

**COMPUTER MATCHING AGREEMENT
BETWEEN
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
THE DEPARTMENT OF DEFENSE
DEFENSE MANPOWER DATA CENTER
FOR VERIFICATION OF
ELIGIBILITY FOR MINIMUM ESSENTIAL COVERAGE
UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
THROUGH A DEPARTMENT OF DEFENSE HEALTH BENEFITS PLAN**

CMS Computer Matching Agreement No. 2021-07
Department of Health and Human Services No. 2102
DoD-DMDC No. 18

Projected Effective Date: May 30, 2021
Projected Expiration Date: November 29, 2022

I. PURPOSE, LEGAL AUTHORITIES AND DEFINITIONS

A. Purpose

The purpose of this Computer Matching Agreement (“Agreement”) is to assist the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) in determining individuals’ eligibility for financial assistance in paying for private health insurance coverage. Through this matching program, the Department of Defense (DoD), Defense Manpower Data Center (DMDC), provides CMS with data verifying whether an individual who is applying for private health insurance coverage under a qualified health plan (QHP) is eligible for coverage under a DoD health plan. CMS, in its capacity as operator of the Federally-facilitated Exchange (FFE) and the Federal enrollment and eligibility platform, and state-based Administering Entities (AEs) will use DoD’s information to verify an Applicant’s eligibility for or enrollment in Minimum Essential Coverage (MEC) through a TRICARE 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.

CMS will make the data provided by DoD available to the FFE and AEs through a data services hub (“the Hub”) to use in determining the Applicant’s eligibility for Insurance Affordability Programs (IAPs), including advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs), in paying for private health insurance coverage. DoD health plans provide MEC, and eligibility for such plans generally precludes eligibility for financial assistance.

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 use of DoD data by CMS and AEs constitute a "matching program" as defined in the CMPPA.

The responsible component for CMS is the Center for Consumer Information & Insurance Oversight (CCIIO). HHS/CMS will serve as the Recipient Agency. The DoD component responsible for the disclosure is the DMDC. DoD/DMDC will serve as the Source Agency in this Agreement.

By entering into this Agreement, the Parties agree to comply with the terms and conditions set forth herein and the applicable law and implementing regulations. The terms and conditions of this Agreement will be carried out by authorized officers, employees and contractors of CMS and DoD. The terms and conditions under which AEs may receive and use DoD data will be set forth in a separate agreement between CMS and the AEs.

B. Legal Authorities

The following statutes 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 implementing guidance promulgated thereunder, including Office of Management and Budget (OMB) Circular A-108 "Federal Agency Responsibilities for Review, Reporting, and Publication under the Privacy Act" published at 81 FR 94424 (Dec. 23, 2016) and OMB guidelines pertaining to computer matching published at 54 FR 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 of 2010 (P. Law No. 111-152) (collectively, the PPACA) and the implementing regulations, certain individuals are eligible for certain financial assistance in paying for private insurance coverage under a QHP when enrollment is through an Exchange. Such assistance includes APTC, under 26 U.S.C. § 36B, § 1412 of the PPACA, and CSRs under § 1402 of the PPACA.
3. Section 36B(c)(2) of the Internal Revenue Code (IRC) of 1986, as added by § 1401 of the PPACA, 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) (such as the coverage under TRICARE Health Care Programs), other than MEC described in 26 U.S.C. § 5000A(f)(1)(C). Section 1402(f)(2) of the PPACA provides that an individual is not eligible for CSRs unless the individual is also eligible for the premium tax credit for the relevant month.
4. Section 1331 of the PPACA authorizes the Basic Health Plan (BHP) and § 1331(e)(1)(C) requires each state administering a BHP to verify whether an individual is eligible for other MEC as defined in 26 U.S.C. § 5000A(f), such as coverage under TRICARE Health Care Programs (45 CFR § 155.320(d)).
5. Section 1411 of the PPACA 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 CSRs. Under 45 CFR § 155.302 and 155.305, the eligibility determinations for APTC and CSRs may be made by an Exchange or HHS. CMS carries out the Exchange-related responsibilities of HHS. The system established by HHS under § 1411(c)(4)(B) and (d) to determine eligibility for APTC and CSRs, requires an Exchange to verify whether an individual is eligible for other MEC, such as coverage under a TRICARE Health Care Program, by sending information to CMS for CMS to provide the response.
6. CMS facilitates the verification against DoD data, and a response with the result of that verification attempt is sent to the entity that determines eligibility for APTC and CSRs.
7. Under the authority of sections 1311, 1321, and 1411(a) of the PPACA, the Secretary of HHS adopted regulations, 45 CFR § 155.330, which further address the requirements for an Exchange to determine eligibility for enrollment in a QHP through an Exchange and for APTC and CSRs during the benefit year based on certain types of changes in circumstances.

8. Section 1411(f) of the PPACA sets forth the appeals authority.
9. 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)) permits a health plan that is a government program providing public benefits, such as TRICARE, 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 applicant eligibility for MEC as part of the eligibility determination process for APTC and CSRs.

C. Definitions

For the purposes of this Agreement:

1. "Administering Entity" or "AE" (sometimes referred to as "state-based AE") means an entity administering an IAP;
2. "Agent" or "Broker" means a person or entity licensed by the State as an agent, broker or insurance producer;
3. "Advanced Payments of the 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 PPACA) that is provided on an advanced basis on behalf of an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the PPACA. An individual's APTC eligibility status is not considered "taxpayer return information" as defined under 26 U.S.C. § 6103;
4. "Applicant" means an individual who is seeking eligibility through an application submitted to an Exchange or AE, excluding individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to 45 CFR Part 155, subpart G, for at least one of the following (a) enrollment in a QHP through an Exchange, or (b) the BHP;
5. "Authorized Representative" means an individual, person or organization acting, in accordance with 45 CFR § 155.227, on behalf of an Applicant or Enrollee in applying for an Eligibility Determination, including a redetermination, and in carrying out other ongoing communications with the Exchange;

6. "Authorized User" means an information system user who is provided with official access privileges to any data resulting from this matching program or to any data created as a result of this match. Authorized Users include AEs;
7. "Benefit Year" means the calendar year for which a health plan purchased through an Exchange provides coverage for health benefits;
8. "Breach" is defined by OMB Memorandum OMB M-17-12 Preparing for and Responding to 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 a non-authorized purpose have access or potential access to personally identifiable information, whether physical or electronic;
9. "CMS" means the Centers for Medicare & Medicaid Services;
10. "Cost-Sharing Reduction" or "CSR" is defined at 45 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 Alaskan Native/American Indian enrolled in a QHP through an Exchange, provided in accordance with section 1402 of the PPACA. An individual's CSR eligibility status is not considered "taxpayer return information" as defined under 26 U.S.C. § 6103;
11. "DEERS" means Defense Enrollment Eligibility Reporting System;
12. "DMDC" means the Defense Manpower Data Center;
13. "DoD" means Department of Defense;
14. "Eligibility Determination" means the determination of eligibility by an AE for enrollment in a QHP through an Exchange, an IAP or for a Certification of Exemption. This includes initial determinations or redeterminations based on a change in the individual's status, and appeals;
15. "Enrollee" means an individual enrolled in a QHP through an Exchange or enrolled in a BHP;
16. "Exchange" may refer to the Federally-facilitated Exchange (FFE) and/or State-based Exchanges (SBEs), as applicable based on context;

17. "Federally-facilitated Exchange" or "FFE" means an Exchange established by HHS and operated by CMS under § 1321(c)(l) of the PPACA;
18. "HHS" means the Department of Health and Human Services;
19. "Hub" or "CMS Data Services Hub" is the CMS managed, single data exchange for AEs to use to interface with Federal agency partners. Hub services allow for adherence to federal and industry standards for security, data transport, and data safeguards as well as CMS policy for AEs for eligibility determination and enrollment services;
20. "Insurance Affordability Programs" or "IAPs" include (1) a program that makes available coverage in a QHP through an Exchange with APTC; (2) a program that makes available coverage in a QHP through an Exchange with CSRs; (3) the Medicaid program established under Title XIX of the Social Security Act (the Act); (4) the 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 PPACA;
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 DoD Health Care Program;
22. "PPACA" means Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), codified at 42 U.S.C. 18001 (collectively, the PPACA);
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., either alone, or when combined with other personal or identifying information, which is linked or linkable to a specific individual;
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 CFR issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155 in title 45 of the CFR;

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" is defined in the Privacy Act at 5 U.S.C. 552a(a)(4) and means any item, collection, or grouping of information about an individual that is maintained by an agency, including but not limited to the individual's education, financial transactions, medical history, and criminal or employment history and that contains the individual's name, or the identifying number, symbol, or other identifying particular assigned to the individual;
27. "Security Incident" means "Incident," which is defined in 44 U.S.C. 3552(b)(2) and OMB Memorandum M-17-12 Preparing for and Responding to a Breach of Personally Identifiable information (January 3, 2017) as an occurrence that (1) actually or imminently jeopardizes, without lawful authority, the integrity, confidentiality, or availability of information or an information system; or (2) constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies;
28. "Source Agency," as defined by the Privacy Act at 5 U.S.C. § 552a(a)(11), means any agency that discloses records contained in a system of records to be used in a matching program;
29. "State-based Exchange" or "SBE" means an Exchange established and operated by a state, and approved by HHS under 45 CFR § 155.105;
30. "System of Records" or "SOR," is defined by the Privacy Act at 5 U.S.C. § 552a(a)(5) and means a group of any records under the control of any agency from which information about an individual is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual; and
31. "TRICARE" as defined at 10 U.S.C. § 1072(7), means the various programs carried out by the Secretary of Defense under 10 U.S.C. Chapter 55 and any other provision of law providing for the furnishing of medical and dental care and health benefits to members and former members of the uniformed services and their dependents.

II. RESPONSIBILITIES OF THE PARTIES

A. CMS Responsibilities

1. CMS will implement procedures through which an Applicant or Enrollee may request an eligibility determination via a single, streamlined application.
2. CMS will implement procedures through which an AE can request information from and match an Applicant's or Enrollee's information with data from DoD's DEERS system of records through the CMS Hub. CMS will only request data from or request a data match with DoD's records when necessary to make an eligibility determination, including an initial determination of eligibility, a determination based on a self-reported change, or a reverification at the end of the inconsistency period.
3. CMS will receive the DoD response data elements through the Hub and will utilize the information provided by DoD in making eligibility determinations.
4. CMS will implement procedures through which an AE can request information from DoD through the Hub to make eligibility determinations.
5. CMS, as the Recipient Agency, will provide Congress and the OMB with advance notice of this matching program, and upon completion of OMB's advance review, will publish the required matching notice in the Federal Register.
6. CMS will enter into agreements with AEs that bind these entities, including employees, contractors, and Agents or Brokers, to comply with the privacy and security standards and protections for PII, including requirements for these entities and their employees, contractors, and Agents or Brokers to comply with the use and disclosure limitations set forth in section 1411(g) of the PPACA, and privacy and security standards that are consistent with the principles outlined under 45 CFR § 155.260, and privacy and security standards that are consistent with the terms and conditions of this Agreement.
7. CMS will ensure the receipt of appropriate consents from Applicants or Enrollees for use of PII collected, used, and disclosed for the purposes and programs outlined in this Agreement. Consent will be received through an Exchange application for QHP coverage and for Medicaid and CHIP.

B. DoD Responsibilities

1. DoD will implement procedures to respond to verification requests by CMS to transmit information from DEERS to verify or validate eligibility for TRICARE health benefit programs that qualify as MEC.
2. DoD will match the identity of the Applicant or Enrollee's inputs with DoD data records.
3. DoD will provide its data to the Hub, in accordance with Section IV.B.2. to verify whether the Applicant or Enrollee was eligible for DoD TRICARE benefit programs within the period requested 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 matching program and seven other "Marketplace" matching programs which CMS conducts with other Federal agencies. The CBA demonstrates that monetary costs to operate the eight Marketplace matching programs are approximately \$39 million, but does not quantify direct governmental cost saving benefits sufficient to offset the costs because the Marketplace matching programs are not intended to avoid or recover improper payments. The CBA, therefore, does not demonstrate that the matching program is likely to be cost effective.

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. Each Party's Data Integrity Board (DIB) therefore is requested to waive the requirements of 5 U.S.C. § 552a(u)(4)(A) and make a determination, in writing, that a cost benefit analysis demonstrating that the matching program is likely to be cost effective is not required, in accordance with 5 U.S.C. § 552a(u)(4)(B) and OMB guidelines, and to approve the agreement based on these other supporting justifications:

1. The Marketplace matching programs have resulted in efficient and accurate consumer eligibility determinations and MEC checks, and substantially reduce the administrative burden on CMS and AEs.

2. The matching programs provide a significant benefit to the public by allowing CMS and AEs to quickly and accurately determine consumer eligibility for QHPs and IAPs while minimizing consumer burden.
3. An efficient eligibility and enrollment process contributes to greater numbers of consumers enrolling in Marketplace QHPs, resulting in a reduction of the uninsured population, therefore improving overall health care delivery.
4. 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

By requiring a single, streamlined application process, the PPACA effectively required use of computer matching to make eligibility determinations. Therefore, the optimal cost-savings result is attained by limiting the costs of conducting the matching program to the extent possible, and by using a matching program operational structure and technological process that is more efficient than any alternatives. CMS estimates that the cost of operating this computer match is about \$39 million per year. CMS' analysis suggests that the benefits of increased enrollment outweigh the costs given the increase in private insurance coverage through the PPACA.

The Privacy 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. DESCRIPTION OF THE DATA TO BE EXCHANGED

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

A. Systems of Records

1. The CMS SOR that supports this matching program is the CMS Health Insurance Exchanges Program (HIX), CMS System No. 09-70-0560, last

published in full at 78 FR 63211 (Oct. 23, 2013), as amended at 83 FR 6591 (Feb. 14, 2018). Routine Use 3 supports CMS' disclosures to DoD: "To disclose information about applicants and relevant individual(s) in order to obtain information from other federal agencies and state agencies and third party data sources that provide information to CMS, pursuant to agreements with CMS, for purposes of determining the eligibility of applicants to enroll in QHPs through an Exchange, in insurance affordability programs, or for a certification of exemption from the individual responsibility requirement."

2. The DoD SOR that supports this matching program is DMDC 02 DoD, Defense Enrollment Eligibility Reporting Systems (DEERS), published at 84 FR 55293 (October 16, 2019) and corrected at 84 FR 65975 (December 2, 2019). Routine Use h supports DoD's disclosure to CMS: "Providing to the Centers for Medicaid and Medicare Services, Department of Health and Human Services, for the purpose of verifying individual's healthcare eligibility status, in accordance with the Affordable Care Act. Data provided to CMS will be used to make eligibility determinations for insurance affordability programs, administered by Medicaid, the Children's Health Insurance Program (CHIP), the Basic Health Program (BHP) and the American Health Benefit Exchange."

B. Specified Data Elements

1. From CMS to DoD. For each Applicant or Enrollee seeking an eligibility determination, the AE will submit a request through CMS by way of the Hub to DMDC that may contain, but is not limited to, the following specified data elements in a fixed record format:

- a. Transaction ID
- b. Social Security Number (SSN)
- c. First Name
- d. Middle Name
- e. Surname
- f. Date of Birth
- g. Gender
- h. Requested QHP coverage effective date
- i. Requested QHP coverage end date

2. From DoD to CMS. For each Applicant or Enrollee seeking an eligibility determination through an AE, DMDC will provide to the Hub one of several outputs indicating whether an individual is eligible for or enrolled in a TRICARE

plan constituting MEC. The response will be in a standard fixed record electronic format (e.g., response file) and may contain, but is not limited to, the following specified data elements:

- a. SSN
- b. Begin Date(s)
- c. End Date(s)

C. Number of Records

The following table provides the base estimates for the total number of transactions in FY 2021 and FY 2022, as well as the number of transactions in the estimated highest month within each of those years. These estimates are subject to change as business assumptions or estimates are updated and/or refined.

	FY 2021 Total	FY 2021 Highest Month	FY 2022 Total	FY 2022 Highest Month
Base Estimate	92,264,646	12,797,823	93,187,292	13,053,779

D. Projected Starting and Completion Dates of the Matching Program

Projected Effective Date - May 30, 2021

Projected Expiration Date - November 29, 2022 (November 29, 2023 if renewed for 1 year)

V. PROCEDURES FOR INDIVIDUAL NOTICE

- A. CMS will publish notice of the matching program in the Federal Register as required by the Privacy Act (5 U.S.C. § 552a(e)(12)).
- B. At the time of application or when an individual reports a change of circumstances, CMS, or an AE administering an IAP, provides a notice to Applicants for enrollment in a QHP or an IAP under PPACA on the streamlined eligibility application. The agency administering the IAP, including CMS in its capacity as an FFE, ensures provision of a Redetermination or Renewal notice in accordance with applicable law. These notices inform Applicants that the information they provide may be verified with information in the records of other federal agencies.

- C. At the time of enrollment in Tricare, DoD provides notice that information may be shared with the Department of Health and Human Services for purposes related to eligibility determinations.

VI. VERIFICATION AND OPPORTUNITY TO CONTEST

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).

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 IAP based on DoD 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 IAP; 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 IAP.

- A. 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 and 155.320, which specifies that individuals have 90 days to present satisfactory documentary evidence via the channels available for the submission of an application to verify their information. The AE will provide the proper contact information and instructions to the individual resolving the inconsistency.
- B. If the AE is an agency administering a Medicaid or CHIP program, an individual seeking to resolve inconsistencies between attestations and the results of electronic for the purposes of completing an Eligibility Determination should be provided the opportunity to follow the procedures outlined in 42 CFR §§ 435.945 through 435.956. The AE will provide the proper contact information and instructions to the individual resolving the inconsistency.

- C. Pursuant to 42 CFR § 600.345, if the AE is a BHP, it must elect either the Exchange verification procedures set forth in paragraph VI.A or the Medicaid /CHIP verification procedures set forth paragraph VI.B.

VII. ACCURACY ASSESSMENTS

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

VIII. PROCEDURES FOR RETENTION AND TIMELY DESTRUCTION OF IDENTIFIABLE RECORDS

DoD and CMS will each retain data received from the other via the Hub only for the period of time required to verify an Applicant or Enrollee's eligibility for TRICARE health benefits under this matching program and will then destroy the data by electronic purging, unless DoD or CMS is 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, DoD and CMS will retire the retained data in accordance with the applicable Federal Records Retention Schedule. DoD and CMS will not create permanent files or a separate system comprised solely of the data provided by the other party.

IX. SECURITY PROCEDURES

- A. General. CMS and DoD will maintain a level of security needed to protect the information contained on the system with the highest appropriate sensitivity level.
- B. Legal Compliance. CMS and DoD 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 PPACA; the Privacy Act of 1974; the E-Government Act of 2002, which includes the Federal Information Security Management Act of 2002 (FISMA), as amended by the Federal Information Security Modernization Act, 44 U.S.C. §§ 3551 et. seq.; HIPAA; the Computer Fraud and Abuse Act of 1986; the Clinger-Cohen Act of 1996; and the corresponding implementation regulations for each statute.

CMS and DoD will comply with OMB circulars and memoranda, such as OMB Circular A-130, Managing Information as a Strategic Resource, published at 81 FR 49689 (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 PII used in Federal agency business processes, as well as related reporting requirements. The Parties recognize and will implement the laws, regulations, NIST standards, and OMB directives including those published subsequent to the effective date of this Agreement.

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

C. Incident Reporting. CMS and DoD 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-21-02, "Fiscal Year 2020-2021 Guidance on Federal Information Security and Privacy Management Requirements" (Nov.12, 2020) and notify the National Cybersecurity and Communications Integration Center/United States Computer Emergency Readiness Team (NCCIC/US-CERT) within one hour of being identified by the agency's top-level Computer Security Incident Response Team (CSIRT), Security Operations Center (SOC), or information technology department. In addition, within one hour of discovering the incident, the Party experiencing the incident will notify the other agency's System Security Contact named in this Agreement within one (1) hour of discovering the loss, potential loss, Security Incident, or Breach. If the Party experiencing the loss, potential loss, Security Incident, or Breach is unable to speak with the other Party's System Security Contact within one (1) hour or if for some reason contacting the System Security Contact is not practicable (e.g., outside of normal business hours), then the following contact information will be used:

- DMDC Privacy Office and Incident Response : dodhra.dodc-mb.dmdc.list.privacy-office@mail.mil and dodhra.dodc-mb.dmdc.list.privacy-office@mail.mil.
- CMS IT Service Desk: 1(800) 562-1963 or CMS_IT_ServiceDesk@cms.hhs.gov

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., NCCIC/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 PII breach notification policies and related procedures as required by OMB guidelines and the US-CERT Federal Incident Notification Guidelines. If the Party experiencing the 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.

- D. Administrative Safeguards. CMS and DoD 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. AEs and their employees, Agents or Brokers, 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 DoD will ensure all authorized personnel who will have access to the data matched and to any data created by the match are trained on the requirements of the Privacy Act of 1974, as well as other agency policies concerning the confidential nature of the PII, the appropriate safeguards for PII, and the civil and criminal sanctions for noncompliance with applicable Federal laws.
- E. Physical Safeguards. CMS and DoD 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 DoD will establish appropriate safeguards for such data, as determined by a risk-based assessment of the circumstances involved.
- F. Technical Safeguards. CMS and DoD 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. DoD and CMS will strictly limit authorization to those electronic data areas necessary for the authorized analyst to perform his or her official duties.
- G. Security Assessment. NIST Special Publication 800-37, Revision 2, encourages agencies to accept each other's security assessments in order to reuse information system resources and/or to accept each other's assessed security posture in order to share information. NIST 800-37 further encourages that this type of reciprocity is best achieved when agencies are transparent and make available sufficient evidence

regarding the security state of an information system so that an authorizing official from another organization can use that evidence to make credible, risk-based decisions regarding the operation and use of that system or the information it processes, stores, or transmits. Consistent with that guidance, the Parties agree to make available to each other upon request system security evidence for the purpose of making risk-based decisions. Requests for this information may be made by either Party at any time throughout the duration or any renewal of this Agreement.

- H. Compliance. CMS must ensure information systems and data exchanged under this matching agreement are maintained compliant with CMS Acceptable Risk Safeguards (ARS) standards. The ARS document can be found at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Information-Security-Library>. To the extent, these documents are revised during the term of this Agreement, CMS must ensure compliance with the revised version.

X. RECORDS USAGE, DUPLICATION AND DISCLOSURE

CMS and DoD 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 DoD will only use or disclose the data for the purposes described in this Agreement or allowed by applicable SORN or federal law.
- B. The matching data provided by DoD under this Agreement will remain the property of DoD. CMS and AEs will dispose of such matching data in accordance with Section VIII, but may retain selected matching data for the purposes of program audits to verify the accuracy of matches and to adjudicate appeals.
- C. CMS and DoD will not duplicate or disseminate the submission and response files, within or outside their respective agencies, without the written consent of the other party, except as required by federal law or for purposes under this agreement.
- D. CMS will restrict access to DoD data solely to officers, employees, and contractors of AEs and CMS. Through the Hub, CMS may disclose the DoD data received under this Agreement to AEs pursuant to separate Agreements that authorize such entities to use the data for eligibility determinations regarding APTC, CSRs, and BHP.

- E. CMS FFE and AEs will restrict access to the results of the data match, i.e. whether an Applicant or Enrollee is eligible for or enrolled in TRICARE constituting MEC, to Applicants and Enrollees, Application Filers, and Authorized Representatives of such persons, and to individuals or entities, such as Agents or Brokers, who have been authorized by CMS and are bound by regulation or are under agreement with CMS or an AE to assist with eligibility determinations and enrollment.

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 DMDC records, as necessary, in order to verify compliance with this Agreement.

XII. REIMBURSEMENT

Expenses incurred by this data match will not involve any payments or reimbursement between DoD and CMS. Cost adjustments, however, may be made in the future between the parties DoD and CMS may make such adjustments by means of a reimbursable agreement between the parties.

XIII. DURATION OF AGREEMENT

- A. Effective Date: The projected Effective Date of this Agreement is May 30, 2021, provided that, before May 30, 2021, CMS reported the proposal to re-establish this matching program to the Congressional committees of jurisdiction and OMB in accordance with 5 U.S.C. § 552a(o)(2)(A) and (r) and OMB Circular A-108 and, upon completion of OMB's advance review, 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. Term: The initial term of this Agreement will be eighteen (18) months.
- C. Renewal: The HHS and DoD DIBs may, within three (3) months prior to the expiration of this Agreement, renew this Agreement for a period not to exceed one year if CMS and DoD certify to their DIBs that:
1. The matching program will be conducted without change; and
 2. The Parties have conducted the matching program in compliance with this agreement.

If either Party does not want to renew this agreement, it must notify the other Party of its intention not to continue at least 90 days before the expiration of the agreement.

- D. Modification: The Parties may modify this Agreement at any time by a written modification, mutually agreed to by both Parties, provided that the modification does not include a significant change. A significant change will require a new matching agreement.
- E. 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. INTEGRATION CLAUSE

This Agreement constitutes the entire agreement of the parties with respect to its subject matter and supersedes all other data exchange agreements between the Parties that pertain to the disclosure of data between DoD and CMS for the purposes described in this Agreement. The parties have made no representations, warranties, or promises outside of this Agreement.

XV. PERSONS TO CONTACT

A. The DoD contacts are:

- 1. DoD Data Integrity Board Issues

Cheryl Jenkins
Management Analyst
Defense Privacy, Civil Liberties, and Transparency Division (DPCLTD)
4800 Mark Center Drive, Box 24
Alexandria, VA 22350-1700
Telephone: (703) 571-0070
Email: cheryl.jenkins8.civ@mail.mil

2. Program Issues

Victoria Rodrigues
Program Manager
Customer Relationship Management
Defense Manpower Data Center
400 Gigling Rd
Seaside, CA 93955-6771
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3. Privacy Issues

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Kimberly Pearman
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Defense Manpower Data Center
PM Support
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4. Security Issues

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Information Assurance Officer
Defense Manpower Data Center
4800 Mark Center Drive
Alexandria, VA 22350
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E-mail: sarah.e.troll.civ@mail.mil

B. The CMS contacts are:

1. Program Issues

Terence Kane
Director, Division of Eligibility Verifications
Marketplace Eligibility and Enrollment Group
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
7501 Wisconsin Avenue
Bethesda, MD 20814
Telephone: (301) 492-4449
Fax: (443) 821- 4263
Email: Terence.Kane@cms.hhs.gov

2. 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
Fax: (443) 796-5622
Email: Julie.Boughn1@cms.hhs.gov

3. Systems and Security

Darrin V. Lyles
Security and Privacy Technical Advisor
Marketplace Information Technology Group
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: (410) 786-4744
Telephone: (443) 979-3169 (Mobile)
Email: Darrin.Lyles@cms.hhs.gov

4. Privacy and Agreement Issues

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
Email: Barbara.demopulos@cms.hhs.gov.

XVI. CENTERS FOR MEDICARE & MEDICAID SERVICES SIGNATURES

Recipient Agency Certification:

A. Centers for Medicare & Medicaid Services Program Officials

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

Subject to the approval of the Data Integrity Boards of the parties to this agreement and the required notifications, the authorized program official, whose signature appears below, accept and expressly agrees to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit the organization to the terms of this Agreement.

Jeffrey Grant -S Digitally signed by Jeffrey Grant -
S
Date: 2021.01.14 12:51:15 -05'00'

Jeffrey D. Grant
Deputy Director for Operations
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services

Date 1.14.2021

Subject to the approval of the Data Integrity Boards of the parties to this agreement and the required notifications, the authorized program official, whose signatures appear below, accept and expressly agree to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit their respective organizations to the terms of this agreement.

Karen M. Shields -S  Digitally signed by Karen M. Shields -S
Date: 2021.01.14 12:00:19 -05'00'

Karen Shields
Deputy Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

Date **1-14-2021**

B. Centers for Medicare & Medicaid Services Approving Official

Subject to the approval of the Data Integrity Boards of the parties to this agreement and the required notifications, the authorized program official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits the organization to the terms of this Agreement.

Michael E. Pagels - S Digitally signed by Michael E. Pagels -S
Date: 2021.01.14 13:47:35 -05'00'

Michael Pagels, Director
Division of Security, Privacy Policy and Governance, and
Senior Official for Privacy
Information Security and Privacy Group
Office of Information Technology
Centers for Medicare & Medicaid Services

Date _____

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

The U.S. Department of Health and Human Services Data Integrity Board, having reviewed this agreement and finding that it complies with applicable statutory and regulatory guidelines, signifies its approval thereof by the signature of the official appearing below.

Pursuant to 5 U.S.C. § 552a(u)(4)(B), based upon the justifications articulated in Section III of this Agreement and in Attachment 1, the U.S. Department of Health and Human Services Data Integrity Board has determined that a cost benefit analysis demonstrating that the matching program is likely to be cost effective is not required and elects to waive the requirements of 5 U.S.C. § 552a(u)(4)(A).

James B. Duncan -S

Digitally signed by James B.
Duncan -S
Date: 2021.02.09 10:50:12 -05'00'

Blair Duncan
Acting Chairperson, HHS Data Integrity Board
U.S. Department of Health and Human Services

Date _____

D. Department of Defense Approving Official

Subject to the approval of the Data Integrity Boards of the parties to this agreement and the required notifications, 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.

SORRENTO.MICH Digitally signed by
AEL.V.1399639162 SORRENTO.MICHAEL.V.1399639162
Date: 2021.01.25 17:12:39 -05'00'

Michael V. Sorrento
Director
Defense Manpower Data Center
Department of Defense

Date _____

E. Department of Defense Data Integrity Board Official

The Department of Defense Data Integrity Board, having reviewed this agreement and finding that it complies with applicable statutory and regulatory guidelines, signifies its approval thereof by the signature of the official appearing below.

Pursuant to 5 U.S.C. § 552a(u)(4)(B), based upon the justifications articulated in Section III of this Agreement and in Attachment 1, the Defense Data Integrity Board has determined that a cost benefit analysis demonstrating that the matching program is likely to be cost effective is not required and elects to waive the requirements of 5 U.S.C. § 552a(u)(4)(A).

CHUNG.JOO.Y.1 Digitally signed by
512306507 CHUNG.JOO.Y.1512306507
Date: 2021.02.04 17:20:41 -05'00'

Joo Y. Chung
Chair
Defense Data Integrity Board
Department of Defense

Date **2/4/2020**

**Attachment 1:
CMA Cost Benefit Analysis**



MARKETPLACE COMPUTER MATCHING PROGRAMS: COST-BENEFIT ANALYSIS

Prepared by:

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

COST-BENEFIT ANALYSIS FOR MARKETPLACE MATCHING PROGRAMS

UPDATED APRIL 3, 2020

Table of Contents

- Introduction 1
 - Costs 2
 - Benefits..... 2
 - Matching Program Structure..... 3
 - Background assumptions 3
- I. Costs..... 4
 - Internal CMS Costs - \$1.8 million / year 4
 - External CMS costs: Hub operations - \$31.2 million/ year..... 5
 - Federal Data Services Hub (Hub) - \$17.7 million / year5
 - Marketplace Security Operations Center (SOC) – \$2.9 million / year.....5
 - Exchange Operations Center (XOC) - \$5.4 million / year5
 - Identity-Proofing Service Costs – \$5.2 million / year6
 - Costs paid by CMS to TDS agencies – \$6.0 million / year 6
 - Social Security Administration (SSA) - \$2.6 million / year..... 6
 - Department of Homeland Security (DHS) – \$2.4 million / year 6
 - Veterans Health Administration (VHA) - \$0.9 million / year..... 6
 - Office of Personnel Management - \$16,800 / year..... 6
 - Other Trusted Data Sources 7
 - Consumer opportunity costs – non-monetary, but quantified 7
- II. Benefits 7
 - Benefits to Agencies –not quantified 7
 - Benefits to Enrollees in health coverage – not directly applicable 7
 - Recovery of improper payments – not applicable at this time 8
- Consideration of Alternative Approaches to the Matching Programs..... 9
- Conclusion..... 9

Introduction

This cost benefit analysis (CBA) provides information about the costs and benefits of conducting the eight required Marketplace matching programs, which are conducted under matching agreements between CMS and each federal data source agency and between CMS and state administering entities (AEs). The objective of the Marketplace matching programs is to support the enrollment of eligible individuals in appropriate health coverage programs, thereby reducing the uninsured population and improving overall health care delivery.

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

The matching programs enable AEs to verify individuals' attested application responses with matched data elements from relevant federal data sources based on the type of eligibility determination being performed. These data elements may include citizenship or immigration status, household income, and 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.

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

stated justifications. This underlying reality of the cost effectiveness of the Marketplace matching programs applies to all eight programs supported by this CBA.

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

Costs

Costs for the recipient and source agencies are primarily personnel costs associated with maintenance and operations supported by information technology resources; therefore, key elements 1 and 2 (personnel costs and computer costs) are combined in this analysis. Note that more detail on the summary figures that follow is provided in later sections of this document.

For Agencies –

- **CMS (Recipient Agency):** \$33.0 million (\$1.8 million internal costs; \$31.2 million external costs) per year.
- **Source Federal Agencies:** \$6.0 million per year (reimbursed by CMS)
- **State AEs:** No data developed.
- **Justice Agencies:** Not applicable, as these matching programs are not currently used to detect and recover past improper payments and therefore do not generate collection cases for justice agencies to investigate and prosecute.

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

- Opportunity costs (time required to apply for coverage) are quantified as \$1 billion per year (\$90.52 per application x 11.4 million applications resulting in QHP enrollment).

For the General Public –

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

Benefits

Avoidance of Future Improper Payments

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

Recovery of Improper Payments and Debts

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

Matching Program Structure

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

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

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

Background assumptions

CMS has made the following assumptions in developing this CBA:

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

as the trusted data sources (TDSs). All data from the TDSs are accessed by CMS and by state AEs via the Hub platform, rather than via direct access from any AE to any TDS.

- Any alternative, non-Hub structure that could be used instead of the current Hub structure would require many more than eight CMAs, as well as many more system interconnections and data transmissions between agencies.
- For a subset of the TDSs, CMS incurs a cost as the recipient agency. The cost of each data transaction is estimated based on a prior year's matching program budget and the estimated number of data transactions occurring that year.
- In addition to the TDSs themselves, additional entities are necessary to provide support services to the Hub. CMS therefore incurs external costs in the hiring, maintenance, and associated costs of contractors to perform numerous functions related to the Hub. In addition, costs are incurred for identity proofing of applicants, troubleshooting, procedure writing, and maintenance support.
- CMS has internal costs related to the funding of CMS federal staff and associated resources to complete processes and responsibilities related to the Hub and the matching programs.
- The benefit of these matching programs is to consumers who apply for and obtain health coverage. The private benefit to them is improved health care delivery and the expected value of the coverage (whether through private insurance, Medicaid, CHIP or a Basic Health Plan).
- Regarding the Recovery of Improper Payments and Debts (Key Element 4), CMS is not currently utilizing the data match result from the matching programs for payment and debt reconciliations; however, the benefit of the match does provide the potential to implement this capability in the future.

I. Costs

Costs for the recipient and source agencies are primarily personnel costs associated with maintenance and operations supported by information technology resources; therefore, **key elements 1 and 2 (personnel costs and computer costs) are combined in this analysis.**

Internal CMS Costs - \$1.8 million / year

Most costs paid by CMS to implement of the Marketplace matching programs and the Hub are external costs paid to contractors, which are addressed in the next section. CMS' internal costs for federal staff tasked to work on these programs are approximately \$1.7 million per year. The below chart attributes all of the costs to federal staff working in the Center for Consumer Information and Insurance Oversight (CCIIO) office; however, many teams across CMS provide support to the implementation of these programs, and CCIIO staff often have other programs in their portfolios beyond the Marketplace matching programs and the Hub.

CCIO Team	Estimated Annual Cost
Eligibility and Enrollment (E&E)	\$681,868
SMIPG (State Policy)	\$288,552
Marketplace Information Technology (MITG/HUB)	\$800,187
Total	\$1,770,607

External CMS costs: Hub operations – an undetermined portion of \$31.2 million/ year

- Federal Data Services Hub (Hub) – a portion of \$17.7 million / year**
 The Hub is maintained by a CMS contract. While the initial build costs of the Hub were largely incurred before the implementation of the Marketplace programs in 2013, there are ongoing costs associated with system maintenance, changes necessitated by ongoing technology development and new program implementation, and general system health monitoring. In FY2020, the average annual cost of the Hub contract was \$17.7 million. The Hub supports many other Marketplace program efforts besides the matching programs, including the transmission of data to and from insurance issuers, and electronic file transfer for many programs within the Marketplace; as a result, \$17.7 million is an overestimate of the annual Hub costs associated with Marketplace matching program operations.
- Marketplace Security Operations Center (SOC) – \$2.9 million / year**
 The Marketplace SOC is responsible for the security operations and maintenance for the Hub and the Federally-facilitated Marketplace (FFM). The current cost of the Marketplace SOC work is \$2.9 million per year. However, because the Marketplace SOC budget is not formally delineated for the Hub and for the FFM, the cost cited above is an overestimate of the costs specific to supporting Hub operations.
- Exchange Operations Center (XOC) - \$5.4 million / year**
 The Exchange Operations Center (XOC) is an entity managed under the Marketplace System Integrator contract tasked with coordinating the technical operations of the Hub and of the FFM. The XOC supports system availability, communication of system issues to stakeholders, and incident triage. Because the XOC budget line is not formally delineated for the Hub and for the FFM, the operational cost cited above is an overestimate of the costs specific to supporting Hub operations. The \$5.4 million cost estimate provided here covers both XOC operations as well as site reliability engineer and metrics costs in support of the XOC.

- **Identity-Proofing Service Costs – \$5.2 million / year**

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

Costs paid by CMS to TDS agencies – \$6.0 million / year

- **Social Security Administration (SSA) - \$2.6 million / year**

The SSA is the source of numerous data elements for the Hub: verification of the applicant's name, date of birth, citizenship, Social Security Number (SSN), a binary indicator for incarceration, Title II income (retirement and disability), and work quarters. Verification of an individual's SSN is a required precursor to accessing consumer information through the other Marketplace matching programs.

Matching with SSA data is accomplished through a reimbursable agreement with CMS. The total cost of the SSA contract with CMS was \$2,617,316 in FY2020 under IAA number IA20-01.

- **Department of Homeland Security (DHS) – \$2.4 million / year**

DHS is the verification source for naturalized and derived citizenship, and immigration status. The total cost of the DHS contract with CMS was \$2,413,277 in FY2020 under IAA number IA20-03.

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

- **Veterans Health Administration (VHA) - \$0.9 million / year**

Data from the VHA are used to identify current enrollment in health coverage through the VHA, which is an eligibility factor for APTC and CSR programs. The VHA contract with CMS is transactions-based. The total cost of the VHA contract with CMS was \$903,839 in FY2020 under IAA number IA20-02.

- **Office of Personnel Management - \$16,800 / year**

For FY2020, OPM charged CMS a flat fee of \$16,800 under IAA number IA20-04.

- Other Trusted Data Sources

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

Consumer opportunity costs – non-monetary, but quantified

Applying for coverage does not have a monetary cost to applicants, but does have an opportunity cost. The average time for a consumer to apply for and enroll (or re-enroll) in a qualified health plan each year has been estimated to average 3.965 hours per applicant. At a rate of \$22.83 per hour, this opportunity cost is roughly estimated at \$90.52 per application per year. The complete number of applications submitted each year across all AEs is not known, but the total number of applications submitted to exchanges and resulting in a QHP enrollment for 2020 is 11.4 million. This results in a consumer opportunity cost of approximately \$1 billion, but is an underestimate as it does not include the opportunity costs for enrollees in Medicaid, CHIP, or BHP programs, or for consumers who submit an application but do not subsequently enroll in coverage.

II. Benefits

Benefits to Agencies – not quantified

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

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

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

For plan year 2019, 10,579,744 consumers enrolled in a QHP across all exchanges. Of these, 87% received an advanced payment of the premium tax credit (APTC), with an average value of

\$514 per month (annualized to \$6,168 per year). In total, therefore, approximately \$56.8 billion in APTC was provided to enrollees in plan year 2019.¹

Approximately 52% of the QHP enrollees in plan year 2019 received financial assistance through cost-sharing reductions when enrolling in a silver-level plan. The financial estimate of this benefit is not quantified here, as it is dependent on individual utilization of medical services.

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

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

While these benefits to consumers are made possible in part by the Marketplace matching programs, the benefits are ultimately paid with federal funds (or, in the case of Medicaid and CHIP enrollees, with a combination of federal and state funds). Neither that funding nor these benefits to consumers can be considered a direct cost or benefit of conducting the Marketplace matching programs. As a result, these benefits are not directly applicable to this analysis.

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

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

Annual reconciliation and recovery of improper tax payments are performed by the IRS through a process that is independent of the 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.

¹ 1/24/20: Plan Year 2019 data from <https://www.cms.gov/newsroom/fact-sheets/early-2019-effectuated-enrollment-snapshot>.

Consideration of Alternative Approaches to the Matching Programs

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

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

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

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

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

Conclusion

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

After careful evaluation of the data presented above, CMS intends to continue using the current matching program structure, which is less costly than the alternative, non-Hub structure and achieves the primary goals of providing a single streamlined application process and accurate eligibility determinations. While CMS intends to retain the existing matching program structure

moving forward, necessary changes will be made as needed to keep the matching programs compatible with changes in program operations and data flow. This cost benefit analysis and the decision to retain the current matching structure should increase the public's trust in the participating agencies as careful stewards of taxpayer dollars.

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