Public Use Files: FAQs

Where does data in the public use files (PUFs) come from and what's included?

The data in these files are obtained from the Multi-Dimensional Insurance Data Analytics System (MIDAS), which serves as a central repository for capturing, organizing, aggregating, and analyzing CMS's Exchange data for the 39 states using HealthCare.gov (HC.gov).

The files also include data reported to CMS for State-based Exchanges (SBEs) that operate their own Exchange. Each SBE has its own platform to conduct eligibility determinations, enrollment, and other related functions. In 2019, these states are: California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington. The state-level PUF also includes data from New York's and Minnesota's Basic Health Program (BHP). Questions about data from SBEs should be directed to those states.

The data in these files contain information on individual Exchange activity including health insurance applications, Qualified Health Plan (QHP) selections, and stand-alone dental plan (SADP) selections. Demographic characteristics of consumers who made a plan selection are also included in the files.

What are SBE-FPs?

SBE-FPs are State-based Exchanges that run their own Exchange, but use the HC.gov platform for eligibility determinations, enrollment and other related functions. In 2019, these states are: Arkansas, Kentucky, Nevada, New Mexico, and Oregon.

What is the reporting period for these Open Enrollment public use files?

For states that use HC.gov, data reflects plan selections and Exchange activity from November 1, 2018 to December 22, 2018. This includes the 2019 Open Enrollment period (OEP) –from November 1, 2018 to December 15, 2018 – in addition to a run-out period of seven (7) days to allow for late Exchange activity.

Data for SBEs reflects plan selections and Exchange activity during each state's respective OEP, and any run-out period. SBEs began Open Enrollment on November 1, 2018 with the exception of California which began 10/15/2018. Any 2019 renewals processed before 11/1/2018 are also included. Data for each SBE are provided through the following dates:

California (1/15/2019, including a run-out period to 1/18/2019),
Colorado (1/15/2019, including a run-out period to 1/18/2019),
Connecticut (1/15/2019),
District of Columbia (2/6/2019),
Idaho (12/22/2018),
Maryland (12/15/2018),
Massachusetts (1/23/2019, including a run-out period to 1/28/2019),
Minnesota (1/13/2019),
New York (1/31/2019),

Rhode Island (12/31/2018),
Vermont (12/15/2018, including a run-out period to 1/18/2019), and
Washington (12/20/2018, including a run-out period to 12/28/2018).

Why is the HC.gov reporting period longer than the OEP?

This year, as in previous years, a clean-up of HC.gov data occurred in the last two weeks of December, after the deadline for coverage beginning January 1 ended. Given that the 2019 OEP ended on December 15, it was necessary to extend the reporting period to include this data cleanup. Late HC.gov activity after December 15 includes: 1) plan selections on December 16 from midnight to 3am EST, which was the official end time of the OEP; 2) new plan selections for consumers eligible for an in-line plan selection due to Call Center volume around the Open Enrollment deadline; 3) new plan selections for consumers eligible for a special enrollment period; 4) consumer cancelations of 2019 active plan selections or automatic re-enrollments; 5) cleanup cancelations of 2019 automatic re-enrollments that duplicate active plan selections or are no longer eligible for automatic re-enrollment as a result of late cancelations and terminations of 2018 coverage; 6) new automatic re-enrollments for a small group of consumers who were not processed before December 15; and 7) updates to existing automatic re-enrollments to reflect changes in application information made during Open Enrollment.

Can data in the state-level PUF file be compared across states?

Data are directly comparable between the 39 states using HC.gov. CMS does not validate application and enrollment figures for SBEs using their own platform, and caution should be used when making comparisons between states using their own platforms as definitions may vary. More detail on differences in metrics for SBEs using their own platform is available in the Definitions document.

Can data in these files be compared between years?

In general, metrics have the same or very similar definitions across years for the states that use HC.gov; specific changes from the 2018 files are noted throughout the FAQs.

SBEs also generally follow the same or similar definitions across years, as defined by CMS. Data for certain metrics may vary year-to-year due to changes and clarifications to reporting. Data may also vary between SBEs due to differences in reporting systems. In addition, as SBEs operate under different Open Enrollment time periods, the length of the reporting periods can vary on a yearly basis. Generally, any differences in reporting between years should be ascertained by reviewing the FAQs, definitions, and any additional footnotes provided for each year.

For 2019, a difference of note is that Maryland and Washington began reporting applications received and processed by the Exchange for modified adjusted gross income (MAGI) Medicaid/CHIP in their application and consumer level data. As a result, these counts are significantly higher than in previous reporting years.

Other state reporting changes for 2019 that may impact specific data comparisons with previous years include the following:

- Colorado implemented an updated eligibility system that allows the Exchange to directly receive and process QHP applications as well as make initial assessments for MAGI Medicaid/CHIP.
- Idaho transitioned to a new Exchange reporting platform (instead of depending on data provided by the state Medicaid agency) and reported application metrics as gross rather than net figures.
- Minnesota included automatic QHP renewals in its application and eligibility metrics.
- Vermont updated its data reporting system, excluded canceled and terminated plans from plan selections, and excluded consumers with $0 advance payment of the premium tax credit (APTC) from the premium and APTC average calculations.
- Vermont and Washington applied new eligibility logic so that a consumer eligible for MAGI Medicaid/CHIP is not also counted as eligible for a QHP.

Does this data change over time?

The Exchanges are dynamic and change on a daily basis as consumers sign up for new coverage or end their current coverage. Data were pulled from MIDAS for the 39 states that use HC.gov as of December 22, 2018. Data for the SBEs using their own platforms were pulled as of the end date of each state's respective OEP or run-out period.

Are all data elements available for every file?

We include data requested and reported to CMS for the SBEs. Data for certain metrics are not provided in this file for these SBEs due to differences in SBE reporting systems or because the data elements were not collected by CMS. Metrics not provided for a SBE for either reason are indicated using "NR."

Application level data are not included in the county-level file since members on an application may not all be located in the same county and therefore, one application may be associated with multiple counties.

The split of plan selections by rural/non-rural status is not included in the county-level file since rural/non-rural status is determined by ZIP code and could lead to privacy concerns when crossed with data at the county-level.

Only a small number of metrics are included in the ZIP-level file due to small cell sizes and the corresponding need to suppress data for privacy protection.

How does Exchange application data differ from plan selection data?

Consumers must submit an application to the Exchange before making a plan selection; the application is where eligibility and financial assistance determinations are made for QHPs, modified adjusted gross income (MAGI) Medicaid, CHIP, or a BHP. Multiple consumers can exist on a single application, and a single application can be associated with multiple plan selections. Generally, one application exists per tax household. Additionally, not every application goes on to make a plan selection, and in cases where a family selects multiple policies, it is possible that some of the policies remain active, while others are canceled or terminated. Application-level data include applications that were created through the automatic re-enrollment process.

Additionally, some SBEs are fully integrated with their state's MAGI Medicaid and CHIP programs and, as a result, their application-level data include applications that were created through the state's MAGI Medicaid or CHIP redetermination process. Further information on those SBEs is provided below and in the Definitions document.

How is QHP eligibility determined?

For details on who may qualify for QHP coverage, please refer to https://www.healthcare.gov/quick-guide. Consumers requesting financial assistance may be eligible for Medicaid or CHIP; consumers ultimately determined eligible for Medicaid/CHIP are not eligible to receive financial assistance with a QHP.

How are Medicaid and CHIP eligibility determinations made on the Health Insurance Exchanges?

States that use HC.gov

States that use HC.gov may choose to be either a Medicaid/CHIP assessment or Medicaid/CHIP determination state. In assessment states, HC.gov makes an initial assessment of Medicaid and CHIP eligibility based on MAGI, and the state's Medicaid or CHIP office makes the final determination of Medicaid or CHIP eligibility. In determination states, HC.gov makes the final MAGI-based Medicaid and CHIP eligibility determination and transmits eligible applications to the state's Medicaid or CHIP office.

For states using the HC.gov, Medicaid and CHIP eligibility totals in these files include HC.gov determinations and assessments, regardless of the state Medicaid or CHIP agency's final eligibility determination. In OEPs prior to 2018, applicants in determination states determined eligible for Medicaid or CHIP with an income or residency inconsistency were not counted in the Medicaid and CHIP eligibility totals. For the 2018 and subsequent OEPs, the files include all Medicaid and CHIP determinations, regardless of the existence of an inconsistency. This is consistent with the decision to include Medicaid and CHIP assessments and determinations with citizenship/immigration inconsistencies in previous years. States are responsible for resolving all Medicaid and CHIP inconsistencies and informing the Exchange if an applicant is ultimately determined ineligible for Medicaid or CHIP.

SBEs that use their own Exchange platforms

SBEs have different operating systems and procedures for handling QHP and MAGI-based Medicaid and CHIP eligibility determinations, which affect the type of applications the SBE receives and processes, and what is reported in the application, consumer, and eligibility level metrics.

Most SBEs have integrated systems with Medicaid and CHIP and thus determine or assess MAGI-based Medicaid and CHIP eligibility determinations for all new consumers and process eligibility redeterminations for current Medicaid/CHIP consumers. The states operating under this model are California, Connecticut, Massachusetts, Maryland, Minnesota, New York, Rhode Island, Vermont, and Washington. Note that California and New York do not report their Medicaid and CHIP eligibility metrics, and Minnesota does not report its Medicaid, CHIP, and BHP redeterminations in the application, consumer or eligibility metrics.

Other SBEs determine or assess MAGI-based Medicaid and CHIP eligibility only when processing new consumer QHP applications received by the Exchange or through a shared eligibility service with the Medicaid agency, and do not process Medicaid and CHIP redeterminations. Additionally, one SBE (Idaho) does not make MAGI Medicaid and CHIP eligibility determinations, as the Medicaid and CHIP agency processes all applications and financial QHP redeterminations before transferring consumers potentially eligible for a QHP, APTC and/or cost sharing reductions (CSRs) to the SBE. Further information is provided in the Definitions document.

The Medicaid and CHIP eligibility totals in this report do not include non-MAGI-based Medicaid and CHIP eligibility determinations for any states.

The number of applicants determined eligible to enroll in QHP coverage and the number of consumers who are determined or assessed eligible for Medicaid/CHIP do not equal the total number of consumers on applications submitted. Why?

For applications on the HC.gov platform, some applicants may not be eligible for a QHP or Medicaid/CHIP. This can occur at the time of application submission when an applicant does not live in the state for which they are applying, or if they do not have an immigration status that qualifies to use the Exchange. This can also occur at a later date if the Exchange initially determines or assesses an applicant as Medicaid/CHIP eligible, but a state subsequently determines that the applicant is not eligible. In the latter case, the Exchange does not automatically grant QHP eligibility.

Applicants using the HC.gov platform can also be eligible for both QHP coverage and Medicaid/CHIP. This can occur when the Exchange initially determines the applicant QHP eligible, but the applicant requests that the application be transferred to the state for a full Medicaid/CHIP determination. If the state subsequently determines the applicant Medicaid/CHIP eligible, the Exchange does not automatically remove the QHP eligibility.

In SBEs, similar operational processes affect the count of individuals determined eligible to enroll in a QHP and the count of individuals determined or assessed eligible for MAGI Medicaid/CHIP.

What is the HC.gov definition of a plan selection?

The plan selection count is the number of unique consumers with a non-canceled medical plan selection as of December 22, 2018. This includes consumers who selected a 2019 medical plan, were automatically re-enrolled into a 2019 medical plan, or were placed into a suggested alternate 2019 medical plan. Plan selections made through HC.gov during the 2019 OEP generally had start dates of January 1, 2019.

In OEPs prior to 2018, plan selections were defined as consumers with non-canceled March coverage, which was the latest effective date granted for these OEPs. The March coverage requirement ensured that the files were not counting consumers who had ended their coverage before the end of the OEP. For the 2018 and later OEPs, plan selections are defined as consumers with any non-canceled coverage, since the OEP for states using HC.gov does not extend into the coverage year (i.e., plan selections made during Open Enrollment did not have a start date within the OEP). All plan selections made by consumers using HC.gov during the 2018 and later OEPs generally have start dates of January 1, and therefore, there is no need to count plan selections with March coverage.

How are consumers who are new to the Exchange differentiated from consumers returning to the Exchange?

For the 2018 and later OEPs, the files classify HC.gov consumers as returning if they had coverage through December 31 of the previous coverage year; this aligns with the logic HC.gov uses to determine who is eligible for automatic re-enrollment. In OEPs prior to 2018, the files classified HC.gov consumers as returning if they had coverage ending on or after November 1 of the previous coverage year; this aligned with the start of the OEP.

This change to using December 31 is not applicable to SBEs, which continue to classify consumers as returning if they had coverage ending on or after November 1 of the previous coverage year. Please see the Definitions tab for details on how new and returning consumer are defined.

How are consumers who switched plans differentiated from consumers who stayed in the same plan from 2018 to 2019? How can consumers switch plans if there is only one issuer offering coverage in their county or zip code?

In these files, consumers are considered a "switcher" when they actively choose a plan other than the plan into which they would have been automatically re-enrolled had they taken no action. Issuers generally sell more than one plan in each geographic area, and consumers may switch from one plan to another plan offered by the same issuer.

What does it mean when a consumer is crosswalked into a plan?

If the same plan is available to a consumer for the new plan year, HC.gov will renew the consumer's coverage in that plan if the consumer makes no active plan selection during the OEP. However, not every issuer has the same offerings from year to year in a given county or zip code. In HC.gov states, when the same plan is no longer available, the Exchange automatically re-enrolls consumers into a different plan, as specified by a crosswalk that generally follows the following hierarchy, defined further in 45 CFR 155.335(j): 1) If an issuer continues to offer the same product, consumers are crosswalked to a different plan within that product; 2) If an issuer continues to offer Exchange plans but discontinues a certain product, consumers are crosswalked into a different product with the same issuer; 3) If an issuer no longer offers any Exchange plans, consumers are crosswalked into a suggested alternate plan with a different issuer. This metric is not tracked by CMS in SBEs since not all SBEs allow for consumers whose product is discontinued or whose issuer no longer offers any Exchange plans to be automatically re-enrolled into a new plan.

When are automatic re-enrollments counted?

For states using HC.gov, automatic re-enrollments are included in the "Week 7" and "Final Snapshot" columns of the "Plan Selections by Week" table in the state- and county-level files. For SBEs, unless otherwise noted, automatic re-enrollments were added to the plan selection counts beginning in Week 1. Automatic re-enrollments were added to the plan selection counts in the following SBEs beginning after Week 1: Connecticut (Week 4), Colorado (Week 8), Massachusetts (Week 3), and New York (Week 3). Given the state-level differences, caution should be used when interpreting data in the "Plan Selections by Week" table.

How is a week of enrollment defined?

For states using HC.gov, the enrollment week begins on a Sunday and ends on a Saturday. Since the 2019 OEP began on a Tuesday, the first week of Open Enrollment has only three days. SBEs define the enrollment week as Sunday to Saturday, except for Massachusetts and Rhode Island, which have a reporting period that runs from Monday to Sunday. In addition, for SBEs, Week 1 includes any 2019 renewals processed before November 1, 2018 and new enrollments in California, which began Open Enrollment on October 15.

What if a consumer returns to the Exchange and makes a second plan selection during Open Enrollment? How are they counted?

The plan selection and accompanying demographic information for states using HC.gov corresponds to the most current non-canceled plan selection. In this scenario, the second plan selection would supersede the first plan selection in these files as long as the second plan selection was not canceled. Details on SBEs are located on the Definitions document.

How are consumers with APTC and/or CSRs counted?

Eligibility for financial assistance is determined on the application; however, not all consumers eligible for APTC or CSRs actually receive such financial assistance. Consumers who are APTC-eligible can elect not to use all or part of their APTC, and instead claim their full premium tax credit when filing taxes. Consumers eligible for CSRs generally need to select a silver plan in order to receive these CSRs (see below for additional details). These files count consumers as receiving financial assistance when the APTC amount applied to their plan selection is greater than $0 or the plan selection includes CSRs. More information about APTC and CSRs is available at https://www.healthcare.gov/lower-costs/save-on-monthly-premiums.

These files use three measures of financial assistance: 1) Consumers with APTC and/or CSRs: any consumer with APTC and CSRs, any consumer with only APTC or any consumer with only CSRs; 2) Consumers with CSRs: any consumer with CSRs (with or without APTC); 3) Consumers with APTC: any consumer with APTC (with or without CSR).

Details on SBEs are located on the Definitions document. Also note that Massachusetts and Vermont provide a "state wrap" in addition to APTC and cost sharing reductions for consumers at specific income levels.

How are average premiums calculated?

In states using HC.gov, the total policy premium for a medical plan is equal to the sum of covered individuals' premiums. Only the first three children, ages 0 to 20 years old, are included in the policy's premium, and additional children have a premium of $0. Average premiums in these files are equal to the average per-person monthly premium on the policy (see Calculation 1 below).

These files contain two measures that calculate the average premium after the APTC is applied -- referred to as the net premium. When APTC is applied to a policy's premium, it is also allocated among policy members using the Federal age curve (available at https://www.cms.gov/CCIIO/Programs-and-

Initiatives/Health-Insurance-Market-Reforms/state-rating.html) as an intermediate calculation step. The first net premium calculation is the average of the difference between an individual's premium and the individual's allocated APTC for all consumers (see Calculation 2 below). The second net premium calculation is the average of the difference between an individual's premium and the individual's allocated APTC for consumers receiving APTC (see Calculation 3 below). Consumers are considered to be receiving APTC if their allocated APTC amount is greater than $0. See the Definitions document for more detail.

Please note that SBEs may calculate average APTC and average premium differently than states using HC.gov.

$$Calculation\ 1 = \frac{sum(individual's\ premium)}{total\ consumers}$$

$$Calculation\ 2 = \frac{sum(individual's\ premium\ -\ individual's\ applied\ APTC)}{total\ consumers}$$

$$Calculation\ 3 = \frac{sum\big(individual's\ premium\ -\ individual's\ applied\ APTC\big)for\ consumers\ with\ APTC > \$0}{consumers\ with\ APTC > \$0}$$

What are Cost Sharing Reductions (CSRs) and how are they related to Actuarial Value (AV)?

Cost sharing reductions are generally available to consumers whose expected household income is between 100% and 250% of the Federal poverty level (FPL) and select a silver plan. More details are available at https://www.healthcare.gov as well as 45 CFR 155.305(g) and 155.350.

The actuarial value, or percentage of total average costs for covered benefits that a plan covers, is higher for a plan with CSRs than a standard plan due to reduced copays, coinsurance values, deductibles, or maximum out of pocket limits. More details are available at 45 CFR 156.135 and 156.420.

Why are some states and counties missing information on Catastrophic and/or Platinum plans?

Not every state or county offers Catastrophic and/or Platinum coverage, these are indicated using an "NA."

How is age measured?

In states that use HC.gov, age is measured as the difference between January 1, 2019 and the consumer's date of birth. Age is rounded down to the nearest whole number. Details on SBEs are located on the Definitions document.

How is household income reported? Why have you included consumers not requesting financial assistance as an income category? Why don't you report household incomes lower than 100% of the FPL? Why don't you report household incomes higher than 400% of the FPL?

Household income is reported as a percentage of the federal poverty level (FPL); guidelines are available at https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references. On some

applications created through the automatic re-enrollment process, the household income comes from the Internal Revenue Service (IRS) and the Social Security Administration (SSA) in accordance with regulations and implementing guidance.

In states that use HC.gov, the application only collects household income data when consumers are requesting financial assistance. Consumers that do not request financial assistance do not enter their household income information, and are classified as "Not Requesting Financial Assistance" in the files. For SBEs, these consumers are classified as "Other/Unknown FPL".

For consumer protection, CMS does not report incomes below 100% FPL or above 400% FPL. These consumers are included in the "Other FPL" category, along with consumers who were requesting financial assistance but have missing incomes. In HC.gov states, missing incomes are due to data anomalies in MIDAS or a tax filing status that makes consumers APTC-ineligible (e.g., married filing separately).

Why don't the FPL metrics match the CSR metrics?

Consumers eligible for CSRs based solely on household income can only receive CSRs if they enroll in silver plans. The CSR metrics represent the number of plan selections with CSRs, not the number of consumers eligible for CSRs. Furthermore, members of federally recognized tribes may receive CSRs at different levels of household income. More information is available at https://www.healthcare.gov/american-indians-alaska-natives/coverage.

How are race and ethnicity defined?

Race and ethnicity are defined using self-reported information collected on the Exchange application. For states using HC.gov, the count of consumers who selected Hispanic or Latino ethnicity is independent of race. Details on the race and ethnicity groups are located on the Definitions document. Note that for HC.gov states in OEPs prior to 2017, race and ethnicity were reported in a substantially different way, where ethnicity was not independent of race. Details on SBEs are located on the Definitions document.

How is rural/non-rural defined?

These files use the Health Resources and Services Administration (HRSA) crosswalk file to determine whether a consumer resides in a rural ZIP code. This file is available at https://www.hrsa.gov/ruralhealth/aboutus/definition/datafiles.html (October 2017 update).

How are standalone dental plans (SADP) counted?

Consumers may purchase SADP coverage on the health insurance Exchanges. Pediatric dental benefits are considered essential health benefits (EHBs), and therefore must be available to all children either as part of a medical plan or as a SADP. In HC.gov states, consumers must purchase a medical plan in order to purchase a SADP. If consumers make a dental plan selection for someone age 18 or younger and have APTC leftover after selecting a medical plan, they can apply this APTC towards the child's dental plan premium. More information is available at https://www.healthcare.gov/coverage/dental-coverage. SBEs may have different procedures for dental enrollment. Please refer to the state Exchange websites for details.

In previous reporting years, the files included dental plans selection counts at two levels of coverage – high and low. High plans typically had higher premiums but lower cost sharing, while low plans typically had lower premiums but higher cost sharing. Beginning with the 2019 plan year, CMS removed the actuarial value level of coverage standard for standalone dental plans (83 FR 17069, Apr. 17, 2018). As a result, the high and low dental coverage counts have been removed from the PUFs.

What is a BHP Plan?

The Affordable Care Act allowed states the option of creating a Basic Health Program (BHP) to provide coverage to consumers with incomes below 200 percent of FPL, who are not eligible for Medicaid or CHIP. BHP plans are offered by Minnesota and New York. New York's BHP is known as the Essential Plan and Minnesota's BHP is known as MinnesotaCare. New York and Minnesota include BHP data in some application, consumer and eligibility metrics. See the Definitions document for details.

New York has also included additional information (age and gender) on consumers with BHP plans and these data can be found on the last tab of the state-level data file. For inquiries about this data, please contact the New York Exchange.

What does * represent in the PUFs?

These files adhere to the CMS cell size suppression policy to protect consumer privacy. This policy stipulates that no cell of 10 or less may be displayed, which may require the use of complimentary cell suppression. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell 10 or less.