

THE MEDICAID EXPANSION AND ATTITUDES TOWARD THE AFFORDABLE CARE ACT TESTING FOR A POLICY FEEDBACK ON MASS OPINION

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Abstract Enacted in 2010, the Affordable Care Act (ACA) has reshaped US health policy. Yet overall opinions on the law remained relatively stable during the few years before and after enactment. In a polarized era, can the implementation of a complex program such as the ACA influence public opinion through a policy feedback? Research on policy feedbacks and self-interest provide competing expectations. To address that question, we consider the impact of the Medicaid expansion that took place in select states. Using differences-in-differences estimation and 2010–2017 surveys of more than 51,000 non-elderly American adults, we show that the Medicaid expansion made low-income Americans on average 4.4 percentage points more favorable toward the ACA ($SD = 1.7$) relative to those in non-expansion states. Given that no such effect emerged for high-income respondents, these results are consistent with an impact via self-interest and with a policy feedback on public opinion.

Since its 2010 enactment, the Affordable Care Act (ACA) has redefined American health policy. Among its impacts, the law has substantially reduced the number of Americans without health insurance. Several of the law's major provisions were implemented in January 2014, markedly increasing

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the number of Americans who had concrete experiences with it. For the first time, Americans could purchase health insurance through new marketplaces, and the number of citizens eligible for Medicaid increased in many states. Yet these policy changes did not seem to induce any major shifts in overall public opinion. In February 2013, 42 percent of Americans had unfavorable views of the ACA, while in June 2016, the figure was a similar 44 percent (Kaiser Family Foundation 2018).

The puzzle of stability in aggregate public opinion amid a transformation in the provision of health insurance encourages us to study the impact of the ACA's implementation on health policy attitudes. Did Americans' experiences with the ACA influence their evaluations of it in the first few years after enactment? This article addresses that question by studying the Medicaid expansion (see also Sances and Clinton 2018; Pacheco and Maltby 2017). Medicaid is a means-tested program that provides health insurance to qualifying, low-income individuals. As enacted, the ACA mandated that states increase Medicaid eligibility to 138 percent of the federal poverty line and cover childless adults. The 2012 Supreme Court ruling in *National Federation of Independent Businesses v. Sebelius*, however, allowed states to opt out of the expansion. In doing so, it also provided the leverage we exploit here, enabling us to compare similar individuals in states that did or did not expand Medicaid before and after the expansion took place.

Research on public policy and political attitudes leads to conflicting expectations about the Medicaid expansion's impact on public opinion. Some research on policy feedbacks provides reason to expect that the Medicaid expansion would reshape public opinion. Research on programs such as Social Security and the GI Bill indicates that they can have far-reaching effects on political attitudes and behavior, sometimes creating constituencies that can sustain them politically (Campbell 2003; Mettler 2005). Relatedly, prior studies indicate that although self-interest is rarely a central driver of political attitudes, it is most likely to matter in cases where the stakes are high and interests are clearly defined (Sears and Funk 1991; see also Brunner, Ross, and Washington 2011; Margalit 2013; Weeden and Kurzban 2017). In keeping with this scholarship, personal experiences with the ACA—both positive and negative—correlate with Americans' ACA attitudes (McCabe 2015; see also Lerman and McCabe 2017). In a panel, respondents were more likely to see the law as affecting health care access in 2014 than in prior years (Jacobs and Mettler 2016). Similarly, counties in states that expanded Medicaid saw increases in voter turnout in 2014 relative to comparable counties elsewhere (Clinton and Sances 2017; Haselswerdt 2017). Medicaid is a substantial benefit, with an average amount spent per enrollee of \$5,736 in 2014 (Kaiser Family Foundation 2018). Thus the ACA, and the Medicaid expansion in particular, may well have reconfigured Americans' political attitudes and behavior.

Yet, prior research also provides evidence that policy feedbacks on mass opinion are contingent on various factors including the policy's design and

implementation as well as any associated stigmas (Soss and Schram 2007; Mettler 2011; Morgan and Campbell 2011; Campbell 2012). Programs such as cash assistance have design features that can demobilize those who participate, in part by subjecting individuals to the whims of street-level bureaucrats (Soss 1999; Weaver and Lerman 2010; Campbell 2012). As a complex, means-tested program whose recipients are required to verify their income periodically, Medicaid may have similar effects (Campbell 2014; Michener 2018). In many cases, Medicaid is provided through non-governmental actors, a fact that may dampen its visibility as a government program (Mettler 2011; Tallevi 2018).

Moreover, some of the archetypal examples of policy feedbacks come from policies enacted in earlier eras, when partisanship was less influential in anchoring public attitudes (Levendusky 2009). The ACA has been the subject of intense partisan debate since 2009, so it is unsurprising that Americans' attitudes toward the law are rooted in their partisanship (Kriner and Reeves 2014; Fowler et al. 2017; Lerman, Sadin, and Trachtman 2017). Given the strength of their preexisting attitudes, it is possible that citizens increasingly disregard information that undercuts those attitudes (Druckman, Peterson, and Slothuus 2013; Lodge and Taber 2013; Hopkins 2018), limiting the impact of new information acquired through the law's implementation. In addition, research on policy feedbacks has more consistently uncovered evidence of feedbacks on political participation than political attitudes, both generally (Soss and Schram 2007; Morgan and Campbell 2011; Campbell 2012) and for the Medicaid expansion specifically (Clinton and Sances 2017; Haselswerdt 2017). Given these competing predictions about the impact of the Medicaid expansion, it provides a valuable test case for the impact of policy feedbacks on public opinion.

Methods and Results

To analyze the Medicaid expansion's impact, we use the rolling cross-sectional telephone surveys conducted by the Kaiser Family Foundation (KFF). The full data set includes 101,586 respondents interviewed in 73 surveys between January 2010 and April 2017. The average response rate across these surveys was 13.46 percent, with a low of 5.5 percent in March 2017 and a high of 25 percent in January 2010.¹ KFF's surveys began asking respondents about their favorability toward the ACA in January 2010, making it a productive starting point.² We focus on 51,471 respondents who are under 65 and fully observed, as older respondents are primarily covered via Medicare and unlikely to be

1. Please see Online Appendix Table 1 for a list of monthly response rates for cell phone and landline calls, Roper Center survey identification numbers, and field dates.

2. The survey data are available through the Roper Center. R code to analyze the data is available at <https://dataverse.harvard.edu/dataverse/DJHopkins>.

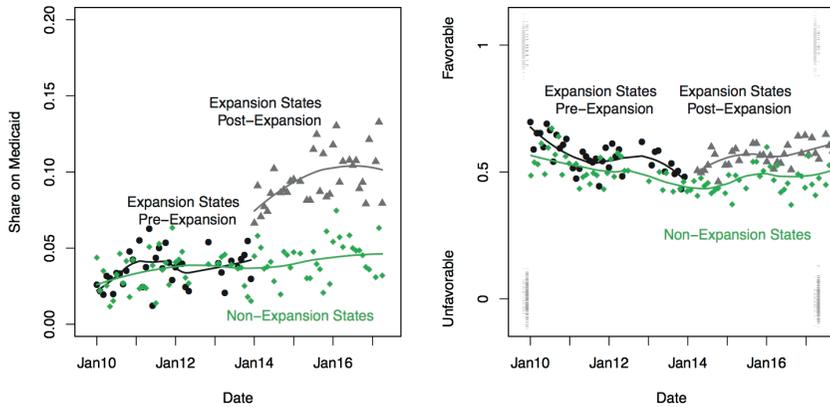


Figure 1. Medicaid receipt and ACA favorability. At left, this figure illustrates the share of respondents on Medicaid for expansion and non-expansion states. At right, it shows the share of respondents under 65 with incomes below \$40,000 reporting favorable ACA attitudes. The light gray hash marks indicate the distribution of responses among Democrats before (left) and after (right) January 2014; the dark gray hash marks show Republicans' opinions.

affected by the Medicaid expansion (Medicaid does make substantial payments for seniors' nursing home care, but our goal is to outline the effects of the expansion of primary insurance coverage). We separate respondents living in one of 31 expansion states plus the District of Columbia, which participated in the expansion, from those in 19 non-expansion states.

As shown in [figure 1](#) (left panel), the Medicaid expansion had a notable impact on Medicaid receipt in the expansion states, with the share of respondents on Medicaid increasing by 5.8 percentage points. Yet even in the expansion states after the expansion occurred, 9.8 percent of all respondents under 65 report receiving Medicaid, meaning that only a fraction of the respondents are likely to have recent personal experiences with Medicaid. As we would expect for a means-tested program, the respondents who report being insured through Medicaid are overwhelmingly low-income. The median respondent on Medicaid reports an income of less than \$20,000.³

But did the Medicaid expansion also shape attitudes toward the ACA? To the extent that the expansion influences attitudes through self-interest narrowly construed, the effects of the Medicaid expansion are likely to be more

3. We measure Medicaid receipt via a self-reported question about respondents' primary source of health insurance, making it valuable to assess this measure's validity (see especially [Tallevi 2018](#)). As [Online Appendix Table 3](#) demonstrates, despite the difficulty of measuring income in telephone surveys ([Davern et al. 2005](#)), the respondents receiving Medicaid are concentrated in the lower end of the income distribution. Of our non-elderly respondents, 5.5 percent report being on Medicaid. However, 87 percent of those who do report being on Medicaid report incomes less than \$40,000.

pronounced among people with lower incomes. Accordingly, we estimate our models below for the full population of non-elderly survey respondents as well as for the subsets of respondents who make more or less than \$40,000. Given that the current income cap for Medicaid eligibility is \$37,825 for a family of five in states that opted for the expansion, with a ceiling at 138 percent of the federal poverty line ([Federal Register 2012](#)), a \$40,000 cutoff is substantively appropriate.⁴

To provide an initial assessment, the right panel of [figure 1](#) illustrates a dichotomized measure of ACA favorability among respondents making less than \$40,000 in three types of states: those that expanded Medicaid after the survey; those that expanded Medicaid before the survey; and those that did not expand Medicaid during this time period. The survey question asks: “As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it? Is that a very favorable/unfavorable or somewhat favorable/unfavorable opinion?” (For more on the impact of question wording on reported ACA attitudes, see [Grande, Gollust, and Asch 2011](#) and [Holl, Niederdeppe, and Schuldt 2017](#)). The figure uses smoothing lines to highlight the trends. On the sides, it illustrates the distribution of favorability before and after implementation by using gray lines indicating the number of low-income Republicans and Democrats who were somewhat or very unfavorable (0) compared to those who were somewhat or very favorable (1) toward the ACA. The light gray lines at left show the distribution among randomly selected Democrats before January 2014, while the dark gray lines show randomly selected Republicans. At right, we see the comparable distributions after January 2014.

Respondents’ attitudes in the two groups of states trend in the same direction before the expansion, providing initial evidence of the “parallel trends” assumption that underpins subsequent analyses. To be sure, there are differences across states: Respondents in states that participated in the Medicaid expansion were slightly more favorable toward the ACA even in the pre-expansion period. But that difference appears to grow in the post-expansion period, as residents begin to experience the Medicaid expansion. Before January 2014, the difference in means was 7.6 percentage points; after January 2014, it grew to 9.3 percentage points (both significant, $p < 0.001$). Notably, after January 2014, attitudes grew slightly more favorable, by 2.3 percentage points ($p = 0.001$), even in the non-expansion states (see also [Sances and Clinton 2018](#)).

To isolate the effect of the Medicaid expansion, we employ “differences-in-differences” estimation ([Bertrand, Duflo, and Mullainathan 2004](#)), a statistical

4. One in 20 (5.4 percent) respondents under 65 reporting that their total family income is between \$30,000 and \$40,000 also report receiving Medicaid, while only 2.9 percent of respondents in the \$40,000 to \$50,000 bracket report receiving Medicaid.

approach that compares the differences across two different groups, one of which experienced a treatment at a certain point in time. This method adjusts for time trends evident in the control group—and so requires the assumption that absent the treatment, the treatment group’s trajectory would have followed the control group’s. This estimation strategy accounts for any fixed differences in ACA favorability between states that did and did not expand Medicaid, as well as any over-time shifts in attitudes that are common across states. Practically, we specify OLS models that isolate the differential change in ACA attitudes among respondents in states that expanded their Medicaid program after the expansion took place.⁵

To estimate the effect of a state’s Medicaid expansion on ACA favorability while accounting for individual-level differences, we include a variety of covariates: education, income, gender, age, race, Hispanic ethnicity, and political identification as Republicans or Independents.⁶ Online [Appendix Table 2](#) provides basic descriptive statistics. We also include fixed effects for each survey (by including 72 indicator variables) as well as the respondents’ states (using 49 indicator variables).⁷ These fixed effects rule out the possibility that any differences are due to time-invariant differences across states or to period effects common to all respondents.

We report the fitted OLS models of the four-category favorability measure for all respondents, low-income respondents, and high-income respondents in [table 1](#). In each case, the key estimate is the interaction between living in an expansion state and being in the post-expansion period. To benchmark effect sizes, note that the dependent variable in these analyses has a range of 3 and a standard deviation of 1.17. The estimated effects are substantively small and indistinguishable from zero for both the full set of respondents (left column; 0.027, SE = 0.018, $p = 0.13$) and the high-income respondents (right column; -0.009 , SE = 0.022, $p = 0.68$), indicating no discernible effect of the expansion. For low-income respondents, however, the effect is 0.098 (SE = 0.031, $p = 0.002$), meaning that those in expansion states averaged 0.098 higher after the expansion took place.⁸ The effect for low-income respondents is meaningful but modest, as it is equivalent to moving 3 percent of the distance from “very unfavorable” (1) to “very favorable” (4).

5. When a state expanded Medicaid after the bulk of states did on January 1, 2014, we code that state as having expanded only for surveys after its state-specific expansion date.

6. Some KFF surveys used a single question about partisan identity that separates self-reported Democrats, Republicans, and Independents without a follow-up identifying closet partisans.

7. There are a total of 51 states (including Washington, DC), but we must exclude two states: one as a generic baseline and a second due to the inclusion of a separate indicator variable for states that expanded Medicaid at any time during this period.

8. When we use standard errors clustered at the state level, the standard error associated with the key interaction *drops* slightly, to 0.0307. This indicates a negative within-cluster correlation conditional on covariates, and makes our preferred specification without clustered standard errors a conservative choice.

Table 1. Predicting ACA favorability

	ACA favorability, all	ACA favorability, low-income	ACA favorability, high-income
Intercept	2.525* (.063)	2.704* (.110)	2.385* (.078)
Male	-0.042* (.009)	-0.007 (.015)	-0.048* (.011)
Republican	-1.422* (.012)	-1.058* (.022)	-1.582* (.014)
Independent	-0.807* (.010)	-0.560* (.017)	-0.958* (.013)
Age (in years)	-0.004* (.000)	-0.003* (.001)	-0.005* (.000)
Black	0.445* (.014)	0.393* (.012)	0.521* (.019)
Hispanic	0.295* (.014)	0.422* (.021)	0.113* (.020)
Asian American	0.291* (.027)	0.324* (.054)	0.265* (.031)
Other ethnic/racial id.	0.055* (.021)	0.025 (.029)	0.075* (.029)
Education	0.029* (.002)	0.014* (.003)	0.041* (.002)
Income	-0.018 (.014)	-0.535* (.146)	0.044* (.017)
Expansion state	-0.014 (.060)	0.013 (.097)	-0.064 (.077)
Post-expansion	-0.016 (.039)	-0.074 (.068)	0.008 (.046)
Expansion state x Post-expansion	0.027 (.018)	0.098* (.031)	-0.009 (.022)
R ²	0.314	0.225	0.372
N	51,471	18,061	33,410
State fixed effects	Y	Y	Y
Month fixed effects	Y	Y	Y

NOTE.—This table presents the results of OLS models predicting a 1–4 measure of ACA favorability among all respondents under 65 (left-hand column), lower-income respondents under 65 (center column), and higher-income respondents under 65 (right-hand column). Standard errors are in parentheses.

**p* < 0.05

Online [Appendix Table 4](#) reports the results of logistic regressions fit using the same covariates in a model in which the outcome has been dichotomized. The results are substantively quite similar, with a meaningful effect appearing

only for low-income respondents. For them, the difference-in-differences estimate indicates that after the expansion, those in Medicaid expansion states became 4.4 percentage points more favorable toward the ACA relative to those elsewhere, with a 95 percent confidence interval between 1.1 and 7.7 percentage points.

Our results prove highly robust to changes in model specification, reweighting observations to ensure demographic comparability, or defensible changes in estimation strategy, as detailed in Online [Appendix Tables 5](#) and [6](#). The Online Appendix also reports the results of two placebo tests, which are tests in which we know that the treatment effect is zero and so can calibrate our estimation strategy ([Sekhon 2009](#)). The first placebo test considers cross-sectional variation: In it, we randomly assign select states that did not expand Medicaid to a placebo group and estimate its effect on attitudes toward the ACA. In the second, we instead examine temporal variation by truncating the data to include only observations before January 2014 and then assessing whether the expansion states saw unexpected jumps in ACA support in January 2012 or January 2013. In all placebo tests, no spurious “effects” emerged (see Online [Appendix Table 7](#)), thereby enhancing our confidence in the core findings. Importantly, our results are also not highly sensitive to omitting particular states, as detailed in the Online Appendix.

What can these results tell us about the role of self-interest in ACA attitudes? Given the polarization of ACA attitudes ([Tesler 2012](#); [Kriner and Reeves 2014](#); [Fowler et al. 2017](#)), one might expect differential effects for groups that were favorably inclined toward the ACA from the outset (but see [Lerman and McCabe 2017](#)). Online [Appendix Table 10](#) shows evidence in that vein. While white, low-income respondents show little change in their ACA attitudes—the key coefficient is -0.008 ($SE = 0.050$)—non-white respondents with similarly low incomes show a sizeable shift (0.091 , $SE = 0.032$). The one-sided p -value testing whether the effect for non-whites is larger is 0.05 , indicating a borderline-significant difference. Similarly, the estimated effect for Democrats (0.176 , $SE = 0.049$) is more than twice as large as that for Republicans (0.075 , $SE = 0.066$). The difference between Democrats and Republicans falls short of statistical significance, however ($p = 0.11$, one-sided). Still, these results are consistent with an influence of self-interest filtered through the prism of partisanship and related group attachments.

To be sure, Americans have been inundated with messaging on the ACA from media outlets, politicians, governments, insurers, and other organizations seeking to enroll new customers ([Gollust et al. 2014](#); [Fowler et al. 2017](#); [Hopkins 2018](#))—and that messaging may well have differed in the expansion states. Some of the ACA-related messaging was likely to have targeted poorer communities where Medicaid recipients are concentrated ([Michener 2017](#)), potentially shaping the attitudes of residents who were ineligible for Medicaid as well. Put differently, there are multiple channels through which the Medicaid expansion may have influenced people in expansion states.

To examine those prospects, a final test estimated the effect of the Medicaid expansion for poor respondents *over* the age of 64. These respondents are likely to be subject to similar messaging and community influence, but by virtue of their age and Medicare eligibility, they are substantially less likely to have been personally affected by the expansion. As Online [Appendix Table 10](#) shows, for that population, the estimated effect of the expansion is quite close to zero (-0.008 , $SE = 0.050$). When we compare the effect for poor, non-elderly respondents and that for poor, elderly respondents, the effect for the non-elderly is significantly larger ($p = 0.04$, one-sided). This finding reinforces the prospect that these effects are driven by self-interest.

Conclusion

Research on policy feedbacks faces outstanding questions, including about the conditions that produce such feedback loops, the mechanisms through which policies shape political behavior, and the breadth of policies' effects ([Kumlin 2004](#)). There are also outstanding concerns about research design, as it is often difficult to differentiate the effects of a policy from the factors that lead people to participate in it ([Campbell 2012](#)). The research design employed herein allows us to differentiate the effects of the Medicaid expansion from self-selection into Medicaid.

In recent decades, Republican and Democratic identifiers have been increasingly likely to adopt political attitudes consistent with their parties' elites. Such sorting has the potential to disrupt the channels through which policies influence public opinion. Here, however, we have demonstrated that the Medicaid expansion undertaken by some states in the wake of the ACA had discernible effects on public opinion. It induced moderate, positive effects on ACA favorability among low-income Americans. Put differently, the Medicaid expansion induced larger effects among the fraction of Americans who were more likely to be Medicaid-eligible. The impacts of the Medicaid expansion are also more apparent among non-white and Democratic respondents than among other groups. There are a variety of mechanisms through which policies can shape political attitudes and behaviors, including the provision of resources, the designation of social groups, and increased or decreased political efficacy ([Campbell 2012](#)). The results here are in keeping with another, straightforward channel: Those in the targeted population develop more favorable opinions of the policy, possibly through self-interest ([Pierson 1994](#)).

The Medicaid expansion is one of the elements of the ACA for which self-interest is more clear-cut, making the study of the law's other key elements critical in understanding public attitudes toward the law overall. At the same time, this analysis underscores why the detection of policy feedbacks is difficult. It is rare that researchers have data as rich as the KFF surveys, and even here, our estimates have considerable uncertainty.

At the federal level, the Republican Party made numerous attempts to curtail the ACA between 2010 and 2017. Yet while efforts to repeal the law's individual mandate were successful in 2017, those to unwind its Medicaid expansion were not. This research provides one potential explanation why: Because the Medicaid expansion provided direct assistance to millions, it may have reshaped public opinion more decisively than the indirect individual mandate. It remains to future work to assess any policy feedbacks associated with the health care exchanges and subsidies established by the ACA.

Supplementary Data

Supplementary data are freely available at *Public Opinion Quarterly* online.

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