2018 Federally-Facilitated Exchange: Plan Selections by Issuer: A Methodological Overview

October 2017
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1. Background

In order to make our healthcare system more transparent for patients, the Centers for Medicare & Medicaid Services (CMS) has prepared public data sets that provide the total number of health plan selections by county for the 38 states that used the HealthCare.gov platform for enrollment in individual market Exchanges during the 2016 plan year. These data tables include the cumulative consumer health and dental plan selections from the Exchanges in those states. These tables include county-level and issuer plan selection information organized by age, household income as a percentage of the Federal Poverty Level (FPL), plan, gender, and tobacco status. The tables also include information on cumulative disenrollment by issuer.

2. Key Data Sources

Data were obtained from the CMS Multi-Dimensional Insurance Data Analytics System (MIDAS). The data represent the number of unique patients eligible to enroll in a qualified health plan (QHP) who selected a 2016 Exchange plan for coverage between January 1, 2016, and December 31, 2016. New this year, the data also represents unique eligible consumer and plan selection information for stand-alone dental plans. The datasets do not include plan selections from the District of Columbia and the states that had State-based Exchanges that did not utilize the HealthCare.gov platform in 2016.

Plan selections for these 38 states were aggregated by county according to the residency address of the policy's subscriber. Metrics with 10 or fewer plan selections were suppressed due to privacy concerns.

3. Data Contents

The following variables are included within the datasets:
County: The County FIPS Code for the residency address provided by the policy's subscriber.
State: The state where the Exchange plan was purchased.
Ever Enrolled Plan Selections: The total number of unique patients with at least one non-canceled plan selection during the 2016 calendar year for the 38 states that were served by Exchanges that used HealthCare.gov, including the Federally- facilitated Exchanges (FFEs), which included FFEs where States perform plan management functions, and State-based Exchanges on the Federal platform. Patients that had multiple enrollments were counted once. Demographics were based off of the most recent plan selection.
Household Income as a Percentage of the Federal Poverty Level (FPL): A consumer's tax household income as a percent of the FPL was set when a consumer provided his or her tax household income data on the application. Patients provided tax household income data, along with the number of tax household members. These two factors were used to calculate the tax household income as a percent of FPL based on guidelines from the HHS (https://aspe.hhs.gov/poverty-guidelines).
Age: A consumer's age was calculated as the difference between his/ her birthdate and the policy start date of the consumer's 2016 policy. A consumer was then classified into the various age groups.

Gender: A consumer's gender was measured by the consumer's response on his/her application.
Tobacco Use: A patient's tobacco use was measured by the consumer's response on his/her application.
Cumulative Disenrollments: The total number of unique patients who only have a canceled plan selection without coverage during the 2016 calendar year for the 38 states that were served by Exchanges that used HealthCare.gov, including the FFEs, which included FFEs where States perform plan management functions, and State-based Exchanges on the Federal platform. Consumers that had multiple cancellations were counted once. In some plans, there were more cumulative disenrollments than ever enrolled plan selections. This occurred when a greater number of consumers selected a plan and never paid for the plan than consumers that effectuated coverage in the plan.