

**COMPUTER MATCHING AGREEMENT
BETWEEN
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
AND
THE DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
FOR THE
VERIFICATION OF ELIGIBILITY FOR MINIMUM ESSENTIAL COVERAGE
UNDER
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT THROUGH A
VETERANS HEALTH ADMINISTRATION PLAN**

**Centers for Medicare & Medicaid Services No. 2018-06
Department of Health and Human Services No. 1807**

**Effective Date - October 2, 2018
Expiration Date - April 1, 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 Department of Veterans Affairs (VA), Veterans Health Administration (VHA). In accordance with the current regulations, CMS, in its capacity as operator of the Federally-facilitated Exchanges (FFE) and the Federal enrollment and eligibility platform, will use VHA's information to verify an Applicant's or Enrollee's enrollment in Minimum Essential Coverage (MEC) through a VHA Health Care Program for the purpose of making Eligibility Determinations, including Eligibility Determinations for which HHS is responsible under 45 Code of Federal Regulations (CFR) § 155.302.

The Privacy Act of 1974, as amended (in particular, by the Computer Matching and Privacy Protection Act of 1988 (CMPPA)(Public Law 100-503)), requires the Parties participating in a matching program to execute a written agreement specifying the terms and conditions under which the matching program will be conducted. CMS has determined that status verification checks to be conducted through the Hub by CMS and Administering Entities (AE) using the Enrollment System's Administrative Data Repository (ADR) and the Claims Processing & Eligibility Database (CP&E) constitute a "computer matching program" as defined in the CMPPA.

The responsible component for CMS is the Center for Consumer Information & Insurance Oversight (CCIIO). CMS will serve as the Recipient Agency. VHA will serve as the Source Agency, and as such, is the agency that discloses records contained in a system of

records (SOR) to be used in a matching program as defined by the Privacy Act (5 U.S.C. § 552a(a)(1)). The VHA component responsible for the disclosure of information is the VHA Privacy Office Manager, Information Access and Privacy Office. VHA acknowledges that AE, which include State-Based Exchanges (SBE) and Basic Health Programs (BHP), will use VHA data, accessed through the CMS Data Services Hub (Hub), to make Eligibility Determinations.

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 employees and contractors of CMS and VHA. The terms and conditions under which state-based AE may receive and use VHA data will be set forth in a separate agreement between CMS and the state-based Administering Entities.

B. Legal Authorities

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

1. This Agreement is executed pursuant to the Privacy Act of 1974 as amended (5 U.S.C.) § 552a), and the regulations and guidance promulgated thereunder, including Office of Management and Budget (OMB) Circular A-108 “Federal Agency Responsibilities for Review, Reporting, and Publication under the Privacy Act” published at 81 Federal Register (Fed. Reg.) 94424 (Dec. 23, 2016) and OMB guidelines pertaining to computer matching published at 54 Fed. Reg. 25818 (June 19, 1989).
2. Under the authority of the Patient Protection and Affordable Care Act (Public Law (P. Law) No. 111-148), as amended by the Health Care and Education Reconciliation Act (P. Law No. 111-152) (collectively, the ACA) and the implementing regulations, certain individuals are eligible for certain financial assistance in paying for private insurance coverage under a Qualified Health Plan (QHP) when enrollment is through an Exchange. Such assistance includes Advanced Premium Tax Credits (APTC), under 26 U.S.C. § 36B, § 1412 of the ACA, and Cost-Sharing Reductions (CSR) under § 1402 of the ACA.
3. Section 36B(c)(2) of the Internal Revenue Code (IRC) of 1986, as added by §1401 of the ACA, provides that an individual is ineligible for APTC if that individual is eligible for other MEC as defined in 26 U.S.C. § 5000A(f), other than MEC described in 26 U.S.C. § 5000A(f)(1)(C), such as the coverage under VHA Health Care Programs. Section 1402(f)(2) of the ACA provides that an individual is ineligible for CSR if the individual is not also eligible for the premium tax credit for the relevant month.
4. Section 1331 of the ACA authorizes the BHP and § 1331(e)(1)(C) requires the states

administering BHP to verify whether an individual is eligible for other MEC as defined in 26 U.S.C. § 5000A(f), such as coverage under VHA Health Care Programs. (45 CFR § 155.320(d)).

5. Section 1411 of the ACA requires the Secretary of HHS to establish a program to determine eligibility for an individual to purchase a QHP through an Exchange and to determine eligibility for APTC and CSR. Under 45 CFR §§ 155.302 and 155.305, the eligibility determinations for APTC and CSR may be made by an Exchange or HHS. CMS carries out Exchange-related responsibilities of HHS. The system established by HHS under § 1411 to determine eligibility for APTC and CSR, requires an Exchange to verify whether an individual is eligible for other MEC, such as coverage under a VHA Health Care Program, by sending information to HHS for HHS to provide the response.
6. Health Plans are only permitted to use or disclose protected health information (PHI), such as eligibility and enrollment information, as permitted or required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Among other things, the HIPAA Privacy Rule (45 CFR § 164.512(k)(6)(i)) permits a health plan that is a government program providing public benefits, such as a VHA Health Care Program, to disclose eligibility and enrollment information to an agency administering another government program providing public benefits if the disclosure is required or expressly authorized under regulation or statute. 45 CFR § 155.320(b)(2) expressly authorizes the disclosure to HHS of information regarding eligibility for and enrollment in a health plan, which may be considered PHI, for the purposes of verification of an applicant's eligibility for MEC as part of the eligibility determination process for APTC or CSR.
7. 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 the purposes of this Agreement:

1. "ACA" means Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), codified at 42 U.S.C. 18001 (collectively, the ACA);
2. "Administering Entity" means an entity administering an Insurance Affordability Program;

3. "Agent" or "Broker" means a person or entity licensed by the State as an agent, broker or insurance producer;
4. "Advanced Premium Tax Credit" or "APTC" means payment of the tax credit specified in section 36B of the IRC of 1986 (as added by section 1401 of the ACA) that are provided on an advance basis on behalf of an eligible individual enrolled in a QHP through an Exchange in accordance with section 1412 of the ACA. APTC are not considered Federal Tax Information under 26 U.S.C. § 6103;
5. "Applicant" means an individual who is seeking eligibility for him or herself through an application submitted to an Exchange, excluding individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of Part 155 of title 45 of the Code of Federal Regulations, submitted to a BHP program, or transmitted to an Exchange by an agency administering an Insurance Affordability Program for at least one of the following (a) enrollment in a QHP through an Exchange; or (b) the BHP;
6. "Authorized Representative" means an individual, person or organization acting, in accordance with 45 CFR § 155.227, on behalf of an Applicant or Enrollee in applying for an Eligibility Determination, including a redetermination, and in carrying out other ongoing communications with the Exchange;
7. "Authorized User" means an information system user who is provided with access privileges to any data resulting from this match or to any data created as a result of this match. Authorized Users include Administering Entities;
8. "Benefit Year" means the calendar year for which a health plan purchased through an Exchange provides coverage for health benefits;
9. "Breach" is defined by OMB Memorandum OMB M-17-12 Preparing for and Responding a Breach of Personally Identifiable Information, (January 3, 2017) as the compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, loss of control, or any similar term or phrase that refers to situations where persons other than Authorized Users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic;
10. "Claims Processing & Eligibility Database" (CP&E) is a database managed by the VHA;
11. "CMS" means the Centers for Medicare & Medicaid Services;
12. "Cost-Sharing Reductions" or "CSR" are defined at 45 CFR § 155.20 and means reductions in cost sharing for an eligible individual enrolled in a silver level plan through an Exchange or for an individual who is an Indian enrolled in a QHP

through an Exchange, provided in accordance with section 1402 of the ACA. CSRs are not considered Federal Tax Information (FTI) under 26 U.S.C. § 6103;

13. "Eligibility Determination" means the determination of eligibility for Insurance Affordability programs, including a redetermination based on a self-reported change pursuant to 45 CFR § 155.330, and the process of appealing an eligibility determination when an appeal is provided pursuant to section 1411(f) of the ACA;
14. "Enrollee" means an individual enrolled in a QHP through an Exchange or enrolled in a BHP;
15. "Enrollment System's Administrative Data Repository" (ADR) is a database managed by VHA;
16. "Exchange" means an American Health Benefit Exchange established under §§ 1311(b), 1311(d)(1), or 1321(c)(1) of the ACA, including both state-based Exchanges and FFE;
17. "Federally-facilitated Exchange" or "FFE" means an Exchange established by HHS and operated by CMS under § 1321(c)(1) of the ACA;
18. "HHS" means the Department of Health and Human Services;
19. "Data Services Hub" or "Hub" is the CMS managed, single data exchange for Administering Entities to interface with Federal agency partners. Hub services allow for adherence to Federal and industry standards for security, data transport, and data safeguards as well as CMS policy for Administering Entities for eligibility determination and enrollment services;
20. "Insurance Affordability Programs" include (1) a program that makes coverage in a QHP through an Exchange with APTC; (2) a program that makes available coverage in a QHP through an Exchange with CSR; (3) the Medicaid program established under Title XIX of the Social Security Act (the Act); (4) Children's Health Insurance Program (CHIP) established under Title XXI of the Act; and (5) The Basic Health Program (BHP) established under §1331 of the ACA;
21. "Minimum Essential Coverage" or "MEC" is defined in IRC § 5000A(f) and includes health insurance coverage offered in the individual market within a state, which includes a QHP offered through an Exchange, an eligible employer-sponsored plan, or government-sponsored coverage such as coverage under Medicare Part A, TRICARE, or a VHA Health Care Program (as defined in Section I.C.31 below);
22. "Navigator" means a private or public entity or individual that is qualified, and licensed, if appropriate, to engage in the activities and meet the standards described in 45 CFR § 155.210;

23. "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.;
24. "Qualified Health Plan" or "QHP" means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 of title 45 of the Code of Federal Regulations issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155 in title 45 of the CFR;
25. "Recipient Agency" is defined by the Privacy Act (5 U.S.C. § 552a(a)(9)) and means any agency, or contractor thereof, receiving records contained in a system of records from a Source Agency for use in a matching program;
26. "Record" means any item, collection, or grouping of information about an individual that is maintained by an agency, including his or her education, financial transactions, medical history, and criminal or employment history and that contains his or her name, or the identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print or a photograph;
27. "Security Incident" means the act of violating an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent;
28. "Source Agency," is defined by the Privacy Act (5 U.S.C. § 552a(a)(11)), means any agency that discloses records contained in a system of records to be used in a matching program;
29. "State-based Exchange" means an Exchange established and operated by a state, and approved by HHS under 45 CFR § 105;
30. "System of Records" or "SOR" is defined by the Privacy Act (5 U.S.C. § 552a(a)(5)), means a group of any records under the control of any agency from which information about an individual is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual; and
31. "VHA Health Care Program" means a health care program under chapter 17 or 18 of title 38 U.S.C., as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury department, as defined in regulations implementing 26 U.S.C. § 5000A.

II. RESPONSIBILITIES OF THE PARTIES

A. CMS Responsibilities

1. CMS will develop procedures through which an Applicant or Enrollee may request an Eligibility Determination via a single, streamlined application.
2. CMS may request verification from VHA of an Applicant's or Enrollee's enrollment status in a VHA Health Care Program; CMS and AE will only request data from VHA's records when necessary for CMS or the AE to make an Eligibility Determination.
3. CMS will provide to VHA the required data elements necessary and agreed upon by both Parties when requesting data from VHA through the Hub, including, but not limited to, first and last name, gender, date of birth and social security number (SSN).
4. CMS will receive the VHA response data elements through the Hub and will utilize the information provided by VHA in making Eligibility Determinations.
5. CMS has developed and will maintain procedures through which a state-based AE can request and receive information from VHA through the CMS Hub to make Eligibility Determinations.
6. CMS will enter into agreements with state-based AE that bind the state-based AE to comply with appropriate privacy and security standards and protections for PII, including requirements for these entities and their employees, contractors, and agents to comply with the use and disclosure limitations set forth in section 1411(g) of the ACA, privacy and security standards that are consistent with the principles outlined under 45 CFR § 155.260, and privacy and security standards that are consistent with the terms and conditions of this Agreement.
7. CMS will provide Congress and the OMB with advance notice of this matching program and, upon completion of their advance review period, will publish the required matching notice in the Federal Register.

B. VHA Responsibilities

1. VHA will develop and maintain procedures to respond to verification requests by CMS and state-based AE, and to transmit information from its relevant SOR of records to verify or validate attestations made by Applicants and Enrollees related to enrollment in VHA Health Care Programs.
2. VHA will perform probabilistic data matching logic activity to match the identity of the Applicant or Enrollee's inputs with VHA data records.

3. VHA will provide VHA data to the Hub, including SSN, MEC start dates and MEC end dates, if present, and transaction ID, in order to verify whether the Applicant or Enrollee was enrolled in VHA Health Care Program within the period requested by CMS or a state-based AE through the Hub.
4. VHA will provide a 'coded' response if the person was either not found within the VHA database or the person was not enrolled within VHA given the time period provided 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.

- a. Certain Marketplace matching programs are required and are not discretionary. However, some Marketplace matching programs are based on VHA’s permissive routine use disclosure authority, not a statutory obligation.
- b. The Marketplace matching programs’ eligibility determinations and MEC checks result in improved accuracy of consumer eligibility, which CMS anticipates will continue to produce expedited Eligibility Determinations while minimizing administrative burdens and achieve operational efficiencies.
- c. The matching programs provide a significant net benefit to the public by accurately determining eligibility for the APTC.
- d. An efficient eligibility and enrollment process contributes to greater numbers of consumers enrolling in Marketplace qualified health plans, resulting in a reduction of the uninsured population, therefore improving overall health care delivery.

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

C. Specific Estimate of Any Savings

There is no cost savings to conducting the Marketplace matching programs, as opposed to not conducting them. By requiring a single, streamlined application process, the ACA effectively required use of computer matching to make eligibility determinations. Therefore, the optimal result is attained by limiting the cost by using a matching program operational structure and technological process that is more efficient than any alternatives.

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

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 exempted 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 for protected data specify a description of the records which will be matched and exchanged, including a sample of data elements that will be used, the approximate number of records that will be matched, and the projected starting and completion dates of the program.

A. Systems of Records.

1. 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 Fed. Reg. 63211 (October 23, 2013), as amended at 83 Fed. Reg. 6591 (February 14, 2018).
2. VHA maintains the following SORNs which include the below-identified routine uses supporting VHA's disclosures to CMS:
 - a. 147VA16 Enrollment and Eligibility Records (VA) Routine Use No. 14; published at 74 Fed. Reg. 44901, August 31, 2009; and
 - b. Routine Use #25 in 54VAI 6 Health Administration Center Civilian Health Medical Record - VA (CHAMPVA), and Spina Bifida Healthcare Program published at 74 Federal Register 34398, July 15, 2009.

B. Number of Records Involved

The Congressional Budget Office (CBO) estimated that up to 12 million records 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 CMS to VHA. For each Applicant or Enrollee seeking an Eligibility Determination from an AE, and for whom VHA has the authority to release information, the AE will submit a request through the Hub to VHA that may contain, but is not limited to, the following specified data elements in a fixed recordformat:
 - a. First Name(required)
 - b. Middle Name/Initial (if provided by applicant)
 - c. Surname (Applicant's Last Name) (required)
 - d. Date of Birth (required)
 - e. Gender (optional)
 - f. SSN (required)
 - g. Requested QHP Coverage Effective Date (required)
 - h. Requested QHP Coverage End Date (required)
 - i. Transaction ID(required)

2. From VHA to CMS. For each Applicant or Enrollee seeking an Eligibility Determination from an AE from whom CMS or an AE has secured consent and VHA has the authority to disclose information, VHA will provide a response to the Hub. The response will be in a standard fixed record format and may contain, but is not limited to, the following specified data elements:
 - a. SSN (required)
 - b. Start/End Date (s) of enrollment period (s) (when match occurs)
 - c. A blank date response when a non-match occurs
 - d. If CMS transmits request and a match is made, but VA's record contains a Date of Death, VA will respond in the same manner as a non-match response, with a blank date
 - e. Enrollment period(s) is/are defined as the timeframe during which the person was enrolled in a VHA Health Care Program

D. Projected Starting and Completion Dates of the Matching Program

Effective Date – October 2, 2018

Expiration Date – April 1, 2020 (April 1, 2021 if renewed 1 year.)

V. NOTICE PROCEDURES

The matching notice which CMS will publish in the Federal Register as required by the Privacy Act (5 U.S.C. § 552a (e)(12)) will provide constructive notice of the matching program to affected individuals.

At the time of application or change of circumstances, CMS, or a State-based agency administering an Insurance Affordability Program, will provide a notice to Applicants for enrollment in a QHP or an Insurance Affordability Programs under ACA on the streamlined eligibility application. The agency administering the Insurance Affordability Program, including CMS in its capacity as an FFE, will ensure provision of a Redetermination or Renewal notice in accordance with applicable law. These notices will inform Applicants that the information they provide may be verified with information in the records of other Federal agencies.

An AE will ensure provision of a redetermination notice in accordance with applicable law. These notices will inform Applicants and Enrollees that the information they provide may be verified with information in the records of other Federal agencies.

VI. VERIFICATION PROCEDURES AND OPPORTUNITY TO CONTEST FINDINGS

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

A. Verification and Opportunity to Contest Procedures.

Before an AE may take any adverse action based on the information received from the match, the individual will 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 by 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 AE 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.

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 VHA through the Hub, the VHA 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 verification 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

VHA 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 VHA 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, VHA and CMS will retire the retained data in their SOR in accordance with the applicable Federal Records Retention Schedule (44 U.S.C. § 3303a). VHA and CMS will not create permanent files or separate system comprised solely of the data provided by the other agency.

VIII. SECURITY PROCEDURES

- A. General. CMS and VHA will maintain a level of security that is commensurate with the risk and magnitude of harm that could result from the loss, misuse, disclosure, or modification of the information contained on the system with the highest appropriate sensitivity level.
- B. Legal Compliance. CMS and VHA shall comply with the limitations on use, disclosure, storage, transport, and safeguarding of data under all applicable Federal laws and regulations. These laws and regulations include § 1411(g) of the ACA, the Privacy Act of 1974; the E-Government Act of 2002, which includes the Federal Information Security Management Act of 2002 (FISMA), 44 U.S.C. §§ 3541-3549, as amended by the Federal Information Security Modernization Act, 44 U.S.C. §§ 3551-3558; HIPAA; the Computer Fraud and Abuse Act of 1986; the Clinger-Cohen Act of 1996; and the corresponding implementation regulations for each statute. Additionally, CMS will

follow Federal, HHS, and CMS policies including the HHS Information Systems Security and Privacy Policy, as amended, and the CMS Information Security Acceptable Risk Safeguards (ARS) and CMS Minimum Security Requirements.

- C. CMS and VHA will comply with OMB circulars and memoranda, such as OMB Circular A-130, Managing Information as a Strategic Resource, published at 81 Fed. Reg. 49,689 (July 28, 2016); and National Institute of Standards and Technology (NIST) directives and publications; and the Federal Acquisition Regulations. These laws, directives, and regulations include requirements for safeguarding Federal information systems and PIT used in Federal agency business processes, as well as related reporting requirements. The Parties recognize and will implement the laws, regulations, NIST standards, and OMB directives including those published subsequent to the effective date of this Agreement.
- D. FISMA requirements apply to all Federal contractors, organizations, or entities that possess or use Federal information, or that operate, use, or have access to Federal information systems on behalf of an agency. Both Parties are responsible for oversight and compliance of their contractors and agents.
- E. Loss, Potential Loss, Incident Reporting, and Breach Notification. CMS and VHA will comply with OMB reporting guidelines in the event of a loss, potential loss, Security Incident, or Breach of PII (see OMB M-17-12, Preparing for and Responding to a Breach of Personally Identifiable Information (Jan. 3, 2017); and OMB M-18-02, Fiscal Year 2017-2018 “Guidance on Federal Information Security and Privacy Management Requirements Guidance on Improving Federal Information Security and Privacy Management Practices” (Oct. 16, 2017)). The Party experiencing the incident will notify the other agency's System Security Contact named in this Agreement within one (1) hour of discovering the loss, potential loss, Security Incident, or Breach. If the Party experiencing the loss, potential loss, Security Incident, or Breach is unable to speak with the other Party's System Security Contact within one (1) hour or if for some reason contacting the System Security Contact is not practicable (e.g., outside of normal business hours), then the following contact information will be used:
 - 1. VA Network and Security Operations Center (NSOC) 1-800-877-4328; VHA IT Service Desk: 303-398-7123; or
 - 2. E-mail: HACTSTCustomerSupport@va.gov
 - 3. CMS IT Service Desk: 1-800-562-1963
 - 4. E-mail: CMS IT Service Desk@cms.hhs.gov
- F. The Party that experienced the loss, potential loss, Security Incident, or Breach will be responsible for following its established procedures, including notifying the proper organizations (e.g., United States Computer Emergency Readiness Team (US-CERT)), conducting a breach and risk analysis, and making a determination of the need for notice and/or remediation to individuals affected by the loss. Parties under this agreement will follow PIT breach notification policies and related procedures as required by OMB guidelines and the US-CERT Federal Incident Notification Guidelines. If the

party experiencing the breach determines that the risk of harm requires notification to the affected individuals or other remedies, then that party will carry out these remedies without cost to the other party.

- G. Administrative Safeguards. CMS and VHA will restrict access to the matched data and to any data created by the match to only those Authorized Users of the Hub, e.g. Administering Entities and their employees, agents, officials, contractors, etc., who need it to perform their official duties in connection with the uses of data authorized in this Agreement. Further, CMS and VHA will advise all personnel who will have access to the data matched and to any data created by the match of the confidential nature of the data, the safeguards required to protect the data, and the civil and criminal sanctions for noncompliance contained in the applicable Federal laws.
- H. Physical Safeguards. CMS and VHA will store the data matched and any data created by the match in an area that is physically and technologically secure from access by unauthorized persons at all times. Physical safeguards may include door locks, card keys, biometric identifiers, etc. Only authorized personnel will transport the data matched and any data created by the match. CMS and VHA will establish appropriate safeguards for such data, as determined by a risk-based assessment of the circumstances involved.
- I. Technical Safeguards. CMS and VHA will process the data matched and any data created by the match under the immediate supervision and control of authorized personnel to protect the confidentiality of the data in such a way that unauthorized persons cannot retrieve any such data by means of computer, remote terminal, or other means. Systems personnel must enter personal identification numbers when accessing data on a party's systems. VHA and CMS will strictly limit authorization to those electronic data areas necessary for the authorized analyst to perform his or her official duties.
- J. Application of Policies and Procedures. The Parties will adopt policies and procedures to ensure that each Party uses the information described in this Agreement that is contained in their respective records or obtained from each other solely as provided in this Agreement. CMS and VHA will comply with their respective policies and procedures and any subsequent revisions.
- K. On-Site Inspections. Each Party has the right to monitor the other Party's compliance with FISMA requirements for data exchanged under this Agreement, and to audit compliance with this Agreement, if necessary, during the lifetime of this Agreement, or any extension of this Agreement. Each Party will provide the other Party with any reports and/or documentation relating to such inspections at the other party's request. Each Party may request an on-site inspection in addition to requesting reports and/or documentation.
- L. Compliance. CMS must ensure information systems and data exchanged under this

matching agreement are maintained compliant with CMS guidance Minimum Acceptable Risk Standards for Exchanges - (MARS-E) Exchange Reference Architecture Supplement. The MARS-E suite of documents can be found at: <http://www.cms.gov/cciiio/resources/regulations-and-guidance/index.html>, under Minimum Acceptable Risk Standards. To the extent, these documents are revised during the term of this Agreement, CMS must ensure compliance with the revised version.

IX. RECORDS USAGE, DUPLICATION AND RE-DISCLOSURE RESTRICTIONS

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

- A. CMS and VHA will only use the data for purposes specified by this Agreement or allowed by applicable SORN or Federal law.
- B. CMS and VHA must seek the consent of the other Party to use or disclose the data for any purpose other than the purposes described in this agreement. VHA and CMS will not give such consent, unless the law permits disclosure, or the disclosure is essential to the matching program. For such permission, the agency requesting permission must specify the following in writing; (1) what data will be used or disclosed, (2) to whom will the data be disclosed, (3) the reasons justifying such use or disclosure, and (4) the intended use of the data.
- C. The matching data provided by VHA under this Agreement will remain the property of VHA and will be retained by CMS and AE to be used for audits to verify the accuracy of matches and to adjudicate appeals.
- D. CMS will restrict access to data solely to officers, employees, and contractors of CMS and state-based AE. Through the Hub, CMS may disclose the data received under this Agreement to AE pursuant to separate CMA that authorize such entities to use the data for Eligibility Determinations regarding APTC, CSR, and BHP.
- E. CMS and AE will restrict access to the results of the data match to Applicants or Enrollees, application filers, and Authorized Representatives of such persons and to Certified Application Counselors, Navigators, Agents, and Brokers who have been authorized by the Applicant and are obligated by regulation and/or under agreement with CMS or an Administering Entity. CMS and AE shall require the same or more stringent privacy and security standards as a condition of contract or agreement with individuals or entities, such as Navigators, Agents, or Brokers that (1) gain access from CMS or an 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 the agreement with the

Exchange. (See 45 CFR §155.260; 42 CFR § 431, subpart F, including §§ 431.301, 431.302, 431.303, 431.305; 42 CFR § 435.945; and 42 CFR § 457.1110.)

X. RECORDS ACCURACY ASSESSMENTS

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

XI. COMPTROLLER GENERAL ACCESS

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

XII. REIMBURSEMENT

All work performed by VHA to perform the computer matches in accordance with this Agreement will be performed on a reimbursable basis. The legal authority for the transfer of funds between CMS and VHA is the Economy Act, 31 U.S.C. § 1535. Reimbursement will be transacted by means of a separate reimbursement instrument in accordance with the established procedures that apply to funding reimbursement actions. CMS and VHA will execute and maintain a separate Interagency Agreement on an annual basis to address CMS reimbursement of relevant VHA costs related to systems access covered by this Agreement. CMS agrees not to process requests directly received from any non-profit entity that VHA does not have the legal authority to bill.

XIII. DURATION OF AGREEMENT

- A. Effective Date: The Effective Date of this Agreement is October 2, 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 VHA certify the following to the HHS DIB:
 - 1. The matching program will be conducted without change; and
 - 2. The parties have conducted the matching program in compliance with this agreement.
- C. Modification: The Parties may modify this Agreement at any time by a written modification, mutually agreed to by both Parties. The proposed modified Agreement must be reviewed by HHS DIB counsel in OGC to determine if the change is significant and

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. The VHA contacts are:

Project Coordinator

Upneet Randhawa
Director, Veterans Point of Service Systems Management
Chief Business Office
U.S. Department of Veterans Affairs
300 Ocean Gate
Long Beach, California 90802
Telephone: 562-826-5963
Mobile: 562-340-1933
E-mail: Upneet.randhawa@va.gov.

Privacy Issues

Andrea Wilson, RHIA, MAM, CIPP-US
VHA Privacy Office Manager
Information Access and Privacy Office
Office of Health Informatics (OHI) 10A7B
810 Vermont Avenue
Washington, D.C. 20420
Telephone: 321-205-4305
E-mail: Andrea.Wilson3@va.gov.

Systems and Security Issues

Adrienne Ficchi, MBA, CHPSE, VHA-CM
Director, Health Care Security Requirements
Health Information Governance (HIG)
VHA, Office of Health Informatics (OHI) (10A7)
810 Vermont Avenue, N.W.
Washington, D.C. 20420
Telephone: 215-823-5826
E-mail: Adrienne.Ficchi@va.gov.

B. The CMS contacts are:

Program Issues

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

Medicaid/CHIP Issues

Julie Boughn Director
Data and Systems Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: S2-22-27 Location: S2-23-06
Baltimore, MD 21244-1850
Telephone: (410) 786-9361
E-mail: julie.boughn1@cms.hhs.gov

Privacy and Agreement Issues

Walter Stone, CMS Privacy Act Officer
Division of Security, Privacy Policy & Governance
Information Security & Privacy Group
Office of Information Technology
Centers for Medicare & Medicaid Services
Location: N1-14-56
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 7 86-5357
E-mail: walter.stone@cms.hhs.gov.

Barbara Demopulos, Privacy Advisor
Division of Security, Privacy Policy & Governance
Information Security & Privacy Group
Office of Information Technology
Centers for Medicare & Medicaid Services
Location: N1-14-40
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-6340

E-mail: Barbara.demopulos@cms.hhs.gov

XV. LIABILITY

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

XVI. INTEGRATION CLAUSE

This Agreement constitutes the entire agreement of the Parties with respect to its subject matter and supersedes all other computer matching agreements between the Parties that pertain to the disclosure of data between VHA and CMS for the purposes described in this Agreement. CMS and VHA have made no representations, warranties, or promises outside of this Agreement. This Agreement takes precedence over any other documents that may be in conflict with it.

XVII. APPROVALS

A. Centers for Medicare & Medicaid Services Program Official

The authorized program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, 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.

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'	
Jeffrey Grant Deputy Director for Operations Center for Consumer Information & Insurance Oversight Centers for Medicare & Medicaid Services	Date:

13. Centers for Medicare & Medicaid Services Approving Official

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

Approved by (Signature of Authorized CMS Program Official)	
	
Timothy Hill, Deputy Director Centers for Medicaid and CHIP Services Centers for Medicare & Medicaid Services	Date: 5/29/18

C. Centers for Medicare & Medicaid Services Approving Official

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

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

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

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

Approved by (Signature of Authorized HHS DIB Official)	
Heather Flick Acting Assistant Secretary for Administration, and Chairperson, HHS Data Integrity Board U.S. Department of Health and Human Services	Date:

E. VHA Approving Official

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

Approved By (Signature of Authorized VHA Approving Official)	
Upneet Randhawa, Director Veterans Point of Service Systems Management Chief Business Office, Member Services Veterans Health Administration Department of Veterans Affairs	Date:

F. Approving Official: VA

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

Approved By (Signature of Authorized VA Official)	
Alan R. Constantian Deputy CIO, Account Manager for Health Department of Veterans	Date:

G. Data Integrity Board: Department of Veterans Affairs

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

Approved by (Signature of Authorized VA DIB Official)

LaShaunne G. david 567193
Digitally signed by LaShaunne G. david
567193
Date: 2018.09.25 09:54:56 -04'00'

Camilo J. Sandoval
Chairman, Data Integrity Board
U.S. Department of Veterans Affairs.

Date:

Attachment 1: Cost-Benefit Analysis:

ATTACHMENT 1



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

Prepared by:

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

Dated January 31, 2018



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

Table of Contents

I. Matching Objective 2

Matching Program Structure..... 2

Background..... 3

II. Costs..... 5

 A. Key Elements 1 and 2: Personnel Costs and Computer Costs 5

III. Benefits 8

 A. Key Element 3: Avoidance of Future Improper Payments 8

 B. Key Element 4: Recovery of Improper Payments and Debts – not applicable 9

IV. Other Benefits and Mitigating Factors Which Justify the Matching Programs 10

V. Detail Supporting CMS and TDS Costs (FY2018)..... 11

VI. Conclusion 13

VII. Appendix A: Details Supporting Other Benefits and Mitigating Factors – The Future State of EDE and Marketplace..... 14

VIII. Appendix B: Details Supporting Other Benefits and Mitigating Factors – The net benefit of Hub Use 31

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 program¹ or be properly determined to be exempt from needing coverage.

Matching Program Structure

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

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.

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

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

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

Background

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

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

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.

are IRS, DHS, SSA, OPM, Peace Corps, VHA, DoD, Current Sources of Income, and state based administering entities (AEs). In addition, several contractors provide a variety of support services to the Hub, such as Identity Proofing, trouble shooting, procedure writing, and maintenance support just to name a few.

- Private citizens (as potential beneficiaries) can apply for applicable State health subsidy programs on the basis of the private benefit and cost of applying. The private benefit from applying is the expected value of health insurance coverage (private insurance, Medicaid, CHIP or a Basic Health Plan) obtained through a State-based Exchange or through the Federally-facilitated Exchange in relation to the value of health insurance that could be obtained without the ACA defined American Health Benefit Exchange³.
- CMS has internal costs related to the funding of CMS federal staff and associated resources to complete processes and responsibilities related to the matching programs.
- CMS has several internal cost centers that work on the Hub. Within CMS, these centers may be assisted by external contractors. This cost category is organized as an internal cost.
- CMS has external costs in the hiring, maintenance, and associated costs of contractors to perform numerous functions related to the Hub.
- CMS has several external cost factors related to the calculation of cost per transaction between a trusted data source and source agency, and CMS as the recipient agency. The cost of each data transaction is estimated from the prior year's matching program budget and the estimated number of data transactions.
- For the recovery of Improper Payments and Debts (Key Element 4), CMS is not currently utilizing the data match result from the matching programs for payment and debt reconciliations; however, the benefit of the match does provide the potential to implement this capability in the future.
- All annual personnel costs and savings are rounded to the nearest dollar.

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

II. Costs

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

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

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

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

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

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

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

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

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

GS Grade	Hourly Rate	Annual Cost
GS11	\$56.49	\$108,461
GS12	\$67.71	\$130,003

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

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

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

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

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

Table 1: Direct Costs of Other CMS Centers

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

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

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

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

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.

approximately \$352,940 per year (\$227 hourly rate with 15 percent overhead, 52 weeks per year.

e. Hub Operations – Monetary, but not quantified

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Medicare Drug and Health Plans' Costs

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

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

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

III. Benefits

A. Key Element 3: Avoidance of Future Improper Payments

1. Benefits to Agencies – not quantified

Costs incurred by CMS are Benefits to Agencies:

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

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

- **Multi-faceted attestation of beneficiary eligibility data.** Using matching data supplied by the eight trusted data sources for attestation in combination with an individual applicant's attestation of his or her personal information is more reliable than relying solely on applicant attestations. Due to the potential and historical presence of identity

fraud, the utilization of matching programs minimizes the risk of incorrect personal information being presented and used to make eligibility determinations; therefore, preventing the incorrect dispersal of federal subsidy program benefits.

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

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

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

3. Benefits to the General Public – not quantified

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

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

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

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

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

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

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

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

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

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

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

V. Detail Supporting CMS and TDS Costs (FY2018)

TDS Costs Reimbursed/Not Reimbursed by CMS

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

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

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

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

a. Social Security Administration (SSA)

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

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

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

Using the estimated FY2018 cost of the contract, the average cost per transaction with the SSA is

¹⁰ Individuals in prison are not eligible for ACA benefits.

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 (FEEs) and State-Based Exchanges on the Federal Platform (SBE-FPs) that rely on HealthCare.gov for individual market eligibility and enrollment functions.” This change will shorten the time necessary for consumers to set up accounts on the Exchanges and allow agents, including health insurers and brokers, who are assisting consumers, to collect consumer information on 3rd party websites and input that information directly into HealthCare.gov.

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

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://acaseignups.net/17/12/21/multiple-updates-hey-trump-repeal-116m-qhps-confirmed-likely-120m-when-dust-settles>.

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

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

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

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

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

* Minutes reduced from elimination of SAML requirement

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

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

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

* Minutes reduced from elimination of SAML requirement

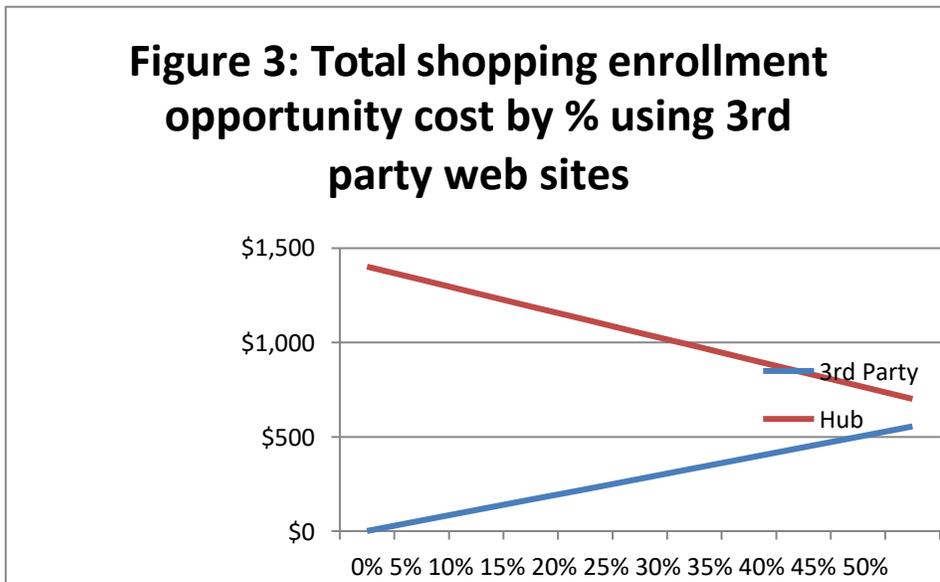
There are at least two pertinent indirect effects of these changes that could affect our cost-benefit results. Both are related to the effect of differential migration of consumers to 3rd party web sites. The first is based on the observation that 3rd party web sites might be more efficient, and therefore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

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

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

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

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



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

alternative scenarios.

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

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

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

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

Marginal Benefits and Costs

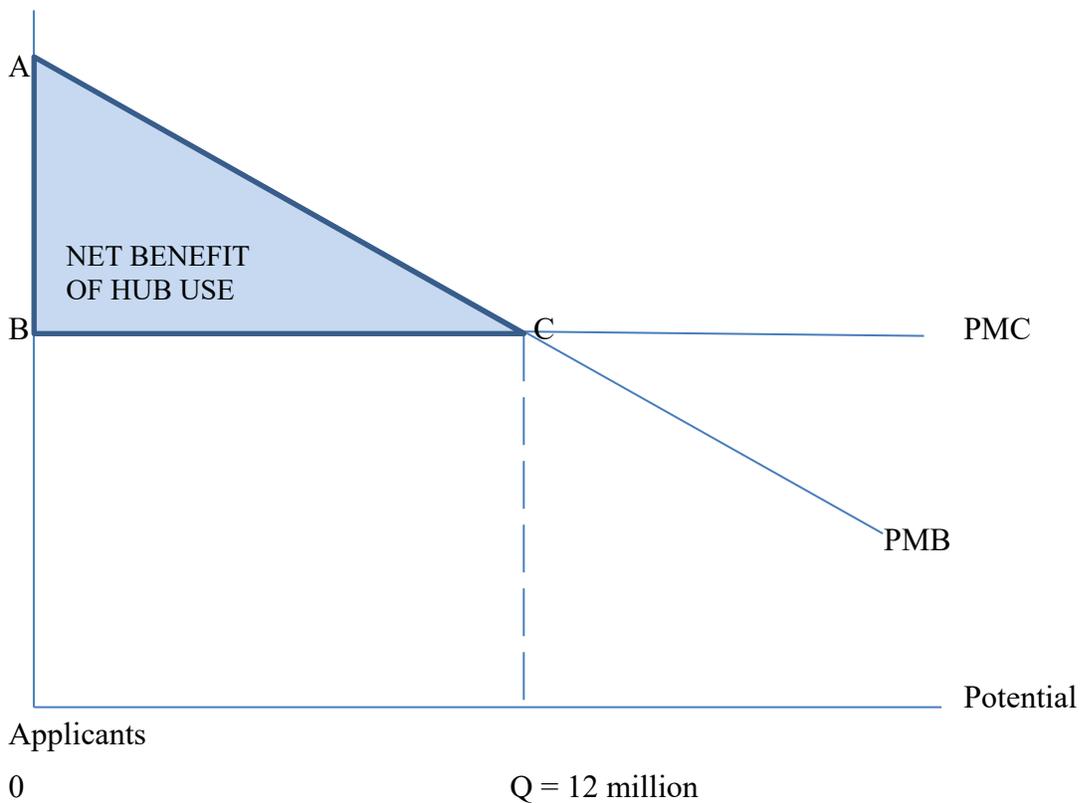


Figure 4: Revised Net Benefit of Hub Use

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

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

Table 9: Net Benefit of Hub Use by Income Class

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

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

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