2026 Health Insurance Exchanges

Public Use Files: Frequently Asked Questions

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

The PUFs include data that CMS captures for the 30 states using HealthCare.gov in 2026. This includes State-based Exchanges on the Federal Platform (SBE-FPs), which run their own exchanges, but use the HealthCare.gov platform for eligibility determinations, enrollment, and other related functions. In 2026, Arkansas and Oregon are SBE-FPs.

The PUFs also include data reported to CMS by State-based Exchanges (SBEs), which operate their own exchanges, with their own platforms, to conduct eligibility determinations, enrollment, and other related functions. In 2026, SBEs operate in California, Colorado, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington. In addition, the state-level PUF includes Basic Health Program (BHP) and other related data from the District of Columbia, Minnesota, New York, and Oregon. The SBEs submit the data to CMS and verify its accuracy as of the date of publication. The data does not reflect cases in which an SBE provides consumers with state subsidies in addition to advance payment of the premium tax credit (APTC) and/or cost sharing reductions (CSRs). Questions about data from SBEs should be directed to those SBEs.

The PUFs contain data on individual Exchange activity, including health insurance applications, qualified health plan (QHP) selections, and stand-alone dental plan (SADP) selections. They also include demographic characteristics of consumers who made a plan selection.

What is the reporting period for these Open Enrollment (OE) PUFs?

For the 30 states using HealthCare.gov, the Health Insurance Exchange reporting period reflects plan selection and Exchange activity during the 2026 Open Enrollment Period (OEP) from November 1, 2025, to January 15, 2026.

For the 21 SBEs using their own platforms, the reporting period reflects plan selection and Exchange activity from the beginning of OE on November 1, 2025 – except Idaho, which has reporting period beginning on October 15, 2025 and New York, which began processing 2026 QHP plan selections on November 16, 2025 – to the end of each SBE's respective OEP and any run-out period that captures remaining in-line applications and post-OE cleanup activities. Any renewals processed before November 1, 2025 are also included.

Data for each SBE are provided through the following dates: California (1/31/2026), Colorado (1/20/2026), Connecticut (2/5/2026), District of Columbia (2/4/2026), Georgia (1/15/2026), Idaho (12/15/2025), Illinois (1/31/2026), Kentucky (1/16/2026), Maine (1/15/2026), Maryland (1/15/2026), Massachusetts (1/28/2026), Minnesota (1/15/2026), Nevada (1/20/2026), New Jersey (1/31/2026), New Mexico (1/15/2026), New York (1/31/2026), Pennsylvania (1/31/2026), Rhode Island (1/31/2026), Vermont (1/15/2026), Virginia (1/30/2026), and Washington (1/15/2026).

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

Data are directly comparable between the 30 states using HealthCare.gov. CMS does not fully validate application and enrollment figures for SBEs using their own platforms, and caution should be used when making comparisons between states using their own platforms as definitions may vary. Additionally, some SBEs provide consumers with additional state premium subsidies that are not reflected in the premium data. More detail on differences in metrics for SBEs using their own platform is available in the *Public Use Files Definitions* document.

Can data in these PUFs be compared between years?

In general, metrics have the same or very similar definitions across years for the states that use HealthCare.gov; specific changes from the 2025 PUFs 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 definitions. Data may also vary between SBEs due to differences in reporting systems. In addition, as SBEs operate under different OEPs, 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 2026, the following are some reporting changes that may impact specific SBE data comparisons with previous years. Please note that this list may not be exhaustive. For further questions regarding the comparability of 2026 SBE metrics to data published in past years, please contact the respective SBE.

- Illinois transitioned from an SBE-FP using the HealthCare.gov platform for 2025 to an SBE using its own eligibility and enrollment platform for 2026. As a result, Illinois' 2026 data may not be directly comparable to past plan years.
- The District of Columbia implemented a BHP with enrollment beginning on January 1, 2026, for newly eligible individuals, and thus Exchange enrollment trends may not be directly comparable to past plan years.
- Some SBEs adjusted renewal timelines for conducting Medicaid and CHIP (if applicable) eligibility determinations, and thus some eligibility breakouts may not be directly comparable to past plan years.
- Some SBEs adjusted and/or implemented state subsidy programs for consumers at specific income levels. While state subsidies remain excluded from these data, Exchange enrollment trends may not be directly comparable to past plan years.
- Other states made updates that impact comparability and/or revised their reporting definitions to better align with CMS's reporting definitions, including Georgia (income metrics), Idaho (race/ethnicity metrics), New York (financial assistance), Oregon (BHP demographic breakouts), and Vermont (financial assistance metrics). In addition, Maine and New Mexico implemented changes to their data warehouse and/or system vendor.

Are all data elements available for every file?

The PUFs include SBE data that CMS requests and SBEs report. Certain metrics in the PUFs do not include data for some SBEs due to differences in SBE reporting systems or because CMS did not collect the data elements. Metrics that an SBE did not provide are indicated using "NR" for no response. 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 county-level file excludes certain metrics when their inclusion would result in values being suppressed for a large number of counties due to small cell sizes. Specifically, the file excludes race categories that are independent from Hispanic/Latino status and combines plan selections with income greater than 400% to less than or equal to 500% of the federal poverty level (FPL) to those with income greater than 500% of the FPL.

The county-level file also excludes plan selections by rural/non-rural status since rural/non-rural status is determined by ZIP code and could lead to privacy concerns when cross-walked 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.

Starting in 2026, the state-level and county-level PUFs also contain data on agent/broker-assisted applications for states using HealthCare.gov.

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 a QHP, modified adjusted gross income (MAGI)-based Medicaid, CHIP, and BHP or other program enrollment. Multiple consumers can be included on a single application for the household, and a single application can be associated with multiple plan selections. Generally, one application exists per tax household. In addition, not every application results in a plan selection, including in cases where the household may be eligible for Medicaid or CHIP. In cases where a family selects multiple plans, it is possible that some of the plans remain active, while others are canceled or terminated. Application-level data include applications that were created through the automatic re-enrollment process, and plan selections include consumers automatically re-enrolled.

Furthermore, 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 *Public Use Files Definitions* document.

How is QHP eligibility determined?

For details on who may qualify for QHP coverage, please refer to HealthCare.gov/quick-guide/eligibility. 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 HealthCare.gov

HealthCare.gov states may choose to be either a Medicaid/CHIP assessment or Medicaid/CHIP determination state. In assessment states, HealthCare.gov makes an initial assessment of Medicaid and CHIP eligibility based on MAGI, then transfers the application to the state and the state's Medicaid or CHIP office makes the final determination of Medicaid or CHIP eligibility. In determination states, HealthCare.gov makes the final MAGI-based Medicaid and CHIP eligibility determination and transmits eligible applications to the state's Medicaid or CHIP office for enrollment.

For HealthCare.gov states, Medicaid and CHIP eligibility totals in these PUFs include HealthCare.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 PUFs 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 metrics.

Most SBEs have integrated systems with Medicaid and CHIP and thus determine or assess MAGI-based Medicaid and CHIP eligibility for all new consumers and process eligibility redeterminations for current Medicaid/CHIP consumers. The states operating under this model are California, Connecticut, Kentucky, 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. Further information is provided in the *Public Use Files 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 HealthCare.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 them 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 HealthCare.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 HealthCare.gov definition of a plan selection?

The plan selection count is the number of unique consumers as of January 15, 2026, with a non-canceled QHP selection that has an end date of January 31, 2026 or later. This includes consumers who selected a 2026 QHP, were automatically re-enrolled into a 2026 QHP, or were placed into a suggested alternate 2026 QHP.

For the 2018 to 2021 OEPs, plan selections were defined as consumers with any non-canceled coverage, since the 2018 to 2021 OEPs for states using HealthCare.gov did not extend into the coverage year (i.e., plan selections made during the OEP did not have a start date within the OEP). All plan selections made by consumers using HealthCare.gov during the 2018 to 2021 OEPs generally had start dates of January 1 and end dates of December 31.

OEPs prior to 2018 and the 2022 to 2025 OEPs ended after the start of the coverage year, resulting in plan selections with varying start and end dates. 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. For the 2022 to 2026 OEPs, the plan selection definition includes a condition requiring an end date of January 31 or later so that only consumers with at least one month of coverage are counted.

Note that plan selections will only become coverage for consumers that effectuate their coverage by paying their first monthly premium.

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

For the 2018 and later OEPs, the PUFs classify HealthCare.gov consumers as returning if they had coverage through December 31 of the previous coverage year; this aligns with the logic HealthCare.gov uses to determine who is eligible for automatic re-enrollment.

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 *Public Use Files Definitions* document for details on how to define new and returning consumers.

Consumers who move from a HealthCare.gov state to an SBE state, from an SBE state to a HealthCare.gov state, or between different SBE states from one plan year to the next are considered new consumers.

How are active re-enrollees who switched plans differentiated from active re-enrollees who stayed in the same plan from 2025 to 2026? How can active re-enrollees switch plans if there is only one issuer offering coverage in their county or ZIP code?

In these PUFs, active re-enrollees who switched plans are consumers who actively choose a plan other than the plan into which they would have been automatically re-enrolled had they taken no action (Actv_Renrl_Sw). Issuers generally sell more than one plan in each geographic area, and active re-enrollees may switch from one plan to another plan offered by the same issuer.

What does it mean when a consumer is cross-walked into a plan?

If the same plan is available to a consumer for the new plan year and the consumer does not make an active plan selection, HealthCare.gov will automatically renew the consumer's coverage in their current plan. However, not every issuer has the same offerings from year to year in a given county or ZIP code. In HealthCare.gov states, when the same plan is no longer available and the consumer doesn't actively choose a new plan, 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):

- If an issuer continues to offer the same product, consumers are cross-walked to a different plan within that product;
- If an issuer continues to offer Exchange plans but discontinues a certain product, consumers are cross-walked into a different product with the same issuer; and
- If an issuer no longer offers any Exchange plans, consumers are cross-walked 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 in a new plan.

For plan years 2024 and 2025, CMS finalized a change to the hierarchy at 45 CFR 155.335(j)(4) that allowed Exchanges to modify their automatic re-enrollment hierarchies such that consumers who are eligible for CSRs and are currently enrolled in a bronze level QHP, and who would otherwise be

automatically re-enrolled in a bronze-level QHP, are instead automatically re-enrolled in a silver-level QHP (with CSRs) in the same product with the same provider network and with a premium after the application of APTC that is lower or equivalent to the premium of the bronze level QHP into which the consumer would have otherwise been re-enrolled, (referred to as the "bronze to silver crosswalk policy"). While HealthCare.gov implemented this change for 2024 and 2025, the PUF does not account for this potential, specific bronze-to-silver cross-walking, which is dependent on a particular household's composition and projected income. This hierarchy change was removed for 2026 and not relevant for the latest Open Enrollment.

When are automatic re-enrollments counted?

Plan selection counts include automatic re-enrollments in Weeks 7-12.

How is a week of enrollment defined?

For states using HealthCare.gov, the enrollment week begins on a Sunday and ends on a Saturday, except for week 1, which begins on November 1 to correspond with the start of the OEP.

SBEs define the enrollment week as Sunday to Saturday.

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 HealthCare.gov corresponds to the most current non-canceled plan selection made during Open Enrollment. In this scenario, the second plan selection supersedes the first plan selection in these PUFs as long as the second plan selection was not canceled. Details on SBEs are located in the *Public Use Files 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 advance payment of the premium tax credit (APTC) or CSRs actually receive such financial assistance. Consumers who are APTC-eligible can elect to use all, part , or none of their APTC. Consumers choosing not to use any APTC can 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. These PUFs count consumers as receiving financial assistance when an APTC amount is applied to their plan selection or the plan selection includes CSRs. More information about APTC and CSRs is available at HealthCare.gov/lower-costs/save-on-monthly-premiums. These PUFs use three measures of financial assistance:

- Consumers with APTC and/or CSRs: any consumer with APTC and CSRs, any consumer with only APTC, or any consumer with only CSRs;
- Consumers with CSRs: any consumer with CSRs (with or without APTC); and
- Consumers with APTC: any consumer with APTC (with or without CSRs).

Any additional details for how consumers with APTC and CSRs in SBEs are counted are located in the *Public Use Files Definitions* document. Also note that California, Colorado, Connecticut, Maryland, Massachusetts, New Jersey, New Mexico, New York, Vermont, and Washington provide a

"state subsidy wrap" in addition to APTC and/or CSRs for consumers at specific income levels. The cost reductions provided by these SBEs are not reflected in the data, except New York which implemented state cost-sharing subsidies for certain on-Exchange enrollees under an approved section 1332 waiver. Review the section 1332 waiver (PDF) for more information about New York's program. Please contact the relevant Exchange for inquiries about this data.

How are average premiums calculated?

Average premiums and APTC amounts are reported as per member per month values in all states. In states using HealthCare.gov, the PUF logic distributes the policy-level premium and applied APTC to policy members according to the relevant age curve and a member's tobacco rating factor, when applicable. When a policy includes more than 3 children such that some children are not rated, the PUF logic distributes the total child rate for 3 children among all children younger than 21 years-old (e.g., if the policy includes 4 children, each with a rate of $100, the policy-level premium is $300 and each child's calculated premium for the PUF is $75).

The Average Premium metric (Avg_Prm) is equal to average total premium for all consumers, without any application of APTC:

$$\frac{sum(member's\ total\ premium)}{total\ consumers}$$

The Average Premium after APTC metric (Avg_Prm_Aftr_APTC) is equal to the average of the difference between a member's total premium and applied APTC for all consumers; for consumers not receiving APTC, their applied APTC is set equal to $0 and their total premium is included in the average:

$$\frac{sum(member's\ total\ premium - member's\ applied\ APTC)}{total\ consumers}$$

The Average Premium after APTC for Consumers with APTC metric (APTC_Cnsmr_Avg_Prm_Aftr_APTC) is equal to the average of the difference between a member's total premium and applied APTC for all consumers whose applied APTC is greater than $0:

$$\frac{sum(member's\ total\ premium - member's\ applied\ APTC)}{consumers\ with\ applied\ APTC > \$0}$$

Please note that SBEs may calculate average APTC and average premium differently than HealthCare.gov. Average premium data also does not reflect state premium subsidies offered by some SBEs to further reduce a member's total premium. Please refer to the section above for additional information on state-specific subsidies.

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

CSRs are generally available to consumers whose expected household income is between 100% and 250% of the FPL and select a silver plan. More details are available at 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 of that metal level 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.

Additional consumer information on how plans work:

- Health plan categories (Bronze, Silver, Gold and Platinum) and how costs are split between the consumer and the health plan when getting care
- Save on out-of-pocket costs: cost-sharing reductions

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 a "+".

How is age measured?

For the 30 states using the HealthCare.gov platform for 2026, age is measured as the difference between January 1 of the coverage year and the consumer's date of birth, rounded down to the nearest whole number. For SBEs, age is measured as of the effective coverage date (i.e. plan start date).

Why is income data not available for all consumers?

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 having an "Other/Unknown FPL."

There are a few SBEs that classify consumers who enter their household income information but are determined not eligible for financial assistance as "Other/Unknown FPL". As a result, some SBEs report zero plan selections in certain income categories. Please refer to the *Public Use Files Definitions* document for additional information on these data.

There are also a small number of consumers who requested financial assistance but may have missing incomes. For HealthCare.gov states, consumers may have missing incomes due to data anomalies or a tax filing status that makes them APTC-ineligible (e.g., married filing separately).

Why don't the income 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, not all consumers with incomes from 100% to 250% of the FPL are CSR-eligible. Individuals are only CSR-eligible when they are not otherwise eligible for minimum essential coverage (MEC), as described in 45 CFR 155.305(f) and 26 CFR 1.36B.

Finally, some consumers with incomes less than 100% or greater than 250% of the FPL are CSR-eligible. Consumers with incomes less than 100% of the FPL who were denied Medicaid or CHIP due to their immigration status can be APTC- and CSR-eligible. In addition, members of federally recognized tribes may receive CSRs at different levels of household income. More information is available at HealthCare.gov/american-indians-alaska-natives.

How are race and ethnicity defined?

Race and ethnicity are defined using self-reported information collected on the Exchange application. In the 2018 to 2021 PUFs, HealthCare.gov race metrics were independent from Hispanic or Latino ethnicity. The 2022 to 2026 PUFs include combined race and ethnicity metrics, where consumers are counted as part of a race category only if they did not attest to having Hispanic or Latino ethnicity or attested they are not Hispanic/Latino. For backwards compatibility, the State-Level and State, Metal Level, and Enrollment Status PUF also include race categories that are independent from Hispanic or Latino ethnicity.

SBEs previously reported and continue to report combined race and ethnicity metrics. However, a number of SBEs updated their definitions beginning with the 2022 PUFs, which resulted in changes in some categories, including Hispanic/Latino ethnicity, multi-racial, other, and unknown. As of the 2022 PUFs, some SBEs also reported race metrics independent from Hispanic or Latino ethnicity. Race and ethnicity application questions and options may vary between SBEs, thus some selections may be counted in the closest applicable category for purposes of this report.

Details on the race and ethnicity groups are located on the *Public Use Files Definitions* document.

How is rural/non-rural defined?

These PUFs use data from the Health Resources and Services Administration (HRSA) "ZIP Codes by County" crosswalk file (as of 2021) to determine whether a consumer resides in a rural ZIP code and county.

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 HealthCare.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 HealthCare.gov/coverage/dental-coverage. SBEs may have different procedures for dental enrollment. Please refer to the state Exchange websites for details.

For OEPs prior to 2019, the PUFs reported dental plans selections 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.

For the 2019 and later OEPs, CMS removed the actuarial value level of coverage standard for SADPs (83 FR 17069, Apr. 17, 2018). This made reporting high and low dental plans irrelevant, and thus the PUFs no longer include these metrics.

What is a BHP Plan?

The Affordable Care Act allowed states the option of creating a Basic Health Plan (BHP) program to provide coverage to consumers with incomes below 200 percent of the FPL, who are not eligible for Medicaid or CHIP. BHP plans are offered by the District of Columbia, Minnesota, and Oregon. Minnesota's BHP is known as MinnesotaCare. The District of Columbia implemented its BHP in January 2026, and Oregon implemented its BHP in July 2024.

Effective April 2024, New York transitioned from operating a BHP to a new coverage program, the Essential Plan Expansion (EP), which was implemented under an approved section 1332 waiver. The EP Expansion generally mirrors the state's previously utilized BHP with expanded eligibility for certain residents with estimated household incomes up to 250% of the FPL. Even though New York's EP is not a BHP, enrollment in this coverage program continues to be reported in the BHP enrollment data for purposes of this report. Review more information about New York's EP Expansion in the 1332 waiver (PDF). Note that the U.S. Department of Health and Human Services and the U.S. Department of the Treasury approved New York's to terminate this Section 1332 State Innovation Waiver on March 20, 2026. This termination is effective July 1, 2026. EP Expansion program enrollment is referenced and reported prior to changes due to this termination for purposes of this report.

These data are provided for each State as of the following dates: District of Columbia (1/31/2026), Minnesota (1/15/2026), New York reports (1/31/2026), and Oregon (1/15/2026). New York and Minnesota include EP Expansion or BHP in some applications, consumer, and eligibility metrics. District of Columbia and New York also included additional (i.e., new and re-enrollee breakouts) information on consumers with enrollment in BHP or Other programs. See the Definitions document for details. For additional inquiries about these data, please contact the State Exchange.

What does "*" represent in the PUFs?

The "*" symbol represents a value that is suppressed to protect consumer privacy. In the county and ZIP code PUFs, values of between 1 and 10 are suppressed. When necessary, complementary cells are also suppressed to prevent users from deriving a value between 1 and 10.

What does "+" represent in the PUFs?

In the state and county PUFs, the "+" represents when:

- A state and/or county does not have any catastrophic or platinum metal level plans available on the Exchange,
- A race category (i.e., Other Race and Multi-Racial) is not an option on an SBE's application and thus not applicable, or
- BHP data are not applicable to a state.

What does "NR" represent in the PUFs?

"NR" stands for "no response," and represents metrics that are not included for an SBE because of differences in SBE reporting systems or because CMS did not collect the data elements.

How are the data stratified in the State, Metal Level, and Enrollment Status PUF?

The State, Metal Level, and Enrollment Status PUF contains data with stratifications by State, Metal Level, and Enrollment Status. The data are presented by Metal Level, with the following categories: B (Bronze), S (Silver), and G (Gold), for all consumer types. Similarly, the data are presented by Enrollment Status, with the following categories: 01-atv (Active Re-enrollees), 02-aut (Automatic Re-enrollees), and 03-new (New Enrollees), for all metal levels.

What does "N/A" represent in the State, Metal Level, and Enrollment Status PUF?

Not applicable (N/A) represents unavailable values for the metal level variables, i.e. Ctstrphc (Catastrophic), Brnz (Bronze), Slvr (Silver), Gld (Gold), and Pltnm (Platinum), when the Enrlmt_Stus (Enrollment Status) value is 'All'.

How do I interpret variables that have a value in a decimal format in the State, Metal Level, and Enrollment Status PUF?

The State, Metal Level, and Enrollment Status PUF contains variables with values that are a combination of proportions and counts. In this PUF, total data records (where State_Abrvtn=Total) are presented as counts; whereas, all other records are presented as proportions in a decimal format. For example, in the table extracted from the PUF shown below, we see that for the state of Arizona, 94% (0.94) of consumers in silver plans had APTC or CSR. We also see that the "Total" count of HealthCare.gov consumers across all states in a silver plan with APTC or CSR is 8,895,354.

State_Abrvtn	Pltfrm	Metal_Lvl	Enrlmt_Stus	Cnsmr_Wth_APTC_CSR
AZ	HealthCare.gov	S	All	0.94
Total	HealthCare.gov	S	All	8,895,354

What is an Agent or Broker?

An agent or broker is a licensed professional who is registered with the Marketplace and authorized to assist consumers with selecting and enrolling in a QHP. Agents and brokers must meet federal and state training and certification requirements to assist consumers with QHP selections.

How is agent or broker assistance counted?

A consumer is counted as 'agent or broker-assisted' when their enrollment into a 2026 QHP plan includes the agent or broker's unique identifier (National Producer Number), indicating that an agent or broker assisted with the plan selection, either in the current year or a prior coverage year (in the case of auto-enrolled consumers).

- A National Producer Number (NPN) is a unique identifier assigned through the National Association of Insurance Commissioner's (NAIC's) licensing application process.