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How is COVID-19 Associated Job-loss affecting Support for Medicare for All?

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Introduction

Sixty percent of working-age Americans[1] received health insurance through an employer-sponsored plan in 2019 (KFF, 2019). Consequently, the massive job losses associated with the COVID-19-induced economic downturn have led to an estimated 27 million Americans losing their employer-sponsored health insurance between the start of the pandemic and May 2020 (Garfield, Claxton, Damico, Levitt, 2020). Given that alternative insurance options are often unaffordable, at least 30 million working-age Americans are now estimated to be uninsured in the midst of a pandemic (Garfield & Colbert, 2020).

The pandemic highlights the risks of relying on employer-sponsored health coverage in two ways: (1) millions of Americans have lost their jobs and therefore health coverage (for any illness) and (2) the pandemic itself brings increased risk of illness and associated costs, as a potential COVID-19-related hospital stay could cost tens of thousands of dollars (KFF, 2020). The increased salience of these risks may affect Americans' views about health insurance in general, and the risks of linking insurance to employment in particular. If so, it offers an opportunity for advocates of expanded health insurance coverage to highlight the limitations of employer-sponsored coverage and make the case for de-linking insurance from employment.

Prior to the emergence of COVID-19, policies to achieve universal health coverage (UHC) through Medicare for All were already on the policy agenda in the US, most notably during the 2019-2020 Democratic presidential primary campaign, when health care was at the center of the debate. Various Democratic candidates proposed plans to increase coverage options. These ranged

[1] The number of working-age Americans is estimated at 214 million.

from wrap-around policies that would fill in gaps in the existing system (labelled as "Medicare for All who want it" or "Medicare buy-ins") to more expansive visions of "Medicare for All" (hereafter, M4A) which has become shorthand for single-payer insurance with universal coverage in the US. Among the plans offered during the 2020 primary season, only Medicare for All would fully de-link health coverage from employment and provide universal, tax-financed health insurance coverage (Uhrmacher, Schaul, Firozi & Stein, 2020). Recently popularized by Senator Bernie Sanders, M4A has been bolstered by a surge in support from progressive left leaders and activists.

Despite the growth in support from progressives, M4A still faces challenges, even within the Democratic party. In June 2020, the candidates most associated with M4A, Sen. Bernie Sanders and Sen. Elizabeth Warren, lost the primary to former Vice President Joe Biden. Biden supports a plan to expand health insurance coverage, including with a public insurance option, but did not support Medicare for All.[2] In August 2020, only 28% of the 161 Democratic National Convention delegates voted to include Medicare for All on the party's platform in the August 2020 convention, (Blanc, 2020).

As this intra-Democratic primary election was concluding in Spring 2020, the COVID-19 pandemic, and unprecedented job loss, became a feature of American life. In this paper we examine whether elements of this pandemic, notably job and health insurance loss, have the potential to change opinion about universal health coverage plans such as Medicare for All.[3]

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[2] In this paper, we will use the term "Medicare for All" (M4A) to refer specifically to single-payer plans that separate insurance from employment through broad-based tax-financing and distinguish it from more incremental "Medicare-for-More" plans that would expand coverage while preserving employer-sponsored coverage as its foundation.
[3] about half of Americans — and 78% of Democrats — supported M4A in May 2020 (KFF, 2020).

Our theoretical motivation on opinions toward health insurance coverage builds on Jacobs and Mettler's (2011) framework of "situational" versus "structural" framing of public opinion about health care. Jacobs and Mettler (2011) argue that public opinion about the US health system is rooted in "structural" factors, which reflect the long-standing institutionalized interactions that citizens actually have with health insurance and the health care system. This suggests the salience of one's own lived experience largely shapes views toward health care and health insurance policy questions. However, in the short run opinions can also vary depending on situational framing, *i.e.*, the way the message is conveyed and the moment or context in which it is conveyed. Such frames may temporarily boost the salience of issues outside one's lived experience. While these situational frames can alter support in the short-term, long-term preferences toward government policy are relatively stable, usually only changing substantially in response to new information or developments (Page and Shapiro 1992), or in response to broader dynamics of partisan opinion change.

There is some indication that support for M4A has increased since the onset of COVID-19 in the US in March 2020. For example, polling by Morning Consult showed a 9 percentage-point increase in support from M4A between February and March 2020 (Murad, 2020). However it remains unclear if COVID-19 is enough of a disruption that it causes structural change in public opinion towards M4A, or whether it is more likely result in a temporary situational boost, which can be easily counteracted by opposition messaging and appeals to partisanship. How can broad structural support for universal health coverage be reconciled with situational framings that often dampen or only temporarily stoke support? In this paper, we explore preferences toward employer-sponsored health coverage versus universal tax-financed health coverage among a sample of 1,211 Americans amidst the COVID-19 pandemic.

First, to understand sensitivity of M4A support to the salience of job (and insurance) loss and how it is framed, we experimentally expose respondents to an emotive narrative about job-loss, with or without a COVID-19 component. In our two treatment groups, we present one of two vignettes of identical, sympathetic victims who experience no-fault job-loss — in one case due to COVID-19 and in another due to technological and market changes. A control group in this survey experiment receives no vignette. Through this experiment, we ask: does the salience of job-loss, and consequent insurance loss, impact stated levels of support for M4A? Priming respondents about job-loss and the risks associated with reliance on employer-sponsored coverage in the context of a global pandemic and economic crisis may alter opinions on M4A. We hypothesized that the exposure to any job-loss vignette will increase support for M4A and that the COVID-19-induced job-loss will have a stronger effect. We further hypothesize that the effect of the framing experiment will vary based on political partisanship and job loss. Specifically, we hypothesize that Independents will be more susceptible to shifting their support towards M4A than those who clearly identify with one of the two major parties. We further hypothesize that people who have recently experienced a job loss and are therefore more personally affected will be more affected by the experimental frames. The survey experiment was pre-registered with Evidence in Governance and Politics (EGAP) and results are reported according to the original study design.

As a preview of the findings, we find that any priming with a job-loss vignette — COVID-19 associated or not — increases support for M4A compared with no priming. We find that priming respondents specifically with a COVID-19 vignette leads to a greater increase in M4A support relative to control, as opposed to priming with another vignette on job-loss. However, the results are modest in magnitude, and sensitive to different ways of assessing M4A support. We find no

differences in the impact of Coronavirus priming by party ID or between those who have personally experienced job loss and those who have not.

The remainder of the paper is organized as follows. First, we review relevant literature on factors influencing support for M4A, and for redistributive programs in general, focusing on findings from the experimental literature. Next, we present the methods and results of our experiment, followed by discussion and conclusions.

Background

Medicare for All

Many health policy experts agree that Medicare for All is a viable model of universal coverage, and view the barrier to this reform effort as lying less in the policy's technical feasibility, but rather in the political feasibility of its adoption, financing, and implementation in a US context (Berwick, Nolan & Whittington 2008). A key part of the political feasibility of reform to M4A is public opinion.

Medicare for All (M4A) plans, in substance if not in name, are generally popular with the public, with majorities expressing support (KFF, 2020; Shapiro and Jacobs 2010).[4] In public opinion polls, large majorities (60%-70%) of the public have consistently, over the past two decades, favored a greater role for government in health care and 50%-60% have been found to be supportive of single-payer health care in general or M4A in particular (Bekkers & Wiepking, 2010;

[4] https://www.dataforprogress.org/memos/Medicare for All-polling

Steinmo & Watts, 1995).[5] Likewise, a majority of US physicians, a group once overwhelmingly opposed to a national health plan, now support a single-payer system (Bluth, 2017).

However, previous studies of the single-payer issue have found support for the policy idea to be highly contingent on question wording and framing of the issue (Karra and Sandoe, 2020). The issue is particularly susceptible to a number of common forms of attack, with high initial support followed by a decline in enthusiasm as the details of the policy come to light (KFF, 2020). Certain stylized counterarguments tend to depress support for M4A — for instance, the idea that a single-payer system could increase wait times for appointments, lead to large tax increases, a doubling of the government budget, and constitute a "government take-over" of health care limiting "choice." This point-counterpoint can be viewed regularly in newspaper reporting on the issue and in arguments circulated by groups with a vested opposition to single-payer (such as representatives of the insurance industry) (New York Times Editorial Board, 2019).[6] The presentation of these counter-arguments tends to dampen initial enthusiasm in and can even tip majority support into opposition polling (KFF, 2020).[7]

Conversely, opposition to health reform toward single-payer can be overcome and support of such plans strengthened with specific frames. Barabas *et al.* (2020) find that providing survey respondents with policy "analogies" for health programs increased support (such as car insurance to describe the "individual mandate" of the Affordable Care Act). Other recent survey experiments

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[5] See *e.g.*, Gallup historical trends: https://news.gallup.com/poll/4708/healthcare-system.aspx; and KFF, 2020: https://www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable

[6] Realities of Single-payer website: https://realitiesofsinglepayer.com/?gclid=EAIaIQobChMIlcztxLzc4AIVoQd9Ch0bzQt9EAEYASAAEgI_YvD_BwE

[7] See Figure 9 of KFF, 2020 Report

find that simpler framing elements can also increase support for the policy — for example by including the policy name "Medicare For All" with a description of the policy (Karra and Sandoe, 2020).

The Medicare for All issue therefore presents a paradox. On the one hand, the public demonstrates strong and enduring policy preferences for a larger role for government in health care — a view that is favorable towards M4A. On the other hand, at critical moments, such as during high profile health reform debates, opinions appear rather easily manipulated by political elites who are able to move public opinion away from its normally favorable status towards greater polarization (Jacobs & Mettler, 2011).

These temporary movements may be driven by "issue framing," which allows individuals and groups to highlight some aspects of the problem to emphasize certain causal links (which may or may not be accurate) that temporarily dampen support at critical moments (Entman, 1993). Frames, classically defined as "schemata of interpretation," are socially constructed and negotiated through "a politics of signification" (Hall, 1982). More colloquially, issue frames represent the "spin" that different actors put on issues to elicit popular support. Health issues frequently typify a competitive framing environment, where two sides or opposing arguments compete with each other in the public sphere (Chong & Druckman. 2007).

Jacobs and Mettler (2011) suggest that there are two types of frames: "Situational framing," which focus on short-term dynamics and to tend to emphasize the impact of discrete messages communicated by individual speakers in particular situations; and, "structural framing" which refers to the ways that institutionalized public health and health care policies impact public opinion and behavior over time through their actual effect on people's lives.

Crises, such as the COVID-19 pandemic that struck the US starting in early 2020, can act as shocks that could theoretically disrupt equilibria and lead to more structural changes in public opinion, as well as changes in political composition/ alignments that may facilitate policy change (and ultimately feedback on attitudes) (Baumgartner & Jones, 1993). However, situational frames may still be invoked that counteract these popular tendencies at critical junctures. A search of Google Scholar for the terms "COVID-19 and Medicare for All" brings up over 83 million weblinks. Scrolling through them illustrates the already polarized nature of the policy debates with a first headline reading "COVID-19 is not an argument for Medicare for All"[8] and a second stating "COVID-19 proves U.S. needs Medicare for All."[9]

The widespread use of situational frames by political elites in a fragmented media market has given rise to concern about how "frame contests" may be contributing to growing political polarization in the U.S. (e.g., Baum, 2011). However, unlike climate science, where the polarization has emerged along factual lines, competing arguments in the health reform field tend to draw more heavily on value conflicts (i.e., health care as a human right versus a government take-over of health care), leading to a highly politicized issue environment. In issue areas with a high degree of value conflict, such as health care, messages designed to appeal to certain values may be more effective in garnering support than messages that rely on scientific information or factual evidence alone (Kreitzer, 2015).

[8] See here: https://www.realclearhealth.com/articles/2020/05/27/ COVID-19_is_not_an_argument_for_Medicare for All__111050.html

[9] See here: https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2020/05/26/the-health-202-COVID-19-proves-we-need-Medicare for All-its-advocates-say/5eca592688e0fa6727004311/

One set of theories about attitude formation posits that *values* are logically prior to *facts* in judging how people receive and process information (Kahan, Jenkins-Smith & Braman, 2011). For instance, research on non-profits and charitable giving has demonstrated that people are more compelled to tithe by social images of suffering rather than the presentation of statistics alone, hence the widespread use of pictures and testimonies of identified victims rather than statistics in donation campaigns. Insights from studies of charitable giving also suggest that values of prosocial behavior and altruism can be drawn upon to motivate people to donate out of concern for the welfare of others and not only by self-interest, if for nothing else then at least for the "warm glow" they get psychologically from helping others (Bhati & Eikenberry, 2016; Tremblay-Boire & Prakash, 2017). This is especially the case when the recipients are constructed as "blameless victims" who had no hand in their own situation (Clark, 1997; Dunn, 2004).

However, the darker side of cognition theory suggests that people may be more motivated by fear of loss than the joy of potential for gain, known broadly as "loss-aversion" (*i.e.,* we derive more pain from losing $100 than pleasure from unexpectedly gaining $100) (Sunstein, 2005). Within the health care debate, there are broadly two sets of value arguments that have been employed on either side of the debate. On the one hand, supporters of single-payer tend to use broad social appeals that emphasize the "right to health" and draw on tragedies of uninsured people that appeal to prosocial, altruistic values, while opponents frame single-payer as a "socialist" policy aimed at increasing taxes, reducing choice, and disrupting peoples' existing relationship with their medical care provides, thereby stimulating loss aversive reactions. To the extent that fear of loss stimulates more profound reactions than the appeal of gains, Medicare for All may be at a disadvantage in that it primarily holds out an uncertain promise of potential gains (*i.e.*, reduced costs, greater efficiency and a more equitable distribution of benefits), against the potential for a

reduction in benefits, choice and competition. For the majority of Americans who feel that they have decent health coverage, this fear of loss may outweigh the potential gains and prosocial impulses, especially if the gains are perceived to mainly accrue to those other than themselves (*i.e.*, the uninsured or underinsured).

However, ultimately, these value-based frames may be merely situational given longer term and generally positive overall reactions to the idea of having more government involvement in health care and coverage for all. Our study design allows for examination of both situational and structural elements of opinion formation and change around Medicare for All. First, to examine the effect of situational framing on attitudes towards Medicare for All, we examine how priming respondents about the effects of job loss on insurance coverage impacts their attitudes towards Medicare for All with a survey experiment. Second, given the broader context of the pandemic, we examine the association between recent job/insurance loss and attitudes towards Medicare for All. We anticipate that the saliency of job/insurance loss during a pandemic will build new constituencies of Americans that find themselves outside of employer-sponsored coverage, highlighting the economic insecurity associated with tying benefits to employment for the broader public at large in ways that may reconfigure the Medicare for All issue moving forward. In this way, we aim to more critically examine the findings of the survey experiment in light of concerns about how framing might be used by motivated political actors to manipulate public opinion and discuss the possibility of that the COVID-19 pandemic has affected the "structural framing" of attitudes towards M4A in the long term (Jacobs & Shapiro, 2000; Jacobs & Mettler, 2011).

Methods

Sampling and data collection

We conducted an online opinion survey with a national sample of 1,211 Americans between 3 and 8 June 2020, during the height of the COVID-19 lockdowns in the US. Respondents had to be at least 18 years of age and consent to completing the survey. The project underwent ethical review and received approval from XX's Institutional Review Board.

We used the third-party firm Qualtrics to sample the respondents and administer the survey. Qualtrics is an internet survey provider that recruits respondents who have signed up to take online surveys in exchange for incentives such as cash, airline miles, and gift cards. Qualtrics aggregates respondents initially recruited by other firms. Recruitment and compensation are handled by the third-party firm but researchers may define the audience and specify certain quotas. Respondents are typically compensated $4.50 for each 15-minute survey that they complete (of approximately 60-80 questions).

While Qualtrics does not provide not a probability sample of the US population as a whole, a recent study found that among internet survey providers, a Qualtrics-recruited sample came closest to a national probability sample on most variables relative to samples recruited through Amazon MTurk or Facebook- (Boas, Christenson & Glick, 2018). Boas *et al*. find their Qualtrics sample reported lower incomes, were younger, more highly educated and less likely to be black or Hispanic compared with what one typically finds in a probability sample of the US population as a whole. We report on key characteristics of our sample, including comparisons to the US population, below.

On average, respondents who completed the survey spent 15 minutes doing so. Qualtrics provides quality-control measures to weed those who do not complete the survey, who do not appear to be taking the survey seriously (such as "speeders") as well as those who appear to be bots based on input provided in open-ended questions. Twenty percent of the starting sample was dropped through the quality checks, leaving us with an analytic sample of 1,211 high-quality responders.

Experimental conditions and randomization procedure

Our experimental condition is a vignette about job loss, intended to prime the reader to think about job loss and consequent loss of employer-sponsored health coverage. When a respondent signed into the Qualtrics survey, they were randomly assigned to one of three groups with equal probability: the control (no vignette), the COVID-19 vignette, or the Airbnb vignette, described below.

In each of the experimental conditions, we present the job-loss vignettes as brief newspaper articles at the beginning of the survey, narrating the story of a white, male, former football player ("Sean McGuire") who gets laid off from his job as hotel concierge in Philadelphia and loses his employer-sponsored health coverage. In one vignette (hereafter "the COVID-19 vignette"), Sean is laid off due to COVID-19-induced economic downturns — plausible as COVID-19 hit the hospitality industry hard. In the second experimental condition, the lay-off is due to competition from Airbnb ("the Airbnb vignette"). We take this second condition as a "normal" unemployment condition related to market changes. Please see the Appendix for the full vignettes.

We chose to use a newspaper article to present the vignette in order to simulate how people might receive information in the real world. The article was adapted from an actual news story.

We chose for the protagonist in the vignette to be a white male in order to avoid known racial biases/empathy gaps in redistributive politics (e.g., Alesina, Glaser & Sacerdote, 2001). In both conditions, we take Sean to be a generally sympathetic victim and his job loss to be no-fault. At the end of our survey, respondents were informed that the newspaper article they had read was fictitious but that the information provided in it was accurate. We included two comprehension questions following each vignette to ensure respondents actually read it and understood the main message (why Sean lost his job and why he lost his health-insurance).

Outcome variable

Our main outcome of interest is support for Medicare for All. Our primary outcome variable is a question that explicitly asks about favor or opposition for Medicare for All, elicited in the following way:

> *"As of today, do you favor or oppose a national health plan or 'Medicare for All' plan, in which all Americans would get their health insurance from a single government plan?"*

Respondents could select: strongly favor, somewhat favor, somewhat oppose, or strongly oppose this statement, or report that they don't know. We show the breakdown of responses in Table 1.

Table 1: Main Outcome Variable- Support for Medicare for All

As of today, do you favor or oppose a national health plan or "Medicare for All" plan, in which all Americans would get their health insurance from a single government plan?

	N	%
Strongly Favor	442	36.5
Somewhat Favor	372	30.72
Somewhat Oppose	164	13.54
Strongly Oppose	135	11.15
Don't know	98	8.09
Total	1,211	100

For analysis, we dichotomized this 4-point Likert scale into support for, opposition to M4A retaining Don't Know as a separate category (we explain and justify this approach below).

We also ask about support for health care reform options through several other questions. We explore these additional as robustness checks presented in the results.

Data analysis

Prior to data collection, the survey experiment was pre-registered with Evidence in Governance and Politics (EGAP) and results are reported according to the original study design. All analyses were completed in Stata 15 according to the original analysis plan. In all of our analyses, we control for sex, age, income, political party affiliation, and race/ethnicity. We modelled the main outcome variable using ordered logistic regression retaining Don't Know as an independent category. After multiple robustness checks, this was our preferred model because we found descriptively that much of the effect of the treatment conditions on support for M4A came from movement of people from the Don't Know category in the control condition to a more favorable position towards M4A in the treatment conditions. **Table 2** below shows the main outcome variable broken down across the treatment arms. We observe a 5 percentage point

difference between the Control Arm and the COVID-19 study arm in the percent reporting that they "Don't Know" as well as a 6 percentage point difference in Favoring M4A moving support from 64% in the control condition to nearly 70% in the COVID-19 arm and 69% in the Airbnb arm. This suggests that the effect of the experimental arms may work primarily through changing the views of people with less well-formed preferences to be more favorable rather than moving people from the opposed category to the favorable category. For this reason, we retain the Don't Know category in our analysis. However, we also run the models with the Don't Knows removed and find that the results are *not* robust to their removal. In other words, without the Don't Knows we find null effects (see Results below and Appendices). We therefore present these results as modest and contingent effects.

Table 2: Support for Medicare for all by Treatment Arm

	Control	**Arm 2 (Airbnb)**	**Arm 1 (COVID-19)**	**Total**
Don't know	48	30	20	98
	10.96	7.67	5.24	8.09
Oppose	111	93	95	299
	25.34	23.79	24.87	24.69
Favor	279	268	267	814
	63.7	68.54	69.9	67.22
Total	438	391	382	1,211
	100	100	100	100

Pearson chi2(4) = 9.9115 Pr = 0.042

To explore the moderating effects of variables such as party affiliation and job-loss/insurance loss, we interacted each variable with the overall treatment (either job-loss vignette) to estimate the joint impact on support for Medicare for All. We repeat these models with different question wordings and with the Don't Knows removed (results available in the Appendix).

Robustness checks

We compare the results of the main outcome measure with two other measures of support for Medicare for All. The first alternative is a continuous measure that allows respondents to rate their support, on a 10-point scale, at or between the poles of "a government insurance plan that would cover all medical and hospital expenses for everyone" and a system in which "medical expenses should be paid by individuals through private insurance plans like Blue Cross or other company paid plans." In the second alternative, respondents choose between three options that might best-describe their opinions: "incrementally building on the Affordable Care Act," "reversing the Affordable Care Act and moving towards more private health insurance coverage," or "creating a universal Medicare for All system that would replace employer-sponsored health insurance coverage." Full question wordings and descriptives are in the Appendix.

These alternate question wordings allow for more nuanced responses that can distinguish between those who are "true believers" in Medicare for All (and decoupling insurance from employment) versus those who want broader coverage, but within the confines of the primarily employer-sponsored insurance paradigm. We ran the similar models for the two other main outcome variables as a robustness check (see Appendix).

Sample balance. The sample was mostly balanced across experimental conditions on key covariates with the exception of age (See **Table 3**). The control condition was significantly younger with 20% of respondents in that condition being under 25, compared to between 10-12% in other study arms. Party identification, ethnicity, income and gender were balanced across treatment arms. We present both unadjusted models as well as those which adjust for age and other covariates (gender, race/ethnicity, income, party ID).

<<**Table 3** about here>>

Hypotheses

We hypothesized that, relative to no priming, stories of both types of job-loss would trigger an emotive response— either empathy towards those losing health insurance due to no cause of one's own or fear for self— which would in turn trigger increased support for health insurance reform that moves away from employer-based coverage toward a single-payer M4A model. We further hypothesize that — in the context of an unprecedented health crisis — priming respondents with a story about COVID-19-related job-loss would lead to more support for single-payer than a story about "no-fault" job-loss unrelated to the pandemic. The rationale is that this can isolate the COVID-19-specific increase support in M4A, by making it salient for only one treatment condition, while keeping the background condition of job-loss consistent across the treatment arms. In addition, these treatments separate individuals who see "normal" unemployment as in some sense the fault of unemployed workers (and part of the normal functioning of a free market economy) from those who see COVID-19-related unemployment as clearly not the fault of the worker and a result of an unusual crisis, which demands a policy response. If the former rationale is pervasive, the COVID-19 priming message could result in additional support for Medicare for All. On the other hand, both vignettes depict a cause of unemployment that falls outside the control of the individual and the challenges this raises to a system dependent on employer-sponsored health coverage.

In addition to this overall priming effect, we examine potential moderators of the priming effect on M4A support, also pre-specified in our EGAP-registered analysis plan. These include:

(1) partisanship, and (2) personal experience with recent job-loss/insurance loss. We elaborate on our hypotheses concerning each of these below.

Political party: Strong partisans may have more rigid attitudes, and therefore be less susceptible to priming. This view aligns with theories of motivated reasoning, which suggest that strong political partisans will be unlikely to change their core positions and may even dig in their heels more firmly in the face of counter-evidence (Strickland, Taber & Lodge, 2011). We therefore hypothesized that among strong partisans of either political party, the priming message would have limited impact. In contrast, we hypothesized that self-described Independent voters and those with looser party affiliations, would be more likely to shift opinions in response to priming.

Recent job-loss: We additionally consider whether having personally experienced a recent job-loss moderates the impact of the priming message. This personal experience could represent a structural basis, in lived experience, for a change in opinion, which would interact with the situational experimental condition. Previous research has shown that individual vulnerability, such as anxiety about one's personal medical expenses, moderates partisan opinion on health care policies such as the Affordable Care Act (Henderson & Hillygus, 2011). We hypothesize that having experienced a recent job-loss and/or insurance loss will strengthen the impact of the priming messages.

Finally, we additionally considered how alternative question wordings of M4A alter support for this policy change, as well as whether they change the experimental finding. As previous research has found that including the policy name "Medicare For All" with a description of the policy increases support (Karra &Sandoe, 2020), we use this as the baseline question, but

also examine question wording that do not mention Medicare for All or provide a "middle-ground" option of expanding the ACA.

Results

Large majorities of the sample reported supporting Medicare for All (67%; 37% strongly) (Table 1). In bivariate analysis across the study arms, there was a 5-6 percentage point difference between support for M4A in the control arm versus each of the two study arms (Table 2). Our survey also collected information about pandemic related health insurance and job loss. Thirteen percent of respondents lost health insurance since the start of the pandemic because of losing their job, and 9% lost health insurance for other reasons. (i.e. over 1 in 5 respondents lost health insurance for some reason since the beginning of the pandemic). Another 18% report that someone close to them lost HI because of losing a job, and 5% report that someone close to them lost health insurance for other reasons. Twelve percent of the sample reports that they have lost their job since the start of the pandemic and an additional 8% were furloughed.

In multivariate analysis, we first examined each study arm separately and then pooled the study arms into any arm. Examining the study arms separately, we find that priming respondents with an emotive vignette of a sympathetic victim having lost his health insurance due to Coronavirus-induced job loss significantly increases stated support for M4A compared with a comparison group with no vignette (coef= 0.40, $p<0.05$) (**Table 4**). We also find that any priming with a vignette about non-Coronavirus-induced job loss increases support for M4A compared with no priming though with weaker effects (coef= 0.25, $p<0.1$) (**Table 4**).

Table 4: **Multivariate Ordered Logistic Regression Results, Separate Study Arms**

VARIABLES	Support M4A COVID-19 arm (w/ controls)	Support M4A COVID-19 arm (no controls)	Support M4A Airbnb arm (w/ controls)	Support M4A Airbnb arm (no controls)
Control (ref)	Ref	Ref	Ref	Ref
COVID-19 Study Arm (Arm 1)	0.33**	0.40**		
	(0.044 - 0.621)	(0.088 - 0.704)		
Airbnb Study Arm (Arm 2			0.24	0.25*
			(-0.046 - 0.522)	(-0.045 - 0.551)
/cut1	-2.26***	-3.40***	-2.16***	-3.06***
	(-2.533 - -1.980)	(-4.059 - -2.748)	(-2.422 - -1.893)	(-3.701 - -2.428)
/cut2	-0.54***	-1.52***	-0.55***	-1.34***
	(-0.730 - -0.342)	(-2.129 - -0.914)	(-0.745 - -0.358)	(-1.938 - -0.740)
Observations	820	820	829	829

Notes: ci in parentheses
*** p<0.01, ** p<0.05, * p<0.1
Controls included but not shown (gender, race, income, party ID)

Next, we compared any treatment effect to the control and introduced the moderating variables of political partisanship and job/insurance loss (see **Table 5**). Compared with the control group, respondents who received the emotive vignette increased their support overall (coef=0.4, p<0.1). Receiving either vignette therefore produced significantly higher support than no vignette around the same magnitude. However, when we replicated these models across the other two question wordings, we did not get significant results, though the results trended in the same direction (see Tables A2 & A4 in the Appendix). Logistic regression results for models with the Don't Knows removed are also in the Appendix (Table A5). When the Don't Knows are removed, the model loses statistical significance though results were similar.

<<Insert **Table 5** about here>>

Exploring moderating effects of Party-ID and Job/Insurance loss

We find no significant differences in the impact of COVID-19 priming by party ID or between those who have personally experienced a loss of job/insurance and those who have not. Contrary to hypothesis, Independents were not more likely to switch their positions and both Republicans and Independents were less likely to support Medicare for All compared with Democrats. While the effect of the frames did not vary by job/insurance loss, we found a large effect of having lost ones insurance during COVID-19 on support for M4A (coef.= 0.52, $p<0.01$). By contrast, job loss on its own was not associated with greater support for M4A suggesting a more direct effect of exposure to risk from insurance loss on support for M4A . Moreover, when asked directly whether COVID-19 had changed their views about whether the US should move towards a "Medicare for All" plan in which all Americans would get their health insurance from a single government plan, 54% reported that they felt more favorable (see Table A6).

Discussion

We find a modest effect of an emotive vignette on support for Medicare for All compared with receiving no additional priming in the context of the Coronavirus pandemic. The effect was stronger in the COVID-19 prime and appeared to primarily work through moving people who would otherwise have had ill-formed preferences on Medicare for All into the more supportive category. We also find an increase in support for Medicare for All in a condition with job loss unrelated to the pandemic, though more weakly so. The effect of receiving was stronger than any one prime on its own. This suggests that a situational frame that provides additional information linking the impact of job loss to insurance loss may help solidify people's views on Medicare for All whether related to COVID-19 or otherwise. Practically speaking, this demonstrates that

advocacy efforts and news articles with the aforementioned headlines such as "COVID-19 proves U.S. needs Medicare for All," may be effective at moving opinion, at least temporarily. However, since counter-frames were not tested (i.e., that "COVID-19 is not an argument for Medicare for All"), we cannot assess how similar subjects respond to competing frames. The frames were not more likely to move people who identify as Independents nor Republicans though suggesting that perhaps the frames primarily evoked stronger support among those already favorable towards more government intervention in healthcare.

Beyond these situational frames, there is a structural element to opinion as well: Larger than any of the priming effects was the association between losing insurance since COVID-19 on M4A support. This suggests that the "structural" drivers of opinion about M4A are larger than any priming effects. While it remains too early to tell, those who have lost valuable employer-sponsored insurance may serve as a future constituency in support of M4A. Within the sample, there was quite broad support for M4A- nearly 70% of the sample registering strong or moderate support. Likewise, nearly 54% of the sample reported that their support for M4A had increased following COVID-19 (see Table A6 in Appendix). However, when given the option of incremental expansion of the ACA, the percent endorsing M4A reduced to 44% (Table 2).

Further, the fact that this finding was not replicated when alternative question wordings were used suggests the possibility that the broad term Medicare for All may mean different things to different people and does not necessarily equate with the idea that insurance coverage should be decoupled from employment in the popular understanding of the term. If this is the case, we can expect that the equation of COVID-19 with a need for universal coverage will not be automatic and requires more explanation, such as the explanation provided in the vignette to produce more support. It can also explain how Democratic primary voters might square support for Biden, whose

health reform platform would maintain employer-sponsored coverage, with their broad support for Medicare for All. Kaiser Family Foundation polls consistently show "more coverage" to be the largest factor in people's support for Medicare for All (KFF, 2020) suggesting people are more concerned about the goals and less concerned about the means of achieving those goals.

Whether COVID-19 might tip the balance between increased situational support for M4A towards more structural support will likely hinge on whether affected groups begin to perceive a "stake" in the programs, particularly the 27 million people who lost employer-sponsored coverage and now find themselves ineligible for public programs not designed for temporary job-loss and the remaining programs unaffordable and wanting (Jacobs & Mettler, 2011). Moreover, if these groups join forces with new constituencies such as workers in the "gig economy" who already found themselves outside of corporatist risk-protection programs, the emphasis on decoupling insurance from employment may gain traction as a motivating force behind M4A rather than expanding coverage per se. Future studies will have to gauge how resilient this new framing is to counterarguments (for instance that countries with universal coverage have had high mortality/had to ration care).

Conclusions

Mass layoffs stemming from the COVID-19-induced economic recession may present an opportunity for proponents of Medicare for All plans to make a stronger case for the need to decouple insurance from employment. However, it is unclear whether this message is being effectively communicated and whether it will substantially and enduringly move the needle on public support for Medicare for All. We find that sympathetic framing of job-loss and its association with insurance loss can bolster support for M4A but explicit invocations of COVID-

19 do not increase support much further than a general emotive appeal. Media framing of issues can influence policy positions (in survey environment), but does not increase support more among Independents, nor for those having experienced personal job loss, constituencies whose support may need to be won to push for policy change.

Tables and Graphs

Table 3: Balance across Study Arms

	control (N, %)	arm 2 (N, %)	arm 1 (N, %)	Total (N, %)	p-value
Age	control	arm 2	arm 1	Total	p-value
<25	90	47	41	178	
	20.55	12.02	10.73	14.7	
25-44	228	217	203	648	
	52.05	55.5	53.14	53.51	
45-64	73	73	95	241	
	16.67	18.67	24.87	19.9	
65+	47	54	43	144	
	10.73	13.81	11.26	11.89	Pr = 0.000
Gender	control	arm 2	arm 1	Total	p-value
Male	199	198	184	581	
	45.43	50.64	48.17	47.98	
Female	239	193	198	630	
	54.57	49.36	51.83	52.02	Pr = 0.324
Race/Ethnicity	control	arm 2	arm 1	Total	
White	306	282	291	879	
	69.86	72.12	76.18	72.58	
Hispanic	30	25	20	75	
	6.85	6.39	5.24	6.19	
Black	64	52	42	158	
	14.61	13.3	10.99	13.05	
Other	38	32	29	99	
	8.68	8.18	7.59	8.18	Pr = 0.623
Income	control	arm 2	arm 1	Total	
<$20,000	109	82	67	258	
	24.89	20.97	17.54	21.3	
$20,000-$74,999	160	148	147	455	
	36.53	37.85	38.48	37.57	
$75,000-$149,000	82	75	73	230	
	18.72	19.18	19.11	18.99	
$150,000+	87	86	95	268	
	19.86	21.99	24.87	22.13	Pr = 0.256
Party ID	control	arm 2	arm 1	Total	

Democrat	185	165	157	507	
	42.24	42.2	41.1	41.87	
Republican	148	142	143	433	
	33.79	36.32	37.43	35.76	
Independent	105	84	82	271	
	23.97	21.48	21.47	22.38	Pr = 0.797
Total	438	391	382	1,211	
	100	100	100	100	

Table 5: Ordered Logistic Models, Any Treatment with Interactions (Party ID/Job and Insurance Loss)

VARIABLES	Support M4A (ologit)	Support M4A (ologit)	Support M4A (ologit)	Support M4A (ologit)	Support M4A (ologit)	Support M4A (ologit)
Control (ref)						
any_treat	0.31**	0.48**	0.32**	0.34**	0.38**	0.35**
	(0.054 - 0.568)	(0.044 - 0.908)	(0.061 - 0.580)	(0.067 - 0.612)	(0.056 - 0.696)	(0.019 - 0.682)
any_treat#Republican		-0.31				
		(-0.912 - 0.283)				
any_treat#Independent		-0.15				
		(-0.805 - 0.510)				
lost job			0.37	0.36		
			(-0.217 - 0.948)	(-0.250 - 0.967)		
any_treat#lost_job			-0.22	-0.21		
			(-0.996 - 0.556)	(-1.010 - 0.596)		
Lost insurance					0.87***	0.52**
					(0.474 - 1.262)	(0.095 - 0.943)
any_treat#lost_insurance					-0.05	-0.05
					(-0.561 - 0.454)	(-0.581 - 0.473)
Party ID						
Democrat (ref)						
Republican	-0.73***	-0.55**		-0.74***		-0.72***
	(-1.029 - -0.429)	(-1.017 - -0.073)		(-1.037 - -0.436)		(-1.026 - -0.423)
Independent	-0.82***	-0.73***		-0.82***		-0.76***
	(-1.149 - -0.487)	(-1.244 - -0.212)		(-1.148 - -0.487)		(-1.093 - -0.426)
Gender						
Female	-0.62***	-0.62***		-0.62***		-0.55***
	(-0.884 - -0.351)	(-0.888 - -0.354)		(-0.882 - -0.349)		(-0.816 - -0.276)
Age						
18-24 (ref)						
25-44	0.15	0.18		0.17		0.2
	(-0.226 - 0.523)	(-0.202 - 0.553)		(-0.203 - 0.550)		(-0.181 - 0.573)

45-64	-0.15	-0.12		-0.11		0.03
	(-0.573 - 0.283)	(-0.548 - 0.316)		(-0.541 - 0.322)		(-0.410 - 0.472)
65+	-0.78***	-0.71***		-0.73***		-0.55**
	(-1.245 - -0.313)	(-1.190 - -0.239)		(-1.202 - -0.254)		(-1.039 - -0.071)
Race/Ethnicity						
White (ref)						
Hispanic	-0.27	-0.27		-0.28		-0.28
	(-0.795 - 0.260)	(-0.801 - 0.256)		(-0.810 - 0.247)		(-0.813 - 0.245)
Black	-0.38*	-0.39*		-0.39*		-0.41**
	(-0.783 - 0.019)	(-0.795 - 0.010)		(-0.788 - 0.016)		(-0.817 - -0.011)
Other	-0.23	-0.25		-0.24		-0.29
	(-0.682 - 0.217)	(-0.703 - 0.199)		(-0.686 - 0.214)		(-0.744 - 0.162)
Income						
<$20,000 (ref)						
$20,000-74,999	-0.23	-0.23		-0.22		-0.22
	(-0.556 - 0.099)	(-0.555 - 0.102)		(-0.545 - 0.112)		(-0.547 - 0.110)
$75,000-149,999	0.22	0.25		0.24		0.23
	(-0.195 - 0.626)	(-0.164 - 0.662)		(-0.170 - 0.656)		(-0.181 - 0.642)
$150,000+	0.60***	0.62***		0.62***		0.57**
	(0.166 - 1.039)	(0.180 - 1.056)		(0.181 - 1.057)		(0.134 - 1.010)
/cut1	-3.28***	-3.13***	-2.21***	-3.20***	-1.88***	-2.92***
	(-3.841 - -2.718)	(-3.726 - -2.525)	(-2.469 - -1.944)	(-3.774 - -2.625)	(-2.183 - -1.580)	(-3.540 - -2.309)
/cut2	-1.42***	-1.27***	-0.49***	-1.34***	-0.12	-1.06***
	(-1.951 - -0.899)	(-1.837 - -0.700)	(-0.695 - -0.281)	(-1.883 - -0.801)	(-0.385 - 0.137)	(-1.643 - -0.469)
Observations	1,211	1,211	1,211	1,211	1,211	1,211

Notes_Titles

Standard errors in parentheses

*** p<0.01, ** p<0.05, * p<0.1

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Appendix

Exhibit 1: Study Arms

Arm I. COVID-19-Induced Unemployment

Please take a few minutes to carefully read the following newspaper article. Once you are finished, you will be asked a few questions to better understand your perspective on the article and gauge your opinions on current events.

Article v1

'It's like we are just a piece of garbage': Laid-off Philly workers face life without health insurance

by Juliana Feliciano Reyes, Updated: April 2, 2020

Days after Mayor Jim Kenney issued a sweeping order requiring most Philadelphia businesses to shut down to slow the spread of the COVID-19, Sean McGuire found out he was losing his job.

McGuire, a 30-year-old former football player who worked as a concierge supervisor at the

Hampton Inn near the Convention Center, was devastated. He had given the last ten years of his life to Hersha Hospitality Management, which owns the inn, working in numerous roles over the past decade with the company: dishwasher, bell clerk, front desk, breakfast bar. But a few weeks later, after reading his layoff letter closely, he realized his situation was even worse than he had thought. Hersha had cut his health insurance on the same day he was laid off. He got a severance check for $1,500, not enough to even meet rent in the South Philadelphia neighborhood where he lives. McGuire had a stroke two years ago, at 29, and the doctors were not able to fully understand why. But his insurance covered tens of thousands of dollars in medical bills. As the COVID-19 rages through Philadelphia, thousands of workers like McGuire are losing their health-care benefits when they lose their jobs. About 830,000 Pennsylvanians filed for unemployment in the last two weeks of March, more than the number of workers who filed in all of 2019. “We’re losing our jobs," McGuire said. "That’s a big thing. And to turn around and you can’t go to the clinic because you don’t have health insurance? It’s just like we’re a piece of garbage. They just threw us to the curb.”

Employees can keep their employer plan for up to three years under a federal program known as COBRA, but they have to foot the entire bill- around $7,000 a year for a single individual. This is more than McGuire, who made too much last year to qualify for Medicaid, says he can afford, but a hospital stay for complications stemming from COVID-19 without health insurance could cost as much as $20,000.

The following questions are about the article you just read. Please select the answer choice that best represents what the article said happened.

Comprehension 1 According to the article, why did Sean McGuire lose his job?

- ○ COVID-19 caused his hotel to shutdown (1)
- ○ Hotel felt pressure from Airbnb and shut-down (2)

Comprehension 2 According to the article, why did Sean lose his health insurance?

- ○ He had employer-sponsored health coverage that was terminated when he lost his job. (1)
- ○ His state did not expand Medicaid coverage to people making under 138% of the federal poverty level. (2)

Arm II. Normal Unemployment

Please take a few minutes to carefully read the following newspaper article. Once you are finished, you will be asked a few questions to better understand your perspective on the article and gauge your opinions on current events.

Article v2


BROKE IN PHILLY

'It's like we are just a piece of garbage': Hotel workers made redundant by Airbnb face life without health insurance

by Juliana Feliciano Reyes, Updated: April 2, 2016

Article v2 When Sean McGuire found out he was losing his job, he was devastated. McGuire, a 30-year-old former football player, had given the last ten years of his life as a concierge supervisor at the Hampton Inn near the Convention Center in downtown Philadelphia working in numerous

roles over the past decade with the company: dishwasher, bell clerk, front desk, breakfast bar. Facing pressure from Airbnb, the Inn was forced to shutter its doors after Philly legalized the service in 2015. A few weeks later, after reading his layoff letter closely, he realized his situation was even worse than he had thought. He had lost his health insurance on the same day he was laid off. He got a severance check for $1,500, not enough to even meet rent in the South Philadelphia neighborhood where he lives. McGuire had had a stroke two years ago, at 28, and the doctors were not able to fully understand why. But his insurance had covered tens of thousands of dollars in medical bills. Without health insurance, he pondered what would happen if he had another stroke. “We’re losing our jobs," McGuire said. "That’s a big thing. And to turn around and you can’t go to the clinic because you don’t have health insurance? It’s just like we’re a piece of garbage. They just threw us to the curb.” Philadelphia is the largest city in the U.S. where residents can rent out their homes legally on a daily basis. From April to September of 2015, Philly saw a 270 percent increase in Airbnb listings. And even before the city legalized the service, the Licensing and Inspections department maintained that it would not crack down on hosts, and especially if there were no complaints.

Since losing his job, McGuire has been trying to make his way in the gig economy as an Uber driver. But Uber does not provide health insurance benefits and buying a plan on the individual market is too expensive. Employees can keep their employer plan for up to three years under a federal program known as COBRA, but they have to foot the entire bill- around $7,000 a year for a single individual. This is more than McGuire, who made too much last year to qualify for Medicaid, says he can afford. But he also made too much last year to qualify for Medicaid, which requires that you make under 138% of the federal poverty level according to last year’s tax return.

"So I am constantly worrying in the back of my mind," he said. "I really don't know where things will go if I have another stroke."

Comprehension 1 The following questions are about the article you just read. According to the article, why did Sean McGuire lose his job?

- ○ He was dismissed for misconduct (1)
- ○ Hotel felt pressure from Airbnb and shut-down (2)

Comprehension 2 Why did Sean lose his health insurance?

- ○ He had employer-sponsored health coverage that was terminated when he lost his job (1)
- ○ His state does not expand Medicaid coverage to people making under 138% of the federal poverty level (2)

Exhibit 2: Dependent Variable- Alternate Question Wording

Main. "As of today, do you favor or oppose a national health plan or "Medicare for All" plan in which all Americans would get their health insurance from a single government plan?"

A. Strongly Favor

B. Somewhat Favor

C. Somewhat Oppose

D. Strongly Oppose

Alternative. On a scale 1 to 10 where 1 means you agree completely with Statement A and 10 means you agree completely with Statement B, which statement do you agree with more:

A. There should be a government insurance plan that would cover all medical and hospital expenses for everyone

B. Medical expenses should be paid by individuals through private insurance plans like Blue Cross or other company paid plans

Agree Statement A	1	2	3	4	5	6	7	8	9	10	Agree Statement B

Of the following approaches to reforming health care in the US, which do you most support?

A. Incrementally building on the Affordable Care Act to expand coverage, but not replacing employer-sponsored coverage

B. Creating a universal Medicare for All system that would replace employer-sponsored coverage

C. Reversing the Affordable Care Act and moving towards more private health insurance coverage with high-risk pools that offer subsidized health insurance to the most expensive patients

D. Something else, _____

Appendix tables

Table A1: Alternate DV, Scale 1-10, 1=Most private, 10=most public

Variable	mean	Median	sd	Min	max
Support for a government insurance plan that would cover all medical and hospital expenses for everyone	6.5	7	3.13	1	10

Table A2: Continuous Measure- Support M4A, Support Private Provision, 10 point scale, OLS

VARIABLES	3-arm, No Coef (CI)	3-arm, Coef (CI)	2-Arm, No Coef (CI)	2-Arm, Coef (CI)
Control (ref)	ref	Ref		
Arm 2	0.07	0.16		
	(-0.360 - 0.494)	(-0.263 - 0.586)		
Arm 1	0.16	0.28		
	(-0.266 - 0.594)	(-0.149 - 0.709)		
Any Treatment			0.12	0.22
			(-0.252 - 0.482)	(-0.147 - 0.586)
Constant	6.47***	7.06***	6.47***	7.05***
	(6.182 - 6.768)	(6.321 - 7.795)	(6.182 - 6.768)	(6.318 - 7.790)
Observations	1,211	1,211	1,211	1,211
R-squared	0	0.034	0	0.033

*** p<0.01, ** p<0.05, * p<0.1

Table A3: Alternate DV: Support Public, Private, Incremental

Of the following approaches to reforming health care in the US, which do you most support?		
	Freq.	Percent
Support Private Insurance	226	18.66
Support incremental expansion of ACA	451	37.24
Support M4A	534	44.1
Total	1,211	100

Table A4: Support Private, Incremental or M4A

VARIABLES	3-arm, No Controls odds ratio	3-arm, Controls odds ratio	2-Arm, No Controls odds ratio	2-Arm, Controls odds ratio
Control (ref)				
Arm 2	1.07	1.18		
	(0.811 - 1.410)	(0.888 - 1.569)		
Arm 1	1.03	1.16		
	(0.780 - 1.361)	(0.867 - 1.542)		
Any Treatment			1.05	1.17
			(0.828 - 1.332)	(0.914 - 1.494)
/cut1	0.48***	0.36***	0.48***	0.36***
	(0.396 - 0.584)	(0.212 - 0.597)	(0.396 - 0.584)	(0.212 - 0.596)
/cut2	0.63***	0.47***	0.63***	0.47***
	(0.522 - 0.765)	(0.283 - 0.793)	(0.522 - 0.765)	(0.283 - 0.793)
Observations	1,211	1,211	1,211	1,211

*** p<0.01, ** p<0.05, * p<0.1

Table A5: Main Results with Don't Know Excluded, OLS

	Support M4A (DK removed)	Support M4A (DK removed)	Support M4A (DK removed)	Support M4A (DK removed)
arm1	0.022	0.025		
	-0.032	-0.031		
arm2	0.027	0.03		
	-0.032	-0.031		
Any treat			0.025	0.028
constant	0.715***	0.406***	0.715***	0.407***
	(0.022)	(0.073)	(0.022)	(0.073)
Observations	1113	1113	1113	1113

Table A6: Did COVID-19 change your opinion on M4A

Has COVID-19 made you think more about whether the US should move towards a "Medicare for All" plan in which all Americans would get their health insurance from a single government plan?		
	Freq.	Percent
More Favorable	657	54.25
Less Favorable	221	18.25
Has not affected my opinion at all	333	27.5
Total	1,211	100