What Information Elicits Policy Enthusiasm? Older Americans, the ACA, and Medicare

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Abstract

Context: Target populations do not always recognize policy benefits. This may be particularly true when policy design, informational environment, or political conflict make a policy's benefits difficult to discern, which is the case for the Affordable Care Act (ACA). While many groups benefited from the ACA, attitudes of seniors, one important target population of the ACA, remain unexplored.

Methods: A survey of 1,206 Americans age 65+ was fielded in the summer of 2021 to assess the effect of three informational treatments about the ACA's benefits including extending the life of the Medicare trust funds, filling the Medicare Part D donut hole, and reducing the number of uninsured on the ACA's favorability and attitudes about its future and party leadership on healthcare.

Findings: Priming individuals about the ACA's benefits improved its favorability, particularly for subgroups generally opposed to the ACA such as Republicans and those high in racial resentment. Attitude changes about the future of the ACA were limited to benefits directly focused on seniors. There were no broader spillover effects on attitudes about partisan healthcare leadership.

Conclusions: The findings have implications for research on the ACA, on policy feedback effects, on self-interest, and on priming effects.

Keywords Affordable Care Act, health reform, older adults, partisanship, Medicare

Public policies can impact public and private institutions, individuals inside and outside of their target populations, and future policy developments through a process known as "policy feedback" (Béland, Campbell, and Weaver 2022; Pierson 1994; Schattschneider 1935). These effects can be diverse, and policy feedback processes can either reinforce or weaken policies after they have become law (Béland, Campbell, and Weaver 2022; Patashnik 2023; Patashnik and Zelizer 2013). Policies' own design features influence their chances of seeing such positive or negative feedback processes (Béland, Campbell, and Weaver 2022; Campbell 2012, 2015;

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Patashnik 2015; Patashnik and Zelizer 2013). So too do factors exogenous to the policy, such as partisan polarization and citizens' political predispositions (Anzia, Jares, and Malhotra 2022; Béland, Campbell, and Weaver 2022; Mettler 2015; Mettler, Jacobs, and Zhu 2023; Patashnik 2015).

The subset of the policy feedback literature that focuses specifically on how target populations respond to policies has identified three mechanisms at least partly internal to a policy that explain how and why people become either supportive or averse to it: the resources conveyed by the policy, the messages sent by the policy, and the potential for the policy to make target population members mobilizable in politics (Béland, Campbell, and Weaver 2022; Pierson 1994). When resources, messages, and mobilization make a program's target population members enthusiastic about the policy, they may become a "protective constituency" around the policy (Campbell 2015, 284), whose support for the policy makes elected officials wary of making salient cuts to the program (Campbell 2003; Pierson 1994).

Of course, individuals' "*perceptions* of material stakes" are what determine their responses to a policy, and these perceptions can at times differ from the actual material stakes that they may have in a policy (Patashnik and Zelizer 2013, 1078, emphasis added). Perceptions and realities of policy benefits may diverge if benefits are complex, delayed, "submerged," or offset by other policy features that impose real or perceived costs (Campbell 2020; Hobbs and Hopkins 2021; Mettler 2011; Patashnik and Zelizer 2013). Importantly, these circumstances also make the policy discourse particularly receptive to misinformation (Nyhan, Reifler, and Ubel 2013). Unclear informational environments may be further be exaggerated by individual-level political predispositions that inform people's policy assessments, especially absent personal experience with the policy, and by how a policy is framed when presented to policy beneficiaries

(Campbell 2020; James and Van Ryzin 2017; McCabe 2016; Patashnik and Zelizer 2013). Taken together, policy and information environment play an important role with regard to potential feedback effects. One of the prime examples of such as a policy is the 2010 Affordable Care Act (ACA).

In recent years, ACA has attracted a great deal of study from scholars of policy feedback effects and public opinion formation in light of its many novel policy benefits for various target populations, its complex design, the politically polarized context in which it was enacted, and the fact that it offers an opportunity to do so through the lens of a new policy rather than an established one (for more on these observations and for reviews of feedback research on the ACA, see Campbell (2020); Haeder (2020); Hobbs and Hopkins (2021)). Yet, one group of Americans that this literature has left largely unexamined are Americans age 65+ (but see Lerman and McCabe 2017), who have unique stakes in the ACA by virtue of being already eligible for guaranteed government-run health insurance through Medicare. Better understanding the perceptions of the ACA among older Americans holds the potential for unique insights because of their special position in U.S. health policy. That is, this group is part of what Starr (2013) calls the "protected public"—already having access to health insurance with which many were happy through policy configurations predating the ACA for whom substantial changes to public health insurance program inevitably raise concerns. While the ACA's implications for Medicare are mixed and somewhat variable at the individual level (Cubanski et al. 2016; Gitterman and Scott 2011; Kaplan 2011; Moon 2012), older Americans' fears were further stoked by blatant misrepresentations on the ACA's effect on seniors, most prominently in the form of "death panels" (Barnett and Marsden III 2021; Cohn 2021; Gitterman and Scott 2011; McDonough 2020; Nyhan 2010). Indeed, these misrepresentations proved so powerful politically

that they "nearly derailed health reform" (Scherer 2010), and there is evidence for their longevity (Brodie et al. 2020; Gonyea 2017; Kirzinger et al. 2024). Beyond death panels, misperceptions about the ACA have been incredibly common, as only 50% of Americans age 65+ knew that the ACA would close the Part D coverage gap and that only 14% knew that the ACA would delay the possible exhaustion of the Medicare trust fund (Gitterman and Scott 2011). Unsurprisingly concerned about their own benefits, many older Americans initially viewed the ACA as a potential threat to Medicare (Gitterman and Scott 2011; Hacker 2015; Kaplan 2011; Kelly 2015; Starr 2015). Later research indicates that awareness of many key provisions of ACA, including the closing of the donut hole, have further declined over time (Brodie et al. 2020; Kirzinger et al. 2024). These findings may be partly explained by the fact that many of the individuals above age 65 today may have paid only limited attention to the issues affecting seniors at the time of the passage of the ACA.

Given the many benefits the ACA bestowed on seniors, their skepticism toward the reform is puzzling. One is the influx of money into the Medicare hospital insurance trust fund facilitated by the ACA's tax increases on working Americans with higher incomes, which substantially improved the fund's finances (Cubanski et al. 2016; Frank and Neuman 2021; Kaplan 2011; Moon 2012). In addition, a number of the ACA's provisions slowed down Medicare spending (Davis, Guterman, and Bandeali 2015). This not only extended the solvency of the trust fund further but as a secondary effect also tamped down beneficiary cost sharing (Davis, Guterman, and Bandeali 2015). Another benefit for older Americans is the ACA's closure of the Medicare Part D "donut hole" or "coverage gap," which long imposed significant financial burdens on a large number of older adults seeking prescription drugs (Kirchhoff 2020). Third, the ACA required Medicare to cover a wide range of preventive services such as

screening and vaccinations as recommended by the U.S. Preventive Services Task Force without cost-sharing (Davis, Guterman, and Bandeali 2015). A fourth—if more indirect—benefit is the long-term stability potentially added to the Medicare program from ACA provisions that insure working-age uninsured persons, and that may thereby improve the health of the population that will enter Medicare in future years (Moon 2012), lead to fewer hospital closures due to the uncompensated care burden (Lindrooth et al. 2018), and reduce cost shifting (Frakt 2011). Taken together, it seems quite plausible that older Americans could well have been an important constituency in support of the ACA instead of one in opposition if the ACA had been presented to them with a better framing. The question emerges: If older Americans are presented with information about these beneficial ACA features, is their support for the ACA higher than if they are not primed to consider these benefits? Do these potential changes in attitudes spill over into preferences about the future of the health law? And do their views of which political party is more trustworthy in handling health care issues change? This paper explores these questions.

Specifically, to examine the effects of policy framing and the potential for positive policy feedback around the ACA from older Americans, I draw on data from a national survey of 1,206 Americans age 65+ fielded in the summer of 2021 via LUCID. The survey contained a priming experiment, which, in addition to the control group, drew respondents' attention to one of three specific benefits delivered by the ACA: (a) extending the life of the Medicare Trust Fund by 12 years, (b) elimination of the donut hole in Medicare Part D, and (c) reducing the number of uninsured Americans from 18 percent to 10 percent. The primes were carefully selected to include policy benefits that would be experienced by older adults as a group (trust fund), by older adults individually (Part D), or sociotropically and remotely (reducing the number of uninsured). After the priming, respondents were asked about their (1) support for the ACA, (2)

support for changes to the ACA, and (3) views about partisan leadership on health policy issues—outcomes modeled after questions frequently asked by survey researchers who study health policy (Kaiser Family Foundation 2021, 2024).

The next two sections of this paper discuss the literature that motivates this research, including literature on what factors influence the perception of policy benefits by target populations, and literature on the intersection of Medicare and the ACA. The subsequent sections describe the data and methods of analysis, the results, and the limitations and implications of the analyses and findings.

What Determines Perception of Policy Benefits by Target Populations?

Studies of policy feedback effects, the notion that "policies shape politics," have been a large and growing field of analysis (Béland, Campbell, and Weaver 2022). This literature has established that the a prerequisite for any feedback effects to occur is that the policies' target populations recognize that they are benefitting from a specific policy and what the sources of these policy benefits are (Béland, Campbell, and Weaver 2022). The ability to recognize is by no means universal and several factors can contribute to whether policy target population members perceive that they are recipients of policy benefits. Primary among these factors are (1) the policy's design (Campbell 2012; Patashnik and Zelizer 2013; Pierson 2015); (2) the information environment around the policy (Mettler 2011; Patashnik and Zelizer 2013; Schneider and Ingram 2005); and (3) the features of a policy that individuals are encouraged to think about through the messages they are exposed to, through what scholars refer to as "framing" or "priming" processes (Druckman 2001; Nelson, Oxley, and Clawson 1997; Zaller 1992).

When policies convey benefits, several features of those benefits can impact target populations' perceptions of whether the benefits are in fact personally applicable and valuable. Such design features include the magnitude of the benefits; whether the benefits are ongoing or rather cycle "on" and "off" with changes in beneficiary circumstances; whether beneficiaries can identify each other and be identified by potential mobilizing organizations; the administrative experiences that benefit use entails; and whether the benefits are readily visible and attributable to the government program (Campbell 2012, 2020). Design factors are often determined during a policy's formulation but can change through post-enactment policy revisions (Patashnik and Zelizer 2013). Of these design features, *visibility* notably intersects with the information context around a policy. Campbell (2012, 346) observes that if a policy's positive effects are "insufficiently visible, traceable, and salient" to intended beneficiaries, the blame sits with an "informational shortcoming." Pierson (2015) has underscored the importance of policy visibility (see also Arnold 1992). For the ACA, which built on the existing patchwork of the American healthcare system, policy design was particularly convoluted (Béland, Rocco, and Waddan 2018; Chattopadhyay 2018, 2019; Haeder and Yackee 2020; Hobbs and Hopkins 2021; Oberlander and Weaver 2015), perhaps best exemplified by the massive scale of statutory and regulatory policies (Haeder 2024a; Haeder and Yackee 2020). As will be described in further detail below, the policy design of the ACA may have offered a particularly muddled picture of its likely impacts on older Americans (Cubanski et al. 2016; Gitterman and Scott 2011; Kaplan 2011; McDonough 2020; Moon 2012).

Yet policy design alone does not determine the extent of policy feedback. Indeed, the information environment that comes to surround a policy plays a key role in determining whether intended policy beneficiaries recognize that they are targeted for policy benefits (Mettler 2011;

Patashnik and Zelizer 2013). One underdeveloped part of the policy feedback literature is how framing and public opinion formation might affect these processes. In regard to framing and priming, scholars note that policies can often be discussed in varying ways, and that the angles of a policy that are emphasized matter because such communications help the public—including subsets of the public intended to receive policy benefits—understand what costs and benefits the policy entails and to whom (Campbell 2012; Druckman 2001; Grogan and Patashnik 2003; Mettler 2011; Nelson, Oxley, and Clawson 1997; Patashnik and Zelizer 2013). Especially for policy benefits that are relatively lacking in salience or contested, emphases on those benefits can play a role in "*reveal*[ing] what is at stake" for the target population (Mettler 2011, 112). Priming effects are particularly powerful because they focus individuals' attention to a specific aspect of a policy, thus reducing its dimensionality, and by often eliciting an emotional response (Kennedy-Hendricks, McGinty, and Barry 2016; Mummolo and Hopkins 2017). Of course, in the political world, not all frames are equally present, or even truthful (Hopkins 2017; Montopoli 2009), and opponents compete over which policy frames should dominate the public discourse (Gollust, Barry, and Niederdeppe 2017; McGinty et al. 2016).

For a number of reasons, the ACA may serve as a particularly poor policy to elicit feedback effects from an informational perspective. The ACA has faced a hyper-partisan and polarized environment (Sances 2024) in which debates about the law were emotional and filled with misinformation (Frankford 2015; Montopoli 2009). Moreover, Democrats—the ACA's sponsoring party—failed at presenting the ACA benefits effectively and the public was consistently confronted with the failures or potential benefit losses related to the ACA (Hacker 2015; Ornstein 2014; Roy 2013; Starr 2015). The informational environment regarding the ACA's implications for older adults has been particularly challenging (Blumberg et al. 2013;

Brodie et al. 2019; Hacker 1997, 2015; Loewenstein et al. 2013; S.K. Long and Goin 2014; Morgan and Campbell 2011; Starr 2015), adding to the inherent complexity of the U.S. healthcare system. To make things worse, the frames focusing on negative effects of the ACA seniors (Hacker 2015) as well as myths and untruths like alleged "death panels" (Nyhan 2010) dominated the public discourse. Lastly, in the immediate aftermath of its passage, many Democrats refused to openly support the ACA and run on its benefits in their electoral campaigns (Abdullah 2014). This is not surprising given that the ACA failed to find support from a majority of the American public and particularly among older Americans. However, even as public opinion turned favorable under the first Trump administration, Democrats failed to incorporate the ACA into their electoral campaigns (Hopkins 2023; Jacobs, Mettler, and Zhu 2022; Mettler, Jacobs, and Zhu 2023).

The Affordable Care Act and Medicare

The above factors—policy design, information environment, and dominant frames—are relevant to thinking about the ways that older Americans may respond to the ACA overall, particularly given the ACA's changes to Medicare, which have generally been less salient to the public discussion of the ACA (Hacker 2015; Starr 2015). As this section will explain, neither policy design nor the information or political environment around the ACA make the ACA's potential benefits to Medicare beneficiaries easy to perceive, with subsequent implications for potential feedback processes. For these reasons, it is relevant to test whether priming older Americans to consider specific benefits emanating from the ACA impacts their attitudes about this policy. As noted, this paper presents the results of such a priming test.

Regarding policy design, the ACA made several revisions to Medicare whose net impacts on the program, and on any given beneficiary age 65+, are potentially mixed and somewhat difficult to predict (Cubanski et al. 2016; Gitterman and Scott 2011; Kaplan 2011; McDonough 2020; Moon 2012). Indeed, many older Americans have shown concern that the ACA may damage Medicare (Gitterman and Scott 2011; Hacker 2015; Kaplan 2011; Kelly 2015). Importantly, some of the changes that the ACA made to Medicare can be interpreted as benefitting Medicare recipients immediately or in the longer term while other changes can be interpreted as potentially weakening the Medicare program or Medicare benefits for at least some recipients (Cubanski et al. 2016; Gitterman and Scott 2011; Moon 2012). For instance, growth in other types of public insurance coverage such as Medicaid and the ACA Marketplaces might come at the expense of the Medicare program. Importantly, endowment effects and the asymmetric perception of gains and losses may have hence made seniors particularly avid opponents of the ACA (Kahneman, Knetsch, and Thaler 1991; Tversky and Kahneman 1991). Second, the ACA's impacts differ somewhat across different Medicare beneficiaries (Kaplan 2011). For example, the ACA included provisions that raise Medicare Parts B and D premiums for higher income recipients (Cubanski et al. 2016; Moon 2012). Moreover, changes to Medicare Advantage payments were initially also expected to reduce access to the program although ultimately resulted in substantial growth (Haeder 2024b). Indeed, the ACA's initial reductions in spending on Medicare Advantage plans met with backlash from beneficiaries enrolled in these plans (as well as from the insurers who operate them), leading to the de facto restoration of a portion of government spending on these plans through the Quality Bonus Payment demonstration project (Haeder 2024b; Kelly 2015). Third, the benefits that the ACA offers to older Americans are, arguably, the sort that emerge only over time and lack visibility, whereas

the costs to older Americans were slated to occur more immediately after the ACA's passage and in a more visible fashion (Gitterman and Scott 2011). Benefits that are slow to emerge tend to lack salience to policy target populations (Patashnik and Zelizer 2013).

Turning to the information environment, the strong partisan discord that surrounded the ACA's enactment and the first ten years of its existence almost certainly shaped the messages about that policy in circulation. "High levels of partisanship and polarization mean the public has been continually bombarded with conflicting messages on the ACA from elites" and that the "benefits of the ACA are thus disputed in the public realm, likely undermining the development of support among beneficiaries" (Campbell 2020, 574-5). Research suggests that in such an environment, partisan identification and motivated reasoning may play a particularly large role in shaping public responses to new laws—a role that sometimes outweighs that of experience with the new law (Campbell 2020; Patashnik and Zelizer 2013). As noted, the ACA's impacts on Medicare are not entirely straightforward, and "partisan politics fills an information gap for seniors" (Gitterman and Scott 2011, 556). Furthermore, there were many conflicting predictions about the ACA's potential impacts in the years surrounding its enactment, some of which focused on the ACA's potential for adverse consequences in a range of areas, and not all of which came from partisan opponents (McMorrow, Blumberg, and Holahan 2020). Nonetheless, opponents of the ACA specifically honed in on the components of the ACA that may potentially be detrimental to seniors (Hacker 2015). Thus, the information environment does not appear likely to have given older Americans clear signals that the ACA contained benefits for them.

In addition to the valid concerns that the ACA might negatively affect them, seniors were also exposed to a number of untruths and myths about the content of the ACA. Most prominently, some ideological conservatives raised the specter of withholding healthcare from

seniors and forcing them into an untimely deaths (Barnett and Marsden III 2021; Cohn 2021; Gitterman and Scott 2011; McDonough 2020; Nyhan 2010). The issue first emerged related to Section 1233 of HR 3200 which sought to provide reimbursement for physicians for voluntary consultations about end-of-life decisions including living wills, advance directives, and end-of-life care options (Barnett and Marsden III 2021; Cohn 2021; Gitterman and Scott 2011; McDonough 2020; Nyhan 2010). The root of the claim can be traced to conservative activist Betsy McCaughey who claimed the ACA contained a provision that would force seniors to "end their life sooner" made on Fred Thompson's radio show (Nyhan 2010, 8). The claim was perpetuated by right-leaning media outlets and commentators including Sean Hannity, Laura Ingraham, and Rush Limbaugh (Nyhan 2010). However, it was also perpetuated by senior Republicans in Congress including John Boehner, Virginia Foxx, and Michele Bachmann (Nyhan 2010). The myth was further amplified when Sarah Palin coined the inflammatory term "death panels," which rapidly increased the political prominence of the issue (D. Altman 2024; Barnett and Marsden III 2021; Cohn 2021; Gitterman and Scott 2011; McDonough 2020; Nyhan 2010; Nyhan, Reifler, and Ubel 2013) and when Senator Grassley, the lead Republican negotiator on the ACA, stoked fears about "pulling the plug on grandma" (Montopoli 2009).

While objectively false, this framing had an immediate impact in the political debates over the ACA, with half of Americans either believing the claim or stating they were unsure about it; the number increased to 70% for Republicans (Nyhan 2010). The issue took on such prominence that "nearly derailed health reform" (Scherer 2010). Importantly, claims about death panels later remerged over the ACA's Independent Payment Advisory Board (McDonough 2017). Political activists have confirmed the "lasting negative effect" of these claims (Gonyea 2017), as substantial minorities' continued belief that the ACA contained death panels more than

a decade after its passage (D. Altman 2024). The myth proved hard to correct for a number of reasons including increasing polarization, biased information processing, and increasing choices in media outlets (Nyhan 2010). As one political observer noted, "One of the hallmarks of the Affordable Care Act is that people don't know what is in the bill, or realize the benefits they've gotten [… and] a huge part of that is how it was defined early by the opposition" (Gonyea 2017).

That said, several ACA provisions can be considered objectively beneficial to Medicare beneficiaries. For one, the ACA as passed "phased out the Part D coverage gap (commonly referred to as the *donut hole*) by requiring drug manufacturers to provide discounts for brand-name drugs purchased by beneficiaries in the Part D coverage gap and gradually phasing in Medicare subsidies to plans to cover 75% of the cost of generic drugs and 25% of the cost of brand name drugs in the coverage gap" (Kirchhoff 2020, 2). The 2018 Balanced Budget Act moved up the timeline for closing the Part D coverage gap for brand name drugs by one year (Kirchhoff 2020). Subsequently, in addition to establishing the Medicare drug price negotiation process and various other provisions, the Inflation Reduction Act (IRA) of 2022 also capped yearly out-of-pocket expenses for Medicare Part D enrollees at $2,000 and expanded the low-income subsidy program (Haeder 2025). However, these changes do *not* mean that beneficiaries bear no cost for prescription drugs. One study concluded that "[f]inancial hardship from purchasing prescription drugs is still experienced by many older adults after the full implementation of the MMA [Medicare Modernization Act] and ACA" (A.W. Olson et al. 2022, 509). Yet, research does suggest that closure of the coverage gap has reduced some beneficiaries' out-of-pocket expenses for prescription drugs (Park and Look 2022; Tehrani and Cunningham 2017), and may thereby have helped some Medicare beneficiaries continue to adhere to prescriptions that they might otherwise have stopped or reduced the use of (Unuigbe 2020). In

other writings, closure of the donut hole has been described as "a major improvement for affected enrollees" (Kaplan 2011, 21) and as one of the ways in which the ACA improved Medicare (Cubanski et al. 2016; Gitterman and Scott 2011; Moon 2012).

Regarding the Medicare trust fund, the ACA contained provisions to extend the duration of the predicted time that the Medicare Part A trust fund in particular remained solvent (Cubanski et al. 2016; Frank and Neuman 2021; Kaplan 2011). Trust fund (in)solvency projections are of course sensitive to many factors, with the COVID-19 pandemic's labor market effects accelerating the projected year of insolvency to 2024 (Frank and Neuman 2021; Muhlestein 2020). Still, observers note that "[t]he trust fund's potential exhaustion represents a significant threat to the Medicare program" (Muhlestein 2020, 1) and that "trust fund insolvency would put beneficiaries and health care institutions at risk and undermine confidence in the program" (Frank and Neuman 2021, 342). Unquestionably, the influx of additional funds—as well as slowing down Medicare spending— has helped the trust fund from a solvency perspective. Thus, a policy that bolsters trust fund solvency should in theory carry material meaning for people on Medicare.

Regarding the ACA's various policies lowering the share of uninsured Americans, Moon (2012, 245) observes that "we all have a stake in an improved health care system that meets the needs of all Americans," and that with respect to Medicare in particular, the ACA's expansion of insurance may assist in improving the health of people during their pre-Medicare years, thereby lowering costs to the Medicare program down the line. Of course, lowering the number of uninsured persons—while not costless—generates a number of benefits that are shared across society to different degrees including increasing the financial viability of hospitals and other providers, particularly those in rural areas (Lindrooth et al. 2018). Moreover, lower

uncompensated care costs also may reduce the amount of cost shifting that medical providers engage in (Frakt 2011), just to name two examples. Moon (2012) also suggests that it is likely that discussion of reducing government spending on Medicare would have occurred in some policy context in 2010 or soon thereafter, had the ACA not itself addressed these changes. It is also possible that older Americans would react to information about the ACA's efforts to reduce the share of (younger) Americans who are uninsured due to beliefs about "fairness" (Lynch and Gollust 2010), feelings of "altruism" (Rueda 2018) or "compassion" (Huddy, Jones, and Chard 2001), or based on a form of self-interest that considers not only themselves but also their children or grandchildren (Chong, Citrin, and Conley 2001; Davenport 2015; Grogan and Patashnik 2003; Holbrook et al. 2016; Sears and Funk 1990). Past research indeed finds that older adults often favor policies that support younger people (Goerres and Tepe 2010; Street and Cossman 2006).

Hypotheses

One crucial pathway from policy design to public reaction in the feedback effect literature is the role that tangible benefits play in the form of resource effects (Campbell 2012; Kelly 2016; Patashnik and Zelizer 2013). Moreover, a large political science literature exists highlighting the connections between personal benefits and vote choice as well as public attitudes (Bechtel and Liesch 2020; Hansford and Gomez 2015; Kiewiet and Lewis-Beck 2011; Kinder and Kiewiet 1981). Indeed, a significant portion of politicians' efforts are spent on securing benefits for their constituents as a means to secure reelection (Fenno 2003; Mayhew 1974/2004; Shepsle and Weingast 1981). However, one indispensable prerequisite for such efforts to work is for individuals to be aware that these policy benefits are being distributed (Mettler 2011). As noted

above, the politics as well as the distribution of benefits of the ACA are complex and muddled (Hobbs and Hopkins 2021). In such instances, individuals are often misinformed or simply unaware that they are benefitting from a policy or that benefits for society at large exist (Campbell 2012, 2020; Mettler 2011; Patashnik and Zelizer 2013). This may particularly hold when no direct connection to the policy benefit can be easily established (Campbell 2020; James and Van Ryzin 2017; McCabe 2016; Patashnik and Zelizer 2013). It may also be exacerbated for issues subject to partisan battles and polarization were politically driven misinformation is common (Nyhan 2010). Unsurprisingly, the existing feedback literature on the ACA has been mixed (Hopkins 2023; Mettler, Jacobs, and Zhu 2023). I thus expect that highlighting clear benefits associated with the ACA will render respondents' attitudes about this policy more positive in two important ways. Specifically, I expect the following:

> H1a: Highlighting the Affordable Care Act's benefits will increase favorability towards the ACA.
>
> H1b: Highlighting the Affordable Care Act's benefits will decrease support for retrenching or eliminating the ACA.

Third, I expect that priming respondents about the benefits of the ACA may have some larger spillover effects, i.e. changes in public attitudes beyond those related to the ACA. That is, given the prominence of the ACA as well of the potential extent of the policy benefits, it is possible that respondents' broader attitudes about the parties as related to their roles in health policy may be affected. And as it is the Democratic Party that is most affiliated with the Affordable Care Act through President Obama and the Act's passage into law with no Republican support, I expect the following:

H1c: Highlighting the Affordable Care Act's benefits will increase trust in the Democratic party to do a better job at handling health care issues.

Yet, as described above, not all of the ACA's benefits equally benefit seniors. Put differently, seniors benefit from the various primes either individually (Part D changes), as a group (Medicare trust fund solvency), or sociotropically (reducing the number of uninsured). As a result, it is reasonable to expect that attitudes will be particularly positively affected by information about benefits closer to the respondents as compared to those that are more distant (Arnold 1992; Chong, Citrin, and Conley 2001; Holbrook et al. 2016). Put differently, individuals will be more likely to respond to policy benefits where causal chains are shorter (Arnold 1992). Hence,

H2: The aforementioned effects will be larger for benefits more closely experienced by Americans age 65+ (the ACA's impacts on the Medicare Trust Fund and particularly the Medicare Part D donut hole) compared to benefits that this age group experiences more remotely and sociotropically (the ACA's impact on the share of Americans who are uninsured).

Various subgroup analyses provide important nuance. First, differences based on partisanship should offer important insights because the politics of health have historically been highly contentious between the parties (Blumenthal and Morone 2010; Brodie et al. 2019; Hacker 1997, 2011). In addition, the politics surrounding the ACA's passage were particularly partisan (S. Altman and Shactman 2011; Haeder 2012; Jacobs and Skocpol 2010, 2011; McDonough 2011; Starr 2011; The Staff of the Washington Post 2010). So too were the politics surrounding the ACA's implementation, including the establishment of the ACA marketplaces (Haeder and Weimer 2013, 2015; Noh and Krane 2016; Oberlander 2016; Rigby and

Haselswerdt 2013; Shor 2018), the expansion of Medicaid (Barrilleaux and Rainey 2014; Callaghan and Jacobs 2017; Oberlander 2016; L.K. Olson 2015; Shor 2018), seemingly technical insurance market reforms (Haeder 2014), and comparative effectiveness research (Sorenson, Gusmano, and Oliver 2014). Opposition to the ACA continues to be salient in American politics many years post-enactment (Haeder and Chattopadhyay 2022; Haeder and Sylvester 2024; Rocco and Haeder 2018; Sances and Clinton 2021; Wang 2022). Further, partisan division over the ACA extends beyond political elites, surfacing in the mass public's attitudes (Gollust, Fowler, and Niederdeppe 2020; Grande, Gollust, and Asch 2011; Hopkins 2023; Kaiser Family Foundation 2021) and actions (Lerman, Sadin, and Trachtman 2017; Sances and Clinton 2019). Indeed, the ACA reemerged as a political topic during the 2024 presidential election (Waddick 2024).

Second, the unique role of President Trump suggests that analyzes based on vote choice may offer further insights beyond those obtained from analyses by partisanship. For one, President Trump communicated his opposition to the ACA frequently during his earlier presidential campaigns, and overturning the ACA occupied a significant part of his policy agenda whilst in office (Haeder and Chattopadhyay 2022), and the ACA also reemerged as a campaign issues in the 2024 presidential election (Waddick 2024). Moreover, the role of President Trump is particularly interesting here because he specifically campaigned on the promise to protect Medicare (Berman 2017).

Lastly, I expect to find consistent differences based on respondents' levels of "racial resentment" (see Kinder & Sanders, 1996). A substantial body of work has accumulated that highlights the racialized nature of the ACA as well the racialization of public attitudes about the ACA (Banks 2013; Fording and Patton 2019; Grogan and Park 2017; Henderson and Hillygus

2011; Knoll and Shewmaker 2013; Knowles, Lowery, and Schaumberg 2010; Lanford and Quadagno 2016; Maxwell and Shields 2014; McCabe 2019; Pasek et al. 2009; Segura and Valenzuela 2010; Snowden and Graaf 2019; Tesler 2012; Valentino, Neuner, and Vandenbroek 2018). ACA critics have linked the ACA to the highly racialized area of "welfare" policy (Fording and Patton 2019; Gilens 1996, 1999; Snowden and Graaf 2019) and have sought to frame ACA as benefitting "undeserving" racial minorities (Haney-López 2015). The racialized effect of the distributive policies of the ACA has only been amplified by its namesake, President Obama (Haeder and Sylvester 2024; Knowles, Lowery, and Schaumberg 2010; Luttig and Motta 2017; Pasek et al. 2014; Tesler 2012). The racialization of the ACA has also been documented in the implementation of its various components (Haeder 2020), and the effects were magnified by the election of President Trump (Abramowitz and McCoy 2019; Luttig, Federico, and Lavine 2017; Ott and Dickinson 2020; Ouyang and Waterman 2020; Tien 2017).

Data and Methods

To better understand the impact that information about the ACA's benefits may have on older persons' attitudes about this policy and about party leadership in the domain of health care overall, I fielded a survey among Americans above the age of 65 using Lucid. Lucid is a reputable survey company whose samples compare well to standard probability samples and whose data is frequently used to conduct public opinion research in the social sciences (Coppock, Leeper, and Mullinix 2018; Coppock and McClellan 2019; Stagnaro et al. 2024). The survey was in the field from June 7, 2021, to June 13, 2021. Overall, 1,270 individuals opted into the survey, and 1,220 consented to take the survey (96%), and 1,206 (95%) of which completed the survey. In terms of demographics, the survey sample aligned well with the U.S. senior

population in terms of gender, age, income, and race and ethnicity while respondents tended to be somewhat more educated than the general population. I further improved fit by weighting the data according to national benchmarks gender, race, income, and education based on the U.S. Census Current Population Survey for Americans above age 65. Appendices 1-4 provide further information about the survey.

Survey Structure

Respondents were randomly assigned to the control group or to one of three treatment groups. Each treatment group was primed with factual information about one of three distinct ACA benefits. The first treatment, focused on the Medicare trust fund, primed respondents for a benefit that older adults on Medicare experience as a group:

> Finally, we would like to ask you a few questions about health reform. The health reform passed in early 2010 and increased the Medicare Trust Funds' life span by 12 additional years. The trust funds finance health services for Medicare beneficiaries.

The second treatment drew attention to the ACA's work phasing out the Medicare Part D donut hole, a benefit experienced by Americans age 65+ individually. That treatment read:

> Finally, we would like to ask you a few questions about health reform. The health reform passed in early 2010 phased out the so-called donut hole in Medicare Part D. This means that seniors no longer have to pay the full cost of their covered drugs in the coverage gap. On average, this change saves Medicare beneficiaries hundreds of dollars per year.

A third set of respondents was primed with information about the ACA's role in reducing rates of uninsurance, a benefit experienced by older adults more sociotropically and remotely:

> Finally, we would like to ask you a few questions about health reform. The health reform passed in early 2010 reduced the number of uninsured Americans from 18 percent to 10 percent.

As noted, I also include a control group that received the following introduction:

> "Next, we would like to ask you a few questions about health reform."

Appendices 2 and 3 provide an overview of the respondent assignment and recap these survey introductions as well as the specific questions asked. Questions and reference to "the 2010 health reform law" were based on the previous polling related to the ACA by KFF (Kaiser Family Foundation 2021, 2024).

The first objective was to determine whether the different primes affect general attitudes towards the ACA. I thus queried respondents about the favorability of the ACA with the standard question:

> "Do you have a generally favorable or generally unfavorable opinion of the 2010 health reform law?"

The survey offered respondents a 5-point scale from "very unfavorable" to "very favorable" with a neutral midpoint. For the analyses, I coded "very favorable" as 5. Thus, a higher score on this variable signals greater favorability toward the ACA.

Next, we were interested whether the varying primes affected respondents' views about the broader outlook for the ACA. I thus asked respondents:

> "What would you like to see policymakers do when it comes to the 2010 health care law?"

Following previous polls, I offered them four response options including (1) build on what the law does, (2) keep the law as it is, (3) scale back what the law does, and (4) repeal the

entire law. For the analyses, I retained this original variable scoring. Thus, a higher score on this variable signals greater support for *retrenchment* of the ACA.

Lastly, we were interested whether perceptions of the ACA then spilled over into the broader views of the political parties' handling of health policy. Thus, I asked:

"Which political party do you trust to do a better job handling health care issues?"

I offered respondents options for each party as well as an option for "neither Republicans nor Democrats." For the analyses, an answer of "Democrats" was scored as 1, "Neither Republicans nor Democrats" as 2, and "Republicans" as 3. Thus, a higher score on this variable signals greater trust in the Republican Party to handle matters of health policy.

Appendix 4 recaps these measures of the dependent variables.

Methods

As the design relies on a survey experiment, I compared outcome variables using weighted least squares to assess changes in predicted means for the various outcomes. I first report results for respondents in the aggregate. Then, I report sub-group analyses, based on interacting the treatment with a 3-category partisan identification variable (Democrat, Independent or Other, Republican), or alternatively, a dichotomous indictor of whether or not the respondent voted for President Trump, and a racial resentment measure that was built from the standard four racial resentment questions (Kinder and Sanders 1996) and then cut into terciles to categorize the respondent as falling into one of three levels of racial resentment (low, medium, and high), respectively. In all cases, I assessed effects by estimating predictive means and comparing differences across the predictive means using mlincom in Stata (S. Long and Freese 2014). Throughout the analyses I considered a p-value lower or equal to 0.05 as statistically significant.

Results

ACA Favorability

Overall, I found substantial support for the hypothesis that highlighting the ACA's benefits raised ACA favorability among older adults as compared to the unprimed control group. Specifically, across all respondents (Table 1, Figure 1), treatment group favorability exceeded control group favorability toward the ACA by a magnitude of 0.670 (on a scale from 1 to 5) for the trust fund treatment ($p<0.001$), 0.826 for the Medicare Part D treatment ($p<0.001$), and 0.397 for the uninsured treatment ($p=0.002$).

Subgroup analyses by respondent partisanship also indicated that the increases in favorability consistently applied to non-partisans with regard to the trust fund treatment (0.904, $p<0.001$) and the Part D treatment (0.830, $p<0.001$) and to Republicans for all three treatments (Trust fund: 0.871, $p<0.001$; Part D: 1.070, $p<0.001$; Uninsured: 0.552, $p=0.026$). For Democrats I only found statistically significant increases for the Part D treatment (0.575, $p=0.001$). The findings for Democrats may indicate potential ceiling effects given their already high support for the ACA. In the alternative specification dichotomizing respondents into those who voted for President Trump and those who did not, contrary to expectations, I found consistent increases in support for both the former (0.826, $p<0.001$; 1.191, $p<0.001$; 0.546, $p=0.003$) and the latter (0.508, $p<0.001$; 0.631, $p<0.001$; 0.333, $p=0.026$) across all treatments. At the same time, I found no effect for respondents who scored low on racial resentment, confirming one of the expectations, while I found that those with medium levels saw increases for the trust fund treatment (0.774, $p<0.001$) as well as the Part D treatment (1.005, $p<0.001$). I saw consistent

increases for the respondents high in racial resentment (0.955, p<0.001; 1.136, p<0.001; 0.602, p=0.020).[1]

Comparison across treatments for all respondents (Table 2) indicated increased support for the ACA for both the trust fund (0.274, p=0.031) and the Part D (0.429, p=0.001) treatments compared to the treatment highlighting reductions in the uninsured, confirming the second hypothesis. However, subgroup analyses revealed certain nuances. While these results were mirrored for non-partisans (0.545, p=0.005; 0.471, p=0.021), I only identified increased support comparing the Part D to the uninsured treatment for Republicans (0.518, p=0.035). I found no effect for Democrats. Among Trump voters, I identified differences favoring the Part D treatment over the uninsured treatment (0.645, p=0.001). This was also the case for non-Trump voters (0.298, p=0.040). I found no differences for those low in racial resentment. For those with moderate levels, support was higher for the trust fund (0.565, p=0.006) and the Part D (0.796, p=0.002) treatments over the uninsured treatment. For those with high levels, support was higher in the Part D over the uninsured treatment (0.534, p=0.029).

Future of the ACA

Assessing attitudes towards the future of the ACA (Table 3), I was only able to identify a statistically significant impact of highlighting the policy benefits of the ACA to seniors across all

[1] I noted that within each individual treatment (Appendix 5), I identified differences based on partisanship in most cases. Favorability differed between Democrats and non-partisans in all treatments except the trust fund treatment (0.534 to 0.789, p<0.003) and in all four cases between Democrats and Republicans (0.444 to 1.204, p<0.040). However, favorability differed between non-partisans and Republicans only in the control (0.415, p=0.023) and the trust fund treatment (0.448, p=0.013). There were also consistent differences between Trump voters and those opposed to President Trump (0.676 to 1.236, p<0.001). I also found differences based on different levels of racial resentment. Here, I identified differences between those with low and medium levels of racial resentment in the control (0.934, p<0.001) and uninsured treatment (0.590, p=0.010) and consistent differences between those with low and high levels of racial resentment (0.621 to 1.504, p<0.006). Difference between moderates and those with high levels were only present in the control (0.570, p=0.004). Second difference are presented in Appendix 6.

respondents for the trust fund (0.546, p<0.001) and the Part D (0.264, p=0.033) treatments, partially confirming H1b. Assessing the various subgroups of interest, the effect for the trust fund treatments appeared to be driven by non-partisans (0.594, p<0.001) as well as Republicans (0.896, p<0.001), with no corresponding change for Democrats. I also saw a decreasing willingness to undo the ACA among Republicans in the Part D treatment (0.619, p=0.005). The effects for both treatments was also present for Trump voters (0.883, p<0.001; 0.588, p=0.002). For those voting against President Trump, I found significant effects for the trust fund treatment only (0.246, p=0.012). Assessing respondents based on their levels of resentments, I identified decreases in support for reining in the ACA among both those with moderate and high levels of resentment for the trust fund treatment (0.667, p<0.001; 0.891, p<0.001). [2]

Comparing the treatments directly benefitting seniors to the treatment focused on the uninsured across all respondents (Table 4), I found that only the trust fund treatment differed from the uninsured treatment (0.503, p<0.001), providing only partial confirmation for H2. Assessing differences based on partisanship, I found no differences for Democrats but analogous differences for non-partisans (0.661, p<0.001), Republicans (0.595, p=0.012), and both Trump voters (0.688, p<0.001) and those opposed (0.280, p=0.004). These effects were also present for respondents with low (0.409, p=0.026), medium (0.709, p=0.001), and high (0.564, p=0.012) levels of racial resentment.

[2] Within treatments (Appendix 7), I found consistent difference between Democrats and non-partisans (0.260 to 0.725, p<0.015) as well as Democrats and Republicans (0.761 to 1.527, p<0.001) whereas non-partisans differed from Republicans in the control (0.803, p<0.001) and trust fund treatment (0.501, p=0.002). I also found consistent differences based on presidential voting (0.845 to 1.481, p<0.001). Differences were statistically significant between those with low and moderate levels of racial resentment in all cases except the Part D treatment (0.263 to 0.890, p<0.044) and consistently significant comparing those with low and high levels (0.712 to 1.562, p<0.002). Moderates and those with high levels differed in the control (0.673, p=0.006), the Part D (0.613, p=0.012) and the trust fund treatments (0.449, p=0.010). Second difference are presented in Appendix 8.

Trust in Parties

Lastly, I found no broader spillover effects (H1c) of priming respondents to the benefits of the ACA (Table 5). That is, highlighting the ACA benefits did not substantially shift public attitudes about broader healthcare issues. The only statistically significant effect I identified was for Republicans where highlighting reductions in the number of uninsured actually shifted respondents slightly away from the Republican party (0.261, p=0.026).

Comparisons with the uninsured treatment (Table 6) also identified few statistically significant differences (H2). Here, Republicans were more strongly pulled towards Democrats in the trust fund treatment compared to the uninsured treatment (0.290, p=0.027). Moreover, Trump voters were pulled further to the Democratic party in the uninsured over the trust fund treatment (0.215, p=0.028).[3]

Discussion

Public policies can distribute new resources to groups within society, but for a number of reasons target populations may not always recognize new policy benefits. This may be particularly true when policy design, the informational environment, or both, make a policy's benefits uncertain or difficult to discern as political opponents fight over the policy's dominant frames (Campbell 2012; Mettler 2011; Patashnik and Zelizer 2013; Pierson 2015; Schneider and Ingram 2005). In addition, political opponents may further create uncertainties by spreading misinformation

[3] However, in the comparisons within treatments (Appendix 9) I again found consistent differences between Democrats and non-partisans (0.466 to 0.831, p<0.001), non-partisans and Republicans (0.563 to 0.983, p<0.001), and Democrats and Republicans (1.339 to 1.623, p<0.001) across all four treatments. These findings also held for those voting for President Trump compared to those not voting for him (1.129 to 1.348, p<0.001). Lastly, differences once more held for respondents with different levels of racial resentment comparing those with low levels to moderates (0.416 to 0.929, p<0.025) and those with high levels (0.842 to 1.250, p<0.001) as well as those with moderate levels to those with high levels (0.320 to 0.426, p<0.031) with the exception of the control group. Second difference are presented in Appendix 10.

(Barnett and Marsden III 2021; Cohn 2021; Gitterman and Scott 2011; McDonough 2020; Nyhan 2010). However, in order to produce meaningful feedback effects, individuals must be aware of a policy's benefit structure (Béland, Campbell, and Weaver 2022; Pierson 1994; Schattschneider 1935). Hence, the question of whether target populations perceive policy benefits is essential to understanding a policy's potential to reap positive policy feedback effects. And while the ACA has attracted a great deal of study from scholars of policy feedback effects and public opinion formation (see Campbell (2020); Haeder (2020); Hobbs and Hopkins (2021)), one important target population of the ACA remains underexplored: older adults. To increase our understanding of the ACA's political effects on this age group, this paper explored the power of priming to elicit support for the 2010 Affordable Care Act (ACA) among Americans age 65+ as well as potential changes in attitudes related to the future of the ACA as well as partisan leadership on healthcare more broadly. The ACA's design and the information environment around the policy in combination with the tense political environment work against obvious benefit legibility for this age group, making the analyses a strong test of the power of priming.

Overall, I found that informational treatments related to the ACA's benefits in the form of the extension of the Medicare trust fund, the filling of the Medicare Part D donut hole, and even a reduction in the number of uninsured all increased the ACA's favorability. This effect was particularly pronounced for groups generally opposed to the ACA such as Republicans, Trump voters, and those high in racial resentment. Importantly, for groups more favorable towards the ACA, differences were generally not discernable. Moreover, I identified consistent differences across partisanship, voting behavior, and levels of racial resentment across all treatments. Treatments also affected attitudes about the future of the ACA. Effects, though, were confined to the trust fund and Part D treatments across all respondents and for groups generally

skeptical of the ACA. Here, the trust fund treatment stood out in particular. Lastly, I could not identify any spillover effects of the treatments into general attitudes about the party's leadership on healthcare issues. That is, reminiscent of the failure of welfare reform to reshape public attitudes about the Democratic party (Soss and Schram 2007), highlighting the objective benefits of the ACA did not transform attitudes about health policy more broadly in favor of Democrats.

The findings here should be viewed in light of several limitations. One limitation of this study is that—while I intend to contribute to the policy feedback literature—the analysis does not illustrate the emergence of a full policy feedback loop around the ACA through the priming of attention to specific provisions (Campbell 2020). That is, research has focused on how policies impact attitudes or behaviors in the public, but not on how those attitudes or behaviors later change politics or policy (Campbell 2020). This paper too focuses only on the front half of the equation in testing how information about ACA benefits impacts older Americans' attitudes. I believe that the finding that information moves older Americans' attitudes about some aspects of the ACA does expand and fine-tune our understanding of the degree to which the ACA does or does not remain vulnerable to slow erosion through acts of "chipping away at the political coalitions behind it" (Hall 2015, 289-90).

In particular, the findings of this paper suggest that older Americans could be mobilized to oppose changes to the ACA that would undermine the revisions that the law made to Medicare Part D and to the Medicare trust fund—potentially even in response to somewhat low-visibility changes to these parts of the ACA (Hacker 2004), since organizations that attend closely to Medicare, like the AARP, have a track record of mobilizing older Americans to action in defense of the program (Campbell 2003, 2020). However, it is also worth noting that the findings here point towards feedback effects that are limited to the ACA, as I did not find effects on healthcare

attitudes more generally. Further, confirmation of an actual feedback loop would require evidence—which I do not have—that older Americans do in fact respond to proposed ACA revisions that could erode closure of the Part D donut hole or that hasten exhaustion of the trust fund.

A second limitation is that a priming experiment is of course an artificial scenario that does not capture the type of messaging that people tend to receive about a policy in real life (Barabas and Jerit 2010; Gaines, Kuklinski, and Quirk 2007). Related to this point, the priming experiment presented here deliberately shines a spotlight on policy features and then queries respondents for their policy opinions. But Campbell (2020, 575) notes that public responses to policy benefits are not likely to take the form of a "flip-the-switch effect" where new benefits immediately motivate recipients to have new positive feelings about the policy. To be sure, I do not view the findings in this paper as evidence of the existence of a strong pro-ACA constituency among older Americans rooted in consideration of Medicare benefits. Rather, I see the results as evidence that older Americans *could* be motivated to express opinions and perhaps to engage in political behaviors that support the ACA through messaging about the ACA's improvements to Medicare Part D and the Medicare trust fund. In other words, I view the insights into the moveability of older Americans' views of the ACA as relevant to understanding the public opinion precursors to feedback effects that could come to fruition (or not) in future decades.

A third limitation is that this paper, in its hypotheses and thus in its research design, has not taken up the call to examine how policy feedback patterns may differ across population subgroups—particularly across racial groups (Maltby 2017; Michener 2019; Rosenthal 2021). I concur with the need for such research. This paper has, however, contributed to understanding responses to the ACA within one population subgroup—older Americans—that has not been the

focus of a large number of studies on public opinion and the ACA to date (for exceptions see Kelly 2015) as well as various politically important subgroups within older Americans.

Lastly, given the analytical approach that relies on a survey experiment embedded in a cross-section, non-probability sample, important methodological limitations also apply. Reliance on this type of sample for older Americans may exacerbate some of these concerns and respondents in the sample might not be fully reflective of the broader population. I sought to mitigate these by utilizing a reputable survey firm that is frequently used for this purpose as well as by utilizing survey weights in the analyses. I also note that sample demographics were generally in line with the general population in terms of age, income, race and ethnicity, and gender but respondents tended to be more educated and more supportive of President Biden. It is also worth noting that Lucid respondents are more politically engaged than the general public (Coppock, Leeper, and Mullinix 2018). However, this similar to a bias towards more educated seniors would likely reduce the probability and size of any experimental effects, thus making our findings conservative estimates of the true effect.

Implications for Research on the ACA, Policy Feedback Effects, Priming, and Self Interest

Despite these limitations, I believe that this analysis has useful implications for research on public opinion about the ACA and about policy more broadly. I view the results as suggesting that information about ACA benefits for people on Medicare can elicit enthusiasm for the policy among older Americans, but simultaneously suggesting that this age group is not a ready constituency of the ACA absent such information. Indeed, the results perhaps suggest that older Americans continue to be—as expected based on design and information considerations—somewhat unaware of the policy benefits that the ACA can be seen as bestowing on them. That

is, even more than a decade into the ACA, the findings here confirm other studies (Brodie et al. 2020; Kirzinger et al. 2024) that the visibility of these benefits has remained low. The implication of the results found here is that older Americans' support for the ACA may wax and wane as political actors draw greater or lesser attention to these benefits over time.

Beyond the ACA, I view this paper as contributing to an issue in policy feedback research that scholars have recently emphasized—namely the possibility that seeming evidence of positive responses to a policy from its target population may owe to selection effects (Anzia, Jares, and Malhotra 2022; Campbell 2020). That is, "for many of the programs analyzed [in policy feedback studies to date], the beneficiaries lean liberal and Democratic […] and might have supported the policies (and government) anyway" (Anzia, Jares, and Malhotra 2022, 1). Key to the reasoning here is that older Americans—despite being a long-standing and readily mobilized political constituency of Social Security and Medicare (Campbell 2003)—are not particularly disposed to support the ACA. Second, as also discussed earlier, the ACA has at times been framed in public discourse as posing harms to Medicare and thus to older Americans (Gitterman and Scott 2011; McDonough 2020; Nyhan, Reifler, and Ubel 2013), and many older Americans may be worried about these (perceived) implications (Gitterman and Scott 2011; Kaplan 2011; Kelly 2015). The finding that older Americans primed with information about the ACA's benefits related to Part D and to the Medicare trust fund were more supportive of the ACA and its maintenance than older Americans who were not primed to consider such information is—I believe—evidence that the benefits within the ACA *itself*, coupled with messaging, can in fact do work to generate positive attitudinal responses to the ACA. The benefits within the policies themselves matter to some extent—that is, policy design matters—as policy feedback theory has proposed (Campbell 2012; Pierson 1994).

Additionally, this paper adds to the literature that explores the role of self-interest in shaping policy attitudes, and in particular to literature that finds that self-interest matters at least some of the time (Alt and Iversen 2017; Campbell 2003; Erikson and Stoker 2011; Sears and Citrin 1985). First, the results suggest that information that appeals to older Americans' self-interest—by referencing closure of the Part D donut hole and extension of the Medicare trust fund—appears to raise support for the ACA beyond what it would be in this age group absent such information. These results are similar to existing findings that consideration of a policy's benefits appears to motivate support for that policy among beneficiaries (Campbell 2003). In other words, what Chong, Citrin, and Conley (2001) and Holbrook et al. (2016) call "objective" self-interest appears to matter in this study. Conversely, the ACA's policy changes which do not directly affect older Americans—or only do so very indirect ways as described earlier—appear to have a more limited effect—at once raising favorability toward the ACA but not reducing support for ACA retrenchment. These results could suggest that, at least in the case of the ACA and older Americans, appeals to objective self-interest are more powerful and that appeals to these other-regarding phenomena —such as "fairness" (Lynch and Gollust 2010) or "compassion" (Huddy, Jones, and Chard 2001)— here fail despite raising support for health care reform in other contexts (Lynch and Gollust 2010).

Finally, this paper has contributed to understanding how policy feedback processes may work in cases where two policies intersect—the ACA and Medicare. In doing so, it helps build the literature responding to calls for such research (Béland, Campbell, and Weaver 2022; Campbell 2012; Mettler and Stonecash 2008).

Conclusion

Feedback effects can have important implications for the future of a specific policy as well as broader implications for the political environment. While research has identified some limited feedback effects related to the ACA (Hosek 2019; Jacobs and Mettler 2018; Jacobs, Mettler, and Zhu 2022; McCabe 2016), a comprehensive assessment of the ACA found few large and lasting impacts (Hopkins 2023). The analyses here found substantial changes in attitudes, a prerequisite for feedback effects, for primes about various benefits of the ACA amongst Americans age 65 and up. It is worth noting that the substantially large effects may indicate a lack of awareness of the ACA's benefits among older adults. As these effects were particularly evident from groups generally opposed to the ACA suggests that priming and information provision has the potential to overcome partisan responses to survey questions and partisan-inflected opposition to the policy in real life. These findings indicate that feedback effects related to the ACA are plausible, perhaps if Democrats had more effectively advertised the contents of the ACA rather than running away from it. Supporters of the ACA should be encouraged that highlighting the ACA's benefits holds potential to shift public attitudes about the ACA and its future into a more favorable direction. Older adults, an important political group, may serve as an underappreciated source of support for the ACA. Ultimately, the findings hence raise the question whether Democrats could have fostered more support among seniors for the reform and perhaps even have blunted a potent Republican weapon, generalized dissatisfaction with the ACA. However, older adults' limited response to information related to one of the ACA's primary achievements, a substantial reduction in the number of uninsured persons, suggests that—for a group to show positive attitudinal feedback effects—direct and tangible benefits for that group must be embedded in the policy's design. At the same time, the findings also point to the lack of more general effects given the polarized nature of American politics today. Ultimately, the results

suggest that political actors may remain able to either elicit or suppress favorable or unfavorable attitudinal responses to the ACA over time, highlighting the contingent and variable impacts of policy feedback effects.

■■■

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Table 1 U.S. Seniors' Favorability Assessments of the Affordable Care Act Compared to Control

Group	Treatment	Control	Treatment	Delta	P-value
Overall	Trust Fund	2.980	3.651	0.670	**0.000**
	Part D	2.980	3.806	0.826	**0.000**
	Uninsured	2.980	3.377	0.397	**0.002**
Democrats	Trust Fund	3.655	3.765	0.111	0.595
	Part D	3.655	4.230	0.575	**0.001**
	Uninsured	3.655	3.937	0.283	0.126
Non-partisans	Trust Fund	2.866	3.770	0.904	**0.000**
	Part D	2.866	3.696	0.830	**0.000**
	Uninsured	2.866	3.225	0.359	0.065
Republicans	Trust Fund	2.451	3.322	0.871	**0.000**
	Part D	2.451	3.521	1.070	**0.000**
	Uninsured	2.451	3.003	0.552	**0.026**
Low Racial Resentment	Trust Fund	3.837	3.967	0.129	0.509
	Part D	3.837	4.090	0.253	0.287
	Uninsured	3.837	3.702	0.136	0.551
Medium Racial Resentment	Trust Fund	2.903	3.677	0.774	**0.000**
	Part D	2.903	3.908	1.005	**0.000**
	Uninsured	2.903	3.112	0.209	0.290
High Racial Resentment	Trust Fund	2.333	3.288	0.955	**0.000**
	Part D	2.333	3.469	1.136	**0.000**
	Uninsured	2.333	2.935	0.602	**0.020**
Not Trump Voter	Trust Fund	3.486	3.994	0.508	**0.000**
	Part D	3.486	4.117	0.631	**0.000**
	Uninsured	3.486	3.819	0.333	**0.026**
Trump Voter	Trust Fund	2.250	3.076	0.826	**0.000**
	Part D	2.250	3.441	1.191	**0.000**
	Uninsured	2.250	2.796	0.546	**0.003**

Notes: Based on survey of 1,206 Americans over age 65 fielded from May 26, 2021, to June 13, 2021. Based on the question: "Do you have a generally favorable or generally unfavorable opinion of the 2010 health reform law?" with answer choices (1) Very unfavorable, (2) Somewhat unfavorable, (3) Neither favorable nor unfavorable, (4) Somewhat favorable , and (5) Very Favorable.

Table 2 U.S. Seniors' Favorability Assessments of the Affordable Care Act, Comparisons Across Treatments

Group	Comparison		Treatment 1	Treatment2	Delta	P-value
Overall	Trust Fund	Uninsured	3.651	3.377	0.274	**0.031**
	Part D	Uninsured	3.806	3.377	0.429	**0.001**
Democrats	Trust Fund	Uninsured	3.765	3.937	0.172	0.407
	Part D	Uninsured	4.230	3.937	0.293	0.090
Nonpartisans	Trust Fund	Uninsured	3.770	3.225	0.545	**0.005**
	Part D	Uninsured	3.696	3.225	0.471	0.021
Republicans	Trust Fund	Uninsured	3.322	3.003	0.319	0.195
	Part D	Uninsured	3.521	3.003	0.518	**0.035**
Low Racial Resentment	Trust Fund	Uninsured	3.967	3.702	0.265	0.185
	Part D	Uninsured	4.090	3.702	0.389	0.107
Medium Racial Resentment	Trust Fund	Uninsured	3.677	3.112	0.565	**0.006**
	Part D	Uninsured	3.908	3.112	0.796	**0.002**
High Racial Resentment	Trust Fund	Uninsured	3.288	2.935	0.353	0.207
	Part D	Uninsured	3.469	2.935	0.534	**0.029**
Not Trump Voter	Trust Fund	Uninsured	3.994	3.819	0.176	0.202
	Part D	Uninsured	4.117	3.819	0.298	**0.040**
Trump Voter	Trust Fund	Uninsured	3.076	2.796	0.280	0.170
	Part D	Uninsured	3.441	2.796	0.645	**0.001**

Notes: Based on survey of 1,206 Americans over age 65 fielded from May 26, 2021, to June 13, 2021. Based on the question: "Do you have a generally favorable or generally unfavorable opinion of the 2010 health reform law?" with answer choices (1) Very unfavorable, (2) Somewhat unfavorable, (3) Neither favorable nor unfavorable, (4) Somewhat favorable , and (5) Very Favorable.

Table 3 U.S. Seniors' Support for Potential Changes to the Affordable Care Act

Group	Treatment	Control	Treatment	Delta	P-value
Overall	Trust Fund	2.019	1.472	0.546	**0.000**
	Part D	2.019	1.755	0.264	**0.033**
	Uninsured	2.019	1.975	0.043	0.746
Democrats	Trust Fund	1.278	1.148	0.130	0.286
	Part D	1.278	1.311	0.033	0.825
	Uninsured	1.278	1.382	0.104	0.485
Nonpartisans	Trust Fund	2.002	1.408	0.594	**0.001**
	Part D	2.002	1.806	0.196	0.325
	Uninsured	2.002	2.069	0.066	0.758
Republicans	Trust Fund	2.805	1.909	0.896	**0.000**
	Part D	2.805	2.186	0.619	**0.005**
	Uninsured	2.805	2.505	0.300	0.224
Low Racial Resentment	Trust Fund	1.230	1.190	0.040	0.727
	Part D	1.230	1.380	0.150	0.383
	Uninsured	1.230	1.598	0.368	0.058
Medium Racial Resentment	Trust Fund	2.119	1.453	0.667	**0.000**
	Part D	2.119	1.699	0.421	0.053
	Uninsured	2.119	2.162	0.042	0.852
High Racial Resentment	Trust Fund	2.792	1.902	0.891	**0.000**
	Part D	2.792	2.311	0.481	0.071
	Uninsured	2.792	2.466	0.326	0.248
Not Trump Voter	Trust Fund	1.401	1.155	0.246	**0.012**
	Part D	1.401	1.293	0.109	0.329
	Uninsured	1.401	1.435	0.033	0.794
Trump Voter	Trust Fund	2.882	2.000	0.883	**0.000**
	Part D	2.882	2.294	0.588	**0.002**
	Uninsured	2.882	2.688	0.195	0.338

Notes: Based on survey of 1,206 Americans over age 65 fielded from May 26, 2021, to June 13, 2021. Based on the question: "What you like to see policymakers do when it comes to the 2010 health care law?" with answer choices (1) Build on what the law does (2) Keep the law as it is (3) Scale back what the law does and (4) Repeal the entire law.

Table 4 U.S. Seniors' Support for Potential Changes to the Affordable Care Act, Comparisons Across Treatments

Group	Comparison		Treatment 1	Treatment 2	Delta	P-value
Overall	Trust Fund	Uninsured	1.472	1.975	0.503	**0.000**
	Part D	Uninsured	1.755	1.975	0.221	0.078
Democrats	Trust Fund	Uninsured	1.148	1.382	0.233	0.066
	Part D	Uninsured	1.311	1.382	0.071	0.641
Nonpartisans	Trust Fund	Uninsured	1.408	2.069	0.661	**0.000**
	Part D	Uninsured	1.806	2.069	0.262	0.187
Republicans	Trust Fund	Uninsured	1.909	2.505	0.595	**0.012**
	Part D	Uninsured	2.186	2.505	0.319	0.200
Low Racial Resentment	Trust Fund	Uninsured	1.190	1.598	0.409	**0.026**
	Part D	Uninsured	1.380	1.598	0.218	0.331
Medium Racial Resentment	Trust Fund	Uninsured	1.453	2.162	0.709	**0.001**
	Part D	Uninsured	1.699	2.162	0.463	0.053
High Racial Resentment	Trust Fund	Uninsured	1.902	2.466	0.564	**0.021**
	Part D	Uninsured	2.311	2.466	0.155	0.570
Not Trump Voter	Trust Fund	Uninsured	1.155	1.435	0.280	**0.004**
	Part D	Uninsured	1.293	1.435	0.142	0.204
Trump Voter	Trust Fund	Uninsured	2.000	2.688	0.688	**0.000**
	Part D	Uninsured	2.294	2.688	0.394	0.051

Notes: Based on survey of 1,206 Americans over age 65 fielded from May 26, 2021, to June 13, 2021. Based on the question: "What you like to see policymakers do when it comes to the 2010 health care law?" with answer choices (1) Build on what the law does (2) Keep the law as it is (3) Scale back what the law does and (4) Repeal the entire law.

Table 5 U.S. Seniors' Attitudes about Which Party to Trust More on Healthcare Issues

Group	Treatment	Control	Treatment	Delta	P-value
Overall	Trust Fund	1.917	1.842	0.075	0.388
	Part D	1.917	1.929	0.012	0.893
	Uninsured	1.917	1.831	0.086	0.320
Democrats	Trust Fund	1.206	1.241	0.035	0.763
	Part D	1.206	1.149	0.058	0.516
	Uninsured	1.206	1.144	0.063	0.491
Non-partisans	Trust Fund	1.851	1.708	0.144	0.214
	Part D	1.851	1.979	0.128	0.278
	Uninsured	1.851	1.919	0.068	0.581
Republicans	Trust Fund	2.744	2.691	0.053	0.579
	Part D	2.744	2.772	0.028	0.787
	Uninsured	2.744	2.482	0.261	0.026
Low Racial Resentment	Trust Fund	1.379	1.394	0.016	0.911
	Part D	1.379	1.334	0.045	0.736
	Uninsured	1.379	1.579	0.200	0.220
Medium Racial Resentment	Trust Fund	2.262	2.137	0.125	0.439
	Part D	2.262	2.263	0.001	0.996
	Uninsured	2.262	1.995	0.267	0.133
High Racial Resentment	Trust Fund	2.328	2.521	0.192	0.236
	Part D	2.328	2.583	0.255	0.083
	Uninsured	2.328	2.421	0.092	0.543
Not Trump Voter	Trust Fund	1.398	1.338	0.060	0.458
	Part D	1.398	1.316	0.082	0.317
	Uninsured	1.398	1.342	0.056	0.510
Trump Voter	Trust Fund	2.655	2.686	0.031	0.702
	Part D	2.655	2.637	0.019	0.814
	Uninsured	2.655	2.471	0.184	0.059

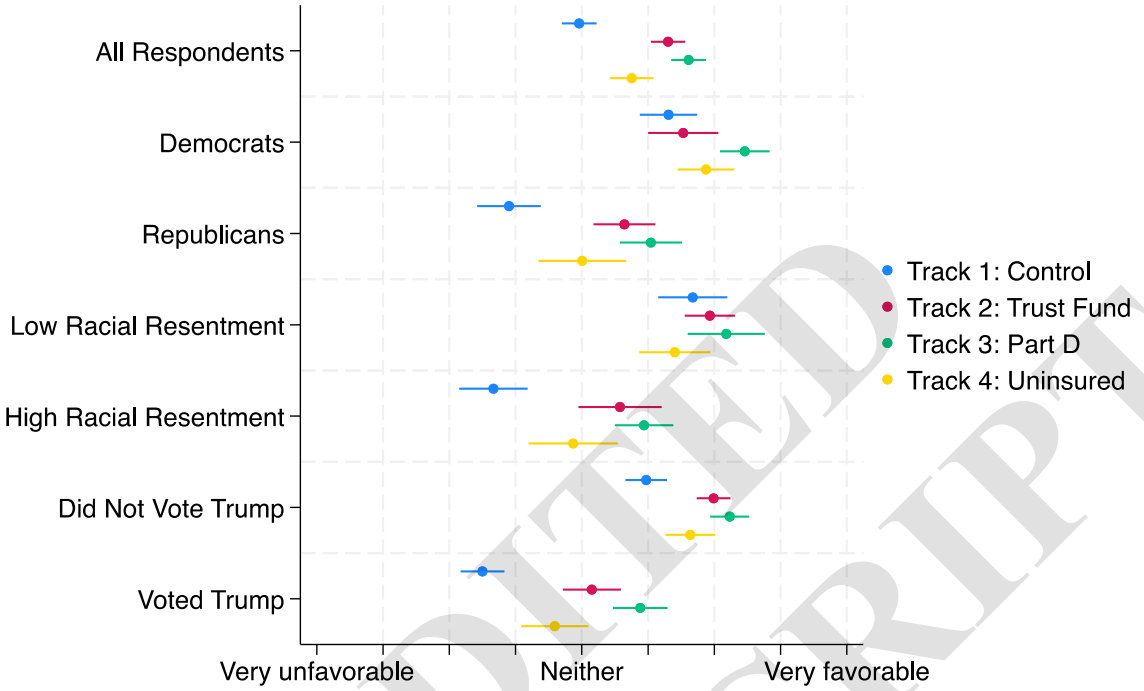
Notes: Based on survey of 1,206 Americans over age 65 fielded from May 26, 2021, to June 13, 2021. Based on the question: "Which political party do you trust to do a better job handling health care issues?" with answer choices (1) Democrats, (2) Neither Republicans nor Democrats", and (3) Republicans.

Table 6 U.S. Seniors' Attitudes about Which Party to Trust More on Healthcare Issues, Comparisons Across Treatments

Group	Comparison		Treatment 1	Treatment2	Delta	P-value
Overall	Trust Fund	Uninsured	1.842	1.831	0.011	0.894
	Part D	Uninsured	1.929	1.831	0.098	0.261
Democrats	Trust Fund	Uninsured	1.241	1.144	0.098	0.341
	Part D	Uninsured	1.149	1.144	0.005	0.942
Non-partisans	Trust Fund	Uninsured	1.708	1.919	0.212	0.078
	Part D	Uninsured	1.979	1.919	0.060	0.627
Republicans	Trust Fund	Uninsured	2.691	2.482	0.209	0.091
	Part D	Uninsured	2.772	2.482	0.290	**0.027**
Low Racial Resentment	Trust Fund	Uninsured	1.394	1.579	0.184	0.236
	Part D	Uninsured	1.334	1.579	0.245	0.101
Medium Racial Resentment	Trust Fund	Uninsured	2.137	1.995	0.143	0.416
	Part D	Uninsured	2.263	1.995	0.268	0.142
High Racial Resentment	Trust Fund	Uninsured	2.521	2.421	0.100	0.470
	Part D	Uninsured	2.583	2.421	0.163	0.176
Not Trump Voter	Trust Fund	Uninsured	1.338	1.342	0.004	0.956
	Part D	Uninsured	1.316	1.342	0.026	0.725
Trump Voter	Trust Fund	Uninsured	2.686	2.471	0.215	**0.028**
	Part D	Uninsured	2.637	2.471	0.166	0.088

Notes: Based on survey of 1,206 Americans over age 65 fielded from May 26, 2021, to June 13, 2021. Based on the question: "Which political party do you trust to do a better job handling health care issues?" with answer choices (1) Democrats, (2) Neither Republicans nor Democrats", and (3) Republicans.

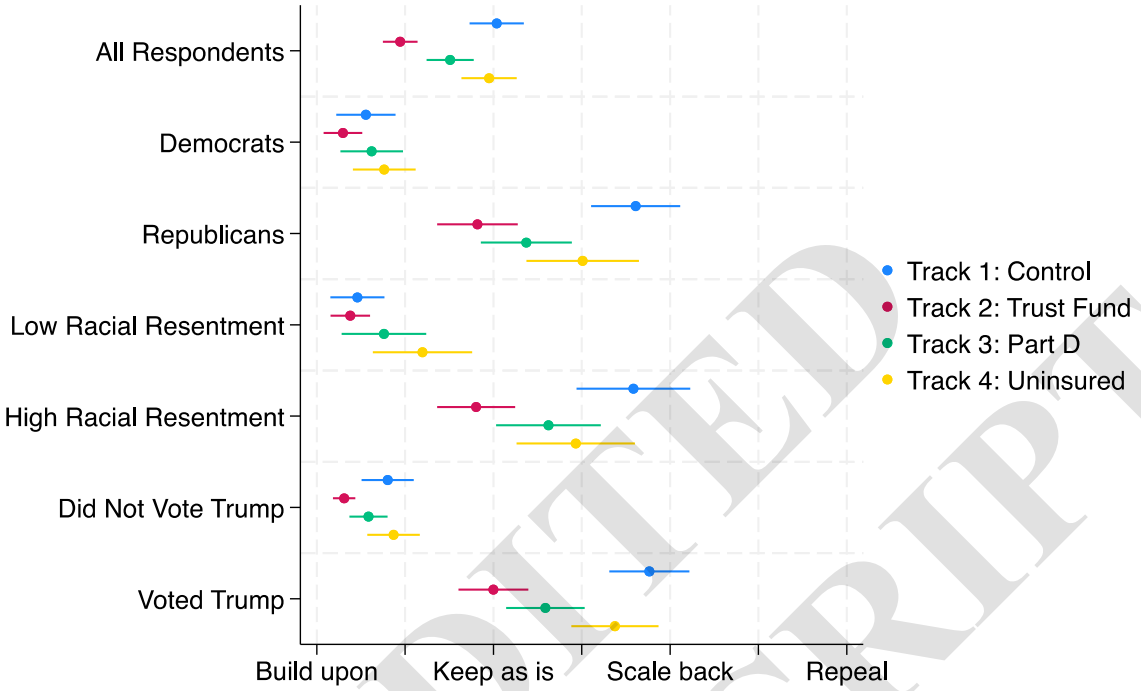
Figure 1 U.S. Seniors' Favorability Assessments of the Affordable Care Act.



Notes: Based on survey of 1,206 Americans over age 65 fielded from May 26, 2021, to June 13, 2021. Based on the question: "Do you have a generally favorable or generally unfavorable opinion of the 2010 health reform law?" with answer choices (1) Very unfavorable, (2) Somewhat unfavorable, (3) Neither favorable nor unfavorable , (4) Somewhat favorable , and (5) Very Favorable. 95% confidence bounds shown.

Figure 1 Alt Text: Figure presenting estimates for respondents' favorability toward the Affordable Care Act

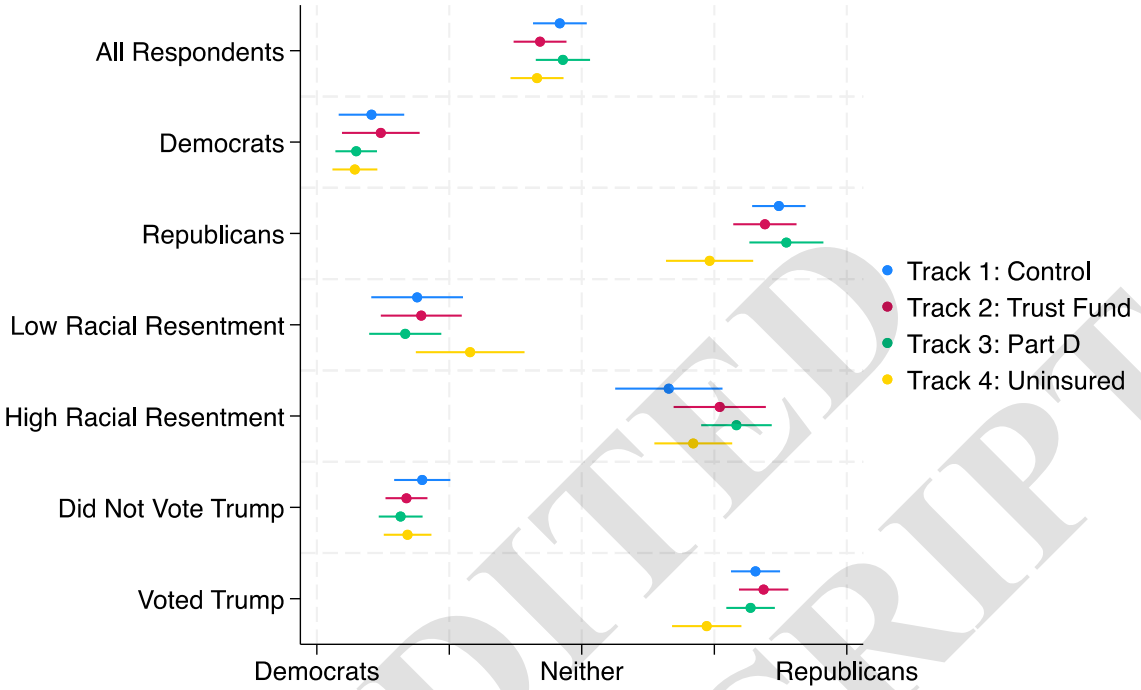
Figure 2 U.S. Seniors' Support for Potential Changes to the Affordable Care Act.



Notes: Based on survey of 1,206 Americans over age 65 fielded from May 26, 2021, to June 13, 2021. Based on the question: "What you like to see policymakers do when it comes to the 2010 health care law?" with answer choices (1) Build on what the law does (2) Keep the law as it is (3) Scale back what the law does and (4) Repeal the entire law.95% confidence bounds shown.

Figure 2 alt text: Figure presenting estimates for respondents' support for changes to the Affordable Care Act

Figure 3 U.S. Seniors' Attitudes about Which Party to Trust More on Healthcare Issues.



Notes: Based on survey of 1,206 Americans over age 65 fielded from May 26, 2021, to June 13, 2021. Based on the question: "Which political party do you trust to do a better job handling health care issues?" with answer choices (1) Democrats, (2) Neither Republicans nor Democrats", and (3) Republicans. 95% confidence bounds shown.

Figure 3 alt text: Figure presenting estimates for which party respondents trust more on healthcare.