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Assessing burden tolerance amid the Medicaid Great Unwinding

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Abstract

The pandemic era ushered in a period of policy adaptation in how states deliver programs. One aspect of this experimentation is how burdensome safety net administrative processes should be. Using national surveys taken before and after the end of the public health emergency, we offer evidence of how tolerant the public is about burdens when allowed to choose between discrete policy implementation options. First, we show that burden tolerance beliefs are durable and largely unmovable, staying relatively consistent over time, and unaffected by experimental frames. Second, while there is varying support for specific strategies, the public is broadly supportive of tools that reduce burdens in Medicaid. Third, we find consistent predictors of burden tolerance: conservative beliefs and racial resentment are associated with support for burdens, while empathy toward others, belief in burdens as a form of systemic racism, and low administrative capital make people less tolerant of burdens.

Evidence for practice

- Policy makers can easily overlook how burdensome administrative processes can be on clients.
- Consulting with the public about their tolerance for burdens should inform policy implementation.
- Two national surveys find that significant majorities support state actions that would reduce burdens in Medicaid. While conservatives are more tolerant of burdens in these programs, support for burden reduction is bipartisan. These attitudes stay broadly consistent over time.

INTRODUCTION

The COVID-19 pandemic brought about substantial political, societal, and economic changes that impacted almost all Americans (Pew Research Center, 2020). On the one hand, it highlighted the substantial inequities and disparities in American society in general as well as the health and social programs more generally (Lynch, 2020). It also led to a period of rapid experimentation when it came to the design and implementation of public policies intended to address those disparities including reducing administrative burdens in public programs like Medicaid, the country's public assistance program for low-income families and individuals (Haeder et al., 2023). Administrative burdens have been defined as an "individual's experience of policy implementation as onerous" (Burden et al., 2012, p. 741) and refer to the learning, compliance, and psychological costs associated with complying with the administrative requirements of public programs (Herd & Moynihan, 2018). Such bureaucratic challenges substantially reduce take-up of public services (Fox et al., 2020, 2023; Rauscher & Burns, 2023) and have both direct and indirect effects on the health and well-being of individuals (Haeder et al., 2021; Haeder & Xu, 2024; Heinrich et al., 2022; Herd & Moynihan, 2020; Phillips et al., 2023) including their mental health (Bell et al., 2023; Cuffey et al., 2023). There is also evidence that they contribute to and further exacerbate inequities (Cuffey et al., 2024; Martin et al., 2023).

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The changes in Medicaid related to the declaration of the public health emergency (PHE) pushed states to significantly reduce administrative burdens which saw Medicaid coverage grow to unprecedented levels (Haeder & Moynihan, 2023a). The simple administrative change of eliminating recertification during the PHE had a greater effect on coverage than the Affordable Care Act marketplaces, a measure of how much administrative processes matter for enrollment (Dague & Ukert, 2023). The end of the PHE, and the reintroduction of those processes to varying degrees, has seen 23.8 million beneficiaries lose Medicaid coverage between April 2023 and June 2024, most of them through procedural denials with millions more set to lose coverage as recertification continues (Kaiser Family Foundation, 2024).

The administrative burden framework identifies the experiences of burden as a function of political and administrative choices, which in turn is at least somewhat responsive to public and policy maker preferences (Halling & Bækgaard, 2023). In recent years, some policy makers have sought to actively reduce burdens in public programs led by the Biden administration (Office of Management and Budget, 2022). Other policy makers have taken the opposite stance, utilizing the often opaque nature of administrative burdens to further their underlying policy preferences, particularly the reduction of public assistance roles, often under the disguise of "preventing fraud, reducing agency error rates, and rationing scarce products or services" (Doughty & Baehler, 2020, p. 273). This makes it even more important to understand public views on the burdens themselves, a concept referred to as "burden tolerance" (Bækgaard et al., 2021).

The governmental response focused on the reduction of administrative burdens during the pandemic, and their subsequent reinstatement in large parts of the country, provides an interesting illustration of the centrality of administrative processes to policy outcomes. Because of the clear mechanism, they also offer an excellent opportunity to better understand how the broader public perceives policy design choices that increase or reduce burdens. That is, we know much about public support for policies, but much less about the administrative processes that are often central to the success of that policy and what the public thinks about them. While such administrative processes are often opaque and difficult to understand, they sometimes take center stage in political disputes (Burns et al., 2023).

Overall, the end of the PHE allows us to assess both basic levels of public support for administrative choices, and whether those beliefs change at a time when the administrative choices themselves are changing in a visible and consequential way. We can learn if the public favors the easing of administrative burdens associated with the pandemic or the degree to which it prefers to go back to the pre-pandemic status quo that placed more burdens on beneficiaries. We can also observe if the end of the PHE shifted public opinion on these questions or if it has remained relatively consistent. Thus, our central research questions are as follows: what explains burden tolerance and how mutable is burden tolerance to major policy events with substantial policy consequences?

To answer these questions, we fielded two large surveys, one from December 21 to December 28, 2022 ($N = 4074$), prior to the unwinding, and one from August 18 to August 19, 2023 ($N = 3932$) as the PHE unwinding was underway. Both surveys sought to help us better understand the American public's support for burden reductions with regard to nine specific evidence-based policies that either *shift burdens to the state* (five policies) or by increased *outreach and communications* (four policies). Both surveys also contained survey experiments to determine whether increasing the salience of some of the particularly detrimental and inequitable effects of the increases in administrative burdens during the unwinding would alter public opinion (Haeder & Moynihan, 2023a; Hopkins, 2023).

The results offer a number of contributions. First, we provide evidence of the durability of burden tolerance beliefs in two ways. The loss of coverage for millions did not seem to alter beliefs about burdens in Medicaid, as our analyses show that responses before the end of the PHE and during the Great Unwinding are remarkably similar. Moreover, survey experiments that sought to increase the salience of losses or point to the ways in which they would worsen patterns of inequity had no determinable effect. Second, we show a broad preference for burden reduction. Overall, the public was more supportive of alternatives that reduced burdens compared to those that increased them. Third, we find consistent predictors of burden tolerance that expand our understanding of this nascent concept: conservative beliefs and racial resentment were associated with support for burdens in Medicaid, while empathy toward others, awareness of the effects of burdens, experiences with social programs and low administrative capital were associated with less tolerance for burdens. Taken together, our findings reveal public preferences toward burden reductions related to the pandemic, as well as the dynamic of these preferences over time.

BURDEN TOLERANCE AND THE GREAT UNWINDING

The existence and effects of administrative burdens have been well-documented over the past several years (Cuffey et al., 2023; Fox et al., 2020; Heinrich, 2016; Herd & Moynihan, 2020; Martin et al., 2023). While administrative burdens are often justified as tools to maintain program integrity (Doughty & Baehler, 2020), the compliance, learning, and psychological costs associated with them have led to a substantial reduction in take-up across public programs. If one aspect of the administrative burden framework centers on the effects of burdens, another

aspect considers the origins of burdens, which can be traced to various sources, from bureaucratic discretion to formal policy choices. Such actions may at times seek to defy popular will, taking advantage of the opacity of burdens, and in some cases reflect public views (Herd & Moynihan, 2018). But we have limited evidence on this point (Halling & Bækgaard, 2023), since until relatively recently it was unusual to assess public views on such details of administration. However, researchers have begun to address this problem, first by developing burden tolerance as a concept, and then empirically exploring this concept. Burden tolerance is defined as "the willingness of policy makers and people more generally to passively allow or actively impose state actions that result in others experiencing administrative burdens" (Bækgaard et al., 2021). This conceptualization provides an overarching theoretical construct to understand how the public views a series of specific policy design choices in the implementation of Medicaid.

Burden reductions in Medicaid during the PHE serve as a good example of service delivery innovations and offer an unusual chance to assess how these changes aligned with public views, and whether public views evolved with policy changes. First under the declaration of a PHE by both the Trump and Biden Administrations (Tolbert & Ammula, 2022) and then under the Families First Coronavirus Response Act, the federal government utilized its discretionary powers to reduce burdens in the Medicaid program related to health insurance enrollment and maintenance (McIntyre, 2022). The results have been staggering, pushing Medicaid to grow from 71.1 million in February 2020 to more than 94 million people by May 2023 (Kaiser Family Foundation, 2024).

The "Great Unwinding," as it became known, began in April 2023. Congress phased out the increased Medicaid matching rates in place during the pandemic and the limitations on Medicaid administration that accompanied them. Republican Governors, in particular, had called for returning greater discretion to the states (Republican Governors, 2022). The federal government offered states substantial discretion in how to proceed during the unwinding (Tolbert & Ammula, 2022). But Congress put in place a number of incentives to support states in maintaining their Medicaid populations (Haeder & Moynihan, 2023b). The Biden Administration also actively encouraged states to utilize proven tools to support beneficiaries in the transition (Tolbert et al., 2023). In short, states were offered significant discretion in managing the unwinding, which might be influenced by federal incentives, prior preparation, and administrative capacity, but also policy maker and public preferences. States have varied significantly in the choices they have taken, with many failing to use evidence-based policy tools that could have minimized the detrimental effects on beneficiaries (Tolbert et al., 2023).

The implementation of the unwinding has led to the largest losses of insurance coverage in US history. Between April 2023 and June 2024, 23.8 million beneficiaries lost Medicaid coverage, compared to 52 million who had their coverage renewed (Kaiser Family Foundation, 2024). The loss of Medicaid coverage during the unwinding, while unprecedented in its extent, is in line with previous research (Askelson et al., 2019; Finkelstein et al., 2022; Fox et al., 2023; Haeder, 2019; Rauscher & Burns, 2023). Coverage losses are more than double the federal government's estimate (Assistant Secretary for Planning and Evaluation [ASPE], 2022). There are wide variations in disenrollment rates, ranging from above 50% in states like Utah and Oklahoma to around 10% in Maine and Wyoming (Kaiser Family Foundation, 2024). Such variance reflects the vastly different levels of preparations states made for the unwinding (Tolbert et al., 2023). About 7 in 10 disenrollments were for procedural reasons, meaning that the individual failed to complete a renewal process, and the state failed to verify if they were no longer eligible (Kaiser Family Foundation, 2024). There is also evidence for widespread system and policy errors artificially augmenting the number of wrongfully terminated beneficiaries (Center for Budget and Policy Priorities, 2023). At the same time, most Medicaid beneficiaries were unaware of the substantial policy changes that affected them (Haley et al., 2023). Many states have also sought to actively add additional burdens to the Medicaid program during the unwinding, such as work requirements (Guth, 2023).

The immediacy of the post-pandemic shifts, as well as the large number of individuals affected, offers an unusually public demonstration of the effect of burdens on access to public services. The stark effects and the public nature of the changes in administrative burdens in the Medicaid program related to the ending of the PHE thus present an excellent opportunity to learn more about public perceptions related to administrative burdens. Here, we seek to understand how this relates to the public's understanding of the issue as it unfolded and the various correlates of burden tolerance in a highly salient policy.

WHAT DRIVES PREFERENCE FOR LOWER BURDENS?

Why do some individuals favor reducing administrative burdens and others do not? The literature on burden tolerance provides some guidance, informing our hypotheses. Collectively, the work shows that burden tolerance is shaped by a variety of factors, including attitudes about the program in question, the people assumed to be served by the program, personal experience with burdens, and political ideology.

Major policy events

Our study has a unique advantage in that we can look at how attitudes about burden tolerance shift over time, in

response to significant real-world events. We ask equivalent questions before and after the end of the PHE to assess if the growing attention to the loss of Medicaid coverage shaped public attitudes. Respondents before the end of the PHE were given information as to the likely effect of burdens on coverage, while those during the PHE were given information on what was actually happening in terms of coverage loss. But the latter group might also be expected to be more responsive to the effects of the PHE ending given potential media coverage of the topic, and the fact that the losses were actually occurring rather than potentially occurring in the future. This logic assumes a citizenry willing to update their beliefs as a result of dynamic policy changes in the form of coverage losses, which in turn assumes that citizens are attentive to these changes and their beliefs are malleable as a result. This assumption might be optimistic, but they also reflect real-world conditions under which the public can be expected to consider major policy changes. Some evidence does exist that political events, such as elections, cause the public to update beliefs, but in motivated ways. For example, Jilke and Baekgaard (2020) use pre–post surveys to show that as elections create a mismatch between citizens and elected officials, they become less satisfied with local public services.

Hypothesis 1. Respondents surveyed during the Great Unwinding will be more sensitive to the effects of administrative burdens than those surveyed beforehand.

Personal experience

Some research has focused on how personal experience matters to how people think about burdens. This experience might take different forms. In this setting, we examine the role of direct experience with Medicaid, as well as personal experience of struggling with administrative tasks. Personal experiences may also exert important feedback effects on individuals associated with public programs. For example, those connected to the Medicaid program are more supportive of the program (Grogan & Park, 2017) and less tolerant of administrative burdens in Medicaid (Halling et al., 2022). These effects have also been shown to be present in policy makers with previous welfare experience (Bækgaard et al., 2021).

Hypothesis 2. Respondents currently on the Medicaid program will be more likely to support reductions in administrative burdens.

Administrative capital

The ability to master administrative tasks, and the potentially negative experiences associated with them, may also affect respondents' willingness to reduce burdens for Medicaid beneficiaries. This is sometimes conceptualized as administrative capital (Masood & Nisar, 2021), administrative literacy (Döring & Madsen, 2022), or bureaucratic self-efficacy (Bisgaard, 2023). The common logic across such work is that some people will have more or less capacity to manage administrative tasks. Such variation might be driven by environmental factors such as scarcity, differences in human capital such as education, or individual differences such as personality or health (Bell et al., 2023; Christensen et al., 2020). Greater administrative capital should generate greater success in claiming benefits. Here, we test if such resources are also associated with burden tolerance, on the straightforward assumption that those who feel confident in their ability to master basic administrative tasks will be more willing to accept such tasks. By contrast, those struggling with common administrative tasks may thus be particularly wary of administrative burdens.

Hypothesis 3. Respondents who struggle with completing administrative tasks will be more likely to support reductions in administrative burdens.

Ideology

The extensive literature on the US public assistance programs has long established that ideology serves as an important predictor of program or policy support. The findings have also been substantiated as they relate to administrative burdens (Haeder et al., 2021). Across different settings, those with more conservative views tend to be more supportive of burdens. This holds true of policy makers, street-level bureaucrats, and the general public (Bækgaard et al., 2021; Bell et al., 2021; Halling et al., 2022). Conservatives also become more supportive of welfare programs when told that they have more burdens (Keiser & Miller, 2019).

Hypothesis 4a. Liberal respondents will be more likely to support reductions in administrative burdens.

Hypothesis 4b. Conservative respondents will be less likely to support reductions in administrative burdens.

Racial resentment

Public assistance programs in the United States are often viewed in racialized terms (Gilens, 2009). This also applies to the Medicaid program (Leitner et al., 2018). While there is evidence of deservingness mattering to burden tolerance (Bækgaard et al., 2021; Nicholson-Crotty et al., 2021), and claims that burdens can easily become "racialized" (Cuffey et al., 2023; Ray et al., 2023), there is little direct evidence on how race matters in burden tolerance (Johnson & Kroll, 2021). We consider the role of race in two ways. First, given the racialization of how public assistance programs are understood, we predict that Whites

with higher racial resentment will be more supportive of burdens.

Hypothesis 5. Respondents with higher levels of racial resentment will be less likely to support reductions in administrative burdens.

We also test if individuals who believe that burdens are associated with racial inequity have lower burden tolerance. While there is significant evidence that views about race matter, and especially that racist beliefs shape policy views, there is less evidence about how beliefs in systemic or structural racism shape views about policy implementation. Individuals who perceive burdens as systemically falling on racial minorities are likely to view burdens as not simply onerous, but a mechanism driving inequality, and therefore hold greater motivation to reduce burdens where possible. Such a view is consistent with much scholarship on the topic as well as policy actions that connect burdens to reducing inequality (Cuffey et al., 2023; Ray et al., 2023).

Hypothesis 6. Respondents who believe that administrative burdens have systemic disparate effects on persons of color will be more likely to support reductions in administrative burdens.

To further probe the question of whether racialized views shape burden tolerance, we introduced a series of framing experiments that emphasized that burdens would increase racial inequity. We also included framing experiments tying burdens to worsening income inequality to offer a nonracial framing on inequality. The theoretical logic for these experiments was consistent with Hypotheses 5 and 6, in that they assume that considerations of race and inequality would shape burden tolerance, but different in that we test if informational treatments could alter these underlying beliefs.

Hypothesis 7. Priming respondents about how burdens affect equity will reduce burden tolerance.

Empathy

Finally, we examine the role of empathy. Other work has examined how personality traits are associated with burden tolerance. One finding is that those "who score higher on the trait of openness to experience are less tolerant of burdens, implying that greater empathy toward the experience of others reduces burden tolerance" (Aarøe et al., 2021, p. 652). Here, we seek a more direct test of that implied mechanism, by examining how empathy for those exposed to burdens is associated with burden tolerance. The theoretical logic also reflects mechanisms we see with variables such as deservingness—as individuals regard others as an unsympathetic out-group, distinct from themselves, they are less willing to extend support, and more willing to impose heavier burdens for their perceived failings. For individuals for whom the subject can empathize, they will be more willing to allow administrative systems that are accessible and welcoming. In short, empathy operates as a prosocial emotional process that can affect judgments, decisions, and behaviors. For example, prior work has shown how empathy can shape prosocial behavior, such as health actions to protect others (Pfattheicher et al., 2019, 2020).

Hypothesis 8. Respondents with higher levels of empathy toward individuals struggling with administrative burdens will be more likely to support reductions in administrative burdens.

DATA

Our analyses rely on two distinct sets of data, both derived from public opinion surveys of the US public (see Appendix Exhibits 1–14). Our first set of data was collected between December 21, 2022, and December 28, 2023, several months prior to the official ending of the PHE. A total of 7805 respondents initiated the survey of which 7360 (94%) consented to take the survey and 4074 respondents completed the survey (56%). The second survey was fielded on August 18 and August 19, 2023. In this round, 6657 respondents opted into the survey and 6251 (96%) consented to take the survey. At this point, the Great Unwinding had begun, and millions had started to lose Medicaid coverage, the vast majority for "procedural denials." Ultimately, 3932 respondents completed the survey (65%). The survey was programmed in Qualtrics and we relied on Lucid to recruit participants. Lucid provides a large online double opt-in panel and relies on quota sampling to approximate national representativeness for important demographic benchmarks including race, age, sex, income, and Census region. Lucid is frequently used by social scientists including public administration scholars to recruit survey respondents (Callaghan et al., 2021; Cassese et al., 2020; Haeder & Moynihan, 2023a; Sylvester et al., 2022). Research indicates that Lucid is a valid and appropriate tool for survey research (Coppock & McClellan, 2019; Stagnaro et al., 2024). The study received approval from the institutional review boards at the appropriate institutions.

Survey structure

The survey structure was similar in both surveys (see Appendix Exhibits 3 and 6). In Survey 1, respondents were first introduced to the topic with some basic factual information (see Appendix Exhibit 7). Afterward, respondents were randomly assigned one of six specific tracks (one control group and five treatments). Specifically, we highlighted various negative consequences of the unwinding. These included the following: (1) overall

coverage losses, (2) disproportionate coverage losses for racial and ethnic minorities, (3) coverage losses exacerbating racial inequities and systemic racism, (4) disproportionate coverage losses for those with the lowest income, and (5) broader community effects of coverage losses (see Appendix Exhibit 9).

In Survey 2, administered after the unwinding had begun, we slightly adjusted our introduction to all respondents to reflect the passing of time and the new status quo (see Appendix Exhibit 10). Outside of the control group, we then deployed two treatments, (1) focusing on coverage losses under the unwinding as well as (2) disproportionate coverage losses for racial and ethnic minorities (see Appendix Exhibit 12).

Subsequent to the introduction and potential treatments, in both surveys, we asked respondents about their opinions about nine evidence-based policies to reduce administrative burdens and coverage losses described in further detail below (see Appendix Exhibits 8 and 11). Wording across the two survey rounds was analogous and only differed to differentiate between future actions in Survey 1 and past actions in Survey 2 to reflect the state of the unwinding.

Methodological approach

We utilized standard *t*-tests implemented in a weighted environment to assess statistical differences between the various treatments. As noted above, none of our treatments in either survey proved to be statistically different from the control and we thus pooled our data (see Appendix Exhibits 15 and 16 for details). We utilized weighted *t*-tests to compare the differences between both surveys. Due to the binary nature of our dependent variables, we also relied on multivariate logit models utilizing survey weights for our analyses.

There are some limitations to our methodological approach. First, both surveys are cross-sectional in nature. In addition, while we utilized two surveys at two distinct points in time, our study is not a panel-style survey where we surveyed the same respondents in wave 1 and wave 2. We also relied on an Internet-based survey platform that makes use of a double opt-in procedure. This means that respondents first agree to become a Lucid panel member. They were then subsequently invited to take our surveys. As noted above, survey data from Lucid approximates US national demographics on key demographics like race, age, sex, income, and Census region. To further improve representativeness, we weighted responses on gender, race, income, and education based on the U.S. Census Current Population Survey. We also address quality concerns by employing two attention checks. We also note that this approach and survey firm are frequently used for work like this (Coppock & McClellan, 2019; Haeder et al., 2023; Haeder & Moynihan, 2023b; Stagnaro et al., 2024).

Dependent variables

In their conceptualization of burden tolerance, Bækgaard et al. (2021) describe it as having a mix of *passive* (accepting burdens that already exist) and *active* (choosing burdens) components. Our survey taps into the active aspect of burden tolerance since we ask the public to express preferences on state actions that could make administrative processes more or less burdensome. We also seek to structure burdens around specific policy choices, rather than abstract considerations of whether the programs should be harder or easier. More recent measurement development has established a generic measure of burden tolerance and has found that it can be applied to policy-specific situations (Bækgaard et al., 2025). Future work could usefully assess if such generic measures predict the type of policy-specific approach to assessing burdens that we employ.

We derived our binary dependent variables from actual administrative actions that state employed to manage the accessibility of social programs, and specifically Medicaid, based on a review of state administrative actions. The actions can be categorized into two distinct umbrella categories (see Appendix Exhibits 8 and 11). First, five of our policies *shift burdens to the state* and reduce compliance costs by actively using administrative capacity rather than burdening beneficiaries. The idea of using specific practices to "shift burdens to the state" closely mirrors foundational work in the field of administrative burden, which also studied Medicaid (Herd et al., 2013). The policies include the following: (1) automatic (ex-parte) renewals, (2) using prefilled forms, (3) ensuring the most recent contact information from other programs (such as the Supplemental Nutrition Assistance Program (SNAP)) or sources (the post office), (4) improving account transfer processes with Affordable Care Act marketplaces, and (5) ensuring enough administrative capacity to perform such tasks. Second, we offered respondents four distinct policies aimed at reducing beneficiary learning costs by augmenting *outreach and communication*, a standard "nudge" approach to reducing burdens, and one squarely aimed at reducing the administrative burden category of learning costs (Bækgaard et al., 2025). These policies included the following: (6) resorting to nontraditional sources of communication like text messaging, (7) sending materials in plain language to potential enrollees, (8) increasing outreach and enrollment efforts, and (9) providing clear information about termination and enrollment procedures and how to get help if needed. All of the tools presented were primarily focused on reducing beneficiary workload and carrying with them the relatively low potential for welfare fraud. We offered respondents two distinct choices that either decreased or increased burdens for beneficiaries. Specifically, we asked whether states should adopt or should have adopted the burden-reducing policy or whether it should return or should have returned its

pre-pandemic policies instead. The policy tools presented were consistent in both surveys.

Independent variables

To explore the burden tolerance of the American public as it is related to the unwinding from the PHE, we tested a number of explanatory variables from the administrative burden literature. First, we included a measure that accounts for the ability of respondents to manage common administrative tasks like "renewing your driver's license, registering your car, or signing up for insurance." We derived this variable (5-point scale) by asking respondents whether they found such administrative tasks easy or difficult. We also accounted for experience with the Medicaid program by including an indicator for whether respondents are currently enrolled in the Medicaid program. In addition, empathy for individuals with burdens has also been found to be an important predictor of burden tolerance (Aarøe et al., 2021; Skinner-Dorkenoo et al., 2022). We measured empathy using of a three-question battery, which inquires whether respondents are concerned, feel compassion, or are moved by the experience of those most vulnerable to administrative burdens (Appendix Exhibit 13). This battery is well established and frequently used in social science and psychological research (Fischer et al., 2023; Pfattheicher et al., 2019, 2020). We adapted it in line with previous research on burden tolerance (Haeder & Moynihan, 2023a, 2023b). We combined the battery into an index (Cronbach's alpha .88 and .89). We also sought to understand if beliefs of structural racism matter and so queried respondents about the degree (5-point scale) to which they believed that burdens have a greater impact for non-Hispanic Whites versus persons of color (Haeder & Moynihan, 2023a, 2023b; Skinner-Dorkenoo et al., 2022). To account for respondents' racial resentment, we relied on the traditional four-question battery developed specifically for that purpose (Peyton & Huber, 2021). The battery asked non-Hispanic White respondents about whether they agree or disagree with statements like Blacks have gotten less than they deserve, need to work their way up, need to try harder to be as well off as Whites, and that slavery and discrimination have made it more difficult for Blacks to be successful (Appendix Exhibit 14). All questions were 5-point scales. We also include indicators for both liberals and conservatives in our models. We combined both "extreme liberals" and "liberals" in the former and both "extreme conservatives" and "conservatives" in the latter. Lastly, we also included various common controls for respondent level of education (eight categories); an indicator for female respondents; age and its square; insurance status (employer-sponsored insurance, Medicare, or uninsured in addition to the previously mentioned Medicaid coverage) and income (six categories).

RESULTS

In this section, we present our results. Given the number of hypotheses and the variety of estimations we employ, Table 1 offers a simple summary of the key findings, with a more detailed explanation to follow.

As noted above, we ran a version of the survey before and during the Great Unwinding. This allows us to see if the public updated their views as millions of people started to lose coverage. We found consistent and strong support for burden-reducing policies across the board. The results do not vary much across time. Prior to the unwinding, support ranged from a low of 0.675 (95% confidence interval: 0.656–0.695) for automatic renewals to a high of 0.782 (0.765–0.800) for increases in administrative capacity. Afterward, it ranged from 0.675 (0.655–0.694) for automatic renewals to 0.788 (0.771–0.805) for increases in administrative capacity. A series of *t*-test indicated only a small number of cases with statistical differences in public support at the 0.05 level occurred (see Appendix Exhibits 17 and 18). However, accounting for Bonferroni adjustments based on the number of analysis ($p \leq .00043$), we did not find any statistically significant differences. Figure 1 contains the graphical representation of respondents' support for burden-lowering policies from our surveys conducted both before and after the implementation of the unwinding from the PHE.

We estimated a series of multivariate logit models for each of the policies we queried respondents about, and we did so for each of our two surveys (for a total of 18 logit models, 9 for each survey). Table 2 displays the results for the 10 logit models for policies *shifting burdens to the state*. Because logit coefficients are not directly interpretable, we present the average marginal effects (AMEs) for those cases where the AMEs were below a *p*-value of .05. Several findings stood out. First, empathy for individuals dealing with administrative burdens was a strong and substantively important predictor of support for burden reductions

TABLE 1 Hypotheses.

Hypothesis	Supported?
H1: Experiencing the Great Unwinding reduces burden tolerance	No
H2: Medicaid recipients are less burden tolerant	Mostly no
H3: Difficulty completing administrative reduces burden tolerance	Generally yes
H4: Liberal respondents are less burden tolerant; conservatives are more burden tolerant	Mostly yes
H5: Racial resentment is associated with more burden tolerance	Yes
H6: Viewing burdens as having systemic disparate effects on persons of color reduces burden tolerance	Yes
H7: Priming about disparate effects reduces burden tolerance	No
H8: Empathy reduces burden tolerance	Yes

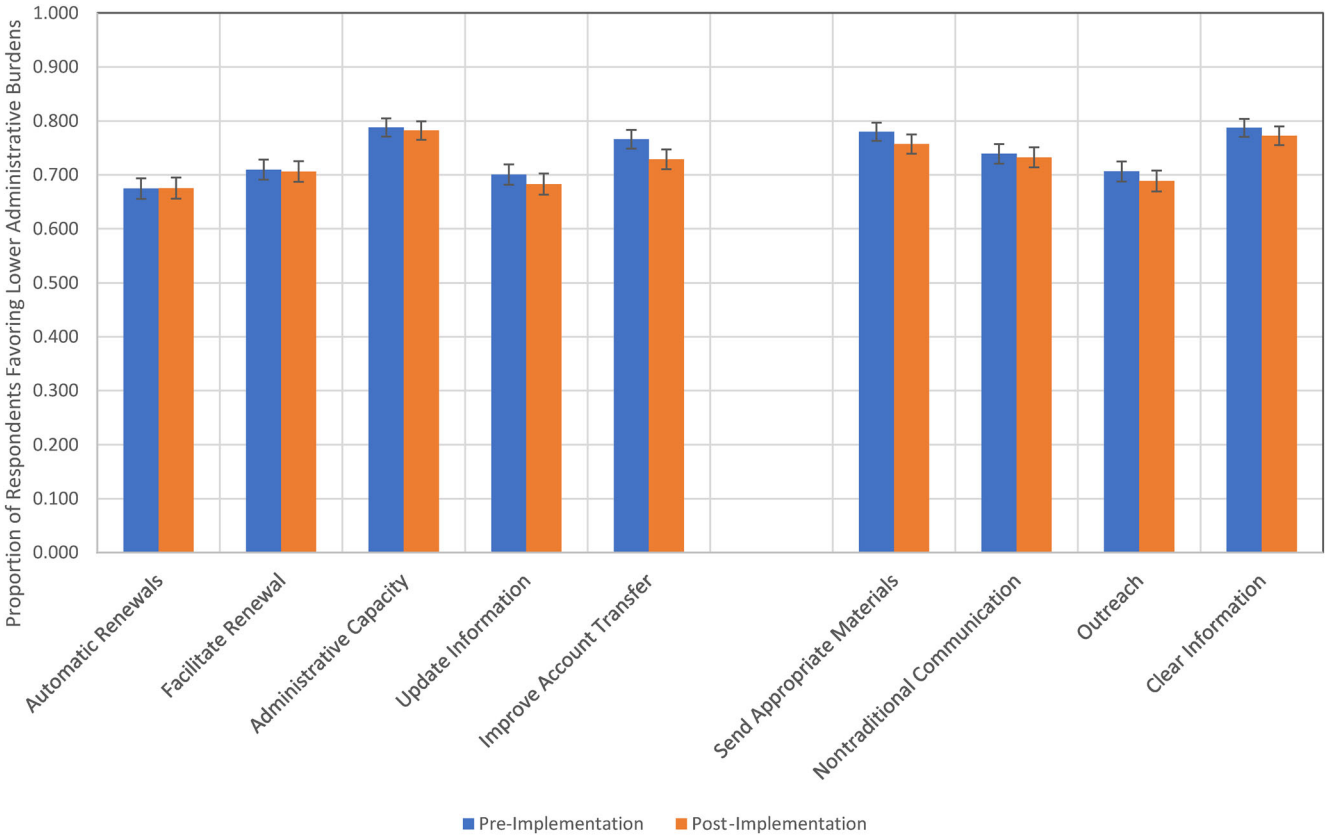


FIGURE 1 Predicted probabilities for various policies, all respondents. Estimates based on authors' surveys conducted from December 21 to December 28, 2022 and from August 18 to August 19, 2023 among US adults. Pre-implementation is before the implementation of the Medicaid unwinding. Post-implementation is after the implementation of the Medicaid unwinding.

both prior (0.072–0.112, *p*-values < .001) and after (0.067–0.096, *p*-values < .001) the ending of the PHE. The same was held for knowledge of inequities related to administrative burdens (AMEs: pre: 0.024–0.042, *p*-values < .016; post: 0.023–0.044, *p*-values < .031). Moreover, we found that personal difficulties with administrative tasks were a predictor in the earlier survey (0.017–0.030, *p*-values < .027) as well as for automatic renewals, efforts to facilitate renewals, and increasing administrative capacity in the second survey (0.022–0.023, *p*-values < .011). In most cases, being on Medicaid was not associated with greater support for burden reductions except in the cases of automatic renewal (0.113, *p*-value < .001) and updating information (0.068, *p*-value = .017). While liberal ideology was an inconsistent predictor of support for burden reductions in the December 2022 survey (0.053, *p*-value = .015 for improved account transfer and 0.092, *p*-value < .001 for automatic renewals), it became a consistent and substantial predictor in the second survey for all policies (0.093–0.139, *p*-values < .001). Conservatism was associated with higher burden tolerance across both legs of the survey (pre: −0.049 to −0.102, *p*-values < .016; post: −0.079 to −0.144, *p*-values < .001). Lastly, our control variables were generally not statistically significant, with certain exceptions like the importance of racial/ethnic variables in the post-unwinding survey for increases in administrative capacity, facilitating renewals, and updating information.

The results for policies focused on *outreach and communication* are presented in Table 3. Our findings were in line with those from policies *shifting the burden to the state*. Empathy (pre: 0.074–0.110, *p*-values < .001; post: 0.071–0.085, *p*-values < .001) and knowledge of inequities in administrative burdens (pre: 0.031–0.040, *p*-values < .001; post: 0.040–0.044, *p*-values < .001) were again consistent predictors. However, personal struggles with administrative tasks became an inconsistent predictor (pre: 0.016–0.020, *p*-values < .037; post: 0.018–0.028, *p*-values < .028). We found no statistically significant effects for Medicaid status. However, conservatism again was consistently associated with greater tolerance for burden (pre: −0.048 to −0.112, *p*-values < .020; post: −0.097 to −0.141, *p*-values <.001), and liberalism emerged as a consistent correlate in the second survey (post: 0.064–0.148, *p*-values < .007), after only being significant for outreach (0.063, *p*-value = .006) and clear information (0.064, *p*-values = .002) in the first one. Controls, again, were inconsistent. It is worth noting that women become consistently less tolerant of burdens in the August survey.

We reestimated our logit models with the racial resentment variable for non-Hispanic Whites only. The

TABLE 2 Estimation results for policies shifting burdens to the state, all respondents.

	Automatic renewals				Facilitate renewal				Administrative capacity				Update information				Improve account transfer			
	Pre		Post		Pre		Post		Pre		Pre		Post		Pre		Post		Pre	
Variables	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME
Liberal (binary)	0.520***	0.092	0.796***	0.139	0.096		0.594***	0.100	0.292		0.873***	0.113	0.263		0.521***	0.093	0.352*	0.053	0.750***	0.118
	(0.000)	(0.000)	(0.000)	(0.000)	(0.497)		(0.000)	(0.000)	(0.066)		(0.000)	(0.000)	(0.056)		(0.000)	(0.000)	(0.020)	(0.015)	(0.000)	(0.000)
Conservative (binary)	−0.405***	−0.077	−0.734***	−0.144	−0.565***	−0.102	−0.749***	−0.141	−0.312*	−0.049	−0.516***	−0.079	−0.339**	−0.063	−0.585***	−0.114	−0.456***	−0.075	−0.648***	−0.117
	(0.000)	(0.001)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.013)	(0.016)	(0.000)	(0.000)	(0.003)	(0.004)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Female (binary)	−0.301**	−0.054	0.121		−0.121		0.211*	0.037	0.050		0.338**	0.050	−0.210*	−0.038	0.130		0.057		0.228*	
	(0.002)	(0.002)	(0.231)		(0.237)		(0.040)	(0.041)	(0.647)		(0.003)	(0.003)	(0.034)	(0.034)	(0.197)		(0.601)		(0.030)	
Empathy (13 points, low to high)	0.706***	0.104	0.576***	0.096	0.845***	0.112	0.558***	0.083	0.616***	0.072	0.556***	0.067	0.718***	0.103	0.556***	0.088	0.654***	0.080	0.499***	0.076
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Difficulties with administrative tasks (5 points, low to high)	0.170***	0.030	0.128*	0.023	0.124*	0.021	0.130**	0.022	0.113*	0.017	0.165**	0.023	0.134**	0.024	0.034		0.131*	0.020	0.089	
	(0.000)	(0.000)	(0.012)	(0.010)	(0.012)	(0.010)	(0.008)	(0.007)	(0.030)	(0.026)	(0.003)	(0.002)	(0.003)	(0.002)	(0.465)		(0.011)	(0.009)	(0.089)	
Knowledge of inequities in administrative burdens (5 points, low to high)	0.133*	0.024	0.129*	0.023	0.165**	0.027	0.191**	0.032	0.184**	0.026	0.257***	0.035	0.204***	0.036	0.252***	0.044	0.285***	0.042	0.257***	0.041
	(0.018)	(0.015)	(0.034)	(0.030)	(0.005)	(0.003)	(0.004)	(0.003)	(0.003)	(0.002)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Uninsured (binary)	0.129		−0.031		0.322		−0.009		0.098		−0.028		0.510*	0.085	0.009		0.332		−0.068	
	(0.540)		(0.899)		(0.179)		(0.971)		(0.695)		(0.916)		(0.024)	(0.014)	(0.971)		(0.168)		(0.775)	
Medicaid beneficiary (binary)	0.656***	0.113	0.078		0.342		−0.152		0.133		−0.217		0.393*	0.068	0.165		0.176		0.085	
	(0.000)	(0.000)	(0.657)		(0.071)		(0.411)		(0.496)		(0.277)		(0.024)	(0.017)	(0.348)		(0.342)		(0.641)	
Employer-sponsored insurance (binary)	0.203		−0.183		0.006		−0.046		−0.022		−0.144		0.057		−0.004		−0.085		−0.074	
	(0.170)		(0.234)		(0.970)		(0.770)		(0.893)		(0.412)		(0.707)		(0.979)		(0.601)		(0.644)	
Medicare beneficiary (binary)	0.267		−0.234		−0.032		−0.245		0.042		−0.206		0.158		−0.040		0.154		0.012	
	(0.099)		(0.165)		(0.847)		(0.161)		(0.812)		(0.281)		(0.311)		(0.812)		(0.375)		(0.947)	
Non-Hispanic White (binary)	0.272		−0.128		0.381		−0.687*	−0.114	0.319		−0.734*	−0.100	0.226		−0.583*	−0.103	0.370		−0.281	
	(0.236)		(0.621)		(0.070)		(0.012)	(0.008)	(0.138)		(0.017)	(0.010)	(0.293)		(0.029)	(0.022)	(0.119)		(0.280)	
Non-Hispanic Black (binary)	0.274		−0.091		0.257		−0.846**	−0.159	0.176		−0.901**	−0.150	−0.028		−0.841**	−0.164	−0.132		−0.345	
	(0.318)		(0.763)		(0.330)		(0.008)	(0.010)	(0.515)		(0.010)	(0.018)	(0.912)		(0.006)	(0.007)	(0.646)		(0.266)	
Non-Hispanic Asian (binary)	0.476		−0.118		1.177**		−0.648		0.830*		−1.107**	−0.194	0.548		−0.455		0.596		−0.504	
	(0.197)		(0.742)		(0.001)		(0.095)		(0.025)		(0.005)	(0.013)	(0.113)		(0.204)		(0.104)		(0.146)	
Hispanic (binary)	0.243		−0.055		0.275		−0.655*	−0.121	0.327		−0.779*	−0.127	0.055		−0.499		0.174		−0.237	
	(0.373)		(0.851)		(0.290)		(0.033)	(0.041)	(0.231)		(0.022)	(0.035)	(0.832)		(0.091)		(0.539)		(0.431)	
Income (6 points, low to high)	−0.018		−0.021		−0.001		−0.103**	−0.018	0.023		−0.034		0.001		−0.149***	−0.028	−0.006		−0.069	
	(0.594)		(0.542)		(0.974)		(0.005)	(0.006)	(0.549)		(0.375)		(0.973)		(0.000)	(0.000)	(0.883)		(0.055)	
Education (4 points, low to high)	0.089		−0.059		0.103		0.034		0.058		−0.006		0.131*	0.023	−0.051		0.146*	0.022	0.020	
	(0.149)		(0.332)		(0.115)		(0.597)		(0.384)		(0.932)		(0.031)	(0.029)	(0.407)		(0.027)	(0.025)	(0.761)	

(Continues)

TABLE 2 (Continued)

	Automatic renewals				Facilitate renewal				Administrative capacity				Update information				Improve account transfer			
	Pre		Post		Pre		Post		Pre		Pre		Post		Pre		Post		Pre	
Variables	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME
Age	0.012		−0.016		0.048**		0.032		0.022		0.032		0.036*		0.020		0.043*		0.015	
	(0.508)		(0.355)		(0.006)		(0.071)		(0.247)		(0.086)		(0.042)		(0.254)		(0.017)		(0.416)	
Age^2	−0.000		0.000		−0.001**		−0.000		−0.000		−0.000		−0.000*		−0.000		−0.000*		−0.000	
	(0.111)		(0.543)		(0.003)		(0.086)		(0.236)		(0.115)		(0.032)		(0.193)		(0.015)		(0.395)	
Constant	−3.164***		−1.029		−4.568***		−1.589**		−2.946***		−1.741**		−4.149***		−1.085		−4.109***		−1.627**	
	(0.000)		(0.075)		(0.000)		(0.008)		(0.000)		(0.007)		(0.000)		(0.053)		(0.000)		(0.005)	
Average prediction		0.676		0.679		0.711		0.708		0.789		0.785		0.703		0.686		0.765		0.732
Observations	3979		3845		3987		3860		3980		3857		3970		3854		3982		3874	

Note: Estimates based on authors' surveys conducted from December 21 to December 28, 2022 and from August 18 to August 19, 2023 among US adults. *p*-Values in parentheses. AME is average marginal effect; Coef is logit coefficient; post is after the implementation of the Medicaid unwinding; pre is before the implementation of the Medicaid unwinding.

***$p < .001$; **$p < .01$; *$p < .05$ for coefficients.

TABLE 3 Estimation results for policies outreach and communication, all respondents.

	Send appropriate materials				Nontraditional communication				Outreach				Clear information			
	Pre		Post		Pre		Post		Pre		Post		Pre		Post	
Variables	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME
Liberal (binary)	0.269		0.463**	0.069	0.206		0.401**	0.064	0.382**	0.063	0.884***	0.148	0.462**	0.064	0.585***	0.083
	(0.086)		(0.005)	(0.003)	(0.166)		(0.009)	(0.006)	(0.008)	(0.006)	(0.000)	(0.000)	(0.003)	(0.002)	(0.000)	(0.000)
Conservative (binary)	−0.301*	−0.048	−0.609***	−0.101	−0.355**	−0.062	−0.629***	−0.111	−0.620***	−0.112	−0.739***	−0.141	−0.355**	−0.055	−0.601***	−0.097
	(0.015)	(0.019)	(0.000)	(0.000)	(0.003)	(0.004)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.006)	(0.008)	(0.000)	(0.000)
Female (binary)	0.121		0.393***	0.062	0.059		0.255*	0.042	−0.055		0.295**	0.053	0.183		0.297**	0.045
	(0.265)		(0.000)	(0.000)	(0.569)		(0.017)	(0.016)	(0.593)		(0.004)	(0.004)	(0.100)		(0.008)	(0.008)
Empathy (13 points, low to high)	0.659***	0.078	0.617***	0.079	0.680***	0.090	0.609***	0.085	0.830***	0.110	0.508***	0.078	0.650***	0.074	0.561***	0.071
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Difficulties with administrative tasks (5 points, low to high)	0.100		0.118*	0.018	0.122*	0.020	0.058		0.097*	0.016	0.163**	0.028	0.090		0.089	
	(0.055)		(0.031)	(0.027)	(0.014)	(0.012)	(0.254)		(0.038)	(0.036)	(0.001)	(0.001)	(0.089)		(0.100)	
Knowledge of inequities in administrative burdens (5 points, low to high)	0.225***	0.033	0.273***	0.040	0.208***	0.034	0.281***	0.044	0.249***	0.040	0.236***	0.040	0.219***	0.031	0.318***	0.043
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Uninsured (binary)	0.078		−0.169		0.314		0.126		0.104		−0.238		0.171		0.163	
	(0.751)		(0.520)		(0.187)		(0.610)		(0.663)		(0.323)		(0.467)		(0.516)	
Medicaid beneficiary (binary)	0.173		−0.092		0.227		0.323		0.237		0.042		0.204		0.074	
	(0.359)		(0.640)		(0.207)		(0.078)		(0.191)		(0.815)		(0.284)		(0.705)	
Employer-sponsored insurance (binary)	0.102		−0.155		0.051		0.064		−0.128		−0.068		0.172		0.054	
	(0.526)		(0.371)		(0.746)		(0.686)		(0.411)		(0.658)		(0.305)		(0.745)	
Medicare beneficiary (binary)	0.083		−0.272		−0.124		0.015		−0.181		0.046		−0.042		−0.066	
	(0.634)		(0.159)		(0.449)		(0.932)		(0.268)		(0.790)		(0.809)		(0.723)	
Non-Hispanic White (binary)	0.366		−0.581*	−0.086	0.485*	0.083	−0.246		0.116		−0.365		0.235		−0.136	
	(0.113)		(0.046)	(0.034)	(0.026)	(0.027)	(0.350)		(0.588)		(0.118)		(0.299)		(0.656)	
Non-Hispanic Black (binary)	−0.023		−0.798*	−0.138	0.169		−0.514		0.009		−0.413		−0.226		−0.619	
	(0.934)		(0.019)	(0.030)	(0.525)		(0.101)		(0.972)		(0.143)		(0.404)		(0.073)	
Non-Hispanic Asian (binary)	0.900*	0.111	−0.746	−0.131	0.806*	0.115	−0.371		0.723*		−0.660*		0.703	0.088	−0.564	
	(0.017)	(0.002)	(0.061)	(0.087)	(0.022)	(0.005)	(0.305)		(0.043)		(0.048)		(0.069)	(0.027)	(0.164)	
Hispanic (binary)	0.080		−0.744*	−0.127	0.281		−0.121		0.099		−0.262		0.289		−0.202	
	(0.776)		(0.022)	(0.033)	(0.291)		(0.691)		(0.706)		(0.339)		(0.302)		(0.547)	
Income (6 points, low to high)	−0.009		−0.094*	−0.015	0.004		−0.050		−0.007		−0.067	−0.013	−0.017		−0.038	
	(0.827)		(0.015)	(0.020)	(0.911)		(0.176)		(0.842)		(0.061)	(0.045)	(0.664)		(0.329)	
Education (4 points, low to high)	0.042		0.012		0.113		0.009		−0.010		0.011		0.082		0.013	
	(0.530)		(0.862)		(0.073)		(0.891)		(0.878)		(0.868)		(0.230)		(0.850)	
Age	0.023		0.009		0.030		0.020		0.046*		0.052**		0.022		0.013	
	(0.226)		(0.630)		(0.080)		(0.292)		(0.011)		(0.005)		(0.239)		(0.501)	

(Continues)

TABLE 3 (Continued)

	Send appropriate materials				Nontraditional communication				Outreach				Clear information			
	Pre		Post		Pre		Post		Pre		Post		Pre		Post	
Variables	**Coef**	**AME**	**Coef**	**AME**	**Coef**	**AME**	**Coef**	**AME**	**Coef**	**AME**	**Coef**	**AME**	**Coef**	**AME**	**Coef**	**AME**
Age^2	−0.000		−0.000		−0.000*		−0.000		−0.000*		−0.001**		−0.000		−0.000	
	(0.188)		(0.648)		(0.034)		(0.158)		(0.013)		(0.006)		(0.291)		(0.639)	
Constant	−3.109***		−1.338*		−3.757***		−2.097***		−4.226***		−2.709***		−3.105***		−2.133***	
	(0.000)		(0.033)		(0.000)		(0.000)		(0.000)		(0.000)		(0.000)		(0.001)	
Average prediction		0.780		0.760		0.739		0.735		0.707		0.692		0.788		0.774
Observations	3983		3868		3985		3864		3980		3877		3979		3880	

Note: Estimates based on authors' surveys conducted from December 21 to December 28, 2022 and from August 18 to August 19, 2023 among US adults. *p*-Values in parentheses. AME is average marginal effect; Coef is logit coefficient; post is after the implementation of the Medicaid unwinding; pre is before the implementation of the Medicaid unwinding.

***$p < .001$; **$p < .01$; *$p < .05$ for coefficients.

TABLE 4 Estimation results for policies shifting burdens to the state, non-Hispanic Whites only.

	Automatic renewals				Facilitate renewal				Administrative capacity				Update information				Improve account transfer			
	Pre		Post		Pre		Post		Pre		Pre		Post		Pre		Post		Pre	
Variables	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME
Liberal (binary)	0.490*	0.085	0.888***	0.156	0.244		0.816***	0.135	0.444	0.063	1.129***	0.142	0.257		0.620***	0.112	0.715**	0.099	0.949***	0.145
	(0.010)	(0.009)	(0.000)	(0.000)	(0.242)		(0.000)	(0.000)	(0.053)	(0.037)	(0.000)	(0.000)	(0.175)		(0.001)	(0.000)	(0.002)	(0.001)	(0.000)	(0.000)
Conservative	−0.291*	−0.052	−0.567***	−0.109	−0.354*	−0.061	−0.622***	−0.115	−0.226		−0.404**	−0.062	−0.195		−0.394**	−0.076	−0.354*	−0.055	−0.592***	−0.104
	(0.033)	(0.037)	(0.000)	(0.000)	(0.012)	(0.014)	(0.000)	(0.000)	(0.132)		(0.006)	(0.008)	(0.159)		(0.003)	(0.004)	(0.019)	(0.023)	(0.000)	(0.000)
Female (binary)	−0.300*	−0.052	0.052		−0.342**		0.114		0.032		0.345*	0.052	−0.248*		0.102		0.004		0.199	
	(0.015)	(0.015)	(0.667)		(0.007)		(0.355)		(0.815)		(0.011)	(0.011)	(0.045)		(0.397)		(0.975)		(0.115)	
Empathy (13 points, low to high)	0.669***	0.098	0.519***	0.083	0.757***	0.103	0.550***	0.083	0.567***	0.068	0.550***	0.068	0.722***	0.104	0.538***	0.087	0.559***	0.069	0.536***	0.077
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Difficulties with administrative tasks (5 points, low to high)	0.166**	0.029	0.086		0.114		0.099		0.165*	0.024	0.164*	0.024	0.125*	0.022	0.071		0.158*	0.023	0.082	
	(0.004)	(0.003)	(0.160)		(0.065)		(0.091)		(0.012)	(0.009)	(0.016)	(0.012)	(0.029)	(0.026)	(0.215)		(0.014)	(0.012)	(0.186)	
Knowledge of inequities in administrative burdens (5 points, low to high)	0.002		−0.057		0.038		−0.036		0.145		0.068		0.111		0.091		0.257**	0.037	0.104	
	(0.981)		(0.490)		(0.637)		(0.676)		(0.085)		(0.471)		(0.136)		(0.276)		(0.001)	(0.001)	(0.251)	
Uninsured (binary)	0.234		0.002		0.236		0.233		0.169		0.194		0.806**		0.226		0.359		−0.340	
	(0.375)		(0.994)		(0.456)		(0.459)		(0.624)		(0.548)		(0.005)	0.127	(0.468)		(0.269)		(0.252)	
Medicaid beneficiary (binary)	1.210***	0.195	0.148	0.082	0.513		−0.189		0.193		−0.222		0.573*	(0.001)	0.172		0.292		−0.173	
	(0.000)	(0.000)	(0.513)	(0.042)	(0.055)		(0.416)		(0.462)		(0.383)		(0.014)	0.096	(0.450)		(0.252)		(0.470)	
Employer-sponsored insurance (binary)	0.415*	0.071	−0.192		0.235		−0.191		0.117		−0.204		0.297	(0.008)	−0.066		−0.040		−0.379	
	(0.021)	(0.018)	(0.307)		(0.222)		(0.318)		(0.566)		(0.341)		(0.111)		(0.723)		(0.845)		(0.059)	
Medicare beneficiary (binary)	0.413*	0.070	−0.410*		0.137		−0.429*		0.111		−0.270		0.311		−0.136		0.336		−0.295	
	(0.032)	(0.026)	(0.043)		(0.497)		(0.039)		(0.593)		(0.235)		(0.103)		(0.506)		(0.107)		(0.183)	
Income (6 points, low to high)	−0.050		−0.071		−0.067		−0.124**	−0.022	−0.040		−0.040		−0.045		−0.183***	−0.035	−0.045		−0.107*	−0.018
	(0.251)		(0.103)		(0.131)		(0.006)	(0.007)	(0.400)		(0.408)		(0.306)		(0.000)	(0.000)	(0.364)		(0.018)	(0.021)
Education (4 points, low to high)	0.091		−0.096		0.080		0.063		0.057		0.031		0.168*	0.029	−0.002		0.131		0.094	
	(0.243)		(0.190)		(0.327)		(0.418)		(0.504)		(0.714)		(0.025)	(0.023)	(0.983)		(0.120)		(0.233)	
Age	−0.001		−0.014		0.047*		0.013		−0.002		0.023		0.025		0.011		0.024		0.009	
	(0.978)		(0.510)		(0.032)		(0.571)		(0.935)		(0.331)		(0.255)		(0.611)		(0.317)		(0.676)	
Age^2	−0.000		0.000		−0.001**		−0.000		−0.000		−0.000		−0.000		−0.000		−0.000		−0.000	
	(0.433)		(0.555)		(0.008)		(0.587)		(0.947)		(0.396)		(0.189)		(0.518)		(0.210)		(0.693)	
Racial resentment	−0.401***	−0.078	−0.364***	−0.079	−0.425***	−0.081	−0.278***	−0.057	−0.244**	−0.042	−0.201*	−0.035	−0.241**	−0.048	−0.233***	−0.050	−0.301***	−0.052	−0.236**	−0.046
	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.003)	(0.005)	(0.013)	(0.016)	(0.002)	(0.002)	(0.001)	(0.001)	(0.000)	(0.001)	(0.002)	(0.002)
Constant	−0.834		1.147		−1.665*		−0.003		−0.831		−1.123		−2.658**		−0.229		−1.750*		−0.485	
	(0.296)		(0.133)		(0.037)		(0.997)		(0.366)		(0.180)		(0.001)		(0.753)		(0.045)		(0.520)	

(Continues)

TABLE 4 (Continued)

	Automatic renewals				Facilitate renewal				Administrative capacity				Update information				Improve account transfer			
	Pre		Post		Pre		Post		Pre		Pre		Post		Pre		Post		Pre	
Variables	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME
Average prediction		0.646		0.653		0.691		0.690		0.775		0.774		0.691		0.666		0.759		0.715
Observations	2714		2665		2720		2672		2719		2668		2709		2668		2718		2674	

Note: Estimates based on authors' surveys conducted from December 21 to December 28, 2022 and from August 18 to August 19, 2023 among US adults. *p*-Values in parentheses. AME is average marginal effect; Coef is logit coefficient; post is after the implementation of the Medicaid unwinding; pre is before the implementation of the Medicaid unwinding.
***$p < .001$; **$p < .01$; *$p < .05$ for coefficients.

TABLE 5 Estimation results for policies outreach and communication, non-Hispanic Whites only.

	Send appropriate materials				Nontraditional communication				Outreach				Clear information			
	Pre		Post		Pre		Post		Pre		Post		Pre		Post	
Variables	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME	Coef	AME
Liberal (binary)	0.391		0.805***		0.314		0.521*	0.083	0.498*	0.082	1.153***	0.187	0.418	0.059	0.930***	0.120
	(0.079)		(0.000)		(0.131)		(0.011)	(0.007)	(0.016)	(0.012)	(0.000)	(0.000)	(0.056)	(0.042)	(0.000)	(0.000)
Conservative (binary)	−0.201		−0.504***		−0.225		−0.540***	−0.095	−0.559***	−0.100	−0.595***	−0.110	−0.303*		−0.464**	−0.071
	(0.182)		(0.000)		(0.124)		(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.048)		(0.001)	(0.002)
Female (binary)	0.050		0.414**		−0.156		0.237		−0.041		0.256*	0.045	0.166		0.193	
	(0.711)		(0.002)		(0.226)		(0.061)		(0.744)		(0.039)	(0.039)	(0.229)		(0.152)	
Empathy (13 points, low to high)	0.640***	0.075	0.605***		0.691***	0.090	0.609***	0.086	0.795***	0.109	0.544***	0.083	0.605***	0.072	0.585***	0.072
	(0.000)	(0.000)	(0.000)		(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Difficulties with administrative tasks (5 points, low to high)	0.145*	0.021	0.114		0.172**	0.027	0.056		0.128*	0.021	0.130*	0.022	0.131*	0.019	0.109	
	(0.022)	(0.020)	(0.087)		(0.005)	(0.004)	(0.363)		(0.029)	(0.027)	(0.034)	(0.030)	(0.047)	(0.042)	(0.107)	
Knowledge of inequities in administrative burdens (5 points, low to high)	0.206*	0.029	0.055		0.132		0.123		0.164*	0.027	0.033		0.164*	0.024	0.219*	0.031
	(0.013)	(0.009)	(0.548)		(0.110)		(0.161)		(0.030)	(0.025)	(0.710)		(0.040)	(0.032)	(0.022)	(0.015)
Uninsured (binary)	0.076		0.096		0.378		0.376		0.270		−0.150		0.341		0.208	
	(0.818)		(0.779)		(0.214)		(0.226)		(0.421)		(0.618)		(0.303)		(0.509)	
Medicaid beneficiary (binary)	0.189		−0.074		0.316		0.392		0.329		0.038		0.202		0.262	
	(0.479)		(0.769)		(0.208)		(0.103)		(0.161)		(0.868)		(0.427)		(0.311)	
Employer-sponsored insurance (binary)	0.221		−0.199		0.089		0.043		0.069		−0.154		0.251		−0.066	
	(0.280)		(0.347)		(0.651)		(0.824)		(0.718)		(0.423)		(0.220)		(0.752)	
Medicare beneficiary (binary)	0.307		−0.305		−0.025		−0.142		0.013		−0.178		0.028		−0.126	
	(0.138)		(0.195)		(0.903)		(0.495)		(0.947)		(0.397)		(0.891)		(0.583)	
Income (6 points, low to high)	−0.047		−0.088		−0.012		−0.072		−0.007		−0.123**	−0.022	−0.055		−0.033	
	(0.342)		(0.063)		(0.799)		(0.118)		(0.879)		(0.007)	(0.007)	(0.274)		(0.497)	
Education (4 points, low to high)	−0.000		0.055		0.081		0.008		0.013		0.080		0.082		0.026	
	(0.997)		(0.498)		(0.319)		(0.922)		(0.875)		(0.297)		(0.333)		(0.756)	
Age	−0.008		−0.001		−0.003		0.007		0.042		0.017		0.028		0.020	
	(0.756)		(0.960)		(0.883)		(0.775)		(0.062)		(0.451)		(0.225)		(0.412)	
Age^2	−0.000		0.000		−0.000		−0.000		−0.000*		−0.000		−0.000		−0.000	
	(0.925)		(0.907)		(0.674)		(0.657)		(0.045)		(0.497)		(0.225)		(0.578)	
Racial resentment (17 points, low to high)	−0.173*	−0.029	−0.245**	−0.045	−0.254**	−0.046	−0.237**	−0.046	−0.293***	−0.055	−0.282***	−0.057	−0.202*	−0.034	−0.234**	−0.041
	(0.041)	(0.048)	(0.001)	(0.002)	(0.001)	(0.002)	(0.002)	(0.002)	(0.000)	(0.000)	(0.000)	(0.000)	(0.017)	(0.021)	(0.004)	(0.005)
Constant	−1.051		−0.394		−1.284		−0.756		−2.903***		−0.758		−1.925*		−1.588	
	(0.228)		(0.641)		(0.140)		(0.339)		(0.000)		(0.335)		(0.023)		(0.062)	
Average prediction		0.776		0.750		0.729		0.718		0.680		0.673		0.777		0.772
Observations	2716		2681		2716		2675		2716		2679		2714		2681	

Note: Estimates based on authors' surveys conducted from December 21 to December 28, 2022 and from August 18 to August 19, 2023 among US adults. *p*-Values in parentheses. AME is average marginal effect; Coef is logit coefficient; post is after the implementation of the Medicaid unwinding; pre is before the implementation of the Medicaid unwinding.
***$p < .001$; **$p < .01$; *$p < .05$ for coefficients.

results and AMEs for policies *shifting burdens to the state* are presented in Tables 4 and 5 for policies related to *outreach and communication*. Across all nine policies in both surveys, racial resentment is strongly correlated with greater burden tolerance (pre: −0.029 to −0.081, *p*-values < .049; post: −0.035 to −0.079, *p*-values < .017). As before, empathy remained consistently associated with preferences for lower burdens (pre: 0.068–0.109, *p*-values < .001; post: 0.068–0.087, *p*-values < .001). At the same time, ideology, both for liberals (0.083–0.187, *p*-values < .008) and conservatives (−0.062 to −0.115, *p*-values < .009), remained a strong and consistent predictor of preferences for burden tolerance in the second survey but were inconsistent in the first survey. Difficulties with administrative tasks were also generally predictive, also more commonly so in the first survey (0.019–0.029, *p*-values < .042) and less so in the second survey (0.024–0.031, *p*-values < .016). Knowledge of racial disparities in administrative burdens, however, became inconsistent as were the control variables.

DISCUSSION

Our findings show high stability in burden tolerance related to the PHE, with a strong preference for burden reduction. Respondents had very similar responses to questions about burden reduction before and during the Great Unwinding, contrary to our first hypothesis. In between these surveys, millions had lost Medicaid. On aggregate, burden tolerance among the public remains remarkably consistent, seemingly unaffected by the end of the pandemic and the experience of the Great Unwinding. One reasonable question is why people failed to update their views? Most respondents in the first survey were told about how Medicaid coverage would decline and so they had information about effects. However, we also did not see differences between those who received no information on coverage loss with those who did. It may also be that while the Great Unwinding did see millions lose coverage, and certainly has received attention from the health-focused media and academics, it did not capture the national imagination as a media topic. We also note the relatively high levels of support for burden reduction efforts at both time periods. It could be that discussing burdens in the context of an "emergency" generated unusually high levels of support, creating a ceiling effect that left little room for increased support in the second survey. The responses reported here are higher than for similarly structured surveys asking about burden tolerance for SNAP and Medicaid (Haeder & Moynihan, 2023a).

We also saw that experimental framings about the scale of coverage loss and associated inequities did not alter responses (Hypothesis 7). This, again, reinforces the impression of relative stability about burden tolerance preferences, at least in this case. Our findings are in line with similar work related to health-related topics like the Affordable Care Act and Medicaid (Haeder & Moynihan, 2023a; Hopkins, 2023). Future work should further explore temporal or framing variation on burden tolerance in other settings. Our work cautions that even if survey experiments with strong treatments might generate what seem to be persuasive changes in espoused beliefs by respondents, the long-term basis for their beliefs might be difficult to alter. For the practical goal of changing political views, the effect of treatments of the kind that we employed had little effect compared to other variables, such as ideology or more general beliefs about the working of the state. This does not mean that informational treatments never work, but that a measure of realism is needed about the flexibility of attitudes on this topic.

While the overall pattern is one of stability, we did identify some shifts. Political ideology matters to burden tolerance. Consistent with Hypotheses 4a and 4b, liberals are more skeptical of state actions that lead to burdens, and conservatives are more supportive. Such ideological divisions became greater over time, with liberals becoming more supportive of reducing burdens and conservatives becoming more tolerant of burdens. We had analogous findings for partisanship. This may reflect a hardening of broader partisan divisions on the topic, as Republican Governors tended to move more aggressively toward reinstating traditional renewal processes (Kaiser Family Foundation, 2024). We also see a change in the gendered nature of responses. Women generally became less tolerant of burdens as time went on.

We do not find that being a recipient of the program being assessed matters for burden tolerance, contrary to Hypothesis 2. One explanation may be that the suspension of renewal processes during the PHE may have altered how respondents thought about the burden in the programs. Since they no longer had to complete renewal processes for a considerable period, they may have come to regard the program as not especially onerous. Future work could better explore how the intensity of burdensome experiences relates to burden tolerance.

Prior work has argued that some will struggle more with burdens than others because of variations in stocks of what has been labeled variously as administrative capital or administrative literacy (Christensen et al., 2020; Döring & Madsen, 2022; Masood & Nisar, 2021). In this paper, and consistent with Hypothesis 3, we offer evidence that people's sense of their ability to manage administrative problems is related to their attitudes about burdens, engendering greater opposition. In most instances, as individuals perceive themselves as lacking administrative capital, they are less tolerant of burdens. The finding is consistent with work showing that those with high conscientiousness are more tolerant of burdens (Aarøe et al., 2021). If how people think about their own skills matters to burdens, we also find that how they think about others also matters a great deal. Greater empathy

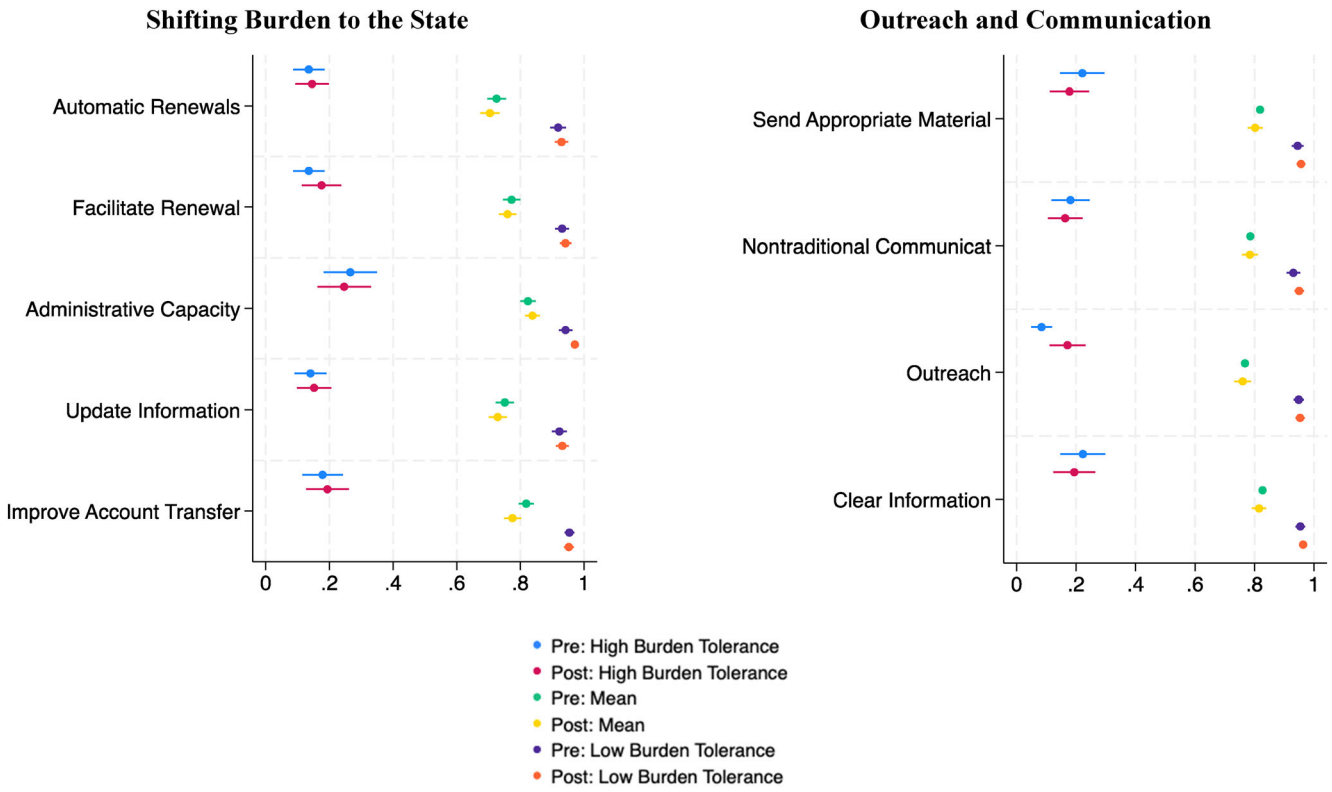


FIGURE 2 Predicted probabilities for policies for three ideal types, pre- and post-implementation of the ending of the public health emergency, all respondents. Estimates based on authors' surveys conducted from December 21 to December 28, 2022 and from August 18 to August 19, 2023 among US adults. Point estimates are shown with 95% confidence bounds. Estimates for low burden tolerances are individual based on a liberal, with high levels of empathy, and who was aware of racial and ethnic disparities in administrative burdens. An individual high in burden tolerance has the opposite values. Pre is before the implementation of the Medicaid unwinding. Post is after the implementation of the Medicaid unwinding.

for those struggling with burdens is associated with lower burden tolerance, consistent with Hypothesis 8.

To better illustrate the effects of some of the important predictors of burden tolerance, we present predicted probabilities for three ideal types for both sets of policies in Figure 2. The first ideal type represents an individual who was low in burden tolerance based on our analyses. In our case, this is an individual who was a liberal, with high levels of empathy, and who perceived racial and ethnic disparities in administrative burdens. Our second ideal type represents an individual with exactly the opposite characteristics. That is, the ideal type was a conservative, with low levels of empathy, who was skeptical of racial and ethnic disparities in administrative burdens. In both cases, all other variables were held at their mean. For comparative purposes, we also include an individual at the mean of our data set. The figures illustrate the predicted probabilities both before and after the unwinding. Stark differences between the ideal types are readily apparent. Individuals with high burden tolerance were clustered around the 0.200 mark for both sets of policies. This is compared to the mean individual around 0.800 and the individual low in burden tolerance with predicated probabilities above 0.900. We also note that individuals with low burden tolerance were much closer to the mean individual than those with high burden tolerance.

Hypotheses 5 and 6 addressed beliefs related to race, predicting that racial resentment (see also Appendix Exhibit 19) and beliefs that burdens operate as a tool of systemic racism will be associated with burden tolerance. However, as noted above, our informational treatments related to race and inequities did not show any effects (Hypothesis 7). We find support for both claims. Individuals who believe that burdens have a disparate effect on people of color were less tolerant of burdens. We also find that racial resentment is a powerful predictor of burden tolerance among White respondents in line with emerging work on the topic (Haeder & Moynihan, 2023a).

CONCLUSION

The concept of burden tolerance allows researchers a means to develop insights into public preferences about the details of policy implementation. In some cases, public beliefs may be erroneous, or anchored in racial biases, but they may still be consequential for policy makers. State actions are more likely to give rise to burdens when policy makers, including administrators, design administrative systems without engagement with the actual people subject to those processes. While there is value in having more generalized and abstract measures of

burden tolerance (Bækgaard et al., 2021), having policy-specific indicators provides a different type of insight, giving policy makers a more nuanced understanding of how the public thinks about administrative arrangements. In our case, we offered members of the public discrete choices about different aspects of administrative experiences. The evidence suggests significant durability of preferences about administrative arrangements during and after an extraordinary policy event. In the policy area we study, we find varying support for different tools to reduce burdens. Overall, however, the picture is one of a public that is broadly supportive of state governments doing more to reduce burdens in order to stem the loss of Medicaid coverage during the Great Unwinding, a degree of support often not mirrored by the actions of state governments in practice (Kaiser Family Foundation, 2024). While some governments did better than others, they collectively did not meet a public demand to protect eligible beneficiaries for coverage loss. We do not know the degree to which such a gap between public preferences and government actions exists in other policy domains. Future work could better understand the degree to which such preferences reflect frustrations with the complex and patchwork nature of the American health system, or a more general desire among the public for policy makers to reduce burdens.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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