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 from the Multi-Dimensional Insurance Data Analytics System (MIDAS). MIDAS serves as a central repository for capturing, organizing, aggregating, and analyzing CMS's Marketplace data for the 33 states using HealthCare.gov (HC.gov) in 2022. This includes State-based Marketplaces on the Federal Platform (SBM-FPs), which run their own Marketplaces, but use the HC.gov platform for eligibility determinations, enrollment, and other related functions. In 2022, Arkansas, Oregon, and Virginia are SBM-FPs.

The PUFs also include data reported to CMS for State-based Marketplaces (SBMs) that operate their own Marketplaces, with their own platforms, to conduct eligibility determinations, enrollment, and other related functions. In 2022, SBMs operate in California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, and Washington. In addition, the state-level PUF includes Basic Health Program (BHP) data from New York and Minnesota. The SBMs submit the data to CMS and verify its accuracy as of the date of publication. Questions about data from SBMs should be directed to those SBMs.

The PUFs contain data on individual Marketplace 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 33 states using HC.gov, the Health Insurance Marketplace reporting period reflects plan selection and Marketplace activity during the 2022 Open Enrollment Period (OEP) from November 1, 2021, to January 15, 2022.

For the 18 SBMs using their own platforms, the reporting period reflects plan selection and Marketplace activity from the beginning of OE on November 1, 2021, to the end of each SBM's respective OEP and any run-out period. Any renewals processed before November 1, 2021 are also included. New York began processing PY 2022 QHP plan selections on November 16, 2021. Data for each SBM are provided through the following dates: California (1/31/2022, including a run-out period to 2/4/2022), Colorado (1/15/2022, including a run-out period to 1/19/2022), Connecticut (1/15/2022), District of Columbia (1/31/2022), Idaho (12/22/2021), Kentucky (1/31/2022), Maine (1/15/2022), Maryland (1/15/2022), Massachusetts (1/23/2022, including a run-out period to 1/28/2022), Minnesota (1/15/2022), Nevada (1/15/2022), New Jersey (1/31/2022), New Mexico (1/15/2022), New York (1/31/2022), Pennsylvania (1/15/2022), Rhode Island (1/31/2022), Vermont (1/15/2022), and Washington (1/15/2022).

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

Data are directly comparable between the 33 states using HC.gov. CMS does not validate application and enrollment figures for SBMs using their own platforms, and caution should be used when making comparisons between states using their own platforms as definitions may vary. More detail on

differences in metrics for SBMs 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 HC.gov; specific changes from the 2021 PUFs are noted throughout the FAQs.

SBMs 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 SBMs due to differences in reporting systems. In addition, as SBMs 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 2022, the following are some reporting changes that may impact specific SBM data comparisons with previous years. Please note that this list is not exhaustive. For questions regarding the comparability of 2022 SBM metrics to data published in past years, please contact the respective SBM.

- Kentucky, Maine, and New Mexico transitioned from an SBM-FP using the HC.gov platform in PY 2021 to an SBM using its own eligibility and enrollment platform in 2022. As a result, Kentucky's, Maine's, and New Mexico's 2022 data may not be directly comparable to past plan years.
- Some SBMs revised their reporting definitions to better align with CMS's reporting definitions, including District of Columbia (federal poverty level metrics), Massachusetts (stand-alone dental plan metrics), New York (financial assistance and premium metrics), and Vermont (financial assistance and premium metrics).
- CMS added new reporting categories and clarified existing category definitions for race and ethnicity, as described below. As a result, some race and ethnicity metrics may not be directly comparable to previous plan years for some SBMs.

Does this data change over time?

The Marketplaces are dynamic and change on a daily basis as consumers sign up for new coverage or end their current coverage. Data were pulled from MIDAS for the 33 states that use HC.gov as of January 15, 2022. Data for the SBMs using their own platforms were pulled as of the end date of each state's respective OEP or run-out period.

Are all data elements available for every file?

The PUFs include SBM data that CMS requests and SBMs report. Certain metrics in the PUFs do not include data for some SBMs due to differences in SBM reporting systems or because CMS did not collect the data elements. Metrics that an SBM did not provide for either reason are indicated using "NR."

Application-level data are not included in the county-level file since members on an application may not all be located in the same county and therefore, one application may be associated with multiple counties.

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 >400% to ≤500% of the federal poverty level (FPL) and those with income >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.

How does Marketplace application data differ from plan selection data?

Consumers must submit an application to the Marketplace 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. Multiple consumers can exist on a single application, and a single application can be associated with multiple plan selections. Generally, one application exists per tax household. In addition, not every application goes on to make a plan selection, and, in cases where a family selects multiple policies, it is possible that some of the policies remain active, while others are canceled or terminated. Application-level data include applications that were created through the automatic re-enrollment process.

Furthermore, some SBMs 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 SBMs 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 https://www.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 Marketplaces?

States that use HC.gov

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

For HC.gov states, Medicaid and CHIP eligibility totals in these PUFs include HC.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 Marketplace if an applicant is ultimately determined ineligible for Medicaid or CHIP.

SBMs that use their own Marketplace platforms

SBMs have different operating systems and procedures for handling QHP and MAGI-based Medicaid and CHIP eligibility determinations, which affect the type of applications the SBM receives and processes, and what is reported in the application, consumer, and eligibility metrics.

Most SBMs 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. (Due to the COVID-19 PHE, for the 2021 and 2022 OEP, Medicaid/CHIP terminations at redetermination were paused.) 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 SBMs determine or assess MAGI-based Medicaid and CHIP eligibility only when processing new consumer QHP applications received by the Marketplace or through a shared eligibility service with the Medicaid agency, and do not process Medicaid and CHIP redeterminations. Additionally, one SBM (Idaho) does not make MAGI Medicaid and CHIP eligibility determinations, as the Medicaid and CHIP agency processes all applications and financial QHP redeterminations before transferring consumers potentially eligible for a QHP, APTC and/or cost-sharing reductions (CSRs) to the SBM. 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 HC.gov platform, some applicants may not be eligible for QHP or Medicaid/CHIP. This can occur at the time of application submission when an applicant does not live in the state for which they are applying, or if they do not have an immigration status that qualifies them to use the Marketplace. This can also occur at a later date if the Marketplace 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 Marketplace does not automatically grant QHP eligibility.

Applicants using the HC.gov platform can also be eligible for both QHP coverage and Medicaid/CHIP. This can occur when the Marketplace 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 Marketplace does not automatically remove the QHP eligibility.

In SBMs, 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 HC.gov definition of a plan selection?

The plan selection count is the number of unique consumers as of January 15, 2022, with a non-canceled QHP selection that has an end date of January 31, 2022, or later. This includes consumers who selected a 2022 QHP, were automatically re-enrolled into a 2022 QHP, or were placed into a suggested alternate 2022 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 HC.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 HC.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 OEP 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 OEP, 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 Marketplace differentiated from consumers returning to the Marketplace?

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

This change to using December 31 is not applicable to SBMs, 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.

How are active re-enrollees who switched plans differentiated from active re-enrollees who stayed in the same plan from 2021 to 2022? 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 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, HC.gov will renew the consumer's coverage in that plan. However, not every issuer has the same offerings from year to year in a given county or ZIP code. In HC.gov states, when the same plan is no longer available, the Marketplace 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 Marketplace 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 Marketplace plans, consumers are cross-walked into a suggested alternate plan with a different issuer.

This metric is not tracked by CMS in SBMs since not all SBMs allow for consumers whose product is discontinued or whose issuer no longer offers any Marketplace plans to be automatically re-enrolled in a new plan.

When are automatic re-enrollments counted?

Plan selection counts include automatic re-enrollments in Weeks 7-11.

How is a week of enrollment defined?

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

SBMs define the enrollment week as Sunday to Saturday, except for Massachusetts and Rhode Island, which have a reporting period that runs from Monday to Sunday, and Vermont, which has a reporting period that runs from Saturday to Friday.

What if a consumer returns to the Marketplace and makes a second plan selection during Open Enrollment? How are they counted?

The plan selection and accompanying demographic information for states using HC.gov corresponds to the most current non-canceled plan selection. In this scenario, the second plan selection supersedes the first plan selection in these PUFs as long as the second plan selection was not canceled. Details on SBMs 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 not to use all or part of their APTC, and instead claim their full premium tax credit when filing taxes. Consumers eligible for CSRs generally need to select a silver plan in order to receive these CSRs. These PUFs count consumers as receiving financial assistance when the APTC amount applied to their plan selection is greater than $0 or the plan selection includes CSRs.

More information about APTC and CSRs is available at https://www.healthcare.gov/lower-costs/save-on-monthly-premiums. These 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).

Details on SBMs are located in the *Public Use Files Definitions* document. Also note that Colorado, Connecticut, Maryland, Massachusetts, New Jersey, and Vermont provide a "state subsidy wrap" in addition to APTC and/or CSRs for consumers at specific income levels.

How are average premiums calculated?

Average premiums and APTC amounts are reported as per member per month values in all states. In states using HC.gov, the PUF logic distributes the policy-level premium and applied APTC to policy members according to the relevant age curve (available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html) 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 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 premium 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 SBMs may calculate average APTC and average premium differently than states using HC.gov.

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 https://www.healthcare.gov as well as 45 CFR 155.305(g) and 155.350.

The actuarial value, or percentage of total average costs for covered benefits that a plan covers, is higher for a plan with CSRs than a standard plan due to reduced copays, coinsurance values, deductibles, or maximum out of pocket limits. More details are available at 45 CFR 156.135 and 156.420.

Why are some states 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 33 HC.gov states, age is measured as the difference between January 1, 2022 and the consumer's date of birth, rounded down to the nearest whole number. For SBMs, age is measured as of the policy effective coverage date.

How have the income categories changed in the 2022 PUFs?

The 2022 PUFs include the following new income categories:

- <100% of FPL
- ≥100% to ≤138% of FPL
- >400% to ≤500% of FPL (state-level PUFs only)
- >500% of FPL (state-level PUFs only)
- >400% of FPL (county-level PUF only)

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 also a small number of consumers who requested financial assistance, but may have missing incomes. For HC.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, federally recognized tribes may receive CSRs at different levels of household income. More information is available at https://www.healthcare.gov/american-indians-alaska-natives/coverage.

How are race and ethnicity defined?

Race and ethnicity are defined using self-reported information collected on the Marketplace application. In the 2018 to 2021 PUFs, HC.gov race metrics were independent from Hispanic or Latino ethnicity. The 2022 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 and State, Metal Level, and Enrollment Status PUF also include race categories that are independent from Hispanic or Latino ethnicity.

SBMs previously reported and continue to report combined race and ethnicity metrics. However, a number of SBMs updated their definitions in the 2022 PUFs, which resulted in changes in some categories, including Hispanic/Latino ethnicity and multi-racial. In the 2022 PUFs, some SBMs also reported race metrics independent from Hispanic or Latino ethnicity.

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 the Health Resources and Services Administration (HRSA) "ZIP Codes by County" crosswalk file to determine whether a consumer resides in a rural ZIP code and county. This file is available at https://www.hrsa.gov/ruralhealth/aboutus/definition/datafiles.html (December 2021 update).

How are stand-alone dental plans (SADP) counted?

Consumers may purchase SADP coverage on the Health Insurance Marketplaces. Pediatric dental benefits are considered essential health benefits (EHBs), and therefore must be available to all children either as part of a medical plan or as a SADP. In HC.gov states, consumers must purchase a medical plan in order to purchase a SADP. If consumers make a dental plan selection for someone age 18 or younger and have APTC leftover after selecting a medical plan, they can apply this APTC towards the child's dental plan premium. More information is available at https://www.healthcare.gov/coverage/dental-coverage. SBMs may have different procedures for dental enrollment. Please refer to the state Marketplace 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 BHP 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 Minnesota and New York. New York's BHP is known as the Essential Plan, and Minnesota's BHP is known as MinnesotaCare. New York and Minnesota include BHP in some application, consumer and eligibility metrics. See the Definitions document for details.

New York has also included additional (i.e., new and re-enrollee breakouts) information on consumers with BHP plans. For inquiries about this data, please contact the New York Marketplace.

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, complimentary 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 Marketplace,
- A race category (i.e., Other Race and Multi-Racial) is not an option on an SBM's application and thus not applicable, or
- BHP data are not applicable to a state.

What does "NR" represent in the PUFs?

NR represents metrics that are not included for an SBM because of differences in SBM 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?

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, 91% (0.91) of consumers in silver plans had APTC or CSR. We see that the "Total" count of HC.gov consumers in a silver plan with APTC or CSR is 5,773,081.

State_Abrvtn	Pltfrm	Metal_Lvl	Enrlmt_Stus	Cnsmr_Wth_APTC_CSR
AZ	HC.gov	S	All	0.91
Total	HC.gov	S	All	5,773,081