How Americans Think About Health Care and Insurance *

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Abstract

This paper investigates how Americans perceive and reason about health insurance policies through two large-scale surveys and experiments conducted in 2019 and 2025. We elicit open-ended considerations, measure factual knowledge, and examine views on equity, fairness, efficiency, and different policies. Across both surveys, respondents consistently emphasize costs, affordability, and access as their main concerns. There is broad agreement about efficiency-related effects: most believe that expanding coverage increases preventive care use, reduces job-lock, and improves overall health. However, perceptions diverge on broader "spillover" benefits—such as reduced disease spread and better community health—which Democrats tend to view more positively. Views on equity are also largely aligned, with widespread recognition that health outcomes are not fully under individual control and that financial protection reduces stress, though partisans differ somewhat in how strongly they prioritize helping low-income households afford insurance. Partisan gaps are much larger when it comes to policy preferences. Democrats show stronger support for single-payer systems, expanded coverage, and greater government involvement, while Republicans express more satisfaction with the current system and prefer limited government roles. These differences stem less from contrasting efficiency or fairness beliefs and more from fundamentally different views of government and its proper scope. Experimental evidence underscores the power of concrete, program-specific information. Abstract messages about efficiency or equity in 2019 had little effect, whereas in 2025, targeted information about Medicare and Medicaid significantly increased support for more government provided health insurance and expansion of existing programs, including among Republicans. Overall, the results suggest that detailed, positive program-based information can meaningfully shift public attitudes toward greater acceptance of government-provided health insurance, perhaps because such information can address the differences in views about government itself.

Keywords: Redistribution, Survey, Perceptions, Taxation, Online Experiment, Fairness, Health Insurance, Medicare, Medicaid.

JEL Codes: D72, D91, H21, H23, H24, H41, I13, I14, H51

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1 Introduction

Access to good health care is essential for people individually and society more broadly. In the United States, health care spending makes up a large share of GDP and access to health care and insurance is a critical matter for millions. Recently, in the run-up to its passage, the One Big Beautiful Bill renewed the controversy over health insurance, particularly over its sweeping Medicaid provisions. It is thus important to understand how people view health insurance to guide better policy decisions in this key area. In this paper, we shed light on two questions: How do U.S. citizens perceive and understand public policies related to health insurance, and can their support for expanded health insurance be altered?

Economists study both the positive and negative efficiency effects of increasing health insurance coverage. Positive effects may include less crowding in the emergency room for non-emergency conditions that are better treated by a primary care provider or specialist, and higher use of the recommended preventive care, e.g., immunizations or screenings at the recommended frequency (Simon et al., 2017). More generous health insurance could improve health overall, which could in turn have positive effects on the economy (Hackmann et al., 2025). More preventive care may, on balance, reduce overall health costs if medical problems are caught early or if it prevents the spread of infectious diseases (Fragala et al., 2019; Sargin, 2024; Gruber, 2025). Moreover, there are broader implications of health insurance beyond simple health outcomes. First, labor market concerns are intrinsically tied to health insurance, since around 50% of Americans are insured through their employer. The "job-lock" effect from health insurance linked to one's employer, i.e., the difficulty in switching jobs for fear of losing one's health insurance or receiving worse coverage through the new employer, has been shown to matter (Madrian, 1994). Second, if the lack of health insurance causes financial stress in low-income households, there may be broader ramifications due to suboptimal decisions made to deal with these financial shocks. On the other hand, expanding health insurance coverage may also entail efficiency costs. For instance, there could be overuse of medical care in response to more generous health insurance (Einav and Finkelstein, 2018). Expanding government-funded health insurance might also require higher (distortionary) taxation or cuts to other government expenditures. In addition to these efficiency concerns, there are many equity- and fairness-related considerations that people can have. For instance, to what extent do they believe that people should be held responsible for their health? Do they think that it is fair to help lower-income people afford health insurance? This paper aims to measure people's understanding and perceptions of the health insurance system along all these dimensions.

To do so, we design and implement two large-scale Social Economics surveys and experiments on a representative sample of the U.S. population in 2019 and 2025. The questions in the surveys are designed to elicit not only respondents' factual knowledge about the health care system and health insurance policies, but also their understanding of the mechanisms at play and the efficiency and distributional implications. We also extract people's first-order considerations that come to mind when they are prompted to think about health insurance and its goals or shortcomings. To avoid priming respondents towards any particular effect, this is done primarily through open-ended questions, which are subsequently evaluated through text analysis methods.

Our survey also contains detailed questions on policy views, attempting to capture the nuances involved in the debates about health insurance in the U.S. For instance, people may assess coverage for different types of conditions or care (e.g., maternity-related services versus specialist non-essential care) differently. In particular, coverage for family planning services such as birth control or abortion-related services can be sensitive and polarized issues. In addition, there is the question of whether individuals should be required to

have health insurance (i.e., whether there should be an individual mandate for health insurance) so as to avoid both individual behavioral failures and negative social spillovers from a lack of insurance. Respondents are also asked whether they support a "Medicare-for-all"-type universal health insurance, whether low-income households' premiums should be subsidized, whether Medicaid or Medicare should be expanded, and how much coverage they believe should exist for different types of situations and health conditions.

Furthermore, in the 2019 survey, we randomized the phrasing of many of the questions. The same root question was asked in two different ways: The first phrasing is generic and impersonal (e.g., "If health insurance were to be made more generous, to what extent would it encourage people to make less use of the emergency room for conditions that do not warrant it?"). The second phrasing is specifically about women ("If health insurance were to be made more generous, to what extent would it encourage women to make less use of the emergency room for conditions that do not warrant it?"). The goal is to elicit whether respondents think differently about a generic person versus women, but without asking the same person different versions of the same question.[1]

Importantly, to better understand how respondents learn and how we can change views on expanded or even universal health insurance, we show different subsamples of randomly selected respondents instructional videos that explain the workings and consequences of health insurance policy from different perspectives. The randomization allows us to estimate the causal effects of the information provided.

We adopted two different approaches. In the 2019 experiment, we focus on providing pedagogical information about health insurance that is more abstract, i.e., without referencing specific government programs in the U.S. The information comes in three distinct forms. The "Distributional" perspective focuses on the positive distributional consequences of health insurance, while the "Efficiency" perspective zeroes in on the efficiency benefits. The "Economist" perspective combines both of the previous perspectives. In the 2025 experiment, we instead explain to respondents how two specific government programs—Medicare and Medicaid—work and what their benefits are. One treatment branch sees the video on Medicare, the other the video on Medicaid.

In both surveys, we decided to focus on the positive aspects of these health insurance policies for substantive and methodological reasons. Substantively, programs such as Medicare, Medicaid, and single-payer systems are typically defended on the grounds that they expand access to medical care, reduce inequality in health outcomes, and provide greater financial protection against medical costs. These features are central to the public and political debate, and highlighting them allows us to capture some of the policy's most widely recognized and salient implications. Methodologically, presenting the benefits creates a clearer and more consistent treatment across respondents: positive information is less ambiguous and more easily comparable than a mixed set of positive and negative effects, which could vary in salience across individuals and dilute the intervention's impact.

Our main findings are as follows. First, when respondents are left to freely write about their main considerations on the issue in the open-text part, "costs," "affordability," and "access" to health care are by far the biggest concern across the board. Second, there is generally agreement about the efficiency impacts of health insurance. Thus, for instance, many respondents believe that higher coverage rates would increase preventive care use and reduce job-lock regardless of political leaning. On the whole, respondents also believe that more health insurance coverage would lead to better overall health and less spread of contagious diseases

[1] We also had a third phrasing, which we do not focus on here, namely one focused directly on the respondent themselves ("If health insurance were to be made more generous, to what extent would it encourage you to make less use of the emergency room for conditions that do not warrant it?").

but there are larger partisan gaps along these latter dimensions, which we can loosely call "spillovers" from health insurance. Democrat respondents are more likely to perceive broader positive spillovers from more generous health insurance. There is also substantial convergence in views regarding the equity implications of health insurance, such that health outcomes are largely outside of one's control and that more generous financial insurance reduces financial stress. There are some partisan gaps in the perceived importance of helping low-income families afford health insurance, with Republican respondents less likely to believe it is important.

Third, partisan gaps in policy views are large. This might seem surprising given that the underlying perceptions along most dimensions, as just described, are not so starkly polarized. For instance, support for a single-payer insurance system or expanded coverage tends to vary widely based on political leaning and is substantially stronger among Democratic respondents. Democratic respondents are also more likely to consider the current system to be unfair and be dissatisfied with it. They are more likely to want increased access to health care, support the expansion of government-provided insurance, Medicaid, Medicare, as well as a "Medicare-for-all" system. There exist significant disagreements regarding how generously certain services should be covered, with most of these centering around maternity, family planning, and women's health. On these issues, gender seems to matter less than political affiliation: Republicans tend to have cohesive views, regardless of their gender; so do Democrats.

What can explain the large partisan gaps in policy views? First, recall that as explained above, perceptions of efficiency and equity are largely shared, but there are some partisan gaps in perceived broader spillovers from health insurance and fairness concerns related to low-income households receiving more help. Most importantly, there are large partisan gaps in respondents' views of the government and what the scope of government should be. If we correlate policy views with efficiency considerations, equity considerations, and views of government, all are predictive but equity concerns and views of government are most predictive. Thus, small discrepancies in specific equity views and some gaps in the perceived positive spillovers from health insurance combined with large divergences in views of government can explain large partisan gaps in policy views.

Fourth, our experimental evidence highlights the power of concrete and specific program-related knowledge in shaping public opinion on health insurance and the limits of abstract—even if pedagogical—information. In the 2019 survey, providing respondents with broad efficiency- or equity-based arguments about health insurance had very limited effects. Efficiency-focused messages modestly increased the belief that generous insurance would reduce inefficient emergency room use and strengthened support for the individual mandate and certain types of coverage. Yet these treatments did not alter views on broader reforms, such as a single-payer system or expanded assistance for low-income households. By contrast, the 2025 survey shows that targeted information about existing government programs can meaningfully shift attitudes. Explaining the benefits of Medicare and especially Medicaid increased perceptions that the U.S. health care system is fair and boosted support for expanding these programs. Notably, the Medicaid treatment had positive spillover effects on support for Medicare expansion, while the Medicare treatment primarily reinforced backing for more generous benefits within Medicare itself. These effects were visible across party lines, including among Republicans who initially held more skeptical views. The contrast between the two survey waves suggests that people respond more strongly to concrete descriptions of how established programs improve access, reduce financial strain, and deliver measurable health gains than to abstract and more general information about efficiency or equity. This aligns with the descriptive findings, since views of government are strongly

correlated with policy views and, therefore, specifically talking about the successes of government programs can address these concerns. Thus, program-specific information seems to be more effective in shifting views on the expansion of government-provided health insurance.

It is worth noting that our two survey waves, conducted in 2019 and 2025, bracketed two major events with potentially far-reaching implications for health policy attitudes: the COVID-19 pandemic and the U.S. Supreme Court's Dobbs v. Jackson Women's Health Organization decision. The pandemic placed unprecedented strain on the health care system and brought issues of coverage, access, and government responsibility to the forefront of public debate, potentially reshaping how individuals evaluate the role of health insurance. The Dobbs decision, by overturning Roe v. Wade, shifted the legal and political landscape surrounding reproductive health care, which may also have broader spillover effects on perceptions of health policy and the scope of government intervention. While our analysis does not focus directly on these events, they form part of the broader context in which our findings should be interpreted, and we do highlight the changes we see over time in various views throughout the paper.

Related Literature:

The use of surveys to study policy attitudes has a long history in economics, with seminal contributions focusing on political economy and public finance. Early work, such as Blendon et al. (1997), compared the views of the public and economists on key economic issues, highlighting divergences in priorities and beliefs. Foundational surveys on price setting (Blinder et al., 1998), wage rigidity (Bewley, 1999), and inflation perceptions (Shiller, 1997) illustrate the role of economic surveys in studying expectations. Subsequent empirical contributions demonstrated how fairness considerations, reciprocity, and social identity shape redistribution views (Gilens, 1999; Fong, 2001; Luttmer, 2001). Blinder and Krueger (2004) explored perceptions about the economy and the determinants of policy views.

Building on this, a growing literature has leveraged new survey technologies to administer large-scale studies and generate causal variation, incorporating experimental techniques. This has also been facilitated by the diffusion of best practices and methodological contributions synthesizing how to use survey experiments to identify causal effects (Haaland et al., 2023; Stantcheva, 2023). Related work highlights the value of open-ended elicitation for uncovering mental models and reasoning processes (Ferrario and Stantcheva, 2022; Roth et al., forthcoming). Recent methodological contributions also systematize the use of surveys to investigate the formation of expectations (Fuster and Zafar, 2023).

The literature has applied these methods to a wide range of policy domains. On taxation and redistribution, studies show systematic misperceptions of taxation and demonstrate how information and framing shift support (Kuziemko et al., 2015; Stantcheva, 2021). Related research connects inequality and mobility beliefs to redistribution preferences (Alesina et al., 2018) and documents how attitudes towards tax policy vary with fairness and efficiency considerations (Bartels, 2005; Gideon, 2017). In trade, Stantcheva (2022) uses surveys to study how individuals reason about trade policy, and how treatments shift support for policies. In the context of inflation, Binetti et al. (2024) combine information provision and structured elicitation to document how people understand the causes and consequences of rising prices and how this shapes support for monetary policy. Recent cross-country studies show that effectiveness, redistributive effects, and self-interest considerations are the main determinants of support for environmental policies (Dechezleprêtre et al., 2025).

Several studies investigate satisfaction with the health care system and opinions towards health insurance policies and health care reforms (see e.g. Mossialos (1997) for views on health care systems in EU countries).

Baker et al. (2014) analyze public preferences regarding the allocation of health care resources, highlighting how different groups weigh priorities in health care. Similarly, van Exel et al. (2015) identify diverse moral perspectives on health care priority setting in European populations. Other research focuses more directly on public attitudes towards health insurance policies. Yörük (2023) finds that age-based health insurance policies can significantly influence perceptions of the necessity of coverage. Ashok et al. (2015) document broader trends in public support for redistributive policies, including health insurance. Khanna et al. (2022) identify key factors influencing public perception of health insurance, such as awareness, transparency, tax benefits, claim settlement ratios, and accessibility of information in India.

Less research, however, focuses specifically on the public's understanding of how health insurance and public health policies work or what their effects are, with a few notable exceptions. Loewenstein et al. (2013) find that consumers commonly misunderstand complex insurance features, such as deductibles and copayments, and that such misunderstandings persist even in the presence of simplified plans. Similarly, Barcellos et al. (2014), using a representative survey just before the rollout of the Affordable Care Act (ACA) exchanges, show that large segments of the U.S. population—especially low-income individuals—lacked basic knowledge of insurance mechanisms. Long et al. (2014), drawing on the Health Reform Monitoring Survey (HRMS), likewise document that over 60% of those targeted by ACA exchanges struggled with core insurance concepts. These studies highlight the existence of widespread information gaps that can affect how individuals interpret policies, navigate insurance options, and make informed decisions.

Our paper contributes to this literature by studying how people understand and reason about health insurance and how their perceptions and understanding drive policy preferences. Many different factors can affect people's attitudes towards health insurance. On the one end of the spectrum, there are efficiency considerations about the costs and gains of health insurance. On the other end of the spectrum, there are fairness considerations, distributional consequences (e.g., unequal health outcomes). Our survey consists of blocks that elicit views and preferences on each of these relevant factors. We can thus measure all these different components and understand how people trade them off. Furthermore, we provide evidence on the strongest predictors of people's views and preferences on health insurance.

The rest of the paper is organized as follows. Section 2 describes the survey, data collection, and sample. Section 3 provides insights on people's first-order considerations and key statistics on respondents' knowledge about health insurance policies. Section 4 analyzes respondents' broader concerns about the efficiency and distributional implications of health insurance, with a special focus on the partisan gap. Section 5 discusses policy views. Section 6 examines the experimental effects of the video treatments. Section 7 concludes.

2 Survey and Sample

This section describes the survey's structure, the data collection process, and the sample. Appendices A-5 and A-6 provide the full questionnaires and additional information on important aspects of the surveys.

2.1 Data Collection and Final Sample

We conducted our first large-scale survey between June and July 2019, collecting responses from approximately 1,800 U.S. residents aged 18 to 70. In July 2025, we carried out a follow-up study, sampling around 1,000 individuals. Both surveys were implemented using the online platform *Qualtrics*. The 2019 survey link was distributed by the commercial survey company *Bilendi* (`https://www.bilendi.co.uk`) and

its U.S.-based partners, while the 2025 follow-up study was distributed via the platform *Prolific* (https://www.prolific.com).

Throughout the paper, we either focus on results from the most recent 2025 survey when there is no interesting change over time, or, when relevant, we compare findings from both the 2019 and 2025 surveys to highlight how beliefs have evolved over time. Additional, more detailed results from the 2019 survey are provided in Appendix A-2.

How were participants enrolled? The commercial survey company *Bilendi*, with whom we partnered, maintains panels of respondents (i.e., email lists) to which they distribute survey links via email. By contrast, on *Prolific*, respondents can browse and directly select studies to participate in. In both cases, respondents were only informed about the length of the survey, but not its topic or the identity of the sender. After clicking on the survey link, respondents were first directed to a consent page (see Appendix A-5.15), which explained that the survey was part of an academic research project conducted solely for research purposes. The consent page emphasized that responses should be as accurate as possible and that participation was entirely voluntary. Following consent, respondents were presented with screening questions to ensure that the final sample was nationally representative with respect to gender, age, and income. This procedure also allowed us to retain demographic and background information from individuals, who chose to drop out after learning the survey topic, thereby enabling us to test for differential attrition across observable characteristics. Participants in the first wave received approximately $3 for completing the survey, while those in the second wave were compensated $3.50. The median time for completion was 37 minutes for the first survey and 25 for the second one. Payment was contingent on completing the survey—that is, reaching the end of it—but respondents were not required to answer every question.

While it is not possible to fully rule out selection on unobservables such as respondents' opportunity cost of time, we can check for differential attrition, based on the topic of the survey. To do so, we regress an indicator equal to one if the participant completed the survey on an array of individual characteristics and treatment. We repeat this analysis using, as the dependent variable, an indicator equal to one if the respondent belongs to the bottom 5th percentile of completion times (i.e., speeders). Table A-1 reports the results. Across specifications, no observable characteristic meaningfully predicts the likelihood of completing the survey or, conditional on completion, the likelihood of spending very little time on it.

Final Sample. The final sample is broadly representative of the U.S. population. Table 1 compares the characteristics of our respondents with population benchmarks drawn from the U.S. Census Bureau (see table notes for details). By construction, the sample is nearly perfectly aligned with the population in terms of age, gender, and income. Beyond these targeted dimensions, the sample is also generally representative along other characteristics, such as marital status and employment.

Respondents' exposure to health insurance. Figure 1 presents the share of respondents with health insurance coverage (top panel) and those enrolled in Medicare or Medicaid (bottom panel), segmented by age and income. In the Appendix, Figure A-1 provides a more detailed breakdown of participants' health insurance exposure using data collected in 2019. In 2025, an average of 90% of respondents report having health insurance coverage—unchanged from 2019. However, the share of individuals insured through Medicare or Medicaid has increased from 35% in 2019 to 40% in 2025.

Health insurance coverage is positively correlated with income. While only 77% of respondents in the lowest income bracket are insured, nearly all respondents (98%) in the highest income bracket report having

health insurance. In contrast, coverage through Medicare or Medicaid follows the opposite pattern: 80% of respondents in the lowest income group are enrolled in one of these programs, compared to just 25% in the highest income group. As expected, a larger share of older respondents are enrolled in Medicare or Medicaid—90% among those aged 65 to 69 versus 40% among those aged 18 to 29. Overall health insurance coverage shows little variation by age, with 88% of the youngest group and 96% of the elderly (60- to 69-year-olds) having some form of insurance.

Measuring political leaning. Examining differences in beliefs across political parties is a natural dimension of interest. In our study, partisanship is measured in two complementary ways. First, in both survey waves, respondents were asked to self-identify their partisan affiliation, choosing among Republican, Democrat, Independent, Non-affiliated, or Other. Second, we elicited retrospective vote choice by asking participants who reported voting which candidate they supported in the most recent presidential election, or, in the case that they did not vote, who they would have expressed their preference for. Accordingly, in the 2019 survey respondents were asked whether they voted for Hillary Clinton, Donald Trump, Jill Stein, or Gary Johnson, while in the 2025 survey they were asked whether they voted for Kamala Harris, Donald Trump, Jill Stein, or Robert Kennedy.

Since we will often show results by political leaning, it is helpful to know the extent to which demographic characteristics are correlated with party affiliation. To explore this, we regress an indicator variable for identifying as Republican on our standard set of demographic controls, including gender, age, income, and education. Tables A-2 and A-3 report the results from the 2025 and 2019 surveys, respectively. In 2019, age emerges as a positive predictor of Republican affiliation, whereas this relationship disappears in 2025. Income shows the following pattern: compared to the low-income reference group, high income is a positive predictor of Republican affiliation in both survey waves, while middle-income status is negatively associated with Republican affiliation in 2025. Lastly, gender does not appear to be associated with Republican affiliation in either survey.

2.2 Surveys' Structure

Figures 2 and A-2 illustrate the structure of the 2025 and 2019 surveys, respectively. To ensure comparability between the two studies, the two surveys follow the same structure and ask mostly the same questions. Below, we outline the main components of the surveys and highlight the sections where the two versions differ. The full questionnaires can be found in Sections A-5 and A-6.

The first block collects background information on respondents' gender, age, income, highest level of education achieved, sector of occupation, employment status, marital status, number of children, place of residence, and political views. We choose to place the demographic questions at the beginning of the survey to address the issue of differential attrition—i.e., the possibility that some respondents may drop out once they learn the topic of the survey. By asking for demographics up front, we can examine whether dropout rates are systematically related to certain characteristics (e.g., age, gender, political affiliation). This information is valuable for understanding potential biases in the data. Of course, there is always a trade-off: placing demographics early helps us capture characteristics before dropout, but it also introduces the risk of order effects—where the positioning of questions influences responses later in the survey. In this case, however, we believe that asking demographics first is unlikely to create meaningful bias, while the benefit of having this information before attrition occurs is substantial.

The second block consists of open-ended questions meant to elicit first-order considerations that people have before being prompted to think about specific aspects of health insurance with more directed closed-ended questions (Ferrario and Stantcheva, 2022). In the third block, we explore respondents' personal exposure to health insurance. For instance, we ask participants if they have health insurance. In the fourth block, we explore people's factual knowledge about the U.S. health care system.[2]

The fifth block features the experimental part in both surveys, covered in more detail in Section 6. In brief, we randomly assign the sample to different groups, each of which watches a different information video or no video at all (the control group). In the first survey, the informational videos are designed to emphasize a different aspect of the health insurance system. In the second survey, the goal of the videos is to explain what Medicare and Medicaid are and to highlight their key benefits.

In the sixth block, we explore how people reason about health insurance and what they think the mechanisms at play are. The penultimate section of both surveys explores respondents' views and preferences regarding health care policies. The final section addresses their opinions about the government. The survey concludes with an open-ended request for feedback.

In the sixth block of the 2019 wave only, the same underlying question is posed using three distinct and randomized formulations. The first is generic and impersonal (e.g., "If health insurance were to be made more generous, to what extent would it encourage people towards the following behaviors?"), and was shown only to treated respondents. The second version is personalized, directly addressing the respondent ("If your health insurance were to be made more generous, to what extent would it encourage you towards the following behaviors?"). The third formulation focuses specifically on women ("If health insurance were to be made more generous, to what extent would it encourage women towards the following behaviors?"). The second and third formulations were shown only to respondents in the control group. Whenever relevant, we highlight notable findings from the *"Women"* formulation and refer the reader to the corresponding tables in the Appendix.

3 First-order Concerns and Knowledge

This section presents the main findings on people's first-order concerns about health insurance and their knowledge about the health care system.

3.1 First-order Concerns

Open-ended questions are important to elicit first-order, intrinsic concerns that people have before they are prompted to think of a particular aspect with the more directed survey questions (Ferrario and Stantcheva, 2022; Roth et al., forthcoming). Thus, these questions minimize influence over respondents by particular effects or issues that economists are used to thinking about and free respondents to focus on the aspects that they find most important. With this in mind, we included several open-ended questions in our surveys. These questions were intentionally broad in scope, covering topics such as the overarching goals of a well-functioning insurance system, the biggest problems facing the U.S. health insurance landscape today, key considerations surrounding universal health coverage, and the population groups most likely to benefit from

[2]In the 2019 survey, six-sevenths of respondents were randomly given monetary incentives rewarding correct answers to knowledge questions, while the remaining respondents were simply asked the questions. As shown in Tables A-4 and A-5, we find no evidence that such incentives affected answer correctness.

the introduction of a single-payer health insurance system. Here, we present results of a subset of the questions asked with additional results in Appendix A-2.

Open-ended questions can be analyzed using various techniques (see Roth et al. (forthcoming) for a comprehensive literature review). The simplest way of analyzing a body of text consists of plotting "word clouds," where the font size and transparency are proportional to the frequency of each group of words relative to the total. The word clouds in Figure 3 show the main words that appear in the answers. The main considerations about universal health insurance (Panel A) are relatively dispersed, but lack of affordability and the long time it takes to get care seem predominant (represented by "wait time", "long wait", "can't afford", and "high tax"). Regarding the goal of a good health insurance system (Panel B), respondents mostly mention universal coverage: "everyone access" and "cover everyone", as well as affordability of coverage ("everyone afford" and "regardless income"). Finally, the shortcomings of the current U.S. health insurance system are very clearly the high costs (represented by "high cost" and "can't afford"). Additional word clouds based on data from the 2019 survey are provided in Figure A-3 and are quite similar.

Another way to analyze a body of text leverages large language models (LLMs), which are increasingly used for tasks such as text classification and narrative extraction (Korinek, 2024). Empirical studies show that LLMs often outperform traditional classification methods (Cunha et al., 2025), align well with human annotators (Ziems et al., 2024), and are capable of extracting structured narratives from unstructured sources like social media and large textual corpora (Gueta et al., 2025; Schmidt et al., 2025). Prompting techniques—such as chain-of-thought prompting—can further enhance model performance by guiding reasoning in sequential steps (Wei et al., 2022), and broader evaluations highlight LLMs' growing impact in economic text analysis across domains (Shahriar et al., 2024; Hansen et al., 2025).

To analyze responses to the open-ended questions, we employ a two-step procedure, based on GPT-4o-mini: first, we prompt the LLM to extract up to ten most common and distinct narratives or "topics" (excluding sentiment) from respondents' answers. In the following step, the LLM assigns, in an unsupervised classification process, independently each response to at most one of the identified narratives. Figure 4 presents the results of this topic analysis. For each narrative, the figure shows the proportion of responses that contain it, split according to the vote in the 2024 presidential election. For each of these two voter groups, the ten narratives collectively account for 100 percent of classified responses. Consistent with the word clouds above, the narratives identified largely revolve around themes of affordability, accessibility, cost, funding, and quality—each of which reveals clear partisan divides. See Appendix A-7 for examples of answers to each of the questions included in both surveys, divided by topic identified.

Panel A summarizes the main considerations that come to respondents' minds when asked whether the United States should adopt universal health insurance. The dominant narrative across both groups is that such a system would ensure access to care for all, cited by 52% of Harris voters and 40% of Trump voters. The most salient point of opposition, by contrast, is concern about higher taxes: 24% of Trump voters raise this issue compared to 12% of Harris voters. Harris voters are somewhat more likely to highlight that universal insurance would guarantee coverage regardless of income (13% vs. 9%), whereas Trump voters are slightly more likely to worry about longer wait times for services (9% vs. 5%). Harris voters also emphasize that universal insurance could reduce overall health care costs (8% vs. 4%), while both groups, in roughly equal measure, point to potential public health benefits (4% each). Concerns about government efficiency are voiced primarily by Trump voters (5% vs. 1%), whereas both groups cite simplification of health care access at similar levels (2% of Harris voters and 3% of Trump voters). Finally, a small share mentions that

universal insurance might help reduce medical bankruptcies (3% Harris, 0% Trump) or could lead to reduced choice of providers (2% Trump, 0% Harris). Overall, these results underscore a shared emphasis on universal access but also reveal clear partisan differences in how respondents weigh potential trade-offs, with Harris voters stressing equity and cost reduction while Trump voters focus more heavily on taxes, efficiency, choice, and wait times.

Panel B asks about respondents' views on what would constitute a good health insurance system. Here, the most common theme across both groups is that a system should be affordable and accessible to all, cited by 43% of Harris voters and 69% of Trump voters. 38% of Harris voters also stress that health insurance is necessary to ensure medical services for all, compared to only 15% of Trump voters. Preventing financial hardship from medical costs is mentioned by 5% of Harris voters and 7% of Trump voters, while including preventive care is emphasized by 5% of Harris voters and 2% of Trump voters. Smaller but still notable shares highlight quality care regardless of income (2% of Harris vs. 3% of Trump voters), ensuring coverage is not tied to employment status (3% vs. 1%), and the importance of transparency for patient trust (2% vs. 2%). These results indicate that while affordability and access dominate respondents' definitions of a good system, Harris voters are more likely to frame these goals in terms of ensuring that everyone receives medical services. Trump voters, while being supportive of universal access, focus more on affordability and individuals' ability to pay.

Panel C then turns to perceptions of the biggest problems with the current U.S. health insurance system. Across the political spectrum, high costs emerge as the dominant concern: 35% of Harris voters and 47% of Trump voters identify cost as the single biggest issue. Beyond affordability, Harris voters are far more likely to emphasize that insurance companies prioritize profit over patient care (29% vs. 11%), whereas both groups mention that the system creates financial barriers to necessary care at comparable rates (9% of Harris voters and 11% of Trump voters). Other issues raised include inadequacy or denial of coverage (6% and 7%), and the confusing nature of insurance, which is mentioned by 4% and 7%, respectively. Concerns about the affordability of medical care more generally are voiced equally by 5% of Harris and 5% of Trump voters. Around 4–5% of respondents also highlight income-based inequality in coverage or the fact that access remains tied to employment. Finally, 2% of Harris voters and 3% of Trump voters argue that adequate care is not guaranteed even for those who are insured, and just 1% draw attention to the excessive presence of middlemen in the system. Taken together, these results show that both groups converge on the view that high costs are the primary problem.

Additional figures presenting the corresponding results from the 2019 survey are reported in Appendix A-2.1. Figure A-4 shows the classification for all six open-ended questions included in the 2019 survey, splitting respondents between Clinton and Trump voters, consistent with the last presidential election at the time. For questions included in both surveys, i.e., Panels A to C of Figures A-4 and 4, both the topics identified and the relative prevalence of them in the corpus of answers exhibit remarkable similarity. For Panel A, the need to ensure everyone has access to health care remains the most prevalent topic. Notably, the political divide has shrunk markedly, driven by a large increase in Trump voters who see this as the main consideration. Funding and the potential increase in taxes remain a concern, with the political gap roughly constant at 10 percentage points. Similarly, wait times have remained among the most prominent concerns. In 2019, 5% of Trump voters expressed their opposition to the extension of health care to illegal immigrants, a topic that did not emerge in 2025. As for Panel B, the main feature of a good system remained the same between the two waves, namely affordability for everyone. However, in 2019 the percentage of respondents

who mentioned other goals was larger vis-à-vis 2025, suggesting a convergence of the attention towards cost and accessibility issues. Lastly, Panel C once again exhibited consistency in the main concerns of respondents, with lack of affordability and mistrust towards insurance companies, accused of prioritizing profits over care, remaining the two most common topics. In 2019, the percentage of respondents pointing out the difficulty in navigating the health insurance system was lower than in 2025. Lastly, pharmaceutical prices, which did not emerge in 2025, were more of a concern in 2019, while the issue of insurance being tied to employment was not.

3.2 Knowledge About U.S. Health Insurance

Figure 5 analyzes respondents' overall knowledge of U.S. health care. Panel A compares individuals' perceptions of how Americans are insured with the actual distribution of coverage in 2019 and 2025. In both years, respondents substantially underestimated the share of people covered through employer-sponsored insurance, perceiving it to be around 30% rather than the true figure of roughly 50%. At the same time, they tended to overestimate the prevalence of public insurance programs such as Medicaid and Medicare, as well as the share of the uninsured. For example, in 2025 respondents believed that more than 20% of Americans rely on Medicare, whereas the actual share is closer to 14–15%. Similarly, they consistently overstated the proportion of uninsured individuals.

Panels B and C illustrate how respondents in 2019 and 2025 perceive the income eligibility threshold for Medicaid, compared to the actual thresholds in their state. The distributions reveal a systematic misperception: the average perception is that the threshold is around 80% of the federal poverty line in 2019 and 100% in 2025, regardless of the actual threshold in the state. As a result, in states where the threshold is higher (above 100%), respondents tend to underestimate the income cutoff, believing that Medicaid eligibility applies to a smaller share of the federal poverty level than is actually the case. Examples of such states include California, New York, Pennsylvania, and Arizona. On the contrary, in states with a lower threshold, they tend to overestimate eligibility. This is the case, for instance, for Texas, Florida, Alabama, and Wyoming. On average, this misperception amounts to 31 percentage points in 2019, but declines to 8 percentage points in 2025. Hence, while the gap between perceived and actual thresholds narrows substantially over time, respondents in 2025 still underestimate the true eligibility criteria.

Figure 6 shows results regarding knowledge more specific to health insurance policies. Panel A focuses on the share of respondents who can correctly answer questions about Medicare and Medicaid. In 2019, around two thirds of respondents could correctly describe what Medicare and Medicaid are, while the proportion is over ten percentage points higher for both questions in 2025. In 2025, half of respondents correctly identified whether the Affordable Care Act (ACA) changed Medicaid eligibility in their state, with the correct answer naturally varying by state. This represents a 10-percentage-point increase from 2019, when only 40% of respondents answered this question correctly. These three were the only knowledge questions repeated in 2025. In Panel B, we can see that the overwhelming majority of respondents in 2019 were aware that there was an individual mandate in 2018 and that a penalty had to be paid by those without insurance. However, while 57% seemed to be aware that there was some change to the individual mandate in 2019, only 22% knew that the change made was the reduction of the penalty for being uninsured to zero. Finally, around half of respondents understood that there is an employer mandate but that small employers are exempt. Panel C summarizes answers to the question of whether insurance premia are allowed to depend on various factors. Most people in 2019 were aware that premia are allowed to depend on age and tobacco use. However, fewer

were aware that premia are allowed to depend on location (62%), but not on gender (54%). Only 32% of respondents correctly said that premia were not allowed to depend on pre-existing conditions.

4 Perceived Efficiency and Equity of U.S. Health Care

This section presents the reasoning of respondents on the efficiency effects and distributional effects of health insurance, as well as their equity concerns related to health policies. Instead of just asking people about their overall policy views, we want to understand how they think and reason about health care policy in-depth. We separate these issues into those most closely related to "efficiency" such as the economic effects of health insurance, and those most related to "equity," i.e., the distributive impacts of health insurance.

A large body of research finds strong and consistent effects of health insurance coverage on health care utilization and financial security. The Oregon Health Insurance Experiment, for example, shows that coverage increases health care use, reduces unpaid medical bills and collections, and improves self-reported health (Finkelstein et al., 2012). Other studies document improvements in broader well-being and long-run outcomes: Medicaid expansions raised life satisfaction (Flavin, 2018) and generated lasting gains for children in education, earnings, and longevity (Brown et al., 2019); among older adults, Medicare expansions improved access and reduced mortality in emergencies (Card et al., 2008, 2009). The efficiency of preventive care, however, is less settled: while some interventions deliver good value, others are costly relative to benefits, with returns depending on the target population (Cohen et al., 2008; Iizuka et al., 2017). More generally, a recent review highlights that insurance tends to support economic performance, especially in developed countries and through public programs (Fan et al., 2024). Taken together, the literature suggests broad consensus that insurance enhances access, utilization, and financial protection, with more mixed evidence on cost savings and the size of health improvements.

A note on how we will present results is helpful here. First, we present tables reporting the results from the 2025 wave, with supplementary tables for the 2019 wave available in Appendix A-2. Where relevant, we compare findings across the two waves to illustrate how beliefs and reasoning have evolved over time. The structure of the tables presented throughout the paper is consistent and follows a standardized format. All regressions include controls for gender, age, race, income, parental status, education, whether the respondent majored in an economics-related field, employment status, self-reported policy knowledge, political affiliation, and indicator variables for all treatments—i.e., question formulations (for 2019 only) and video courses. Detailed definitions of all variables are provided in Appendix A-2.1. Due to space constraints, we report only a subset of coefficients in each panel. Panel A displays the coefficients for demographic and personal characteristics (e.g., gender, age, income class, political affiliation). The omitted categories are male, age 18–29, low income, and Democrat. Panel B ("Video treatment effects") presents the effects of the video interventions relative to the omitted category (no video), which will be discussed in Section 5. In addition to the main treatment effects, we also examine heterogeneity by political affiliation by interacting the treatment indicators with an indicator for being Republican. The omitted categories in this case are Democrat and no video. Panel C ("Underlying mechanisms"), when included, illustrates the relation between underlying beliefs on equity, efficiency, and government and respondents' views on health policy. The final panel reports the mean of the dependent variable for respondents assigned to the generic question formulation and no video treatment ("Control mean"), as well as subgroup means for male respondents ("Male control mean"), Democrats ("Democrat control mean") and Republicans ("Republican control mean"). Second, we

also present figures that visualize key statistics—also reported in the tables—disaggregated by group (e.g., political affiliation and gender) and over time (2019 and 2025). These are intended to offer a more intuitive understanding of the patterns observed in the formal results. All the numbers we refer to in this section are for respondents who did not see any of the videos. They can therefore be interpreted as the baseline views in our (representative) sample, before any additional information is provided.

In Appendix A-2, we report tables from the 2019 wave. As explained in Section 2, the 2019 study includes an additional layer of randomization involving the formulation of the survey questions. Specifically, some questions were presented using the "Women" framing. Accordingly, in these tables, we also report the coefficient on the "Women" indicator variable, both on its own and interacted with the Republican indicator, following the same structure described earlier. This allows us to explore potential heterogeneity in how Democrats and Republicans respond to questions framed around women.

4.1 Efficiency Considerations

Table 2 considers the perceived behavioral responses and other efficiency mechanisms to increased health insurance coverage using data from the 2025 wave. The corresponding table with data from the 2019 wave can be found in the Appendix A-2. In the first three columns of Table 2, the dependent variables are the shares of respondents who think that, in response to more generous health insurance, people would be encouraged to adopt the behaviors listed in each column from "a lot" to a "great deal." The fourth column shows the share of respondents who believe that employer-provided insurance discourages people from *"quitting a bad job or switching jobs from fear of losing their health insurance."* These statistics are also shown in the first rows of Figure 7. The figure shows the share of Republican versus Democrat respondents in 2019 and 2025 agreeing with the statements listed on each row.

Overall, respondents are highly convinced that there is a job-lock effect (90% on average in 2025) and that more generous health insurance encourages higher use of preventive care. Around 40% of respondents believe that more generous insurance will lead to lower (inefficient) emergency room use and only around a third believe it will encourage higher use of medical services overall. Compared to 2019, individuals today express stronger belief in the existence of the job-lock effect, but weaker belief in the notion that expanded coverage would lead to lower use of the emergency room. Overall, negative behavioral responses do not seem to be a prime concern.

Considering again Table 2, Column 5 shows that 89% of respondents agree that less generous health insurance in the U.S. would lead to worse health outcomes overall. 91% of respondents believe that an increase in insurance coverage for preventive care would reduce overall health care costs (Column 6); 90% believe that it is important to ensure that everyone can afford proper health care to avoid negative spillovers on others and contagion (Column 7). Therefore, on balance, there are mainly positive efficiency effects expected. Although there are sizable partisan gaps in these perceived efficiency and spillover effects, with Democrats much more likely to see the positive impacts of health insurance, the shares remain high among Republicans too. For instance, 93% of Democrats believe that less generous health insurance can reduce positive health outcomes in the U.S., and 80% of Republicans do so. 97% of Democrats and 83% of Republicans believe that more coverage for preventive care can decrease overall health costs, and 96% of Democrats as well as 83% of Republicans think that health care is important to prevent contagious diseases from spreading.

Interestingly, and perhaps because of the COVID pandemic, respondents are significantly more convinced about the positive efficiency and spillover effects of more generous health insurance in 2025 than in 2019.

This is also true within political leanings and especially so for Republican voters, which implies that the partisan gap in these perceptions has shrunk from 2019 to 2025.

The last column summarizes all efficiency and behavioral responses in an "Efficiency Index." This index is constructed using all variables listed in columns (1) through (7), which capture perceived efficiency costs and spillover effects. It is calculated by first averaging the standardized values of these variables (i.e., z-scores computed by subtracting the control group mean and dividing by the control group standard deviation), and then standardizing the resulting average once more. Higher values of the index indicate greater belief in the positive efficiency impacts of health insurance coverage. This index will be used to study underlying mechanisms shaping policy preferences in Section 5.4.

4.2 Equity and Fairness Considerations

Table 3 focuses on respondents' perceptions around equity and fairness (see also Figure 7). 93% of respondents agree that more generous health insurance could reduce financial stress on families (Column 1 of Table 3), and 88% believe it is important to help low-income families afford medical care (Column 2). The share of respondents who believe it is unfair to pay more for health care due to pre-existing conditions is 80% overall; 85% believe it is unfair to pay more because of worse health. 76% think health issues are outside of one's control. There is, thus, widespread agreement on the positive equity effects of improved health insurance, alongside a recognition that current health outcomes are largely inequitable.

There are overall only small partisan gaps in these beliefs and preferences, with Democrat respondents being somewhat more likely to consider health outcomes to be outside of the realm of individual control and more deserving of "compensation" through public policy. Thus, 90% of Democrats and 79% of Republicans find it unfair that someone must pay more for health insurance due to worse health overall, while 87% and 69% find it unfair to do so because of pre-existing conditions. 79% of Democrats versus 71% of Republicans believe that health issues are mostly outside of one's own control. 94% of Democrats compared to 90% of Republicans believe that more generous health insurance could reduce financial stress on families. There is a slightly larger partisan gap on whether low-income families should be helped when it comes to affording health care, with 95% of Democrats and 79% of Republicans in favor of helping low-income households. Overall, however, respondents across the political aisle largely agree in the equity benefits of health insurance.

Over the six years since 2019, there is suggestive evidence that concerns related to the equity benefits of the insurance system have become more salient, especially among Republican respondents, who started from a lower baseline level in 2019. Thus, Republican respondents have become increasingly likely to say that more generous health insurance can reduce financial stress and that it is important to help low-income families afford health care. There is also (but to a lesser extent) an increase in the belief that health issues are outside of one's control. Perhaps these changes are due to the experience of the COVID pandemic. Therefore, the partisan gap on these issues has actually narrowed over time—a contrast, perhaps, to many other domains where it has increased. However, there is little movement in the beliefs about whether it is fair to pay more for health insurance if one has worse health or pre-existing conditions.

The last column in Table 3 summarizes all equity responses in an "Equity Index" in the same fashion as described above for the efficiency index. Indeed, it is constructed using all variables listed in columns (1) through (5) that reflect equity considerations and fairness-related arguments. Each variable is first standardized (i.e., transformed into z-scores by subtracting the control group mean and dividing by the control group standard deviation). The index is then computed by averaging these standardized values and

standardizing the resulting average once more. Higher values of the index correspond to stronger endorsement of equity-based arguments in favor of health insurance coverage. This index will be used to study underlying mechanisms shaping policy preferences in Section 5.4.

Gender effects. As described in Section 2, some of the questions in the blocks investigating people's reasoning and policy views were not only asked in the neutral and impersonal phrasing, but also in a phrasing asking specifically about women (e.g., how women would react if health insurance were made more generous) in the 2019 survey. Key results from this analysis are summarized below, with full tables available in Appendix A-2.

In general, there are no large differences in how people answered the question based on the phrasing (generic vs. women-centered). However, more respondents (80%) believe that women's health issues are outside of their control, compared to 66% who agree with this statement for a generic person. Furthermore, there appears to be a significant partisan gap when it comes to judgments about women's health situations (this will also be true for supporting women-specific health services coverage). Panel B in Table A-7 shows that Republicans are much less likely to think it is unfair if women with worse health pay more for health care than when confronted with the same question about a generic person (76% versus 61%). On the other hand, Democrats make no significant distinction between men and women in these answers: over 80% of Democrats believe that paying more for worse health is unfair, regardless of whether this refers to men or women.

Women's views: Women are more likely to use equity arguments in favor of health insurance; close to 10% more women than men say that it is unfair to pay more for health insurance because of pre-existing conditions and that it is unfair to pay more for insurance or care overall because of worse health. They also tend to have a higher overall equity index. Hence, on health care issues, women appear more attuned to concerns of fairness and equity.

5 Policy Views

In this section, we turn to a descriptive analysis of respondents' policy views related to health care and insurance.

5.1 Support for Specific Types of Coverage

One important policy question is what types of services respondents believe should be covered more or less generously. Figure 8 shows the share of respondents who support full insurance coverage for the types of situations listed, split by political views (Panel A) and gender (Panel B) for both 2019 and 2025.

The highest support is for preventive care, followed by catastrophic situations and pediatric and maternity care (on average 60% in the control group across both waves). Coverage for primary care visits and specialist care has much lower support. Between 2019 and 2025, support for more generous coverage has increased, except for specialist non-essential care.

There are consistently partisan gaps, with Republican respondents much less likely to support full coverage. However, several of these gaps seem to have diminished over time, mainly driven by Republican respondents increasing their support over time, even more so than Democrat respondents, most strikingly on

maternity-related care and pediatric care. On the contrary, the partisan gap on preventive care has grown wider, with Democrats increasing their support even further post-COVID but Republican respondents not changing their support.

Table 4 shows that there are no significant gender differences in support for coverage for different types of services. Older respondents are significantly more supportive of preventive care, primary care visits, as well as pediatric care. Higher-income respondents are significantly less supportive of coverage for specialist care and emergency room visits. Overall, however, the largest differences in views are along the partisan dimension.

5.2 Reproductive Health Services

Figure 9 shows respondents' attitudes towards reproductive health policies, again split by political views (Panel A) and gender (Panel B), in 2019 and 2025.

There are large partisan divides in these views and, although views have shifted within political leaning groups over time, the partisan gaps have remained relatively stable. In 2025, 94% of Democrats and 64% of Republicans agree that employers should be required to provide birth control coverage in their employer-provided health insurance plan, even if they have personal religious objections. 80% of Democrats and 45% of Republicans agree that it is unfair that women who use birth control pay for the cost on their own. A support gap of around 40 percentage points between Republicans and Democrats also appears when asked whether health providers should be allowed to opt out of abortion-related treatments and whether insurance providers should have to cover abortion-related medicine or procedures.

An interesting finding is that, in general, there are only small gender gaps in these views (see Panel B). The notable exception concerns attitudes towards birth control: women are significantly more likely than men to state that it is unfair for women to bear the cost of birth control out-of-pocket. Views have not drastically changed over time, except that there seems to have been a sharp increase of 25 percentage points in the proportion of men who believe it is unfair that women using birth control have to pay more out-of-pocket.

5.3 Health Insurance, Medicare-for-All and Mandates

Table 5 highlights other policy support for health insurance. Figure 10 illustrates the partisan gaps specifically. A key finding is the large partisan gaps along most health policy dimensions.

A large majority of respondents (81%) believes that the current health care system is unfair and that access to health care should be improved (87%), but with significant heterogeneity in views by political leaning. The share of Democrats who think the health care system is currently unfair is 90% and the share of Republicans is 60%. These views have also become more prevalent over time for both groups. There is also growing support over time for transfers to low-income families so that they can afford health care. The share of Democrats supporting this increased from 78% to 91%, and the share of Republicans from 44% to 61%.

There are large partisan gaps in support for expanding government-provided insurance (these questions specifically were asked only in 2025). There is much higher average support for Medicaid expansion (75%) than for Medicare expansion (63%), but similar average support for making these programs more generous (around 80%). However, this average masks very large partisan gaps in support (of around 30 percentage

points). Partisan gaps are smaller with respect to support for Medicare than Medicaid.

In both 2019 and 2025, we also asked about support for a Medicare-for-all system. This particular policy was described as a *"single-payer health insurance program that would be administered by the federal government and financed through taxes."* Support for this policy has increased over time for both Democrats and Republicans. In 2025, 44% of Republicans and 71% of Democrats supported it. In 2019, these shares were 23% and 65%, respectively.

Support for an individual mandate has experienced a marked convergence in support, with the partisan gap shrinking from over 30% to a mere 4%. Support for an employer mandate still exhibits a significant partisan gap but overall support has increased notably, rising from 71% in 2019 to 83% in 2025. The rise in support is especially pronounced among Republican respondents.

The table also highlights further heterogeneity in support. Older respondents are significantly more opposed to expanding Medicaid or making it more generous, perhaps out of concern that such expansions could compete with Medicare benefits. Higher-income individuals also tend to oppose expansions of both Medicare and Medicaid, perhaps because they anticipate that these would be financed with higher taxes.

5.4 Which Concerns Best Predict Health Policy Views?

Section 4 outlined the main factors expected to shape attitudes towards health insurance. Broadly speaking, these factors fall into two categories: arguments centered on equity and fairness, and arguments emphasizing efficiency concerns. As described when discussing Tables 2 and 3, we construct two indices that capture these dimensions. Each index is based on all survey questions pertaining to the corresponding mechanism (efficiency and equity). Specifically, we calculate the index by averaging the standardized values of the relevant variables (z-scores computed by subtracting the control group mean and dividing by the control group standard deviation), and then standardizing this average once more. Higher values of the efficiency index, for instance, reflect stronger endorsement of efficiency-based arguments in favor of health insurance coverage.

A third potentially important consideration is the perceived effectiveness and capacity of government in providing health services. To capture this dimension, the survey included a final block of questions asking respondents about the role of government in addressing health insurance, their trust in government, their views on how broad the scope of government should be, and the extent to which the government should try to solve the country's problems (these variables are depicted in Figure 11 and discussed below). Based on these responses, we construct, in a similar fashion, a government trust index that increases with greater confidence in the trustworthiness and scope of government. Appendix A-2.1 reports the full set of survey items used to construct each index.

Together, these indices provide a structured way of capturing the correlation between underlying beliefs and views on health policy. Panel C of Tables 4–5 presents these correlations for the 2025 survey, while Tables A-8 and A-9 report the corresponding estimates for 2019. In all specifications, we regress policy preferences on the three reasoning indices, controlling for standard demographics (coefficients not shown for brevity).

A consistent pattern emerges: equity-oriented beliefs are strongly linked to redistributive and expansionary health policy preferences. Respondents who emphasize fairness are substantially more likely to view the current system as unfair and, in turn, to support transfers to low-income households, an employer mandate, and expansions of both Medicare and Medicaid. They also express greater support for making these

programs more generous and, ultimately, for the adoption of a universal Medicare-for-all system.

Beliefs in the efficiency gains from health insurance are also positively correlated with more support for health policy but to a lesser extent than equity-related beliefs. Individuals with stronger efficiency concerns are also more likely to perceive the current system as unfair and tend to favor transfers to low-income households, an employer mandate, and expansions of Medicare. However, these associations do not extend to Medicaid. As might be expected, efficiency considerations are especially predictive of support for full coverage of preventive care, where their effect is nearly twice as large as that of the equity index. For most other medical services, efficiency-related correlations are generally smaller in magnitude than equity-related ones.

A distinct set of patterns appears with the government trust index. Individuals who view government as more trustworthy are more likely to consider the current system fair, yet they also show broader policy support across the board: expansions of Medicare and Medicaid, the employer mandate, the individual mandate, and Medicare-for-all. In terms of quantitative impact, trust in government produces effects that are often larger than those of equity considerations. However, when focusing specifically on support for full coverage of different medical services, trust plays a more limited role. With the exception of emergency room care and maternity, higher government trust does not translate into stronger preferences for comprehensive coverage. By contrast, equity-oriented reasoning continues to predict support for universal coverage across nearly all services.

Overall, the results for the 2019 survey mirror those of 2025 in broad terms. While magnitudes vary somewhat across years, the qualitative patterns—equity-linked support for redistribution and program expansion, efficiency-linked emphasis on preventive coverage, and broad pro-policy effects of government trust are consistent across both survey waves.

These results also help explain why the partisan gaps in policy views are large, especially relative to the gaps in the underlying perceptions about the efficiency and equity-related aspects of health insurance: Most importantly, trust in government is very predictive of policy views and is also highly polarized. Figure 11 shows attitudes about the government among Republican and Democrat respondents. Republican respondents are much less likely than Democrat ones to think that the scope of the government should be broad, i.e., that the government should take active steps in more areas and instead to believe that the government should only provide basic government functions. They are also much less likely to answer that the government should do more to solve the country's problems and more likely to say that the government is already doing too much or doing just the right amount. Trust in government shows a different pattern: it is overall very low but especially low for Democrats because it is asking directly about the "government in Washington," which during both survey waves was from the Republican party. The previous two questions, on the contrary, are about the government as an institution and arguably more relevant to the question of what should be done with health insurance. Second, there certainly are some partisan gaps in the perceived equity and efficiency impacts of health insurance that also reinforce the partisan gaps in policy views. Recall from Section 4.1 that there were substantial partisan gaps in the perceived positive spillovers from health insurance, with Republican respondents less likely to think that such spillovers occur. The partisan gaps in support for preventive care for instance seem to align with these different perceived spillovers. Furthermore, there was a partisan gap in the importance that respondents assigned to helping low-income households afford medical care, with Democrat respondents more likely to consider it important.

To sum up, these patterns highlight important complementarities and distinctions across the three in-

dices. Equity-oriented reasoning consistently predicts redistributive and expansionary policies as well as universal coverage. Efficiency-oriented reasoning channels support towards measures seen as cost-effective, most notably preventive care. Trust in government broadens support for major policy initiatives and amplifies willingness to endorse systemic reform, though it has less influence on coverage decisions at the service-specific level. Importantly, they can help explain why there are such large partisan gaps in policy views: they are due to important disagreement on the role of government, as well as on some of the broader efficiency spillovers from health insurance.

6 Experimental Results

6.1 Video Treatments

Each survey features an experimental component in the form of video-based information provision to better understand how respondents learn and how the presentation of a policy affects perspectives. The randomization allows us to estimate the causal effects of the information provided. An important question is whether beliefs give rise to preferences or, alternatively, adapt in order to rationalize pre-existing preferences. While it is impossible to fully answer this question, the experimental component goes some way because it exogenously manipulates individuals' knowledge and understanding of the policy to see whether this affects their preferences.

It is important to note that, in designing the videos, we deliberately chose to emphasize the positive effects associated with more generous health coverage. In particular, we highlighted the potential benefits of policies such as Medicare, Medicaid, or, more generally, a single-payer system. The goal is to see whether these (positive) arguments, provided by economic theory and empirical evidence, can shift people's views on health insurance.

In the first survey, we show different subsamples of randomly selected respondents instructional videos that explain the workings and consequences of health insurance policy from three different perspectives. The "Distributional" perspective focuses on the distributional consequences of health insurance, while the "Efficiency" perspective zeroes in on the efficiency costs. Finally, the "Economist" perspective presents issues in light of trade-offs, combining both of the previous perspectives.

In all three videos, the first part of the video considers the corresponding arguments (redistributive or efficiency-based) for universal coverage, while the second part considers how such coverage could be provided (private sector versus single-payer). The Redistribution treatment starts by stating that health insurance can greatly improve people's lives and provides several arguments as to why: i) people can afford to be treated, ii) it can improve their health, and iii) it can reduce financial stress and worries about the costs of care. It provides the examples of a bad accident that requires the protagonist to have an expensive surgery, and a protagonist with a serious medical condition. The video then presents two ways of providing health insurance: private insurance or a government-run, single-payer system financed through general taxation. It then details the advantages of the single-payer system, the first of which is that such a system could pool all risk and cover everyone; this is in contrast to the current system, wherein if private companies are left to their own devices, only the sickest people will remain in the scheme and these companies will be forced to raise premia and insurance costs. Other advantages of a single-payer system include helping poor families by reducing their out-of-pocket costs and severing the ties between insurance and employment, which would make switching jobs or looking for a better job easier.

The Efficiency treatment again starts by stating that health insurance can greatly improve people's lives and that they would then have to worry less about being able to afford treatment. It then focuses on how broader coverage can lower total health care costs in the U.S.: i) it allows people to get preventive care, which makes it easier to detect problems before they escalate; ii) it leads to less overcrowding of emergency rooms, as non-emergency conditions would be treated elsewhere; and iii) there would be fewer untreated and contagious diseases, resulting in less transmission and negative spillovers on others. The treatment then focuses again on the two ways of providing insurance (private and single-payer) and details the efficiency advantages of the single-payer system: i) there would be less distortion from people being unable to switch jobs due to fears of losing health insurance, which could improve economic activity overall; and ii) there could be lower insurance costs as the government has more bargaining power with pharmaceutical companies and providers to obtain lower prices. The Economist video combines these two videos into one. Screenshots from each of these videos can be found in Figures 12-14, and each video can be seen by following the links below the screenshots.

In the second survey in 2025, the videos instead focus on two major health insurance programs currently in effect in the United States: Medicare and Medicaid. One key difference with the 2019 experiment, then, is that these videos do not talk about health insurance in general but refer to specific programs. Respondents are randomly assigned to one of three groups: those who watch a video about Medicare, those who watch a video about Medicaid, or those who receive no video at all (control group). Figures 15 and 16 display screenshots from the video treatments and include links to the full videos, which are accompanied by voiceover narration. In particular, the Medicare video outlines the role of Medicare as a major federal health insurance program covering over 66 million Americans, primarily those over 65 and individuals with serious disabilities. It presents research indicating that Medicare increases access to health care, improves health outcomes, and reduces mortality, particularly at age 65 when eligibility begins. The video also notes evidence that Medicare helps narrow disparities in health care access between income groups and suggests that broader coverage could have positive economic effects. It concludes by raising the question of whether expanding Medicare could extend these benefits to more people. The Medicaid video follows a similar structure, presenting the policy as a public health insurance program that provides coverage to low-income individuals, people with disabilities, and many families with children.[3] It highlights that Medicaid reduces mortality rates, improves access to care and mental well-being, lowers financial stress, and enhances life satisfaction. The video also mentions that long-term benefits include better educational and economic outcomes for children. It concludes by posing the question of whether broader access to Medicaid could extend these effects to more Americans.

6.2 Treatment Effects

Pedagogical treatments on health insurance in the 2019 survey. In the 2019 survey, there are barely any effects on either the perceived impacts of health insurance or on policy views. The efficiency-based arguments prove to be a little more persuasive than the equity-focused ones, but neither are very impactful. As shown in Table A-6, the Efficiency treatment increases respondents' perception that more generous health insurance would increase overall medical use, the effect being 28% of the control group mean, but it also convinces them that people will be less likely to use the emergency room in an inefficient

[3]There was a small mistake in this video, whereby we mistakenly used the word "Medicare" in a sentence on two separate screens. We describe this issue in more detail in Appendix A-3 and provide a comparison of the responses to those in a newly collected sample which saw the correct version of the video. There are no significant differences in the responses. Therefore, we believe that the typos were not very salient and it is very unlikely that they affected our results in any meaningful way.

way (40% effect size relative to the control group mean). The Economist treatment is also effective in convincing respondents that people will use the emergency room less in response to more generous health insurance—the effect is 27% of the control group mean. The Efficiency treatment also increases overall support for the individual mandate by 24% relative to the control group mean (Table A-9), and support for full coverage of non-essential specialist care and preventive care (Table A-8).

None of these treatments have any effects on support for broader access to health care, a "Medicare-for-all" single-payer system, or more help for low-income families to be able to afford health insurance. This is possibly due to the strong polarization in views on the role of government as it relates to health insurance and the positive spillover effects of health insurance overall, documented earlier. One group of respondents—best represented by Democrats—believes that there are large positive spillovers from expanded health insurance and that government involvement in health insurance is beneficial. Another group—best represented by Republicans—perceives fewer social benefits from expanding health insurance and is warier of government involvement. The videos are perhaps providing the former group with information with which they already strongly agree, while not being convincing enough for the latter group to change their views. Overall, the partisan gap on health insurance issues seems large and, when it comes to broadening access to health care via a single-payer system, the videos are not able to change the negatively inclined views of people on these matters.

Explaining the benefits of specific programs: Medicaid and Medicare Treatments (2025 survey). In contrast, the two treatments focusing on the benefits of Medicaid and Medicare have significant effects. We benchmark treatment-effect magnitudes by dividing them by the control group mean in the outcome between Democrats and Republicans. Both video treatments significantly increase respondents' perceptions that the U.S. health care system is fair, with an average effect of the two treatments of 30% of the control group mean difference between Democrats and Republicans, which suggests that participants may be learning about the extent and benefits of government-provided health care. The effect is not uniform, however, and the relative magnitude of the impacts is revealing. The most notable change is produced by the Medicaid treatment: in addition to substantially boosting support for Medicaid expansion itself, with an effect of around 27% of the difference between Democrat and Republican mean control groups, it generates spillover effects by also raising, with a substantial magnitude of just below 50%, the support for expanding Medicare, even though it does not shift views on the more ambitious and polarizing proposal of "Medicare-for-all." The Medicare treatment, by contrast, primarily strengthens support for expanding Medicare coverage (39% in magnitude), without producing meaningful gains in support for Medicaid expansion. We interpret these results as suggesting that the Medicaid treatment might highlight to people the overall effects of health insurance, while the Medicare treatment might be more narrowly viewed as only relevant for the older population.

Interestingly, the treatment effects are not confined to one side of the political spectrum: they are visible across ideological lines, even though baseline attitudes diverge considerably, with Republican respondents starting from a much lower level of support for these expansions. Indeed, one of the more surprising findings is that the Medicare treatment increases (and markedly so, with a magnitude of 57%) Republican respondents' willingness to make Medicare more generous in terms of benefits—although not to expand eligibility—suggesting that even among initially skeptical groups, targeted information can move opinions more effectively.

The findings highlight that providing information on specific existing programs and their demonstrated

benefits and real-world outcomes appears to be particularly effective in fostering support. We can trace this back to the finding above, namely that views about the government are especially predictive of policy views on health insurance. Therefore, specifically describing the successes of these two major government programs, as done in these videos, is likely addressing this important underlying attitude. By contrast, more abstract pedagogical explanations of the benefits of health insurance (whether from an efficiency or equity perspective) do not appear to have much impact. Clear, concrete descriptions of how programs like Medicaid and Medicare tangibly improve access and outcomes can generate broader support, even among groups typically resistant to government-led expansions of health care.

7 Conclusion

This paper examined how Americans understand and evaluate health insurance policies using two large-scale, nationally representative surveys and embedded experiments conducted in 2019 and 2025. Respondents consistently emphasize the importance of costs, affordability, and access as the main concerns regarding health care. There is broad agreement on several efficiency-related aspects of health insurance, such as the belief that increased coverage can improve preventive care use and reduce job-lock. While respondents generally associate more coverage with better health and less disease spread, partisan gaps emerge around these broader "spillover" effects, with Democrats more likely to perceive widespread benefits. Views also converge on the equity aspects of health insurance, including recognition that health outcomes are not fully within individual control and that generous financial coverage can reduce stress, though there are partisan gaps in how much to prioritize help for low-income households.

Despite this general agreement on efficiency and equity, policy preferences differ sharply along partisan lines. Democratic respondents are substantially more supportive of expanded coverage and single-payer systems and are more dissatisfied with the current system's fairness. Republicans, by contrast, show more skepticism toward government-provided insurance and prefer more limited coverage expansions. These differences appear to reflect divergent views about the role and scope of government rather than fundamental disagreements about efficiency or equity per se. Small gaps in perceptions of fairness and spillover benefits, combined with much larger differences in views toward government intervention, together explain the strong partisan divide in health policy preferences.

Finally, the experimental evidence shows how specific, concrete information about existing government programs can shape attitudes more effectively than abstract arguments. General efficiency- or equity-based messages had limited influence on respondents' views, while targeted descriptions of Medicare and Medicaid significantly increased perceived fairness and support for expansion, even among initially skeptical groups. These findings suggest that when the successes of concrete and widely used government programs are made salient, they can help bridge partisan divides (which, as shown, are particularly large when it comes to views of government) and shift opinions toward greater acceptance of government-provided health insurance.

Future research should investigate more closely the mechanisms through which information can shift deeply held policy views. For instance, it would be interesting to test whether differently framed interventions, such as narratives linking personal experiences to health policy or cost-benefit explanations that highlight trade-offs, are more effective at bridging partisan divides. While our survey spanned the pre- and post-pandemic period, it would also be interesting to see whether people or areas more affected by it have seen a change in their attitudes towards health care.

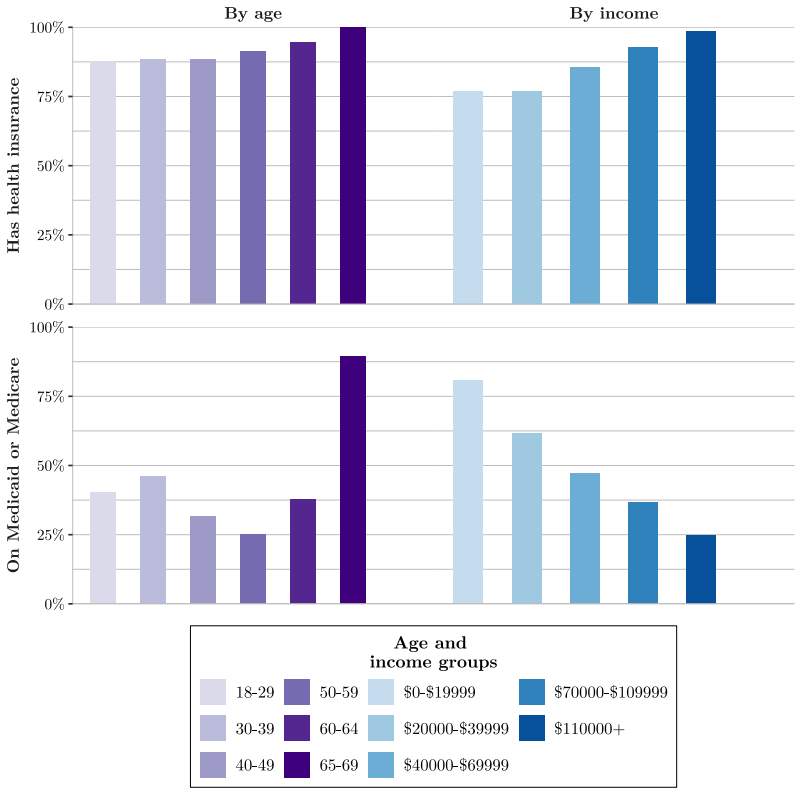
FIGURES AND TABLES

Table 1: Sample and U.S. Population Characteristics

	2019 Survey	2018 US Population	2025 Survey	2024 US Population
Male	45	49	53	50
18-29 years old	18	24	23	23
30-39 years old	21	20	24	21
40-49 years old	20	19	18	19
50-59 years old	23	19	20	18
60-69 years old	19	18	16	18
$0-$19,999	13	12	10	10
$20,000-$39,999	20	16	12	12
$40,000-$69,999	23	21	18	18
$70,000-$109,999	20	20	19	19
$110,000+	24	31	40	42
Four-year college degree or more	47	34	62	36
Less than 4-year college	51	28	34	26
Less than High School	2	38	4	37
Employed	66	70	77	71
Unemployed	5	3	8	3
Student	3	0	4	0
Retiree	15	9	5	9
Married	56	53	49	51
White	80	61	58	58
Black/African-American	5	12	13	13
Hispanic/Latino	5	18	19	19
Asian/Asian-American	5	6	8	7
Democrat	34	30	40	28
Republican	32	26	32	28
Independent	24	42	24	43
Democratic vote at the last Pres. Election	41	48	50	48
Trump vote at the Last Pres. Election	43	46	43	50
Sample size	1826		1055	

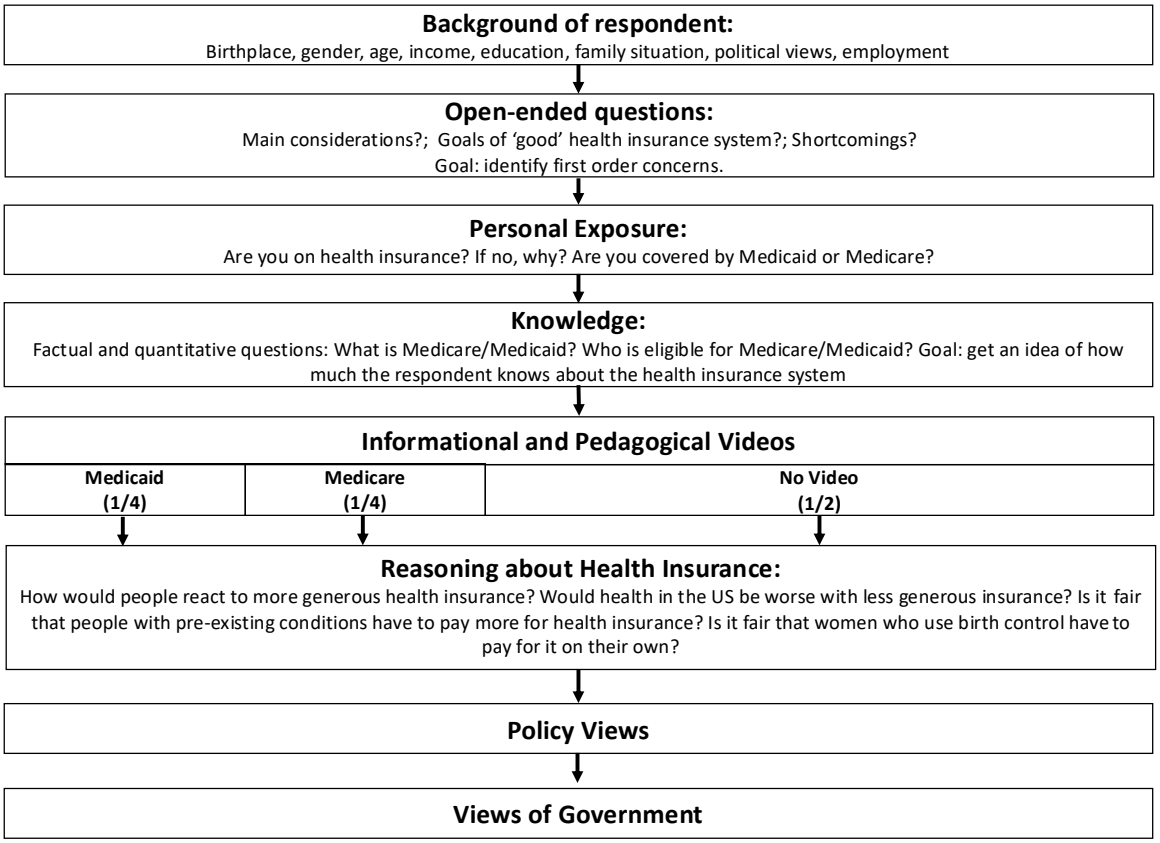
Notes: This table compares the proportion of survey respondents with specific characteristics to the corresponding proportions in the U.S. population. U.S. population statistics are derived from the Current Population Survey, supplemented with 2016 and 2024 election data. Other sources: Liep, D. (n.d.). Election Data Spreadsheets (Excel and csv Formats). https://uselectionatlas.org/BOTTOM/store_data.php, and Jones, J. M. (2025). GOP Holds Edge in Party Affiliation for Third Straight Year. https://news.gallup.com/poll/655157/gop-holds-edge-party-affiliation-third-straight-year.aspx.

Figure 1: Personal Exposure to Health Insurance



Notes: The bars represent the proportion of respondents in 2025 who had health insurance (upper panel) and who were enrolled in Medicaid or Medicare (bottom panel), broken down by age and income groups.

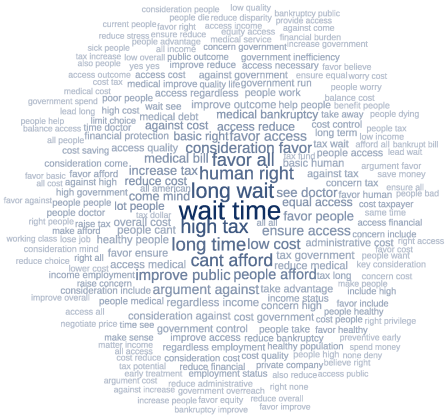
FIGURE 2: 2025 QUESTIONNAIRE SURVEY FLOW



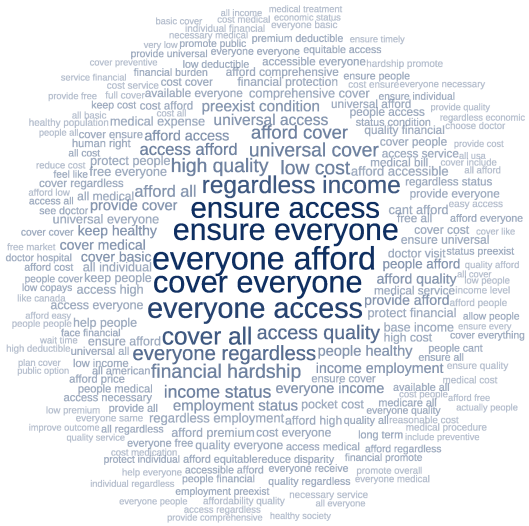
Notes: This figure illustrates the survey flow, which is structured into eight sequential blocks. The first block collects demographic and socioeconomic details, including gender, age, income, education, occupation, employment status, marital status, number of children, place of residence, birthplace, ethnicity/race, political views, and voting status in the most recent presidential and midterm elections. The second block features open-ended questions designed to capture respondents' initial, unprompted thoughts about health insurance before introducing more structured, close-ended questions, following Ferrario and Stantcheva (2022). The third block gathers information on respondents' personal experiences with health insurance and their broader health-related experiences. The fourth block assesses their factual knowledge of Medicaid and Medicare eligibility and the proportion of Americans enrolled in U.S. health care programs. In the fifth block, the experimental component is introduced, where respondents are randomly assigned to one of three groups: 1) an informational video on Medicaid, 2) an informational video on Medicare, 3) no video at all (control group). The fractions in parentheses indicate the proportion of respondents assigned to each treatment, with 25% of respondents assigned to Medicaid, 25% assigned to Medicare, and the other 50% assigned to the control group. The sixth block explores all respondents' reasoning about health insurance, including whether they believe health insurance should be made more generous and the effects of expanding U.S. health insurance programs. The seventh block examines respondents' policy preferences regarding health insurance - whether it is fair, whether they support individual and employer mandates, and their support for expanding U.S. health insurance programs. The final block explores respondents' broader views on what the extent of government involvement should be.

Figure 3: Word clouds for Health Insurance

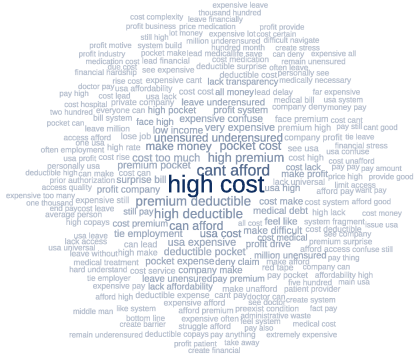
(a) What are your Main Considerations about Universal Health Insurance and Whether the U.S. should have Universal Health Insurance?



(b) What would be the Goal of a Good Health Insurance System?



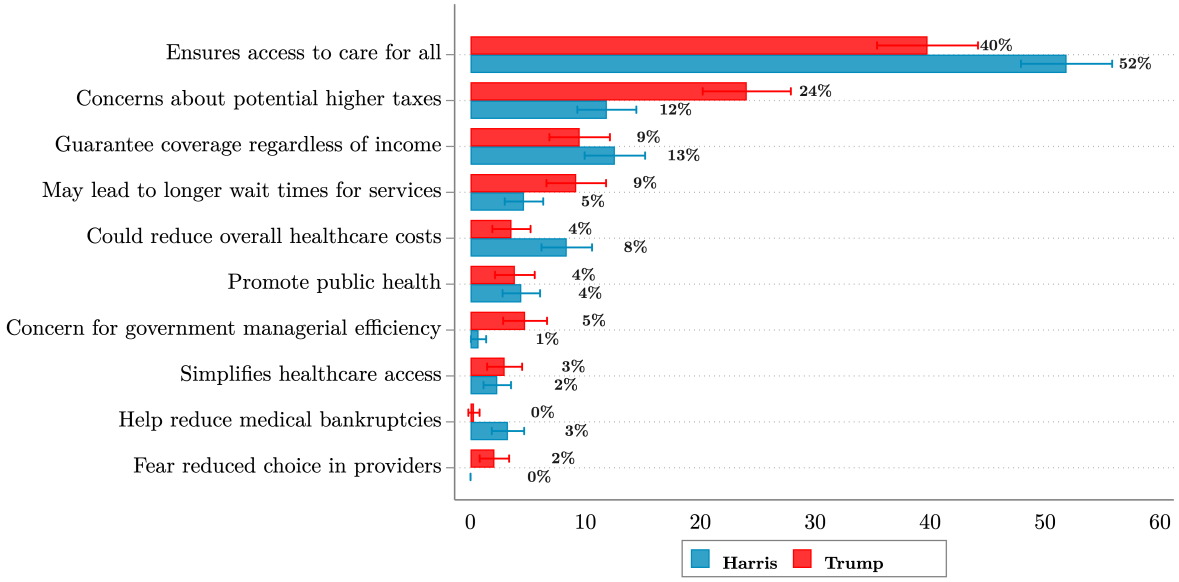
(c) What is the Biggest Problem with Health Insurance in the U.S.?



Notes: The figure shows word clouds based on the text analysis of the open-ended health insurance questions. Each panel refers to the open-ended question indicated in the caption. Raw answers are processed by removing *stop words*, and the words explicitly used in the text of the questions, and all *don't know* answers. The largest label, *everyone afford*, appears in 6.74% of responses. Labels for panels (A) and (B) were increased by 30% to improve legibility. Data from the 2025 survey.

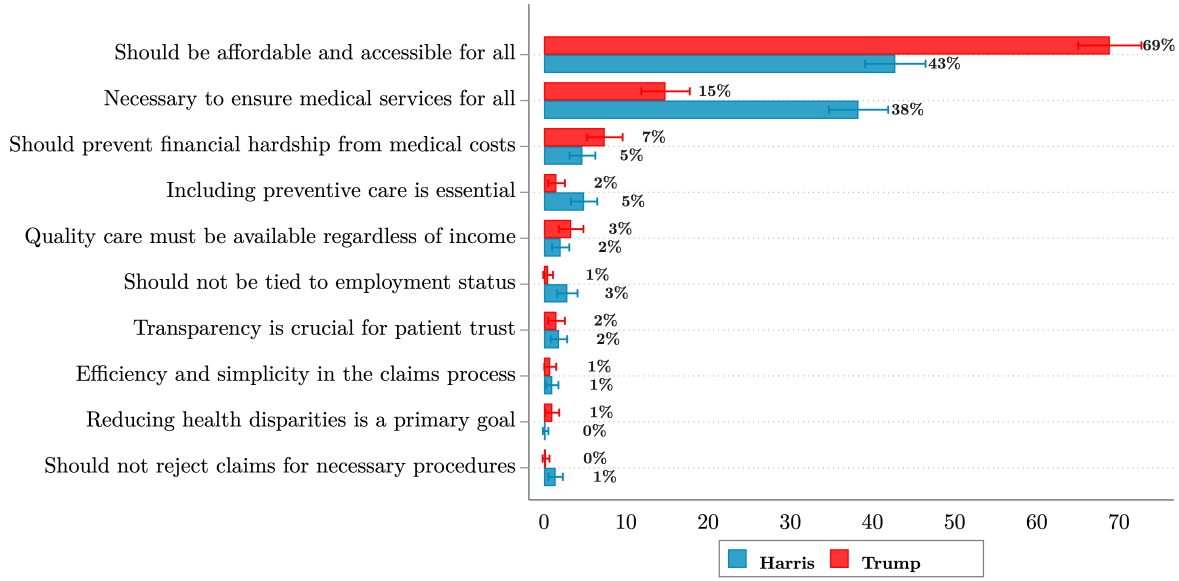
Figure 4: Text Analysis of Open Ended Questions

(a) When you think about health insurance and whether the U.S. should have universal health insurance for all, what are the main considerations — in favor or against it — that come to your mind?



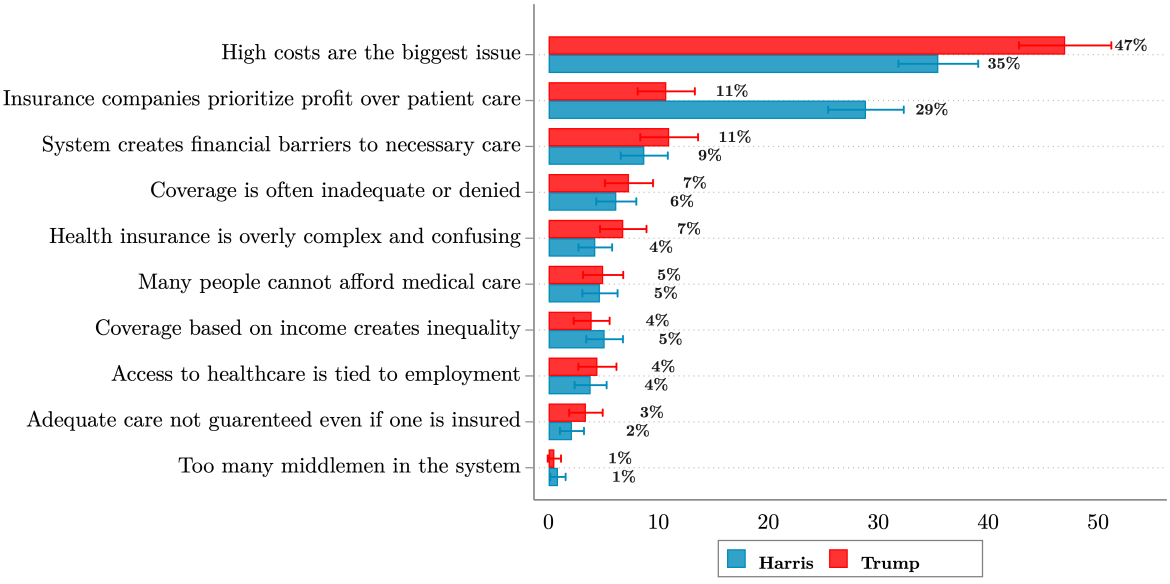
Notes: This chart displays the proportion of answers that match the respective narrative, as identified by the LLM, along with their 90% confidence intervals. Percentages sum to 100% for each political affiliation. Data from the 2025 survey.

(b) What would be a good health insurance system in your view? What would be the goal of a good health insurance system?



Notes: This chart displays the proportion of answers that match the respective narrative, as identified by the LLM, along with their 90% confidence intervals. Percentages sum to 100% for each political affiliation. Data from the 2025 survey.

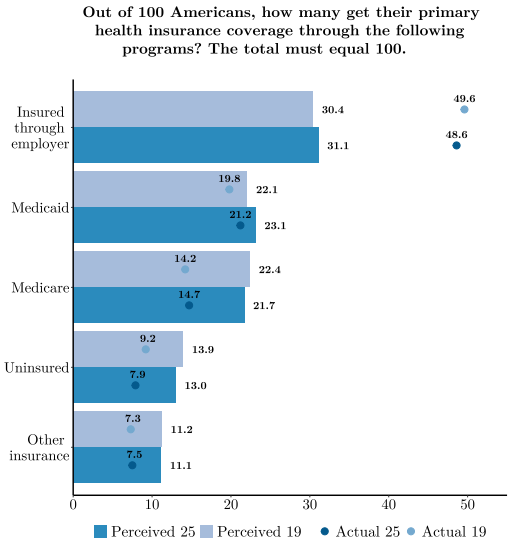
(c) What do you personally see as the biggest problem with health insurance in the United States today?



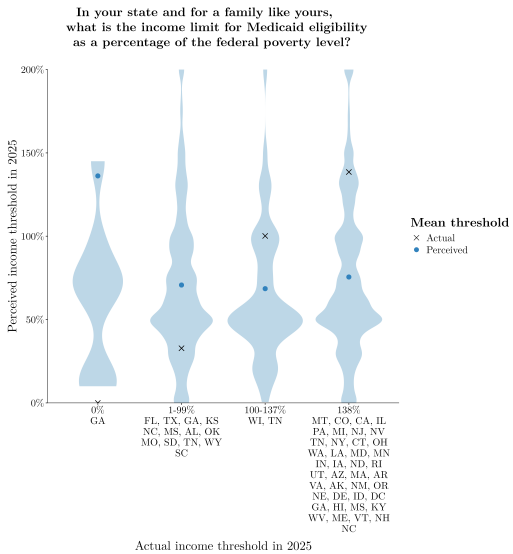
Notes: This chart displays the proportion of answers that match the respective narrative, as identified by the LLM, along with their 90% confidence intervals. Percentages sum to 100% for each political affiliation. Data from the 2025 survey.

Figure 5: Knowledge about the Health Insurance System

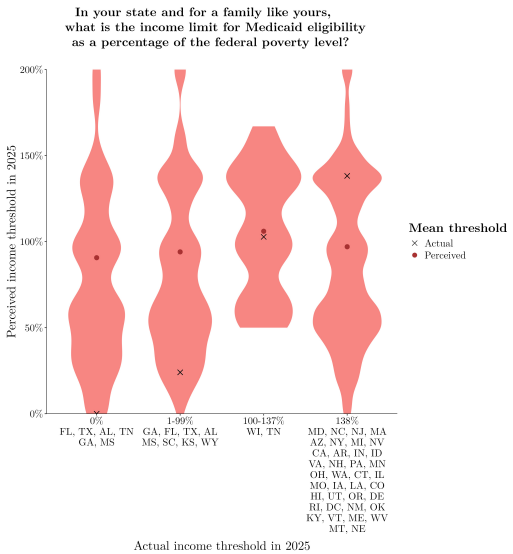
(a) Misperception about Share of People Relying on Different Modes of Insurances



(b) Misperception about Medicaid Income Eligibility, 2019

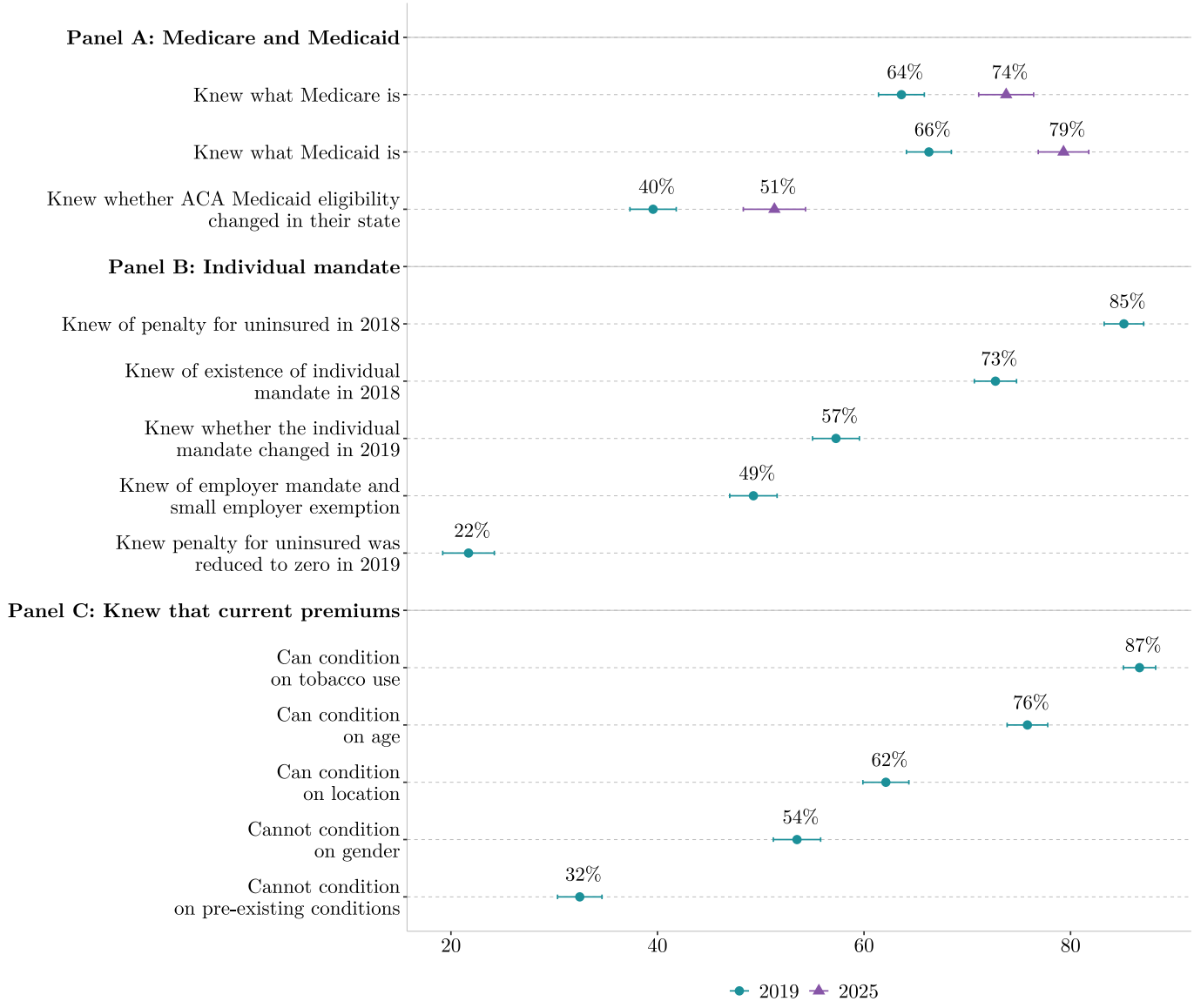


(c) Misperception about Medicaid Income Eligibility, 2025



Notes: Panel (A) compares the average perception among respondents of the prevalence of different health insurance programs across the U.S. population to the actual program distribution. Panels (B) and (C) show the perceived Medicaid eligibility as a percentage of the federal poverty level, and as a function of the respondent's true threshold. The true Medicaid eligibility threshold was computed using information on a respondent's state, number of children, and marital status. Violins show distributions of perceived thresholds as a function of binned true thresholds, and dots indicate mean "Insured through employer," "Medicaid," "Medicare," "Uninsured," and "Other insurance." Panels (B) and (C) show on their x-axes U.S. states grouped into four groups by actual income threshold for Medicaid eligibility as a percentage of the federal poverty level in 2019 and 2025, respectively. The groups are 0%, 1-99%, 100-137%, and 138%. On the y-axis, the distribution of the perceived income threshold by actual income threshold is visualized with the help of violin plots where a dot is used to indicate mean perceived responses and an x to indicate the mean actual threshold.

Figure 6: Knowledge about Health Insurance Programs, Mandates, and Premiums



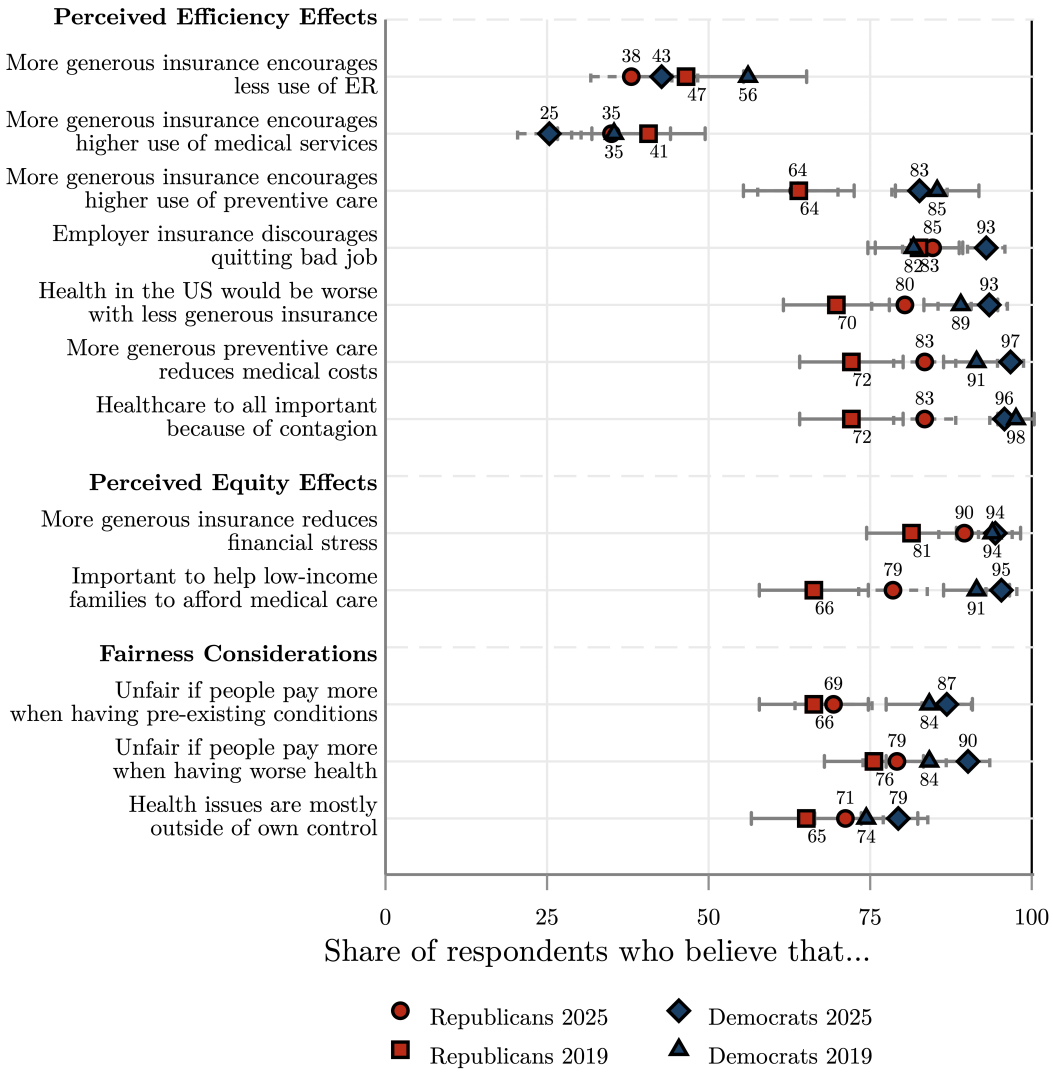
Notes: This chart presents the proportion of respondents who were aware of the respective health insurance programs, mandates, and premiums, along with their 90% confidence intervals. Data from the 2019 and 2025 surveys. Appendix A-4 describes how the correctness of answers was assessed.

Table 2: Efficiency Costs and Spillover Effects of Health Insurance

	More generous insurance would encourage: less use of emergency rooms (1)	higher use of medical services (2)	higher use of preventive care (3)	Employer insurance discourages quitting bad job (4)	Health in U.S. worse if ↓ insurance (5)	↑ preventive healthcare, ↓ costs (6)	Healthcare to all important bc of contagion (7)	Efficiency index (8)
Panel A: Personal Characteristics								
Female	0.14***	-0.02	0.10***	0.05**	0.06***	0.07***	0.05**	0.20***
	(0.03)	(0.03)	(0.03)	(0.02)	(0.02)	(0.02)	(0.02)	(0.03)
Republican	-0.12***	0.12***	-0.18***	-0.09***	-0.12***	-0.13***	-0.12***	-0.34***
	(0.04)	(0.03)	(0.03)	(0.03)	(0.02)	(0.02)	(0.02)	(0.04)
Age 30-49	0.09**	0.02	0.01	0.02	0.04	0.04	-0.04	0.03
	(0.04)	(0.04)	(0.04)	(0.03)	(0.03)	(0.03)	(0.03)	(0.05)
Age 50-69	0.17***	0.01	0.03	-0.04	0.03	0.03	-0.00	0.04
	(0.05)	(0.04)	(0.04)	(0.03)	(0.03)	(0.03)	(0.03)	(0.05)
Middle-Income	-0.04	-0.03	0.03	0.02	-0.07**	-0.04	0.02	-0.06
	(0.05)	(0.04)	(0.04)	(0.03)	(0.03)	(0.03)	(0.03)	(0.05)
High-Income	-0.06	-0.08**	0.03	0.02	-0.03	-0.04	0.01	-0.08*
	(0.04)	(0.04)	(0.04)	(0.03)	(0.03)	(0.03)	(0.03)	(0.05)
Panel B: Video treatment effects								
Medicaid T	0.03	0.01	-0.00	-0.06**	0.01	-0.03	0.01	-0.01
	(0.04)	(0.03)	(0.03)	(0.03)	(0.02)	(0.02)	(0.02)	(0.04)
Medicare T	0.05	0.02	-0.01	-0.08***	-0.01	-0.01	-0.01	-0.04
	(0.04)	(0.03)	(0.03)	(0.03)	(0.02)	(0.02)	(0.02)	(0.04)
Medicaid T	0.12**	-0.02	-0.04	-0.05	0.00	-0.02	-0.00	0.01
	(0.06)	(0.06)	(0.05)	(0.04)	(0.04)	(0.04)	(0.04)	(0.07)
Medicare T	0.15***	0.00	-0.06	-0.12***	0.01	-0.00	-0.01	0.00
	(0.06)	(0.05)	(0.05)	(0.04)	(0.04)	(0.04)	(0.04)	(0.06)
Republican	-0.04	0.11**	-0.18***	-0.10***	-0.12***	-0.13***	-0.11***	-0.29***
	(0.05)	(0.05)	(0.05)	(0.04)	(0.03)	(0.03)	(0.03)	(0.06)
Medicaid T × Republican	-0.11	0.07	0.01	0.01	0.03	-0.01	0.01	-0.04
	(0.09)	(0.08)	(0.08)	(0.06)	(0.06)	(0.06)	(0.06)	(0.10)
Medicare T × Republican	-0.18**	-0.02	0.00	0.01	-0.03	0.00	-0.03	-0.16
	(0.09)	(0.08)	(0.08)	(0.06)	(0.06)	(0.05)	(0.05)	(0.10)
Panel C: Descriptive statistics								
Control mean	0.42	0.28	0.74	0.90	0.89	0.91	0.90	-0.00
Male control mean	0.40	0.27	0.70	0.86	0.87	0.88	0.88	-0.09
Democrat control mean	0.43	0.25	0.83	0.93	0.93	0.97	0.96	0.13
Republican control mean	0.38	0.35	0.64	0.85	0.80	0.83	0.83	-0.17
Observations	1055	1055	1055	1055	1055	1055	1055	1055

Notes: The dependent variables in columns 1-3 are indicator variables equal to one if the respondent thinks that the extent to which more generous health insurance would encourage people towards the behaviors listed ranges from *a lot* to *a great deal*. *Employer insurance discourages quitting bad job:* the dependent variable is an indicator variable equal to one if the respondent thinks that health insurance through the employer would discourage people from quitting a bad job or switching jobs out of fear of losing their health insurance. The dependent variables in columns 5-7 are indicator variables equal to one if: *Health in US worse if ↓ insurance:* the respondent agrees or strongly agrees that with less generous health insurance, health in the U.S. would be worse since they could not afford appropriate medical care; *↑ preventive healthcare, ↓ costs:* the respondent agrees or strongly agrees that more generous insurance coverage for preventive care can lead to a reduction in total medical costs; *Healthcare to all important bc of contagion:* the respondent agrees or strongly agrees that it is important that everyone can afford proper health care because people who become sick with a contagious disease could have negative effects on others too; *Efficiency index:* index that captures whether the respondent supports efficiency arguments in favor of having health insurance. Standard errors in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. Data from the 2025 survey.

Figure 7: Perceived Mechanisms of Health Insurance



Notes: This chart displays the proportion of respondents who agree with statements about the mechanisms of health insurance, along with their 90% confidence intervals. Data from the 2019 and 2025 surveys.

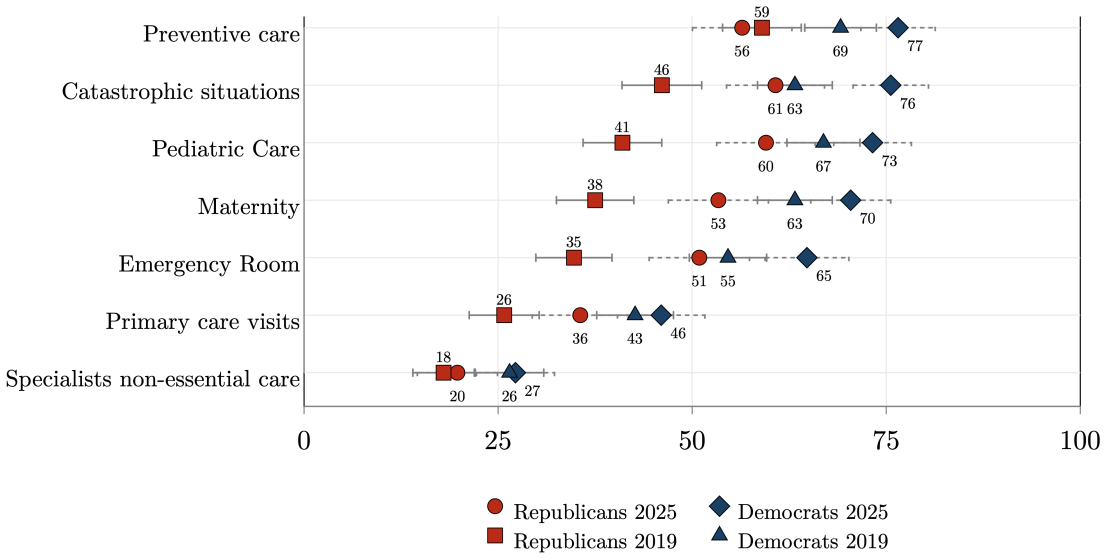
Table 3: Equity Considerations of Health Insurance

	↑ insurance, ↓ financial stress	Important to to help low-incomes	Unfair to pay more if: Pre-existing conditions	Worse health	Health issue outside of own control	Equity index
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A: Personal Characteristics						
Female	0.07***	0.01	0.09***	0.07***	0.05*	0.16***
	(0.02)	(0.02)	(0.03)	(0.02)	(0.03)	(0.04)
Republican	-0.07***	-0.16***	-0.18***	-0.11***	-0.11***	-0.51***
	(0.02)	(0.02)	(0.03)	(0.03)	(0.03)	(0.05)
Age 30-49	0.02	-0.03	0.05	0.05	-0.06*	0.04
	(0.02)	(0.03)	(0.04)	(0.03)	(0.04)	(0.06)
Age 50-69	0.00	-0.04	0.01	0.04	-0.09**	-0.04
	(0.02)	(0.03)	(0.04)	(0.03)	(0.04)	(0.06)
Middle-Income	0.01	0.01	0.02	-0.01	-0.07	-0.06
	(0.03)	(0.03)	(0.04)	(0.04)	(0.04)	(0.07)
High-Income	-0.01	-0.00	0.02	0.00	-0.06	-0.06
	(0.02)	(0.03)	(0.03)	(0.03)	(0.04)	(0.06)
Panel B: Video treatment effects						
Medicaid T	0.01	-0.00	-0.02	-0.02	0.02	-0.08
	(0.02)	(0.02)	(0.03)	(0.03)	(0.03)	(0.05)
Medicare T	0.01	0.03	-0.01	0.01	0.00	-0.00
	(0.02)	(0.02)	(0.03)	(0.03)	(0.03)	(0.05)
Medicaid T	0.01	0.00	-0.01	-0.03	0.11**	-0.02
	(0.03)	(0.04)	(0.05)	(0.05)	(0.05)	(0.08)
Medicare T	0.04	0.01	-0.04	-0.02	0.01	0.01
	(0.03)	(0.04)	(0.05)	(0.04)	(0.05)	(0.08)
Republican	-0.05*	-0.17***	-0.18***	-0.11***	-0.09**	-0.47***
	(0.03)	(0.03)	(0.04)	(0.04)	(0.04)	(0.07)
Medicaid T × Republican	-0.02	0.01	-0.02	-0.02	-0.15*	-0.13
	(0.05)	(0.06)	(0.07)	(0.07)	(0.08)	(0.12)
Medicare T × Republican	-0.07*	0.04	0.00	0.01	0.04	-0.03
	(0.05)	(0.06)	(0.07)	(0.06)	(0.07)	(0.12)
Panel C: Descriptive statistics						
Control mean	0.93	0.88	0.80	0.85	0.76	0.00
Male control mean	0.89	0.89	0.76	0.82	0.74	-0.05
Democrat control mean	0.94	0.95	0.87	0.90	0.79	0.20
Republican control mean	0.90	0.79	0.69	0.79	0.71	-0.26
Observations	1055	1055	1055	1055	1055	1055

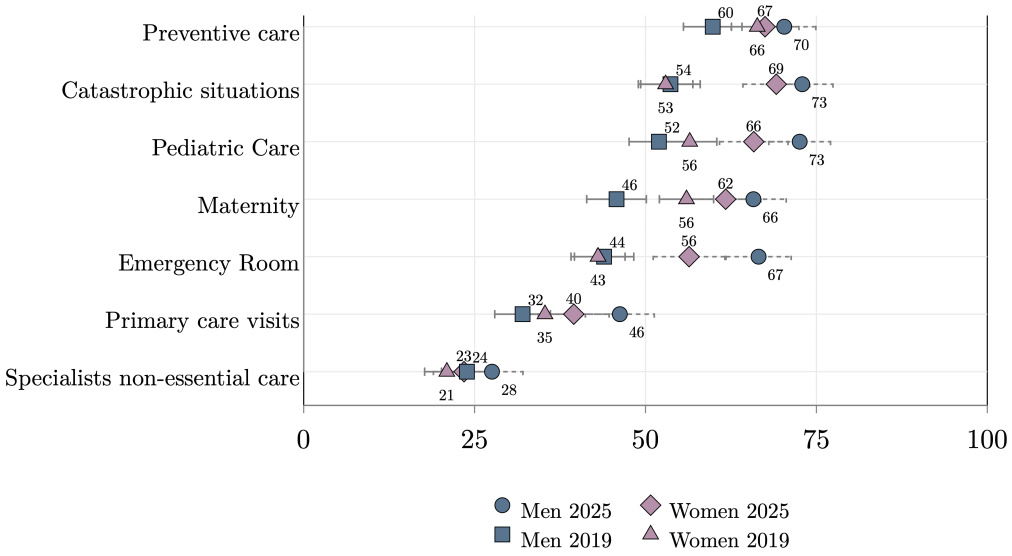
Notes: The dependent variables, with the exception of column (6), are indicator variables equal to one if the following conditions are met. For ↑ *insurance,* ↓ *financial stress:* the respondent agrees or strongly agrees that more generous health insurance can help people deal with unexpected large medical costs, reducing financial stress. For *Important to help low-incomes:* the respondent agrees or strongly agrees that it is important to financially help low-income families so that they can afford medical care. For *Unfair to pay more if pre-existing conditions:* the respondent believes that it is unfair or very unfair that people with pre-existing conditions have to pay more for their health insurance than people without pre-existing conditions. For *Unfair to pay more if worse health:* the respondent believes that it is unfair or very unfair that people born with worse health have to pay more for health care or insurance than people born with better health. For *Health issue out of own control:* the respondent believes that health issues are mostly the result of circumstances outside of one's control. Finally, *Equity index* is an index that captures whether the respondent supports equity arguments in favor of having health insurance. Standard errors in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. Data from the 2025 survey.

Figure 8: Support Full Coverage for the Following Services

(a) By Political Affiliation



(b) By Gender



Notes: Panel (A) presents the proportion of respondents who support full coverage for the listed categories of medical services, categorized by political affiliation (Republican or Democrat), along with their 90% confidence intervals. Panel (B) displays the results separated by gender. Data from the 2019 and 2025 surveys.

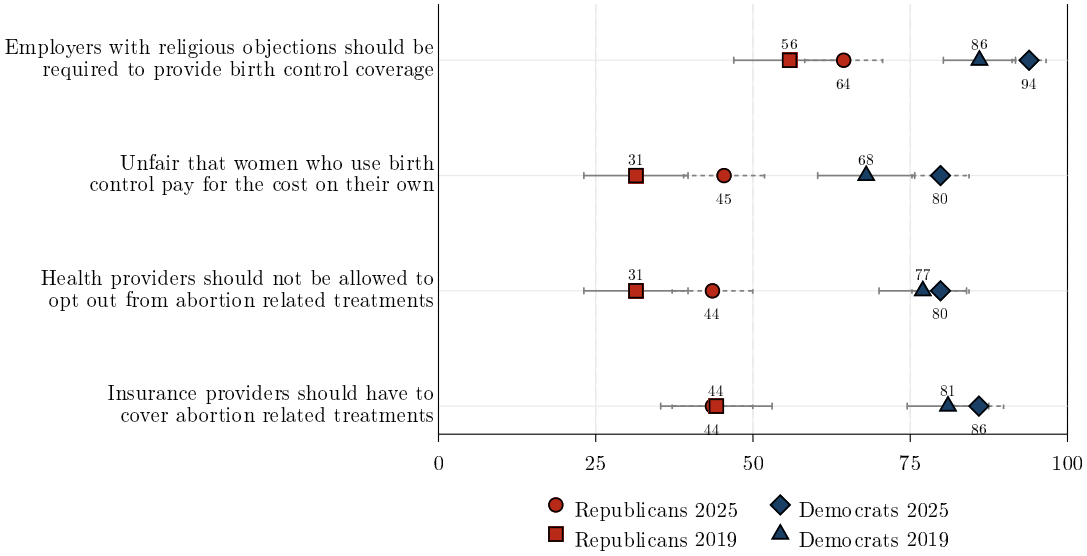
Table 4: Support Full Coverage for the Following Services

	Catastrophic situations	Pediatric care	Preventive care	Maternity	Emergency room	Primary care visits	Specialists non-essential care
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Panel A: Personal Characteristics							
Republican	-0.16***	-0.15***	-0.20***	-0.15***	-0.12***	-0.13***	-0.09***
	(0.03)	(0.04)	(0.03)	(0.04)	(0.04)	(0.04)	(0.03)
Female	-0.02	0.02	0.05*	-0.01	-0.04	-0.05	-0.04
	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)
Age 30-49	-0.03	0.08*	0.13***	0.04	0.00	0.07	-0.03
	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)
Age 50-69	-0.02	0.07*	0.18***	-0.05	0.00	0.08*	-0.05
	(0.04)	(0.04)	(0.04)	(0.04)	(0.05)	(0.05)	(0.04)
Middle-Income	0.01	-0.03	0.05	-0.01	-0.05	0.05	-0.03
	(0.04)	(0.05)	(0.04)	(0.05)	(0.05)	(0.05)	(0.04)
High-Income	0.02	-0.04	0.07*	-0.03	-0.08**	-0.03	-0.11***
	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)
Panel B: Video treatment effects							
Medicaid T	-0.02	-0.02	-0.01	0.03	0.02	0.01	0.07**
	(0.03)	(0.04)	(0.03)	(0.04)	(0.04)	(0.04)	(0.03)
Medicare T	-0.02	-0.02	-0.01	0.05	0.02	0.03	0.03
	(0.03)	(0.03)	(0.03)	(0.04)	(0.04)	(0.04)	(0.03)
Medicaid T	0.02	-0.01	0.03	0.03	0.06	0.07	0.15***
	(0.06)	(0.06)	(0.06)	(0.06)	(0.06)	(0.06)	(0.05)
Medicare T	-0.03	0.03	-0.01	0.04	0.01	0.02	0.01
	(0.05)	(0.05)	(0.05)	(0.05)	(0.06)	(0.06)	(0.05)
Medicaid T × Republican	-0.06	0.05	-0.05	0.02	0.01	-0.14	-0.14*
	(0.08)	(0.08)	(0.08)	(0.09)	(0.09)	(0.09)	(0.08)
Medicare T × Republican	0.00	-0.08	0.02	0.03	0.05	0.02	0.01
	(0.08)	(0.08)	(0.08)	(0.08)	(0.08)	(0.09)	(0.08)
Panel C: Underlying mechanisms							
Republican	-0.06	-0.03	-0.09***	-0.05	-0.01	-0.03	-0.03
	(0.03)	(0.04)	(0.03)	(0.04)	(0.04)	(0.04)	(0.03)
Efficiency index	0.11***	0.11***	0.20***	0.08***	0.03	0.10***	0.04
	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)
Equity Index	0.12***	0.15***	0.09***	0.13***	0.17***	0.12***	0.10***
	(0.02)	(0.03)	(0.02)	(0.03)	(0.03)	(0.03)	(0.02)
Government trust Index	0.03	0.03	-0.01	0.05**	0.05**	0.00	0.02
	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
Panel D: Descriptive statistics							
Control mean	0.71	0.69	0.69	0.64	0.62	0.43	0.26
Male control mean	0.73	0.73	0.70	0.66	0.67	0.46	0.28
Democrat control mean	0.76	0.73	0.77	0.70	0.65	0.46	0.27
Republican control mean	0.61	0.60	0.56	0.53	0.51	0.36	0.20
Observations	1055	1055	1055	1055	1055	1055	1054

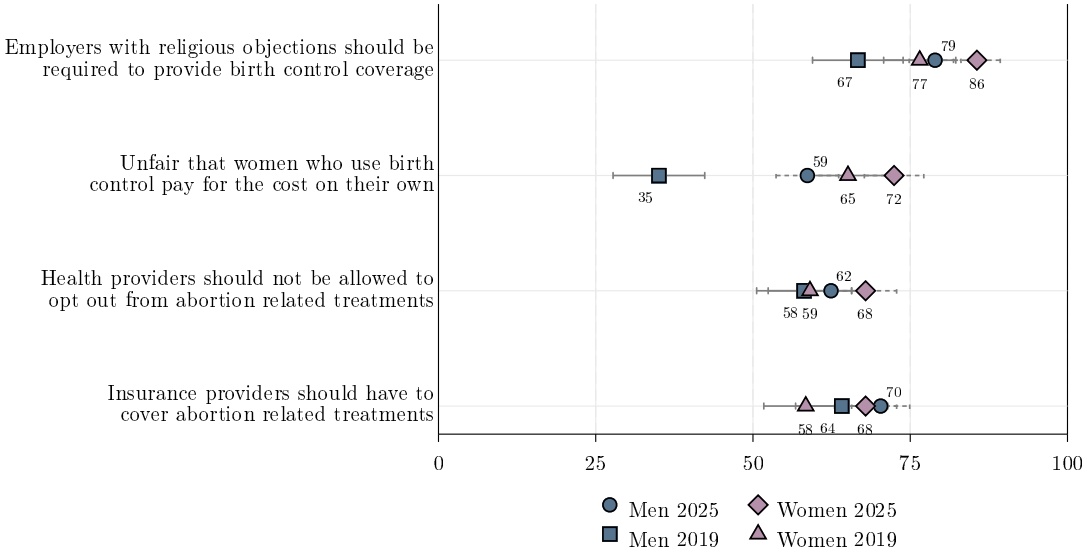
Notes: The dependent variables are indicator variables equal to one if the respondent supports full coverage (the patient pays no costs out of pocket) for the medical services listed. Standard errors in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. Data from the 2025 survey.

Figure 9: Reproductive Health

(a) By Political Affiliation



(b) By Gender



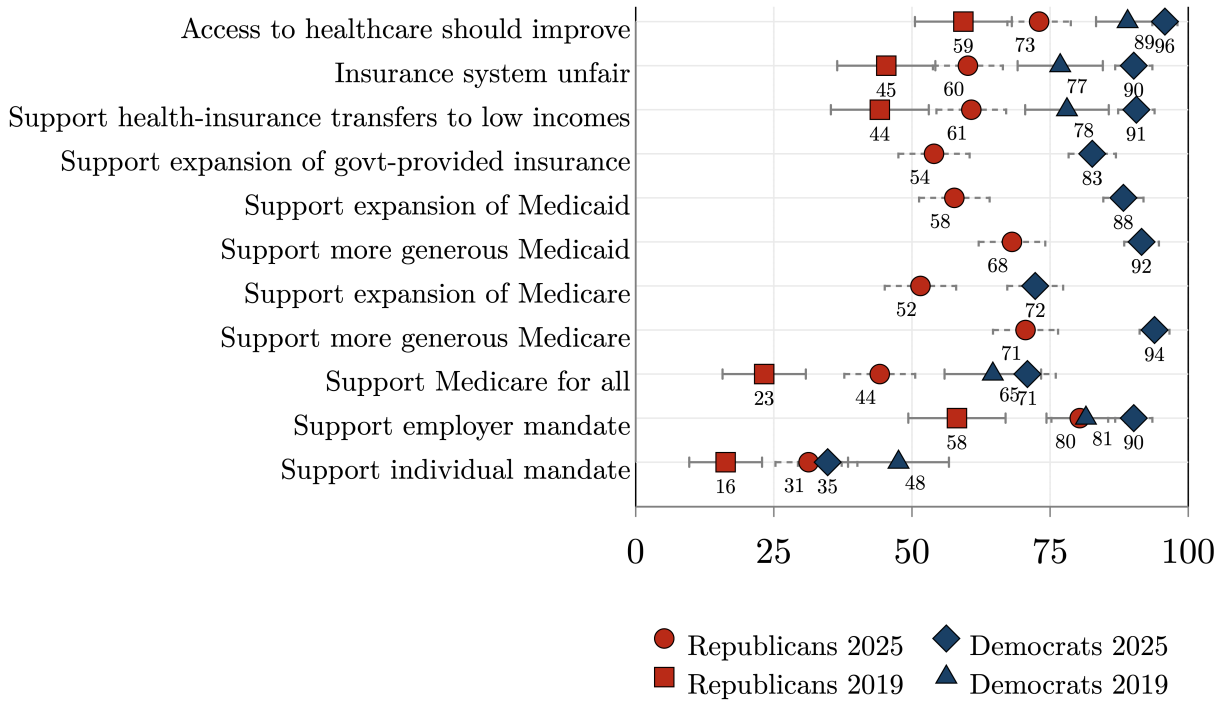
Notes: Panel (A) presents the proportion of respondents who agree with statements about reproductive health policies, categorized by political affiliation (Republican or Democrat), along with their 90% confidence intervals. Panel (B) displays the results separated by gender. Data from the 2019 and 2025 surveys.

Table 5: Policy Views on Health Insurance

	Access to healthcare should be improved (1)	Insurance system unfair (2)	Support transfers to low-inc. (3)	Support govt. prov. expansion (4)	Support Medicaid expansion (5)	Support Medicaid more gen. (6)	Support Medicare expansion (7)	Support Medicare more gen. (8)	Support Medicare for all (9)	Support employer mandate (10)	Support individual mandate (11)
Panel A: Personal Characteristics											
Republican	-0.20***	-0.23***	-0.30***	-0.29***	-0.28***	-0.25***	-0.17***	-0.18***	-0.30***	-0.10***	-0.04
	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.04)	(0.03)	(0.03)
Female	0.03	0.03	-0.00	0.03	0.02	0.02	-0.00	0.04*	-0.02	0.01	-0.00
	(0.02)	(0.03)	(0.03)	(0.03)	(0.03)	(0.02)	(0.03)	(0.02)	(0.03)	(0.02)	(0.03)
Age 30-49	0.10***	0.07*	0.02	-0.05	-0.07*	-0.03	0.01	-0.03	-0.00	0.01	-0.05
	(0.03)	(0.04)	(0.03)	(0.04)	(0.03)	(0.03)	(0.04)	(0.03)	(0.04)	(0.03)	(0.04)
Age 50-69	0.09***	0.05	0.02	-0.06	-0.12***	-0.09***	-0.01	-0.03	-0.07*	-0.02	-0.02
	(0.03)	(0.04)	(0.04)	(0.04)	(0.04)	(0.03)	(0.04)	(0.03)	(0.04)	(0.04)	(0.04)
Middle-Income	0.02	0.01	-0.06	0.01	-0.05	-0.04	-0.03	-0.01	-0.05	0.05	-0.02
	(0.03)	(0.04)	(0.04)	(0.04)	(0.04)	(0.04)	(0.05)	(0.03)	(0.05)	(0.04)	(0.04)
High-Income	0.03	0.01	-0.07**	-0.00	-0.14***	-0.09***	-0.11***	-0.02	-0.04	0.06*	0.05
	(0.03)	(0.03)	(0.03)	(0.04)	(0.03)	(0.03)	(0.04)	(0.03)	(0.04)	(0.03)	(0.04)
Panel B: Video treatment effects											
Medicaid T	-0.07***	-0.08***	-0.02	0.03	0.08***	0.03	0.10***	0.02	0.06	0.02	-0.01
	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.04)	(0.03)	(0.03)
Medicare T	-0.01	-0.10***	-0.01	0.04	0.04	0.01	0.08**	0.01	0.05	-0.01	-0.04
	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.04)	(0.03)	(0.03)
Medicaid T	-0.06	-0.09*	-0.03	0.04	0.05	0.05	0.06	-0.00	0.04	0.04	-0.04
	(0.04)	(0.05)	(0.05)	(0.05)	(0.05)	(0.05)	(0.06)	(0.04)	(0.06)	(0.05)	(0.05)
Medicare T	-0.03	-0.14***	0.02	0.06	0.02	0.01	0.05	-0.05	0.09	-0.02	-0.04
	(0.04)	(0.05)	(0.05)	(0.05)	(0.05)	(0.04)	(0.05)	(0.04)	(0.05)	(0.04)	(0.05)
Republican	-0.22***	-0.28***	-0.30***	-0.29***	-0.30***	-0.23***	-0.20***	-0.22***	-0.30***	-0.10**	-0.06
	(0.04)	(0.04)	(0.04)	(0.05)	(0.04)	(0.04)	(0.05)	(0.04)	(0.05)	(0.04)	(0.05)
Medicaid T × Republican	-0.02	0.06	0.01	-0.01	0.02	-0.06	0.07	0.05	0.00	-0.03	0.06
	(0.06)	(0.07)	(0.07)	(0.08)	(0.07)	(0.07)	(0.08)	(0.06)	(0.09)	(0.07)	(0.08)
Medicare T × Republican	0.10	0.13*	-0.01	0.02	0.05	-0.01	0.07	0.13**	-0.01	-0.00	0.02
	(0.06)	(0.07)	(0.07)	(0.08)	(0.07)	(0.06)	(0.08)	(0.06)	(0.08)	(0.07)	(0.08)
Panel C: Underlying mechanisms											
Republican	-0.11***	-0.15***	-0.14***	-0.15***	-0.15***	-0.12***	-0.04	-0.06**	-0.16***	-0.02	-0.02
	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)	(0.03)
Efficiency index	0.05**	0.08***	0.10***	0.10***	0.02	0.02	0.08***	0.07***	0.04	0.07***	-0.01
	(0.02)	(0.03)	(0.02)	(0.03)	(0.02)	(0.02)	(0.03)	(0.02)	(0.03)	(0.02)	(0.03)
Equity Index	0.12***	0.15***	0.18***	0.11***	0.15***	0.15***	0.12***	0.13***	0.15***	0.07***	-0.01
	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
Government trust Index	0.03*	-0.06***	0.10***	0.17***	0.19***	0.17***	0.15***	0.10***	0.19***	0.07***	0.11***
	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)
Panel D: Descriptive statistics											
Control mean	0.87	0.81	0.78	0.72	0.75	0.81	0.63	0.84	0.58	0.83	0.30
Male control mean	0.85	0.78	0.80	0.71	0.74	0.81	0.65	0.83	0.61	0.83	0.35
Democrat control mean	0.96	0.90	0.91	0.83	0.88	0.92	0.72	0.94	0.71	0.90	0.35
Republican control mean	0.73	0.60	0.61	0.54	0.58	0.68	0.52	0.71	0.44	0.80	0.31
Observations	1055	1055	1055	1055	1053	1055	1055	1055	1055	1055	1055

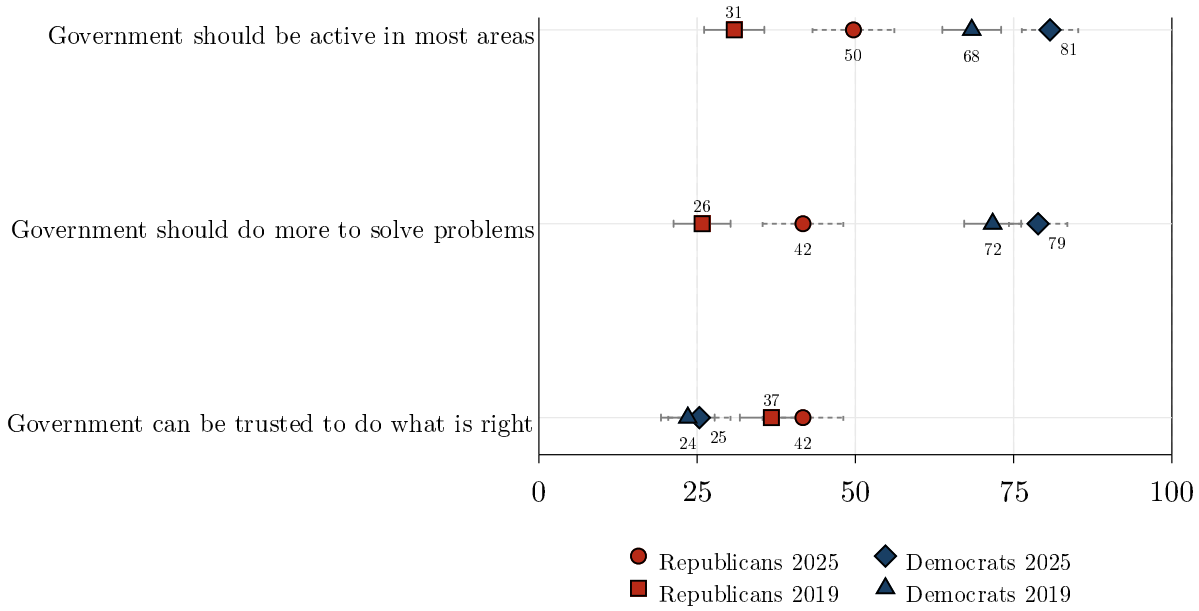
Notes: The dependent variables are indicator variables equal to one if the following conditions are met. For *Access to healthcare should improve:* the respondent believes that access to healthcare should be improved for many families. For *Insurance system unfair:* the respondent believes that the U.S. insurance system is somewhat unfair or very unfair. For *Support transfers to low-inc.:* the respondent supports or strongly supports providing additional transfers or subsidies to low-income families to help them with the costs of their health care. For *Support govt. prov. expansion:* the respondent supports or strongly supports expanding U.S. government-provided insurance, reducing people's reliance on employer-provided insurance. For *Support Medicaid expansion:* the respondent supports or strongly supports expanding Medicaid's eligibility. For *Support Medicaid more gen.:* the respondent supports or strongly supports making Medicaid more generous by expanding the services it covers. For *Support Medicare expansion:* the respondent supports or strongly supports lowering the age eligibility threshold for Medicare, expanding its coverage. For *Support Medicare more gen.:* the respondent supports or strongly supports making Medicare more generous by expanding the services it covers. For *Medicare for all: support:* the respondent supports or strongly supports Medicare-for-all. For *Support employer mandate:* the respondent supports or strongly supports having an employer mandate whereby every large employer is obliged to offer health insurance plans for employees. For *Support individual mandate:* the respondent supports or strongly supports having an individual mandate. Standard errors in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. Data from the 2025 survey.

Figure 10: Policy Preferences for Health Insurance



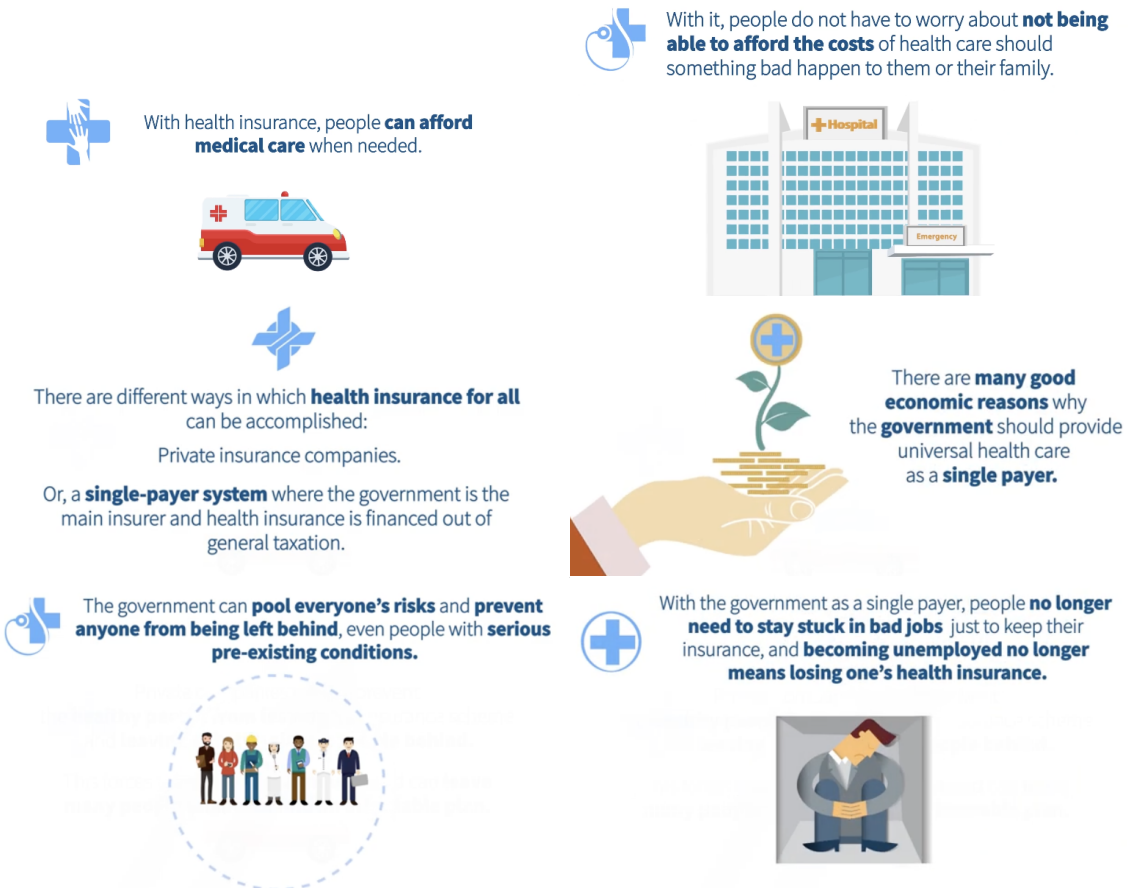
Notes: This chart shows the proportion of respondents who agree with the listed statements about health insurance policy, along with their 90% confidence intervals. Data from the 2019 and 2025 surveys.

Figure 11: Trust and involvement of the government



Notes: The row *Government should be active in most areas* is the share of respondents who answer 4 or 5 on a scale from 1 to 5, where 1 means the respondent thinks that the government should only provide basic government functions and 5 means they think that the government should take active steps in every area to improve lives. *Government should do more to solve problems* is the share of respondents who answer that the government should do more to solve the country's problems (as opposed to already doing too much or doing just the right amount); *Government can be trusted to do what is right* is the share of respondents who think that they can trust the federal government to do what is right almost always/ a lot of the time. 90% confidence intervals are depicted. Data from the 2019 and 2025 surveys.

Figure 12: Redistribution treatment



Notes: The figure shows screenshots from the information treatment on the distributive effects of health. The link to the video can be found here.

FIGURE 13: EFFICIENCY TREATMENT

Notes: The figure shows screenshots from the information treatment on the efficiency effects of health. The link to the video can be found here.

Figure 14: Economist treatment

Notes: The figure shows screenshots from the information treatment on the economic effects of health. The link to the video can be found here.

Figure 15: Medicaid Treatment

Notes: The figure shows screenshots from the information treatment on Medicaid. The link to the video can be found here.

Figure 16: Medicare Treatment

Notes: The figure shows screenshots from the information treatment on Medicare. The link to the video can be found here.

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