CMS Center for Consumer Information & Insurance Oversight (CCIIO), Health Insurance Exchange Public Use Files (Exchange PUF) Data Dictionary for Transparency in QHP Coverage PUF

1. Overview of the Transparency in QHP Coverage PUF

The Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) is releasing the Transparency in Qualified Health Plan (QHP) Coverage Public Use File (PUF) to increase access to QHP issuer data reported pursuant to section 1311(e)(3) of the Affordable Care Act. The Transparency in QHP Coverage PUF includes data on QHPs and Stand-alone Dental Plans (SADPs) offered in states with Federally-Facilitated Exchanges (FFEs), including issuers in the FFEs where states perform plan management functions, and State-based Exchanges on the Federal Platform for eligibility and enrollment (SBE-FPs).

The data dictionary describes the variables contained in the Transparency in QHP Coverage PUF. Each record relates to coverage at the issuer level. The Transparency in QHP Coverage PUF separates issuer- and plan-level claims data into three different tabs by plan type: specifically, Individual QHPs, Individual SADPs and Small Business Health Options Program (SHOP) small group QHPs. The Transparency in QHP Coverage PUF is available for plan years 2017 through 2026. PUF data always reflect data from the plan year that was two years prior. Therefore, the plan year 2026 PUF contains data from plan year 2024. This is because complete plan year 2025 data does not exist when issuers submit the PUF data (for example, during summer 2025 for plan year 2026).

2. Variable Attributes

Variable Name:	Individual or SHOP Plan
Variable Definition:	Indication of whether the plan is offered in the Individual or SHOP Marketplace.
Data Type:	Text
Variable Label:	Individual/SHOP
Allowable Values:	Free Text
Data Source:	System-generated field
Field Name from Data Source:	Market_Coverage
Comments:	N/A

Variable Name:	Exchange Type
Variable Definition:	Indication of the exchange type of the state where the issuer is offering plans.
Data Type:	Text
Variable Label:	Exchange_Type
Allowable Values:	Free Text
Data Source:	System-generated field
Field Name from Data Source:	Exchange Type
Comments:	N/A

Variable Name:	State

Variable Definition:	Two-character state abbreviation indicating the state where the issuer offers coverage on the Exchange.
Data Type:	Text
Variable Label:	State
Allowable Values:	All 50 state abbreviations + 9 territory abbreviations
Data Source:	System-generated field
Field Name from Data Source:	State Code
Comments:	N/A

Variable Name:	Issuer Name
Variable Definition:	Name of the company issuing the plan.
Data Type:	Text
Variable Label:	Issuer_Name
Allowable Values:	Free text
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	N/A

Variable Name:	Issuer ID
Variable Definition:	Five-digit numeric code that identifies the issuer organization in the Health Insurance Oversight System (HIOS).
Data Type:	Text
Variable Label:	Issuer_ID
Allowable Values:	Free text
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	N/A

Variable Name[i]*:*	New or Returning Issuer Status
Variable Definition:	Indication of whether issuer is new or returning to the Exchange for PY2025.
Data Type:	Text
Variable Label:	Is_Issuer_New_to_Exchange? (Yes_or_No)
Allowable Values:	Yes; No
Data Source:	Issuer
Field Name from Data Source:	Was this Issuer on the Exchange in 2024?
Comments:	N/A

Variable Name[ii]*:*	SADP Only
Variable Definition:	Indication of whether issuer is a Stand Alone Dental Plan (SADP) issuer.
Data Type:	Text
Variable Label:	SADP_Only? (Yes or No)
Allowable Values:	Yes; No
Data Source:	Issuer
Field Name from Data Source:	SADP Only?

Comments:	N/A

Variable Name:	2026 Plan ID
Variable Definition:	Fourteen-digit PY2026 plan ID.
Data Type:	Text
Variable Label:	Plan_ID
Allowable Values:	Free text
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	N/A

Variable Name[i]:	Medical or Dental Plan Type
Variable Definition:	Indication of whether plan is medical or dental.
Data Type:	Text
Variable Label:	QHP or SADP?
Allowable Values:	QHP; SADP
Data Source:	System-generated field
Field Name from Data Source	QHP/SADP
Comments:	N/A

Variable Name[i]:	Plan Type
Variable Definition:	Indication of plan type.
Data Type:	Text
Variable Label:	Plan_Type
Allowable Values:	EPO; HMO; Indemnity; PPO; POS
Data Source:	System-generated field
Field Name from Data Source:	Plan Type
Comments:	N/A

Variable Name[i]:	Plan Metal Level
Variable Definition:	Indication of plan metal level.
Data Type:	Text
Variable Label:	Metal_Level
Allowable Values:	Platinum, Gold, Silver, Bronze, Catastrophic
Data Source:	System-generated field
Field Name from Data Source:	Metal Level
Comments:	N/A

Variable Name:	URL Claims Payment Policies & other Information
Variable Definition:	URL link to policies on issuer websites.
Data Type:	Text
Variable Label:	URL_Claims_Payment_Policies
Allowable Values:	Free text
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Record relates to coverage at the issuer level.

Variable Name:	Number of Issuer Level In-Network Claims with DOS in 2024 That Were Also Received in Calendar Year 2024
Variable Definition:	Number of claims received by an issuer asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO). These data are reported for plan years 2022- 2024.
Data Type:	Text
Variable Label:	Issuer_Claims_Received_In_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Exchange. 2015-2021 Issuer-level claims received and denied are aggregated by network status.

Variable Name:	Number of Issuer Level Out-of-Network Claims with DOS in 2024 That Were Also Received in Calendar Year 2024
Variable Definition:	Number of issuer-level out-of-network claims received that asked for a payment or reimbursement by or on behalf of a health care provider (such as a hospital, physician, or pharmacy) that is not contracted to be part of a network (such as an HMO or PPO). These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Issuer_Claims_Received_Out_Of_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the state level, for all QHPs on Exchange. 2015-2021 Issuer-level claims received and denied are aggregated by network status.

Variable Name:	Number of Issuer Level In-Network Claims with DOS in 2024 That Were Also Denied in Calendar Year 2024
Variable Definition:	Number of claims received by an issuer asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital or doctor) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied. These data are reported for plan years 2022-2024
Data Type:	Text
Variable Label:	Issuer_Claims_Denied_In_Network
Allowable Values:	Numerical
Data Source:	Issuer

Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Exchange. 2015-2021 Issuer-level claims received and denied are aggregated by network status.

Variable Name:	Number of Issuer Level Out-of-Network Claims with DOS in 2024 That Were Also Denied in Calendar Year 2024
Variable Definition:	Number of issuer-level out-of-network claims you received that asked for a payment or reimbursement by or on behalf of a health care provider (such as a hospital, physician, or pharmacy) that is not contracted to be part of your network (such as an HMO or PPO) that you subsequently denied. These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Issuer_Claims_Denied_Out_Of_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the state level, for all QHPs on Exchange. 2015-2021 Issuer-level claims received and denied are aggregated by network status.

Variable Name[iii]:	Number of Issuer Level In-Network Claims with DOS in 2024 That Were Also Resubmitted in Calendar Year 2024
Variable Definition:	Number of issuer–level in-network claims resubmissions received that asked for a payment or reimbursement by or on behalf of a health care provider (such as a hospital or doctor) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer previously denied. These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Issuer_Claims_Resubmitted_In_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the state level, for all QHPs on Exchange. Issuer-level resubmitted claims data required beginning with QHP certification for plan year 2024.

Variable Name[iii]:	Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2024
Variable Definition:	Number of issuer-level out-of-network claims resubmissions received that asked for a payment or reimbursement by or on behalf of a health care provider (such as a hospital or doctor) that is not contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer previously denied. These data are reported for plan years 2022-2024.

Data Type:	Text
Variable Label:	Issuer_Claims_Resubmitted_Out_Of_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the state level, for all QHPs on Exchange. Issuer-level resubmitted claims data required beginning with QHP certification for plan year 2024.

Variable Name:	Number of Internal Appeals Filed
Variable Definition:	Number of requests by the insured for internal reviews of grievances involving adverse determinations. An internal review is a process by which the insured may have an adverse determination reviewed by the issuer with respect to a denial of an admission, availability of care, continued stay, or health care service for a covered person. These data are reported for plan years 2015-2024.
Data Type:	Text
Variable Label:	Issuer_Internal_Appeals_Filled
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the state level, for all QHPs on Exchange.

Variable Name:	Number of Internal Appeals Overturned
Variable Definition:	Number of final adverse determinations overturned upon request for internal review. An internal review is a process by which the insured may have an adverse determination reviewed by the issuer with respect to a denial of an admission, availability of care, continued stay, or health care service for a covered person. All overturned internal appeals must be included, including those overturned in whole or in part. These data are reported for plan years 2015-2024.
Data Type:	Text
Variable Label:	Issuer_Number_Internal_Appeals_Overturned
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Exchange.

Variable Name:	Percent of Internal Appeals Overturned
Variable Definition:	Percentage of adverse benefit determinations Overturned (# internal appeals overturned/# of internal appeals filed) by plan/issuer in favor of the beneficiary. These data are reported for plan years 2015-2024.

Data Type:	Text
Variable Label:	Issuer_Percent_Internal_Appeals_Overturned
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Exchange.

Variable Name:	Number of External Appeals Filed
Variable Definition:	Number of requests by the insured for appeals on final adverse determinations to an external review organization. These data are reported for plan years 2015-2024.
Data Type:	Text
Variable Label:	Issuer_External_Appeals_Filed
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Exchange.

Variable Name:	Number of External Appeals Overturned
Variable Definition:	Number of final adverse determinations overturned upon request for external review, in whole or in part. These data are reported for plan years 2015-2024.
Data Type:	Text
Variable Label:	Issuer_Number_External_Appeals_Overturned
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Exchange.

Variable Name:	Percent of External Appeals Overturned
Variable Definition:	Percent of final adverse determinations overturned (# external appeals overturned/# of external appeals filed) upon request for external review. These data are reported for 2015-2024.
Data Type:	Text
Variable Label:	Issuer_Percent_External_Appeals_Overturned
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Exchange.

Variable Name:	Number of Plan Level In-Network Claims with DOS in 2024 That Were Also Received in Calendar Year 2024

Variable Definition:	Plan level number of claims received by an issuer asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO). These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Received_In_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan-level submission required beginning with QHP certification for plan year 2020. 2018-2021 Plan-level claims received and denied are aggregated by network status.

Variable Name:	Number of Plan Level Out-Of-Network Claims with DOS in 2024 That Were Also Received in Calendar Year 2024
Variable Definition:	Plan level number of claims received by an issuer asking for a payment or reimbursement by or on behalf of an out-of-network health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO). These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Received_Out_Of_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan-level submission required beginning with QHP certification for plan year 2020. 2018-2021 Plan-level claims received and denied are aggregated by network status.

Variable Name:	Number of In-Network Plan Level Claims with DOS in 2024 That Were Also Denied in Calendar Year 2024
Variable Definition:	Number of plan level claims asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital or doctor) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied. These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Denied_In_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A

Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan-level submission required beginning with QHP certification for plan year 2020. 2018-2021 Plan-level claims received and denied are aggregated by network status.

Variable Name:	Number of Out-of-Network Plan Level Claims with DOS in 2024 That Were Also Denied in Calendar Year 2024
Variable Definition:	Number of plan level claims asking for a payment or reimbursement by or on behalf of an out-of-network health care provider (such as a hospital or doctor) that is not contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied. These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claim_Denied_Out_of_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan-level submission required beginning with QHP certification for plan year 2020. 2018-2021 Plan-level claims received and denied are aggregated by network status.

Variable Name[iii]:	Number of In-Network Plan Level Claims with DOS in 2024 That Were Also Resubmitted in Calendar Year 2024
Variable Definition:	Number of plan level in-network claim resubmissions asking for a payment or reimbursement by or on behalf of a health care provider (such as a hospital or doctor) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer previously denied. These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Resubmitted_In_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan-level resubmitted claims data required beginning with QHP certification for plan year 2024.

Variable Name[iii]:	Number of Out-Of-Network Plan Level Claims with DOS in 2024 That Were Also Resubmitted in Calendar Year 2024

Variable Definition:	Number of plan level out-of-network claim resubmissions asking for a payment or reimbursement by or on behalf of a health care provider (such as a hospital or doctor) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer previously denied. These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Resubmitted_Out_Of_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan-level resubmitted claims data required beginning with QHP certification for plan year 2024.

Variable Name:	Number of Plan Level Claims with DOS in 2024 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2024
Variable Definition:	Number of plan level in-network non- emergency claims for service that required prior/pre-authorization, referral, prior approval, or precertification that were denied. These data are reported for plan years 2018-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Denied_Referral_Required
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan level submission required beginning with QHP certification for plan year 2020.

Variable Name:	Number of Plan Level Claims with DOS in 2024 That Were Also Denied Due to an Out-Of-Network Provider Claims in Calendar Year 2024
Variable Definition:	Number of plan level claims denied for services from outside of the plan's network of healthcare providers when the plan has a closed network. These data are reported for plan years 2018-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Denied_Due_To_Out_of_Network
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan level submission required beginning with QHP certification for plan year 2020.

Variable Name:	Number of Plan Level Claims with DOS in 2024 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2024.
Variable Definition:	Total number of claims denied due to limitations or exclusions of certain services, test, treatment, admissions, supplies, etc. that are excluded, not covered, and/or limited under the plan, including claims denied as a result of a drug not being on the formulary. These data are reported for plan years 2018-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Denied_Services_Excluded
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan level submission required beginning with QHP certification for plan year 2020.

Variable Name:	Number of Plan Level Claims with DOS in 2024 That Were Also Denied Due to Lack of Medical Necessity, excluding Behavioral Health in Calendar Year 2024
Variable Definition:	Number of in-network plan level claims denied for healthcare services or supplies that do not meet the accepted standards to diagnose or treat an illness, injury, condition, disease, or its symptoms related to medical services. These data are reported for plan years 2018-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Denied_Not_Medically_Necessary_Excluding_Behavioral_Health
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan level submission required beginning with QHP certification for plan year 2020.

Variable Name:	Number of Plan Level Claims with DOS in 2024 That Were Also Denied Due to Lack of Medical Necessity, including Behavioral Health only in Calendar Year 2024
Variable Definition:	Number of in-network plan level claims denied for healthcare services or supplies that do not meet the accepted standards to diagnose or treat an illness, injury, condition, disease, or its symptoms related to medical services, related to behavioral/mental health. These data are reported for plan years 2018-2024.
Data Type:	Text

Variable Label:	Plan_Number_Claims_Denied_Not_Medically_Necessary_Behavioral_Health_Only
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan level submission required beginning with QHP certification for plan year 2020.

Variable Name[iii]:	Number of Plan Level Claims with DOS in 2024 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2024.
Variable Definition:	Number of in-network plan level claims denied due to the beneficiary reaching an annual benefit limit. These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claim_Denied_Due_To_Enrollee_Benefit_Limit_Reached
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Submission required beginning with QHP certification for plan year 2024.

Variable Name[iii]:	Number of Plan Level Claims with DOS in 2024 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2024
Variable Definition:	Number of in-network plan level claims denied due to beneficiary's enrollment status at the time services were rendered. These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claim_Denied_Due_To_Member_Not_Covered
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Submission required beginning with QHP certification for plan year 2024.

Variable Name[iii]:	Number of Plan Level Claims with DOS in 2024 That Were Also Denied Due to Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2024

Variable Definition:	Number of in-network plan level claims denied due to the procedure being investigational, cosmetic, or experimental. These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claim_Denied_Due_To_Investigational_ Experimental_Cosmetic_Procedure
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Submission required beginning with QHP certification for plan year 2024.

Variable Name[iii]:	Number of Plan Level Claims with DOS in 2024 That Were Also Denied for Administrative Reasons in Calendar Year 2024
Variable Definition:	Number of in-network plan level claims denied due to administrative reasons, such as: - Duplicate Claim - Missing/Insufficient Information - Untimely Claim Filing - Billing Provider Not Approved - Coordination of Benefit - Inconsistent Procedure Code/Diagnosis - Workers Comp/Liability Issue - Paid by Auto or Other Insurance - Unable to identify patient. These data are reported for plan years 2022-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claim_Denied_Due_To_Administrative_ Reason
Allowable Values:	Numerical
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Submission required beginning with QHP certification for plan year 2024.

Variable Name:	Number of Plan Level Claims with DOS in 2024 That Were Also Denied for “Other” Reasons in Calendar Year 2024
Variable Definition:	Number of in-network plan level denial of claims rejected for any reason not enumerated in another denial category. These data are reported for plan years 2018-2024.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Denied_Other
Allowable Values:	Numerical
Data Source:	Issuer

Field Name from Data Source:	N/A
Comments:	Plan-level data at the State level, for all QHPs on Exchange. Plan level submission required beginning with QHP certification for plan year 2020.

Variable Name:	Financial Information
Variable Definition:	URL link to prior calendar year issuer-level information about premiums, assets, and liabilities
Data Type:	Text
Variable Label:	Financial_Information
Allowable Values:	Free text
Data Source:	National Association of Insurance Commissioners
Field Name from Data Source:	N/A
Comments:	Record relates to coverage at the issuer level. The information provided in the URL link reflects financial information that is current as of the date of initial publication of the PUF.

Variable Name:	Rate Review
Variable Definition:	URL link to issuer rate review information.
Data Type:	Text
Variable Label:	Rate_Review
Allowable Values:	Free text
Data Source:	Healthcare.gov
Field Name from Data Source:	N/A
Comments:	Record relates to coverage at the issuer level. The information provided in the URL link reflects rate review information that is current as of the date of initial publication of the PUF.

Variable Name:	Average Monthly Enrollment
Variable Definition:	The average monthly number of enrollees who had effectuated coverage during the 2024 plan year. This metric is calculated by summing the member months of effectuated enrollment and dividing this sum by 12; partial months of coverage are prorated.
Data Type:	Text
Variable Label:	Enrollment_Data
Allowable Values:	Free text
Data Source:	CMS
Field Name from Data Source:	N/A
Comments:	2015-2018 enrollment data reported at Issuer-level, for all QHPs on Exchange. 2015-2020 data represent plan level enrollment numbers, as measured by non-cancelled plan selections, based on the end of the prior calendar year's information.

Variable Name:	Average Monthly Disenrollment
Variable Definition:	The average monthly number of enrollees who both 1. had effectuated coverage during the 2024 plan year, and 2. terminated their coverage in the given plan or issuer-county combination prior to the end of the plan year. This metric is a subset of the Average Monthly Enrollment.
Data Type:	Text
Variable Label:	Disenrollment_Data
Allowable Values:	Free text
Data Source:	CMS
Field Name from Data Source:	N/A
Comments:	2015-2018 disenrollment data reported at Issuer-level, for all QHPs on Exchange. 2015-2020 data represent plan level disenrollment numbers, as measured by cancelled plan selections, based on the end of the prior calendar year's information.

[i] New variable for the PY2021 PUF
[ii] New variable for the PY2022 PUF
[iii] New variable for the PY2024 PUF