

**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. 2025-12
Department of Health and Human Services No. 2601
The Social Security Administration No. 1097**

I. PURPOSE, LEGAL AUTHORITY AND DEFINITIONS

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 (PPACA) (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, PPACA) and its implementing regulations. CMS will use SSA data to determine individuals' eligibility for initial enrollment in a Qualified Health Plan (QHP) through an Exchange¹ established under the PPACA; for Insurance Affordability Programs (IAPs); and certificates of exemption from the shared responsibility payment; and to make eligibility redeterminations and renewal decisions, including appeal determinations. IAPs include:

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

¹ Since January 1, 2014, consumers in every state (including the District of Columbia) have had access to health insurance coverage through Health Insurance Marketplaces operated by State-based Exchanges (SBEs) or by the Federal government through the Federally-facilitated Exchange (FFE). 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), 1311(d)(1), or 1321(c)(1) of the PPACA.

4. Basic Health Program (BHP).

SSA will provide CMS with the following information about each individual identified in finder files provided by CMS, as relevant: (1) Social Security number (SSN) verifications, (2) death indicator, (3) Title II disability indicator, (4) incarceration information, (5) monthly and annual Social Security benefit information under Title II of the Social Security Act (the Act), (6) Quarters of Coverage (QC), and (7) confirmation that an allegation of citizenship is consistent with SSA records.

Authorized employees and contractors of CMS and SSA will carry out the terms and conditions of this agreement.

B. Legal Authority

This agreement is executed in compliance with the Privacy Act of 1974, as amended (5 United States Code (U.S.C.) §552a); PPACA; the E-Government Act of 2002 which includes the Federal Information Security Management Act (FISMA), (44 U.S.C. §§3541-3549), as amended by the Federal Information Security Modernization Act of 2014 (U.S.C. §§3551-3558), 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 matching program:

1. Section 1411(a) of the PPACA requires the Secretary of the Department of Health and Human Services (HHS) to establish a program meeting the requirements of the PPACA to determine eligibility for enrollment in coverage under a QHP through an Exchange or participation in certain IAPs, and for certifications of exemption. Pursuant to section 1311(d)(4)(H) of the PPACA, an Exchange, subject to section 1411 of the PPACA, 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 the PPACA, the Secretary of HHS shall submit certain identifying information, including SSNs to the Commissioner of Social Security for a determination as to whether the information is consistent with the information in the records of SSA. Under section 1411(d) of the PPACA, the Secretary of HHS is directed to establish a system for verification of other information necessary to make an eligibility determination. Section 1411(e)(1) of PPACA 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 matching program through regulations at 45 Code of Federal Regulations (C.F.R.) Part 155.

2. Section 1413(a) of the PPACA 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 IAPs or enrollment in a QHP through an Exchange. Section 1413(c) of the PPACA directs the use of a secure electronic system for transmitting information to determine eligibility for IAPs and enrollment in a QHP through an Exchange and section 1413(d) of the PPACA authorizes the Secretary of HHS to enter into agreements to share data pursuant to section 1413. The program established by the Secretary under section 1413 of the PPACA 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 the PPACA 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 (50 U.S.C. §401) 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, incarceration 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 the PPACA 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 the PPACA 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 certificates of exemptions. Under the authority of sections 1311, 1321, and 1411 of the PPACA, 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 certificate 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 PPACA (as added by section 2201 of the PPACA) requires that Medicaid and CHIP agencies utilize the same streamlined enrollment system and secure electronic interface established under section 1413 of the PPACA to verify data and determine eligibility.
10. Section 1331 of the PPACA 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 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 IAPs.
11. The Privacy Act at 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 published routine uses for their respective systems of records to authorize their disclosures under this agreement.

C. Definitions

1. "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 the PPACA), 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 the PPACA;
2. "Applicant" means an individual seeking enrollment in a QHP through an Exchange, eligibility for himself or herself in an IAP, or a certificate of

exemption; this term includes an individual whose eligibility is determined at the time of a renewal or redetermination;

3. “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;
4. “Basic Health Program” or “BHP” means an optional state program established under section 1331 of the PPACA;
5. “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;
6. “Children’s Health Insurance Program” or “CHIP” means the state program established under Title XXI of the Social Security Act;
7. “CMS” means the Centers for Medicare & Medicaid Services. The Centers for Medicare and Medicaid Services combines the oversight of the Medicare program, the federal portion of the Medicaid Program and State Children’s Health Insurance Program, the Health Insurance Marketplace, and related quality assurance activities;
8. “Eligibility determination” means the determination of eligibility for enrollment in a QHP through an Exchange, IAP, or exemption, and includes the process of resolving an appeal of an Eligibility Determination;
9. “Exchange” (otherwise known as Marketplace) means a State-based Exchange (including a not-for-profit Exchange) or a Federally Facilitated Exchange (FFE) established under sections 1311(b) and 1311(d)(1) or 1321(c)(1) of the 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;
10. “Exemption” means an exemption from the requirement or penalty imposed by section 5000A of the IRC - pursuant to section 1311(d)(4)(H) of the PPACA, an Exchange, subject to section 1411 of the PPACA, must grant a certificate of

exemption attesting that an individual is exempt from the individual responsibility requirement or penalty imposed by section 5000A of the IRC;

11. “HHS” means the Department of Health and Human Services;
12. “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;
13. “Insurance Affordability Program” or “IAP” means a program that is one of the following: (1) a state Medicaid program under Title XIX of the Social Security Act; (2) a state CHIP program under Title XXI of such Act; (3) a state BHP established under section 1331 of the PPACA; (4) a program that makes coverage in a QHP through the Exchange with APTC; or (5) a program that makes available coverage in a Qualified Health Plan through the Exchange with CSR;
14. “Matching Program” is defined at 5 U.S.C. § 552a(a)(8) and 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;
15. “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.;
16. “PPACA” means Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as amended by the Healthcare and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (collectively, PPACA);
17. “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;
18. “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 their earnings covered under Social Security;
19. “Redetermination” means the process by which an Exchange determines eligibility for enrollment in a QHP and/or an IAP or certificate 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 eligibility;

20. "Relevant Individual" means any individual listed by name and SSN on an application for enrollment in a QHP through an Exchange, an IAP, or for a certificate of exemption whose PII may bear upon determination of the eligibility of an individual for enrollment in a QHP and/or for an IAP or certificate of exemption;
21. "Renewal" means the annual process by which the eligibility of Medicaid and CHIP beneficiaries is reviewed for continuation of coverage;
22. "Routine Use" is defined at 5 U.S.C. §552a(a)(7) and refers to a description of a disclosure recipient and purpose to and for which the agency may disclose a Privacy Act record to parties who are not employees or official of the agency without the individual record subject's prior, written consent. To be valid, a routine use must be published in the System of Records Notice (SORN) for the applicable system of records for a public notice and comment period of at least 30 days and must be compatible with the purpose for which the agency collected the record;
23. "SSA" means the Social Security Administration;
24. "System of Records" is defined at 5 U.S.C. §552a(a)(5) and means a group of any records under the control of a federal 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

D. CMS's Responsibilities

1. Pursuant to sections 1411 and 1413 of the PPACA, CMS will develop procedures to transmit information to SSA.
2. 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.
3. 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.
4. CMS will use the information disclosed by SSA for the purposes set forth in this agreement.

5. 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.
6. When both the HHS Data Integrity Board (DIB) and the SSA DIB approve this agreement, CMS will provide Congress and the OMB with advance notice of this Matching Program. Upon completion of OMB's advance review CMS will publish the required matching notices in the *Federal Register* and will provide a copy of the published notice to SSA.
7. CMS will reimburse SSA for the costs associated with SSA's performance of this agreement pursuant to a separately executed Interagency Agreement (IAA).
8. 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.

E. 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.

III. JUSTIFICATION AND ANTICIPATED RESULTS

F. Cost Benefit Analysis

As required by §552a(u)(4) of the Privacy Act, a cost benefit analysis (CBA) is included as an Attachment, 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 are approximately \$74.5 million, but it does not quantify direct governmental cost saving benefits sufficient to offset the costs because 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.

G. Other Supporting Justifications

Even though the Marketplace matching programs cannot be demonstrated to be cost-effective to conduct, 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 (i.e., a CBA demonstrating likely cost-effectiveness) is not required (i.e., is not required to approve this matching

program). The Privacy 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 is requested to approve this agreement based on other justifications, which include the following:

1. 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.
2. The Marketplace matching programs' eligibility determinations and minimum essential coverage 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.
3. The matching programs provide a significant net benefit to the public by accurately determining eligibility for APTC.
4. An efficient eligibility and enrollment process contributes to greater numbers of consumers enrolling in Marketplace qualified health plans, resulting in a reduction of the uninsured population, therefore improving overall health care delivery.
5. Continuing to use the current matching program structure, which is less costly than any alternative structure, is expected to increase the public's trust in the participating agencies as stewards of taxpayer dollars.

H. Specific Estimate of Any Savings

There are no cost savings to conducting the Marketplace matching programs, as opposed to not conducting them. However, use of matching programs is effectively mandated by statute and regulation in order to provide for the streamlined application process required by Congress in section 1413 of the PPACA. Therefore, the optimal result is attained by limiting the cost of conducting the matching programs by using a matching program operational structure and technological process that is more efficient than any alternatives.

IV. RECORDS DESCRIPTION

CMS and SSA have published SORNs that cover the records used in this matching program. CMS and SSA will maintain data obtained through this agreement in accordance with the Privacy Act and SORN requirements.

Each party is responsible for ensuring that its uses and disclosures of the information it receives from the other in this matching program comply with OMB guidance relevant to matching programs, the Privacy Act, and other applicable federal law.

A. Systems of Records

1. The CMS SORN that supports this matching program is the CMS Health Insurance Exchange System (HIX), CMS System No. 09-70-0560, last published in full at 78 Fed. Reg. 63211 (Oct. 23, 2013) and partially updated at 83 Fed. Reg. 6591 (Feb. 14, 2018). Routine use 3 authorizes CMS's disclosures of identifying information about applicants to SSA for use in this matching program.
2. The SSA SORNs and routine uses that support this matching program are identified below:
 - a. Master Files of SSN Holders and SSN Applications (referred to as the Enumeration System), 60-0058, last fully published at 87 Fed. Reg. 263 (January 4, 2022);
 - b. Prisoner Update Processing System (PUPS), 60-0269, last fully published at 64 Fed. Reg. 11076 (March 8, 1999) and updated at 72 Fed. Reg. 69723 (December 10, 2007), 78 Fed. Reg. 40542 (July 5, 2013), and 83 Fed. Reg. 54969 (November 1, 2018);
 - c. Master Beneficiary Record (MBR) 60-0090, last fully published at 71 Fed. Reg. 1826 (January 11, 2006), and updated at 72 Fed. Reg. 69723 (December 10, 2007), at 78 Fed. Reg. 40542 (July 5, 2013), at 83 Fed. Reg. 31250-31251 (July 3, 2018) and at 83 Fed. Reg. 54969 (November 1, 2018) 89 Fed. Reg. 825 (January 5, 2024), and 89 Fed. Reg. 14554 (February 27, 2024); and
 - d. Earnings Recording and Self-Employment Income System (referred to as the Master Earnings File (MEF)), 600059, last fully published at 71 Fed. Reg. 1819 (January 11, 2006) and amended at 78 Fed. Reg. 40542 (July 5, 2013), 83 Fed. Reg. 54969 (November 1, 2018), and 89 Fed. Reg. 825 (January 5, 2024)

The systems of records involved in this computer matching program have routine uses permitting the disclosures needed to conduct this match.

The information in these systems of records may be updated during the effective period of this agreement as required by the Privacy Act.

B. Number of Records Involved

The following table provides the total number of transactions in fiscal years FY 2024 actual amounts and FY 2025 projected base estimates, 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 2024 Total (Actual)	FY 2024 Highest Month (Actual)	FY 2025 Total (Projected)	FY 2025 Highest Month (Projected)
Real-time	182,913,270	21,189,793	175,933,282	23,016,410
Batch	63,377,812	8,733,562	69,352,192	8,214,495

C. Specified Data Elements Used in the Match

Applicants for enrollment in a QHP through an Exchange, IAPs, and certificate of exemption are only required to provide information strictly necessary to authenticate identity, determine eligibility, and determine the amount of APTC or CSRs. Accordingly, CMS will request a limited amount of SSA information for purposes of PPACA eligibility determinations, redeterminations, and renewals.

1. For each applicant and for Relevant Individuals, CMS will submit a submission 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' request, SSA's response may include the following data elements: CMS provided last name, SSN, first name, and date of birth; death indicator; disability indicator; incarceration information; Title II (annual and monthly) income information; and confirmation of attestations of citizenship status and SSN. SSA may also provide QC data when applicable to CMS submitted requests.
3. For Relevant Individuals, CMS will request a limited amount of SSA information. Based on CMS' 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 provide verification of SSNs with a death indicator, Title II income information, and disability indicator.
5. For self-reported redeterminations, CMS will provide SSA with the following: updated or new information reported by the applicant-or enrolled individual, last

name, first name, date of birth, and SSN. Depending on CMS' request, SSA's response will include each of the following data elements that are relevant and responsive to CMS's request: CMS provided last name, SSN, first name, and date of birth; death indicator; disability indicator; incarceration 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 SSA last name, SSN, first name, date of birth, and citizenship indicator. SSA will provide CMS with a response including: CMS provided last name, SSN, first name, and date of birth; confirmation of attestations of citizenship status; verification of SSN; death indicator; disability indicator; incarceration information; and Title II (annual and monthly) income information.

D. Frequency of Data Exchanges

The data exchange under this agreement will begin March 9, 2026, and continue through September 8, 2027, in accordance with schedules set by CMS and SSA. CMS will submit requests electronically in real-time and batch processing on a daily basis throughout the year.

V. NOTICE PROCEDURES

- A. CMS will publish notice of the Matching Program in the *Federal Register* as required by the Privacy Act (5 U.S.C. §552a(e)(12)).
- B. At the time of application or change of circumstances, CMS provides actual notice to applicants for enrollment in a QHP, or an IAP, on the streamlined eligibility application, that the information they provide may be verified with information in the records of other federal agencies. CMS also provides this actual notice to individuals seeking a redetermination or renewal decision.
- C. When an applicant applies for a certificate of exemption, CMS will provide the individual with actual notice on the exemption application regarding the collection, use, and disclosure of the applicant's PII and a Privacy Act statement describing the purposes for which the information is intended to be used and disclosed, which encompasses the disclosures made in this matching program.

VI. VERIFICATION PROCEDURES AND OPPORTUNITY TO CONTEST FINDINGS

Information maintained or created by CMS regarding any individual that becomes part of the CMS' HIX system of records can be corrected by an individual at any time by contacting CMS.

CMS established and maintains notice and opportunity to contest procedures by which individuals may correct information about them in the match results CMS obtains from SSA before an adverse action is taken on the basis of the match results. CMS will ensure that, prior to any adverse action, the individual is provided proper contact information and instructions for contesting the contents of the information depending on the source and type of information being contested.

VII. 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 then destroy all such files by electronic purging, except to the extent required to retain files longer to meet evidentiary requirements, for internal audits, for accuracy checks, or to adjudicate appeals. In the case of such longer 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 maintain PII in the submission files received from CMS for future verification purposes, except as provided in Section XI for General Accountability Office (GAO) audit purposes. The submission files provided by CMS remain the property of CMS.

VIII. SECURITY PROCEDURES

SSA and CMS will comply with the requirements of the Federal Information Security Management Act of 2002 (FISMA) 44 U.S.C. Chapter 35, Subchapter II, as amended by the Federal Information Security Modernization Act of 2014 (Pub. L. 113-283); related OMB circulars and memoranda, such as OMB Circular A-130, *Managing Information as a Strategic Resource* (July 28, 2016) and Memorandum M-17-12, *Preparing for and Responding to a Breach of Personally Identifiable Information* (January 3, 2017); 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, regulations, and directives include requirements for safeguarding Federal information systems and personally identifiable information (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 CMS Information Systems Security and Privacy Policy and the CMS Acceptable Risk Safeguards (ARS) standards.

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. Breach Reporting

If either SSA or CMS experiences an incident involving the suspected or confirmed breach (i.e., loss) of PII provided by SSA or CMS under the terms of this agreement, they will follow the breach reporting guidelines issued by OMB. In the event of a PII breach, the agency experiencing the breach is responsible for following its established procedures, including notification to the proper organizations. In addition, the agency experiencing the breach will also notify the other agency's point of contact named in this agreement within one hour of discovering the breach. If CMS is unable to speak with the SSA Office of Privacy and Disclosure Breach Contact within one hour or if for some other reason notifying the Breach contact is not practicable (e.g., it is outside of the normal business hours), CMS will call SSA's National Network Service Center 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 only those users (e.g., employees, contractors, etc.) 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 (e.g., door locks, card keys, biometric identifiers, etc.). Only authorized personnel will transmit or transport the data matched and any data created by the match. SSA and CMS established, and will comply with appropriate

safeguards for the data 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 their official duties.

F. Application of Policies and Procedures

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

G. Security Assessments

NIST Special Publication (SP) 80037, as revised, encourages agencies to accept each other's security assessments in order to reuse information system resources and/or to accept each other has assessed security posture in order to share information. NIST SP 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 making risk-based decisions. Either party may make requests for this information at any time throughout the duration or any renewal of this agreement.

H. Compliance

CMS must ensure information systems that process information provided by SSA under this matching agreement are compliant with CMS ARS standards. The ARS documents can be found online (subject to revision):

- *CMS Acceptable Risk Safeguards (ARS)* at <https://security.cms.gov/policy-guidance/cms-acceptable-risk-safeguards-ars>; and
- *Acceptable Risk Safeguards 5.1x* at <https://www.cms.gov/research-statistics-data-and-systems/cms-information->

To the extent these documents are revised during the term of this agreement, CMS will comply 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 maintain a log of transactions submitted to SSA for matching under this agreement for audit purposes. This logged information will be retained by CMS and will be available upon request to facilitate analysis and investigations of reported security incidents related to the 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 the Act may also share information regarding the operational status of those entities to other federal agencies that supply information in support of operations under the Act.

IX. RECORDS USAGE, DUPLICATION, AND REDISCLOSURE RESTRICTIONS

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 compliant with the Privacy Act, federal law, and OMB guidance.

CMS and SSA will comply with the following limitations on use, duplication, and re-disclosure of the data in the submission and response files exchanged under this agreement:

- 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, except as required by federal law.
- 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 VII 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 the PPACA are potentially subject to the civil penalty provisions of section 1411(h)(2) of the PPACA, which carries a fine of up to \$25,000.

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 information covered by 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 also evaluated through audits conducted by HHS Office of Inspector General and the Government Accountability Office. SSA independently assessed the benefits data used in this matching program to be more than 99 percent accurate when the benefit record is created. Incarceration 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 incarceration data through applicable CMS verification procedures and the notice and opportunity to contest procedures specified in Section VI of this agreement before taking any adverse action. The SSA Enumeration System used for SSN matching is 96.5 percent accurate based on SSA’s Office of Quality Review “FY 2022 Enumeration Accuracy Review Report (March 2023).”

Upon initial application for a Social Security Number (SSN), applicants are required to provide identifying information, including citizenship status. SSA has required applicants for an SSN to provide their citizenship status since 1981. SSN holders are not required to update SSA regarding changes in immigration or citizenship status unless they are filing

a claim for benefits or requesting a replacement card. As a result, SSA's citizenship information is accurate for the effective administration of its own programs; however, this information may not be current and SSA cannot guarantee its accuracy if used later for other purposes. SSA is not the official custodian of U.S. citizenship records.

XI. 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 agreement.

XII. REIMBURSEMENT

This agreement does not authorize SSA to incur obligations through the performance of the services described herein. Only the execution of Form FS-7600A, Form FS-7600B and an executed Interagency 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 FS-7600A, Form FS-7600B, and an executed IAA that provide authorization for SSA to perform services under this agreement in FY 2023. SSA's ability to perform work beyond FY 2023 is subject to the availability of funds.

XIII. DURATION OF AGREEMENT, MODIFICATION, AND TERMINATION

- A. Duration: The Effective Date of this agreement is March 9, 2026, 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, after completion of OMB's advance review, CMS published notice of the matching program in the *Federal Register* for at least 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.

The DIBs of HHS and SSA may, within 3 months prior to the expiration of this agreement, renew this agreement for a period not to exceed one year 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 renew this agreement, it must notify the other party of its intention not to continue at least 90 days before the expiration of the agreement.

- B. Modification: The parties may modify this agreement at any time by submitting a Form FS 7600A and Form FS 7600B modification, agreed to by both parties and approved by the authorized signatories 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 as 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.

XIV. 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, regarding the use of any data furnished pursuant to this agreement.

XV. DISPUTE RESOLUTION

In the event of a dispute related to reimbursements under Section XII 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 5, *Intragovernmental Transaction Guide*.

XVI. 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.

XVII. INTEGRATION CLAUSE

This agreement, including Forms FS-7600A, FS-7600B, 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. This agreement takes precedence over any other documents that may be in conflict with it, including any conflicting terms in any Interconnection Security Agreement entered into in accordance with NIST SP 800-47 governing the interconnection between information technology systems that will be utilized for the transfer of information under this agreement.

XIII. 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 affect 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. PERSONS TO CONTACT

A. SSA Contacts:

Matching Agreement Issues

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Government Information Specialist

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Office of Privacy and Disclosure

Social Security Administration

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Data Exchange Issues

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Data Exchange Liaison
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Office of Data Exchange, Policy Publications, and International Negotiations
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B. CMS Contacts:

Program Issues

Terence Kane

Director

Division of Automated Verifications and Special Enrollment Policy

Marketplace Eligibility and Enrollment Group

Center for Consumer Information & Insurance Oversight

Centers for Medicare & Medicaid Services

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Medicaid/CHIP Issues

Brent Weaver

Director

Data and Systems Group

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Centers for Medicare & Medicaid Services

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Systems and Security

Darrin V. Lyles

Information System Security Officer (ISSO)

Division of Marketplace IT Operations

Marketplace IT Group

Center for Consumer Information & Insurance Oversight

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Privacy and Agreement Issues

Barbara Demopulos

CMS Privacy Act Officer

Division of Security, Privacy Policy and Governance

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Telephone: (443) 608-2200
Email: Barbara.Demopulos@cms.hhs.gov

XX. APPROVALS

Electronic Signature Acknowledgement: The signatories may sign this document electronically by using an approved electronic signature process. By signing this document electronically, the signatories agree that the signature they provide has the same meaning and legal validity and effect as a handwritten signature.

A. Centers for Medicare & Medicaid Services Program Officials and Approving Appointed Senior Level Official

The authorized program and approving officials, whose signatures appear 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 commit the organization to the terms of this agreement.

Recipient Agency Certification:

As the authorized representatives of the source agency named above, I certify that I have competent authority on behalf of CMS to enter into the obligations set forth in this agreement.

Approved by (Signature of Approving Appointed Senior Level Official)

ELIZABETH E.
PARISH -S



Digitally signed by ELIZABETH E.
PARISH -S

Date: 2025.12.05 09:28:12 -05'00'

Date _____

Elizabeth Parish
Deputy Director for Operations
Center for Consumer Information and Insurance Oversight
Deputy Administrator
Centers for Medicare & Medicaid Services

Approved by (Signature of Authorized CMS Program Official)

**SARA M.
VITOLO -S**

Digitally signed by SARA M.
VITOLO -S
Date: 2025.12.01 15:19:33
-05'00'

Date _____

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

Approved by (Signature of Authorized CMS Program Official)

**PATRICK I.
NEWBOLD -S2**

 Digitally signed by PATRICK I.
NEWBOLD -S2
Date: 2025.12.04 14:39:28 -05'00'

Date _____

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

B. U.S. Department of Health and Human Services Data Integrity Board 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 Approving Data Integrity Board Official)

Clark Minor

Clark Minor (Dec 29, 2025 16:01:38 CST)

Date 12/29/2025

Clark Minor
Chairperson
HHS Data Integrity Board
U.S. Department of Health and Human Services

C. Social Security Administration Signatures

The authorized approving official, whose signature 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.

Source Agency Certification:

As the authorized representatives of the source agency named above, I certify that I have competent authority on behalf of SSA to enter into the obligations set forth in this agreement.

Jennifer
Karangelen

 Digitally signed by Jennifer
Karangelen
Date: 2025.11.21 12:43:12 -05'00'

Date _____

Jennifer Karangelen
Acting FOIA and Privacy Officer
Privacy & Disclosure Policy
Law and Policy

D. SSA Data Integrity Board Approval

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.

**Matthew
Ramsey**

Digitally signed by
Matthew Ramsey
Date: 2025.12.05 07:26:29
-05'00'

Date _____

Matthew D. Ramsey
Chair
Data Integrity Board
Social Security Administration



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 Exchange¹ 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

¹ '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.

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 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.

A. 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
 - \$2.3 million internal costs per year
 - \$45.6 million external costs) per year
 - **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.

B. 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.

C. 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.

D. 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.

I. 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.**

A. 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

B. 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.

C. 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.

D. 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.² 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,³ 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, CHIP, or BHP, if applicable, programs, or for consumers who apply but do not subsequently enroll in coverage.

II. Benefits

A. Benefits to Agencies - not quantified

² 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.

³ 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. 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.

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.

B. 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 2025.⁴

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 CHIP enrollees, with a combination of federal and state funds). Neither that funding nor these

⁴ 5/12/2025: Plan Year 2025 data from <https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf>

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.

C. 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.