

Who Benefited from the ACA? Gains in Insurance Coverage by Political Partisanship*

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Abstract

Did the effects of the Affordable Care Act benefit some partisans more than others? Answering this question is important for understanding the ACA's potential to create a constituency invested in its support, and for understanding the vast partisan differences in subjective attitudes toward the law. Using geographical and temporal variation created by the implementation of the ACA combined with county- and individual-level data, we consistently reject the hypothesis that Democratic voters saw bigger gains in insurance coverage as a result of the ACA. Instead, increases in insurance coverage appear to have been made similarly across the political spectrum. The stark contrast between these objectively neutral impacts and the vast differences in subjective opinions suggests that resources alone are insufficient for generating policy feedback effects.

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Public policies often have impacts beyond the proximate problem they are intended to address: while also giving program participants new benefits, these benefits and their distribution can also shape mass opinions and voting behavior. Thus, the extent to which the effects of public policies impact politically relevant behaviors – whether “new policies can create new politics” – is important for judging a policy’s prospects for survival (Schattschneider 1935; Pierson 1993; Soss 1999; Mettler 2005; Soss and Schram 2007; Patashnik 2008; Weaver and Lerman 2010; Campbell 2003; 2012). For these politically relevant effects to occur, however, policies must presumably first have a policy impact, and this impact must be distributed in a politically optimal way.

In general, the extent to which policy feedback can occur depends not only on the existence of the effect itself, but also on the ability of those experiencing the effect to recognize and appreciate the relationship between the effect and its cause. Objective impacts may not be enough, as personal experiences with and interpretations of a program may influence the ability of recipients to assign credit or blame. Even so, it is something of an open empirical question whether policy feedback effects do, in fact, correspond to actual policy effects. If they did, then we would expect new government programs to mobilize new constituents with relative ease. If they did not, this would raise important questions about the conditions under which policy feedback effects are possible, and the extent to which feedback effects are contingent on other factors, such as elite rhetoric and individual partisanship.

We explore the extent to which objective policy changes are related to feedback effects using the most consequential, and controversial, policy enacted in recent years – the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA was the signature policy of Democratic President Barack Obama, and the policy upon which the Democrats in control of the House and Senate exerted all of their political capital to enact into law without the vote of a single Republican in Congress. The ACA had wide-ranging impacts on nearly every aspect of the health care infrastructure in the United States, and its impacts have been widely documented. Most importantly, about 20 million Americans gained health insurance as a direct result of the ACA (Sommers and Epstein 2017). Rather than looking directly at the relationship between policy impact and political

changes, as others have done (Haselswerdt 2016; McCabe 2016; Clinton and Sances 2017; Hopkins and Hobbs 2017; Sances and Clinton 2018), we focus on characterizing what is arguably the first order-question of whether these insurance effects varied along partisan lines. In particular, we ask if Democrats, Republicans, or independents saw higher or lower gains in insurance as a result of the law.

Examining the partisan distribution of impacts is important for at least three reasons. First, from the point of view of a policy designer who also cares about influencing future politics, it is likely optimal to create a bipartisan coalition of recipients who will work as a check on elected officials – in this case Republicans – who might otherwise be intent on repealing the policy. Second, the stability and partisan tint of ACA opinions is well-known, with Republicans and Democrats differing in their ACA approval ratings by about 60 points. Establishing whether objective benefits were, in fact, also maldistributed across the parties could potentially explain this gap, while a finding of a more uniform distribution would point to the importance of non-policy factors in shaping these opinions. Third, recent work points to a potentially unequal distribution of gains due to partisan differences in the uptake of marketplace insurance, a result that suggests program participation itself as a type of political behavior (Lerman, Sadin, and Trachtman 2017). Using a more wide-ranging analysis from multiple vantage points, our paper helps to assess whether differential partisan uptake might extend to the ACA broadly construed, and if the differential uptake of private insurance impacts the overall gains in health insurance coverage among partisans.

We approach this question using what we believe is the most comprehensive data on gains in insurance by voter partisanship. We begin with an analysis of the geographic distribution of health insurance gains. At the county level, we combine administrative data on health insurance gains with election results, finding little evidence that Democratic-leaning areas saw larger gains in insurance. Indeed, the only time we observe a positive relationship between gains in insurance and Democratic vote share is when we fail to adjust for state-level factors, such as the expansion of Medicaid. Otherwise, the relationship between gains in insurance and Democratic vote is actually negative, though at no point in this analysis are the differential gains between partisan areas

statistically significant. Probing the relationship further using a geographic discontinuity design – which both allows us to focus on the Medicaid expansions and to rule out omitted confounders – we again find roughly equal impacts.

Moving beyond the ecological relationships, we next analyze individual-level data. Using a panel survey conducted between 2012 and 2014, we find that political independents appear to have seen the largest gains in insurance, followed by Democrats. Again, we find the Medicaid expansion appears to matter critically for these effects in interesting ways. In states choosing to expand Medicaid, independents and Republicans appear to see the biggest gains, while in non-expansion states, it is Democrats and independents. Again, however, we are never able to reject the null hypothesis that these differences arise due to chance. Because these null effects may be partly driven by small samples, we then turn to a time-series analysis of the Kaiser Family Foundation’s monthly tracking polls. These data give largely the same result: we are able to detect some small differences in gains across partisan subgroups, differences that vary in interesting ways by expansion status, but we generally can not reject the null of equally distributed gains.

In sum, we find the health insurance gains created by the ACA were distributed roughly evenly across partisans. In particular, we never reject the null that Democratic-leaning areas or Democratic voters saw larger gains in insurance than Republican areas or voters. We also find that some of the apparently larger gains by Democrats is a result of failing to take into account state Medicaid expansion status. In general, any apparent differences between partisans are reduced in states that expanded Medicaid. These results suggest that the ACA does seem well-poised, at least in terms of policy impact, to create a broad-based constituency. Yet they also suggest that stark partisan differences in opinions toward the law are largely disconnected from these policy impacts, and that partisan differences in uptake of marketplace insurance were not enough to give the overall ACA a partisan skew.

Our findings are consequential for several reasons. The fact that Democrats and Republicans are equally impacted by the ability to get health insurance under the ACA suggests, but certainly does not prove, that the continuing partisan-gap in opinions towards the ACA are largely inde-

pendent of the actual policy consequences. At the same time, it is possible that this broad-based impact made it more difficult for Republicans to fulfill their promise to “repeal and replace” the ACA – while Republican voters may say on surveys that they disapprove of the law, they may stop short of supporting repeal.

1 The Policy Effects of the ACA

A growing body of literature examines how the ACA has impacted both the health care infrastructure of the United States, and the well-being of its’ citizens in terms of health and finances (see, for example, the exhaustive summary of Antonisse et al. 2017 pertaining to the consequences of Medicaid expansion). In addition to gains in insurance, scholars have also examined how the ACA has impacted such diverse outcomes as: employer-sponsored health plans (Abraham and Royalty 2017), the creditworthiness of low-income Americans (Allen and Gross 2017), the financial well-being of low-income families (Miller, Kaestner, and Mazumder, 2017; Nikpay, Levy and Buchmueller 2017), labor market outcomes (Shore-Sheppard, Schmidt, and Watson 2017), and even criminal recidivism (Bird and McConville, 2017). Still others have looked at the political consequences of these policy effects on political participation (see, for example, Haselswerdt 2017; Clinton and Sances 2017) and public support for the ACA (see, for example, Pacheco 2017; Hopkins and Parish 2017, Hopkins and Hobbs 2017; Lerman and McCabe 2017).

We pivot from the focus in such prior work to instead examine the distribution of policy effects of the ACA and whether those effects were distributed unequally across the population. While the question of “who gained” can be examined from many angles, including race and class, we focus on whether the impact varies by partisan affiliation. The question of whether policy effects are equally felt across partisan groups is important, and critical for assessing whether policy effects have the potential to build a bipartisan coalition of beneficiaries invested in the continuing survival of the policy (Patashnik 2014; Patashnik and Zelizer 2013). If policy effects are concentrated, then it becomes harder for the policy to sustain itself when the opposition gains power. For example,

was the inability of the unified Republican party to repeal and replace the ACA following the election of President Trump in 2017 a failure at the elite level, or was it a failure driven by the reluctance of Republican voters who came to realize how they benefitted personally from the ACA (Sommers and Epstein 2017)? While our investigation cannot unpack the precise reasons as to the failure of the repeal efforts, we can identify whether the policy effects of the ACA are distributed in ways that either exacerbate or ameliorate partisan differences in opinions.

To be clear, the ACA was an extremely complicated policy that affected nearly every aspect of the health care system in the United States to some extent. As a result, nearly everyone was affected by the policy in some capacity because of changes in the tax code, changes in what insurance plans had to cover, and the way in which insurance was obtained. For our purposes, we examine the impact of the ACA in terms of what was arguably its most salient aspect – the attempt to increase health insurance coverage via the mechanisms of tax subsidies, the expansion of Medicaid, and rules mandating that insurance policies cover dependents under the age of 26 and those with pre-existing conditions.

To the extent that the reform increased health coverage evenly, there seems to be the potential for policy effects to bridge partisan differences and to create a bipartisan coalition in support of a policy – perhaps even for a policy as politically contentious as the ACA. If, however, the policy effects are concentrated more among Democrats than Republicans, it seems unlikely that the policy effects will likely be able to overcome initial divisions. Moreover, the persistence of the ACA will likely depend on the reactions of political independents – joining with Democrats – to protect the law against efforts by those who benefit the least from the law. Characterizing the empirical regularity regarding which partisan groups are most impacted by the effects of the ACA on health insurance coverage is therefore an important first step to understanding the potential political dynamics at work in the policy feedbacks that have been identified to date.

A priori, expectations about who gained more are unclear. On one hand, we might expect Democratic-leaning citizens to benefit more. Much of the increase in insurance coverage occurred as a consequence of the expansion of Medicaid in the states that chose to do so. Because the

states that chose to expand Medicaid were more likely to be controlled by Democrats than Republicans – reflecting the fact that expansion states generally contain more Democratic-leaning than Republican-leaning citizens – the increases could result in larger effects among Democrats. A second reason why Democrats may be more impacted by the provisions in the ACA related to insurance coverage relates to the fact that Democrats, on average, are worse off financially than Republicans (Leighley and Nagler 2014). Given that the ACA created subsidies for the purchase of health insurance nationwide for those making up to 400% of the federal poverty limit, to the extent that there are more Democrats than Republicans making less than 400% of the federal poverty limit they will also benefit more from the tax credits being provided by the ACA for health insurance. A third potential reason for differential effects follows from recent work by Lerman, Sadin, and Trachtman (2017). Their research suggests there may also be differences in policy uptake based on partisan beliefs, with Republicans less likely to enroll in the ACA's marketplace coverage due to their opposition to government intervention. If so, this could also result in Republicans being less personally impacted than Democrats.

Even so, it is also possible that Republicans are more likely to benefit from the ACA. To the extent that the social welfare state, the health care infrastructure, or the health and well-being of citizens in Republican-led states are systematically worse than those in states led by Democrats, it is possible that the national policy effects of the ACA improved the situations of those living in Republican-led states much more than those living in Democratic led states. Put differently, the marginal impact of the ACA given the differences in pre-existing conditions may be sufficiently larger in Republican states that it overcomes those aspects that would seem to suggest a larger impact among Democrats. Alternatively, if Democratic voters in expansion states were more likely to benefit from pre-existing programs, it could be that the effects of the expansion of Medicaid – or the requirement that insurance plans cover dependents up to the age of 26 and those with pre-existing conditions – impacted Republicans more than Democrats.

Exactly what the net impact of these various policies are in terms of how the ACA affects the ability of individuals of varying political affiliations to obtain health insurance is unclear, and there

are reasons to think that Democrats might be more impacted than Republicans, Republicans might be more impacted than Democrats, or that both groups are equally impacted. While we cannot decompose the total insurance effects of the ACA into these various mechanisms – e.g., the impact due to coverage of pre-existing conditions, versus the impact due to the expansion of Medicaid – understanding the net impact of all of these mechanisms is important for understanding the net effect of the law.

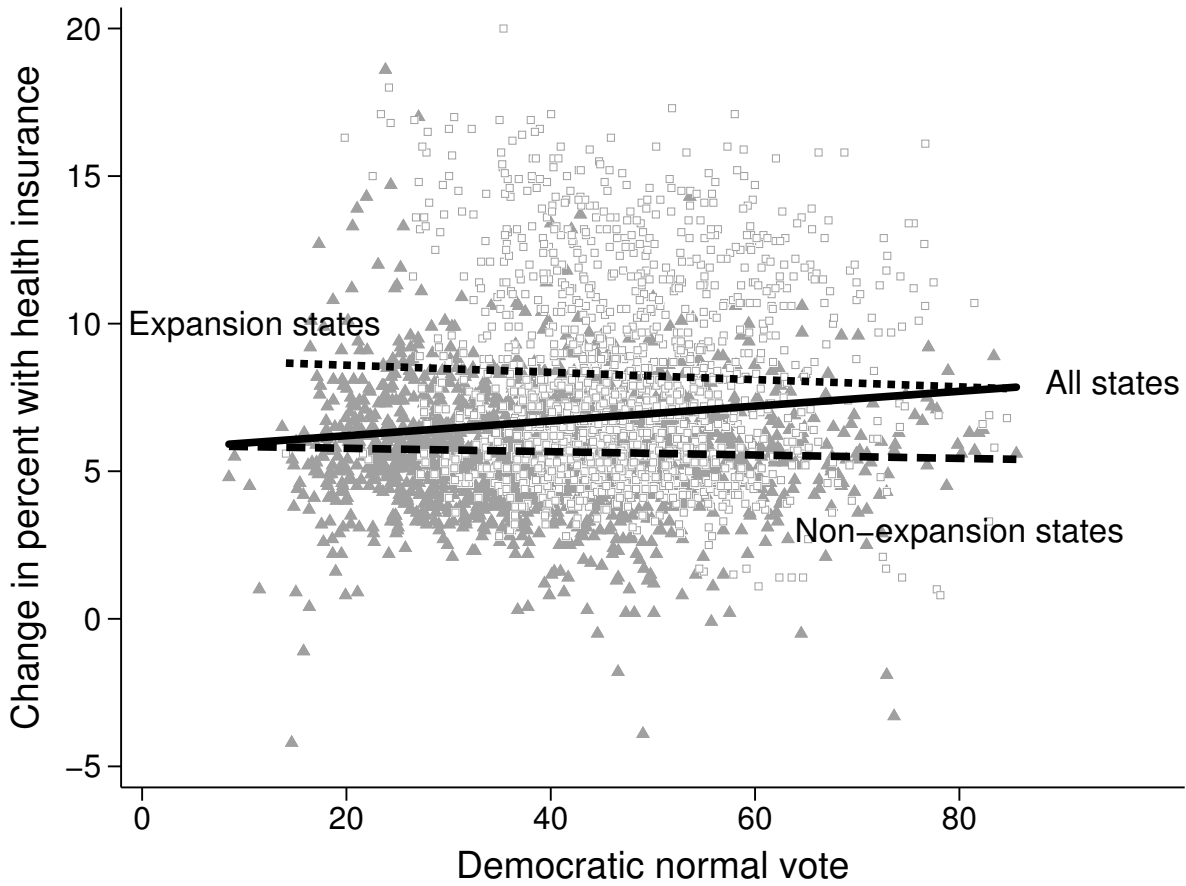
One caveat worth noting is that we are focusing exclusively on the impact of the ACA on insurance coverage. This focus is sensible, as increasing access to insurance was a primary goal and a primary result of the law.¹ However, the ACA had numerous other impacts, including increasing taxes on medical devices, requiring insurance plans to cover birth control, and more. Even keeping to impacts on insurance, some of those we see gaining insurance in our data may have preferred to stay uninsured, and some of those maintaining their status as insured may have seen decreases in quality or increases in costs. It is obviously impossible for us to determine the relative weights of the various aspects of the law within each voter – and consequently whether this valuation varies by partisanship – but it is worth noting that our discussion of effects is restricted to just one aspect of the ACA, namely gains in health insurance coverage.

2 County-Level Analysis

We conduct multiple analyses at varying levels of aggregation and using multiple research designs. In each, we seek to identify how the percentage of individuals insured changed after the passage of the ACA, and how those changes vary by the political affiliation. To do so we use both administrative, county-level data on health insurance coverage and election results, and also self-reported, individual-level data on coverage and partisan affiliation. Neither approach is perfect; the county-level analysis relies on ecological inferences to establish whether a differential relationship exists, and the individual-level data relies on the accuracy of self-reports of insurance coverage – but to

¹Indeed, even critics of the ACA focus on its allegedly negative impacts on access via increased premiums and private insurers' exiting the marketplaces.

Figure 1: Gains in insurance and Democratic vote by county.



the extent that consistent effects are obtained, we can be more confident in our conclusions.

We begin with an examination of county-level gains in insurance and county-level Democratic vote share. We measure changes in insurance using the Census’s Small Area Health Insurance Estimates (SAHIE). Specifically, we compute the share of those between age 18 and 64 with health insurance in each county in 2013, the same share in 2015, and then take the difference. To measure Democratic vote share, for each county, we average the Democratic share of the two-party vote received in all statewide races (president, governor, and senator) in 2004, 2006, 2008, and 2010.

Figure 1 plots these two measures against one another. On first inspection, the figure suggests a positive correlation between Democratic vote and gains in insurance. However, closer inspection reveals the overall positive correlation is an artifact of aggregation. When we separate counties by

Table 1: Gains in insurance and Democratic vote by county: regression results.

	Without state fixed effects			With state fixed effects		
	All	No expansion	Expansion	All	No expansion	Expansion
Democratic vote	1.93 (1.22)	-0.44 (0.78)	-0.94 (3.34)	-0.48 (0.58)	-0.22 (0.77)	-0.96 (0.73)
Constant	5.92*** (0.60)	5.84*** (0.27)	8.73*** (2.13)	5.04*** (0.37)	4.58*** (0.33)	5.86*** (0.60)
Sample size	3,104	1,762	1,342	3,104	1,762	1,342

Notes: Standard errors in parentheses clustered by state. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

whether they are located in states that expanded Medicaid (represented by hollow squares) versus those that did not (represented by triangles), the relationship between insurance gains and Democratic vote is revealed as spurious: counties in expansion states have bigger gains in insurance, and are also more likely to vote for Democrats; counties in non-expansion states have smaller gains in insurance, and are less likely to vote for Democrats. When we look within counties grouped by state expansion status, the overall pattern is reversed, and it appears that *Republican*-leaning counties made larger gains in insurance coverage in both groups of states.

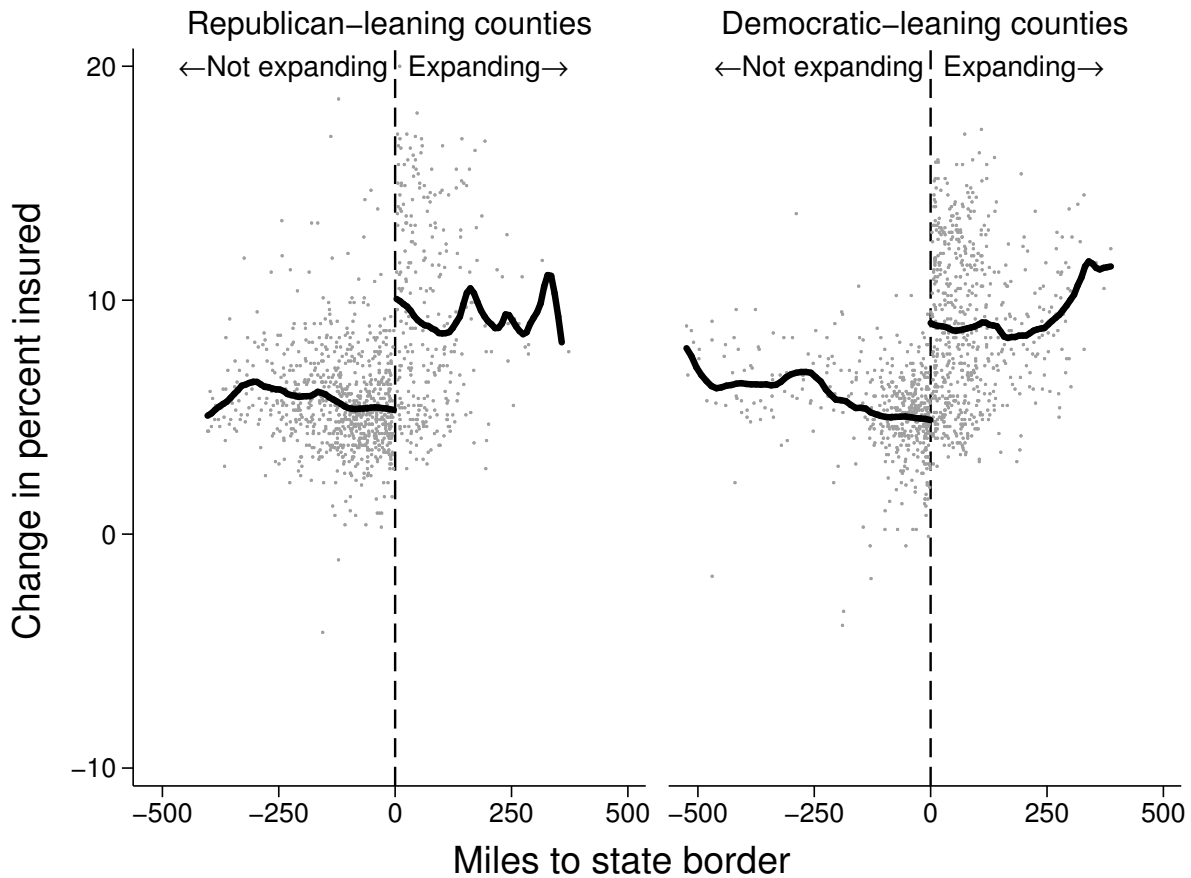
The data in Figure 1 are highly variable, which means that any of these slopes may have occurred due to chance. To test this possibility, Table 1 reports regressions of change in share insured between 2013 and 2015 on Democratic vote share. To ease interpretation, we rescale Democratic vote such that a zero represents the sample minimum (8.5 points) and a one represents the sample maximum (86 points). Because counties are not independent within states, we cluster standard errors at the state level.

The first column in Table 1 reports the results from the regression on all counties regardless of expansion status and other state-level factors. This specification is the only one in which we find a positive relationship between past Democratic vote and gains in insurance at the county level.

Compared to the least Democratic leaning county, which saw a gain of 5.92 points in insurance coverage (the constant in the regression) the most Democratic county saw a gain in insurance coverage that was 1.93 points higher. However, we are unable to reject the null hypothesis of no difference: the standard error is 1.22 points. The second and third columns repeat the analysis separately by expansion state status, mirroring the split in Figure 1. As in the figure, the coefficient on Democratic vote is negative in both specifications, suggesting Republican-leaning counties gained more; however, the estimates are too imprecise for us to reject the null hypothesis of no difference. Moreover, the constants in these regressions show that expansion status is a much more important factor than county partisanship: the baseline gain in insurance is 5.84 (standard error of 0.27) in counties in non-expansion states, and it is more than 3 points higher, at 8.73 (standard error of 2.13) in expansion states.

The remaining columns repeat the analysis, but adding state fixed effects (not shown) to account for the many other state-level factors that jointly influence county voting behavior and county gains in health insurance. Supporting the interpretation of any positive correlation between gains in insurance and Democratic voting as spurious, adding state effects flips the sign when estimating the regression in all counties; again, however, the impact is too imprecise to reject the null of no difference. The remaining columns, which split the sample by expansion status and include state fixed effects, show much the same: the point estimates suggest that Republican-leaning counties gained more, but there is too much uncertainty to reject the null.

Figure 2: The impact of Medicaid expansion on gains in insurance by county partisanship.



To further separate out possible confounding factors, and to focus in on the Medicaid expansions in particular, we use a regression discontinuity design (Clinton and Sances 2017) to examine gains in insurance in counties in expansion states that are just over the border from non-expansion states. For this analysis, we focus in on the roughly 2,000 counties in states that share a border with an opposite expansion status (e.g., Tennessee–Kentucky, Virginia–West Virginia, etc.) To visually demonstrate this strategy, Figure 2 plots county-level changes in insurance against miles to or from the border of an opposite-expansion state. We code distance such that counties to the right of zero are those in expansion states, while counties to the left are those in non-expansion states. We display this analysis separately for Republican-leaning counties (those below the median (42 points) on Democratic vote share) and Democratic-leaning counties (those above the median). Consistent

Table 2: The impact of Medicaid expansion on gains in insurance by county partisanship: regression discontinuity results.

	Full sample	Median split		Quintiles				
	All	Below	Above	1st	2nd	3rd	4th	5th
Expansion	3.94** (1.42)	4.28* (2.03)	3.95** (1.29)	6.18 (3.05)	4.09 (2.12)	3.70* (1.50)	3.34* (1.39)	4.59** (1.25)
Distance	-0.00*** (0.00)	-0.00* (0.00)	-0.00*** (0.00)	-0.00 (0.00)	-0.00 (0.00)	-0.01 (0.00)	-0.00 (0.00)	-0.00*** (0.00)
Expansion X Distance	0.00 (0.01)	-0.00 (0.01)	0.01 (0.01)	-0.01 (0.02)	0.00 (0.01)	0.00 (0.01)	0.01 (0.01)	0.01 (0.01)
Constant	5.04*** (0.30)	5.28*** (0.29)	4.76*** (0.37)	5.73*** (0.50)	5.06*** (0.29)	4.78*** (0.38)	4.64*** (0.41)	4.89*** (0.43)
Sample size	2,166	1,083	1,083	434	433	433	433	433

Notes: Standard errors in parentheses clustered by state. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

with the well-known impact of the Medicaid expansions on insurance coverage, there is a large positive jump of about 5 points at the threshold. That is, compared to counties just in non-expansion states, counties in expansion states saw changes in insurance that were 5 points larger. Notably, the jumps do not appear to differ significantly by whether counties are red- or blue-leaning.

To more precisely estimate these jumps and potential differences across counties, Table 2 reports regressions of changes in insurance on expansion status (being just across the border of an expansion state), distance to or from an expansion state border, and their interaction. The first column estimates the discontinuity for all counties. The point estimate tells us that, compared to counties just inside non-expansion states, counties just inside expansion states saw gains in insurance of 3.94 points. The effect is precisely estimated, with a standard error of 1.42 points. The next two columns repeat the analysis, splitting the sample by Republican- or Democratic-leaning counties (as in the figure above). Republican-leaning counties actually see a slightly larger gain in insurance, according to these estimates: 4.28 points versus 3.95 points in Democratic-leaning

counties. However, we again fail to reject the null of no differential effect when we test this hypothesis using a single regression with an interaction between expansion status and an indicator for being above or below the median ($p=0.8$). Importantly, our inability to detect an effect is not due to our choice to dichotomize the Democratic vote share variable. The remaining columns in the table estimate the discontinuity separately by quintile of Democratic vote. Again, while the estimates are generally larger in more Republican-leaning counties, we fail to reject the null hypothesis that the impacts are equal across quintiles.

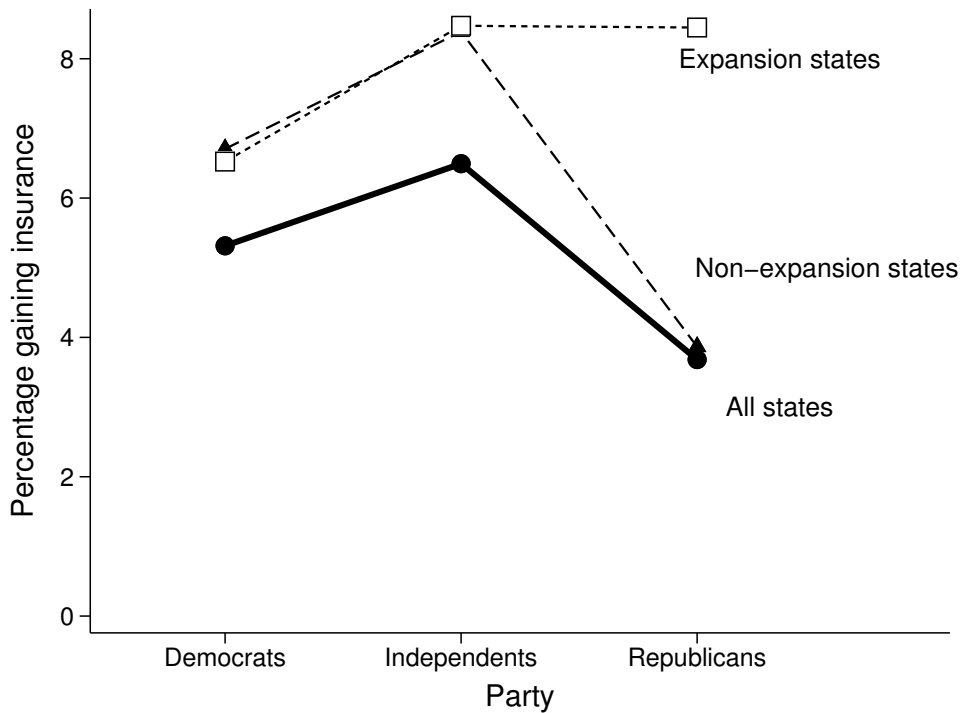
3 Results: Individual-Level

While the geographic analysis is suggestive, it can not tell us with much certainty which types of individuals gained insurance under the ACA. For instance, even though Republican-leaning areas may have seen insurance coverage increase as much as Democratic-leaning areas, it could still be the case that Democratic voters in both areas gained more than Republican voters in both areas. To account for this possibility, we turn to individual-level panel data from the Cooperative Congressional Election Study (CCES), which surveyed the same group of voters in fall 2010, 2012, and 2014. In all waves of the panel, the CCES asked respondents, “Do you currently have health insurance?” Following McCabe (2016), we code respondents as gaining insurance if they did not have insurance in 2012, but did have insurance in 2014, and we use survey weights to correct for the slight non-representativeness of the sample. Overall, 7% of the 4,343 CCES respondents reported gaining insurance by this measure.

Figure 3 plots the percentage gaining insurance by party identification and by state expansion status.² Looking first at the results for all states (thick black line), we see that independents see the biggest increases in insurance coverage, at roughly 6 percentage points, followed by Democrats at roughly 5 percentage points, followed by Republicans at 3.5 points. The ordering is similar in non-

²We treat “leaners” as independents, rather than partisans, in order to make the analysis consistent with the Kaiser Family Foundation data, analyzed below, that does not differentiate partisans beyond a three-category classification. Coding leaners as partisans gives similar results in the CCES data.

Figure 3: Gains in insurance coverage by partisanship in the CCES.



expansion states, represented by the thin dashed line. Interestingly, however, the gains are highest of all, and roughly equal, for Republicans and independents in expansion states, represented by the thin dotted line.

Table 3 reports the results of regressions corresponding to these patterns, allowing us to test the null hypothesis that these differences arise due to chance. Again, we cluster standard errors at the state level. The baseline category in these regressions is Democrat, so the constant terms tell us that Democrats saw gains in insurance of about 7 percentage points in all states, in non-expansion states, and in expansion states. The coefficients on “Independent” and “Republican”, moreover, tell us that independent voters saw larger insurance gains than Democrats regardless of expansion status, while Republicans saw smaller gains than Democrats in non-expansion states, and larger gains in expansion states. However, as with the county-level test of partisan differences, we are never able to reject the null hypothesis that gains in insurance are not equal across subgroups. Notably, the difference in differences – how much Republicans gained or lost relative to Democrats,

Table 3: Gains in insurance coverage by partisanship in the CCES: regression results.

	All states	Not expanding	Expanding
	(1)	(2)	(3)
Independent	1.86 (2.16)	1.68 (3.17)	1.95 (2.92)
Republican	-0.08 (2.14)	-2.84 (2.12)	1.92 (3.37)
Constant	6.58*** (1.45)	6.71* (2.38)	6.52** (1.83)
Sample size	4,295	1,567	2,728

Notes: Standard errors in parentheses clustered by state. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

in expansion states versus non-expansion states – is also statistically insignificant. In a single regression estimated among the full sample, and including interactions between partisan categories and expansion status, the p-value on the interaction between Republican and expansion is 0.232.³

4 Results: Time-Series Analysis

While the CCES data allow us to zoom in on individuals, bypassing the issue of ecological inference, the relatively small number of respondents impacted by the law, as well as the fact that we have only two time periods, may prevent us from detecting statistically significant differences in insurance gains across parties. We therefore turn to another data set, the Kaiser Family Foundation (KFF) tracking poll. The KFF polls have been administered to nationally representative samples of U.S. adults on a regular basis since 2010. While these are not panel data, meaning we can not

³In separate analysis, not shown, we also find no evidence that different groups were more or less likely to lose insurance over this period. Overall, about 3 percent of the weighted sample reported that they had insurance in 2012 but not in 2014.

observe individual-level changes in insurance coverage, they do allow us to see whether the proportions of Democrats or Republicans with health insurance change in different ways before and after the ACA's implementation. We obtain the individual polls from the Roper Center database hosted at Cornell University. Overall, we have 86,309 unique respondents covering 66 time periods between 2010 and 2016.

Figure 4 plots the percentage of survey respondents reporting health insurance coverage by date. As in our analysis of the CCES, we adjust these percentages using survey weights provided by KFF. The thin lines represent the raw weighted percentages in each survey, and the thick lines represent moving averages computed using local polynomial smoothers. To capture the sharp change in insurance coverage attributable to the ACA's implementation beginning in 2014, we fit the moving average separately for pre- and post-2014, as in a regression discontinuity design. The vertical dashed line marks the start of 2014 and the ACA's implementation.

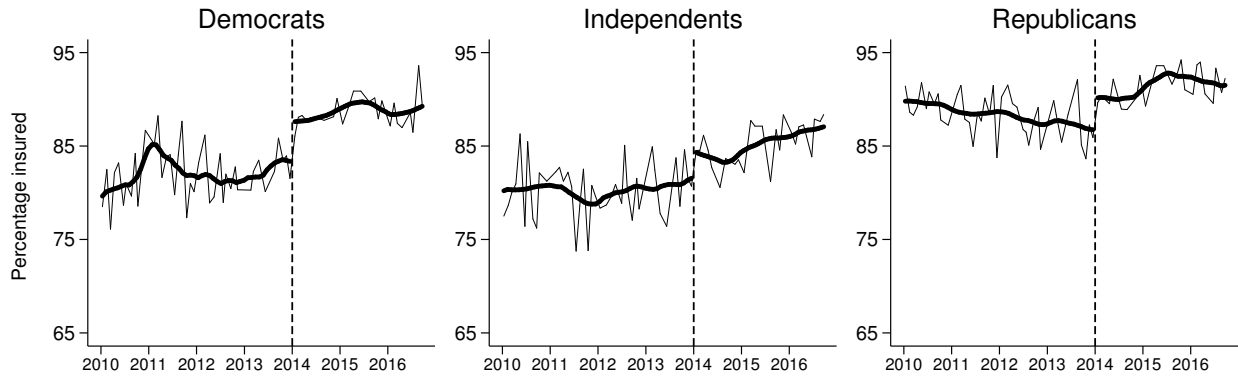
The top panel of Figure 4 shows these plots by party, but across all states. According to these plots, all groups saw gains in insurance, though Democrats saw the largest gains, followed by Republicans and independents. The gains appear to be on the order of 5 percentage points for Democrats, and about a percentage point or two lower for the other groups.

As in our prior analyses, however, the overall patterns obscure important variation within groups of states. The middle panel focuses in on states that did not expand Medicaid. Strikingly, gains in insurance coverage are found among Democrats only. When we turn to expansion states in the bottom panel, however, we see gains for all subgroups that are roughly equal, based on the magnitude of the jumps in moving averages at the 2014 mark.

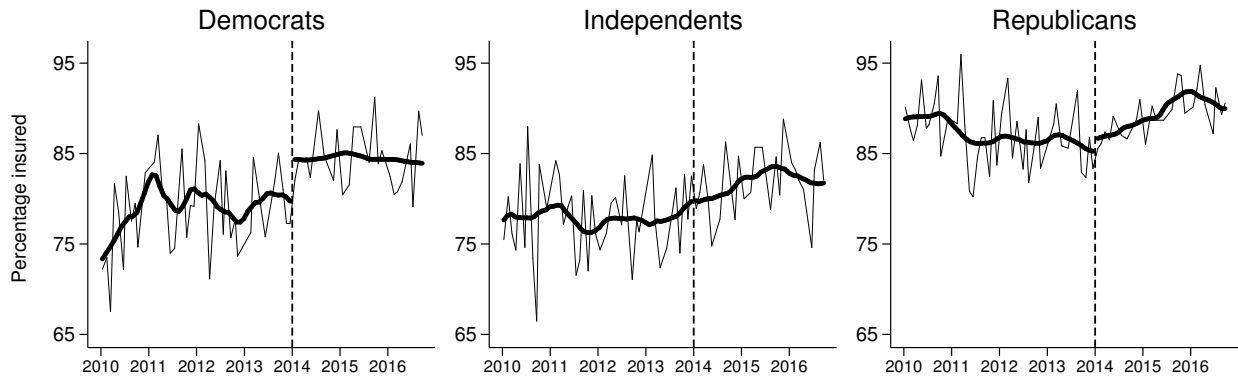
Table 4 uses regressions to test whether these jumps, and the differences between them, could occur due to chance. Specifically, we regress an indicator for having insurance (multiplied by 100 to ease interpretation) on an indicator for being surveyed in 2014 or later, linear date (the running variable), and their interaction. Thus, the coefficient on "Post" corresponds to the jump in the percentage insured between the end of 2013 and the 2014. We cluster standard errors at the level of survey date, though the results are substantively the same if we cluster errors by state.

Figure 4: Gains in insurance coverage by party in the KFF data.

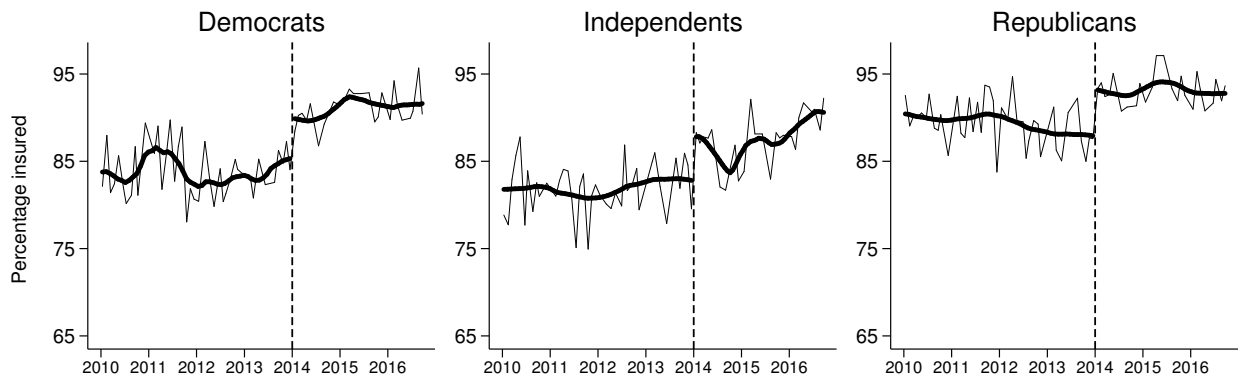
(a) All states.



(b) Non-expansion states.



(c) Expansion states.



As before, we estimate this regression by partisan subgroup and by expansion status; we begin with an analysis of all states in the top panel of Table 4. The first column indicates that among all respondents, insurance coverage increased by 3.7 percentage points between late 2013 and early 2014. Gains were highest, at 4.97 points, among Democrats, followed by Republicans at

Table 4: Gains in insurance coverage by party in the KFF data: regression results.

(a) All states.				
	All	Democrats	Independents	Republicans
Post	3.71*** (0.50)	4.97*** (0.81)	2.66* (1.18)	3.55*** (0.88)
Time	-0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	-0.00** (0.00)
Post X Time	0.00*** (0.00)	0.00 (0.00)	0.00* (0.00)	0.00*** (0.00)
Constant	81.65*** (0.38)	82.90*** (0.68)	80.65*** (0.97)	86.64*** (0.74)
Sample size	85,873	27,749	27,969	21,380
(b) Non-expansion states.				
	All	Democrats	Independents	Republicans
Post	2.83** (0.99)	3.37* (1.67)	2.42 (1.86)	1.73 (1.13)
Time	-0.00 (0.00)	0.00 (0.00)	-0.00 (0.00)	-0.00* (0.00)
Post X Time	0.00** (0.00)	-0.00 (0.00)	0.00 (0.00)	0.01*** (0.00)
Constant	79.25*** (0.75)	81.02*** (1.32)	77.75*** (1.37)	85.15*** (1.01)
Sample size	35,190	10,228	11,341	9,960
(a) Expansion states.				
	All	Democrats	Independents	Republicans
Post	4.36*** (0.63)	6.11*** (0.92)	2.77 (1.43)	5.23*** (0.94)
Time	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	-0.00* (0.00)
Post X Time	0.00*** (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Constant	83.31*** (0.37)	83.91*** (0.69)	82.71*** (0.95)	87.95*** (0.73)
Sample size	50,683	17,521	16,628	11,420

Notes: Standard errors in parentheses clustered by date. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

3.55 percentage points, and independents at 2.66 points. Within subgroups, all these increases are statistically significant. However, the difference in the differences – that is, the degree to which Democrats gained more than the other groups – is not significant. In a combined regression with

triple interactions, we fail to reject the null hypothesis of no difference in differences.⁴

The remaining panels of Table 4 split the sample by expansion status. Looking at the middle panel, we see gains in insurance were smaller for all groups in non-expansion states compared to the full sample, and we only observe statistically significant increases in insurance for all respondents (gain of 2.83 points) and Democrats (3.37 points). While the estimates for independents and Republicans are positive – 2.42 and 1.73 points, respectively – they are imprecisely estimated. Again, however, the difference in gains between Democrats and the other groups is not significant in this group of states.⁵

Turning to expansion states, the bottom panel shows gains were generally higher here, and we can reject the null of no significant gain for all respondents (gain of 4.36), Democrats (gain of 6.11), and Republicans (5.23), but not for independents (2.77). In these states, we are able to reject the null of no differential gain by Democrats – but only when we compare the Democratic gain to the independent gain. The gains among Democrats and Republicans are statistically the same in expansion states.⁶

The KFF surveys are also interesting because they asked respondents the source of their insurance coverage: from an employer (or spouse’s employer), the individual market, Medicaid, Medicare, or other sources. Thus, we can decompose the gain in insurance by different subgroups into transitions into different insurance sources. Figure 5 plots the percentage of KFF respondents receiving health insurance from their employer, the individual market, Medicaid, or no source over the sample period. The drop in uninsured appears to be matched by an increase in the share of respondents receiving insurance from Medicaid or the individual market, which is exactly what we would expect given the design of the ACA.

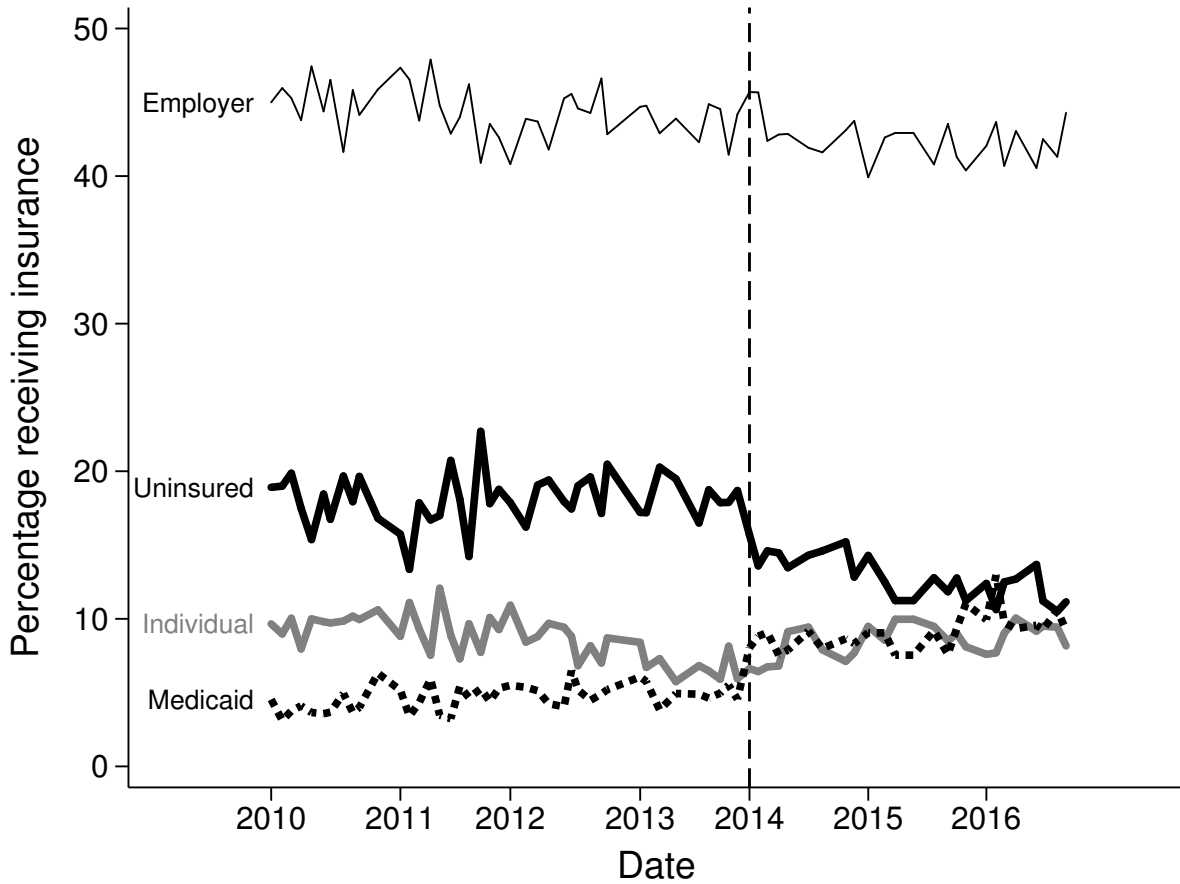
To save space and ease presentation, we proceed directly to regression estimates rather than replicating this plot by party and state. We use a similar specification as before, except now our

⁴This pooled regression includes a post indicator, linear time, indicators for each party, an interaction between post and time, interactions between post and party, interactions between time and party, and interactions between post, party, and time. The p-value on the coefficient corresponding to the difference in gains between Democrats and Republicans is 0.26; it is 0.10 when comparing Democrats to independents.

⁵The relevant p-values are 0.41 (Democrats vs. Republicans) and 0.69 (Democrats vs. independents).

⁶The relevant p-values are 0.51 (Democrats vs. Republicans) and 0.04 (Democrats vs. independents).

Figure 5: Changes in insurance coverage by source in the KFF data.



dependent variable is an indicator for receiving insurance from a given source (equal to 100 if a respondent is in that category, and 0 otherwise). Table 5 summarizes the results from a series of regressions on different subsamples. We present only the coefficient on “post” and its standard error, omitting the estimates for distance and the interaction. The first row corresponds to the trends shown in the figure above: among all respondents, there was no sharp post-ACA decrease in those receiving insurance from their employer: the estimate is -0.08 on a zero to one hundred scale, with a large standard error of 0.72 . There was an increase in the share receiving insurance from the individual market, about 0.76 points, but the estimate is statistically insignificant with a standard error of 0.51 points. Interestingly, then, among the full sample, the primary gains in insurance were seen via the Medicaid program.

Table 5: Changes in insurance coverage by source and party in the KFF data: regression results.

Expansion status	Party	Employer	Individual	Medicaid
All states	All	-0.08 (0.72)	0.76 (0.51)	2.74 (0.31)***
	Dem	-0.87 (1.20)	2.14 (0.70)**	2.26 (0.87)**
	Ind	-0.94 (1.43)	-0.41 (0.66)	3.25 (0.68)***
	Rep	1.18 (1.41)	0.74 (1.06)	2.16 (0.61)***
Not expanding	All	0.49 (0.93)	1.30 (0.56)*	0.59 (0.57)
	Dem	-0.29 (2.26)	2.77 (0.85)**	-1.39 (1.06)
	Ind	0.45 (1.95)	-0.23 (0.94)	0.46 (1.06)
	Rep	0.24 (1.56)	0.93 (1.40)	1.74 (0.83)*
Expanding	All	-0.47 (1.20)	0.37 (0.62)	4.29 (0.45)***
	Dem	-1.09 (1.57)	1.78 (0.90)*	4.48 (1.05)***
	Ind	-1.93 (2.00)	-0.55 (0.78)	5.17 (0.90)***
	Rep	2.06 (1.95)	0.55 (1.34)	2.56 (0.90)**

Notes: Standard errors in parentheses clustered by date. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

The next row examines changes among Democrats, not restricted to any particular group of states. Here again we see no change in employer-based insurance, but roughly equal gains in the individual market (estimate of 2.14, standard error of 0.7) and Medicaid (2.26, 0.87). Among independents and Republicans, we only see statistically significant increases in the share receiving insurance from Medicaid, and for Republicans the increase in those receiving employer-based insurance is larger in magnitude than the share receiving insurance from the individual market.

The next set of rows repeats the analysis for non-expansion states only. Intuitively, given the lack of Medicaid expansion in these states, we see sharp increases only in the share receiving insurance from the individual market: the estimate is 1.30 with a standard error of 0.56. Breaking this out by party shows that the overall gain in individual market insurance is driven by Democrats,

who see a 2.77 point increase (standard error of 0.85), whereas the changes among the other subgroups are smaller and insignificant, and negative in the case of independents. Strangely, we also see a gain in the share receiving Medicaid of 1.74 points among Republicans, and the estimate is significant with a standard error of 0.83.

The last four rows examine states that participated in the Medicaid expansions. We see statistically significant gains in the percent covered by Medicaid for all subgroups. Within parties, the gains are largest for independents, at 5.17 points (standard error of 0.90 points), followed by Democrats at 4.48 points (1.05 points), followed by Republicans at 2.56 points (0.90). Even with a substantively large difference of 1.92 points between Democratic and Republican gains, however, we still fail to reject the null that the difference in differences is due to chance: the relevant p-value is 0.22. And again in the expansion states, we see a statistically significant increase in individual insurance only among Democrats: in these states the increase is 1.78 points with a standard error of 0.90. Interestingly, the overall gain in insurance observed for Republicans in these states reported in Table 5 (5.23 points) is driven in part by an increase in the share with employer-provided insurance: 2.06 points, but with a standard error of 1.95 points.

5 Discussion and Conclusion

We consistently fail to provide any evidence that the percentage of individuals gaining health insurance following the implementation of the ACA differed between Democrats and Republicans. Despite reasons to think that Democrats may have been more likely to benefit from a policy that was passed without a single Republican vote in Congress, whose effects depended on the actions of state governments to expand Medicaid, and which was also subject to a repeal effort by Republicans when they gained control of the presidency in 2016, there is no evidence that these policy benefits were more likely to flow to Democrats.

These apparently neutral impacts on insurance coverage are important for what they reveals about the relationship between policy effects and policy feedback, especially in light of continuing

differences in partisans evaluations of the ACA. That both Democrats and Republicans benefitted from a highly politicized policy, yet continue to diverge sharply in their attitudes toward the law, speaks to the importance of the existing political context in generating feedback effects. Even so, the precise implications are somewhat unclear, and deserving of further inquiry. On one hand, that benefits went to both Democrats and Republican in statistically indistinguishable amounts suggests that the ACA may, in principle, be able to generate a bipartisan coalition of supporters. It is even possible that the gains among Republicans were large enough so as to safeguard the ACA against the Republicans' attempt at repeal in 2017.

The bipartisan nature of the actual policy effects also raises important questions about the continuing partisan divide in opinion about the ACA. The fact that Republicans' access to health insurance has matched that of Democrats, but that Democrats continue to support the ACA at much higher rates, strongly suggests that the ability to receive health insurance as a result of the ACA does not obviously affect political opinions about the underlying policy. There are many reasons why there may be different reactions to similar benefits, and our findings highlight the importance of further investigations into why similar policy effects appear to produce such different effects, and what this implies about the possibility of policy feedback effects more generally.

Perhaps the direct effects of a policy are swamped by the interpretive frames created by party elites, or perhaps the relative value of health insurance to Democrats and Republicans compared to increased government intervention or other aspects related to the ACA is such that the same policy effects are evaluated differently by Democrats and Republicans. Or, perhaps what matters for policy feedback is not what the policy actual does, but rather what it is thought to do to others. If political opinions and behavior are impacted by perceptions of who benefits from a policy (Sears and Citrin 1982; Cramer 2016; Chattopadhyay 2018) perceptions of who benefits from a policy may be just as important, if not more so, than actual policy effects.

References

- Abraham, Jean, and Anne Beeson Royalty. 2017. "Employer Sponsored Insurance Under the Affordable Care Act and Comparisons with Insurance in the Exchanges," Working Paper.
- Antonisse, Larisa, Rachael Garfield, Robin Rudowitz, and Samantha Artiga. 2017. "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review," Accessed Jan 22, 2018 via [\url{https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/}](https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/)
- Allen, Heidi, and Tal Gross. 2017. "Can the Affordable Care Act Medicaid Expansions Protect the Creditworthiness of Low-Income Americans?" Working Paper.
- Bird, Mia, and Shannon McConville. 2017. "The Effect of Health Insurance Enrollment on Recidivism in the Criminal Justice Population," Working Paper.
- Campbell, Andrea Louise. 2003. *How Policies Make Citizens: Senior Political Activism and the American Welfare State*. Princeton University Press: Princeton, NJ.
- Campbell, Andrea Louise. 2012. "Policy Makes Mass Politics." *Annual Review of Political Science* 15: 333-351.
- Chattopadhyay, Jacqueline. 2018. "Is the Affordable Care Act Cultivating On a Cross-Class Constituency? Income, Partisanship, and a Proposal for Tracing the Contingent Nature of Positive Policy Feedback Effects." *Journal of Health Politics, Policy and Law* forthcoming.
- Clinton, Joshua, and Michael W. Sances. 2017. "The Politics of Policy: The Initial Mass Political Effects of Medicaid Expansion in the States." *American Political Science Review* forthcoming.
- Cramer, Katherine J. 2016. *The Politics of Resentment: Rural Consciousness in Wisconsin and the Rise of Scott Walker*. Chicago: University of Chicago Press.
- Fingerhut, Hannah. 2017. "Support for 2010 health care law reaches new high." Pew Research Center. Accessed Feb 26, 2017 via [\url{http://www.pewresearch.org/fact-tank/2017/02/23/support-for-2010-health-care-law-reaches-new-high/}](http://www.pewresearch.org/fact-tank/2017/02/23/support-for-2010-health-care-law-reaches-new-high/)
- Haselswerdt, Jake. 2016. "Expanding Medicaid, Expanding the Electorate: The Affordable Care Act's Short-Term Impact on Political Participation." *Journal of Health Politics, Policy and*

Law.

- Hopkins, Daniel J. and Kalind Parish. 2017. "The Medicaid Expansion and Attitudes towards the Affordable Care Act." Working Paper, Department of Political Science, University of Pennsylvania. Accessed August 15, 2017 via https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2990576.
- Hopkins, Daniel J. and William R. Hobbs. 2017. "Attitudes Towards the Affordable Care Act," Working Paper.
- Leighley, Jan E., and Jonathan Nagler. 2014. *Who Votes Now?: Demographics, Issues, Inequality, and Turnout in the United States*. Princeton University Press; Princeton, NJ.
- Lerman, Amy E., and Katherine T. McCabe. 2017. "Personal Experience and Public Opinion: A Theory and Test of Conditional Policy Feedback," *The Journal of Politics* 79(2): 624-641.
- Lerman, Amy E., Meredith L. Sadin, and Samuel Trachtman. 2017. "Policy Uptake as Political Behavior: Evidence from the Affordable Care Act," *American Political Science Review* forthcoming.
- Long, Sharon K., and Dana Goin. 2014. "Most Adults Are Not Aware of Health Reform's Coverage Provisions." Health Reform Monitoring Survey (February 6). Accessed December 12, 2017 via <http://hrms.urban.org/briefs/awareness-of-provision.html>
- Miller, Sarah, Robert Kaestner, and Bhaskar Mazumder. 2017. "Health Care and the Financial Wellbeing of Low-Income Families," Working Paper.
- McCabe, Katherine T. 2016. "Attitude Responsiveness and Partisan Bias: Direct Experience with the Affordable Care Act." *Political Behavior* 38(4): 861-882.
- Mettler, Suzanne. 2005. *Soldiers to Citizens: The G.I. Bill and the Making of the Greatest Generation*. Oxford University Press, NY, NY.
- Nikpay, Sayeh, Helen Levy, and Thomas Buchmueller. 2017. "The Impact of the Affordable Care Act on Household Economic Wellbeing," Working Paper.
- Patashnik, Eric M. 2014. *Reforms at Risk: What Happens After Major Policy Changes Are Enacted: What Happens After Major Policy Changes Are Enacted*. Princeton University Press:

Princeton, NJ.

- Patashnik, Eric M., and Zelizer, Julian E. 2013. "The Struggle to Remake Politics: Liberal Reform and the Limits of Policy Feedback in the Contemporary American State." *Perspectives on Politics* 11(4), 1071-1087
- Pacheco, Julianna. 2017. "Attitudinal Policy Feedback and the Affordable Care Act," Working Paper.
- Pierson, Paul. 1993. "When Effect Becomes Cause: Policy Feedback and Political Change." *World Politics* 45(4): 595-628.
- Schattschneider, E.E. 1935. *Politics, Pressures, and the Tariff*. New York: Prentice-Hall.
- Sears, David O., and Jack Citrin. 1982. *Tax Revolt: Something for Nothing in California*. Cambridge: Harvard University Press.
- Shore-Sheppard, Lara, Lucie Schmidt, and Watson. 2017. "The Impact of the ACA Medicaid Expansion on Public Program Participation and Labor Market Outcomes of Low-Wage Workers," Working Paper.
- Soss, Joe. 1999. "Lessons of Welfare: Policy Design, Political Learning, and Political Action." *American Political Science Review* 93(2): 363-380.
- Soss, Joe, and Sanford F. Schram. 2007. "A public transformed? Welfare reform as policy feedback." *American Political Science Review* 101(1): 111-127.