Consensus in Care:
Deservingness, Policy Feedback, and Partisanship
in the U.S. Long-Term Care System

DARTMOUTH

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Abstract

In the United States, the public long-term care program is a politically unique entity. Medicaid long-term care combines elements of social and health policy, sits at the intersection of means-tested and universal programs, and is rapidly departing from its original purpose to meet the demands of an aging middle-class population. Currently, it is unclear how the unique program structure of the United States' public long-term care benefit impacts support for the program and its beneficiaries. This paper investigates three main research questions: (1) Do cues about the deservingness of long-term care beneficiaries, such as the ailment necessitating care, impact support for long-term care in a manner similar to other health and social benefits? (2) How does the long-term care benefit's relationship to Medicaid, a means-tested program, impact both overall evaluations and the effect of cues about beneficiary deservingness? (3) Does public opinion about the hypothetical beneficiaries of government programs change when the beneficiaries' political party is known? Using a survey experiment, we manipulate various characteristics of a hypothetical long-term care beneficiary to investigate these questions. While survey respondents have stronger support for providing long-term care to dementia patients rather than smokers, the effect is small and overall support for the program remains high. Further, the program's relationship to Medicaid does not change this pattern and, if anything, serves to decrease the effect of cues about deservingness on evaluations of beneficiaries and the program. Finally, contrary to a broad body of literature on affective partisan polarization, partisans do not consistently or significantly disfavor beneficiaries of the opposite political party in the context of support for receiving government long-term care. This research suggests that in a time of increasing partisan polarization, the long-term care benefit does not activate many of the partisan hostilities that traditionally accompany means-tested health and social policy. Americans generally support long-term care, regardless of its relationship to Medicaid, and these patterns of support are not substantially altered in the face of cues about long-term care beneficiaries' political party or level of responsibility for their current condition.

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Chapter 1

Introduction

As this thesis is completed at the height of the COVID-19 pandemic and nursing homes have exhibited a propensity for infection outbreaks, long-term care has taken center stage in the public consciousness (Margolies 2020). Perhaps more than anything, this crisis has revealed the invaluable role of long-term care in a thriving society and underscored the urgency of creating a functional long-term care system. As part of that effort, this research seeks to understand how the program structure of the United States' public long-term care benefit impacts support for the long-term care program and the citizens who are its beneficiaries. Long-term care (LTC), also known as long-term services and supports (LTSS), is defined as "assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping)" (Reaves and Musumeci 2015). In the United States, Medicaid, the public health insurance program for low-income citizens, is the primary payer and sole government provider of long-term care services for Americans requiring assistance with daily self-care tasks. In the coming decades, long-term care will account for an increasingly large share of federal and state budgets as the population rapidly ages and more citizens require long-term care.

Currently, it is unclear how public perceptions of the LTC program fit into the existing

frameworks of public opinion formation about government programs and their beneficiaries. This research seeks to understand whether people are responsive to deservingness cues about hypothetical public LTC beneficiaries and in turn whether these cues extend to their overall support of the program. While there has been an abundance of research about deservingness evaluations in the context of welfare, social insurance programs, and health care, research has yet to address this question in the context of long-term care. There is value in studying the long-term care benefit specifically, as this program uniquely sits at the intersection of health care and social policy. Long-term care has neither the high level of technicality that comes with traditional health care, nor the abundant partisan rhetoric surrounding welfare programs in the United States. Further, long-term care's targeting of a historically sympathetic beneficiary population (the frail and elderly) may generate political dynamics that are distinct from traditional health care and welfare programs (Schneider and Ingram 1993).

The nature of long-term care itself is not the only relevant consideration in assessing public opinion. In addition, this research seeks to assess whether the eligibility design of the long-term care benefit impacts evaluations of long-term care beneficiaries, responsiveness to deservingness cues, and overall program support. Specifically, does the relationship of public LTC with Medicaid (a means-tested program) impact evaluations of beneficiary deservingness, or does the de-facto universal nature of the program and its sympathetic beneficiary population dominate? Government LTC is administered through Medicaid, which is traditionally classified as a contentious and partisan means-tested program (Grogan and Park 2017; Henderson and Hillygus 2011). However, the program's position as the de-facto LTC provider to millions of middle class Americans challenges this reality. Because Medicare does not cover the majority of LTC services, many Americans who are part of the middle class for the majority of their lives will engage in asset spend-down and transfer behaviors to become eligible for Medicaid LTC in their old age (Ramsay 2000). Thus, the beneficiary population for Medicaid long-term care is distinct from the rest of the Medicaid beneficiary

population and, more broadly, distinct from the beneficiary population of most means-tested programs. This research seeks to understand if the perception of public LTC beneficiaries is modified by considerations about its unique program structure, or if people activate evaluative frameworks more akin to those used for the social insurance programs with elderly and middle-class beneficiary populations.

Finally, this study seeks to understand whether citizens are more or less willing to allocate the long-term care benefit to beneficiaries of the same or opposite political party. While the impact of party cues has been well-studied in the context of issue positions and elite messaging, very little research has investigated how the partisanship of program beneficiaries impacts the desire to allocate or restrict benefits to fellow citizens. This research investigates whether people are significantly more likely to view copartisans as deserving of government benefits and whether they are significantly less likely to view opposite partisans as deserving of government benefits. This represents a new contribution to the literature on deservingness and literature on affective partisan polarization in the United States.

Due to the paucity of public opinion research on the long-term care benefit, we design a survey experiment to shed light on these three research questions. Survey respondents are asked to evaluate their support for a hypothetical beneficiary of the long-term care benefit and are subsequently asked about their support for the program generally and whether they support increased funding to the program. We manipulate various characteristics of the hypothetical beneficiary and framings of the long-term care program to investigate drivers of public opinion. To test whether deservingness is a relevant consideration in calculations of support for long-term care, we manipulate the hypothetical beneficiary's ailment that warrants long-term care. To test whether the program's relationship to Medicaid impacts these patterns, we manipulate how we frame the definition of the long-term care program given to survey respondents. Finally, we manipulate the political party of the beneficiary to examine whether people evaluate beneficiaries of the opposite political party more harshly than beneficiaries of their own political party.

Overall, the results indicate that deservingness cues have a small but significant effect on support for long-term care and its beneficiaries, and these effects are larger for Republicans and Independents than for Democrats. However, these cues do not completely reverse otherwise strong support for the program and its beneficiaries. Further, the long-term care benefit's relationship to Medicaid does not significantly change the way long-term care is evaluated. If anything, the provision of information about Medicaid serves to mitigate an otherwise reliable effect of deservingness cues on beneficiary and program support. When the the opposite causal framework is investigated, the evidence supports that attributing the long-term care benefit to Medicaid increases Medicaid support among Republicans and Independents, rather than Medicaid diminishing support for long-term care. Finally, the results do not indicate a powerful or consistent effect of the relationship between a respondent's political party and a beneficiary's political party on evaluations of deservingness and program support. Contrary to a broad body of literature, in this instance, partisans do not consistently or significantly disfavor beneficiaries of the opposite political party in the context of support for receiving government long-term care.

In the following chapter, we provide a review of existing literature motivating our analysis. In Chapter 3, we provide an overview of our survey design and hypotheses. In Chapter 4, we analyze responsiveness to deservingness cues, including treatment effects by party identification, health behaviors, and personal experience with the long-term care program. In Chapter 5, we review whether attributing the long-term care benefit to Medicaid impacts overall evaluations of the long-term care program and the effect of deservingness cues discussed in the previous chapter. In Chapter 6, we evaluate whether attributing the long-term care benefit to Medicaid impacts support for Medicaid itself. In Chapter 7, we report results for the partisanship portion of the survey experiment. In Chapter 8, we discuss additional demographic factors that impact support for long-term care. In the final chapter, we conclude and discuss remaining questions that warrant further research.

Chapter 2

Literature Review

2.1 Policy Background: Medicaid Long-Term Care

Public long-term care is a particularly important program to study because its implementation diverges sharply from the program's original purpose. For the majority of its existence, the Medicaid long-term care benefit has been extended beyond its articulated mission of providing care to indigent citizens to providing long-term care for the middle class. Due to the lack of a social insurance program, like Medicare or Social Security, providing long-term care in the United States, many middle class seniors who would not normally qualify for Medicaid plan their estates so that they will qualify for Medicaid in their old age. While regulations prohibit asset transfers immediately prior to application for Medicaid, a number of legal loopholes still allow assets to be transferred with the proper planning. Spending-down behaviors, gifting, trust creation, and home equity asset protection represent some of the most common mechanisms by which middle-income seniors legally qualify for Medicaid in order to acquire long-term care coverage (Ramsay 2000). An entire industry of Medicaid estate planning has been constructed to adapt to evolution in Medicaid's complex eligibility regulations.

Attitudes surrounding this phenomenon reflect a great deal of ambivalence. Some laud

Medicaid estate planning as a way to preserve seniors' financial legacy while also allowing them to receive affordable long-term care services (Ramsay 2000). Others have dubbed the practice "legal welfare fraud" and noted the consequences this practice has for diverting scarce resources away from poor families in need of health care (Wegner and Yuan 2004). Given the divergent opinions on this practice at the elite and individual level, it is unclear how beneficiaries of the long-term care program are perceived. Regardless of public perception about Medicaid's extension to the middle class, it is a ubiquitous practice that makes it difficult to classify the political dynamics of the long-term care program.

The long-term care program will only become more salient in the future. Today, at least 64 percent of Americans in nursing homes are dependent on Medicaid. While these beneficiaries account for only 6 percent of Medicaid enrollees, nursing homes account for 42 percent of all Medicaid spending (Rau 2017). Not only is the elderly population projected to grow substantially in the next decade, but seniors are also projected to have lower overall savings and fewer will have pensions (Pearson et al. 2019). As the demand for public long-term care and its strain on the Medicaid budget will only increase, public opinion about this program, its relationship to Medicaid, and its beneficiaries warrants further exploration.

2.2 Deservingness

The well-established deservingness heuristic holds that support for government programs is influenced by whether program beneficiaries are perceived as "deserving." In the words of Ellis and Faricy (2019), the deservingness heuristic "undergirds how citizens make sense of social policy: above and beyond cultural or partisan predispositions, citizens wish to bestow government aid on those perceived as unlucky... and wish to behold benefits from those perceived as lazy and unsympathetic" (Ellis and Faricy 2019). Due to the power of the deservingness heuristic in shaping public attitudes, public impressions of beneficiary populations in turn shape the policy structure of the programs targeted at the population.

As such, scholars find value in establishing whether and to what degree people change their support for individual beneficiaries and the programs themselves in the face of cues about beneficiary deservingness.

There is a robust body of literature surrounding citizens' attitudes toward beneficiaries of various social insurance and welfare programs. Beneficiaries of welfare programs, which are typically redistributive in nature and target high-need populations, are evaluated by others based on cues about their deservingness (Applebaum 2001; Petersen et al. 2011; Aarøe and Petersen 2014; Hansen 2019). While people generally support aid for people who are the victims of circumstances outside of their control, they oppose welfare provision for those who require services as a result of laziness (Petersen et al. 2011). Recent research has found that deservingness heuristics may also play a role in attitude formation for certain social insurance programs, in addition to means-tested welfare programs (Fang and Huber 2019).

With respect to the role deservingness heuristics play in the evaluation of public health care programs, the literature lacks a clear consensus. Some literature suggests that health care is distinct from traditional social policies in the heuristic frameworks employed to evaluate the deservingness of policy beneficiaries. Whereas welfare policies tend to activate a deservingness heuristic, researchers have found that those in need of medical care are viewed as inherently deserving of medical services, regardless of their circumstances (Jensen and Petersen 2017). This bias may exist because caring for the sick is an evolutionarily developed practice, whereas unemployment is a relatively new phenomenon. This bias may also exist because health care is politically distinct from traditional welfare. Generally speaking, health care policies are traditionally viewed as less politicized than social policies. Compared to redistributive federal welfare programs, support for federal health initiatives has historically been less identified with minorities, less constrained by notions of individual responsibility, more associated with concerns about equal opportunity, and more constrained by choices between federal and local government (Schlesinger and Lee 1993; Carpenter 2012).

Recent literature, however, challenged the consensus on attitudes about health care. Fang

and Huber's research on Social Security Disability Insurance (SSDI) found that citizens utilize informational cues about the specific kind of health impairments of SSDI beneficiaries to inform opinions about their deservingness of disability benefits (Fang and Huber 2019). The authors posit that this could be due to the recent politicization of SSDI benefits. Similarly, Gollust and Lynch (2011) found that while people are reluctant to blame or deny social support for health care cost in the face of explicit racial cues, they are responsive to explicit cues about the causal impact of individual behaviors on health. These attitudes extend beyond individual evaluations of deservingness to program support. Cook (1992) found that criteria of deservingness were important factors in predicting public support for Medicaid in 1992.

There is value in studying long-term care separately from general health care because it is unique in multiple respects. There is a high degree of misinformation about long-term care and its relationship to existing government programs. The majority of people are misinformed about Medicaid LTC along many dimensions, including cost, the risk of needing LTC, and the structure of government programs for public LTC. Only a small minority of Americans are able to correctly estimate the cost of LTC. Research has also shown that people chronically underestimate the cost and likelihood of needing LTC (Dick 2007). Only one quarter of Americans can identify Medicaid as the primary payer of LTC services. In a recent survey, 57% of Americans planned to rely on Medicare to provide ongoing living assistance, despite the fact that Medicare does not cover nursing home care or home health care (Swanson 2017). Clearly, there is wide variation in levels of knowledge about LTC, and this variation may prove significant in evaluations of deservingness.

Some people attribute the de-politicization of health care programs to the nature of the services provided. Health care involves highly technical work that generates professional sponsors which may mitigate politicization (Carpenter 2012). The majority of LTC services, however, require relatively lesser skilled labor over extended periods of time. Traditional health care tends to be highly technical, oftentimes with substantial and acute risks involved. It is possible that LTC and its relatively lower level of technicality generate different political

dynamics. While Americans are generally more accepting of redistribution in the context of traditional illnesses (Naumann 2018), it is not clear whether this applies to slowly progressing chronic illnesses that necessitate LTC late in life. Unlike most health-care, the nature of the social risk associated with needing LTC is a relatively new phenomenon. As people live longer and geographic dispersion of families is increasingly common, there are unprecedented numbers of Americans who will require the provision of LTC by a third party. Compared to generic medical ailments and traditional economic hardships, the need for third parties to provide LTC is a relatively new phenomenon that warrants further study.

Finally, there is utility in studying attitudes about the beneficiaries of government programs and their specific policy features, rather than health care, welfare, or social insurance in the abstract. Abstracting away from the eligibility criteria, target populations, and implementation of government programs diminishes "external validity for understanding actual political conflicts around existing policies" (Fang and Huber 2019). There is value in exploring these questions as they apply to the complex structure of the long-term care program and its actual implementation.

2.3 Policy Feedback

The nature of the long-term care benefit is not the only relevant consideration for assessing evaluations of deservingness. The policy design of the program is an additional potentially significant factor in shaping support for the long-term care program and its beneficiaries. Policy feedback is the process by which existing policies reshape the political environment, and in turn shape future policy (Campbell 2012). Initial analyses of policy feedback tended to focus on how existing policies shaped the attitudes and option sets of elite figures (Pierson 1993; Schneider and Ingram 1993), but more recently policy feedback literature has shifted to studying how policy design impacts the political behaviors and political attitudes of mass publics (Campbell 2012). There are a number of policy characteristics that generate policy

feedback effects, including the size and visibility of benefits (Mettler 2011), the proximity of beneficiaries, the program administration (Soss and Schram 2007), and more (Campbell 2012). Most policy feedback literature regarding mass publics focuses on how actual lived experience with the implementation of a program affects public attitudes and behaviors. However, recent research has shown that the design of a public program alone can influence public attitudes about the program and its target population. As one example of policy design impacting deservingness considerations, a public program's delivery mechanism (direct benefits versus benefits delivered through the tax code) is known to yield different perceptions of deservingness. Recipients of direct social spending are generally perceived as less deserving of benefits and these perceptions are more strongly conditioned by racial attitudes (Ellis and Faricy 2019).

The policy characteristic of interest in this study is the eligibility criteria for the long-term care benefit. It is well-established that the design of welfare policies can shape how the beneficiaries of those programs are viewed (Gilens 2000; Soss and Schram 2007; Ellis and Faricy 2019). Generally speaking, policies with universal eligibility (such as Social Security or Medicare) are perceived as having positive feedback effects insofar as they "help incorporate beneficiaries as full members of society, bestowing dignity and respect on them" (Mettler and Stonecash 2008). Means-tested programs, on the other hand, tend to "convey stigma and thus reinforce or expand beneficiaries' isolation" (Mettler and Stonecash 2008). As a result of these dynamics, universal programs tend to enjoy greater political and public support than means-tested programs in the United States. In the United States, "[m]iddle class universalism" has often "protected the welfare state against backlash" (Esping-Andersen 1990).

In their analysis of the political history of the long-term care program, Grogran and Patashnik assert that the long-term care benefit challenges the dichotomy between universal and means-tested programs that is traditionally utilized in public policy and political science literature. Medicaid's means-tested eligibility, in concert with its capacity to serve

mainstream populations, have placed Medicaid at a "political crossroads" between welfare and a mainstream social entitlement (Grogan and Patashnik 2003). They argue that the long-term care benefit has played a critical role in blurring the political rhetoric around Medicaid because it has given Medicaid the kind of middle class beneficiary population that has long been the political bulwark of social insurance programs, thus empowering a political response that "questioned the fundamental meaning of this ambiguously targeted program." (Grogan and Patashnik 2003) In other words, the highly sympathetic nature of Medicaid long-term care's beneficiary population (the formerly middle-class elderly) has served to make Medicaid more expansive and politically supported than it would be without this benefit.

While the long-term care benefit has likely shaped views of Medicaid, the relationship of influence is not unidirectional. What we aim to study through this paper is the inverse of this causal relationship. Namely, has the delivery of the long-term care benefit through Medicaid made citizens more critical of the long-term care benefit than they would otherwise be? In addition to studying an alternative causal framework, this study also examines a distinct dimension of support. Grogan and Patashnik primarily center their argument around elite rhetoric, claiming that politicians have strategically used the long-term care benefit to reframe discussions around Medicaid and increase elite support for its expansion. This study investigates this theory at the level of public opinion, asking whether the dynamic relationship between the long-term care benefit and Medicaid extends beyond the rhetoric of political actors to public opinion.

Fang and Huber (2019) recently studied a similar political dynamic, in which the beneficiary population of a government program complicated the political significance of its eligibility design. They explored how the implementation of the Social Security Disability Insurance (SSDI) Program has impacted evaluations of beneficiary deservingness. While SSDI is a universal program, some have argued that its discretionary eligibility criteria (namely, the medical ailments that cause disability), give the beneficiary population an appearance more akin to those of targeted means-tested programs. Fang and Huber (2019)

empirically demonstrated that this "targeting within universalism" has consequences for how people perceive this social insurance program and its beneficiaries. Building on this work at the intersection of deservingness literature and policy feedback literature, we aim to study the complement of this dynamic. In this case, the long-term care benefit causes Medicaid to benefit a broader middle class constituency than this means-tested program would otherwise serve. In this sense, Medicaid's long-term care benefit causes the program to effectively practice "universalism within targeting" (Grogan and Patashnik 2003). It is plausible that the de-facto universal nature of the LTC benefit affects the political dynamics typically associated with means-tested programs like Medicaid.

2.4 Partisanship

Scholars have studied how a variety of government program beneficiary characteristics, ranging from race to age, impact perceptions of beneficiary deservingness and, in turn, affect government program support. To our knowledge, however, existing research has not yet investigated the party identification of a program beneficiary as a potential factor influencing public opinion. This is a relevant consideration given that many government programs have the appearance of administering disproportionate benefits to certain political constituencies over others. For example, one study found that Democrats are about twice as likely as Republicans to have received food stamps at some point in their lives (Morin 2017). Other analyses have shown that, contrary to popular belief, federal programs reduced poverty among the GOP's base (working class whites) more so than non-college educated blacks and Latinos, which are traditionally Democratic constituencies (Brownstein 2017). On both sides of the aisle, discussions about the political constituencies that benefit from federal anti-poverty measures are prevalent.

It is well established that partisan identity has been used as a cue for political choices, ranging from issue positions to candidate choice (Dancey and Sheagley 2013; Jacoby 1988).

Recent scholarship has turned to explore the impact of partisan identity on interpersonal interactions. Iyengar and Westwood (2015) found that implicit affect and behavior discrimination based on partisanship are equally as powerful as affect and discrimination based on race (Iyengar and Westwood 2015). In fact, this discrimination may be even stronger than other forms of discrimination because partisan discrimination is not constrained by the same social norms that apply to discrimination based on race and other social categories. Partisan discrimination extends beyond traditional political contexts to traditionally apolitical areas of life. For example, party cues were shown to have a strong impact on the selection of job candidates in an experimental setting (Iyengar and Westwood 2015). More broadly, there is a growing body of literature supporting evidence of increased partisan sorting and animosity between political parties in the United States (Mason 2015; Nicholson et al. 2016). From marital selection to residential neighborhoods, Americans are increasingly sorted and segregated by party (Bishop 2008; Rosenfeld 2011; Huber and Malhotra 2017).

While there has not been a direct investigation of the impact of political party identification on deservingness evaluations, the impact of political party identification on generosity toward others has been investigated in other, less applicable, contexts. Fowler and Kam (2007) used party identification as a proxy for social identification to examine whether social identification is a driving force in political participation and behaviors. In the context of an anonymous dictator game in which participants could allocate benefits to hypothetical opponents, Democrats and Republicans both gave more to recipients from their own party than the opposing party and Independents gave more to recipients without a party than to partisan recipients. Further, the impact increased with strength of a respondent's partisanship: stronger partisans exhibited a stronger in-group bias. Another study of support for social spending and redistribution found that subjects in dictator games across four countries (The U.S., UK, Canada, and Sweden) were significantly less generous when donating money to someone from a different political party than their own. Interestingly, in-group effects through partisanship were consistently stronger among left-leaning partisans (Dawes et al.

2012).

Evidence of how political party identification affects perceptions of beneficiary deservingness so far has been limited to simulations that do not transfer directly to the program-specific considerations associated with health care and social insurance in the United States. As such, this research aims to investigate whether affective partisan polarization is a powerful factor when evaluating support for someone's receipt of an existing social benefit.

Chapter 3

Methods

3.1 Research Design

We employ a survey experiment to investigate these research questions. 3,680 American respondents completed the survey, conducted by Lucid Theorem, between February 12th, 2020 and February 18th, 2020. Survey respondents are asked to evaluate a hypothetical beneficiary of the public long-term care program. They are asked to provide their opinion on a 5-point scale (Strongly Disagree to Strongly Agree) regarding how much they agree that the beneficiary should receive support from the government for their long-term care costs. In addition to this dependent variable, respondents are also asked about their general support for the long-term care benefit and their opinion on whether funding to the benefit should be increased. We theoretically understand these measures as different dimensions of a general outcome measure: a respondent's degree of support for public long-term care and its beneficiaries.

In order to determine whether deservingness heuristics apply to public LTC , we investigate how evaluations of deservingness vary in the face of different deservingness cues. To prompt considerations about deservingness, we vary the source of the ailment that leads the hypothetical beneficiary to require long-term care. This methodology mimics Fang and Hu-

ber's study examining evaluations of beneficiary deservingness of Social Security Disability Insurance (SSDI) (Fang and Huber 2019). Their experiment randomly assigned participants to one of five hypothetical beneficiary descriptions, which varied the medical impairment of each beneficiary which warranted the receipt of SSDI. In our experiment, the source of the ailment necessitating long-term care services is either hereditary dementia or breathing problems resulting from a lifetime of smoking. While a beneficiary with breathing problems due to smoking is ostensibly responsible for their current condition, a beneficiary with hereditary dementia requires help due to reasons outside of their own control. Under Oorschot (2000)'s framework of deservingness criteria, the level of control over one's current condition is a key tenet of deservingness evaluations. In accordance with Fang and Huber, to isolate the impact of this cue we hold other elements of the beneficiary deservingness constant. In all vignettes, the hypothetical beneficiary is an 82-year old male named John who worked for his entire adult life. Holding these elements at the same level allows us to isolate the impact of the deservingness cues.

It is possible that the nature of the care administered by the benefit is not the only factor driving perceptions of deservingness. Of potentially greater importance is the benefit's relationship to Medicaid. In order to test whether long-term care's relationship to Medicaid impacts attitudes about deservingness, we randomize the definition of public long-term care services that respondents read before they are given information about the hypothetical beneficiary. Given the relatively low level of public knowledge about the policy specifics of the long-term care benefit, a definition is necessary to precede information about the beneficiary. Previous research has shown that simply providing information about an obscure public program can change the way in which citizens evaluate it (Mettler 2011). We leverage the relatively low political salience of long-term care to better understand whether the program's relationship to Medicaid has an independent impact on evaluations. The control definition frames public LTC as a "government program." The treatment definitions frame public LTC as part of Medicaid. We include both a "short" Medicaid definition ("Medicaid Short") and

a "long" Medicaid definition ("Medicaid Long") to better understand whether the program itself or reminders of its means-tested nature drives any potential effect of changing the definition. The Medicaid Short definition simply credits Medicaid as the government program paying for long-term care, while the Medicaid Long definition includes an additional sentence stating that the program is only for low-income individuals. We measure how the definition impacts both overall evaluations and the magnitude of any difference between the smoking and dementia treatments.

The randomized definition is as follows:

> "Long-term care is defined as the services and supports given to people who need assistance with daily self-care tasks. These tasks include eating, bathing, dressing, preparing meals, managing medication, and housekeeping. Some people pay for their own insurance to cover the costs of long-term care. [Definition Randomization]"

Definition Randomization

- GOVERNMENT: "The government pays for long-term care when individuals cannot afford it."
- MEDICAID SHORT: "Medicaid pays for long-term care when individuals cannot afford it."
- MEDICAID LONG: "Medicaid pays for long-term care when individuals cannot afford it. Medicaid requires individuals to be below a certain level of income and assets to receive benefits."

The second experiment embedded in the survey tests whether party cues affect respondents' evaluations of beneficiary deservingness. Specifically, we examine whether people reward co partisans or punish opposite partisans in their evaluation of deservingness. While previous literature has examined this phenomenon in the distinct contexts, existing research has not explored how political parties impact generosity toward others and perceptions of

deservingness in the context of government benefits. The hypothetical beneficiary is identified as a lifelong Democrat, lifelong Republican, or a sentence about party identification is omitted altogether.

The combination of treatments presented through both experiments yields a total of 18 treatments with three randomizations: (1) Definition Framing (Government, Medicaid Short, or Medicaid Long), (2) Beneficiary Ailment (Smoking or Dementia), and (3) Beneficiary Party (Democrat, Republican, or No Party Given).

The randomized beneficiary vignette is as follows:

> "John is an 82-year-old male who worked most of his adult life. [Party randomization]. John requires assistance with most activities of daily living, including getting dressed, preparing meals, and housekeeping. He requires these services because [Ailment randomization]. He applied for government assistance and now [Payment randomization] pays for most of his long-term care services."

Party Randomization

- "John identifies as a lifelong Republican."
- "John identifies as a lifelong Democrat."
- No party given

Ailment Randomization

- "He was a smoker for most of his life and now has increasingly severe breathing problems, which impair his daily functions."
- "He has severe dementia and has trouble remembering things, which impairs his daily functions. Dementia runs in John's family."

Payment Randomization (Corresponding to Definition Randomization)

- Definition = GOVERNMENT: "the government"
- Definition= MEDICAID SHORT or MEDICAID LONG: "Medicaid"

Dependent variables

There are three dependent variables of interest: (1) beneficiary deservingness, (2) program support, and (3) funding support. To measure perceived beneficiary deservingness, respondents are asked to evaluate their agreement to the following statement on a 5-point scale: "How much do you agree that the government should support John with long-term care costs?" To measure general programmatic support, respondents are asked to evaluate their support for the program on a 5-point scale: "In general, do you support the government long-term care benefit?" To measure support for program funding, respondents are asked "Do you think funding to the government long-term care program should increase, decrease, or stay about the same?" To ensure that each respondent received the treatment, respondents are asked to answer which program paid for long-term care, the hypothetical beneficiary's ailment, and the hypothetical beneficiary's political party.

Moderating Variables and Heterogeneous Treatment Effects

There are a number of potential moderators for any observed treatment effect. To measure general political knowledge, respondents are asked a number of questions about federal spending. To measure programmatic knowledge, respondents are asked to evaluate what percentage of people will require long-term care, the average cost of long-term care, and the government programs that pay for long-term care. To measure personal experience or connection to long-term care, respondents are asked whether they know someone who benefited from the public long-term care benefit and whether they have purchased private long-term care insurance.

3.2 Hypotheses

Experiment 1: Deservingness Cues and Program Definition Framing

Hypothesis 1 *Within each framing treatment group, respondents are more supportive of long-term care beneficiaries receiving government aid when they require care due to dementia rather than breathing problems from smoking.*

Health care programs are generally less polarizing than means-tested programs, but recent research has shown that people are nonetheless susceptible to deservingness cues for health-related needs (Gollust and Lynch 2011; Fang and Huber 2019). We do not expect the sympathetic nature of the beneficiary population to completely overpower the deservingness heuristic in this context.

Hypothesis 2 *The difference in approval of LTC based on deservingness cues is larger when LTC is framed as means-tested than when it is not framed as means-tested.*

As discussed in the literature review, it is well established that people who evaluate means-tested programs, and even social insurance programs that are framed as being redistributive, are particularly sensitive to cues about deservingness (Applebaum 2001; Petersen et al. 2011; Aarøe and Petersen 2014; Hansen 2019; Fang and Huber 2019). As such, it is likely that respondents who receive a frame of LTC as a means-tested program are even more sensitive to cues about deservingness than those who are not exposed to frames. Specifically, we hypothesize that, among those who are exposed to the frame of LTC as means-tested, there is a larger difference in support for government aid to the hypothetical beneficiary that requires support due to heredity dementia and the hypothetical beneficiary that requires support due to a lifetime of smoking. In line with previous literature on welfare programs, respondents likely distinguish between beneficiaries whose need is a product of chance and beneficiaries whose need is a product of their actions. If the magnitude of the difference between the dementia and smoking treatments varies across the framings of the public LTC program, this supports the theoretical causal mechanism that the function of Medicaid as

a means-tested program has an impact on how people evaluate their support for the LTC benefit.

Hypothesis 3 *Deservingness cues have a smaller effect among those with more personal experience with LTC.*

Given the low salience of public LTC, program sophistication likely has a moderating effect on the impact of the treatment through diminishing the effect of cues about deservingness. Given that people with more personal experience with Medicaid LTC (and thus more knowledge about LTC) are more likely to oppose program retrenchment (Grogan and Park 2017), it is possible that people with differing degrees of experience with LTC also differ in their evaluations of individual beneficiary deservingness. More broadly, consistent with the literature on policy feedback, people who are aware of the benefits they receive from a government program are more likely to support the program and mobilize politically around it (Mettler 2011).

Experiment 2: Beneficiary Partisanship

Hypothesis 1 *Both Republicans and Democrats are more likely to view members of the opposite political party as less deserving of the long-term care benefit than members of their own party. Independents are more likely to view hypothetical beneficiaries with a political party label as less deserving of the long-term care benefit than members without a political party label.*

Existing literature demonstrates that partisan cues have a powerful ability to trigger in-group and out-group considerations in a diverse array of social and political contexts. Despite the generally sympathetic nature of the beneficiary in the vignette scenarios, we hypothesize that party cues maintain some relevance in determining beneficiary deservingness. In line with previous studies, we hypothesize that respondents are more sympathetic to co partisans and that the magnitude of this effect increases with the strength of the respondent's party affiliation. Similarly, respondents who identify as political Independents are more sympathetic to respondents without a political party than those identified with a

partisan leaning (Fowler and Kam 2007).

Hypothesis 2 *The effects in Hypothesis (1) are larger for the Medicaid Long definition than the effects under the Government and Medicaid Short definitions of long-term care.*

Various framings of the government long-term care program are likely to prime different partisan considerations. The Medicaid Long framing, which highlights the means-tested nature of the long-term care benefit, activates partisan considerations more forcefully than the generic Government framing. In turn, we expect that this increases the effect of the party relationship between the respondent and the hypothetical beneficiary when evaluating deservingness. We remain agnostic about the impact of the Medicaid Short framing, as there remains a large degree of misinformation about Medicaid and it is plausible that a substantial number of respondents will conflate Medicaid with Medicare, the government health care program for the elderly. As such, the Medicaid Short framing may generate the same effects for partisanship as the Government framing.

Hypothesis 3 *The effects in Hypothesis 1 are larger when the cause of the ailment is smoking versus dementia.*

Just as priming partisan considerations via the definition of government long-term care is likely to activate in-group/ out-group considerations, so, too, does priming reciprocity considerations via the source of the ailment. By manipulating control over the condition, it is plausible that concerns about reciprocity and perceived group threat strengthen partisan identification. Put another way, smokers are a less sympathetic beneficiary population than dementia patients, leaving space for a greater effect of party on deservingness evaluations.

Method of Analysis

Distributions of responses for the three outcomes are analyzed using a Mann-Whitney test. This test is utilized because responses for all three dependent variables may not be normally distributed and instead may skew toward favoring beneficiary deservingness, program support, and funding support. This is not surprising, as the hypothetical beneficiary is relatively sympathetic on all dimensions and health care-related problems are known to elicit

more generous evaluations of government programs. We measure the magnitude effect of changing the ailment source in two ways. First, we examine the shift in the scale, or the literal difference in means across treatment groups with significant effects. Second, we examine changes in proportions, or the fraction of responses in each response category (Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree for the first dependent variable).

As an additional robustness check, we regress the dependent variables on treatment variables while controlling for demographic and political characteristics of respondents that may increase or decrease the baseline of support for long-term care. Interaction terms between the deservingness treatment (dementia or smoking) and definition treatment (Government, Medicaid Long, or Medicaid Short) indicate whether the magnitude of the effect of deservingness cues varies significantly across the definition of long-term care. Similarly, interaction terms between the partisan treatments and respondent's political party indicate whether treatment effects vary significantly across the party of the respondent. Finally, controlling for respondent demographic characteristics allows us to determine whether certain demographic characteristics are significant predictors of attitudes about long-term care and its beneficiaries independent of other treatments.

Chapter 4

Deservingness Cues

4.1 Results

How does manipulating a long-term care beneficiary's level of control over their condition impact support for the beneficiary and the long-term care benefit? Respondents are universally responsive to deservingness cues via shifting the source of the ailment that necessitates long-term care coverage. When a hypothetical beneficiary requires long-term care due to breathing problems resulting from smoking as opposed to hereditary dementia, respondents are less supportive of the beneficiary receiving support from the government for long-term care costs. This trend holds true for Republican, Independent, and Democrat respondents with one exception (Democrat respondents do not significantly change their support for program funding). It is also true regardless of the hypothetical beneficiary's identified political party.

The magnitude of this effect varies slightly across respondents' political party. Viewing magnitude in terms of changes in the proportions of responses in each category, Democrat respondents experience a roughly 3 percentage point increase in the percent of responses in the "Strongly Disagree" and "Disagree" categories, while Republican respondents experience a roughly 10 percentage point increase in the percent of responses in these categories.

Table 4.1: Difference between smoking and dementia treatment by respondent political party for deservingness.

Respondent Party	Ailment Source	Mean Response	Percent Disagree	Percent Neutral	Percent Agree	n	p-value
Democrat	Dementia	4.26	6.5	6.2	87.3	695	
	Smoking	3.93	9.7	11.9	78.3	730	
	Difference	-0.33	3.2	5.7	-9		0.001
Independent	Dementia	4.1	5.4	13.8	80.8	542	
	Smoking	4.68	13.3	21.2	65.6	514	
	Difference	-0.58	7.9	7.4	-15.2		0.001
Republican	Dementia	4	8.1	11	80.8	554	
	Smoking	3.62	18.5	18.8	63.7	553	
	Difference	-0.38	10.4	7.8	-17.1		0.001

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents. The Percent Disagree column represents the percent of responses in the Strongly Disagree and Disagree categories. The Percent Agree column represents the percent of responses in the Strongly Agree and Agree columns.

Independent respondents experience a roughly 8 percentage point increase in the percent of responses in these categories. It seems, then, that Republicans and Independents are more responsive to deservingness cues than Democrats. This holds true when measuring magnitude via shift in scale, with Republican support decreasing by 0.38 points on a 5 point scale, Independents by 0.58 points, and Democrat support decreasing by just 0.33 points.

Table 4.2: Difference between smoking and dementia treatment by respondent political party for program support.

Respondent Party	Ailment Source	Mean Response	Percent Disagree	Percent Neutral	Percent Agree	n	p-value
Democrat	Dementia	4.29	4.3	8.4	87.4	695	
	Smoking	4.14	4.4	12.3	83.2	730	
	Difference	-0.15	0.1	3.9	-4.2		0.001
Independent	Dementia	4.08	3.7	16.8	79.5	542	
	Smoking	3.99	5.3	18.7	76.1	514	
	Difference	-0.09	1.6	1.9	-3.4		0.001
Republican	Dementia	3.99	5.4	15.4	79.2	554	
	Smoking	3.78	8.9	23.6	67.6	553	
	Difference	-0.21	3.5	8.2	-11.6		0.001

In addition to changing their evaluations of individual deservingness, Republican, Demo-

crat, and Independent respondents also all report significantly less program support when the ailment source shifts to smoking. Measured in terms of shift in scales, Republicans experience the biggest shift, with a 3.5 percentage point increase in the percent of responses in the "Strongly do not support" and "Do not support" categories, while Democrats experience just a 0.1 percentage point increase in these categories. Measured via shift in scales, however, the magnitude of the effect is only slightly larger for Republicans than Democrats, with 0.21 and 0.15 point decreases on the five point scale of program support, respectively.

Table 4.3: Difference between smoking and dementia treatment by political party experience for funding support.

Respondent Party	Ailment Source	Mean Response	Percent Disagree	Percent Neutral	Percent Agree	n	p-value
Democrat	Dementia	2.77	1.4	20.5	78.1	695	
	Smoking	2.72	3.3	21.2	75.52	730	
	Difference	-0.05	1.9	0.7	-2.6		0.018
Independent	Dementia	2.58	5.4	31.2	63.5	542	
	Smoking	2.48	10.1	31.7	58.2	514	
	Difference	-0.1	4.7	0.5	-5.3		0.03
Republican	Dementia	2.52	5.6	36.3	58	554	
	Smoking	2.42	9.8	38.7	51.5	553	
	Difference	-0.1	4.2	2.4	-6.5		0.01

There is some variation in whether shifting the ailment source significantly impacts support for increased funding. While both Republicans and Independents have significant differences in funding support across the two ailment sources, Democrat respondents do not. Republicans and Independents have comparable decreases in mean support (0.1 and 0.1 points, respectively). When the ailment source shifts to smoking, Independents increase their percent of responses in the "Decrease" funding category by roughly 4.7 percentage points and Republicans increase their percent of responses in this category by 4.2 percentage points.

Table 4.4: Difference between smoking and dementia treatment by respondent smoker status.

Deservingness							
Smoker Status	Ailment Source	Mean Response	Percent Disagree	Percent Neutral	Percent Agree	n	p-value
Non-Smoker	Dementia	4.15	4.4	12.9	82.7	364	
	Smoking	3.59	16.7	18.8	64.4	382	
	Difference	-0.56	12.3	5.9	-18.3		0.001
Smoker	Dementia	4.2	7	7.9	85.1	342	
	Smoking	4.01	7.9	11.8	80.3	355	
	Difference	-0.19	0.9	3.9	-4.8		0.001
Program Support							
Smoker Status	Ailment Source	Mean Response	Percent Disagree	Percent Neutral	Percent Agree	n	p-value
Non-Smoker	Dementia	4.11	3.8	13.7	82.4	364	
	Smoking	3.89	5.8	19.6	74.7	382	
	Difference	-0.22	2	5.9	-7.7		0.001
Smoker	Dementia	4.25	3.8	10.5	85.7	342	
	Smoking	4.12	5.5	13.5	81.1	355	
	Difference	-0.13	1.7	3	4.6		0.04
Funding Support							
Smoker Status	Ailment Source	Mean Response	Percent Decrease	Percent Stay Same	Percent Increase	n	p-value
Non-Smoker	Dementia	2.61	4.4	29.9	65.7	364	
	Smoking	2.47	10.2	32.7	57.1	382	
	Difference	-0.14	5.8	2.8	-8.6		0.01
Smoker	Dementia	22.7	2.3	25.1	72.5	342	
	Smoking	2.7	3.1	23.7	73.2	355	
	Difference	0	0.8	-1.4	0.7		0.88

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents. The Percent Disagree column represents the percent of responses in the Strongly Disagree and Disagree categories. The Percent Agree column represents the percent of responses in the Strongly Agree and Agree columns.

4.2 Subgroup Analysis: Smokers

For a subset of respondents (n = 1541), our survey platform, Lucid Theorem, provided information on the smoking behaviors of respondents based on their responses to prior surveys. We examine whether the magnitude of the treatment effect varies across smokers (and respondents who use other tobacco products) and nonsmokers. This analysis reveals that

nonsmokers are more likely than smokers to express a difference in the deservingness of long term care for people with dementia compared to people who smoked. For individual deservingness, the difference between the smoking and dementia treatments is nearly 3 times bigger for nonsmokers than smokers. Change in program support is also larger for nonsmokers than smokers (0.22 and 0.13, respectively). Finally, nonsmokers also have significantly lower funding support, while smokers do not. This suggests that people are less responsive to deservingness cues when they are able to personally identify with the behaviors that trigger concerns about reciprocity and fairness.[1]

4.3 Subgroup Analysis: Personal Experience

In addition to analyzing responses by respondent party, we look for heterogeneous treatment effects among respondents with different levels of personal experience with the long-term care benefit. One mechanism by which public programs change political behaviors and political attitudes is through generating public constituencies that have personal experience with the program. People who have positive experiences with certain government programs are more likely to support the program and mobilize politically around them (Campbell 2012; Lerman and McCabe 2017). The high degree of misperception about the long-term care benefit's relationship to existing government programs is another reason to study how these dynamics vary across groups with differing personal experience with the Medicaid long-term care benefit. Personal experience is an especially powerful mechanism for shaping political attitudes among low-information voters (Lerman and McCabe 2017). More than having a positive experience with a program, simply having the awareness that a certain government benefit exists can also impact political behavior and opinion (Mettler 2011).

[1]Because we do not know why some respondents have smoking data and others do not, we regress a binary indicator of whether we have a respondent's smoking data on all relevant independent variables. This allows us to examine whether the group for which we have data differs significantly from the rest of the respondent pool. Respondents for which we have data are slightly older (+0.002 years) and more educated (+0.0001), and slightly less likely to be a Republican or Independent than respondents for which we do not have data on smoking behaviors.

Personal experience can serve as a proxy for programmatic knowledge in this analysis, as people who have experience with the public long-term care benefit are more likely to know the policy specifics of the program.

Personal experience is measured with by asking respondents whether they someone who has used public long-term care. 1,084 respondents reported knowing a public long-term care beneficiary, while 2,534 did not report knowing a public long-term care beneficiary.

Unsurprisingly, respondents who know a public long-term care beneficiary have significantly higher evaluations of beneficiary deservingness, general program support, and funding support for the long-term care benefit than respondents who do not know a beneficiary. At the aggregate level, both respondents with and without personal experience have significantly lower deservingness evaluations and program support under the smoking treatment than the dementia treatment. However, respondents with personal experience do not have significantly lower evaluations of funding support for the smoking treatment, while respondents without personal experience do.

In line with our hypothesis, the magnitude of the effect size is consistently smaller for respondents who know a public long-term care beneficiary. For deservingness evaluations, respondents with personal experience have a roughly 3.8 percentage point increase in the percent of responses in the "Strongly Disagree" and "Disagree" categories, while respondents without personal experience have a 7.6 percentage point increase in the percent of responses in these categories. For program support, respondents with personal experience have just a 0.5 percentage point increase in the Strongly Disagree and Disagree categories, while respondents without personal experience have a 2 percentage point increase in these categories.

Table 4.5: Difference between smoking and dementia treatment by respondent personal experience for all three dependent variables.

Deservingness							
Knows a Beneficiary	Ailment Source	Mean Response	Percent Disagree	Percent Neutral	Percent Agree	n	p-value
No	Dementia	4.15	6.5	11.8	81.7	1266	
	Smoking	3.77	14.1	18.5	67.5	1268	
	Difference	-0.38	7.6	6.7	-14.2		0.001
Yes	Dementia	4.23	7	6	86.5	554	
	Smoking	3.86	10.8	12.6	76.6	530	
	Difference	-0.37	3.8	6.6	-9.9		0.001
Program Support							
Knows a Beneficiary	Ailment Source	Mean Response	Percent Disagree	Percent Neutral	Percent Agree	n	p-value
No	Dementia	4.12	4.3	15.2	80.5	1266	
	Smoking	3.97	6.3	20	73.8	1268	
	Difference	-0.15	2	4.8	-6.7		0.001
Yes	Dementia	4.32	4.8	8.3	86.8	554	
	Smoking	4.08	5.3	11.9	82.8	530	
	Difference	-0.24	0.5	3.6	-4		0.001
Funding Support							
Knows a Beneficiary	Ailment Source	Mean Response	Percent Decrease	Percent Stay Same	Percent Increase	n	p-value
No	Dementia	2.62	4.4	31.5	64.2	1266	
	Smoking	2.52	8.8	32.6	58.7	1268	
	Difference	-0.1	4.4	1.1	-5.5		0.001
Yes	Dementia	2.74	2.9	22.2	74.9	554	
	Smoking	2.72	3.6	22.5	74	530	
	Difference	-0.02	0.7	0.3	-0.9		0.68

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents. The Percent Disagree column represents the percent of responses in the Strongly Disagree and Disagree categories. The Percent Agree column represents the percent of responses in the Strongly Agree and Agree columns.

4.4 Discussion

The small but significant effect of deservingness cues on beneficiary and program support is an important finding for long-term care policy. The dynamics we observe for the long-term care program are consistent with previous literature, finding that the cause of health-related ailments is generally viewed as a relevant factor when evaluating deservingness of government

aid for health care costs. Despite the highly sympathetic nature of the beneficiary and general program support, respondents are nonetheless responsive to changes in the source of the ailment. Across all respondent parties, lower perceptions of deservingness are also linked to significantly lower general program support. This, too, is consistent with literature finding that perceptions of fairness play an important role in determining attitudes about public health insurance (Lynch and Gollust 2010). At least in this respect, then, long-term care is not a politically unique health care program.

The size of these effects should not be over interpreted, however. The majority of respondents in every category agree or strongly agree that the hypothetical beneficiary should receive support from the government for long-term care costs. Similarly, support for the program and its funding are also quite high. The majority of respondents in every category support or strongly support the government long-term care benefit and want to see funding to the program increase. Further, no group of respondents shifts their average response below the neutral threshold to "Do not support" for any of the dependent variables when the hypothetical beneficiary is a smoker. While deservingness cues may generate on average less enthusiastic support for the long-term care program and its beneficiaries, they do not entirely reverse patterns of support. This can be contrasted with other studies, in which deservingness cues change patterns of support such that they have substantive significance (Fang and Huber 2019).

The different effect magnitudes for changing the ailment source across respondent parties is another relevant finding. Across all three dimensions of support for long-term care and for both measurements of effect magnitude, Republicans and Independents are more sensitive to deservingness cues than Democrats. This, too, is consistent with previous findings that people on the political right tend to have a heightened emphasis on deservingness criteria when evaluating their support for social welfare programs (Jeene, van Oorschot, and Uunk 2013; Fang and Huber 2019).

It is also of note that people who identify with the deservingness cue (smokers) react

differently than people who do not engage in this behavior. This suggests that people are less responsive to deservingness cues when they are able to personally identify with the behaviors that trigger concerns about reciprocity and fairness.

Finally, respondents who have personal experience with the long-term care program react less harshly to deservingness cues than respondents with no personal experience with the long-term care program. People with a heightened awareness of the long-term care benefit are generally more supportive of the benefit and are less receptive to deservingness cues than those without this heightened awareness. As the population ages and more Americans confront the necessity of acquiring long-term care, evidence from this experiment indicates that overall support for the program may increase.

Chapter 5

Framing Effects

5.1 Framing Effects on Overall Evaluations

Does the long-term care benefit's relationship to Medicaid change evaluations of the program and its beneficiaries? We examine whether different framings of the government long-term care benefit change evaluations of program and beneficiary support support. To test whether a difference exists between the three framings, we perform a Kruskal-Wallis test. For all three dependent variables measured, there is not a significant difference between the Government, Medicaid Short, and Medicaid Long definitions. In pairwise analyses of the different definitions using a Mann-Whitney test, there is significantly lower program support when prompted with the Medicaid Short definition instead of the Government definition. There is no significant difference for deservingness or funding support.

When broken down by the respondent party, the Kruskal-Wallis test still finds no significant difference between the three definitions for each dependent variable. However, in a pairwise analysis of different definitions (using the Mann-Whitney test), Republican respondents have significantly lower evaluations of program support and funding support when exposed to the Medicaid Long definition instead of the Government definition. Thus, while Republicans are sensitive to cues about the means-tested nature of the program in evaluat-

ing programmatic support, Democrats and Independents are not. Additionally, Democrat respondents have significantly lower program support under the Medicaid Short definition versus the Government definition.

5.2 Framing Effects on Response to Deservingness Cues

Our primary interest is not just whether different definition framings independently impact support for long-term care and its beneficiaries, but also whether different definition framings impact the degree to which respondents change their evaluations in the face of deservingness cues. Specifically, does framing the long-term care benefit as means-tested and administered through Medicaid cause respondents to react more harshly to deservingness cues?

Table 5.1: Difference between smoking and dementia treatment by definition framing for deservingness.

Definition Framing	Ailment Source	Mean Response	Percent Disagree	Percent Neutral	Percent Agree	n	p-value
Government	Dementia	4.23	6.3	9.5	84.3	611	
	Smoking	3.69	15	17.8	67.2	601	
	Difference	-0.54	8.7	8.3	-17.1		0.001
Medicaid Long	Dementia	4.17	7.1	10.5	82.5	593	
	Smoking	3.85	12	16.4	71.7	611	
	Difference	-0.32	4.9	5.9	-10.8		0.001
Medicaid Short	Dementia	4.11	6.7	10.1	83.3	616	
	Smoking	3.83	12.4	15.9	51.7	586	
	Difference	-0.28	5.7	5.8	-31.6		0.001

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents. The Percent Disagree column represents the percent of responses in the Strongly Disagree and Disagree categories. The Percent Agree column represents the percent of responses in the Strongly Agree and Agree columns.

Across all three framings of the long-term care program, shifting the ailment from smoking to dementia significantly lowers impressions of beneficiary deservingness. In the Medicaid Long and the Government Program definition, program and funding support are also impacted. In the Medicaid Short definition, however, support for the program and funding is

not significantly impacted.

Measuring effect magnitude through shifts in scale, the effect of changing the ailment source on individual deservingness evaluations is largest for the Government definition (0.43 decrease) and comparable for the Medicaid Short and Medicaid Long definitions (0.34 and 0.32 point decreases, respectively). When measured through changes in proportions, the relative magnitude of the effect for each definition is the same. When the ailment source is smoking instead of dementia, the percentage of responses in the "Strongly Disagree" and "Disagree" category increases by roughly 9 percentage points for the Government definition, while the percent in these categories for the Medicaid Long and Medicaid Short definition increases by roughly 5 and 6 percentage points, respectively. This does not support our initial hypothesis that the effect would be largest on the Medicaid Long definition, which prompts respondents about the means-tested nature of the program.

Table 5.2: Difference between smoking and dementia treatment by definition framing for program support.

Definition Framing	Ailment Source	Mean Response	Percent Disagree	Percent Neutral	Percent Agree	n	p-value
Government	Dementia	4.19	4.2	11.8	84	611	
	Smoking	3.9	6.3	16.5	77.2	601	
	Difference	-0.24	2.1	4.7	-6.8		0.001
Medicaid Long	Dementia	4.25	3.5	13.7	82.8	593	
	Smoking	4.01	5.4	20.6	73.9	611	
	Difference	-0.24	1.9	6.9	-8.9		0.001
Medicaid Short	Dementia	4.1	5.6	13.8	80.6	616	
	Smoking	4.03	6.3	15.6	78.1	586	
	Difference	-0.07	0.7	1.8	-2.5		0.1

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents. The Percent Disagree column represents the percent of responses in the Strongly Disagree and Disagree categories. The Percent Agree column represents the percent of responses in the Strongly Agree and Agree columns.

Regarding changes in program support, there is no significant difference in support for dementia and smoking ailments when the definition framing is Medicaid Short, but there is a significant difference between the two ailment sources for the Medicaid Long and Government

definitions. The magnitude of the effect is equal for the Medicaid Long definition and the Government definition (0.24 decrease). When measuring effect magnitude via change in proportions, the magnitude for the Government and Medicaid Long definitions is again similar. The percentage of responses in the "Strongly do not support" and "do not support" categories increase by roughly 2 percentage points for both definitions.

Table 5.3: Difference between smoking and dementia treatment by definition framing for funding support.

Definition Framing	Ailment Source	Mean Response	Percent Decrease	Percent Stay the Same	Increase	n	p-value
Government	Dementia	2.68	3.6	27.2	69.2	611	
	Smoking	2.54	7	29.6	63.4	601	
	Difference	-0.14	3.4	2.4	-5.8		0.02
Medicaid Long	Dementia	2.64	4.6	29	55.4	593	
	Smoking	2.59	6.9	30.9	62.2	611	
	Difference	-0.05	2.3	1.9	6.8		0.08
Medicaid Short	Dementia	2.65	3.6	29.7	66.7	616	
	Smoking	2.61	7.8	28.2	64	586	
	Difference	-0.04	4.2	-1.5	-2.7		0.15

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents. The Percent Disagree column represents the percent of responses in the Strongly Disagree and Disagree categories. The Percent Agree column represents the percent of responses in the Strongly Agree and Agree columns.

For changes in funding support, there is similarly no significant difference in support for different ailments when the definition is Medicaid Short, but there is a significant difference for the Medicaid Long and Government definitions. In this instance, the magnitude of the effect is again smaller for the Medicaid Long definition (0.05 point decrease on a 3 point scale) than the Government definition (0.14 point decrease). For change in proportions, the percentage of responses in the "Decrease" funding category increased by 3.4 percentage points for the Government definition and 2.3 percentage points for the Medicaid Long definition.

We also examine the relative magnitude of changes between the smoking and dementia treatments across definitions by respondent party. We determine whether the magnitude of the differences between the smoking and dementia treatments across each definition varies

significantly for each subset of partisan respondents. For Republican respondents, the effect of shifting the ailment source is consistently largest under the Government definition for both shifts in scale and changes in proportions. There is not a clearly observable pattern for either Democrats or Independents.

5.3 Discussion

Regarding the impact of the definition on overall program and beneficiary evaluations, we do not find robust evidence that linking the long-term care benefit to Medicaid significantly changes perceptions of beneficiaries, as no group of respondents significantly changes their perceptions of beneficiary deservingness under either Medicaid definition framing. Knowledge of the fact that long-term care is means-tested does not significantly change how beneficiaries are perceived in the aggregate. Regarding framing effects on program support, the party-based heterogeneity is an interesting finding. Republican respondents are the only group that is responsive to information about the means-tested nature of the long-term care benefit in their overall evaluations of the program, having generally lower levels of program and funding support when prompted with the Medicaid Long framing. However, this framing does not significantly affect their overall perceptions of individual deservingness.

We also examine whether divergence between the smoking and dementia treatments is of greater magnitude under different definition frames. Regarding evaluations of deservingness, our initial hypothesis that the greatest effect of deservingness cues would be seen under the Medicaid Long definition is not supported. Instead, Medicaid Long and Medicaid Short have comparable effect sizes, while the Government definition has a larger effect size than both Medicaid Long and Medicaid Short. While the magnitude of effect for the program and funding support varies some, there is not a substantial difference between the only definitions with significant differences, the Government and Medicaid Long definitions. Moreover, this pattern holds true for respondents that are less supportive of long-term care when it is

associated with Medicaid. While Republicans have lower overall evaluations of program support and funding support under the Medicaid Long definition, they do not have a greater response to deservingness cues under this definition framing. Instead, Republicans experience the biggest shift in attitudes when the ailment is smoking instead of dementia when prompted with the Government definition, not the Medicaid Long definition. While the means-tested nature of the Medicaid program makes Republicans more critical of the program overall, it does not make them more sensitive to deservingness cues than framings without information about the means-tested nature of the long-term care benefit.

The lack of support for our hypothesis about the Medicaid Long definition extends further credence to Grogran and Patashnik's (2003) assertion about the false dichotomy between means-tested and universal programs, this time in the context of how this policy feature impacts political attitudes. In this case, the beneficiary population and/or the nature of the long-term care benefit seems to have generated a high baseline level of support such that additional cues about means-testing are not a significant driver in attitudes about the program or its beneficiaries.

Under the Medicaid Short definition, the lack of a significant difference between the dementia and smoking treatments for program and funding support dependent variables is another relevant finding. Contrary to common narratives about the stigmatizing and/or negative political connotation associated with Medicaid, this indicates that Medicaid may be seen as a moderating force in an environment with otherwise reliable sensitivity to deservingness cues. This interpretation lends support to existing literature, finding that, contrary to popular narratives about the program's partisan nature, most Americans support Medicaid and do not view it as stigmatizing (Grogan and Park 2017). However, it is possible that we observe this result because people have the tendency to conflate Medicaid with Medicare, the government health insurance program for all individuals over 65 (Klein 2011). Without the additional sentence about the means-tested nature of the program, individuals may have conflated Medicaid with Medicare. Additional research on whether ignorance about

Medicaid's definition or the lack of priming about means-testing drives this conclusion is warranted.

The generally larger effects of the smoking treatment under the Government definition are another phenomenon worth exploring. While we expected that the Government definition would be seen as a neutral control group from which to compare the Medicaid Long and Medicaid Short definition framing, it is not treated as such, often having the largest differences between the dementia and smoking treatments. Respondents may be more harsh when judging beneficiaries of abstract "government" programs as opposed to when they are given policy-specific information. How the provision of other policy-specific details (aside from eligibility criteria) impacts receptiveness to deservingness cues is an interesting line of inquiry for further research.

In sum, we do not find evidence that the long-term care program's relationship to Medicaid impacts support for its program or its beneficiaries, nor do we find evidence that beneficiaries are evaluated more harshly when the long-term care benefit is associated with Medicaid. If anything, the provision of information about long-term care's relationship serves as a moderating force in an environment with otherwise significantly different evaluations of beneficiaries based on the cause of their ailment.

Chapter 6

Medicaid Opinion

Does attributing the long-term care benefit to Medicaid impact public support for Medicaid? It has been argued that instead of Medicaid threatening the political viability of long-term care, the inclusion of the long-term care benefit as part of Medicaid works to increase the political popularity of the Medicaid program (Grogan and Patashnik 2003). As a secondary outcome of interest, we examine whether attributing the long-term care benefit to Medicaid increases support for the program. This represents the inverse of the causal mechanism examined in the previous chapter, in which we explored whether long-term care's relationship to Medicaid significantly affects evaluations of the long-term care program. We measure support for Medicaid with two dimensions: (1) whether the respondent supports increased funding to Medicaid as a whole and (2) whether the respondent views Medicaid as closer to a health insurance program or a welfare program.

6.1 Results

We examine these effects separately for each respondent party due to the frequent partisan discussions around Medicaid, especially after its expansion in some states as part of the Affordable Care Act (Henderson and Hillygus 2011). For Democrat respondents, changing

the definition framing from Government to either Medicaid Short or Medicaid Long does not have a significant impact on their view of the Medicaid program or their support for its funding. For Republican respondents, however, the Medicaid Short framing, which omits the low-income requirement for Medicaid, makes them significantly more likely to view Medicaid as health insurance instead of a welfare program. Independent respondents, too, have different impressions of Medicaid when the definition framing attributed LTC to Medicaid. For both Medicaid Short and Medicaid Long framings, Independent respondents have significantly higher funding support for Medicaid than when they are given the generic Government definition.

Table 6.1: Mean responses for Medicaid funding support and Medicaid opinion by definition framing group.

	Definition Framing	Medicaid Funding Support	Medicaid Opinion
Republican Respondents			
	Govt	2.19	0.54
	Medicaid Long	2.25	0.56
	Medicaid Short	2.29*	0.61*
Independent Respondents			
	Govt	2.36	0.61
	Medicaid Long	2.52***	0.64
	Medicaid Short	2.49**	0.71***
Democrat Respondents			
	Govt	2.65	0.65
	Medicaid Long	2.66	0.66
	Medicaid Short	2.67	0.66

Note: P- values indicate significant levels for t-test between a given framing and the Government framing *** $p < 0.01$, ** $p < 0.05$, * $p < 0.10$ (two sided).

6.2 Discussion

Rather than supporting our hypothesis that the program's eligibility structure impacts its political support, this evidence supports the initial causal claim posed by Grogan and Patashnik (2003) that the LTC benefit serves to increase support for Medicaid. Generally speaking,

respondents do not become more critical of long-term care when they are given information about the benefit's relationship to Medicaid. Instead, they become more supportive of Medicaid when the long-term care benefit is attributed to the program. However, this result implies multiple important additions to Grogan and Patashnik's causal framework, which posits that the LTC benefit's extension to the middle class is the driver of this dynamic. In this experiment, however, there is no information provided about the income of the hypothetical beneficiary, other than the fact that he worked for most of his adult life. This suggests that the long-term care benefit itself has an impact on support for Medicaid, in addition to (or instead of) the socioeconomic status of its beneficiary population. The heterogeneous party effects are of additional importance. While Democrats do not significantly change their attitudes about Medicaid in response to accrediting the long-term care benefit to Medicaid, both Republicans and Independents become more supportive of Medicaid funding. In other words, accrediting the long-term care benefit to Medicaid makes groups that have traditionally lower political support for this program more supportive of it. Advocates of Medicaid expansion may find it politically advantageous to emphasize Medicaid's provision of the long-term care benefit, irrespective of the socioeconomic status of its beneficiary population, in order to garner support from traditionally hostile political constituencies.

Chapter 7

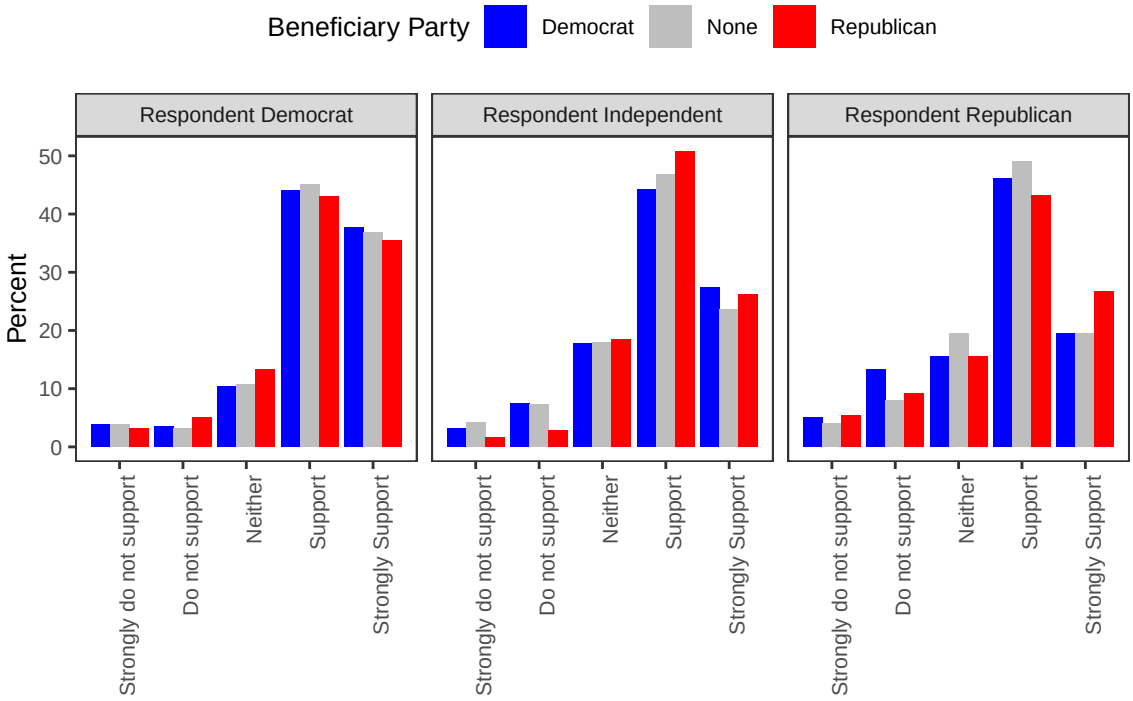
Beneficiary Partisanship

In addition to manipulating the ailment source and definition framing, we also manipulate the political party of the hypothetical beneficiary. The aim of this treatment is to examine whether respondents change their evaluations of individual deservingness and program support when the party of the program beneficiary is the opposite of their party. Similarly, we aim to examine whether individual and program level support is higher when the respondent and hypothetical beneficiary share the same party.

7.1 Results

The hypothetical beneficiary is either identified as a lifelong Democrat or a lifelong Republican, or a sentence about party identification is omitted altogether. At the aggregate level (all ailments and definitions), Republican and Democrat respondents do not change their responses to any of the three measures in the face of differing party cues. Independents, on the other hand, are significantly more supportive of funding the long-term care benefit when the hypothetical beneficiary is identified as a Republican versus when no party is given. However, they do not have a significant difference in their evaluations of deservingness and program support. A Kruskal-Wallis test (which examines the significance of the three-way difference

Figure 7.1: Evaluations of beneficiary deservingness by respondent and beneficiary party.



in outcome distributions between the three beneficiary party treatments) is also employed. At the aggregate level, there is not a significant difference for Republican, Democrat, or Independent respondents across the three party treatments for the hypothetical beneficiary.

7.1.1 Framing

It is possible that responsiveness to party cues varies across program framings because different government programs elicit different partisan dynamics. As such, we examine whether the party treatment has differing effects when the data is subsetted by definition framing.

Government definition: Republicans do not significantly change any of their evaluations when exposed to party cues under the Government definition. Independents have lower evaluations of program support when the hypothetical beneficiary is identified as a Republican versus when hypothetical beneficiary has no party information. Democrats have significantly lower program support when the hypothetical beneficiary is a Republican versus

when no party is given. When employing a KW test, only Independent respondents have a significant difference show a significant difference in program support across the three .

Medicaid Short definition: Republicans have significantly lower evaluations of beneficiary deservingness when the hypothetical beneficiary is identified as a Democrat versus a Republican. There is no significant effect of changing the beneficiary party for Democrat respondents or Independent respondents. Employing the KW test, only Republicans have a significant difference across the three party cues for deservingness.

Medicaid Long definition: For Republican respondents and Democrat respondents, there is no significant effect of political party on any evaluation. For Independent respondents, when the hypothetical beneficiary is identified as a Republican versus when no party information is given, evaluations of the program are significantly higher on all 3 dimensions. When the hypothetical beneficiary is identified as a Democrat versus when no party information is given, Independent respondents have significantly higher support for program funding. When the hypothetical beneficiary is identified as a Democrat versus a Republican, individual deservingness is significantly lower. The KW test similarly finds significant differences for all dependent variables for Independent respondents. For Republican and Democratic respondents, there is no significant difference.

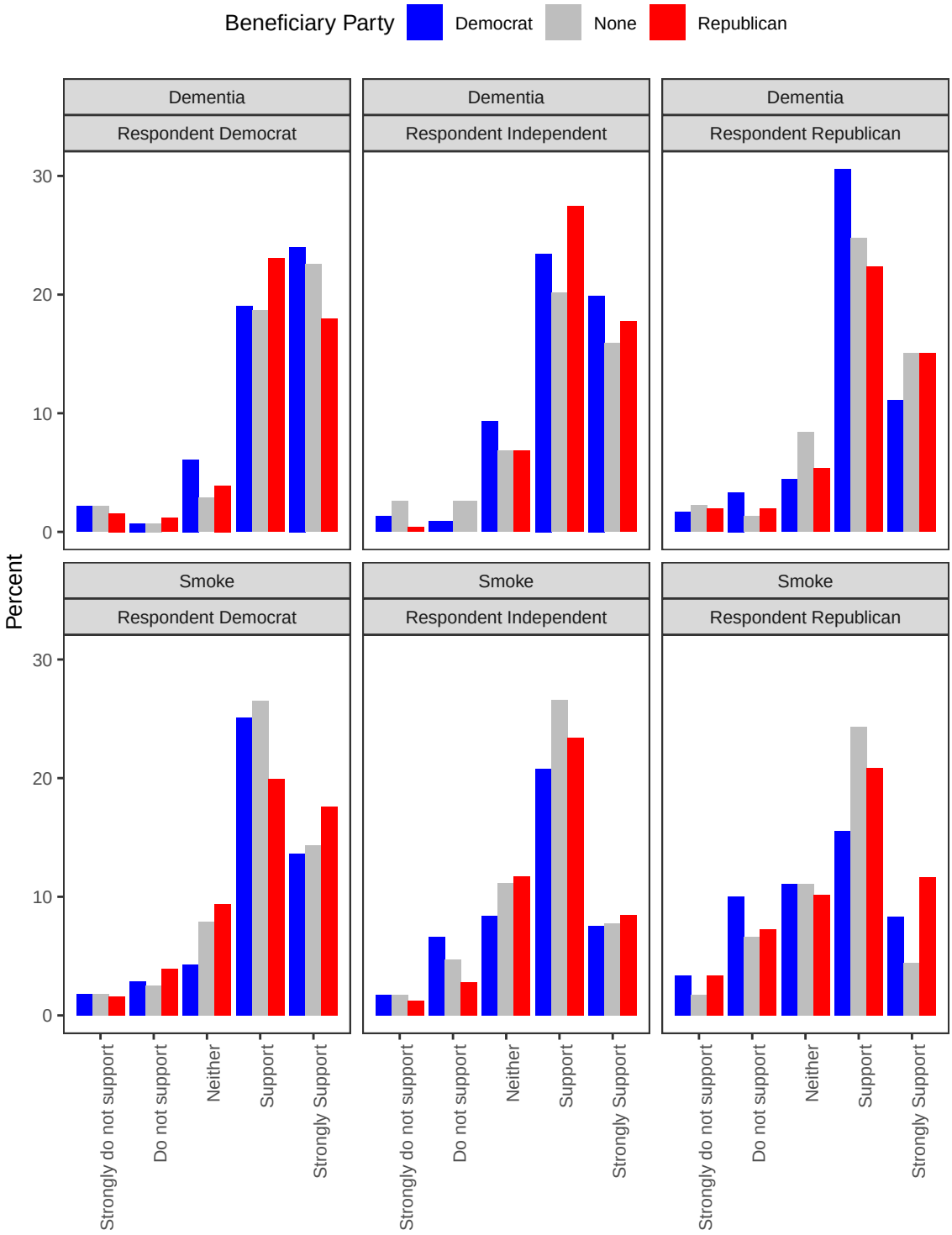
7.1.2 Ailment

Just as different program framings programs could elicit different partisan dynamics, so too could different ailment sources. We repeat a similar analysis to examine whether the party treatment has differing effects when the data are examined by ailment source.

Dementia: When the hypothetical beneficiary requires long-term care support due to dementia, no group of respondents has significantly different evaluations for hypothetical beneficiaries with different political party identification. The KW test similarly finds no significant difference for any respondent party.

Smoking: When the hypothetical beneficiary requires long-term care support due to a life-

Figure 7.2: Evaluations of beneficiary deservingness by respondent party, beneficiary party, and beneficiary ailment.



time of smoking, Republicans have lower evaluations of deservingness and program support when the hypothetical beneficiary is a Democrat versus when the hypothetical beneficiary is a Republican. Republicans also have lower evaluations of deservingness when the hypothetical beneficiary is a Democrat versus has no party. Democrats have lower evaluations of deservingness when the hypothetical beneficiary is a Republican versus a Democrat. Independents have significantly higher funding support when the hypothetical beneficiary is a Republican versus when he has no party. The KW test finds no significant difference in any of the three dependent variables for any respondent party.

7.1.3 Strength of Party Identification

It is possible that the strength of the party effect changes across respondents with varying degrees of partisanship. Strong partisans may be more responsive to party cues than weak partisans. We examine response patterns for self-identified "Strong" and "Not so strong" Republicans and Democrats to determine whether party cues vary across the strength of respondent partisanship.

Among Republican respondents, the only significant party effects are for Strong Republicans. Under the Medicaid Short definition, Strong Republicans have significantly higher evaluations of deservingness for Republican beneficiaries than Democrat beneficiaries or beneficiaries with no party. Under the smoking ailment, Strong Republicans have higher evaluations of deservingness and program support for Republicans than Democrats.

Among Democrat respondents, the results are mixed. Both Strong and Weak democrats have lower scores for program support when the hypothetical beneficiary is a Republican versus has no party. Weak Democrats also have significantly lower evaluations of deservingness for Republican beneficiaries than Democrat beneficiaries or beneficiaries with no party.

7.1.4 Programmatic Knowledge

Finally, it is plausible that the effect of changing the beneficiary party differs across respondents with their level of knowledge about the long-term care program. Low-knowledge respondents may be more likely to use party cues as shortcuts to determine their stance on a program they otherwise know little about. To test this theory, we examine whether responses between high knowledge and low knowledge respondents are significantly different in the face of the same party cues. In this analysis, the impact of respondent programmatic knowledge on responsiveness to party cues is mixed. In two instances, it seems that high knowledge respondents are more sensitive to party cues than low knowledge respondents. In one instance, the reverse is true. This evidence does not clearly support the hypothesis that individuals with less programmatic knowledge are more responsive to party cues than individuals with high knowledge.

7.2 Discussion

Overall, changing the party identification of the hypothetical beneficiary does not have a powerful or consistent effect. Contrary to recent studies showing the reach of partisanship into people's evaluations of each other (Iyengar and Westwood 2015; Mason 2015), we find that partisan bias has its limits. Partisans are not less likely to support a government benefit going to members of the other party than to members of their own party. We expected partisans, especially Republicans, to oppose a government benefit for members of the opposite party. Instead, neither Democrats nor Republicans show partisan biases in their evaluations of the long-term care benefits.

While some significant results emerge when broken down by definition framing, no pattern emerges to support our initial hypothesis that the most powerful partisan effects would occur under the Medicaid Long definition framing, which prompts respondents about the means-tested nature of the program. In fact, under this definition framing, there are no significant

effects for either Republican or Democrat respondents.

When broken down by the hypothetical beneficiary's ailment source, the patterns change. On the whole, smoking is a much more polarizing ailment source. While there is no effect of changing the beneficiary party when the beneficiary's need results from dementia, there are at least some significant party effects for all three respondent party groups when the beneficiary ailment results from smoking. Both Republicans and Democrats have significantly lower evaluations of individual deservingness for hypothetical beneficiaries of the opposite party. This suggests that partisan tensions may be heightened in the face of cues about deservingness and reciprocity.

Finally, strength of party identification and programmatic knowledge does not seem to clearly change the effects we observe for Republicans and Democrats. In this context, strong partisans are not consistently more responsive to partisan cues than weak partisans. Further, we do not find that respondents with less programmatic knowledge are consistently more eager to use a beneficiary's political party as a shortcut in evaluating their support for the beneficiary.

In sum, though the party of a hypothetical beneficiary matters under the smoking condition, we do not find the powerful partisan effect we initially hypothesized. This is an important null finding insofar as it draws an upper bound on the limits of affective partisanship. Whether this pattern extends to government programs with less general support and less sympathetic beneficiary populations is an important question for further research. What this example supports, however, is that inter-party hostility does not extend to every aspect of social life.

Chapter 8

Regression Results

In addition to differences in distribution of responses, we also analyze ordered logistic regressions in which deservingness, program support, and funding support are regressed on treatment variables and demographic variables of interest. Coefficients on treatment variables largely confirm findings discussed in the previous sections. Controlling for a variety of respondent demographic characteristics, when a hypothetical beneficiary requires long-term care due to a lifetime of smoking rather than hereditary dementia, respondents are significantly less likely to support aid to the hypothetical beneficiary, the long-term care benefit generally, and funding to the long-term care program.

In line with our discussion in Chapter 5, the way long-term care is defined does not have a significant effect on perceptions of beneficiary deservingness. Respondents do not have significantly different evaluations of hypothetical beneficiaries when treated with the Medicaid Long definition or Medicaid Short definition, compared to respondents treated with the Government definition. Contrary to our initial hypothesis, indicating that the long-term care benefit is associated with Medicaid, a targeted government program, does not significantly change perceptions of beneficiaries. Similarly, neither the interaction term between the Medicaid Long treatment and the smoking treatment, nor the interaction term between the Medicaid Short treatment and the smoking treatment, is significant. We hypothesized

that attributing the long-term care benefit to Medicaid would make respondents have even less support for hypothetical beneficiaries who are smokers. However, associating the long-term care benefit with Medicaid does not make respondents significantly harsher in their evaluations of beneficiary deservingness.

To analyze the beneficiary party treatments, separate regressions are created for each set of partisan respondents. We hypothesized that partisan respondents would oppose government benefits for members of the opposite party, but do not find support for this in either of our analyses. The coefficients on hypothetical beneficiary political party for beneficiary deservingness are not significant for any group of partisan respondents. Again, this aligns with our prior analysis, finding that a hypothetical beneficiary's political party does not have a significant effect on how opposite partisans evaluate the beneficiary's deservingness of government benefits.

A number of demographic characteristics also have a significant effect on opinion about long-term care, controlling for all treatments. Both Republicans and Independents are significantly less likely than Democrats to support the long-term care benefit on all three dimensions of program support. Respondents with personal experience with public long-term care, measured by whether they know someone who is a public LTC beneficiary, are significantly more likely to support the long-term care benefit on all dimensions. Levels of programmatic knowledge, however, have no independent significant effect, suggesting that the direct interaction with the long-term care benefit drives support more than awareness of the benefit itself. Respondents with high levels of political knowledge are less likely to support the long-term care benefit on all dimensions. Given that we measure political knowledge through awareness of federal budget expenditures on health care and national defense, we can also interpret these coefficients as indicating that individuals with more awareness of national budget expenditures have less support for the long-term care benefit.

Table 8.1: Ordered logistic regression.

	Dependent variable:		
	Deservingness	Program Support	Funding Support
	(1)	(2)	(3)
Medicaid Long	−0.190	−0.214	−0.276
	(0.158)	(0.159)	(0.174)
Medicaid Short	−0.124	−0.244	−0.221
	(0.158)	(0.159)	(0.172)
Smoke	−0.888***	−0.507***	−0.303**
	(0.109)	(0.110)	(0.124)
Beneficiary No Party	−0.0001	0.078	−0.047
	(0.077)	(0.077)	(0.087)
Beneficiary Republican	0.013	0.039	0.024
	(0.078)	(0.079)	(0.089)
Respondent Democrat	−0.137	0.171*	−8.978***
	(0.084)	(0.088)	(0.099)
Respondent Independent	−0.742***	−0.532***	−9.892***
	(0.089)	(0.094)	(0.097)
Respondent Republican	−0.761***	−0.708***	−9.940***
	(0.092)	(0.095)	(0.100)
Know a Beneficiary	0.427***	0.542***	0.645***
	(0.070)	(0.071)	(0.084)
Private LTC Insurance	0.019	−0.055	−0.043
	(0.083)	(0.084)	(0.095)
Political Knowledge	−0.136***	−0.144***	−0.162***
	(0.049)	(0.050)	(0.056)
Observations	3,588	3,587	3,588

Note: Ordered logistic models, regressing each outcome variable on treatment variables and respondent demographic characteristics. In addition to controls indicated in the table, models also control for education, gender, race, geographic region, interaction terms between definition and respondent party, and interaction terms between definition and beneficiary illness. *p<0.1; **p<0.05; ***p<0.01

Chapter 9

Conclusion

This paper investigates three main research questions, motivated principally by a desire to understand the political dynamics of support for public long-term care. First, do deservingness cues impact support for long-term care and its beneficiaries? Second, how does the long-term care benefit's relationship to Medicaid, a means-tested program, impact both overall evaluations and the effect of deservingness cues? Third, do people change their opinion of the hypothetical beneficiary of a government program when they know the beneficiary's political party?

We find that deservingness cues have a small but significant effect on support for long-term care and its beneficiaries. When a hypothetical beneficiary of long-term care requires help due to an illness resulting from their own actions, people have less enthusiastic support for the beneficiary's receipt of government aid and for the program as a whole. This effect applies to respondents of all political parties, but is larger for Republicans and Independents. While there is a significant effect, deservingness cues do not completely reverse patterns of support. Even in the face of deservingness cues, overall support for the program is quite high. This indicates that the moralizing frameworks of deservingness that traditionally accompany means-tested programs are not as powerful in determining support for the long-term care benefit.

Table 9.1: Hypotheses and results, summarized.

Hypothesis	**Result**
1) Respondents are more supportive of long-term care beneficiaries receiving government aid when they require care due to dementia rather than breathing problems from smoking.	Our hypothesis is supported. Respondents of all political parties have significantly lower support for long-term care beneficiaries that require long-term care due to smoking rather than dementia. However, the effect size is small and does not reverse otherwise strong patterns of support.
2) The difference in approval of LTC based on deservingness cues is larger when LTC is framed as means-tested than when it is not framed as means-tested.	Our hypothesis is not supported. We observe the largest effects of deservingness cues under the Government definition, not the Medicaid Long or Medicaid Short definition.
3) Deservingness cues have a smaller effect among those with more personal experience with LTC.	Our hypothesis is supported. The effect magnitude of deservingness cues is smaller for respondents who know a public long-term care beneficiary than those who do not.
4) Republicans and Democrats are more likely to view members of the opposite political party as less deserving of the long-term care benefit than members of their own party. Independents are more likely to view hypothetical beneficiaries with a political party label as less deserving of the long-term care benefit than members without a political party label.	Our hypothesis is not supported. At the aggregate level, beneficiary partisanship does not have a significant effect on beneficiary or programmatic evaluations for Republicans, Independents, or Democrats.
5) The effects in Hypothesis 4 are larger for the Medicaid Long definition than the effects under the Government and Medicaid Short definitions of long-term care.	Our hypothesis is not supported. Under the Medicaid Long definition, there are no significant effects for either Republican or Democrat respondents.
6) The effects in Hypothesis 4 are larger when the cause of the ailment is smoking versus dementia.	Our hypothesis is supported. Under the smoking treatment, both Republicans and Democrats have significantly lower evaluations of individual deservingness for hypothetical beneficiaries of the opposite party.

We do not find that the long-term care benefit's relationship to Medicaid significantly changes the way long-term care is evaluated. If anything, the provision of information about Medicaid serves to mitigate otherwise reliable sensitivity to deservingness cues. Further, we

find evidence that rather than Medicaid diminishing support for long-term care, attributing the long-term care benefit to Medicaid increases Medicaid support among Republicans and Independents, political constituencies traditionally more hostile to Medicaid expansion.

Finally, we do not find a powerful or consistent effect of the relationship between the respondent and beneficiary party on evaluations of deservingness and program support. Contrary to a broad body of literature, we do not find that partisans consistently or significantly disfavor beneficiaries of the opposite political party in the context of support for receiving government long-term care.

This research has a number of relevant limitations and areas for further research. While this research allowed us to empirically verify public support for long-term care, it remains unclear what aspect of long-term care drives this support. Is it age of the beneficiary population, the care itself that is administered, or the program's de-facto status as the primary provider of long-term care to the middle class that drives this dynamic? How would the patterns be different if the hypothetical beneficiary were younger than 80, identified by race, or identified as a member of the middle class? Additionally, different dependent variables for evaluating opinion on long-term care may be illuminating. Because our research measured overall support and did not ask respondents to consider long-term care in the context of a number of other budget priorities, support for the program was quite high. Observing opinion patterns in experimental contexts that highlight the tradeoffs associated with funding a program of this magnitude is an interesting avenue for further research. It would be particularly illuminating to further explore opinion on long-term care during the era of COVID-19, when nursing homes and assisted living facilities have become prominent in news coverage due to their propensity for infection outbreaks.

Building on our finding that the Medicaid framings decreased responsiveness to deservingness cues, future research should investigate how the provision of other policy-specific details (aside from eligibility criteria) impacts receptiveness to deservingness cues. Given the rich literature on Medicaid estate planning, replicating this experiment with deservingness cues

based on estate planning and asset spend-down behaviors represents another pertinent area for further investigation. Finally, future research on affective partisanship should investigate whether the pattern we observe in the context of long-term care extends to government programs with less general support and less sympathetic beneficiary populations.

In addition to this paper's relevance to political science, it has important policy implications. This research suggests that in a time of increasing partisan polarization, the long-term care benefit does not activate many of the partisan hostilities that traditionally accompany means-tested health and social policy. While deservingness cues have a significant effect on program support, the effect is small and overall support for the program remains high. Further, the program's relationship to Medicaid does not change this pattern and, if anything, serves to decrease responsiveness to these cues. The salience of long-term care is bound to increase in the coming decades, as the rapidly growing need for these services will continue to place a strain on both the national budget and American families. This research suggests that the political discussions surrounding long-term care policy may be unique from traditional social and health policy in their ability to garner consensus, increase support for means-tested programs among traditionally hostile constituencies, and circumvent long-standing affective partisan hostility.

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Appendix A

Additional Figures

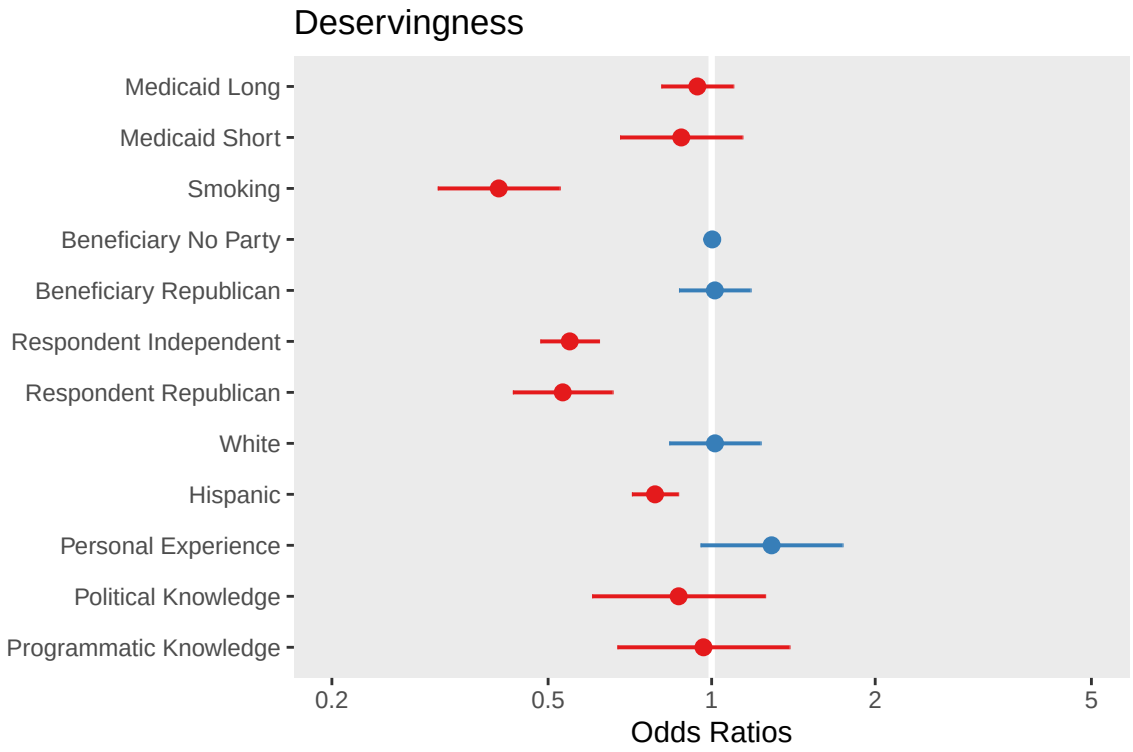

Figure A.1: Regression coefficients for impact of treatments and demographic factors on perceived beneficiary deservingness.

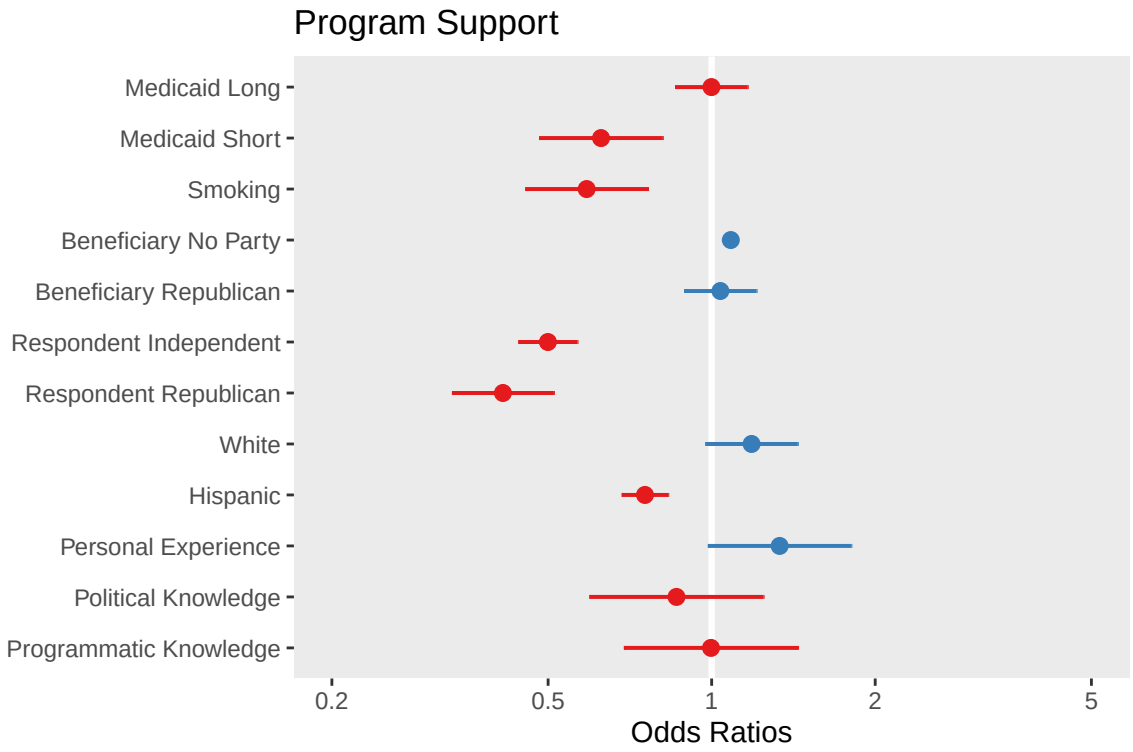

Figure A.2: Regression coefficients for impact of treatments and demographic factors on program support.

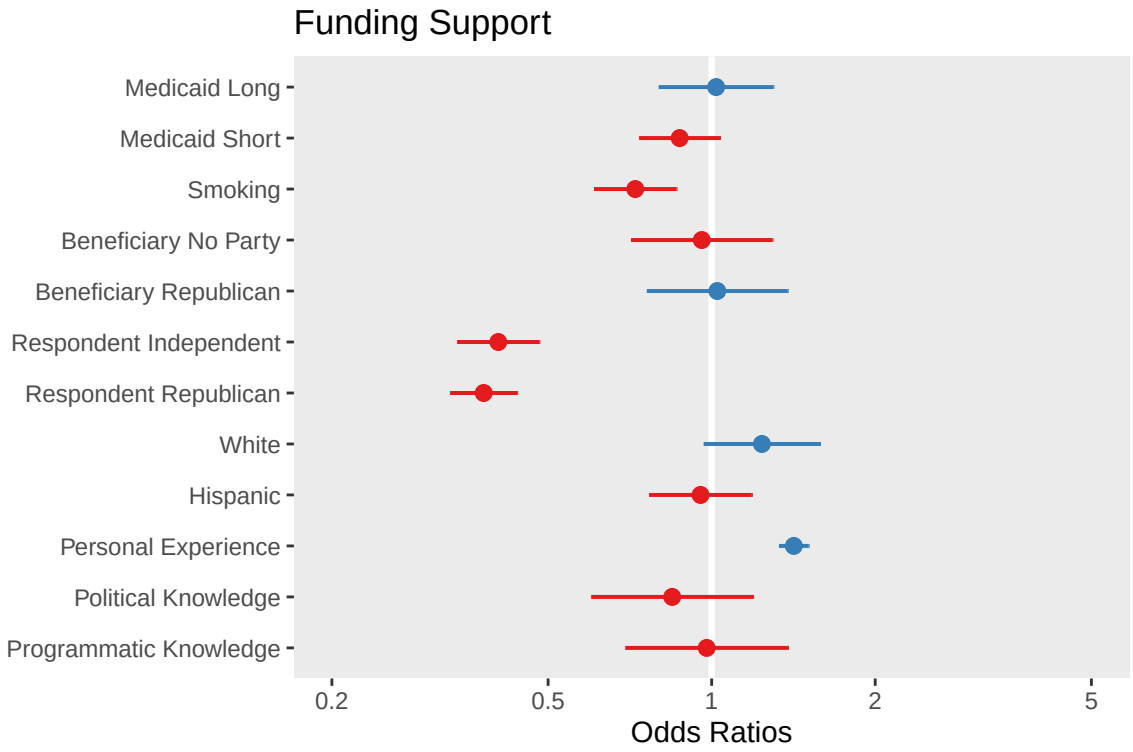

Figure A.3: Regression coefficients for impact of treatments and demographic factors on funding support.

Appendix B

Additional Tables

[1]

Table B.1: Respondent demographics.

Demographic	Sample (Percent)
Gender	
Male	48.12
Female	51.88
Respondent Party	
NA	0.83
Democrat	39.39
Independent	29.19
Republican	30.60
Region	
NA	0.06
Northeast	20.62
Midwest	19.13
South	38.36
West	21.84
Age	
18-24	12.30
25-34	20.81
35-54	15.62
55-64	18.19
65-74	13.38
75-84	2.68
85-94	0.25
Education	
College Degree	38.03
No College	61.91
NA	0.06
Race	
Non-White	25.46
White	74.54
Hispanic	
Non-Hispanic	89.83
Hispanic	10.17

Table B.2: Number of respondents per treatment.

Definition	Beneficiary Ailment	Beneficiary Party	Count
Govt	Dementia	Democrat	202
Govt	Dementia	None	215
Govt	Dementia	Republican	194
Govt	Smoke	Democrat	193
Govt	Smoke	None	200
Govt	Smoke	Republican	208
Medicaid Long	Dementia	Democrat	198
Medicaid Long	Dementia	None	196
Medicaid Long	Dementia	Republican	199
Medicaid Long	Smoke	Democrat	176
Medicaid Long	Smoke	None	231
Medicaid Long	Smoke	Republican	204
Medicaid Short	Dementia	Democrat	222
Medicaid Short	Dementia	None	207
Medicaid Short	Dementia	Republican	187
Medicaid Short	Smoke	Democrat	194
Medicaid Short	Smoke	None	208
Medicaid Short	Smoke	Republican	184

Table B.3: Demographic table for smoking data.

	Have Smoking Data
Personal Experience	−0.002
	(0.013)
Income	−0.0002
	(0.0002)
Respondent Independent	−0.046**
	(0.020)
Respondent Republican	−0.043**
	(0.020)
Age	0.002***
	(0.001)
Education	0.0001*
	(0.00004)
Political Knowledge	−0.012
	(0.013)
Program Knowledge	0.003
	(0.008)
Constant	0.372***
	(0.037)
Observations	3,586
Log Likelihood	−2,544.555
Akaike Inf. Crit.	5,127.110

Note: Model also controls for gender, region, race, and all treatment variables, none of which are significant.
*** $p < 0.01$, ** $p < 0.05$, * $p < 0.10$ (two sided).

Table B.4: Percent of responses in each response category for deservingness evaluations by respondent party and beneficiary ailment source.

Respondent Party	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Democrat	Dementia	4.6 %	1.9 %	6.2 %	37.9 %	49.4 %	695	
Democrat	Smoke	4.5 %	5.2 %	11.9 %	49 %	29.3 %	730	0.00
Independent	Dementia	2.4 %	3 %	13.8 %	44.1 %	36.7 %	542	
Independent	Smoke	3.5 %	9.7 %	21.2 %	46.5 %	19.1 %	514	0.00
Republican	Dementia	4.3 %	3.8 %	11 %	49.5 %	31.3 %	554	
Republican	Smoke	4.5 %	13 %	18.8 %	43.4 %	20.3 %	553	0.00

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.5: Percent of responses in each response category for program support by respondent party and beneficiary ailment source.

Respondent Party	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Democrat	Dementia	1.9 %	2.4 %	8.4 %	39.8 %	47.6 %	695	
Democrat	Smoke	1.5 %	2.9 %	12.3 %	46.4 %	36.8 %	730	0.00
Independent	Dementia	0.7 %	3 %	16.8 %	46.3 %	33.2 %	542	
Independent	Smoke	1.4 %	3.9 %	18.7 %	53.3 %	22.8 %	514	0.00
Republican	Dementia	2 %	3.4 %	15.4 %	51.9 %	27.3 %	554	
Republican	Smoke	2.2 %	6.7 %	23.6 %	46.6 %	21 %	553	0.00

Note: P-values are located in parentheses and indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.6: Percent of responses in each response category for funding support by respondent party and beneficiary ailment source.

Respondent Party	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
Democrat	Dementia	1.4 %	20.5 %	78.1 %	695	
Democrat	Smoke	3.3 %	21.2 %	75.5 %	730	0.18
Independent	Dementia	5.4 %	31.2 %	63.5 %	542	
Independent	Smoke	10.1 %	31.7 %	58.2 %	514	0.03
Republican	Dementia	5.6 %	36.3 %	58 %	554	
Republican	Smoke	9.8 %	38.7 %	51.5 %	553	0.01

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.7: Percent of responses in each response category for deservingness evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	3.8 %	2.5 %	9.5 %	42.6 %	41.7 %	611	
Government	Smoke	4.2 %	10.8 %	17.8 %	42.1 %	25.1 %	601	0.001
Medicaid Long	Dementia	4.2 %	2.9 %	10.5 %	42.7 %	39.8 %	593	
Medicaid Long	Smoke	4.1 %	7.9 %	16.4 %	48.6 %	23.1 %	611	0.001
Medicaid Short	Dementia	3.6 %	3.1 %	10.1 %	45.1 %	38.2 %	616	
Medicaid Short	Smoke	4.4 %	8 %	15.9 %	49 %	22.7 %	586	0.001

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.8: Percent of responses in each response category for program support evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	1.3 %	2.9 %	11.8 %	43.7 %	40.3 %	611	
Government	Smoke	2.3 %	4 %	16.5 %	48.4 %	28.8 %	601	0.00
Medicaid Long	Dementia	1 %	2.5 %	13.7 %	45.2 %	37.6 %	593	
Medicaid Long	Smoke	1.1 %	4.3 %	20.6 %	47.1 %	26.8 %	611	0.00
Medicaid Short	Dementia	2.4 %	3.2 %	13.8 %	47.8 %	32.8 %	616	
Medicaid Short	Smoke	1.5 %	4.8 %	15.6 %	49.7 %	28.4 %	586	0.10

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.9: Percent of responses in each response category for funding support by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
Government	Dementia	3.6 %	27.2 %	69.2 %	611	
Government	Smoke	7 %	29.6 %	63.4 %	601	0.02
Medicaid Long	Dementia	4.6 %	29 %	66.4 %	593	
Medicaid Long	Smoke	6.9 %	30.9 %	62.2 %	611	0.08
Medicaid Short	Dementia	3.6 %	29.7 %	66.7 %	616	
Medicaid Short	Smoke	7.8 %	28.2 %	64 %	586	0.15

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.10: Republican Respondents: Percent of responses in each response category for deservingness evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	3.8 %	2.7 %	10.4 %	45.4 %	37.7 %	183	
Government	Smoke	6.2 %	14.7 %	19.2 %	39 %	20.9 %	177	0.00
Medicaid Long	Dementia	5 %	4.4 %	10.6 %	53.9 %	26.1 %	180	
Medicaid Long	Smoke	2.5 %	11.4 %	21.3 %	47 %	17.8 %	202	0.00
Medicaid Short	Dementia	4.2 %	4.2 %	12.1 %	49.5 %	30 %	191	
Medicaid Short	Smoke	5.2 %	13.2 %	15.5 %	43.7 %	22.4 %	174	0.00

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.11: Republican Respondents: Percent of responses in each response category for program support evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	1.1 %	2.2 %	14.2 %	51.9 %	30.6 %	183	
Government	Smoke	4.5 %	4.5 %	20.9 %	49.2 %	20.9 %	177	0.001
Medicaid Long	Dementia	1.7 %	5 %	15 %	53.3 %	25 %	180	
Medicaid Long	Smoke	0.5 %	7.9 %	27.7 %	46 %	17.8 %	202	0.001
Medicaid Short	Dementia	3.2 %	3.2 %	16.8 %	50.5 %	26.3 %	191	
Medicaid Short	Smoke	1.7 %	7.5 %	21.4 %	44.5 %	24.9 %	174	0.24

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.12: Republican Respondents: Percent of responses in each response category for funding support by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
Government	Dementia	4.4 %	32.8 %	62.8 %	183	
Government	Smoke	9 %	36.7 %	54.2 %	177	0.06
Medicaid Long	Dementia	7.2 %	36.1 %	56.7 %	180	
Medicaid Long	Smoke	10.4 %	42.1 %	47.5 %	202	0.06
Medicaid Short	Dementia	5.3 %	40 %	54.7 %	191	
Medicaid Short	Smoke	9.8 %	36.8 %	53.4 %	174	0.54

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.13: Democrat Respondents: Percent of responses in each response category for deservingness evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	4.4 %	1.6 %	5.2 %	41 %	47.8 %	251	
Government	Smoke	3.2 %	6.3 %	13.8 %	44.3 %	32.4 %	253	0.001
Medicaid Long	Dementia	5.6 %	0.9 %	7 %	34.9 %	51.6 %	215	
Medicaid Long	Smoke	6.5 %	4.9 %	10.2 %	48.4 %	30.1 %	246	0.001
Medicaid Short	Dementia	3.9 %	3.1 %	6.6 %	37.3 %	49.1 %	229	
Medicaid Short	Smoke	3.9 %	4.3 %	11.7 %	55 %	25.1 %	231	0.001

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.14: Democrat Respondents: Percent of responses in each response category for program support evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	2 %	2.4 %	8 %	37.1 %	50.6 %	251	
Government	Smoke	1.6 %	2.4 %	11.1 %	45.5 %	39.5 %	253	0.02
Medicaid Long	Dementia	1.4 %	1.4 %	7 %	38.6 %	51.6 %	215	
Medicaid Long	Smoke	2 %	0.8 %	15.4 %	44.3 %	37.4 %	246	0.001
Medicaid Short	Dementia	2.2 %	3.5 %	10.1 %	43.9 %	40.4 %	229	0.10
Medicaid Short	Smoke	0.9 %	5.6 %	10.4 %	49.8 %	33.3 %	231	0.19

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.15: Democrat Respondents: Percent of responses in each response category for funding support by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
Government	Dementia	0.8 %	19.9 %	79.3 %	251	
Government	Smoke	2.8 %	22.5 %	74.7 %	253	0.19
Medicaid Long	Dementia	2.3 %	20.5 %	77.2 %	215	
Medicaid Long	Smoke	2.4 %	19.9 %	77.6 %	246	0.92
Medicaid Short	Dementia	1.3 %	21.1 %	77.6 %	229	
Medicaid Short	Smoke	4.8 %	21.2 %	74 %	231	0.28

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.16: Independent Respondents: Percent of responses in each response category for deservingness evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	2.8 %	3.4 %	14.8 %	41.5 %	37.5 %	176	
Government	Smoke	3.5 %	13.5 %	22.4 %	42.4 %	18.2 %	170	0.001
Medicaid Long	Dementia	2 %	3.5 %	14.1 %	40.9 %	39.4 %	198	
Medicaid Long	Smoke	2.5 %	8 %	19.6 %	50.9 %	19 %	163	0.001
Medicaid Short	Dementia	2.4 %	1.8 %	12.5 %	50.6 %	32.7 %	168	
Medicaid Short	Smoke	4.4 %	7.7 %	21.5 %	46.4 %	19.9 %	181	0.001

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.17: Independent Respondents: Percent of responses in each response category for program support evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	0.6 %	4.5 %	14.8 %	44.3 %	35.8 %	176	
Government	Smoke	1.2 %	5.9 %	20 %	52.4 %	20.6 %	170	0.00
Medicaid Long	Dementia	0 %	1.5 %	19.7 %	44.9 %	33.8 %	198	
Medicaid Long	Smoke	0.6 %	4.9 %	19.6 %	52.8 %	22.1 %	163	0.03
Medicaid Short	Dementia	1.8 %	3 %	15.5 %	50 %	29.8 %	168	
Medicaid Short	Smoke	2.2 %	1.1 %	16.6 %	54.7 %	25.4 %	181	0.60

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.18: Independent Respondents: Percent of responses in each response category for funding support by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
Government	Dementia	6.8 %	31.8 %	61.4 %	176	
Government	Smoke	11.2 %	32.9 %	55.9 %	170	0.21
Medicaid Long	Dementia	4.5 %	31.8 %	63.6 %	198	
Medicaid Long	Smoke	9.2 %	33.7 %	57.1 %	163	0.13
Medicaid Short	Dementia	4.8 %	29.8 %	65.5 %	168	
Medicaid Short	Smoke	9.9 %	28.7 %	61.3 %	181	0.28

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.19: Percent of responses in each response category for deservingness evaluations by respondent personal experience and beneficiary ailment source.

Know a LTC Beneficiary	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
No	Dementia	3.5 %	3 %	11.8 %	45.6 %	36.1 %	1266	
No	Smoke	3.7 %	10.4 %	18.4 %	45.9 %	21.6 %	1268	0.001
Yes	Dementia	4.7 %	2.3 %	6 %	38.4 %	48.6 %	554	
Yes	Smoke	5.5 %	5.3 %	12.6 %	48.1 %	28.5 %	530	0.001

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.20: Percent of responses in each response category for program support by respondent party and beneficiary ailment source.

Know LTC Beneficiary	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
No	Dementia	1.2 %	3.1 %	15.2 %	48.5 %	32 %	1266	
No	Smoke	1.5 %	4.8 %	20 %	48.2 %	25.6 %	1268	0.001
Yes	Dementia	2.3 %	2.5 %	8.3 %	38.8 %	48 %	554	
Yes	Smoke	2.1 %	3.2 %	11.9 %	49 %	33.8 %	530	0.001

Note: P-values are located in parentheses and indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.21: Percent of responses in each response category for funding support by respondent party and beneficiary ailment source.

Know a LTC Beneficiary	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
No	Dementia	4.4 %	31.5 %	64.2 %	1266	
No	Smoke	8.8 %	32.6 %	58.7 %	1268	0.001
Yes	Dementia	2.9 %	22.2 %	74.9 %	554	
Yes	Smoke	3.6 %	22.5 %	74 %	530	0.68

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.22: Respondents who know a LTC beneficiary: Percent of responses in each response category for deservingness evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	4.1 %	1.5 %	6.2 %	37.1 %	51 %	194	
Government	Smoke	5.6 %	7.9 %	15.8 %	45.2 %	25.4 %	177	0.001
Medicaid Long	Dementia	6.6 %	2.2 %	6.6 %	41 %	43.7 %	183	
Medicaid Long	Smoke	6.2 %	3.1 %	15 %	47.7 %	28 %	193	0.001
Medicaid Short	Dementia	3.4 %	3.4 %	5.1 %	37.3 %	50.8 %	177	
Medicaid Short	Smoke	4.4 %	5 %	6.2 %	51.9 %	32.5 %	160	0.001

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.23: Respondents who know a LTC beneficiary: Percent of responses in each response category for program support evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	1.5 %	3.1 %	8.2 %	37.6 %	49.5 %	194	
Government	Smoke	1.7 %	4.5 %	14.7 %	48 %	31.1 %	177	0.001
Medicaid Long	Dementia	2.2 %	2.2 %	9.8 %	40.4 %	45.4 %	183	
Medicaid Long	Smoke	2.6 %	2.1 %	12.4 %	51.3 %	31.6 %	193	0.02
Medicaid Short	Dementia	3.4 %	2.3 %	6.8 %	38.4 %	49.2 %	177	
Medicaid Short	Smoke	1.9 %	3.1 %	8.2 %	47.2 %	39.6 %	160	0.14

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.24: Respondents who know a LTC beneficiary: Percent of responses in each response category for funding support by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
Government	Dementia	3.6 %	20.6 %	75.8 %	194	
Government	Smoke	6.2 %	20.3 %	73.4 %	177	0.53
Medicaid Long	Dementia	3.3 %	23 %	73.8 %	183	
Medicaid Long	Smoke	2.6 %	25.4 %	72 %	193	0.74
Medicaid Short	Dementia	1.7 %	23.2 %	75.1 %	177	
Medicaid Short	Smoke	1.9 %	21.2 %	76.9 %	160	0.72

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.25: Respondents who do not know a LTC beneficiary: Percent of responses in each response category for deservingness evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	3.6 %	2.9 %	11 %	45.1 %	37.4 %	417	
Government	Smoke	3.5 %	12 %	18.6 %	40.8 %	25 %	424	0.001
Medicaid Long	Dementia	3.2 %	3.2 %	12.2 %	43.4 %	38 %	410	
Medicaid Long	Smoke	3.1 %	10 %	17 %	49 %	20.8 %	418	0.001
Medicaid Short	Dementia	3.7 %	2.9 %	12.2 %	48.4 %	32.8 %	439	
Medicaid Short	Smoke	4.5 %	9.2 %	19.5 %	47.9 %	19 %	426	0.001

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.26: Respondents who do not know a LTC beneficiary: Percent of responses in each response category for program support evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	1.2 %	2.9 %	13.4 %	46.5 %	36 %	417	
Government	Smoke	2.6 %	3.8 %	17.2 %	48.6 %	27.8 %	424	0.001
Medicaid Long	Dementia	0.5 %	2.7 %	15.4 %	47.3 %	34.1 %	410	
Medicaid Long	Smoke	0.5 %	5.3 %	24.4 %	45.2 %	24.6 %	418	0.001
Medicaid Short	Dementia	2 %	3.7 %	16.9 %	51.8 %	25.7 %	439	
Medicaid Short	Smoke	1.4 %	5.4 %	18.3 %	50.7 %	24.2 %	426	0.39

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.27: Respondents who do not know a LTC beneficiary: Percent of responses in each response category for funding support by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
Government	Dementia	3.6 %	30.2 %	66.2 %	417	
Government	Smoke	7.3 %	33.5 %	59.2 %	424	0.02
Medicaid Long	Dementia	5.1 %	31.7 %	63.2 %	410	
Medicaid Long	Smoke	8.9 %	33.5 %	57.7 %	418	0.06
Medicaid Short	Dementia	4.4 %	32.5 %	63.1 %	439	
Medicaid Short	Smoke	10.1 %	30.8 %	59.2 %	426	0.09

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.28: Percent of responses in each response category for deservingness evaluations by respondent LTC insurance status and beneficiary ailment source.

Insurance Status	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
No Insurance	Dementia	3.6 %	2.6 %	11.9 %	45.7 %	36.2 %	1099	
No Insurance	Smoke	4 %	10 %	18.6 %	46 %	21.5 %	1062	0.001
Purchased Insurance	Dementia	3 %	5.4 %	11.4 %	44.9 %	35.3 %	167	
Purchased Insurance	Smoke	2.4 %	12.6 %	17 %	45.6 %	22.3 %	206	0.001

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.29: Percent of responses in each response category for program support by respondent LTC insurance status and beneficiary ailment source.

Insurance Status	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
No Insurance	Dementia	1 %	2.7 %	15.3 %	48.8 %	32.1 %	1099	
No Insurance	Smoke	1.2 %	4.5 %	20.2 %	48.5 %	25.6 %	1062	0.001
Purchased Insurance	Dementia	2.4 %	5.4 %	14.4 %	46.7 %	31.1 %	167	
Purchased Insurance	Smoke	2.9 %	6.3 %	18.9 %	46.6 %	25.2 %	206	0.13

Note: P-values are located in parentheses and indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.30: Percent of responses in each response category for funding support by respondent LTC insurance status and beneficiary ailment source.

Insurance Status	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
No Insurance	Dementia	4 %	31.5 %	64.5 %	1099	
No Insurance	Smoke	9.4 %	31.5 %	59.1 %	1062	0.001
Purchased Insurance	Dementia	6.6 %	31.1 %	62.3 %	167	
Purchased Insurance	Smoke	5.3 %	38.3 %	56.3 %	206	0.33

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.31: Respondents who have private LTC insurance: Percent of responses in each response category for deservingness evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Govt	Dementia	4.1 %	6.1 %	14.3 %	44.9 %	30.6 %	49	
Govt	Smoke	5.6 %	11.3 %	16.9 %	36.6 %	29.6 %	71	0.09
Medicaid Long	Dementia	1.9 %	3.8 %	11.5 %	36.5 %	46.2 %	52	
Medicaid Long	Smoke	0 %	14.3 %	16.9 %	46.8 %	22.1 %	77	0.001
Medicaid Short	Dementia	3 %	6.1 %	9.1 %	51.5 %	30.3 %	66	
Medicaid Short	Smoke	1.7 %	12.1 %	17.2 %	55.2 %	13.8 %	58	0.39

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.32: Respondents who have private LTC insurance: Percent of responses in each response category for program support by definition framing and beneficiary ailment source..

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Govt	Dementia	2 %	6.1 %	14.3 %	46.9 %	30.6 %	49	
Govt	Smoke	4.2 %	2.8 %	12.7 %	45.1 %	35.2 %	71	0.96
Medicaid Long	Dementia	0 %	3.8 %	13.5 %	44.2 %	38.5 %	52	
Medicaid Long	Smoke	2.6 %	7.8 %	19.5 %	45.5 %	24.7 %	77	0.001
Medicaid Short	Dementia	4.5 %	6.1 %	15.2 %	48.5 %	25.8 %	66	
Medicaid Short	Smoke	1.7 %	8.6 %	25.9 %	50 %	13.8 %	58	0.67

Note: P-values are located in parentheses and indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.33: Respondents who have private LTC insurance: Percent of responses in each response category for funding support by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
Government	Dementia	6.1 %	36.7 %	57.1 %	49	
Government	Smoke	4.2 %	33.8 %	62 %	71	0.51
Medicaid Long	Dementia	3.8 %	17.3 %	78.8 %	52	
Medicaid Long	Smoke	3.9 %	36.4 %	59.7 %	77	0.13
Medicaid Short	Dementia	9.1 %	37.9 %	53 %	66	
Medicaid Short	Smoke	8.6 %	46.6 %	44.8 %	58	0.84

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.34: Respondents who do not have private LTC insurance: Percent of responses in each response category for deservingness evaluations by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	3.5 %	2.4 %	10.6 %	45.1 %	38.3 %	368	
Government	Smoke	3.1 %	12.2 %	19 %	41.6 %	24.1 %	353	0.001
Medicaid Long	Dementia	3.4 %	3.1 %	12.3 %	44.4 %	36.9 %	358	
Medicaid Long	Smoke	3.8 %	9.1 %	17 %	49.6 %	20.5 %	341	0.001
Medicaid Short	Dementia	3.8 %	2.3 %	12.8 %	47.8 %	33.2 %	373	
Medicaid Short	Smoke	4.9 %	8.7 %	19.8 %	46.7 %	19.8 %	368	0.001

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.35: Respondents who do not have private LTC insurance: Percent of responses in each response category for program support by definition framing and beneficiary ailment source..

Definition Framing	Ailment Source	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Government	Dementia	1.1 %	2.4 %	13.3 %	46.5 %	36.7 %	368	
Government	Smoke	2.3 %	4 %	18.1 %	49.3 %	26.3 %	353	0.001
Medicaid Long	Dementia	0.6 %	2.5 %	15.6 %	47.8 %	33.5 %	358	
Medicaid Long	Smoke	0 %	4.7 %	25.5 %	45.2 %	24.6 %	341	0.001
Medicaid Short	Dementia	1.5 %	3.2 %	17.2 %	52.5 %	25.7 %	373	
Medicaid Short	Smoke	1.4 %	4.9 %	17.1 %	50.8 %	25.8 %	368	0.11

Note: P-values are located in parentheses and indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.36: Respondents who do not have private LTC insurance: Percent of responses in each response category for funding support by definition framing and beneficiary ailment source.

Definition Framing	Ailment Source	Decrease	Stay the Same	Increase	n	p-value
Government	Dementia	3.3 %	29.3 %	67.4 %	368	
Government	Smoke	7.9 %	33.4 %	58.6 %	353	0.001
Medicaid Long	Dementia	5.3 %	33.8 %	60.9 %	358	
Medicaid Long	Smoke	10 %	32.8 %	57.2 %	341	0.15
Medicaid Short	Dementia	3.5 %	31.5 %	65 %	373	
Medicaid Short	Smoke	10.3 %	28.3 %	61.4 %	368	0.09

Note: P-values indicate the significance level of a Mann-Whitney test between the Dementia and Smoking treatments for each group of respondents.

Table B.37: Percent of responses in each response category for deservingness evaluations by respondent, hypothetical beneficiary political party, and hypothetical beneficiary ailment source.

Respondent Party	Beneficiary Party	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Democrat								
	Democrat	4.3 %	3.4 %	7.7 %	43.6 %	41 %	467	-
	None	4.6 %	2.3 %	9.4 %	45.2 %	38.5 %	480	0.49
	Republican	4.8 %	5 %	10.3 %	42.1 %	37.9 %	478	0.13
Republican								
	Democrat	5 %	10.7 %	13.9 %	45.1 %	25.2 %	338	0.32
	None	4.3 %	6.3 %	16.2 %	48.6 %	24.6 %	414	0.68
	Republican	3.9 %	8.7 %	14.4 %	45.4 %	27.6 %	355	-
Independent								
	Democrat	3.7 %	8 %	16.5 %	41.9 %	29.9 %	351	0.64
	None	3.9 %	7.5 %	17.1 %	44.2 %	27.3 %	362	-
	Republican	1.2 %	3.2 %	18.7 %	49.9 %	27.1 %	343	0.68

Note: P-values for a given beneficiary party indicate the significance level of a Mann-Whitney test between that beneficiary group and the beneficiary group of the respondent's party. For Independent respondents, reference group is beneficiaries with no identified party.

Table B.38: Percent of responses in each response category for deservingness evaluations by respondent and hypothetical beneficiary political party.

Smoking								
Respondent Party	Beneficiary Party	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Democrat								
	Democrat	4.2 %	5.5 %	7.6 %	51.3 %	31.5 %	238	-
	None	5.1 %	3.1 %	12.6 %	50.8 %	28.3 %	254	0.33
	Republican	4.2 %	7.1 %	15.5 %	45 %	28.2 %	238	0.08
Republican								
	Democrat	7.3 %	17.7 %	19.5 %	34.8 %	20.7 %	164	0.06
	None	2.1 %	10.3 %	20 %	50.8 %	16.9 %	195	0.74
	Republican	4.6 %	11.9 %	17 %	43.3 %	23.2 %	194	-
Independent								
	Democrat	5.6 %	14.3 %	18 %	41.6 %	20.5 %	161	0.45
	None	3.2 %	9 %	20.1 %	50.3 %	17.5 %	189	-
	Republican	1.8 %	6.1 %	25.6 %	47 %	19.5 %	164	0.74
Dementia								
Respondent Party	Beneficiary Party	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Democrat								
	Democrat	4.4 %	1.3 %	7.9 %	35.5 %	50.9 %	229	-
	None	4 %	1.3 %	5.8 %	38.9 %	50 %	226	0.94
	Republican	5.4 %	2.9 %	5 %	39.2 %	47.5 %	240	0.52
Republican								
	Democrat	2.9 %	4 %	8.7 %	54.9 %	29.5 %	174	0.94
	None	6.4 %	2.7 %	12.8 %	46.6 %	31.5 %	219	0.57
	Republican	3.1 %	5 %	11.2 %	47.8 %	32.9 %	161	-
Independent								
	Democrat	2.1 %	2.6 %	15.3 %	42.1 %	37.9 %	190	0.55
	None	4.6 %	5.8 %	13.9 %	37.6 %	38.2 %	173	-
	Republican	0.6 %	0.6 %	12.3 %	52.5 %	34.1 %	179	0.57

Note: P-values for a given beneficiary party indicate the significance level of a Mann-Whitney test between that beneficiary group and the beneficiary group of the respondent's party. For Independent respondents, reference group is beneficiaries with no identified party.

Table B.39: Government definition: Percent of responses in each response category for deservingness evaluations by respondent and hypothetical beneficiary political party.

Government								
Respondent Party	Beneficiary Party	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Democrat								
	Democrat	5.5 %	4.3 %	6.7 %	39.6 %	43.9 %	164	-
	None	3.9 %	2.8 %	10.1 %	44.1 %	39.1 %	179	0.53
	Republican	1.9 %	5 %	11.8 %	44.1 %	37.3 %	161	0.32
Republican								
	Democrat	7.5 %	11.2 %	13.1 %	36.4 %	31.8 %	107	0.65
	None	5.4 %	7.8 %	14 %	44.2 %	28.7 %	129	0.87
	Republican	2.4 %	7.3 %	16.9 %	45.2 %	28.2 %	124	-
Independent								
	Democrat	1.6 %	10.6 %	17.1 %	40.7 %	30.1 %	123	0.57
	None	6.6 %	11.3 %	16 %	34.9 %	31.1 %	106	-
	Republican	1.7 %	3.4 %	22.2 %	49.6 %	23.1 %	117	0.87

Note: P-values for a given beneficiary party indicate the significance level of a Mann-Whitney test between that beneficiary group and the beneficiary group of the respondent's party. For Independent respondents, reference group is beneficiaries with no identified party.

Table B.40: Medicaid Short Definition: Percent of responses in each response category for deservingness evaluations by respondent and hypothetical beneficiary political party.

Med Short								
Respondent Party	Beneficiary Party	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Democrat								
	Democrat	2.6 %	3.3 %	9.3 %	45 %	39.7 %	152	-
	None	4.6 %	2 %	9.2 %	49.3 %	34.9 %	152	0.45
	Republican	4.5 %	5.8 %	9 %	44.2 %	36.5 %	156	0.37
Republican								
	Democrat	6.1 %	11.4 %	14 %	47.4 %	21.1 %	115	0.03
	None	4.3 %	5.8 %	17.4 %	46.4 %	26.1 %	138	0.26
	Republican	3.6 %	8.9 %	8.9 %	46.4 %	32.1 %	112	-
Independent								
	Democrat	2.5 %	6.6 %	15.7 %	46.3 %	28.9 %	121	0.92
	None	5.6 %	2.4 %	16.8 %	47.2 %	28 %	125	-
	Republican	1.9 %	5.8 %	19.4 %	52.4 %	20.4 %	103	0.26

Note: P-values for a given beneficiary party indicate the significance level of a Mann-Whitney test between that beneficiary group and the beneficiary group of the respondent's party. For Independent respondents, reference group is beneficiaries with no identified party.

Table B.41: Medicaid Long Definition: Percent of responses in each response category for deservingness evaluations by respondent and hypothetical beneficiary political party.

Med Long								
Respondent Party	Beneficiary Party	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	n	p-value
Democrat								
	Democrat	4.6 %	2.6 %	7.3 %	46.4 %	39.1 %	151	-
	None	5.4 %	2 %	8.7 %	42.3 %	41.6 %	149	0.84
	Republican	8.1 %	4.3 %	9.9 %	37.9 %	39.8 %	161	0.47
Republican								
	Democrat	1.7 %	9.5 %	14.7 %	50.9 %	23.3 %	116	0.35
	None	3.4 %	5.4 %	17 %	54.4 %	19.7 %	147	0.49
	Republican	5.9 %	10.1 %	16.8 %	44.5 %	22.7 %	119	-
Independent								
	Democrat	7.5 %	6.5 %	16.8 %	38.3 %	30.8 %	107	0.90
	None	0 %	9.2 %	18.3 %	48.9 %	23.7 %	131	-
	Republican	0 %	0.8 %	14.6 %	48 %	36.6 %	123	0.49

Note: P-values for a given beneficiary party indicate the significance level of a Mann-Whitney test between that beneficiary group and the beneficiary group of the respondent's party. For Independent respondents, reference group is beneficiaries with no identified party.

Table B.42: Republican Respondents: Ordered logistic regression.

	Dependent variable:		
	Deservingness	Program Support	Funding Support
	(1)	(2)	(3)
Medicaid Long	−0.133	−0.175	−0.218
	(0.285)	(0.287)	(0.310)
Medicaid Short	−0.436	−0.197	−0.152
	(0.288)	(0.288)	(0.315)
Smoke	−1.458***	−0.938***	−0.486*
	(0.269)	(0.268)	(0.284)
Beneficiary No Party	−0.144	0.040	−0.068
	(0.281)	(0.281)	(0.304)
Beneficiary Republican	0.063	−0.088	0.015
	(0.291)	(0.290)	(0.315)
Medicaid Long* No Party	−0.166	0.040	0.073
	(0.338)	(0.342)	(0.365)
Medicaid Short* No Party	0.216	−0.158	−0.095
	(0.345)	(0.348)	(0.370)
Medicaid Long* Republican	−0.526	−0.252	0.011
	(0.351)	(0.352)	(0.374)
Medicaid Short* Republican	0.322	−0.033	−0.251
	(0.355)	(0.356)	(0.379)
Smoke* Beneficiary No Party	0.487*	0.223	0.211
	(0.274)	(0.278)	(0.296)
Smoke* Beneficiary Republican	0.461	0.684**	0.117
	(0.288)	(0.289)	(0.307)
Observations	1,106	1,105	1,106

Note: Ordered logistic models, regressing each outcome variable on treatment variables and respondent demographic characteristics. In addition to controls indicated in the table, models also control for education, gender, race, geographic region, programmatic knowledge, political knowledge, LTC insurance status, knowledge of LTC beneficiary, interaction terms between definition and respondent party, and interaction terms between definition and beneficiary illness. *p<0.1; **p<0.05; ***p<0.01

Table B.43: Democrat respondents: Ordered logistic regression.

	Dependent variable:		
	Deservingness	Program Support	Funding Support
	(1)	(2)	(3)
Medicaid Long	−0.027	0.128	0.158
	(0.252)	(0.252)	(0.317)
Medicaid Short	0.016	−0.244	−0.089
	(0.252)	(0.252)	(0.308)
Smoke	−0.587***	−0.347	−0.024
	(0.226)	(0.226)	(0.281)
Beneficiary No Party	−0.038	0.350	0.264
	(0.242)	(0.245)	(0.306)
Beneficiary Republican	−0.182	−0.133	0.420
	(0.249)	(0.251)	(0.323)
Medicaid Long* No Party	0.213	−0.085	−0.258
	(0.303)	(0.306)	(0.390)
Medicaid Short* No Party	−0.001	−0.450	0.248
	(0.299)	(0.301)	(0.380)
Medicaid Long* Republican	0.112	0.024	−0.575
	(0.304)	(0.305)	(0.392)
Medicaid Short* Republican	0.0004	0.124	−0.287
	(0.302)	(0.304)	(0.382)
Smoke* No Party	−0.210	−0.125	−0.409
	(0.249)	(0.250)	(0.319)
Smoke* Republican	−0.164	0.041	−0.306
	(0.249)	(0.250)	(0.316)
Observations	1,424	1,424	1,424

Note: Ordered logistic models, regressing each outcome variable on treatment variables and respondent demographic characteristics. In addition to controls indicated in the table, models also control for education, gender, race, geographic region, programmatic knowledge, political knowledge, LTC insurance status, knowledge of LTC beneficiary, interaction terms between definition and respondent party, and interaction terms between definition and beneficiary illness. *p<0.1; **p<0.05; ***p<0.01

Table B.44: Independent Respondents: Ordered logistic regression.

	Dependent variable:		
	Deservingness	Program Support	Funding Support
	(1)	(2)	(3)
Medicaid Long	0.020	−0.702**	−0.026
	(0.293)	(0.294)	(0.306)
Medicaid Short	0.181	−0.523*	0.263
	(0.300)	(0.303)	(0.319)
Smoke	−0.894***	−0.589**	−0.465
	(0.270)	(0.271)	(0.284)
Beneficiary Democrat	0.331	−0.224	0.011
	(0.299)	(0.300)	(0.313)
Beneficiary Republican	0.110	−0.653**	0.099
	(0.291)	(0.297)	(0.313)
Medicaid Long* Democrat	−0.316	0.622*	0.262
	(0.361)	(0.362)	(0.380)
Medicaid Short*Democrat	−0.273	0.220	−0.090
	(0.353)	(0.355)	(0.376)
Medicaid Long* Republican	0.532	1.286***	0.255
	(0.345)	(0.352)	(0.372)
Medicaid Short*Republican	−0.305	0.739**	−0.054
	(0.352)	(0.359)	(0.387)
Smoke*Democrat	−0.280	−0.174	0.245
	(0.286)	(0.289)	(0.305)
Smoke*Republican	−0.059	0.105	0.317
	(0.280)	(0.286)	(0.309)
Observations	1,056	1,056	1,056

Note: Ordered logistic models, regressing each outcome variable on treatment variables and respondent demographic characteristics. In addition to controls indicated in the table, models also control for education, gender, race, geographic region, programmatic knowledge, political knowledge, LTC insurance status, knowledge of LTC beneficiary, interaction terms between definition and respondent party, and interaction terms between definition and beneficiary illness. *p<0.1; **p<0.05; ***p<0.01