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Spencer Marshall Moore April 10, 2023

Donor-induced Divergence? Issue Polarization and Responsiveness in the Context of the Affordable Care Act, 2006-2016

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Abstract

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This thesis develops a theory of issue divergence to explain why American political parties take polarized issue positions. I contend that on issues of low salience, elected officials may disregard uncrystallized voter opinion and instead respond to polarized donor opinion. My proposed causal mechanism is the necessity of fundraising; as individual donors make up most of politicians' fundraising, continuing to appeal to donors on issues is essential. I apply my theory to the American health care reform debate of the 2000s and 2010s, focusing on the Patient Protection and Affordable Care Act (ACA). Using an original panel dataset composed of survey and American census data, I run twenty-four regressions involving two-way fixed effects and district-level economic controls. Modeling representative vote choice on the ACA as a function of non-donor and donor constituent opinion, I do not find evidence supporting my theory. Increased support for the ACA among a representative's donor constituents did not increase the likelihood of voting in support of the ACA in Congress. Notably, non-donor opinion was also not predictive. I find evidence that partisanship made Republican representatives significantly less likely to vote in support of the ACA than Democrat representatives. My analysis confirms several of the trends present in the literature, namely that donors are more ideological and polarized than non-donors, that partisanship is a significant predictor of ACA vote choice, and that the ACA was a polarizing issue from the beginning. Further research should address the data limitations present in my study, continue to study how polarized voters may lock in politicians to the party position, and continue to study elite responsiveness on other, less polarizing issues.

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Tables and Figures

Introduction

American politics is increasingly divided on the basis of race, religiosity, and partisan identity (Abramowitz 2018). The divisive nature of many American political issues exacerbates these divisions. American voters and politicians disagree on partisan issues such as abortion, gun control, and climate policy. And while policy disagreement is not inherently unfavorable, it is necessary to understand what creates and encourages these disagreements. Reasonably, we may attribute some blame to political parties which advocate for extreme issue positions. But if political parties seek to win over voters in elections, why do they put forth polarized policies that might turn away potential supporters? This puzzle looms over modern American political life. We can begin to answer it by considering the linkage between parties and issues. Parties may bring issues to the forefront by running candidates in elections, articulating positions through votes in the legislature, or appealing to donors and activists. Previous scholars have also identified parties as issue advocates, with parties advocating for ideologically distinct positions on issues. Through such advocation, parties own certain issue positions, becoming more trusted by voters to handle those issues (Aldrich 2011; Wright et al. 2022).

We can refine the question. Why do parties articulate distinct issue positions when there are seemingly strong electoral incentives for moderation? Parties are composed of politicians seeking office via election and carrying out their duties once in government (Aldrich 2011). In this case, position-taking may serve to distinguish candidates in elections. Or, in a broader conceptualization, parties may be the embodiment of coalitions of different interest groups and activists which demand policies and control the flow of candidates into elections (Bawn et al. 2012; McCarty and Shickler 2018). Here, position-taking on issues reflects both the views of the

coalitions undergirding the parties as well as voter inattentiveness to the nuances of policy debates. These parties, emboldened by voters' lack of knowledge, push non-centrist policies, producing polarized issue positions.

This first puzzle assumes that the mass public prefers political moderation and will penalize parties for political extremism. Fundamental political economy agrees, theorizing that on a unidimensional spectrum of electoral competition, the best strategy is for candidates to locate at the ideal point of the median voter (the "median voter theorem"; Downs 1957). This would predict parties that are ideologically indistinguishable from each other. This prediction has failed to hold today. We see that the two major American political parties, the Democratic Party and the Republican Party, take extremely distinct positions on issues. For example, immigration, gun control, and climate change are some of the most contentious issues among politicians and the public today and the division between the parties on these issues is immense (USC 2021)[1].

Partisan positioning on issues may yet reflect political polarization. Empirically, polarization shows in the widening ideological gap between members of the Democratic and Republican Parties in Congress and the American electorate (Jacobson 2013). Naturally, polarization must be related to issue positioning because as parties move further apart ideologically, so should their stances on certain issues. Is polarization itself a function of diverging policy positions? Does party positioning cause polarization in the mass public, or do elites respond to trends within the mass public? These separate yet related questions are embedded within a deep literature that debates the degree of polarization in the American electorate.

[1] Additionally, abortion remains an issue that is incredibly polarized among political elites–Democratic and Republican officials advocate pro-choice and pro-life positions, respectively–but experiences relative consensus among the mass public. Yet, many Republicans advocate for the relatively extreme position of completely restricting abortion access (Blazina 2022).

We then have two closely related puzzles. Why do parties take polarized positions on issues? And does the public follow elites in forming polarized opinions, or do politicians react to trends among voters? In this thesis, I closely address the first question, introducing a theory of issue divergence under conditions of uncertainty to model issue positioning among elites. My theory identifies polarization as a top-down process. I propose that when elites are uncertain of mass opinion on newly salient issues, they stake out polarized positions in response to a skewed unidimensional ideological distribution of party donors. Elites appeal to donors due to the necessity of their financial support. Polarized policy positions are then communicated via cues to the public, contributing to opinion formation. In such a process, once elite positioning is apparent to the public, deviating away from the stated positions becomes problematic for elected officials. Ideological lock in occurs whereby well-formed voter opinions prevent elites from reneging on their past positions.

I apply the theory to the American health care reform debate, studying the period from 2006–2016. The health care case is notable for its position on the national political agenda, contributing to the rise of the Tea Party movement and a yearslong push to repeal President Barack Obama's signature legislative achievement, the Patient Protection and Affordable Care Act (ACA). Despite the ACA's heritage as a plan supported and signed into law by Mitt Romney, then Republican Governor of Massachusetts, it soon became a partisan flashpoint. How did we arrive to this point? There is no lack of scholarship on the relationship between health care policy, mass opinion, and partisanship. However, my work contributes an additional way to think about the American health care debate and other potentially similar issues, with my theory providing a potential approach to evaluate issue polarization. While I do not find strong evidence

supporting the theory with respect to the ACA, my analysis confirms previous research on the polarizing nature of the health care issue.

The thesis proceeds as follows. First, I review the literature upholding contemporary theories and studies of parties, political polarization, contributions, issue positioning, and responsiveness in America. Second, I build a theory of issue divergence under uncertainty, adding donor preferences and voter opinion as competing dynamics. Third, I introduce the case of the debate over government-provided health care that began prior to the 2008 election and sparked fierce backlash from Congressional Republicans. Utilizing the case, I test the theory empirically, building a quantitative and qualitative narrative of polarization over the ACA. The results do not support my theory but do speak to the importance of partisanship in legislator decision making. I briefly discuss the Tea Party's involvement in the case and how polarization and partisanship may have prevented Republican representatives from deviating away from the party line. I then conclude.

Literature Review

Parties

Two essential conceptualizations of the party include Aldrich's (2011) theory of endogenous institutions, and the coalitional framework described by Bawn et al. (2012). I utilize these two theories to frame the party. Aldrich presents parties as institutions created by legislators, designed to overcome the coordination problems inherent in republican government. Among Aldrich's many conceptions of the party is the party-in-government. I take the party-in-government to mean the party. The party-in-government consists of the elected officials–interchangeable in this thesis with "elites" or "politicians"–who obtain office and seek reelection. By choosing this definition, I equate the party with its elected officials. Following in Aldrich's

mold, the central actors in my theory are the individual elected officials. The motivations for these actors are both election- and policy-oriented; however, as I later detail, modeling donors as antecedent to elite behavior may allow us to expand our understanding of what drives party positioning. When responsive to these networks, elites may still be electorally and policy motivated, but in conditions of uncertainty over voter preferences, skew toward donor preferences. Notably, Aldrich's theory does not highlight a donor network within the party, seeing party action as downstream from politicians' preferences.

Aldrich's theory implies the existence of coalitions formed by like-minded legislators. But these coalitions might be temporary and are not responsive to any actors outside of government. Do parties exist solely to serve legislators? One way of answering this question is by tying the party to tangible policy goals or outcomes. Indeed, policy may serve a motivation for individual actors in Congress, and by extension the party (Aldrich 2011; Fenno 1978). Parties must then be linked to policy. The UCLA School of parties contends that the modern American political party is best described as a coalition of policy demanders, or interest groups and activists (Bawn et al. 2012). This theory contributes an expanded notion of the party, adding invested activists and stakeholders outside of government. The UCLA conceptualization includes a more prominent role for issues and activist networks and describes how group decision-making may produce distinct party issue platforms that reflect group consensus. This theory suggests that party decisions are made by the extended networks of policy demanders, with important decisions like the nomination of presidential candidates and setting of party platforms being subject to rigorous selection procedures. This implies that actions taken by the party should be preferred by the extended network. Extending the party beyond Congress opens a route for studying the impact of outside actors on party decisions, and this thesis follows in the style of the

UCLA school in considering an extended network of ideological donors. While I differ in only defining elected elites to constitute the party, my consideration of donors meshes with the UCLA view.

Polarization

Combining both theories of the party helps us understand how a party's focus on issues may lead to elite polarization. The UCLA school predicts that policy demanders will propel parties to propose extreme policies. Utilizing Aldrich's definition of the party-in-government, this implies that elites will polarize according to the preferences of the extended network of policy demanders.

Political polarization, broadly, is the growing ideological distance between two actors, be they voters, parties, or legislators (Barber and McCarty 2015; Fiorina and Abrams 2008; Jacobson 2013; Wilson et al. 2020). Many scholars have contributed understandings of polarization and how we may detect it. Fiorina and Abrams (2008) provide the most succinct starting point. They define polarization as a "movement away from the center toward the extremes" (567). This is the phenomenon whereby ideological moderates lose numbers to both extremes–liberal and conservative–on a unidimensional ideological spectrum. Visually, we would expect increased bimodality in the ideological distribution, with higher peaks at both ends, to be evidence of political polarization.

The political science literature has developed a distinction between elite polarization and mass polarization (Enders 2021). Elite polarization entails ideological divergence among actors within the government. I take elite polarization to include the growing divergence between the two parties and their policy platforms. The broad consensus within the political science literature is that elite polarization is a valid phenomenon, with elites growing ever more polarized over the

past several decades (Barber and McCarty 2015; Fiorina and Abrams 2008; McCarty et al. 2006). The literature debates the degree of mass polarization. Abramowitz and Saunders (2008) and Abramowitz (2010; 2018) provide substantial evidence of increasing divisions within the American electorate, most notably cleavages that have accelerated party sorting based on racial attitudes and religiosity. Fiorina et al. (2011) and Fiorina and Abrams (2008) contend that although elites have polarized, the mass public remains mostly unpolarized, attributing such findings to inaccurate measurements or interpretations of polarization. Despite the disagreement on mass polarization, party sorting is a topic of relative agreement within the literature. Party sorting is where voters increasingly filter into the party that matches their ideology. This process produces parties that are more internally homogenous and externally distinct. Fiorina and Abrams (2008) allow that party sorting has occurred, although they do not take this as evidence of increasing ideological extremity among voters. This directly contrasts with Abramowitz's argument that party sorting among increasingly polarized voters has driven the parties further apart.

What causes party sorting? How might elite polarization contribute to mass polarization dynamics, if at all? While evidence for polarization is commonly demonstrated with survey and public opinion data, establishing a causal link between elite messaging and mass opinion remains challenging with observational data. Experimental survey research designs have been employed to overcome these limitations. Experiments like these seek to identify the causal mechanisms underpinning mass uptake of polarization. Two major mechanisms identified within the literature include framing and cue-taking. Robison and Mullinix (2016) study how communications about polarization impact political attitudes. They find that framing polarization as problematic and

resulting from strategic motivations among politicians increases support for bipartisanship among respondents but fails to militate against existing partisan loyalties.

Communication about polarization and its negative effects has the potential to alter some aspects of mass opinion, but individuals may still adapt or strengthen partisan views upon learning about elite polarization. This process is related to cue-taking. Levendusky (2010) demonstrates how elite polarization enables more coherent cues and signaling, potentially increasing voter consistency across issue positions. In his study, one benefit of elite polarization is greater consistency among voters and the mass public in political attitudes. As a causal mechanism, more credible cues from elites signal to voters that certain positions are worth holding, influencing them to adopt those views along with other correlated viewpoints. A key implication of Levendusky's study is that elite polarization should contribute to more party sorting among the electorate. However, as Levendusky notes, elite signaling should not have similar effects on crystalized issues compared to new ones. Broockman and Butler (2017), also with an experimental design, find that voters are likely to defer to their elected officials' issue positions after exposure to them. Elected officials must have some ability to frame issues and persuade on different issue positions, but this ability might be limited to those issues on which the public does not have well-formed opinions. What is the interplay between new issues and elite-led polarization? Although much work exists on elite signaling, a greater understanding of how new issues strengthen elites' ability to lead polarization is needed.

Parties today have issue positions that are communicated to the mass public. Regardless of whether voters are aware of certain issues, they must eventually receive cues from elites or the media. But what encourages the public to take up polarized views? How do elites steer positioning on issues, causing polarization to flow top-down? A deep strand of the literature

argues that elites drive opinion formation among the public (Zaller 1992). Buttressing this argument is elite cue communication. Moreover, issues rise and fall in salience and party issue positions evolve. These movements may impact voter patterns as well. Carmines and Stimson (1989) contribute their seminal theory of issue evolution, in which elites lead party positioning on an especially salient, persistent issue. Issue evolution creates lasting change in party alignments among the mass public, fundamentally altering the political system (Carmines and Wagner 2006). The key here is the role of elites in leading position change, first on the party level, and then driving realignment in the electorate. Carmines and Stimson studied the lasting effects of racial realignment; scholars have extended their theory to abortion and other "culture war" issues like the environment and gun control (Adams 1997; Lindaman and Haider-Markel 2002; O'Brian 2020).

Carmines and Stimson's theory explains how elites enact long-term political change on the backs of issues. Yet, we need more elaboration on the mechanism by which public opinion responds to elite behavior and positioning. Additionally, while they demonstrate how elites may lead a long-term partisan realignment, their theory does not discuss actual opinion change or formation among the public. And although elite-led communication is a consistent theory within the literature, there is not a consensus that the public always follows elite messaging. For example, O'Brian (2020), extending Adams' study of the abortion issue evolution, finds that beliefs among Republicans in the electorate limited elite positioning on the issue, predating elite signaling. Likewise, Lindaman and Haider-Markel (2002), while acknowledging the importance of issue evolution, find that the public did not follow elite polarization equally across all issues studied, attributing the gaps to salience. Kertzer and Zeitzoff (2017) show that even in foreign policy, where theories commonly assume public opinion formation as a top-down process,

individuals take a more active role in their own opinion than thought. They find that public opinion on foreign policy is mediated significantly by an individual's social context and preexisting attitudes, with elite cues having inconsistent effects. Although foreign policy issues may be more salient among the public due to media coverage, the results contribute to the debate over the strength of elite cues and signaling. While further experimental research is needed to distinguish the dynamics at play, the literature suggests that there is a role for elite cues in public opinion formation.

In addition to the debate over the degree to which the public follows elite positioning and communication, there remain gaps concerning whether an issue's age moderates public opinion formation. While it is logical that decreased issue salience would limit the public's reception of elite cues, there has not been as much work studying issue salience as a condition for driving elite-led polarization. This research path may engender a new debate. To clarify, the theory of issue evolution requires the issue at hand to be incredibly salient; yet, with salience presumably comes greater voter awareness and more stable, formed preferences. Thus, salient issues could plausibly limit elite-led position change due to crystallized preferences (Levendusky 2010). This generates a feedback loop scenario: if elite-led polarization on a new issue spurs voter polarization on the issue, do voter preferences, once formed because of elite communication, limit further elite positioning? There is a lack of literature grappling with this final question; this thesis seeks to further address this feedback loop dynamic by studying polarization over the ACA.

Contributions, Positioning, and Responsiveness

I study the effect of voter and donor opinion on representatives' votes in Congress. Donors are influential because they are a significant source of fundraising for Congressional

members. Individual donors account for most of the contributions to candidates (Ensely 2008). Why do donors choose to donate, and who do they choose to donate to? Previous research has shown that donors are aware of candidate ideology when donating, with contributions dependent on candidate ideology (Barber et al. 2017; Ensely 2008). Further, the literature agrees that donors are more ideologically extreme than non-donors and tend to donate to more ideologically extreme candidates (Bafumi and Herron 2010; Barber 2016). Barber (2016) shows that this has an institutional effect, producing more polarized state legislatures when individual contribution limits are relaxed.

Logically, donors tend to be in ideological alignment with recipients because they would not want to benefit candidates they do not agree with. Is ideology the sole reason for donating? One potential explanation for donating is that donors hope to curry favor with politicians, seeking a specific position on a policy issue. This would seem to only apply to donors with enough wealth and status to sway politicians or groups such as unions and political action committees. This theory of contributions views a donation as a political investment. Here, investment refers to donating with the expectation of policy concessions from the recipient. Ansolabehere et al. (2003) address this theory and the question of why organized groups do not contribute more in American politics. The authors note that individuals are the primary fundraising source for candidates and that this prevents firms and organized groups from exercising leverage via contributions. It then becomes fruitless for firms to extract policy concessions in exchange for contributions because candidates are already well-funded by individuals. Contributions lack efficacy on the firm level.

How responsive are candidates to individual donors? Since donors contribute a large share of candidates' funds, candidates should be incentivized to align with donor preferences.

While there is an extensive literature studying the efficacy of donations from organized groups, less research exists about candidates' responsiveness to individual donors. Compared to non-donors, are candidates more responsive to donors? This is another question that remains. A common way to measure responsiveness is to compare candidate policy positions to district preferences. As I address above, political economy predicts that competing candidates will converge in districts to win elections, producing responsive candidates. Ansolabehere et al. (2001) provide evidence that this is not accurate and that competing American political candidates diverge. However, the authors show that candidate divergence is a function of the national party position, not donor opinion. Then, evidence of responsiveness is due to voters choosing the candidate closest to them based on partisan affiliation. Essentially, candidates may seem responsive to their districts, but this is somewhat of an illusion. But the questions remain. Can candidates be selectively responsive to some constituencies? Could this selective responsiveness induce divergence?

Peress' (2012) work approaches my questions. He addresses the resource theory of divergence, which holds that candidates polarize to attract ideologically extreme donors. First, Peress finds that candidates are responsive to district ideology. Second, Peress shows that because both Congressional voting behavior and large donor preferences may be organized on a single, economic ideological dimension, when preferences align candidates may be inclined to be more responsive to donors. However, absent modeling a direct relationship between donor opinion and candidate positioning, it is not apparent how valid Peress' conclusion is.

Overall, I find evidence in the literature that donors are ideological and that responsiveness in Congress is imperfect. If legislators are not responsive to their districts, then two potential substitutes could be the party or donors. Even though donating as a political

investment lacks efficacy, donor opinion should still matter. I extend Peress' study in this analysis by attempting to model elite positioning, via roll-call votes, as a function of donor opinion. In the next section, I detail my theory.

Theory

Party stances on issues are communicated to the public by elected officials. Elected officials may communicate their positions on the campaign trail, through media, or in the legislature by voting. As elected officials are the party, serving as a visible face of the party label, we can say that their issue positions produce the aggregate party position on any given issue. Often, elites may communicate issue positions that are relatively extreme ideologically. Issues become polarized among elites when elites increasingly take extreme positions on them, decreasing the degree of moderation on the issue (Fiorina and Abrams 2008). Polarized issues are common today in American politics (Abramowitz 2018). These partisan issues may not have a broad consensus among the public.

Voter preferences may depend on issue salience. The public may not know or even care about issues that are not prominently featured in the news media or mentioned by politicians. Or, the public may express a general opinion towards the issue but not have any specific stance on detailed policy positions relating to the issue. Reasonably, I expect voters to be less certain of their own stances on issues on which they are less informed. I call preferences "crystallized" when they are static and unlikely to change. Using the definition from Erikson et al. (2008), crystallization means that preferences become "increasingly structured" as an individual's opinion becomes in line with descriptors such as demographics, ideology, or partisan identification. We would expect these identifiers to predict individual opinions (484). For example, O'Brian (2020) details the crystallization of preferences on abortion in the Republican

Party, meaning the process by which the pro-life position became entangled with being a conservative Republican. Crystallization may occur as a gradual process as ideas shift in and out of the national agenda. It may be led by elected officials or group ideologies may be incorporated into party platforms. Sometimes new issues become salient during campaigns or extended debates. These new issues may not have been as prominent before, so we would expect voters to have uncrystallized voter opinions on policy stances relating to these issues. On these new issues, we would also expect that partisan voters would not be polarized due to lacking prior knowledge of, and elite cues on, the issue. I take "uncrystallized" to mean when preferences are uncertain, not strongly formed according to an individual's personal identifiers, and highly subject to change. In this thesis, I will use "crystallized" and "polarized" as synonyms when forming my case-specific hypotheses to simplify matters.

Even if we assume that elite cues overwhelmingly shape voter opinion, we are still uncertain why party elites should polarize on issues. Political economy predicts that diverging from the ideal point of the median voter is a losing electoral strategy (Downs 1957). To address this puzzle, I introduce new actors to the theory: donors. Donors exist in American politics to support electoral candidates, coordinate contributions, and push for policy outcomes. Donors may range from individuals, to partisan megadonors, to political action committees (PACs) aligned with certain candidates or issue movements. PACs and political interest groups serve to raise funds and coordinate action to advocate for certain issues. These groups and actors form parts of the networks that lobby politicians to take certain positions on legislation. Whether these networks affect elite decision-making is an open debate in the literature. Yet, the fact that these networks are so active in building connections with policymakers suggests that there must be some benefit to doing so–or at least that the networks perceive some benefit. If we look

backward from party elites to their respective donor networks, we might be able to understand why party issue platforms diverge.

Donors provide substantial support to elected officials. During campaigns, they can provide contributions to would-be candidates. Once in office, elected officials rely on donors to fund the next round of elections. It is in a politician's favor to appeal to and align with their donors as they wield tremendous resources critical for electoral success. Note that elites need not be solely motivated by reelection; policy-minded politicians would also want to align with their respective donors, as policy goals can only be achieved while in office. Thus, as politicians prefer to remain in office and enact their preferred policies, they should maintain close ties with their donors.

Donors must expect something of their efforts. They would not give resources if they were not motivated by the benefits those politicians could distribute once in office. One expectation might be certain policy positions from elites (the investment theory of contributions; Ansolabehere et al. 2003). Or, donations may be a form of political consumption spending made by enthusiastic political "consumers" (the consumption theory of contributions; Ansolabehere et al. 2003). Here these consumers donate due to the gratification received from supporting a like-minded politician.

However, both theories apply to my theory of divergence as in both cases donors would be motivated to support their preferred candidates. Moreover, if donors are ideologically motivated and have their own issue stances, then these preferences should reflect in whomever they are supporting. Thus, my theory assumes that donors expect the politicians they support to stand for policy positions that align with their own. Likewise, to tie elite action with the donations they receive, I assume that elites align ideologically with their respective donors and

that the benefit of aligning outweighs the cost of choosing not to. Because donors choose who to support, their choice should indicate who they see as ideologically aligned. Barber et al. (2017) show that donations are more likely when donors and legislators align ideologically, so these seem to be fair assumptions. These assumptions do not preclude politicians from accepting donations from donors who are not in explicit ideological alignment. These donations should not compose a significant amount of the politician's support base, so if politicians accept them, it shouldn't weigh heavily on their strategic calculations. Comparing donors to the mass public, we should expect that donors are more ideologically extreme and policy-motivated (Bafumi and Herron 2010; Barber 2016). Additionally, donors should be more informed than the public on political issues. As they commit valuable resources and make high-stakes decisions on who to support, it seems logical to assume that donors are more informed than the public.

To clarify, I believe that politicians should align with donor policy preferences for two reasons: politicians are policy-motivated, and it is politically advantageous to appease donors. Policy-motivated, in a theoretic sense, means that elites care about the location of a policy proposal on a unidimensional ideological spectrum. We can simplify this to say that policy-motivated elites care about passing their desired laws. The conditions of my theory require elites to be policy-motivated, and thus elites should agree with donors' polarized policy preferences. Essentially, politicians in my theory derive their utility from enacting their preferred policies and staying in power. The latter is a condition for the former; thus, appealing to donors is a way to continuously curry favor with donors, stay in power, and enact policies.

If we take donors to be antecedent to party elites, then the mechanism(s) linking the two is the support that donors contribute with policy goals in mind and the support that politicians rely on. When donors prefer a policy position, they will contribute to their favored politician and

seek to influence accordingly. Elites are then linked to voters by the cues communicated through the political system. Voters, aware of party positions, receive elite cues and these cues assist voters in forming political opinions on issues. I do not preclude the possibility of politicians forming positions based on voter opinions, as this could occur in a world without policy-motivated elites. Because this theory deals with new issues, however, I assume that elite opinion formation will predate voter opinion formation.

Issue salience is crucial. If the issue is new to the political environment, voter preferences will be relatively uncrystallized. While the public may be familiar with the issue's presence in discussions and debates, mass opinion will be unformed. Mass preferences will not hold consistently over time until voters receive elite cues. A corollary of this point is that elites may be uncertain of voter preferences on new issues. In a simple unidimensional Downsian model of electoral competition, such uncertainty over preferences, along with policy motivation, gives elites leeway to diverge from the median voter's ideal point (Gehlbach 2013). Voter preferences are still crucial due to politicians needing votes. But, in the presence of uncrystallized preferences and uncertainty over the median ideal point, elites can successfully "convince" voters of extreme positions. Because politicians rely upon capturing a majority of votes to win, policy-motivated parties *and* uncertainty over voter preferences are necessary but not sufficient conditions of the theory. If voters were to have stable preferences on an issue, it would not make sense for elites to disregard voter preferences and advocate for polarized positions on the issue. We would expect parties to suffer an electoral penalty for doing this. Thus, in my theory, crystallized voter preferences dominate donor preferences. Assuming the conditions hold, elites have leeway and should follow and support the policy proposal most preferred by their respective donor networks. This produces divergence in issue positions.

My theory's logic of divergence is akin to Frymer's (1999). Frymer notes that adding new voters into the distribution should mechanically shift the median voter towards those voters' preferences, altering the underlying ideological distribution and changing candidate positioning to be in line with the new median. But absent some constraining force encouraging divergence, politicians will still locate at the median because that produces the greatest chance of winning. I similarly propose shifting distributions, but my theory contributes to an understanding of the necessity of appealing to donors for elected officials. This necessity impels elites to diverge away from the median on an issue.

Party divergence on issue positions hinges on donors being polarized ideologically and supporting polarized issue positions themselves. Because elites must continually appease their support networks, they should roughly approximate the policy ideal points of the donors with whom they most align ideologically. Therefore, if we expect a polarized ideological distribution of donors, then my theory predicts a similarly skewed distribution of policy stances on a new issue with uncrystallized mass opinion. To substantiate my theory, I note Campante's (2010) model of voting with divergence. Campante contributes a model whereby inequality in the distribution of wealth among voters endogenously induces divergence in policy. Greater contributions from wealthier voters produce divergence in tax policy because as parties receive greater contributions from wealthier individuals, they locate at the median of a wealthier (right-biased) distribution of voters. Critically, the result from Campante's model is a tax rate that is not at the median voter. My theory's logic is similar: a skewed distribution of an underlying support base encourages parties to locate policy at a polarized point. While Campante posits that parties have the freedom to diverge because of increased efficiency in turning out voters, the freedom in

my theory comes from uncrystallized voter preferences, allowing parties leeway to lead polarization on a new issue.

Consider the theory as a model of voting. Figure 1 presents an assumed normal distribution of voters along a unidimensional liberal-conservative spectrum. The median voter's ideal point is labeled m and the initial equilibrium outcome is for candidates and parties to locate at m. Suppose that Figure 1 represents the distribution of opinion on an issue that is relatively new to the national policy agenda, meaning that the public should have uncrystallized opinion on the issue. Figure 1 displays how elected officials should view mass opinion, with ideology mapping to opinion. Elected officials may also consider m to represent the status quo, so deviation from m in either the liberal or conservative direction represents liberal or conservative policy reform to the status quo policy. Now we incorporate donors into the distribution. Donors have crystallized preferences and their opinion should be bimodally distributed, demonstrated in Figure 2. As in the conditions described above, elected officials are more concerned with donor preferences than voters. With mass opinion being unfixed and uncertainty over which way mass opinion could sway, politicians have the freedom to diverge. There is no need to cater to mass opinion on the issue. But there is a need to align with donor opinion due to the necessity of financial support, so voter preferences are dominated. Thus, when we incorporate donors, the distribution shifts. I assume that Republican (Democrat) and conservative (liberal) leaning elected officials only consider conservative (liberal) donor opinion. Polarized donors should not give contributions across party lines, so politicians need to appeal to donors that align with their party (Barber et al. 2017).

Take conservative and conservative-leaning donors as an example. Figure 3 displays the theoretical distribution of voters and adds conservative donors, with *m* shifted right to *m'* to

reflect the skewed distribution that is now more conservative overall. However, the effect applies in both directions. If we consider both conservative and liberal donors with voters, the distribution should become bimodal with peaks spaced further apart than the original distribution, providing evidence of polarization. Again, assuming rational behavior and that elected officials and donors' interests are aligned, officials should appeal to the largest support base possible. If elected officials were to consider voter opinion here, this would not produce divergence in the party platform. But remember that voter preferences on the issue are uncrystallized. Thus, the necessary conditions for divergence are met. Politicians concerned with policy and needing to raise money must mobilize their financial support bases. To appeal to their donors, they support policies that align with donor preferences. This constraining effect is strong enough to produce polarized party medians. Figure 4 demonstrates the effect in both directions. $m*$ is the median of the liberal-leaning distribution.

Donor opinion on the issue will intensify the impulse to diverge from the median voter's preferences. The party positions itself in line with donors, capturing the greatest possible financial and otherwise tangible support. Voters do not view this as negatively as they would if they had well-formed opinions. Thus, the party's position should diverge from the median voter, producing issue polarization. Mass polarization may follow on the back of elite cue signaling to voters.

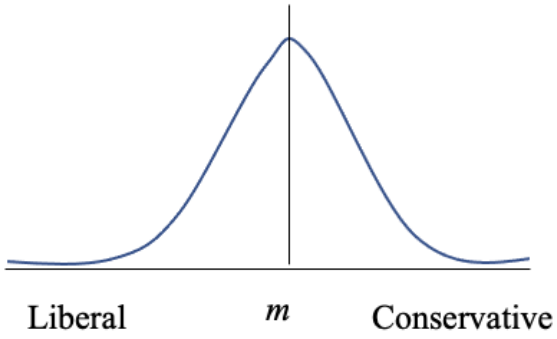

Figure 1: a theoretical distribution of voters

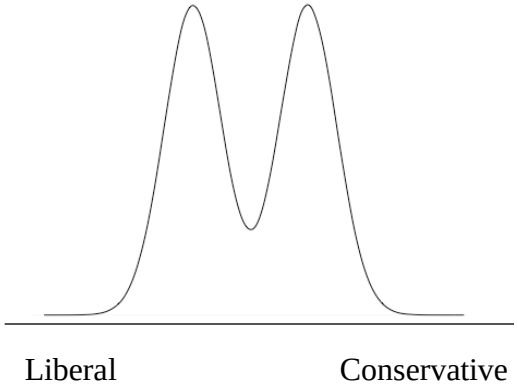

Figure 2: a theoretical distribution of donors

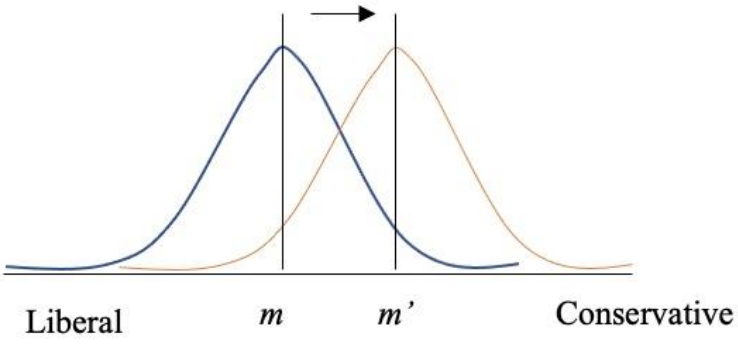

Figure 3: a right-skewed distribution that includes conservative donors

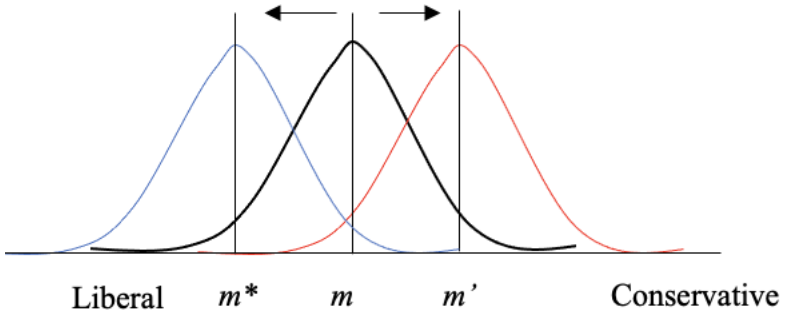

Figure 4: the polarization effect in both directions

I note the similarity of my polarization mechanism to that of Bawn et al. (2012) (the UCLA School). The UCLA School's theory also allows divergence on issues. In this theory, voters are relatively ignorant on certain issues, not holding the requisite knowledge to judge policy positions. Thus, the theory assumes that "voters notice and react to differences in positions only when they are sufficiently large" (578). "Electoral blind spots" are those positions that voters view as equivalent; the more uninformed voters are, the larger the electoral blind spot and the greater leeway parties have to take extreme positions. Low voter knowledge of policy also allows divergence in my theory, but it is a condition that must be met and does not necessarily reflect voter inattentiveness as in the UCLA theory. Remember that in my theory, donor preferences stimulate divergence on issues with uncrystallized voter preferences. Voters may still be able to distinguish between policy positions, but due to a lack of knowledge on issues, they do not know what to think on the issue until elite cues assist in deciding.

If we consider a set of hypothetical policy issues, assume that donors and elites are more ideological and have greater knowledge than voters, and assume that elite cues assist mass opinion formation, then my theory produces the following generally applicable hypotheses: General hypothesis 1: Voter preferences on the issues will be more (less) crystallized as the issues increase (decrease) in salience.

General hypothesis 2: The more uncrystallized voter opinion is on the issue, the more elected officials will espouse polarized stances on the issue, responsive to donor opinion.

General hypothesis 3: On a certain issue, assuming uncrystallized voter opinion, the greater Democrat (Republican) donor opinion is polarized, the more Democrat (Republican) party elites diverge to the left (right) according to donor preferences.

General hypothesis 4: The greater the exposure to polarized elite cues on the issue, the more voter opinion polarizes accordingly on the issue.

Concerning the health care reform case, the new (case-specific) hypotheses become:

H_1: The more (less) polarized voter opinion is on health care reform, the less (more) representatives will be responsive to donor opinion.

H_2: The more donors in a representative's district support (oppose) health care reform, the more representatives will vote to support (oppose) health care reform in Congress.

H_3: As the health care reform debate progresses, voter opinion will polarize based on partisanship.

I slightly adjust the hypotheses to accord with the empirical nature of my analysis and the data I collect. I reword H2 to capture how much representative positioning aligns with donor opinion. I also assume, concerning H3, that as the debate progresses the issue becomes more salient and that voters receive elite cues. These assumptions combine general hypotheses 1 and 4 into H3. In this thesis, I focus the bulk of my analysis on explicitly treating H2 with statistical methods.

An interesting dynamic arises once voter opinion crystallizes. If mass opinion on the issue becomes well-known among elites, then that limits movement away from the polarized status quo. The process leading from elite polarization to mass polarization locks in the party to

whatever stance was signaled to voters. As voters take cues from elites, those cues become strongly held in voters' minds. The issue cues may become associated with other political heuristics such as the party of the elected official signaling the cue. As more cues on the issue are received, the issue becomes more partisan. This linkage becomes firm and prevents politicians of a certain party from changing their messaging on the issue because now voters have preferences on the issue. Of course, this assumes that voters with crystallized views do not change their views. While I believe that it would be possible for voters to "depolarize" on an issue, this would require either the reception of new cues from elites or for the issue to fade in salience over time. Essentially, the linkage between party and issue stance would have to sever. And because new cues from elites on the issue would not be credible to voters, it is likely for voter opinion to stick for at least some time.

If politicians were to deviate from the new polarized median, their voters would penalize them electorally. Thus, the theory implies that elite-led polarization may produce a feedback loop in which voter opinion limits elite moderation. Once a platform is set, there is no credible way for elites to deviate back to the middle if voter opinion matches elite polarization on the issue. This result has important implications. Any movement or push by politicians to lead their party away from the issue stance would not be credible, nor would attempts at bipartisanship. This dynamic applies to the health care issue to which I now apply my theory. To analyze the case of American health care reform, we must understand a narrative that begins in 2006.

Case Introduction: The Patient Protection and Affordable Care Act

I apply my theory to partisan polarization among elites and the mass public from 2006-2016, studying the debate over U.S. health care reform. The debate centered on the Patient Protection and Affordable Care Act (ACA), legislation that massively overhauled the American

market for private and government-provided health insurance. The ACA, signed into law on March 23, 2010, was President Barack Obama's most significant domestic policy accomplishment. It capped a bipartisan push for health care reform. Not since President Bill Clinton's administration had there been such a heightened national focus on health insurance as a salient issue (Oberlander 2020).

The health care reform debate serves as a useful case to test my theory. As there had not been serious talk of health care reform since the middle of the 1990s, the topic's emergence onto the national scene represented a new debate with new policy proposals. The debate was initially a low-salience issue, with relative consensus among the mass public as to the principle of government-provided health care, yet soon become a bitter partisan fight that would come to define 2010s American politics. The ACA's enactment kicked off a yearslong battle in Congress and the courts to repeal and replace it. Before the debate, however, there did not seem to be any clear ideological reasons for people to support or not support the policies that would form the ACA. With the status quo–a mix of government- and employer-provided health care–being relatively popular and uncertainty about what reform would bring, deeply held, fixed opinions on expanding government-provided health care should not have correlated with partisanship or ideology.

I also choose the ACA because there is a lack of scholarship studying the effect of constituent opinion on ACA implementation on a national level. Shor (2018) identifies that on the state level, legislatures had three primary choices related to the ACA: implement a state or federal health insurance exchange, expand Medicaid, and prohibit the individual mandate. Shor studies these implementation votes in state legislatures from 2011 to 2015 and finds that legislator party and ideology are the most significant predictors of the votes, with ideology

having a stronger effect than party. Shor also finds that state district opinion does not explain ACA implementation votes when combined with party and ideology. Applying Shor's study to the national stage allows me to see whether similar dynamics are at play. Shor notes that significant heterogeneity existed in the state-level implementation of the ACA's policies. Did similar heterogeneity occur on national-level ACA votes? Do partisanship and ideology militate against district opinion on the national stage? I address these questions in my study.

Because polarization on health care did eventually occur, the case offers an opportunity to validate this paper's theory. My theory works in two stages. First, elected officials diverge on a policy issue due to donor opinion drawing them away from the median on the issue. Then, polarized elite positions reach voters and voters polarize according to cue reception. The ACA is a critical test for my argument because the debate was initially dominated by elites. Conversations on reform were occurring primarily among elite-level elected officials. It was not until the Obama Administration began work on a potential bill that popular sentiment began to turn against the Administration's efforts.

More importantly, public opinion polling showed that overall, Americans were relatively supportive of government-provided health care prior to the debate. Voter opinion was not relatively polarized. Put differently, voter preferences on health care should not have been correlated with ideology or partisan identification. This was not true in Congress; the ACA debate quickly sparked resistance from Republicans. Voter polarization then followed as the debate progressed, culminating in the rise of the Tea Party movement and colossal losses for the Democrats in the 2010 midterm elections. The rise in the salience of this issue, followed by the quick rise in polarized elite backlash and then voter backlash, offers an opportunity to study the dynamics involved and test whether donor preferences played a role in elite positioning.

Falsifying my theory requires testing whether there is an association between donor preferences and elite positioning and studying the timeline of polarization on a certain issue. There is an abundance of news coverage, academic scholarship, and data available on all aspects of the debate. This enables me to construct a thorough analysis to characterize the health care reform debate. The case also presents a puzzle of its own. The health care reform model that served as the basis for the Obama team's plan originated out of a proposal from the conservative think tank the Heritage Foundation. The plan's key contribution was the "individual mandate", the stipulation that all individuals purchase a minimum level of health insurance coverage or face a tax penalty. The individual mandate was added to Republican Governor Mitt Romney's health care reform plan ("Romneycare") for the State of Massachusetts. It formed a critical leg of what Stephen Brill (2015) calls the "three-legged stool" plan: ensuring coverage for individuals with pre-existing conditions, an individual mandate for those without government or employer-provided insurance, and government subsidies for low-income individuals to purchase coverage. Romneycare passed in 2006 and the three-legged stool would live on in the ACA. Brill notes that the individual mandate was then viewed as a conservative tenet, upholding the principle of individual responsibility (33). Yet when the individual mandate became a part of the Obama Administration's proposal, the program sparked intense backlash, and "Obamacare", as the program came to be referred to, morphed into a symbol of government excess and overreach.

Why would Republicans turn against a plan that had Republican origins? There are several potential dynamics to explain the shift in elite opinion. First, the backlash may be a function of electoral competition and partisanship, with it being politically expedient to simply take the opposite position to reform. Second, President Obama's personal association with the policy may have stirred up negative sentiment, racial or otherwise, among those in a position to

oppose his reform efforts. Tesler (2012) studies public and elite opinion on the ACA, demonstrating that racial attitudes affected opinion on policy areas in which President Obama was active and salient. The "racialization" of health care turned public opinion against the policy. However, we might also consider whether ideologically motivated donors could sway elected officials' opinions on the issue. Given that the health care reform issue brought together a diverse collection of professional trade groups, lobbying groups, industry representatives, and other stakeholders, many of whom wielded significant financial resources, it is important to consider how responsive elected officials were to these stakeholders.

The health care reform debate thus offers a strong test of my theory and works better than other important policy issues from the period because of its relatively contained timeframe. Health care reform appeared on the national policy agenda in 2006 after not having been a salient topic since the 1990s. This allows me to study the polarization of a relatively new issue untainted by previous debates. Mass health care opinion seems to have been relatively uncrystallized prior to the ACA debate, and subsequent polarization allows me to empirically test how this polarization related to donor preferences. In the next section, I briefly summarize health care opinion at the beginning of the debate.

The beginnings of the American health care debate: 2006

I choose 2006 to begin my study because it represents a transition point between the War on Terror-centered politics of the George W. Bush Administration and the health care and economy focus of the Obama Administration. While health care was present in voters' minds in 2006, it was not the main issue. Just six percent of Americans saw health care as the most important issue facing the country, behind Iraq, the economy, unemployment, and poverty (Pew 2006). Just two percent said that health care mattered the most to them when voting in the 2006

congressional election, and in a separate poll seven percent identified health care reform as the most important problem for voters to address (Pew 2006; Kaiser Family Foundation 2006). This is despite Congressional Democrats naming affordable health care as a legislative goal in the summer of 2006, prior to the election (Bash and Barrett 2006).

This is not to suggest that voters did not have opinions when asked about the health care issue. When asked about reforming the American health care system, forty-six percent thought the system required major changes, and thirty-two percent thought it needed to be completely rebuilt. Similarly, forty percent saw the affordability of health care as a very big problem for the U.S. economy (Pew 2006). More broadly, in November 2006 sixty-nine percent of Americans thought that it was the responsibility of the federal government to ensure health care coverage for all Americans (Gallup 2023). These topline survey results show that in 2006 the American public was not overly concerned with health care as a voting or political concern. But when prompted on health care, the public had opinions that the system needed reform. Sixty-nine percent believing in federal government-provided universal health care coverage indicates broad consensus on the issue and suggests that most Americans would have supported reforms to the health care system at the time.

Broad consensus on general health care reform does not mean consensus on specific reform proposals. What came to be the ACA was the result of a long series of bargaining between members of Congress, lobbyists, and representatives from many medical and pharmaceutical trade organizations. Considering that the ACA inherited the tenets of the Massachusetts Romneycare plan, I contend that there were no clear ideological reasons for people to support or not support the policies that came to be the ACA. Considering majority support for health care reform in America, majority opinion that the health care system was

broken, and a relatively moderate policy proposal, mass polarization on the ACA should have followed elite polarization, which was itself–I contend–responsive to donor ideology. In the following section, I move on to detailing my strategy for empirically analyzing the American health care debate.

Data and Methods

Overview

First, I gather empirical evidence using American public opinion data to validate the conditions of my theory. In doing so, I treat my case-specific hypothesis H_3 above. While I do not conduct robust statistical testing for this hypothesis, I demonstrate that donor opinion on health care was more polarized than voter opinion in American congressional districts and that voters become more polarized as the debate progresses. Second, using an original dataset constructed from survey, Census, and Congressional vote data, I analyze how responsive elite positioning was to donor and voter opinion during the debate. Third, I address elite polarization on the health care reform issue, demonstrating that elected officials were relatively locked into their positions for the entirety of the debate. Finally, I detail the Tea Party movement and explain two mechanisms by which elites may have been locked into their ACA positions.

Data collection and operationalization

I begin testing the conditions of my theory. My implicit assumption is that politicians are policy-motivated individuals. Then, voter opinion on an issue must be uncrystallized to encourage elected officials to polarize on the policy. An uncrystallized opinion means that it is not consistently expressed and sorted neatly among groups based on individual characteristics, i.e., polarized. As demonstrated by the polling evidence presented above, health care reform was

not necessarily a salient issue in 2006. According to the aggregated individual-level survey data used in this thesis, only eight percent of individuals believed health care reform to be the most important policy problem in 2006.

The quantitative data for this project come from the Cooperative Election Study (CCES)[2]. The CCES is a yearly survey administered nationwide to American individuals. Running from 2006 to the present, the CCES surveys individuals on their political beliefs, affiliations, and behaviors, in addition to collecting extensive demographic information on respondents. The CCES contains questions that are classified as "Common Content" (CC) material, meaning that some form (or the exact same version) of the question appears in every survey administered as part of the CCES. In this project, I solely use CC material for my study.

To quantitatively analyze the American health care debate, I gathered the CCES surveys from 2006 to 2016. The value of the CCES is that it asks questions on political activity, such as whether the respondent makes political donations. To limit the reliance on multiple datasets for the project, I used the CCES to gather the opinion data for non-donors and donors. An important implication is that for this empirical study, "donor" denotes an individual flagged by the CCES survey as having answered "yes" to the question of having donated money to a candidate, campaign, or political organization in the past year. This is an important limitation of the study, as I do not distinguish between donors based on wealth. In my study, donor could mean having made a relatively small or large donation to a politician. Those donors who make large contributions may also hold more sway with politicians due to other factors, such as social status. Thus, my definition of donor is very broad. Additionally, because the CCES surveys did not ask who respondents donated to, I cannot ensure that the donors in a congressional district donated to

[2] https://dataverse.harvard.edu/dataverse/cces; datasets are cited in the references

the district representative. Thus, I make a major assumption that donors grouped into congressional districts are the relevant donors representatives would consider when making decisions.

I constructed an individual-level dataset from the 2006–2016 CCES yearly surveys[3]. A hurdle I immediately ran into was that questions asking for approval of the ACA or health care reform were not available in non-election years. Additionally, the question identifying donors was not present in the 2006 survey. Moreover, in 2006 there were scant data on recorded health care reform preferences among elites in Congress. As there would not be a vote on the ACA until 2010, it would be difficult, and irrelevant, to operationalize preferences on legislation that had not been proposed at the time. I made the decision to narrow down the years under study to 2008, 2010, 2012, 2014, and 2016. This has two important limitations for the study. First, I am not able to study the dynamics of health care polarization in donors, voters, and representatives prior to 2008. By 2008, we might expect that polarization had started to occur as the issue was becoming more salient. Thus, I lose some understanding of how voter and donor preferences evolved from 2006 to 2008. Second, my model loses identification from non-election years, when there were still ACA repeal attempts. The final individual-level dataset for these years contains 263,535 individual responses with 60,753 individuals coded as donors.

The primary independent variables for the study are overall district non-donor opinion on health care reform, district co-partisan non-donor opinion on health care reform, and district co-partisan donor opinion on health care reform. Because my theory contends that elected officials should only be concerned with and respond to the opinion of ideologically similar donors, I only consider co-partisan donors. I am interested in how responsive elites are to donors compared to

[3] I analyzed all data for the project using the tidyverse, reshape2, and vtable packages in RStudio (v2.0.0, Wickham et al. 2023; v1.4.4, Wickham 2020; v1.4.2, Huntington-Klein 2023).

non-donors of similar ideology, so I compare co-partisan donors to co-partisan non-donors. I operationalized these concepts by selecting questions from the CCES surveys that targeted respondent opinions on health care reform. At the beginning of the study, in 2008, the question I used was: "Do you favor or oppose the U.S. government guaranteeing health insurance for all citizens, even if it means raising taxes?" Because the ACA proposal was not yet available, I proxy ACA support with this question. While the ACA (and connotations of "Obamacare") were not present in voters' minds in 2008, health care reform was a prominent political topic. The question at hand is worded somewhat differently compared to the policy proposals of the time. One of the objectives of the health care reform push was to ensure coverage for uninsured Americans and prevent insurance companies from excluding those with preexisting conditions. This question may be interpreted as being consistent with these objectives. However, to survey respondents, the question may signal a diversion from the status quo in the creation of a single-payer, government-provided system. The question also primes respondents on their opinion on raising taxes, a politically sensitive issue. Because of this, I believe those answering yes to this question may be a smaller sample than the realistic number of voters who would've been open to health care reforms. Thus, in the dataset 2008 individual-level support for health care reform may be downwardly biased.

In 2010, the question asks for respondent support for a "Comprehensive Health Reform Act" that "Requires all Americans to obtain health insurance. Allows people to keep current provider. Sets up health insurance option for those without coverage. Increase taxes on those making more than $280,000 a year." This question more accurately includes components of the Obama administration's reform proposals. Indeed, by the time the survey was administered the ACA had been debated for some time, so voter awareness of the issue should have been higher

than in 2008. Beginning in 2012 and continuing until 2016 the CCES asks respondents whether they would repeal the Affordable Care Act. For each individual-level observation of the dataset, I coded whether individuals supported health care reform efforts in 2008 or 2010 or the ACA in later years. This created new variables for each year's support. I only included support and oppose responses from the surveys, omitting "skipped" or "not asked" responses. Coding support as 1 and oppose as 0 for these variables enabled easy aggregation into district-level responses. In addition, I segmented the individual-level dataset down into individual datasets for those who identified as Republican and Democrat non-donors in the dataset, and datasets for those who identified as Republican and Democrat donors. Along with the variables on health care opinion, these datasets contained identifying information on the respondent's home congressional district, representative, gender, age, race, and level of education.

The final unit of analysis for the study is district-year. To create the final dataset, I first grouped individual-level observations for each dataset by congressional district and year. In these new datasets, I created columns for each year's health care opinion where the relevant measure was the weighted proportion, using the CCES survey weights, of district respondents supporting health care reform. If a certain year's health care support variable was titled *year_HC_support* (for example), and the variable coded as 1 for support or 0 for oppose, the formula for calculating the weighted proportions was the sum of all district respondents' *year_HC_support*weight* divided by the sum of *weight* for the district respondents.

I repeated this process for each group's dataset. This process produced variables denoting district-wide health care support for each group: Democrat non-donors, Democrat donors, Republican non-donors, and Republican donors. I then merged the Democrat non-donor, Republican non-donor, Democrat donor, and Republican donor datasets into the district-wide

dataset. With this master district-year dataset, I created my primary independent variables, described in Table 1 below. Summary statistics tables for each variable and year under study are available in Appendix A.

Table 1: Description of primary independent variables

Primary variable name	Description
$HC\_support_{it}$	The proportion of representative *i*'s district respondent population in year *t* supporting the major health care reform efforts of the late 2000s/2010s
$HC\_support\_nodonor_{it}$	The proportion of representative *i*'s district respondent population in year *t* who are not donors, supporting health care reform
$HC\_copartisan\_nondonor\_support_{it}$	The proportion of representative *i*'s district respondent population in year *t*, who are not donors AND of the same party affiliation as the district's representative, supporting health care reform
$HC\_copartisan\_donor\_support_{it}$	The proportion of representative *i*'s district respondent population in year *t*, who ARE donors AND of the same party affiliation as the district's representative, supporting health care reform

Each primary variable in Table 1 refers to the representative for each district-year pairing. If the representative was a Democrat, the primary variable refers to the Democrat opinion variables for the district-year pairing, as co-partisan here means that the Democrat representative should refer to district opinion among Democrat donors and non-donors. Similar logic applies to Republicans. In defining Democrat and Republican individuals I included those who identified as leaning one way or the other. In this analysis, I did not deal with independents or those with no stated party affiliation as I wanted to target how elites respond to those in similar party

alignments. My theory contends that donors donate to officials with similar ideological alignment; in my study, party is proxying for ideology. Although parties may encompass a wider set of beliefs and orientations than individual ideologies themselves, I am comfortable with this distinction. Due to data limitations, I am not coding elites based on their ideology, but on their party. It then makes sense to match them with the mass public based on party. So long as I am using a similar measure to classify elected officials, voters, and donors, I am comfortable proceeding with the analysis.

I operationalize the dependent variable, HC_vote_{it}, by gathering roll call vote data from VoteView on health care reform legislation from each between-survey period and coding accordingly[4]. For each year, I identify a roll call vote from the House of Representatives concerning the ACA. grouped the votes with their years as long as each vote occurred before the next survey phase. For example, the roll call vote that enabled the ACA to pass the House of Representatives for the final time occurred on March 21, 2010. I group this vote with the survey data from 2008, so I assume that representatives were considering 2008 district-level opinion on the ACA when making their votes. Naturally, there are drawbacks to this approach. First, I am omitting 2009, or other interim years for other votes, from the analysis. While we lose some information on how district-level opinion evolves, I am comfortable with this choice due to data limitations in the CCES. Second, as the time between survey collection and roll call vote increases, the supposed effect of donor opinion on vote choice wanes. This should dampen any findings from the model, so this is not a major problem. So long as the roll call vote for each year occurs before the next year's survey, I include it as the dependent variable. Roll call votes were merged into the master dataset and coded as 1 for supporting the ACA in the House of

[4] https://voteview.com/data; also cited in references

Representatives and 0 for opposing. After 2008, the relevant pieces of legislation become repeal attempts, so "Yea" votes for those bills were coded as 0 and "Nay" as 1. Table 2 lists the roll call votes and their respective bills that I selected for the study[5]. For visualizations of how these votes break down by district representative partisanship, see the bar graphs in Appendix B.

Table 2: Selected roll call votes for measuring elite health care positioning

Congress	Bill and roll call number	Title	Date
111th	H.R. 3590, roll 165	Patient Protection and Affordable Care Act	03/21/2010
112th	H.R. 2, roll 14	Repealing the Job Killing Health-Care Act	01/19/2011
113th	H.R. 45, roll 154	To repeal the Patient Protection and Affordable Care Act and health-care related provisions	05/16/2013
114th	H.R. 596, roll 58	To repeal the Patient Protection and Affordable Care Act and health-care related provisions	02/03/2015
115th	H.R. 1628, roll 256	American Health Care Act of 2017	05/04/2017

Empirical distributions of donors and voters

Before discussing model construction, I demonstrate how well my theory lines up with reality. Recall that my theory assumes a normal distribution of voters on any given issue. When ideological donors are added, we should see double peaked distributions, which is evidence of polarization. Thus, we should be able to tell that donors are more polarized than voters.

[5] Information courtesy of Congress.gov; bills are cited in references

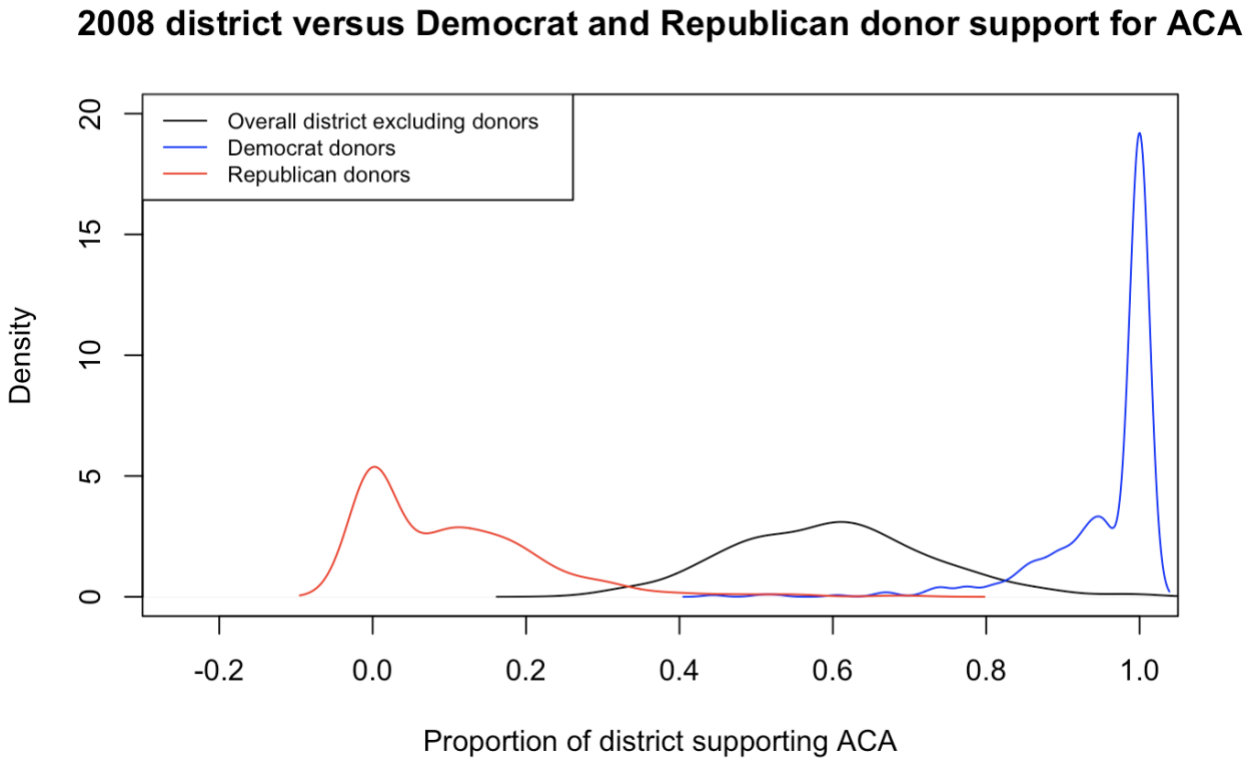

Figure 5: 2008 empirical distribution of district support, donors compared to non-donors

Figure 5 presents the 2008 empirical densities of district non-donor support, district Democrat donor support, and district Republican donor support for all districts. We see that in 2008, Republican donor support in congressional districts was predictably and significantly lower than Democrat donor support, with minimal overlap in the tails of the distributions. Figure 5 resembles Figure 4 above, with a visible polarization effect in both directions. The black line, representing non-donor district support, has a median of 0.593, indicating that half of all congressional districts in the data in 2008 had less than 59.3% of their non-donor populations supporting the ACA. This is comfortably in line with my theorizing, as the distribution of voters resembles a normal distribution and the addition of donors creates a polarization effect in both the liberal and conservative direction.

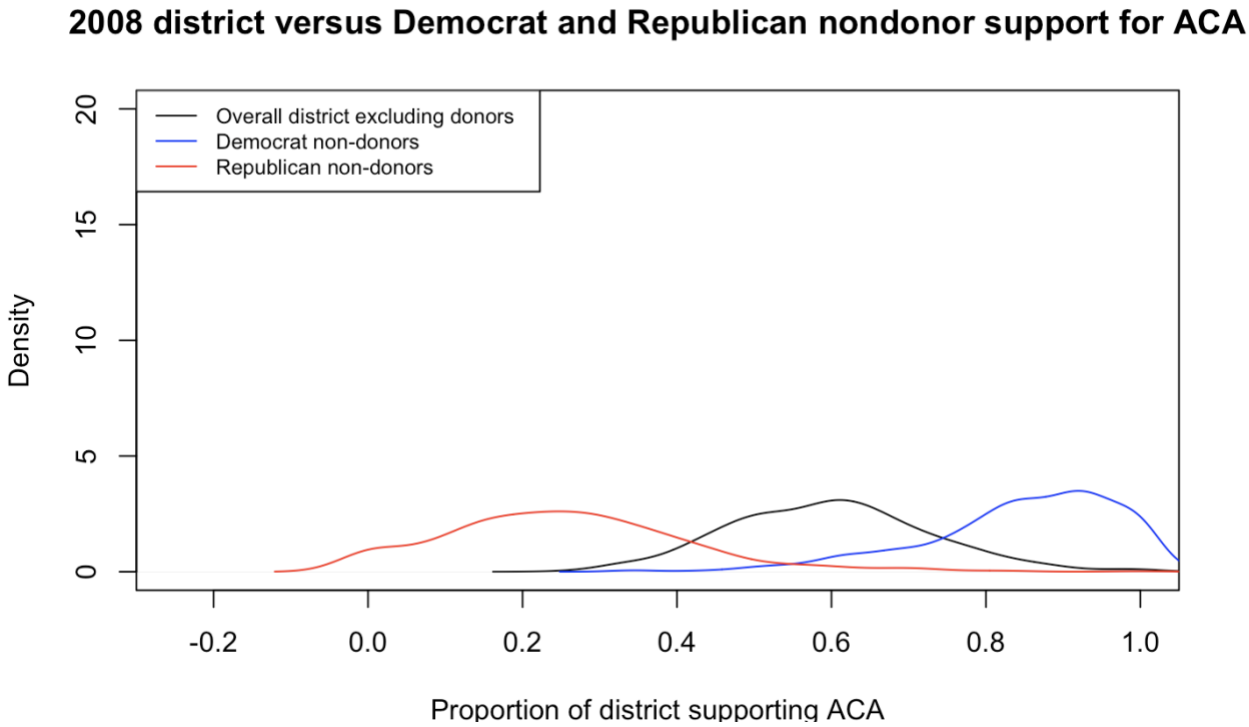

Figure 6: 2008 empirical distribution of district support among non-donors

To further illustrate the point, I include Figure 6 which compares partisan non-donor opinion to partisan donor opinion in Figure 5. Notice that the tails of the partisan distributions, which now exclude donors, are longer and overlap with each other more than in Figure 5. Furthermore, the partisan distributions are flatter and less peaked. While it appears that there is still polarization on the issue, it does not appear to be as severe as among donors (who I assumed were more ideologically extreme than voters). To demonstrate how voter polarization evolves on the issue, I jump ahead to 2016.

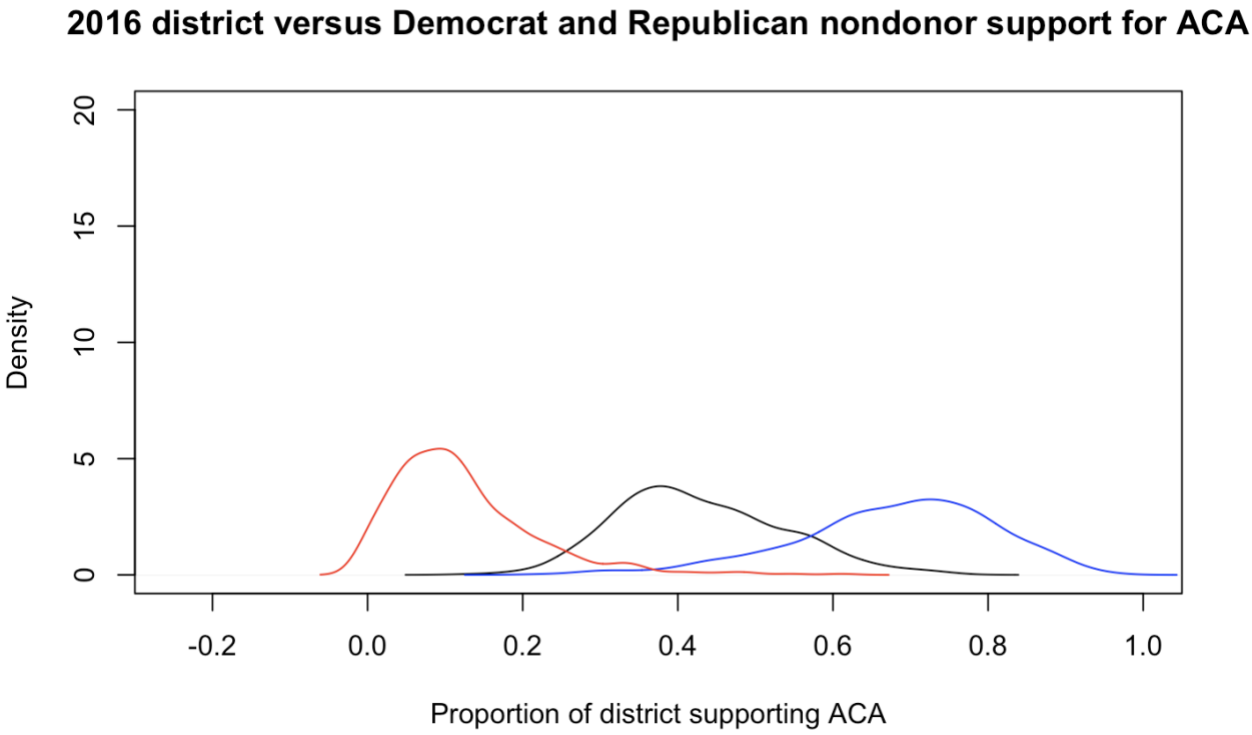

Figure 7: 2016 empirical distribution of district support among non-donors

Compared to 2008, the 2016 Republican distribution is more peaked, and both distributions have shorter tails with less overlap. This is evidence of greater polarization on the ACA compared to 2008. While we cannot say whether this polarization is the result of cue uptake, I believe that my H_3 is weakly supported. As the ACA debate progressed, with the issue becoming more salient, polarization among voters increased. For further evidence supporting H_3, empirical distributions from the other years under study are in Appendix B. Recall that my theory requires unpolarized distributions of voters on a given issue to encourage elites to follow donor preferences. From Figure 6, it does not appear that voters were entirely unpolarized at the start of the debate. So, I proceed with caution, acknowledging that elected officials may not have had the full ability to diverge on the health care reform issue. This means that my theory may not apply to the ACA case.

Finally, there are two potential limitations of the dataset to discuss. First, the timing of the responses in the individual year CCES surveys was not random, so this might militate against the responses being truly representative. Second, although I analyze the district-year dataset as if it were a panel dataset, it is a pseudo-panel dataset in the sense that I aggregate observations that were not in panel form. The district populations being analyzed for each year are not the same. I do not believe this limits my analysis because my theory does not hinge on representatives responding to the same populations of donors and voters. I believe it is sufficient for representatives to consider district voter and donor opinion in the aggregate.

Model description

The final district-year dataset contains 2,163 observations spread out across the years 2008, 2010, 2012, 2014, and 2016. I removed the seats from each year that were vacant at the time the survey was run, as well as the District of Columbia non-voting delegate seat for all years. A major limitation of the data was the lag between the survey and the votes in Congress. Because the surveys for each year were administered before the congressional votes, not all recorded district representatives would go on to vote on the relevant legislation in the House of Representatives. This means that for each year there are missing observations for HC_voteit. Across the entire dataset, I count 354 missing values for HC_voteit. This prevents running any models including these observations.

Given the panel structure of the dataset, I employ a two-way fixed effects regression to model representative vote choice on the ACA as a function of voter and donor opinion[6]. The two-way fixed effects model is especially useful here due to the potential for endogeneity in the data. I am dealing with group and individual political behavior, both of which have the potential

[6] All models were run via the fixest package in R (v0.11.1, Berge et al. 2023).

to be correlated with numerous factors that are difficult or impossible to measure. Given the potential number of confounding variables[7] that could complicate the analysis, using a model with representative and time fixed effects allows me to control for unmeasurable factors that could simultaneously influence the independent and dependent variables. The two-way fixed effects model looks at within-unit variation, controlling for any variables that are constant over time. Applying this logic to the analysis, the model isolates the effect of voter and district opinion on representatives' votes by looking at within-representative variation from the mean vote and regressing it on variation in voter and donor opinion. The addition of representative fixed effects means I am controlling for any confounding factors on the representative level, including party, ideology, or other personal characteristics. This assumes that these factors do not vary over time. The addition of time fixed effects means the model also compares variation across representatives within each year of the study, controlling for any year-specific trends that are constant across representatives.

The general form of the two-way fixed effects model with one regressor X for entity i at time t is

$$Y_{it} = \beta_0 + \beta_1 X_{it} + \gamma_t + \alpha_i + \epsilon_{it}$$

with time and entity fixed effects represented by γ_t and α_i respectively. Note that the models I run are also linear probability models due to the dependent variable being binary (0 or 1). The linear probability model as it applies here is

$$P(Y_{it} = 1|X_{it}) = \beta_0 + \beta_1 X_{it} + \gamma_t + \alpha_i + \epsilon_{it}$$

[7] Potential confounding variables include representative characteristics including representative partisanship, representative ideology, representative age, representative education, etc. Furthermore, year-specific trends such as economic or political shocks that affect all representatives in a year could also confound analysis.

Thus, the coefficient estimates will tell us the effect of a unit increase in the independent variables on the change in probability of a representative voting to support the ACA in Congress. I adopt the following baseline specification for my model, estimating coefficients for the following variables:

(1) $HC\_vote_{it} = HC\_support_{it} + HC\_copartisan\_nondonor\_support_{it} + HC\_copartisan\_donor\_support_{it} + \gamma_t + \alpha_i + \epsilon_{it}$

In this model representative i's vote in year t is a function of her overall district support, district co-partisan non-donor support, and district co-partisan donor support in year t. In the following specifications I add control variables to account for the absence of district-level fixed effects. Here I am adding variables that on the district level could simultaneously influence any of the primary explanatory variables and the vote outcome variable. Using the American Community Survey (ACS) data from the U.S. Census Bureau, I obtained data on each congressional district's percentage of population below the poverty line, mean social security earnings, per capita income, percentage with a bachelor's degree, and percentage without health insurance[8]. When gathering potential controls, I considered whether a variable could influence voter and donor opinion on health care reform, and also sway a representative's positioning on the issue. Logically, voters living in districts that are poorer and more uninsured should support the expansion of health care. Simultaneously, representatives from those same districts, aware of the district-level statistics, should vote accordingly assuming they are acting in the best interest of their districts. I included social security earnings to account for a district's predisposition to rely on government support and education to account for any district-level unobservable factors tied up with education level. I chose a bachelor's degree as the cutoff level to proxy for a high

[8] Data were pulled directly from the Census website in R via the tidycensus package (v1.3.2, Walker et al. 2023).

level of education, as that seemed to be a more differentiating factor than a high school diploma. The yearly data going back to 2008 were obtained from the ACS 1-year comparison profiles. The control variables are listed in Table 3.

Table 3: Description of primary control variables

Control variable name	Description
$no\_health\_ins_{it}$	In year *t*, percentage of representative *i*'s district population without health insurance coverage
$pct\_bachelors_{it}$	In year *t*, percentage of representative *i*'s district population holding a bachelor's degree
$percap\_inc_{it}$	Per capita income of representative *i*'s district in year *t*
$all\_below\_poverty_{it}$	In year *t*, percentage of representative *i*'s district below the poverty line
$mean\_soc\_sec_{it}$	In year *t*, mean social security earnings of representative *i*'s district

I decide to use the above variables because they adequately cover the potential district-level economic factors that I believe could plausibly explain health care opinion and positioning. In accounting for these economic factors, I further restrict the model to explaining ACA votes solely as a function of voter and donor opinion. As my proposed causal pathway hinges on both ideological agreement with donors and voters and concern with appealing to them, I believe have accounted for as many factors as possible. Notably, I do not include district partisanship or ideology measures in the analysis. However, as the representative fixed effects account for a representative's party, I proxy district partisanship and ideology with the representative's partisanship. I believe this is a fair step to take as the district's partisanship is accounted for in

the representative, who the district elected. Below I detail the rest of the models I run for the study.

Baseline specifications

(2) $$HC\_vote_{it} = HC\_support_{it} + HC\_copartisan\_nondonor\_support_{it} + HC\_copartisan\_donor\_support_{it} + HC\_support\_nodonor_{it} + \gamma_t + \alpha_i + \epsilon_{it}$$

(3) $$HC\_vote_{it} = HC\_support_{it} + HC\_copartisan\_nondonor\_support_{it} + HC\_copartisan\_donor\_support_{it} + HC\_support\_nodonor_{it} + no\_health\_ins_{it} + \gamma_t + \alpha_i + \epsilon_{it}$$

(4) $$HC\_vote_{it} = HC\_support_{it} + HC\_copartisan\_nondonor\_support_{it} + HC\_copartisan\_donor\_support_{it} + HC\_support\_nodonor_{it} + no\_health\_ins_{it} + pct\_bachelors_{it} + \gamma_t + \alpha_i + \epsilon_{it}$$

(5) $$HC\_vote_{it} = HC\_support_{it} + HC\_copartisan\_nondonor\_support_{it} + HC\_copartisan\_donor\_support_{it} + HC\_support\_nodonor_{it} + no\_health\_ins_{it} + pct\_bachelors_{it} + percap\_inc_{it} + \gamma_t + \alpha_i + \epsilon_{it}$$

(6) $$HC\_vote_{it} = HC\_support_{it} + HC\_copartisan\_nondonor\_support_{it} + HC\_copartisan\_donor\_support_{it} + HC\_support\_nodonor_{it} + no\_health\_ins_{it} + pct\_bachelors_{it} + percap\_inc_{it} + all\_below\_poverty_{it} + \gamma_t + \alpha_i + \epsilon_{it}$$

Interaction specifications

For models 7 through 12 I interact the variables with the $Party_{it}$ variable, which denotes whether the district's representative is a Democrat or Republican. I make this choice to see whether the representative's party mediates the influence of any of the independent variables. Because the health care reform proposals were Democrat-led, making the issue relatively one-sided in Congress, it is possible that partisanship may explain most of the variation in health care

vote. Even though party is included with the representative fixed effects, I interact it with the independent variables to identify whether Democrats, for instance, took greater note of voter and donor opinion. Moreover, there is reason to believe that a district's economic data and educational attainment may signal conflicting information about predisposition to supporting health care reform. Due to polarization, a relatively poor or uninsured district may not support the ACA because it is logical but instead oppose it due to partisanship. Due to the partisan valence of the ACA, my selected control variables may not have uniform effects; rather, their influence may be mediated by partisanship. My theory suggests that voters become more aware of party positions over time and absorb those positions, so it is necessary to account for this. As I explained above, a representative's party may serve as a useful proxy for district partisanship here. Model 7 displays how I interact the variables with $Party_{it}$. In the interest of brevity, I omit writing out the specifications of models 8 through 12 here, but $Party_{it}$ is successively interacted with each independent variable from models 1 through 6 in each model. For example, $Party_{it}$ is also interacted with $HC\_support\_nodonor_{it}$ in model 8, and so on. For the baseline and interaction specifications, I cluster the standard errors by representative due to the pooled nature of the dataset.

(7) $$HC\_vote_{it} = HC\_support_{it} + HC\_copartisan\_nondonor\_support_{it} + HC\_copartisan\_donor\_support_{it} + HC\_support_{it} * Party_{it} + HC\_copartisan\_nondonor\_support_{it} * Party_{it} + HC\_copartisan\_donor\_support_{it} * Party_{it} + \gamma_t + \alpha_i + \epsilon_{it}$$

Year-by-year specifications

For models 13 through 17, I conduct a year-by-year analysis, where each year is its own model. For the specification I apply model 6 to each year, adding $Party_{it}$ as an independent

variable to control for a representative's party. The advantage of this strategy is to see how the effect of voter and donor opinion changes from year to year. My theory suggests that representatives' sensitivity to donor and voter opinion wanes over time as party positioning becomes salient. Additionally, my H_1 conjectures that as voter polarization increases, elite responsiveness to donors decreases. Thus, in conjunction with the empirical densities addressing H_3 (voter polarization on health care), this strategy addresses H_1. We might expect that the coefficient estimates decrease in value in each successive model. The trade-off of this strategy is in sacrificing the causal rigor of the model; by removing the fixed effects terms, we lose the ability to control for as many unobservable factors. Model 13 takes the form

(13) $HC_{vote} = \beta_0 + HC\_support + HC\_support\_nodonor +$
$HC\_copartisan\_nondonor\_support + HC\_copartisan\_donor\_support + no\_health\_ins +$
$pct\_bachelors + percap\_inc + all\_below\_poverty + Party + \epsilon$

Models 14 through 17 take the identical form but applied to years 2010, 2012, 2014, and 2016. For the year-by-year models I use heteroskedasticity-robust standard errors due to estimating linear probability models on cross-sectional data. As I explain later, I also run models 18 through 22 which remove the *Party* variable from the equation.

Conflicting opinion specifications

The final identification strategy is to identify those districts where donor and non-donor conflict and run the full baseline specification on them. Such districts are interesting because they signal two alternative messages to representatives: either donors support the ACA more than nondonors do or vice versa. By applying the model to these districts, I may be able to determine which group holds greater sway with representatives. What I am really seeking to identify is either representatives who switch their ACA vote over time or representatives who are

faced with conflicting opinions, forcing them to value one higher than the other. In essence, variation is critical to identifying an effect in my models. By targeting districts with conflicting approval, I am capturing all possible facets of the health care reform issue. I run two final models which take the exact same functional form as model 6 but are applied to different subsets of the data. I first subset the data down to those district-year combinations where non-donor support outweighs donor support, and then to those where donor support outweighs non-donor support. I identify such districts by filtering for districts where non-donor support is greater than 0.5 and donor support less than 0.5, and then vice versa, respectively. I again cluster the standard errors by representative for these specifications. Model 23 concerns districts where non-donor support outweighs donor support, and model 24 concerns those where donor support outweighs non-donor support.

Results

My empirical results show weak support for H_3 and do not support H_1 or H_2. Table 4 shows the results of my baseline specifications, Table 5 shows the results of my interaction specifications, Table 6 shows the results of my year-by-year specifications, Table 7 displays the year-by-year results without the *Party* variable, and Table 8 shows the results of my conflicting approval specifications.

Table 4: Baseline regression model results

	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Dependent Var.:	HC_vote	HC_vote	HC_vote	HC_vote	HC_vote	HC_vote
HC_support	0.0352	0.0806	0.0777	0.0776	0.0791	0.0781
	(0.1066)	(0.1843)	(0.1855)	(0.1856)	(0.1853)	(0.1849)
HC_copartisan_n	-0.0039	0.0061	0.0072	0.0084	0.0060	0.0076
ondonor_support	(0.0610)	(0.0732)	(0.0737)	(0.0736)	(0.0735)	(0.0734)
HC_copartisan_d	-0.1146*	-0.1176*	-0.1207*	-0.1230*	-0.1224*	-0.1227*
onor_support	(0.0506)	(0.0537)	(0.0539)	(0.0542)	(0.0543)	(0.0543)
HC_support_nodo		-0.0482	-0.0473	-0.0528	-0.0521	-0.0533
nor		(0.1373)	(0.1381)	(0.1383)	(0.1384)	(0.1386)
no_health_ins			0.0008	0.0024	0.0028	0.0021
			(0.0024)	(0.0023)	(0.0024)	(0.0029)
pct_bachelors				0.0017	0.0002	0.0003
				(0.0017)	(0.0026)	(0.0026)
percap_inc					2.04e-6	2.39e-6
					(3.04e-6)	(3.04e-6)
all_below_povert						0.0015
y						(0.0038)
Fixed-Effects:	----------	----------	----------	----------	----------	----------
	-----	-----	-----	-----	-----	-----
rep_icpsr	Yes	Yes	Yes	Yes	Yes	Yes
year	Yes	Yes	Yes	Yes	Yes	Yes

S.E.: Clustered	by: rep_icpsr	by: rep_icpsr	by: rep_icpsr	by: rep_icpsr	by: rep_icpsr	by: rep_icpsr
Observations	1,808	1,808	1,797	1,797	1,792	1,792
R2	0.91016	0.91017	0.90967	0.90978	0.90981	0.90982
Within R2	0.00368	0.00383	0.00402	0.00523	0.00554	0.00570

Signif. codes: p < 0.001 ***, p < 0.01 **, p < 0.05 * p < 0.1 .

Table 4 shows almost no statistically significant results. However, in all model specifications, the coefficient on co-partisan donor support is negative and significant at 5%. The coefficient estimate ranges between -0.1146 and -0.1248, indicating that for each 1% increase in share of a given district's co-partisan donors who support health care reform, that district's representative is less likely to vote to support the ACA. This is a puzzling result and is the exact opposite of what my H_2 claims. This result is robust to adding district-level control variables to the model.

Table 5: Interaction regression model results

	Model 7	Model 8	Model 9	Model 10	Model 11	Model 12
Dependent Var.:	HC_vote	HC_vote	HC_vote	HC_vote	HC_vote	HC_vote
HC_support	-0.0035	-0.0405	-0.0451	-0.0510	-0.0649	-0.0028
	(0.1464)	(0.2360)	(0.2385)	(0.2401)	(0.2402)	(0.2416)

HC_copartisan_nondo	0.0305	-0.0188	-0.0218	-0.0228	-0.0254	-0.0289
nor_support	(0.0916)	(0.1234)	(0.1244)	(0.1242)	(0.1249)	(0.1252)
HC_copartisan_donor_	-0.1229	-0.1298	-0.1366	-0.1420	-0.1395	-0.1459.
support	(0.0866)	(0.0880)	(0.0871)	(0.0878)	(0.0884)	(0.0885)
HC_support x	0.0821	0.3166	0.3249	0.3333	0.3654.	0.2141
PartyRepublican	(0.1422)	(0.1982)	(0.2024)	(0.2064)	(0.2091)	(0.2133)
HC_copartisan_nondo	-0.0710	0.0531	0.0561	0.0575	0.0552	0.0613
nor_support x	(0.1060)	(0.1490)	(0.1500)	(0.1498)	(0.1498)	(0.1494)
PartyRepublican						
HC_copartisan_donor_	0.0191	0.0203	0.0246	0.0292	0.0184	0.0294
support x	(0.0944)	(0.0924)	(0.0909)	(0.0915)	(0.0927)	(0.0922)
PartyRepublican						
HC_support_nodonor		0.0893	0.0841	0.0778	0.0932	0.0399
		(0.2055)	(0.2081)	(0.2084)	(0.2100)	(0.2132)
HC_support_nodonor		-0.3143	-0.2998	-0.2944	-0.3219	-0.1960
x PartyRepublican		(0.1966)	(0.2005)	(0.2001)	(0.2028)	(0.2084)
no_health_ins			0.0010	0.0030	0.0024	0.0021
			(0.0029)	(0.0026)	(0.0028)	(0.0032)
no_health_ins x			-0.0019	-0.0030	0.0004	-0.0020
PartyRepublican			(0.0030)	(0.0034)	(0.0040)	(0.0042)
pct_bachelors				0.0021	0.0021	0.0019
				(0.0023)	(0.0038)	(0.0038)

pct_bachelors x				-0.0015	-0.0071	-0.0069
PartyRepublican				(0.0027)	(0.0051)	(0.0050)
percap_inc					-1.75e-7	-4.93e-7
					(3.67e-6)	(3.49e-6)
percap_inc x					1.02e-5	1.38e-5.
PartyRepublican					(6.83e-6)	(7.24e-6)
all_below_poverty						-0.0019
						(0.0049)
all_below_poverty x						0.0129*
PartyRepublican						(0.0056)
Fixed-Effects:	----------	----------	----------	----------	----------	----------
	-----	-----	-----	-----	------	------
rep_icpsr	Yes	Yes	Yes	Yes	Yes	Yes
year	Yes	Yes	Yes	Yes	Yes	Yes
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
____	___	___	___	___	___	___
S.E.: Clustered	by:	by:	by:	by:	by:	by:
	rep_icpsr	rep_icpsr	rep_icpsr	rep_icpsr	rep_icpsr	rep_icpsr
Observations	1,808	1,808	1,797	1,797	1,792	1,792
R2	0.91020	0.91048	0.91000	0.91012	0.91028	0.91060
Within R2	0.00417	0.00721	0.00762	0.00893	0.01077	0.01422

Signif. codes: p < 0.001 ***, p < 0.01 **, p < 0.05 * p < 0.1 .

Table 5 displays one significant estimate at the 5% level: *all_below_poverty*PartyRepublican*. This estimate indicates that for each percentage point increase in percentage of the district in poverty, a Republican representative is slightly more likely to vote in support of the ACA compared to a Democrat.

Table 6: Year-by-year regression results

	Model 13 - 2008	Model 14 - 2010	Model 15 - 2012	Model 16 - 2014	Model 17 - 2016
Dependent Var.:	HC_vote	HC_vote	HC_vote	HC_vote	HC_vote
Constant	1.012***	0.7315**	1.063***	0.9361***	0.9038***
	(0.1171)	(0.2205)	(0.1540)	(0.1468)	(0.1734)
HC_support	0.0412	0.4700	-0.3716	-0.0308	0.3649
	(0.1660)	(0.3364)	(0.3972)	(0.3293)	(0.3053)
HC_support_nodonor	-0.0412	-0.1638	0.2562	-0.1169	-0.0086
	(0.1527)	(0.2337)	(0.3409)	(0.2661)	(0.2304)
HC_copartisan_nondonor_support	-0.0080	-0.1083	-0.1405	0.0746	-0.1366
	(0.1025)	(0.1409)	(0.1429)	(0.1121)	(0.2224)
HC_copartisan_donor_support	0.0098	-0.1258	-0.0277	-0.0265	-0.0664
	(0.0762)	(0.1620)	(0.0847)	(0.0838)	(0.1074)
no_health_ins	0.0015	0.0034	-0.0023	-0.0016	-0.0002
	(0.0024)	(0.0021)	(0.0037)	(0.0028)	(0.0026)

pct_bachelors	-0.0053.	0.0041	0.0002	0.0021	-0.0022
	(0.0029)	(0.0030)	(0.0029)	(0.0024)	(0.0019)
percap_inc	5e-6. (2.7e-6)	2.03e-8 (3.27e-6)	1.8e-6 (3.3e-6)	-2.18e-6 (3.51e-6)	4.88e-6. (2.95e-6)
all_below_poverty	-0.0050	0.0011	0.0015	0.0028	-0.0008
	(0.0034)	(0.0033)	(0.0041)	(0.0035)	(0.0026)
PartyRepublican	-0.9661***	-1.029***	-1.011***	-0.9067***	-0.9994***
	(0.0933)	(0.1757)	(0.0952)	(0.0837)	(0.1340)
S.E. type	Heteroskeda st.-rob.	Heterosked as.-rob.	Heterosked as.-rob.	Heteroskeda st.-rob.	Heteroskeda st.-rob.
Observations	376	338	336	372	375
R2	0.89026	0.81837	0.81421	0.85943	0.83086
Adj. R2	0.88756	0.81338	0.80908	0.85594	0.82669

Signif. codes: p < 0.001 ***, p < 0.01 **, p < 0.05 * p < 0.1 .

As expected, Table 6 contains significant results at the 0.1% level for the *Party* variable. In all years a representative being a Republican makes her significantly less likely to vote in support of the ACA. This effect does not wane with time and is robust to the included control variables and heteroskedastic robust standard errors. This is strong evidence that a representative's party may be the best predictor of ACA support; in other words, vote choice on the ACA comes down to party loyalties. This agrees with Shor's (2018) results, but on a national level. Of course, there are many representative-level factors besides partisanship that may

account for this, but Table 6 presents clear evidence that party is a strong factor, exceeding the influence of donor or voter support for the ACA. Because I do not explicitly include ideology in these models, that remains a strong potential influence on ACA support.

Because *Party* was consistently significant, I reran models 13 through 17 with the *Party* variable removed to confirm whether a representative's party was capturing donor preferences. If removing *Party* produces significant estimates for co-partisan donor opinion, then that would indicate that donors' effects reflect in the selection of candidates who align with their preferences. Then, candidate vote choice is post-treatment with respect to donor preferences.

Table 7: Year-by-year regression results without *Party* variable

	Model 18 - 2008	Model 19 - 2010	Model 20 - 2012	Model 21 - 2014	Model 22 - 2016
Dependent Var.:	HC_vote	HC_vote	HC_vote	HC_vote	HC_vote
Constant	-0.0377	-0.3470**	-0.1261	-0.0138	-0.2662**
	(0.0826)	(0.1133)	(0.1192)	(0.1041)	(0.0852)
HC_support	-0.0292	0.3394	-0.4822	0.0849	0.3707
	(0.1816)	(0.3543)	(0.4166)	(0.3515)	(0.3423)
HC_support_nodonor	-0.0967	-0.1512	0.1434	-0.4553	-0.3643
	(0.1613)	(0.2469)	(0.3580)	(0.2903)	(0.2752)
HC_copartisan_nondonor_support	0.2581**	0.3031*	0.3758**	0.8206***	0.5374***
	(0.0945)	(0.1408)	(0.1424)	(0.1287)	(0.1600)

HC_copartisan_don	0.9146***	0.6839***	0.7484***	0.4174***	0.6535***
or_support	(0.0585)	(0.1004)	(0.0961)	(0.1010)	(0.0968)
no_health_ins	-0.0002	0.0033	-0.0019	-0.0017	0.0023
	(0.0026)	(0.0023)	(0.0042)	(0.0030)	(0.0028)
pct_bachelors	-0.0044	0.0050	-0.0006	0.0021	-0.0022
	(0.0030)	(0.0032)	(0.0031)	(0.0025)	(0.0022)
percap_inc	4.68e-6	-8.84e-7	4.94e-6	-1.96e-6	7.31e-6*
	(2.94e-6)	(3.57e-6)	(3.56e-6)	(3.6e-6)	(3.15e-6)
all_below_poverty	-0.0033	0.0027	0.0049	0.0052	0.0066*
	(0.0036)	(0.0038)	(0.0044)	(0.0039)	(0.0029)
S.E. type	Heterosked as.-rob.	Heterosked as.-rob.	Heterosked as.-rob.	Heterosked as.-rob.	Heterosked as.-rob.
Observations	376	338	336	372	375
R2	0.86695	0.79473	0.77960	0.83503	0.79158
Adj. R2	0.86405	0.78974	0.77421	0.83140	0.78703

Signif. codes: p < 0.001 ***, p < 0.01 **, p < 0.05 * p < 0.1 .

We see from Table 7 that the estimates for co-partisan donor support are consistently positive and significant for all years of the model. Co-partisan non-donor support is also predictive in 2008, 2010, and 2012. This confirms that without controlling for a representative's party, co-partisan donor support and non-donor support correlate significantly with representative vote choice. While this would seem to confirm my theory, without controlling for

party we cannot say that a representative's party is not a significant influence on elite positioning. Because removing party from the models makes donor opinion significant, this seems to indicate that the effect of donors is through candidate selection, and not necessarily through directly affecting representative behavior. The estimates for district per capita income and poverty rate are marginally positive and significant in 2016.

Table 8: Conflicting opinion regression results

	Model 23 – Non-donor > donor	Model 24 – Donor > non-donor
Dependent Var.:	HC_vote	HC_vote
HC_support	0.3166 (0.2537)	0.7853 (0.5186)
HC_support_nodonor	-0.3184 (0.2737)	-0.8116 (0.5849)
HC_copartisan_nondonor_support	0.0595 (0.0556)	-0.1916 (0.1629)
HC_copartisan_donor_support	-0.0314 (0.0482)	0.1573 (0.1955)
no_health_ins	0.0063 (0.0064)	0.0017 (0.0072)
pct_bachelors	9.8e-6 (0.0024)	-0.0053 (0.0108)
percap_inc	-1.82e-6 (3.55e-6)	-1.75e-5 (2.7e-5)
all_below_poverty	-0.0036 (0.0042)	-0.0038 (0.0310)
Fixed-Effects:	----------	----------
rep_icpsr	Yes	Yes
year	Yes	Yes
S.E.: Clustered	by: rep_icpsr	by: rep_icpsr

Observations	293	246
R2	0.90020	0.81894
Within R2	0.05598	0.06528

Signif. codes: p < 0.001 ***, p < 0.01 **, p < 0.05 * p < 0.1 .

There are no significant results in Table 8. While the *HC_support* estimate for model 24, when donor support outweighs non-donor support, appears larger than the *HC_support* estimate for model 23, the result is not significant. This might indicate that representatives are more responsive to overall district opinion (which includes donors) when donors support health care reform more, but we cannot draw any conclusions.

Discussion

Concerning H_1, I do not find evidence that representatives became less responsive to donor opinion as a result of increasing voter polarization on health care reform. According to the density distributions in Appendix B, voters appear to become more polarized over time on the issue. However, my year-by-year models do not pick up statistically significant decreasing amounts of responsiveness to voter opinion. This could suggest that voters may have polarized early on the health care reform issue or had been sufficiently polarized to prevent representatives from following donor preferences in the first place. However, this does not suggest that representatives were becoming more responsive to voters over time either. I do not find evidence for this. An interesting result was the coefficient estimate for *HC_support* in model 24, suggesting that representatives become more likely to vote for the ACA in districts where donors support the ACA more than voters. Although the estimate was not statistically significant, it raises an interesting question as to whether elites truly defer to donor opinion when faced with conflicting signals.

Regarding H_2, I find evidence contrary to my hypothesis. Instead of ACA support being positively correlated with donor opinion, I find in models 1 through 6 that representatives were less likely to support the ACA the more co-partisan donors supported it. This is somewhat of a strange finding given my theory, as at minimum I assume that co-partisan donors and representatives should be aligned on policy goals. This raises the question as to whether there was measurement error in the data. However, numerous sanity checks of the data–displayed in my figures–indicate that the variables map out to my expectations. Given that the ACA was proposed by a Democrat president, I would expect on balance Democrat non-donors and donors to support the ACA, and Republican non-donors and donors to oppose it. Furthermore, I expected this trend to be the baseline for all analyses.

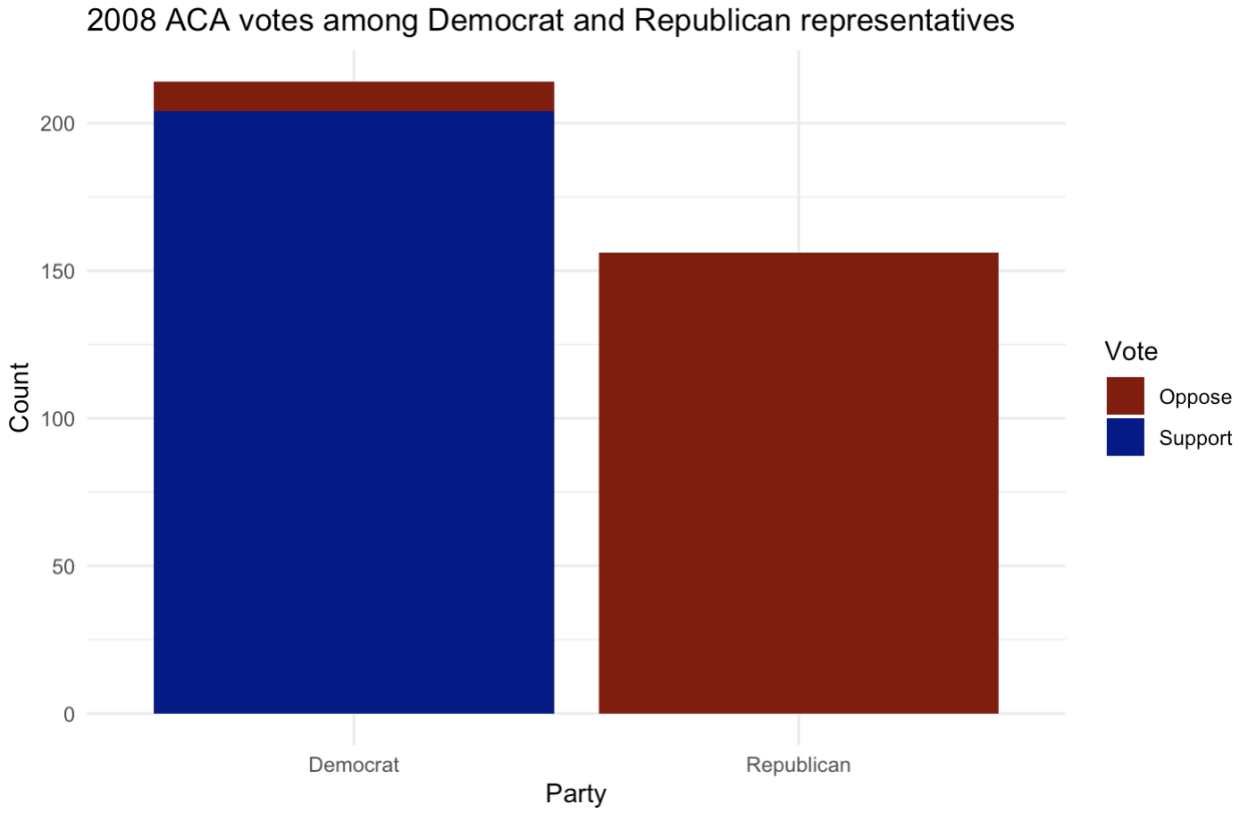

Figure 8: 2008 ACA congressional votes broken down by partisanship of district rep.

Figure 8 demonstrates how many Democrat and Republican representatives voted to support or oppose the ACA based on the 2008 survey data. Remember that this figure links the 2008 representatives with the 2010 ACA vote. Although there are missing observations from representatives who were not present for the vote, the trend plays out as I expected. Democrats are overwhelmingly voting for the ACA and Republicans are unanimously opposing it. The breakdowns for the rest of the years are presented in Appendix B. The trend continues throughout all years. Partisanship is a strong dividing line for determining who supported or opposed the ACA in congressional votes.

Table 9: Summary of ACA support over time by district representative party and group

Year	Party	Representatives voting in favor of health care reform	Representatives voting against health care reform	Mean district support	Mean district support among co-partisans	Mean district support among co-partisan donors	Difference between co-partisan donor support and district support
2008	Democrat	209	11	0.524	0.847	0.963	0.439
2008	Republican	0	156	0.429	0.252	0.09	-0.339
2010	Democrat	166	18	0.582	0.838	0.938	0.356
2010	Republican	0	154	0.466	0.172	0.036	-0.43

2012	Democrat	134	17	0.666	0.855	0.956	0.29
2012	Republican	0	196	0.525	0.221	0.093	-0.432
2014	Democrat	157	14	0.549	0.787	0.927	0.378
2014	Republican	0	201	0.372	0.09	0.05	-0.322
2016	Democrat	166	0	0.503	0.685	0.885	0.382
2016	Republican	18	191	0.373	0.112	0.05	-0.323

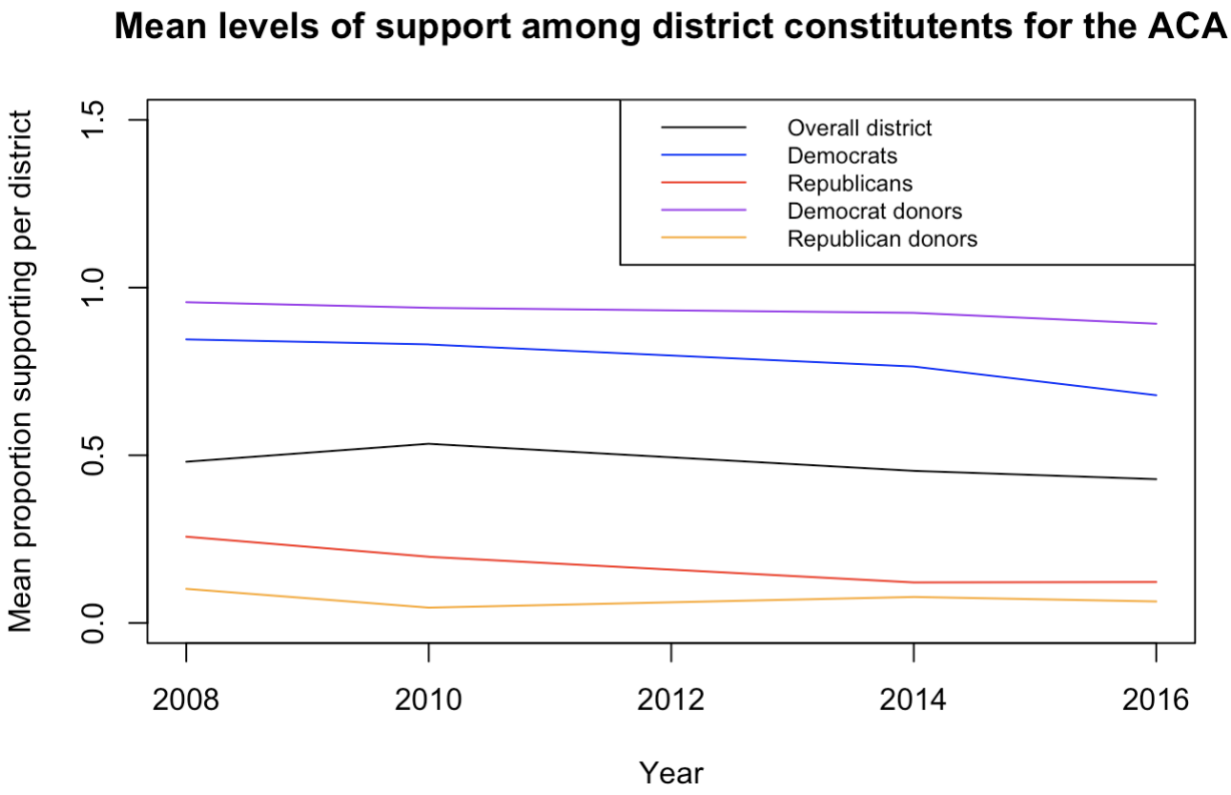

Figure 9: ACA support by group, 2008-2016

Table 9 and Figure 9 further illustrate that the partisan dynamics played out as expected over time. Democrat representatives were more likely to vote in support of the ACA than Republican representatives, and Democrat-represented districts expressed consistently higher

levels of support than Republican districts. Co-partisan donors seem to have expressed higher support than the overall district when Democrats and lower support when Republicans. Indeed, Table 8 confirms that Democrat and Republican donors consistently expressed greater preferences in support and against the ACA, respectively. Figure 9 visualizes these trends and confirms my expectations of how the different groups' preferences should have played out. For separate graphs for each of the groups, see figures 14 through 18. Overall, we can say that Democrats were always more likely in the data to support the ACA than Republicans and that donors had more extreme preferences for each group. In models 18 through 22 I do find that co-partisan donor and non-donor opinion becomes predictive of elite positioning once we remove a representative's party as a control variable. However, this is really evidence in favor of party as a strong influence on elite positioning.

Why did I find such puzzling results? Part of the reason could be data limitations. By not including data on big donations or highly influential donors, I am surely losing some measure of a more substantial relationship between donor and politician. Moreover, cutting 2006 from the study loses the crucial year when the debate was beginning, and voter preferences may have been even more unclear. With confirmation that support for the ACA was neatly sorted–polarized, even–among voters and donors for the entire period of study, it seemed that these preferences were not affecting how representatives voted. So, according to my theory, I maybe should not have expected responsiveness to donors at all. This would then suggest that my theory's necessary conditions may be accurate. However, we must study more issues to confirm this.

Perhaps the results confirm that party is the most important factor determining whether a politician voted to support the ACA. Despite my theory claiming that politicians polarize after recognizing that voters have uncrystallized preferences, it seems as if politicians were polarized

on the ACA from the start of the debate. There was never a major overlap between parties on ACA positioning. Either my theory is somewhat off, or voters did have crystallized preferences at the start of the debate, perhaps due to partisan messaging. The fact that the parties do not seem to have been divided, and instead were neatly sorted on health care reform, tells me that they might have been locked in quickly due to party loyalty. These findings fit with the general trends in the literature I reviewed: the importance of partisanship, national party identity, and ideology means that district opinion and donor opinion are tenuously influential on votes in Congress, at best.

A major reason why I may have failed to find significant results is the lack of vote-switching among representatives. The strongest identification in the models would have come from members who did not vote for the same policy stance over the entire time period, because then the models could identify which constituency's preferences they were varying with. However, in my analysis of the data I found that only thirty-seven distinct representatives changed their vote over the entire study. Out of over a thousand observations, only thirty-seven were providing the model with variation in the dependent variable. Furthermore, twenty-five of these individuals were Democrats. Because the majority of switchers were Democrats, the models were not picking up much variation from Republican representatives. This lack of within-representative variation most likely weakened my ability to draw any serious conclusions from the data. It further illustrates that party may be the strongest deciding factor in a representative's support of the ACA. Because the variation was mostly limited to the Democrat representatives, however, we should consider whether responsiveness would be different among Republicans and whether the results truly provide evidence against selective responsiveness. This is a further reason to apply the theory and methods to a different issue.

Finally, my H_3 was weakly supported. Although I do not conduct statistical testing on how voter polarization changed over the study, the density plots in Appendix B appear to show a slight increase in polarization among non-donors as the ACA debate progressed. The evidence is in the increased bimodality of non-donor distributions, with increased peaks as time progresses. While I raise the possibility that increased voter polarization may have resulted from increased exposure to elite cues and coverage of the ACA debate, I do not conduct enough analysis to say for sure. I now briefly discuss the implications of the ACA debate for elite positioning and voter polarization at the end of the study, circa 2016.

The Tea Party and lock in

A discussion of the ACA debate would be incomplete without mentioning the Tea Party. Retrospective coverage of the time details how the introduction of the ACA created a fiery environment in Republican districts and among Republican voters. While the Tea Party was a diffuse movement focused on many different issues, it seemed to coalesce around opposition to President Obama's policy agenda. Given that the Affordable Care Act was one of the most significant and salient goals of the Obama administration, it sparked a massive backlash in the Republican Party vis a vis the Tea Party. Schmitt et al. (2019) describe the Tea Party as a fringe movement that began within the Republican Party around 2009-2010, united solely on contempt for the federal government. Beyond that, it appears that the ideological tenets of the Tea Party go in two directions: fiscal conservatism and reactionary conservatism. Fiscal conservatism entails a desire to limit government spending and maintain a balanced government budget. Schmitt et al. (2019) detail how some members of the Tea Party sought to remove Republicans who did not espouse fiscal conservatism, with this stance a reaction to increased government spending.

Reactionary conservatism may be defined as a more visceral form of conservatism where the concern is on preserving established social and cultural hierarchies, defending them against threats to change (Blum 2020). Scholars have observed that the social and cultural politics of the Tea Party were reactionary, aligned against the perceived threats of Barack Obama's presidency to the American political order (Blum 2020; Parker and Barreto 2013; Skocpol and Williamson 2012). To the Tea Party, President Obama was the face of its perceived threats to fiscal conservatism and the established American political tradition. Opposition to his agenda became the priority. And given that the ACA was so important to President Obama's policy agenda, it faced massive backlash from the Republican Party as the debate progressed.

Blum's (2020) study of the Tea Party centers it as an insurgent faction that sought to take over the Republican Party from the inside and reshape it. Although its takeover of the 2010s Republican Party may have seemed surprising to political outsiders, its rise was methodical. Via progressive takeover of state legislatures and election of candidates to the House of Representatives, the movement was able to create gridlock in Congress and hold a tight grip on establishment Republicans. After the Republican Party's success in retaking the House of Representatives in 2010, Tea Party conservatives began a scorched-earth method of politics, refusing to compromise on the ACA. Blum notes how this resulted in the lengthy federal government shutdown from October 1 to October 2013 and the resignations of Speakers of the House John Boehner and Paul Ryan in 2015 and 2018, respectively. Since the ACA was passed, there have been many attempts to repeal it, indicating how much of a priority the Tea Party coalition placed on the health care issue (Brown 2017; Cohn 2020).[9]

[9] Somewhat humorously, there is a website that provides this exact information: https://howmanytimeshasthehousevotedtorepealobamacare.com.

Parker and Baretto (2013) contend that the Tea Party arose largely in response to President Obama's election in 2008. Further, this resistance is evidence that the Tea Party is more than conservatism, but reactionary conservatism, distinguished by supporters' negative opinion of minorities. Concerning health care, they show evidence that compared to health care reform opinion among the general population, Tea Party supporters disapproved significantly more. Their work also demonstrates that resistance to the ACA was well-established early in the debate. This accords with my evidence that health care reform opinion among non-donor partisans showed evidence of polarization somewhat immediately in the period under study.

My theory also proposes that policy stances on a certain issue reach voters through cue signaling and media coverage. Skinner (2012) discusses the media coverage of the ACA debate in the context of the Tea Party. He notes that the Tea Party was focused only on repealing the ACA and never replacing it with a better alternative. His analysis of media coverage suggests that the news media assisted in spreading the Tea Party's notion of the ACA, legitimizing it rather than adequately critiquing it. The result was a muddied understanding of the ACA among the public, potentially contributing to further polarization on the issue. Kriner and Reeves (2014) provide potential evidence backing my theory. They find that during the health care reform debate of the 2000s, partisan elites were able to lead public opinion. Specifically, as opposition to reform increased among co-partisan congressional elites, statistically significant decreases in co-partisan public opinion occurred, supporting the idea that partisan elites can affect popular support. The causal mechanism in their study was elite rhetoric received through the mass media.

My theory suggests that once elite stances become apparent to partisan voters, voters prevent deviation away from the new party status quo. Evidence from the health care reform debate suggests that this is plausible. Opposition to the ACA became the defining issue for Tea

Party Republicans and the greater Republican Party. The Tea Party and the Republican Party never deviated away from their stance on the issue. However, this is not evidence that it was voters holding politicians in line. In my study, I found that a representative's party could potentially be the best explainer of her vote in Congress. Here, deviation away from the party line would not be prevented by voter opinion, but by partisan loyalties.

Kriner and Reeves (2014) do show that party identification was the best explainer of individual-level opinion on health care in their study, so partisan ties may supersede individual-level opinion of the actual policy at hand. But then this would suggest that party becomes a proxy for understanding the policy. Voters, identified with the Republican Party, took in the party stance on health care opinion, and held onto it. Otherwise, it may simply be that the ACA was so consistently unpopular among Republican voters that opposing it was the smart thing for politicians to do. The authors note that Republican support for health care reform was already low at the start of the Obama administration and only fell further as time progressed. Overall, there are two interesting dynamics at play: whether representatives were locked in on health care by voter opinion or by party ties in Congress. While I do not go further in discovering which dynamics dominated, I leave it open as a promising route for further understanding the American health care reform debate.

Conclusion

This thesis has studied the American health care reform debate in the context of two puzzles: why parties propose polarized policies, and in what direction issues polarize. I framed the study primarily around investigating the first puzzle, proposing a theory that explains issue polarization as a function of legislators following donor opinion on issues. In my theory, on new issues with low salience and low polarization among the mass public, elected officials are free to

diverge from the median position. Elected officials, aware of these conditions, act in line with a polarized distribution of donors. I chose to study the health care reform debate and the ACA because I believed it was a model issue. After not having been salient for several years, health care reform became one of the most prominent issues in the American political environment. The debate also engendered the Tea Party, a group whose purpose was a complete shutdown of the Obama administration and the ACA along with it.

While I uncovered multiple interesting dynamics, I did not find strong support for my theory. I found that opinion on the ACA was polarized from the beginning of the study, with Democrat and Republican non-donors and donors neatly sorted into supporting or opposing the ACA, respectively. This dynamic held steady throughout the study. I also found that Democrat and Republican elites were polarized from the beginning of the debate, with minimal overlap in positions. Finally, I found from the survey data that at the beginning of the debate, donors appeared to be more polarized than non-donors. Additionally, non-donors became more polarized as the debate progressed. This was the strongest support for my theory from my analysis. In fact, these findings suggest that my theory may be somewhat accurate, because crystallized voter preferences may have prevented appealing to donors on the ACA. However, we must still consider partisanship to be a primary explainer of vote choice, and we need to test more issues to assess the theory further.

I addressed the following health care-specific hypotheses:

H_1: The more (less) polarized voter opinion is on health care reform, the less (more) representatives will be responsive to donor opinion.

H_2: The more donors in a representative's district support (oppose) health care reform, the more representatives will vote to support (oppose) health care reform in Congress.

H_3: As the health care reform debate progresses, voter opinion will polarize based on partisanship.

Concerning H_1, I do not find that representatives became less responsive to donor opinion as voters became more polarized. I do not find evidence that representative positioning was positively correlated with donor opinion (H_2). I find weak evidence supporting H_3 (Appendix B) but I do not conduct enough statistical testing to make a strong conclusion. Overall, the results from the regressions do not support my conjecture that donor opinion influences elite positioning. The most significant result was from my year-by-year models, which showed that a representative's party was a strong predictor of ACA vote choice. A representative being a Republican significantly decreased the likelihood of that representative voting to support the ACA.

This result, in conjunction with the results from the two-way fixed effects models, suggests that party and other representative-level characteristics may be the strongest predictors of vote choice. Furthermore, donor influence may manifest in candidate selection and not directly on representative vote choice. While I did not find evidence supporting my hypotheses, I do find evidence that the ACA was an incredibly polarizing issue. Table 8 and Figures 8 and 9, along with the rest of the figures in Appendix B, show that the ACA debate played out on partisan lines. My analysis also revealed that only thirty-seven distinct representatives changed their ACA vote from 2008 to 2016. Simply put, the ACA was a very polarizing issue, and strong dynamics preventing deviation may have been at play.

I identify two such possible dynamics. Representatives may have been locked into positions based on voter polarization or by party association in Congress. While there is secondary evidence that the public was receptive to elite cues on health care reform, and that the

public developed well-formed opinions on health care reform, this does not prove that voter opinion prevented representatives from deviating away from the party line. My analysis and secondary analyses indicate that party was predictive of ACA support among elites. Further work concerning these dynamics that incorporates an understanding of the Tea Party would be useful.

The Tea Party led the way in attempting to repeal the ACA, and the public must have been aware of this fight. Did the Tea Party movement, in leading resistance to the ACA, engender disapproval among the public? Or did the Tea Party arise out of this disapproval? Secondary analysis suggests that the public was already quite polarized on the issue, which my analysis agrees with. However, there should be further attempts at uncovering the direction of causality. While my study did not indicate that elite support for the ACA was responsive to donor opinion, it did confirm the polarization dynamic that other scholars have observed. Issue polarization was present but did not occur due to donor opinion. My work has thus contributed by confirming this result and validating previous scholars' findings that donors are more polarized than the general voting population.

The ACA was a highly partisan issue from the beginning and this dynamic shaped how the debate progressed. This indicates that a different issue would better test my theory. Perhaps health care reform was too salient? There were limitations with my study, namely, that I was not able to conduct quantitative analysis beginning in 2006 and that votes were not linked with survey years. Many representatives were locked into their positions for the entirety of the debate. Variation in ACA vote choice was mostly among Democrat representatives, so an issue that includes variation across the political aisle is necessary to further evaluate my theory. Finally, a major limitation was my definition of donors. Future studies should incorporate those donors who hold more sway with politicians and verify contributions from donor to politician. Although

I do not find evidence supporting my theory, this thesis provides a resource for continuing to study issue polarization and issue positioning among elites. As I have described, there are many promising routes for future research.

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Appendices

Appendix A: Tables of Descriptive Statistics for Primary and Control Variables

Primary variables

Table 10: Primary variable descriptive statistics for 2008

Variable	N	Mean	Std. Dev.	Min	Pctl. 25	Pctl. 50	Pctl. 75	Max
HC_support	435	0.481	0.104	0.2	0.41	0.475	0.545	0.84
HC_support_nodonor	435	0.597	0.13	0.263	0.507	0.595	0.676	1
HC_copartisan_nondonor_support	382	0.6	0.319	0	0.289	0.698	0.891	1
HC_copartisan_donor_support	382	0.6	0.438	0	0.103	0.9	1	1

Table 11: Primary variable descriptive statistics for 2010

Variable	N	Mean	Std. Dev.	Min	Pctl. 25	Pctl. 50	Pctl. 75	Max
HC_support	433	0.534	0.117	0.265	0.452	0.524	0.609	0.924
HC_support_nodonor	433	0.547	0.128	0.262	0.454	0.542	0.63	0.96
HC_copartisan_nondonor_support	433	0.566	0.345	0	0.187	0.732	0.876	1
HC_copartisan_donor_support	433	0.57	0.454	0	0	0.868	1	1

Table 12: Primary variable descriptive statistics for 2012

Variable	N	Mean	Std. Dev.	Min	Pctl. 25	Pctl. 50	Pctl. 75	Max
HC_support	431	0.587	0.119	0.302	0.504	0.577	0.67	0.979
HC_support_nodonor	431	0.567	0.135	0.17	0.481	0.56	0.649	0.968
HC_copartisan_nondonor_support	431	0.502	0.334	0.021	0.193	0.378	0.849	1
HC_copartisan_donor_support	431	0.475	0.441	0	0.048	0.237	0.987	1

Table 13: Primary variable descriptive statistics for 2014

Variable	N	Mean	Std. Dev.	Min	Pctl. 25	Pctl. 50	Pctl. 75	Max
HC_support	432	0.454	0.134	0.168	0.357	0.432	0.533	0.888
HC_support_nodonor	432	0.432	0.143	0.145	0.328	0.416	0.529	0.867
HC_copartisan_nondonor_support	432	0.411	0.361	0	0.063	0.23	0.8	0.985
HC_copartisan_donor_support	432	0.454	0.454	0	0	0.203	0.986	1

Table 14: Primary variable descriptive statistics for 2016

Variable	N	Mean	Std. Dev.	Min	Pctl. 25	Pctl. 50	Pctl. 75	Max
HC_support	432	0.429	0.107	0.135	0.35	0.414	0.497	0.753
HC_support_nodonor	432	0.401	0.118	0.14	0.31	0.387	0.478	0.752
HC_copartisan_nondonor_support	432	0.359	0.3	0	0.092	0.194	0.68	0.894
HC_copartisan_donor_support	432	0.41	0.427	0	0	0.156	0.893	1

Control variables

Table 15: Control variable descriptive statistics for 2008

Variable	N	Mean	Std. Dev.	Min	Pctl. 25	Pctl. 50	Pctl. 75	Max
Percentage below poverty line	435	13.404	5.412	3.2	9.7	12.6	16.25	39.9
Per capita income	435	27841.271	7830.499	12008	22807.5	26210	31260	77730
Mean social security earnings	435	15122.816	1338.352	9950	14357.5	15134	15994	18998
Percentage with bachelor's degree	435	27.429	9.71	7.1	20.15	25.6	32.95	65.7
Percentage without health insurance	435	14.469	6.03	3.2	10	13.6	17.95	40.4

Table 16: Control variable descriptive statistics for 2010

Variable	N	Mean	Std. Dev.	Min	Pctl. 25	Pctl. 50	Pctl. 75	Max
Percentage below poverty line	433	15.459	5.747	4.4	11.7	14.9	18.7	38.9
Per capita income	433	26030.628	6993.059	11992	21649	24726	29205	66242
Mean social security earnings	433	16126.284	1432.217	10695	15315	16223	17035	20302
Percentage with bachelor's degree	433	27.907	9.712	7.1	20.9	26	33.6	64.1
Percentage without health insurance	433	15.429	6.03	3.6	11	14.8	18.6	41.1

Table 17: Control variable descriptive statistics for 2012

Variable	N	Mean	Std. Dev.	Min	Pctl. 25	Pctl. 50	Pctl. 75	Max
Percentage below poverty line	419	15.85	5.842	4.3	11.85	15	19.05	41
Per capita income	419	28627.15	7883.834	13539	23532.5	27073	32202.5	78424
Mean social security earnings	419	17683.84	1576.598	11973	16791	17841	18703.5	21711
Percentage with bachelor's degree	419	28.926	10.09	7.7	21.6	27.7	34.45	70.3
Percentage without health insurance	419	14.55	5.577	2.8	10.55	14.1	17.15	35.8

Table 18: Control variable descriptive statistics for 2014

Variable	N	Mean	Std. Dev.	Min	Pctl. 25	Pctl. 50	Pctl. 75	Max
Percentage below poverty line	432	15.537	5.707	4.2	11.575	14.65	18.825	41
Per capita income	432	29201.275	8215.821	13493	23893.25	27666.5	32700.25	79690
Mean social security earnings	432	18057.35	1645.574	11974	17165.75	18246	19029	22474
Percentage with bachelor's degree	432	29.678	10.341	7.1	22.275	28	35.125	71.8
Percentage without health insurance	432	11.661	4.875	2.7	8	11	14.2	33.1

Table 19: Control variable descriptive statistics for 2016

Variable	N	Mean	Std. Dev.	Min	Pctl. 25	Pctl. 50	Pctl. 75	Max
Percentage below poverty line	432	14.05	5.091	4.7	10.3	13.5	16.7	36
Per capita income	432	31056.35	8656.029	14846	25618.75	29301	34854	83122
Mean social security earnings	432	18562.104	1694.709	12080	17660.25	18691	19577.5	23443
Percentage with bachelor's degree	432	30.9	10.553	7.9	23.275	29.2	36.9	72.2
Percentage without health insurance	432	8.552	4.335	1.8	5.375	7.8	10.8	30.6

Appendix B: Additional Figures

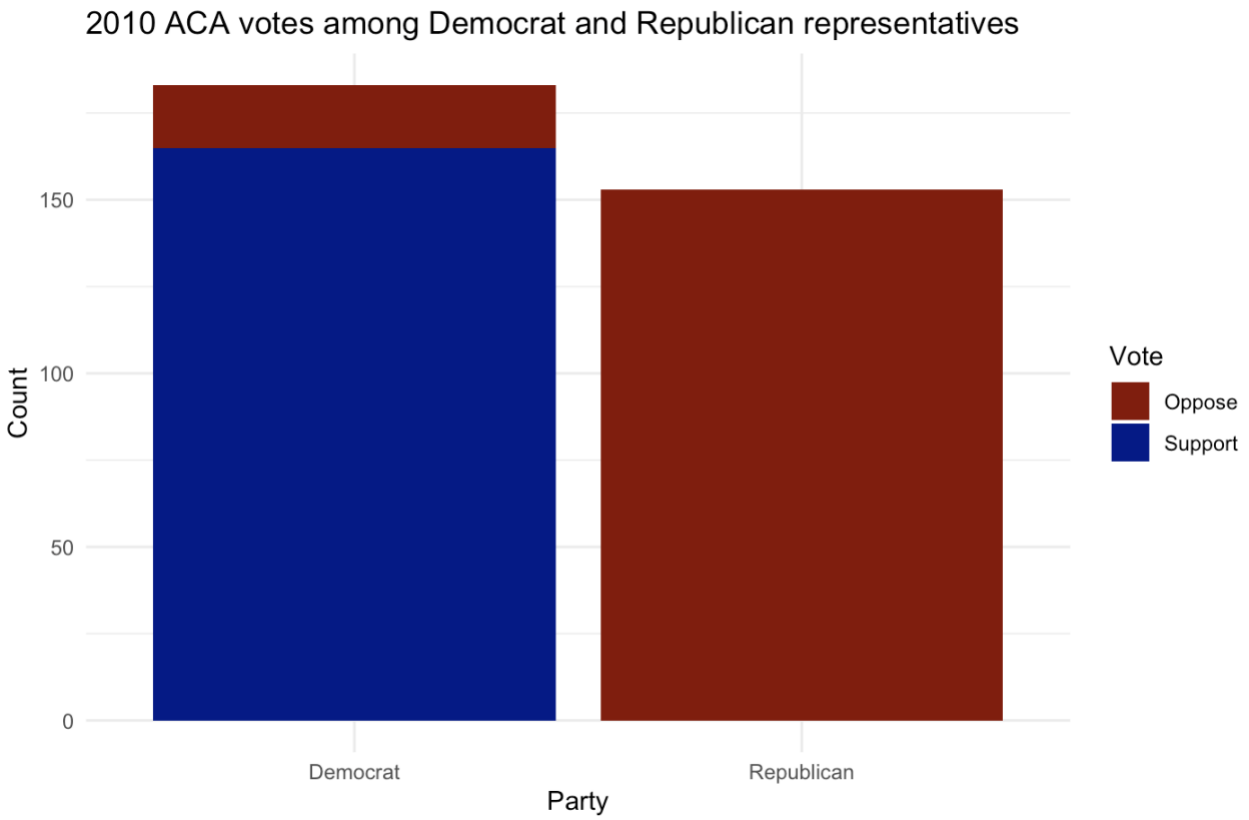

Figure 10: 2010 ACA congressional votes broken down by partisanship of district rep.

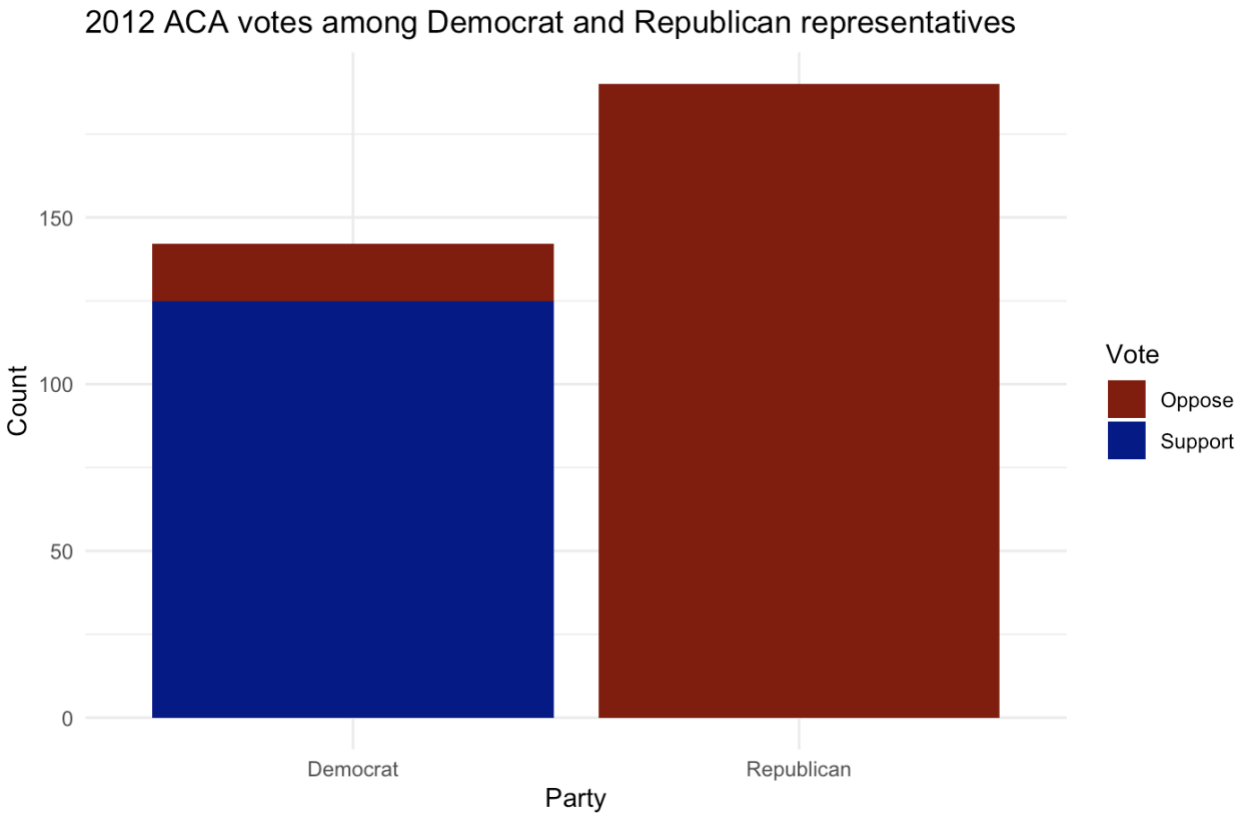

Figure 11: 2012 ACA congressional votes broken down by partisanship of district rep.

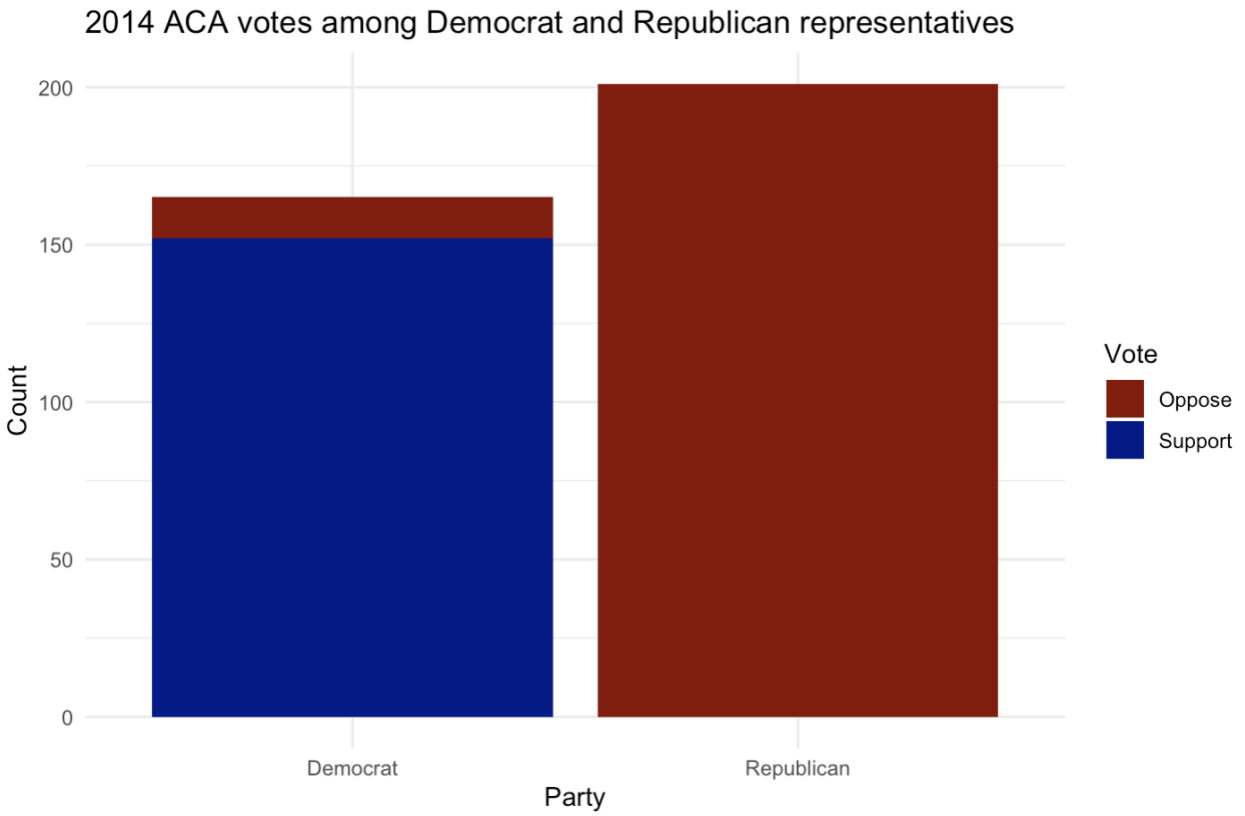

Figure 12: 2014 ACA congressional votes broken down by partisanship of district rep.

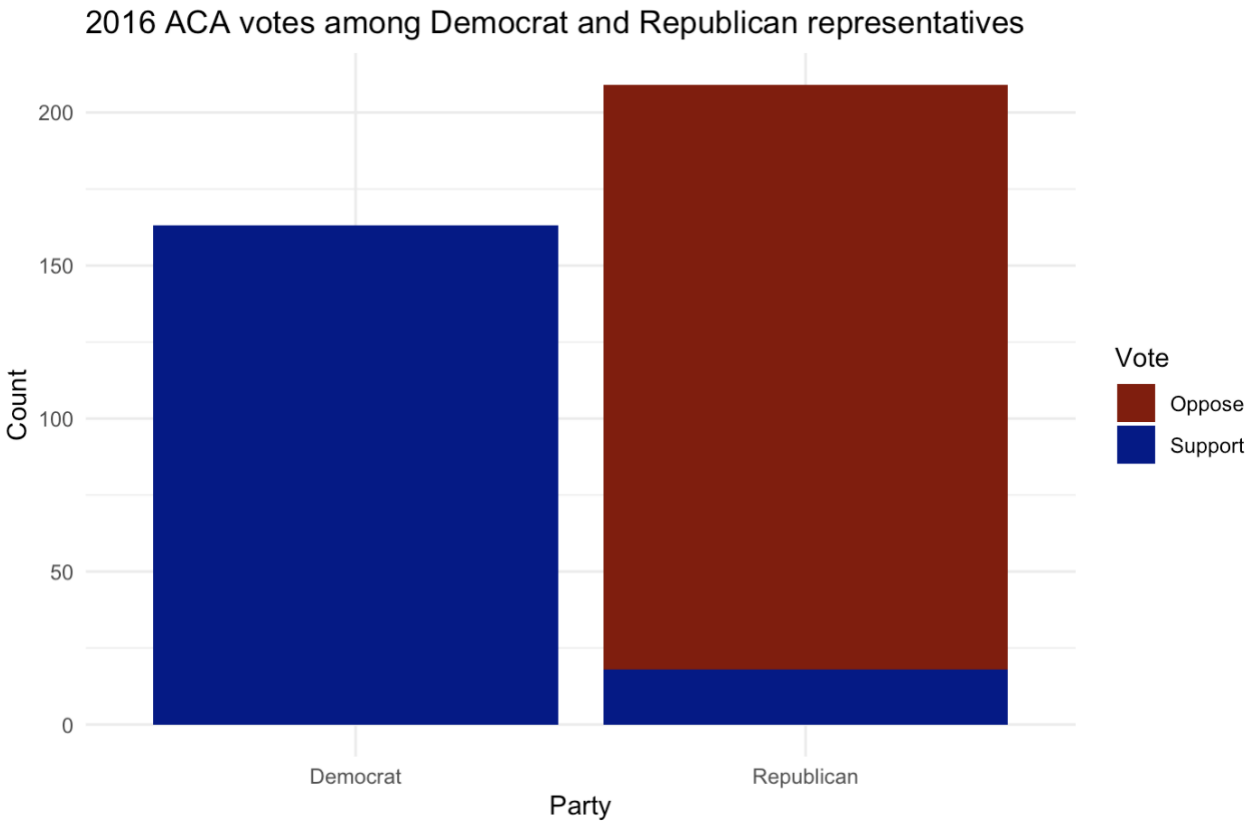

Figure 13: 2016 ACA congressional votes broken down by partisanship of district rep.

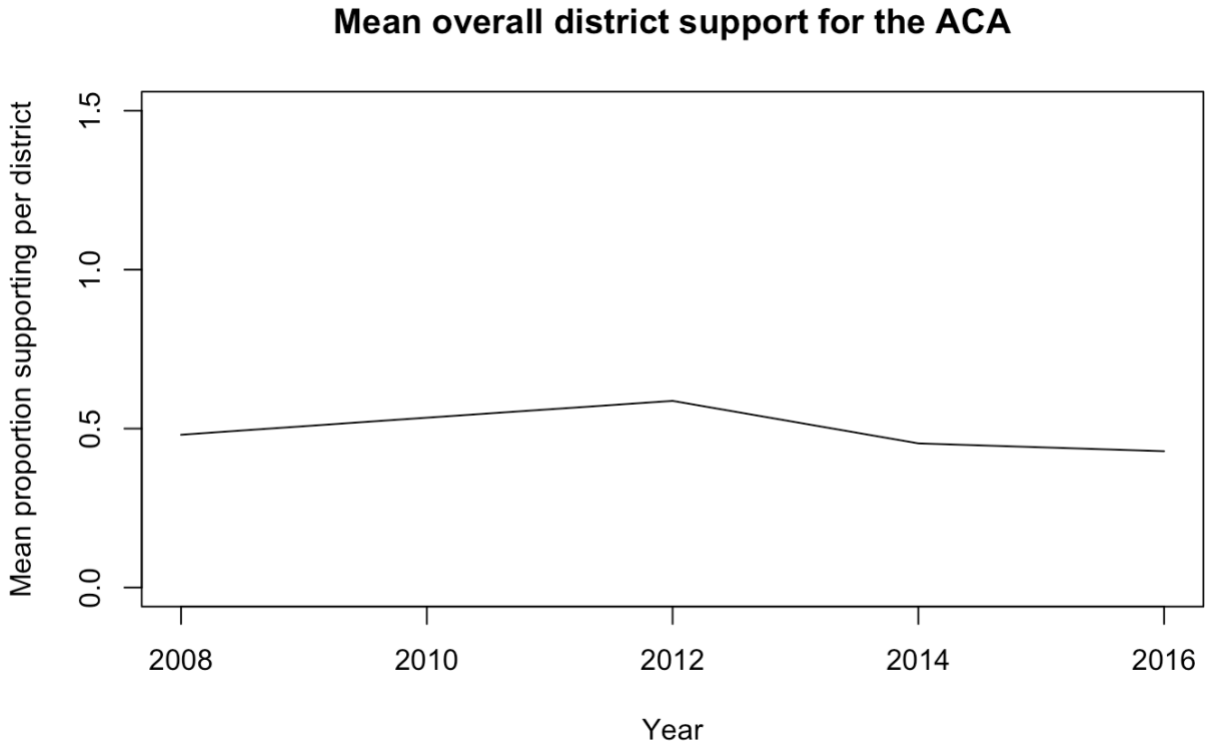

Figure 14: Mean overall district support for the ACA, 2008-2016

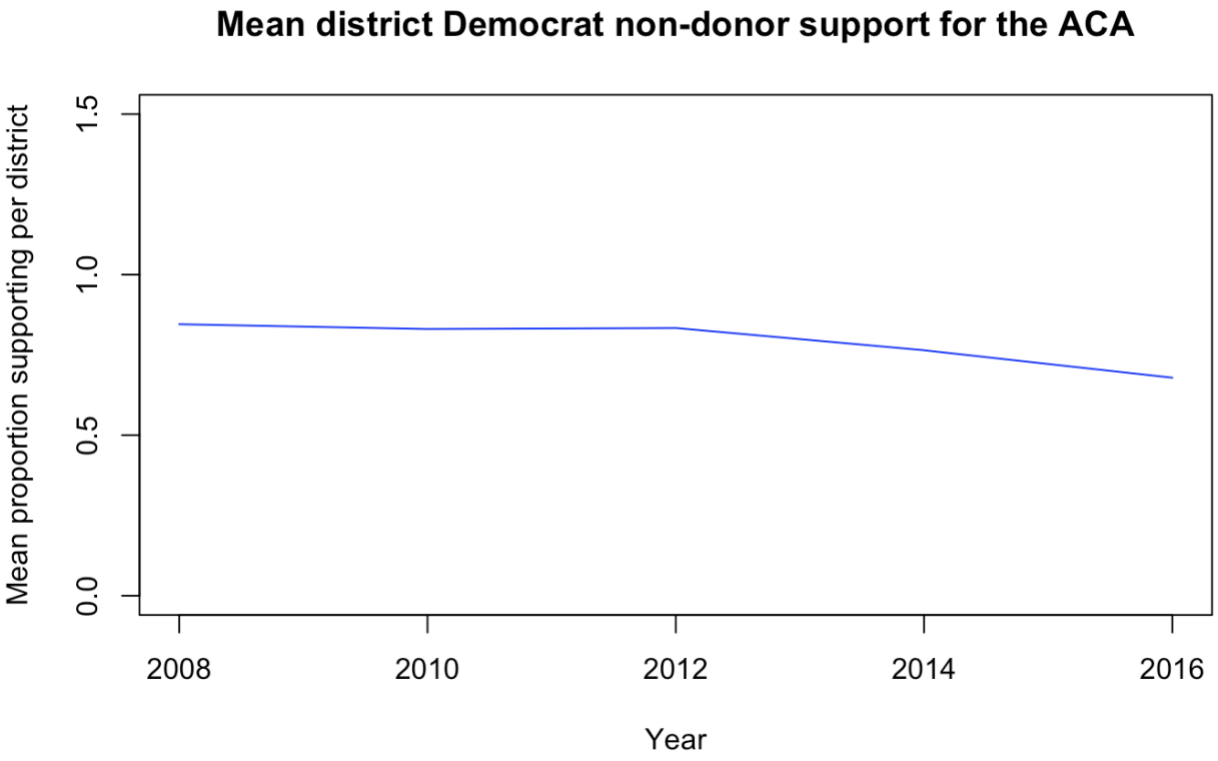

Figure 15: Mean district Democrat non-donor support for the ACA, 2008-2016

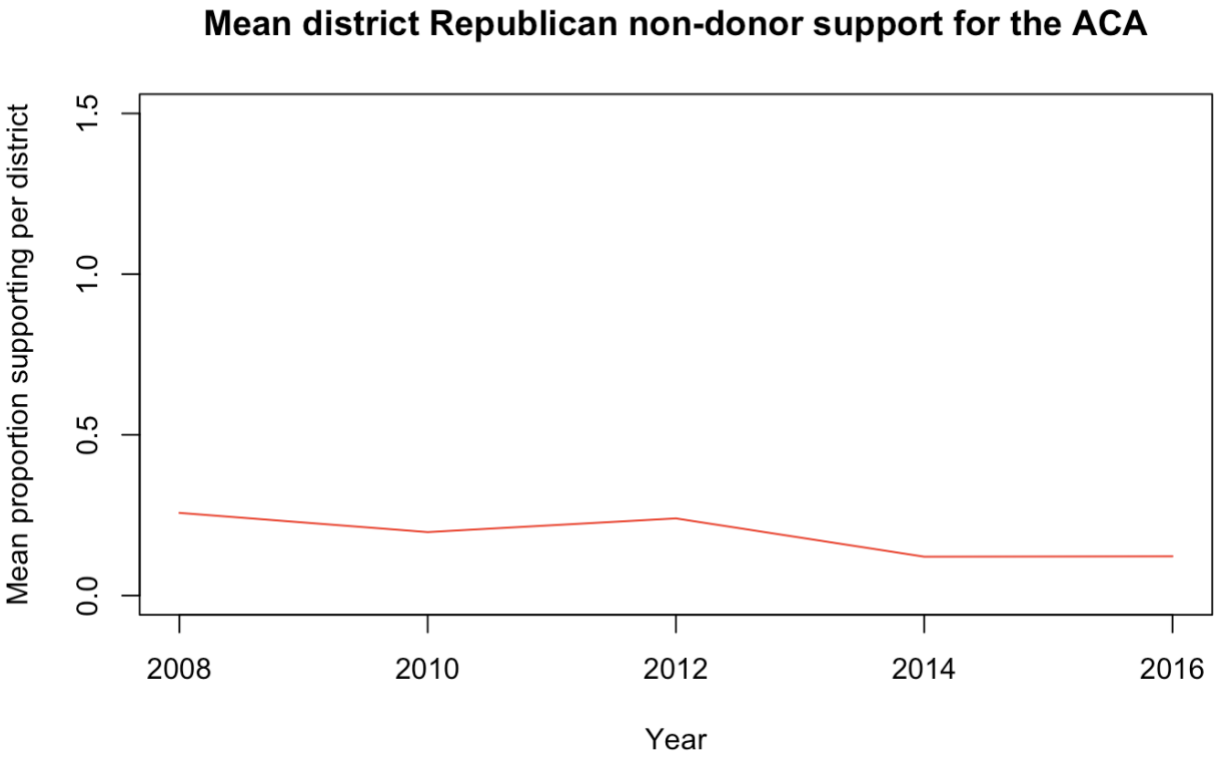

Figure 16: Mean district Republican non-donor support for the ACA, 2008-2016

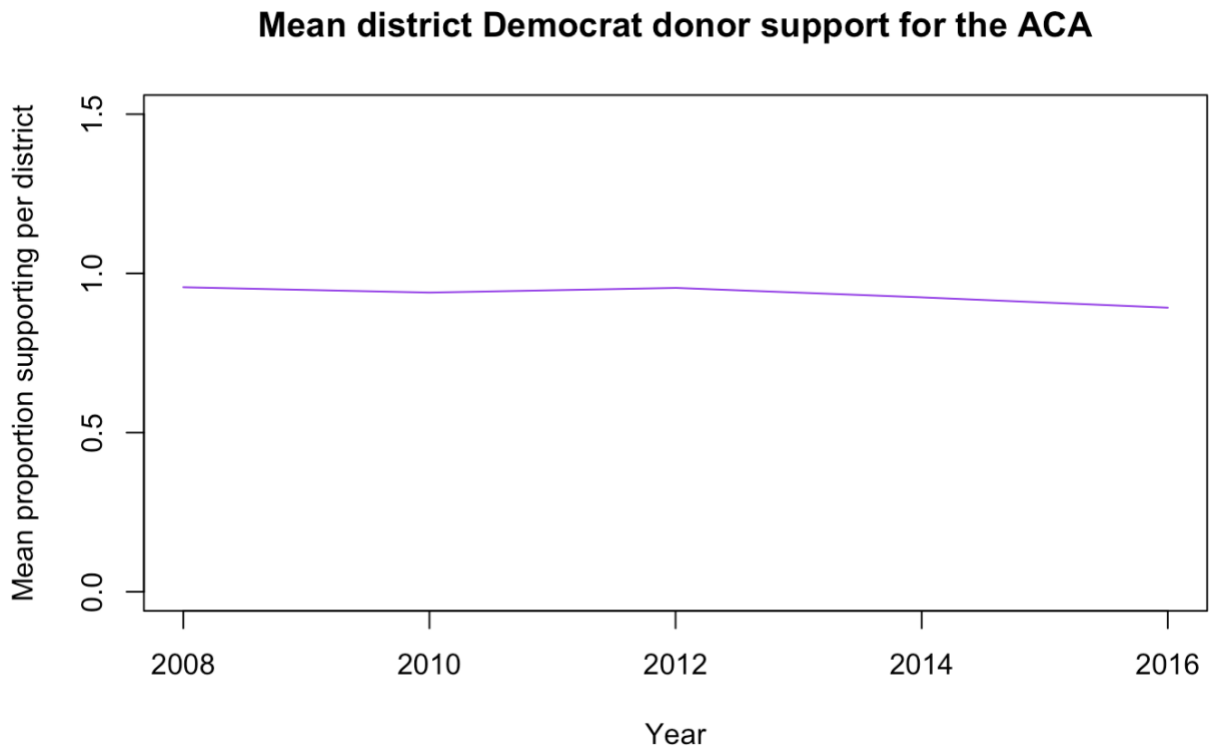

Figure 17: Mean district Democrat donor support for the ACA, 2008-2016

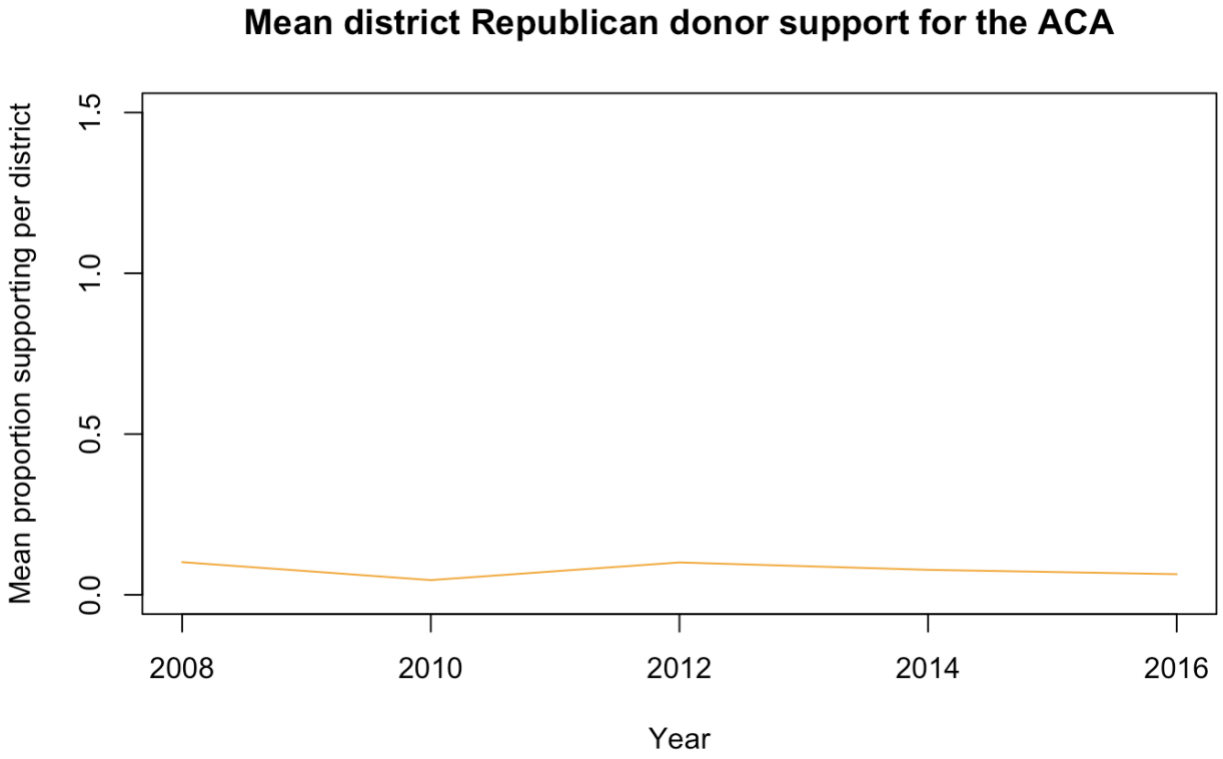

Figure 18: Mean district Republican donor support for the ACA, 2008-2016

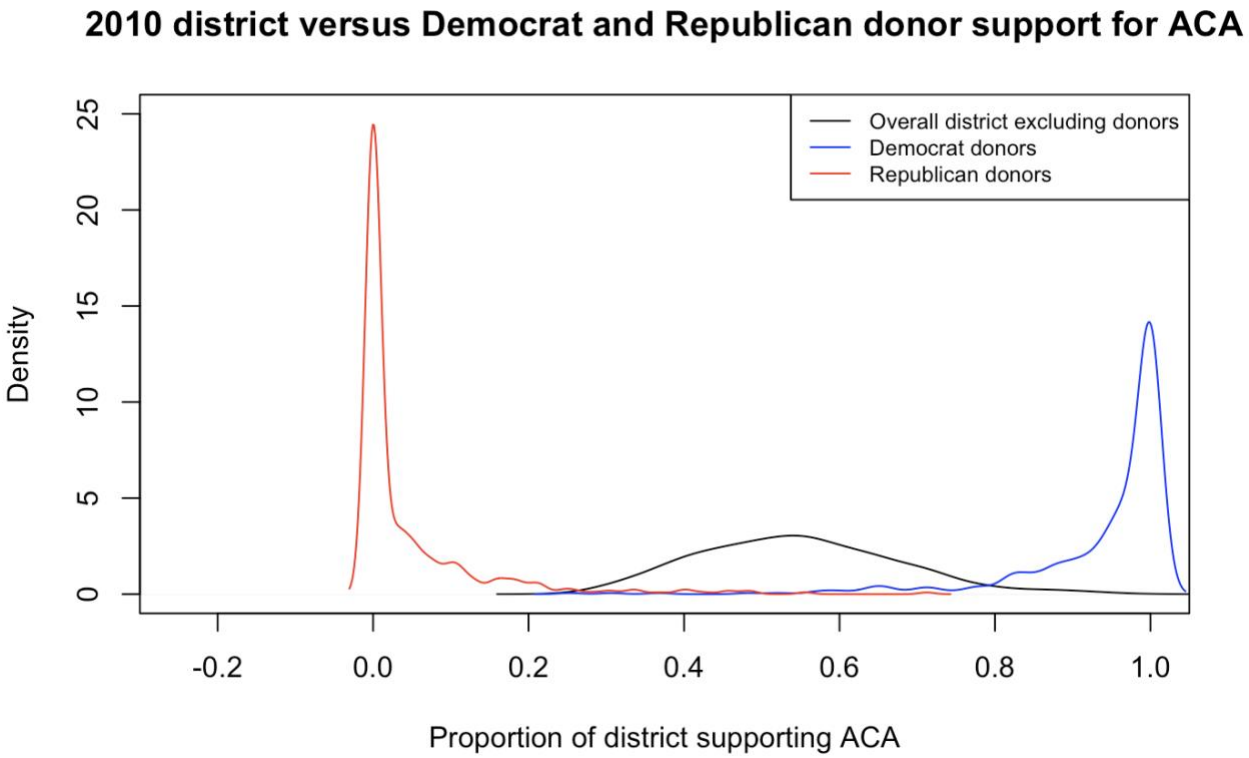

Figure 19: 2010 empirical distribution of district support among donors

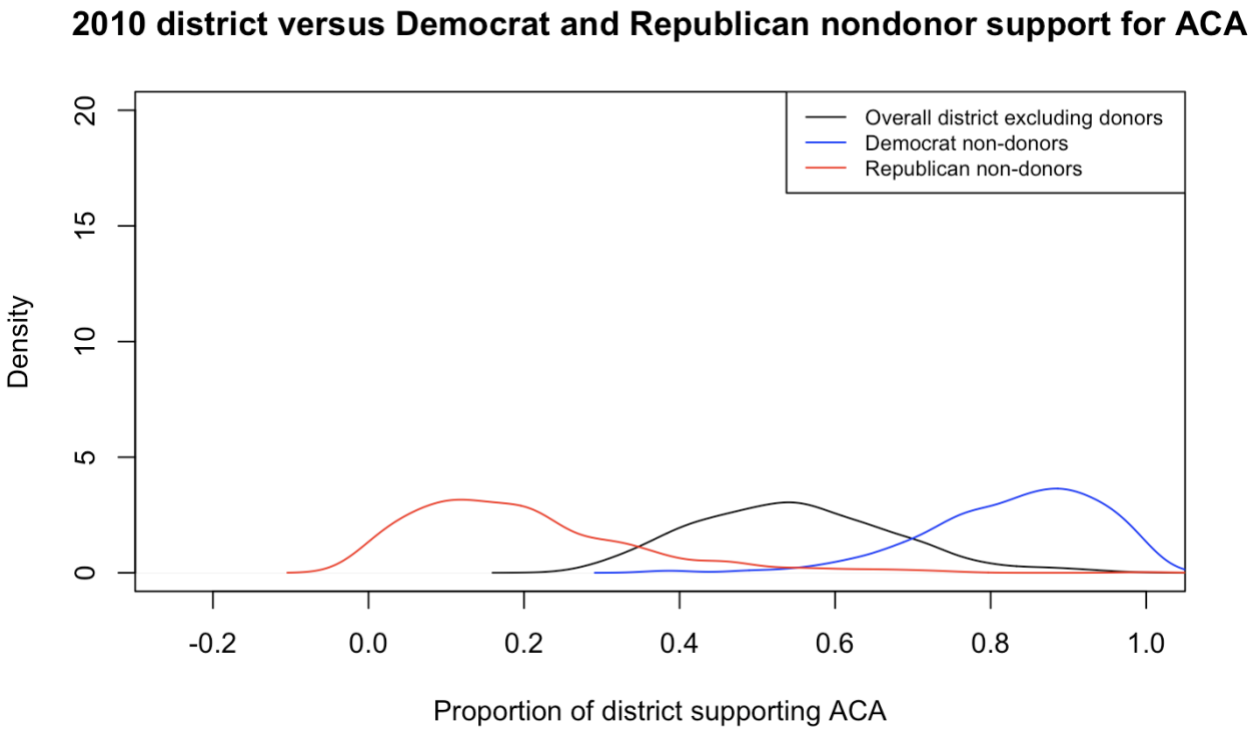

Figure 20: 2010 empirical distribution of district support among non-donors

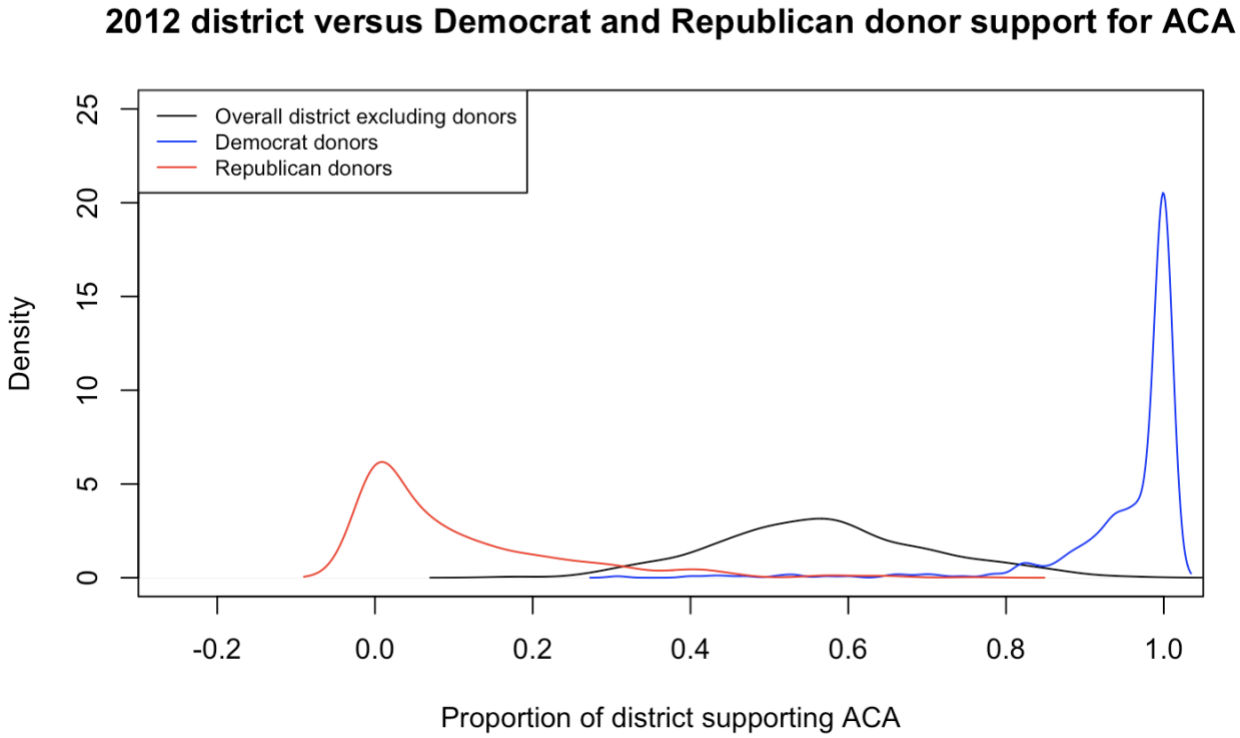

Figure 21: 2012 empirical distribution of district support among donors

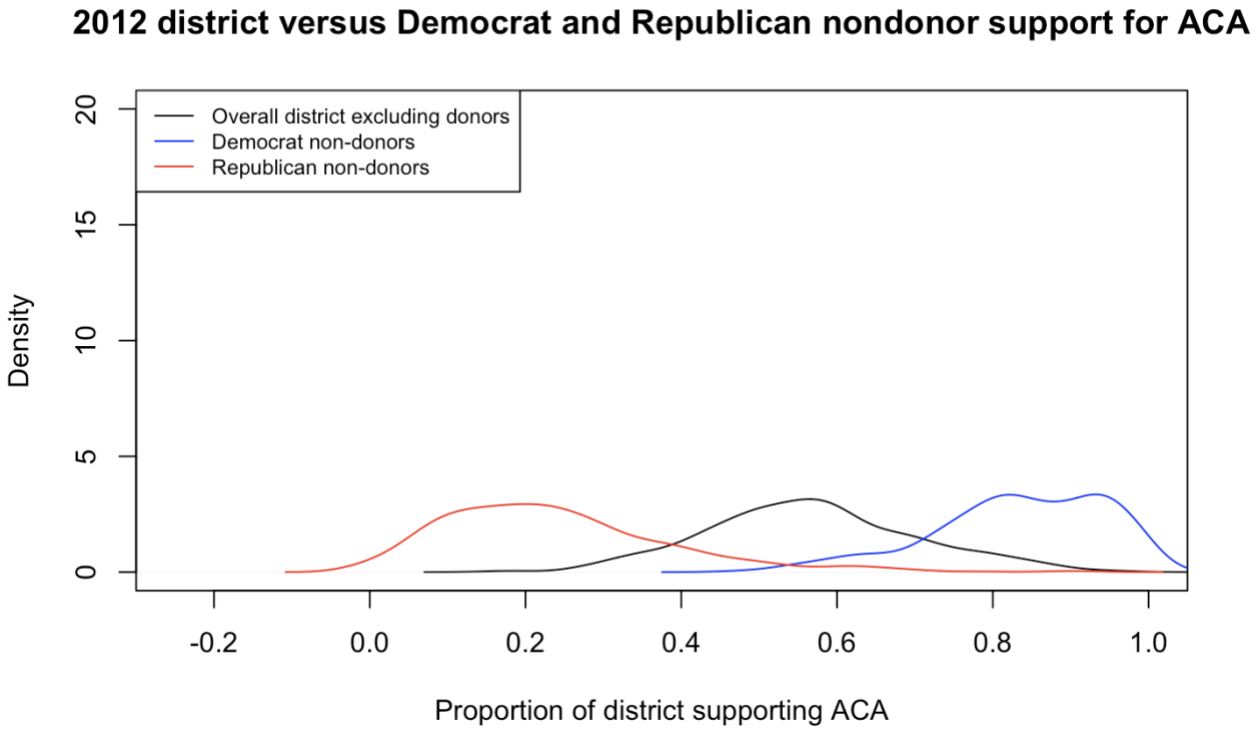

Figure 22: 2012 empirical distribution of district support among non-donors

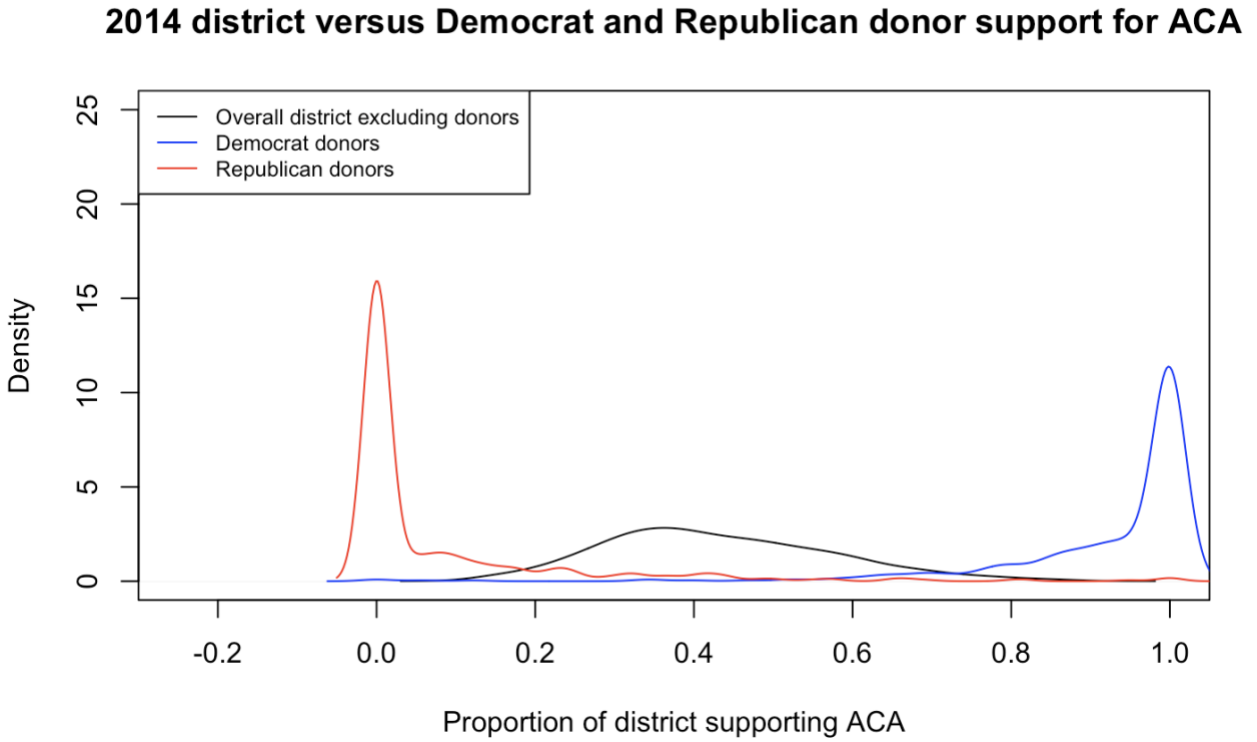

Figure 23: 2014 empirical distribution of district support among donors

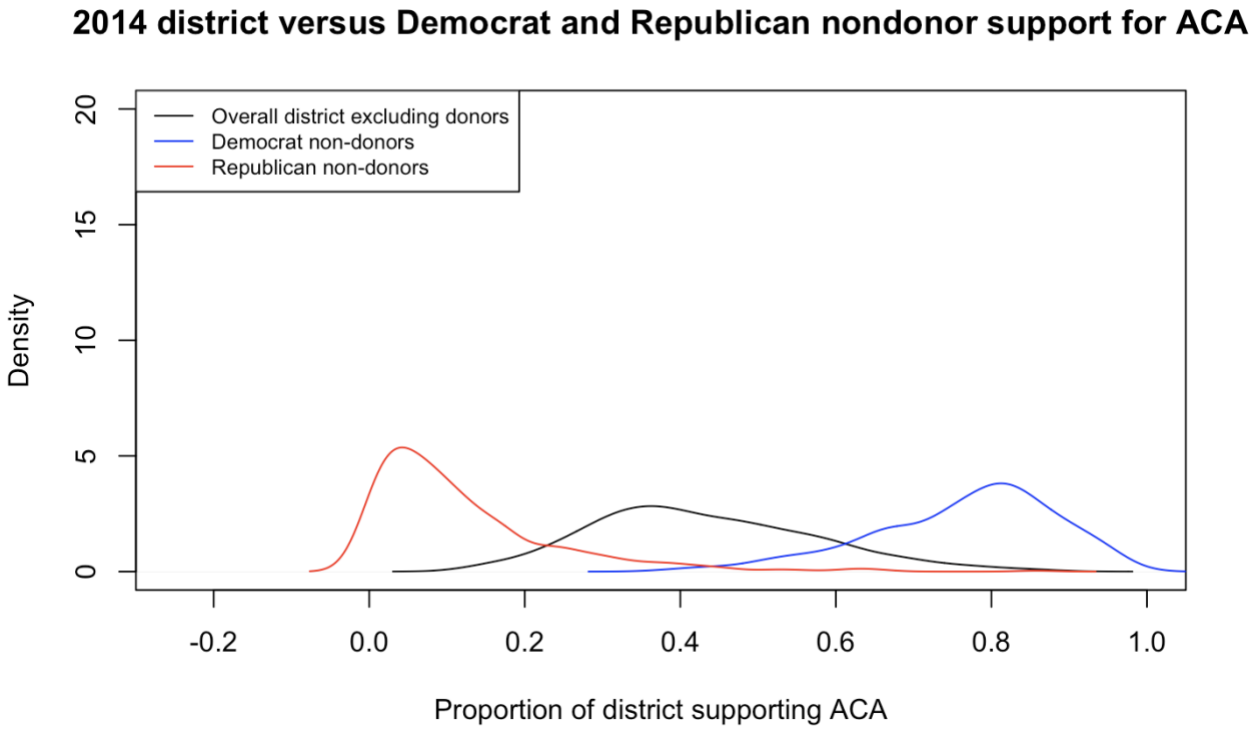

Figure 24: 2014 empirical distribution of district support among non-donors

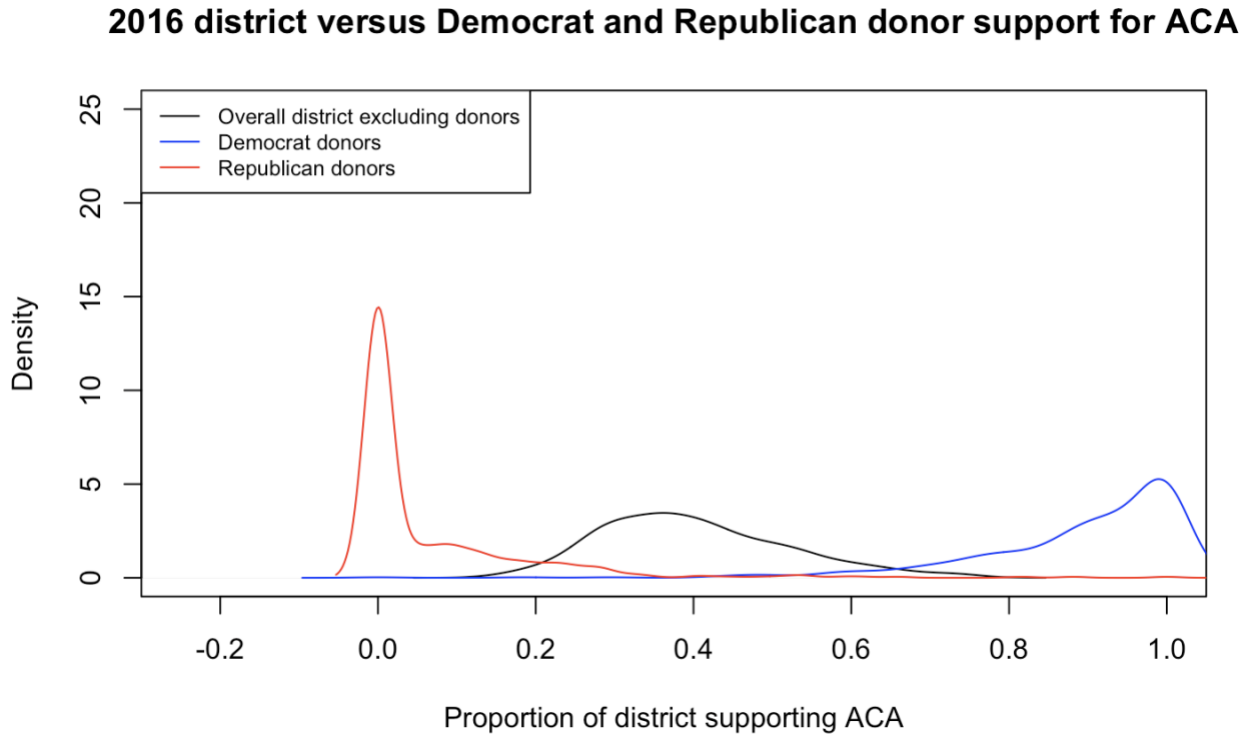

Figure 25: 2016 empirical distribution of district support among donors

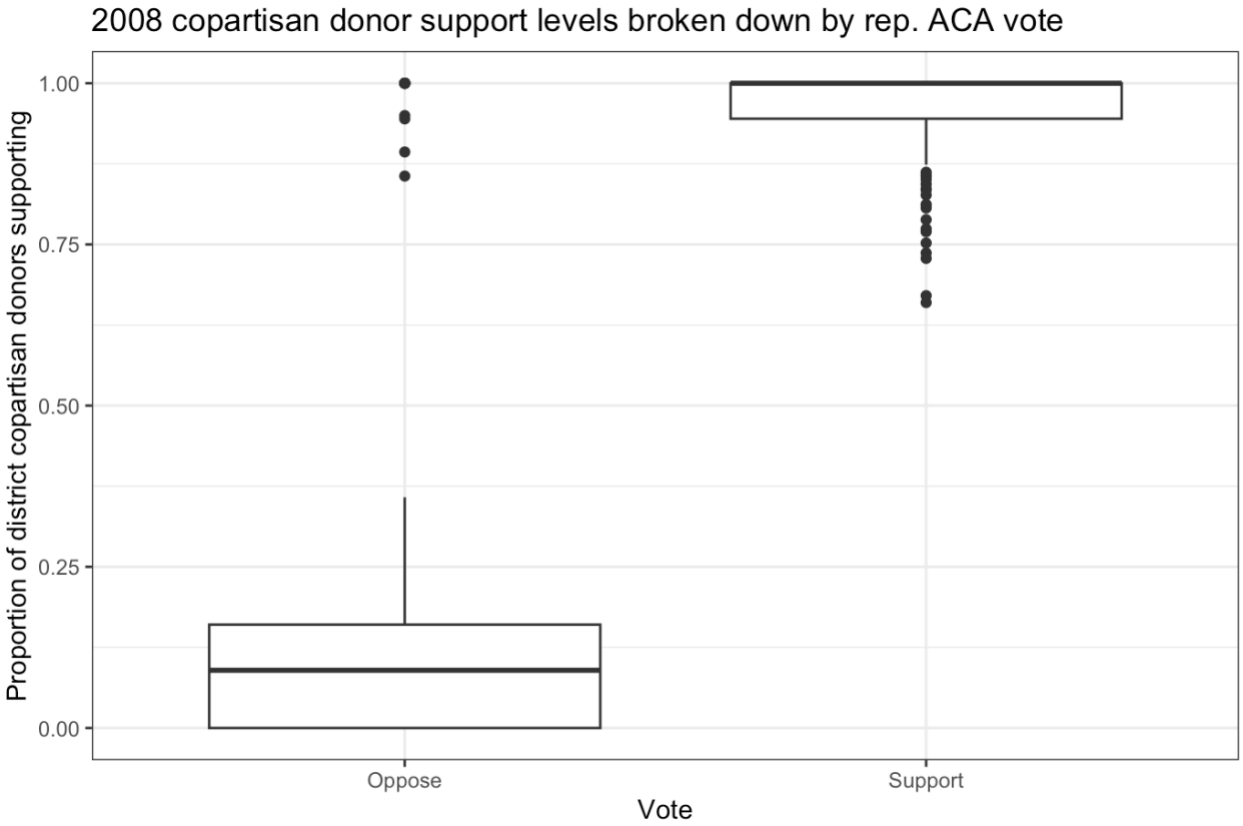

Figure 26: 2008 boxplot of co-partisan donor support by representative ACA vote

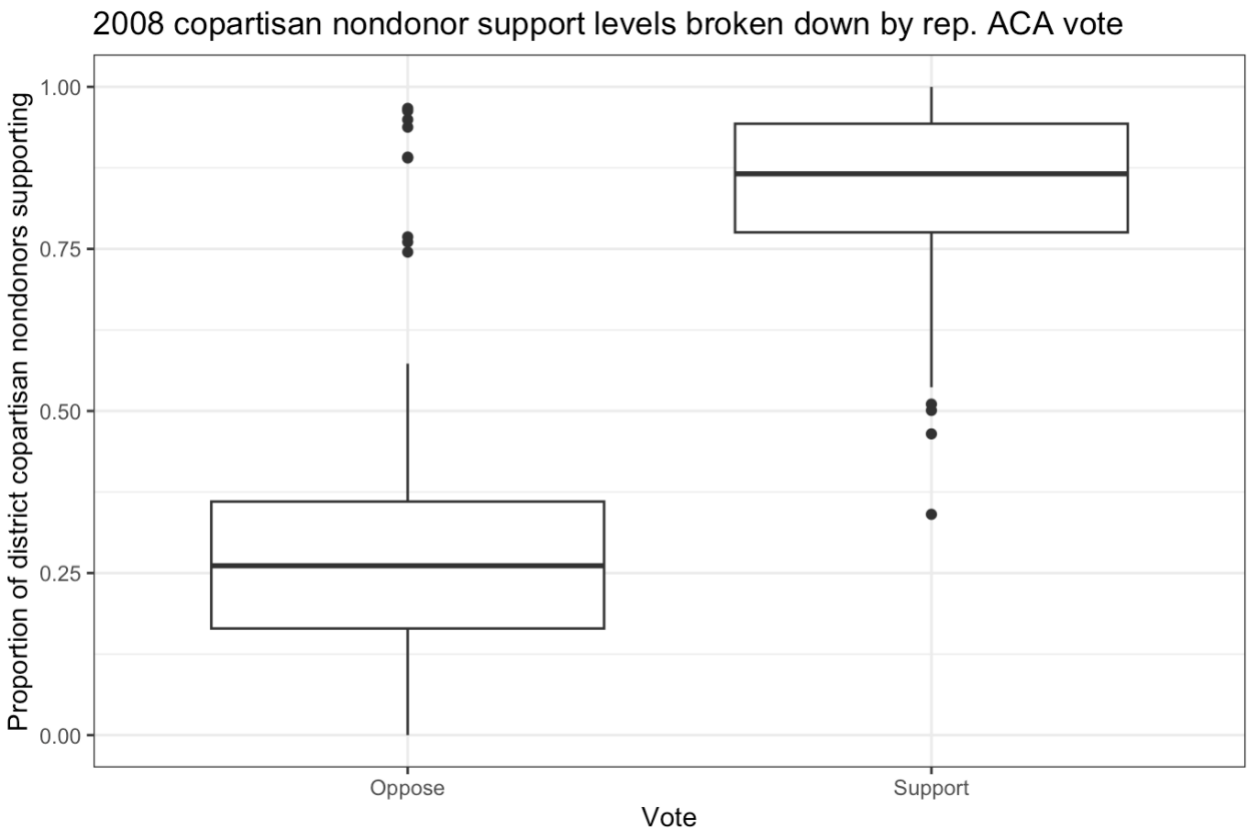

Figure 27: 2008 boxplot of co-partisan non-donor support by representative ACA vote

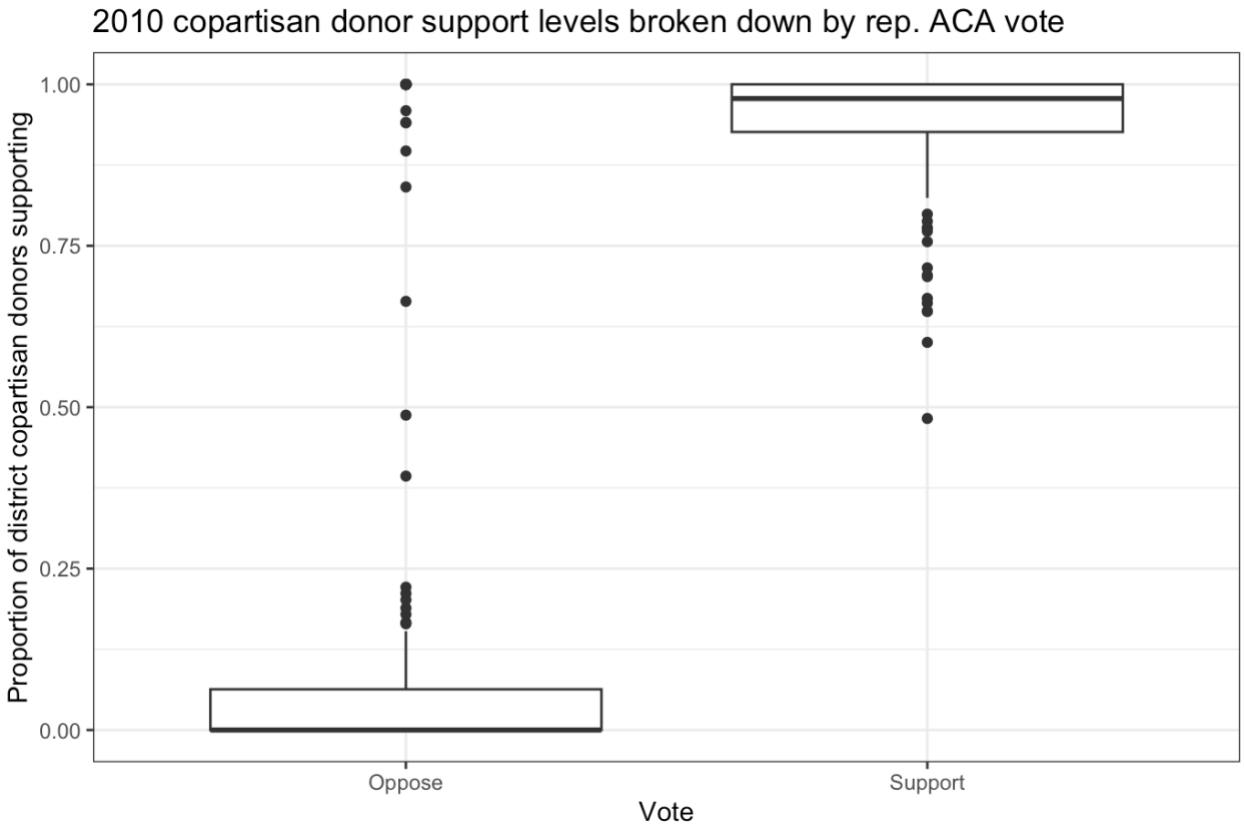

Figure 28: 2010 boxplot of co-partisan donor support by representative ACA vote

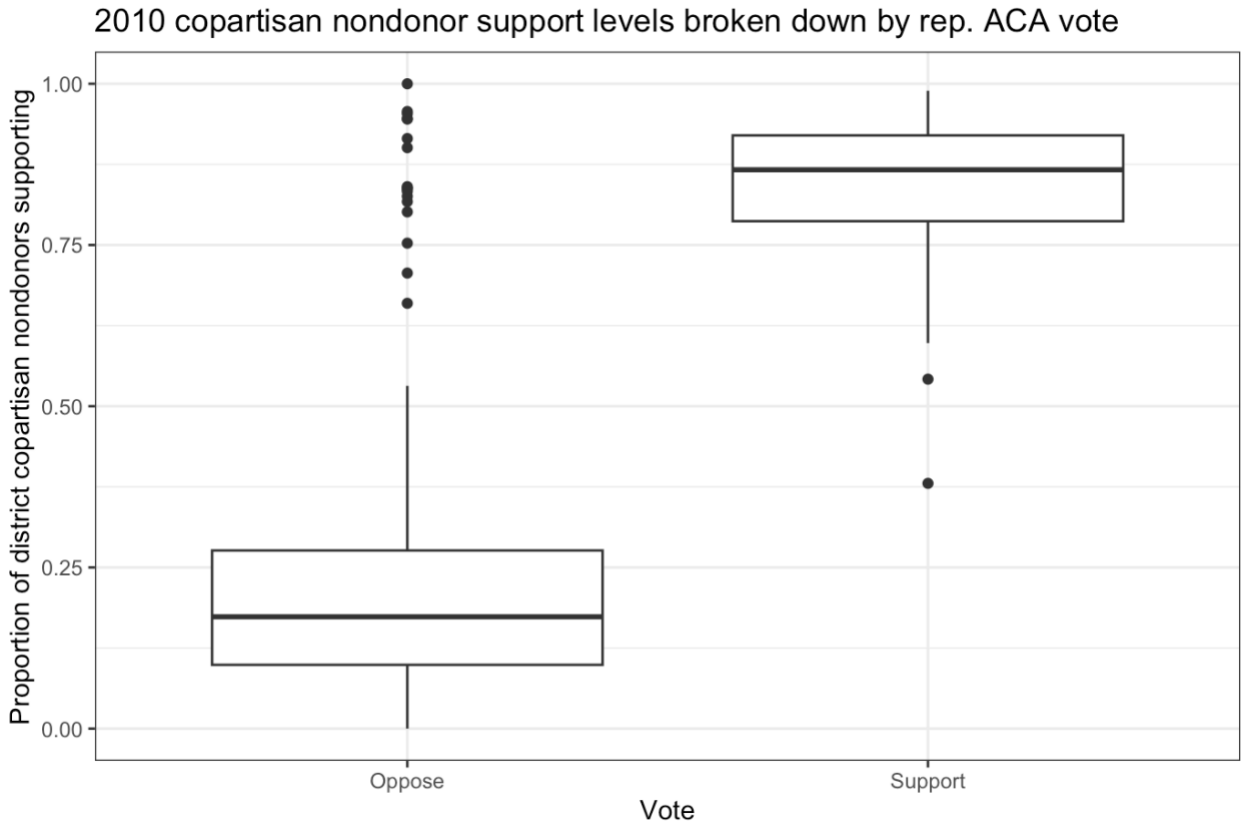

Figure 29: 2010 boxplot of co-partisan non-donor support by representative ACA vote

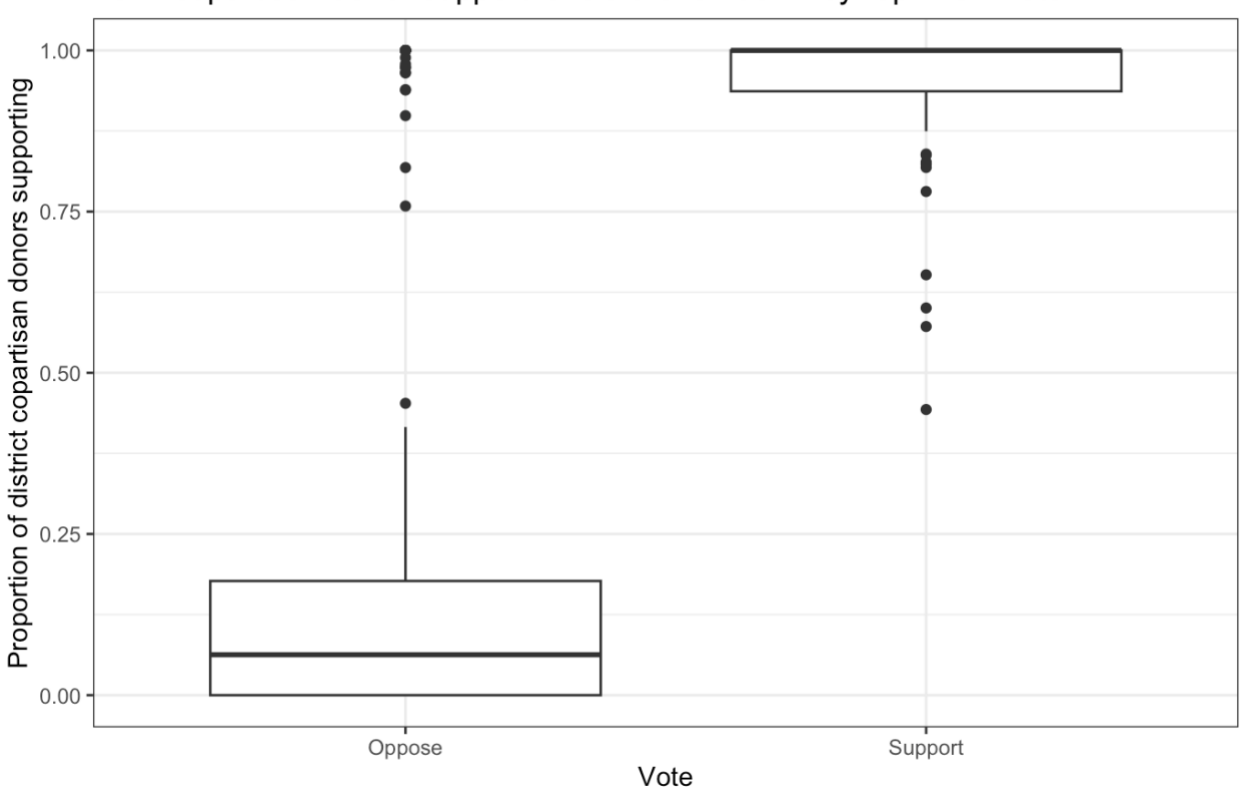

Figure 30: 2012 boxplot of co-partisan donor support by representative ACA vote

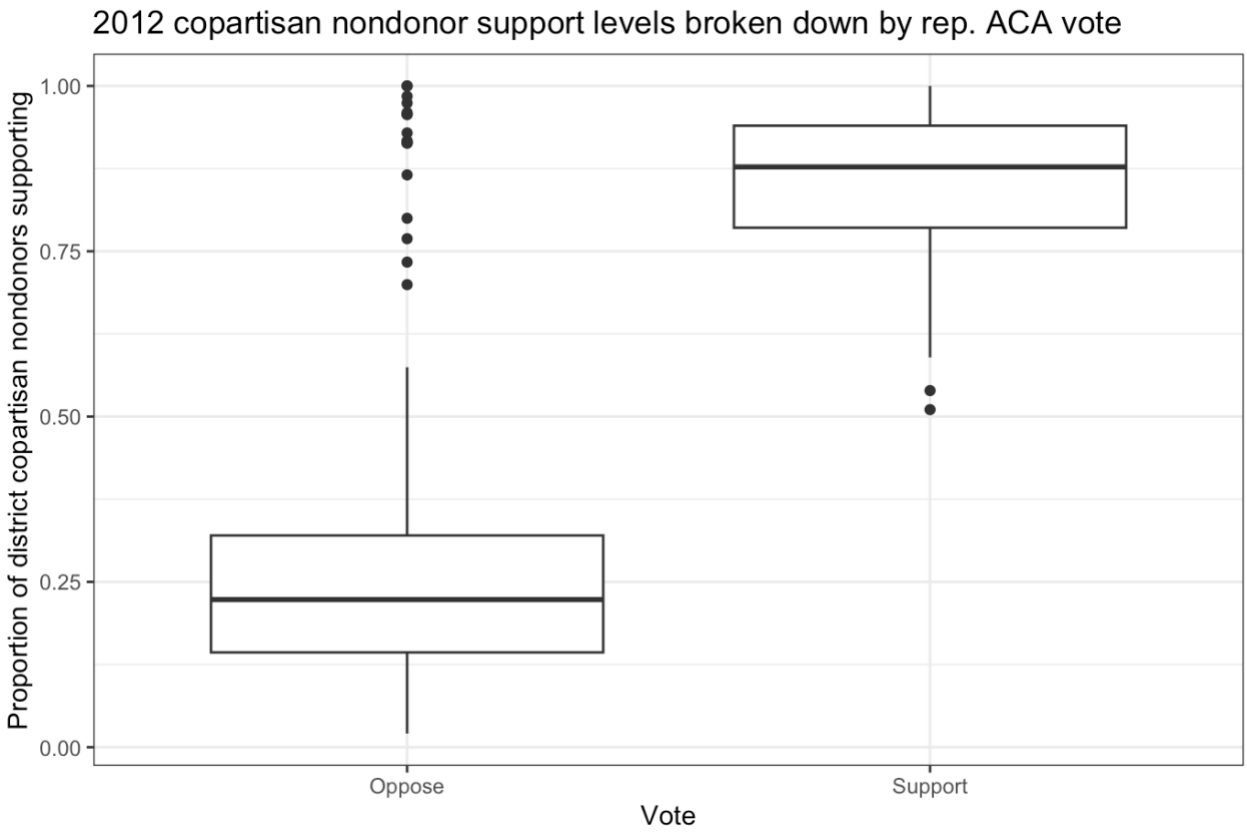

Figure 31: 2012 boxplot of co-partisan non-donor support by representative ACA vote

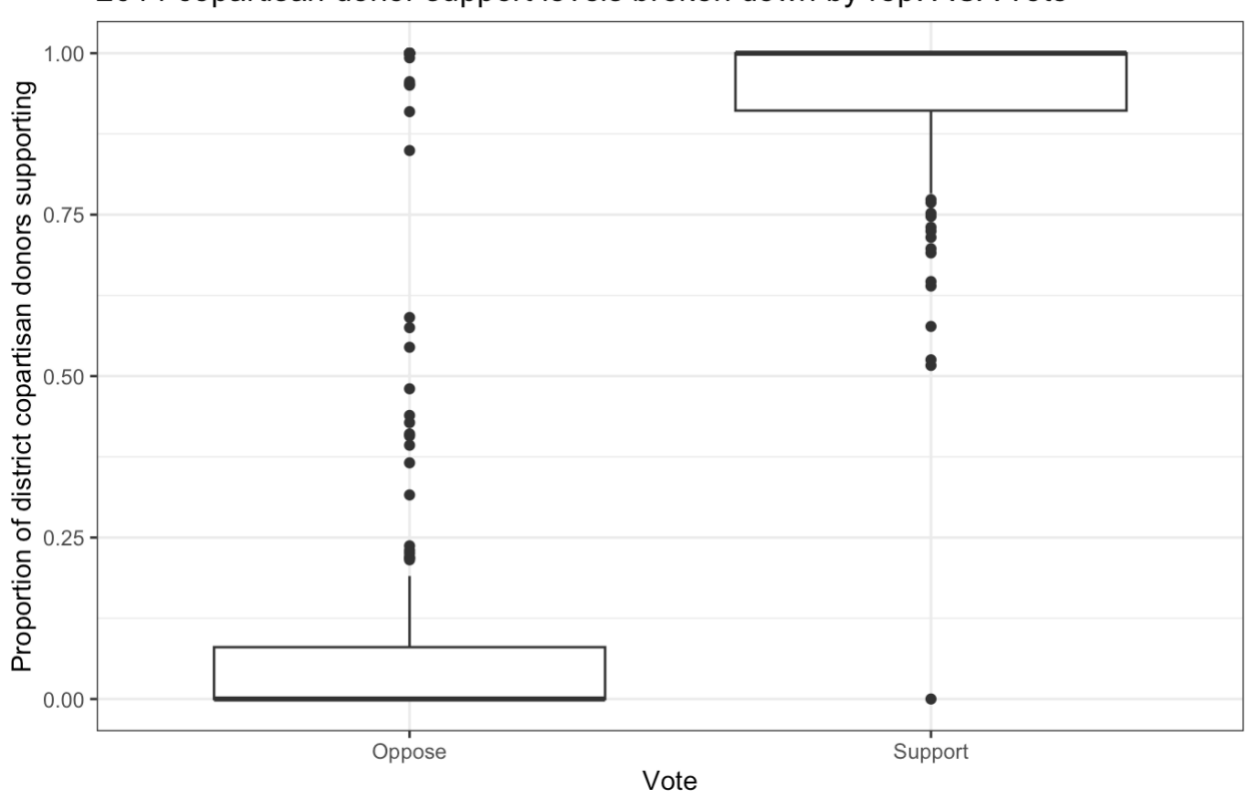

Figure 32: 2014 boxplot of co-partisan donor support by representative ACA vote

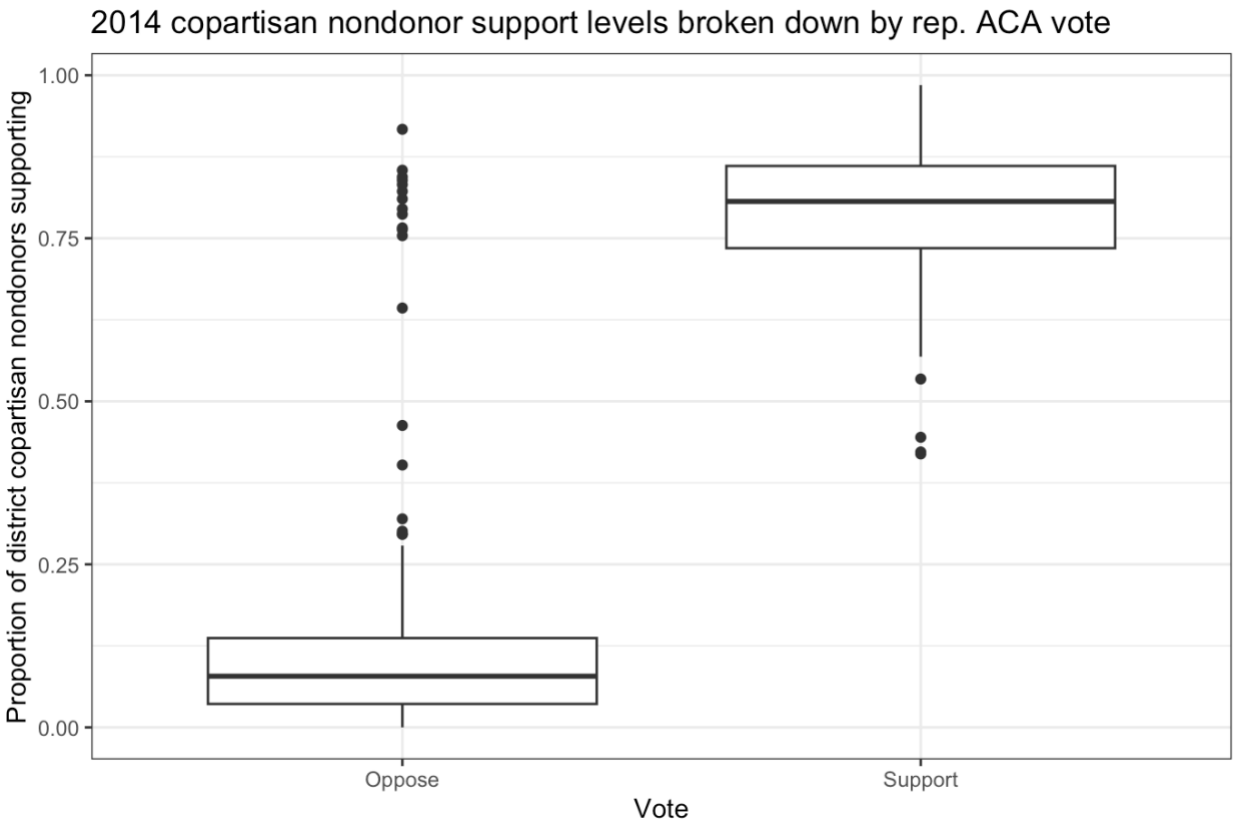

Figure 33: 2014 boxplot of co-partisan non-donor support by representative ACA vote

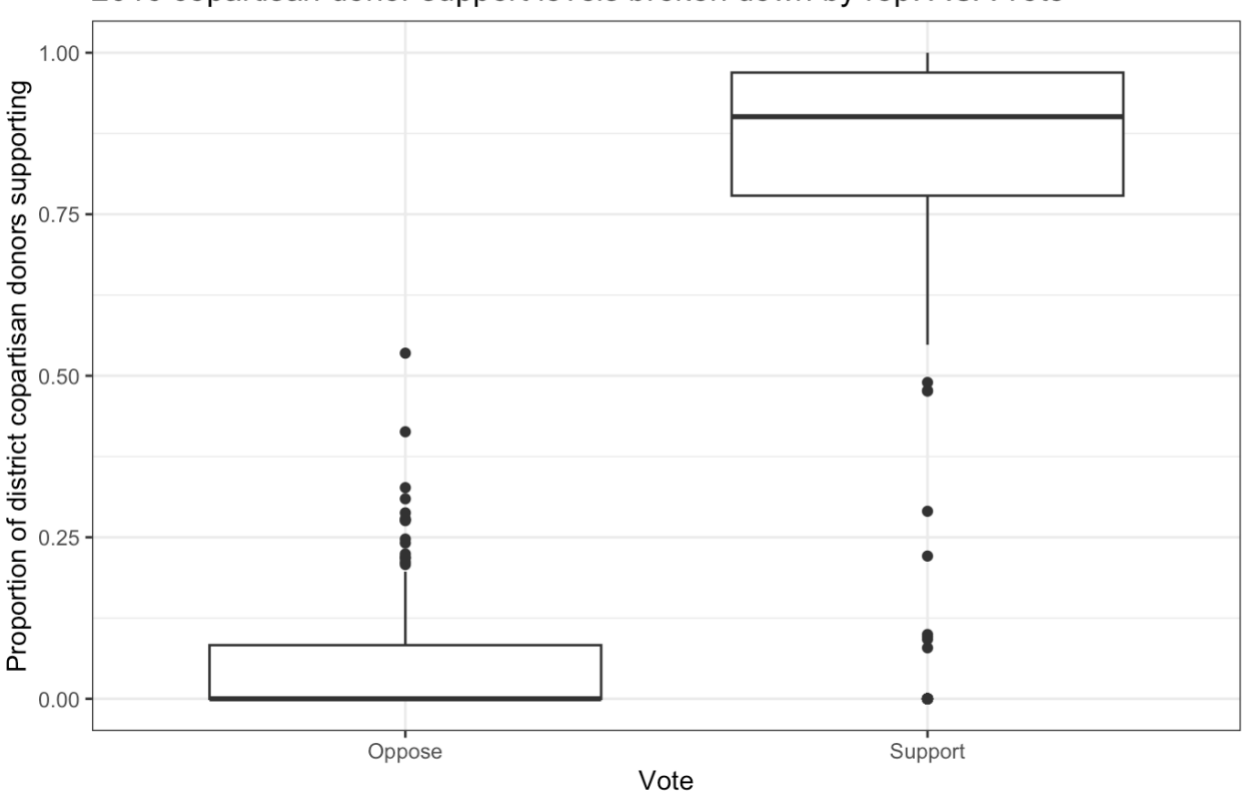

Figure 34: 2016 boxplot of co-partisan donor support by representative ACA vote

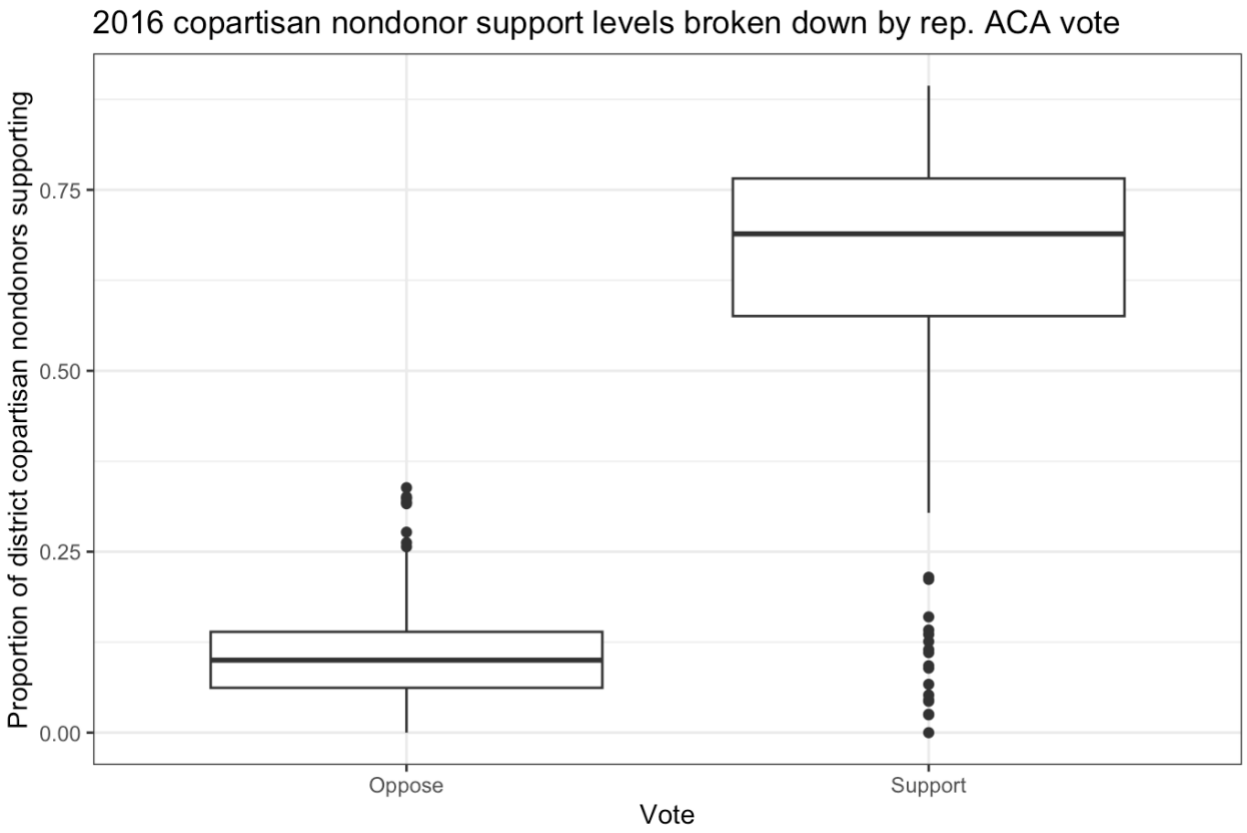

Figure 35: 2016 boxplot of co-partisan non-donor support by representative ACA vote