

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). In the state-level PUF we also include data reported to CMS for the 12 State-based Exchanges (SBEs) using their own platform; 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 plans (SADP). Demographic characteristics of consumers who made a plan selection are also included in the files.

Data from the Basic Health Programs (BHP) for New York and Minnesota are included in the state-level PUF.

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 2018, these states are: Arkansas, Kentucky, Nevada, New Mexico, and Oregon.

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

These files include data for the 2018 Open Enrollment period (OEP) – which corresponds with November 1, 2017 to December 15, 2017. We also included a run-out period of eight (8) days to allow for late Exchange activity. For states that use HC.gov, data represents plan selections and Exchange activity from November 1, 2017 to December 23, 2017.

Data for SBEs using their own platform reflects plan selections and Exchange activity from November 1, 2017 to the end date of each state's respective Open Enrollment: California (1/31/2018 including a run-out period to 2/2/2018), Colorado (1/12/2018), Connecticut (12/22/2017), District of Columbia (2/5/2018), Idaho (12/22/2017), Maryland (12/22/2017), Massachusetts (1/23/2018), Minnesota (1/14/2018), New York (1/31/2018), Rhode Island (12/31/2017), Vermont (12/15/2017), and Washington (1/15/2018).

Why is the HC.gov reporting period longer than the 2018 OEP?

This is the first year these PUFs include data that extends past 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 2018 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 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

2018 Health Insurance Exchanges

enrollment deadline; 3) new plan selections for consumers eligible for a special enrollment period; 4) consumer cancelations of 2018 active or automatic re-enrollment plan selections; 5) cleanup cancelations of 2018 automatic re-enrollment plan selections that duplicate active plan selections or are no longer eligible for automatic re-enrollment as a result of late cancelations and terminations of 2017 coverage; 6) new automatic re-enrollment plan selections for a small group of consumers which were not processed before December 15; and 7) updates to existing automatic re-enrollment plan selections 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 slightly. 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 2017 files are included in the FAQs.

Does this data change over time?

The Exchange is dynamic and changes 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 23, 2017. Data for the SBEs using their own platforms were pulled as of the end date of each state's respective Open Enrollment or run-out period.

Are all data elements available for every file?

We include data requested and reported to CMS for the SBEs using their own platform. 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." Certain metrics are not reported for any state due to data privacy concerns, these are represented 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.

Only a small number of metrics are included in the ZIP-level file due to small cell sizes and suppression issues.

How does Exchange application data differ from plan selection data?

2018 Health Insurance Exchanges

Consumers must submit an application to the Exchange before making a plan selection; the application is where eligibility and financial assistance determinations are made. 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 using their own platforms have fully integrated with their state's modified adjusted gross income (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 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 on a QHP.

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

SBEs that use their own Exchange platforms generally have integrated QHP and MAGI-based Medicaid and CHIP eligibility systems. 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. Assessment states currently include Arizona, Delaware, Florida, Georgia, Hawaii, Iowa, Illinois, Kansas, Kentucky, Maine, Michigan, Missouri, Mississippi, North Carolina, North Dakota, Nebraska, New Hampshire, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, and Wisconsin.

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. Determination states during the 2018 OEP include: Alabama, Alaska, Arkansas, Louisiana, Montana, New Jersey, Tennessee, West Virginia, and Wyoming.

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 previous OEPs, 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 OEP, 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.

2018 Health Insurance Exchanges

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

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 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.

Similar operational processes affect the count of individuals determined eligible to enroll in an Exchange plan and the count of individuals determined or assessed eligible for Medicaid/CHIP in states using their own platforms. This includes some states which run all or part of their Medicaid/CHIP eligibility/redeterminations through their platform, and would therefore also be included in this count.

How did the HC.gov definition of a plan selection change from previous years? Why was the change made?

In previous OEPs, the Open Enrollment data counted plan selections as consumers with non-canceled March coverage, which was the latest effective date granted for the OEP. 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 OEP, these files count plan selections as consumers with any non-canceled 2018 coverage, since open enrollment for states using HC.gov did not extend into the 2018 coverage year (i.e., plan selections made during open enrollment did not have a start date within the open enrollment period). All plan selections made by consumers using HC.gov during the 2018 OEP generally had start dates of January 1, 2018 and therefore, there was no need to count plan selections with March coverage.

How are HC.gov consumers who are new to the Exchange differentiated from consumers returning to the Exchange? How is this different than previous years?

In previous OEPs, we classified 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. For the 2018 OEP, the files classify consumers as returning if they had coverage through December 31, 2017; this aligns with the logic HC.gov uses to determine who is eligible for automatic re-enrollment. This change has a marginal effect on the classification of any given consumer as either new or returning. Please see the Definitions tab for details on how new and returning consumer are defined. This change is not applicable to SBEs using their own platform. Generally, these SBEs continue to classify consumers as

2018 Health Insurance Exchanges

returning if they had coverage ending on or after November 1 of the previous coverage year, with some exceptions.

How are consumers who switched plans differentiated from consumers who stayed in the same plan from 2017 to 2018? 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 which they would have been automatically re-enrolled into 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. 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. In SBEs, consumers whose product is discontinued or whose issuer no longer offers any Exchange plans may not always be automatically re-enrolled in a new plan.

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 2018 OEP began on a Wednesday, the first week of Open Enrollment has only four days. Week 7 of Open Enrollment ran from December 10 to December 15, the a priori end of Open Enrollment for a majority of states, and therefore has only six days. The final snapshot of Open Enrollment data for states that use HC.gov has eight days because data for open enrollment was run through Saturday, December 23. SBEs using their own platform define the enrollment week as Sunday to Saturday, except for the following states that have a reporting period that runs from Monday to Sunday: California, Connecticut, Washington, DC, Maryland, Massachusetts, and Minnesota.

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 was not canceled.

How are consumers with APTC and/or CSR counted?

2018 Health Insurance Exchanges

Eligibility for financial assistance is determined on the application; however, not all consumers eligible for advance payment of the premium tax credit (APTC) or cost sharing reductions (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 CSR: any consumer with APTC and CSR, any consumer with only APTC or any consumer with only CSR; 2) Consumers with CSR: any consumer with CSR (with or without APTC); 3) Consumers with APTC: any consumer with APTC (with or without CSR). Details on SBEs using their own platform are located on the Definitions tab.

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 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 states using their own eligibility and enrollment platforms may calculate average APTC and average premium differently than states using HC.gov.

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

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

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

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

2018 Health Insurance Exchanges

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 missing information on Catastrophic and/or Platinum plans?

Not every state offers Catastrophic and/or Platinum coverage.

How is age measured?

For the 39 states that use HC.gov, age is measured as the difference between January 1, 2018 and the consumer's date of birth. Age is rounded down to the nearest whole number. Details on SBEs using their own platform are located on the Definitions document.

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?

For the 39 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 consumer protection, we do 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 may have missing incomes due to data anomalies in MIDAS or a tax filing status that makes them APTC-ineligible (e.g., married filing separately).

Why are there additional tables with household income as a percent of FPL included in the state-level PUF this year?

States using their own enrollment and eligibility platforms were able to report household incomes as a percent of FPL this year. A more compact set of categories was requested and these have been provided as addendums to the more granular categories reported for states using HC.gov. The categories of household income as a percent of FPL in the addendum tables include: 100% - 250% FPL, 250% - 400% FPL, and Other/Unknown Income.

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

2018 Health Insurance Exchanges

different levels of household income. More information is available at <https://www.healthcare.gov/american-indians-alaska-natives/coverage>.

How is race defined? Why is it reported differently than last year?

Race is defined using self-reported information collected on the Exchange application. This year in states using HC.gov, the files include the count of consumers who selected "Other Race" on their application in addition to the race categories included in 2017. Details on the racial groups are located on the Definitions tab.

How is ethnicity defined? Why is it reported differently than last year?

Ethnicity is 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. This year, in states using HC.gov, the files include the count of consumers who did not indicate their ethnicity (in previous OEPs, these consumers were included in the "Not Hispanic/Latino" category).

How is rural/non-rural defined?

CMS uses 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 stand-alone 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>. States using their own Exchange platforms may have different procedures for dental enrollment. Please refer to the state Exchange websites for details.

Dental plans are offered at two levels of coverage – high and low. High plans typically have higher premiums but lower cost sharing, while low plans typically have lower premiums but higher cost sharing.

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 the federal poverty level (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 has 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. For inquiries about this data, please contact the New York Exchange.

2018 Health Insurance Exchanges

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.

Why were Washington's financial assistance and premium figures updated after the original release of the State-level PUF?

Washington's Exchange identified logic errors in the data originally submitted to CMS for publication. Washington submitted revised data to CMS, which we have updated accordingly. Please note, changes were only made to data on Table 5, Consumers by Premiums and Financial Assistance. [April 2018]

Why were California's financial assistance figures updated after the original release of the State-level PUF?

California's original metrics submission at the end of the 2018 Open Enrollment period defined financial assistance based on the consumer's eligibility at the time of plan selection. The revised submission reports financial assistance based on whether the chosen plan includes CSRs and the actual amount of APTC received. [August 2018]