsistent with information provided on the streamlined eligibility application or otherwise by an Applicant or Enrollee, the agency administering the Insurance Affordability Program will comply with applicable law and will notify each Applicant or Enrollee of the match findings and provide the following information: (1) the agency received information that indicates the Applicant or Enrollee 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 ineligible for the relevant Insurance Affordability Program.

B. Opportunity to Contest Findings

In the event that information attested to by an individual for matching purposes is inconsistent with information received through electronic verification obtained by use the OPM data through the Hub, the individual must be provided notice that the information he/she submitted did not match information received through electronic verifications as follows:

- 1.If the AE is an Exchange, an individual seeking to resolve inconsistencies between attestations and the results of electronic verification for the

purposes of completing an Eligibility Determination will be provided the opportunity to follow the procedures outlined in 45 CFR §§ 155.315 and 155.320. The AE will provide the proper contact information and instructions to the individual resolving the inconsistency.

2.If the AE is an agency administering a Medicaid or CHIP program, an individual seeking to resolve inconsistencies between attestations and the results of electronic verification for the purposes of completing an Eligibility Determination will be provided the opportunity to follow the procedures outlined in 42 CFR §§ 435.945 through 435.956. The AE will provide the proper contact information and instructions to the individual resolving the inconsistency.

3.Pursuant to 42 CFR § 600.345, if the AE is a BHP, it must elect either the Exchange verification procedures set forth in VI.B.1 or the Medicaid /CHIP verification procedures set forth at VI.B.2.

VII. DISPOSITION OF MATCHED ITEMS

CMS will retain the electronic files received from OPM only for the period of time required for any processing related to the matching program and will then destroy all such data by electronic purging, unless OPM and CMS are required to retain the information for enrollment, billing, payment, program audit, or legal evidentiary purposes, or where they are required by law to retain the information. AEs will also retain data for such purposes and under the same terms. In case of such retention, CMS will retire the retained data in accordance with the applicable National Archives and Records Administration (NARA) approved records disposition schedule. CMS will not create permanent files or a separate system comprised solely of the data provided by OPM. The source data provided to CMS from OPM will be overwritten approximately every thirty (30) days as OPM provides updated files.

VIII. SECURITY PROCEDURES

1.General. CMS (and OPM, in transmitting OPM data to CMS) will maintain a level of security that is commensurate with the risk and magnitude of harm that could result from the loss, misuse, disclosure, or modification of the information contained on the system with the highest appropriate sensitivity level in accordance to NIST Special Publication (SP) 800-175B Revision 1 and other applicable regulatory guidance and standards.

2.Legal Compliance. CMS (and OPM, in transmitting OPM data to CMS) shall comply with the limitations on use, and disclosure, storage, transport/transmission, retention, and safeguarding of data under all applicable Federal laws and regulations. These laws and regulations include section 1411(g) of the PPACA, the Privacy Act of 1974, as

amended (5 U.S.C. § 552a); the E-Government Act of 2002, which includes the Federal Information Security Management Act of 2002 (FISMA), 44 U.S.C. §§ 3541-3549, as amended by the Federal Information Security Modernization Act, 44 U.S.C. §§ 3551-3558; HIPAA; the Computer Fraud and Abuse Act of 1986; the Clinger-Cohen Act of 1996; and the corresponding implementation regulations for each statute.

3. CMS and OPM will comply with applicable OMB circulars and memoranda, including OMB Circular A-130, Managing Information as a Strategic Resource, published at 81 FR 49689 (July 28, 2016); applicable National Institute of Standards and Technology (NIST) directives and publications; and the Federal Acquisition Regulations. These laws, directives, and regulations include requirements for safeguarding Federal information systems and PII used in Federal agency business processes, as well as related reporting requirements. The Parties recognize and will implement the laws, regulations, NIST standards, and OMB directives including those published subsequent to the effective date of this Agreement.

4. Federal Information Security Modernization Act (FISMA) Compliance. FISMA requirements apply to all Federal contractors, organizations, or entities that possess or use Federal information, or that operate, use, or have access to Federal information systems on behalf of an agency. Both parties are responsible for oversight and compliance of their contractors and agents.

5. Incident Reporting

CMS and OPM will comply with OMB reporting guidelines in the event of a loss, potential loss, security incident, or breach of PII. (See OMB M-17-12, "Preparing for and Responding to a Breach of Personally Identifiable Information" (Jan. 3, 2017), and OMB M-25-04, Fiscal Year 2025 "Guidance on Federal Information Security and Privacy Management Requirements" (Jan. 15, 2025)) and notify the National Cybersecurity and Communications Integration Center/United States Computer Emergency Readiness Team (NCCIC/US-CERT) within one hour of being identified by the agency's top-level Computer Security Incident Response Team (CSIRT), Security Operations Center (SOC), or information technology department. In addition, within one hour of discovering the incident, the Party experiencing the incident will notify the other agency's System Security Contact named in this Agreement within one (1) hour of discovering the loss, potential loss, Security Incident, or Breach. If the Party experiencing the loss, potential loss, Security Incident, or Breach is unable to speak with the other Party's System Security Contact within one (1) hour or if for some reason contacting the System

Security Contact is not practicable (e.g., outside of normal business hours), CMS will contact OPM Security Operations Center at 1-844-377-6109 or via email at Cybersolutions@opm.gov. If OPM is unable to speak with CMS System Security Contact within one hour, OPM will contact CMS IT Service Desk at 1-800-562-1963 or via email at [CMS IT Service Desk@cms.hhs.gov](mailto:CMS_IT_Service_Desk@cms.hhs.gov).

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

6. Administrative Safeguards

CMS will comply with the existing and future requirements set forth in the laws, directives, and regulations referenced in the preceding subsections and any applicable amendments published after the effective date of this Agreement. These laws, directives and regulations include requirements for safeguarding Federal information systems and personally identifiable information used in Federal agency business processes, as well as related reporting requirements. Specifically, 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.

CMS will ensure that personnel with access to the data matched and created by the match receive training to ensure proper verification in a manner consistent with this agreement. Accordingly, CMS will restrict access to the matched data and to any data created by the match to only those authorized users of the Hub who need it to perform their official duties in connection with the uses of data authorized in this Agreement. Further, CMS will advise all personnel who will have access to the data matched and to any data created by the match of the confidential nature of the data, the safeguards required to protect the data, regulations applicable to retention of the data, and the civil and criminal sanctions for noncompliance contained in the applicable Federal laws.

7. Physical Safeguards

CMS will store the data received and any data created by the match in an area that is physically and technologically secure from access by unauthorized persons at all times. Physical safeguards may include door locks, card keys, biometric identifiers, etc. Those records will be maintained under conditions that restrict access to persons who need them in connection with their official duties related to the matching process. Only authorized personnel will transport the data matched and any data created by the match. It is the responsibility of the user's supervisor to ensure that both Parties are notified when a user has departed or duties have changed such that the user no longer needs access to the system, to ensure timely deletion of the user's account and password.

8. Technical Safeguards

CMS will process any data under this Agreement under the immediate supervision and control of the authorized users 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. CMS will also ensure that only authorized users have access to the data and will protect the confidentiality of the data. CMS will provide training to the authorized users on the usage of the system and the data.

9. Application of Policies and Procedures

CMS will adopt policies and procedures to ensure that it uses the information obtained under this Agreement and retained in its respective records or is obtained from the other party solely as provided in this Agreement. CMS will comply with these policies and procedures and any subsequent revisions.

10. Security Assessment

NIST Special Publication 800-37, as revised, encourages agencies to accept each other's security assessments in order to reuse information system resources and/or to accept each other's assessed security posture in order to share information. NIST 800-37 further encourages that this type of reciprocity is best achieved when agencies are transparent and make available sufficient evidence regarding the security state of an information system so that an authorizing official from another organization can use that evidence to make credible, risk-based decisions regarding the operation and use of that system or the information it processes, stores, or transmits. Consistent with that guidance, the Parties agree to make available to each other upon request system security evidence for the purpose of making risk-based decisions. Requests for this information may be made by either Party at any time throughout the duration or any renewal of this Agreement.

11. Compliance

CMS must ensure information systems and data exchanged under this matching agreement are maintained compliant with CMS Acceptable Risk Safeguards (ARS) standards. The ARS document can be found at: <https://security.cms.gov/policy-guidance/cms-acceptable-risk-safeguards-ars>. To the extent these documents are revised during the term of this Agreement, CMS must ensure compliance with the revised version.

IX. RECORDS USAGE, DUPLICATION, AND RE-DISCLOSURE RESTRICTIONS

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

- A. CMS will not use or disclose the data for any purpose other than the purposes authorized by this Agreement or allowed by the applicable Systems of Records Notice or Federal law.
- B. CMS will not duplicate or disseminate the OPM data, within or outside HHS, without the written consent of OPM, except as required by Federal law or for purposes under this Agreement. CMS will ensure that AEs using the Hub will not duplicate or disseminate the submission and response files within or outside of their respective agencies, without the written consent of OPM, except as where required by law, under this Agreement. To gain consent for a use or disclosure of the Data that is not authorized by this Agreement, the agency requesting the consent must specify in writing at least the following: (1) the data to be used or disclosed, (2) to whom the data will be disclosed, (3) the reasons justifying such use or disclosure, and (4) the intended use of the data. Where duplication or dissemination is required by law, CMS will notify OPM of the disclosure.
- C. CMS will not use the OPM data to extract information concerning individuals therein for any purpose not specified by this Agreement or allowed by applicable Systems of Records Notices (SORN) or Federal law.
- D. Through the Hub, CMS may disclose the data received from OPM to Exchanges and AEs pursuant to separate Computer Matching Agreements that authorize such entities to use the data for eligibility determinations regarding APTC, CSRs and BHP. Exchanges, including CMS in its capacity performing eligibility determinations for the FFEs and State-based Exchanges who rely on CMS for eligibility and enrollment functions, and agencies administering BHPs may share the results of the data matches under this Agreement with Applicants or Enrollees; Application Filers; and the Authorized Representatives of such persons.
- E. Any individual, including any officer, employee, and contractor of the Parties, who knowingly and willfully uses or discloses information obtained pursuant to

this Agreement in a manner or for a purpose not authorized by 45 CFR §§ 155.260 and section 1411(g) of the PPACA will be subject to the civil penalty provisions of 1411(h)(2) and 45 CFR § 155.285, which carry a fine of up to \$25,000 per use or disclosure.

X. ACCURACY ASSESSMENTS

The Privacy Act at 5 U.S.C. § 552a(o)(1)(J) requires that a CMA include “information on assessments that have been made” on the accuracy of the records that will be used in the matching program. CMS has not explicitly assessed the accuracy of the identifying information in the HIX systems of records, but Exchange operations are continually subject to rigorous examination and testing as required by Appendix C of OMB Circular A-123 and they are also evaluated through audits conducted by HHS Office of Inspector General and the Government Accountability Office. OPM currently estimates that 99% of the information is accurate for PPACA purposes in cases where: (1) an exact Applicant match is returned, (2) the Applicant has an enrollment status of "verified," and (3) the Applicant's enrollment period coincides with the dates received from the Hub.

XI. COMPTROLLER GENERAL ACCESS

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

XII. REIMBURSEMENT/FUNDING

All work performed by OPM to carry out the matching program under this Agreement will be performed on a reimbursable basis. OPM will allocate sufficient funds annually to support the completion of its responsibilities under this Agreement.

The legal authority for transfer of funds is the Economy Act at 31 U.S.C. § 1535. Reimbursement will be transacted by means of a separate reimbursement instrument in accordance with the established procedures that apply to funding reimbursement actions. CMS and OPM will execute and maintain a separate Interagency Agreement on an annual basis to address CMS reimbursement of relevant OPM costs related to requests covered by this Agreement.

XIII. DURATION OF AGREEMENT

A. Effective Date and Duration

The Effective Date of this Agreement is June 8, 2026, provided that CMS reported the proposal to re-establish this matching agreement to the Congressional committees of jurisdiction and OMB in accordance with 5 U.S.C. § 552a(o)(2)(A) and (r) and OMB Circular A-108 and, upon completion of their advance review period, CMS published notice of the matching program in the Federal Register for

at least thirty (30) days in accordance with 5 U.S.C. § 552a(e)(12). This agreement will be in effect for a period of eighteen (18) months.

B. Renewal

The parties may, within three (3) months prior to the expiration of this Agreement, renew this Agreement for a period not to exceed one additional year if CMS and OPM certify the following to their DIB:

1. The matching program will be conducted without change; and
2. The parties have conducted the matching program in compliance with this Agreement.

C. Modification

The parties may modify this Agreement at any time by a written modification, mutually agreed to by both parties, provided that the change is not significant. A significant change would require a new agreement.

D. Termination

This Agreement may be terminated at any time upon the mutual written consent of the parties. Either party may unilaterally terminate this Agreement upon written notice to the other party, in which case the termination will be effective ninety (90) days after the date of the notice, or at a later date specified in the notice.

XIV. LIABILITY

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

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. 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.

XV. INTEGRATION CLAUSE

This Agreement constitutes the entire agreement of the Parties with respect to its subject matter and supersedes all other data exchange agreements between the Parties that pertain to the disclosure of data between OPM and CMS for the purposes described in this Agreement. CMS and OPM 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.

XVI. PERSONS TO CONTACT

A. Office of Personnel Management Contacts

IT Security Issues

Danielle Rowell
Office of the Chief Information Officer
U.S. Office of Personnel Management
1900 E Street
Washington, DC 20415
Telephone: 202-936-1715
E-Mail: James.Saunders@opm.gov

Privacy Act Agreement Issues

Becky Ronayne
Senior Agency Official for Privacy
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415
Telephone: (202) 936-0124
E-Mail: Becky.Ronayne@opm.gov

Personnel Data

Caleb Judy
Program Manager
Human Resources Solutions
U.S. Office of Personnel Management
Telephone: (202) 808-1933
E-Mail: Caleb.Judy@opm.gov

Data Requests or Issues

E-mail: EHRlhelp@opm.gov

B. Centers for Medicare & Medicaid Services Contacts

Program Issues

Terence Kane
Director, Division of Automated Verifications and SEP Policy
Marketplace Eligibility and Enrollment Group
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services
7501 Wisconsin Avenue
Bethesda, MD 20814
Telephone: (301) 492-4449
Email: Terence.Kane@cms.hhs.gov

Medicaid/CHIP Issues

Brent Weaver
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) 786-0070
Email: Brent.Weaver@cms.hhs.gov

Systems and Security

Nicole Graham
Information Security Officer
Division of Marketplace IT Operations
Marketplace Innovation Technology Group
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Address: 7500 Security Boulevard Baltimore, MD 21244
Telephone: 410-786-2626
E-mail: Nicole.Graham1@cms.hhs.gov

Privacy and Agreement Issues

Barbara Demopulos
CMS Privacy Act Officer
Division of Security, Privacy Policy and Governance
Information Security and Privacy Group
Office of Information Technology
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Location: N1-14-56
Baltimore, MD 21244-1849
Telephone: (443) 608-2200
Email: Barbara.Demopulos@cms.hhs.gov

XVII. APPROVALS

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

Electronic Signature Acknowledgement: The signatories may sign this document electronically by using an approved electronic signature process. Each signatory who electronically signs this renewal agrees that his/her electronic signature has the same legal validity and effect as his/her handwritten signature on the document, and that it has the same meaning as his/her handwritten signature.

A. Centers for Medicare & Medicaid Services Program Official

ELIZABETH E.
PARISH -S

Digitally signed by ELIZABETH
E. PARISH -S
Date: 2026.05.20 14:39:43 -04'00'

Date _____

Elizabeth Parish

Deputy Director for Operations

Center for Consumer Information and Insurance Oversight

Centers for Medicare & Medicaid Services

B. Centers for Medicare & Medicaid Services Program Official

SARA M.
VITOLO -S

Digitally signed by SARA M.
VITOLO -S

Date: 2026.05.20 14:47:22 -04'00'

Date _____

Sara Vitolo
Deputy Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

C. Centers for Medicare & Medicaid Services Approving Official

PATRICK I. NEWBOLD -S2 Digitally signed by PATRICK I. NEWBOLD -S2
Date: 2026.05.22 07:04:49 -04'00'

Patrick Newbold
Chief Information Officer (CIO) & Director
Office of Information Technology
Centers for Medicare & Medicaid Services

D. U.S. Office of Personnel Management Approving Official

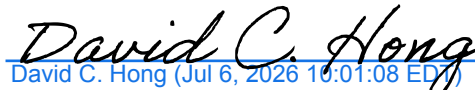
JASON PARMAN Digitally signed by JASON PARMAN Date: 2026.06.03 08:29:51 -04'00' 06/03/2026

Jason Parman
Principle Deputy Associate Director
Human Resources Solutions
U.S. Office of Personnel Management

E. U.S. Department of Health and Human Services Data Integrity Board Official

Electronic Signature Acknowledgement: The signatories may sign this document electronically by using an approved electronic signature process. Each signatory who electronically signs this renewal agrees that his/her electronic signature has the same legal validity and effect as his/her handwritten signature on the document, and that it has the same meaning as his/her handwritten signature.

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


David C. Hong (Jul 6, 2026 10:01:08 EDT)

Date _____

Clark Minor

Chairperson

HHS Data Integrity Board

U.S. Department of Health and Human Services

F. Office of Personnel Management Data Integrity Board Official

Electronic Signature Acknowledgement: The signatories may sign this document electronically by using an approved electronic signature process. Each signatory who electronically signs this renewal agrees that his/her electronic signature has the same legal validity and effect as his/her handwritten signature on the document, and that it has the same meaning as his/her handwritten signature.

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

Becky Ronayne Digitally signed by Becky Ronayne
Date: 2026.06.10 15:22:33 -04'00' Date _____
Becky Ronayne
Chairperson
OPM Data Integrity Board
U.S. Office of Personnel Management



EXCHANGE COMPUTER MATCHING PROGRAMS:
COST-BENEFIT ANALYSIS

Prepared by:
Center of Consumer Information and Insurance Oversight (CCIIO)
Centers for Medicare and Medicaid Services (CMS)

COST-BENEFIT ANALYSIS FOR EXCHANGE
MATCHING PROGRAMS
UPDATED AUGUST 12, 2025

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Introduction

This cost benefit analysis (CBA) provides information about the costs and benefits of conducting the eight required Exchange² matching or query programs, which are conducted under matching or other agreements between CMS and each federal data source agency and between CMS and state administering entities (AEs). The objective of the matches is to support the enrollment of eligible individuals in appropriate health coverage programs.

The matches enable AEs to make efficient and accurate eligibility determinations and redeterminations for enrollment in qualified health plans (QHPs), insurance affordability programs, Medicaid and Children Health Insurance Programs (CHIP), and Basic Health Programs (BHP), and support the issuance of certificates of exemption to individuals who are exempt from the individual mandate to maintain health insurance coverage. The matches provide for a single streamlined application process as required by the Affordable Care Act (ACA), support accurate and real-time eligibility determinations, and ensure that consumers can enroll in the correct program or be properly determined to be exempt from needing coverage.

The matching programs enable AEs to verify individuals' attested application responses with matched data elements from relevant federal data sources based on the type of eligibility determination being performed. These data elements may include verification of citizenship or immigration status (Department of Homeland Security), household income (Internal Revenue Service), social security information (Social Security Administration), and access to non-employer-sponsored and/or employer-sponsored minimum essential coverage (MEC). Non-employer-sponsored coverage includes coverage through TRICARE (Department of Defense), Veteran's Health Benefits (Department of Veterans Affairs, Veterans Health Administration), 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 (OPM).

While the matching programs support accurate eligibility determinations, which help avoid improper payments (e.g., improper payments of tax credits to ineligible individuals), no data is available to quantify the amount of improper payments avoided. In addition, the match results are not currently used to identify or recover past improper payments. Consequently, there are no estimates of avoided or recovered improper payments in key elements 3 and 4 (i.e., the "benefits" portion) of the CBA to offset against the personnel and computer costs estimated in key elements 1 and 2 (i.e., the "cost" portion) of the CBA, so the four key elements of the CBA do not demonstrate that the matching or query programs are likely to be cost-effective. However, the CBA describes other justifications (i.e., factors demonstrating that the matches are effective in maximizing enrollments in QHPs and are structured to avoid unnecessary costs) which support Data Integrity Board (DIB) approval of the matching programs. As permitted by the Privacy Act at 5 U.S.C. § 552a(u)(4)(B), the Justification section of each matching agreement

² 'Exchange' means a State-based Exchange (SBE, 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 the PPACA. For purposes of this analysis, all references to an Exchange shall refer equally to and include a state agency that is responsible for administering the Insurance Affordability Program under which individuals and small businesses may enroll in Qualified Health Plans (QHP) in the state.

requests the DIB(s) to determine, in writing, that the CBA is not required in this case to support approval of the agreement and to approve the agreement based on the other stated justifications.

The four key elements and sub-elements required to be addressed in the CBA are summarized on the CBA template below. The name of each key element and sub-element is highlighted in bold in the narrative portion of the CBA to indicate where that element is discussed in more detail.

Costs

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 (personnel costs and computer costs) are combined in this analysis. Note that more detail on the summary figures that follow is provided in later sections of this document.

For Agencies –

- **CMS (Recipient Agency):** \$74.5 million o \$2.3 million internal costs per year o \$45.6 million external costs) per year
 - o **Source Federal Agencies:** \$26.6 million per year (reimbursed by CMS)
- **State AEs:** No data developed.
- **Justice Agencies:** Not applicable, as these matching programs are not currently used to detect and recover past improper payments and therefore do not generate collection cases for justice agencies to investigate and prosecute.

For Clients (Applicants/Consumers), and any Third Parties assisting them –

- Opportunity costs (time required to apply for coverage) are quantified as \$1.2 billion per year (\$49.52 per application x 24.3 million consumers enrolled in QHPs).

For the General Public –

- No data developed. Costs to the public (such as discouragement of legitimate potential participants from applying, and threats to privacy, Constitutional rights, and other legal rights) would be less significant in these matching programs than in other matching programs, because these matching programs are intended to support enrollments and are not currently used to detect and recover past improper payments.

Benefits

Avoidance of Future Improper Payments

For advance payments of the premium tax credit (APTC), consumers must reconcile the tax credit at the time of tax filing, and so improper payment is mitigated. For state and federal costs associated with Medicaid coverage, the avoidance of future improper payment is not quantified here. However, the use of matching programs mitigates the risk of fraud and abuse by applicants or third parties by requiring that personal information provided on an eligibility application match known data on the individuals.

Recovery of Improper Payments and Debts

Not applicable, because data from the Exchange matching programs are not currently used to identify and recover improper payments and debts.

Matching Program Structure

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

CMS has entered into matching agreements with the following federal source agencies: 1) Social Security Administration (SSA), 2) Department of Homeland Security (DHS), 3) Internal Revenue Service (IRS), 4) Department of Veterans Affairs (VA) Veterans Health Administration (VHA), 5) Department of Defense (DoD), 6) Office of Personnel Management (OPM), and 7) the Peace Corps. In addition, CMS has developed a matching program that is executed with every state AE, including state Medicaid and CHIP agencies and State-based Exchanges (SBEs). CMS designed the Federal Data Services Hub (the “Hub”) to be a centralized platform for the secure electronic interface that connects all AEs and trusted data sources (TDS).

Without the Hub, each State AE would be required to enter into a separate arrangement with each federal agency to determine whether applicants for state health subsidy programs are eligible for coverage. If the match operations were conducted through separate arrangements outside of the Hub, the costs to CMS, the source federal agencies, the AEs, and consumers (applicants) would be significantly greater than under the current structure.

Background assumptions

CMS has made the following assumptions in developing this CBA:

- The ACA does not expressly mandate the use of computer matching, but effectively requires it by requiring a single, streamlined application process for consumers. Because matching must be conducted to provide the single, streamlined application process Congress required (i.e., is not optional), this CBA does not evaluate whether the matching programs should be conducted versus not conducted, but rather it evaluates whether the matching programs are efficiently structured and conducted, and whether the current structure is less costly than an alternative structure.
- Eight matching programs are currently operational. CMS receives data from seven source federal agencies (IRS, DHS, SSA, OPM, Peace Corps, VHA, and DoD) under separate respective individual CMAs. Under an eighth CMA, CMS makes the data from those seven source federal agencies, as well as CMS data regarding Medicare enrollment, available to state AEs; in addition, the eighth CMA makes state Medicaid and CHIP enrollment data available to CMS. The seven source federal agencies, CMS, and the state AEs are collectively known as the TDSs. All data from the TDSs are accessed by CMS

and by state AEs via the Hub platform, rather than via direct access from any AE to any TDS.

- Any alternative, non-Hub structure that could be used instead of the current Hub structure would require many more than eight CMAs, as well as many more system interconnections and data transmissions between agencies.
- For a subset of the TDSs, CMS incurs a cost as the recipient agency. The cost of each data transaction is estimated based on a prior year's matching program budget and the estimated number of data transactions occurring that year.
- In addition to the TDSs themselves, additional entities are necessary to provide support services to the Hub. CMS therefore incurs external costs in the hiring, maintenance, and associated costs of contractors to perform numerous functions related to the Hub. In addition, costs are incurred for identity proofing of applicants, troubleshooting, procedure writing, and maintenance support.
- CMS has internal costs related to the funding of CMS federal staff and associated resources to complete processes and responsibilities related to the Hub and the matching programs.
- The benefit of these matching programs is to consumers who apply for and obtain health coverage. The private benefit to them is improved health care delivery and the expected value of the coverage (whether through private insurance, Medicaid, CHIP, or a Basic Health Plan, if applicable).
- Regarding 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.

Costs

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 (personnel costs and computer costs) are combined in this analysis.**

Internal CMS Costs - \$2.3 million / year

Most costs paid by CMS to implement the Exchange matching programs and the Hub are external costs paid to contractors, which are addressed in the next section. CMS' internal costs for federal staff tasked to work on these programs are approximately \$2.3 million per year. The below chart attributes all of the costs to federal staff working in the Center for Consumer Information and Insurance Oversight (CCIIO) office; however, many teams across CMS provide support to the implementation of these programs, and CCIIO staff often have other programs in their portfolios beyond the Exchange matching programs and the Hub.

CCIIO Team	Estimated Annual Cost
Eligibility and Enrollment (E&E)	\$844,053
SMIPG (State Policy)	\$361,737
Marketplace Information Technology (MITG/HUB)	\$1,085,211
Total	\$2,291,001

External CMS costs: Hub operations - \$45.6 million/ year

Federal Data Services Hub (Hub) – \$29 million / year

The Hub is maintained by a CMS contract. While the initial build costs of the Hub were largely incurred before the implementation of the Exchange programs in 2013, there are ongoing costs associated with system maintenance, changes necessitated by ongoing technology development and new program implementation, and general system health monitoring. In fiscal year (FY) 2025, the average annual cost of the Hub contract was \$29 million. The Hub supports many other Exchange program efforts besides the matching programs, including the transmission of data to and from insurance issuers, and electronic file transfer for many programs within the Exchange; as a result, \$29 million is an overestimate of the annual Hub costs associated with Exchange matching program operations.

Exchange Security Operations Center (SOC)

The Exchange SOC is responsible for the security operations and maintenance for the Hub and the Federally-facilitated Exchange (FFE). For FY2025, the CMS Office of Information Technology (OIT) Information Security and Privacy Group (ISPG) budget team determined that there are no direct CCIIO budget contributions for the SOC operation costs. Previously, ISPG took on security operations functions for the Exchange, and multiple funding sources were added to the OIT budget to share the cost load across funding sources. As there are no direct CCIIO contribution to the SOC budget, there were enterprise funding changes made to support the Exchange as part of the enterprise security program upon its inception.

Exchange Operations Center (XOC) - \$6.0 million / year

The Exchange Operations Center (XOC) is an entity managed under the Exchange System Integrator contract tasked with coordinating the technical operations of the Hub and of the FFE. The XOC supports system availability, communication of system issues to stakeholders, and incident triage. Because the XOC budget line is not formally delineated for the Hub and for the FFE, the operational cost cited above is an overestimate of the costs specific to supporting Hub operations. The \$6,012,506 cost estimate provided here covers both XOC operations as well as site reliability engineer and metrics costs in support of the XOC.

Identity-Proofing Service Costs – \$10.6 million / year

Before consumer information can be submitted to a data source for data verification, a consumer's online account must be identity proofed. Remote identity proofing (RIDP) is a service supported through the Hub for AE programs. While identity proofing is not an eligibility requirement, it is a requirement for online application submission.

Costs paid by CMS to TDS agencies – \$26.6 million / year

Social Security Administration (SSA) - \$3.5 million / year

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, Title II income (retirement and disability), and work quarters. Verification of an individual's SSN is a required precursor to accessing consumer information through the other Exchange matching programs.

Matching with SSA data is accomplished through a reimbursable agreement with CMS. The total cost of the SSA contract with CMS in FY 2025 was \$3,476,719.03 under Inter Agency Agreement (IAA) number IA25-34.

Department of Homeland Security (DHS) – \$22.5 million / year

DHS is the verification source for naturalized and derived citizenship, and immigration status. The total cost of the DHS contract with CMS in FY 2025 was \$22,500,000 under IAA number IA25-31.

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 3-5 days for additional database searches. The third step requires manual touch from a DHS Status Verification Officer. Costs are currently \$2.25 per use at Steps 1, 2 and 3. Ongoing automation through DHS’s paperless initiative will impact these costs in the future.

Veterans Health Administration (VHA) - \$596K / year

Data from the VHA are used to identify current enrollment in health coverage through the VHA, which is an eligibility factor for APTC and cost sharing reduction (CSR) programs. The VHA contract with CMS is transactions-based. The total cost of the VHA contract with CMS in FY 2025 was \$595,902 under IAA number IA25-38.

Office of Personnel Management - \$25,100 / year

For FY 2022, OPM charged CMS a flat fee of \$25,100 under IAA number IA25-39.

Other Trusted Data Sources

CMS does not pay the other Trusted Data Sources (IRS, DoD, Peace Corps, and State Medicaid and CHIP Agencies) for access to and use of their data.

Consumer opportunity costs – non-monetary, but quantified

Applying for coverage does not have a monetary cost to applicants, but does have an opportunity cost. CMS estimates that the average time for a consumer to apply for and enroll (or re-enroll) in a QHP each year averages 1 hour and 12 minutes.³ At a rate of \$41.27 per hour, this opportunity cost is estimated at \$49.52 per application per year. The complete number of applications submitted each year across all AEs is not known, but the total number of QHP enrollees for PY 2025 is 24.3 million,⁴ resulting in a consumer opportunity cost of approximately \$1.2 billion. It should be noted that this estimate does not include opportunity costs for enrollees in Medicaid,

³ Estimate is based on a 12 minute average to complete an application for QHP coverage plus an additional 1 hour for the consumer to provide supporting documentation to the Exchange should a data matching issue occur.

⁴ Enrollees in QHPs have the opportunity each year to be automatically reenrolled in a QHP or to return to the Exchange to choose a new plan – however, Exchanges encourage enrollees to update their information and reevaluate their health coverage needs for the coming year. Furthermore, enrollees are required to report certain life changes as they occur, since they may impact coverage and/or participation in insurance affordability programs.

CHIP, or BHP, if applicable, programs, or for consumers who apply but do not subsequently enroll in coverage.

Benefits

Benefits to Agencies – not quantified

The Exchange matching programs improve the accuracy of data used for making program eligibility determinations and ensure that individuals are correctly determined and are not inappropriately enrolled in multiple programs. Improved data quality helps ensure that eligibility determinations and other decisions affecting APTC are accurate, which helps avoid future improper payments. This avoidance of future improper payments fits the third cost benefit analysis key element but hasn't been quantified.

Using data made available through the Exchange matching programs in combination with an individual applicant's attestation of his or her personal information is more reliable than relying solely on applicant attestations. The use of data matching mitigates the risk of fraud and abuse by applicants or third parties by requiring that personal information provided on an eligibility application match known data on the individuals.

Benefits to Enrollees of obtaining health coverage – quantified, but outside the scope of the 4 key elements

For PY2025, 24,319,713 consumers enrolled in a QHP across all Exchanges. Of these, 92% received APTC, with an average value of \$550 per month (annualized to \$6,600 per year). In total, therefore, approximately \$148 billion in APTC will be provided to enrollees in Plan Year 2025.⁵

Approximately 51% of the QHP enrollees in PY2025 received financial assistance through cost-sharing reductions when enrolling in a silver-level plan. The financial estimate of this benefit is not quantified here, as it is dependent on individual utilization of medical services.

Additionally, a significant number of consumers receive health coverage through Medicaid, CHIP, or a BHP, if applicable, and received eligibility determinations for that coverage based on data made available through these agreements. Because of the wide variety in state approaches to making and reporting eligibility determinations, the number of enrollees in these programs is not quantified here.

The financial benefit of having health coverage, whether through a QHP, Medicaid, CHIP, or BHP, if applicable varies by individual and individual health needs, and is therefore not estimated here.

While these benefits to consumers are made possible in part by the Exchange matching programs, the benefits are ultimately paid with federal funds (or, in the case of Medicaid and

⁵ CMS has elected to use the entire universe of 2025 QHP enrollees (24.3 million) in this CBA in order to present the most conservative case for consumer opportunity costs.

CHIP enrollees, with a combination of federal and state funds). Neither that funding nor these benefits to consumers can be considered a direct cost or benefit of conducting the Exchange matching programs. As a result, these benefits are not directly applicable to this analysis.

Recovery of improper payments – not germane (not an objective) at this time

The fourth cost benefit analysis key element (recovery of improper payments and debts) is not germane to this cost benefit analysis, because data from the Exchange matching programs are not currently used to identify and recover improper payments and debts.

Annual reconciliation and recovery of improper tax payments are performed by the IRS through a process that is independent of the Exchange matching programs and other CMS eligibility determination activities. While the Exchange matching programs could provide for annual and monthly reporting of data by Exchanges 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 Exchange 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.

Consideration of Alternative Approaches to the Matching Programs

In requiring a single, streamlined application process and specifying electronic data access, the ACA effectively required use of computer matching to make eligibility determinations. As a result, wholly manual alternatives for verification of application information (such as a paper-based documentation process) are not considered as a viable alternative in this analysis.

The Exchange matching programs currently leverage the Hub to minimize connections between AEs and the federal partners. This model has successfully met program needs by providing for a single, streamlined application process for consumers, and supporting accurate eligibility determinations, which in turn increase program integrity for the Exchange programs.

An alternative, non-Hub approach, for AEs to manage matching programs individually without using the Hub, was considered through this analysis. Without the Hub, each State AE would be required to enter into separate matching arrangements with each federal partner and build direct connections to each system. CMS believes a non-Hub approach 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).

Based on this analysis, CMS believes the current structure minimizes duplication of effort and is therefore less costly for CMS, federal partners, and State AEs, than an alternative structure that would not leverage the Hub.

Conclusion

The Exchange matching programs are effectively required, not discretionary, in order to provide the single streamlined application process Congress required. As a result, Exchange matching programs must continue in the absence of a cost-effectiveness finding.

After careful evaluation of the data presented above, CMS intends to continue using the current matching program structure, which is less costly than the alternative, non-Hub structure and achieves the primary goals of providing a single streamlined application process and accurate eligibility determinations. While CMS intends to retain the existing matching program structure moving forward, necessary changes will be made as needed to keep the matching programs compatible with changes in program operations and data flow. This cost benefit analysis and the decision to retain the current matching structure should increase the public's trust in the participating agencies as careful stewards of taxpayer dollars.

Because the Exchange matching programs incur a net cost (i.e., do not demonstrate that the matching programs are likely to be cost-effective), the Exchange matching agreements should be worded to provide for data integrity board (DIB) approval to be based on the other benefits and mitigating factors described in this analysis and in each individual agreement. Specifically, the agreements should provide justification for each DIB's written determination that the cost benefit analysis is not required to demonstrate cost-effectiveness for Exchange matching programs.