

# Polarization and Public Policy: Political Adverse Selection under Obamacare\*

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## Abstract

Politicizing policies designed to address market failures can diminish their effectiveness. We document a pattern of “political adverse selection” in the health insurance exchanges established under the Affordable Care Act (ACA; “Obamacare” in political debates): Republicans enrolled at lower rates than Democrats and independents, a gap driven by healthier Republicans. This selection raised public subsidy spending by approximately \$124 per enrollee annually (2.4% of average cost). We field a survey to show this selection does not exist for other insurance products. Lower enrollment and higher costs are concentrated in more Republican areas, potentially contributing to polarized views of the policy.

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# 1 Introduction

Governments increasingly rely on markets to provide essential impure public goods, such as health care, education, or retirement savings. This approach is often characterized by subsidized private provision, which can deliver greater choice and higher efficiency. Achieving those goals depends on matching consumers to products or options, a process policymakers and economists typically view as determined by individual or household preferences and market conditions (e.g. prices and product characteristics). Notably, while public intervention affects these market conditions, economists usually assume that preferences and market outcomes are independent of the role of government.

We consider an alternative view in which government intervention also affects preferences and choices directly: government involvement becomes a product attribute, the value of which depends on consumers' ideology or partisan affiliation. Because government involvement is more prominent in markets with externalities — for example, markets with asymmetric information leading to adverse selection — such political enrollment may affect not only individuals' own consumption decisions and utility, but also costs, prices, government spending, and aggregate welfare.

We study this phenomenon in the context of the Patient Protection and Affordable Care Act of 2010 (ACA). Popularly known as “Obamacare,” the ACA was one of the most significant and politically divisive expansions of the American welfare system in decades. The law passed on party lines in 2010, and even as late as 2019, the political divide remained: 80% of Democrats held a favorable view of the ACA, compared to only 20% of Republicans (Brodie, Hamel, Kirzinger and Altman, 2020).

To the extent that partisanship makes some of the intended beneficiaries more likely to stay out of the government-sponsored ACA marketplaces, this “political enrollment” poses an obstacle to the primary ACA goal of near-universal insurance coverage. Moreover, if political selection out of the ACA marketplaces is stronger among healthier, low-cost consumers (e.g. because these individuals have more appealing outside options), partisanship can not only reduce enrollment but also worsen risk selection in the marketplaces. This “political adverse selection” then increases insurers' average costs, leading to higher premiums and, in the ACA context, higher subsidies.

This paper formalizes the concepts of political enrollment and political adverse selection and measure their effects on ACA marketplace outcomes. A stylized model that builds on Einav, Finkelstein and Cullen (2010b) allows us to derive necessary and sufficient conditions

for political enrollment and political adverse selection to increase average costs. Taking the model to the data, we show that these conditions hold in the ACA marketplaces. Controlling for demographics, health status, and product characteristics, we find that Republicans were significantly less likely to enroll in ACA marketplace insurance plans than independents and Democrats. Most importantly, this difference is driven by healthy Republicans. While unhealthy Republicans were 4 percentage points less likely to enroll than unhealthy independents and Democrats, healthy Republicans were 12 percentage points less likely to enroll than healthy independents and Democrats.

In order to rule out the possibility that these effects are driven by partisan differences in demand for insurance more generally or by partisan differences in the interaction between insurance enrollment and health, we field a representative national survey eliciting partisanship, health status, and consumption of other insurance products: comprehensive auto insurance, life insurance, homeowner’s insurance, and renter’s insurance. We do not detect comparable political adverse selection out of these markets. We conclude that the differences in enrollment decisions observed under the ACA are politically motivated and that politicization thus worsened risk selection in the marketplaces.

We then quantify the magnitude of political adverse selection in ACA marketplaces. For this, we combine our estimates with survey data on health expenditure and demographic information and calculate the implied effects on average cost in the insurance pools. In a simple counterfactual, we remove the effect of ideology on enrollment and find that political adverse selection led to a 2.7% increase in average cost. In the context of the ACA, higher costs translate to higher premiums for high-income households and higher subsidies to low-income households. Since most enrollees on ACA insurance exchanges receive large subsidies, our estimates suggest that political adverse selection increased the public spending necessary to provide subsidies to low-income enrollees by around \$124 per enrollee per year. Considering cross-sectional heterogeneity, we find that moving from a market in which fewer than 30% of enrollees are Republican to a market in which more than 60% of enrollees are Republican more than quadruples the premium increase due to political adverse selection (from 1.20% to 5.82%).

Our work showcases significant economic costs arising from increased political polarization (see, e.g., [Gentzkow, 2016](#); [Iyengar, Lelkes, Levendusky, Malhotra and Westwood, 2019](#)), and in particular, the increased politicization of policy adoption ([DellaVigna and Kim, 2022](#)). In markets featuring government involvement or private-public competition — for example, health insurance ([Epple and Romano, 1998](#); [Curto, Einav, Finkelstein, Levin](#)

and Bhattacharya, 2019), education (Dinerstein and Smith, 2021), pharmaceuticals (Duggan and Scott Morton, 2006; Atal, Cuesta, González and Otero, 2021), and broadcasting (Berry and Waldfogel, 1999) — politically-motivated consumer behavior may generate important externalities arising from adverse selection or unrealized economies of scale. As a result, stronger political preferences may not only shape *individual* consumption choices (Fouka and Voth, 2013; McConnell, Margalit, Malhotra and Levendusky, 2018; Nardotto and Sequeira, 2021; Atkin, Colson-Sihra and Shayo, 2021) — but also distort aggregate market prices and quantities.

A small body of work has studied consumer behavior in the ACA marketplace through a political economy lens. Lerman, Sadin and Trachtman (2017) and Sances and Clinton (2019) examine the association between partisanship and ACA marketplace plan take-up; Trachtman (2019) examines the association between partisanship and health care premiums; and Hobbs and Hopkins (2021) studies the association between local price increases and anti-ACA attitudes. Our analysis adds two crucial elements. First, we document enrollment differences by partisanship *interacted with* health status — which we label “political adverse selection” — and quantify the resulting externality. Second, our empirical strategy isolates demand-side factors by examining behavior *within* year and insurance rating areas, the level at which consumers face the same menu of plans and prices.

Lastly, we speak to the vast literature studying consumer choice and market outcomes in health insurance markets (see Einav, Finkelstein and Levin, 2010a, for an early review), and mainly to work studying deviations from narrowly rational consumer choice (see Handel and Kolstad, 2015; Chandra, Handel and Schwartzstein, 2019, for reviews). We add to this literature evidence that political preferences affect health plan choices for consumers with otherwise similar characteristics, including health status. Our work also contributes to understanding the performance of the ACA marketplace and insurance exchanges, adding to Hackmann, Kolstad and Kowalski (2012); Dickstein, Duggan, Orsini and Tebaldi (2015); Ericson and Starc (2015); Hackmann, Kolstad and Kowalski (2015); Handel, Hendel and Whinston (2015); Orsini and Tebaldi (2017); Aizawa (2019); Tebaldi (2024), among others.

## 2 Politicization of Policy and the Affordable Care Act

### 2.1 The ACA Marketplaces

A key provision of the ACA was to establish insurance marketplaces in all fifty states and the District of Columbia, providing private coverage beginning in 2014. The regulation and design of these marketplaces was multifaceted and complex. A large and growing literature has developed focusing on the industrial organization of these markets, considering numerous policies and market design variables (see, e.g., [Handel and Kolstad 2021](#); [Handel and Ho 2021](#), and references therein). In the discussion that follows, we abstract away from many of these details and focus on the key components relevant for our empirical strategy and interpretation of our findings: the design and importance of subsidies (premium tax credits), product regulations, and market definitions.

Each state is divided into geographic rating areas — groups of counties or ZIP codes — defining the level at which insurers set plans and premiums. In a given coverage year, the supply side of each marketplace is fixed within each rating area: participating insurers are mandated to offer a specific set of plans (or metal tiers, Bronze, Silver, Gold, and Platinum). For each plan, insurers set a baseline premium, which is then adjusted for each household as a function of income and age composition following a federally mandated formula.

The ACA defines a maximum affordable amount for every household with income between 100% and 400% of the Federal Poverty Level (FPL); the amount is increasing in income. Given premiums in each rating area, subsidies are adjusted so that a Silver plan can be purchased for this amount. As highlighted in [Jaffe and Shepard \(2020\)](#) and [Tebaldi \(2024\)](#), price-linked subsidies of this kind imply that changes in premiums result in changes in subsidies, rather than changes in the premiums facing consumers. Therefore, regulatory or behavioral interventions affecting costs and premiums have a first-order effect on the level of public spending necessary to guarantee broad insurance coverage in the marketplaces.<sup>1</sup> Although marketplace-based insurance is available for the entire individual market, including those at higher incomes, in practice the vast majority of ACA marketplace purchases were by households receiving a subsidy: as of 2016, around 85 percent of the 18 million buyers in the marketplaces were subsidized ([Layton, Montz and Shepard, 2018](#)).

Between 2014 and 2020, premiums and participating insurers varied widely, and participation was lower than the Congressional Budget Office predictions. On average across rating

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<sup>1</sup>We focus on the cost of expanding health insurance coverage rather than the total cost of the program. Total costs can be reduced simply by reducing coverage, which is at odds with the policy’s primary goal.

areas, the minimum (pre-subsidy) premium in 2018 was 70% higher than the 2014 average.<sup>2</sup> While subsidized enrollment was stable over time, given that subsidized buyers are shielded from premium increases, unsubsidized enrollment in the individual insurance market in 2018 was half its 2015 level.<sup>3</sup>

## 2.2 Political Conflict and ACA Market Outcomes

The Affordable Care Act was politically divisive immediately upon its passage in March 2010: Kaiser Family Foundation Health Tracking Polls showed that around 70% of Democrats viewed the legislation favorably in 2010, compared to fewer than 20% of Republicans (see [Brodie et al., 2020](#)). Precisely *why* the ACA was so divisive remains a matter of active debate, with work emphasizing media and political messaging (e.g. [Gollust, Fowler and Niederdeppe 2020](#)), the role of general political polarization (e.g. [Oberlander 2020](#)), and the (often racialized) perception that the policy represented a massive redistribution toward “undeserving” beneficiaries (e.g. [Michener 2020](#); see also [Luttmer 2001](#)). What is clear, however, is that experience with the ACA has not diminished the partisan divide: as of 2019, around 80% of Democrats held a favorable view of the ACA, compared to only 20% of Republicans. Thus, ever since its passage, the ACA was a fundamentally *partisan* public policy, with its policy impact experienced by US citizens alongside its political implications.

Many competing factors jointly determined outcomes in ACA marketplaces, and a comprehensive analysis is far beyond our scope. What we argue here is that the politicization of the ACA was a relevant factor in lowering enrollment in the marketplaces (see also [Sances and Clinton, 2019](#); [Trachtman, 2019](#); [Hobbs and Hopkins, 2021](#)), and, most importantly, that this had an impact on average cost and per-buyer public spending in the program.

## 2.3 Data and Descriptive Evidence

To study how political considerations affected insurance uptake in ACA Marketplaces and whether partisanship impacted average cost, we draw upon two primary data sources: (1) the Kaiser Family Foundation Health Tracking Poll, which provides data on individual-level

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<sup>2</sup>Authors’ calculations using data from the Centers for Medicare & Medicaid Services (CMS).

<sup>3</sup>See: <https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollmen-t-in-the-individual-health-insurance-market-through-early-2019/>; and <https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-Marketplaces-2014-2021/>, last accessed on February, 13, 2022.

enrollment decisions; and (2) the Medical Expenditure Panel Survey (MEPS), which provides data on individual-level healthcare costs.

**KFF Health Tracking Poll** Our measure of individuals’ ACA marketplace plan enrollment decisions relies on the Health Tracking Poll, a nationally representative cross-section conducted monthly by the Kaiser Family Foundation (KFF). Uniquely among datasets on health insurance enrollment, the Health Tracking Poll includes questions on partisan affiliation and support, allowing us to separately examine self-reported Republicans, Democrats, and independents. The poll includes questions on demographics, household income, and health insurance coverage; most waves also include a question about health status. We use all 48 waves between 2014 and 2019 that include questions on health status.

To focus our analysis on the relevant population — those who could choose a subsidized plan through an ACA exchange — we restrict our sample to individuals who are aged between 26-64, who are not covered under Medicare or Medicaid, and who are not covered by employer-sponsored health insurance.<sup>4</sup> Our resulting sample, summarized in Columns 1–3 of Table 1, contains 5,152 individuals, 16% of whom purchase coverage in an ACA marketplace.

We group the measure of health status into two discrete bins, approximately corresponding to splitting the sample by half: “Unhealthy” encompasses individuals who report that they are in “Poor”, “Only fair”, or “Good” health (49% of our sample), while “Healthy” encompasses individuals who report they are in “Very good” or “Excellent” health (51% of our sample). We also collapse our five values of partisan affiliation (Republican, Republican-leaning independent, non-leaning independent, Democrat-leaning independent, Democrat) into a single indicator taking value one if the individual is a Republican or a Republican-leaning independent and value zero otherwise. The constructed Republican/non-Republican indicator takes value one for 38.5% of our sample.

The Kaiser Family Foundation provided us with individual-level ZIP code identifiers, allowing us to match individuals to their health insurance rating areas.<sup>5</sup> The menu of plans

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<sup>4</sup>We do not restrict our sample based on income due to missing information on children in the household (which is needed to establish the Federal Poverty Level, FPL, for a household). When we approximate households’ incomes relative to the FPL and limit our analysis to households (roughly) below 400% of the FPL, we find results similar to, and slightly larger in magnitude than, those presented here.

<sup>5</sup>In our preferred specification, we drop individuals living in ZIP codes that are not fully contained in a single rating area. However, our results are virtually unchanged if we instead duplicate these individuals across rating areas and assign each duplicate a regression weight of the percentage of the population of the individual’s ZIP code that lies in the corresponding rating area.

**Table 1: Summary statistics**

	KFF			MEPS			Placebo Survey		
	Overall	Healthy	Unhealthy	Overall	Healthy	Unhealthy	Overall	Healthy	Unhealthy
Age	46.0 (11.8)	45.4 (12.0)	46.7 (11.5)	44.6 (11.2)	43.2 (11.2)	46.3 (10.9)	41.9 (15.1)	41.3 (15.1)	42.3 (15.1)
Male	0.565 (0.496)	0.581 (0.494)	0.549 (0.498)	0.466 (0.499)	0.485 (0.500)	0.443 (0.497)	0.463 (0.499)	0.495 (0.500)	0.442 (0.497)
White	0.778 (0.416)	0.809 (0.393)	0.746 (0.435)	0.709 (0.454)	0.715 (0.452)	0.703 (0.457)	0.810 (0.393)	0.810 (0.392)	0.809 (0.393)
Black	0.141 (0.348)	0.120 (0.325)	0.162 (0.369)	0.181 (0.385)	0.166 (0.372)	0.199 (0.399)	0.090 (0.286)	0.098 (0.298)	0.084 (0.278)
Asian	0.019 (0.137)	0.021 (0.142)	0.017 (0.130)	0.074 (0.262)	0.087 (0.282)	0.059 (0.235)	0.059 (0.236)	0.055 (0.229)	0.062 (0.241)
College degree	0.342 (0.474)	0.450 (0.498)	0.230 (0.421)	0.298 (0.457)	0.383 (0.486)	0.196 (0.397)	0.587 (0.492)	0.681 (0.466)	0.525 (0.499)
Married	0.431 (0.495)	0.466 (0.499)	0.396 (0.489)	0.557 (0.497)	0.595 (0.491)	0.511 (0.500)	0.412 (0.492)	0.478 (0.500)	0.369 (0.483)
Income	45936 (31502)	53682 (31874)	37989 (29049)	58359 (33592)	65438 (32280)	49823 (33158)	73434 (49521)	85918 (51381)	65301 (46508)
Expenditures	—	—	—	5054 (15464)	3021 (9023)	7506 (20453)	—	—	—
Republican	0.385 (0.487)	0.405 (0.491)	0.365 (0.482)	—	—	—	0.439 (0.496)	0.478 (0.500)	0.414 (0.493)
Independent	0.148 (0.355)	0.135 (0.342)	0.161 (0.368)	—	—	—	0.217 (0.412)	0.202 (0.401)	0.227 (0.419)
Democrat	0.467 (0.499)	0.460 (0.498)	0.473 (0.499)	—	—	—	0.344 (0.475)	0.321 (0.467)	0.359 (0.480)
Marketplace insurance	0.158 (0.365)	0.180 (0.384)	0.135 (0.342)	—	—	—	—	—	—
Observations	5152	2609	2543	63113	34499	28614	5809	2290	3515

*Notes:* The first three columns present means and standard deviations of key variables from the KFF subsample used for analysis: individuals who are aged between 26-64, who are not covered under Medicare or Medicaid, and who are not covered by employer-sponsored health insurance. The middle three columns present means and standard deviations of key variables from the MEPS subsample used for analysis: individuals who are aged between 26-64 and who have some form of coverage. The last three columns present means and standard deviations of key variables from the Placebo Insurance sample collected through Lucid and Prolific.

and premiums individuals face is fixed within a rating area in a given year; we observe 399 distinct rating areas and 1383 distinct rating area  $\times$  year cells.<sup>6</sup>

**Medical Expenditure Panel Survey** The data from KFF lack information on individuals' insurable healthcare costs. We therefore turn to the Medical Expenditure Panel Survey (MEPS), a large-scale survey administered by the Department of Health and Human Ser-

<sup>6</sup>While KFF provides sample weights to allow researchers to better match the US population on observables, because we focus on a very particular subgroup of the population, weighting may increase, rather than attenuate, bias (Solon, Haider and Wooldridge, 2015). In most specifications, we thus weight observations equally, though we show that our results are extremely similar if we use the provided survey weights.

vices. The MEPS is the most widely used publicly-available dataset recording individual healthcare spending; it includes each individual’s Census region and a wide range of demographics that overlap with those included in the KFF Health Tracking Poll. We limit the sample to 2014-2019 and to insured individuals who are between the ages of 26 and 64. The resulting sample has 63,113 observations, summarized in Columns 4–6 of Table 1.

**Original Survey on Alternative Insurance Decisions** In June 2023, we fielded a large-scale survey on two survey providers, Prolific and Lucid, to investigate consumption of three alternative forms of insurance: (comprehensive) auto insurance, home or renter’s insurance, and life insurance.<sup>7</sup> To maximize comparability with our KFF analysis, we targeted the same sample size and elicited the same demographics as in the KFF data, including ZIP codes (which we match to rating areas), partisan affiliation, and health status. Dropping those respondents who we are unable to match to a unique rating area or who did not complete the survey ( $n = 283$ ), we are left with 5809 observations, which we summarize in Table 1.

**Descriptive Evidence** The left panel of Figure 1 shows how enrollment varies with partisanship in the raw KFF data. Republicans and Republican-leaning independents represent 39% of our sample, but account for fewer than 30% of marketplace enrollees. The difference in enrollment becomes even more stark if we split the sample by health status.

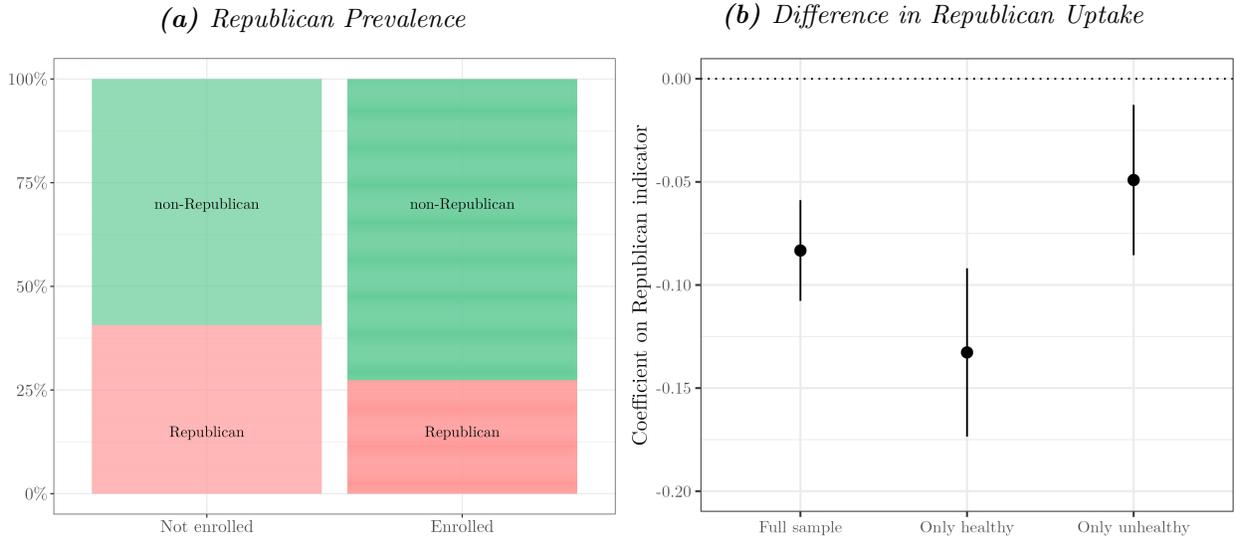
The right-hand panel of Figure 1 shows OLS coefficients from regressing an indicator for ACA Marketplace coverage on a Republican indicator for different samples. Considering the entire sample, Republicans are 8.0% less likely to purchase Marketplace coverage. Yet among healthy survey respondents, Republicans are 12.9% less likely to purchase Marketplace coverage (8.9%-16.9%) than Democrats and independents. In contrast, unhealthy Republicans are only 4.7% less likely to purchase Marketplace coverage (1.1%-8.3%) than unhealthy Democrats and independents.

While these patterns in the raw data are suggestive, they may reflect other characteristics of individuals or of the health insurance markets in which they act that are correlated with partisanship and health and are relevant to insurance choices. In Section 4, we employ a simple empirical strategy allowing us to address these confounds. First, we present a conceptual framework to introduce political enrollment and political adverse selection.

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<sup>7</sup>See Appendix B for the survey instrument.

**Figure 1:** Republican vs. non-Republican enrollment in ACA marketplaces



Notes: Panel A presents the share of Republicans and non-Republicans who comprise the non-enrolled population (left) and the enrolled population (right). Panel B presents OLS coefficients from regressing an indicator for ACA Marketplace coverage on a Republican indicator, using the full sample (left), only healthy individuals (center), and only unhealthy individuals (right).

### 3 Politicization of Policy and Equilibrium Outcomes

**Framework** We extend the canonical model of insurance markets developed by Einav, Finkelstein and Cullen (2010b) — EFC henceforth — to explicitly include partisanship as a determinant of individual choices. A consumer chooses whether to buy insurance or not; our focus is on the extensive margin decision to insure, rather than the intensive margin decision of plan generosity within a market (e.g. Geruso, Layton, McCormack and Shepard, 2019; Marone and Sabety, 2022).

The population of consumers is defined by a distribution  $G$  of types  $\tilde{\zeta}$ . Letting partisanship be denoted by  $\iota \in \{0, 1\}$ ,  $\tilde{\zeta} = (\zeta, \iota)$ , where  $\zeta$  is a generic, multidimensional EFC-type that encompasses non-political determinants of insurance preferences and all determinants of costs. We denote by  $c(\zeta_i)$  the expected monetary cost associated to the insurable risk for individual  $i$ . This is not varying by  $\iota_i$ : we assume that conditional on  $\zeta_i$ , partisanship does not affect healthcare risk or medical care utilization when insured.

Partisanship does affect willingness to pay for insurance. In EFC notation, we let  $\pi(\tilde{\zeta}_i)$  be the maximum premium at which individual  $i$  purchases coverage. If  $\pi(\zeta_i, 0) = \pi(\zeta_i, 1)$ ,

our model is identical to EFC. If instead

$$\begin{aligned} \pi(\zeta, 0) &\geq \pi(\zeta, 1), \text{ with} \\ \pi(\zeta, 0) &> \pi(\zeta, 1) \text{ for at least one value of } \zeta, \end{aligned} \tag{1}$$

the model features what we call *political enrollment*: that is, individuals of partisan affiliation  $\iota = 1$  (Republicans in the ACA context), are willing to pay less for insurance than the other individuals, with  $\iota = 0$  (non-Republicans).

**Political enrollment** Letting  $Q^I(p)$  be the total enrollment given the population  $G$ , and  $Q^{NI}(p)$  the total enrollment given a counterfactual population in which  $\iota_i = 0$  for all  $i$  (holding constant the marginal distribution of  $\zeta$ ),<sup>8</sup> an immediate implication of Equation (1) is:

$$\begin{aligned} Q^I(p) &= \int \mathbf{1}(\pi(\zeta, 0) \geq p) dG(\zeta, 0) + \int \mathbf{1}(\pi(\zeta, 1) \geq p) dG(\zeta, 1) \\ &< \int \mathbf{1}(\pi(\zeta, 0) \geq p) dG(\zeta, 0) + \int \mathbf{1}(\pi(\zeta, 0) \geq p) dG(\zeta, 1) = Q^{NI}(p), \end{aligned} \tag{2}$$

that is, partisan considerations lower total enrollment for a given premium  $p$ .

**Political adverse selection** A key determinant of the equilibrium premium and quantity is the average cost of insured individuals, which can be written as

$$AC^I(p) = \frac{\int c(\zeta) \mathbf{1}(\pi(\zeta, 0) \geq p) dG(\zeta, 0)}{Q^I(p)} + \frac{\int c(\zeta) \mathbf{1}(\pi(\zeta, 1) \geq p) dG(\zeta, 1)}{Q^I(p)}. \tag{3}$$

Removing partisanship from the population, we would have the counterfactual average cost curve

$$AC^{NI}(p) = \frac{\int c(\zeta) \mathbf{1}(\pi(\zeta, 0) \geq p) dG(\zeta, 0)}{Q^{NI}(p)} + \frac{\int c(\zeta) \mathbf{1}(\pi(\zeta, 0) \geq p) dG(\zeta, 1)}{Q^{NI}(p)}. \tag{4}$$

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<sup>8</sup>To avoid ambiguity, since we use  $p$  for premium, we use the superscript  $I$  for situations in which choices may be influenced by political, or *ideological*, considerations, and the superscript  $NI$  for the “standard” situations in which ideological and political considerations do not play any role.

While (2) is simply derived from political enrollment, (1) does not imply a clear ordering of  $AC^I$  and  $AC^{NI}$ . We say that the market features *political adverse selection* if

$$AC^I(p) > AC^{NI}(p), \quad (5)$$

that is, political considerations imply higher average costs for any level of premium  $p$ .

**Testable sufficient conditions for political adverse selection** Trivially, political enrollment is a necessary condition for political adverse selection. But even under political enrollment,  $AC^I(p) = AC^{NI}(p)$  as long as political considerations do not change the cost-composition of the enrollment pool (even if it shrinks its size).

To see this, let

$$f^I(\widehat{c}; p) = \frac{\sum_{\iota=0,1} \int \mathbf{1}(c(\zeta) = \widehat{c}) \mathbf{1}(\pi(\zeta, \iota) \geq p) dG(\zeta, \iota)}{Q^I(p)}, \text{ and} \quad (6)$$

$$f^{NI}(\widehat{c}; p) = \frac{\sum_{\iota=0,1} \int \mathbf{1}(c(\zeta) = \widehat{c}) \mathbf{1}(\pi(\zeta, 0) \geq p) dG(\zeta, \iota)}{Q^{NI}(p)}. \quad (7)$$

The expression in (6) defines the density  $f^I(\widehat{c}; p)$  of expected cost among individuals buying coverage at premium  $p$  when individuals act politically. The density  $f^{NI}(\widehat{c}; p)$  is analogously defined in (7) for the counterfactual situation in which partisanship does not affect consumption.

We can then rewrite

$$AC^I(p) = \int_0^\infty \widehat{c} f^I(\widehat{c}; p) d\widehat{c}, \quad AC^{NI}(p) = \int_0^\infty \widehat{c} f^{NI}(\widehat{c}; p) d\widehat{c}, \quad (8)$$

so that

$$AC^I(p) - AC^{NI}(p) = \int_0^\infty \widehat{c} \underbrace{(f^I(\widehat{c}; p) - f^{NI}(\widehat{c}; p))}_{\text{difference in share of buyers with expected cost } \widehat{c}} d\widehat{c}. \quad (9)$$

A sufficient condition for political adverse selection is that the distribution  $f^I$  first-order stochastically dominates  $f^{NI}$ , since average cost is the expectation of  $\widehat{c}$  taken with respect

to the density corresponding to each scenario, as shown in (8). Formally,

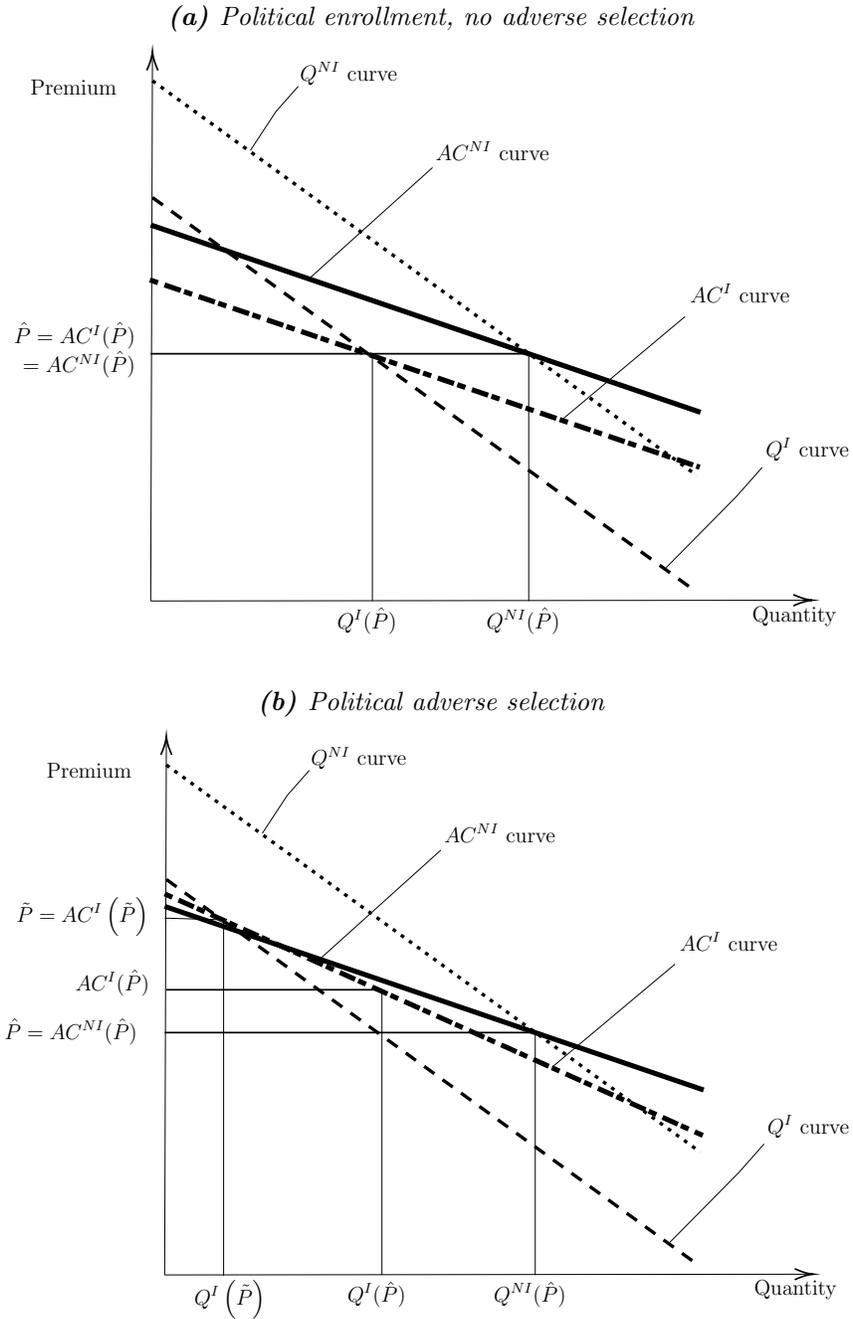
$$\int_0^{\hat{c}} f^I(s; p) - f^{NI}(s; p) ds < 0 \text{ for all } \hat{c} \Rightarrow AC^I(p) > AC^{NI}(p). \quad (10)$$

Thus, political considerations can reduce enrollment, and if they disproportionately reduce enrollment among low-cost individuals, they will also increase the market average cost.

**Equilibrium: graphical analysis** We graphically summarize the case of political enrollment, with no political adverse selection, in Figure 2a. We plot the demand curves  $Q^I$ ,  $Q^{NI}$  and the cost curves  $AC^I$ ,  $AC^{NI}$ . With political considerations, demand and cost intersect at the (competitive) equilibrium premium  $\hat{P}$ , determined by setting  $AC^I(\hat{P}) = \hat{P}$ , and enrollment is equal to  $Q^I(\hat{P})$ . We draw average cost as downward sloping to indicate the presence of adverse selection, as in EFC (see also [Einav and Finkelstein, 2011](#)). In the counterfactual scenario, we remove political considerations, affecting preferences and choices and therefore shifting  $Q^I$  to  $Q^{NI}$  and  $AC^I$  to  $AC^{NI}$ . The market features political enrollment —  $Q^{NI}(\hat{P}) > Q^I(\hat{P})$  — but there is no relationship between expected cost and the effect of partisanship on preferences: the average cost curve shifts upward from  $AC^I$  to  $AC^{NI}$ , and  $AC^I(\hat{P}) = AC^{NI}(\hat{P})$ . This is the case if individuals changing their insurance choice due to partisan considerations do so in a manner orthogonal to their expected costs. That is, under political enrollment depicted in Figure 2a, the size of the market varies when political considerations do or do not affect demand, but the equilibrium premium remains the same.

Figure 2b instead shows political adverse selection, in which choices by riskier individuals are less affected by partisanship than choices by less risky individuals. When this is the case, removing political considerations leads to a shift *and* a rotation of the average cost curve:  $AC^I$  and  $AC^{NI}$  are similar at low enrollment levels and further apart at higher enrollment levels. Political considerations, therefore, affect both equilibrium enrollment and premiums. In Figure 2b,  $\hat{P}$ , defined above as the competitive equilibrium premium for the non-political case, is no longer an equilibrium:  $AC^I(\hat{P}) > Q^I(\hat{P})$ . Because of political adverse selection, insurers must also increase the premium to avoid negative expected profits. The equilibrium premium with political considerations would be the point  $\tilde{P}$ , at which  $AC^I$  and  $Q^I$  intersect; this is higher than  $\hat{P}$ , and equilibrium enrollment would be further reduced (beyond the reduction directly caused by political enrollment) to  $Q^I(\tilde{P})$ . This shows how political factors that differentially affect the enrollment of riskier and less-risky individuals would deteriorate welfare in this market. Even if the  $Q^{NI}(\hat{P}) - Q^I(\hat{P})$  individuals leaving the market due

**Figure 2:** Graphical illustration of political enrollment and political adverse selection



Notes: The figure illustrates political enrollment (top panel) and political adverse selection (bottom panel) using the standard framework of [Einav et al. \(2010a\)](#); [Einav and Finkelstein \(2011\)](#). Curves with the *I* subscripts correspond to a population in which choice is affected by ideology, while curves with the *NI* subscripts correspond to the more “standard” situation in which choice does not depend on ideological or political considerations.

to political considerations are acting rationally (i.e. political preferences over products are welfare relevant) political considerations also affect the  $Q^I(\hat{P}) - Q^I(\tilde{P})$  consumers who find the new equilibrium premium too high and thus leave the market. Furthermore, by increasing premiums, it also reduces the surplus of the remaining  $Q^I(\tilde{P})$  enrollees.

**Application to the ACA context** For high-income households that are not eligible for premium subsidies under the ACA (that is, those above 400% of the FPL), average cost increases are passed through to consumers in the form of higher premiums. For low-income households, the incidence of higher average cost is primarily absorbed by the government (ultimately, the taxpayer), since premium subsidies increase to ensure that households pay no more than the maximum affordable amount. The increase in average subsidies paid by the government is then the difference between average costs with and without political enrollment.

## 4 Empirical Strategy and Results

Our empirical analysis proceeds in three main steps. First, we use the KFF data to measure the impact of partisanship and health status on ACA enrollment. In the language of Section 3, we estimate  $Q^I - Q^{NI}$  and examine whether this difference varies with a component of  $\zeta$  — health status — that affects costs. Second, we consider enrollment in alternative, non-politicized insurance products in our original survey data and examine whether the patterns of differential enrollment we observe are specific to the politicized ACA setting. Finally, we incorporate the cost of insuring individuals given their health status, calculating expected costs for individuals in the KFF survey using estimates obtained from the Medical Expenditure Panel Survey. We then compare the distribution of expected costs among ACA enrollees with and without political considerations influencing enrollment. In addition to testing for the sufficient conditions leading to political adverse selection, our model allows us to quantify the resulting changes in average cost.

## 4.1 Partisanship and ACA Enrollment

We begin with a simple model of the decision to enroll in a marketplace plan. Our primary estimating equation is:

$$Y_{irt} = \delta_{rt} + \beta X_i + \gamma_0 \text{Republican}_i + \gamma_1 \text{Republican}_i \times \text{Healthy}_i + \varepsilon_{irt}, \quad (11)$$

where  $Y_{irt} = 1$  if individual  $i$  in rating area  $r$  and year  $t$  enrolls in the ACA marketplace, and  $Y_{irt} = 0$  otherwise. The key coefficients of interest for our analysis are  $\gamma_0$  and  $\gamma_1$ . If  $\gamma_0 < 0$ , the data shows evidence of political enrollment among the unhealthy; if  $\gamma_1 \neq 0$ , the data shows evidence of *differential* political enrollment among the healthy relative to the unhealthy (that is, political selection). Crucially, we include rating area  $\times$  year fixed effects  $\delta_{rt}$ , so that our estimates are obtained comparing enrollment decisions across individuals who face *identical* options in terms of insurers and number (and type) of plans. We are also include a wide range of individual characteristics  $X_{irt}$ , including the direct effect of  $\text{Healthy}_{irt}$ , a quadratic polynomial in age, a gender indicator and its interaction with age, an indicator for college education or higher, an indicator for marital status, an indicator for white, family size, and seven income brackets. Controls for age and income are particularly important, as these are the only variables that affect premiums within a rating area in a given year.

Panel A of Table 2 presents our estimates for equation (11) across a variety of specifications. We find consistent evidence that Republicans enrolled less than Democrats or independents, and that political differences are far larger for the healthy. In Column 1, our preferred specification, which includes demographic controls (age, age squared, gender, gender  $\times$  age, education, marital status, race, family size, and income) and rating area  $\times$  year fixed effects, we estimate that unhealthy Republicans are four percentage points less likely to enroll than unhealthy Democrats and independents ( $\gamma_0 = -0.042$ ), and that this gap is larger for healthy Republicans ( $\gamma_1 = -0.081$ ). Thus, the enrollment difference between healthy Republicans and healthy Democrats/independents is 12 percentage points, three times larger than the gap between unhealthy Republicans and unhealthy Democrats/independents.

We next probe the robustness of our results to alternative choices of control variables. Column 2 presents a parsimonious specification, including neither the demographic controls nor the rating area  $\times$  year fixed effects. We continue to find significant political enrollment and large and significant political adverse selection. Column 3 includes the demographic controls but not the rating area  $\times$  year fixed effects, thus exploiting variation both across

**Table 2:** Predictive effects of partisanship and health on marketplace enrollment

	Individual is on marketplace plan					
	(1)	(2)	(3)	(4)	(5)	(6)
	<b>Panel A</b>			OLS		
Republican	-0.042*** (0.016)	-0.035** (0.014)	-0.058*** (0.015)	-0.087 (0.189)	-0.044** (0.022)	-0.037** (0.016)
Republican × healthy	-0.081*** (0.023)	-0.084*** (0.019)	-0.075*** (0.019)	-0.061** (0.025)	-0.086*** (0.032)	-0.073*** (0.022)
	<b>Panel B</b>			Logit		
Republican	-0.527*** (0.196)	-0.310** (0.127)	-0.505*** (0.137)	-1.748 (2.566)	-0.459** (0.231)	-0.584** (0.231)
Republican × healthy	-0.748*** (0.275)	-0.572*** (0.164)	-0.502*** (0.174)	-0.628** (0.290)	-0.724** (0.354)	-0.677** (0.308)
Demographic controls	Yes	No	Yes	Yes	Yes	Yes
Demographic controls × Republican	No	No	No	Yes	No	No
Rating area × year FE	Yes	No	No	Yes	Yes	Yes
Sample restrictions	None	None	None	None	Large cells	None
Survey weights	No	No	No	No	No	Yes
Observations	5152	5152	5152	5152	2250	5151
Dep. var. mean	0.158	0.158	0.158	0.158	0.157	0.158
Dep. var. std. dev.	0.365	0.365	0.365	0.365	0.364	0.365

*Notes:* Table presents coefficient estimates from regressions of an indicator for whether the individual is on a Marketplace plan on an indicator for whether the individual is a Republican or a Republican-leaning independent, an indicator for whether the individual is healthy, and the interaction of the two. Demographic controls include age, age squared, gender, gender × age, college degree, marital status, race (whether white or not), family size, and income. Column 4 includes the interactions between all controls and the Republican indicator. Column 5 keeps only individuals in rating area × year cells for which the KFF data contain ten or more observations meeting our sample restrictions. Column 6 weights observations by KFF’s provided sample weights. Standard errors are clustered at the state × year level.

and within rating area × year cells. We find effects here that are very similar to our baseline. To examine whether the lower enrollment we observe among healthy Republicans reflects the effects of some other characteristic correlated with health, Column 4 reports a specification that includes our baseline controls (in Column 1) as well as the interaction of all controls with a Republican indicator. In Column 5, we restrict our sample to individuals living in “large” rating area × year cells (those in which there are at least ten individuals in the KFF data who meet our sample restrictions), to ensure that our findings are not driven by very small cells. Finally, in Column 6, we weight individuals by KFF’s provided survey weights. Across all alternative sample restrictions and weighting choices, we continue to estimate economically and statistically significant political adverse selection.

It is worth noting that we are unable to distinguish among precise mechanisms underlying

Republicans’ differential enrollment in ACA marketplace plans. For example, Republicans may face a welfare-relevant expressive cost of enrolling in marketplace plans, or they may have different beliefs about marketplace plan quality. Since we are unable to assess the microfoundations, we do not consider partisanship in a normative assessment of enrollment decisions.<sup>9</sup> We instead focus on the impact of partisanship on enrollment and costs.

**Logit model** Measuring the implications of political considerations for selection and average cost requires to construct the counterfactual composition of enrollment without political considerations, which depends on the probability of enrollment after removing the effects of ideology highlighted above. We thus estimate a binary logit model with indirect utility corresponding to the right-hand side of equation (11). Panel B of Table 2 reports the results.

We consistently find coefficient estimates in line with the OLS results in Panel A. In our preferred specification (Column 1) we find that unhealthy Republicans are less likely to enroll than unhealthy Democrats and independents; the coefficient estimate of  $-0.527$  translates to a marginal effect of  $-0.128$ . Our primary interaction of interest demonstrates that healthy Republicans are differentially less likely to enroll: the coefficient on  $\text{Republican} \times \text{healthy}$  is  $-0.748$  (marginal effect =  $-0.099$ ). As shown in Columns 2–6 of Panel B, the logit estimates, too, are robust to including fewer or more controls, exploiting variation across or only within rating area  $\times$  years, examining only either all rating area  $\times$  year cells or only large cells, or applying survey weights.

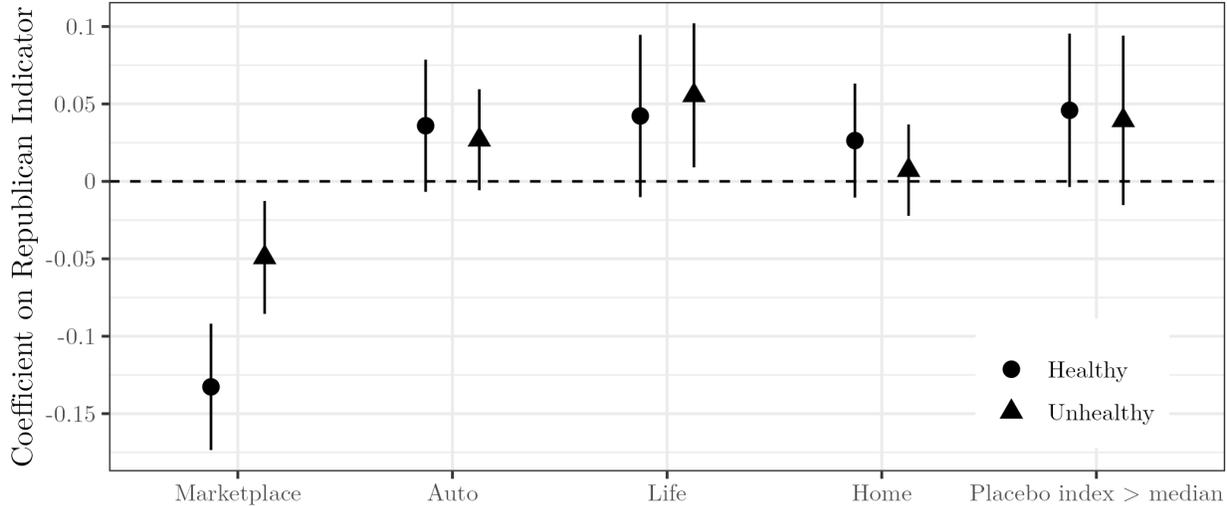
Based on these demand parameters, we compute the counterfactual probability of enrollment without political considerations by setting  $\text{Republican}_i = 0$  for all individuals. We estimate that overall enrollment would be 4 percentage points higher (or 25% higher) if demand was unresponsive to partisan affiliation. As a back of the envelope calculation, since total enrollment in ACA marketplaces fluctuated between 10 and 20 million between 2014 and 2019 (Handel and Kolstad, 2021), extrapolating our estimates implies that approximately 3-4 million more individuals would have enrolled in the absence of political considerations during the same time period.

**Placebo outcomes** Our results thus far suggest that holding fixed supply-side factors, Republicans are less likely to enroll in ACA coverage, and this effect is stronger among healthy Republicans. Is this because these individuals have different preferences for insurance

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<sup>9</sup>See Handel and Schwartzstein (2018) for a discussion of these distinctions in health insurance choice generally and Handel and Kolstad (2021) for a discussion of how these factors may impact assessment of the ACA exchanges.

**Figure 3: Difference in Republican uptake for alternative insurance products**



*Notes:* Figure presents coefficient estimates from regressions of five binary variables on an indicator for whether the individual is a Republican or a Republican-leaning independent, estimated separately for healthy and unhealthy individuals. The outcomes are whether an individual is enrolled in a marketplace plan, enrolled in one of three placebo insurance plans, and an indicator for whether an inverse covariance-weighted index of the three placebo outcomes is above its median value. All regressions include rating area  $\times$  year fixed-effects. The demographic controls used in all regressions include age, age squared, gender, gender  $\times$  age, college degree, marital status, race (whether white or not), family size, and income. Standard errors are clustered at the state level.

products that we do not control for, and might therefore be differentially likely to select *any* insurance product, or are these patterns specific to the ACA context?

Drawing upon our survey data summarized in Table 1, we re-estimate our preferred specification from Table 2 with three alternative (binary) outcomes: enrollment in comprehensive auto insurance, enrollment in home or renters insurance, and enrollment in life insurance. We define a fourth binary outcome as an indicator of whether an inverse covariance-weighted index of the three placebo outcomes is above its median value.

In Figure 3 we summarize our main finding: in contrast to the statistically significant differential selection of (healthy) Republicans out of ACA marketplaces, we find neither evidence of political enrollment nor political adverse selection for these three alternative products.<sup>10</sup> This difference supports our view that the ACA enrollment patterns we document are indeed driven by political considerations.

<sup>10</sup>Appendix Table A.1 presents results with coefficient estimates.

## 4.2 Partisanship and Costs in ACA Marketplaces

To quantify the extent to which political enrollment and selection impacted average costs and public spending, we need to link our enrollment model to a model of expected medical spending. This is necessary because the KFF data include partisan affiliation, demographic information, and health indicators but do not contain information on medical spending. The MEPS data, in contrast, include medical spending, demographic information, and health indicators but do not contain information on political positions.

Using the MEPS data, we predict expected healthcare costs that can then be linked to individuals in the KFF data. Specifically, we estimate

$$C_{ict} = \phi_{ct} + \eta X_{ict} + \omega_{ict}, \quad (12)$$

where  $C_{ict}$  is the total annual healthcare spending for individual  $i$ , living in Census region  $c$ , in year  $t$ . The demographic controls included in  $X_{ict}$  are an indicator  $\text{Healthy}_{ict}$ , a quadratic polynomial in age, a gender indicator and its interaction with age, an indicator for college education or higher, an indicator for whether the respondent is white, an indicator for whether the respondent is married, family size, and seven income brackets.<sup>11</sup> We report detailed estimation results in Appendix Table A.2.

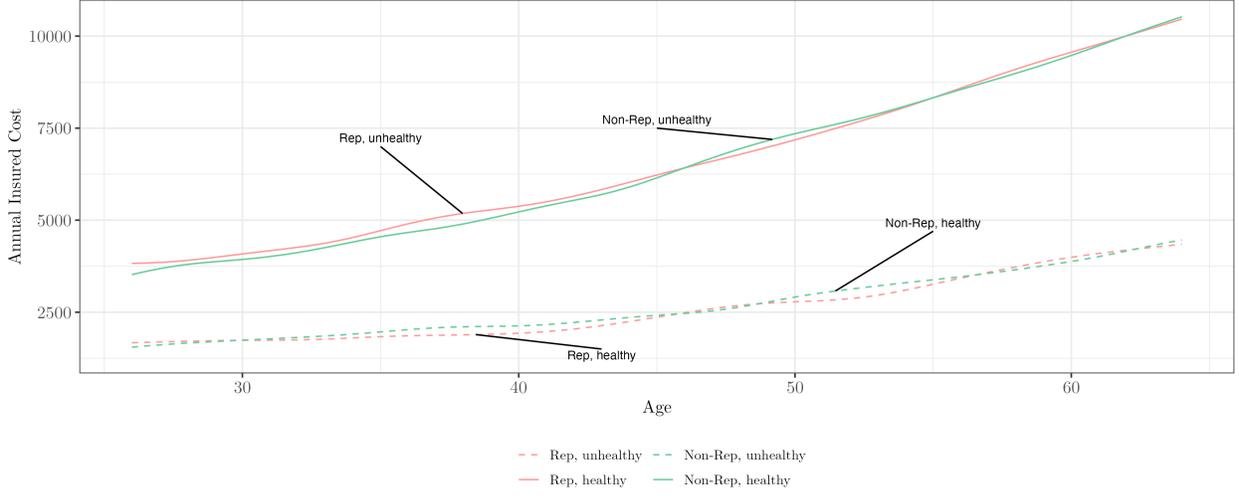
Using these estimates, we impute predicted annual spending for every individual in the KFF sample.<sup>12</sup> In Figure 4 we summarize the resulting cost measure ( $\hat{c}_{irt} = 0.75(\hat{\phi}_{c(r)t} + \hat{\eta}X_{irt})$ ) by plotting its mean across buyers of different age (horizontal axis), health status, and political position. Although Equation (12) cannot include political affiliation (not observable in the MEPS), the small differences in cost between Republican and non-Republican are due to the correlations between political positions and other controls (income, gender, marital status, education, race, etc.). These differences are negligible when compared to the differences across age and health status. The correlation between political position and age,

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<sup>11</sup>We replace the rating area  $\times$  year indicators used above with Census region  $\times$  year indicators because MEPS does not include disaggregated rating area identifiers, and we omit the Republican indicator and its interaction with  $\text{Healthy}_{ict}$  because MEPS does not include partisan affiliation. We maintain the assumption that costs and partisan affiliation are conditionally independent after controlling for our rich set of covariates (this is equivalent to  $c(\zeta) = c(\zeta)$  in Section 3).

<sup>12</sup>To be conservative in our calculations, we adjust our cost model for the fact that insurers (and the government) do not cover all healthcare spending. Under the ACA, consumers are responsible to pay approximately 25% of their annual medical costs. Therefore, we adjust the fitted value by this factor. Our main results are robust to varying this factor, since we focus on interpreting relative changes in average costs. Imposing cost sharing between 20-35%, we estimate average costs in the ACA marketplaces that match average costs from other sources (Saltzman, 2021; Tebaldi, 2024).

**Figure 4:** Predicted Costs by Partisan Affiliation, Age and Health Status



Notes: Figure presents average predicted insured costs as a function of age, split by Republican vs. non-Republican survey respondents and by healthy vs. unhealthy respondents.

and the extent to which healthy Republicans disproportionately choose to not enroll in ACA plans, will be the main drivers of our results.

The combination of demand and cost estimates allows us to compute the effect of partisanship on average cost. The cumulative density functions of expected costs among ACA enrollees with political considerations “turned on,”  $\hat{F}^I(\hat{c})$ , and political considerations “turned off,”  $F^{NI}(\hat{c})$ , are

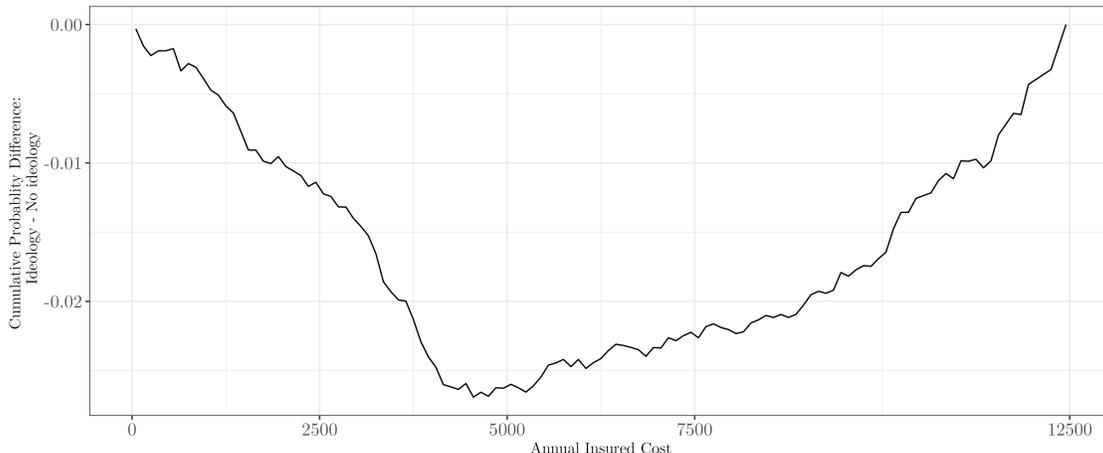
$$\hat{F}^I(\hat{c}) = \frac{\sum_{i:\hat{c}_{irt} \leq \hat{c}} \hat{\sigma}_{irt}^I}{\sum_i \hat{\sigma}_{irt}^I}, \quad \hat{F}^{NI}(\hat{c}) = \frac{\sum_{i:\hat{c}_{irt} \leq \hat{c}} \hat{\sigma}_{irt}^{NI}}{\sum_i \hat{\sigma}_{irt}^{NI}}, \quad (13)$$

where  $\hat{\sigma}_{irt}^I$  is the predicted probability of enrollment from the logit model estimated above (incorporating political enrollment), and  $\hat{\sigma}_{irt}^{NI}$  is the corresponding probability of enrollment from the same logit model, where we set the Republican indicator to zero (i.e.  $\gamma_0 = \gamma_1 = 0$ ).

As shown in Equation (10), a sufficient condition for political adverse selection is that  $\hat{F}^I(\hat{c}) - \hat{F}^{NI}(\hat{c}) < 0$  for all  $\hat{c}$ . Figure 5 shows that this condition indeed holds: the empirical density of costs among ACA enrollees with political considerations is always lower than the counterfactual density induced by non-political demand. Thus, our empirical model implies that  $AC^I > AC^{NI}$ .

To quantify the difference, we compute the two quantities as the weighted mean of pre-

**Figure 5:** Sufficient condition for political adverse selection:  $\widehat{F}^I(\widehat{c}) - \widehat{F}^{NI}(\widehat{c})$



*Notes:* Figure presents the difference between the CDF of predicted cost when partisanship is allowed to influence enrollment decisions vs. when it does not influence enrollment decisions.

dicted costs, where the weights are given by  $\widehat{\sigma}_{irt}^I$  for  $\widehat{AC}^I$  and  $\widehat{\sigma}_{irt}^{NI}$  for  $\widehat{AC}^{NI}$ :

$$\widehat{AC}^I = \frac{\sum_i \widehat{c}_{irt} \widehat{\sigma}_{irt}^I}{\sum_i \widehat{\sigma}_{irt}^I}, \text{ and } \widehat{AC}^{NI} = \frac{\sum_i \widehat{c}_{irt} \widehat{\sigma}_{irt}^{NI}}{\sum_i \widehat{\sigma}_{irt}^{NI}}. \quad (14)$$

Table 3 summarizes our results. We estimate that political adverse selection increased average (per enrollee) cost in ACA marketplaces from \$4656 to \$4780, corresponding to a 2.66% increase. This effect is primarily driven by the increase in adverse selection amongst Republicans because healthy Republicans are less likely to enroll than their Democratic and independent counterparts. In the Republican subsample, we find that political considerations increased average cost by 11.49%.

Political preferences are geographically heterogeneous, which leads to meaningful differences in the magnitude of political adverse selection across markets. Columns 3-5 of Table 3 demonstrate these differences. In rating areas in which Republicans comprise less than 30% of the population, we estimate that political adverse selection increased costs by 1.20%. In contrast, in rating areas in which Republicans comprise more than 60% of the population, political adverse selection increased costs by 5.82%, while it increased costs in rating areas with intermediate levels of Republicans (30-60%) by 3.62%. Across states, the 25 states with below-median share of Republican enrollees experienced cost increases due to political adverse selection of around half the size of the increases experienced by the states with above-median Republican enrollees share (2.14% instead of 4.02%).

**Table 3:** Change in average cost due to political adverse selection

	Full Sample	Only Republican	By ACA Rating Region			By State	
			<30% Republican	30-60% Republican	>60% Republican	25 Least Republican	25 Most Republican
$\widehat{AC}^I$	\$4780	\$5289	\$4633	\$4835	\$5287	\$4672	\$5024
$\widehat{AC}^{NI}$	\$4656	\$4744	\$4578	\$4666	\$4996	\$4574	\$4830
$\frac{\widehat{AC}^I - \widehat{AC}^{NI}}{\widehat{AC}^{NI}}\%$	+2.66%	+11.49%	+1.20%	+3.62%	+5.82%	+2.14%	+4.02%

*Notes:* Table presents average costs in the marketplaces when partisan considerations influence enrollment decisions ( $\widehat{AC}^I$ ) and counterfactual average costs when partisan considerations do not influence enrollment decisions ( $\widehat{AC}^{NI}$ ). Column 1 presents average costs among the full sample; Column 2 presents average costs among Republican enrollees; Columns 3–5 present average costs among enrollees living in rating areas in which Republicans comprise fewer than 30%, 30-60%, and greater than 60% of the enrollees, respectively; and Columns 6–7 present average costs among enrollees living in states with the share of Republican enrollees below and above the median, respectively.

## 5 Politicization of Policy and Self-Fulfilling Prophecies

Our findings suggest that partisanship and partisan narratives affect not only which policies are adopted (Della Vigna and Kim, 2022), but also how these policies perform. In our setting, this may, in turn, have *reinforced* the partisan differences that existed upon the law’s passage: individuals in rating areas with more Republicans (and thus more healthy Republicans) are more likely to see anemic ACA marketplaces with higher costs than individuals in rating areas with more Democrats. This endogenous outcome of political adverse selection may thus reinforce Republicans’ unfavorable views of the ACA.

We explore whether the data supports this possibility. Using data on individuals’ *perceptions* of the ACA from the KFF Health Tracking Poll, we estimate the equation:

$$P_i = \phi_0 S_{r(i)}^R + \phi_1 S_{r(i)}^H + \phi_2 S_{r(i)}^{HR} + X_i \beta + \varepsilon_{irt}. \quad (15)$$

The outcome of interest is  $P_i$ , which takes value  $P_i = 1$  if individual  $i$  reports being “very favorable” or “somewhat favorable” towards the ACA and  $P_i = 0$  otherwise.  $S_{r(i)}^R$  is the share of eligible buyers in  $i$ ’s rating area of residence who are Republicans;  $S_{r(i)}^H$  is the share of healthy individuals, and  $S_{r(i)}^{HR}$  is the share of healthy Republicans. The controls  $X_i$  include individual demographics used in Section 4, individual health, individual partisanship, the interaction of individual health and partisanship, year fixed effects, and a set of county-level controls: share under the federal poverty line, median household income, unemployment

**Table 4:** Political spillovers on favorability toward the ACA

	Favorable toward the ACA				
$\phi$ :					
Share Republican	-0.604*** (0.057)	-0.606*** (0.054)	-0.199*** (0.047)	-0.141*** (0.047)	-0.082 (0.051)
Share healthy	0.369*** (0.051)	0.366*** (0.047)	0.254*** (0.039)	0.219*** (0.039)	0.086** (0.043)
Share healthy Republican	-0.295*** (0.092)	-0.288*** (0.087)	-0.203*** (0.075)	-0.200*** (0.075)	-0.128* (0.077)
$\beta$ :					
Republican			-0.525*** (0.007)	-0.502*** (0.008)	-0.501*** (0.008)
Healthy			0.048*** (0.006)	0.040*** (0.006)	0.038*** (0.006)
Republican $\times$ healthy			-0.075*** (0.008)	-0.075*** (0.008)	-0.074*** (0.008)
Year FE	No	Yes	Yes	Yes	Yes
Ind. demographic controls	No	No	No	Yes	Yes
County demographic controls	No	No	No	No	Yes
Observations	43640	43640	43640	43640	43640
Dep. var. mean	0.503	0.503	0.503	0.503	0.503
Dep. var. std. dev.	0.500	0.500	0.500	0.500	0.500

*Notes:* The dependent variable is an indicator for whether the individual reports being very favorable or somewhat favorable towards the ACA. Share Republican is the share of Republicans within the individual's rating area. Share healthy is the share of healthy individuals within the individual's rating area. Share healthy Republican is the share of healthy Republicans within the individual's rating area. All shares are calculated leaving out the individual themselves. Individual demographic controls include age, age squared, gender, gender  $\times$  age, college degree, marital status, race (whether white or not), family size, and income. County demographic controls are as of 2018 and include the rating area's share under the FPL, median household income, unemployment rate, share with a high school degree, share with a college degree, log population, log population density, share white, share black, share Hispanic, share over the age of 65, share under the age of 18, and the age-adjusted average number of physically unhealthy days reported in the past 30 days. We keep individuals in rating area  $\times$  year cells for which the KFF data contains ten or more observations meeting our sample restrictions. Standard errors are clustered at the state  $\times$  year level.

rate, share with high school and college degrees, log population, log population density, shares white, black, and Hispanic, shares over the age of 65 and under the age of 18, and the average (age-adjusted) number of days residents reported being unable to work due to physical health issues.

Table 4 shows results. We document across specifications a robust, negative relationship between favorability toward the ACA and the share of healthy Republicans in the rating area (see also [Hobbs and Hopkins, 2021](#)): even controlling for a respondent’s own political affiliation (Democrat, independent, or Republican), and observable characteristics of the county, there is a negative correlation between the share of individuals in the same area who are Republican — and, therefore, the magnitude of political adverse selection as shown in Table 3 — and favorable opinions on the reform.

Although we emphasize that these results do not have an immediate causal interpretation, they are suggestive of the extent to which political adverse selection may have led negative political views of the reform to become self-fulfilling prophecies. By worsening market outcomes — or even by increasing uncertainty about the future nature of the policy (e.g. [Luttmer and Samwick 2016](#)) — political adverse selection may also facilitate a dynamic process through which negative views become factual even if they were not at the outset. We view providing more definitive evidence on the potential for “narrative entrepreneurs” to exploit these dynamics to undermine policy outcomes as a promising direction for future research.

## 6 Conclusion

We argue that when a reform is politicized, the relationship between individuals’ partisan identity and their (policy-relevant) underlying characteristics can be an important determinant of the policy’s success. If the reform’s objective is to alter the equilibrium in a market with externalities, political polarization may have meaningful economic consequences.

This paper highlights this mechanism and provides empirical evidence from one of the most politically-divisive policy reforms undertaken by the US federal government in decades: the Affordable Care Act (ACA). We find that Republicans enrolled less in the newly created, highly subsidized marketplaces, and that this effect was stronger among healthy Republicans. We show that partisan identity, and the political adverse selection it induced, affected not only the size of the program but also its average cost. We provide suggestive evidence that this partisan adverse selection may also facilitate a dynamic process through which negative narratives translate into consumer behavior, undermining the policy and thus making those original narratives factual even if they were not at the outset.

As polarization and trust in institutions continue to decline, both in the United States and in Western Europe ([Draca and Schwarz, 2020](#)), the performance of the ACA might

foreshadow a future in which public policy is increasingly undermined by political behavior and fake and misleading information (Guriev, Henry, Marquis and Zhuravskaya, 2023). Particularly in settings where individuals’ engagement with government programs generates externalities — such as vaccination campaigns or public education — political adverse selection may have significant consequences for the effectiveness of public policy.

## References

- Aizawa, Naoki**, “Labor market sorting and health insurance system design,” *Quantitative Economics*, 2019, 10 (4), 1401–1451. 3
- Atal, Juan Pablo, José Ignacio Cuesta, Felipe González, and Cristóbal Otero**, “The economics of the public option: Evidence from local pharmaceutical markets,” *Available at SSRN*, 2021. 3
- Atkin, David, Eve Colson-Sihra, and Moses Shayo**, “How do we choose our identity? a revealed preference approach using food consumption,” *Journal of Political Economy*, 2021, 129 (4), 1193–1251. 3
- Berry, Steven T. and Joel Waldfogel**, “Free Entry and Social Inefficiency in Radio Broadcasting,” *The RAND Journal of Economics*, 1999, 30 (3), 397–420. 3
- Brodie, Mollyann, Elizabeth C. Hamel, Ashley Kirzinger, and Drew E. Altman**, “The past, present, and possible future of public opinion on the ACA,” *Health Affairs*, 2020, 39 (3), 462–470. 1, 5
- Chandra, Amitabh, Benjamin Handel, and Joshua Schwartzstein**, “Behavioral economics and health-care markets,” in “Handbook of Behavioral Economics: Applications and Foundations 1,” Vol. 2, Elsevier, 2019, pp. 459–502. 3
- Curto, Vilsa, Liran Einav, Amy Finkelstein, Jonathan Levin, and Jay Bhattacharya**, “Health care spending and utilization in public and private Medicare,” *American Economic Journal: Applied Economics*, 2019, 11 (2), 302–32. 2
- DellaVigna, Stefano and Woojin Kim**, “Policy Diffusion and Polarization across U.S. States,” Working Paper 30142, National Bureau of Economic Research, 2022. 2, 22
- Dickstein, Michael J., Mark Duggan, Joe Orsini, and Pietro Tebaldi**, “The impact of market size and composition on health insurance premiums: Evidence from the first year of the affordable care act,” *American Economic Review*, 2015, 105, 120–125. 3
- Dinerstein, Michael and Troy D Smith**, “Quantifying the supply response of private schools to public policies,” *American Economic Review*, 2021, 111 (10), 3376–3417. 3
- Draca, Mirko and Carlo Schwarz**, “How polarized are citizens? Measuring ideology from the ground-up,” *Measuring Ideology from the Ground-Up (June 1, 2020)*, 2020. 24
- Duggan, Mark and Fiona M Scott Morton**, “The distortionary effects of government procurement: evidence from Medicaid prescription drug purchasing,” *The Quarterly Journal of Economics*, 2006, 121 (1), 1–30. 3

- Einav, Liran, Amy Finkelstein, and Jonathan Levin**, “Beyond testing: Empirical models of insurance markets,” *Annual Review of Economics*, 2010, *2* (1), 311–336. 3, 13
- , – , and **Mark R Cullen**, “Estimating welfare in insurance markets using variation in prices,” *The Quarterly Journal of Economics*, 2010, *125* (3), 877–921. 1, 9
- and – , “Selection in insurance markets: Theory and empirics in pictures,” *Journal of Economic Perspectives*, 2011, *25* (1), 115–38. 12, 13
- Epple, Dennis and Richard E Romano**, “Competition between private and public schools, vouchers, and peer-group effects,” *American Economic Review*, 1998, pp. 33–62. 2
- Ericson, Keith Marzilli and Amanda Starc**, “Measuring consumer valuation of limited provider networks,” *American Economic Review*, 2015, *105* (5), 115–119. 3
- Fouka, Vasiliki and Hans-Joachim Voth**, “Reprisals remembered: German-Greek conflict and car sales during the Euro crisis,” Discussion Paper DP9704, Center for Economic and Policy Research, 2013. 3
- Gentzkow, Matthew**, “Polarization in 2016,” *Working Paper*, 2016, pp. 1–23. 2
- Geruso, Michael, Timothy J Layton, Grace McCormack, and Mark Shepard**, “The two margin problem in insurance markets,” *The Review of Economics and Statistics*, 2019, pp. 1–46. 9
- Gollust, Sarah E., Erika Franklin Fowler, and Jeff Niederdeppe**, “Ten Years of Messaging about the Affordable Care Act in Advertising and News Media: Lessons for Policy and Politics,” *Journal of Health Politics, Policy and Law*, October 2020, *45* (5), 711–728. 5
- Guriev, Sergei, Emeric Henry, Théo Marquis, and Ekaterina Zhuravskaya**, “Cur-tailing False News, Amplifying Truth,” *SSRN Electronic Journal*, 2023. 25
- Hackmann, Martin B., Jonathan T. Kolstad, and Amanda E. Kowalski**, “Health reform, health insurance, and selection: Estimating selection into health insurance using the massachusetts health reform,” *American Economic Review*, 2012, *102* (3), 498–501. 3
- , – , and – , “Adverse selection and an individual mandate: When theory meets practice,” *American Economic Review*, 2015, *105* (3), 1030–1066. 3
- Handel, Ben and Jonathan Kolstad**, *Getting the Most from Marketplaces: Smart Policies on Health Insurance Choices*, Brookings Institution Washington (DC), 2015. 3
- and **Kate Ho**, “The industrial organization of health care markets,” in “Handbook of Industrial Organization,” Vol. 5, Elsevier, 2021, pp. 521–614. 4
- Handel, Benjamin and Joshua Schwartzstein**, “Frictions or mental gaps: what’s behind the information we (don’t) use and when do we care?,” *Journal of Economic Perspectives*, 2018, *32* (1), 155–78. 17
- , **Igal Hendel, and Michael D. Whinston**, “Equilibria in health exchanges: Adverse selection versus reclassification risk,” *Econometrica*, 2015, *83*, 1261–1313. 3

- Handel, Benjamin R and Jonathan T Kolstad**, “The Affordable Care Act After a Decade: Industrial Organization of the Insurance Exchanges,” Working Paper 29178, National Bureau of Economic Research, 2021. 4, 17
- Hobbs, William R and Daniel J Hopkins**, “Offsetting Policy Feedback Effects: Evidence from the Affordable Care Act,” *The Journal of Politics*, 2021, 83 (4), 1800–1817. 3, 5, 24
- Iyengar, Shanto, Yphtach Lelkes, Matthew Levendusky, Neil Malhotra, and Sean J. Westwood**, “The Origins and Consequences of Affective Polarization in the United States,” *Annual Review of Political Science*, 2019, 22 (1), 129–146. 2
- Jaffe, Sonia and Mark Shepard**, “Price-linked subsidies and imperfect competition in health insurance,” *American Economic Journal: Economic Policy*, 2020, 12 (3), 279–311. 4
- Layton, Timothy J, Ellen Montz, and Mark Shepard**, “Health Plan Payment in US Marketplaces: regulated competition with a weak mandate,” in “Risk Adjustment, Risk Sharing and Premium Regulation in Health Insurance Markets,” Elsevier, 2018, pp. 491–522. 4
- Lerman, Amy E., Meredith L. Sadin, and Samuel Trachtman**, “Policy uptake as political behavior: Evidence from the affordable care act,” *American Political Science Review*, 2017, 111 (4), 755–770. 3
- Luttmer, Erzo F.P.**, “Group Loyalty and the Taste for Redistribution,” *Journal of Political Economy*, 2001, 109 (3), 500–528. 5
- **and Andrew A. Samwick**, “The Welfare Cost of Perceived Policy Uncertainty: Evidence from Social Security,” *American Economic Review*, 2016, 106 (10), 2988–3019. 24
- Marone, Victoria R and Adrienne Sabety**, “When Should There Be Vertical Choice in Health Insurance Markets?,” *American Economic Review*, 2022, 112 (1), 304–42. 9
- McConnell, Christopher, Yotam Margalit, Neil Malhotra, and Matthew Levendusky**, “The economic consequences of partisanship in a polarized era,” *American Journal of Political Science*, 2018, 62, 5–18. 3
- Michener, Jamila**, “Race, Politics, and the Affordable Care Act,” *Journal of Health Politics, Policy and Law*, August 2020, 45 (4), 547–566. 5
- Nardotto, Mattia and Sandra Sequeira**, “Identity, Media and Consumer Behavior,” Discussion Paper DP15765, Center for Economic and Policy Research, 2021. 3
- Oberlander, Jonathan**, “The Ten Years’ War: Politics, Partisanship, And The ACA: An exploration of why the Affordable Care Act has been so divisive despite the law’s considerable accomplishments,” *Health Affairs*, March 2020, 39 (3), 471–478. 5
- Orsini, Joe and Pietro Tebaldi**, “Regulated age-based pricing in subsidized health insurance: Evidence from the Affordable Care Act,” Working Paper 2017-02, Becker Friedman Institute for Research in Economics, 2017. 3
- Saltzman, Evan**, “Managing adverse selection: underinsurance versus underenrollment,” *The RAND Journal of Economics*, 2021, 52 (2), 359–381. 19

- Sances, Michael W. and Joshua D. Clinton**, “Who participated in the ACA? Gains in insurance coverage by political partisanship,” *Journal of Health Politics, Policy, and Law*, June 2019, *44* (3), 349–379. 3, 5
- Solon, Gary, Steven J Haider, and Jeffrey M Wooldridge**, “What are we weighting for?,” *Journal of Human resources*, 2015, *50* (2), 301–316. 7
- Tebaldi, Pietro**, “Estimating Equilibrium in Health Insurance Exchanges: Price Competition and Subsidy Design under the ACA,” *The Review of Economic Studies*, 02 2024, p. rdae020. 3, 4, 19
- Trachtman, Samuel**, “Polarization, participation, and premiums: How political behavior helps explain where the ACA works, and where it doesn’t,” *Journal of Health Politics, Policy, and Law*, December 2019, *44* (6), 855–884. 3, 5

# Online Appendix:

## Not for publication

### A Appendix Figures and Tables

**Table A.1:** *Predictive effects of partisanship and health on alternative insurance decisions*

	Panel A OLS			
	Auto	Home	Life	Index > median
Republican	0.035** (0.014)	0.018 (0.018)	0.059*** (0.018)	0.040* (0.020)
Republican $\times$ healthy	-0.002 (0.024)	0.005 (0.026)	-0.021 (0.029)	0.008 (0.034)
	Panel B Logit			
	Auto	Home	Life	Index > median
Republican	0.193** (0.082)	0.018 (0.018)	0.302*** (0.094)	0.192* (0.110)
Republican $\times$ healthy	-0.010 (0.146)	0.005 (0.026)	-0.110 (0.146)	0.051 (0.183)
Demographic controls	Yes	Yes	Yes	Yes
Rating area FE	Yes	Yes	Yes	Yes
Observations	5319	4360	5248	4243
Dep. var. mean	0.525	0.773	0.494	0.482
Dep. var. std. dev.	0.499	0.419	0.500	0.500

*Notes:* Table presents coefficient estimates from regressions of four binary variables on an indicator for whether the individual is a Republican or a Republican-leaning independent, an indicator for whether the individual is healthy, and the interaction of the two. In Columns 1-3 the outcome is an indicator for whether the individual is enrolled in a placebo insurance plan. In Column 4 the outcome is an indicator for whether an inverse covariance-weighted index of the three placebo outcomes is above its median value. Demographic controls include age, age squared, gender, gender  $\times$  age, college degree, marital status, race (whether white or not), family size, and income. Standard errors are clustered at the state level.

**Table A.2:** *MEPS cost estimates*

	Total cost (yearly)			
Healthy	-4857.976*** (255.070)	1274.909** (593.813)	1325.639** (583.529)	1389.158** (583.475)
Age	-180.779*** (44.191)	-26.114 (44.614)	-21.580 (44.783)	-7.910 (44.452)
Age squared	3.481*** (0.523)	2.723*** (0.518)	2.664*** (0.521)	2.492*** (0.516)
Male	-2523.617*** (254.181)	-3059.494*** (391.404)	-3099.816*** (397.159)	-2972.691*** (403.838)
Male $\times$ age	28.957*** (7.900)	35.084*** (7.233)	35.610*** (7.303)	33.767*** (7.234)
College	612.872*** (187.160)	695.624*** (188.577)	621.760*** (195.901)	583.774*** (180.188)
White	972.757*** (170.666)	1026.811*** (169.821)	994.459*** (168.621)	1023.494*** (169.852)
Marital status	-0.872 (221.755)	55.375 (221.968)	100.624 (206.896)	154.335 (187.144)
Family size	-457.517*** (47.796)	-460.795*** (46.077)	-473.164*** (44.851)	-478.084*** (49.275)
Healthy $\times$ age		-149.513*** (13.346)	-150.537*** (13.366)	-150.210*** (13.190)
Healthy $\times$ male		380.314 (379.565)	400.480 (382.263)	369.248 (384.331)
RMSE	15287.41	15259.10	15231.40	15219.58
Census region $\times$ year FE	No	No	Yes	Yes
Income category FE	No	No	No	Yes
Observations	61980	61980	61980	61980
RMSE	15287.41	15259.10	15231.40	15219.58
Dep. var. mean	5192.013	5192.013	5192.013	5192.013
Dep. var. std. dev.	15709.414	15709.414	15709.414	15709.414

*Notes:* Table presents coefficient estimates from regressions of yearly total cost on individual characteristics. All columns weight observations by provided sample weights. Standard errors are clustered at the census region  $\times$  year level.

## B Survey Instrument

## Consent

We are a group of **nonpartisan researchers** interested in compiling an accurate and unbiased report about political and social attitudes in the US.

Consent for Participation in a Research Study

Study Title: Political and Social Attitudes

Principal Investigator: Leo Bursztyn

**DESCRIPTION:** We are doing a research study about political and social attitudes in the United States. The research project will consist of reading information and answering a few short questions. Participation should take approximately three minutes.

**RISKS and BENEFITS:** The risks to your participation in this online study are those associated with basic computer tasks, including boredom, fatigue, mild stress, or breach of confidentiality. The only benefit to you, other than survey compensation, is the learning experience from participating in a research study. The benefit to society is the contribution to scientific knowledge.

**COMPENSATION:** Upon completion of the study, you will receive compensation in the amount you have agreed to with the platform through which you entered this survey. Partially-completed survey responses will not be compensated.

**CONFIDENTIALITY:** All data will be stored on password-protected servers and hard drives. We do not ask for any identifying information.

Any reports and presentations about the findings from this study will not include any identifying information. We may share the data we collect in this study with other researchers doing future studies – if we share your data, we will not include information that could identify you.

**SUBJECT’S RIGHTS:** Your participation is voluntary. You may stop participating at any time by closing the browser window or the program to withdraw from the study.

For additional questions about this research, you may contact:  
Leonardo Bursztyn, normal-lab@uchicago.edu

For questions about your rights as a research participant, you may contact:  
The Social & Behavioral Sciences Institutional Review Board, University of Chicago  
Phone: (773) 834-7835  
E-mail: sbs-irb@uchicago.edu

## **attention**

The next question is about the following problem. In questionnaires like ours, sometimes there are participants who do not carefully read the questions and just quickly click through the survey. This means that there are a lot of random answers which compromise the results of research studies. To show that you read our questions carefully, please choose both “**Extremely interested**” and “**Not at all interested**” as your answer in the below question.

Given the above, how interested are you in sports?

- Extremely interested
- Very interested
- A little bit interested

- Almost not interested
- Not at all interested

## Demographics

Please indicate your gender.

- Male
- Female
- Other/prefer not to say

What is your age?

Which category best describes your highest level of education?

- Eighth grade or less
- Some high school
- High school degree/GED
- Some college
- 2-year college degree
- 4-year college degree
- Master's degree
- Doctoral degree
- Professional degree (JD, MD, MBA)

Which of the following best describes your race or ethnicity?

- African American/Black

- Asian/Asian American
- Caucasian/White
- Native American, Inuit or Aleut
- Native Hawaiian/Pacific Islander
- Other

Are you of Hispanic, Latino, or Spanish origin?

- Yes
- No

What was your family's gross household income in 2020 in US dollars?

- Less than \$15,000
- \$15,000 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$149,999
- \$150,000 to \$200,000
- More than \$200,000

In politics, as of today, do you consider yourself a Republican, a Democrat, or an Independent?

- Republican
- Democrat
- Independent

What is your ZIP code?

What is your current employment status?

- Full-time employee
- Part-time employee
- Self-employed or small business owner
- Unemployed and looking for work
- Student
- Not in labor force (for example: retired or full-time parent)

What is your marital status?

- Never married
- Separated
- Divorced
- Widowed
- Married

How many other adults live in your household?

- 0 (I live alone)
- 1
- 2
- 3
- 4
- 5
- 6+

How many children live in your household?

- 0
- 1
- 2
- 3
- 4
- 5+

How would you describe your physical health?

- Poor
- Only fair
- Good
- Very good
- Excellent

Which best describes your current living situation?

- I rent from someone not in my family
- I own my home
- I live with parents
- I live in a student dormitory
- Other

## Insurance

Do you have life insurance?

- Yes
- No
- Not sure

Which of the following best describes your auto insurance?

- I do not have auto insurance
- I have basic auto insurance
- I have comprehensive auto insurance
- Not sure

Do you have homeowner's insurance?

- Yes
- No
- Not sure

Do you have renter's insurance?

- Yes
- No
- Not sure

**Thank you!**

Thanks for completing our survey!

Powered by Qualtrics