

Health Reform and Changes in Health Insurance Coverage in 2017

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Executive Summary

The change in administration in January 2017 brought significant changes to the oversight of the Affordable Care Act (ACA), including reduced funding of enrollment-related advertising and assistance, an executive order indicating relaxed enforcement of the individual mandate, and ongoing debate over repealing the law. Concerns also persist about premium increases and marketplace instability dating to the Obama Administration.

Using data from the Gallup-Sharecare Well-Being Index, a validated nationally-representative daily telephone survey, we assessed changes in coverage across three time periods: before the ACA's major marketplace and Medicaid coverage expansions (2012-2013); during the Obama administration's oversight of the ACA expansion (2014-2016); and during the Trump administration's oversight of the ACA (2017). Our sample was composed of non-elderly adults ages 18 to 64 ($n=821,748$) in the 2012-2017 Gallup-Sharecare Well-Being Index. We used multivariate regression to adjust for demographic and economic confounders, and we examined subgroups based on demographic and state policy decisions. We also analyzed several secondary outcomes related to access to care and self-reported health, which were only consistently present in the dataset through 2016.

We found that the uninsured rate among non-elderly adults declined by 6.3 percentage points (95% Confidence Interval -7.1, -5.6; $p<.001$) between the 4th quarter of 2013 and the 4th quarter of 2016, after adjusting for confounders. Among our secondary outcomes, access to a personal doctor and to medications significantly improved during this period, and cost-related barriers to care significantly decreased, while self-reported health measures showed some positive but inconsistent changes.

In contrast, between the 4th quarter of 2016 and the 4th quarter of 2017, the uninsured rate increased by 1.3 percentage points (95% CI 0.5, 2.0; $p<.001$). Significant increases in uninsurance in 2017 were evident across most demographic and state policy subgroups. Overall, roughly one-fifth (21%) of the coverage gains associated with the ACA between 2014 and 2016 were reversed during 2017.



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Coverage gains from the ACA's first three years have eroded in 2017. It is unclear how much of this is attributable to premium increases and challenges in the ACA's marketplaces that began in 2016 versus changes in policy under the new administration, but in either case, renewed policy efforts may be necessary to protect the ACA's previous coverage gains. The elimination of the individual mandate as part of the 2017 tax law may accelerate these coverage losses; alternatively, Maine's recent referendum to expand Medicaid could be a harbinger of more state-level coverage expansions. Given that the ACA's coverage expansion was associated with favorable changes in access to care, ongoing policy attention to changes in coverage, utilization, and health outcomes related to the ACA will be critical.

Introduction

Under the Affordable Care Act (ACA), the U.S. witnessed an historic decrease in the number of people who were uninsured, primarily through the creation of health insurance marketplaces and Medicaid expansion starting in 2014.¹ Expanding insurance coverage was a priority for the administration of President Barack Obama: federal funds were devoted to outreach, communication campaigns advertised the availability of subsidized coverage, and technical assistance to potential enrollees increased take-up of insurance.² Prior research indicates that this coverage expansion was associated with favorable changes in access to medical care, financial security, and – in some studies though not all – improved health status.³⁻¹⁰

This policy environment changed substantially since January 2017. The new administration has cut back funding for outreach to potential enrollees, including canceling advertisements for the end of the 2017 open enrollment period.¹¹ Shortly after inauguration, an executive order indicated that the administration would seek to weaken enforcement of the individual mandate.¹² President Trump has issued public statements declaring that the ACA is collapsing due to major increases in premiums, at one point declaring, “The White House has issued public statements declaring that the ACA is collapsing due to major increases in premiums.”¹³ Finally, there have been prolonged Congressional debates about repealing the ACA, including a repeal of the individual mandate as part of the 2017 tax bill, and public opinion polls show that nearly a quarter of Americans mistakenly think the law is no longer in effect.¹⁴

This new policy environment has focused significant attention on health care. What is less clear is whether these factors have affected rates of insurance coverage in the U.S., and more specifically, whether policy changes during 2017 have been associated with a reversal in coverage gains made during the ACA's first three years.

In this paper, we use current nationally-representative data to examine changes in coverage over three time periods: before the ACA's major coverage expansions took effect in 2014; during President Obama's term after the expansion began in 2014; and during President Trump's term in 2017. We examine subgroups of patients at risk for disparities and adverse outcomes – including racial/ethnic minorities and those with chronic conditions – as well as state policies related to Medicaid expansion and state vs. federally-administered insurance marketplaces. This report builds on our recently published study using these data¹⁵ by providing a deeper look at the results and secondary outcomes including access to care and self-reported health.

Methods

Data

Our data source was the Gallup-Sharecare Well-Being Index (WBI), a nationally-representative telephone survey conducted throughout the year. The survey includes adult respondents ages 18 and older from all 50 states, and it assesses demographic information, insurance coverage, and other health-related measures. It has been used previously to assess changes in access to care and self-reported health status under the ACA.^{4,16} However, the portion of the survey focused on access to care and self-reported health was revised in 2017, with several measures dropped from the survey's main sample or eliminated entirely. Thus, we focused primarily on health insurance coverage, which was continuously measured throughout our study period from January 2012 through the end of December 2017. Coverage rates in 2010-2011 were in flux due to a provision in the ACA allowing young adults to remain on their parents' plans, so we began our study period in 2012 after that provision reached full effect.¹⁷ As a secondary analysis, we analyzed changes in access to care and self-reported health through the end of 2016, building on prior research examining these outcomes in the WBI through mid-2015.⁴

The WBI is conducted in English or Spanish on both landlines and cellphones. The response rate is 9 percent, using the standard AAPOR-III definition. Gallup provides national survey weights based on demographic targets from federal data (see Appendix). The WBI has been validated in previous research, which demonstrated that its trends over time in the uninsured rate track well with federal surveys conducted by the Census Bureau and the National Center for Health Statistics,¹⁸ as well as with official state-level ACA enrollment statistics.¹⁶ The WBI has distinct advantages in that it is available several months in advance of the other data sources and allows for state-specific and monthly estimates.

Outcomes and Statistical Analysis

Our primary outcome was whether a person has health insurance coverage. Secondary outcomes available in the dataset through the end of the 2016 were 3 measures of access to care – lacking a personal physician, whether it is “easy to get” medications, and any cost-related barriers to obtaining medical care in the prior 12 months; and 2 measures of self-reported health – overall health status (with the outcome of interest being “fair or poor health”), and the percentage of days in the past month in which activities were limited by poor health (see Appendix for exact wording).

We estimated models analyzing the data over three distinct time periods: before the ACA's major marketplace and Medicaid coverage expansions took effect (2012-2013); during the Obama administration's oversight of the ACA expansion (2014-2016); and during the Trump administration's oversight of the ACA (2017). Our primary model used quarterly fixed effects to flexibly estimate changes in each outcome over time, without imposing any assumptions of linear trends. For ease of comparison year-to-year and to eliminate any bias from seasonality, we compare the fourth quarters of 2013, 2014, 2015, 2016, and 2017, and we present both unadjusted and adjusted estimates. In secondary analyses (see Appendix), we present a spline model, in which a linear slope was estimated for each of the three periods, with the slopes permitted to change at the two transition points of January 2014 and January 2017.

In all cases, adjusted models controlled for age, sex, race/ethnicity, marital status, education, income, employment status, rural vs. urban residence, and state fixed effects. Our sample excluded adults ages 65 and over. See Appendix for regression equations.

After analyzing changes in outcomes for the full sample, we analyzed our primary outcome across several demographic and policy-related subgroups, including Medicaid expansion status¹⁹ and state-based vs. federal marketplaces (both as of September 2017).²⁰ For income-stratified analyses, we followed previous research using this dataset and converted categorical levels of income into an imputed percentage of the Federal Poverty Level (FPL) in three ACA-relevant groups – less than 138 percent of FPL (Medicaid-eligible in expansion states), 138-400 percent of FPL (marketplace-subsidy eligible); and greater than 400 percent of FPL (non-subsidy eligible).⁴ For analyses of race/ethnicity, we divided

the sample into four mutually-exclusive groups – Latinos, Black non-Latinos, White non-Latinos, and Other. For White non-Latinos, we further split the sample into those with and without a college degree, given recent evidence on worsening health outcomes in the latter subgroup.²¹

All analyses used survey weights to produce nationally-representative estimates, and Stata 14.0 survey-based commands were used to account for the sample design. The study was deemed non-human subjects research by the Harvard School of Public Health’s Institutional Review Board.

Results

Table 1 presents descriptive statistics. The sample contained 821,748 adults between the ages of 18 and 64. The sample was 62 percent White, 16 percent Latino, and 11 percent Black. 44 percent had at least one chronic condition.

Figures 1-3 present unadjusted trends from 2012-2017 for the study outcomes. Figure 1 shows the percentage without health insurance, which ranged between 19-22 percent in the pre-expansion period and then fell rapidly beginning in 2014, hitting a low of 13 percent in late 2016. In 2017, the uninsured rate climbed gradually back up to nearly 15 percent. Figure 2 shows three measures of access to care (only available through the end of 2016). Rates of adults without a personal doctor or with difficulties affording care fell beginning in 2014, while lacking easy access to medicines declined modestly. Figure 3 shows two measures of self-reported health. The share of adults in fair/poor health rose from 2012-2013, and then declined slightly thereafter, while there was little obvious change in trend throughout the study period in the percentage of days limited by poor health.

Table 2 presents unadjusted 4th-quarter means from 2013-2017 and regression-based estimates for changes in each outcome during this period. Consistent with Figures 1-3, the uninsured rate and access to care outcomes all significantly declined (i.e. improved, given the negative framing of each outcome) during the 2014-2016 years. By the 4th quarter (Q4) of 2016, the adjusted uninsured rate had fallen by 6.3 percentage points compared to Q4 2013 (95% Confidence Interval [CI] -7.1, -5.6; $p < .001$), the percentage of people without a personal doctor had fallen by 1.9 percentage points (95% CI -2.8, -1.1; $p < .001$), and difficulties affording care had fallen 1.8 percentage points (95% CI -2.6, -1.1; $p < .001$). Adjusted changes in the percentage of days limited by poor health increased by 1.1 percentage points (95% CI 0.6, 1.5; $p < .001$) from Q4 2013 to Q4 2016, while changes in fair/poor health were not significant.

Table 2 also shows changes in 2017 for the primary outcome of being uninsured. The unadjusted mean rose from 13.1 percent in Q4 2016 to 14.9 percent in Q4 2017. After multivariate adjustment, this reflected a 1.3 percentage-point increase (95% CI 0.5, 2.0; $p < .001$).

Table 3 presents adjusted and unadjusted quarterly estimates for the uninsured rate for various subgroups. In all groups, the uninsured rate declined significantly from Q4 2013 to Q4 2016. The largest changes occurred among Blacks, Latinos, and those with incomes below 138 percent of FPL. The decline in the uninsured rate was significantly larger in Medicaid expansion states than non-expansion states (-7.8 vs. -4.1 percentage points, between-group difference $p < .001$). In contrast, between Q4 2016 and Q4 2017, the uninsured rate increased significantly for the majority of subgroups we assessed.

Figure 4 compares the magnitude of coverage changes for the full sample and several subgroups between 2013-2016 and 2016-2017. In the full sample, the increase in the uninsured rate in 2017 represented 21 percent of the total 2013-2016 decline (1.3 vs. 6.3).

Table 4 presents unadjusted and adjusted changes in uninsured rates between 2016 and 2017 for all 50 states and Washington DC. We used full-year data given the smaller sample sizes, and also use the WBI state-specific weights for these results. The majority of states saw an increase in their uninsured rates from 2016 to 2017, though the adjusted

changes were only statistically significant in seven states; the smaller state-specific sample sizes reduced our power considerably, particularly in less populous states. The seven states with significant increases in the uninsured rate between 2016 and 2017 were Arizona, Colorado, Illinois, Iowa, New Mexico, Texas, and West Virginia. The largest change was in West Virginia, with an estimated increase of 4.6 percentage points (95% CI 0.6, 8.5; $p=.02$).

In sensitivity analyses using linear time trends for each part of the study period, there was significant improvement in all 6 outcomes during the Obama ACA years (Appendix Table 1) – in contrast to the findings for self-reported health in Table 3. Meanwhile, the uninsured rate increased by 0.48 percentage-points per month in 2017 ($p<0.001$), compared to the pre-2017 trend.

Discussion

This study provides some of the earliest evidence to date on how national coverage rates have changed since the change of administrations in 2017. After several years of declining uninsured rates associated with implementation of the ACA, we find a significant uptick in the uninsured rate – increasing over the course of the year – that was present in nearly all segments of the U.S. population. Our estimate of a 1.3 percentage-point increase in the uninsured rate between the fourth quarter of 2016 and the fourth quarter of 2017 represents a reversal of 21 percent of the gains in coverage during the Obama years. Based on a population of roughly 200 million adults in the 18-64 year-old age range,²² this indicates that approximately 2.6 million adults lost coverage during the first 12 months of the Trump administration. While consistent with a recent report published by Gallup using the same dataset,²³ our analysis has the advantage of controlling for potential confounders including the economy, using formal regression-based hypothesis testing, and presenting a rich set of subgroups. Our results also include new results on the changes in access to care and self-reported health through 2016, updating a prior study though mid-2015.⁴

While detailed federal survey estimates for 2017 are not yet available, a preliminary report from the National Health Interview Survey showed a modest but non-significant increase in the uninsured rate for non-elderly adults from 2016 to January-June 2017, with a larger increase in non-expansion states.²⁴ Meanwhile, administrative data provide support for our findings of reduced coverage in 2017. The Centers for Medicare and Medicaid Services reported total enrollment in Medicaid and the Children’s Health Insurance Program (CHIP) in December 2016 was 75.0 million,²⁵ but in the most recently released statistics from August 2017, this had fallen to 74.3 million.²⁶ This 700,000 person decrease stands in contrast to the enrollment increase of 2.3 million between December 2015 and December 2016.²⁷ Meanwhile, open enrollment statistics for the ACA marketplaces indicate that sign-ups for 2017 initially were 300,000 ahead of the prior year’s pace as of December.²⁸ But enrollment slowed in January 2017 and ultimately ended up with 500,000 fewer enrollees in 2017 than in 2016.²⁹

These changes in coverage in 2017 may reflect the new administration’s efforts to alter the ACA. The cessation of advertising in January 2017 was one of the earliest ACA-related decisions the administration made, and prior research indicates that marketplace advertising efforts played an important role in increasing participation in open enrollment.³⁰ The possibility of reduced enforcement of the individual mandate may have decreased insurance rates – not only marketplace coverage but also Medicaid and employer sponsored insurance – though there is limited evidence on the ACA’s mandate effects thus far.^{31,32} Finally, given the negative attention focused on the ACA in the “repeal and replace” debate, some consumers may have mistakenly thought the law was no longer in effect or that its uncertain future made enrollment less worthwhile.¹⁴

It is also possible that the 2017 uptick in the uninsured rate could reflect a natural plateau of coverage expansion or relate to rising premiums in the marketplaces. However, if the latter were the primary mechanism, the initially brisk marketplace sign-ups in December 2016 would be hard to explain, as would the reduction in Medicaid enrollment.

Overall, the coverage losses in 2017 occurred across the majority of subgroups we assessed. Middle-income adults were hit hardest – potentially consistent with at least some of the coverage decline being related to declining Marketplace participation. Blacks experienced large coverage gains in 2014-2016, and then the largest absolute coverage loss in 2017 of any racial/ethnic group. Older adults also experienced disproportionately large coverage losses in 2017. Meanwhile, our state specific analysis was limited by fairly imprecise estimates, but it is still clear from the state-level results that the changes in 2017 were not equally distributed across states. As higher-quality data and more precise state estimates become available from the Census Bureau in the fall of 2018, this will be an important area for policymakers to consider, given the range of state options being considered to alter Medicaid and/or the ACA's marketplaces.^{33,34}

Meanwhile, our results through the end of 2016 demonstrate significant improvements in access to a usual source of care and prescription medications, as well as affordability of care, consistent with a large body of evidence on the ACA.^{3,4,8,10,35} Changes in self-reported health were mixed, as we found a significant worsening in health-related limitations in our primary analysis from 2014-2016, but significant improvements in this outcome and self-reported health in spline models. We specified the quarterly-fixed effects model as our primary approach given that it is more flexible than a model imposing linear time trends; however, the latter may have the advantage of greater statistical power by combining all months of data into a single estimate and better accounting for baseline trends. Overall, the results on self-reported health are clearly less robust than the improvements in access to care. To our knowledge, these results reflect the first national look at these trends through the end of 2016.

There are important limitations to our study. The WBI response rate is considerably lower than those in federal government surveys, although the WBI has been validated showing results consistent with federal survey estimates.¹⁸ Moreover, research has demonstrated that random-digit dialing telephone surveys using appropriate population weights can mitigate potential non-response bias.^{36,37} While the WBI survey is able to accurately ascertain whether respondents are uninsured, it does not accurately identify the type of insurance.¹⁸ Measurement of income in the survey is also imprecise, since the survey asks about income in discrete categories. We also lacked a control group, and residual confounding is always possible. Thus, our analysis describes suggestive trends and is unable to establish causality.

Unfortunately, changes in the WBI survey instrument precluded an assessment of trends in health care access and health in 2017. The Gallup WBI is undergoing even more dramatic changes in 2018, shifting entirely to a mail-survey, which makes its ongoing ability to accurately track these outcomes unclear. Future validation research with the new survey design will be essential.

Conclusions

Our findings document a significant increase in the number of uninsured adults in 2017. Thus far, Congressional efforts to repeal and replace the ACA have failed, but these results indicate that the administration's policy choices have likely already taken a toll. Looking ahead, there is substantial uncertainty as to which direction coverage trends will go. The repeal of the individual mandate, reduced funding for outreach, a shortened open enrollment period for 2018, and higher premiums related to the White House's decision to stop paying for cost sharing reductions (CSRs)³⁸ might drive uninsurance rates even higher.

However, some factors may lead in the opposite direction or at least to stable coverage rates in the near-term. For 2018, a broad-based repeal of the ACA seems less likely now than 6 months ago, which may increase confidence among consumers that enrolling is worthwhile. Overall 2018 marketplace open enrollment figures were reasonably close to the prior year's (down by roughly 400,000 compared to 2017, or 3.7%), offering some support for this view.³⁹ In addition, the November 2017 elections raised the possibility of additional states opting into the Medicaid expansion, including Maine's successful referendum on expansion.

In conclusion, the policy debate over the ACA's expansion of health insurance shows no signs of abating. In this setting, there is clear need for ongoing, rigorous and timely analysis of coverage changes in the United States.

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Table 1: Sample Characteristics (N=821,748)

VARIABLE	N	WEIGHTED PERCENT (SE)
Full Sample	821,748	100.0
Age 18-34	232,782	36.0 (0.1)
Age 35-54	341,470	42.3 (0.1)
Age 55-64	247,496	21.7 (0.0)
Male	439,030	50.0 (0.1)
Female	382,718	50.0 (0.1)
White Non-Latino	557,576	62.2 (0.1)
— White, Non-College Graduate	289,273	39.3 (0.1)
— White College Graduate	268,303	22.9 (0.0)
Latino	96,508	16.3 (0.1)
Black Non-Latino	72,381	11.3 (0.0)
Other/Missing Race	95,283	10.2 (0.0)
Rural	165,607	18.9 (0.1)
Married	437,750	49.9 (0.1)
Income Under 138 percent of the Federal Poverty Level	142,256	23.3 (0.1)
Income Between 138-400 percent of the Federal Poverty Level	339,697	43.1 (0.1)
Income Over 400 percent of the Federal Poverty Level	339,795	33.6 (0.1)
Currently Employed	604,448	71.8 (0.1)
Chronic Condition†	382,506	43.7 (0.1)
Medicaid Expansion State	501,685	61.3 (0.1)
Medicaid Non-Expansion State	320,063	38.7 (0.1)
State-Based Insurance Marketplace	240,058	29.4 (0.1)
Federal Insurance Marketplace	581,690	70.6 (0.1)

NOTES: Sample contains U.S. adults ages 18-64 in the Gallup-Sharecare Well-Being Index (formerly the Gallup-Healthways Well-Being Index), from January 2012 to December 2017.

†Reports at least one of the following: Hypertension, High Cholesterol, Diabetes, Depression, Heart Attack, or Cancer. SE = Standard Error.

Table 2: Regression-Based Estimates of Changes in Coverage, Access to Care, and Self-Reported Health, 2012-2017

OUTCOME	PRE-ACA	INITIAL ACA CHANGES: 2013-2016						RECENT ACA CHANGES: 2016-2017	
	Mean, Q4 2013 (20.2, 21.4)	Mean, Q4 2014 (15.0, 16.1)	Adjusted Change, Q4 2014 – Q4 2013 (-5.9, -4.4)	Mean, Q4 2015 (13.8, 14.9)	Adjusted Change, Q4 2015 – Q4 2013 (-6.2, -4.7)	Mean, Q4 2016 (12.6, 13.6)	Adjusted Change, Q4 2016 – Q4 2013 (-7.1, -5.6)	Mean, Q4 2017 (14.2, 15.5)	Adjusted Change, Q4 2017 – Q4 2016 (0.5, 2.0)
Uninsured	20.8 (20.2, 21.4)	15.6 (15.0, 16.1)	-5.2** (-5.9, -4.4)	14.4 (13.8, 14.9)	-5.5** (-6.2, -4.7)	13.1 (12.6, 13.6)	-6.3** (-7.1, -5.6)	14.9 (14.2, 15.5)	1.3** (0.5, 2.0)
No Personal Doctor	27.7 (27.0, 28.3)	25.1 (24.4, 25.7)	-2.7** (-3.5, -1.9)	25.7 (25.1, 26.3)	-1.4** (-2.2, -0.6)	24.7 (24.1, 25.4)	-1.9** (-2.8, -1.1)	N/A	N/A
No Easy Access to Medicine	9.3 (8.9, 9.8)	8.0 (7.6, 8.4)	-1.2** (-1.7, -0.6)	7.7 (7.3, 8.1)	-1.0** (-1.5, -0.4)	7.3 (6.9, 7.7)	-1.1** (-1.7, -0.6)	N/A	N/A
Cannot Afford Care	21.1 (20.5, 21.7)	19.5 (18.9, 20.0)	-1.3** (-2.1, -0.6)	17.5 (17.0, 18.1)	-1.7** (-2.5, -1.0)	17.0 (16.5, 17.6)	-1.8** (-2.6, -1.1)	N/A	N/A
Fair/Poor Health	19.8 (19.2, 20.4)	19.8 (19.3, 20.4)	-0.1 (-0.9, 0.7)	19.0 (18.4, 19.5)	0.4 (-0.3, 1.2)	18.7 (18.2, 19.3)	0.6 (-0.2, 1.3)	N/A	N/A
Percentage of Days Limited by Poor Health	9.9 (9.5, 10.2)	10.4 (10.1, 10.8)	0.5* (0.1, 1.0)	9.9 (9.6, 10.3)	0.8** (0.4, 1.2)	10.0 (9.7, 10.4)	1.1** (0.6, 1.5)	N/A	N/A

NOTES: Sample size N= 821,748, minus item non-response for each item. Means report unadjusted survey-weighted means for each outcome for the specified quarter. Adjusted models controlled for age, sex, race/ethnicity, marital status, education, income, employment status, rural vs. urban, quarterly fixed effects, and state fixed effects. All adjusted estimates are in percentage-point terms.

N/A = not available for 2017 due to changes in the Gallup survey instrument.

**p<0.01, *p<0.05. 95 percent Confidence Intervals in parentheses.

Table 3: Regression-Based Estimates of Changes in Coverage by Subgroup, 2012-2017

GROUP	% UNINSURED BY QUARTER, UNADJUSTED					ADJUSTED CHANGES		
	Q4 2013	Q4 2014	Q4 2015	Q4 2016	Q4 2017	Initial ACA Changes, Q4 2016 – Q4 2013	Recent ACA Changes, Q4 2017 – Q4 2016	Relative Increase in 2017 as % of 2013-2016 Change
ALL	20.8	15.6	14.4	13.1	14.9	-6.3**	1.3**	20.6
White Non-Latino	14.9	10.5	9.2	8.5	9.6	-4.9**	0.8*	16.3
— Non-College Graduate	19.8	14.2	12.2	11.7	12.9	-6.1**	0.5	8.2
— College Graduate	6.5	4.0	3.6	2.9	4.0	-2.6**	1.0**	38.5
Latino	41.5	34.4	32.7	29.4	31.8	-9.2**†	1.7	18.5
Black Non Latino	23.7	15.5	15.0	14.0	16.7	-9.3**†	2.8*	30.1
Age 18-34	25.9	20.1	18.4	16.8	18.4	-7.4**	1.3	17.6
Age 35-54	20.0	15.3	14.3	12.7	14.5	-5.4**	0.9	16.7
Age 55-64	14.0	8.7	7.8	7.7	9.7	-5.9**	1.9**	32.2
Male	22.6	17.0	16.6	15.1	16.5	-6.1**	1.1*	18.0
Female	19.0	14.2	12.1	11.0	13.2	-6.6**	1.6**	24.2
Income Under 138% FPL	39.7	31.7	30.1	28.4	30.7	-11.8**†	1.6	13.6
Income 138-400% FPL	18.3	13.5	15.1	14.3	16.7	-5.5**†	1.9**†	34.5
Income Over 400% FPL	6.7	4.2	4.0	3.8	4.4	-2.9**	0.4	13.8
Any Condition	19.4	13.5	12.4	11.8	13.2	-6.8**	0.9	13.2
No Condition	21.9	17.2	15.8	14.1	16.2	-5.8**	1.5**	25.9
Rural	24.2	17.7	14.0	14.3	16.1	-8.4**†	1.4	16.7
Urban	20.0	15.1	14.4	12.8	14.6	-5.9**	1.3**	22.0
Medicaid Expansion State	18.6	12.9	11.3	9.7	11.4	-7.8**†	1.2**	15.4
Non Expansion State	24.4	19.8	19.2	18.4	20.4	-4.1**	1.6*	39.0
State-based Marketplace	18.8	12.9	12.2	9.8	11.6	-7.7**†	1.2	15.6
Federal Marketplace	21.6	16.8	15.3	14.5	16.3	-5.7**	1.4**	24.6

NOTES: Sample size N= 821,748 (see Table 1 for subgroup N). Means report unadjusted survey-weighted means for the specified quarter. Adjusted models controlled for age, sex, race/ethnicity, marital status, education, income, employment status, rural vs. urban, quarterly fixed effects, and state fixed effects. All adjusted estimates are in percentage-point terms.

FPL = "Federal Poverty Level."

**p<0.01, *p<0.05. †Reports at least one of the following: Hypertension, High Cholesterol, Diabetes, Depression, Heart Attack, or Cancer.

†Between-group difference p<0.05; reference group for race/ethnicity is White Non-Latino, for income is >400 percent FPL, and for age is 55-64.

Table 4: Changes in Uninsured Rate, 2016 vs. 2017 by State

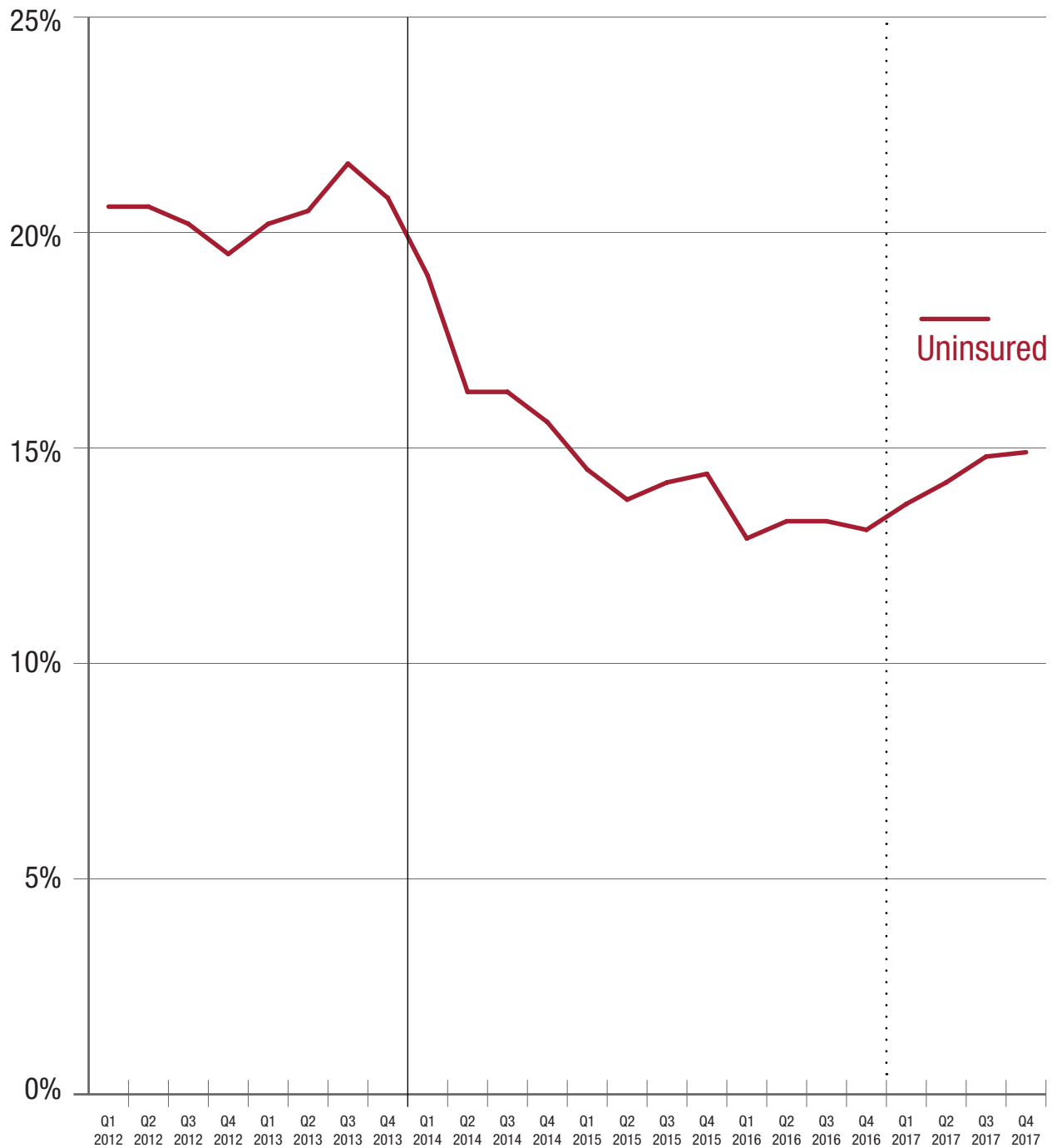
	% UNINSURED BY YEAR, UNADJUSTED		UNADJUSTED DIFFERENCE: FULL YEAR 2017 – 2016	ADJUSTED DIFFERENCE: FULL YEAR 2017 – 2016
	2016	2017		
United States	13.1 (12.9, 13.4)	14.3 (14.1, 14.6)	1.2** (0.8, 1.5)	1.0** (0.7, 1.3)
Alabama	17.3 (15.1, 19.5)	16.4 (14.2, 18.6)	-0.9 (-4.0, 2.2)	-0.1 (-3.0, 2.8)
Alaska	13.2 (9.2, 17.3)	16.4 (11.9, 20.9)	3.2 (-2.9, 9.3)	1.6 (-4.2, 7.4)
Arizona	13.9 (12.1, 15.7)	17.3 (15.2, 19.4)	3.4* (0.7, 6.1)	3.5** (0.9, 6.1)
Arkansas	12.8 (10.5, 15.1)	13.6 (11.1, 16.2)	0.8 (-2.6, 4.3)	1.3 (-1.9, 4.6)
California	12.6 (11.8, 13.3)	12.6 (11.9, 13.3)	0.0 (-1.0, 1.1)	0.4 (-0.6, 1.4)
Colorado	11.7 (10.1, 13.2)	14.2 (12.5, 15.9)	2.5* (0.2, 4.8)	2.4* (0.3, 4.6)
Connecticut	7.8 (6.1, 9.4)	9.3 (7.4, 11.3)	1.6 (-1.0, 4.1)	0.7 (-1.7, 3.1)
Delaware	10.4 (6.0, 14.7)	9.9 (5.8, 14.1)	-0.4 (-6.5, 5.6)	0.1 (-5.5, 5.6)
District of Columbia	5.1 (2.4, 7.8)	6.4 (3.3, 9.5)	1.3 (-2.8, 5.4)	0.1 (-3.8, 4.0)
Florida	19.4 (18.2, 20.5)	21.0 (19.8, 22.2)	1.6 (-0.1, 3.3)	1.1 (-0.4, 2.7)
Georgia	19.1 (17.6, 20.7)	20.2 (18.6, 21.8)	1.1 (-1.1, 3.3)	0.9 (-1.1, 2.9)
Hawaii	4.4 (1.5, 7.4)	8.1 (4.6, 11.7)	3.7 (-0.9, 8.3)	3.5 (-1.1, 8.1)
Illinois	9.6 (8.3, 10.8)	11.0 (9.8, 12.3)	1.5 (-0.3, 3.3)	2.0* (0.3, 3.7)
Indiana	10.8 (9.3, 12.4)	12.3 (10.6, 14.1)	1.5 (-0.8, 3.8)	1.4 (-0.8, 3.6)
Iowa	4.6 (3.2, 6.0)	8.7 (6.9, 10.6)	4.1** (1.8, 6.5)	3.4** (1.2, 5.6)
Kansas	14.9 (12.4, 17.5)	16.3 (13.6, 19.0)	1.3 (-2.4, 5.1)	0.7 (-2.7, 4.1)
Kentucky	9.4 (7.7, 11.2)	9.4 (7.6, 11.2)	-0.1 (-2.5, 2.4)	0.7 (-1.7, 3.2)
Louisiana	15.3 (13.2, 17.5)	15.5 (13.4, 17.5)	0.1 (-2.9, 3.1)	0.1 (-2.8, 3.0)
Maine	12.7 (9.3, 16.0)	13.2 (9.9, 16.5)	0.6 (-4.1, 5.3)	-1.2 (-5.7, 3.3)
Maryland	9.2 (7.7, 10.6)	9.4 (8.0, 10.9)	0.3 (-1.8, 2.3)	-1.3 (-3.2, 0.6)

	% UNINSURED BY YEAR, UNADJUSTED		UNADJUSTED DIFFERENCE: FULL YEAR 2017 – 2016	ADJUSTED DIFFERENCE: FULL YEAR 2017 – 2016
	2016	2017		
Massachusetts	4.0 (3.1, 4.9)	4.6 (3.6, 5.5)	0.6 (-0.7, 1.9)	0.4 (-0.9, 1.7)
Michigan	8.2 (7.0, 9.4)	9.0 (7.9, 10.2)	0.8 (-0.8, 2.5)	1.1 (-0.5, 2.7)
Minnesota	7.0 (5.6, 8.4)	7.8 (6.4, 9.2)	0.8 (-1.2, 2.8)	0.4 (-1.5, 2.2)
Mississippi	20.9 (17.8, 24.0)	23.8 (20.4, 27.3)	2.9 (-1.7, 7.5)	1.8 (-2.4, 6.1)
Missouri	13.3 (11.6, 15.0)	15.4 (13.6, 17.2)	2.1 (-0.4, 4.6)	1.6 (-0.7, 3.9)
Montana	14.1 (10.8, 17.3)	13.0 (9.9, 16.1)	-1.1 (-5.6, 3.4)	-1.2 (-5.6, 3.2)
Nebraska	13.7 (11.2, 16.1)	17.0 (13.9, 20.0)	3.3 (-0.6, 7.2)	3.3 (-0.2, 6.8)
Nevada	13.6 (10.9, 16.3)	14.1 (11.2, 16.1)	0.5 (-3.5, 4.5)	0.1 (-3.7, 3.9)
New Hampshire	9.4 (6.0, 12.8)	10.5 (6.9, 14.1)	1.1 (-3.8, 6.0)	-0.6 (-5.4, 4.2)
New Jersey	11.5 (10.2, 12.9)	12.1 (10.6, 13.5)	0.6 (-1.4, 2.6)	0.7 (-1.1, 2.5)
New Mexico	11.5 (8.9, 14.0)	15.5 (12.5, 18.4)	4.0* (0.1, 7.9)	4.0* (0.1, 7.9)
New York	8.7 (7.9, 9.5)	9.9 (9.1, 10.7)	1.2* (0.1, 2.3)	0.8 (-0.3, 1.8)
North Carolina	17.1 (15.7, 18.6)	18.4 (16.8, 19.9)	1.2 (-0.9, 3.4)	1.7 (-0.3, 3.6)
North Dakota	7.9 (4.6, 11.3)	11.2 (6.8, 15.7)	3.3 (-2.2, 8.9)	4.7 (-0.6, 10.1)
Ohio	9.0 (8.0, 10.1)	9.4 (8.2, 10.5)	0.3 (-1.2, 1.9)	0.4 (-1.1, 1.9)
Oklahoma	20.0 (17.8, 22.3)	21.7 (19.3, 24.2)	1.7 (-1.7, 5.1)	1.2 (-1.9, 4.4)
Oregon	11.6 (9.8, 13.4)	10.3 (8.6, 12.0)	-1.3 (-3.8, 1.2)	-1.7 (-4.1, 0.7)
Pennsylvania	8.1 (7.2, 9.0)	9.0 (8.0, 10.1)	0.9 (-0.4, 2.3)	0.2 (-1.1, 1.6)
Rhode Island	8.1 (4.6, 11.5)	8.7 (5.2, 12.2)	0.6 (-4.3, 5.5)	0.0 (-4.6, 4.6)
South Carolina	16.2 (14.0, 18.4)	19.2 (16.9, 21.5)	3.0 (-0.2, 6.1)	2.5 (-0.4, 7.3)
South Dakota	12.4 (8.1, 16.7)	14.1 (9.3, 18.9)	1.7 (-4.7, 8.2)	1.6 (-4.0, 7.3)
Tennessee	15.1 (13.4, 16.7)	15.3 (13.6, 17.0)	0.3 (-2.2, 2.7)	-0.2 (-2.4, 2.0)

	% UNINSURED BY YEAR, UNADJUSTED		UNADJUSTED DIFFERENCE: FULL YEAR 2017 – 2016	ADJUSTED DIFFERENCE: FULL YEAR 2017 – 2016
	2016	2017		
Texas	24.5 (23.4, 25.6)	26.6 (25.5, 27.7)	2.1** (0.6, 3.7)	1.9** (0.6, 3.3)
Utah	11.6 (9.5, 13.7)	14.2 (12.0, 16.4)	2.6 (-0.4, 5.6)	1.8 (-0.9, 4.6)
Vermont	7.0 (3.7, 10.2)	7.9 (4.1, 11.7)	0.9 (-4.1, 5.9)	1.2 (-3.7, 6.0)
Virginia	12.0 (10.6, 13.4)	13.3 (11.8, 14.8)	1.3 (-0.7, 3.4)	0.0 (-1.9, 1.8)
Washington	8.8 (7.5, 10.0)	10.8 (9.4, 12.2)	2.1* (0.2, 3.9)	1.4 (-0.4, 3.1)
West Virginia	6.9 (4.7, 9.2)	12.1 (8.7, 15.4)	5.1* (1.1, 9.1)	4.6* (0.6, 8.5)
Wisconsin	7.8 (6.3, 9.2)	10.2 (8.5, 12.0)	2.4* (0.2, 4.7)	1.4 (-0.8, 3.6)
Wyoming	15.6 (11.1, 20.1)	19.5 (13.9, 25.1)	3.9 (-3.3, 11.1)	2.9 (-3.5, 9.3)

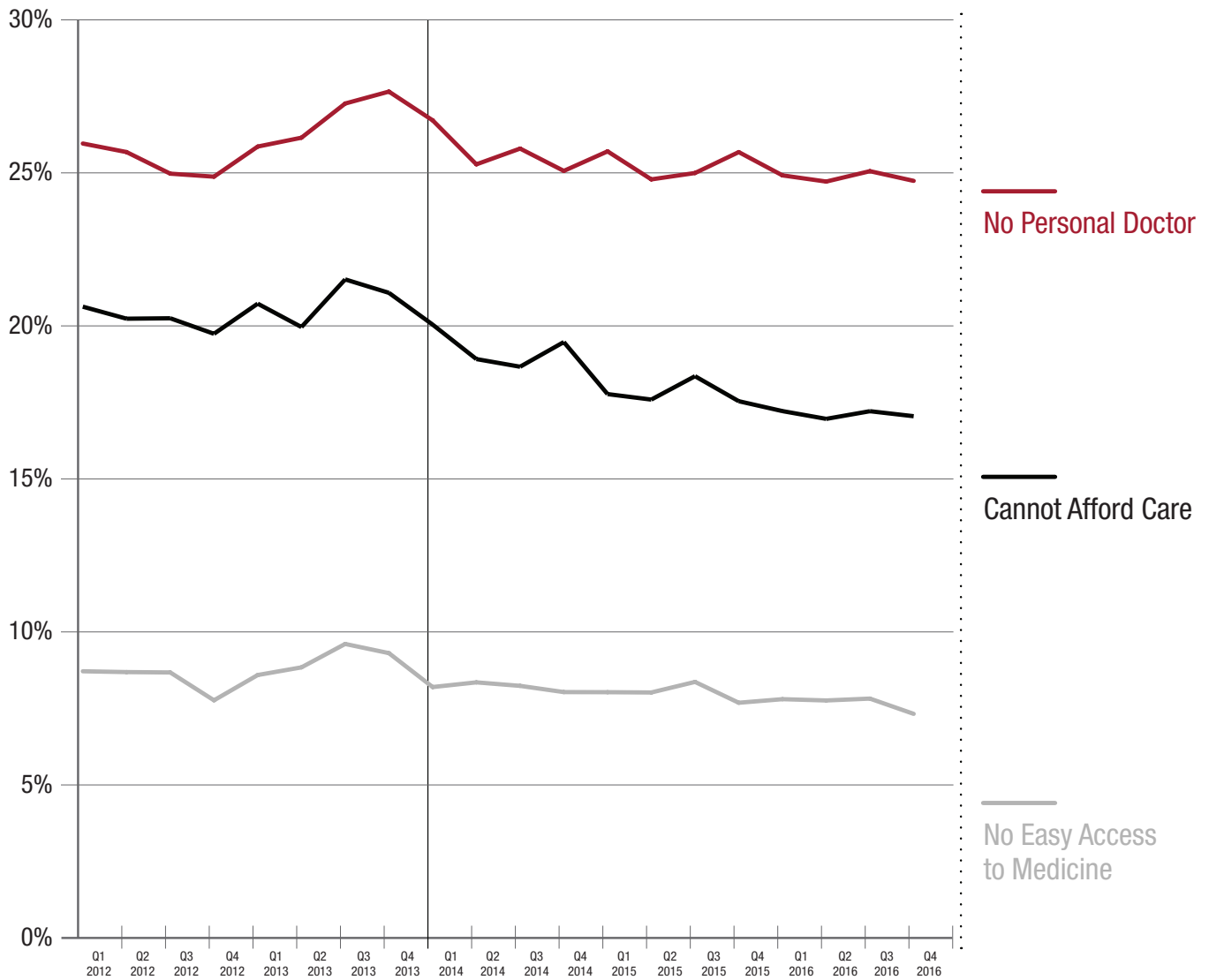
NOTES: Sample size N= 821,748. Means report unadjusted survey-weighted means for the specified year. All survey weights are state specific weights. Adjusted models controlled for age, sex, race/ethnicity, marital status, education, income, employment status, rural vs. urban, and yearly fixed effects. All estimates are in percentage-point terms.

**p<0.01, *p<0.05. 95 percent Confidence Intervals in parentheses.

Figure 1: Changes in Health Insurance Coverage Among Non-Elderly Adults, 2012-2017

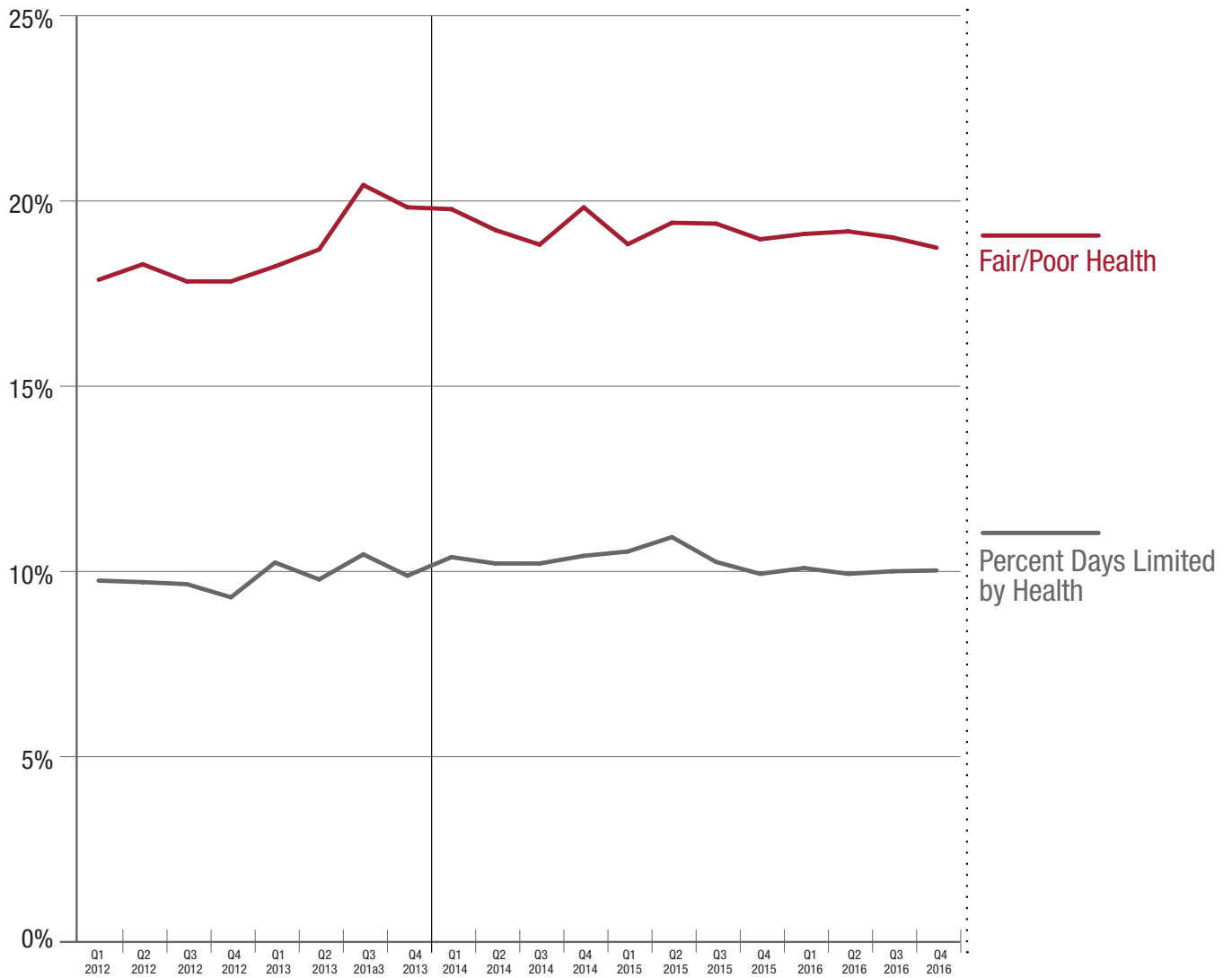
NOTES: Unadjusted means for the percentage of U.S. adults ages 18-64 without health insurance, in the Gallup-Sharecare Well-Being Index, from January 2012 to December 2016. Solid black line represents beginning of the Affordable Care Act's major Medicaid expansion and subsidized marketplace coverage under President Barack Obama in January 2014. Dashed black line represents inauguration of President Donald Trump in January 2017.

Figure 2: Changes in Access to Care Among Non-Elderly Adults, 2012-2016

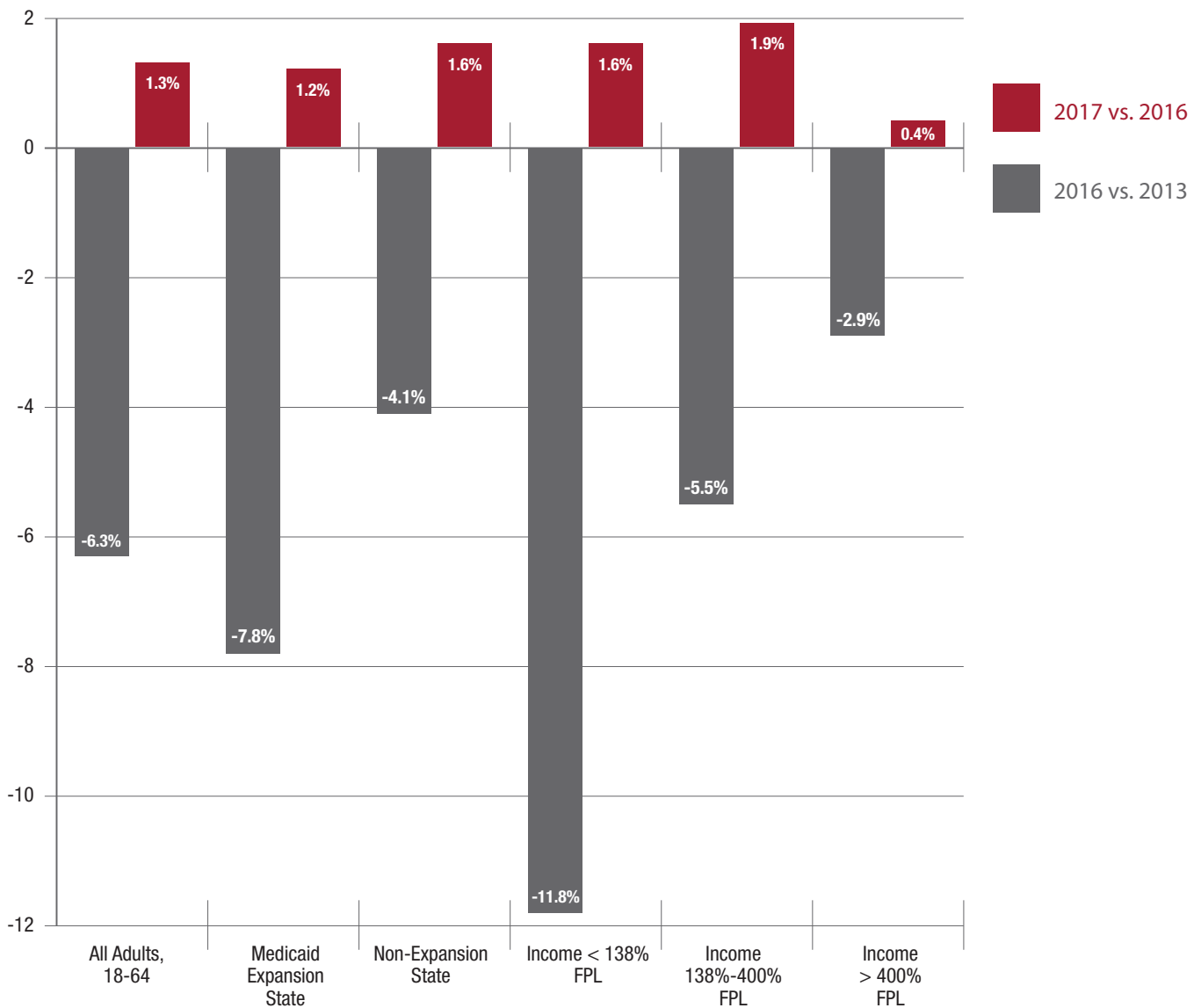


NOTES: Unadjusted means for each outcome among U.S. adults ages 18-64, in the Gallup-Sharecare Well-Being Index, from January 2012 to December 2016. Solid black line represents beginning of the Affordable Care Act's major Medicaid expansion and subsidized marketplace coverage under President Barack Obama in January 2014. Dashed black line represents inauguration of President Donald Trump in January 2017. Due to changes in the survey instrument, estimates for 2017 are not available for access to care or self-reported health.

Figure 3: Changes in Access to Care Among Non-Elderly Adults, 2012-2016



NOTES: Unadjusted means for each outcome among U.S. adults ages 18-64, in the Gallup-Sharecare Well-Being Index, from January 2012 to December 2016. Solid black line represents beginning of the Affordable Care Act’s major Medicaid expansion and subsidized marketplace coverage under President Barack Obama in January 2014. Dashed black line represents inauguration of President Donald Trump in January 2017. Due to changes in the survey instrument, estimates for 2017 are not available for access to care or self-reported health.

Figure 4: Adjusted Changes in the Uninsured Rate Under the ACA, 2013-2016 vs. 2016-2017

NOTES: Sample size N= 821,748. Blue bars compare adjusted estimates for Q4 2016 vs. Q4 2013, and red bars compare adjusted estimates for Q4 2017 vs. Q4 2016. All estimates controlled for age, sex, race/ethnicity, marital status, education, income, employment status, rural vs. urban, quarterly fixed effects, and state fixed effects. All estimates are in percentage-point terms. FPL = "Federal Poverty Level." See Table 3 for confidence intervals and p-values.

Appendix

Regression Equations:

Primary Model – Quarterly Fixed Effects

$$Uninsured_{ist} = \beta_0 + \beta_t Q_t + \beta_x X_i + \Omega State_s + \varepsilon_{ist} \quad \text{Equation (1)}$$

where i indexed person, s state, and t date. X_i was a vector of sociodemographic variables (age, self-reported race/ethnicity, urban vs. rural residence[†], marital status, sex, educational attainment, income, and employment status (employed full-time, employed part-time [split into looking or not looking for full time work], unemployed, or not in workforce). Ω was a vector of state fixed effects. Q was a vector of quarterly fixed effects from 2012 to 2017. The coefficients of interest in vector β_t captured the quarterly change in the uninsured rate, compared to the omitted reference period of Q4 2013. All models were survey-weighted linear regressions. Tables 2 and 3 report the coefficients in β_t for Q4 2014, Q4 2015, Q4 2016, and Q4 2017 (all compared to Q4 2013); other quarterly estimates are available from the authors. We then conducted a post-estimation test (using the command *lincom* in Stata 14.0) comparing Q4 2016 to Q4 2017.

Survey weights in the WBI are based on benchmarks from federal surveys for: age, sex, region, gender, education, race/ethnicity, population density, and cell-phone vs. landline use. Observations without insurance information (0.2%) were excluded from the sample.

Interrupted Time Series Model (Spline Model)

$$Uninsured_{ist} = \beta_0 + \beta_1 TimeTrend_t + \beta_2 ObamaPostACA_TimeTrend_t + \beta_3 TrumpPostACA_TimeTrend_t + \beta_x X_i + \Omega State_s + \varepsilon_{ist} \quad \text{Equation (2)}$$

All terms are defined the same as in Equation 1, with the replacement of quarterly fixed effects with three linear time trend variables. *TimeTrend* was a linear variable measuring the number of months since the beginning of the study period (January 2012).

ObamaPostACA_TimeTrend measured the number of months since the beginning of the ACA's major coverage expansion (January 2014). *TrumpPostACA_TimeTrend* measured the number of months since the beginning of the Trump Presidency (January 2017). Thus, the latter two terms measure the changes in slope as of January 2014 and January 2017, respectively, compared to the preceding time trend.

NOTE: For additional details on the dataset, income imputation, and sensitivity analyses, please see the *Supplementary Appendix published with the research letter in the New England Journal of Medicine 2018*.

[†] Rural residence was defined based on living in a zip code classified as “rural” by the Federal Office of Rural Health Policy in the U.S. Department of Health and Human Services.

Survey Questions for Study Outcomes:

A) Do you have health insurance coverage?

Yes

No

B) Do you have a personal doctor?

Yes

No

C) In the city or area where you live, is it easy or not easy to get medicine?

Easy

Not Easy

D) Have there been times in the past twelve months when you did not have enough money to pay for health care and/or medicines that you or your family needed?

Yes

No

E) Would you say your own health, in general, is _____?

Excellent

Very Good

Good

Fair

Poor

F) During the past 30 days, for about how many days did poor health keep you from doing your usual activities?

0-30 days, open-ended response (*converted to percentage by dividing by 30*)

Appendix Table 1: Changing Trends in Coverage, Access to Care, and Self-Reported Health, 2012-2017 (Spline Model)

OUTCOME	LINEAR TRENDS (CHANGE PER MONTH)		
	PRE-ACA (2012-2013)	ACA: OBAMA ADMINISTRATION (2014-2016)	ACA: TRUMP ADMINISTRATION (2017)
Uninsured	-0.10**	-0.05**	0.48**
No Personal Doctor	0.03**	-0.06**	N/A
No Easy Access to Medicine	0.02**	-0.03**	N/A
Cannot Afford Care	0.00	-0.04**	N/A
Fair/Poor Health	0.08**	-0.05**	N/A
Percentage of Days Limited by Poor Health	0.04**	-0.02*	N/A

NOTES: Sample size N= 821,748, minus item non-response for each item. Models controlled for age, sex, race/ethnicity, marital status, education, income, employment status, rural vs. urban, and state fixed effects.

N/A = not available for 2017 due to changes in the Gallup survey instrument.

All adjusted estimates are in terms of percentage points per month.

**p<0.01, *p<0.05.