DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
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Description of Data Elements

Tables 1, 2, 3, and 4 below provide the data elements that are included in the 2017 and 2018 benefit years enrollee-level EDGE limited data set (LDS).

Table 1: Enrollment File Data Elements (RARECALE)

Data Element	Variable Name	Description	Data Type	Length	Informat	Notes
SysID	sysid	System generated random number used to link the unique enrollee records across files.	Char	250	$250.	
Enrollee Age	age	Age of the enrollee as of December 31, 2017 or December 31, 2018.	Num (Integer)	8	4	Censored to 89 for enrollees age older than 89.
Enrollee Sex	gender	Sex of enrollee.	Char	1	$1.	M = Male F = Female
Enrollment Length – Months	enroll_mnths	The number of months the enrollment period is active in the specified payment year.	Num (Decimal)	8	5.2	Calculated as Enrollment Length – Days divided by 30.
Enrollment Length – Days	enroll_days	The number of days the enrollment period is active in the specified payment year.	Num (Integer)	8	3	
Metal Level	metal	The Metal Level of the plan in the specified benefit year.	Char	1	$1.	P = Platinum G = Gold S = Silver B = Bronze C = Catastrophic Missing = plans grouped into CSR 11 category (see below)
CSR Variant	csr	The cost-sharing reduction variant of the plan in the specified benefit year.	Char	2	$2.	00 = Non-Exchange variation 01 = Exchange qualified health plan (QHP) variation (standard plan)

Data Element	Variable Name	Description	Data Type	Length	Informat	Notes
						04 = 73% AV silver plan variation 05 = 87% AV silver plan variation 06 = 94% AV silver plan variation 11 = limited cost-sharing, zero cost-sharing, Medicaid expansion private or cost-sharing wrap plans If the 2 digit variant does not exist for the plan, Variant = 'XX' is used.
Market Coverage Type	Market	Market type for the plan in the specified benefit year.	Char	Length = 1;		Enumeration Values description: 1 = Individual 2 = Small group Issuers associated enrollees in merged market states to either individual or small group market based on the type of coverage sold.

Table 2: Medical Claims File Data Elements (RARECALM, RARECALMR)

Data Element	variable name	Description	Data Type	Length	Informat	Notes
SysID	sysid	System-generated random number used to link the unique enrollee records across files.	Char	250	$250.	
Hashed IssuerID+ Medical ClaimID	ClaimID	System generated identifier used to link the records belonging to the same claim across Medical and Supplemental extracts.	Char	minLength = 1 maxLength = 250		

Data Element	variable name	Description	Data Type	Length	Informat	Notes
Market Coverage Type	Market	Market type for the plan in the specified payment year.	Char	Length = 1;		Enumeration Values description: 1 = Individual 2 = Small group Issuers associated enrollees in merged market states to either individual or small group market based on the type of coverage sold.
Form Type Code	form_type	Describes claim form type as professional or institutional.	Char	1	$1.	'I' = Institutional; 'P' = Professional
Bill Type Code	bill_type	The code indicating a specific type of bill as reported on institutional claims only.	Char	3	$3.	Values should comply with X12 industry standards. If value is not applicable, then the value is empty.
Diagnosis Codes	diag_cds	Code value for the diagnosis code as determined by classification of International Classification of Diseases.	Char	3069	$3069.	Values must comply with X12 industry standards. Does not include a decimal. For medical claims with multiple diagnosis codes, dx codes will be separated with '-'
Discharge Status Code	disch_cd	The facility discharge status of the enrollee.	Char	2	$2.	Values must comply with X12 industry standards.
Claim type code	claim_type	Identifies if claim is to original or replaced claim	Char	1	$1.	
Start Date	start_dt	Claim start date	Num (Integer)	8	MMDDYY10.	
End Date	end_dt	Claim end date	Num (Integer)	8	MMDDYY10.	
Paid Date	paid_dt	Issuer claim paid date.	Num (Integer)	8	MMDDYY10	

Data Element	variable name	Description	Data Type	Length	Informat	Notes
Allowed Total Amount	allowed_amt	Total amount allowed for this claim.	Num (Decimal)	8	20.2	At the header level (should be only counted once for multiple service lines).
Policy Paid Total Amount	paid_amt	Total paid amount for this claim	Num (Decimal)	8	20.2	At the header level (should be only counted once for multiple service lines).
Derived Service Claim Indicator	claim_ind	Indicator used to distinguish between fee-for-service claims and claims covered under capitation.	Char	1	$1.	'Y' = Derived (Capitated Service); 'N' = Actual (Fee-For-Service)
Claim Line Sequence Number	claim_seq	Unique number generated to represent service(s) submitted on the claim.	Num (Integer)	8	3	
From Date	from_dt	Service line start date	Num (Integer)	8	MMDDYY10.	
To Date	to_dt	Service line end date	Num (Integer)	8	MMDDYY10.	
Revenue Code	rev_cd	Describes the revenue center in which the service was provided.	Char	4	$4.	Values must comply with X12 industry standards.[1] If value is not applicable, then the value should be empty.
Service Code Qualifier	service_cd_qual	A code that identifies the source of the procedure code (CPT, CDT, or HCPCS).	Char	2	$2.	01 – Dental service codes; 03 - Healthcare Common Procedure Coding System (HCPCS),Current Procedural Terminology (CPT) or Current Dental Terminology (CDT)[2]

[1] https://www.aapc.com/medicalcodingglossary/x12.aspx.

[2] Includes dental claims covered under major medical plans. We do not collect data from stand-alone dental or vision plans.

Data Element	variable name	Description	Data Type	Length	Informat	Notes
						If value is not applicable, then the value should be empty.
Service Code	service_cd	A procedure code that identifies the service rendered: CPT or HCPCS.	Char	5	$5.	Values must comply with X12 industry standards. If value is not applicable, then the value should be empty.
Service Code Modifiers	service_cd_mod	A 2-digit code that may be billed with a CPT/HCPCS service code.	Char	11	$11.	Values must comply with X12 industry standards. If value is not applicable, then the value should be empty. For medical claims with multiple service code modifiers, codes will be separated with "-".
Place of Service	place_serv	A code that identifies where the service was rendered.	Char	2	$2.	Values must comply with X12 industry standards. If value is not applicable, then the value should be empty.
Amount Allowed	plan_allow_amt	Total amount allowed by plan.	Num (Decimal)	8	20.2	At the line level.
Amount Paid	plan_paid_amt	Total amount paid, or derived, by plan.	Num (Decimal)	8	20.2	At the line level.
Derived Amount Indicator	derived_amt_ind	Indicator used to distinguish between fee-for-service claims and claims covered under capitation.	Char	1	$1.	'Y' = Derived (Capitated Service) 'N' = Actual (Fee-For-Service)

Table 3: Pharmacy Claims File Data Elements (RARECALP)

Data Element	variable name	Description	Data Type	Length	Informat	Notes
SysID	sysid	System-generated random number used to link the unique enrollee records across files.	Char	250	$250.	
Market Coverage Type	Market	Market type for the plan in the specified payment year.	Char	1	$1	Enumeration Values description: 1 = Individual 2 = Small group Issuers associated enrollees in merged market states to either individual or small group market based on the type of coverage sold.
Fill date	fill_dt	Indicates the date that the prescription was dispensed by the dispensing pharmacy.	Num (Integer)	8	MMDDYY10.	
Paid date	paid_dt	Paid date	Num (Integer)	8	MMDDYY10.	
Product/Service ID	prod_id	Unique ID of the product or service dispensed using the National Drug Code (NDC).	Char	11	$11.	
Fill Number	fill_no	Code identifying whether the prescription is an original (0) or refill (1-999).	Num (Integer)	8	3	
Dispensing Status	disp_st	Indicates if the prescription was a partial fill (P) or the completion of a partial fill (C).	Char	1	$1.	C = Completion of a partial fill; P = Partial fill A blank implies a complete fill at

						the time dispensed. If value is not applicable, then the value should be empty.
Claim type code	claim_type	Identifies if claim is to original or replaced claim	Char	1	$1.	
Total Allowed Cost	allowed_amt	Represents the sum of allowed charges for ingredient cost, dispensing fee, and sales tax.	Num (Decimal)	8	20.2	
Plan Paid Amount	paid_amt	The total cost of the product/service paid by the plan.	Num (Decimal)	8	20.2	
Derived Amount Indicator	derived_amt_ind	Indicator used to distinguish between fee-for-service claims and claims covered under capitation.	Char	1	$1.	'Y' = Derived (Capitated Service); 'N' = Actual (Fee-For-Service)

Table 4: Supplemental Claims File Data Elements (RARECALS, RARECALSR)

Data Element	variable name	Description	Data Type	Length	Informat	Notes
SysID	sysid	System-generated random number used to link the unique enrollee records across files.	Char	250	$250.	
Hashed IssuerID+ Medical ClaimID	ClaimID	System generated identifier used to link the records belonging to the same claim across Medical and Supplemental extracts.	Char	250	$250	
Market Coverage Type	Market	Market type for the plan in the specified payment year.	Char	1	$1	Enumeration Values description: 1 = Individual 2 = Small group

Data Element	variable name	Description	Data Type	Length	Informat	Notes
						Issuers associated enrollees in merged market states to either individual or small group market based on the type of coverage sold.
Claim Type	claim_type	Identifies if claim is add or delete claim.	Char	1	$1.	'A' = Add; 'D' = Delete Note: To determine whether an enrollee has a particular diagnosis, we recommend counting diagnoses if the count of those diagnosis codes appearing in the medical claims and the supplemental add claims subtracted for the supplemental delete claims is greater than 0.
From Date	from_dt	Claim start date	Num (Integer)	8	MMDDYY10.	
To Date	to_dt	Claim end date	Num (Integer)	8	MMDDYY10.	
Supplemental Diagnosis Codes	sup_diag_cds	Code value for the Diagnosis Code as determined by classification of International Classification of Diseases (ICD-10)	Char	3069	$3069.	Values should comply with X12 industry standards. Explicit decimal is not required. For Supplemental claims with multiple diagnosis codes, dx codes will be separated with "-".