

**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. ###
Department of Health and Human Services No. ###**

**Effective Date – October 2, 2018
Expiration Date –April 2, 2020**

I. PURPOSE, LEGAL AUTHORITY, 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 ACA) and the implementing regulations, CMS, in its capacity as the Federally-Facilitated Exchange, and other Administering Entities 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.

The Computer Matching and Privacy Protection Act of 1988 (CMPPA) (Public Law 100-503), amended the Privacy Act (5 U.S.C. § 552a) and requires the parties participating in a matching program to execute a written agreement specifying the terms and conditions under which the matching program will be conducted. CMS has determined that status verification checks conducted by Administering Entities using the Enterprise Human Resources Integration (EHRI) data source Status File provided to CMS by OPM constitute a "computer matching program" as defined in the CMPPA.

The responsible component for CMS is the Center for Consumer Information & Insurance Oversight (CCIIO). CMS will serve as the Recipient Agency, and as such, is 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 Office of the Chief Information Officer and the Office of Planning and Policy Analysis. OPM will serve as the Source Agency in this Agreement.

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 Authority

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

1. This Agreement is executed pursuant to the Privacy Act of 1974 (5 U.S.C. § 552a), as amended by the Computer Matching Privacy Protection Act (CMPPA) and the regulations and guidance promulgated thereunder; the Office of Management and Budget (OMB) Circular A-130, "Management of Federal Information Resources" published at 61 Federal Register (Fed. Reg.) 6428 (February 20, 1996); and OMB guidelines pertaining to computer matching published at 54 Fed. Reg. 25818 (June 19, 1989).
2. Under the ACA, certain individuals are eligible for certain financial assistance in paying for private insurance coverage under a Qualifying Health Plan (QHP) when enrollment is through an Exchange. Such assistance includes APTCs, 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, as added by §1401 of the ACA, 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(f)(2) of the ACA provides that an individual is ineligible for CSRs if the individual is not also eligible for the premium tax credit for the relevant month.
4. Section 1331 of the Affordable Care Act authorizes the Basic Health Program (BHP) and requires that states administering BHPs verify whether an individual is eligible for certain Minimum Essential Coverage, such as an OPM Health Benefits Plan (45 C.F.R. §155.320(d)).
5. Section 1411 of the ACA requires the Secretary of HHS to establish a program to determine an individual's eligibility to purchase a Qualified Health Plan (QHP) through an Exchange and to determine eligibility for APTC and CSRs. The system

established by HHS under § 1411 to determine eligibility for APTC and CSRs requires an Exchange to verify whether an individual is eligible for certain eligible employer sponsored plan, such as an OPM Health Benefits Plan (45 C.F.R. §155.320(d)), by OPM sending information to HHS for HHS to provide the response.

6. Pursuant to § 1411(c)(4)(B) and 1411(d) of the ACA, the Secretary of HHS has determined that verification of eligibility for an OPM Health Benefits Plan is best made using a computer matching program as described in this Agreement. An Exchange may use this verification service through the Hub to support eligibility determinations for APTC and CSRs by sending a request to the Hub. CMS facilitates the verification against OPM data and a response with the result of that verification attempt is sent to the entity that determines eligibility for APTC and CSRs. Under 45 C.F.R. §§ 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 Fed. Reg. 4703 (Jan. 26, 2011)).
7. Under the authority of sections 1311, 1321, and 1411(a) of the ACA, the Secretary of HHS adopted the regulation at 45 C.F.R. § 155.330, which further addresses 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.
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. OPM has a routine use in its system of records 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. "ACA" means Patient Protection and Affordable Care Act of 2010 (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152) (collectively, the ACA).
2. Administering Entity means a state Medicaid agency, Children's Health Insurance Program (CHIP), a basic health program (BHP), or an Exchange administering an Insurance Affordability Program;
3. "Advanced payments of the premium tax credit" or "APTC" is defined under 45 C.F.R. § 155.20 to mean payment of the tax credit specified in § 36B of the IRC (as added by § 1401 of the ACA) which are provided on an advance basis on behalf of an eligible individual enrolled in a QHP through an Exchange in accordance with § 1412

of the ACA. APTCs are not considered Federal Tax Information under 26 U.S.C. § 6103.

4. "Applicant" means an individual who is seeking eligibility for him or herself through an application submitted to an Exchange, excluding individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of Part 155 of title 45 of the Code of Federal Regulations, submitted to a BHP program, or transmitted to an Exchange by an agency administering an Insurance Affordability Program for at least one of the following (i) enrollment in a QHP through an Exchange; or (ii) the BHP.
5. "Authorized Representative" means an individual person or organization acting, in accordance with 45 C.F.R. § 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 match or to any data created as a result of this match. Authorized Users include Administering Entities.
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 by Office of Management and Budget (OMB) Memorandum M-07-16, Safeguarding and Responding to the Breach of Personally Identifiable Information (May 22, 2007) as the compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, loss of control, or any similar term or phrase that refers to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic.
9. "CMS" means the Centers for Medicare & Medicaid Services.
10. "Cost-sharing reduction" or "CSR" is defined at 45 C.F.R. § 155.20 and means reductions in cost sharing of an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange. CSRs are not considered Federal Tax Information under 26 U.S.C. § 6103.
11. "Eligibility Determination" means the determination of eligibility for Insurance Affordability Programs, including a redetermination based on a self-reported change pursuant to 45 C.F.R. § 155.330, and the process of appealing an eligibility determination when an appeal is provided pursuant to section 1411(f) of the ACA.
12. "Enrollee" means an individual enrolled in a QHP through an Exchange or in enrolled in a BHP.

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13. "Exchange" means an American Health Benefit Exchange established under sections 1311(b), 1311(d)(1), or 1321(c)(1) of the ACA, including both State-based Exchanges and Federally-facilitated Exchange (FFE).
 14. "FFE" means Federally-facilitated Exchange, which is an Exchange established by HHS and operated by CMS under § 1321(c)(1) of the ACA;
 15. "HHS" means the Department of Health and Human Services;
 16. "Hub" or "Data Services Hub" is the CMS federally managed, single data exchange for agencies administering Insurance Affordability Programs 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 agencies administering Insurance Affordability Programs 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) Children's Health Insurance Program (CHIP) established under Title XXI of the Social Security Act; and (5) the Basic Health Program (BHP) established under Section 1331 of the Affordable Care Act.
 18. "Minimum Essential Coverage" or "MEC" is defined in IRC § 5000A(f), and includes health insurance coverage offered by a QHP and provided through an Exchange, an eligible employer-sponsored plan or government-sponsored coverage such as coverage under Medicare Part A, TRICARE, or a health plan under 22 U.S.C. § 2504(e) (relating to Peace Corps volunteers).
 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. "PII" or "personally identifiable information" is defined by OMB Memorandum M-07-16 (May 22, 2007) and means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.
 21. "QHP" means Qualified Health Plan, which 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 Code of Federal Regulations 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 Code of Federal Regulations.

22. "Recipient Agency" as defined by the Privacy Act (5 U.S.C. § 552a(a)(9)) means any agency, or contractor thereof, receiving records contained in a system of records from a source agency for use in a matching program;
23. "Record" means any item, collection, or grouping of information about an individual that is maintained by an agency, including his or her education, financial transactions, medical history, and criminal or employment history and that contains his or her name, or the identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print or a photograph.
24. "Security Incident" means the act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent.
25. "Source Agency" as defined by the Privacy Act (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. OPM is the Source Agency in this Agreement.
26. "State-based Exchange" means an Exchange established and operated by a State, and approved by HHS under 45 C.F.R. § 155.105.
27. "Status File" is a file provided by OPM to CMS that includes data about an individual's Federal Employee's Health Benefit eligibility.
28. "System of Records" as defined by the Privacy Act (5 U.S.C. § 552a(a)(5)) means a group of any records under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

D. Responsibilities of the Parties

1. CMS Responsibilities

- a. CMS will develop procedures through which an Applicant or Enrollee may request an Eligibility Determination via a single, streamlined application.
- b. CMS will receive a monthly Status File with all Federal employee health care insurance information from OPM.

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- c. Administering Entities administering Insurance Affordability Programs will access the status file through the Data Services Hub. The Hub will use the information contained in the OPM status file to indicate if an Applicant or Enrollee is enrolled or eligible for an OPM Health Benefits Plan, which is a form of MEC under the ACA.
 - d. CMS will receive a Premium Spread Index File on an annual basis that identifies the lowest premium available to a Federal employee in each of the 32 premium localities.
 - e. Administering Entities will receive data from the Premium Spread Index File when an individual is identified in the OPM Status file. The Administering Entity will use this data to determine whether the lowest cost self-only plan offered to the employee is affordable.
 - f. CMS has developed and will maintain procedures through which Administering Entities can request and receive information verifying eligibility for MEC from the OPM Status File through the CMS Hub to make Eligibility Determinations.
 - g. CMS will enter into agreements with State-based Administering Entities 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 privacy and security requirements that are consistent with section 1411(g) of the ACA, 45 C.F.R. § 155.260, and the terms and conditions of this Agreement.
 - h. CMS will provide Congress and the OMB with notice of this matching program and will publish the required matching notice in the Federal Register.
 - i. 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.
2. OPM Responsibilities
- a. OPM will provide CMS with data that reside in an OPM Privacy Act System of Records (SOR). The OPM system of records for general personnel records has been published as OPM/GOVT-1 (General Personnel Records), 77 Federal Register, 73694, December 11, 2012. The disclosure of information will be made in accordance with routine use "rr."
See <http://www.gpo.gov/fdsys/pkg/FR-2012-12-11/html/2012-29777.htm>.
 - b. OPM will submit the following to CMS: (1) a monthly Status File containing personnel data; and (2) a premium spread index file, which gives information identifying the lowest premium available to a Federal employee in each of the thirty-two (32) OPM premium localities, on an annual basis. The individual

data elements contained in the monthly Status File sent from OPM to CMS are detailed in section IV. B. 2.

3. Liability

- A. Each Party to this Agreement shall be liable for acts and omissions of its own employees.
- B. Neither Party shall be liable for any injury to another Party's personnel or damage to another Party's property, unless such injury or damage is compensable under the Federal Tort Claims Act (28 U.S.C. § 1346(b)), or pursuant to other Federal statutory authority.
- C. Neither Party shall be responsible for any financial loss incurred by the other, whether directly or indirectly, through the use of any data furnished pursuant to this Agreement.

I. Justification and Anticipated Results

A. Cost Benefit Analysis

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

B. Other Supporting Justifications

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

instead of a manual process for eligibility verifications and to approve the agreement based on these other stated justifications:

- i. 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.
- ii. The Marketplace matching programs' eligibility determinations and MEC checks result in improved accuracy of consumer eligibility, which CMS anticipates will continue to produce expedited Eligibility Determinations while minimizing administrative burdens and achieve operational efficiencies.
- iii. The matching programs provide a significant net benefit to the public by accurately determining eligibility for the advanced payment of the premium tax credit (APTC).
- iv. 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.
- v. Continuing to use the current matching program structure, which is less costly than any alternative structure, is expected to increase the public's trust in the participating agencies as stewards of taxpayer dollars.

C. Specific Estimate of Any Savings

There is no cost savings to conducting the Marketplace matching programs, as opposed to not conducting them. However, the execution of the marketplace matching programs is mandated by statute and regulation. Therefore, the optimal result is attained by limiting the cost by using a matching program operational structure and technological process that is more efficient than any alternatives.

CMS estimates that the cost of operating this computer match with OPM was about \$30.5 million (\$30,563,340) per year. The estimated net benefit is \$45.378 billion, for a benefit-to-cost ratio of 1487.8:1. CMS's analysis suggests that the benefits outweigh the costs given the increase in private insurance coverage through the ACA.

II. Records Description

A. Systems of Records

1. CMS System of Records

The CMS System of Records for this matching program is the "Health Insurance Exchanges Program (HIX)", CMS System No. 09-70-0560, originally published at

78 Fed. Reg. 8538 (Feb. 6, 2013), and last amended at 78 Federal Register, 63211 (October 23, 2013).

2. OPM System of Records

The OPM System of Records for this matching program is titled "General Personnel Records" (OPM/GOVT-1), published at 77 Federal Register, 73694 (December 11, 2012). The disclosure of information to CMS will be made in accordance with routine use "rr." See <http://www.gpo.gov/fdsys/pkg/FR-2012-12-11/html/2012-29777.htm>.

B. Specified Data Elements

1. From CMS to OPM. 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 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.
2. From OPM to CMS. OPM will send a monthly, full refreshed 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. Gender;
 - j. Date of birth; and
 - k. Health Plan Code.
3. OPM will also 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;

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- 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; and
 - n. Future change in employee payment monthly premium.

C. Number of Records

The base estimates for the total number of transactions in FY 2016 is 115,522,668. The base estimates for the total number of transactions in FY 2017 is 154,799,288. The number of transactions for the estimated highest month in FY 2016 is 18,605,649. The number of transactions for the estimated highest month in FY 2017 is 24,341,786. These estimates use current business assumptions. These estimates are subject to change as business assumptions or estimates are updated and/or refined.

D. Projected Starting and Completion Dates of the Matching Program

- 1. Starting Date – [INSERT DATE]
- 2. Completion Date [INSERT DATE].

IV. 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, an Administrative Entities administering an Insurance Affordability Program will provide a notice to the Applicants or Enrollees about the OMB-approved streamlined eligibility application.
- C. The Administering Entity 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.

V. Verification Procedures and Opportunity to Contest Findings

- A. Before an agency administering an Insurance Affordability Program may take any adverse action based on the information received from the matches under this Agreement,

the individual will be permitted 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. Dispute Resolution:

CMS and OPM will resolve disputes related to this Agreement in accordance with instructions provided in the Treasury Financial Manual (TFM) Volume I, Part 2, Chapter 4700, Appendix 10, *Intragovernmental Transactions Guide*, available on the TFM Website at <http://tfm.fiscal.treasury.gov/v1/p2/c470.pdf>.

VI. Accuracy Assessments

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

VII. Procedures for Retention and Timely Destruction of Identifiable Records

OPM and CMS will retain the electronic files received from the other Party only for the period of time required for any processing related to the Eligibility Determination under the matching program and will then destroy all such data by electronic purging, unless OPM or CMS is required to retain the information for enrollment, billing, payment, program audit, legal evidentiary purposes, or where they are required by law to retain the information. Administering Entities administering Insurance Affordability Programs will also retain data for such purposes and under the same terms. In case of such retention by OPM and CMS, OPM and CMS will retire the retained data in their system of records in accordance with the applicable Federal Records Retention Schedule (44 U.S.C. § 3303a). OPM and CMS will not create permanent files or separate systems comprised solely of the data provided by the other Party.

VIII. Security Procedures

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- A. **General.** 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.
- B. **Legal Compliance.** CMS shall comply with the limitations on use, storage, transport, and safeguarding of data under all applicable Federal laws and regulations. These laws and regulations include section 1411(g) of the ACA; the Privacy Act of 1974; the E-Government Act of 2002, which includes the Federal Information Security Management Act of 2002 (FISMA), 44 U.S.C. §§ 3541-3549, as amended by the Federal Information Security Modernization Act, 44 U.S.C. §§ 3551-3558; Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Computer Fraud and Abuse Act of 1986, the Clinger-Cohen Act of 1996, and the corresponding implementation regulations for each statute. Additionally, CMS will follow Federal, HHS, and CMS policies including the HHS Information Security Acceptable Risk Safeguards (ARS) CMS Minimum Security Requirements.

CMS will comply with OMB circulars and memoranda, such as Circular A-130, revised, Management of Federal Information Resources (November 28, 2000), and Memorandum M-06-16, Protection of Sensitive Agency Information (June 23, 2006); National Institute of Standards and Technology (NIST) directives and publications; and the Federal Acquisition Regulations. These laws, directives, and regulations include requirements for safeguarding Federal information systems and PII used in Federal agency business processes, as well as related reporting requirements. The parties recognize and will implement the laws, regulations, NIST standards, and OMB directives including those published subsequent to the effective date of this Agreement.

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

- C. **Loss, Potential Loss, Incident Reporting, and Breach Notification.** CMS will comply with OMB reporting guidelines in the event of a loss, potential loss, Security Incident or Breach of PII (see OMB Memorandum M-06-19, Reporting Incidents Involving Personally Identifiable Information and Incorporating the Cost for Security in Agency Information Technology Investments (July 12, 2006); OMB M-07-16, Safeguarding Against and Responding to the Breach of Personally Identifiable Information (May 22, 2007); and OMB M-15-01, Fiscal Year 2014-2015 Guidance on Improving Federal Information Security and Privacy Management Practices (Oct. 3, 2014)). If CMS experiences such an event, CMS will notify OPM's System Security Contact named in this Agreement within one (1) hour of discovering the loss, potential loss, Security Incident, or Breach. If CMS is unable to speak with OPM's System Security Contact within one (1) hour or if contacting the System Security Contact is not practicable (e.g., outside of normal business hours), then the following contact information will be used.

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1. If CMS is unable to speak with the OPM Systems Security Contact within one hour or if for some other reason notifying the OPM Systems Security Contact is not practicable (e.g., it is outside of the normal business hours), CMS will call the OPM Situation Room at: sitroom@opm.gov, (202) 418-0111, Fax (202) 606-0624.

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

- D. **Administrative Safeguards.** CMS will restrict access to the matched data and to any data derived from the match to only those Authorized Users of the Hub, e.g., agencies administering Insurance Affordability Programs and their employees, agents, officials, contractors, etc., who need it to perform their official duties in connection with the uses of data authorized in this Agreement. Further, CMS will advise all personnel who will have access to the data matched and to any data created by the match of the confidential nature of the data, the safeguards required to protect the data, and the civil and criminal sanctions for noncompliance contained in the applicable Federal laws.
- E. **Physical Safeguards.** CMS will store the data matched and any data created by the match in an area that is physically and technologically secure from access by unauthorized persons at all times. Physical safeguards may include, but are not limited to, door locks, card keys, and biometric identifiers. Only authorized personnel will transport the data matched and any data derived from the match. CMS will establish appropriate safeguards for such data, as determined by a risk-based assessment of the circumstances involved.
- F. **Technical Safeguards.** CMS will process the data matched and any data derived from the match under the immediate supervision and control of authorized personnel to protect the confidentiality of the data in such a way that unauthorized persons cannot retrieve any such data by means of computer, remote terminal, or other means. Systems personnel must enter personal identification numbers when accessing data on a Party's systems. CMS will strictly limit authorization to those electronic data areas necessary for the authorized analyst to perform his or her official duties.
- G. **Application of Policies and Procedures.** The parties will adopt policies and procedures to ensure that each Party uses the information described in this Agreement that is contained in their respective records or obtained from each other solely as provided in this Agreement. CMS will comply with their respective policies and procedures and any subsequent revisions.

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- H. **On-Site Inspections.** OPM has the right to monitor CMS's compliance with FISMA and OMB Memorandum M-06-16 requirements for data exchanged under this Agreement, and to audit compliance with this Agreement, if necessary, during the lifetime of this Agreement, or any extension of this Agreement and for a short span to conduct audits after the Agreement terminates. CMS will provide OPM with any reports and/or documentation relating to such inspections at OPM's request. OPM may request an on-site inspection in addition to requesting reports and/or documentation.
- I. **Compliance.** CMS must ensure information systems that process information provided by OPM under this matching Agreement are compliant with CMS standards contained in the Minimum Acceptable Risk Standards for Exchanges (MARS-E) and CMS Acceptable Risk Safeguards. The MARS-E suite of documents can be found at: <http://www.cms.gov/ccio/resources/regulations-and-guidance/index.html>, under Minimum Acceptable Risk Standards. To the extent these documents are revised during the term of this Agreement, CMS must ensure compliance with the revised version. 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.

IX. Records Accuracy Assessments

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

- A. CMS will not use or disclose the Data for any purpose other than the purposes authorized by this Agreement or permissible under applicable Federal law, without the consent of the other party.
- B. OPM and CMS will not duplicate or disseminate the other Party's Data, 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. CMS will ensure that Administering Entities 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 required by law or for purposes 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.
- C. CMS and OPM will not use the 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 Administering Entities administering BHPs 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.

D. Any individual, including officers, employees, and contractors 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 C.F.R. § 155.260 and § 1411(g) of the ACA are subject to the civil penalty provisions of § 1411(h)(2) and 45 C.F.R. § 155.285, which carries a fine of up to \$25,000 per use or disclosure.

X. 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.

XI. Reimbursement/Funding

All work performed by OPM to perform the computer match 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.

XII. Duration of Agreement

A. **Effective Date:**

The Effective Date of this Agreement is October 2, 2018, provided that the following review periods have lapsed: thirty (30) days from the date CMS publishes a Notice of Computer Matching in the Federal Register; thirty (30) days from the date the matching program report is transmitted to the Congressional committees of jurisdiction consistent with the provisions of 5 U.S.C. §§ 552a (r), (o)(2)(A), and (o)(2)(B); and forty (40) days from the date the matching program report is sent to OMB, consistent with the provisions of 5 U.S.C. § 552a (r) and OMB Circular A-130, Revised (Transmittal Memorandum No. 4), November 28, 2000, Appendix I, entitled "Federal Agency Responsibilities for Maintaining Records about Individuals" (A-130 Appendix I).

B. **Term:** This initial term of this Agreement will be eighteen (18) months.

C. **Renewal:** The Parties may, within three (3) months prior to the expiration of this Agreement agree to renew this Agreement for a period not to exceed twelve (12) months.

D. **Modification:** The parties may modify this Agreement at any time by a written modification, mutually agreed to by both Parties and approved by the DIBs of HHS and OPM.

E. **Termination:** This Agreement may be terminated at any time upon the mutual written consent of the parties.

XIII. 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.

XIV. Person to Contact

A. The OPM contacts are:

1. IT Security Issues

Darrin McConnell,
Acting Chief, IT Security and Privacy
Office of the Chief Information Officer
U.S. Office of Personnel Management
1900 E Street, NW4H28A
Washington, DC. 20415
Phone: (202) 606-6210 E-Mail: darrin.mcconnell@opm.gov

2. Privacy Act Agreement Issues

Rebecca Ronayne
Attorney
Office of General Counsel
U.S. Office of Personnel Management
1900 E. Street NW, Room 7542
Washington, DC 20415
Phone: (202) 606-1700
E-Mail: Becky.Ronayne@opm.gov

3. Data Issues

Jerry Clark, Program Manager
Enterprise Human Resources Integration Data Warehouse (EHRIDW)
Federal Data Solutions
Office of the Chief Information Officer
U.S. Office of Personnel Management
1900 E Street, NWB443
Washington, DC 20415
Phone: (202) 606-1378
E-Mail: jerry.clark@opm.gov

B. The CMS contacts are:

1. Program Issues

Elizabeth Kane, Director
Verifications Branch, Division of Eligibility and Enrollment
Center for Consumer Information & Insurance Oversight

Centers for Medicaid and Medicare Services
7501 Wisconsin Avenue
Bethesda, Maryland 20814
Phone: 301-492-4418
E-Mail: Elizabeth.Kane@cms.hhs.gov.

2. Privacy Act Issues

Walter Stone
CMS Privacy Officer
Division of Information Security, Privacy Policy & Governance
Information Security & Privacy Group
Office of Enterprise Information
Centers for Medicaid and Medicare Services
Mail Stop: N1-24-08
Phone: 410-786-5357
E-Mail: walter.stone@cms.hhs.gov.

3. Privacy Incident Reporting

LaTasha Grier
Division of Cyber Threat & Security Operations
Division of Information Security, Privacy Policy & Governance
Information Security & Privacy Group
Office of Enterprise Information
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: N1-24-08
Baltimore, MD 21244-1849
Telephone: (410) 786-3328
E-mail: LaTasha.Grier@cms.hhs.gov.

4. Systems and Security

Darrin V. Lyles
Information Security Officer, CIISG
CMS/OIS/CIISG
Consumer Information and Insurance Systems Group
7500 Security Boulevard
Baltimore, MD 21244
Phone: 410-786-4744
Mobile: 443-979-3169
E-mail: Darrin.Lyles@cms.hhs.gov

XV. Approvals


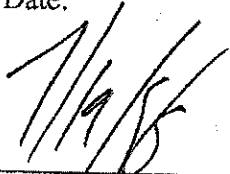
A. Centers for Medicare & Medicaid Services Program Official

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

Approved by (Signature of Authorized CMS Program Official)	
Jeffrey Grant <small>Digitally signed by Jeffrey Grant -S</small>	
<small>-S Date: 2018.07.16 13:19:43 -04'00'</small>	
Jeffrey Grant Deputy Director for Operations Center for Consumer Information & Insurance Oversight Centers for Medicare & Medicaid Services	Date:

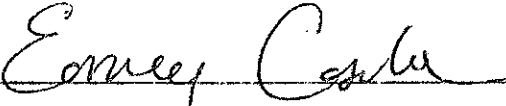
B. Centers for Medicare & Medicaid Services Program Official

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

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


C. Centers for Medicare & Medicaid Services Approving Official

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

Approved by (Signature of Authorized CMS Approving Official)	
	
Emery J. Csulak, Director Information Security and Privacy Group, and Senior Official for Privacy Centers for Medicare & Medicaid Services	Date: 9/27/18

D. Office of Personnel Management Approving Official

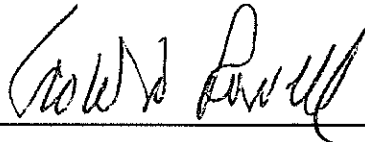
The authorized approving official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this Agreement.

Approved by (Signature of Authorized OPM Approving Official)	
	
Dovarius Peoples Associate Chief Information Officer Office of Personnel Management	Date: 7 / 2 / 13

XVIII. DATA INTEGRITY BOARD APPROVALS

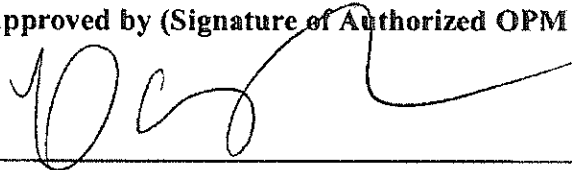
A. Department of Health and Human Services DIB Approving Official

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

Approved by (Signature of Authorized HHS DIB Approving Official)	
	
Scott W. Rowell Assistant Secretary for Administration HHS Data Integrity Board Chairperson U.S. Department of Health and Human Services	Date 9/24/18

B. Office of Personnel Management DIB Official

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

Approved by (Signature of Authorized OPM DIB Approving Official)	
	
Dovarius Peoples Associate Chief Information Officer Office of Personnel Management	Date: 7/2/19

Attachment A

DHS/USCIS and CMS CMA Cost-Benefit Analysis



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

Prepared by:

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

Dated January 31, 2018



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

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

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

I. Matching Objective

The objective of the marketplace matching programs is to make initial eligibility determinations, redeterminations and renewals for enrollment in a qualified health plan, insurance affordability programs, and to issue certificates of exemption to individuals who are exempt from the individual mandate to maintain health insurance coverage. For those consumers who request financial assistance, they will be determined eligible for an amount of advanced premium tax credits (APTC) and cost sharing reductions, Medicaid, CHIP or BHP, where applicable. The Exchange and Medicaid/CHIP agencies verify data elements dependent on the eligibility determination they are performing. These may include citizenship or immigration status, household income, access to non-employer-sponsored and/or employer-sponsored minimum essential coverage. Non-employer-sponsored coverage includes coverage through TRICARE, Veteran’s Health Benefits, Medicaid, Medicare, or benefits through service in the Peace Corps. Employer-sponsored coverage for Federal Employee Health Benefits can be verified with the Office of Personnel Management. The matching programs provide a single streamlined process for making accurate and real-time assessments of each applicant’s eligibility and affordable insurance options and ensuring that the consumer can enroll in the correct applicable State health subsidy program¹ or be properly determined to be exempt from needing coverage.

Matching Program Structure

The Patient Protection and Affordable Care Act, Public Law No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (ACA) requires that each State develop secure electronic interfaces for the exchange of data under a matching

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

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

CMS has entered into eight matching agreements with other Federal agencies including Social Security Administration (SSA), Department of Homeland Security (DHS), Internal Revenue Service (IRS), Veterans Health Administration (VHA), Department of Defense (DoD), Office of Personnel Management (OPM), and the Peace Corps. In addition, CMS has developed a matching program that is executed with every State-based Administering Entity (AE)² State Medicaid agency and each State-based Marketplace. The Federal Data Services Hub (Hub) was designed to be the centralized platform for the secure electronic interface that connects all State Medicaid agencies, State-based Exchanges and the Federal data sources (TDS or trusted data source).

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

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

Background

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

- Because the ACA mandates use of computer matching and requires a single streamlined application process for consumers, the issue to address in the CBA isn't whether to conduct the matching programs, but how efficiently the matching programs are structured

² "Administering Entity" or "AE" means a State-based entity administering an Insurance Affordability Program. An AE may be a Medicaid agency, a Children's Health Insurance Program (CHIP), a basic health program (BHP), or a State-based Marketplace (SBM) established under Section 1311 of the ACA.

-
- and conducted (i.e., how streamlined the eligibility determination process is for consumers, and whether the structure is less costly than an alternative structure).
- The eight matching programs, when re-established, will use processes currently in place by the source agencies and entities known as the trusted data sources (TDS). The TDSs are IRS, DHS, SSA, OPM, Peace Corps, VHA, DoD, Current Sources of Income, and state based administering entities (AEs). In addition, several contractors provide a variety of support services to the Hub, such as Identity Proofing, trouble shooting, procedure writing, and maintenance support just to name a few.
 - Private citizens (as potential beneficiaries) can apply for applicable State health subsidy programs on the basis of the private benefit and cost of applying. The private benefit from applying is the expected value of health insurance coverage (private insurance, Medicaid, CHIP or a Basic Health Plan) obtained through a State-based Exchange or through the Federally-facilitated Exchange in relation to the value of health insurance that could be obtained without the ACA defined American Health Benefit Exchange³.
 - CMS has internal costs related to the funding of CMS federal staff and associated resources to complete processes and responsibilities related to the matching programs.
 - CMS has several internal cost centers that work on the Hub. Within CMS, these centers may be assisted by external contractors. This cost category is organized as an internal cost.
 - CMS has external costs in the hiring, maintenance, and associated costs of contractors to perform numerous functions related to the Hub.
 - CMS has several external cost factors related to the calculation of cost per transaction between a trusted data source and source agency, and CMS as the recipient agency. The cost of each data transaction is estimated from the prior year's matching program budget and the estimated number of data transactions.
 - For the recovery of Improper Payments and Debts (Key Element 4), CMS is not currently utilizing the data match result from the matching programs for payment and debt reconciliations; however, the benefit of the match does provide the potential to implement this capability in the future.
 - All annual personnel costs and savings are rounded to the nearest dollar.

³ American Health Benefit Exchange is defined @ 1311(b)(1).

II. Costs

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

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

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

Cost estimates are based on established definitions and practices for program and policy evaluation.⁴ CMS estimated the number of hours for its staff to complete the systems changes based on experience with other systems adjustments of similar magnitude. CMS also collected cost estimates provided by its current contractors for this proposed effort.⁵

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

The marketplace SOC is responsible for the security operations and maintenance for Healthcare.gov. In total, more than 130 people work in data security; about 100 are contractors and 35-38 are federal employees. One midlevel contractor costs \$150,000 per year and a senior contractor costs \$200,000 per year. On the federal side the most common civil service grade is GS-13, which costs around \$100,000 to \$110,000 per year, not including benefits. The current cost of all Healthcare.gov data security is \$8.5 million per year.⁶ The Healthcare.gov data

⁴ E.J. Mishan, *Cost-Benefit Analysis: An Introduction*, New York: Praeger Publishers, 1971. Also see U.S. Office of Management and Budget, OMB Circular No. A-94 Revised, *Guidelines and Discount Rates for Benefit-Cost Analysis of Federal Programs*, October 29, 2002.

⁵ For personnel costs, CMS used publicly available wage data from the Bureau of Labor Statistics (BLS: www.bls.gov/oes/current/oes_nat.htm) for May 2016, which is the most current data available at the time in which this cost benefit analysis was drafted, for Medicare plan and contractor personnel (i.e., third party) rates. To estimate the government staff personnel costs, CMS used the 2017 salary table with locality of pay for the Washington, D.C., Baltimore, MD and Northern Virginia area from the Office of Personnel Management (www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2015/DCB_h.pdf).

⁶ The cost of data security was provided to us by CMS as a lump-sum amount. When we performed independent calculations of federal salaries we used the following information for FY2018.

GS Grade	Hourly Rate	Annual Cost
GS11	\$56.49	\$108,461

security budget is not itemized by matching program; therefore, the matching program costs to the marketplace SOC are not quantifiable.

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

The Exchange Operations Center (XOC) is an internal group in CMS that manages the Hub contract. XOC's costs are significant given that the proposed appropriation for exchange operations (not including user fees) in the FY 2018 federal budget was \$18.4 million.⁷ At the time of this report we were unable to secure an exact budget amount for the XOC outlay in 2017.

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

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

Table 1: Direct Costs of Other CMS Centers

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

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

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

CMS contracts with a support vendor to perform numerous tasks related to the Hub, including writing procedures and standards and general trouble-shooting. Over time, the support contractor's role has tapered off so they currently have two subcontractors working 25 hours per week and 1 hour per week,

GS12	\$67.71	\$130,003
GS13	\$80.52	\$154,598
GS14	\$95.15	\$182,688
GS15	\$111.93	\$214,906

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

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

respectively, at CMS. The current value of the support contract is approximately \$352,940 per year (\$227 hourly rate with 15 percent overhead, 52 weeks per year).

e. Hub Operations – Monetary, but not quantified

CMS contracts with a vendor to provide service-oriented activities for the Hub. We assume that the associated costs are significant given that the original cost of the Hub in 2013⁸ was \$55 million. It is likely that the Hub has become more efficient since that time. At the time of this report we were unable to secure an exact budget amount for the Hub operations vendor outlay in 2017.

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

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

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

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

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

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

Another consumer credit reporting agency is accessed via the Hub for “remote identity proofing” (RIDP). Even though a person has a form of identification, there needs to be an identity check so SSA knows the person’s identification has been validated. RIDP is typically completed before a person can submit an online application, and while it is not an eligibility requirement it is a way to confirm people are who they say they are.⁹ CMS pays a fee per transaction for RIDP, but we did not have access to this information.

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

⁸ <https://www.reuters.com/article/usa-healthcare-hiring/insight-it-takes-an-army-tens-of-thousands-of-workers-roll-out-obamacare-idUSL2N0EW28820130621?feedType=RSS&feedName=marketsNews&rpc=43>

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

CMS does not reimburse costs incurred by IRS, DoD, and Peace Corps to supply data to the Hub, and has no information about their costs.

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

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

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

4. *Medicare Drug and Health Plans' Costs*

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

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

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

III. **Benefits**

A. Key Element 3: Avoidance of Future Improper Payments

1. *Benefits to Agencies – not quantified*

Costs incurred by CMS are Benefits to Agencies:

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

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

- **Multi-faceted attestation of beneficiary eligibility data.** Using matching data supplied by the eight trusted data sources for attestation in combination with an individual applicant's attestation of his or her personal information is more reliable than relying

solely on applicant attestations. Due to the potential and historical presence of identity fraud, the utilization of matching programs minimizes the risk of incorrect personal information being presented and used to make eligibility determinations; therefore, preventing the incorrect dispersal of federal subsidy program benefits.

- **Verification and contest procedures.** The “verification and opportunity to contest findings” requirements specified in the Marketplace matching agreements, which are required by subsection (p) of the Privacy Act (5 USC 552a(p)), also improve data quality, thereby ensuring accurate eligibility determinations and other decisions, and avoiding improper payments. Before an Administering Entity (AE) may take any adverse action based on the information received from the match, the individual must be permitted to provide the necessary information or documentation to verify eligibility information. When an AE determines that an individual is ineligible for an Insurance Affordability Program based on the information provided through the match, and that information is inconsistent with information provided on the streamlined eligibility application or otherwise by an Applicant or Enrollee, the AE will comply with applicable law and will notify each Applicant, or Enrollee of the match findings and provide the following information: (1) The Administering Entity received information that indicates the individual is ineligible for an Insurance Affordability Program; and (2) the Applicant, or Enrollee has a specified number of days from the date of the notice to contest the determination that the Applicant or Enrollee is not eligible for the relevant Insurance Affordability Programs.

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

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

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

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

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

Key Element 4 is not applicable, because data from the Marketplace matching programs is not currently used to identify and recover improper payments and debts, as this is not a primary goal of the matching programs. Annual reconciliation and recovery of improper tax payments are performed by the IRS through a process that is independent of the Marketplace matching

programs and other CMS eligibility determination activities. While the Marketplace matching programs could provide for annual and monthly reporting of data by Marketplaces to the IRS and consumers for the purpose of supporting IRS's annual reconciliation, annual and monthly reporting is not currently an activity covered in the IRS-CMS CMA; rather, that information is exchanged between the agencies through Information Exchange Agreements. At most, the data used in the Marketplace matching programs has the future potential benefit of being used in an analytical form, to assist IRS in identifying and/or recovering improper payments and debts.

IV. Other Benefits and Mitigating Factors Which Justify the Matching Programs

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

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

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

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

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

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

v. Detail Supporting CMS and TDS Costs (FY2018)

TDS Costs Reimbursed/Not Reimbursed by CMS

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

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

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

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

a. Social Security Administration (SSA)

The SSA is the source of numerous data elements for the Hub: verification of the applicant's name, date of birth, citizenship, Social Security Number (SSN), a binary indicator for incarceration,¹⁰ and Title II income (retirement and disability).

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

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

¹⁰ Individuals in prison are not eligible for ACA benefits.

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

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

If the SSA were not a Trusted Data Source, CMS believes it would be very difficult to find an alternative data source. For example, self-verification of Social Security Numbers (SSNs) would invite a high incidence of fraud (e.g., using another person's number). If SSA did not provide information on incarceration, prisons might provide it, but this would be on a voluntary basis. The Department of Justice (DOJ) is also a possible source of information on incarceration, but SSA is not sure how DOJ keeps this information.

b. Department of Homeland Security (DHS)

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

c. Veterans Health Administration (VHA)

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

d. Office of Personnel Management

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

e. Other Trusted Data Sources

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

VI. Conclusion

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

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

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

VII. Appendix A: Details Supporting Other Benefits and Mitigating Factors – The Future State of EDE and Marketplace

CMS has released data on the number of people who have enrolled in plans for 2018 coverage in the 39 state exchanges that use the HealthCare.gov platform. As of December 15, 2017, 8,822,329 people had made plan selections.¹¹ The total tally of enrollment, including states that use their own platforms, was not available at the time of this report. Many of the state-based marketplaces are still running open enrollment. Charles Gaba of ACASignups.net has run his own operation to verify enrollment levels in state-based marketplaces and estimates that total enrollment will reach at least 11.6 million and possibly 12 million people in 2018.¹²

If we assume marketplace enrollment of 12 million and a conversion ratio of 72 percent (see footnote 20), we can solve for the number of people who begin an application: $12,000,000 / 0.72 = 16,666,667$. If each of these people “spends” \$87.63 in applying, the total time cost of Hub users is \$1.46 billion.¹³

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

Both of these changes have the potential to change the results, and possibly the conclusions, of our cost-benefit analysis presented in the previous sections. The elimination of consumer-facing redirect with SAML will provide an immediate reduction in the shopping enrollment time for all consumers both those using the traditional exchanges and those using the new direct enrollment process. We currently have no estimate of the shopping enrollment time savings because of this change but it is not inconsequential. Even a 10 minute reduction results in a 4%

¹¹ Centers for Medicare and Medicaid Services, “Weekly Enrollment Snapshot: Week Seven,” December 21, 2017; available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-21.html>.

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

¹³ People who start an application but fail to complete it may spend more or less time than those who complete the application. We do not have data to make this adjustment.

reduction in opportunity cost. However, as noted above, this change applies to both pathways equally and simply reduces the opportunity cost of all consumers regardless of pathway.

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

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

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

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

* Minutes reduced from elimination of SAML requirement

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

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

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

* Minutes reduced from elimination of SAML requirement

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

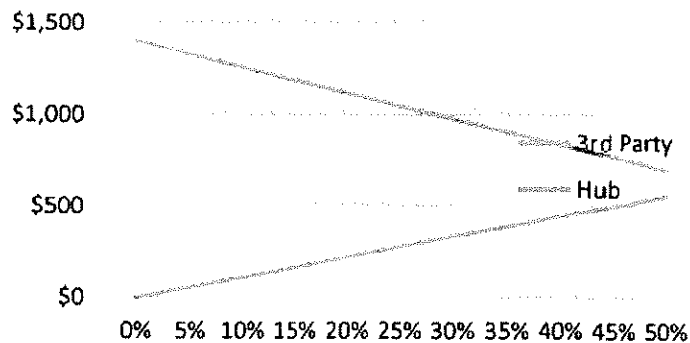
To estimate the total consumer opportunity cost due to differential migration to 3rd party web sites, we assumed a 10% reduction in shopping enrollment time due to the removal of the SAML requirement and a subsequent 25% reduction in shopping enrollment time for those using 3rd party web sites. We assumed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

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

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

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

Figure 3: Total shopping enrollment opportunity cost by % using 3rd party web sites



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

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

VIII. Appendix B: Details Supporting Other Benefits and Mitigating Factors – The net benefit of Hub Use

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

This cost-benefit model resembles Figure 4. Area 0BCQ is the cost of using the Hub for those who get covered, which we estimate as $\$87.63 \times 12$ million people = $\$1,051,560,000$. The net benefit of the Hub is area ABC. To account for the time cost of people who start the application process but do not get covered, we will subtract $\$87.63 \times 4,666,667$ people = $\$408,940,029$ from the net benefit.

Marginal Benefits and Costs

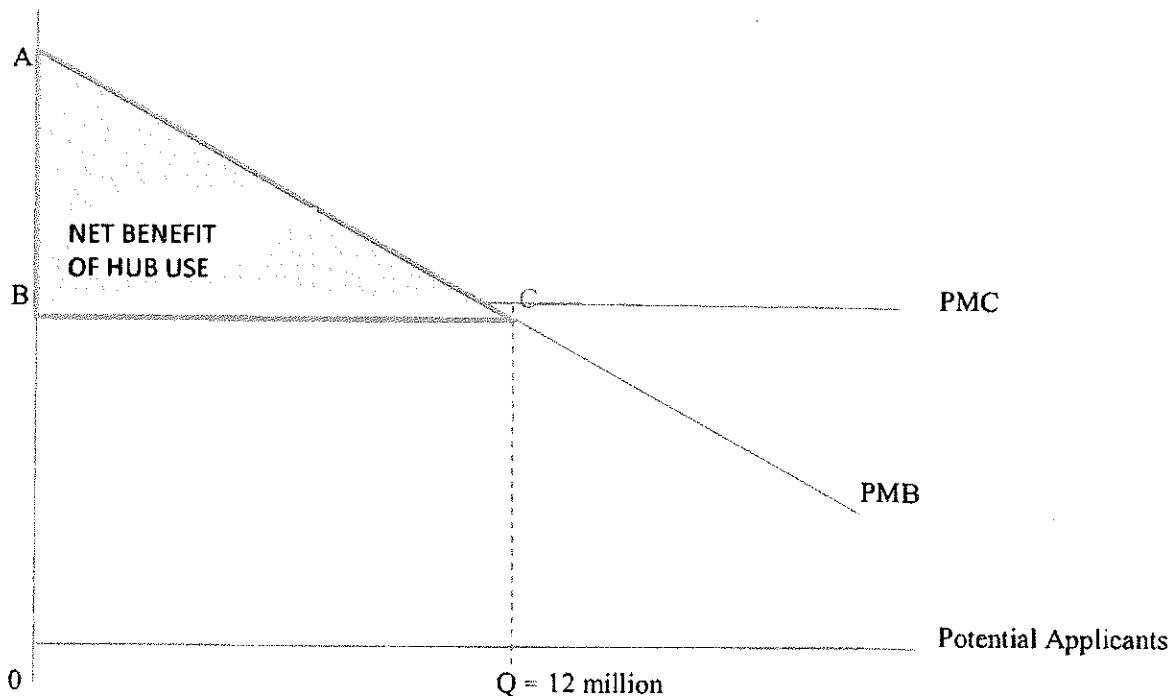


Figure 4: Revised Net Benefit of Hub Use

The size of the net benefit depends on how the demand for insurance responds to the price of coverage. Inelastic demand (less price-responsiveness) implies that the net benefit is larger, and

vice versa. According to our calculations, the demand for insurance is relatively inelastic and the net benefit is large. Table 9 shows the net benefit of using the Hub to obtain insurance by income class:

Table 9: Net Benefit of Hub Use by Income Class

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

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

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