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) in order 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 (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 2017-2024. The 2017 Transparency PUF reflects data from plan year 2015, 2018 reflects data from plan year 2016, 2019 reflects data from plan year 2017, 2020 reflects data from plan year 2018, 2021 reflects data from plan year 2019, 2022 reflects data from plan year 2020, and 2023 reflects data from plan year 2021. For the plan year 2024 Transparency in QHP Coverage PUF, CCIIO collected and reviewed issuer claims and denials data from plan year 2022. Therefore, the plan year 2024 PUF will reflect data from plan year 2022.

2. Variable Attributes

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 Code
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[1]:	New or Returning Issuer Status
Variable Definition:	Indication of whether issuer is new or returning to the Exchange for PY2024.
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 2022?
Comments:	N/A
Variable Name[2]:	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:	2024 Plan ID
Variable Definition:	Fourteen-digit PY2024 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[1]:	Medical or Dental Plan Type
Variable Definition:	Indication of whether plan is medical or dental.
Data Type:	Text
Variable Label:	QHP/SADP
Allowable Values:	QHP; SADP
Data Source:	System-generated field
Field Name from Data Source	QHP/SADP
Comments:	N/A
Variable Name[1]:	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[1]:	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 2022 That Were Also Received in Calendar Year 2022
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 year 2022.
Data Type:	Text
Variable Label:	Issuer_Claim_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 2022 That Were Also Received in Calendar Year 2022
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 year 2022.
Data Type:	Text
Variable Label:	Issuer_Claim_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 2022 That Were Also Denied in Calendar Year 2022
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 year 2022.
Data Type:	Text
Variable Label:	Issuer_Claim_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 2022 That Were Also Denied in Calendar Year 2022
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 year 2022.
Data Type:	Text
Variable Label:	Issuer_Claim_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[3]:	Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022
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 year 2022.
Data Type:	Text
Variable Label:	Issuer_Claim_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 starting in plan year 2024.
Variable Name[3]:	Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022
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 year 2022.
Data Type:	Text
Variable Label:	Issuer_Claim_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 starting in 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. This applies to each plan year; these data are reported for 2015-2022.
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. This applies to each plan year; these data are reported for 2015-2022.
Data Type:	Text
Variable Label:	Issuer_Number_of_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. This applies to each plan year; the data are reported for 2015-2022.
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. This applies to each plan year, these data are reported for 2015-2022.
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. This applies to each plan year, these data are reported for 2015-2022.
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. This applies to each plan year; these data are reported for 2015-2022.
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 2022 That Were Also Received in Calendar Year 2022
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 year 2022.
Data Type:	Text
Variable Label:	Plan_Number_Claim_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 starting in 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 2022 That Were Also Received in Calendar Year 2022
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 2022.
Data Type:	Text
Variable Label:	Plan_Number_Claim_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 starting in 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 2022 That Were Also Denied in Calendar Year 2022
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 2022.
Data Type:	Text
Variable Label:	Plan_Number_Claim_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 starting in 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 2022 That Were Also Denied in Calendar Year 2022
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 2022.
Data Type:	Text
Variable Label:	Plan_Number_Claim_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 starting in plan year 2020. 2018-2021 Plan-level claims received and denied are aggregated by network status.

Variable Name[3]:	Number of In-Network Plan Level Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022
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 2022.
Data Type:	Text
Variable Label:	Plan_Number_Claim_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 starting in plan year 2024.

Variable Name[3]:	Number of Out-Of-Network Plan Level Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022
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 2022.
Data Type:	Text
Variable Label:	Plan_Number_Claim_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 starting in plan year 2024.

Variable Name:	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2022
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. This applies to each plan year; these data are reported for 2018-2022.
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 starting in plan year 2020.

Variable Name:	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to an Out-Of-Network Provider Claims in Calendar Year 2022
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. This applies to each plan year; these data are reported for 2018-2022.
Data Type:	Text
Variable Label:	Plan_Number_Claims_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 starting in plan year 2020.

Variable Name:	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2022.
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. This applies to each plan year; these data are reported for 2018-2022.
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 starting in plan year 2020.

Variable Name:	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, excluding Behavioral Health in Calendar Year 2022
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. This applies to each plan year; these data are reported for 2018-2022.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Denied_Not_Medically_ Necessary_Excl_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 starting in plan year 2020.

Variable Name:	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, including Behavioral Health only in Calendar Year 2022
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. This applies to each plan year; these data are reported for 2018-2022.
Data Type:	Text
Variable Label:	Plan_Number_Claims_Denied_Not_Medically_ Necessary_Incl_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 starting in plan year 2020.
Variable Name[3]:	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2022
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 year 2022.
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 starting in plan year 2024.

Variable Name[3]:	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2022
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 year 2022.
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 starting in plan year 2024.

Variable Name[3]:	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2022
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 year 2022.
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 starting in plan year 2024.

Variable Name[3]:	Number of Plan Level Claims with DOS in 2022 That Were Also Denied for Administrative Reasons in Calendar Year 2022
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.
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 starting in plan year 2024.

Variable Name:	Number of Plan Level Claims with DOS in 2022 That Were Also Denied for "Other" Reasons in Calendar Year 2022
Variable Definition:	Number of in-network plan level denial of claims rejected for any reason not enumerated in another denial category. This applies to each plan year; these data are reported for 2018-2022.
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 starting in 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 2021 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:	Average_Monthly_Enrollment
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 2021 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:	Average_Monthly_Disenrollment
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.

[1] New variable for the PY2021 PUF
[2] New variable for the PY2022 PUF
[3] New variable for the PY2024 PUF