Opposition to the Affordable Care Act has Little to do with Health Care

Abstract

The Affordable Care Act (ACA) has vastly reduced racial health insurance disparities, but continued efforts work to weaken and repeal this health care law. It is not clear, however, whether this policy is rejected because of its health care provisions or if the ACA is interpreted primarily as a social welfare policy aimed at providing resources specifically to non-White or other marginalized Americans. In this paper, we assess whether the racial divide in opposition to the ACA is unique to this law or represents a reflection of a longer history of racialized social welfare policies in the United States. The data for this research come from the American National Election Studies 2016 Time Series Study, which targets U.S.-based citizens aged 18 years and older. We conducted logistic regression to understand how racial attitudes and support for social policies relate to opposition to the ACA. Perceptions of the ACA, especially among White Americans, were related both to support for affirmative action in hiring and education and to racial resentment more generally. Attitudes toward the ACA were unrelated to support for policies that have not been explicitly framed as transferring resources to non-White Americans or women. As public debates continue regarding whether to amend the ACA or repeal and replace it altogether, scholars and public health practitioners should emphasize the role that racism and racial resentment continue to play in public evaluations of health care and other social policies.

The Patient Protection and Affordable Care Act (ACA) was passed in the midst of a decades-long partisan fight over how health care should be organized in the United States. Passed in 2010, the ACA was supported along party lines—with Republicans in office during its vote unanimously opposing the bill's passage (Dalen, Waterbrook, & Alpert, 2015). Since its enactment, the Republican party has initiated to repeal, delay, or defund the bill more than a dozen times, despite the public's growing support for the bill in the years since implementation and the ACA's positive impact on uninsurance rates and health disparities in the United States (Garfield et al., 2019; Jacobs & Mettler, 2016). Although public support continues to follow party lines, survey results show that Blacks and Latinos have consistently reported more favorable views of the ACA than have Whites (Fiscella, 2016; Foundation Kaiser Family, 2020; Henderson & Hillygus, 2011). Previous research suggests that the racial divide in support for the ACA is unique as compared to similar health policies such as President Clinton's health care plan proposed nearly 2 decades prior (Tesler, 2012). Although racial resentment has been tied empirically to rejection of the ACA (Byrd et al., 2011; Milner & Franz, 2019), less is known about whether this policy is rejected because of the changes proposed to the health care system or whether the ACA is interpreted primarily as a social welfare policy aimed at providing resources specifically to non-White or other marginalized Americans. In this paper, we assess whether racialized support for the ACA is unique to this law or is related to support for other social welfare policies in the United States.

How Does the ACA Relate to a Broader History of Health Care Reform in the United States?

Opposition to the ACA has been substantial and has focused on a few central themes, including the cost of premiums, concerns about government intervention in personal health care decisions, and the lack of a focus on personal responsibility (Dalen, Waterbrook, Alpert, & Boehner, 2015; P. R. Gordon et al., 2017). Political scientists in particular have demonstrated the durability of these themes in media framing of the ACA and the way that

framing has shaped both public opinion and knowledge of the health care law (Bergan & Risner, 2012; Fowler et al., 2017; Haeder, 2020). Against the backdrop of predominantly partisan objection to the ACA, scholars argue that when viewed within the historical context of the country's health care system, which has shared responsibility between the federal government and states, the ACA does not break with tradition or engage in federal overreach, as is claimed by opponents (Haeder & Weimer, 2015a). Instead, the primary components of the ACA—the health care exchanges and Medicaid expansion—seem to align with previous health care grants that supported states' budgets and the implementation of programs when states were unable to provide for those in need, such as in the development of the Social Security and Medicaid programs (Engel, 2006; Haeder & Weimer, 2015b). In other words, throughout the past century of health policy development, policies have been trending toward shared governance between the federal government and states in administering programs and expanding insurance coverage for individuals in need. Given this history, the ACA can be viewed as a natural progression—particularly as compared with alternative proposed changes such as the transition to a single-payer system, which would be more in line with plans in peer countries (Boychuk, 2008).

Who Has Benefitted From the ACA?

The ACA has helped millions of Americans obtain health care coverage through either the public exchanges or the Medicaid expansion that many states adopted. From 2010 to 2016, the uninsured rate dropped by nearly half in the United States (Tolbert et al., 2019). Health insurance gains were widespread, although non-White Americans were disproportionately uninsured and therefore benefited considerably from new insurance provisions. Although in absolute numbers there were more White Americans insured as a result of the ACA, a greater percentage of non-White Americans were insured, thereby narrowing existing insurance-based disparities in the country (Artiga et al., 2019).

Early studies also provided empirical evidence of how insurance gains associated with the ACA among non-White Americans have improved health outcomes. For example, studies using the Behavioral Risk Factor Surveillance System survey found initial evidence that the ACA has reduced health disparities in access to care and chronic disease outcomes. One study found that outcomes related to cardiovascular disease, which disproportionately affects racial minorities, were improved in Medicaid expansion states (Khatana et al., 2019). Another study found that the ACA reduced socioeconomic inequality as measured by individuals' financial ability to access health care, their having a personal doctor, and their receiving routine checkups (Kino & Kawachi, 2018). Although the ACA narrowed health disparities, its effects have been enjoyed more broadly by many Americans who benefit from lower rates of uninsurance, reduced health care spending, and improved disease prevention (Agirdas & Holding, 2018; Colla & Skinner, 2020).

What Do We Know About Racial Attitudes and Perceptions of the ACA?

Although health policy changes to increase health care utilization and investments in the social determinants of health stand to improve health equity, debates about how best to structure the U.S. health care system are highly politicized. Following a sharp partisan division in the ACA's passing and a legal fight over its implementation, a Republican-held Congress came close to repealing the policy in the first 2 years of Donald Trump's presidency. In an effort to understand why many Americans would actively support efforts to repeal the ACA despite so many people benefitting from this policy, scholars have elucidated political and cultural factors that underlie contestations of the statute (Maxwell & Shields, 2014). Recent studies, for example, have highlighted how the ACA was unique in its ability to evoke racial sentiments compared with previous health reform proposals. Public polls suggest that the divide between Blacks and Whites on the issue of health care reform was about 20 percentage points greater for President Obama's plan than it was for Clinton's

(Tesler, 2012). These same findings also offer that Obama's status as the first president of color in the United States may serve as a key reason why racial resentment is associated with health care reform (Tesler, 2012). Because health care was the defining piece of legislation for the Obama administration, this association with his presidency may have intensified the relationship between racial resentment and health policy support. Indeed, one study found that unfavorable views of the ACA increased when polls referred to the policy as Obamacare rather than the ACA (Holl, Niederdeppe, & Schuldt, 2018). These findings are in line with portrayals of Obama by his political opponents as the "food stamp president" who was primarily focused on transferring resources to poor and non-White Americans (Haney-López, 2015; Kessler, 2011). It is unclear, however, whether racial attitudes connected to ACA opposition are unique to this policy and Obama's role in its passing or are linked with a broader process of racialization of social welfare policies in the United States.

Although the ACA was not explicitly framed as a policy to address racial inequality in the United States, Ian Haney-López (2015) argued that legislation often becomes racialized by opponents in attempts to cast discredit by framing new policies as disproportionately helping undeserving racial minorities. By relying on abstract, color-blind ideals such as fairness, policies can evoke racial attitudes without having to explicitly mention or acknowledge the continuing significance of race (Bonilla-Silva, 2003/2018). Beyond health care, this process of embedding covert racial messages in policy debates has been associated with a number of policies aimed at improving social welfare, such as immigration and drug policy reform and efforts to reduce economic inequality (Drakulich, 2015; Gilens, 2000; Haney-López, 2015).

The covert racialization of many social policies, rather than their specific provisions, helps us understand why Whites contest social welfare policies even if they personally stand to benefit (Maxwell & Shields, 2014; Stein & Allcorn, 2018). These findings build on earlier

studies which suggest that Whites have more disparaging views of social-welfare policies if they believe their group will suffer at the expense of other racial groups, particularly Blacks (Gilens, 2000). As an example of this phenomenon, one study found that the degree to which Whites felt that they ever lost out on a job because of affirmative action was unrelated to their views on the policy; the degree to which they believed their group would suffer because of the policy, however, was related to their opposition to the policy, as were their beliefs that Blacks are lazy or undeserving (Kinder & Sanders, 1996). These studies lend insight into how the ACA may be perceived among White Americans.

Are Whites Focused on the Merit of the ACA as a Health Policy?

Knowledge of the ACA and its provisions has consistently been limited among Americans (Kaiser Family Foundation, 2011, 2013, 2014). Opposition by Whites may be due to other factors than the provisions themselves, such as the political framing of the law as taking away resources from hardworking Americans despite the fact that many opponents stand to benefit from its passing (Metzl, 2019). Racialized debates around public assistance programs are deeply rooted in the United States, and thus there is reason to suspect that the ACA may be associated with other social welfare policies. Attempts at introducing nationalized health care nearly a century ago faced arguments of opposition similar to those against the ACA, as have more recent initiatives to expand welfare and affirmative action policies (C. Gordon, 2003; Hoffman, 2003). Scholars have argued that threats to Whites' social status is at the heart of the objection to a broad range of social welfare programs and that political framing of policies often is intended to evoke racial fears (Bennett & Walker, 2018; Wetts & Willer, 2018)

Recent studies suggest that a similar framing surrounded the ACA and had tangible effects on public support for the health care law more generally and on states' decisions to adopt voluntary provisions such as Medicaid expansion. For example, states with large Black

populations and high racial resentment were less likely to adopt this voluntary program leveraging federal support, presumably because it was perceived as a social welfare policy aimed at promoting the advancement of Black Americans (Grogan & Park, 2017; Lanford & Quadagno, 2016). To date, however, no studies have assessed the extent to which support for the ACA relates to support for other social welfare policies, particularly among White Americans. In the present study, we explore whether racial divides in support for the ACA are unique to this policy or are tied to the more general racialization of social welfare policies. We test this research question by comparing the rejection of the ACA with attitudes toward social welfare policies and policies that have not been explicitly associated with racial equity, such as increased taxes on millionaires, job protections for sexual and gender minorities, and paid maternity leave. Although racial resentment has been associated with support for the ACA, we aim to understand whether this is unique to the ACA and its association with President Obama or reflects long-standing opposition to social welfare policies. We expect that support for the ACA will be related to support for social welfare policies that focus explicitly on racial equity or have been framed as taking resources from hardworking White Americans and will be unrelated to social policies that are not as clearly racialized.

Methods

Data

Data for this research come from the American National Election Studies (ANES; 2016) 2016 Time Series Study, which targets U.S.-based citizens aged 18 and older. The ANES was collected in two waves: A preelection wave was collected between September 7 and November 7, 2016, and as many participants as possible were reinterviewed for the postelection survey between November 9, 2016, and January 8, 2017. The data include a face-to-face sample (1,180 preelection and 1,058 postelection interviews) and internet sample

(2,090 preelection and 2,590 postelection interviews). ANES-provided weights for the data were applied to balance the greater number of internet cases and ensure generalizability to the U.S. population (ANES, 2016). The sample includes only individuals who completed both the pre- and postelection wave, because the dependent and focal variables of interest were measured only in the postelection wave (N = 3,633).

Measures

The dependent variable was measured by the question "Has the 2010 health care law, also known as the Affordable Care Act, improved, worsened, or had no effect on the quality of health care services in the United States?" Responses were coded 1 (*ACA has worsened the quality of health services*) and 0 (*The act improved quality or had no effect because of our focus on critical attitudes towards the law*). Two focal independent variables measured respondents' feelings toward affirmative action. The first associated question was "Do you favor, oppose, or neither favor nor oppose allowing universities to increase the number of Black students studying at their schools by considering race along with other factors when choosing students?" Responses were coded 1 (*favor a great deal*), 2 (*favor a moderate amount*), 3 (*favor a little*), 4 (*neither fav nor oppose*), 5 (*oppose a little*), 6 (*oppose a moderate amount*), and 7 (*oppose a great deal*). The second affirmative action question was "What about your opinion for or against preferential hiring/promotion of Blacks—are you for or against preferential hiring and promotion of Blacks?" Responses were coded 1 (*strongly for preferential hiring and promotion of Black individuals*), 2 (*not strongly for preferential hiring and promotion of Black individuals*), 3 (*not strongly against preferential hiring and promotion of Black individuals*), and 4 (*strongly against preferential hiring and promotion of Black individuals*).

Because research (Milner & Franz, 2019) has shown that anti-Black attitudes are associated with negative attitudes toward the ACA, we measure racial resentment with four

of the eight indicators used in Henry and Sears's (2002) Symbolic Racism Scale. Respondents were asked how strongly they agreed or disagreed with the following statements: (a) "Irish, Italians, Jewish and many other minorities overcame prejudice and worked their way up. Blacks should do the same without any special favors." (b) "Generations of slavery and discrimination have created conditions that make it difficult for Blacks to work their way out of the lower class." (c) "Over the past few years, Blacks have gotten less than they deserve." (d) "It's really a matter of some people not trying hard enough; if Blacks would only try harder they could be just as well off as Whites." Responses to the first and last statements were coded 1 (*strongly disagree*), 2 (*disagree somewhat*), 3 (*neither agree nor disagree*), 4 (*agree somewhat*), and 5 (*agree strongly*), whereas responses to the other two statements were reverse coded such that higher scores represent greater adoption of symbolic racist attitudes (Cronbach's $\alpha = 0.84$).

Included variables also measured respondents' feelings toward other social policies. Two questions regarding whether the respondent favors, opposes, or neither favors nor opposes requiring employers to offer paid leave to parents of new children and requiring employers to pay women and men the same amount for the same work were coded 1 (*favor a great deal*), 2 (*favor a moderate amount*), 3 (*favor a little*), 4 (*neither fav nor oppose*), 5 (*oppose a little*), 6 (*oppose a moderate amount*), and 7 (*oppose a great deal*). A question on whether the respondent favors or opposes laws to protect gays and lesbians against job discrimination was coded 1 (*favor strongly*), 2 (*favor not strongly*), 3 (*oppose not strongly*), and 4 (*oppose strongly*). Two questions measuring whether the respondent favors, opposes, or neither favors nor opposes increasing income taxes on people making more than $1 million dollars per year and the government trying to reduce the difference in incomes between the richest and poorest households were coded 1 (*opposes*) and 0 (*favors or neither favors nor opposes*).

We also controlled for respondents' self-identified race (Black; Hispanic; and other race/ethnic minority, including Asian/Pacific Islanders, Native/Alaskan Native, and multiple races, with White as the reference category) and for whether the respondent had health insurance (1 = no insurance; 5 = have insurance). Other controlled demographic factors included age (in continuous years), sex (1 = male; 0 = all other), household income (1 = $22,499 or less, 2 = $22,500–$44,999, 3 = $45,000–$69,999, 4 = $70,000–$109,999, 5 = $110,000 and above), education level (1 = high school or less, 2 = some college, 3 = associate's degree, 4 = bachelor's, 5 = master's or higher), state of residency (1 = resides in a state listed by the census as in the south, southern state = 1; 0 = all others), and political party (variables for Republican and Independent, with Democrat as the reference category).

Analysis

We performed descriptive analyses for all measured variables. Exploratory analysis confirmed a significant interaction association between White participants' (but not Black, Hispanic, and other race respondents) race, levels of racial resentment, and the dependent variable. Exploratory analysis also revealed a significant interaction relationship between the affirmative action measures by race and as a result we present results for white participants as well as the full sample, controlling for race.

Results

Descriptive Statistics

Table 1 presents univariate results for the full sample and the White sample (approximately 70% of the total sample). Almost half (49.34%) of the full sample and more than half (56%) of the White sample stated that the ACA has worsened the quality of health care in the United States. On the scales measuring respondents' feelings toward affirmative action, both the full sample and White sample were more opposed than supportive; the White sample was slightly more opposed. In terms of opposition to affirmative action in universities

measured on a scale from 1 to 7, the mean scores were 4.64 for the full sample and 4.92 for the White sample. Similarly, on the opposition to affirmative action in employment measured on a scale from 1 to 4, the mean score was 3.12 for the full sample and 3.33 for the White sample.

This pattern was also observed in the mean score on the 5-point Symbolic Racism Scale, on which White participants (M = 3.34) scored slightly higher than the total sample (M = 3.19); the 7-point Opposition to Paid Leave Scale (full sample = 2.49, White sample = 2.56); and 4-point Opposition to Protection for Gays and Lesbians Against Job Discrimination Scale (full sample = 1.64, White sample = 1.65). The 7-point Equal Pay for Women and Men Scale was the only scale for which the White sample (1.61) was less opposed than the full sample (1.65). However, the White sample was still marginally more opposed than the full sample to a tax on those earning more than $1 million a year (approximately 15% opposition in the full sample and 16% in the White sample) and to the government reducing inequality between the richest and poorest households (approximately 30% opposition in the full sample and 34% in the White sample).

The White sample was slightly older than the full sample and on average more likely to have health insurance, have a higher household income, hold a college degree, and identify as a Republican or Independent rather than a Democrat. The White sample, however, was slightly less likely to live in a southern state compared with the full sample (34.95% and 38.14%, respectively).

[Insert Table 1 here]

Multivariate Analyses

Table 2 presents the results for both the full and White samples of the models that examined the associations of predictor variables with stating that the ACA has worsened the quality of

health care services in the United States. Opposition to affirmative action in universities was significantly associated with negative feelings toward the ACA in both the full sample, odds ratio [*OR*] = 1.08, 95% confidence interval (CI) [1.02, 1.14], $p < .01$, and White sample, *OR* = 1.07, 95% CI [1.001, 1.15], $p < .05$. However, opposition to affirmative action in employment was only significantly related to feelings that the ACA worsened health care in the White sample, *OR* = 1.01, 95% CI [1.01, 1.32], $p < .05$.

The Symbolic Racism Scale was significantly associated with negative feelings toward the ACA. Respondents who scored higher on the scale for the full sample, *OR* = 1.89, 95% CI [1.71, 2.09], $p < .001$, and White sample, *OR* = 2.00, 95% CI [1.77, 2.27], $p < .001$, approximately doubled the likelihood of stating that the ACA worsened health care.

In terms of other social policy preferences apart from affirmative action, only opposition toward equal pay for women and men (full sample *OR* = 1.16, 95% CI [1.08, 1.24], $p < .001$; White sample *OR* = 1.17, 95% CI [1.17, 1.28], $p < .01$) and opposing the government reduce income inequality (full sample *OR* = 2.13, 95% CI [1.73, 2.62], $p < .001$; White sample *OR* = 1.75, 95% CI [1.36, 2.24], $p < .001$) were significantly related to negative feelings toward the ACA.

[Insert Table 2 here]

In the full model, those who self-identified as Black were less than half as likely to state that the ACA worsened health care than were participants who self-identified as White, *OR* = .46, 95% CI [.33, .65], $p < .001$; however, no significant differences occurred between Hispanic and other racial minority identity and White identity. Not having health insurance was related to higher odds of stating that the ACA worsened health care in both the full sample model, *OR* = 1.74, 95% CI [1.30, 2.33], $p < .001$, and White sample model, *OR* = 2.01, 95% CI [1.35, 2.97], $p < .01$.

In terms of demographic correlates, in both models men were less likely to state that the ACA worsened health care, whereas those living in southern states and Independents were more likely to state this. In the full model but not the White model, more educated individuals were slightly less likely to state that the ACA worsened health care. In both models, Republican identity was the strongest predictor of negative feelings toward the ACA; Republicans were nearly 4 times more likely than Democrats in the full model, and nearly 5 times more likely in the White model, to state that the ACA worsened health care: full sample $OR = 3.88$, 95% CI [3.07, 4.91], $p < .001$; White sample $OR = 4.76$, 95% CI [3.60, 6.30], $p < .001$.

The Cox and Snell–type pseudo-R-squared in both the full (pseudo-$R^2 = .31$) and White (pseudo-$R^2 = .32$) models are high, indicating that the independent variables and correlates are explaining a large portion of the variation in feelings toward the ACA. For results for non-white participants alone, see supplementary materials.

Discussion

The aim of this study was to understand whether racialized perceptions of the ACA simply reflect Barack Obama's position as the first U.S. president of color or were connected to the more general legacy of racialized policy framing in the United States. The ACA was the first major change to the U.S. health care system in decades, but our findings suggest that efforts to block its passage and in recent years to dismantle and repeal this statute may have appealed to some White voters because opponents covertly racially framed the ACA as a handout for the undeserving and lazy poor. Indeed, even after controlling for political affiliation we find that detractors of the ACA also tend to oppose affirmative action programs, to believe that Blacks find themselves in their social-economic disadvantaged position because of their own doing, and to be more comfortable with social inequality. These findings are important because each of these policies has been clearly racialized in American

political debates (Haney-López, 2015) and lend credit to the hypothesis that political leaders may effectively add racial frames to domestic policies, such as the ACA, so as to build opposition to said policies, particularly among Whites.

The fact that the ACA has been framed by opponents as being associated with poor and non-White Americans is important because this health care law is considerably complex, with provisions not simply related to insurance but to public health more generally. Some scholars have argued that many aspects of the ACA, in the absence of partisan policymaking, would be appealing to many Americans (Gross et al., 2012). The emphasis on individual responsibility for one's own health through maintaining at least minimal health care coverage was initially a provision in the Massachusetts state health care plan, passed collaboratively by a Republican governor and Democrat-controlled state legislature (Doonan & Tull, 2010).

But, as scholars have noted in discussions of social welfare policies, the issue seems to be how policies are framed to the American public (Haney-López, 2015). Our results suggest that Americans interpret the ACA much like previous welfare policies and that important differences exist between this and other social policies that have not been racialized in public policy debates. The fact that, especially among White respondents, perceptions of the ACA were related to support for affirmative action in hiring and education and to opposition to equal pay for women and government efforts to reduce inequality suggests that the ACA is viewed primarily as a social welfare policy.

Although policies aimed to close the gender gap in wages have not been previously described as racialized in mainstream debates, we argue that this type of policy may be perceived similarly to social welfare policies in that gender equity has historically been framed as taking resources away from men or disincentivizing hard work and merit-based pay structures (Goetz & Jenkins, 2018; Hughes, Schilt, Gorman, & Bratter, 2017). It is also possible that opposition to gender equity could be associated with attitudes toward the ACA

given that this health care law included explicit measures to reduce health-care-based discrimination, including the process of gender-rating or charging women more for health insurance (Lee, Monuteaux, & Galbraith, 2020). Attitudes toward the ACA, correspondingly, were unrelated to support for paid parental leave; job protections for lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual Americans; or taxes for millionaires. We argue that these policies have not been framed as strongly, either explicitly or implicitly, as being focused on promoting racial equity as have other social welfare policies.

Our results build on previous research that finds racism and racial resentment to be key predictors of rejection of the ACA (Milner & Franz, 2019; Tesler, 2012). Although partisanship is a strong predictor of attitudes toward this health care law, scores on a symbolic racism scale also were strongly predictive of ACA opposition above and beyond political affiliation. Partisanship is important, in other words, but does not tell the whole story. Racial resentment and a longer history of racialized policy making may help us understand rather peculiar findings, such as why Americans may be willing to risk potential benefits from health policies if it means that other groups are not able to receive benefits (Metzl, 2019).

Although the ACA has helped millions of Americans gain health care coverage and access to preventive health services, the health care law remains threatened by continued efforts to weaken the law's provisions or repeal it entirely (Haeder, 2020). Our results suggest that the decade-long fight over the ACA is not a unique moment in American history but a product of a much longer narrative surrounding social welfare policies and who stands to benefit from the action of federal and state governments. Previous studies have linked ACA opposition to Obama, but our findings suggest that the salience of "Obamacare" may be its ability to elicit feelings that this policy, like racialized policies before it, are taking resources from hardworking White Americans and giving them to the undeserving poor. In this sense,

the ACA is not unique just because Obama was the first president of color but is related to a much longer history of criticizing social policies by linking them to racial stereotypes about who is hardworking and to beliefs in the openness of the American opportunity structure. Although the ACA was not framed by its proponents as a policy explicitly aimed at reducing coverage disparities among poor and non-White Americans, its detractors used implicit racial frames that seemingly resonated with many Americans, particularly White Americans, who ended up opposing the policy.

Limitations

Our study findings are limited in several ways that should be acknowledged. First, our dependent variable asked about whether the ACA has improved or worsened the quality of health care services, which was not the only or most newsworthy aim of the ACA. Second, because our dependent variable was collected in only one wave, we are limited in our ability to interpret causality or assess differences in ACA support over time. Our use of secondary data also limited the number and type of policy variables that we could include as predictors of ACA opposition. Third, more than 70% of our sample identified as non-Hispanic White, which is higher than the national total listed in the 2018 census (60.7%) (U.S. Census Bureau QuickFacts: UNITED STATES, 2018) and correspondingly there was an underrepresentation of Blacks and Hispanics in our sample. Finally, the nature of this survey did not allow for open-ended questions about the ACA. Future studies should consider using qualitative methods to understand how the ACA is interpreted in racialized ways and in relation to other social welfare policies.

Public Health Implications

The ACA was the first successful attempt at reforming the U.S. health care system in decades. Although its passing was politically contested, support for this health care law has grown as data have emerged to demonstrate its efficacy at reducing the very high uninsurance

rate in the United States. As health care policy debates continue regarding whether to amend the ACA or repeal and replace it altogether, scholars and public health practitioners should recognize the role that racism and racial resentment more specifically play in policy debates. To promote health equity in the United States and reduce barriers to health care access, we need more public dialogue about how enduring patterns of racial resentment in U.S. policy debates, in addition to partisan disagreement, serves as a fundamental barrier to enacting health policy change.

References

Agirdas, C., & Holding, J. G. (2018). Effects of the ACA on Preventive Care Disparities. *Applied Health Economics and Health Policy*, *16*(6), 859–869. https://doi.org/10.1007/s40258-018-0423-5

American National Election Studies (ANES). (2016). 2016 Time Series Study. Retrieved May 13, 2019, from https://electionstudies.org/project/2016-time-series-study/

Artiga, S., Orgera, K., & Damico, A. (2019). *Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017*. Washington DC. Retrieved from http://files.kff.org/attachment/Issue-Brief-Changes-in-Health-Coverage-by-Race-and-Ethnicity-since-Implementation-of-the-ACA-2013-2017

Bennett, D., & Walker, H. (2018). Cracking the Racial Code: Black Threat, White Rights and the Lexicon of American Politics. *American Journal of Economics and Sociology*, *77*(3–4), 689–727. https://doi.org/10.1111/ajes.12240

Bergan, D., & Risner, G. (2012). Issue ads and the health reform debate. *Journal of Health Politics, Policy and Law*, *37*(3), 513–549. https://doi.org/10.1215/03616878-1573103

Bonilla-Silva, E. (2003). *Racism without Racists: Color-Blind Racism and the Persistence of Racial Inequality in America*. New York: Rowman and Littlefield. Retrieved from https://rowman.com/isbn/9781442276239/racism-without-racists-color-blind-racism-

and-the-persistence-of-racial-inequality-in-america-fifth-edition

Boychuk, G. W. (2009). *National Health Insurance in the United States and Canada | Georgetown University Press*. Washington, D.C.: Georgetown University Press. Retrieved from http://press.georgetown.edu/book/georgetown/national-health-insurance-united-states-and-canada

Byrd, D., Saporta, C., & Martinez, R. M. (2011). *THE ROLE OF RACE IN THE HEALTH CARE DEBATE*. Berkeley, California.

Colla, C., & Skinner, J. (2020, March 13). The Affordable Care Act Made Health Care (Slightly) More Affordable | Health Affairs. Retrieved April 14, 2020, from https://www.healthaffairs.org/do/10.1377/hblog20200313.368916/full/

Dalen, J. E., Waterbrook, K., & Alpert, J. S. (2015). Why do so Many Americans Oppose the Affordable Care Act? *American Journal of Medicine*, *128*(8), 807–810. https://doi.org/10.1016/j.amjmed.2015.01.032

Dalen, J. E., Waterbrook, K., Alpert, J. S., & Boehner, J. (2015). Why do so Many Americans Oppose the Affordable Care Act? *The American Journal of Medicine*, *128*, 807–810. https://doi.org/10.1016/j.amjmed.2015.01.032

Doonan, M. T., & Tull, K. R. (2010, March). Health care reform in massachusetts: Implementation of coverage expansions and a health insurance mandate. *Milbank Quarterly*. Milbank Memorial Fund. https://doi.org/10.1111/j.1468-0009.2010.00589.x

Drakulich, K. M. (2015). Explicit and Hidden Racial Bias in the Framing of Social Problems. *Social Problems*, *62*(3), 391–418. https://doi.org/10.1093/socpro/spu003

Engel, J. (2006). *Poor People's Medicine: Medicaid and American Charity Care since 1965*. Durham, NC: Duke University Press.

Fiscella, K. (2016). Why Do So Many White Americans Oppose the Affordable Care Act? *The American Journal of Medicine*, *129*, e27.

https://doi.org/10.1016/j.amjmed.2015.08.041

Foundation Kaiser Family. (2020). KFF Health Tracking Poll: The Public's Views on the ACA. Retrieved February 7, 2020, from https://www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable&group=Race%2520%252F%2520Ethnicity::White::Black::Hispanic&label&aRange=all

Fowler, E. F., Baum, L. M., Barry, C. L., Niederdeppe, J., & Gollust, S. E. (2017). Media messages and perceptions of the affordable care act during the early phase of implementation. *Journal of Health Politics, Policy and Law*, *42*(1), 167–195. https://doi.org/10.1215/03616878-3702806

Garfield, R., Orgera, K., & Damico, A. (2019). *The Uninsured and the ACA: A Primer*. San Fransisco. Retrieved from https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-many-people-are-uninsured/

Gilens, M. (2000). *Why Americans hate welfare : race, media, and the politics of antipoverty policy*. University of Chicago Press.

Goetz, A. M., & Jenkins, R. (2018). Feminist Activism and the Politics of Reform: When and Why Do States Respond to Demands for Gender Equality Policies? *Development and Change*, *49*(3), 714–734. https://doi.org/10.1111/dech.12389

Gordon, C. (2003). *Dead on arrival : the politics of health care in twentieth-century America*. Princeton University Press.

Gordon, P. R., Gray, L., Hollingsworth, A., Shapiro, E. C., & Dalen, J. E. (2017). Opposition to Obamacare: A Closer Look. *Academic Medicine*, *92*(9), 1241–1247. https://doi.org/10.1097/ACM.0000000000001725

Grogan, C. M., & Park, S. E. (2017). The racial divide in state medicaid expansions. *Journal*

of Health Politics, Policy and Law, *42*(3), 539–572. https://doi.org/10.1215/03616878-3802977

Gross, W., Stark, T. H., Krosnick, J., Pasek, J., Sood, G., Tompson, T., … Junius, D. (2012). Americans' Attitudes Toward the Affordable Care Act: Would Better Public Understanding Increase or Decrease Favorability? *Princeton, NJ: Robert Wood Johnson Foundation Inc.* Retrieved from http://www.stanford.edu/dept/communication/faculty/krosnick/docs/2012/Health Care 2012 - Knowledge and Favorability.pdf

Haeder, S. F. (2020). Political Science and U.S. Health Policy in the Era of the Affordable Care Act. *Policy Studies Journal*, *48*(S1), S14–S32. https://doi.org/10.1111/psj.12385

Haeder, S. F., & Weimer, D. L. (2015a). Inching Toward Universal Coverage: State-Federal Health-Care Programs in Historical Perspective. *Journal of Policy History*, *27*(4), 746–770. https://doi.org/10.1017/S0898030615000330

Haeder, S. F., & Weimer, D. L. (2015b). You can't make me do it, but i could be persuaded: A federalism perspective on the affordable care act. *Journal of Health Politics, Policy and Law*, *40*(2), 281–323. https://doi.org/10.1215/03616878-2882219

Haney-López, I. (2015). *Dog whistle politics : how coded racial appeals have reinvented racism and wrecked the middle class*. Oxford University Press.

Henderson, M., & Hillygus, D. S. (2011). The dynamics of health care opinion, 2008 - 2010: Partisanship, self-interest, and racial resentment. *Journal of Health Politics, Policy and Law*, *36*(6), 945–960. https://doi.org/10.1215/03616878-1460533

Henry, P. J., & Sears, D. O. (2002). The Symbolic Racism 2000 Scale. *Political Psychology*, *23*(2), 253–283. https://doi.org/10.1111/0162-895X.00281

Hoffman, B. (2003, January 1). Health care reform and social movements in the United States. *American Journal of Public Health*. American Public Health Association Inc.

https://doi.org/10.2105/AJPH.93.1.75

Holl, K., Niederdeppe, J., & Schuldt, J. P. (2018). Does Question Wording Predict Support for the Affordable Care Act? An Analysis of Polling During the Implementation Period, 2010–2016. *Health Communication*, *33*(7), 816–823. https://doi.org/10.1080/10410236.2017.1315676

Hughes, C. C., Schilt, K., Gorman, B. K., & Bratter, J. L. (2017). Framing the Faculty Gender Gap: A View from STEM Doctoral Students. *Gender, Work and Organization*, *24*(4), 398–416. https://doi.org/10.1111/gwao.12174

Jacobs, L., & Mettler, S. (2016, June 21). Why public opinion on ObamaCare should worry us all. Retrieved February 7, 2020, from https://thehill.com/blogs/pundits-blog/healthcare/284217-why-public-opinion-on-obamacare-should-worry-us-all

Kaiser Family Foundation. (2011, November 2). Kaiser Health Tracking Poll: November 2011. Retrieved September 28, 2020, from https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-november-2011/

Kaiser Family Foundation. (2013, March 20). Kaiser Health Tracking Poll: March 2013. Retrieved September 28, 2020, from https://www.kff.org/health-reform/poll-finding/march-2013-tracking-poll/

Kaiser Family Foundation. (2014, February 6). The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA. Retrieved September 28, 2020, from https://www.kff.org/uninsured/report/the-uninsured-at-the-starting-line-findings-from-the-2013-kaiser-survey-of-low-income-americans-and-the-aca/

Kessler, G. (2011, December 8). Barack Obama: the ‘food-stamp president’? . *The Washington Post*. Retrieved from https://www.washingtonpost.com/blogs/fact-checker/post/barack-obama-the-food-stamp-

president/2011/12/07/gIQAzTdQdO_blog.html

Khatana, S. A. M., Bhatla, A., Nathan, A. S., Giri, J., Shen, C., Kazi, D. S., … Groeneveld, P. W. (2019). Association of Medicaid Expansion with Cardiovascular Mortality. *JAMA Cardiology*, *4*(7), 671–679. https://doi.org/10.1001/jamacardio.2019.1651

Kinder, D., & Sanders, L. (1996). *Divided by color: Racial politics and democratic ideals.* Chicago: University of Chicago Press. Retrieved from https://psycnet.apa.org/record/1996-98093-000

Kino Id, S., & Kawachi, I. (2018). The impact of ACA Medicaid expansion on socioeconomic inequality in health care services utilization. https://doi.org/10.1371/journal.pone.0209935

Lanford, D., & Quadagno, J. (2016). Implementing ObamaCare: The Politics of Medicaid Expansion under the Affordable Care Act of 2010. *Sociological Perspectives*, *59*(3), 619–639. https://doi.org/10.1177/0731121415587605

Lee, L. K., Monuteaux, M. C., & Galbraith, A. A. (2020). Women and Healthcare Affordability After the ACA. *Journal of General Internal Medicine*, *35*(3), 959–960. https://doi.org/10.1007/s11606-019-05248-4

Maxwell, A., & Shields, T. (2014). The Fate of Obamacare: Racial Resentment, Ethnocentrism and Attitudes about Healthcare Reform. *Race and Social Problems*, *6*(4), 293–304. https://doi.org/10.1007/s12552-014-9130-5

Metzl, J. (2019). *Dying of whiteness : how the politics of racial resentment is killing America's heartland*.

Milner, A., & Franz, B. (2019). Anti-black Attitudes Are a Threat to Health Equity in the United States. *Journal of Racial and Ethnic Health Disparities*, *7*(1), 169–176. https://doi.org/10.1007/s40615-019-00646-0

Stein, H., & Allcorn, S. (2018). A Fateful Convergence Animosity Toward Obamacare,

Hatred of Obama, the Rise of Donald Trump, and Overt Racism in America. *The Journal of Psychohistory*, *45*(4), 234–243.

Tesler, M. (2012). The Spillover of Racialization into Health Care: How President Obama Polarized Public Opinion by Racial Attitudes and Race. *American Journal of Political Science*, *56*(3), 690–704. https://doi.org/10.1111/j.1540-5907.2011.00577.x

Tolbert, J., Orgera, K., & Damico, A. (2019). *Key Facts about the Uninsured Population*. Washington DC. Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/09/8488-key-facts-about-the-uninsured-population.pdf

U.S. Census Bureau QuickFacts: UNITED STATES. (n.d.). Retrieved May 13, 2019, from https://www.census.gov/quickfacts/fact/table/US/PST045218

Wetts, R., & Willer, R. (2018). Privilege on the Precipice: Perceived Racial Status Threats Lead White Americans to Oppose Welfare Programs. *Social Forces*, *97*(2), 793–822. https://doi.org/10.1093/sf/soy046

Table 1. Sample Characteristics

	Full Sample[a]		***White Sample***[b]	
	M*/*n	***SD*/%**	***M*/*n***	***SD*/%**
Variables				
ACA worsened health care	1,767	49.34%	1,392	56.11%
Oppose Affirmative Action in Universities Scale (1–7)	4.64	1.91	4.92	1.79
Oppose Affirmative Action in Employment Scale (1–4)	3.12	1.09	3.33	.95
Symbolic Racism Scale (1–5)	3.19	1.13	3.34	1.12
Oppose Paid Leave to New Parents Scale (1–7)	2.49	1.79	2.56	1.80
Oppose Equal Pay for Women and Men Scale (1–7)	1.65	1.29	1.61	1.24
Oppose Protection for Gays and Lesbians Against Job Discrimination Scale (1–4)	1.64	1.03	1.65	1.04
Oppose tax on millionaires	556	15.30%	406	16.10%
Oppose government reducing income inequality	1094	30.20%	843	33.60%
R identifies as Black	397	10.94%		

R identifies as Hispanic	432	11.91%		
R identifies as other racial minority	268	7.04%		
No health insurance	364	9.98%	209	8.25%
Age	47.39	17.69	49.20	17.92
Male	1733	47.94%	1202	47.78%
Household income	$57,500	1.44	$61,300	1.42
College degree or higher	1156	31.88%	878	34.89%
R resides in southern state	1391	38.14%	884	34.95%
Republican	1016	28.09%	869	34.61%
Independent	1161	32.08%	837	33.37%

Note. ACA = Affordable Care Act; R = respondent.

[a]*N* = 3,633. [b]*n* = 2,521.

Table 2. Odds Ratios for Logistic Regression Stating the Affordable Care Act Worsened Health Care

	Full Sample[a]		***White Sample***[b]	
Variables	**OR**	**95% CI**	**OR**	**95% CI**
Oppose Affirmative Action in Universities Scale (1–7)	1.08**	1.02, 1.14	1.07*	1.00, 1.15
Oppose Affirmative Action in Employment Scale (1–4)	1.04	.94, 1.14	1.16*	1.01, 1.32
Symbolic Racism Scale (1–5)	1.89***	1.71, 2.09	2.00***	1.77, 2.27
Oppose Paid Leave to New Parents Scale (1–7)	1.02	.97, 1.08	1.04	.97, 1.11
Oppose Equal Pay for Women and Men Scale (1–7)	1.16***	1.08, 1.24	1.17**	1.06, 1.28
Oppose Protection for Gays and Lesbians Against Job Discrimination Scale (1–4)	1.05	.96, 1.15	1.07	.96, 1.19
Oppose tax on millionaires	1.16	.09, 1.51	1.13	.82, 1.55
Oppose government reducing income inequality	2.13***	1.73, 2.62	1.75***	1.36, 2.24
R identifies as Black	.46***	.33, .65		
R identifies as Hispanic	.80	.61, 1.03		
R identifies as other racial minority	.78	.56, 1.09		

No health insurance	1.74***	1.30, 2.33	2.01**	1.35., 2.97
Age	.995	.990, 1.00	.995	.995., 1.00
Male	.79**	.66, .94	.77*	.63, .96
Household income	1.04	.97, 1.11	1.07	.99, 1.16
Education	.93*	.87, .99	.93	.86, 1.01
R resides in southern state	1.39***	1.16, 1.66	1.32*	1.06, 1.16
Republican	3.88***	3.07, 4.91	4.76***	3.60, 6.30
Independent	1.51***	1.24, 1.84	1.76***	1.38, 2.24
Pseudo R^2	.31		.32	

Note. R = respondent.

[a]N = 3,202. [b]n = 2,351.

*p < .05. **p < .01. ***p < .001.