The Politics of Policy: The Initial Mass Political Effects of Medicaid Expansion in the States

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October 30, 2015

Abstract

Whether public policy affects electoral politics by altering the composition and preferences of the electorate is an enduring question with an elusive answer. We use variation in the implementation of the Affordable Care Act resulting from the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* to compare the behavior and opinions of otherwise similar counties and individuals in states that differ in terms of their decision to expand Medicaid. Using county-level vote returns, we show that counties in expansion states experience a slightly higher number of voters than similar counties in non-expansion states. Moreover, this impact is largest in counties with below average median household incomes. Leveraging an opt-in internet exit poll of 30,000 respondents conducted during the 2014 election to probe this finding further reveals that the expansion of Medicaid decreased the importance of health care as an issue among respondents living in expansion states – particularly among the least educated respondents – but there was little evidence of a pro-Democratic shift in opinions. Thus, while there is some evidence consistent with the policy producing political impacts via increased turnout among recipients, the magnitude appears limited.

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In addition to affecting the problems that they are designed to address, public policies also often thought to have important political impacts. The creation of Social Security, for example, not only provided a solution to the problem of senior poverty, but it also created a powerful constituency with a vested political interest that has arguably constrained social policy ever since (Campbell 2003). Understanding the political effects of public policies are important not only because they create constituencies invested in the scope and durability of a particular program, but also because they may alter the electoral landscape and affect policymaking on other issues.

The claim that "new policies create a new politics" is as old as Schattschneider's (1935) study of the tariff in the United States, but it has been taken seriously as an empirical prediction only recently (Pierson 1993; Campbell 2002; Mettler and Soss 2004). In addition to Campbell's (2002) pioneering work on the Social Security program and senior political activism, scholars have examined this hypothesis using various social programs, including pension reform (Pierson 1992), welfare (Soss 1999) and the GI Bill (Mettler 2002) to name but a few. Despite such investigations, however, questions remain about the impact and nature of "policy feedbacks." Chief among these is the issue of causality: do policies affect the political behavior of beneficiaries, or is there something different about these beneficiaries that would have affected their behavior even in the absence of the policy?

We explore the mass political effects of public policy outcomes by examining whether the passage of the Affordable Care Act (ACA) and its attempt to extend insurance to low-income residents through the expansion of Medicaid affected the political behavior and opinions of citizens. In addition to being one of the most significant social welfare policies in decades, if not since the 1935 Social Security Act (Balz 2010), the ACA was also marked by a highly contentious and partisan political debate that left little doubt as to where the parties stood on the issue. Unlike notable social policies of the past, the law was enacted along party lines and not a single Republican in either the House or the Senate voted in its' favor. In addition to the clear consequences it created by expanding eligibility for health insurance, the conditions required for social policy to affect mass politics appear to be exceptionally satisfied for the case of the ACA. If there are limited effects on the mass electorate for a policy addressing a long-standing public priority that was enacted in a highly partisan fashion, it is unclear what policy would ever galvanize the electorate.

In addition to characterizing the scope and magnitude of possible policy feedbacks among the electorate that may result from social policies, characterizing the ACA's political impact is also

important for assessing its' own durability. As the continuing attempts to repeal the ACA by its opponents demonstrate, the ACA's continued existence depends critically on its' ability to generate and maintain a supportive constituency (Patashnik 2014).

The ACA is not only a substantively important and appropriate case to examine, but it is also particularly well-suited to empirical investigation. Unlike most previously studied social policies, the ACA's application varies across states because the Supreme Court's 2012 decision in *National Federation of Independent Business v. Sebelius* created significant state-level variation in the implementation of the ACA's Medicaid expansion provisions. This variation is important because it allows us to leverage the fact that otherwise similar geographic areas and individuals have vastly different experiences with the law. For example, whereas a lower-income individual living in rural Tennessee near the TN-KY border may be ineligible for Medicaid, an otherwise similar individual in Kentucky is newly eligible because of actions taken by their state government for which they are presumably non-pivotal.

In our exploration of the ACA's impact on the mass electorate, we focus on two fundamental questions. First, does the expansion of Medicaid as provided by the ACA affect the political behaviors of individuals? Are citizens in states that expanded Medicaid more likely to vote relative to otherwise identical citizens in non-expansion states, and is there evidence that the the targeted benefits helped to alleviate existing participatory differences related to social inequality? Has the expansion of Medicaid produced a negative-feedback in which opponents of the policy become more mobilized in response to the expansion? While much of the elite-level discourse surrounding the law presumes positive participatory effects for the recipients (e.g., Novack 2013), existing research on means-tested programs tend to find null (Sharp 2012) or even negative (Soss 1999; 2002) impacts on participation. It is also unclear whether previous results are confounded by selection bias – those who participate in social programs – and perhaps means-tested social programs (e.g., Schneider and Ingram 1993)) – may already be less likely to participate than those who do not. Because eligibility for means-tested programs often depend on factors known to predict voting behavior (e.g., education, income), it can be difficult to identify the political consequences of such policies.

Second, given the politicized nature of the ACA, has the expansion of Medicaid shifted citizen opinion? Again, while the public debate surrounding the law often hypothesizes such impacts, systematic evidence on past social programs finds little effect on attitudes (Campbell 2012). How-

ever, this lack of evidence may be due to the difficulty of identifying the effect relative to possible confounders. By leveraging the variation in program experiences created by pattern of Medicaid expansion in the states, we explore the relationship between policy and opinion by comparing the opinions of otherwise similar individuals who do and do not experience a policy change.

We show that consistent with the claim that the expansion of Medicaid had detectable policy consequences, the expansion of Medicaid was associated with roughly a 4% increase in insurance coverage in counties located in expansion states compared to otherwise similar counties located in non-expansion states and the increase was 1% higher for those counties with below average median household incomes. Comparing the change in the number of votes cast between 2014 and 2012 as a fraction of the voting age population in the county, the decrease in votes cast between the presidential and midterm elections was roughly 4% smaller in counties located in expansion states and this difference was concentrated almost entirely in the lower income counties. Pivoting to an analysis of 30,000 responses to an exit poll conducted by *Survey Monkey* on the eve of the 2014 midterm election reveals correlations that are consistent with these electoral impacts but which also suggest that the mobilization effects are likely not enduring – the importance of "health care" as an issue priority decreases for those most likely to benefit from the Medicaid expansion, and there is only suggestive evidence that opinions shifted in a pro-Obama or pro-Democratic direction among these respondents. Thus, while we demonstrate that there does appear to be an impact of Medicaid expansion on voter behavior, it seems unlikely that the effects are likely to endure as there is limited evidence to suggest that the policy created a newly mobilized constituency.

Section 1 briefly describes the politics surrounding the implementation of the Affordable Care Act and why the enacted policy may affect the actions and opinions of affected citizens. Section 2 describes the identification strategy that we employ using county level data to demonstrate the existence of traceable impacts from Medicaid expansion in the states. Having demonstrated the existence of policy impacts, section 3 explores whether political impacts on turnout occur in patterns that are consistent with the policy effects identified in section 2. Section 4 probes this aggregate level relationship further using individual level data from a survey conducted on the eve of the 2014 election that allows us to test whether citizens in states that expanded Medicaid differ in their opinions and attitudes relative to otherwise identical citizens residing in states that decided not to expand Medicaid, and section 5 concludes with a discussion about how the unique insights

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we identify contribute to our understanding of how policymaking may alter the nature of politics and the conditions under which such an effect may occur.

1 The Politics of Medicaid Expansion in the States And its Potential Political Impact

The Affordable Care Act was unambiguously the most important legislative priority of President Obama and it was a priority on which both the president and his party were willing to use their filibuster-proof majority in the Senate to ensure passage. As efforts to craft a bipartisan solution in Congress fell apart, the parties took divergent views about the desirability and likely impact of the bill and the Democrats eventually passed the bill into law without a single Republican vote in Congress. The partisan divide on the ACA was exceptional, and far different from the bipartisan coalitions enacting earlier prominent social programs such as the 1935 Social Security Act or the Servicemen's Readjustment Act of 1944 (the so-called "G.I. Bill") that have been studied previously for policy impacts. Moreover, the enactment was often referred to as "Obamacare," and it is a highly salient political issue with stark partisan divisions that has continued to dominate political debates at both the state and national level ever since it was initially proposed.

The ACA aimed to cut health care costs by increasing the percentage of insured citizens and, in so doing, to increase access to preventative care. To achieve this goal, the law provided for federal subsidies to help underwrite the insurance costs of individuals making less than 138% of the federal poverty limit. Importantly, those making less than 138% of the poverty limit would also now be eligible for the public Medicaid insurance program. Prior to the ACA, Medicaid eligibility varied by state, but generally left a significant portion of low-income, childless adults without insurance (Brooks et al 2015). For example, in the 28 states expanding Medicaid as of January 2015, the median Medicaid eligibility limit was 106% of the federal poverty limit for parents and 0% for childless adults (the federal poverty limits for 2014 were $19,790 for a family of 3 and $11,670 for an individual) and this increased to 138% following the expansion of Medicaid. Among those states opting not to expand Medicaid, however, the median income eligibility limit was 45% of the federal poverty limit for parents and 0% for childless adults. While the passage of the ACA creating a sliding scale of tax subsidies capped between 2 percent and 9.5 percent of income for those making between 100% and 400% of the federal poverty limit and whose constitutionality was upheld by the U.S. Supreme Court in the 2015 decision to *King v. Burwell*, in states choosing not to expand

Medicaid this means that individuals making more than the state's eligibility limit but less than 100% of the federal poverty limit were effectively ineligible for financial assistance.[1] As of July 2015, using data from the American Community Survey conducted by the U.S. Census Bureau and accounting for the differential eligibility limits between states, some groups estimated that the expansion of Medicaid resulted in 7.8 million residents gaining access to Medicaid.[2]

While the law presumed that the federal government could compel the states to expand Medicaid using the threat of federal aid, this provision of the ACA was ruled unconstitutional by the US Supreme Court. In its' 2012 decision in *National Federation of Independent Business v. Sebelius*, the Court ruled that the federal government could not force states to expand Medicaid and the decision of whether or not to expand Medicaid was left to the discretion of the states themselves.[3]

The aftermath of this ruling created a patchwork pattern of Medicaid expansion across the country and neighboring states with similar political and economic circumstances sometimes made different decisions. Figure 1 plots the expansion status of the 35 states that border at least one neighboring state making a contrary decision as of 2014 (e.g., California is not graphed because all of its neighbors also expanded Medicaid; Florida is not graphed because all of its neighbors similarly decided not to expand Medicaid).[4]

Beyond the intended effect of expanding the percentage of insured residents, there are several reasons to suspect that the expansion of Medicaid may have also had important political consequences on the mass electorate.[5] We consider two possible policy feedbacks concerning the mass public – the potential impacts of the effect of Medicaid expansion on political participation, and the impact of expansion on citizens' political opinions. While we acknowledge that there are multiple channels and mechanisms that might be responsible for such effects, in what follows we focus on

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[1]Health and Education Reconciliation Act of 2010, Sec. 1001 and ACA Sec. 1401.

[2]FamiliesUSA. 2015. "A 50-state look at Medicaid expansion: 2015," July 24. Accessed Oct 24, 2015.

[3]"As for the Medicaid expansion, that portion of the Affordable Care Act violates the Constitution by threatening existing Medicaid funding. Congress has no authority to order the States to regulate according to its instructions. Congress may offer the States grants and require the States to comply with accompanying conditions, but the States must have a genuine choice whether to accept the offer," *National Federation of Independent Business v. Sebelius*, no. 11-393, p. 44-45. U.S. Supreme Court (June 28, 2012).

[4]Even though Montana expanded its Medicaid, because the expansion took place after the 2014 elections and after the outcome variables we analyze we treat it as a non-expansion state.

[5]To be clear, there are arguably many effects of such a massive policy intervention and characterizing the impact of the ACA on the nature of lawmaking is beyond the scope of this paper. Interest groups are active on this issue – both in support and in opposition, and groups are highly invested in the policy decisions that are made. Our focus, however, is on the effects in the mass public. Understanding future lawmaking activity related to the ACA and the politics of Medicaid expansion would clearly require accounting for interest group activity and the preferences of critical political elites, but we focus on how the passage of the policy has affected the electoral landscape and whether it has helped create a constituency that is personally invested in maintaining that policy. Moreover, once enacted, it may be very difficult to change if the beneficiaries are sufficiently numerous and political engaged.
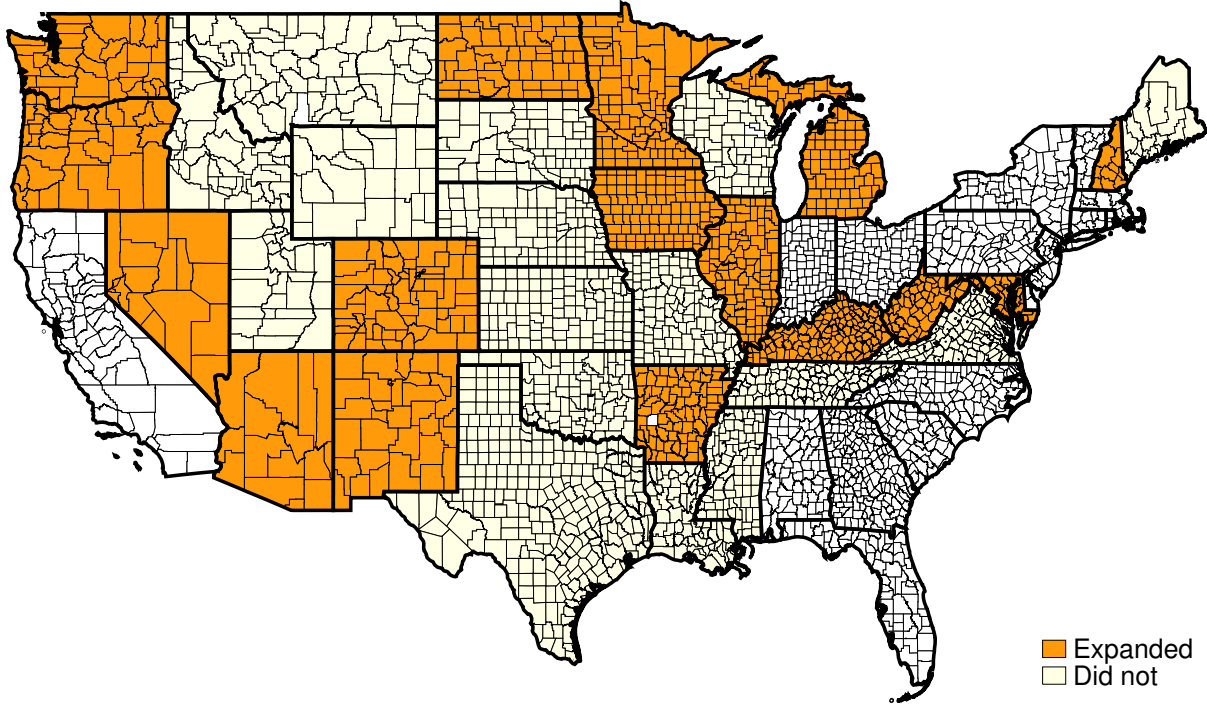
Figure 1: STATUS OF MEDICAID EXPANSION IN THE STATES AS OF 2014: EXPANSION STATUS FOR "BORDER" STATES

the first-order question of estimating the net political effects of the expansion.

Consider first the possible impact of Medicaid expansion on political participation. Theoretically and empirically, the expected effects are unclear.

One possibility is that the expansion of health insurance – and the resulting wealth and health effects – increases the participation of recipients by improving their ability and desire to access the voting booth. There are several reasons to suspect a positive effect on participation. First, there is an incredibly robust empirical correlation between economic status and turnout (Verba, Schlozman, and Brady 1995), and increasing access to health insurance may boost the political participation of recipients by increasing the health and welfare of its recipients (Godefroy and Henry 2010), or allowing recipients to better integrate with normal civic life by limiting adverse health outcomes (Blais 2000). Figure 1 depicts the robust correlation between income and political participation by plotting the relationship between county-level turnout and health insurance coverage.

Increased participation by recipients of the expanded Medicaid program may also occur because of the connection between the ACA and the 1993 National Voting Registration Act (NVRA). The NVRA requires that departments of motor vehicles and other public assistance agencies provide voter registration services in addition to their normal social services. Because the health exchanges
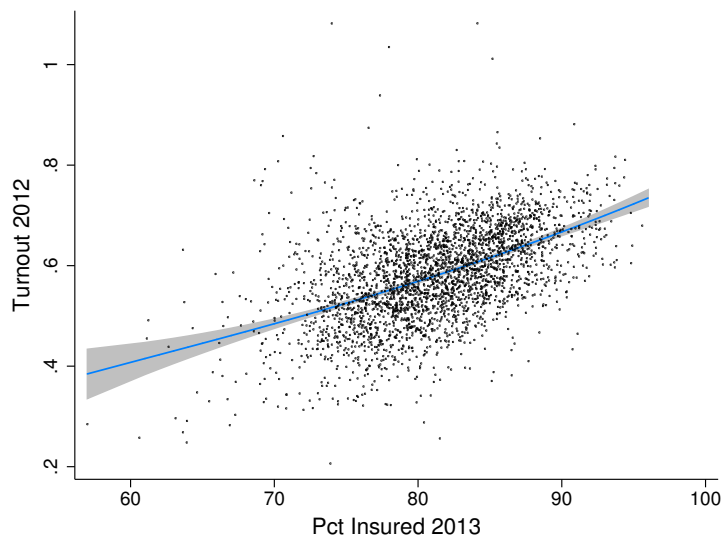
Figure 2: County Level Turnout and Health Insurance Coverage, 2012

created by the Affordable Care Act are public assistance agencies according to the Department of Health and Human Services, the process whereby individuals register for health insurance must also allow them to register to vote. In fact, some individuals tasked with helping individuals sign up for health insurance – so-called navigators – actively engaged in voter registration efforts.[6] Barriers related to vote registration are often cited as a key reason for low turnout in the U.S. relative to other advanced democracies (Powell 1986), and several prominent conservative commentators such as Rush Limbaugh decried the ACA specifically because of its connection to voter registration efforts, noting that "What do you really think is going on? Voter registration. In addition to you going to get your health care, there is obviously massive Democrat voter registration going on at these exchanges." (Roth 2014).

While the expansion of Medicaid in the states would seem to increase the ability of recipients to participate in the political process by increasing personal well-being and decreasing registration costs, there are equally strong reasons to doubt the mobilization of newly eligible recipients. Prior studies exploring whether social assistance programs produce detectable differences in the attitudes

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[6]To date, the Department of Health and Human Services has not legally required navigators to actively register new enrollees to vote despite lobbying efforts by some interest groups such as Project Vote (Eichelberger 2014). While some states have decided to enforce voter registration requirements through the ACA (e.g., California), the practice is not universal and it is currently left to the discretion of the states themselves (Novak 2013). The states who have publicly announced an active enforcement of the NVRA include: CA, CT, MD, NY, RI, and VT. To be clear, the connection between the ACA and the NVRA is a connection that exists in every state, so a differential impact in participation due to this linkage would require that the expansion of Medicaid is responsible for more citizens taking advantage of this connection.

and behavior of recipients has generally failed to find robust positive effects. While some argue that universalistic social programs are most likely to produce positive benefits (Skocpol 1991, Wilson 1987), research on the impact of means-tested programs tends to find null (Sharp 2012) or even negative (e.g., Soss 1999; 2002; Mettler and Stonecash 2008) impacts on participation. Besides the potential demobilizing impacts of that may result because of stigmatization related to the means-testing that some have claimed (e.g., Schneider and Ingram 1993), it is well-known that the population benefitting from the expansion of Medicaid has relatively lower participation rates than the average citizen (Verba, Schlozman, and Brady 1995). In addition, because many of those eligible for Medicaid expansion may already be eligible for social services of some sort, it is unclear whether the additional marginal benefits that are provided by the expansion of Medicaid are sufficient to overcome the costs of voting for these individuals given their lack of participation in the past.

In addition to having an ambiguous impact on the recipients themselves, it is also possible that the largest political impacts occur among those opposing Medicaid expansion. Given the politicized nature of the policy, the expansion of Medicaid under the ACA may serve to mobilize opponents interested in either repealing or preventing its expansion.

A second, independent, potential impact of the Medicaid expansion relates to its impact on opinions and attitudes. Here again, expectations regarding the impact of the expansion are unclear. While a recent review on the impact of social programs on attitudes finds little impact (Campbell 2012), no social policy has arguably been as heavily politicized as the ACA. Not only is it directly connected to President Obama through its pseudo-name "Obamacare" and the fact that it was passed without a single Republican vote, but the continuing efforts of Republicans to repeal the ACA in Congress and the promises of Republican presidential candidates in 2012 and 2016 ensure that it has remained a salient and politicized policy over the time period we examine. Because of this, it seems likely that citizens can discern and trace many of the policy consequences of the ACA to the ACA – a key condition for there to be a political impact of the policy (Arnold 1990).[7]

Following arguments made with respect to the strategic choices made by political parties in a comparative context (Boix 1998; Bechtel and Hainmueller 2011, Stokes et al 2013), we may expect that beneficiaries of the policy may become more supportive of the party so closely connected

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[7]That said, whether citizens are cognizant of all of the consequences of the ACA is unclear. As Obama himself remarked following the Supreme Court's decision to uphold the constitutionality of subsidies for the ACA: "And unlike Social Security or Medicare, a lot of Americans still don't know what Obamacare is beyond all the political noise in Washington. Across the country, there remain people who are directly benefitting from the law but don't even know it. And that's okay. There's no card that says "Obamacare" when you enroll" (Obama, June 25, 2015).

to expansion of Medicaid. That is, recipients may become more supportive of the party largely responsible for increasing their access to health insurance, although some ambiguity may result as a consequence that the expansion of Medicaid sometimes depends on the actions of Republican elites. Moreover, as with the case of political participation, it is possible that the largest political impacts are felt by opponents; the expansion may create backlash among those opposing expansion if beliefs about the costs and consequences of the expansion are sufficiently worse than expected.

If voters are mobilized by the economic and health benefits of the expansions, if they act in a clientelistic fashion to reward politicians for providing them with social services, or if they are motivated to act so as to try to preserve the services that were newly provided for by the Affordable Care Act, we should see evidence of either an increase in turnout or an increase in pro-Democratic attitudes as a result of the expansion of Medicaid and the extension of health insurance among eligible recipients. Depending on the relative responsiveness of the individuals involved, it is also possible that the political impacts are largest among the opposition and that the largest political impacts of the expansion of Medicaid is to galvanize and mobilize the opposition.

From the perspective of understanding the political impact of public policy any finding is substantively consequential. If, for example, the considerable benefits and scope of the ACA and the highly politicized manner in which the policy was enacted and implemented are insufficient to change the behavior and opinions of the mass public, then claims about the ability of related social programs targeting similar constituents to create a mobilized constituency dedicated to the preservation of the program may be overstated. If there are limited effects on the mass electorate for a policy addressing a long-standing public priority that was enacted in a highly partisan fashion, it is unclear what type of policy might ever significantly galvanize the electorate.

2 Identifying the Effects of Medicaid Expansion: Policy Impact on Insurance Coverage

We begin by exploring whether the decision to expand Medicaid produced a detectable impact on insurance coverage. To the extent that there are clear material benefits to the expansion of Medicaid, the political impacts hypothesized about in the prior section are presumably more likely. While it is possible that citizens are motivated by the political theatre related to Medicaid expansion regardless of the actual policy impacts, if there are measurable policy consequences mass political impacts seem more likely. Existing work has shown an impact on mortality rates (e.g., Sommers et

al 2012), but we focus on consequences that are more directly related to Medicaid expansion and which recipients are therefore more likely to connect with the expansion of Medicaid in the state – the extent to which insurance coverage increases. Insofar as the expansion of Medicaid produces a tangible increase in the percentage of residents with health insurance coverage, it seems likely that the connection between policy consequences and policy can be perceived and appreciated by citizens (Arnold 1990) so as to provide a reasonable expectation for the potential realization of the political impacts discussed in the prior section.

Prior work using empirical methods to quantify the impact of policy on politics has largely relied on cross-sectional variation in self-reported behavior using survey respondents (e.g, Soss 1999; Mettler and Stonecash 2008). While much can be learned from such studies, it is difficult to dispel concerns about selection effects using such methods. For example, it is difficult to identify whether the outcomes of interest are due to policy impacts or the characteristics of those receiving the policy using a cross-sectional research design because those who receive the program are different from those who are not in several respects. This is especially true when considering the political impact of means-tested programs whose eligibility criteria select upon distinguishing characteristics known to be related to decreased participation (Schlozman, Verba, and Brady, 2012).[8]

To avoid the difficult selection issues involved with characterizing the impact of means-tested policies, we identify the policy and political impacts of Medicaid expansion using the spatial policy discontinuities (e.g, Holmes 1984; Card and Krueger 1994; Dell 2010; Dube et. al 2010; Lee and Lemieux 2010; Keele and Titiunik 2015) produced by the patchwork expansion pattern that resulted from the Supreme Court's decision in *National Federation of Independent Business v. Sebelius.* The basic idea behind our identification strategy is that while states differed in their decision to expand Medicaid or not, this decision can be thought of as an exogenous to the behavior of otherwise similar counties and individuals residing near the border of states that differ in their decision to expand Medicaid or not.[9] Comparing how otherwise similar counties and individuals behave depending on whether their state decides to expand Medicaid provides an estimate of the impact of Medicaid expansion on the measure of interest. As of 2014, there were 32 instances in which expansion and non-expansion states shared a common border – including states that shared only a corner

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[8]But see Weaver and Lerman (2010) for a longitudinal analysis of the political impact of incarceration.

[9]Put differently, insofar as counties located near the border of a neighboring state were not pivotal for the expansion of Medicaid we can treat the expansion as exogenous to their decision. This assumption seems reasonable – especially for comparisons involving poorer counties where low rates of turnout are unlikely to make them pivotal in statewide elections.

(e.g. Oklahoma-New Mexico) and those sharing longer borders (e.g., Virginia-West Virginia and Tennessee-Kentucky).

To measure the relative change in insurance status between expansion and non-expansion states, we use estimates of insurance coverage provided by Enroll America.[10] Figure 3 maps the change in the percentage of insured residents in each county for states that did (top map) and did not (bottom map) expand Medicaid for those states. Darker areas represents counties with greater increases in the percentage insured, while lighter areas represent smaller increases. A visual inspection of the differences graphed in Figure 3 reveals that the percentage of insured residents increased in nearly every county – as would be expected given that many provisions of the ACA related to the availability of insurance were nationally applicable (e.g., parent's could choose to insure their children on their personal insurance plan until the children turned 26; residents with pre-existing conditions could not be denied insurance) – but the increase was greater in counties located in states that chose to accept the federal subsidies to help expand Medicaid. In counties located in states choosing to expand Medicaid, the average change in the percentage of insured residents was 2.3% higher relative to the change in counties located in states opting not to expand.

While states choosing to expand Medicaid are more likely to support Democratic politicians at the ballot box, Figure 3 reveals that the decision to expand Medicaid or not was not entirely determined by party; several states voting for the Republican presidential candidate in every election since 2000 voted to expand Medicaid (e.g., North Dakota, New Mexico, Arkansas, West Virginia), several states that have voted for the Democratic candidate in every election since 2000 chose not to expand (e.g., Wisconsin, Maine) and several states that have on by each party twice since 2000 decided to expand (e.g., Nevada, Colorado, Virginia). Table 1 continues this investigation and summarizes how counties located in expansion states compare to counties located in non-expansion states according to several demographic characteristics that are well-known to correlate with political participation (Lewis-Beck et al 2008). The largest difference that is distinguishable from zero is that counties located in states expanding Medicaid are more likely to vote for Democratic politicians. Given the partisan nature of the debate over Medicaid expansion and the close connec-

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[10]See https://www.enrollamerica.org/research-maps/maps/changes-in-uninsured-rates-by-county/. The data are generated using a targeting model based on public and proprietary data and while it is certainly an advocacy group, there is no reason to suspect that the estimates are biased because Enroll America has an interest in properly measuring insurance coverage so as to effectively target uninsured citizens for enrollment in health insurance. It may also be possible to use estimates from the Census Small Area Health Estimates, which at the time we conducted our analysis were not yet released for 2014.
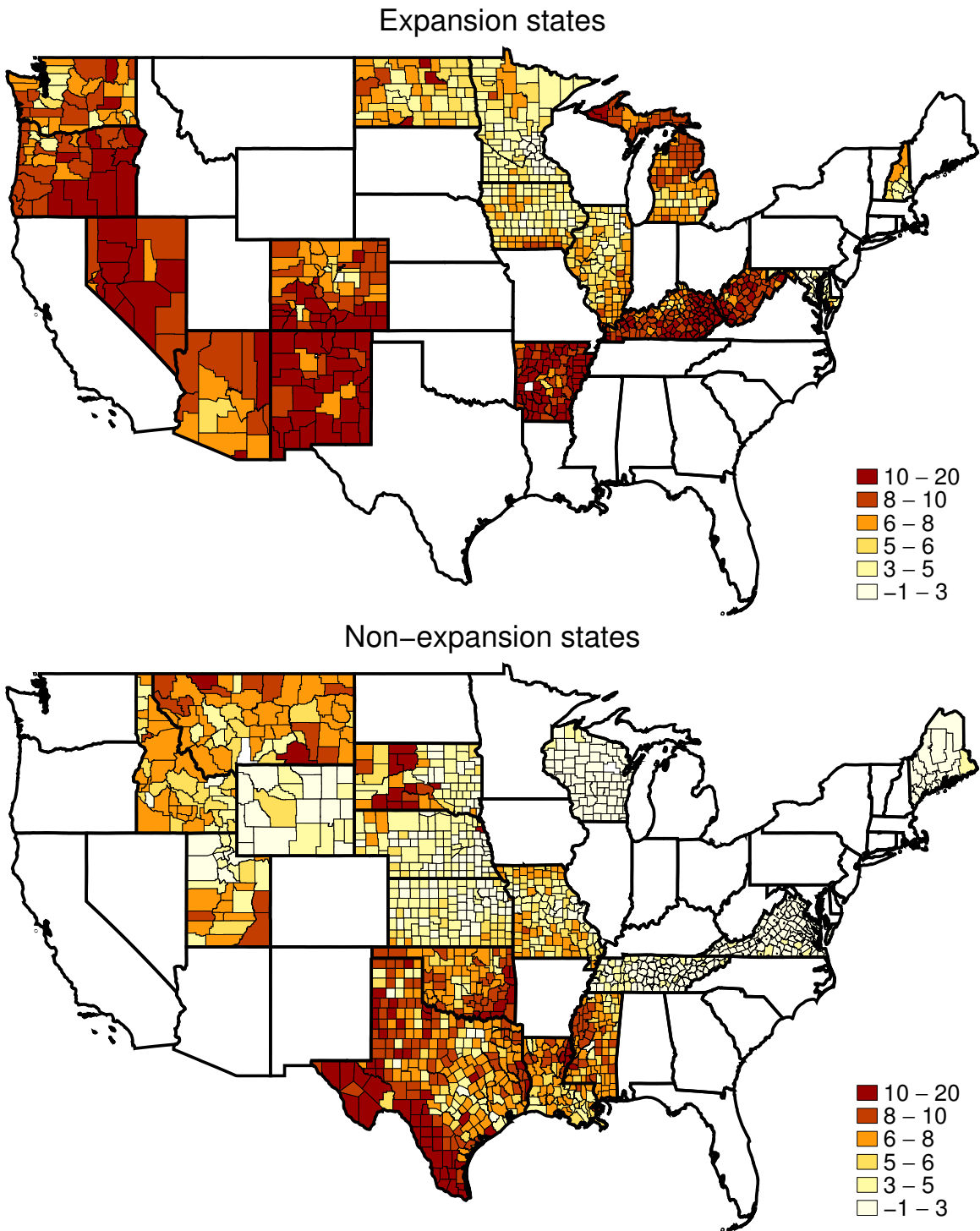
Figure 3: CHANGE IN THE PERCENT INSURED 2014-2013

tion between the policy and President Obama, this difference is unsurprising. Other county-level differences are less obvious – counties located in states expanding Medicaid are slightly more populous, and slightly whiter than those that did not – but there are no differences in the percentage

of uninsured residents in 2013, the percentage of lower educated residents, or average household median income. The lack of observable differences is encouraging for our design, which assumes counties in expansion and non-expansion states are similar aside from their expansion status.

Covariate	Non Expansion States County Average	Difference in Expansion States	95% CI
Δ_i Insured	5.53	+2.30	[-0.002,4.39]
% Uninsured 2013	19.52	-1.62	[-5.24,1.71]
% White	84.47	+4.57	[-0.28,9.51]
log(VAP)	9.50	+0.41	[-0.01,0.86]
% 65+	15.69	+0.41	[-0.76,1.53]
% HS or less	23.28	+0.88	[-1.07,2.83]
% Dem Vote Share	35.87	+10.07	[4.31,15.33]
log(Median Income)	10.63	+0.01	[-0.08,0.11]
Number of Counties	1,063	892	

Table 1: **Comparing Counties in Expansion and Non-Expansion States:** Difference of means and 95% confidence interval using the wild bootstrap (clustered by state) of Cameron et al (2008) using 1,995 counties in adjacent states with differences in expansion status.

To provide another characterization of how the variation in the change in the percentage of insured residents differs between counties in states that did and did not expand Medicaid, Figure 2 plots how the county-level changes in the percentage of insured residents varies depending on how far (in miles) the county is from the closest border with a state with a different expansion status for counties in the states graphed in Figure 3. Each point represents a county in a state bordering a state with a different expansion status. Negative numbers on the horizontal axis indicate being further from the border of a state that has expanded Medicaid, and positive numbers indicate being further from a state that has not expanded Medicaid. Thus, points to the right of 0 are county-level changes in the percentage of insured residents in states expanding Medicaid and points to the left of 0 are county level changes in states opting not to. The loess smoother summarizes the relationship between the change in insurance coverage and the distance to the border.

The left-hand plot in Figure 2 presents the relationship for all counties in these states, and the right-hand plot focuses on counties within 100 miles from the nearest border because it is possible that closer counties are more similar in their observable and unobservable characteristics. Several conclusions emerge. First, the percentage of insured residents between 2013 and 2014 increases in nearly every county – presumably due to the provisions in the ACA that were nationally applicable. Second, focusing on those counties that are closest to the border clearly reveals that the average

Figure 4: Change in Insurance Rates 2014-2013 by Distance to Border

change in the percentage of insured residents between 2013 and 2014 increases notably at the border. In fact, except for a few counties in non-expansion states located more than 400 miles from the border of a state that chose to expand Medicaid, the average change in the percentage of insured residents is uniformly higher in counties located in expansion states.

Figures 3 and 2 suggest that the decision to accept federal subsidies for the purposes of expanding Medicaid to those making up to 138% of the federal poverty line increased the percentage of insured residents in the state, but to quantify the impact more precisely we employ a regression framework. To do so, we estimate the following regression for ΔI_{csb} – the change in the percentage of insured residents between 2014 and 2013 in county c in state s at border b:

$$\Delta I_c = \alpha T_s + \beta d_{cs} + \gamma \left(T_s \times d_{cs} \right) + \boldsymbol{X}_c \pi + \psi_b + e_{csb} \tag{1}$$

where α is the average conditional effect of expansion, T_s is an indicator for whether the state

expanded Medicaid (1) or not (0), d_{csb} is a measure of distance (in miles) of county c from the closest border b of a neighboring state with a different treatment status, and $\boldsymbol{X}$ is a vector of county-level covariates. e_{csb} denotes idiosyncratic errors, which we cluster by state using the wild bootstrap of Cameron et al (2008) to account for state-level differences. In addition to differencing the percentage of insured residents to control for possible omitted factors, we also include border fixed effects ψ_b in some specifications to allow for systematic differences. State level fixed effects are impossible because the "treatment" varies by state.

The parameter of primary interest in equation (1) is α, which reflects the average increase in the percentage of insured citizens conditional on county-level characteristics $\boldsymbol{X}_{csb}$ and how far the county is from the border. The latter is intended to control for possible omitted characteristics if nearby counties are more similar than distant counties.

Several assumptions are required to interpret α as the causal impact of Medicaid expansion on the change in insurance coverage in county c. First, the outcome in county c must not depend on the treatment status of counties c. That is, whether or not other counties experience an expansion of Medicaid cannot directly affect the change in insurance coverage of other counties. This assumption would be violated – and our estimates would be biased upwards – if individuals living in non-expansion states relocated into expansion states because of the Medicaid expansion.The impact of such sorting seems limited – only those making between 138% of the federal poverty limit and the eligibility limit established by the state would benefit from such a move – and relocation costs are likely non-trivial. Consistent with this view, recent work estimates that Medicaid based migration is at most responsible for 1,600 people per year in expansion states (Schwartz and Abigail, 2014).

A second assumption is that the other state-varying determinants of insurance coverage do not simultaneously covary with the expansion of Medicaid. If states opting to expand Medicaid took additional steps at the same time to increase coverage beyond that which was provided for by the ACA, our research design will be unable to disentangle the effects of Medicaid expansion from the effects of the other policy changes and α will therefore measure the upper bound for the average effect of Medicaid expansion because the confounding effects, if any, would only impact a subset of the states. Even if such confounding effects exist, it is unclear whether they matter for our analyses if voters are unable to distinguish such policies from Medicaid expansion given the attention paid to the Medicaid expansion and the inability of voters to perceive policy nuance (Gilens 2001).

Finally, we use the perpendicular distance to the border as a "forcing variable" to control for other relevant but omitted characteristics. This is the appropriate distance because we are interested in the distance to the closest point where the policy differs; additional covariates and fixed-effects are used to control for differences along and between borders.

Table 3 reports the results of estimating specification (1) and reveals reassuringly stable results regardless of whether or not covariates are used and regardless of whether the impact of distance is assumed to be linear, quadratic (or a higher-order polynomial) and county-level covariates are included. Specifications (1) - (5) reveal that the expansion of Medicaid increased coverage rates in the county between 2.3% and 4.3% depending on the particular specification. Restricting the analysis to counties within 100 miles of the border in specification (6) reveals a similarly sized estimated impact of 3.8%. Although we consider several difference functions of distance to account for potentially omitted factors, the evidence is generally weak regarding the impact of difference related omitted factors.

| | (1) | (2) | (3) | (4) | (5) | (6) |
| | Δ insured | Δ insured | Δ insured | Δ insured | Δ insured | Δ insured |
	All	All	All	All	All	Close
Medicaid expansion state	2.30	3.61	3.66	4.28	3.89	3.78
	[-0.002,4.39]	[0.77,6.23]	[1.03,7.46]	[3.04,4.25]	[3.14,4.58]	[3.10,4.43]
% Uninsured 2013			0.58		0.58	0.62
			[0.49,0.65]		[0.49,0.65]	[0.53,0.71]
Number of counties	1955	1955	1955	1955	1955	1142
Distance	no	linear	linear	quadratic	quadratic	linear
Covariates?	no	no	yes	no	yes	yes
R^2	.12	.18	.91	.19	.91	.93

Table 2: Predicting the Change in the Percentage of Uninsured by County: Covariates include the percentage of white residents, the percentage of residents above the age of 65, the percentage of residents with a high school degree or less, the log of the median income, the log of the voting age population, and the percentage of uninsured residents in 2013. The interaction of Low Income × Distance is omitted from the table for expositional reasons but it is included in the specification. 95% confidence intervals based on the wild cluster bootstrap of Cameron et. al. (2008) clustered by state are reported in the brackets.

We next examine whether the increases that are estimated to occur in expansion states are largest in the poorest counties. Recall that although many provisions of the ACA were nationally applicable, access to insurance by the less fortunate – and especially the less fortunate without children – largely depended upon the state's decision to Medicaid. Because the means-tested benefits of Medicaid expansion were to assist those making between the state-determined eligibility income limit and 138% of the federal poverty limit, the change in insurance coverage should be

largest in low-income counties.[11]

Figure 2 graphs whether the change in county-level insurance coverage depends on whether the median household income in the county is above (right) or below (left) the sample average. The results reassuringly reveal that not only is the increase in insured citizens greatest in lower income counties regardless of expansion status, the largest impact occurs in lower income counties located in expansion states. In expansion states, the average increase in insurance coverage for below average counties is nearly twice as great as the increase in wealthier counties. Moreover, the increase in insurance coverage in the wealthier counties of expansion states nearly equals the increase occurring in counties of below-average median household income in non-expansion states. The smallest increase in insurance coverage occurs in counties of above average income located in non-expansion states.

To better compare the relative magnitude of the impact in counties based on the median household income of its residents we extend equation (1) to estimate differential effects using:

$$\begin{aligned}
\Delta I_{csb} &= \alpha T_s + \beta d_{csb} + \mu M_{csb} \\
&+ \gamma \left(T_s \times d_{csb}\right) + \nu \left(T_s \times M_{csb}\right) + \delta \left(T_s \times d_{csb} \times M_{csb}\right) \\
&+ \boldsymbol{X}_{csb}\pi + e_{csb}
\end{aligned} \tag{2}$$

where M_{csb} is an indicator if the median household income in county c in state s is less than the sample average and $\boldsymbol{X}$ is a row-vector of the remaining interaction terms and covariates.

Table 3 reports the results of lower income (7) and higher income counties (8) separately, as well as interactive models excluding (9) and including covariates (10). Consistent with the pattern evident in Figure 2, the expansion of Medicaid is related to a larger increase in the percentage of insured citizens in all counties, but especially so in counties with below average median household income. The differential increase in the percentage of insured residents is roughly 1-2% higher in counties of below average median household income.

Together, these findings suggest that the decision to expand Medicaid or not did indeed have a differential impact on the socio-economic status of residents. In states choosing to expand Medicaid

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[11]While the sliding scale of federal subsidies meant that everyone making between 100% and 400% of the federal poverty limit was eligible for federal tax subsidies – a provision that was upheld by the Supreme Court in its 2015 decision in *King v. Burwell* – the starkest change is likely to have been felt by those that were newly eligible to purchase insurance because of the expansion of Medicaid.

Figure 5: CHANGE IN INSURANCE RATES 2014-2013 BY DISTANCE TO BORDER AND COUNTY INCOME

the average effect on insurance rates in counties with above average median household income levels was roughly 3.5% higher than similar counties in states deciding not to expand Medicaid and the change increases to roughly 4.5% for lower income counties located in expansion states. Having demonstrated that the expansion of Medicaid is related to tangible benefits among recipients in terms of improved access to health insurance via Medicaid, we now turn to the question of whether these policy impacts produce detectable political impacts. That is, do citizens who become insured because of the Affordable Care Act become more politically active as a result of these policy consequences? Or do opponents mobilize in response to either the expansion or attempted expansion of Medicaid in their state?

	(7)	(8)	(9)	(10)
	Δ insured	Δ insured	Δ insured	Δ insured
	Lower Income	Higher Income	All	All
Medicaid expansion state	4.60	3.21	2.22	3.47
	[4.02,5.19]	[2.72,3.67]	[-0.19, 4.56]	[2.83,4.06]
Medicaid × Low Income			1.89	0.84
			[0.28,3.46]	[0.36,1.31]
Distance	linear	linear	linear	linear
Covariates?	yes	yes	no	yes
Number of counties	1010	944	1955	1954
R^2	.88	.92	.38	.91

Table 3: Predicting the Change in the Percentage of Uninsured by County: Covariates include the percentage of white residents, the percentage of residents above the age of 65, the percentage of residents with a high school degree or less, the log of the median income, the log of the voting age population, and the percentage of uninsured residents in 2013. The interaction of Low Income × Distance is omitted from the table for expositional reasons but it is included in the specification. 95% confidence intervals based on the wild cluster bootstrap of Cameron et. al. (2008) clustered by state in brackets.

3 Identifying the Effects of Medicaid Expansion: Political Impact on Turnout

To assess the political consequences of Medicaid expansion we focus on the relationship between whether a state expands Medicaid and the number of votes that are cast in statewide elections. While the policy is more directly related to voter registration because of its connection to the 1993 NVRA, we focus on turnout rather than registration because it is the more politically relevant outcome. Politicians are most responsive to actual rather than potential voters (Fenno 1974), and unless an increase in the number of registered voters also affects the size and composition of the voting electorate it seems unlikely that the hypothesized political feedback impacts would occur.

To assess whether the expansion of Medicaid affected political participation, we employ the same identical identification strategy we use to identify the impacts of Medicaid expansion on insurance coverage. That is, we compare the number of votes cast in a county during a post-expansion statewide election relative to the number of votes cast for a statewide race held prior to the expansion of Medicaid relative to the voting age population of the county. Our main dependent variable is therefore $\Delta Y_{csb} = \frac{TotalVotes_{csb,post} - TotalVotes_{csb,pre}}{VotingAgePopulation_{csb}}$.

Because there has only been one national election post-treatment, we measure post-treatment turnout using the turnout on the top-level state race in the 2014 midterm election. Even so, this is

perhaps the most appropriate election cycle to use as the issue of the ACA and Medicaid expansion was at issue in nearly every race. As a result, using this election cycle to measure the impact post-expansion likely provides the upper-bound on the effects we might expect. To measure pre-treatment turnout, we use the number of votes cast in the county presidential race in the 2012 election. The 2012 election is the appropriate choice because not only is it the most recent election prior to the expansion of Medicaid in the states, but because the same candidates are running in every state it provides the cleanest baseline for assessing the change in votes cast.[12] While the same top-of-the-ticket candidates were running in every state in 2012, to account for variation in mobilization efforts, we control for whether the county is located in one of the 9 swing states identified by the *Washington Post*.[13]

We face several issues when relating Medicaid expansion to turnout effects. Because laws governing who is eligible to vote – e.g., laws related to the voting eligibility of felons for example (Meredith and Morse 2015) – as well as the administration of elections vary by state (and even lower-level political geographies), both Medicaid expansion and laws potentially related to voter participation (e.g., Voter ID laws (e.g., Erikson and Minnite 2009)) vary at state borders. By examining the difference in turnout at the county level, however, we are able to identify the effect of Medicaid expansion as long as the administrative differences affecting political participation do not change simultaneously with the expansion of Medicaid in the state. Because we focus on the change in county level voter turnout, the effect cannot be attributed to stable differences in the administration of elections between states or counties.[14]

A more serious limitation is that the post-expansion election was the 2014 midterm election – an election in which the candidates and races necessarily vary between states. For instance, some states only had a senatorial election in 2014, some only had a gubernatorial election, some had both, and at least one state had only an at-large House election (North Dakota). If the candidates who are running and the types of campaigns being run in expansion and non-expansion systematically vary in ways that affect also turnout, we will be unable to identify the impact of Medicaid expansion from confounding electoral differences. Even so, it is not obvious that this potential electoral

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[12]The appendix reveals qualitatively similar, but less precisely estimated, effects when using the 2010 midterm elections.

[13]The list includes: CO, FL, IA, NC, NH, NV, OH, VA, and WI.

[14]Moreover, even if some changes in the administration of elections that affect voter participation did occur simultaneously in some states, because such changes did not occur in every state, the existence of time-varying confounders in some states would mean that the average effect we identify is an upper bound of the effect of Medicaid expansion.

variation actually poses a problem for our larger questions. In particular, if the electoral differences are correlated with expansion status and the decision to expand (or not) is what is responsible for the electoral differences then while it may be impossible to disentangle whether the impacts are due to voters being mobilized by policy consequences or candidate strategies this distinction is irrelevant for answering the first-order question of whether there are political consequences that emerge from the policy. That is, our investigation is primarily interested in whether there are political impacts of the expansion of Medicaid regardless of whether the impacts occur because of the direct effects of the policy or else because the policy debate affects the nature of the campaign being run by the candidates. While the former is arguably a better predictor of the durability of the policy and the extent to which the policy is able to create an invested constituency, both are meaningful political effects from the perspective of understanding the connections between policy and politics. If the electoral differences were related to the expansion of Medicaid, this difference would be meaningful from the perspective of identifying the political impacts of Medicaid expansion although the mechanism of the impact would presumably operate through the elites and campaigns involved rather than the impacts on the electorate due to the policy impacts.

In light of these issues, we employ several strategies to establish the robustness of our results to between state variation in electoral circumstances. First, we sometimes include fixed-effects for borders to identify the difference relative to systematic differences that may result as a consequence of different candidates running in the post-expansion 2014 midterm elections across different borders. Second, we also estimate specifications that measure the relative intensity of the races being compared using the number of statewide races, the difference in the number of state-level races in the pre and post elections, and also differences in the campaign intensity (and therefore get-out-the-vote efforts) of statewide races using whether the *Cook Political Report* rates each race competitive or not.[15] Finally, we conduct a series of placebo tests to determine whether electoral variation in states with identical expansion status match the effects we identify between states of different expansion status, and whether changes in participation pre-date Medicaid expansion.

To begin, Figure 3 presents the pattern that is evident in the raw data we analyze. The left-hand graph plots the change in votes cast in the largest state-level race in 2014 relative to the number of votes cast in the 2012 presidential election as a fraction of VAP for every county in a

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[15]On the seven point scale ranging from Solid Democrat (1) to Solid Republican (7), we use those races that are classified as either "toss-ups" or leaners (3,4,5).

state bordering a state with a contrasting expansion status.[16] Reflecting the fact that turnout in midterm elections are lower than in presidential elections, nearly all of the effects are negative. (The cluster of counties in the non-expansion state with a positive change – indicating that turnout was greater in the 2014 midterm election than it was in the 2012 presidential election – are counties located in Oklahoma; Oklahoma had a both Gubernatorial and a Senatorial election in 2014, but nothing other than an uncompetitive presidential contest in 2012.) To focus the comparison on more similar counties, the right-hand graph excludes counties in Oklahoma and it only includes counties located within 100 miles of a bordering state with a contrary expansion status. (There are 599 counties in expansion states and 515 counties in non-expansion states that meet this criteria.) The critical question of interest for the analysis that follows is whether the decrease in the number of votes cast in 2014 is less in counties located in expansion states relative to similar counties in states located in non-expansion states.

The raw relationships plotted in Figure 3 provide suggestive evidence that the expansion of Medicaid appears to have resulted in a smaller decrease in turnout relative to the 2012 presidential election in counties located in expansion states. To probe the relationship further and to control for additional sources of confounding we utilize the spatial discontinuity that occurs at state borders to identify the impact of Medicaid expansion in the explaining the difference in the number of votes cast for the top-of-the-ticket races in 2014 and 2012. As before, the measure of distance we use is a function of the perpendicular distance to the nearest border.

To do so, we estimate the following regression for ΔY_{csb} – the change in votes cast in the 2014 and 2012 elections as a fraction of the voting age population in county c in state s at border b:

$$\Delta Y_c = \alpha T_s + \beta d_{cs} + \gamma \left(T_s \times d_{cs} \right) + \boldsymbol{X}_c \pi + \psi_b + e_{csb} \tag{3}$$

where α is the average conditional effect of expansion, T_s is an indicator for whether the state expanded Medicaid (1) or not (0), d_{csb} is a measure of distance (in miles) of county c from the closest border b of a neighboring state with a different treatment status, and $\boldsymbol{X}$ is a vector of county-level covariates. e_{csb} denotes idiosyncratic errors, which we cluster by state using the wild bootstrap of Cameron et al (2008) when feasible to account for state-level differences. In addition to differencing the votes cast to control for possible omitted factors, we also include border fixed

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[16]The Appendix reports the analogous results using 2010 as a baseline.
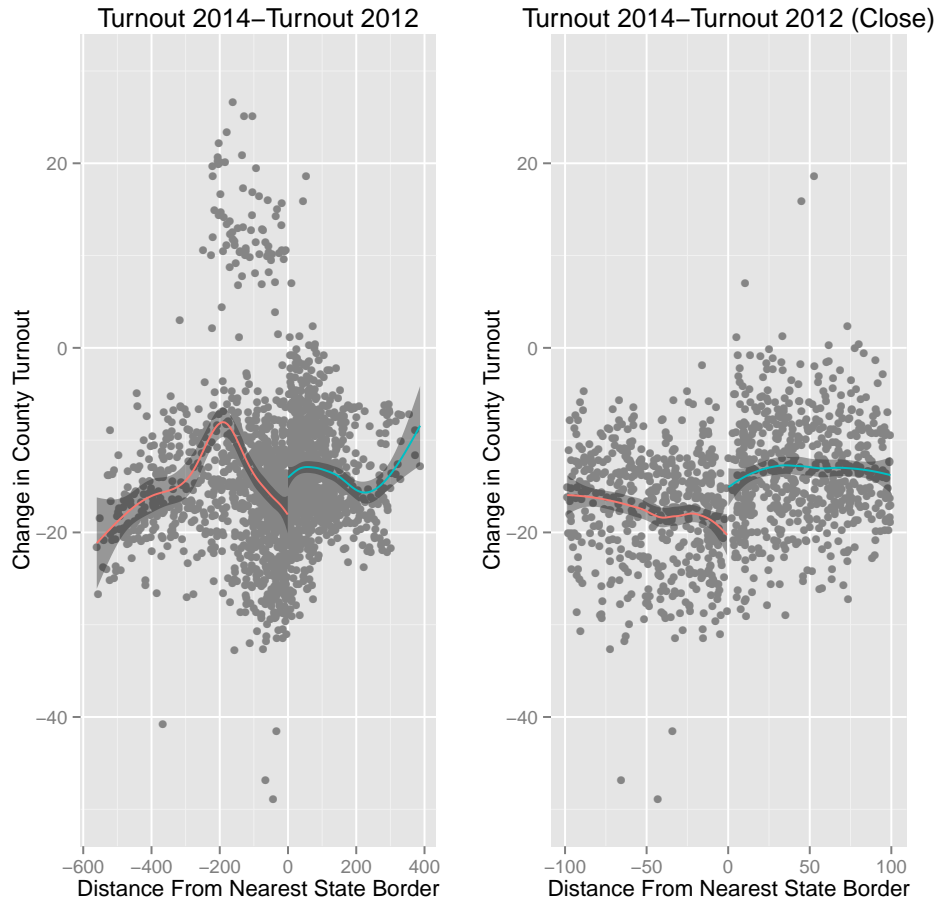
Figure 6: CHANGE IN TURNOUT BY DISTANCE TO BORDER: The right-hand figure includes the 599 counties in expansion states and 515 counties in non-expansion states located within 100 miles of the closest border.

effects ψ_b in some specifications to account for common trends affecting counties sharing a border.

Recalling the discussion of section 1, if the expansion of Medicaid results in the mobilization of recipients, then relative to similar counties in states that opt not to expand Medicaid, counties in expansion states should experience a smaller decrease in the number of votes cast in the 2014 midterm elections relative to the number cast in 2012 as a percentage of their voting age population – i.e., $\alpha > 0$. If the impact of the expansion is to mobilize opponents in expansion states more than opponents in non-expansion states then we should observe a similar effect – thus, an increase in votes cast in expansion counties is consistent with increased mobilization of either recipients or opponents. Finding a decrease in turnout in expansion states relative to non-expansion states (i.e., i.e., $\alpha < 0$) is consistent with an increased mobilization of either supporters or opponents in non-expansion states. Finally, a finding of no difference – $\alpha = 0$ – is consistent with either the

lack of a mobilization among recipients and opponents or else an instance where the mobilization of recipients in expansion states equals the mobilization of supporters and opponents in non-expansion states seeking and opposing expansion.

Table 4 provides the estimated effect of Medicaid expansion on turnout – α – in a county relative to the impact in similar counties in states that opt not to expand Medicaid. Initially we include all counties in all states bordering a state with a contrary expansion status. To probe the robustness of the results, the reported specifications vary in whether they include or exclude covariates using both linear and quadratic functions of distance but the results are remarkably stable regardless of the specification employed. As Table 4 reveals, relative to the decrease in the fraction of votes cast as a fraction of VAP in expansion states during the 2014 midterm elections, counties located in expansion states cast between 3.15% (when using no controls in equation 1) to 5.96% (specification 3 using a quadratic distance measure and no covariates) more votes. Moreover, the point estimate from the simple difference of means comparison reported in specification (1) is contained in the confidence interval from every other specification – suggesting that the included covariates do not greatly affect the estimated effect. Despite a stable magnitude, the precision of the effect is estimated to range between 0% and 10% using the wild cluster bootstrap of Cameron et al (2008) to account for hetereoskedastic errors that vary by state.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Medicaid Expansion	3.15	3.98	5.96	3.79	5.67	3.43	5.05
	[-0.25,6.96]	[-0.75.9.57]	[0.84,11.68]	[-0.88,8.92]	[0.69,11.20]	[-0.72,8.03]	[1.00,9.26]
Lagged turnout				-0.12	-0.12	-0.08	-0.09
				[-0.23,-0.01]	[-0.24,-0.02]	[-0.22, 0.06]	[-0.23,0.05]
Number of counties	1877	1877	1877	1877	1877	1877	1877
Distance	no	linear	quad	linear	quad	linear	quad
Covariates	no	no	no	no	no	yes	yes
R^2	.06	.07	.09	.11	.13	.26	.28

Table 4: Predicting the Change in Turnout as a percentage of VAP for All Counties: Covariates include the percentage of white residents, the percentage of residents with a high school degree or less, the percentage of residents above the age of 65, the log of the median income, the log of the voting age population, the percentage of democratic vote share, and whether the state was a "swing" state in 2012. Bootstrap standard errors are clustered by state using the wild cluster bootstrap of Cameron et al (2008).

The negative coefficient on Lagged Turnout indicates that counties with larger turnouts in 2012 had a smaller change in turnouts than counties with a smaller turnout in 2012 all else equal, but the effects are imprecisely estimated. Table A5 in the appendix reports the results from applying the specifications used in Table 4 to just those counties located within 100 miles of the border and

reveals substantively identical results.

To further control for possible confounders, we also include fixed effects for state-borders to account for systematic differences that may result from comparing different races in 2014. Including border fixed effects will account for systematic influences that similarly affect all counties closest to the particular border. While both the treatment and the electoral environment vary by state, border fixed effects account for systematic variation affecting counties in both states at the border. Thus, if the electoral differences in expansion and non-expansion states differ as is almost certainly the case, the border-fixed effects allow us to account for comparisons that are more and less similar by accounting for common variation due to similar electoral circumstances. Table 5 reports the results and it reveals nearly identical effects.[17]

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Counties Used	All	All	All	All	All	Close	Close
Medicaid Expansion	3.38	3.61	3.68	3.91	4.58	4.16	4.47
	[2.76,4.00]	[2.79,4.43]	[2.94,4.41]	[3.19,4.62]	[3.67,5.50]	[3.02,5.31]	[3.35,5.58]
Lagged turnout			-0.22	-0.23	-0.23	-0.21	-.21
			[-0.24,-0.20]	[-0.24,-0.20]	[-0.26,-0.20]	[-0.24, -0.17]	[-0.25,-0.17]
Number of counties	1877	1877	1877	1877	1877	1114	1114
Border Fixed Effects	yes	yes	yes	yes	yes	yes	yes
Distance	no	linear	linear	linear	quad	linear	linear
Covariates	no	no	no	yes	yes	no	yes
R^2	.90	.90	.92	.93	.93	.91	.93

Table 5: Predicting the Change in Turnout as a percentage of VAP using border fixed effects: Covariates include the percentage of white residents, the percentage of residents with a high school degree or less, the percentage of residents above the age of 65, the log of the median income, the log of the voting age population, the percentage of democratic voter share, and whether the state was a a "swing" state in 2012.

Rather than attempt to control via covariates and distance, we also focus on states sharing a substantial border and estimating the effect separately for each pair to examine the extent to which the estimates reported above vary. To do so, Table 3 reports the average difference in the number of votes cast relative to the VAP in each county conditional on covariates and a linear distance measure and reveals that despite having a similar number of state level races, turnout was higher in the expansion states of KY, WV and NM than it was in the neighboring non-expansion states of TN, VA, and TX. There was no difference in the difference of average county level turnout for ND and SD relative to the 2012 presidential election, but this is likely because there was no Senate or Gubernatorial race in 2014 in North Dakota (there was only an at-large election

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[17]One difference is that the estimation of standard errors clustered by state become more problematic given the sample sizes involved and the number of parameters being estimated.

State$_{expand}$	State$_{noexpand}$	Counties	Effect	95 % CI	Races$_{expand}$	Races$_{noexpand}$
KY	TN	164	9.68	[6.98,12.39]	S	S,G
WV	VA	101	8.17	[5.91,10.43]	S	S
NM	TX	285	3.78	[0.43,7.12]	S,G	S,G
ND	SD	73	0.08	[-3.01,3.17]	None	S,G
MI	WI	97	-2.63	[-4.74,-0.52]	S,G	G

Table 6: Estimates for State Pairs: The reported effect is the estimated α for a regression specification controlling for a linear function of distance to the border as well as the percentage of white residents, the percentage of residents with a high school degree or less, the percentage of residents above the age of 65, the log of the median income, the log of the voting age population, the percentage of democratic voter share, and whether the state was a a "swing" state in 2012.

for the single U.S House district) whereas there were both senatorial and gubernatorial races in South Dakota. Contrary to the patterns evident in Figure 3 and the specifications reported above, turnout actually decreased in the expansion state of Michigan relative to Wisconsin despite having both a senatorial and a gubernatorial election. However, the estimated decrease is arguably still attributable to the politics of the ACA as the gubernatorial election in 2012 was dominated by whether WI would extend Medicaid or not, with the winning candidate Scott Walker promising to oppose the extension. This instance therefore likely reflects an instance in which the issue of Medicaid expansion itself – rather than the policy consequences of Medicaid expansion — impacted political behavior by mobilizing opponents.

Given the variabilty in both the point estimates and the precision of the estimates in Table 4, the appendix conducts two additional placebo tests to help provide a baseline for interpreting the effects. To account for the impact that state-level electoral variation may have on our estimated effects Table A3 compares voting behavior in 2014 relative to 2012 states sharing an identical expansion status. To identify the effects that may result because of electoral variation, we compare states with different electoral environments but a common expansion status to demonstrate that there is no difference in change in votes cast between states with similar expansion statuses despite different electoral circumstances. So long as the electoral differences are uncorrelated with treatment status, this investigation provides some sense of how candidate differences alone may impact the average difference in voter turnout. The results reveal null effects – unless the relevant electoral variation was related to the expansion status, electoral variation by itself appears insufficient for explaining the systematic 3% difference in the percentage of votes cast in expansion states relative to non-expansion states. However if the electoral differences were related to the expansion of Medicaid,

this difference would be meaningful from the perspective of identifying the political impacts of Medicaid expansion (although the mechanism would be through elite action rather than the policy impacts experienced by the electorate).

To determine whether the expansion of Medicaid was a consequence rather than a cause of the differential voting patterns we identify, Table A4 estimates the change in votes being cast in counties for races occurring prior to expansion to determine if changes in in county-level turnout pre-exist the expansion of Medicaid in the state as would be the case if the changing voting behavior were a cause rather than a response of Medicaid expansion (or as would be the case if an omitted variable was related to both relative increases in turnout and the decision to expand Medicaid). The null results that are obtained suggest that the changing participation rates are consistent with the effect being caused by the expansion of Medicaid.

3.1 Political Impact on Turnout by Income

As was the case when examining the impact of Medicaid expansion on the percentage of insured citizens in a county, if turnout effects we identify in the prior section are due to the mobilization of newly eligible Medicaid recipients we should find the largest impacts in poorer counties. Just as the results of Section 2 demonstrated that the largest impact of Medicaid expansion sensibly occurred in counties with below average median household incomes given the mean-tested nature of the program, if the mobilization effects are largely because of the increased participation of recipients the largest effects on turnout should occur in the same set of counties.

In contrast, if the turnout differences we identify are due to the increased participation of those most opposed to the policy we would likely observe a different pattern, as it seems likely that either turnout does not depend on the relative income of the county (as perhaps the mobilization of recipients and opponents occurs equally), or turnout may increase wealthier counties given the partisanship of the issue. A finding of no difference would also be consistent with the differences being attributable to differences in the candidates running in expansion and non-expansion states.

Figure 3.1 presents the raw data and it reveals that the magnitude of the discontinuity in turnout depends critically on a county's income – whereas there is almost no difference in turnout between counties in expansion and non-expansion states with above average median household incomes, there appears to be an effect in those counties with below average median household incomes.

To refine the comparison further, Table 7 presents the results of specifications which isolate the average effect in counties that are above and below the average income. (The appendix reports the substantively identical results that result when using border fixed effects in Table A6.) The results of Table 7 show that the average increase in the number of votes case evident in prior specifications are nearly entirely attributable to the effects that are estimated to occur in counties with below average incomes. While otherwise similar counties with below average median household incomes have 5.59% more votes cast if they are located in expansion states, the difference in votes cast in counties with above average median household income are indistinguishable. This is true regardless of whether the comparison includes all counties (specifications (1) - (3) in Table 7) or just those within 100 miles of the border (specifications (4) - (6)).

This pattern of differential effects is important because it is consistent with what would be expected if the policy impacts of Medicaid expansion were responsible for the behavior. If the impact of the policy were to occur largely through elite actions and discourse we would expect to observe a more uniform, and less income-contingent effect on participation. Precisely because effects on voting behavior are largest in the very same counties where insurance rates were calculated to increase the most following the expansion of Medicaid, it is not implausible to suggest a relationship.

	(1) All Counties Below Avg.	(2) All Counties Above Avg.	(3) All Counties All	(4) Close Counties Below Avg.	(5) Close Counties Above Avg.	(6) Close Counties All
Medicaid Expansion	5.29	1.94	0.18	6.30	2.38	-0.12
	[1.07,9.57]	[-3.22,7.72]	[-3.75,4.48]	[2.46,9.97]	[-3.25,8.18]	[-4.48,4.99]
Turnout 2012	-0.04	-0.84	0.24	-0.03	-0.14	0.23
	[-0.12,.06]	[-0.20,0.05]	[0.18,0.31]	[-0.14,0.08]	[-0.30,0.04]	[0.17,0.31]
Low Income ×			5.38			5.91
Expansion			[1.65,9.43]			[0.55,10.53]
Number of counties	954	923	1877	573	541	1114
Distance	linear	linear	linear	linear	linear	linear
R^2	.15	.06	.32	.22	.13	.38

Table 7: Predicting the Change in Turnout Based on Median Income of the County: Effect allows to vary if median household in the county is above or below the sample average. Wild Cluster Bootstrap errors by Cameron et al (2008) are clustered by state.

Note that the increase in votes that are cast is not a consequence of the fact that we are characterizing the difference in votes cast in a county between 2012 and 2014. In fact, separately predicting the number of votes cast in the 2012 and 2014 elections using covariates and border fixed effects in Table A7 in the appendix reveals that while there are fewer votes cast as a fraction of VAP in low income counties as we would expect, the interaction between low income county and expansion is positive in 2014 and negative in 2012. That is, whereas poorer counties in expansion
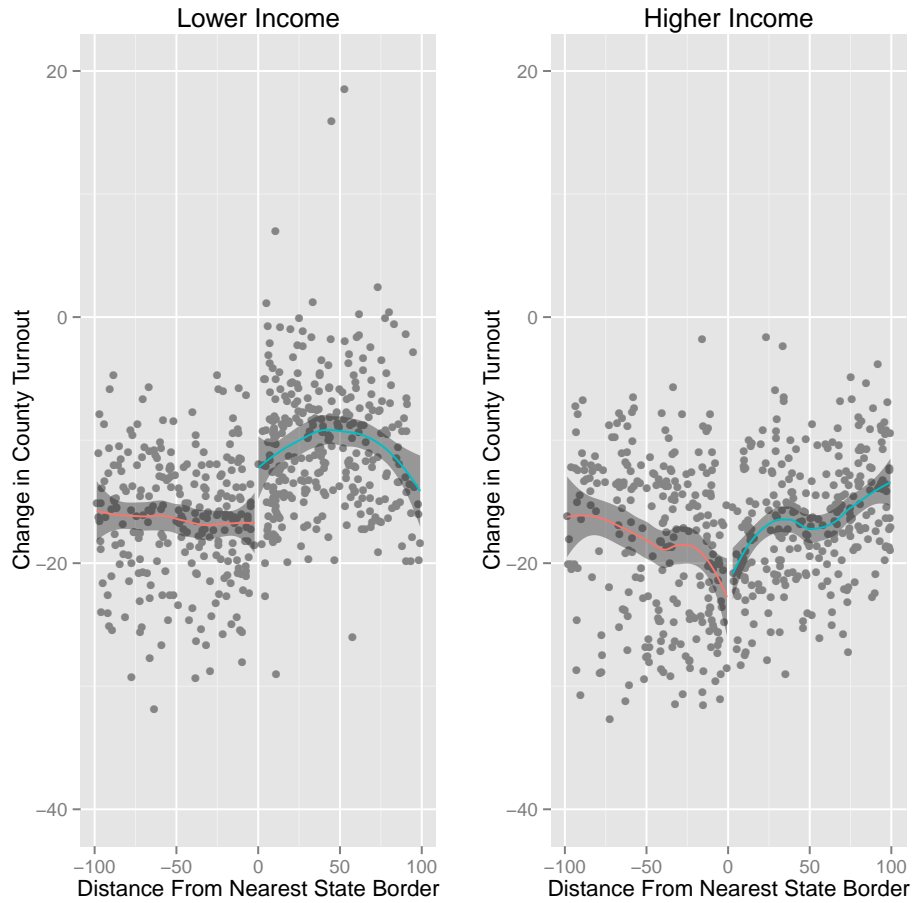
Figure 7: Change in Turnout by Distance to Border

states were less likely to cast as many votes as similar counties in non-expansion states prior to the expansion, this relationship flips after the expansion of Medicaid in the state with poorer counties being more likely to cast more votes in expansion states than similarly situated counties in non-expansion states relative to wealthier counties.

The relationship that was evident in the raw data plotted in Figure 3.1 and which persists even after employing a variety of statistical controls to account for observable and unobservable confounders reveals that the increase in the number of votes cast in expansion states is an effect that is nearly entirely attributable to an increase in voting in the poorest counties. Given the concentrated impact of the effect, the effect seems most likely attributable to changes that are concentrated in the poorest counties of expansion states. This is consistent with the expect we would expect if the expansion of Medicaid eligibility were responsible for the increase in the number of votes cast because of the actions taken by recipients rather than actions taken by elites that would

likely have less differentiated effects.

4   Individual-Level Results

At the county level, the results suggest that the expansion of Medicaid led to an increase in turnout, particularly among counties with below average household median income and which would therefore be most affected by the policy changes. To probe the issue further, we also examine whether the expansion of Medicaid is also correlated differences in the political opinions of individuals.

Our investigation of individual level effects are motivated by two considerations. First, is there individual-level evidence consistent with county-level effects we identify that improve our confidence in the attribution of the differences to the expansion of Medicaid in the state? Second, to the extent that individual level effects are evident, are the changes consistent with the creation of a mobilized and enduring constituency interested in preserving the policy, or are the effects suggestive of a more limited and transient impact?

Ideally, we would mimic the identification strategy of the prior sections and compare the change in individuals' opinions before and after expansion to determine whether individuals residing in expansion states experience a greater change than similar individuals residing in a non-expansion state. Unfortunately, we are not aware of the existence of such data. Instead, our data consists of a cross-sectional survey with nearly 30,000 respondents conducted by *Survey Monkey* in October and November prior to Election Day 2014.[18]

Relying on cross-sectional variation and covariates to identify the effect of Medicaid expansion using a survey taken after the expansion occurs requires heroic assumptions to make causal statements.[19] As such, our motivation is more limited and we question whether there is evidence of correlations consistent with the expansion of Medicaid having a political impact even despite the potential selection issues. To determine whether there are differences in individuals' opinions correlated with the expansion of Medicaid all else equal, we model the opinions of individual $i...N$

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[18]The responses were drawn from several non-probability surveys *Survey Monkey* conducted using the nearly three million people who take surveys on the SurveyMonkey platform each day. Because the results are from several different surveys, not every question was asked of every respondent.

[19]For example, it is unclear how severely selection issues might bias the results. If participation on an online survey conducted by *Survey Monkey* depends on characteristics affected by the expansion of Medicaid then the ability to compare opinions between expansion and non-expansion states may be compromised because the samples will reflect different populations. Note that this is separate from the concern that the respondents may not accurately reflect the composition of the electorate itself.

residing in a zip code in a state bordering another state with a different expansion status using:

$$y_i = \alpha_{expand}T_s + \delta d_i + \gamma\alpha_{expand} \times d_i + \boldsymbol{X}_i\beta + e_i \tag{4}$$

where y_i is the survey response of interest for individual i, T_s is whether the respondent's state expanded Medicaid (1) or not (0), d_i is the distance individual i lives from the border (based on the zip code of residence), and $\boldsymbol{X}_i$ are individual level covariates that are plausibly related to the outcome of interest. α_{expand} estimates the average difference in opinions for individuals living in a state that expands Medicaid conditional on the included covariates and distance from the border. Note that zip codes sometimes cross state lines, in which case we use information on the self-reported state of residence by the respondent to determine expansion status.

To explore possible changes, we examine the importance of health care to the respondent, whether the respondent is registered to vote or not, the extent to which the respondent approves of the job being done by President Obama, and the likelihood of self-identifying with the Democratic party. The first two questions assess the extent to which it is possible to identify individual-level impacts that are consistent with a mobilization impact. Examining the responses on the second two questions probe whether there is evidence of a pro-Democratic shift given the extremely partisan nature of the debate over health care. As section 1 makes clear, the expected effects are largely unclear. In addition to the issues created by potential selection effects, whether a larger change occurs among recipients or opponents, for example, is unclear. Relatedly, does "health care" increase in importance because of the expansion of Medicaid because recipients and opponents are willing to support and repeal it accordingly, or does it fade in importance because the policy effects help ameliorate the situation?

We begin by considering the extent to which the respondent names "health care" as the most important issue for the 2014 election. Table 8 reports the results of the conditional impact of residing in an expansion state using a linear probability model. Regardless of whether distance to the border of the nearest state with a contrary expansion status is measured using linear (1) or quadratic (2) specification, the impact is about a 2% decrease in the importance of the issue, although the precision of the estimate suggests that the impact likely ranges from a 6% decrease to a 2% increase.

If this decrease is attributable to Medicaid expansion successfully mollifying respondents' con-

| | (1) | (2) | (3) | (4) | (5) |
	All	All	≤ HS	College+	All
Medicaid Expansion	-0.02	-0.02	-0.06	-0.02	-0.02
	[-0.06,0.02]	[-.06,.02]	[-0.11,-0.02]	[-0.07,0.03]	[-0.07,0.03]
Expansion × ≤ HS					-0.04
					[-0.08,0.01]
Obama Voter 2012	0.10	0.10	0.06	0.10	0.10
	[0.08,0.12]	[0.08,0.12]	[0.02,0.11]	[0.08,0.12]	[0.08,0.12]
Number of respondents	33,714	33,714	3,049	21,251	24,300
Distance	linear	quad	linear	linear	linear
Covariates	yes	yes	yes	yes	yes
R^2	0.02	0.02	0.02	0.02	0.02

Table 8: Predicting the importance of "health care" using a linear probability model: Covariates include the indicators for age range, educational attainment, race/ethnicity, the presence of a competitive Gubernatorial or Senatorial race, born again status, and self-reported vote for Obama in 2012. Standard errors are clustered by state.

cerns, the largest impact should be concentrated among those who benefit from the expansion. Unfortunately, the survey failed to ask about household income. As a second-best approximation we therefore rely upon educational attainment given its correlation with income to determine whether the impact is largest among those who would most benefit from the expansion of Medicaid. Specification (3) estimates the relationship for those with a high school education and less and specification (4) does the same for those with at least some college. Consistent with the variation in the importance of health care being due to the expansion of Medicaid, the decreased importance of the issue of health care in expansion states is largest among the least educated respondents. To determine whether the differences in specifications (3) and (4) are statistically distinguishable from zero we estimate a triple-interaction model using expansion status, educational attainment, and distance from the border. The results of this specification – specification 5 – reveals that the 4% difference in the importance of health care based on educational attainment is distinguishable from zero; while those who self-report voting for a President Obama in 2012 prior to the expansion are uniformly more likely to mention "health care as an important issue, even controlling for this difference we find that lower education voters in expansion states are the least likely to identify "health care" as an issue relative to similar individuals residing in non-expansion states.

This differential impact suggests that while the expansion of Medicaid may have been a successful policy both in terms of increasing insurance coverage and addressing concerns about health care, the fact that those that are most affected report the least concern suggests that the success of the expansion may paradoxically improved the lives of those benefitting from the policy and also failed to create a mobilized constituency around the issue because voters in expansion states are

less likely to see health care as a concern relative to similarly situated individuals in non-expansion states. The fact that those who are most likely to benefit from the expansion of Medicaid are also those who are most willing to downgrade the importance of health care suggests that the potential for an enduring constituency that is mobilized to support and expand the policy may be limited. To be clear, it may be the case that the decrease we detect is due to a constituency being created by the expansion of Medicaid and, once mobilized, such voters reporting that they are primarily engaged by other issues (perhaps because the expansion of Medicaid addressed their concerns), but it is impossible to assess this possibility using the available data.

To probe the mass political impacts further, we also consider whether respondents living in expansion states are more likely to report being registered to vote relative to those living in non-expansion states. That said, it is difficult to interpret the impact of this relative to the effects we identify in the county-level estimates on the number of votes cast given that self-reported registration status is known to be biased upwards because of social desirability (Vavreck 2007). Despite the fact that 92% of respondents to the *Survey Monkey* surveys report being registered to vote for the 2014 midterm elections (compared to 71.2% of respondents to the 2012 Current Population Survey), the difference we estimate is most accurately conceived of as identifying the difference in the willingness of respondents to indicate that they are registered to vote.

While slightly more residents in expansion states report being registered to vote, the substantive difference is miniscule – 92.2% of respondents living in non-expansion states report being registered to vote compared to 92.9% of respondents living on expansion states. While this slight difference of 0.07% is nearly distinguishable from zero when conducting a simple difference of means test with state-clustered standard errors and no covariates – the 95% confidence interval for the difference range from [-0.004,0.02] – including covariates to control for observable differences and including the distance that the respondent's zip code is from the closest border reveals that respondents in expansion and non-expansion states are equally likely to report being registered to voter regardless of whether a linear (1) or quadratic (2) measure of distance is used.

To explore whether the expansion of Medicaid moved voters in a Democratic direction we consider the relationship between Medicaid expansion and President Obama's job approval and the probability that a respondent chooses to self-identify with the Democratic party. Identifying the causal impact of expansion using cross-sectional variation in responses to a survey taken after

	(1)	(2)	(3)	(4)
	Registration	Registration	Obama Approval	Obama Approval
	(0,1)	(0,1)	(3)	(4)
Medicaid Expansion	-0.005	-0.004	0.01	0.03
	[-.01,.01]	[-.02,.01]	[-.05,0.08]	[-0.05,0.11]
Number of respondents	34010	34010	7062	7062
Distance	linear	quad	linear	quad
Covariates	yes	yes	yes	yes
R^2	.08	.08	.65	.65

Table 9: Predicting the Self-Reported Registration Status and Obama Approval: Covariates include the indicators for age range, educational attainment, race/ethnicity, the presence of a competitive Gubernatorial or Senatorial race, born again status, and self-reported vote for Obama in 2012. Sample size differences reflect the fact that fewer respondents were asked Obama approval. Standard errors are clustered by state.

expansion is impossible; a positive relationship between expansion and support for President Obama or the willingness to self-identify with the Democratic party would be consistent with the claim that expansion improved the willingness to approve of President Obama's job or the Democratic party because of the benefits of "Obamacare," or it may be the fact that respondents in the state were more likely to approve of President Obama and self-identify as a Democrat than otherwise identical individuals in states that chose not to expand and that these differences were what led to the state's decision to expand Medicaid. In the analyses that follow we attempt to control for the latter possibility by controlling for whether the respondent reports voting for Obama in the 2012 election. Thus, the effect we identify is how much the opinions towards Obama and the Democratic party differ relative to the support given to Obama in the 2012 election.[20]

The results of specifications (3) and (4) in Table 9 suggest that the approval of President Obama approval does not vary depending on whether the state expanded Medicaid or not. Respondents in expansion states are slightly more approving on average, but the magnitude is exceptionally small on the 4 point scale ranging from strongly disapprove (1) to strongly approve (4). Whether the null effect is due to the methodological difficulties with the measures and identification strategy, the possibility that the benefits of the expansion were minor relative to the other considerations that may affect presidential job performance, or the possibility that the Supreme Court's decision to make the decision a state-level decision rather than a national decision muted the impact of expansion on opinions towards the national leader of the Democratic party, there is no obvious impact of the expansion of Medicaid in a state for the support for President Obama as we might

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[20]An obvious complication is that not only are self-reports of past voting behavior are known to be problematic (CITE), but because the past vote is a binary indicator it is possible that there are consequential differences in the distribution of affinity towards Democrats that are not reflected in the comparison of binary measures.

suspect if the policy were successful in creating a galvanzied constituency.

While there is no obvious impact on the opinions towards President Obama, there is some evidence that individuals living in expansion states are slightly more willing to self-identify with the Democratic party. Table 10 reveals that residents of expansion states were slightly – 0.03 – more likely to self-identify with the Democratic party all else equal. Whether this is a cause or a consequence of expansion is hard to identify given the cross-sectional design, but the best we can do is to control for whether the respondent reported voting for President Obama in the 2012 presidential election; if the 2012 vote measures respondents' sentiments towards Democrats prior to the expansion of Medicaid we may be willing to interpret the current self-identification as a measure of the extent to which the expansion has affected the willingness of respondents living in expansion states to self-identify with the party largely responsible for the expansion.[21]

	(1) All	(2) All	(3) $\leq$ HS	(4) College+	(5) All
Medicaid Expansion	0.03	0.04	0.05	0.03	0.03
	[-.01,.08]	[-.02,.09]	[-.01,.12]	[-0.01,0.07]	[-.01,.07]
Expansion $\times \leq$ HS					0.01
					[-.05,.07]
Obama Voter 2012	0.53	0.53	.47	.55	.54
	[0.51,.54]	[.51,.54]	[.42,.52]	[.53,.57]	[.52,.56]
Number of respondents	33801	33801	3054	21329	24383
Distance	linear	quad	linear	linear	linear
Covariates	yes	yes	yes	yes	yes
R^2	.40	.40	.29	.43	.41

Table 10: Probability of Identifying as a Democrat: Covariates include the indicators for age range, educational attainment, race/ethnicity, the presence of a competitive Gubernatorial or Senatorial race, born again status, and self-reported vote in 2012. Sample size differences reflect the fact that fewer respondents were asked Obama approval. Standard errors are clustered by state.

Estimating the relationship separately for those with a high school diploma or less (specification 3) and for those with some college or more (specification 4) reveals that those living in expansion states are slightly more likely to self-identify with the Democratic party conditional on covariates and their self-reported vote in 2012. Pooling the subsets and estimating a triple-interaction between expansion status, educational attainment and distance from the border reveals that while those of lower educational attainment are roughly 2% more likely to self-identify with the Democratic party, but the impact could range from -4% to 8% when estimation uncertainty is accounted for.

Together, the results suggest that those living in an expansion state are slightly less likely to consider "health care" as the most important consideration in the 2014 election, and they are

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[21]An unavoidable limitation of this strategy is that because every measure is taken post-expansion it is possible that the decision to expand Medicaid may affect what the respondent reports about their previous vote choice.

slightly more likely to self-identify as a Democrat on the eve of the 2014 midterm elections. These effects are slightly larger among the less educated, as would be expected if the impact is due to the expansion of Medicaid. No evidence is found that suggests a large change in the registration of respondents or in the job approval of President Obama.

Given the obvious limitations in both the measures and the identification strategy available to us, we interpret these results as complementary and suggestive to the aggregate level results reported earlier. The fact that a coherent narrative about the political impacts of Medicaid expansion can be constructed using several analyses and data sources provides some reassurance that the results are not purely spurious, but it is hard to reach definitive conclusions on the basis of these data. Even so, the results suggest that while there may be mass political effects of the policy, the effects are limited. There is no evidence of a fundamental restructuring of the political landscape and rearrangement of opinions because of one of the most wide-ranging and redistributive social policies in recent history. Moreover, when effects exist, they are of limited magnitude.

5 Conclusion & Implications

Does policy affect politics? This is a longstanding question with important implications for our understanding of the extent to which policies are durable because of the impacts that they have on the mass public. It has also been a difficult question to answer – especially for means-tested programs – where eligibility often depends on the very same factors that are thought to be related to political participation.

To make progress on this important, but difficult question we focus on the political consequences of Medicaid expansion in the states as was provided for by the Affordable Care Act. The ACA was arguably the most impactful social welfare program since the 1935 Social Security Act and it is also unprecedented in the extent to which it has been politicized. Unlike other prominent social welfare programs such as the Social Security Act, the GI Bill that have been the subject of prior studies of policy feedback, the ACA was enacted along party lines with not a single Republican supporting the policy in either rate House of the Senate. Moreover, the salience of the issue has persisted ever since – parties have sent clear and unambiguous signals regarding the desirability of the ACA during the 2014 elections at both the federal and state levels.

While identifying the policy impacts of social welfare programs has proven elusive in the past –

in part because the characteristics that make one eligible for the program are also often related to aspects affecting political participation – the variation in the expansion of Medicaid resulting from the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* creates a unique opportunity to examine how otherwise similar counties and individuals behave when they experience the expansion of Medicaid or not because of actions taken by their state government.

Our investigation reveals that there appears to be qualified political impact of Medicaid expansion. Consistent with the policy effects we would expect, counties located in states that expand Medicaid are estimated to have a greater increase in the percentage of insured residents following the expansion of Medicaid, and the difference is greatest in counties whose median household income is below average. Exploring whether the expansion of Medicaid also results in more votes being cast reveals that the counties experiencing the largest increase in the percentage of insured residents also experience the smallest decrease in votes cast between the 2012 and 2014 elections. While turnout is well-known to be lower in midterm elections than presidential elections, in counties located in expansion states with below average median household incomes, the decrease was the least. The 3-4% difference in turnout is stable across specifications regardless of the inclusion of border-fixed effects, county covariates, and narrowing the cases to those located within 100 miles of the border. Placebo tests also reveal no evidence of a preexisting pattern of increasing turnout in expansion states or similar magnitudes when comparing county differences in states sharing an identical expansion status. In light of these results, the fact that the largest increases in turnout occur in precisely those counties that most benefit from the expansion of Medicaid suggests that the expansion of Medicaid increased turnout by mobilizing newly eligible recipients.

To probe this finding further, we analyze 60,000 individual-level survey responses taken on the eve of the 2014 election. The results from such analyses are weaker, as is the identification strategy given the cross-sectional nature of the data and the inability to account for possible selection effects. Even so, we find that respondents in expansion states are less concerned about health care than those residing in non-expansion states and the concern decreases the most for those that were presumably most affected by the expansion of Medicaid. The fact that the importance of the issue decreases among those who presumably benefit the most suggest that despite the positive turnout effects we document, it is unlikely that the policy will create an enduring constituency that is mobilized around the policy. While respondents are slightly more likely to self-identify

as a Democrat, and the effect is largest among those that were presumably most affected by the expansion – the overall impact is estimated to be a 5% increase in the probability of self-identifying as a Democrat in the population that benefits the most, there is no impact on the approval towards President Obama – perhaps reflecting the federal nature of the expansion because of the Supreme Court Decision. Combined with the decreased importance of health care mentioned above, even if the expansion of Medicaid succeeded in getting more citizens to the polls, it did not obviously create a constituency mobilized to sustain it. Thus, even if the expansion of Medicaid was successful in creating increased access to the ballot box, the lasting impact of the policy in terms of changing electoral politics seems limited.

The relationship between policy and politics is critical for understanding not only the demand for lawmaking action, but also the persistence of the status quo. To the extent that public policies create invested constituencies of beneficiaries, understanding the causes and consequences of lawmaking requires studying both the actions of elected officials as well the impact of the surrounding electoral environment. Such investigations are involved, complicated, and often hard to conduct given the pervasive connections that make identifying the impacts of each difficult. Fortunately we are sometimes provided with circumstances that enable us to untangle such connections and the expansion of Medicaid as provided for under the ACA is both an substantively important and an methodologically exemplary case.

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Appendix

Tables A1 and A2 replicate the results for Tables 4 and A5 respectively using the 2010 midterm elections as the baseline rather than the 2012 presidential election. The results are generally stable across specifications and suggestive of a positive effect, but the estimates are imprecisely estimated. Given that electoral variation is now present in both the pre and the post election, the increased imprecision is not terribly surprising. However, unlike the case in 2014 when the electoral variability is still arguably of theoretical interest insofar as it is a consequence of the Medicaid expansion, when using the 2010 midterm elections the interpretation of between state variation is unclear. Perhaps the most accurate summary of the results evident in Tables A1 and A2 is that they do not undermine our confidence in the results reported in the text given the difficulty of interpreting the meaning of the additional between state variability that results from using the 2010 midterm election as a baseline.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Medicaid Expansion	-0.11	2.00	0.80	1.95	1.02	2.21	2.27
	[-3.57,2.93]	[-1.62,5.71]	[-2.86,4.27]	[-2.01,5.75]	[-2.78,4.84]	[-1.76,6.05]	[-1.84,6.29]
Number of counties	1786	1781	1781	1781	1781	1780	1780
Distance	no	linear	quad	linear	quad	linear	quad
Lagged turnout	no	no	no	yes	yes	yes	yes
Covariates	no	no	no	no	no	yes	yes

Table A1: Predicting the Change in Turnout as a percentage of VAP for All Counties: Using 2010 as the baseline.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Medicaid Expansion	0.83	0.41	0.30	0.65	0.37	2.17	1.65
	[-2.53,3.91]	[-2.79,3.37]	[-3.07,3.72]	[-2.69, 3.98]	[-3.16,3.98]	[-1.27,5.65]	[-1.91,5.08]
Number of counties	1038	1038	1038	1038	1038	1038	1038
Distance	no	linear	quad	linear	quad	linear	quad
Lagged turnout	no	no	no	yes	yes	yes	yes
Covariates	no	no	no	no	no	yes	yes

Table A2: Predicting the Change in Turnout as a percentage of VAP for Nearby Counties: Using 2010 as the baseline.

Placebo Tests

Given the variabilty in electoral environment, we attempt to identify the extent to which electoral variable may be responsible for the differences we estimate in county-level turnout differences. To do so, we compare whether there are notable differences across state borders for states sharing the same expansion status. To the extent that there are turnout differences of a similar magnitude when comparing counties in different states that nonetheless share a common expansion status then it seems unlikely that Medicaid expansion would be responsible for the differences. On the other hand, if the differences between states of a similar expansion status are not systematically different than one another than this would be consistent with the claim that the differences we detect in the text may not be due to electorally variability alone.

Table compares the average difference in county-level voting behavior in non-expansion states (specifications (1) and (2) and expansion states (specifications (3) and (4)) differ when the "treatment" is randomly assigned to half of the states in each. As the results make clear, unlike the differences that are reported in the text, the differences are never distinguishable from zero and the confidence intervals are sufficiently wide so as to permit both large positive and large negative effects. While the comparisons being made in Table A3 are comparisons in which the electoral environment differs, the fact that the differences are not systematic is suggestive, but certainly not definitive, regarding the extent to which electoral variability alone may produce the 3% difference in the percentage of votes cast in expansion states relative to non-expansion states.

	(3) Δ turnout Post: 2014 Pre: 2012	(4) Δ turnout Post: 2014 Pre: 2012	(3) Δ turnout Post: 2014 Pre: 2012	(4) Δ turnout Post: 2014 Pre: 2012
Border effect	-7.22	-4.60	-0.85	-0.89
	[-30.79,16.35]	[-20.25,11.04]	[-6.92,5.23]	[-7.51,5.73]
States	Non-expansion	Non-expansion	Expansion	Expansion
Covariates?	N	Y	N	Y
Number of counties	1040	1012	894	795

Table A3: Placebo Tests: effect of crossing border in states with the same expansion status.

As a second set of placebo analyses we explore whether the pattern we identify is due to pre-existing trends in expansion states. To do so, we replicate the analyses using post-treatment measures that occur prior to the decision to expand Medicaid. So doing explores whether the change in turnout in the county occurs prior to the expansion of Medicaid in the state and whether the expansion of Medicaid may actually be a consequence of increased mobilization rather than visa-versa. Table A4 reported the results and it reveals that there is no evidence that this is the case. While the change in turnout between 2008 and 2012 was slightly higher in counties located in expansion states, the magnitude of the effect is small (roughly 1%) and the effect cannot be distinguished from zero. Looking further back and considering the change between 2004 and 2008 reveals an even smaller magnitude and more imprecisely estimated effect.

	(1)	(1)	(2)	(2)
	Δ turnout	Δ turnout	Δturnout	Δturnout
	Post: 2012	Post: 2012	Post: 2008	Post: 2008
	Pre: 2008	Pre: 2008	Pre: 2004	Pre: 2004
Medicaid expansion state	0.90	1.20	-0.38	0.24
	[-1.16,2.95]	[-0.20,2.60]	[-7.16,6.40]	[-1.15,1.62]
Covariates?	N	Y	N	Y
Number of counties	1954	1954	1954	1954

Table A4: Placebo Tests: effect of Medicaid expansion on pre-2012 turnout.

Given these results, there is no evidence that the expansion of Medicaid in the state was likely to have occurred because of pre-existing trends in voter mobilization.

Robustness Tests of Votes Cast Specifications

Table A5 replicates the specifications of Table 4 in the text using only those counties that are located within 100 miles of the nearst state with a contrary expansion status. While the precision of the estimates decreases slightly due to the loss of observations, the substantive impacts remain unchanged.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Medicaid Expansion	4.26	5.39	4.53	5.18	5.18	4.07	3.92
	[-0.01,9.03]	[0.49.10.69]	[-0.05,9.43]	[0.52,10.26]	[-0.52, 10.26]	[0.71,7.48]	[0.58,7.51]
Turnout 2012				-0.16	-0.16	-0.07	-0.07
				[-0.29,-0.02]	[-0.30,-0.02]	[-0.21, 0.08]	[-0.21,0.08]
Number of counties	1114	1114	1114	1114	1142	1114	1114
Distance	no	linear	quad	linear	quad	linear	quad
Covariates	no	no	no	no	no	yes	yes
R^2	.10	.11	.11	.18	.18	.36	.36

Table A5: Predicting the Change in Turnout as a percentage of VAP for Counties within 100 miles of a bordering state. Covariates include the percentage of white residents, the percentage of residents with a high school degree or less, the percentage of residents above the age of 65, the log of the median income, the log of the voting age population, and the percentage of democratic vote share. Other covariates include if the state was a "swing" state in 2012. Bootstrap standard errors are clustered by state using the wild cluster bootstrap of Cameron et al (2008).

Robustness of Income-Based Results

Table A6 replicates the results of Table 7 in the text using border fixed effects. The results are substantively identical – the impact on voting behavior is largely, if not entirely, found in counties with below average median household incomes and there is a detectable difference in the percentage of votes cast in counties located in expansion states even after controlling for border fixed effects which are able to account for a great deal of the variability in the data.

	(1) All Counties Below Avg.	(2) All Counties Above Avg.	(3) All Counties All	(4) Close Counties Below Avg.	(5) Close Counties Above Avg.	(6) Close Counties All
Medicaid Expansion	7.05	0.23	0.90	7.60	-0.55	0.003
	[6.00,8.08]	[-0.81,1.28]	[-0.06,1.86]	[6.05,9.14]	[-2.15,1.04]	[-1.46,1.46]
Turnout 2012	-0.21	-0.21	-0.21	-0.18	-0.18	-0.19
	[-0.24,-0.18]	[-0.23,-0.18]	[-0.23,-0.19]	[-0.23,-0.14]	[-0.23,-0.14]	[-0.22,-0.16]
Low Income ×			5.02			7.02
Expansion			[3.81,6.24]			[5.25,8.80]
Number of counties	954	923	1877	573	541	1114
Distance	linear	linear	linear	linear	linear	linear
Border FE	yes	yes	yes	yes	yes	yes
R^2	.90	.94	.92	.91	.94	.92

Table A6: Predicting the Change in Turnout Based on Median Income of the County with Border Fixed Effects: Effect allows to vary if median household in the county is above or below the sample average.

Table A7 estimates the same specification on the pre and post turnout numbers separately to determine if the increases we identify are a consequence of post-treatment changes. Separately predicting the votes that are cast in 2012 and 2014 as a fraction of the VAP in the county determines whether the variation we identify in poorer counties located in expansion states is a consequence of differential behavior in 2014, 2012, or both. While counties with median household incomes below average have a smaller percentage voting in both elections (by roughly 4-5%), the variable of most interest is the interaction between Low Income status and Medicaid expansion as this coefficient identifies how otherwise poor counties in expansion and non-expansion states differ in their voting behavior. Regardless of whether the comparison is based on all counties or only those counties that are located within 100 miles of a border, the results are the same – while fewer voters were cast in low income counties prior to Medicaid expansion in 2012, the same counties cast more votes relative to similar counties in non-expansion states in 2014. This shift is entirely consistent with the possibility that the voters become mobilized as a result of the expansion of Medicaid in their county.

	(1) 2014	(2) 2012	(3) 2014	(4) 2012l
Medicaid Expansion	2.50	1.36	3.19	2.87
	[0.96,4.05]	[-0.24,2.97]	[0.85,5.53]	[0.52,5.22]
Low Income	-4.33	-4.28	-4.93	-4.74
	[-5.34,-3.31]	[-5.33,-3.21]	[-6.38,-3.49]	[-6.20,-3.29]
Low Income ×	2.96	-2.29	5.52	-0.63
Expansion	[1.05,4.86]	[-4.21,-0.24]	[2.76,8.27]	[-3.40,2.15]
Number of counties	1877	1877	1114	1114
Distance	linear	linear	linear	linear
Border FE	yes	yes	yes	yes
R^2	.97	.98	.97	.99

Table A7: 2014 and 2012 Turnout Based on Median Income of the County