Political Partisanship and Policy Uptake: Experimental Evidence from Obamacare

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ABSTRACT:
Studies concerning the decision to enroll in public programs have focused on a variety of predictive factors: the availability and accuracy of information; the structure of stipends and penalties; the importance of outreach; and the stigmatization of program recipients. Somewhat surprisingly, however, existing theories of policy uptake neglect the role of political partisanship. In this study, we examine the case of the Affordable Care Act to illustrate that policy uptake is not just about information and incentives; it is also about ideology. Using descriptive data, we find that Republicans are much less likely than Democrats to have purchased health insurance through either a state or federal insurance exchange. These relationships hold even when we account for other factors. However, we also find evidence that uptake can be increased through policy framing. Employing a large-scale field experiment, we show that emphasizing the role of private industry (as opposed to the role of government) can significantly increase enrollment in Obamacare among Republicans. Our findings make clear that political considerations are an integral part of policy uptake, with significant implications for individual outcomes.
A lifelong Republican from South Carolina, Luis Lang was an outspoken critic of the Affordable Care Act (ACA). Despite being aware that the ACA mandated coverage or imposed a penalty, Lang had made a principled decision to forego health insurance. Not long after making this decision, though, Lang suffered a severe medical emergency and quickly exhausted his financial savings. He subsequently tried to enroll through the health insurance exchange established under the ACA, only to discover that the annual enrollment window had closed.

In order to treat a partially detached retina and bleeding in his eyes, which if left untreated would result in blindness, Lang began to solicit online donations to cover his medical expenses. As his story began to circulate on the internet, Lang voiced regret about failing to take advantage of the insurance options made available to him by the government’s healthcare reform package. At the time, though, as one reporter surmised: “the ideological satisfaction [to Lang] of resisting ‘big government’ [had] outweighed the practical benefit of access to medical care” (Maloy 2015).

Political partisanship matters for nearly every aspect of American political attitudes and behavior. One’s partisan loyalties influence patterns of information seeking and information processing (e.g., Zaller 1992), shape our political identities and networks (e.g., Jennings and Stoker 2005; Weatherford 1992; Green, Palmquist and Schickler 2004), and predict campaign contributions, vote choice, and a host of other important outcomes (e.g., Campbell et al. 1960). Moreover, research has shown that partisanship is not just a heuristic for policy preferences – it is a social identity akin to a religious affiliation or ethnic group membership (Green, Palmquist, and Schickler 2004) and an “enduring attachment” (Campbell et al.1960). This identity is established at an early age, is extremely stable throughout the life course, and is large unaffected by other political attitudes (Niemi and Jennings 1991).
Individuals also use partisanship as a primary heuristic in determining their public policy preferences. Rather than gather all the relevant information about a policy—such as whether and how it will benefit them and those like them, or what taking advantage of benefits will cost them relative to what they will gain—citizens employ partisanship as a shortcut for political decision making. Essentially, partisans in the electorate can save time by simply adopting the policy positions of their own party (or the opposite position from the opposing party) as their own (e.g., Lenz 2012).

Yet while it is clear that partisanship is a primary driver of citizens’ attitudes toward public policy, we do not yet know the extent to which party loyalties play a role in shaping policy behavior, such as whether to apply for government benefits or take advantage of public services. Those who study decisions about whether to enroll in a public program, frequently referred to as “policy uptake,” focus on a variety of factors: levels of justification or stigma; the availability and accuracy of information; the structure of incentives and penalties; and the importance of outreach and mobilization. Somewhat surprisingly, however, the role of partisanship and political orientation has been almost entirely overlooked.

In this paper, we test the idea that policy uptake is not just about information and incentives; it is also about ideology. To assess this hypothesis, we examine participation in the state and federal health insurance exchanges, which were set up as part of the Affordable Care Act (ACA). According to recent estimates, more than 41 million uninsured Americans may have become eligible for relatively low-cost insurance plans under the ACA (U.S. Department of Health and Human Services 2013). However, millions of Americans remain uninsured despite the availability of these new options and the threat of financial penalties for failing to enroll. In 2015, after the end of the second enrollment period and roughly five years after the ACA was
passed, about 11.5% of the non-elderly population still did not report having health insurance coverage (U.S. Department of Health and Human Services 2016).

We hypothesize that persistent uninsurance rates are at least in part a function of persistent political rancor over Obamacare. In this paper, we first assess whether partisanship is a significant predictor of ACA enrollment. In other words, is Luis Lang’s partisan-motivated choice to abstain from enrollment an isolated case or a widespread phenomenon? We then examine the consequences of a partisan uptake gap for policy implementation. We ask: Can ideological policy framing induce greater enrollment among otherwise reluctant partisans? Specifically, does emphasizing the “private” rather than “public” aspects of Obamacare affect the probability that Republicans will choose to sign up for health insurance? Our answer on both counts is yes. We find that Republicans have been systematically less likely to obtain health insurance in the years since the ACA was passed. However, emphasizing the “private” nature of the ACA substantially increases insurance enrollment among this partisan group.

There are numerous implications of this work. Most centrally, our results make clear that partisan politics do not end when policies pass. Rather, partisan political behavior only intensifies on the ground with respect to policy framing and uptake. Yet while there is abundant research on the role of partisanship as it pertains to the formation of policy preferences, extant literature has missed the role of partisanship in shaping policy uptake and behavior. Our evidence indicates that once a policy is passed, its social benefits are not a foregone conclusion. Rather, the extent to which individuals participate in a public program is determined by both supply (policy framing) and demand (individual partisanship).
Predicting and Increasing Policy Uptake

Recent estimates suggest that large proportions of Americans fail to enroll in public programs through which they are eligible to receive benefits. For instance, according to a report by Health and Human Services (2007), uptake for major social benefits ranges from 75 percent of the eligible population for the Earned Income Tax Credit (EITC) to just 55 percent for the Supplemental Nutrition Assistance Program (SNAP), 46 percent for Social Security Insurance (SSI) and just 42 percent for Temporary Assistance for Needy Families (TANF). These choices can be extremely consequential; the average individual who fails to enroll for EITC benefits loses out on about $1,096, which is equal to roughly a month of income (Bhargava and Manoli 2015).

A rational model of policy uptake suggests that individuals choose not to enroll in programs for which they are eligible because they perceive any potential benefits to be outweighed by the associated costs (e.g., Moffitt 1983). In the case of insurance enrollment, we can also understand abstaining by examining risk tolerance and intertemporal substitution; those who choose not to enroll may simply prefer to take their chances of illness or injury later, rather than making regular payments into an insurance pool now (Barsky et al. 1997).

In fact, studies of uptake have pointed to a variety of cognitive factors, or “psychological frictions” (Bhargava and Manoli 2015), that shape whether individuals enroll in programs for which they are eligible (Currie 2006). First and most obviously, individuals must be aware that a program exists in order to take part in it (Chetty et al 2013; Chetty and Saez 2013; Smeeding et al 2000). They must then overcome the costs and barriers related to information seeking in order to gather accurate knowledge about whether they qualify for the program, and what benefits they might expect (Lieberman and Zeckhauser 2004). They must subsequently actually enroll in the
program, rather than succumbing to procrastination or being unable to successfully navigate the enrollment process (Madrian and Shea 2001). Notably, these factors are not independent of the objective costs and benefits associated with a given program. For instance, there is evidence that individuals are more likely to be aware of and enroll in a program when it offers larger benefits (Daponte et al 1999; Blank and Ruggles 1996).

In these ways, the enrollment process involves substantial transaction costs (Bertrand et al 2006) and requires individuals to possess the cognitive tools, disposition, and capacity to navigate required paperwork and processes (Bertrand et al 2006; O’Donoghue and Rabin 1999; Mullainathan and Shafir 2003; Ericson and Starc 2012). The social construction of the target population might additionally either encourage or discourage enrollment (Moffitt 1983; Currie 2000). Perceptions of personal or social stigma associated with a given program, such as the negative stereotypes of welfare clients (Gilens 2000), may reduce the propensity for eligible individuals to apply. Conversely, positive social evaluations might encourage eligible individuals to take advantage of public benefits. For example, communicating public esteem for veterans (Mettler 2007) might increase applications for GI Bill and other benefits made available to those who have served in the military. Again, a theory of policy uptake based on social construction is not mutually exclusive from one that emphasizes the role of transaction costs. Program enrollment processes that require individuals to divulge a great deal of personal information may increase feelings of stigmatization among eligible recipients who apply (Currie 2006).

While these standard explanations are useful, they ignore the role that political partisanship might play in predicting whether and when individuals choose to take advantage of public benefits, or enroll in public programs for which they are eligible. Political scientists have definitively shown that partisanship is a fundamental component of individual orientations
toward the policy world. Among other things, party identification is a significant predictor of the actual policy-related information (and misinformation) individuals hold (Druckman, Peterson and Slothus 2013); the resources they use to gather policy-relevant information (Lau and Redlawsk 2001); the elites they trust when forming their policy opinions (Zaller 1992); and what policies they support or oppose (Lenz 2012). It is not hard to imagine that partisanship might also be brought to bear on the decision of whether or not to engage with government through policy uptake. In the case of the ACA, we expect that Republicans, who on average are much less supportive of the health insurance reform, will be significantly less likely to enroll for coverage through the state and federal insurance exchanges.

Like other explanations for policy uptake, a model that takes political partisanship into account has practical implications for increasing policy uptake. Rational and cognitive models of policy uptake, which have been well-explored in extant literature, each generate testable hypotheses regarding the potential policy levers that might increase enrollment. If enrollment decisions are rational, for example, then incentives and penalties are critical components of program design, as these levers should increase the expected utility of uptake (e.g., Moffitt 2003). If eligible individuals procrastinate (Madrian and Shea 2001) or simply have time-inconsistent preferences (Currie 2006), then moving from opt-in to opt-out enrollment might improve uptake rates (Madrian and Shea 2001). If program awareness is low (Chetty et al 2013; Chetty and Saez 2013; Smeeding et al 2000) or information costs are high (Lieberman and Zeckhauser 2004), campaigns designed to educate about programs and eligibility criteria likely will prove fruitful (Bhargava and Manoli 2015; Daponte et al 1999). Transaction costs might be minimized by decreasing the frequency with which participants need to provide information to maintain enrollment (Currie and Grogger 2002). And if perceived stigma diminishes uptake,
increasing overall program enrollment within particular communities might serve to encourage other eligible community members to apply (Aizer and Currie 2004).

Our explanation, which focuses on partisan resistance, similarly suggests a specific but distinct set of policy interventions. If political orientations predict the likelihood of enrollment, it follows that ideological framing might work to overcome this resistance. There is considerable evidence suggesting that the way policies are framed heavily influences the predispositions that are factored into one’s opinion (Chong and Druckman 2007, Kinder and Sanders 1990, Zaller 1992). These findings follow from the theory that citizens may possess opposing considerations on a multitude of issues and any of these may be brought to bear on an issue depending on how that issue is presented (Nelson and Kinder 1996). As Sniderman and Theriault (2004) write, “[I]t now is widely agreed that citizens in large numbers can be readily blown from one side of an issue to the very opposite depending on how the issue is specifically framed.” In the case of the ACA, we expect that policy frames emphasizing the private rather than public nature of a policy choice will increase support for that policy among Republicans, and also increase enrollment among this subset of Americans.

**Partisan Resistance to the ACA**

A primary distinction between Democrats and Republicans is their divergent preferences over the optimal size of government. In a 2012 Gallup poll, a large majority (82 percent) of Republicans voiced the belief that the government is doing too much; only 15 percent of this group took the opposite position that government should do more. Among Democrats, patterns were reversed. Sixty-seven percent said that government should do more, compared to 24 percent who believed the government should leave more to individuals and businesses.
Partisans also hold distinct views of government itself. In a 2010 Pew Center survey of a representative sample of Americans, fully 70 percent concurred that government waste and inefficiency is a major problem. However, Democrats and Republicans differ substantially on this question: eighty-one percent of Republicans, 76 percent of Independents and 58 percent of Democrats gave this response. In turn, this perception predicts sizable variation in attitudes toward public service provision, public spending, and the optimal size of government. Specifically, those who express lower confidence in government efficiency and more concern about waste are also less likely to support government intervention into the private market (Molyneux et al. 2010).

These ideological differences are reflected in public attitudes toward healthcare reform. From the inception of the debate about the Affordable Care Act, there has been a stark partisan divide in public opinion. Figure 1 presents overall favorability towards the ACA from July of 2010 through January of 2016 by partisan identification. As is clearly evident, the party gap is stable and large: approval of the law hovers between 60-70% for Democrats and between 10-20% for Republicans throughout the last five and a half years. Republicans are also significantly more likely than Democrats to say they would like to see the ACA repealed (Kaiser Family Foundation 2015).

This persistent gap in attitudes towards the recent healthcare reform leads us to suspect that political partisanship might also be a factor in whether Republicans choose to actually take advantage of the benefits offered by the ACA. Republicans are certainly more likely to claim that they will not participate: A 2013 Gallup poll of 4,000 uninsured Americans found that 45% of Republicans reported they would choose to remain uninsured despite the financial penalty, relative to only 15% of Democrats.
Evidence suggests that these attitudes may translate into (in)action: work by Michael Tesler shows that uninsurance rates of Democrats fell significantly faster from 2010 to 2014 than the uninsurance rates of Republicans. Using weekly surveys conducted by YouGov for *The Economist*, he finds that Democrats’ uninsurance rates have been halved since the inception of the online marketplace, while Republican uninsurance rates have held somewhat steady. In fact, Tesler finds that in early 2015, Republicans actually surpassed Democrats in their likelihood of being uninsured – despite a long history of having far more coverage than Democrats. Using the Cooperative Congressional Election (CCES) and Kaiser Foundation’s monthly Health Tracking Surveys (2010-2014), he again found that partisan identification was a significant predictor of a change in health insurance status between 2012 and 2014. In models controlling for demographic factors, uninsured Republicans were 20 percentage points less likely than strong Democrats to have insurance two years later.
We confirm and extend this analysis using the Kaiser Family Foundation (KFF) Health Tracking Poll from 2010 through April of 2016. The KFF surveys, conducted every month since 2010, are fielded among a nationally representative, random digit dial telephone sample of adults ages 18 and older living in the United States. They thus provide an excellent source for examining cross-sectional trends in both insurance coverage and uptake.

Figure 2 illustrates the percentage of Democrats and Republicans (including leaners) that report they are uninsured at the time of each monthly poll. As in previous work, we find that the rate of uninsurance for Democrats fell faster than for Republicans. However, our data suggest that by the later period, there is again a larger share of Democrats than Republicans who remain uninsured. (The trend remains relatively stable when excluding partisan leaners.)

Figure 2: Percent Uninsured by Party Identification (2010-2016)

![Uninsured Demographics Graph]


Using these same 2010-2016 KFF survey data, we next examine the relationship between partisanship and insurance enrollment (relative to the option of remaining uninsured). Because there are a variety of differences between partisans that might predict insurance status (i.e.,
average income), we employ a logistic regression in which we control for potential confounders. We find a negative and significant effect of being Republican (relative to being a Democrat), as presented in Table 1. In calculating predicted probabilities, we find that Republicans are 11 percentage points less likely to enroll in the state and federal exchanges relative to staying uninsured compared to Democrats. In Model 1, we assess the relationship between signing up on the state-based or federal exchange and political partisanship, while Model 2 relates the same outcome to strong partisanship. The magnitude of the relationship increases slightly when we compare uptake among the strongest partisans.

**Table 1. Partisanship Predicts Signing Up for Insurance on the Exchanges Relative to Remaining Uninsured**

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Republican (relative to Democrat)</td>
<td>-0.88 (0.12)*</td>
<td>-1.07 (0.16)*</td>
</tr>
<tr>
<td>Strong Republican (relative to Strong Democrat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.03 (0.00)*</td>
<td>0.02 (0.00)*</td>
</tr>
<tr>
<td>Education</td>
<td>0.38 (0.05)*</td>
<td>0.36 (0.07)*</td>
</tr>
<tr>
<td>Income</td>
<td>0.17 (0.02)*</td>
<td>0.18 (0.03)*</td>
</tr>
<tr>
<td>Female</td>
<td>0.43 (0.11)*</td>
<td>0.31 (0.14)*</td>
</tr>
<tr>
<td>Pseudo R2</td>
<td>0.29</td>
<td>0.30</td>
</tr>
<tr>
<td>N</td>
<td>2,834</td>
<td>1,703</td>
</tr>
</tbody>
</table>

Note: Also included but omitted from table: employment, race, survey date and state of residence. Cells report model coefficients. Asterisks denote point estimates that were statistically significant (at the p < 0.05 level in two-tailed tests). Partisanship is coded with Republicans as 1 and Democrats as 0 in Model 1 and Strong Republicans as 1 and Strong Democrats as 0 if Model 2. Data are compiled Kaiser Family Foundation Health Tracking Surveys from April of 2010 through April of 2016.

We then examine whether Republicans have been less likely to enroll in the state and federal exchanges (relative to purchasing insurance elsewhere), again controlling for other factors. Here, we are interested not just in whether partisanship predicts insurance status, but
whether Republicans specifically have been less likely to use the government insurance exchanges to secure health coverage. Table 2 presents the results from logistic regression models predicting enrollment in the exchanges with partisan identity and controlling for a host of demographic factor, such as age, race and ethnicity, gender, state of residence, employment, education, income, as well as the date of the poll. We again consider both partisanship (Model 1) and strong partisanship (Model 2) as predictors.

Table 2. Partisanship Predicts Signing Up for Insurance on the Exchanges Relative to Purchasing Coverage Elsewhere

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Republican (relative to Democrat)</td>
<td>-1.13</td>
<td>-1.31</td>
</tr>
<tr>
<td></td>
<td>(0.11)*</td>
<td>(0.14)*</td>
</tr>
<tr>
<td>Strong Republican (relative to Strong Democrat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-0.00</td>
<td>-0.00</td>
</tr>
<tr>
<td></td>
<td>(0.00)</td>
<td>(0.00)</td>
</tr>
<tr>
<td>Education</td>
<td>0.18</td>
<td>0.18</td>
</tr>
<tr>
<td></td>
<td>(0.06)*</td>
<td>(0.07)*</td>
</tr>
<tr>
<td>Income</td>
<td>-0.16</td>
<td>-0.16</td>
</tr>
<tr>
<td></td>
<td>(0.02)*</td>
<td>(0.03)*</td>
</tr>
<tr>
<td>Female</td>
<td>0.04</td>
<td>-0.08</td>
</tr>
<tr>
<td></td>
<td>(0.10)</td>
<td>(0.12)</td>
</tr>
<tr>
<td>Pseudo R2</td>
<td>0.16</td>
<td>0.17</td>
</tr>
<tr>
<td>N</td>
<td>2,696</td>
<td>1,811</td>
</tr>
</tbody>
</table>

Note: Also included but omitted from table: employment, race, survey date and state of residence. Cells report model coefficients. Asterisks denote point estimates that were statistically significant (at the p < 0.05 level in two-tailed tests). Partisanship is coded with Republicans as 1 and Democrats as 0 in Model 1 and Strong Republicans as 1 and Strong Democrats as 0 if Model 2. Data are compiled Kaiser Family Foundation Health Tracking Surveys from April of 2010 through April of 2016.

In both models, we find a statistically significant coefficient for the Republican indicator. In fact, of those that had recently purchased an insurance plan, Democrats had a 38% probability of signing up using the exchanges, while Republicans had an 18.4% probability of doing the same. In other words, Republicans who purchased insurance were 20 percentage points less likely to use the exchanges than Democrats who purchased insurance. Moreover, partisan identification is the strongest predictor of having signed up for health insurance on the exchanges.
out of all the demographic characteristics included in the model—over and above the effect of income, education, race, or gender.

Policy Frames and Partisan Uptake

These data make clear that there is a significant gap between the uptake rates of Republicans and Democrats. Additionally, we find that Republicans have been significantly less likely to enroll for health insurance through the government exchanges, even when they do procure health insurance. These effects continue to hold when we control for potential confounders. We argue, however, that this stark inequality in the rate of uptake between Democrats and Republicans is not necessarily a fixed aspect of the debate over healthcare. Instead, asymmetrical uptake might be a reflection of prevailing policy frames, which stress the government’s role in regulating the insurance marketplace.

In order to test whether uptake is responsive to framing, we partnered with a national, non-partisan health outreach organization whose goal is to maximize the number of Americans enrolled in and retaining health insurance coverage. In a large-scale field experiment, we randomly assigned a sample of uninsured individuals to one of two websites through which they could enroll in the healthcare exchanges: either a private website called HealthSherpa.com that emphasizes the private aspects of the ACA, or the government’s website, Healthcare.gov, which emphasizes the ACA’s public dimensions. We then conducted two surveys to assess whether Republicans are more likely to enroll through the exchanges when there is a private “face” on the government effort. In other words, we compare the effect of randomly assigning partisans to either a private or public frame on subsequent policy uptake.
Each website provided a portal through which respondents could learn about and register for health insurance. The processes by which individuals registered through the two sites are parallel and comparable; individuals on both sites are asked to enter their zip codes and a variety of demographic information before an assortment of plans are presented. However, the design of Healthcare.gov makes clear that the healthcare exchanges are government-initiated programs. The website explicitly mentions the “Affordable Care Act,” “Regulatory and Policy Information,” and “Tax Info and Tools;” it emphasizes that the site is a “federal government website managed by the U.S. Centers for Medicare and Medicaid Services;” and it includes a symbol of the White House and USA.gov branding (see Appendix A).

In contrast, HealthSherpa.com emphasizes the private nature of the exchanges, explicitly stating that it “is not affiliated with any lobbying or trade group, or any government agency, and has no political agenda.” Instead, it describes itself as a portal for consumers, providing choice among “innovative products that help consumers easily understand, sign up for and use health insurance.” Imagery on the private site includes photographs of doctors and patients, families in medical waiting rooms, and the logos of major private insurance providers, including Cigna, UnitedHealthcare, and Kaiser Permanente (see Appendix B).

Our sample consists of individuals drawn from the twelve states (AL, AZ, FL, GA, NC, NJ, OH, PA, TN, TX, IL, MI) in which our partner organization maintained a field program during the second open enrollment period. These states were chosen by the organization because they were identified as having particularly large proportions of uninsured individuals. Ten of these states use the federal exchange, while two states – Illinois and Michigan – had state-partnership marketplaces.
People in these states were directed to our partner organization through two sources. First, individuals that reported being uninsured in these states were targeted through the field program and asked to fill out a card committing to enroll in health insurance. These individuals were then re-contacted and directed to our partner organization’s website. The second source of the sample consisted of people that went online to our partner organization’s website of their own accord and filled out a form to get more information about enrollment. From December 2014 through February 2015, roughly 20,000 people went through the digital platform of our partner research organization to express interest in getting coverage. They were then randomly assigned by zip code to one of the two sources of information about and access to ACA marketplaces: the government website Healthcare.gov, or HealthSherpa.com, the private site.1 The information they provided was then matched back to the organization’s database, which contained additional information about the individual from public records and consumer files.

We conducted two follow-up surveys to assess enrollment, the first online and the second by phone. The online survey was conducted in February and March of 2015. Participants in the online survey received an email notification asking them to participate. Invitations were sent to the full email list maintained by our partner organization and the survey yielded 1,329 participants. Of survey participants, 388 live in zip codes assigned to Healthcare.gov and 941 live in zip codes that were assigned to HealthSherpa.com.

In the subsequent phone survey, we attempted to contact a random sample of individuals three months after the close of the open enrollment period in May and June 2015. Calls were made to a total of 4,972 individuals who resided in zip codes assigned to Healthcare.gov; 884 of these individuals completed the phone survey. Calls were made to 6,090 individuals residing in

1 For programmatic reasons, the partner organization assigned 70% of zip codes to HealthSherpa.com and 30% of zip codes to Healthcare.gov.
zip codes assigned to HealthSherpa.com, and 1,144 of these individuals completed the survey. Our research design is summarized in Box 1.

Despite differences in mode, sampling, and response rates, results across the two surveys were substantively equivalent and we therefore combined results whenever possible (i.e., where we asked identical questions across the two surveys). We check covariate balance by regressing treatment assignment on race, income, party, education, gender, and age. The likelihood ratio chi-squared statistic for this model in the phone survey data with six predictors is 3.07. The model p-value (p=0.80) indicates that the likelihood is small that at least one of the regression coefficients in the model is not equal to zero. (Additional details of balance checks are provided in the online appendix).

**Box 1. Field Experimental Design**

![Experimental Sample Diagram]

Our research design relies on the assumption that partisanship and treatment assignment do not influence participants’ willingness to respond to the survey. This is difficult to test,
however, as it requires knowledge of the attempted sample’s partisanship—regardless of whether individuals completed the survey. We had access to data on partisanship from public records for these individuals, but there is considerable noise in the data; the majority (76%) of the sample we attempted to contact by phone call is labeled as partisanship “Unknown.” However, for those whose partisanship we can identify in these records, we find little evidence of response bias. While 20.2% of Democrats made it halfway through the survey, 22.6% of Republicans did the same (p=0.28). With respect to treatment assignment, 14.4% of those assigned to Healthcare.gov made it through the mid-point of the survey and 15.1% of those assigned to HealthSherpa.com did the same (p=0.32). There is also no evidence that treatment interacted with partisan identification to determine survey participation: 18.5% of Democrats assigned to Healthcare.gov completed at least half of the survey, while 21.5% of Democrats assigned to HealthSherpa.com did the same (p=0.12), and 26% of Republicans assigned to the government site made it to the mid-point, as did 20.4% of Republicans assigned to HealthSherpa.com (p=0.20).

In our analyses, we restrict the sample to include only individuals who either remained uninsured or enrolled through the online exchanges (N=1,830). This sub-sample is fairly representative of the population in the 12 states from which it was derived (see Appendix C). The average age of sampled respondents is 44.5 years, 69% of respondents have a college degree, and 63% are male. As expected, the Republican sample (N=178) is slightly older and wealthier than Democrats and Independents.

We first examine rates of enrollment across the entire sample for those assigned to HealthSherpa.com relative to those assigned to Healthcare.gov (presented in Figure 5). Confirming our expectations, we find no significant differences across enrollment rates for the entire sample. When we divide the sample by partisan identification, we also find no effect of
treatment for either Democrats or Independents. Individuals in both groups were equally likely to enroll in health insurance, irrespective of whether they were assigned to the private or public site. However, when we compare enrollment rates for Republicans, the difference is striking. While 27.7% of Republicans reported they enrolled when they were assigned to healthcare.gov, fully 47.9% said they enrolled when they were assigned to HealthSherpa.com ($|t|=2.75; p < 0.01$). In other words, Republicans assigned to the private website were 20 percentage points more likely to enroll in health insurance than those assigned to the public site.

**Figure 5. Percent Enrolled in Marketplace Insurance by Party**

Points represent percent of respondents enrolled in Marketplace insurance by treatment group. Sample split by respondent party identification and include respondents recruited via phone and online. Error bars represent the 95% confidence interval.

How much does the policy frame close the enrollment gap for Republicans? Our initial analysis of the predicted probability of enrolling via the exchanges revealed that Republicans were 11 percentage points less likely to enroll in the exchanges (relative to staying uninsured) compared to Democrats, and 20 points less likely to enroll in the exchanges relative to purchasing another insurance plan compared to Democrats. In both cases, the policy frame
results in a 20 percentage point boost in enrollment for Republicans, which suggests that framing might actually have the potential to close—or even eclipse—the partisan gap in enrollment.

One question these results raise is whether the effect is due to Republicans’ underlying ideology or whether this is instead a byproduct of some other feature of their partisan identity. For example, past work has found that Obama’s close association with the ACA resulted in opinions about healthcare policy becoming intrinsically linked with opinions on race and with attitudes towards the president himself (Tesler 2012). As such, it is possible that assignment to the government website may have primed racial attitudes or negative affect towards the president among Republicans.

Respondents were asked about their approval of the president in one survey, so we are able to provide at least a nominal placebo test of this alternate hypothesis. In a simple comparison of means, we find that the effect of the treatment is not moderated by approval of Obama. While sample sizes are small (N=447) since this question was only asked in the phone poll, there is no distinguishable difference in the rates of policy uptake across those that disapprove, approve or neither disapprove nor approve of the president’s performance in office (see Figure 6).²

Due to the fact that the approval question was asked in only one set of data (the phone poll) and at the end of that survey, our sample size shrinks below levels at which we can reliably examine enrollment within party (N=56 Republicans). However, we find no distinguishable differences in the treatment effect between those that approve and those that disapprove of Obama within any partisan group.

² We also performed analysis based on education and education-by-party and found no meaningful differences across treatment assignment.
Figure 6. Percent Enrolled in Marketplace Insurance by Presidential Approval

Points represent percent of respondents enrolled in Marketplace insurance by treatment group. Sample split by Obama approval and include respondents recruited via phone. Error bars represent the 95% confidence interval.

While the heterogeneous treatment effect does not appear driven by Obama approval, it does appear to associate with underlying ideological beliefs. In the phone poll, we asked respondents to place themselves on a 7-point liberal-conservative ideological scale. In examining the effect of the treatment across ideology, we find that liberals and moderates enroll at the same rate across platforms. In contrast, only 18.5% of conservatives enrolled when assigned to Healthcare.gov, while 39.4% of conservatives enrolled in insurance when assigned to HealthSherpa.com (in Figure 7). This 21-percentage point effect is large and statistically significant (p=0.01).
Points represent percent of respondents enrolled in Marketplace insurance by treatment group. Sample split by ideology and include respondents recruited via phone. Error bars represent the 95% confidence interval.

One final alternate hypothesis is simply that the private website is easier to use, and that this is especially salient given confounding variables like computer literacy and age that differ across partisan groups. Certainly, the early rollout of the ACA enrollment process was marred by technical problems with the government website. The Office of the Inspector General released a 2014 report that put the total cost of the Healthcare.gov site at a whopping $1.7 billion and the Government Accountability Office produced a non-partisan report that stated that the administration did not provide “effective planning or oversight practices” in developing the website (Alonso-Zaldivar 2014). These widely-reported problems potentially served to reify Republican perceptions of the government as inefficient and to spur greater concern among conservatives about government involvement in the private insurance market.
However, when we ask respondents to rate the ease of signing up, the two sites are evaluated comparably (see Figure 6). Those that were assigned to the private website were 6.5 percentage points more likely to say their experience signing up was very easy ($|t|=1.41; p=0.16$), but respondents assigned to the public site were 10.5 percentage points more likely to say their experience was somewhat easy ($|t|=2.27; p=0.02$). Despite these minor differences, respondents overall seemed to consider both websites as relatively easy to use. More importantly, there is no discernible difference in perceived ease of enrollment between websites by partisan identification (presented in Figure 8). Within each group—among Democrats, Independents and Republicans—there is no statistically significant difference in the perceived ease of enrollment based on treatment assignment. As such, differences in enrollment among Republicans assigned to the public-frame site relative to the private-frame site cannot likely be attributed to the functionality of the website alone.

**Figure 8. Perceptions of the Ease of Enrolling by Party**

Points represent means values of how difficult the process of enrolling for health insurance on the online marketplace was (coded from 0 to 1 where 1 is very difficult and 0 is very easy). Respondents recruited by phone and online are included. Error bars represent the 95% confidence interval.
Discussion

It is not surprising that partisans in the mass public hold distinct views of Obamacare. Partisan elites have staked out clear and opposing positions on healthcare, sending explicit signals to the public about where partisans in the electorate should stand on the policy reform. As one political pundit concluded, remarking on the particularly bitter debate in Congress over the ACA, Republicans and Democrats “have existentially different views of the world” when it comes to what government can do well, what it should be doing, and how much of a role American government should play in the health policy domain (*The Guardian* 2011).

In addition to these differences in partisan attitudes towards health reform, though, we hypothesized that partisanship would be a strong predictor of whether or not individuals actually chose to take advantage of health insurance options made available through the state and federal exchanges. Specifically, we expected Republicans to evidence greater resistance when it comes to policy uptake. Descriptive data from the Kaiser Family Foundation confirmed this expectation.

Given this finding, we hypothesized that Republicans would be more responsive to a policy frame emphasizing the private nature of the Affordable Care Act, as opposed to one that highlighted the role of government in the health insurance marketplace. Data from a 12-state field experiment provided evidence to support this contention: Republicans were much more likely to enroll through the state and federal exchanges when they were randomly assigned to a portal emphasizing the private aspects of the ACA. In addition, we find evidence to suggest that
this behavior is associated with ideological attitudes, as opposed to either sentiments about the president or the relative ease of enrollment.

These findings suggest a variety of compelling directions for future research. One clear next step is to examine whether our effects are moderated by variation in the strength of partisanship. Our sample for this study necessarily consisted only of individuals who took the initial step of going on-line to seek information about health insurance options. Certainly, there may be some uninsured individuals from our target states who are excluded from this sample due to non-political characteristics, such as a lack of information, a lack of motivation, or the inability of our partner organization to contact these individuals. We might expect many of these individuals, if they could be contacted and encouraged to go to the government website or HealthSherpa, to respond similarly to those in our sample. However, those who are particularly ideologically resistant, and who for this reason resist even going online to investigate their insurance options, might plausibly be less influenced by the treatment.

Future work might also assess whether partisanship interacts with other demographics to influence both uptake and responsiveness to policy frames. For instance, we have substantial evidence suggesting that political interest, as well as income and education, are important moderators of partisanship when it comes to how citizens seek out and process policy information (Zaller 1992). It stands to reason that these interaction effects might similarly shape policy behavior, though we do not find statistically significant effects of the treatment by income or education either within party or across the entire sample.

Our results on the ACA also lay the groundwork for a fruitful agenda related to uptake more broadly. Given large gaps between eligibility for a wide range of public benefits and rates of policy uptake (Health and Human Services 2007), we suspect our findings have significant
implications across a host of major government programs. Replicating our results as they apply to other policies and programs would help to elucidate whether specific aspects of programs themselves, such as the stigmatization of participants, interacts with partisanship in predictive ways. In addition, this would allow us to examine whether macro-political dynamics shape the ideological aspects of implementation; for instance, we suspect that more polarizing policies at the elite level should evidence larger ideological gaps when it comes to citizen uptake.

Finally, we would note that we were limited in our ability to shape the specifics of the ideological-framing treatment. This was a calculated compromise; one of the best ways to gain external validity is to work with external organizations and test for treatment effects in a field experimental context. The strength of using a field experiment to examine our questions of policy uptake is twofold. First, like any experiment, this study employs random assignment to hold everything constant except for the treatment. Any differences we see in the outcome variables are thus attributable to the treatment alone. Second, this experiment was conducted in the context of an actual open enrollment insurance period and uninsured Americans in our twelve states were in contact with a well-established health policy organization, rather than with researchers from a University. As such, there was little risk that subjects recognized or responded as if they were part of an experiment.

However, while the process of signing up for health insurance was comparable across the public and private website, the actual aesthetic design and text of the sites were different in a number of ways, making this study a test of a “grand treatment” rather than a single manipulation. While numerous references to the government and to legislation on Healthcare.gov (as opposed to the absence of any such references on HealthSherpa.com and an emphasis instead on doctors and private insurance companies) helps explain the potency of the
treatment, it also makes it impossible to determine which specific cues, symbols, references or text on each site had the most influence on the outcome. Future work might attempt to isolate more specific aspects of the treatment that shape uptake, such as identifying whether visual symbols or text have distinct effects.

It seems similarly useful to pursue a line of scholarship to examine whether other ideological frames, beyond “public versus private,” shape policy behavior. Potential frames might include a focus on in-group effects, such as by emphasizing the costs or benefits that accrue to members of one’s own political party, or a focus on moral arguments that previous work has found to be particularly compelling to either Republicans or Democrats (Feinberg and Willer 2015). We might also estimate the effects of the same policy frame, but experimentally manipulate the source of the frame, such as whether it comes from in-partisan or out-partisan elites.

These various streams of future scholarship could build substantially on the novel framework we have outlined here. To the best of our knowledge, ours is the first study to systematically explore the role of partisan identification in shaping policy uptake. We find that party and political ideology matter in predicting whether individuals will enroll in public programs. In addition, ours is the first field experiment to show causal evidence that highlighting the private aspect of the health insurance marketplace relative to emphasizing the public aspect has a positive effect on Republicans’ rate of insurance enrollment.

Taken together, our results have broad implications for the ways in which we think about both policy implementation and uptake. There are significant partisan differences in support for a wide range of social policies – especially policies that are considered part of the social safety net. In a recent Pew Research poll, about three-quarters of Democrats (74%) expressed the belief that
government has a responsibility to take care of those who cannot take care of themselves. Only 38% of Republicans said the same (Morin et al. 2012). Our results make clear that these differences in attitudes may translate to sizable differences in uptake across partisan groups, resulting in significant effects on the wellbeing of a large number of citizens (Barsky et al. 1997). Indeed, our results make clear that politics is a critical part of the policy implementation process, and plays a central role in determining who takes advantage of government benefits.

Previous scholarship on uptake has focused attention on a variety of policy levers that can be used to increase program participation: incentives and penalties, commitment devices, information campaigns and streamlined signup processes, among others. By identifying partisanship as a key predictor of uptake, we are able to test a distinct way that advocates, nonprofits and government might increase enrollment: targeted policy framing, which might help recipients situate programs within an acceptable ideological framework. In fact, our results suggest that such partisanship is a stronger predictor of uptake on the ACA than any other basic demographic indicator, but that targeted framing has the potential to close the partisan gap.
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### Appendix C. Demographic Characteristics of Analysis Sample

<table>
<thead>
<tr>
<th></th>
<th>Full Sample</th>
<th>Democrats</th>
<th>Independents</th>
<th>Republicans</th>
<th>Other</th>
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<td>Age</td>
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<td>Income(^1)</td>
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<td>393</td>
<td>178</td>
<td>585</td>
</tr>
</tbody>
</table>

\(^1\)Income is coded by quartile from 1 (lowest income) to 4 (highest income). \(^2\)College is coded 1 if respondent has college experience and 0 otherwise. \(^3\)Male is coded 1 if respondent identifies as male and 0 otherwise. Number of respondents varies by question, total number is reported.