

## Taking Stock: Health Insurance Coverage under the ACA as of September 2014

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December 3, 2014

### At a Glance

- The number of uninsured nonelderly adults fell by an estimated 10.6 million between September 2013 and September 2014 as the uninsurance rate fell from 17.7 percent to 12.4 percent—a drop of 30.1 percent.
- Most of the gain in coverage was among the low- and middle-income adults targeted by the ACA's Medicaid and Marketplace provisions.
- The uninsurance rate dropped 36.3 percent in states that implemented the ACA's Medicaid expansion, compared with 23.9 percent in nonexpansion states; 54.7 percent of uninsured nonelderly adults lived in nonexpansion states in September 2014.

The Urban Institute's Health Reform Monitoring Survey (HRMS) has been tracking insurance coverage since the first quarter of 2013. Data from the HRMS have provided an early look at changes in the nation's uninsurance rate following the implementation of the Affordable Care Act's (ACA) key coverage expansion provisions, including the launch of new health insurance Marketplaces and the state option to expand Medicaid to nearly all adults with family income at or below 138 percent of the federal poverty level (FPL).<sup>1</sup> The HRMS provides early feedback on ACA implementation to complement the more robust assessments that will be possible when the federal surveys, which are on a slower schedule, begin to release data (Long, Kenney, Zuckerman, Goin, et al. 2014).<sup>2</sup>

Between September 2013, just before the first Marketplace open enrollment period, and early March 2014, just before the end of the open enrollment period, an estimated 5.4 million nonelderly adults (ages 18 to 64) gained coverage as the uninsurance rate fell by 2.7 percentage points (Long, Kenney, Zuckerman, Wissoker, Goin, et al. 2014). By June 2014, following a surge in Marketplace enrollment in March and April (Assistant Secretary for Planning and Evaluation 2014) and accelerated growth in Medicaid enrollment through the spring and summer,<sup>3</sup> the estimated decline in the uninsurance rate was 4.0 percentage points—equivalent to approximately 8.0 million nonelderly adults—since September 2013 (Long, Kenney, Zuckerman, Wissoker, Shartzter, et al. 2014). Data from other rapid-cycle surveys tracking changes in coverage show similar patterns (Carman and Eibner 2014; Collins, Rasmussen, and Doty 2014; Sommers et al. 2014), and the US Centers for Disease Control and Prevention estimates that 3.8 million nonelderly adults gained coverage between 2013 and January-March 2014 (Cohen and Martinez 2014).<sup>4</sup>

This brief examines continued changes in the uninsurance rate for nonelderly adults through September 2014, when the most recent round of the HRMS was completed. Though the Marketplace open enrollment period ended in April 2014, those who have since experienced a qualifying life event, such as marriage, divorce, birth or adoption of a child, or loss of coverage, have been eligible to apply for coverage through the Marketplace during a special enrollment period.<sup>5</sup> Also, coverage may change because enrollment in Medicaid is available to eligible adults any time during the year, and the nation's ongoing economic recovery may cause gains in private coverage. Moreover, states' continued processing of their Medicaid application backlogs may have led to

increased Medicaid enrollment (including coverage retroactive to the application date).<sup>6</sup> Simultaneously, other factors may dampen coverage gains, such as a decline in coverage because some Marketplace plan enrollees failed to pay their premiums.

## What We Did

Our analysis compares the estimated uninsurance rate for nonelderly adults from September 2013 through September 2014. We focus on estimated changes in the uninsurance rate because estimates of the level of uninsurance often vary across survey programs because of differences in the surveys unrelated to the ACA (State Health Access Data Assistance Center 2013). Although the HRMS includes information for all four quarters of 2013, we focus on changes between quarter 3 2013 (the survey for which was fielded in September 2013, just before the first Marketplace open enrollment period) and quarter 3 2014 (the survey for which was fielded in September 2014).<sup>7</sup>

Although each round of the HRMS is weighted to be nationally representative, it is important in examining changes over time that we base our estimates on comparable samples over time. For example, if the share of those with insurance grows simply because more respondents were older or from higher income groups than in an earlier round of the survey, it would be incorrect to associate such a change with the ACA Marketplaces and Medicaid expansions. This is particularly challenging for comparing estimates from survey samples over time because the composition of the sample surveyed can change from round to round in ways that are not fully captured in the weights and that may distort the estimates of change.

To control for the potential influence of changes in the characteristics of the HRMS sample, we estimate weighted regression models that control for demographic and socioeconomic characteristics, internet access, and geography.<sup>8</sup> We consider changes in insurance coverage for (1) all nonelderly adults;<sup>9</sup> (2) adults targeted by the Medicaid expansion and the Marketplaces; (3) adults in states that had and had not adopted the ACA's optional Medicaid expansion by September 1, 2014; and (4) adults in important demographic and socioeconomic subgroups such as age, gender, race and ethnicity, and family income. Controlling for differences in the respondents' characteristics through time allows us to remove variation in insurance coverage caused by changes in the types of people responding to the survey rather than by changes in the health insurance landscape. In presenting the regression-adjusted estimates, we use the predicted rate of uninsurance in each quarter for the same nationally representative population. For this analysis, we base the nationally representative sample on survey respondents from the most recent 12-month period of the HRMS (i.e., quarter 4 of 2013 and quarters 1–3 of 2014). Although we control for sample characteristics over time, we are not attempting to disentangle the effects of the ACA from other factors that also changed between September 2013 and September 2014, such as gains in insurance coverage caused by the economy continuing to recover from the recession.

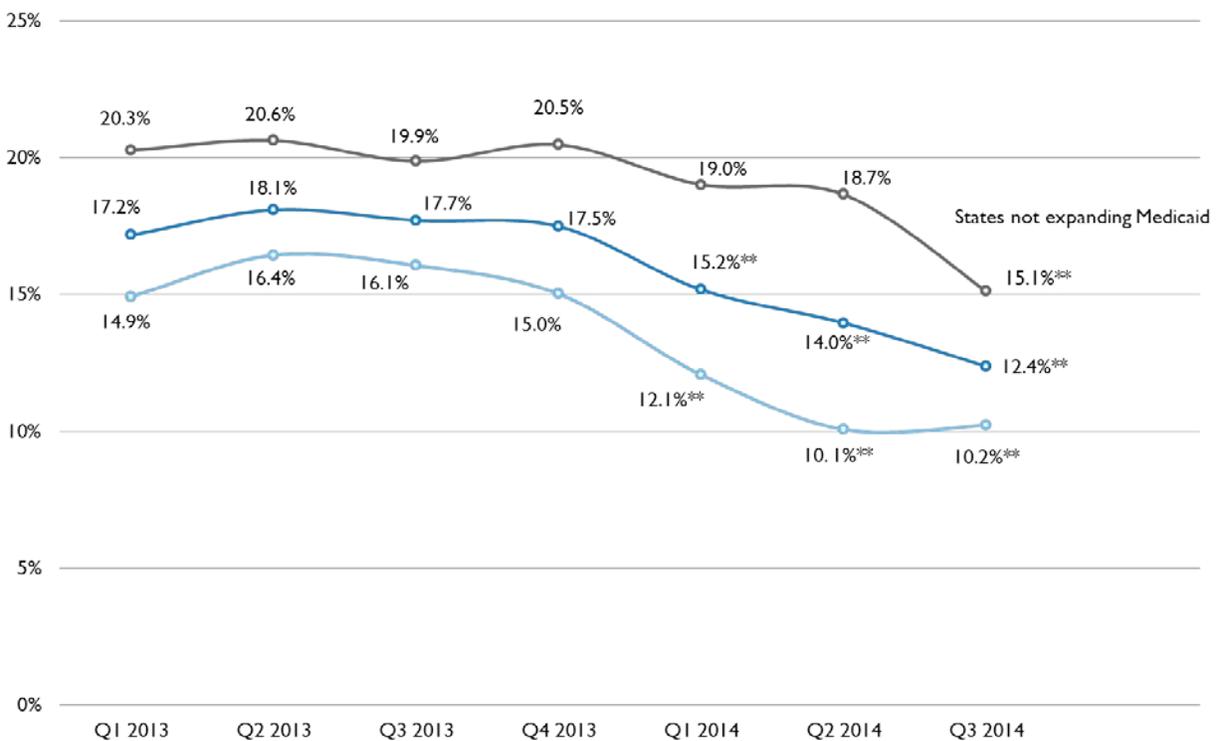
In discussing our findings, we focus on statistically significant changes in insurance coverage over time (defined as differences that are significantly different from zero at the 5 percent level or lower) and highlight changes relative to September 2013. We provide a 95 percent confidence interval (CI) for key estimates. The basic patterns shown for the regression-adjusted measures are similar to those based solely on simple weighted (unadjusted) estimates. To extrapolate our estimates of changes in uninsurance rates to the number of adults who have gained coverage over the same period, we use projections for the size of the 2014 population from the US Census Bureau.<sup>10</sup>

## What We Found

The number of uninsured nonelderly adults fell by an estimated 10.6 million between September 2013 and September 2014: a drop of 30.1 percent in the uninsurance rate. In September 2014, the uninsurance rate for nonelderly adults was estimated to be 12.4 percent (95% CI [11.6, 13.2]) for the nation, a drop of 5.3 percentage points (95% CI [4.3, 6.4]) since September 2013 (figure 1).<sup>11</sup> Applying the estimated 5.3 percentage-point decrease in the uninsured rate to the estimated national population of nonelderly adults implies that the number of uninsured adults declined by 10.6 million between September 2013 and September 2014 (95% CI [8.5 million, 12.6 million]).

Adults in states that implemented the ACA's Medicaid expansion sustained the large coverage gains from the previous quarter, and insurance coverage also rose sharply for adults in nonexpansion states. The uninsurance rate for adults in expansion states dropped 5.8 percentage points (95% CI [4.5, 7.2]) since September 2013; the rate dropped 4.8 percentage points (95% CI [3.2, 6.3]) in the nonexpansion states. This is a decline in the uninsurance rate of 36.3 percent in expansion states and 23.9 percent in nonexpansion states. Most of the estimated decline in the uninsurance rate in the nonexpansion states occurred between June and September 2014 (figure 1). Consequently, the gap in the uninsurance rate between expansion and nonexpansion states, which had widened between September 2013 and June 2014, narrowed somewhat between June 2014 and September 2014. Nonetheless, in September 2014, the uninsurance rate in expansion states was 4.9 percentage points lower than in nonexpansion states; that difference was 3.8 percentage points in September 2013. In September 2014, 54.7 percent of uninsured adults resided in nonexpansion states.

**Figure 1. Trends in Uninsurance for Adults Ages 18 to 64 from Quarter 1 2013 to Quarter 3 2014**



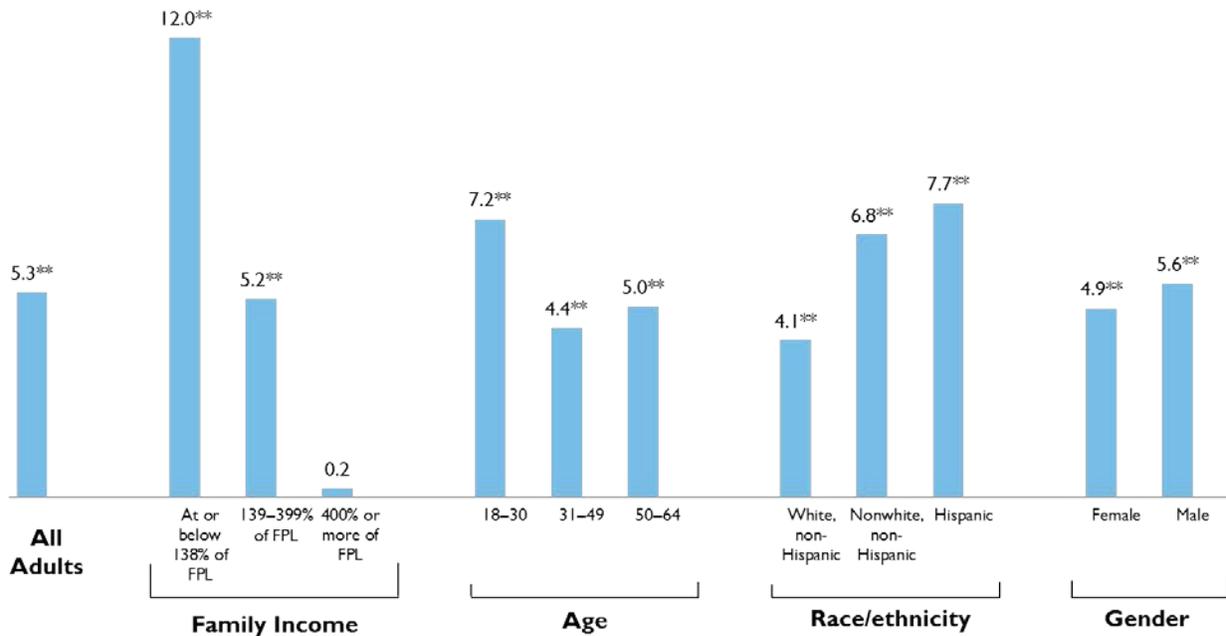
Source: Health Reform Monitoring Survey, quarter 1 2013 through quarter 3 2014.

Notes: Estimates are regression adjusted.

\*\*p<.05 Estimate differs significantly from quarter 3 2013 at the .05/.01 levels, using two-tailed tests.

Low- and middle-income adults targeted by the ACA's key coverage provisions reported large gains in insurance coverage. Insurance coverage increased by 12.0 percentage points (95% CI [9.2, 14.7]) between September 2013 and September 2014 for low-income adults (those with family income at or below 138 percent of FPL, the target population for the ACA's Medicaid expansion) and by 5.2 percentage points (95% CI [3.4, 6.9]) for middle-income adults (those with family income from 139 to 399 percent of FPL, the target population for the new health insurance subsidies available through the Marketplaces) (figure 2).

**Figure 2. Percentage-Point Increase in Insurance Coverage for Adults Ages 18 to 64 between Quarter 3 2013 and Quarter 3 2014**

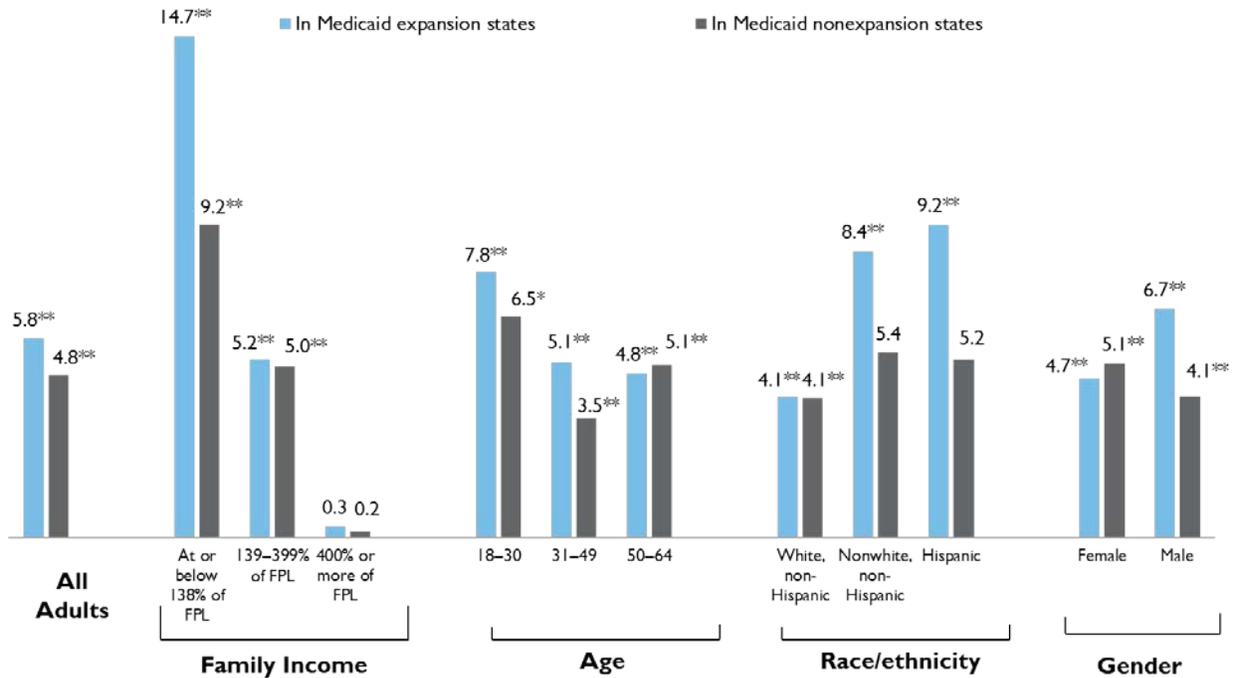


Source: Health Reform Monitoring Survey, quarter 1 2013 through quarter 3 2014.  
 Notes: Estimates are regression adjusted. FPL is federal poverty level.  
 \*/\*\* Estimate differs significantly from zero at the .05/.01 levels, using two-tailed tests.

Low-income adults targeted by the Medicaid expansion had large gains in insurance coverage in expansion states (figure 3). Insurance coverage increased by 14.7 percentage points (95% CI [9.7, 19.7]), or 40.2 percent, between September 2013 and September 2014 for low-income adults in expansion states. Dissimilar to earlier HRMS findings, insurance coverage increased 9.2 percentage points (95% CI [6.9, 11.4]) for low-income adults in nonexpansion states, with the majority of the increase occurring between June and September 2014. This increase in coverage was likely caused by a gain in Medicaid coverage: there was no evidence of an increase in employer-sponsored coverage over the period (data not shown), and most of the low-income adults would not be eligible for subsidized Marketplace coverage.

Middle-income adults who could potentially qualify for Marketplace subsidies experienced similar gains in coverage in expansion and nonexpansion states from September 2013 to September 2014: an increase of 5.2 percentage points (95% CI [3.3, 7.2]) and 5.0 percentage points (95% CI [2.1, 7.9]), respectively.

**Figure 3. Percentage-Point Increase in Insurance Coverage for Adults Ages 18 to 64 between Quarter 3 2013 and Quarter 3 2014, by State Medicaid Expansion Status**



Source: Health Reform Monitoring Survey, quarter 1 2013 through quarter 3 2014.  
 Notes: Estimates are regression adjusted. FPL is federal poverty level.  
 \*\*/\*\*\* Estimate differs significantly from zero at the .05/.01 levels, using two-tailed tests.

### Assessing the Estimate of Coverage Gains in the Nonexpansion States

We conducted several analyses to assess the significant gains in coverage for low-income adults in nonexpansion states between June 2014 and September 2014, which drove the overall decline in uninsurance estimated for adults in those states between September 2013 and September 2014. These analyses included (but were not limited to) (1) a comparison across quarters of the characteristics of the HRMS sample, survey respondents, and survey nonrespondents to see if the results could be attributed to changes in sampling or response patterns; (2) the use of alternative regression-adjustment models that included additional demographic and socioeconomic characteristics, interactions between quarters and characteristics, and measures of sampling for the survey and survey response in previous rounds of the HRMS<sup>12</sup> to see whether there was evidence of panel conditioning; (3) a comparison between changes in the uninsurance rate among those who completed the survey in the previous quarter (June 2014) and the change for the portion of each sample that did not complete the survey in both quarters, to test whether changes reported by individuals followed over time were consistent with those estimated for the remaining sample; and (4) an analysis of coverage changes in individual states to see whether there were changes in coverage in particular states that were driving the results. Our results were robust to all of the sensitivity tests that were conducted. We found no evidence that the results were driven by changing sample or respondent characteristics, by outlier states, or by sample members’ participation in earlier rounds of the survey.

We also benchmarked our estimates with external data sources where possible, including administrative data and data from other surveys. The overall coverage gains for low-income adults in nonexpansion states between September 2013 and September 2014 are consistent with administrative data on the change in Medicaid and CHIP enrollment in nonexpansion states between July through September 2013 and September 2014 (Centers for Medicare and Medicaid Services 2014a, 2014b).<sup>13</sup> However, most of those enrollment gains occurred before June 2014 in the administrative data. One possible explanation for the HRMS data showing a gain between June 2014 and September 2014 is that individuals with Medicaid applications in processing backlogs may not have realized they were covered by Medicaid as they waited for official notice of Medicaid coverage. Administrative data would capture coverage gains caused by retrospective eligibility that would not be reported by the individual.

The comparison to data from other sources included a comparison to findings from the Gallup-Healthways Well-Being Index, which has a much larger sample size than the HRMS. Though the patterns of change across quarters are different (Gallup data shows no decline in uninsurance beyond quarter 2 2014), both the HRMS and Gallup show a 5.3 percentage-point decline in uninsurance among nonelderly adults between quarter 3 2013 and quarter 3 2014 (data not shown).<sup>14</sup> HRMS and Gallup also estimate similar reductions in uninsurance in expansion states (6.4 percentage points in Gallup compared with 5.8 percentage points in the HRMS) and nonexpansion states (4.3 percentage points in Gallup compared with 4.8 percentage points in the HRMS). Furthermore, the two data sources are generally consistent when coverage changes are compared across broad income and age groups.

Finally, HRMS and Gallup estimates of the change in the overall uninsurance rate for nonelderly adults in both expansion and nonexpansion states are similar to estimated changes between 2013 and 2014 reported by Enroll America and Civis Analytics, which rely on a different methodology than both the HRMS and Gallup.<sup>15</sup> They estimate that the uninsured rate fell by approximately 5.1 percentage points for the national population of nonelderly adults, including declines of 5.7 percentage points in Medicaid expansion states and 4.4 percentage points in nonexpansion states.

*The gains in coverage benefited adults across all age, sex, and race and ethnicity groups, with stronger gains among groups that historically have had higher uninsurance rates.* As shown in figure 2, there were large gains in coverage for adults ages 18 to 30 (a 7.2 percentage-point increase; 95% CI [4.2, 10.3]), nonwhite, non-Hispanic adults (a 6.8 percentage-point increase; 95% CI [3.6, 10.1]) and Hispanic adults (a 7.7 percentage-point increase; 95% CI [4.3, 11.0]), groups that have historically had higher than average uninsurance rates. Coverage rates increased for both men and women (5.6 percentage points, 95% CI [3.5, 7.7], and 4.9 percentage points, 95% CI [3.2, 6.7], respectively). Historically, men have had a higher rate of uninsurance than women.

All of the population subgroups examined in the expansion states experienced gains in coverage except high-income adults (those with family incomes at or above 400 percent of FPL). Young adults, men, and minority adults reported strong gains in insurance coverage. In nonexpansion states, young adults and women reported the strongest gains. Though the magnitude of coverage gains for minority adults was greater than the gains for white, non-Hispanic adults, only the estimated increase in coverage for white, non-Hispanic adults was statistically significant, likely because of smaller sample sizes for minority groups in the HRMS.

## What It Means

The uninsurance rate for nonelderly adults has fallen sharply since the first Marketplace open enrollment period began in October 2013, with larger gains in states that expanded Medicaid and among adults targeted by the Medicaid expansion and the new Marketplace subsidies. Our estimates show that approximately 10.6 million nonelderly adults (with a 95 percent confidence interval of 8.5 million to 12.6 million) gained coverage between September 2013 and September 2014: a 30.1 percent decrease in the national uninsurance rate for this population. As noted previously (Long, Kenney, Zuckerman, Wissoker, Shartzter, et al. 2014), these estimates do not reflect the effects of ACA provisions implemented before 2013 (such as the ability to keep dependents on a parent's health plan until age 26 and early state Medicaid expansions), nor do they account for changes in health insurance coverage that would have occurred independently of the ACA, such as those associated with an improving economy.

Beyond changes at the national level, we see a continued drop in uninsurance in the expansion states, at roughly 6 percentage points in September 2014 (a drop of 36 percent since September 2013), and, for the first time, a significant drop in uninsurance in the nonexpansion states: about 5 percentage points in September 2014 (a drop of 24 percent since September 2013). Most of the coverage gains in both the expansion and nonexpansion states are among low-income adults targeted by the Medicaid expansion. In the expansion states, nearly all low-income adults are now eligible for Medicaid; in the nonexpansion states, low-income adults include those who are eligible for Medicaid under the state's existing, and lower, income eligibility standards and those between 100 and 138 percent of FPL who are newly eligible for coverage (and subsidies) through the Marketplace.

Though the timing of the gains in nonexpansion states differs across survey and administrative sources, the overall change in coverage between September 2013 and September 2014 is consistent with existing survey and administrative data. However, we recognize that the magnitude of the quarter-to-quarter changes in HRMS do not line up as well with those sources. Consequently, we will continue to assess the timing of the coverage changes reported throughout the past year. For example, though we would have expected some increased enrollment among those previously eligible for Medicaid because of the expanded outreach and education efforts coinciding with the Marketplace open enrollment period (Sonier, Boudreaux, and Blewett 2013), administrative data from the end of May to the end of September suggest that at best, such gains were small in the nonexpansion states (Centers for Medicare and Medicaid Services 2014a, 2014b). However, the administrative data would include retrospective enrollment decisions, which may not reflect the respondent's assessment of his or her insurance coverage at the time of the survey. Individuals who had yet to be informed of their Medicaid eligibility might well have reported that they were uninsured. We have added survey questions to the quarter 4 2014 HRMS to better understand coverage changes among the low-income adults going forward, and we will benchmark the quarterly HRMS estimates for 2014 against quarterly data from the National Health Interview Survey as those data become available.

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## About the Series

This brief is part of a series drawing on the Health Reform Monitoring Survey (HRMS), a quarterly survey of the nonelderly population that is exploring the value of cutting-edge Internet-based survey methods to monitor the Affordable Care Act (ACA) before data from federal government surveys are available. The briefs provide information on health insurance coverage, access to and use of

health care, health care affordability, and self-reported health status, as well as timely data on important implementation issues under the ACA. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation, the Ford Foundation, and the Urban Institute.

For more information on the HRMS and for other briefs in this series, visit [www.urban.org/hrms](http://www.urban.org/hrms).

## About the Authors

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## Notes

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<sup>1</sup> The list of states that have expanded Medicaid is increasing over time as more states decide to implement the ACA expansion. States that expanded Medicaid by September 1, 2014, are AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MI, MN, NH, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, and WV. Several of those states, including CA, CT, DC, and MN, expanded Medicaid under the ACA before 2013.

<sup>2</sup> Benchmarking of the HRMS data against federal survey data is provided in Long, Kenney, Zuckerman, Goin, et al. 2014.

<sup>3</sup> "Medicaid and CHIP Application, Eligibility Determination, and Enrollment Data," Centers for Medicare and Medicaid Services, accessed November 21, 2014.

<sup>4</sup> Because data collection through the National Health Interview Survey was ongoing between January 2014 and March 2014, this figure does not fully reflect the change in health insurance coverage that occurred by March.

<sup>5</sup> "Getting Help Outside Open Enrollment: Applying for a Special Enrollment Period," Centers for Medicare and Medicaid Services, accessed November 21, 2014.

<sup>6</sup> Phil Galewitz, "More Than 1.7 Million Consumers Still Wait for Medicaid Decisions," *Kaiser Health News*, June 9, 2014.

<sup>7</sup> Although Marketplace coverage for people enrolling between October 2013 and December 2013 did not start until January 2014, some who signed up in the fall may have reported having coverage during the December 2013 HRMS survey. Further, some of those seeking coverage through the Marketplace between October 2013 and December 2013 were enrolled in Medicaid.

<sup>8</sup> Specifically, we control for the variables used in the poststratification weighting of the KnowledgePanel (the internet-based survey panel that underlies the HRMS) and the poststratification weighting of the HRMS. These variables are sex, age, race and ethnicity, language, education, marital status, whether any children are present in the household, household income, family income as a percentage of FPL, homeownership status, internet access, urban or rural status, and census region. In this analysis, we also control for citizenship status and participation in the previous quarter's survey (i.e., whether the respondent completed survey in the previous quarter, was sampled in the previous quarter but did not complete the survey, or was not sampled in the previous quarter).

<sup>9</sup> In this brief, we are not looking at the effects of the ACA on coverage for children, but we recognize that their coverage and well-being may be affected by their parent's enrollment in coverage or by other ACA provisions.

<sup>10</sup> We use 2014 national population predictions available from the US Census Bureau. These files give population projections by race, ethnicity, and sex of all ages from 2012 to 2060 based on estimated birth rates, death rates, and net migration rates. Using the "Table 1, Middle Series" file (which has a 2014 projected population of 318,892,103), we summed the 2014 population projections for all 18-to-64-year-olds to arrive at 198,461,688 nonelderly adults in 2014. See

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US Census Bureau, “2012 National Population Projections: Downloadable Files,” US Department of Commerce, last revised May 15, 2013.

<sup>11</sup>The uninsurance estimates reported here differ from some early estimates reported elsewhere. This reflects two factors: (1) we revised the editing process for insurance coverage in quarter 3 2013 to make better use of information from an open-ended follow-up question that was added in quarter 2 2013 to learn the type of insurance coverage of those who said they were covered but did not pick a type of coverage from the list provided, and (2) the regression-adjusted estimates are always based on the most recent four quarters of data (this brief, for example, uses quarter 4 2013 and quarters 1–3 2014).

<sup>12</sup> Because the HRMS is drawn from an Internet panel, there is the possibility of panel conditioning (American Association for Public Opinion Research 2010). To assess the possibility of such bias, we estimate models that included (1) the number of past quarters in which respondents completed the survey, (2) the number of past quarters in which the respondent was included in the HRMS sample but did not respond to the survey, (3) the number of quarters included in the HRMS sample, and (4) simple dummy variables for whether respondents completed the survey or did not respond to the survey in any past quarter.

<sup>13</sup> Between July 2013 through September 2013 and September 2014, Medicaid and CHIP enrollment increased by about 1.3 million people (both children and adults of all ages) in nonexpansion states, including Pennsylvania, where the Medicaid expansion will not take effect until 2015 (Centers for Medicare and Medicaid Services 2014c). Though the HRMS only distinguishes between adults with incomes at or below 100 percent of FPL and those with incomes 100–138 percent of FPL beginning in the September 2014 round, combining lower-income adults’ estimated September 2013 to September 2014 coverage gain in nonexpansion states with the estimated September 2014 population of poor adults (those with under 100 percent of FPL) in nonexpansion states shows an increase in coverage of about 1.6 million poor adults, if we assume that they experienced the same change as all low-income adults in nonexpansion states. Therefore, our estimates may overstate the gains in coverage among poor adults in nonexpansion states. Simultaneously, we may be understating the gains in expansion states. Administrative data show Medicaid/CHIP enrollment growth of about 7.8 million from July 2013 through September 2013 to September 2014; our estimates imply a total coverage gain of about 6.4 million for nonelderly adults of all income groups.

<sup>14</sup> Quarterly estimates of uninsurance among nonelderly adults at the time of the Gallup survey were provided by the US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. These estimates are based on survey data collected throughout the quarter (e.g., July through September 2014 for quarter 3 2014, compared with HRMS estimates for quarter 3 2014 that rely on surveys completed only in September). We thank staff at the Office of the Assistant Secretary for Planning and Evaluation for providing these tabulations. More information on the Gallup-Healthways Well-Being Index is available at <http://www.well-beingindex.com>.

<sup>15</sup> Kevin Quealy and Margot Sanger-Katz, “Obamacare: Who Was Helped Most?” *New York Times*, October 29, 2014.