COMPUTER MATCHING AGREEMENT
BETWEEN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
STATE BASED ADMINISTERING ENTITIES
FOR
DETERMINING ELIGIBILITY FOR ENROLLMENT IN APPLICABLE STATE HEALTH SUBSIDY PROGRAMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Department of Health and Human Services No. 1805
Centers for Medicare & Medicaid Services No. 2018-11
(Insert State AE Name)

Effective Date: October 3, 2018
Expiration Date: April 2, 2020

I. PURPOSE, LEGAL AUTHORITIES, and DEFINITIONS

A. Purpose

The purpose of this Computer Matching Agreement (Agreement) is to establish the terms, conditions, safeguards, and procedures under which the Department Health and Human Services, Centers for Medicare & Medicaid Services (CMS) will disclose certain information to the State Based Administering Entities (AE) to verify applicant information in order to make Eligibility Determinations for enrollment in "applicable State health subsidy programs", including exemption from the requirement to maintain Minimum Essential Coverage (MEC) or from the individual responsibility payment.

In accordance with the current regulations, State Medicaid and Children's Health Insurance Program (CHIP) agencies shall be the Source Agencies when making Eligibility Determination via the CMS Data Services Hub (Hub). To avoid dual enrollment, CMS as the Federally-facilitated Exchange (FFE), and the State Based Exchanges (SBE) shall also serve as the Recipient Agency under this Agreement, with respect to verifying whether an Applicant or Enrollee who has submitted an application to the FFE or an SBE has current eligibility or enrollment in a Medicaid/CHIP program.

The responsible component for CMS is the Center for Consumer Information & Insurance Oversight (CCIIO). CMS will serve as the Source Agency for this Agreement. The participating AE shall be the Recipient Agency under this Agreement with respect to information that AE will receive via the Hub.

By entering into this Agreement, the Parties agree to comply with the terms and conditions set forth herein, as well as applicable law and regulations. The terms and conditions of this Agreement will be carried out by authorized officers, employees, and contractors of CMS and the participating AE. For each State agency signatory to

this Agreement, CMS and the relevant AE are each a "Party" and collectively "the Parties."

B. Legal Authorities

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

1. This Agreement is executed pursuant to the Privacy Act 5 U.S.C. § 552a and the regulations and guidance promulgated thereunder, including Office of Management and Budget (OMB) Circular A-108 "Federal Agency Responsibilities for Review, Reporting, and Publication under the Privacy Act" published at 81 Fed. Reg. 94424 (Dec. 23, 2016), and OMB guidelines pertaining to computer matching published at 54 Fed. Reg. 25818 (June 19, 1989). The Privacy Act at 5 U.S.C. § 552a(b)(3) authorizes a federal agency to disclose information about an individual that is maintained in a system of records, without the individual's prior written consent, when the disclosure is pursuant to a routine use published in a System of Records Notice (SORN) as required by 5 U.S.C. § 552a(e)(4)(D). The Parties have published routine uses for their applicable systems of records which authorize the disclosures made under this Agreement.

2. This Agreement is executed to implement certain health care reform provisions of the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148, 42 U.S.C. § 18001), as amended by the Health Care and Education Reconciliation Act (Public Law 111-152) referred to collectively as the Affordable Care Act (ACA), and implementing regulations at 42 Code of Federal Regulations (CFR) Parts 431, 435, 457, and 45 CFR Parts 155-157.

3. Section 1331 of the ACA authorizes States to establish Basic Health Plans (BHP), and BHP regulations require that states administering BHP verify whether an individual meets the eligibility requirements in § 1331(e) for enrollment in a BHP. BHP also require periodic redeterminations of eligibility and the opportunity to appeal denials of eligibility under 42 CFR § 600.335.

4. Medicaid and CHIP programs require periodic renewals and redeterminations of eligibility for those programs and the opportunity to appeal denials of eligibility under §§ 1902(a)(8) and 1902(a)(3) of the Social Security Act (the Act) and 42 CFR §§ 435.916, 457.343 and Part 431, Subpart E and Part 457 Subpart K. Pursuant to 42 CFR § 435.945 and 42 CFR § 457.348, a Medicaid or CHIP agency must disclose certain income and eligibility information, subject to regulations at 42 CFR part 431, subpart F, needed for verifying eligibility for an Insurance Affordability Program.

5. 26 U.S.C. § 6103(l)(21) authorizes the disclosure of certain tax return information as defined under 26 U.S.C. § 6103(b)(2) (hereinafter "Return Information") for purposes of determining eligibility for certain Insurance Affordability Programs and prohibits disclosure of Federal tax information to an Exchange or State agency administering a State program, unless the program is in compliance with the safeguards requirements of 26 U.S.C. § 6103(p)(4), and unless the information is used

to establish eligibility for certain Insurance Affordability Programs.

C. Definitions

For purposes of this Agreement, the following definitions apply:

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" 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 Exchange (SBE) established under § 1311 of the ACA.

3. "Applicant" means an individual who is seeking eligibility for him or herself through an application submitted to the Exchange, excluding those individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of Title 45, or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following: Enrollment in a QHP through the Exchange; or Medicaid, CHIP, and the BHP, if applicable.

4. "APTC" means advance payments of the premium tax credit specified in § 36B of the Code (as added by § 1401 of the ACA) which are provided on an advance basis on behalf of an eligible individuals enrolled in a QHP through an Exchange in accordance with §§ 1402 and 1412 of the ACA.

5. "Authorized Representative" means an individual or organization who acts on behalf of an Applicant or beneficiary and meets the requirements set forth for Exchanges at 45 CFR §155.227 or for Medicaid at 42 CFR § 435.923.

6. "Breach" is defined by OMB Memorandum M-17-12, Preparing for and Responding to a Breach of Personally Identifiable Information, January 3, 2017, as the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, or any similar occurrence where (1) a person other than an authorized user accesses personally identifiable information or (2) an authorized user accesses or potentially accesses personally identifiable information for an other than authorized purpose.

7. "CHIP" means the Children's Health Insurance Program established under Title XXI of the Act.

8. "CSR" means cost-sharing reductions for an eligible individual enrolled in a silver level plan through the Exchange or for an individual who is an Indian enrolled in a QHP through the Exchange.

9. "Eligibility Determination" means the determination of eligibility for enrollment in an applicable State health subsidy program, or certifications of exemption from the

requirement to maintain minimum essential coverage or the individual shared responsibility payment. The term "Eligibility Determination" includes initial assessments and determinations, mid-year and annual redeterminations, and renewals, and any appeal process related to an Eligibility Determination.

10. "Insurance Affordability Programs" means (1) the program under title I of the ACA that makes available coverage in a QHP through an Exchange with APTC or CSR; (2) a Medicaid program under title XIX of the Act; (3) a Children's Health Insurance Program (CHIP) under title XXI of the Act; and (4) a program under § 1331 of the ACA establishing qualified basic health plans.

11. "Medicaid" means the health insurance program established under Title XIX of the Act and is one of the Insurance Affordability Programs.

12. "Personally Identifiable Information" or "PII" is defined by OMB M-17-12 (January 3, 2017), and means information which can be used to distinguish or trace an individual's identity, such as 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.

13. "Qualified Health Plan" or "QHP" means an insurance plan under the Affordable Care Act, that is certified by an Exchange in each state in which it is sold, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and satisfies other requirements.

14. "Relevant Individual" means any individual listed by name and SSN on the application whose personally identifiable information or financial information may bear upon an Eligibility Determination of an Applicant.

15. "State Based Exchange," or "SBE," means an Exchange established and operated by a State, and approved by HHS under 45 CFR § 155.105.

16. "Source Agency" means any agency which discloses records contained in a system of records to be used in a matching program, or any State or local government, or agency thereof, which discloses records to be used in a matching program.

II. RESPONSIBILITIES OF THE PARTIES

A. CMS Responsibilities:

1. CMS will develop and maintain the Hub to support activities described in this Agreement.

2. CMS will develop the appropriate form and manner of submission of data to and from the Hub.

3. CMS will develop procedures and conditions through and under which an AE may

request information via the Hub from available data sources, which include but are not limited to CMS, the Internal Revenue Service (IRS), Social Security Administration (SSA), Department of Homeland Security (DHS), Department of Veterans Affairs (VA), Department of Defense (DOD), Peace Corps (PC), Office Personnel Management (OPM), and commercial databases of income and employment, to support an Eligibility Determinations.

4. CMS will develop procedures through which an AE can request information via the Hub to support identity proofing for an Applicant or Application Filer prior to the release of matching data under this Agreement.

5. CMS will not use the Hub to transmit data to an authorized AE to support an Eligibility Determination, unless specifically authorized in Section IV of this Agreement.

6. CMS will provide Congress and the OMB with advance notice of this matching program and, upon completion of their advanced review period, will publish the required matching notice in the Federal Register.

B. Administering Entity Responsibilities:

1. AE will only request data or data verifications from CMS that are necessary to make Eligibility Determinations as described under Section IV.C

2. AE will develop procedures to transmit Applicant, Enrollee, or Relevant Individual information to CMS in order to verify or validate data and attestations made on the application for Eligibility Determinations, or to meet other program requirements as specifically authorized in Section IV of this Agreement.

3. AE will provide the data elements identified in Section IV, part C of this Agreement in the manner established by the Secretary of HHS when transmitting Applicant, Enrollee, or Relevant Individual information to the Hub.

4. AE will not use or re-disclose matching data received from the Hub to any entity or individual for any purpose other than making Eligibility Determinations. Nothing in this Agreement shall be construed to prohibit disclosure where required by applicable law. Notwithstanding, AE may not use or disclose Federal Tax Information to any entity or individual unless such disclosure is permitted under the Code and approved by the IRS.

5. Where AE is a Medicaid or CHIP agency in a state where the FFE is operating, it will respond to requests sent via the Hub to verify an Applicant or Enrollee's enrollment in the Medicaid or CHIP program.

6. AE will comply with identity proofing procedures described in "Guidance Regarding Identity Proofing for the Exchange, Medicaid, and CHIP, and the Disclosure of Certain Data Obtained through the Hub" issued to the AE by CMS.

III. 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 1, covering this and seven other "Marketplace" matching programs which CMS conducts with other Federal agencies. The CBA demonstrates that monetary costs to operate the eight Marketplace matching programs exceed $30.5 million, but does not quantify direct governmental cost saving benefits sufficient to offset the costs since the Marketplace matching programs are not intended to avoid or recover improper payments. The CBA, therefore, does not demonstrate that the matching program is likely to be cost-effective.

B. Other Supporting Justifications

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

1. Certain Marketplace matching programs are required and are not discretionary. However, some Marketplace matching programs are based on permissive routine use disclosure authority, not a statutory obligation.

2. The Marketplace matching programs' eligibility determinations and MEC checks result in improved accuracy of consumer eligibility determinations, which CMS anticipates will continue to produce expedited Eligibility Determinations while minimizing administrative burdens and achieve operational efficiencies.

3. The matching programs provide a significant net benefit to the public by accurately determining eligibility for financial assistance (including the APTC and CSR).

4. An efficient eligibility and enrollment process contributes to greater numbers of consumers enrolling in Marketplace QHP, resulting in a reduction of the uninsured population, therefore improving overall health care delivery.

5. Continuing to use the current matching program structure, which is less costly than any alternative structure, is expected to increase the public's trust in the participating agencies as stewards of taxpayer dollars.

C. Specific Estimate of Any Savings

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

The Act does not require the showing of a favorable ratio for the match to be continued,

only that an analysis be done unless statutorily excepted or waived by the DIB. The intention is to provide Congress with information to help evaluate the cost-effectiveness of statutory matching requirements with a view to revising or eliminating them where appropriate.

IV. RECORDS DESCRIPTION

The Privacy Act requires that each CMA specify a description of the records which will be matched and exchanged, including a sample of data elements that will be used and the approximate number of records that will be matched.

A. System of Records

The CMS SOR that supports this matching program is the "CMS Health Insurance Exchanges System (HIX)", CMS System No. 09-70-0560, last published in full at 78 Federal Register (Fed. Reg.) 63211 (October 23, 2013), as amended at 83 Fed. Reg. 6591 (February 14, 2018).

B. Number of Records Involved

The Congressional Budget Office (CBO) estimated that up to 12 million beneficiary records in total may be transacted for coverage in QHP and other Insurance Affordability Programs in calendar year 2018.

C. Specified Data Elements Used in the Match

1. From AE to CMS. The AE will send data identifying Applicants, Enrollees, and Relevant Individuals, via the Hub as part of the request for data or verification of attestations on an application for eligibility for enrollment in a QHP through an Exchange, another Insurance Affordability Program or certification of exemption. These data elements the AE may submit via the Hub may include the following:
   a. Social Security Number (if applicable).
   b. Last Name.
   c. First Name.
   d. Date of Birth.

2. From CMS to AE. CMS will receive via the Hub the data inputs listed above, transmit them via the Hub to the appropriate Federal agency or other approved data source, receive responses from the data source, and transmit those responses through the Hub to the requesting AE. Alternatively, CMS will receive via the Hub the data inputs listed above and provide a response based on data received in a secure electronic manner from the appropriate Federal agency, with such response being transmitted through the Hub to the requesting AE. The data elements the AE will receive from CMS via the Hub may include:

a. Validation of SSN
b. Verification of Citizenship or Immigration Status
c. Incarceration status
d. Eligibility and/or enrollment in certain types of minimum essential coverage
e. Income, based on Federal Tax Information (FTI), Title II benefits, and current income sources
f. Quarters of Coverage
g. Death Indicator

D. Projected Starting and Completion Dates of the Matching Program

Effective Date – October 3, 2018
Expiration Date – April 2, 2020 (April 2, 2021 if renewed for 1 year).

V. NOTICE PROCEDURES

The Privacy Act, at 5 U.S.C. § 552a(o)(1)(D), requires that each matching agreement specify procedures for providing individualized notice at the time of application and periodically thereafter.

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

B. At the time of application, AE will provide individual notice (Privacy Act Statement) on the approved streamlined eligibility application regarding the collection, use, and disclosure of the Applicant's PII by the AE; such application shall be either the CMS developed model application (approved under OMB No. 0938-1191) or an alternate state application approved by HHS. The single streamlined application which CMS has developed contains a Privacy Act statement describing the purposes for which the information is intended to be used and the authority which authorizes the collection of the information.

   In addition, when an Applicant submits an application for an exemption, depending on whether the SBE will make the Eligibility Determination for the exemption itself or whether the SBE will utilize the federally managed service to make the Eligibility Determination for an exemption, the SBE or CMS will provide individual notice on the exemption application regarding the collection, use and disclosure of the Applicant's PII. The exemption application contains a Privacy Act statement describing the purposes for which the information is intended to be used and the authority which authorizes the collection of the information.

C. At the time of redetermination, SBE must provide redetermination notices that will inform individuals about how their information is used, and where more information can be found about privacy and security policies. Requirements for Medicaid and CHIP agencies to provide notice at the time of Medicaid and/or CHIP Renewal are at 42 CFR §§ 435.916 and 457.343.

VI. VERIFICATION PROCEDURES AND OPPORTUNITY TO CONTEST FINDINGS

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

A. Verification and Opportunity to Contest Findings

Correcting information with a relevant data source is not necessary to resolve inconsistencies or complete an Eligibility Determination. Resolving an inconsistency with an AE will not correct information contained in the records of the relevant data source.

Any information provided via the Hub by other data sources, or information that originates with other data sources and is disclosed by CMS through the Hub, cannot be corrected by contacting CMS. Individuals must contact the relevant data source that provided those records via the Hub in order to correct such records. An individual seeking to contest the content of information that HHS or another data source provided to an Exchange for matching purposes should contact the relevant data source. Under 26 U.S.C. § 7852(e), return information cannot be corrected without filing an amended tax return with the IRS.

B. Contesting Findings:

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

1. If the AE is an Exchange, an individual seeking to resolve inconsistencies between attestations and the results of electronic verification for the purposes of completing an Eligibility Determination should be provided the opportunity to follow the procedures outlined in 45 CFR § 155.315(f). The AE will provide the proper contact information and instructions to the individual resolving the inconsistency.

2. If the AE is an agency administering a Medicaid or CHIP program, an individual seeking to resolve inconsistencies between attestations and the results of electronic for the purposes of completing an Eligibility Determination should be provided the opportunity to follow the procedures outlined in 42 CFR §§ 435.952, 435.956 and 457.380. The AE will provide the proper contact information and instructions to the individual resolving the inconsistency.

3. Per 42 CFR § 600.345, if the AE is a BHP, it must elect either Exchange verification procedures at 45 CFR §§ 155.315 and 155.320, or Medicaid verification procedures at 45 CFR § 435.945-956; and will resolve inconsistencies as set forth in paragraphs VI.B.1 and 2 above.

VII. DISPOSITION OF MATCHED ITEMS

The AE 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 matching program and will then destroy all such data by electronic purging, unless the AE or CMS are required to retain the information for enrollment, billing, payment, program audit purposes, or legal evidentiary purposes or where they are required by law to retain the information. The CMS FFE and AE will retain data for such purposes and under the same terms. In case of such retention, the AE and CMS will retire the retained data in their databases in accordance with the applicable Federal Records Retention Schedule (44 U.S.C. § 3303a). The AE and CMS will not create permanent files or separate systems comprised solely of the data provided by the other agency.

VIII. SECURITY PROCEDURES

A. Safeguards

An AE shall comply with all applicable regulations regarding the privacy and security of PII (see e.g., § 1411(g) of the ACA, 45 CFR § 155.260). Medicaid and CHIP agencies shall comply with all applicable regulations regarding the privacy and security of PII, including provisions of the HIPAA Privacy and Security Rules at 45 CFR Parts 160 and 164, that govern protections for individually identifiable health information (such as eligibility for health care under the Medicaid or CHIP program(s)).

B. An AE must comply with the latest version of the suite of documents entitled, "Minimum Acceptable Risk Standards for Exchanges" (MARS-E) as published by CMS, which provides guidance and requirements related to implementing the privacy and security standards with which AE must comply. Further, AE agree to comply with all current guidance (including revisions to MARS-E as they are published and made effective), regulations and laws that apply to them on this subject.

C. Officers, employees and agents who inspect or disclose Return Information obtained pursuant to this Agreement in a manner or for a purpose not so authorized by 26 U.S.C. 6103 are subject to the criminal sanction provisions of 26 U.S.C. sections 7213 and 7213A, and 18 U.S.C. section 1030(a)(2), as may be applicable. In addition, the AE could be required to defend a civil damages action under section 7431.

D. An AE shall ensure that its employees, contractors, and agents implement the appropriate administrative, physical and technical safeguards to protect matching data furnished by CMS under this Agreement (including matching data which constitutes PII) from loss, theft or inadvertent disclosure.

1. Administrative Safeguards. Both Parties will advise all users who will have access to the matching data (including but not limited to matched and to any data derived from 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 applicable Federal laws.

2. Physical Security/Storage: Both Parties will store the matching data and any data derived from the match in an area that is physically and technologically secure from access by unauthorized persons during duty hours, as well as non-duty hours or when not in use (e.g., door locks, card keys, biometric identifiers, etc.). Only authorized personnel will transport the matching data and any data derived from the match. Both Parties will establish appropriate safeguards for such data, as determined by a risk-based assessment of the circumstances involved.

3. Technical Safeguards: Both Parties agree that the data exchanged under this Agreement will be processed 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. AE personnel must enter personal identification numbers when accessing data on the Party's systems. Both Parties will strictly limit authorization to those electronic data areas necessary for authorized persons to perform his or her official duties.

4. An AE shall ensure that its employees, contractors, and agents understand that they are responsible for safeguarding this information at all times, regardless of whether or not the AE employee, contractor, or agent is at his or her regular duty station.

5. An AE shall ensure that its employees', contractors', and agents' laptops and other electronic devices/media containing matching data that constitutes PII are encrypted and/or password protected.

6. An AE shall ensure that its employees, contractors, and agents send e-mails containing matching data that constitutes PII only if encrypted and being sent to and received by e-mail addresses of persons authorized to receive such information. In the case of FTI, AE employees, contractors, and agents must comply with IRS Publication 1075's rules and restrictions on e-mailing return information.

7. An AE shall ensure that its employees, contractors, and agents restrict access to the matching data to only those authorized AE employees, contractors, and agents who need such data to perform their official duties in connection with purposes identified in this Agreement; such restrictions shall include, at a minimum, role-based access that limits access to those individuals who need it to perform their official duties in connection with the uses of data authorized in this Agreement ("authorized users"). Further, the AE shall advise all users who will have access to the data provided under this Agreement and to any data derived from the data matching contemplated by this Agreement 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. The AE shall require its contractors, agents, and all employees of such contractors or agents with authorized access to the data disclosed under this Agreement, to comply with the

terms and conditions set forth in this Agreement, and not to duplicate, disseminate, or disclose such data unless authorized under this Agreement.

8. For receipt of FTI, AE agree to maintain all return information sourced from the IRS in accordance with IRC section 6103(p)(4) and comply with the safeguards requirements set forth in Publication 1075, "Tax Information Security Guidelines for Federal, State and Local Agencies", which is the IRS published guidance for security guidelines and other safeguards for protecting return information pursuant to 26 CFR 301.6103(p)(4)-1. In addition, IRS safeguarding requirements require all AE to which CMS provides return information to:

   a. Establish a central point of control for all requests for and receipt of Return Information, and maintain a log to account for all subsequent disseminations and products made with/from that information, and movement of the information until destroyed, in accordance with Publication 1075, section 3.0.

   b. Establish procedures for secure storage of return information consistently maintaining two barriers of protection to prevent unauthorized access to the information, including when in transit, in accordance with Publication 1075, section 4.0.

   c. Consistently label return information obtained under this Agreement to make it clearly identifiable and to restrict access by unauthorized individuals. Any duplication or transcription of return information creates new records which must also be properly accounted for and safeguarded. Return Information should not be commingled with other Agency records unless the entire file is safeguarded in the same manner as required for return information and the FTI within is clearly labeled in accordance with Publication 1075, section 5.0.

   d. Restrict access to return information solely to officers, employees, agents, and contractors of AE whose duties require access for the purposes of carrying out this Agreement. Prior to access, AE must evaluate which personnel require such access on a need-to-know basis. Authorized individuals may only access return information to the extent necessary to perform services related to this Agreement, in accordance with Publication 1075, section 5.0.

   e. Prior to initial access to FTI and annually thereafter, ensure that AE employees, officers agents, and contractors that will have access to return information receive awareness training regarding the confidentiality restrictions applicable to the return information and certify acknowledgement in writing that they are informed of the criminal penalties and civil liability provided by §§ 7213, 7213A, and 7431 of the Code for any willful disclosure or inspection of return information that is not authorized by the Code, in accordance with Publication 1075, section 6.0.

   f. Prior to initial receipt of return information, have an IRS approved Safeguard Security Report (SSR). Each AE must annually thereafter submit an SSR. Each Administering Entity's Head of Agency must certify the SSR fully

describes the procedures established for ensuring the confidentiality of return information, addresses all outstanding actions identified by the Office of Safeguards from a prior year's SSR submission; accurately and completely reflects the current physical and logical environment for the receipt, storage, processing and transmission of FTI; accurately reflects the security controls in place to protect the FTI in accordance with Publication 1075 and the commitment to assist the Office of Safeguards in the joint effort of protecting the confidentiality of FTI; report all data incidents involving return information to the Office of Safeguards and Treasury Inspector General for Tax Administration (TIGTA) timely and to cooperate with TIGTA and Office of Safeguards investigators, providing data and access as needed to determine the facts and circumstances of the incident; support the Office of Safeguards' on-site review to assess compliance with Publication 1075 requirements by means of manual and automated compliance and vulnerability assessment testing, including coordination with information technology (IT) divisions to secure pre-approval, if needed, for automated system scanning and to support timely mitigation of identified risk to return information in a Corrective Action Plan (CAP) for as long as return information is received or retained. SSR will be transmitted in electronic format and on the template provided by Office of Safeguards using an IRS approved encryption method in accordance with Publication 1075, Section 7.0.

g. Ensure that Return Information is properly destroyed or returned to the IRS when no longer needed based on established AE record retention schedules in accordance with Publication 1075, section 8.0, or after such longer time required by applicable law.

h. Conduct periodic internal inspections of facilities where Return Information is maintained to ensure IRS safeguarding requirements are met and will permit the IRS access to such facilities as needed to review the extent to which AE is complying with the requirements of this section.

i. Ensure information systems processing return information are compliant with § 3544(a)(1)(A)(ii) of the Federal Information Security Management Act of 2002 (FISMA). Each AE will maintain an SSR which fully describes the systems and security controls established at the moderate impact level in accordance with National Institute of Standards and Technology (NIST) standards and guidance. Required security controls for systems that receive, process, store and transmit federal tax returns and Return Information are provided in Publication 1075, section 9.0.

j. Report suspected unauthorized inspection or disclosure of return information within 24 hours of discovery to the appropriate Agent-in-Charge, Treasury Inspector General for Tax Administration (TIGTA), and to the IRS Office of Safeguards in accordance with as specified in Publication 1075, section 10.0.

k. Allow IRS to conduct periodic safeguard reviews of the AE to assess whether security and confidentiality of Return Information is maintained consistent with the safeguarding protocols described in Publication 1075. Periodic safeguard reviews will involve the inspection of AE facilities and contractor facilities where FTI is maintained; the testing of technical controls for computer systems storing, processing or transmitting FTI; review of AE recordkeeping and policies and interviews of AE employees and contractor employees as needed, to verify the use of FTI and assess the adequacy of procedures established to protect FTI.

l. Recognize and treat all IRS Safeguards documents and related communications as IRS official agency records; that they are property of the IRS; that IRS records are subject to disclosure restrictions under Federal law and IRS rules and regulations and may not be released publicly under state Sunshine or Information Sharing/Open Records provisions and that any requestor seeking access to IRS records should be referred to the Federal Freedom of Information Act (FOIA) statute. If the AE determines that it is appropriate to share Safeguards documents and related communications with another governmental function/branch for the purposes of operational accountability or to further facilitate protection of FTI that the recipient governmental function/branch must be made aware, in unambiguous terms, that Safeguards documents and related communications are property of the IRS; that they constitute IRS official agency records; that any request for the release of IRS records is subject to disclosure restrictions under Federal law and IRS rules and regulations and that any requestor seeking access to IRS records should be referred to the Federal Freedom of Information Act (FOIA) statute. Federal agencies in receipt of FOIA requests for safeguards documents must forward them to IRS for reply.

E. Incident Handling and Reporting

1. AE are responsible for creating their own formal written policies and procedures for responding to privacy and security incidents in accordance with applicable state and federal law, MARS-E, and CMS guidance. AE shall handle and report Incidents in accordance with their organization's documented incident handling and breach notification procedures. These policies and procedures should include the scope, roles, responsibilities and how to:

   a. Identify Incidents involving matching data that constitute PII.

   b. Report all suspected or confirmed incidents involving matching data that constitute PII. This requirement applies to all system environments (e.g., production, pre-production, test, and development).

   c. Identify and convene a core response group within the AE who will determine the risk level of incidents involving matching data that constitute PII, and determine risk-based responses to such incidents.

e. Determine whether breach notification is required, and, if so, identify appropriate breach notification methods, timing, source, and contents from among different options, and bear costs associated with the notice as well as any mitigation.

f. Limit the disclosure of information about individuals whose information may have been compromised, misused, or changed without proper authorization, and the persons who improperly disclosed matching data that constitute PII, to authorized Federal, state, or local law enforcement investigators in connection with efforts to investigate and mitigate the consequences of any such incidents.

2. AE shall report all suspected or confirmed incidents (including loss or suspected loss of involving matching data that constitute PII) within one hour of discovery to CMS and IRS as follows:

   a. SBE and BHP report a Security Incident or Breach of PII to HIX.incidents@cms.hhs.gov within one hour of discovery of the incident by completing incident form (CALT doc53607). That e-mail will inform the appropriate designated CMS staff and the following affected Federal agency data sources, i.e., Department of Defense, Department of Homeland Security, Social Security Administration, Peace Corps, Office of Personnel Management, and Veterans Health Administration. If an SBE suspects a security incident may warrant a disconnection of the system-to-system connection to CMS and/or the Hub due to the severity of the incident and potential threat to CMS and other Federal systems, the SBE must immediately contact the CMS IT Service Desk at (410) 786-2580 or via email at CMS_IT_Service_Desk@cms.hhs.gov.

   b. SBE and BHP report any incident involving FTI to the Internal Revenue Service (IRS) Office of Safeguards by e-mail to safeguardreports@irs.gov. Additionally, SBE must telephone the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-589-3718. SBE should not wait until after their own internal investigation has been conducted to report an incident to CMS, TIGTA, and the IRS.

   c. Medicaid and CHIP agencies operating in a state in which the FFE operates will report a loss, potential loss, Security Incident or Breach of PII to the CMS IT Service Desk at (410) 786-2580. CMS will then notify the following affected Federal agency data sources, i.e., Department of Defense, Department of Homeland Security, Social Security Administration, Peace Corps, Office of Personnel Management, and Veterans Health Administration. State Medicaid and CHIP agencies are also responsible for reporting any suspected or confirmed incident involving FTI directly to the office of the appropriate Special Agent-in-Charge, Treasury Inspector General for Tax Administration (TIGTA), and the IRS Office of Safeguards within 24 hours of discovery of any potential Breach, loss, or misuse of return information. Contact information is contained in § 10.1, IRS Publication 1075,

http://www.irs.gov/pub/irs-pdf/p1075.pdf

d. A Medicaid and/or a CHIP agency, when operating as an AE performing Exchange functions under a SBE, report to HIX.Incidents@cms.hhs.gov. Affected Federal agency data sources, i.e., Department of Defense, Department of Homeland Security, Social Security Administration, Peace Corps, Office of Personnel Management, or Veterans Health Administration receive notifications from the HIX mailbox. Additionally, the Medicaid/CHIP agency shall contact the office of the appropriate Special Agent-in-Charge, TIGTA, and the IRS Office of Safeguards within 24 hours of discovery of any potential Breach, loss, or misuse of FTI. Contact information is contained in Section 10.1, IRS Publication 1075, http://www.irs.gov/pub/irs-pdf/p1075.pdf. The Medicaid and/or CHIP agency shall handle and report incidents in accordance with the organization's documented incident handling and breach notification procedures in accordance with 42 CFR §§ 431.300-431.306, and 435.945.

3. AE shall refer to the Interconnection Security Agreement (ISA) for instructions on handling disconnects from the Federal Services Data Hub (FDSH). The Change Management section provides instructions for handing an emergency or planned disconnect, initiated by the AE or CMS, as well as restoration procedures.

F. Administering Entity Opt Out for Receiving FTI

Notwithstanding the requirements related to FTI in this Section VIII or in any section of this Agreement, if the AE that is the Party to this Agreement opts out of receiving FTI provided by the IRS in connection with Eligibility Determinations and does not receive such FTI, the AE shall not be bound by any of this Agreement's terms governing the receipt, use, disclosure or safeguarding of FTI. Should the AE revise its position at any time during the term of this Agreement and so notify CMS of its intent to receive FTI, AE will comply with the terms of this Agreement as it relates to the safeguarding of FTI as of the date of such notice, provided that no FTI will be disclosed without an IRS approved Safeguard Security Report.

IX. RECORDS USAGE, DUPLICATION, AND REDISCLOSURE RESTRICTIONS

A. CMS and AE will only use, duplicate, and disclose the electronic files and data provided by the other Party under this Agreement as permitted or required by this Agreement or as required by applicable Federal law.

B. CMS and AE will not use the matching data to extract information concerning individuals therein for any purpose not specified by this Agreement or allowed by applicable system of records notices (SORN) or Federal law.

C. The matching data exchanged under this Agreement remain the property of the Party that provided the data and will be retained and destroyed as described in Section VII of this matching Agreement.

D. CMS and AE will restrict access to data solely to officers, employees, and contractors of CMS and AE.

a. The AE will restrict access to the matching data to Applicants, Enrollees, Application Filers, and Authorized Representatives of such persons. AE shall execute with each individual or entity such as agents or brokers that (1) gain access from the AE to PII submitted to an Exchange or (2) collect, use, or disclose PII gathered directly from Applicants, or Enrollees while that individual or entity is performing the functions outlined in its agreement with the AE, a written contract or agreement that includes (1) a provision describing the functions to be performed by the individual or entity and strictly limiting the use and disclosure of PII to those functions; (2) a provision(s) binding the individual or entity to comply with the same privacy and security standards and obligations that are made applicable to the PII under this Agreement, as appropriate, and specifically listing or incorporating those privacy and security standards and obligations; (3) a provision requiring the individual or entity to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls; (4) a provision requiring the individual or entity to inform the AE of any change in its administrative, technical, or operational environments defined as material within the contract; (5) a provision that requires the individual or entity to bind any downstream entities to the same privacy and security standards and obligations to which the individual or entity has agreed in its contract or agreement with the AE. Medicaid and Children's Health Insurance Program (CHIP) agencies also must assure that it will provide safeguards which restrict the use or disclosure of information concerning Applicants and recipients to purposes directly connected with the administration of the Medicaid and CHIP programs. This includes the disclosure of electronic data used to make an Eligibility Determination. 42 CFR § 431, subpart F, including §§ 431.301, 431.302, 431.303, 431.305, and 435.945, and 42 CFR § 457.1110.

b. Any individual who receives information from an Exchange or via the Hub in connection with an Eligibility Determination for enrollment in an applicable State health subsidy program and who knowingly and willfully uses or discloses information obtained pursuant to this Agreement in a manner or for a purpose not authorized by 45 CFR § 155.260 and § 1411(g) of the ACA are potentially subject to the civil penalty provisions of Section 1411(h)(2) of the ACA and 45 CFR §155.285, which carries a fine of up to $25,000.

X. RECORDS ACCURACY ASSESSMENTS

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

XI. COMPTROLLER GENERAL ACCESS

Pursuant to 5 U.S.C. § 552(o)(1)(K), the Government Accountability Office (Comptroller

General) may have access to all CMS and AE records, as necessary, in order to verify compliance with this Agreement.

XII. REIMBURSEMENT/FUNDING

This Agreement does not itself authorize the expenditure or reimbursement of any funds. Nothing in this Agreement obligates the Parties to expend appropriations or enter into any contract or other obligations.

XIII. DURATION OF AGREEMENT, MODIFICATION, AND TERMINATION

A. The Effective Date of this Agreement is October 3, 2018, provided that CMS reported the proposal to re-establish this matching agreement to the Congressional committees of jurisdiction and OMB in accordance with 5 U.S.C. § 552a(o)(2)(A) and (r) and OMB Circular A-108 and, upon completion of their advance review period, CMS published notice of the matching program in the Federal Register for a minimum of thirty days as required by 5 U.S.C. 552a(e)(12).

B. The AE and CMS may, within three (3) months prior to the expiration of this Agreement, renew this Agreement for a period not to exceed twelve (12) months if CMS and AE certify the following to the HHS DIB:

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

C. Modification: The Parties may modify this Agreement at any time by a written modification, mutually agreed to by both Parties. The Agreement must be reviewed by HHS DIB counsel in OGC to determine if the change requires a new agreement.

D. Termination: This Agreement may be terminated at any time upon the mutual written consent of the Parties. Either party may unilaterally terminate this agreement upon written notice to the other party, in which case the termination date shall be effective ninety (90) days after the date of the notice or at a later date specified in the notice provided this date does not exceed the approved duration for the agreement. A copy of this notification should be submitted to the Secretary, HHS DIB.

XIV. PERSONS TO CONTACT

A. CMS

1. Programmatic Issues between CMS and the Federal Hub Data Partners:

   Elizabeth Kane
   Director, Verifications Policy & Operations Division
   Eligibility and Enrollment Policy and Operations Group
   Center for Consumer Information and Insurance Oversight
   Centers for Medicare & Medicaid Services

7501 Wisconsin Avenue
Bethesda, MD 20814
Telephone: (301) 492-4418
E-mail: elizabeth.kane@cms.hhs.gov

2. State Based Exchange Programmatic Issues:

Jenny Chen
Director, Division of State Technical Assistance
State Marketplace and Insurance Programs Group
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
7501 Wisconsin Avenue
Bethesda, MD 20814
Telephone: 301-492-5156
E-mail: Jenny.Chen@cms.hhs.gov.

3. Medicaid/CHIP Programmatic Issues:

Anne Marie Costello
Director, Children & Adults Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicaid & Medicare Services
Baltimore, MD 21244-1850
Phone: (410) 786-5075
E-Mail: AnneMarie.Costello@cms.hhs.gov

4. Medicaid/CHIP System issues:

Julie Boughn
Director, Data and Systems Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Location: S2-23-06
Baltimore, MD 21244-1850
Telephone: (410) 786-9361
E-mail: Julie.Boughn1@cms.hhs.gov.

5. Privacy Policy and Agreement Issues:

Walter Stone
CMS Privacy Officer
Division of Security, Privacy Policy and Governance
Information Security and Privacy Group
Office of Information Technology
Centers for Medicare & Medicaid Services
7500 Security Boulevard

Mail Stop: N1-14-56
Baltimore, MD 21244-1850
Telephone: (410)786-5357
E-mail: walter.stone@cms.hhs.gov.

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

6. Marketplace Privacy and Security Issues:

Marc Richardson
Acting Director, Marketplace Information Technology Group
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: N1-26-05
Baltimore, MD 21244-1850
Telephone: (410) 786-0016
E-mail: Marc.Richardson@cms.hhs.gov.

B. The contact person for the AE can be found on the Administering Entity's signature page.

XV. APPROVALS

A. Centers for Medicare & Medicaid Services Program Official

B.

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

<table>
<tr><td colspan="2">Approved by (Signature of Authorized CMS Approving Official)

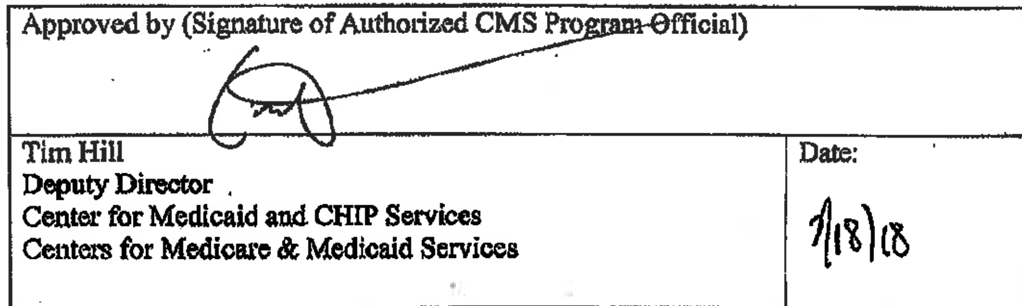
Jeffrey Grant Digitally signed by

Jeffrey Grant –S

Date: 2018.05.29 23:05:16 -04'00'</td></tr>
<tr><td>Jeffrey Grant
Deputy Director for Operations
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services</td><td>Date:</td></tr>
</table>

B. Centers for Medicare & Medicaid Services Program Official

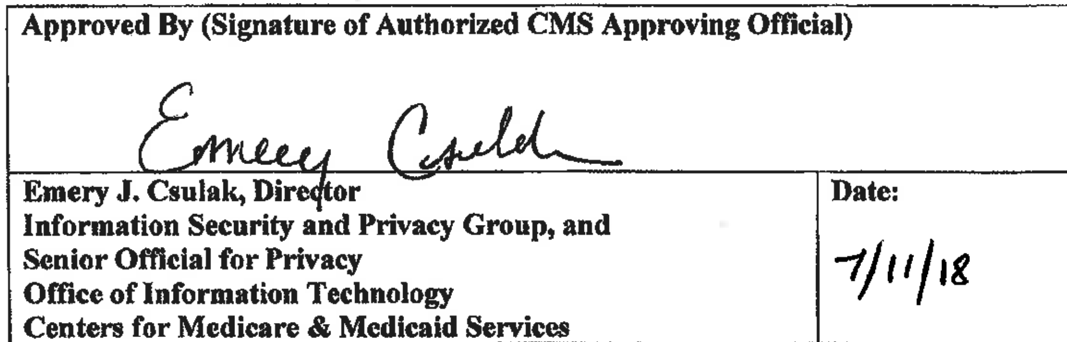
The authorized program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits the organization to the terms of this Agreement.



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

C. Centers for Medicare & Medicaid Services Approving Official

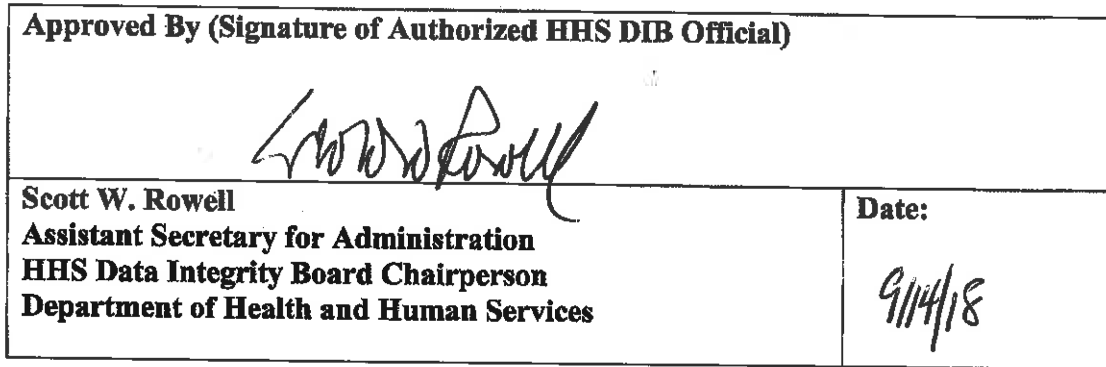
The authorized privacy official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commits his respective organizations to the terms of this Agreement.



Approved By (Signature of Authorized CMS Approving Official)	
Emery J. Csulak, Director **Information Security and Privacy Group, and** **Senior Official for Privacy** **Office of Information Technology** **Centers for Medicare & Medicaid Services**	**Date:** 7/11/18

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

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



Approved By (Signature of Authorized HHS DIB Official)	
Scott W. Rowell **Assistant Secretary for Administration** **HHS Data Integrity Board Chairperson** **Department of Health and Human Services**	**Date:** 9/14/18

E. Participating Administering Entity Program Official

1. Administering Entity Model

The Administering Entity will request via the Hub information necessary to verify applicant information in support of an Eligibility Determination. The Hub will facilitate the sharing of information for a data match with federal agencies and other data sources, as appropriate for the type of Eligibility Determination and Administering Entity, and then transmit the results of the data match back to the Administering Entity.

The Administering Entity under this Agreement is: (Check all that apply.)

€ Medicaid Agency (Includes any Medicaid Agency Administering Eligibility Verifications for a State Based Exchanges)
€ Children's Health Insurance Program
€ Basic Health Program
€ State Based Exchange

The Administering Entity will verify applicant information for the following Eligibility Determinations: (Check all that apply.)

€ Medicaid
€ Children's Health Insurance Program
€ Basic Health Program
€ Qualified Health Plan Enrollment
€ Qualified Health Plan with Advance Payments of the Premium Tax Credit
€ Qualified Health Plan with Cost-Sharing Reductions

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

Approved by (Signature of Authorized Administering Entity Official)	
(Insert name and Title of person signing for the Administering Entity)	**Date:**

Attachment 1: Master Cost Benefit Analysis

ATTACHMENT 1

Centers for Medicare & Medicaid Services (CMS)

Marketplace Computer Matching Agreement (CMA)

Cost / Benefit Analysis (CBA)

For the Renewal of Eight Matching Programs in 2018

Prepared by:

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

Dated January 31, 2018

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

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

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

I. MATCHING OBJECTIVE

The objective of the marketplace matching programs is to make initial eligibility determinations, redeterminations and renewals for enrollment in a qualified health plan, insurance affordability programs, and to issue certificates of exemption to individuals who are exempt from the individual mandate to maintain health insurance coverage. For those consumers who request financial assistance, they will be determined eligible for an amount of advanced premium tax credits (APTC) and cost sharing reductions, Medicaid, CHIP or BHP, where applicable. The Exchange and Medicaid/CHIP agencies verify data elements dependent on the eligibility determination they are performing. These may include citizenship or immigration status, household income, access to non-employer-sponsored and/or employer-sponsored minimum essential coverage. Non-employer-sponsored coverage includes coverage through TRICARE, Veteran's Health Benefits, Medicaid, Medicare, or benefits through service in the Peace Corps. Employer-sponsored coverage for Federal Employee Health Benefits can be verified with the Office of Personnel Management. The matching programs provide a single streamlined process for making accurate and real-time assessments of each applicant's eligibility and affordable insurance options and ensuring that the consumer can enroll in the correct applicable State health subsidy program[1] or be properly determined to be exempt from needing coverage.

MATCHING PROGRAM STRUCTURE

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[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.

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

CMS has entered into 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):

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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.

- Because the ACA mandates use of computer matching and requires a single streamlined application process for consumers, the issue to address in the CBA isn't whether to conduct the matching programs, but how efficiently the matching programs are structured and conducted (i.e., how streamlined the eligibility determination process is for consumers, and whether the structure is less costly than an alternative structure).
- The eight matching programs, when re-established, will use processes currently in place by the source agencies and entities known as the trusted data sources (TDS). The TDSs are IRS, DHS, SSA, OPM, Peace Corps, VHA, DoD, Current Sources of Income, and state based administering entities (AEs). In addition, several contractors provide a variety of support services to the Hub, such as Identity Proofing, trouble shooting, procedure writing, and maintenance support just to name a few.
- Private citizens (as potential beneficiaries) can apply for applicable State health subsidy programs on the basis of the private benefit and cost of applying. The private benefit from applying is the expected value of health insurance coverage (private insurance, Medicaid, CHIP or a Basic Health Plan) obtained through a State-based Exchange or through the Federally-facilitated Exchange in relation to the value of health insurance that could be obtained without the ACA defined American Health Benefit Exchange[3].
- CMS has internal costs related to the funding of CMS federal staff and associated resources to complete processes and responsibilities related to the matching programs.
- CMS has several internal cost centers that work on the Hub. Within CMS, these centers may be assisted by external contractors. This cost category is organized as an internal cost.
- CMS has external costs in the hiring, maintenance, and associated costs of contractors to perform numerous functions related to the Hub.
- CMS has several external cost factors related to the calculation of cost per transaction between a trusted data source and source agency, and CMS as the recipient agency. The cost of each data transaction is estimated from the prior year's matching program budget and the estimated number of data transactions.
- For the recovery of Improper Payments and Debts (Key Element 4), CMS is not currently utilizing the data match result from the matching programs for payment and debt reconciliations; however, the benefit of the match does provide the potential to implement this capability in the future.
- All annual personnel costs and savings are rounded to the nearest dollar.

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

II. COSTS

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 1: Direct Costs of Other CMS Centers

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

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

GS Grade	Hourly Rate	Annual Cost
GS11	$56.49	$108,461
GS12	$67.71	$130,003
GS13	$80.52	$154,598
GS14	$95.15	$182,688
GS15	$111.93	$214,906

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

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

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

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

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

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

e. Hub Operations – Monetary, but not quantified

CMS contracts with a vendor to provide service-oriented activities for the Hub. We assume that the associated costs are significant given that the original cost of the Hub in 2013[8] was $55 million. It is likely that the Hub has become more efficient since that time. At the time of this report we were unable to secure an exact budget amount for the Hub operations vendor outlay in 2017.

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

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

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

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

To overcome the limitations of IRS data, CMS works with a contractor to provide a commercial

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

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 RIPD, but we did not have access to this information.

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

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

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

3. *State Administering 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

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

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.

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

The DHS charges according to a graduated fee schedule for using the database called "SAVE" (Systematic Alien Verification for Entitlements Program). There are up to 3 steps of SAVE verification process: Step 1 is a real-time "ping" to their system. Consumers who could not be successfully verified may go to Step 2, which takes a 3-5 days for additional database searches. The third step requires manual touch from a DHS Status Verification Officer and requires a G-845 form. Costs are currently 50 cents per use at Steps 1 and 2 and $1.50 per use at Step 3. Automation through DHS's paperless initiative will impact these costs in the future.

c. Veterans Health Administration (VHA)

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

d. Office of Personnel Management

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

e. Other Trusted Data Sources

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

VI. CONCLUSION

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

One of the major policy considerations is whether any of the proposed changes to the ACA would impact the costs and benefits of the Hub. Our analysis suggests that the benefits of increased enrollment 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 (FFEs) and State-Based Exchanges on the Federal Platform (SBE-FPs) that rely on HealthCare.gov for individual market eligibility and enrollment functions." This change will shorten the time necessary for consumers to set up accounts on the Exchanges and allow agents, including health insurers and brokers, who are assisting consumers, to collect consumer information on 3rd party websites and input that information directly into HealthCare.gov.

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

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

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

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

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

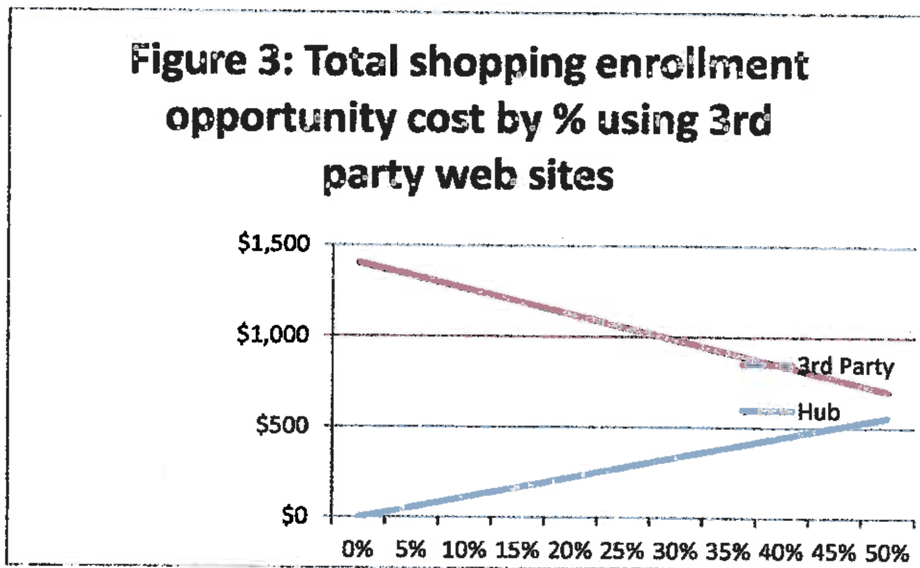
There are at least two pertinent indirect effects of these changes that could affect our cost-benefit results. Both are related to the effect of differential migration of consumers to 3rd party web sites. The first is based on the observation that 3rd party web sites might be more efficient, and therefore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

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

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



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

alternative scenarios.

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

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

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

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

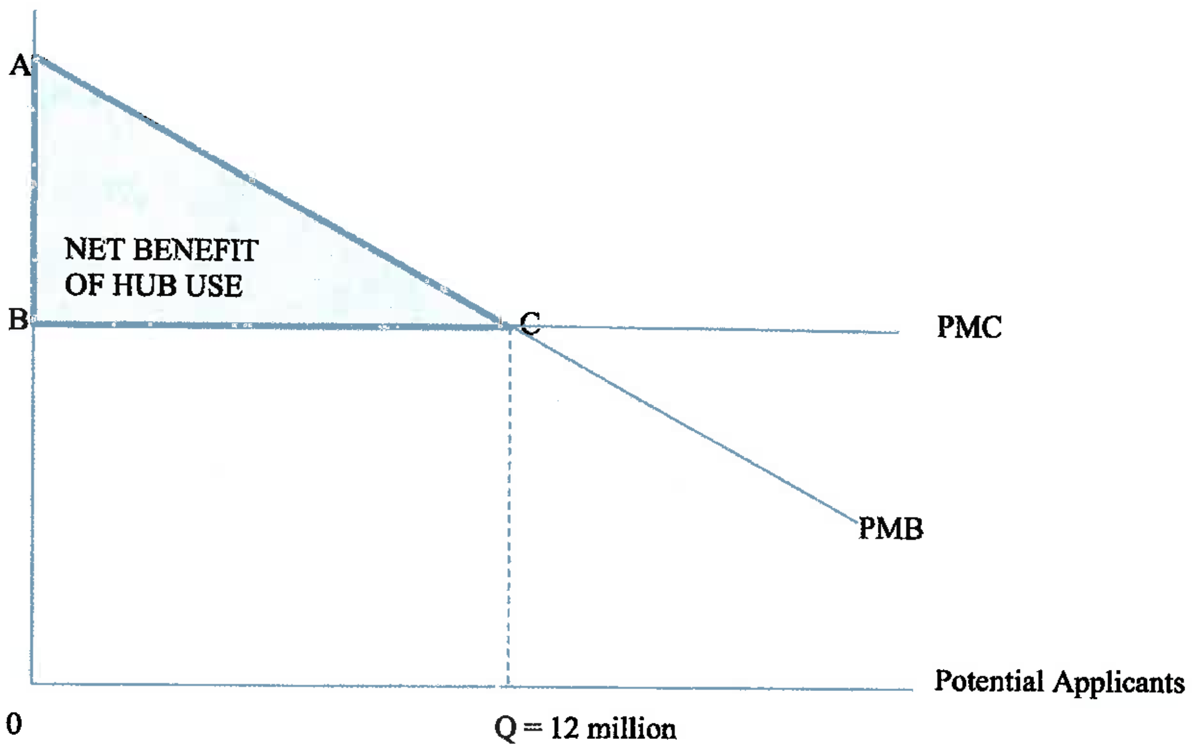


Figure 4: Revised Net Benefit of Hub Use

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.