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UNDERSTANDING ATTITUDES TOWARD HEALTHCARE REFORM: THE ROLES OF SELF-INTEREST, GROUP IDENTITY AND RACIAL RESENTMENT

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BY

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DISSERTATION

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Requirements for the Degree of

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DEDICATION

Dedicated to Amelia Loretta Maderal Chanco Baja and America Maria Otero Livaudais.

The hearts and fire of our family.

ACKNOLWEDGEMENTS

This dissertation would not be possible without the support of my family, friends and committee. First, I would like to acknowledge my family who shaped me and provided me with the skills and opportunities to thrive. It is overwhelming to think of how much your love and intentions made me the person I am today. Mom, your food and phone calls always sustain my body and soul. Dad, thank you for passing on your wisdom, humor, and insomnia which undoubtedly helped me finish this dissertation. A special shout out to my brother who had nothing but words of encouragement along this journey. I owe an immense amount of gratitude to my husband Cody who has been with me every step of the way. Thank you for sharing this journey with me and for celebrating every milestone.

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"I am the product of all of the ancestors getting together and deciding these stories need to be told."

-Rupi Kaur

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ABSTRACT

The Patient Protection and Affordable Care Act (ACA) cemented itself as one of the most controversial pieces of legislation of the decade. Public opinion polls find Americans are often evenly split in support of the ACA. This dissertation explores the roles of self-interest, group identity, and racial resentment on attitudes toward the ACA and healthcare reform. The dissertation centers our attention on variation by race and the impact racial tensions beyond the Black-White paradigm on these attitudes. I find group identity shapes attitudes Blacks' and Latinos' attitudes toward the ACA but not Whites' and racial resentment, directed toward Blacks, Latinos and Immigrants, plays a strong role when people evaluate the ACA but not when they consider healthcare reform broadly. The landscape of healthcare reform is constantly shifting. Having an accurate pulse on attitudes toward healthcare reform is essential to ensuring the system is responding to citizens needs and expectations.

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CHAPTER ONE:

INTRODUCTION

In 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. The ACA sought to address the growing number of uninsured individuals, lack of affordable care, and lack of access to health care. Since the ACA's passage, it cemented itself as one of the most controversial pieces of legislation of the decade. Public opinion polls demonstrate the public is often evenly split in support of the ACA. This split in public opinion often falls along party lines, Republicans are more likely than Democrats to oppose the ACA (Brodie, Deane, and Cho 2011; Gallup 2017; Kaiser 2018). In several studies, the effects of party have been so strong that they outweigh self-interest (Brodie, Deane, and Cho 2011; Legerski and Berg 2016a). For example, Brodie, Deane, and Cho (2011) demonstrate regions with large portions of uninsured individuals who would benefit from the ACA rely on political ideology over their self-interest at the aggregate level.

This puzzle prompts scholars to investigate the multifaceted public opinion of healthcare reform, including the role of political ideology, self-interest, and awareness of available resources (Backhouse 1996; Brooks and Cheng 2001). Before the implementation of the ACA, Schlesinger (2010) demonstrated how economic insecurity from the Great Recession facilitated support for healthcare reform when framed in terms of affordability. Henderson and Hillygus (2011) confirm this finding, verifying individuals who identify as Republicans are more likely to oppose government-directed healthcare reform, but self-interest dilutes the relationship when they consider their medical expenses. LeCount and Abrahamson (2017) include a self-rated health measure into their model and find that individuals with poorer self-rated health are more

likely to support an active role for the government to provide healthcare and increase spending on healthcare.

In contrast to the literature on self-interest, there is a significant amount of literature that establishes symbolic beliefs (i.e., Democrat and Republican or conservative and liberal) are much stronger predictors of political attitudes and policy preferences than self-interest (Lau, Brown, and Sears 1978; Lau and Heldman 2009; Sears et al. 1980; Sears and Funk 1991; Sears, Hensler, and Speer 1979). The general conclusion drawn from this line of study is that symbolic attitudes defined by party identification, liberal-conservative ideology, and racial resentment are stronger predictors of policy preferences than self-interest (Lau and Heldman 2009). Yet these studies are often limited to Whites and Blacks attitudes toward the ACA and fail to explain variation by race.

This dissertation follows this line of inquiry with new measures that add new variables, specifically linked fate and racial resentment across racial/ethnic groups, to build a more robust model to understand public opinion of healthcare reform. The broad research question is: what explains public opinion for healthcare reform? In this introduction, I will review the history of the ACA and the primary components of the bill. I will then provide the format of the dissertation.

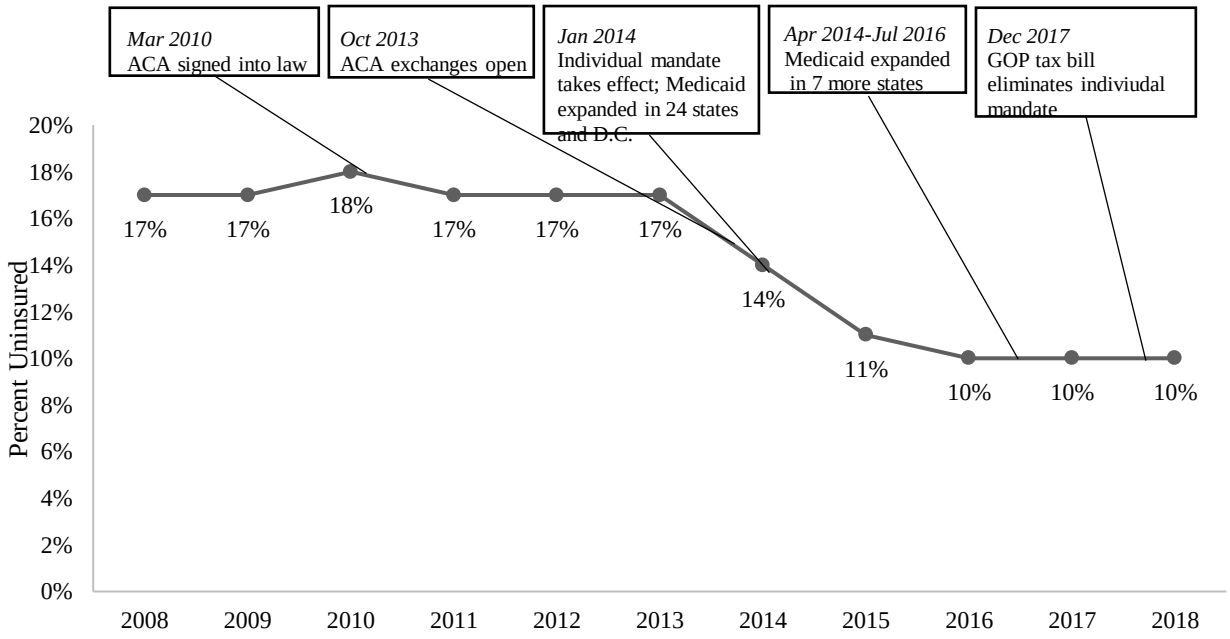
The Patient Protection and Affordable Care Act

America has a healthcare problem. Gaps in health insurance and the cost of care for families and business are long standing problems and have accelerated health inequities over the last century. The 2008 presidential elections highlighted the broken healthcare system which leaves too many without health insurance due to preexisting conditions, financial barriers, and poor coverage. Furthermore, the rising cost of care in the years before 2008 meant that an

increasing number of people with coverage through their jobs or individual plans paid more for less adequate coverage (Jacobs and Skocpol 2012, p. 24-29). Almost a fifth of the American population was without health insurance (Fuchs and Emanuel 2005; Kaiser 2011a). Both political parties agreed there was a problem with healthcare but significantly differed in how to fix it.

Under the new Obama administration, the Democratic Party introduced the Patient Protection and Affordable Care Act (ACA) in 2009. A year later, the Senate and House of Representatives narrowly passed the bill along party-lines and President Obama March signed it into law in 2010 (see Figure 1). That same year, the percent of uninsured nonelderly adults peaked at 18% (Kaiser 2018c).

Figure 1. Timeline of the ACA and Percent of Uninsured Non-Elderly Adults, 2008-2018



Source: Kaiser 2018

The ACA sought to increase access to health coverage and improve the healthcare system by (see Table 1). The primary provisions of the ACA include the expansion of Medicaid, allowing dependents to remain on their guardians' insurance until age 26, subsidies for low income individuals and families to gain health insurance, and the health insurance marketplaces which simplified the process to gain health insurance (Patient Protection and Affordable Care Act 2010). Immediately after its passage, the Republican Party led multiple attacks to delay its implementation and broadly weaken the policy (Jacobs and Skocpol 2012).

Table 1. Key Components of the Patient Protection and Affordable Care Act (ACA)

Key Components of the ACA	
Expansion of public health coverage programs (Medicaid, Medicare, Children's Health Insurance Program (CHIP))	• Medicaid and CHIP expansion • Enhance Medicare coverage, changes to payment system
Health insurance exchanges	• Allowed states to choose between federal marketplace, state/federal partnership or state-run health insurance marketplace
Changes to private insurance	• Dependents can remain on insurance until age 26 • Minimum set of services, out of pocket spending caps • Cannot deny coverage for any reason
Employers required to provide insurance to full-time employees	• Applicable to companies with more than 50 employees
Tax credits for income and cost of coverage	• Tax credit for low- or middle-income families to put toward insurance purchased through marketplaces
Individual mandate	• Requires basic level of health insurance coverage or face a tax penalty (no longer active since 2019)

The ACA faced several legal challenges, three of which went to the Supreme Court (Altman 2015; Kaiser 2012; Sobel and Salganicoff 2013). The first challenge was led by 28 states, the majority Republican, who joined a lawsuit against the federal government which

argued the Medicaid expansion and individual mandate were violations of state sovereignty. These legal challenges culminated in the Supreme Court Case, *National Federation of Independent Businesses v. Sebilius* (2012) which upheld the constitutionality of the individual mandate and paved the way for the opt-in version of the Medicaid expansion. The second case, in 2014, provided for-profit corporations the option to refuse to pay for legally mandated coverage of certain contraceptive drugs and devices in their employees' health plans (Burwell v. Hobby Lobby Stores, Inc. 2014). The final case was likely the most tedious, *King v. Burwell* (2015) which challenged the legality of IRS-issued subsidies for the states that depended on the federal marketplaces. The case hinged on the interpretation of four words in the ACA "established by the State." These four words referred to a component of the law which stated "exchanges established by the State" could issue subsidies but failed to mention states that relied on the federal marketplaces. The Supreme Court ruled the subsidies were legal in all health insurance marketplaces, state or federal (King v. Burwell 2015). Most recently, the 5th US Circuit Court of Appeals eliminated the individual mandate, it and the Supreme Court will likely it after the 2020 election (Berman et al. 2019).

Outside of the court, the Republican Party, who had linked their resistance to President Obama and the Democratic party with the policy, continued attacking the ACA. The House of Representatives voted to repeal the ACA 60 times between 2010 and 2017 (Cowan and Cornwell 2017). The ACA catalyzed Tea Party activists' anti-reform demonstrations at public meetings that House and Senate members held with constituents in their districts. Some of the anti-reform demonstration adopted a vociferous and startling rhetoric, claiming the ACA would create "death panels" which would decide life or death for the elderly on Medicaid (Jacobs and Skocpol 2012, p.53).

The discord regarding the ACA extended to implementation of the law. Medicaid expansion differed largely along party lines; Democratic-led states were quick to adopt Medicaid expansion whereas Republican-led states deferred (Barrilleaux and Rainey 2014). There were Republican-led states that were cross pressured through political party dynamics tilted against adoption and other dynamics, such as the needs of citizens and state economic conditions (Barrilleaux and Rainey 2014; Jacobs and Callaghan 2013).

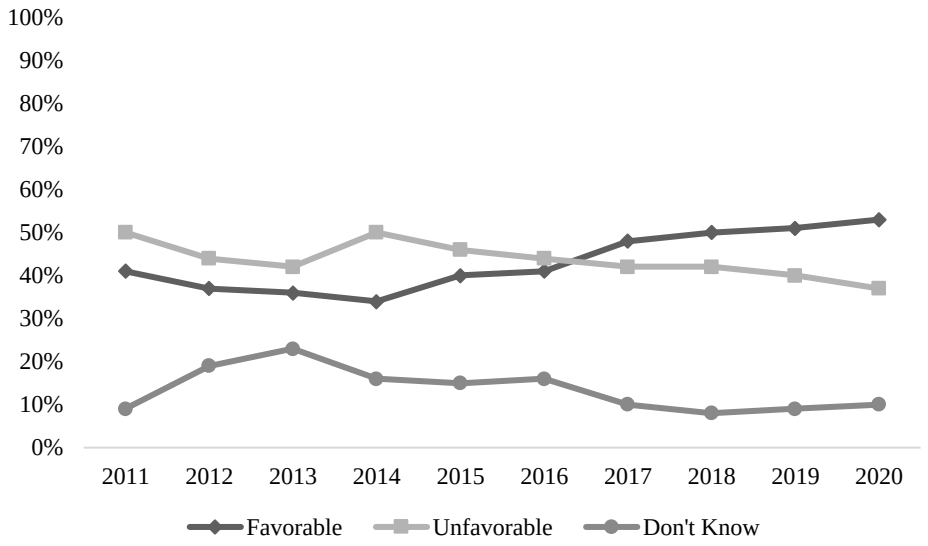
Division on healthcare is not new; stances on healthcare and health insurance have been polarized since the 1970s as a part of a larger ideological divide on social and cultural issues (Layman et al. 2010). Republicans preferred private health insurance marketplaces aligned with Ronald Reagan's conservative stance whereas Democrats favored government-sponsored health insurance (Brewer 2005, p.223). These attitudes were only reaffirmed in the 1990s when healthcare reform was highly salient and partisan due to Clinton's 1994 healthcare plan (M. D. Brewer 2005). It is not surprising that these party line divisions continued through the enactment and implementation of the ACA.

Public Opinion and Healthcare Reform

In 2008, the majority of Americas felt the US health care system was "in crisis" or "has major problems" (Blendon et al. 2008). The cost, quality, and access to health insurance were all major concerns for Americans at the time. Therefore, it is somewhat surprising that public opinion on the ACA, which set out to resolve many of these concerns, received such mixed reviews (see Figure 2). The Kaiser Family Foundation Health Tracking Poll (2020) documented attitudes toward the ACA over the last decade, asking respondents whether they have a "generally favorable or generally unfavorable opinion" of the ACA. Since its enactment, attitudes toward the ACA is almost evenly split. There are subtle trends; prior to 2016,

Americans were somewhat less supportive of the ACA, and after 2016, it appears that they are slightly more supportive of the ACA.

Figure 2. Publics Attitudes Toward the ACA, 2011-2018



Source: Kaiser 2020

This variation in public opinion is even more perplexing when we consider the decrease in the percentage of uninsured and amelioration of health disparities as a result of the ACA (Baumgartner et al. 2020; Kaiser 2018c). The percentage of uninsured, non-elderly adults dropped by 7% since the ACA marketplaces opened (Kaiser 2018c). In 2013, almost a third of Americans (27.8%) avoided care in the past 12 months, and in 2018, this decreased to 21.2% (Baumgartner et al. 2020). At the aggregate level, it is clear the ACA did what it aimed to do, improve access to care and improve health disparities, yet a substantial portion of the population finds healthcare reform unfavorable and supports political candidates who seek to weaken and repeal the ACA.

Many scholars document the role that political party plays in attitudes toward healthcare reform (Abramowitz and McCoy 2018; Bendersky 2014; Brady and Kessler 2010; Gramlich

2016; Kriner and Reeves 2014; Legerski and Berg 2016a). It is not surprising that the polarized attitudes toward healthcare of political elites extends itself to the public's views toward healthcare. Republicans are consistently more likely to oppose the ACA than Democrats (Legerski and Berg 2016a). Yet, party identification does not explain all of the variation, especially when attitudes toward the ACA are dissected by race. This dissertation tests the roles of self-interest, racial resentment, and group identity on attitudes toward the ACA.

Format of the Dissertation

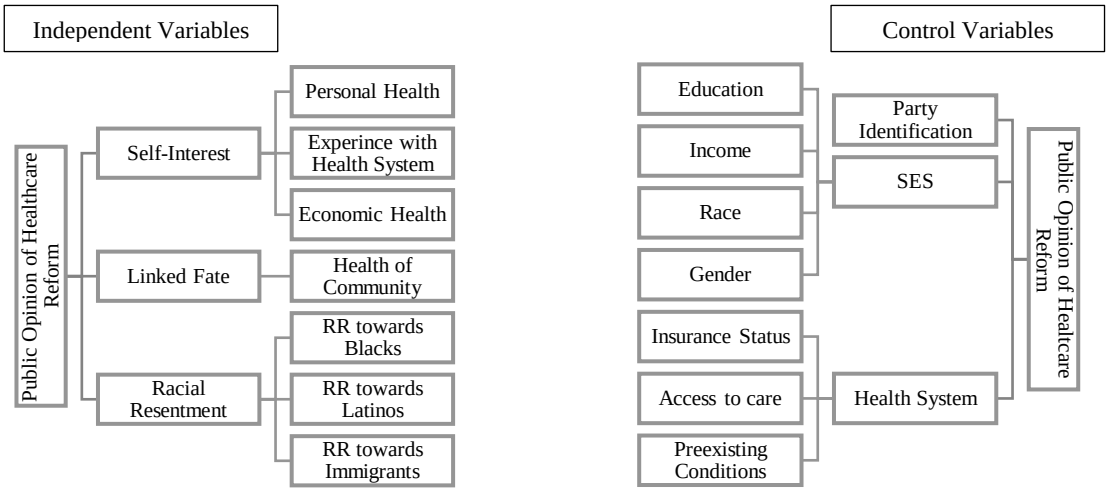
This dissertation comprises three empirical chapters which test the role of self-interest, racial resentment, and group identity. The second chapter tests the role of self-interest measured as health-related and economic-related self-interest on attitudes toward the ACA among Latinos using the 2018 Midterm National Association of Latino Elected Officials (NALEO) Educational Fund/Latino Decisions Weekly Political Tracking Poll. This chapter suggests self-interest does not play a strong role on attitudes toward the ACA among Latinos, which motivates the exploration of group identity and racial resentment. The third chapter investigates the role of linked fate and cross-racial linked fate on attitudes toward the ACA among Blacks, Latinos, and Whites. Chapter 4 explores the role of racial resentment on attitudes toward healthcare reform broadly and the ACA among Blacks, Latinos, and Whites. Chapters 3 and 4 rely on the Center for Social Policy Social Policy Survey of 2019. These chapters show that factors beyond party identification, such as group identity and racial resentment, predict attitudes toward healthcare reform.

Theoretical Framework

Evaluating public policies is not a linear nor straightforward process. Therefore, it is necessary to develop a framework that can accommodate the complexities of multiple inputs and

the way they interact. To bring all of the factors involved with evaluating the ACA, I created a conceptual model (see Figure 3).

Figure 3. Conceptual Model of Public Opinion of Healthcare Reform



In this conceptual model, my primary variable of interest is public opinion of healthcare reform. I expect a myriad of factors relevant to the formation of attitudes toward healthcare reform to influence attitudes toward the ACA. The left side of Figure 3 shows the three theories of self-interest, linked fate, and racial resentment, which I anticipate shape attitudes toward healthcare reform. The right side is also an outline of the chapters in this dissertation. The right side of Figure 3 shows the control variables known to influence attitudes toward healthcare reform (Verba and Nie 1972).

Chapter 2: The Role of Self-Interest on Latinos Attitudes Toward the Affordable Care Act

Self-interest is one of the cardinal elements in explaining human behavior since Thomas Hobbes' Leviathan (2000). It is a cornerstone for many in the social sciences and highlighted especially by neoclassical economics. According to neoclassical economics, individuals are

primarily concerned with maximizing their gains and minimizing their losses (Becker 1993). Yet in the context of healthcare reform, its impact is mixed.

Henderson and Hillygus (2011) find self-interest related to concerns about personal medical expenses significantly influences attitudes toward the ACA even when controlling for party identification. On the opposing end, Legerski and Berg (2016) find that an individual's political values associated with party ideology play a larger role in shaping their attitudes towards the ACA than their self-interest. It is worth noting Legerski and Berg's (2016) measure of self-interest is limited to health insurance status or use of healthcare services which is not a strong predictor of health status (Kasper, Giovannini, and Hoffman 2000; Sohn 2017). This dissertation departs from this work, measuring self-interest as it relates to personal health and economic health. I find that self-interest fails to shape Latinos' attitudes toward healthcare reform, even when they consider their personal health and economic well-being. Instead, party identification and age influence Latinos' attitudes toward healthcare reform.

Chapter 3: How Linked Fate and Cross-Racial Linked Fate Shape Attitudes Toward the Affordable Care Act

Linked fate is a popular measure of group identity that relies on heuristics cued by race, gender, or partisan affiliation to make complicated decisions. To operationalize linked fate, Dawson's book *Behind the Mule* (1995) creates an index using two questions in the National Black Election Panel Study (NBES): (1) 'Do you think what happens generally to Black people in this country will have something to do with what happens in your life?' and (2) Will it affect you a lot, some, or not very much?" (p.77). Dawson elucidates if the respondent believes blacks as a group have a subordinate position relative to other racial groups, their perception of linked fate as an individual should be strengthened. Moreover, if the respondent believes that their fate

is tied to that of their group, then it is likely attributed to their belief that their group is subordinate and exploited.

Group identity and, thereby, linked fate for Blacks manifests from a shared history and set of shared experiences (Dawson 1995, 2003; McClain et al. 2009; Tate 1994). To a lesser extent, the effects of linked fate have been documented among Latinos (Masuoka 2006; G. R. Sanchez 2006; G. R. Sanchez and Masuoka 2010; G. R. Sanchez, Masuoka, and Abrams 2019) and Whites (Berry, Ebner, and Cornelius 2019; Marsh and Ramírez 2019; Schildkraut 2015). The formation of group identity for Latinos and Whites significantly differs from that of Blacks. Latinos are a more disparate group because of their pan-ethnic identity (D. Lopez and Espiritu 1990; Masuoka 2006) and Whites share a history not of oppression but as oppressors and of privilege (Schildkraut 2015).

In the context of healthcare reform, Sanchez and Medeiros (2016) find that linked fate predicts Latinos' support for expanding access to healthcare under healthcare reform. McCabe (2019) finds weak support for the role of linked fate on Blacks' support for the ACA. In this dissertation, I expand this line of inquiry, testing the role of linked fate on Blacks', Latinos', and Whites' attitudes toward the ACA. Furthermore, I test the role of cross-racial linked fate, a nascent measure of group identity which finds that linked fate with groups with whom individuals do not identify correlate with less support for the ACA. The effects of linked fate and cross-racial linked fate are especially strong among Blacks and Latinos whereas they appear to have very limited effects among Whites.

Chapter 4: Racial Resentment Beyond the Black-White Dichotomy and its Impact on Attitudes Toward Healthcare Reform

Building off this momentum, the fourth chapter tests the role of racial resentment toward Blacks, Latinos, and immigrants on attitudes toward healthcare reform generally and the ACA. A growing body of evidence suggests racial resentment plays a substantial role in opinions of healthcare reform (Byrd, Saporta, and Martinez 2011; Henderson and Hillygus 2011; Kam and Burge 2019; Maxwell and Shields 2014; Tesler 2012). A consistent theme emerges from research on racial resentment and attitudes toward healthcare reform. Byrd, Saporta, and Martinez (2011) found "whites who were racially resentful were less likely to support the healthcare reform law" using the American National Election Survey (ANES) from 2008-2010. Henderson and Hillygus (2011) confirm that racial attitudes are a strong predictor of opposition towards healthcare reform. Maxwell and Shields (2014) apply this framework on several different aspects of the ACA and find that racial resentment is a strong predictor for support and opposition towards healthcare reform.

Traditionally, scholars employ racial resentment to better understand the Black-White dichotomy as it relates to individual policy evolution. I expand this measure to include Latinos and immigrants. It is important to recognize the changing demographics of the United States and how minority communities continue to be institutionally and structurally disenfranchised which has repercussions in the context of healthcare. I include Latinos in this battery because the ACA was racialized around Latinos through specifically focusing on their enrollment under the Obama administration and then removing Spanish-language materials for enrollment under the Trump administration. I include immigrants in the racial resentment battery because they have been explicitly barred from accessing any of the provisions of the ACA. The exclusion of immigrants

from the ACA and the current political climate polarizing the immigration debate under the Trump administration warrants their inclusion in the racial resentment battery.

I find racial resentment, regardless of who it is directed toward, plays a strong role when people evaluate the ACA but not when they consider healthcare reform broadly. This is a testament to the strong racialization of the ACA and its continuation in the post-Obama era. Racial resentment toward Blacks, Latinos, and immigrants are significant predictors of support for repealing the ACA. Still, racial resentment toward Blacks is a stronger predictor of attitudes toward the ACA than racial resentment toward Latinos and immigrants.

Conclusion

In sum, this dissertation takes an exploratory, yet important approach to understanding the formation of attitudes toward healthcare reform. Healthcare reform continues to be at the forefront of contemporary politics, perhaps now more than ever as the world faces the worst pandemic of the century. It is necessary to take a robust approach to understanding the contours of public opinion toward healthcare reform especially since it carries important implications for future efforts to uphold and strengthen the healthcare system.

The broad conclusions drawn from this dissertation is that there is meaningful variation by race in attitudes toward healthcare reform. Group identity plays a strong role for Blacks' and Latinos' attitudes toward the ACA whereas Whites rely on their party identification. Chapter 3 finds that linked fate for Blacks and Latinos predicts more support for the ACA whereas cross-racial linked fate predicts less support for the ACA. This is relevant since Blacks and Latinos are more likely to be uninsured, experience barriers to care, and poorer health outcomes than Whites. I attribute the effects of cross-racial linked fate to group competition.

Another conclusion drawn from this dissertation is that the ACA continues to be a racialized policy in a post-Obama era. During the Obama administration, many scholars attributed the spillover of racial resentment to healthcare to President Obama's identity as the first Black President and his closeness to the bill (Kriner and Reeves 2014; Tesler 2012). Chapter 4 finds racial resentment continues to spill over into attitudes toward the ACA in a post-Obama era and that it goes beyond the Black-White dichotomy. Racial resentment toward Blacks, Latinos, and Whites all predict less support for the ACA. This effect is especially strong among Whites.

The landscape of healthcare reform is constantly shifting. Having an accurate pulse on attitudes toward healthcare reform is essential to ensuring the system is responding to citizens needs and expectations. As we approach the 2020 elections during the corona virus pandemic, this work is even more important since healthcare reform is the top issue for voters (Kirzinger, Kearney, and Brodie 2020). There is work to do.

CHAPTER TWO:

THE ROLE OF SELF-INTEREST ON LATINOS' ATTITUDES TOWARD THE AFFORDABLE CARE ACT

Introduction

The Affordable Care Act (ACA) has been among the most prominent and polarizing policies in the last decade. Divisions that surround the enactment and implementation of the ACA have inundated presidential and midterm elections (Collins and Lambrew 2019; Frum 2015; C. Hall and Tolbert 2018; Newton-Small 2014; Sances and Clinton 2018), court cases in state and federal courts (Altman 2014, 2015; Johnston, Hillygus, and Bartels 2014; Kaiser 2012; Musumeci 2020; Sobel and Salganicoff 2013), and a stalemate in Congress which ultimately led to a government shutdown (Cunningham 2013). The enmity toward the ACA from the Republican party bolstered by the Trump administration continues to challenge the legislation and create barriers to health insurance enrollment (Jost 2018). Even during the Coronavirus pandemic, the Trump administration continues to undermine the ACA by refusing to have an open enrollment period to help individuals gain health insurance during the public health crisis (Luhby 2020).

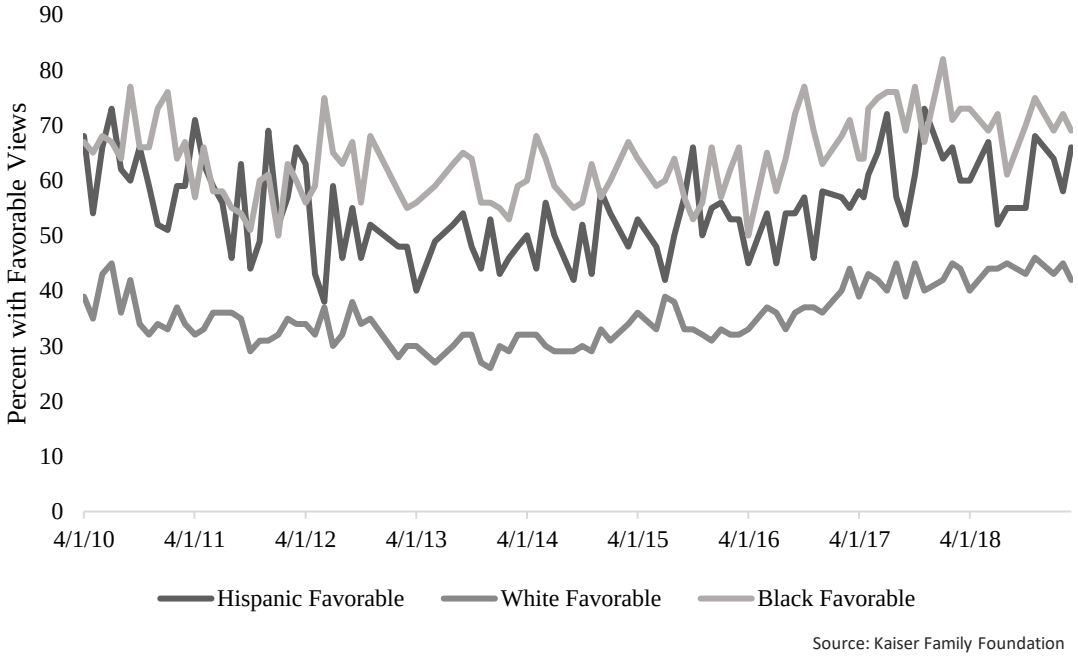
Despite challenges and roadblocks instigated by partisan attempts to dismantle the ACA, it has largely accomplished what it set out to do. One of the ACA's primary goals was to decrease the percent of uninsured individuals by removing financial barriers for individuals with preexisting conditions and low income and expanding state Medicaid programs, and increasing primary care services. Data show nearly 20 million people have gained health insurance under provisions provided by the ACA (J. Tolbert et al. 2019).

Given the substantial gains in health insurance and coordination of healthcare services under the ACA, it is reasonable to presume attitudes toward the ACA would mostly be positive. Yet data from the Kaiser Family Foundation Health Tracking Poll demonstrates attitudes toward the ACA are often evenly divided between favorable and unfavorable (Kaiser 2020b). This presents an interesting puzzle; as a significant number of previously uninsured individuals gained health insurance across the nation through provisions of the ACA, public opinion remains steadily divided and unpopular among certain groups who have benefited from the ACA, such as low income Republicans (Legerski and Berg 2016b).

I argue Latinos are the best group to investigate this phenomenon. Latinos have benefitted most from the ACA relative to other racial/ethnic groups. In 2010, 33% of nonelderly adult Latinos were uninsured and arguably faced the most barriers to enrollment in health insurance (Commonwealth Fund 2016; Kaiser 2018a). In fact, the ACA explicitly appropriated funds to actively engage the Latino community and facilitate their enrollment. Ten years after the implementation of the ACA, Latinos made the most gains in health insurance enrollment compared to Blacks and Whites, dropping the percentage of uninsured nonelderly adult Latinos by 14% (Kaiser 2018a). Yet there is variance among Latinos when they evaluate the ACA.

When public opinion is parsed by race, it is clear Latinos and Blacks hold more favorable views of the ACA than Whites (see Figure 1). It is possible that Latinos' favorable views toward the ACA reflect their substantial gains in health insurance.

Figure 1. Hispanic, Black, and White Views on the Affordable Care Act



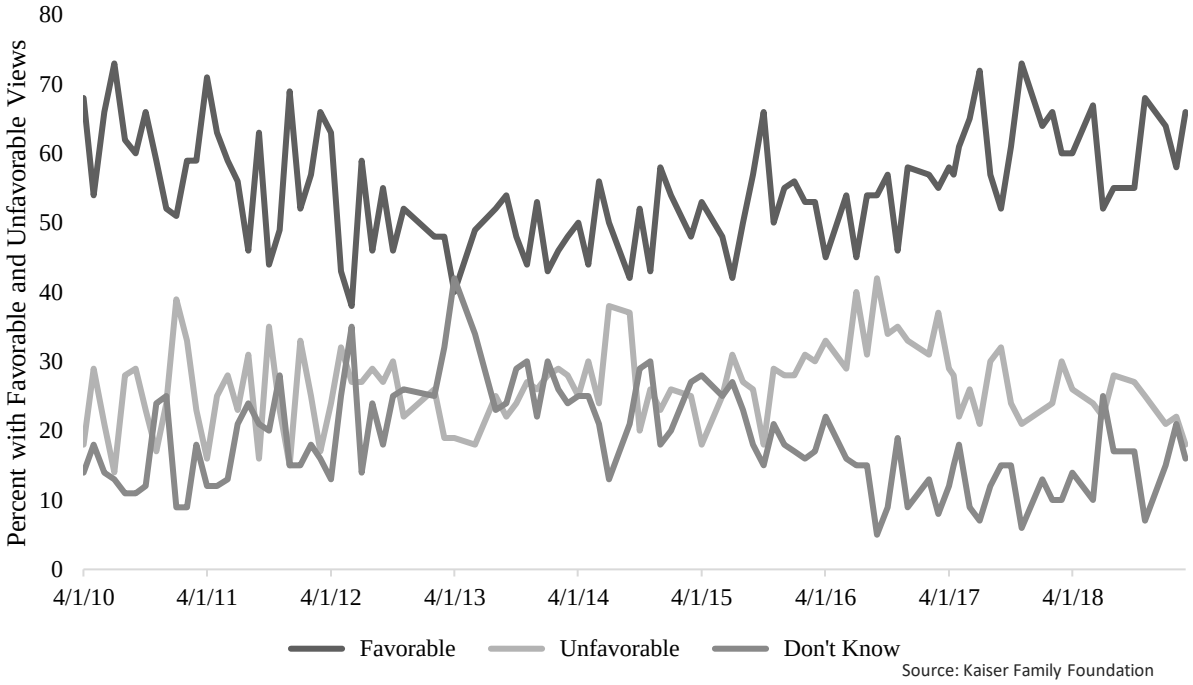
Latinos do not act as a monolith when evaluating the ACA (Branton 2007; G. R. Sanchez et al. 2010; G. R. Sanchez and Medeiros 2016; Tirado, Guadalupe, and Sequeira 2018; S. J. Wallace 2012). A little over half of Latinos (55%) hold favorable views towards healthcare reform, and 26% hold unfavorable views towards healthcare reform (see Figure 2). Scholars have explained these differences in Latino attitudes toward healthcare reform by concentrating on the role of party identification and political ideology (Davila 2008; Huddy, Mason, and Horwitz 2016), and theories of acculturation (Branton 2007), and group identity (G. R. Sanchez and Medeiros 2016).

In 2010, over a third of nonelderly Latinos did not have health insurance (Kaiser 2019). A decade later, Latinos have gained a disproportionate amount of health insurance coverage under provisions by the ACA relative to Whites and Blacks (Kaiser 2019). The ACA also provided tens of thousands of Latinos preventative healthcare services (DHHS 2012). Missing

from these studies is the possibility that attitudes toward the ACA, especially since its implementation, have adjusted to account for whether a person has benefitted from the ACA. This is an important contribution to better understand how Latinos may be motivated to enroll in health insurance. Latinos still represent the highest percent of uninsured by race/ethnicity (Kaiser 2018a). This study also contributes to the existing literature on Latinos public policy attitudes by accounting for self-interest.

This chapter probes the possibility that self-interest guides attitudes toward the ACA, seeks to fill that gap by engaging theories of self-interest. What role does self-interest play in Latinos' prioritization of continuing the ACA and expanding healthcare? I theorize and test two kinds of self-interest, personal health and financial health, to better understand the role of self-interest in Latino opinions of the ACA and healthcare reform using data from the 2018 National Association of Latino Elected Officials (NALEO) survey (n=752). This work helps advance our understanding of Latinos' attitudes towards healthcare reform in hopes that it will help future outreach efforts to facilitate enrollment in health insurance and advance measures used in studies that seek to study healthcare attitudes across race.

Figure 2. Latinos Views on the Affordable Care Act



Background: The Role of Self-Interest

Self-interest is broadly accepted as a strong motivator in public opinion (Campbell et al. 1960; Henderson and Hillygus 2011; A. Kim 2010; D. T. Miller 1999; Weeden and Kurzban 2017). The most common definition of self-interest employed by political scientists, economists, is "the motive to maximize material resources and to minimize harm to one's wealth and health" (Kim 2010, p.100). In addition, traditional theories in economics and political science also assume individuals are rational actors and therefore will be motivated to maximize their wealth and health (Sears and Funk 1991; Sen 1977). According to this model, individuals will support policies that will maximize their self-interest. By this definition, in the context of healthcare individuals who are uninsured may be more likely to support healthcare reform that expands health insurance relative to individuals who already have health insurance.

Yet there is a division in the literature on whether self-interest matters when it comes to the public's issue opinions. Several political scientists have claimed self-interest does not have an effect or a very weak effect on individuals political beliefs and behaviors (Chong, Citrin, and Conley 2001; Huddy 2013; Kinder 1998; Lau and Heldman 2009; Sears and Funk 1991). Weeden and Kurzban (2017) raise well founded concerns that the literature that has dismissed self-interest as a strong motivator and has adopted narrow definitions of self-interest. This operationalization of self-interest focuses on short-term material or tangible interest and generally exclude long-term interest, social status, and group interests (Weeden 2017, p.77).

In fact, there is a significant amount of literature that has demonstrated the effects of self-interest on political attitudes when the benefits are clearly defined and contextualized (Green and Gerken 1989; Henderson and Hillygus 2011; Huddy 2013; Kinder 1998; LeCount and Abrahamson 2017; Sears and Citrin 1985b; Weeden and Kurzban 2017). In the context of healthcare, LeCount and Abrahamson (2017) find that individuals who have poor self-rated health are more likely to support government provided healthcare and endorse increased spending on healthcare. However, LeCount and Abrahamson (2017) limit their study of race to White and non-White respondents and do not take financial self-interest into account.

Self-interest may play a stronger role for an individual who identifies as Latino when considering healthcare reform because it is a relevant issue within their community, and they are more likely than Whites and Blacks to lack health insurance. There are clear domain specific connections between issues and demographics. Weeden and Kurzban (2017) find that individuals with certain identities are more likely to rely on self-interest when the issue is relevant to their identity. The following sections review Latinos' experiences with the ACA and hypotheses on the role of self-interest Latinos' on attitudes toward healthcare reform.

Prior to the ACA, Latinos represented the racial/ethnic group with the highest percent of uninsured relative to Whites, Blacks, Asians and American Indians/Alaskan Natives. In 2010, one in three nonelderly Latinos lacked health insurance. In the years since the enactment and implementation of the ACA, the percent of nonelderly Latinos who are uninsured dropped to 19% by 2018 (Kaiser 2018c). These gains in health insurance have significantly dropped the percent of uninsured Latinos but Latinos remain the highest percent of uninsured racial/ethnic group (Kaiser 2018a). Still, the decrease in the percent of uninsured Latinos reflects significant investments made by the public and private sector to educate, engage, and enroll Latinos in the health insurance marketplace.

As the ACA health insurance provisions rolled out, the potential for Latinos from this policy were very high which is why it is unexpected that Latinos support for the ACA wavered in 2014 when the health insurance marketplace opened. When we take the complicated and sometimes troubled implementation of the ACA, including enrollment programs and marketing directed toward Latinos, into account it helps explain the variation in Latinos' attitudes toward the ACA. The initial outreach efforts to educate and engage the Latino community can be best described as disappointing. Despite investing millions of dollars into advertisements and extensive news media coverage, the public was largely ignorant of specific components of the ACA and mechanics of the federal and state health insurance marketplaces (Hill, Wilkinson, and Courtot 2014; Kaiser 2013). During the first few years of ACA implementation, the primary goal of engagement was to educate and direct the uninsured toward the online marketplaces to enroll in health insurance programs. This approach proved especially ineffective for Latinos at three separate points.

The first misstep and perhaps most crucial was that the majority of marketing for the ACA encouraged Latinos to use online platforms to enroll in health insurance. Latinos are less likely than Blacks and Whites to have access to the internet and use the internet (A. Brown, Lopez, and Hugo Lopez 2016). When using the internet to identify resources for health insurance enrollment, Blavin et al. (2014) found Latinos were less likely than Whites and Blacks to use online resources to learn about the ACA and enroll in health insurance plans on the marketplace. Latinos spend a lot of time on the internet but do not often make transactions on the internet which further demonstrates the disconnect between the early engagement practices and effective engagement practices (Dembosky 2014).

Moreover, poor translations riddled the Spanish version of healthcare.gov and missed key components that were available on the English-version of healthcare.gov (Johnson 2013; Sanchez 2013). Healthcare.gov was meant to serve as the primary source of information to guide Latinos through the enrollment process. The consequences of this were felt strongly in California, where a significant portion of Latinos live (Antonio Flores 2017). The Covered California campaign mimicked the poor translations and emphasis on online platforms that the federal government did. The Covered California ad featured a series of people addressing the camera directly in Spanish saying "Welcome to a new state of health. Welcome to California" (KQED News 2013). Despite being grammatically correct, the message was lost in poor translation and led to more confusion than clarity (Dembosky 2014).

The final misstep was messaging. Under the Obama administration, record numbers of deportations were felt broadly across the Latino community. So much so that a largest Latino advocacy group, National Council of La Raza, named Obama "Deporter in Chief" (Epstein 2014). Therefore, it was not surprising that when President Obama appeared on a town-hall-style

event hosted by Univision and Telemundo, two of the largest Spanish-language television networks what was meant to be a promotion for health insurance enrollment among the Latino community turned into a discussion on the role of immigration status and mixed status families (Keith 2014). This moment demonstrated that the barriers for Latinos to enroll in health insurance under provisions from the ACA were more nuanced that originally anticipated.

To recover from these early missteps, federal and state governments invested more traditional marketing techniques and dedicated funds to states to decide how to best engage and educate the Latino community. This approach generated outreach campaigns that were able to address population and locality specific barriers to enrollment in health insurance (Blavin et al. 2014). Some of the best outreach efforts in the Latino community relied on community-based application assistors who were familiar with eligible families and could guide them through the enrollment process (Kaiser 2013; Rosman et al. 2015). For Latinos who planned on using online resources, investments were made into bi-lingual call centers, navigators and other resources that overlapped with online enrollment (Blavin et al. 2014).

Hypotheses

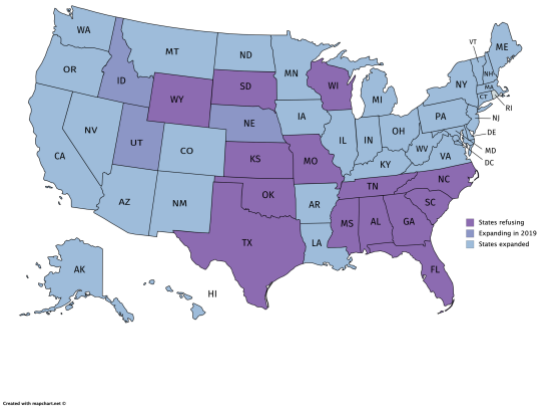
Medicaid Expansion

The shift in marketing techniques was positively reflected in the increase in enrollment among Latinos (Kaiser 2020). One of the primary sources of health insurance among Latinos is Medicaid (Artiga, Orgera, and Damico 2020; Kaiser 2011). The expansion of state Medicaid programs played a crucial role in decreasing the percent of uninsured adults. Despite the overarching benefits to increase health insurance coverage, several states were slow to adopt and implement Medicaid expansion and several have yet to expand Medicaid (see Figure 3) (Kaiser 2019). Several studies cite partisan conflicts that spilled over into the implementation of key

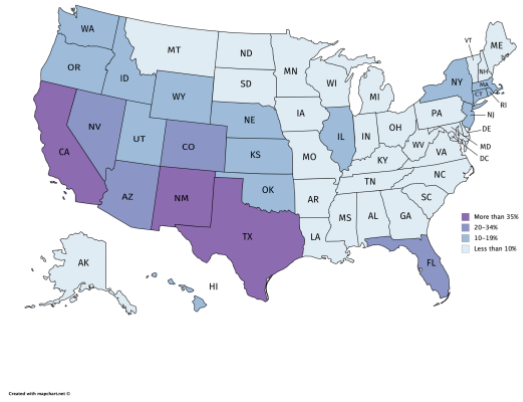
components of the ACA (Barrilleaux and Rainey 2014; Jacobs and Callaghan 2013; Lanford and Quadagno 2016). Apart from partisan politics other factors have been identified that deterred states from expanding Medicaid such as policy legacies, provider interest, political ideologies and racial attitudes (Lanford and Quadagno 2016).

Figure 3. US Map of States that Expanded Medicaid and Density of Latino Population

States that have expanded Medicaid



Latinos as a Percent of Population by State, 2014



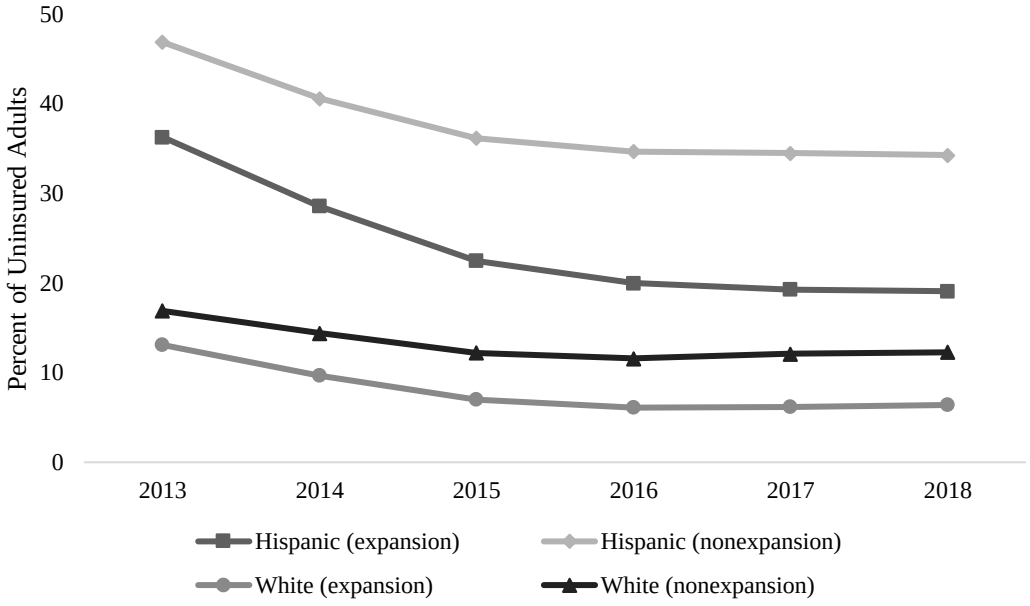
The states that chose to expand Medicaid saw significant decreases in the percent uninsured (Kaiser 2019). The drop in uninsured was especially heightened in racial/ethnic minority communities relative to Whites (Buchmueller et al. 2016). States that expanded

Medicaid saw a 15% decrease in the percent of uninsured Latinos from 2010 to 2018 relative to a 12% decrease in the percent of uninsured Latinos in states that did not expand Medicaid (Artiga, Orgera, and Damico 2020). Several of the states that have not expanded Medicaid have a significant number of Latinos as a percent of population, see Figure 3. This means a substantial number of Latinos have not experienced the benefits from the expansion of Medicaid.

Research on health policy and attitudes toward healthcare reform and the ACA indicate self-interest may encourage positive attitudes toward the ACA. In most cases, self-interest does not play a significant role unless the benefits and costs of a public policy are clearly defined (Sears and Funk 1991). This finding is confirmed in the health policy literature, that positive and negative experiences with the ACA correlate with attitudes toward the ACA (Lerman and McCabe 2017; McCabe 2016).

Prior to the ACA, Medicaid insured over a quarter of Latino and became a crucial resource for health insurance for Latinos during the 2008 economic recession (Kaiser 2011b). The expansion of Medicaid under the ACA increased eligibility to 133% below the federal poverty line which extended health insurance to nearly eight million Latinos (Kaiser 2010). States have expanded Medicaid not only saw a decrease in uninsured rates but also reduced disparities among Latino adults, see Figure 4. Latinos who live in states that expanded Medicaid reported lower cost barriers to care and modest improvement in constant sources of care relative to Latinos in states that did not expand Medicaid (Baumgartner et al. 2020). Medicaid expansion is a clear and substantial benefit which should cue a sense of self-interest.

Figure 4. Percent of Uninsured Adults, Race and Ethnicity by Medicaid Expansion Status



Source: Baumbartner et al. 2020

In sum, Latinos have broadly benefited from the ACA, especially the provision that expanded Medicaid, yet approval of the ACA has vacillated since its enactment due to several challenges Latinos faced engaging the ACA. Over the last ten years, the percent of Latinos who approve of the ACA fluctuated between 38% and 67%, see Figure 2 (Kaiser 2020). To explain some of this variation, I believe whether or not the state Latinos live in have expanded Medicaid will play a role in attitudes toward the ACA. Previous studies confirm that people who live in states that expanded Medicaid are more likely to hold more positive attitudes toward the ACA (Hopkins and Parish 2019; Sances and Clinton 2018) but have not studies this phenomena among Latinos. Sances and Clinton's (2018) find that even those who did not qualify for Medicaid but lived in a state that had expanded Medicaid had more positive attitudes toward the ACA. I anticipate there is a positive correlation between states that have expanded Medicaid and positive attitudes toward the ACA among Latinos motivated by self-interest. Latinos have broadly benefited from the expansion of Medicaid which should be associated with more positive views

toward healthcare reform. Furthermore, it is in Latinos self-interest to prioritize healthcare reform when it reflects better access to health insurance and healthcare. This leads me to my first hypothesis:

H1: Latinos who live in states that have expanded Medicaid will prioritize healthcare reform more than Latinos who live in states that have not expanded Medicaid.

Economic Self-Interest and Latino's Perception of Healthcare Reform

There are several ways to conceptualize self-interest. One of the most common forms of self-interest that are tested in the literature relates to economic self-interest. It is generally accepted that personal economic circumstances are pertinent to political attitudes and behaviors (Feldman 1982). The majority of economic self-interest studies have focused on monetary issues (Doherty, Gerber, and Green 2006; Fong 2001; Sears and Citrin 1985). The most common measure for economic self-interest is income. Several studies have demonstrated the correlation between income and attitudes toward income redistribution (Kluegel and Smith 1986) and various tax proposals (Sears and Citrin 1985b).

In line with theories of economic self-interest, economic self-interest should be a strong predictor of attitudes toward healthcare reform. The cost of healthcare is consistently reported as one of the most common barriers to health insurance and healthcare access (Blendon et al. 2006; Blendon and Benson 2009, 2010; Henderson and Hillygus 2011). Sears et al. (1980) find some support for economic self-interest. Less substantial but still statistically significant, they find those with low income prefer a government insurance plan over a private insurance plan (Sears et al. 1980). Brady and Kessler (2010) confirm income has substantial effects on support for healthcare reform.

In a more recent study Henderson and Hillygus (2011) find stronger support for the economic self-interest with a different measure. Henderson and Hillygus (2011) define self-interest as concern about economic distress posed by unanticipated healthcare costs. They find those with "great concern about medical expenses" were adamantly less likely to hold negative views toward universal coverage (Henderson and Hillygus 2011, p. 954). In a similar line of inquire, Schlesinger (2010) finds broad evidence for economic self-interest in his study on support for the ACA. He finds that individuals who express more concern about medical expenses are more supportive of expanded healthcare services (Schlesinger 2010, p.1006). However, the effects of economic self-interest are limited to individuals who express intense concern about medical expenses.

Economic self-interest holds when contextualized by identity and interest. Gelman, Lee, and Ghitza's (2010) pre-ACA study finds that younger and poorer Americans are more supportive of healthcare reform than older and wealthier individuals. More recently, Hall et al. (2015) find that women with lower incomes, Black women, and women on Medicaid or Medicare are more likely to support the ACA.

Applied to Latinos' views toward healthcare reform, economic self-interest theories would predict Latinos' healthcare reform preferences will be based on the degree to which they perceive greater economic benefits than costs associated with healthcare reform. Economic self-interest has been broadly studied among Latinos in the context of immigration policy (Newton 2000; Rouse, Wilkinson, and Garand 2010) but there is a paucity in studies on the role of economic self-interest on Latinos' attitudes toward healthcare reform.

The cost of healthcare and health insurance is often cited as the strongest barrier to care (Claxton, Sawyer, and Cox 2019; Cox and Sawyer 2016). The ACA significantly diminished the

cost barrier to health insurance and care by expanding Medicaid and offering subsidies to healthcare for Latinos (Alcalá et al. 2017). Yet, the cost barrier to health insurance and care was not completely dissolved (Alcalá et al. 2017; Baumgartner et al. 2020; Medeiros, Sanchez, and Valdez 2012). In 2018, 16% of non-elderly Latino adults reported they had a difficult time paying medical bills regardless of insurance status (Kaiser 2018a).

Still the reduced cost barrier to care encouraged regular use of healthcare and promoted primary care visits (Alcalá et al. 2017; Baumgartner et al. 2020; Bustamante et al. 2018; Heintzman et al. 2017). The coverage provisions provided by the ACA were primarily focused on removing the cost barriers to health insurance. Therefore, the legislation heavily leaned on the Medicaid expansion and health insurance subsidies to reduce the percent of uninsured individuals. Because Latinos are more likely to be uninsured and have lower incomes than Whites, I anticipate economic self-interest will play a strong role in determining attitudes toward healthcare reform. I test the influence of economic self-interest in two ways that correspond with the following hypotheses. My second hypothesis test the role of economic self-interested defined by income:

H2: Latinos with lower incomes are more likely to prioritize healthcare reform more than Latinos with higher incomes.

The third hypothesis operationalizes economic self-interest beyond income. Building off the work of Henderson and Hillygus (2011) and Schlesinger (2010), economic self-interest is contextualized by self-reported economic health. Income has a direct influence on access to healthcare and financial resources available to use on healthcare services (John Lynch and Kaplan 2000) but fails to capture the complexity and multiple factors that contribute to economic health. Self-reported economic health is distinctly different from income because it requires

individuals to consider their own circumstances as it relates to the economic well-being (Fong 2001).

Self-reported economic health captures material factors, working conditions, and living conditions broadly and whether or not they are sufficient for personal and family needs (Cheng et al. 2002). Several studies indicate subjective measures of economic health are more closely related to health and healthcare use than actual level of income (Cheng et al. 2002; Ullah 1990; Wilkinson 2002). This may be especially accurate for Latinos. If the influence of income on health and healthcare use depends on income to meet the personal and family needs, then subjective measures of economic health may be useful.

Across multiple measures, Latinos are more likely than non-Hispanic whites to have poor economic health (Federal Reserve 2018; Finegold and Wherry 2004; Morales et al. 2002). Latinos are more likely than non-Hispanic whites to have lower incomes, experience poverty, have high risk occupations and have a low social status (Morales et al. 2002). Therefore, Latinos are likely to perceive their economic health as poor especially when compared to their non-Hispanic white counterparts (Curtis and Andersen 2015).

Therefore, when Latinos consider their economic health their economic self-interest will be triggered and result in high prioritization of healthcare reform. Especially when Latinos consider that they have immensely benefited from the health insurance provisions of the ACA. This brings me to my third hypothesis:

H3: Latinos who consider their economic health will prioritize healthcare reform more than Latinos who do not consider their economic health.

Health Self-Interest and Latino's Perception of Healthcare Reform

Beyond economic-self-interest scholar have often discussed the role of health as a strong determinant of self-interest (A. Kim 2010). Individuals are more likely to support policies that they may benefit from, therefore individuals who believe they have poor health may be more likely to see personal benefits from health care reform (LeCount and Abrahamson 2017). For the purposes of this chapter, health-related self-interest will encompass self-interest related to physical health, mental health, and overall well-being.

Relative to studies on economic self-interest the literature on health-related self-interest is wanting. Measuring health-related self-interest poses unique challenges because there are many definitions of health and ways to measure health (Baker, Stabile, and Deri 2004). Health is a multidimensional concept that comprises physical health and mental health with meaningful variation between 'good health' and 'poor health' (Pacheco 2019). In this chapter, I define health as a self-measured concept of general well-being. Empirically, I will use self-rated health status to measure health. Self-rated health status is a valid indicator of health because it is related to objective measures of mortality, health conditions, and healthcare use (Angel and Gronfein 1988; Bjorner, Fayers, and Idler 2005; Jylhä 2009).

Recently political scientists have incorporated measures of health in studies of political behavior (Burden et al. 2017; Pacheco 2019; Pacheco and Ojeda 2019) but there appears to be a scarcity of studies on the effects of health on political attitudes. LeCount and Abrahamson (2017) use measure of self-rated health to test the role of health-related self-interest. They find that individuals with poorer self-rated health are more likely to support a strong role for government in providing health care and more likely to support increase spending on healthcare although moderated by political ideology. Sears, Lau, Tyler, and Allen (1980) find support for

national health insurance is highest among uninsured individuals and those with inadequate healthcare coverage to protect them from a major illness. Therefore, when cued to consider their personal health, it is reasonable to assume individuals will prioritize the ACA and healthcare expansion. Lynch and Gollust (2010) use both health insurance status and self-rated health as measures for health-related self-interest. They find that a recent history of uninsurance and individuals with poor health are more likely to support government-provided health insurance (p.864).

These studies confirm health-related self-interest plays a role in attiude formation toward healthcare reform but they faily to account for variation in race. LeCount and Abrahamson (2017) compare whites to non-whites and find whites are associated with low support for government involvement in healthcare and spending. This chapter fills a meaningful gap in the health-related self-interest literature by testing this concept among Latinos.

Furthermore, there is reason to believe the effects of health-related self-interest will be heightened among Latinos because they are more likely be unsinured, have poor health outcomes, and experince adverse health events relative to other races (Alcalá et al. 2017; Kaiser 2018c; Ortega, Rodriguez, and Vargas Bustamante 2015; Velasco-Mondragon et al. 2016). The reasons for these persererant disparities are multifacted. Some of the factors that contribute to these disparities are citizenship status, language barriers, socioeconomic factors (Morales et al. 2002; Ortega, Rodriguez, and Vargas Bustamante 2015; Velasco-Mondragon et al. 2016).

Prior to the ACA, Latinos had a more negative pattern of access and utilization of health care than non-Hispanic whites (NCHS-CDC 2014; Velasco-Mondragon et al. 2016). The health insurance gains among the Latino community have resulted in higher use of healthcare services (Montesi, Caletti, and Marchesini 2016; Wang et al. 2015). When health-related self-interest is

applied in this context, Latinos who consider themesleves to have poor health are more likely to support health care reform because they have more to gain than their healthier counterparts. I test the influence of health-related self-interest with the following hypothesis:

> *H4: Latinos who consider themselves to be in poor health will prioritize the continuation of the ACA and expansion of healthcare reform more than Latinos who consider themselves to be in good health*.

Symbolic Politics and Latino's Perception of Healthcare Reform

There is another body of research that explores why self-interest may not always explain political attitudes. Symbolic politics theory is what largely leads this branch of the literature (Lau, Brown, and Sears 1978; Lau and Heldman 2009; Sears et al. 1980; Sears and Funk 1991; Sears, Hensler, and Speer 1979). Symbolic politics theory posits political symbols, such as party-identification, can be strong enough to "evoke long-standing emotional responses rather than rational, self-interested calculations" (Sears and Funk 1991, p.248). Consequently, when individuals evaluate healthcare reform, it is possible that symbolic political predispositions override their self-interest.

To measure symbolic politics, most scholars rely on party affiliation and political ideology in studies on attitudes toward healthcare reform (Lau and Heldman 2009; Legerski and Berg 2016a; Julia Lynch and Gollust 2010; Sears et al. 1980). Research confirms party identification is a strong determinant of support for healthcare reform. Democrats are more likely to have favorable attitudes toward healthcare reform than Republicans (Berk, Gaylin, and Schur 2006; Blendon and Benson 2010; Oakman et al. 2010).

The political context that surrounds the ACA matters. After the implementation of the ACA, (McCabe 2016) find that initial reactions to the ACA were heavily influenced by party

identification. Republicans are resistant to updating their opinions of toward the ACA (McCabe 2016). Legerski and Berg (2016) explicitly test the role of symbolic politics versus self-interest. They find that an individual's political values play a larger role in shaping their attitudes towards the ACA than their self-interest. Legerski and Berg (2016) measure self-interest as insurance status and reasons respondents do not have health insurance. Henderson and Hillygus (2011) confirm the partisan divide that Republicans are less likely to support healthcare reform than Democrats. However, they find that self-interest moderate attitudes towards the ACA in the form of concern about personal medical expenses.

These studies demonstrate the strength of symbolic politics on attitudes toward healthcare reform. I do not argue symbolic politics does not play a strong role in attitudes toward healthcare reform, but that self-interest when contextualized and clearly defined it will have a stronger impact on attitudes toward healthcare reform than symbolic attitudes. This leads me to my final hypothesis:

H5: Economic and health related self-interest will play a larger role in determining Latino prioritization of healthcare reform than symbolic politics.

Data and Methods

To test these hypotheses, I use the 2018 National Association of Latino Elected Officials (NALEO) and Latino Decisions National Weekly Political Tracking Poll, which consists of 752 adult Latino registered voters[1]. Respondents were randomly selected from Latino Decisions

[1] The sample of registered Latino voters fits well within this research design because I am interested in public opinion of Latino eligible for expansions in access to healthcare provided by the ACA. This means the Latinos who

partner web panels and confirmed registered to vote. These survey data were collected between September 19-October 15, 2018. The survey was self-administered and available in Spanish and English. The geographic coverage of the survey encompassed 39 states[2] which account for 97.6% of the U.S. Hispanic population. Data were compared to U.S. Census Current Population Survey (CPS) for demographic profile of Latino registered voters, and weights were applied to balance the data with Census estimates and carries a 4.4% margin of error. The survey asks specific questions about various aspects of the ACA and current healthcare reform.

Experimental Design

In a normal survey environment, it is hard to emphasize these forms of self-interest without extraneous influences (Mutz 2011). Therefore, I use an experimental design to isolate the impact of self-interest as it relates to personal economics and personal health. Participants were randomly assigned one of the three treatments. Figure 5 shows the process undertaken to randomize survey participants to three modules. The treatment for Group 1 emphasizes personal health status for respondents when evaluating five aspects of healthcare reform. In Group 2, the economic self-interest prime, respondents were told to think about their financial health prior to evaluating five aspects of healthcare reform[3]. I compare the two treatments to a control group

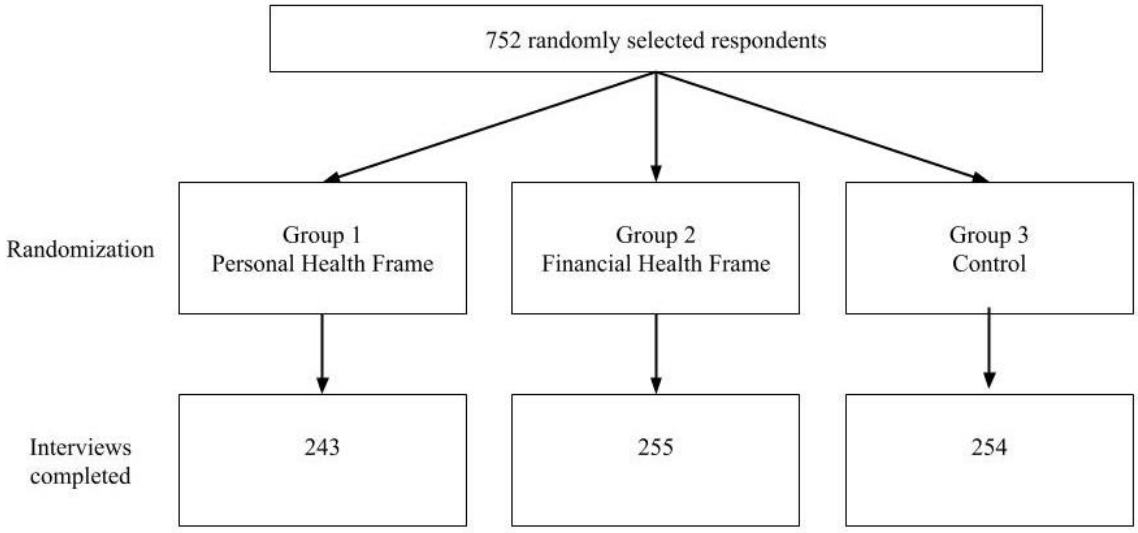
are not US citizens have been excluded from this analysis, and there may be a bias towards higher-income and higher-educated Latino in this sample (DeSipio 1998).

[2] Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, Wyoming.

[3] The experiment was tested prior to fielding the survey among college students at the University of New Mexico (n=77).

who did not receive any prime (see Appendix A for question wording). The main explanatory variable is the variant of self-interest frames to which the respondent was randomized.

Figure 5. Experimental Design and Interviews Completed



Dependent Variable

I measure the effect of the treatments on a scale composed of five aspects of the health care: continuing protections for people with pre-existing conditions, passing legislation to bring down the price of prescription drugs, repealing the ACA, stabilizing the ACA, and passing a national health plan. The responses were indicated on a 1-10 scale, where 1 = not important at all and 10 = the most important issue. To measure the overall importance of the healthcare reform, I used an additive index scaled measure of support made up of the five questions (Cronbach's alpha =.74). I recoded the third question on prioritization of repealing the ACA to reflect the low to high response scale the other four questions have. Higher values indicate greater favorability towards the ACA.

Table 1. Descriptive Summary of Prioritization of Healthcare Reform

	M	SD	Min	Max
Continue protections for people with pre-existing conditions	8.04	2.25	1	10
Passing legislation to bring down the price of prescription drugs	7.92	2.41	1	10
Repealing the 2010 Affordable Care Act	4.81	3.25	1	10
Passing legislation to stabilize the Affordable Care Act	7.32	2.78	1	10
Passing a national health plan, or Medicare-for-all	7.86	2.59	1	10
Additive index of Prioritization of Healthcare Reform	7.19	1.62	1	10

Controls

I use the respondents' reported income as a measure for economic security. To measure income respondents were asked their combined household income in 2017 before taxes. The the response categories are divided into $20,000 increments. Seemingly, individuals with lower incomes are more likely to be less financially secure and, therefore, are likely to benefit from ACA subsidies to gain health insurance. Cost of healthcare is often cited as the most common barriers to health insurance (Blendon et al. 2006). Unfortunately, there are no measures to indicate an individuals' health insurance status, self-rated health, frequency of doctors' visits, or ability to pay for care and prescriptions, which would be good indicators for the economic self-interest hypothesis.

Furthermore, income is an important variable to include because the ACA relies on a carrot and stick approach to health insurance enrollment as it pertains to subsidies and taxes. For

individuals with low incomes, the federal government provided subsidies to decrease the cost of health insurance overall. To make this policy possible, individuals who went without health insurance for the year were penalized with a tax to support the increased number of people enrolled in Medicaid. Income is important to include to provide context around the ACA which heavily ties personal economics to health insurance.

I include a measure for state-level Medicaid expansion. I coded states that expanded Medicaid equal to 1 and states that did not expand Medicaid equal to 0 (see Figure 3). Idaho, Utah and Nebraska committed to expanding Medicaid in 2019. Since the Medicaid expansion in these states is so novel, I coded them as states that did not expand or are in the early stages of expansion.

To measure symbolic politics, I rely on party-identification. Party identification asks respondents to identify as Democrat, Republican, or Other. This variable was recoded to be dichotomous, 1 equals Democrat and 0 equals Republican. Party identification is a strong predictor of attitudes toward healthcare reform (Berk, Gaylin, and Schur 2006; Blendon and Benson 2010; Oakman et al. 2010).

I include control variables for education, age, and gender. The educational question asks for the highest degree of educational attainment rather than the number of years. I recoded the education variable as a dummy variable, where 1 is equal to a college degree or more and 0 otherwise. Educational attainment serves as a place holder for health literacy, since educational attainment positively correlates with health literacy (Clouston, Manganello, and Richards 2016).

For gender, respondents indicated their gender between Male, Female, and Other. I recoded the gender variable as a dummy variable where 1 is equal to female, and 0 is equal to male[4].

Analysis

To analyze this data, I use a series of regressions with survey weights to estimate the effects of the independent and control variables on Latinos' attitudes and prioritization of healthcare reform. To test overall attitudes towards healthcare reform, I use the additive scale of the health prioritization subset of questions in a regression and include all controls. The second model tests disaggregate the additive scale of healthcare prioritization to test the impact of self-interest on each measure.

Results

I begin the analysis with a simple bivariate distribution of the dependent variable, overall prioritization of healthcare reform, with the experimental treatment (see Table 2). This bivariate analysis fails to provide rudimentary support for my third hypothesis that economic self-interest will play a stronger role than personal health self-interest. This table demonstrates very little variation by experimental treatment. However, it appears that both the physical and economic health frame cue self-interest results in higher prioritization of healthcare reform relative to the control group.

[4] The survey question allowed respondent to answer Male, Female, or Other. In this sample there were only four respondents who chose Other. I attempted to run my results using Other as the baseline category, but because of the small sample size, they have been excluded from this analysis which is not ideal.

Table 2. Bivariate Distribution of Latino Attitudes Toward Healthcare Reform Prioritization (in percentages) by Experimental Treatment

	Health-Related Self-Interest	Economic Self-Interest	Control
High Prioritization	21.71	21.12	17.16
Relatively High	55.26	49.69	50.75
Moderate	17.11	24.22	25.37
Relatively Low	5.92	4.97	5.97
Low Prioritization	0.00	0.00	0.75
N			502

Table 3 is the primary model used in this study. This linear regression has a p-value of 0.00. The dependent variable is the additive scale of prioritization of healthcare reform among Latinos, which ranges from 1 "low prioritization" to 10 "high prioritization". The first two cells of the table test the personal health self-interest frame and economic self-interest frame against the control frame. I find that neither of these conceptions of self-interest are significant in this model. Instead, age and party identification are the two primary drivers of this model.

This analysis demonstrates that both personal and economic health do not play a significant role in prioritization of healthcare reform among Latinos. This provides support for the null hypothesis for Hypotheses 3 and 4, which relied heavily on the experimental treatment. Both Hypotheses 3 and 4 anticipated the personal health self-interest and economic self-interest treatments would be significantly stronger than the control among Latinos. Overall, these results suggest that priming Latinos to think of self-interest, economic, or personal health did not substantially alter their prioritization of healthcare reform.

In place of self-interest, it appears that age and party-identification play a much stronger role among Latinos' prioritization of healthcare reform. This finding does not provide support for Hypothesis 5 which predicted economic self-interest would play a stronger role than party identification. Latinos who identify as Democrats are more likely than Latinos who identify as Republicans to prioritize healthcare reform. There is little evidence that Latinos with lower incomes prioritize the ACA differently than Latinos with higher incomes. Latinos with lower incomes are less likely to prioritize the ACA and healthcare expansion than Latinos with higher incomes, however, this finding is not significant. This finding fails to find support for Hypothesis 2 that Latinos with higher incomes would prioritize healthcare less than Latinos with lower incomes.

I find that there is no significant difference between Latinos who live in states that expanded Medicaid and Latinos who live in states that did not expand Medicaid, see table 3. This shows support for the null hypothesis for Hypothesis 1 which anticipated Latinos who live in states that expanded Medicaid would prioritize healthcare reform more than Latinos who live in states that did not expand Medicaid.

Table 3. Regression Results for Overall Prioritization of Healthcare

	Coef.
Experimental Treatment	
When thinking of your *physical* health,	0.097
	(0.570)
When thinking of your *financial* health,	0.137
	(0.378)
Controls	
College	0.130
	(0.0.351)
Age	0.263**
	(0.001)
Female	-0.037
	(0.774)
Income	-0.013
	(0.746)
Democrat	1.27***
	(0.000)
Medicaid Expanded	0.103
	(0.437)
N	502

Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1
Note: T-statistics in parentheses

Since the overall prioritization of healthcare reform failed to find strong support for self-interest as it relates to personal health and economic health, I disaggregate the additive scale to observe the impact of the experimental treatment on each component of healthcare reform. Table 4 presents a set of multivariate models and reveals the data supports the null hypothesis for Hypothesis 3 and 4, which expected self-interest, health-related and economic, to play a stronger role than the control group. It appears that symbolic politics has a stronger influence over prioritization of healthcare reform than self-interest and sometimes age and living in a state that

expanded Medicaid impact prioritization of healthcare reform.

Table 4. Multivariate Regression for Affordable Care Act Prioritization Battery

	Continue support for preexisting conditions	Decrease cost of prescription drugs	Repeal the ACA	Stabilize the ACA	Support Medicaid for All
Experimental Treatment					
When thinking of your *physical* health,	0.146 (0.38)	-0.112 (-0.41)	0.899 (1.92)	-0.255 (-0.76)	0.001 (0.00)
When thinking of your *financial* health,	0.421 (1.23)	0.265 (1.06)	0.739 (1.73)	-0.112 (-0.36)	-0.138 (-0.50)
Controls					
Medicaid Expanded	0.255 (0.92)	0.035 (0.16)	0.756* (2.03)	0.083 (0.31)	0.090 (0.35)
Education (1=college+)	0.130 (0.55)	0.297 (1.40)	-0.279 (-0.74)	0.513 (1.77)	-0.016 (-0.06)
Age	0.555*** (4.05)	0.558*** (4.31)	0.401 (1.84)	0.209 (1.29)	0.139 (0.87)
Gender (1=female)	0.158 (0.58)	0.081 (0.38)	-0.649 (-1.79)	-0.151 (-0.58)	-0.261 (-1.07)
Income	0.069 (0.88)	0.007 (0.11)	-0.011 (-0.10)	-0.195* (-2.22)	-0.029 (-0.40)
Democrat	0.561* (1.99)	0.723* (0.16)	-1.487*** (2.03)	2.303*** (6.14)	1.63*** (4.81)
Observations	502	502	502	502	502

Robust standard errors in parentheses
*** p<0.01, ** p<0.05, * p<0.1
Note: T-statistics in parentheses

Party identification is a strong predictor of prioritization of different healthcare reform components. The party identification effect is strongest when Latinos are asked how they prioritize support for the ACA, Medicare for All, and if the ACA should be repealed. This finding falls along polarized party lines; Latino Democrats are much more likely to prioritize continued support for the ACA than Latino Republicans. Latino Republicans are much more likely to prioritize the repeal of the ACA than Latino Democrats. This finding confirms party identification has a strong impact on attitudes toward healthcare reform.

In addition to party identification, income has an impact on Latinos when they are asked how stabilization of the ACA should be prioritized. Latinos with lower incomes are more likely to support the stabilization of the ACA than Latinos with higher incomes. This finding supports Hypothesis 2, which anticipated Latinos with lower incomes would act in their self-interest to stabilize the ACA and, thereby, the financial subsidies the ACA provides to lower financial barriers to health insurance enrollment.

Living in a state that expanded Medicaid only appears to make a difference among Latinos who prioritize the repeal of the ACA. This suggests, that Latinos who have experienced the expansion of Medicaid in their state have led to negative sentiments toward the ACA. This directly challenges Hypothesis 1, which predicted Latinos who live in states that expanded Medicaid would prioritize healthcare reform because of new opportunities to gain health insurance.

An unanticipated finding is that older Latinos are more likely to prioritize the continued support for individuals with preexisting conditions and decreasing the cost of prescription drugs (see Table 4). In an unanticipated way, this finding provides support for a self-interest argument. Elder Latinos are more likely to have some sort of pre-existing condition and require more

prescription drugs as they experience poorer health as they age. Therefore, it is in their self-interest that they prioritize these two components of healthcare reform more than younger Latinos who have yet to develop preexisting conditions and require fewer prescription drugs.

Conclusion

In summary, self-interest does not appear to be a factor for Latinos when they prioritize the ACA and other aspects of healthcare reform, even when they take their health and economic health into account. Instead, the results find stronger support for symbolic politics. Party identification is a stronger predictor of attitudes toward healthcare reform than self-interest. In some cases age, gender, and income can also influence attitudes toward healthcare reform but not as strongly as party identification.

There appears to be no support for health-related self-interest and tenuous support for the economic self-interest hypothesis. When evaluating prioritization of healthcare reform broadly, income does not influence Latinos' attitudes toward healthcare reform, see Table 3. Under the economic self-interest hypothesis, one would anticipate if income were to play a strong role in determinant attitudes toward healthcare reform it would be especially heightened when they consider the cost of prescription drugs. This is an example of applying economic self-interest when it is clearly defined and contextualized within a policy area. Yet, income does not play a role which further diminishes support for the economic self-interest hypothesis.

The only break from this narrative occurs when Latinos prioritize stabilizing the ACA. In this case, Latinos with lower incomes are more likely to prioritize efforts to stabilize the ACA than Latinos with higher incomes. This supports the economic self-interest hypothesis because Latinos with low incomes are more likely to benefit from several key provisions under the ACA to improve enrollment such as Medicaid expansion and subsidies to relieve cost barriers

An unexpected finding in this analysis is the role that Medicaid expansion plays in Latinos' prioritization of aspects of healthcare reform. Living in a state that expanded Medicaid is not significant when Latinos consider prioritizing the ACA, Medicaid for All, or support for individuals with preexisting conditions with the exception of Latinos prioritization of efforts to repeal the ACA. This is especially puzzling considering that Latinos have largely benefited from the Medicaid expansions made possible by the ACA (Sinsi, Dee, and Kathleen 2015).

The Trump administration and Republican Party's vocal criticism and legislative push to dismantle the ACA may explain this phenomenon. Sances and Clinton (2018) find that attitudes towards the ACA shift significantly after the 2016 election. In these data, it is possible that the impact of living in a state that expanded Medicaid has jaded Latinos' attitudes towards the ACA and, therefore, results in prioritization of repealing the ACA. More research should be done to better understand what the dismantlement of the ACA under the Trump administration did to attitudes towards the ACA.

In sum, it appears that self-interest does not play a significant role in determining Latinos prioritization of healthcare reform, even when Latinos take their physical health and economic health into account. Instead symbolic politics is the primary predictor of attitudes toward healthcare reform. When Latinos consider specific aspects of healthcare reform, income, whether they live in a state that expanded Medicaid and age play a role in Latinos attitudes toward healthcare reform. These null findings set up a challenging environment for researchers to better understand how attitudes form towards healthcare reform. Symbolic politics as it relates to party identification and political ideology are one component of the study, but symbolic politics can include predispositions developed from socialization in early years of life which remain stable in

adulthood (Sears and Funk 1991). Under this definition, there is reason to investigate the roles of racial resentment and group identity theories on attitudes toward healthcare reform,

There are significant limitations to this study. The first is the weakness of the experimental design. There are stronger treatments that can cue self-interest as it relates to economic and physical health. Measures such as health insurance state, self-rated health, and experiences with cost of care are important prisms to view self-interest through. Future research should consider further testing the measures of symbolic politics among the Latino population.

CHAPTER THREE:

GROUP IDENTITY AND ATTITUDES TOWARD HEALTHCARE REFORM: THE ROLES OF LINKED FATE AND CROSS-RACIAL LINKED FATE

Introduction

A wealth of information has been generated over the last decade in response to the ACA which documents its multiple influences on healthcare reform and impacts on access to healthcare, health outcomes, and public opinion toward healthcare and healthcare reform. The ACA expanded access to health insurance and healthcare services and, thus, improved health outcomes through multiple federal and state programs (Patient Protection and Affordable Care Act 2010). Over the last decade, it largely accomplished its goals. The percent of uninsured individuals decreased from 17.8% in 2008 to 10.4% in 2018 (Kaiser 2019a). Yet, public opinion toward the ACA remains consistently divided over the last decade (Kaiser 2020b).

One of the most discernible explanations is political polarization. From its inception, the ACA was met with fraught with political tension. It passed by narrow margins across party lines and has since been challenged in multiple state and federal courts (Altman 2014, 2015; Johnston, Hillygus, and Bartels 2014; Musumeci 2020; Sobel and Salganicoff 2013). The opposition falls cleanly across political party lines, the Republican party led efforts to disassemble the ACA while the Democratic party met their rebuttals and attempted to strengthen the policy. Public opinion toward the ACA reflects this political division; individuals who identify as Republican are less likely to support the ACA than Democrats (Kaiser 2020b). Still, there remains substantial ambiguity on part of the public opinion as a whole, with notable variation in

favorable attitudes toward the ACA and a lack of awareness of basic tenants of the legislation (Dropp and Nyhan 2017).

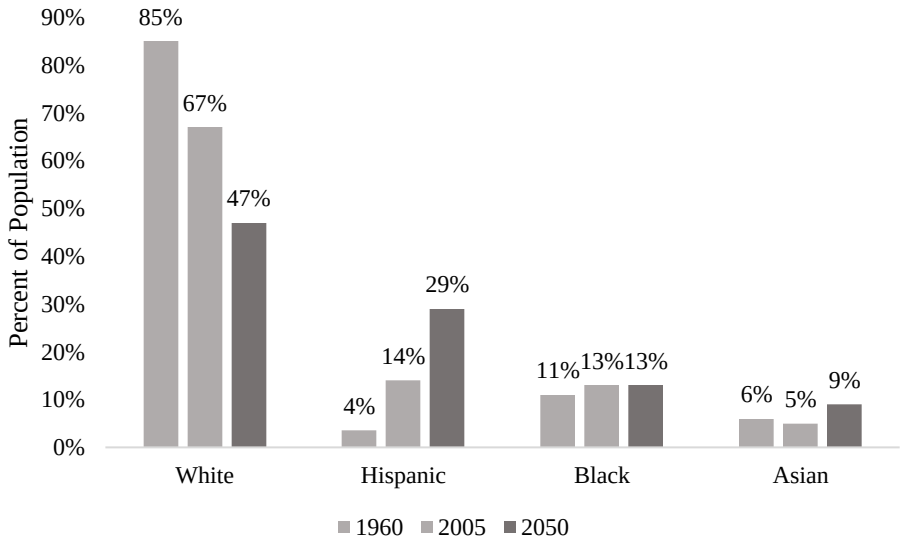
Another prominent division in attitudes toward healthcare reform falls along racial/ethnic groups. Over the last decade, the Kaiser Family Foundation (2020) documented Blacks and Latinos are more likely to hold favorable attitudes toward the ACA than Whites. As of April 2020, 69% of Latinos and 68% of Blacks had favorable views toward the "a health reform bill signed into law in 2010" compared to 45% of Whites (Kaiser 2020b). Other nationally representative surveys confirm this trend as well (Collins and Lambrew 2019; Gallup 2017). One of the explanations of the variation by race is that Latinos and Blacks represented a higher percentage of the uninsured population than non-Hispanic Whites. In 2010, the year the ACA passed, 33% of Latinos, 20% of Blacks and 13% of Whites nonelderly adults were uninsured (Kaiser 2018c). Eight years later, the percent of uninsured nonelderly adults dropped to 19% among Latinos, 11% among Blacks and 8% among Whites (Kaiser 2018c). Latinos and Blacks disproportionately benefited from health insurance provisions under the ACA relative to Whites.

Another explanation for the variation by race in healthcare attitudes is group identity. Group identity is especially important in explaining strong group cohesion in policy preferences among Blacks (Dawson 1995; Tate 1994) and to a slightly lesser extent Latinos (G. R. Sanchez 2006; G. R. Sanchez and Masuoka 2010; G. R. Sanchez, Masuoka, and Abrams 2019; Stokes 2003) and Whites (Berry, Ebner, and Cornelius 2019; Marsh and Ramírez 2019). There is a general paucity of studies in how linked fate operates in the context of healthcare reform. Sanchez and Medeiros (2016) study the effects of linked fate, a measure of group identity, on Latinos attitudes toward expanding healthcare coverage. They find that linked-fate is a significant predictor of registered Latinos' support for healthcare coverage expansion (G. R.

Sanchez and Medeiros 2016). McCabe (2019) studies the relationship between linked-fate and Blacks' attitudes toward the ACA. McCabe finds small, but insignificant support that linked fate leads to more positive views of the ACA.

Employing a nationally representative survey of Blacks, Latinos, and Whites offers new insight in the relationship of linked fate and attitudes toward the ACA. Furthermore, the Center for Social Policy Social Policy Survey (2019) provides a unique opportunity to investigate the role of linked fate while controlling for multiple health and healthcare controls. In addition to the traditional measure of linked fate, I use a cross-racial measure of linked fate to explain attitudes toward the ACA. The United States is undergoing a major demographic shift (see Figure 1). By 2050, there will be more individuals of color than Whites (Pew 2008). This demographic shift makes the investigation into cross-racial linked fate especially relevant to understanding cohesion between racial and ethnic groups and its impact on attitudes toward the ACA.

Figure 1. Population by Race and Ethnicity, Actual and Projected



Source: Pew 2008

Beyond the demographic shift, there are multiple reasons to surmise cross-racial linked fate should impact attitudes toward the ACA. The ACA is a policy that relies on collective engagement to be successful. Therefore, a considerable amount of the narrative encourages engagement across race and ethnicity (Dawes 2016; Hill, Wilkinson, and Courtot 2014), especially among Latinos and Blacks who are more likely to be uninsured (Kaiser 2018c), face more barriers to care (Blendon et al. 2006; Claxton, Sawyer, and Cox 2019), and experience adverse health outcomes (Adler and Rehkopf 2008; Baumgartner et al. 2020) compared to Whites. Motivated by their shared grievances in the healthcare system, Blacks and Latinos may have an especially strong sense of cross-racial linked fate which translates into support for the ACA.

The purpose of this chapter is to explore relationships between linked fate, cross-racial linked fate, and attitudes toward the ACA. I first review the literature on group identity which serves as the theoretical foundation for linked fate and cross racial linked fate. Then I summarize the work done using measures of linked fate and cross-racial linked fate. The final section of the literature review explains why linked fate and cross-racial linked fate are relevant measures to consider when investigating the formation of attitudes toward the ACA. Subsequent sections cover the hypotheses, methods, results, and conclusion. I find linked fate is a significant predictor of Blacks' and Latinos' support for strengthening the ACA but not for Whites. Cross-racial linked fate has a more complicated narrative. Blacks who report a sense of linked fate with Latinos are significantly more likely to support efforts that strengthen the ACA, but Latinos do not mirror the relationship. There is no significant relationship between Latinos' linked fate with Blacks, but Latinos who report a sense of linked fate with Whites are less likely to support efforts to strengthen the ACA.

Literature Review

Group Identity and Group Consciousness

It is necessary to take a step back to review the theoretical foundation for linked fate which is a measure of group identity. Group identity refers to an individual's "awareness of belonging to a certain group and having a psychological attachment to that group based on a perception of shared beliefs, feelings, interests, and ideas with other group members" (McClain et al. 2009, p. 474). Group identity has its roots in psychology and sociology's social identity theory (SIT) which assumes an individual's membership to a group they ascribe to based on shared characteristics with the group primarily influences their identity (McClain et al. 2009). Under SIT, individuals make comparisons between their in-group and out-group, usually with a bias toward their own group (Tajfel 1981; Tajfel et al. 1971). Even subtle distinctions between groups of individuals can foster intergroup bias (Tajfel et al. 1971).

African Americans have a distinct sense of group identity linked to political attitudes and behaviors (S. D. W. Austin, Middleton, and Yon 2012; Dawson 1995; Tate 1994). Blacks who strongly identify with their race are more likely to hold pro-group attitudes toward a variety of racial and social welfare issues (Tate 1994). One of the most common measurements of group identity is group consciousness.

Group consciousness stems from the idea that individuals who share similar attributes (e.g., physical characteristics, cultural norms, etc.) will collectively share a set of politicized beliefs about their group's social standing and a view of how they can collectively improve their status (Jackman and Jackman 1973; McClain et al. 2009; McClain and Johnson Carew 2018). It is important to emphasize that this is not the same as group identity which refers to an individual's awareness of belonging to a specific group and having a psychological attachment to

it (McClain et al. 2009, p.474). Political science literature includes group consciousness to further explain minority groups' political participation (Bobo and Gilliam 1990; Dawson 1995; Tate 1994; Verba and Nie 1972).

Under this theory, the higher the level of group consciousness is among a group, the more likely they will mobilize around a political actor or policy goal that will advance the status of the group. Group consciousness has been applied with a racial lens since the 1930s. In Brown's (1931) article, he asserts that individuals who are race conscious link their personal identity with their group. Furthermore, race-conscious individuals who perceive their group being subordinate to other groups aspire to see their group, collectively, gain higher social and political status (Brown 1931, p.95). This puts a political lens on race consciousness. Ferguson (1938) reinforces this, emphasizing the solidarity minority groups, especially those oppressed, feel towards each other. Group identity and group consciousness serve as the theoretical foundation for linked fate and applying it in the context of healthcare to Blacks, Latinos, and Whites.

Linked Fate

Another prominent measure of group identity is linked fate. Linked fate relies on heuristics cued by race, gender, or partisan affiliation to make complicated decisions. Michael Dawson created this measure in his seminal book *Behind the Mule* (1995) in which he provides the theoretical underpinnings for linked fate, also described as a "black utility heuristic." The three underpinnings for this measure are:

1. Race still strongly affects Blacks' economic status, life chances, and growth of the middle class.
2. Because race continues to strongly influence Blacks' life chances, it is rational for Blacks to view their fate as linked to that of the whole group.

3. Consequently, it is advantageous for Blacks to use group interests as a proxy for their own self-interest (Dawson 1995).

Dawson explains if the respondent who identifies as Black believes Blacks as a group have a subordinate position relative to other racial groups, their perception of linked fate as an individual should be strengthened. Moreover, if the respondent believes that their fate is tied to that of their group, then it is likely they believe that their group is subordinate and exploited. Dawson refers to this as the "black utility heuristic" which explains blacks' political behavior regardless of class. Linked fate embodies the aphorism "a rising tide lifts all boats." The key distinction between group consciousness and linked fate examines the underlying bonds that lead individuals to act in the interest of their group-interest rather than their self-interest.

Scholars measure linked fate using a pair of survey questions: (1) "Do you think what happens generally to Black people in this country will have something to do with what happens in your life?" and (2) "Will it affect you a lot, some, or not very much?" (p.77). Dawson (1995) first tested this question in the National Black Election Panel Study (NBES) and found that it was a strong predictor for Blacks' political behaviors and attitudes. Numerous surveys include measures of linked fate. The keywords "linked fate" return 2,910 separate items in Google Scholar as of March 25, 2020 which suggest not only the extent of Dawson's work but also the diffuse use of linked fate as a measure to explain behavioral outcomes.

Historically, linked fate explains Black participation and policy preferences (R. A. Brown and Shaw 2002; Dawson 1995, 2003; Hoston 2009; Reese and Brown 1995; Tate 2003; White 2007). The exclusively painful history of Blacks' slavery and continued race-based oppression provides a profound bond within the Black community which readily cues group identity (Levine 1978). Furthermore, much of Blacks' individual lives are overdetermined by their race

(Alexander 2012; G. D. Smith, Bartley, and Blane 1990). Therefore, Blacks often rely on their own community to represent their needs and policy goals. Dawson states, " that as along as race remains dominant in determining the lives of individual Blacks, it is 'rational' for Blacks to follow group cues in interpreting and acting in the political world" (1995, p.57). As long as race is prevalent in society, Blacks will continue to rely on group identity to determine their political choices and behaviors.

There is an active debate on whether linked fate applies to other racial minority group other than Blacks. Latinos and Asians represent the two largest racial minority groups other than Blacks (Cohn and Caumont 2016). McClain et al. summarize the valid concerns of applying this concept broadly:

> "Maybe we should take a step back to consider the implications of employing concepts intricately intertwined with the oppressive history of Blacks in the United States, and measures developed during a time of civil rights activism, civil strife, and racial conflict between white and black Americans… Scholars should acknowledge potential problems with their transference and be systematic in testing whether these measures are measuring the latent characteristic of other groups as they have for African Americans" (2009, p.479).

Unlike Blacks, Latinos and Asians have a panethnic racial identity. Panethnicity is defined as a social group identity that is made up of multiple ethnic subgroups, whose ethnic identities are defined by distinct national-origin boundaries and are perceived to collectively share certain homogeneous characteristics and features (D. Lopez and Espiritu 1990; Padilla 1985; Valdez 2011). Both of these groups are comprised of large immigrant populations. Since Latinos and Asians represent a relatively new group in the United States, they lack a shared

history which weakens ties among these groups. This does not dismiss the long histories of Mexicans, Chinese, and Japanese in the United States but highlights that these histories do not necessarily resonate with the larger panethnic group. In addition, there is a considerable amount of diversity within Latinos and Asians. Both groups are made up of multiple national-origin groups which come from different nations with different languages, cultures and histories. These factors can prevent Latinos and Asians from developing a sense of linked fate.

Unique to Latinos, the Federal government defines Latinos as a panethnic group which includes people of "Mexican, Puerto Rican, Cuban, Central or South America or other Spanish culture or origin, *regardless of race*" (US Census Bureau 2020, emphasis added). Yet, not all Latinos ascribe to a panethnic identity (M. H. Lopez, Gonzalez-Barrera, and Lopez 2017; Valdez 2009). For example, the 2007 Latino National Survey asks Latinos about their racial identity based on the U.S. Census and their primary racial identity. Almost half of respondents, 48%, identify as White according to the U.S. Census categories. When asked to identify their "primary identity," 44% of Latinos adopted a panethnic identity (i.e. Latino or Hispanic) and 47% self-identified nationally (i.e., Mexican, Cuban, etc.) (Valdez 2009, p.3). This may further impede Latinos' ability to develop a sense of linked fate.

Nevertheless, there is a body of literature that demonstrates that linked fate is an important measure to consider among Latinos when considering group identity (Jones-Correa and Leal 1996; Marsh and Ramírez 2019; Masuoka 2006; G. R. Sanchez and Masuoka 2010; Stokes 2003; Valdez 2011). G. R. Sanchez and Masuoka (2010) find linked fate can apply to Latinos, but the politicized form of Latino identity is different from that of African Americans. They identify three dimensions, panethnicity, race, and immigration, which break the formation of group identity into three smaller groups rather than one collective politicized identity.

Panethnic identity among Latinos develops as a response to cultural, structural, and historical developments (Calderon 1992; D. Lopez and Espiritu 1990). Calderon (1992) finds that panethnic identity forms among Latinos in response to structural conditions that threaten class and ethnic interests. For instance, Padilla (1985) finds panethnic identity mobilizes Mexicans and Puerto Ricans in Chicago through their shared language and shared interest in issues, such as affirmative action. Jones-Correa and Leal (1996) determine Latinos are willing to use panethnic identifiers, such as "Latino" or "Hispanic," which correlate with heightened political engagement and motivate political behaviors. Stokes (2003) confirms that Latinos' use of panethnic identifiers and perceptions of Latino inequality lead to increased political participation.

G. R. Sanchez and Masuoka (2010) confirm that panethnic identity and, thereby, linked fate are context dependent. Using the 2006 Latino National Survey (LNS), G. R. Sanchez and Masuoka (2010) find that linked fate is strong among Latinos who primarily speak Spanish. Work that finds Spanish langauge is a motivator of Latino group consiousness supports this finding (Padilla 1985). In addition, foreign-born Latinos are more likely to have higher linked fate than U.S. born Latinos (G. R. Sanchez and Masuoka 2010). This suggests Latinos form a panethnic identity upon arrival to the U.S. due to the hostile environment that includes punitive immigration policies and enforcement (Massey and Sanchez 2010).

More recent research confirms and challenges some of the contexts that linked fate is stregthened among Latinos. Vargas, Sanchez, and Valdez (2017) find punitive immigration laws directly correlate with Latino linked fate. G. R. Sanchez, Masuoka, and Abrams (2019) revisit G. R. Sanchez and Masuoka's (2010) study on the brown-utility heuristic with the 2016 Collaborative Multi-Racial Post Election Survey (CMPS) and find that linked fate among

Latinos evolves over time. G. R. Sanchez, Masuoka, and Abrams (2019) find several noteworthy differences between the two data sets. In the 2016 CMPS, older Latinos were less likely to have a strong sense of linked fate than younger Latinos whereas age was not a significant predictor of linked fate among Latinos in the 2010 LNS. One of G. R. Sanchez, Masuoka, and Abrams' (2019) unexpected findings is that discrimination, both perceived and actual experiences, are significantly and positively associated with linked fate among Latinos. This differs from earlier findings which did not find any significant relationships between discrimination and linked-fate (G. R. Sanchez and Masuoka 2010).

As a comparison group, the role of linked fate and group consciousness has been studied among Whites. I include a brief summary of group consciousness among Whites since the literature of the role of linked fate among Whites is relatively limited. It appears that White group consciousness is less ubiquitous and less politically potent than Black and Latino group consciousness (Berry, Ebner, and Cornelius 2019; Citrin and Sears 2014; Jardina 2019; A. H. Miller et al. 1981; G. R. Sanchez 2006; Sears and Savalei 2006; Wong and Cho 2005). A sense of group consciousness may be possible among Whites because of their collective experiences with privilege, social dominance, and general benefits of Whiteness (Berry, Ebner, and Cornelius 2019; Weller and Junn 2018). Wong and Cho (2005) find about half of Whites feel a sense of racial identity but argue that it is not politically salient. Whites' identity serves as a measure of in-group attitudes but has not become a politicized identity (Wong and Cho 2005, p.716). Citrin and Sears (2014) find that white ethnic identity and consciousness are muted relative to group consciousness among Blacks and Latinos. It appears that Whites' antagonism toward Blacks and Latinos are better predictors of White opposition to racialized policies (Citrin and Sears 2014, p.217). Jardina (2019) distinguishes between White in-group attitudes and out-group behavior,

arguing that White individuals may subscribe to a White identity, but it does not necessarily result in White outgroup behavior. Essentially, Jarinda (2019) argues that it is possible for Whites to subscribe to White identity politics without engaging in out-group and racial animosity.

The mechanisms for Whites' linked fate are similar to their group consciousness. Whites with linked fate are more likely to support restrictive immigration policies (Masuoka and Junn 2013) and have a preference for descriptive representation (Schildkraut 2015). McConnaughy et al. (2010) find that high levels of "political linked fate" among Whites is related to support for White political candidates when a Latinx candidate is on the same ballot. Recent work by Berry, Ebner, and Cornelius (2019) directly tests the role of linked fate among Whites using the 2012 American National Election Study (ANES) and the 2016 CMPS. They find that linked fate is significantly and positively associated with electoral participation for White Republicans but not White Democrats during the 2012 and 2016 presidential elections. Marsh and Ramírez (2019) develop a modified version of linked fate called linked anxiety which captures Whites' development of group consciousness in response to perceived changes that threaten the status quo of their racial-ethnic dominance (p. 628). The findings do not demonstrate strong support that linked anxiety impacts political behaviors or attitudes. They find that there is a small and insignificant increase in political participation among Whites who feel "a lot" of linked anxiety and that linked anxiety has no impact on favorability for the Republican candidate (Marsh and Ramírez 2019).

This study adopts the position that linked fate is strong among Blacks because of their shared history of oppression and continued experiences with discrimination and structural racism but that group consciousness can apply to other racial and ethnic groups depending on the

context. In this study, I will test the role of linked fate and cross-racial liked fate among Blacks, Latinos, and Whites on their attitudes toward healthcare reform. Due to data limitations, I do not include Asian Americans, Middle Eastern or Arab, and Native Americans in this analysis.

Cross-Racial Linked Fate

Linked fate explains group identity of one racial group and its impact on political behaviors and attitudes. Yet as the nation experiences significant demographic shifts, it is plausible that cross-racial linked fate may explain political behaviors and attitudes. Cross-racial linked fate is a nascent measure that captures how linked one may feel their personal gains are to that of other racial groups. The theoretical foundation for applying linked fate in a cross-racial context falls on contact theory.

Contact theory, or propinquity, argues that increased contact between two groups with negative attitudes toward each other will lead to a decrease in negative attitudes (Allport 1954). Yet, the positive effects of contact theory only occur under certain conditions. Allport (1954) identified four key conditions: equal group status within a situation (Pettigrew et al. 2011; Pettigrew and Tropp 2006), common goals (Turner et al. 2010), inter group cooperation (M. B. Brewer 1996), and the support of authorities. Consequently, as two groups increase in size, their contact with each other should increase which can lead to more positive views toward each other. Still, several researchers find that increased contact does not always result in more positive views. In fact, an increase in contact is sometimes associated with more competition and prejudice among groups (Fossett and Kiecolt 1989; Quillian 1996; Schlueter and Scheepers 2010).

Perhaps the most relevant component of contact theory to developing and applying a cross-racial linked fate measure is shared status and shared grievances. Shared status and shared

grievances can help groups develop a sense of commonality which may then translate into cross-racial linked fate (Dowe, Franklin, and Carter 2018; Kaufmann 2003; Merseth 2018; Subašić, Reynolds, and Turner 2008). For example, Hurwitz, Peffley, and Mondak (2015) draw on shared experiences of discrimination among Blacks and Latinos and find that it not only results in higher levels of linked fate but also support for more equity in the criminal justice system. Merseth (2018) tests the role of cross-racial linked fate among Asian Americans' support for the Black Lives Matter movement. Merseth (2018) finds Asian Americans who support Black Lives Matter are more likely to perceive their fates as linked with other Asian Americans and other non-White groups.

Similarly, Dowe, Franklin, and Carter (2018) find that cross-racial linked fate impacts Black and Latino attitudes toward immigration, healthcare, same-sex marriage and affirmative action. Dowe, Franklin, and Carter (2018) study Black and Latino policy symmetry, which occurs when diverse groups that usually compete with each other and are prone to inter-group stereotyping coalesce around a common political agenda (p. 2). They argue cross-racial linked fate shaped policy symmetry during Obama's first term, given systemic racism and similar political grievances adversely affect Blacks and Latinos. They find that cross-racial linked fate had the most positive impact on Black and Latino policy symmetry when associated with Obama and partisanship. Blacks and Latinos who affiliated themselves with Obama were more likely to have similar attitudes toward various policies.

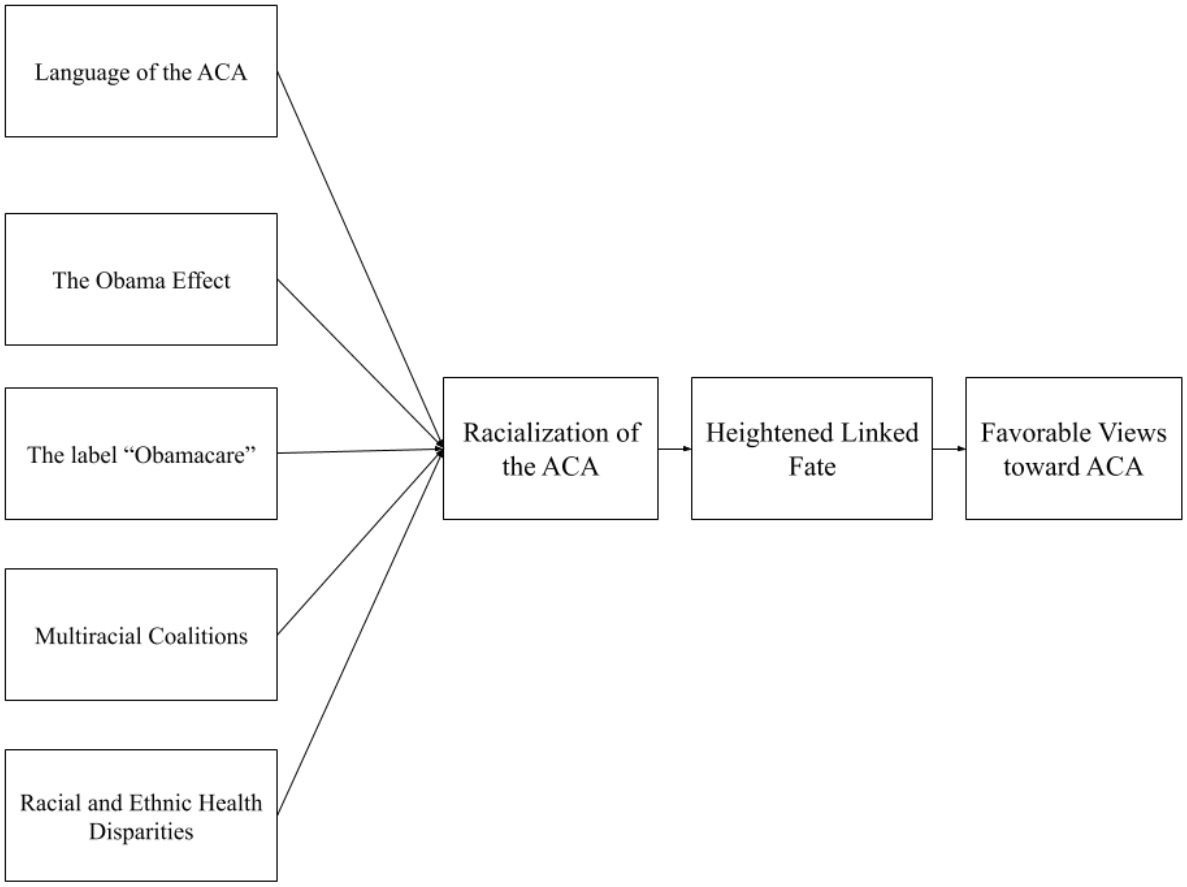
Why Healthcare and Linked Fate

Scholars largely use linked fate to explain variation in attitudes toward racialized public policies, such as affirmative action, criminal justice, and welfare (Dawson 1995; Dowe, Franklin, and Carter 2018; Tate 1994; White 2007). In general, higher measures of linked fate correlate

with higher approval of the expansion of social policies. The literature on the role of linked fate on attitudes toward healthcare is more limited and mixed (Dowe, Franklin, and Carter 2018; McCabe 2019; G. R. Sanchez and Medeiros 2016).

There is reason to anticipate linked fate may influence attitudes toward healthcare reform, especially among Blacks and Latinos. Multiple dimensions of the ACA and the political environment it was passed and enacted make it a racialized policy. In this section, I review five dimensions that racialized the ACA which I argue make applying linked fate especially relevant when considering attitudes toward the ACA (see Figure 2). At the end of this section, I summarize the academic work done on the relationship between linked fate, cross-racial linked fate and attitudes toward healthcare reform.

Figure 2. Pathways for Linked Fate in the Context of the ACA



First, addressing race and ethnicity-based health inequities was at the forefront of the ACA (Michner 2020). The majority of Obama's political agenda was deracialized with the clear exception of the ACA (Lewis, Dowe, and Franklin 2013). The original bill contained numerous references to race, ethnicity, disparities and discrimination (Patient Protection and Affordable Care Act 2010). Despite facing strong political resistance during the first few years of implementation, the ACA had "the potential to truly alter the landscape of racial and ethnic health disparities in the United States" (Mitchell 2015, p. e-66). Including clear language that highlights racial and ethnic health disparities and ways they may be resolved contributed to the racialization of the ACA.

Second is what is widely known as the "Obama effect," which intertwined Obama's racial identity as the first Black president with the ACA (Kriner and Reeves 2014; Tesler 2012; Tesler and Sears 2010). Thereby, racialized attitudes linked to Obama also extended to attitudes toward the ACA. Several studies comparing attitudes toward former President Clinton's healthcare proposal and the ACA proposed by Obama demonstrate this racialization. Racial attitudes in the form of racial resentment are strong predictors of attitudes toward the ACA (Kriner and Reeves 2014; Tesler 2012).

The ACA was one of the most contentious policies. The ACA passed amidst unprecedented opposition in Congress (Kaiser 2011a), survived several challenges before the Supreme Court (Altman 2015; Sobel and Salganicoff 2013), and endured discordant implementation throughout the states (Barrilleaux and Rainey 2014). This contention gave rise to two factors that racialized the ACA. In an attempt to generate opposition toward the ACA, the Republican party relabeled the ACA "Obamacare" (G. Wallace 2012). A majority White and male group generated the term and racialized the Obamacare by cue, distancing themselves from the first Black president (Harris-Perry 2013; Hopper 2015).

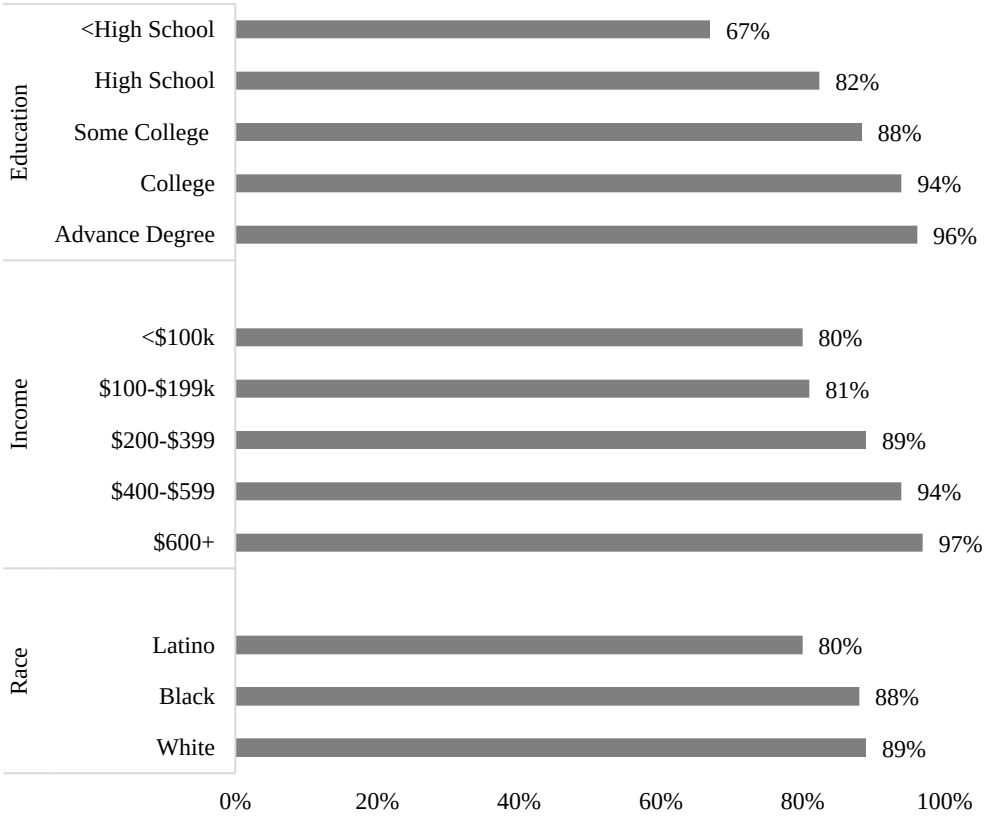
While the Democratic party is often credited with leading and defending the ACA through its passage and implementation, it is important to recognize the broad coalitions of civil rights and social advocates with close ties to often overlooked Black and Latino communities (Dawes 2016). Dawes (2016) maintains that multi-racial coalitions of advocates pressured Obama and Congress to incorporate and defend dozens of provisions in the ACA which address racial and ethnic health disparities (see Appendix C for list of organizations). These multi-racial coalitions support the exploration of cross-racial linked fate in the context of healthcare.

Health disparities that fall along race/ethnic lines are deeply entrenched in the American healthcare system (Adler and Rehkopf 2008). The literature lacks a broadly accepted definition of health disparities. The Health People 2010 report references health disparities as "differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation" (Healthy People 2010 2012). It is impossible to discuss health disparities without taking race and ethnicity into account. Definitions of racial/ethnic disparities suggest the group's health status should be compared with the majority, the population average, or the healthiest group (Adler and Rehkopf 2008, p.137). It is necessary to review several of the most prominent racial and health inequities to better contextualize how linked fate and cross racial linked fate may impact attitudes toward the ACA. I review health insurance, cost of care and health outcome inequities that fall along the racial/ethnic divide.

In 2010, the year the ACA passed, 33% of Latinos, 20% of Blacks and 13% of Whites nonelderly adults were uninsured (Kaiser 2018c). Eight years later, the percent of uninsured nonelderly adults dropped to 19% among Latinos, 11% among Blacks and 8% among Whites (Kaiser 2018c). The gains in health insurance were felt across racial and ethnic groups yet, Latinos and Blacks clearly benefited more than Whites. In another study Sohn (2017) finds prolonged racial and ethnic disparities in health insurance coverage using a longitudinal 2008 panel of the Survey of Income and Program Participation. Sohn (2017) finds prominent differences in rates of health insurance loss between racial and ethnic groups through their life-course. Blacks are expected to almost five more years without health insurance and Latinos are expected to spend almost 14 more years without health insurance through their life-courses than Whites (Sohn 2017, p.194).

There are unique barriers that Blacks and Latinos face to gaining health insurance relative to Whites. Blacks and Latinos are more likely than Whites to have lower socio-economic statuses (de Brey et al. 2019; Doty et al. 2016; Kochhar and Cilluffo 2018). Lower socioeconomic status correlates with barriers to accessing health insurance because of the cost of coverage (DeVoe et al. 2007; Giovannelli and Curran 2016) and lack of resources to navigate the complex health insurance enrollment process (Garrett and Gangopadhyaya 2016; Lu, Samuels, and Wilson 2004). The most recent data on the percent of nonelderly adults with health insurance reflects these findings (see Figure 3). Adults with less than a high school education are much less likely than their counterparts with a high school diploma to have health insurance. A similar trend occurs when looking at income; adults with lower incomes are less likely to have health insurance than those with higher incomes. This income disparity is especially concerning when we consider the tenets of the ACA was to provide financial resources and remove financial barriers to health insurance. Finally, the disparity in health insurance remains prominent across race. Lower levels of income and education only compound the barriers for Latinos and Blacks to gain health insurance.

Figure 3. Percent of Nonelderly Adults with Health Insurance, 2018



Source: CDC/NCHS 2019

There are gaps in awareness about health insurance options under the ACA among Blacks and Latinos. Awareness of health insurance options the ACA provides is a powerful predictor of whether a person applied for and obtains health insurance (Doty et al. 2016). More than half of uninsured Latinos, 55%, and almost half of uninsured Blacks, 42%, are unaware of the health insurance marketplaces compared to 21% of Whites. This knowledge gap is even more severe among younger uninsured Blacks and Latinos, those who had low income and low levels of education (Doty et al. 2016).

In addition to the listed barriers to health coverage, Latinos face significant language barriers to gaining health insurance. The ACA provided multiple resources in Spanish to help alleviate some of the language barrier, but poor translations and website crashes further

complicated Latino engagement with health insurance provisions under the ACA (Sanchez 2013; Voxxi 2013). Over the last decade, Spanish-language outreach efforts improved. Many states invested in bi-lingual call centers, health insurance navigators and other Spanish-language resources to overcome this barrier (Blavin et al. 2014). The sharp decrease in the percent of uninsured Latinos over the last decade reflects these efforts.

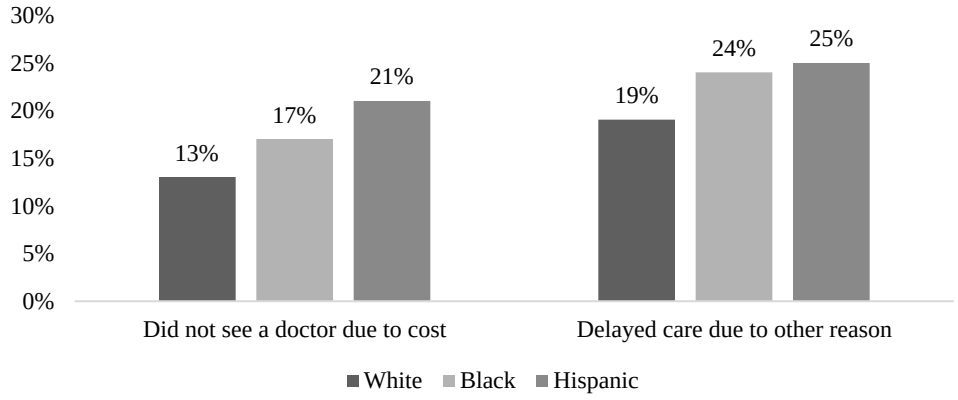
Latinos' nativity and citizenship status also affect their health insurance status. The ACA passed and began implementation during a turbulent time of immigration politics. Obama made several changes to immigration policy, largely in response to protests from immigration rights activists (Sakuma 2017). Despite passing an executive order called the Deferred Action for Childhood Arrivals (DACA) which provided a pathway to citizenship for undocumented youth brought to the U.S. as children, the Latino community knew Obama as the "Deporter-in Chief" among because of the extensive number of deportations that occurred under his administration (Epstein 2014; Sakuma 2017). Therefore, it was impossible for Latinos to engage with the ACA without taking the current immigration climate into account. The best example of this is when Obama went to a townhall style meeting with the two largest Spanish language television outlets, Telemundo and Univision. It was meant to be a discussion about how Latinos can enroll in health insurance provisions under the ACA, however, it turned into a discussion on immigration reform and the deportations impacting the Latino community (Nakamura 2014).

It is not surprising that health insurance coverage issues negatively impacted Latinos entangled at the intersection of the ACA and immigration. The ACA did not extend health insurance coverage to undocumented individuals and required a five-year waiting period for legal permanent residents to be eligible for participation in ACA health insurance provisions (Patient Protection and Affordable Care Act 2010). This especially impacted the significant

number of Latino families who have one or more family members without citizenship status, also known as mixed-status families, (Ortega, Rodriguez, and Vargas Bustamante 2015). G. R. Sanchez et al. (2017) found there is no difference between foreign-born and U.S.-born Latinos' health insurance coverage but that permanent residents have lower levels of access to health insurance than naturalized citizens.

Another barrier to healthcare is the cost of care. Because Blacks and Latinos are more likely to have lower incomes and experience poverty compared to Whites, cost of care is a commonly cited barrier to care. A Kaiser Family Foundation study found that 21% of Latinos and 17% of Blacks delayed a doctor's visit because of cost relative to 13% of Whites (see Figure 4). Delaying care is associated with higher risk of mortality and worsening health outcomes (Kraft et al. 2009; Prentice and Pizer 2007).

Figure 4. Share of Nonelderly Adults Who Did Not Receive Care or Delayed Care in the Past Year by Race/Ethnicity, 2018

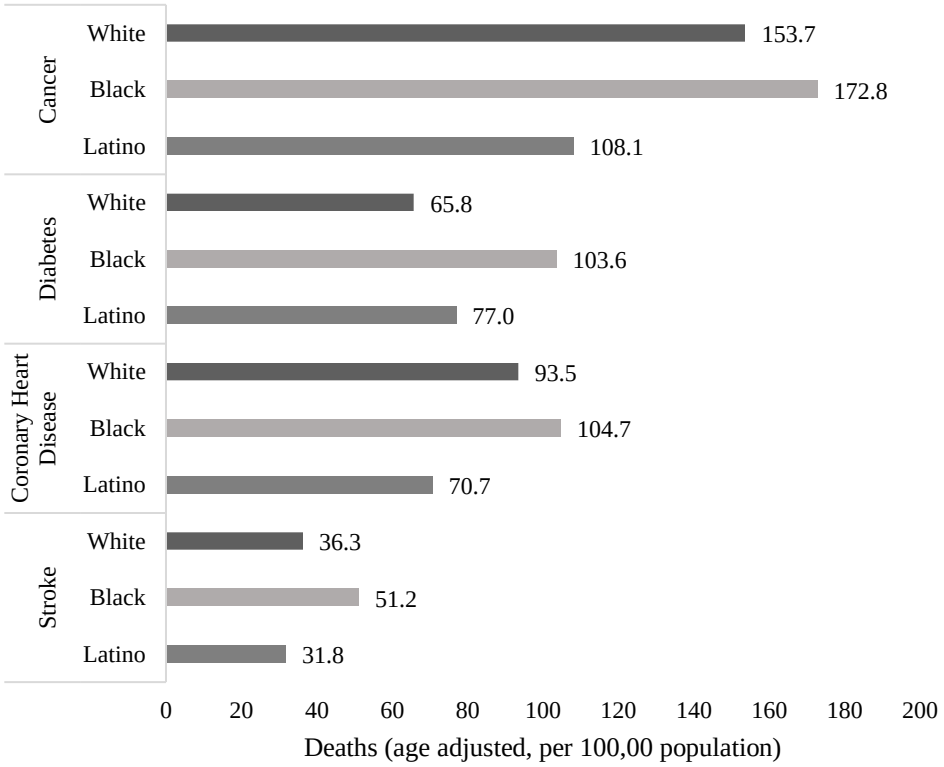


Source: Kaiser 2020a

These barriers to care, both cost and health insurance status, have consequences on health outcomes for Blacks and Latinos. Health disparities between Blacks and Whites are very pronounced in national data on the leading causes of death (see Figure 5). Blacks outpace Whites

in all leading causes of death. A study by the Congressional Black Caucus Health Braintrust (2015) found that Blacks have a higher mortality rate than any other racial or ethnic group for the top ten causes of death. The literature provides multiple explanations for these enduring health disparities. It is clear that lack of access to health insurance and quality healthcare play a strong role (Kelly 2015), as do structural racism (Bailey et al. 2017; Gee and Ford 2011) and racial discrimination (Penner et al. 2009; Williams and Mohammed 2009).

Figure 5. Age Adjusted Deaths per 100,000 by Leading Causes of Death, 2017



Source: Healthy People 2020

Latinos have a more complicated narrative in health outcome disparities. In national data, Latinos have better healthcare outcomes than Whites (see Figure 4). Yet, Latinos are more likely to have lower socioeconomic statuses, less likely to have health insurance and face language barriers relative to Whites (Hostetter and Klein 2018; Kaiser 2018c; Kochhar and Cilluffo 2018).

The Latino health paradox puzzles researchers. A Center for Disease Control and Prevention (CDC) study found that overall Latinos have higher rates of diabetes, obesity prevalence, and higher portions of deaths related to diabetes and chronic liver disease compared to Whites (CDC 2015). It appears that these health advantages diminish with increased acculturation or duration of residency in the U.S. (Abraído-Lanza, Chao, and Flórez 2005; Daviglus et al. 2012; Gordon-Larsen et al. 2003).

This review of health disparities by race is central to applying linked fate and cross racial linked fate in the context of healthcare. There are a limited number of studies that test the role of linked fate on attitudes toward healthcare (Dowe, Franklin, and Carter 2018; McCabe 2019; G. R. Sanchez and Medeiros 2016). G. R. Sanchez and Medeiros (2016) test the role of linked fate on support for expansion of healthcare coverage among Latinos. They argue that since Latinos are more likely to have be uninsured, their sense of linked fate should be heightened and reflected in preferences for expanding access to health insurance. This may explain why Latinos have distinct attitudes toward healthcare reform relative to Blacks and Whites. G. R. Sanchez and Medeiros (2016) find that linked fate positively correlates with support for expanding health coverage to a wider segment of the population.

McCabe (2019) tests the role of linked fate on support for the ACA among Blacks. McCabe (2019) argues that the racialization of healthcare and the fact that Obama, the first Black president, was so involved with the ACA may activate linked fate. Therefore, linked fate may lead Blacks to be more supportive of healthcare reform. However, McCabe (2019) finds that linked fate plays a small and non-significant role in preference for an active government role in healthcare reform.

Dowe, Franklin, and Carter (2018) investigate the relationship between cross-racial linked fate among Blacks' and Latinos' attitudes toward the ACA. They argue cross-racial linked fate shapes policy symmetry between Blacks' and Latinos because of their adverse experiences and similar political grievances. They find that linked fate shapes Blacks and Latinos' views toward the ACA. Blacks and Latinos who reported higher levels of linked fate translated to favorable views toward the ACA, although not always significant (Dowe, Franklin, and Carter 2018, p. 20).

This chapter deviates from these three studies, testing both linked fate and cross-racial linked fate among Blacks, Latinos, and Whites. Moreover, the Center for Social Policy Social Policy Survey used to test the role of linked fate and cross racial linked fate on attitudes toward the ACA includes multiple health related control variables to test whether group-interests are more influential than self-interest when evaluating the ACA. For example, a Latino respondent with a heightened sense of linked fate with health insurance and without preexisting conditions who supports strengthening the ACA is arguably more reliant on his/her group-interest than self-interest.

Hypotheses

Thus far, we examined the existing literature on group identity which serves as the theoretical foundation for the measures of linked fate and cross-racial linked fate and why linked fate and cross-racial linked fate are applicable in the context of healthcare. I extend the theory of linked fate and test its impact on attitudes toward the ACA among Blacks, Latinos, and Whites. Similar to previous theories, I argue that linked fate will promote more favorable views toward the ACA even while controlling for healthcare and health disparities that usually are divided by race and ethnicity.

H1: Individuals with a strong sense of linked fate will support efforts to strengthen the ACA more than those with a weaker sense of linked fate.

I also anticipate variation by race in the relationship between linked fate and attitudes toward healthcare reform. Linked fate is an especially strong measure among Blacks because of their shared history of oppression and continued experiences based on race. Blacks should have a stronger sense of linked fate relative to Latinos and Whites given the first African American president's proposal, passage, and defense of the ACA. Furthermore, the racial health disparities severely felt among the Black community should intensify this effect.

Since Latinos' panethnic identity precludes their development of linked fate, I expect the impact of linked fate on their attitudes toward healthcare should fall between that of Blacks and Whites in terms of strength. Linked fate should influence Latinos attitudes toward the ACA when considering the lack of healthcare coverage.

Similar to Blacks, a shared history unified Whites yet it is distinctly different since it is one as the oppressors and privilege rather than the oppressed and disadvantaged. Whites are less likely to be uninsured and less likely to experience adverse health outcomes relative to Blacks and sometimes Latinos (Adler and Rehkopf 2008; Sohn 2017). Therefore, linked fate may not influence Whites' attitudes toward the ACA as strongly as it does for Blacks and Latinos since they have less to gain than their respective groups. I expect linked fate to be strongest among Blacks' attitudes toward the ACA and weakest among Whites; Latinos will fall somewhere in the middle of the two.

H2: Linked fate will play the strongest role in Blacks' support for strengthening the ACA, the weakest among Whites' support for strengthening the ACA, and fall somewhere in the middle for Latinos' support for strengthening the ACA.

The remaining hypotheses address the concept of cross-racial linked fate, examined among Blacks, Latinos, and Whites. Cross-racial linked fate appears to be motivated by a shared sense of discrimination or struggle (Dowe, Franklin, and Carter 2018; Hurwitz, Peffley, and Mondak 2015). The multiracial coalitions built among Black and Latinos' coalitions to strengthen the ACA and to alleviate racial/ethnic health disparities which Dawes (2016) identified give cause to anticipate cross-racial linked fate may impact Blacks and Latinos' attitudes toward the ACA more than Whites. The ACA made progress in ameliorating health insurance coverage among Latinos and Blacks which translates to incipient improvements in health outcomes among Blacks and Latinos (Baumgartner et al. 2020). However, Latinos and Blacks are still more likely to be uninsured than Whites and more likely to endure health outcome inequities (Baumgartner et al. 2020). Therefore, Blacks and Latinos should have an acute sense of cross-racial linked fate relative to Whites which should translate to more positive views toward the ACA.

H3: Blacks and Latinos will have a stronger sense of cross-racial linked fate then Whites.

Cross-racial linked fate should also translate into more favorable views toward the ACA. The ACA explicitly sought to ameliorate some of the health and healthcare disparities that fall along the lines of race and ethnicity (Patient Protection and Affordable Care Act 2010). To achieve this goal, the success of the ACA is partially dependent on the ability of Americans to engage with the health insurance provisions under the ACA and continue to support its expansion. Thereby, cross-racial linked fate can explain how individuals shape their attitudes toward the ACA.

H4: Cross-racial linked fate will have a positive relationship with support for the ACA.

Methods

Data

I use the Center for Social Policy Social Policy Survey of 2019 (n=2613) to test these hypotheses. The survey was self-administered over an online platform between April 5, 2019-May 2, 2019. The invitation to participate and survey were available to registered and non-registered voters. The full data are weighted within each racial group to match the population of the 2017 ACS-one-year data file for age, gender, education, nativity, ancestry, and voter registration status. A post-stratification raking algorithm balanced each category within +/- 1 percent of the ACS estimates. Within the sample, 56.49% self-identify as Latinos, 21.66% as White and 21.85% as Black. Respondents received a $10-$20 gift card as compensation for their participation. Pacific Market Research oversaw programming and data collection for the full project.

Dependent Variable

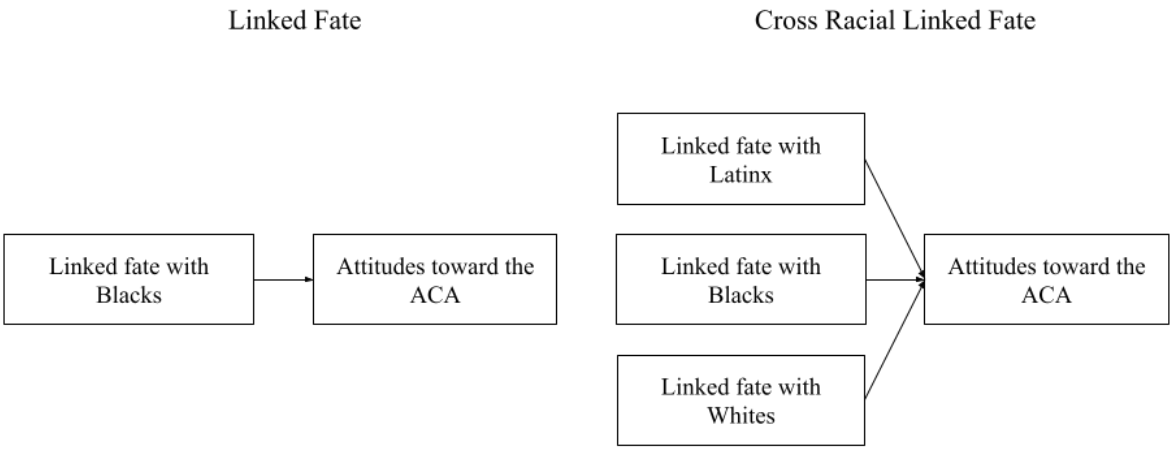
To test attitudes toward healthcare reform, I use a dichotomous variable which captures attitudes toward healthcare reform but uses racialized language. The survey asked respondents, "Please tell us which comes closer to your view about the Affordable Care Act, passed by Congress and the President in 2010, often referred to as Obamacare." This question significantly differs in explicitly highlighting the Affordable Care Act. The question wording include the term Obamacare since almost a third of Americans are not aware that the ACA and Obamacare are the same thing (Dropp and Nyhan 2017). The survey gave respondents two response categories: repeal the ACA or strengthen the ACA and is coded to reflect that (1=strengthen, 0=repeal).

Explanatory Variables

Linked fate is the primary explanatory variable in this analysis. The measure of linked fate is based on survey questions that ask respondents how much they feel their personal success is dependent on the success of their group. The survey asked all participants, "Do you think what happens generally to Black/Latino/White people in this country will have something to do with what happens in your life?" Respondents who feel their fate tied to that of their racial/ethnic group ranked how much their group affects their success, (1) not very much to (3) a lot. The survey asked this question of the whole sample to capture levels of linked fate toward Blacks, Latinos, and Whites (see Appendix B for questions wording).

The traditional measure of self-interest is race/ethnicity dependent. For instance, the survey asked Blacks how dependent their fate is on the fate of other Blacks. The same measure applied to Latinos and Whites. Cross-racial linked fate differs from the classic measure by asking individuals who may not identify with a certain group if their fate is tied to it. For example, Figure 6 walks through the traditional measure of linked fate and the cross-racial measure of linked fates impact on attitudes toward healthcare reform. In this example, the survey asks Blacks whether and by how much their fate is linked to the fate of Latinos and Whites. Thereby, I can test the role of cross-racial linked fate which captures Blacks' linked fate with Latinx and Whites (see Figure 6). The same process respectively applies to Latinx and Whites.

Figure 6. Linked Fate and Cross-Racial Linked Fate



Control Variables

The Center for Social Policy Social Policy Survey provides the opportunity to control a host of factors that may impact attitudes toward healthcare reform. Since the theoretical underpinnings of linked fate influencing attitudes toward healthcare reform rely on health disparities, I control for a series of health and healthcare measures. Including these health-related controls allows for testing whether respondents rely on their group interest more than their self-interest in the context of health and healthcare.

The first health-related control variable is health insurance status. Hall et al. (2015) find women without health insurance are more likely to support healthcare reform. Similarly, Legerski and Berg (2016) find marginal support that individuals without health insurance are more likely to have favorable views toward the ACA. As a result, I include a control variable for health insurance coded as 1, and I code respondents who do not have health insurance as 0. I anticipate this study will confirm Legerski and Berg's (2016) findings.

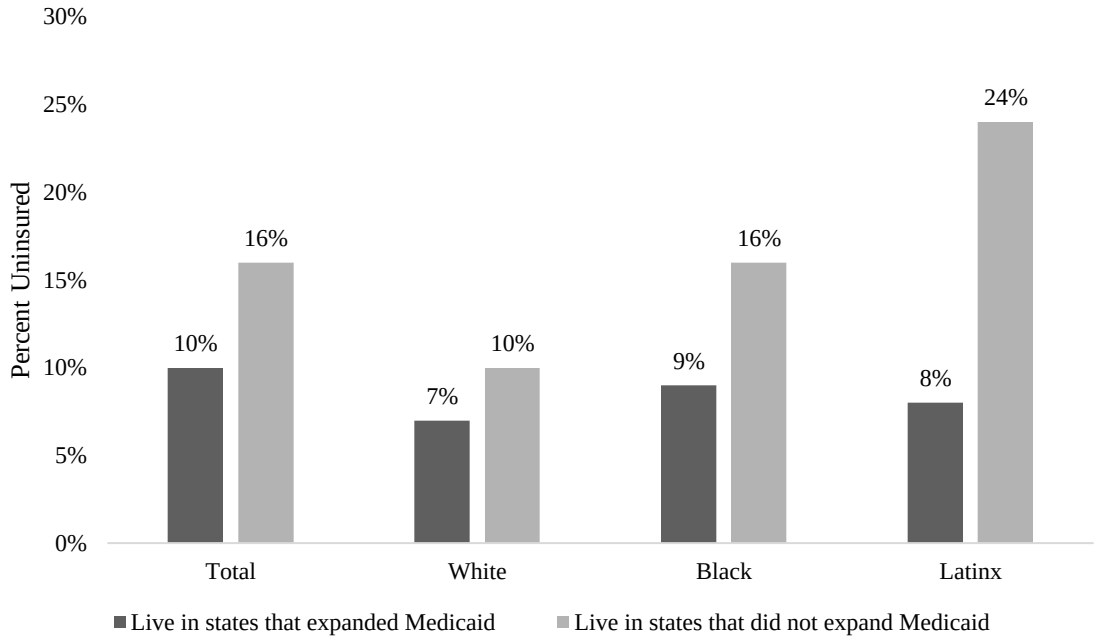
I also control for cost barriers to care. The survey asked respondents if they had put off any sort of medical treatment because of the cost. I coded respondents who delayed care because of cost as 1 and those who did not delay care as 0. The role of financial barriers to care in

attitudes toward healthcare reform is not well developed. Legerski and Berg (2016) find cost barriers to health insurance do not play a significant role on attitudes toward healthcare reform. Still, I anticipate that respondents who delayed medical care because of cost will be more likely to support the ACA and healthcare reform. The basic tenets of the ACA were to remove financial barriers to health insurance and healthcare broadly.

I include a control variable for whether respondents have a preexisting condition. A pre-existing condition is a health condition that exists before one applies for or enrolls in a new health insurance policy (CMS 2010). The first asks respondents if they have a preexisting condition. I coded respondents with a preexisting condition as 1 and those without a preexisting condition as 0. A Kaiser Family Foundation poll (2018a) found that households with preexisting conditions are more likely to support the ACA and continuing protections for individuals with preexisting conditions. I anticipate individuals with preexisting conditions will support healthcare reform and the ACA more than those who do not have preexisting conditions.

The final health related control variable included in this analysis is whether the respondent lives in a state that expanded Medicaid. As of March 2020, 37 states including DC adopted the Medicaid expansion. There are still 14 states that have not expanded Medicaid. This variation is important to control for since scholars find that individuals who live in states that expanded Medicaid are more likely to support the ACA than those who live in states that did not (Clinton and Sances 2018; Hopkins and Parish 2019; Lerman and McCabe 2017). This is partially due to gains in health insurance in states that expanded Medicaid (see Figure 7). Moreover, states that expanded Medicaid saw substantial decreases in the percent of uninsured nonelderly Black and Latinos.

Figure 7. Percent of uninsured nonelderly adults, 2018



Source: Baumgartner et al. 2020

In the spring of 2019, three of the states that committed to expanding Medicaid had not yet implemented the policy and, therefore, I coded them as states that had not yet expanded. I coded states that expanded Medicaid as 1 and states that did not expand Medicaid or implement the Medicaid expansion as of April 2019 as 0. I anticipate that respondents who live in states that expanded Medicaid will have favorable views toward healthcare reform and the ACA.

It is impossible to study attitudes toward healthcare reform and the ACA without taking political party into account. The ACA is one of the most politically polarizing policies of the decade (Barrilleaux and Rainey 2014; Clinton and Sances 2018; Jones, Bradley, and Oberlander 2014; McCabe 2016). A large amount of research finds Democrats have more favorable attitudes toward healthcare reform and that ACA relative to Republicans (Brodie, Deane, and Cho 2011; Kriner and Reeves 2014; Sances and Clinton 2019). Therefore, it is important to include party identification as a control variable. I include party identification as two dichotomous variables,

Democrat (1= Democrat, 0=Republican/other) and Republican (1= Republican, 0=Democrat/other) (see Table 1 for descriptive statistics).

I include several demographic controls from the survey for socio-economic status which correlate with political attitudes (Verba and Nie 1972). In the context of linked fate, Tate (1994) finds that class influences linked fate among Blacks. African Americans who identify with upper economic classes are less likely to have strong racial identities (Dawson 1995; Tate 1994). In the context of healthcare reform, individuals who fall in the upper brackets of income are less likely to support healthcare reform (Kaiser 2015; Lerman and McCabe 2017). The income variable asks respondents for their combined household income in 2019 before taxes, and the response categories are divided into $20,000 increments. I expect that individuals with lower incomes are more likely to support healthcare reform especially since one of the primary objectives of the ACA was to provide financial assistance in the form of subsidies for low income individuals in families to gain health insurance and the expansion of Medicaid.

I also include education as a control variable. In the context of healthcare reform, education often serves as a proxy for health literacy and health insurance literacy both of which are positive predictors of healthcare reform (J. Kim, Braun, and Williams 2013). The educational question asks for the highest degree of educational attainment rather than the number of years. I code education at four levels, “High school or less”, “Some college”, “College graduate,” and “Graduate degree.” Each education variable is a dummy variable; 1 equals the degree, anything else is 0. I presume respondent with higher levels of education will have more favorable views toward healthcare reform and the ACA than those with lower levels of education.

I control for gender in this study as well. Women are more likely than men to support the ACA (LeCount and Abrahamson 2017; Lizotte 2016). The survey asked respondents to indicate

their gender between “male,” “female,” and “other.” I coded the gender variable as a dummy variable where 1 is equal to female and 0 is equal to male[5]. I anticipate that respondents who identify as female will be more likely to have favorable views toward healthcare reform and the ACA.

The final control variable is race. Latinos and Blacks are more likely to have more favorable views toward healthcare reform and the ACA than non-Hispanic Whites (Kaiser 2020b). The survey asked respondents to identify their race. Only individuals who identified as White, Black, or Hispanic/Latino completed the survey. I created a correlation matrix to test for multicollinearity for the linked fate variables separated by the respondents’ race. No two variables had correlations greater than 0.5. I anticipate that Blacks and Latinos will have more favorable attitudes toward healthcare reform and the ACA.

[5] The survey question allowed respondent to answer “male,” “female,” or “other.” In this sample, there were only four respondents who chose “other.” I attempted to run my results using “other” as the baseline category but because of the small sample size, I excluded them from this analysis which is not ideal.

Table 1. Descriptive Statistics for Weighted Model

Variable	Mean	SD	Min	Max
Linked Fate toward Blacks	2.47	1.26	1	4
Linked Fate toward Latinos	2.50	1.25	1	4
Linked Fate toward Whites	2.42	1.24	1	4
Health				
Has health Insurance	0.852	0.355	0	1
Cost Barrier to care	0.366	0.482	0	1
Preexisting condition personal	0.367	0.482	0	1
Lives in a state that expanded Medicaid	0.624	0.485	0	1
Party Identification				
Republican	0.213	0.410	0	1
Democrat	0.553	0.497	0	1
Independent	0.298	0.457	0	1
Income	5.06	3.06	1	12
Education				
High school graduate/Some high school	0.320	0.467	0	1
Some College	0.328	0.470	0	1
College Graduate	0.253	0.435	0	1
Graduate Degree	0.098	0.297	0	1
Female	0.564	0.496	0	1
Race				
Latino	0.565	0.496	0	1
Black	0.219	0.413	0	1
White	0.217	0.412	0	1

Results

I begin my analysis with an overview of the descriptive results from the dependent variable, willingness to repeal the ACA. Blacks and Latinos are much more willing to support efforts that strengthen the ACA than Whites (see Table 2). The apparent differences in support for expansion of the coverage based on race provide support for my effort to better understand the role of linked fate and cross racial linked fate in attitudes toward the ACA by race.

Table 2. Willingness to Repeal the ACA by Race (Bivariate Results in Percentages)

	Blacks	*Latinos*	*Whites*
Strengthen the ACA	71.7	78.3	49.7

Table 3 presents a preliminary investigation of the correlation between linked fate the support for repealing the ACA. Here I provide both cross-tabulations between the linked fate toward Blacks, Latinos, and Whites and willingness to repeal the ACA. The bivariate cross tabulation statistics provide initial evidence for my first hypothesis on linked fate, as there is an apparent positive relationship between linked fate and strengthening the ACA. The effects appear strongest among Blacks. Table 3 suggests support for Hypothesis 2 which expects the role of linked fate among Blacks' attitudes toward the ACA to be strongest. Over half of Blacks who feel "a lot" of their fate is tied to other Blacks support efforts that strengthen the ACA. The effects of linked fate on Latinos and Whites support for strengthening the ACA are weaker.

Table 3. Cross-Tabulation Results for Linked Fate by Race

(Bivariate results in percentages)

Policy Response				
	Levels of Link Fate with Blacks, Among Blacks			
	Not at all	*Not very much*	*Some*	*A lot*
Strengthen the ACA	14.4	2.4	22.6	60.6
	Levels of Link Fate with Latinos, Among Latinos			
	Not at all	*Not very much*	*Some*	*A lot*
Strengthen the ACA	25.6	3.2	35.0	36.2
	Levels of Link Fate with Whites, Among Whites			
	Not at all	*Not very much*	*Some*	*A lot*
Strengthen the ACA	18.1	4.5	41.6	35.8

Table 4. provides the results from the fully specified logistic regression model, which examines the relationships between linked fate and strengthening the ACA while controlling for several demographic, political, and health factors. The purpose of these models is to determine if the relationship between linked fate and attitudes toward strengthening the ACA at the bivariate level hold once we account for other factors perceived to influence healthcare policy preferences. To test the role of linked fate, I ran three separate logistic regressions to capture the impact of Blacks' linked fate (M1), Latinos' linked fate (M2) and Whites' linked fate (M3).

Table 4. Logistic Regression of Linked Fate on Strengthening the ACA

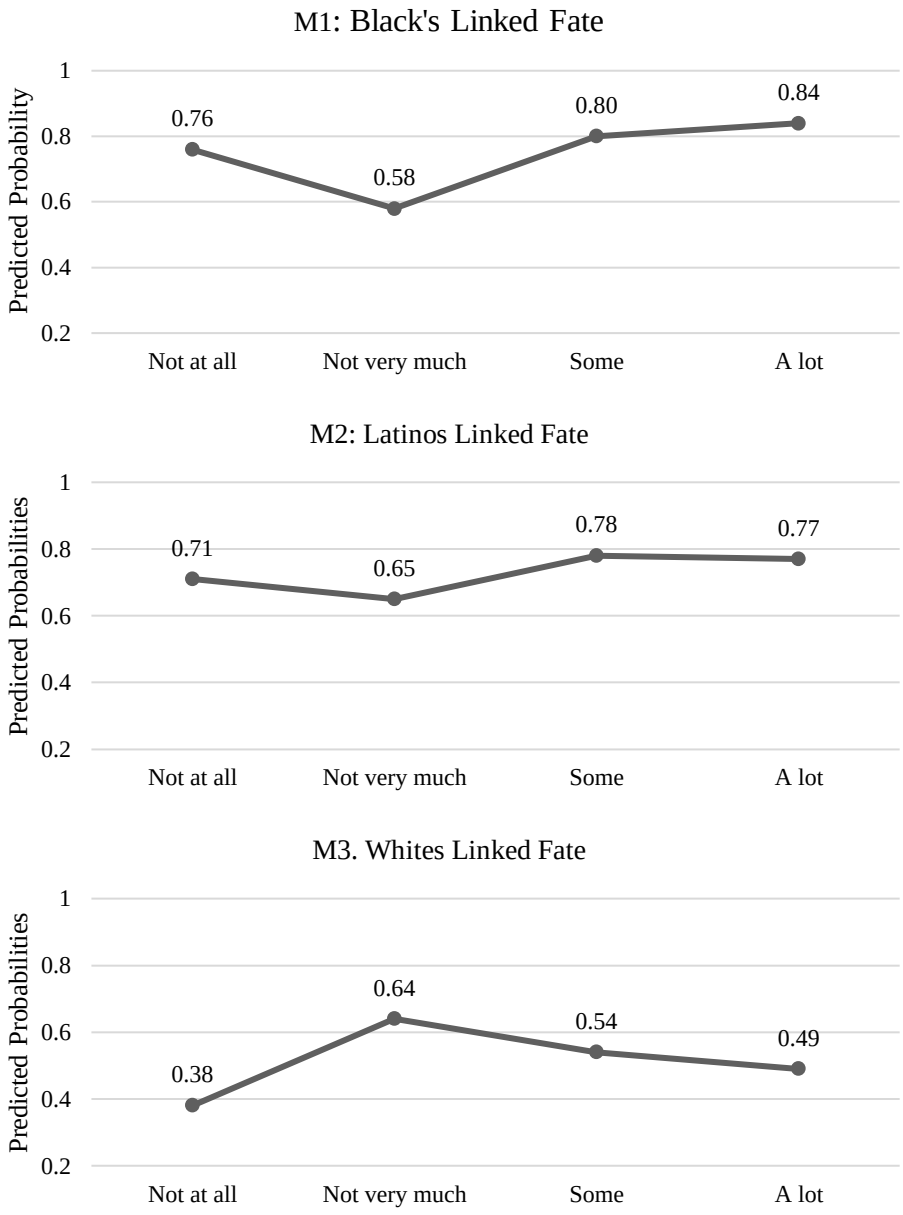
	M1: Blacks	*Odds Ratio*	*M2: Latinos*	*Odds Ratio*	*M3: Whites*	*Odds Ratio*
Linked Fate						
Linked Fate with Blacks	0.212**	1.23**				
	(0.106)					
Linked Fate with Latinos			0.123*	1.13*		
			(0.066)			
Linked Fate with Whites					0.148	1.16
					(0.111)	
Health Controls						
Health Insurance	0.328	1.39	-0.015	0.99	-0.302	0.74
	(0.315)		(0.228)		(0.398)	
Financial Barriers to Care	-0.907***	0.40***	-0.214	0.81	-0.308	0.73
	(0.252)		(0.169)		(0.254)	
Preexisting Condition	-0.178	0.84	-0.166	0.85	0.211	1.24
	(0.259)		(0.169)		(0.249)	
Medicaid Expanded	0.105	1.11	0.302*	1.35*	0.324	1.38
	(0.245)		(0.165)		(0.248)	
Party Identification						
Republican	-1.524***	0.22***	-2.397***	0.09***	-2.527***	0.08***
	(0.387)		(0.199)		(0.286)	
Independent	-0.921***	0.40***	-0.811***	0.44***	-0.911***	0.40***
	(0.277)		(0.189)		(0.291)	
Education						
High School or less	-0.667	0.51	-0.800**	0.45**	-0.701*	0.50
	(0.559)		(0.364)		(0.401)	
Some College	-0.415	0.66	-0.577	0.56	-0.746**	0.47
	(0.545)		(0.355)		(0.351)	
College Degree	0.029	1.03	-0.740**	0.48**	-0.856***	0.42
	(0.541)		(0.364)		(0.364)	
Age	0.287**	1.33**	-0.047	0.95	-0.072	0.93
	(0.124)		(0.086)		(0.133)	
Income	-0.038	0.96	-0.074**	0.93**	-0.023	0.98
	(0.046)		(0.029)		(0.043)	
Female	0.343	1.41	0.466***	1.59***	0.339	1.40
	(0.238)		(0.154)		(0.237)	
Constant	0.816		2.285***		1.661**	
	(0.848)		(0.499)		(0.797)	
Pseudo R2	0.136		0.173		0.214	
N	*516*		*1361*		*436*	

Note: Dependent Variable is 0 or 1, 1=Strengthen the ACA.
Democrats are the reference category for Republicans and Independents.
Whites are the reference category for race.
Graduate degree is the reference category for education.

Robust standard errors in parentheses.
**** p<0.01, ** p<0.05, * p<0.1*

Most critical to the focus of this chapter, and in line with the first hypothesis and second hypothesis, the linked fate measure correlates with support for strengthening the ACA and is significant among Blacks and Latinos. Therefore, Blacks and Latinos with a stronger sense of linked fate are more likely to support efforts to strengthen the ACA when controlling other factors, including partisanship and health measures. This finding suggests that the ACA cues racial and ethnic solidarity among Blacks and Latinos. To illustrate the substantive of linked fate on support for strengthening the ACA among Blacks and Latinos, I conduct a postestimation analysis to isolate the influence of linked fate when other factors in the model are held at their means in Figure 8.

Figure 8. The Substantive Impact of Linked Fate on Strengthening the ACA



As depicted in Figure 8, support for strengthening the ACA increases with greater levels of linked fate for Blacks and Latinos. More specifically, the probability of a Black respondent supporting efforts that strengthen the ACA increase from 0.73 for those with low levels of linked fate to 0.84 for those with high levels of linked fate. The same trend is mimicked among Latinos to a lesser extent; Latino support for strengthening the ACA increases from 0.71 for those with

low levels of linked fate to 0.78 for Latinos with some linked fate and 0.77 for Latinos with at the higher end. In both groups, Black and Latino respondents who have feel their fate is not very linked to their racial/ethnic group the probability decreases relative to the other response categories. The role of linked fate is not significant among Whites, but I still include the relationship in Figure 8. There is more variation within the relationship between linked fate and Whites' support for strengthening the ACA. In general, if Whites reported any sense of linked fate, they were more likely to support strengthening the ACA compared to Whites who did not feel any sense of linked fate. However, the relationship between heightened levels of linked fate and support for strengthening the ACA are inverse compared to that of Latinos and Blacks.

In Figure 8, it is clear that all respondents who reported "not very much" of their fate was determined by the fate of their respective racial/ethnic group interrupts the anticipated trend line. It is surprising that Blacks and Latinos with "not very much" linked fate dip in support for strengthening the ACA and Whites increase. I attribute the wane in the data to the small number of Blacks (n=18), Latinos (n=55), and Whites (n=22) who felt "not very much" of their fate was linked to their racial/ethnic group.

Several of the control variables are also significant predictors of support for strengthening the ACA. Across all three model, party identification is a strong predictor of strengthening the ACA. Republicans and Independents are significantly less likely than Democrats to support efforts that strengthen the ACA. The difference between Republican and Democrat support for strengthening the ACA is largest among Blacks (M1). The odds of Black Republicans supporting efforts that strengthen the ACA are 0.22 lower than Democrats. The odds of Independents supporting efforts that strengthen the ACA are between 0.40 (M1, M2) and 0.44 (M3) lower relative to Democrats.

The healthcare and health controls are not significant predictors with the exception of financial barriers to care among Blacks (M1). The odds of Blacks who delayed medical care in the last 12 months supporting efforts that strengthen the ACA are 0.40 less than Blacks who have not delayed care because of cost. Blacks are more likely to have incomes below poverty than Latinos and Whites (Artiga, Garfield, and Orgera, Kendal 2020). It is possible that the acute financial disparities in the black community make financial barrier to care particularly relevant to attitudes toward the ACA. Also unique to Model 1, is the significance of age. Older Blacks are more likely than younger Blacks to support efforts to strengthen the ACA. It is possible that the health outcome disparities felt later in life and more pervasive in the Black community are partially responsible for this finding.

Living in a state that expanded Medicaid is only significant among Latinos' support for strengthening the ACA (M2). During the early years of the ACA implementation, a significant amount of funds and effort was made to educate and enroll Latinos into health insurance provisions under the ACA (Blavin et al. 2014; Voxxi 2013). Since Latinx are the more likely to be uninsured relative to Blacks and Whites and are likely to qualify for Medicaid because of low incomes, it is possible that the robust outreach efforts directed toward the Latino community and heightened need for health insurance among the Latinos makes them uniquely aware of the benefits the ACA has in their community.

Blacks, Latinos, and Whites with high incomes are less likely to support strengthening the ACA than those with lower incomes. This relationship is only significant among Latinos. There is a substantial amount of variation in education's role in attitudes toward strengthening the ACA. I compare the levels of education in Table 4 to respondents with graduate degrees. Across all three models, respondents with lower levels of education appear to be less supportive

of strengthening the ACA. None of these relationships are significant among Blacks (M1), however, they are all significant among Whites (M3). Whites with a college degree or less are significantly less likely to support strengthening the ACA compared to Whites with a graduate degree. Latinos appear to follow the same pattern as Whites with the exception of Latinos with a college degree who are significantly more likely to support strengthening the ACA than Latinos with a graduate degree.

Identifying as a female is only significant among Latinos. The odds of a female Latino supporting strengthening the ACA are 1.59 times higher than male Latino, holding all other variables constant ($p < 0.01$). Black and White females are more likely than their male counterparts to support strengthening the ACA, but the relationship is not significant. These trends support Lizotte's (2016) which finds women are more likely than men to support healthcare reform and the ACA.

Prior to running a logistic regression, I provide cross-tabulation results for cross-racial linked fate in Table 5. These preliminary results show that cross-racial linked fate is not as strong as in-group linked fate. The large majority of Blacks (85%) felt some sense of linked fate with other Blacks, whereas a little over half of Blacks report having some sense of linked fate with Latinos (53%) and Whites (57%). The distribution of Blacks' levels of linked fate toward Latinos and Whites is similar across all levels of linked fate. Latinos' sense of linked fate is stronger with other Latinos compared to Whites and Blacks. There is little variation between Latinos' levels of linked fate with Blacks and Whites. The narrative is very similar among Whites who have higher levels of in-group linked fate than out-group linked fate with Latinos and Blacks. Whites' levels of linked fate is slightly higher toward Blacks than Latinos.

Table 5. Cross-Tabulation Results for Cross-Racial Linked Fate by Race

(Bivariate results in percentages)

Link Fate	*Blacks' Levels of Linked Fate*			
	Not at all	*Not very much*	*Some*	*A lot*
Toward Blacks	*15.2*	*3.4*	*23.2*	*58.1*
Toward Latinos	46.9	3.8	29.1	20.2
Toward Whites	43.1	3.4	29.5	24.0
	Latinos' Levels of Link Fate			
	Not at all	*Not very much*	*Some*	*A lot*
Toward Blacks	43.7	5.5	29.9	20.9
Toward Latinos	*28.5*	*3.9*	*33.8*	*33.9*
Toward Whites	43.4	4.0	30.8	21.8
	Whites' Levels of Link Fate			
	Not at all	*Not very much*	*Some*	*A lot*
Toward Blacks	46.7	4.3	29.7	19.3
Toward Latinos	53.7	2.9	25.6	17.8
Toward Whites	*22.5*	*4.9*	*38.0*	*34.6*

It is unexpected that Blacks and Latinos levels of cross-racial linked fate are not more heightened toward each other given their shared status and grievances. Table 5 fails to find preliminary support for my third hypothesis which expected Blacks and Latinos to have higher levels of cross-racial linked fate than Whites. It appears there is limited variation in the levels of cross-racial linked fate toward other groups regardless of race/ethnicity.

To test cross-racial linked fates impact on attitudes toward strengthening the ACA, I run a fully specified logistic-regression model (see Table 6). Model 1 tests the role of cross-racial linked fate among Blacks; Model 2 tests the role of cross-racial linked fate among Latinos; and Model 3 tests the role of cross-racial linked fate among Whites. The effects of cross-racial linked fate appear are mixed.

Table 6. Logistic regression of cross-racial linked fate on strengthening the ACA

	M1: Blacks	*Odds Ratio*	*M2: Latinos*	*Odds Ratio*	*M3: Whites*	*Odds Ratio*
Linked Fate						
Linked Fate with Blacks			0.097	1.10	-0.010	0.99
			(0.073)		(0.132)	
Linked Fate with Latinos	-0.223*	0.80*			-0.018	0.98
	(0.116)				(0.135)	
Linked Fate with Whites	-0.012	0.99	-0.184***	0.83***		
	(0.113)		(0.071)			
Health Controls						
Health Insurance	0.456	1.58	0.009	1.09	-0.284	0.75
	(0.319)		(0.227)		(0.407)	
Financial Barriers to Care	-0.779***	0.46***	-0.156	0.85	-0.244	0.78
	(0.259)		(0.170)		(0.252)	
Preexisting Condition	-0.111	0.89	-0.142	0.87	0.192	1.21
	(0.261)		(0.170)		(0.249)	
Medicaid Expanded	0.068	1.07	0.300*	1.35*	0.330	1.39
	(0.243)		(0.166)		(0.245)	
Party Identification						
Republican	-1.572***	0.21***	-2.429***	0.09***	-2.536***	0.08***
	(0.388)		(0.203)		(0.288)	
Independent	-0.949***	0.39***	-0.863***	0.42***	-0.928***	0.40***
	(0.277)		(0.191)		(0.289)	
Education						
High School or less	-0.790	0.45	-0.847**	0.43**	-0.774*	0.46*
	(0.560)		(0.365)		(0.398)	
Some College	-0.467	0.63	-0.601*	0.55*	-0.762**	0.47**
	(0.560)		(0.355)		(0.353)	
College Degree	0.028	1.03	-0.740**	0.48**	-0.901**	0.41**
	(0.544)		(0.364)		(0.366)	
Demographics						
Age	0.306**	1.31**	-0.062	0.94	-0.071	0.93
	(0.126)		(0.086)		(0.132)	
Income	-0.033	0.97	-0.073**	0.93**	-0.022	0.98
	(0.050)		(0.030)		(0.043)	
Female	0.299	1.35	0.459***	1.58***	0.340	1.40
	(0.240)		(0.154)		(0.236)	
Constant	1.990		2.859***		2.140**	
	(0.824)		(0.504)		(0.736)	
Pseudo R2	0.138		0.176		0.211	
N	*516*		*1361*		*436*	

Note: Dependent Variable is 0 or 1, 1=Strengthen the ACA.
Democrats are the reference category for Republicans and Independents.
Whites are the reference category for race.

Graduate degree is the reference category for education.
Robust standard errors in parentheses.
**** p<0.01, ** p<0.05, * p<0.1*

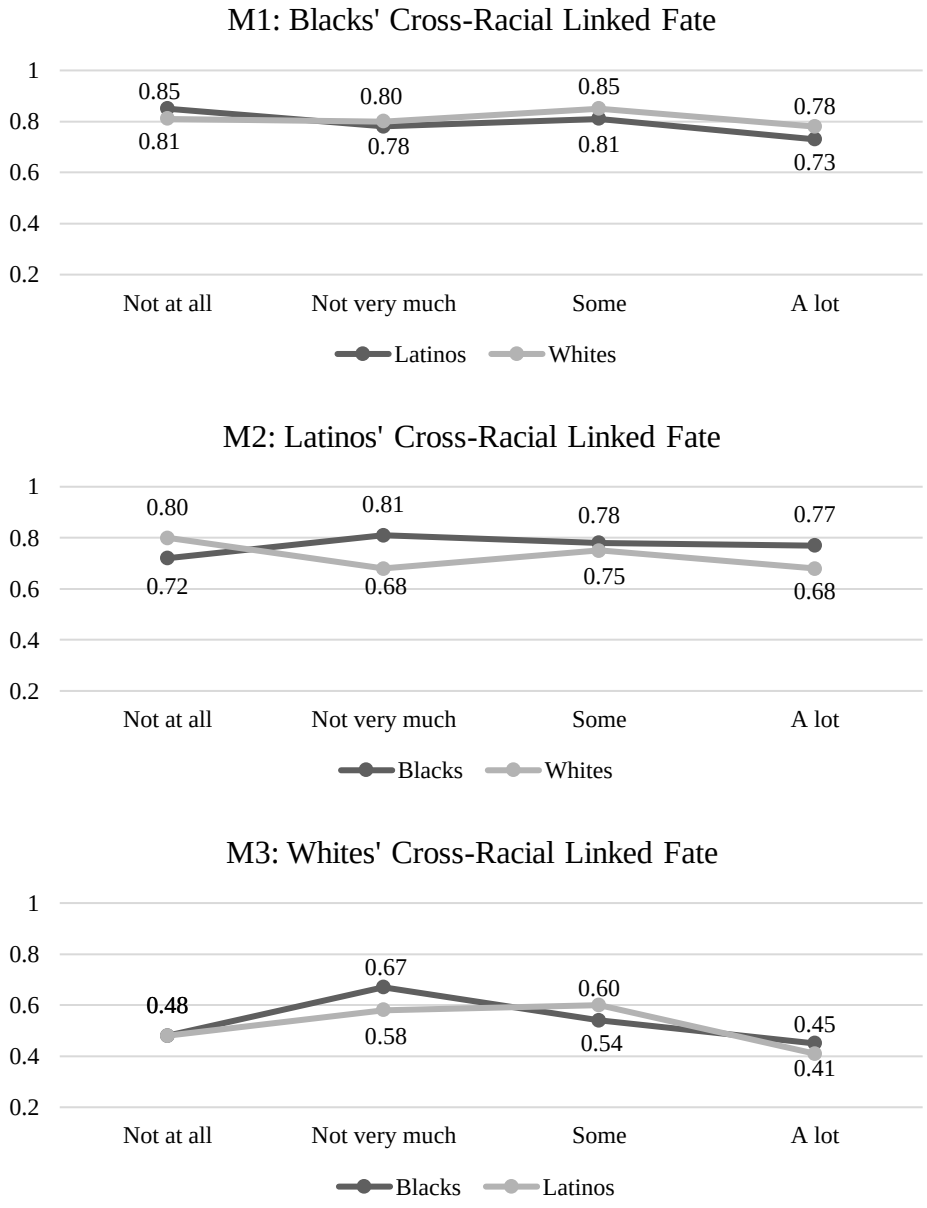
The effects of cross-racial linked fate are easier to observe in the post-estimation analysis provided in Figure 9. Cross-racial linked fate appears to have a different effect for Blacks, Latinos and Whites. Blacks with higher levels of linked fate toward Latinos are significantly less likely to support strengthening the ACA than Blacks with lower levels of linked fate toward Latinos (M1). The relationship between Blacks' linked fate with Whites and attitudes toward strengthening the ACA are similar but not significant. These findings do not provide any support for Hypothesis 4 which expected cross-racial linked fate to be positively correlated with support for strengthening the ACA.

The effects of Latinos' cross-racial linked fate with Blacks and Whites is more nuanced (M2). Latinos with higher measure of linked fate are significantly less likely to support strengthening the ACA than those with lower measure of linked fate with Whites. The relationship between Latinos' linked fate with Blacks and attitudes toward the ACA is the inverse of their relationship of Latinos' linked fate with Whites. Although lacking significance, Latinos with higher measure of linked fate with Blacks are more likely to support for strengthening the ACA. Although not a perfectly linear relationship, the probability of Latinos supporting strengthening the ACA increases from 0.72 for those with no linked fate with Blacks to 0.77 for Latinos with "a lot" of linked fate with Blacks. This finding does not confirm Hypothesis 4 but does provide some encouragement for future research.

Cross-racial linked fate is not a significant predictor of Whites' support for strengthening the ACA. Figure 9-Model 3 shows that the effect of cross-racial linked fate is similar to the effect of the traditional measure of linked fate on Whites' attitudes toward the ACA. Only at the

two opposing ends do Whites' linked fate with other Whites' slightly differ from their levels of cross-racial linked fate. Whites who felt no linked fate with other white are vaguely less likely to support efforts that strengthen the ACA and Whites who felt "a lot" of linked fate are marginally more likely to support efforts that strengthen the ACA, yet this relationship is not significant.

Figure 9. The Substantive Impact of Cross-Racial Linked Fate on Strengthening the ACA



Apart from cross-racial linked fate, party identification remains a significant predictor of support for strengthening the ACA. Republicans and Independents are significantly less likely to support efforts that strengthen the ACA compared to Democrats. It is clear the political polarization of the policy continues to influence attitudes toward healthcare reform across race.

The health-related control variables are not significant with the exception of financial barriers to care among Blacks and living in a state that expanded Medicaid for Latinos both of which are correlated with support for strengthening the ACA. I maintain the rationalizations for the significance of these two variables is similar to Table 4. Blacks are more likely to experience poverty, thereby the financial barriers to care may be especially relevant when they consider strengthening the ACA (Artiga, Garfield, and Orgera, Kendal 2020). The extensive amount of outreach and engagement with the Latino community to enroll in health insurance provisions may make living in a state that has expanded Medicaid particularly influential on Latinos support for strengthening the ACA.

Similar to Table 4 several of the demographic control variables are significant in Table 6. Education is a significant predictor of Latino and White support for strengthening the ACA but not Blacks'. Latinos and Whites with less than a graduate degree are less likely to support strengthening the ACA than Latinos and Whites with graduate degrees. This relationship is significant for all Whites and significant for Latinos with a high school degree or less and Latinos with a college degree. Income is significant among Latinos. Latinos with higher incomes are significantly less likely to support strengthening the ACA than Latinos with lower incomes. Age is significant among Blacks. Older Blacks are more likely than their younger counterparts to support strengthening the ACA. Gender is significant and positively correlated with support for strengthening the ACA among Latino women.

Conclusion

This chapter explores whether group identity measured by linked-fate and cross-racial linked fate impacted attitudes toward the ACA among Blacks, Latinos, and Whites. I find linked fate predicts support for strengthening the ACA among Blacks and Latinos but not for Whites. This may be explained by the shared status and grievances among the Black and Latino communities when health disparities are taken into account. Blacks and Latinos are more likely to face barriers to healthcare and experience health outcome disparities than Whites (Kaiser 2020a; Kelly 2015; Mitchell 2015). Yet this relationship does not extend itself to cross-racial linked fate.

One of the contributions this chapter makes is applying cross-racial linked fate in the context of healthcare reform. I anticipated cross-racial liked fate to be heightened especially among Blacks and Latinos because of their shared status and grievances to translate to more support for strengthening the ACA. Furthermore, exploring this relationship in the context of the ACA should provide an environment primed for cross-racial linked fate to impact attitudes toward ACA. The success of the ACA depends on collective engagement across race. Moreover, the ACA explicitly addressed racial/ethnic health disparities and has ameliorated them over the last decade (Baumgartner et al. 2020; Doty et al. 2016; Michner 2020). Yet, I find mixed results for the role of cross-racial linked fate among Blacks, Latinos, and Whites.

Cross-racial linked fate appears to have a negative impact on Blacks' attitudes towards Latinos. It is possible that the shared status and grievances among Blacks and Latinos are not strong enough to facilitate the role of cross-racial linked fate in the context of healthcare reform. Conditions such as resource competition, perceived or actual, and discrimination may be at the barriers preventing cross-racial linked fate from being realized among Blacks and Latinos. There

was a disproportionate investment in the Latino communities' engagement and enrollment with the ACA (Common Wealth Fund 2016). It is possible that this was perceived as a form of resource competition within the Black community which has manifested itself in Blacks' linked fate with Latinos correlation with lower support for strengthening the ACA. This effect extends to Blacks' linked fate with Whites which is correlated with lower support for strengthening the ACA although not significant. Further research is necessary to explore the effects of competition on Blacks' cross-racial linked fate and its role on attitudes toward healthcare reform.

Latinos' cross-racial linked fate with Whites is significantly related with lower support for strengthening the ACA. We know that a substantial number of Latinos identify was White, it is possible Latinos who adopt this identity are more likely to also adopt Whites' status which is not associated with the high percent of uninsured. Latinos' panethnicity may also play a role in the role of cross-racial linked fate which should be explored. Distinct from Latinos cross-racial linked fate with Whites, their liked fate with Blacks predicts support for strengthening the ACA although this relationship is not significant nor linear. In fact, Latinos with "not very much" and "some" linked fate are more likely to support strengthening the ACA more than those with "a lot" of linked fate with Blacks. The overall relationship between Latinos' linked fate with Blacks and attitudes toward the ACA provides a footing to explore the roll of cross-racial linked fate among Latinos and Blacks. However, it is necessary to pay close attention to the variation within the relationship. Cross-racial linked fate is a relatively new measure in the group identity literature. Further research in how cross-racial linked fate is formed and its impact on policy attitudes is needed.

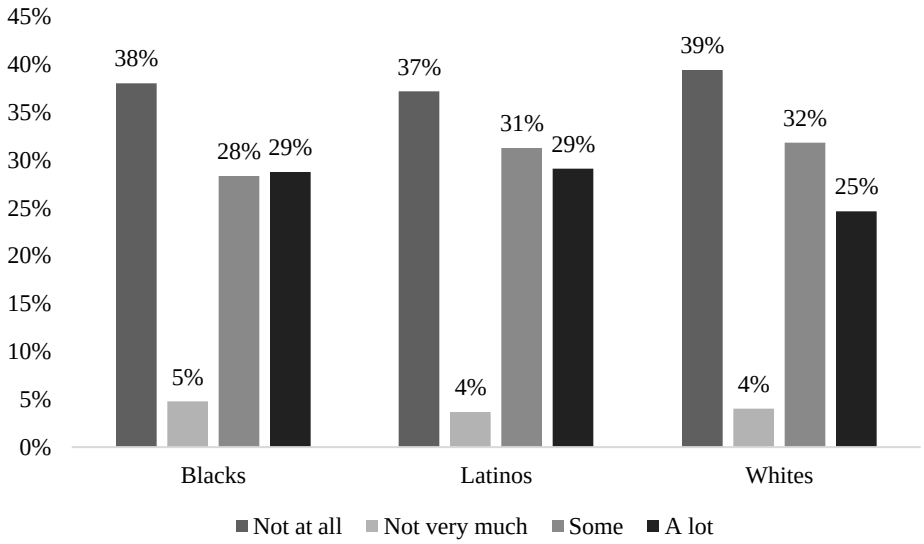
Finally, it is worth noting the role of linked fate and cross-racial linked fate among Whites. Neither linked fate nor cross-racial linked fate played a significant role on Whites'

attitudes toward the ACA. Whites are the most likely to be insured and less likely to experience adverse health outcomes relative to Blacks and Latinos. Since they have few, if any, shared grievances in the context of healthcare it is probable that linked fate and cross racial do not influence their attitudes toward the ACA. Instead Whites' party ID and level of education influence their attitudes toward strengthening the ACA.

Party identification remains a strong predictor through both models testing the role of linked fate and cross-racial linked fate. Regardless of race/ethnicity, Republicans and Independent are significantly less likely to support strengthening the ACA. This is not surprising given the historical political polarization of the policy and the continued political polarization. The Republican party continues to dismantle and weaken the ACA while the Democratic party seeks to rebuff their efforts and strengthen the policy (Abramowitz and McCoy 2018; Sances and Clinton 2019). The political division of the ACA is so strong Sances and Clinton (2019) find that Democrats were more likely than Republicans to gain health coverage in the ACA health insurance marketplaces.

There are considerable limitations to this study. The first is with the measure of linked fate and cross racial linked fate. Using Dawson's (1995) two question measure to capture respondents linked fate and cross racial linked fate created a unique phenomenon which few respondents felt "not very much" of their fate was impacted by the fate of their group (see Figure 10). It is possible that in lieu of using Dawson's two questions measure of linked fate that a single question can better capture the variation.

Figure 10. Distribution of Linked Fate for full sample



Another limitation of the study is the dependent variable. Because the dependent variable is dichotomous, the analysis is unable to account for people who may feel in between strengthening the ACA and repealing the ACA. The next step for this research is to employ another dependent variable which captures a wider range of attitudes toward the ACA and healthcare reform.

There has been a significant expansion of research focused on attitudes toward healthcare reform in recent years. Driven largely by the ACA which celebrated 10 years since its enactment this year. This literature has explored the roles of political polarization, party id (Bendersky 2014; Dawes 2016; Sances and Clinton 2019) and race (Legerski and Berg 2016a; Tesler 2012) on attitudes toward healthcare reform yet relatively little is known about the role of group identity. Using linked fate as a measure of group identity, scholars find linked fate positively influences attitudes toward expansion of healthcare reform among Latinos (G. R. Sanchez and Medeiros 2016) but linked fate does not appear to impact Blacks attitudes toward healthcare reform (McCabe 2019). This study advances this line of inquiry by providing evidence that

linked fate can in fact drive the way Blacks and Latinos view healthcare reform. This effect is not present among Whites.

Beyond linked-fate this study confirms the work of Dowe, Franklin, and Carter (2018) who find cross-racial linked fate influence Blacks' and Latinos' attitudes toward the ACA. This study provides a more nuanced understanding to this relationship by examining cross-racial linked fate across Blacks, Latinos, and Whites. This work becomes more relevant and meaningful as the racial and ethnic diversity of the U.S. increases and healthcare reform remains a central point of political contention.

CHAPTER FOUR:

RACIAL RESENTMENT BEYOND THE BLACK-WHITE DICHOTOMY AND ITS IMPACTS ON ATTITUDES TOWARD HEALTHCARE REFORM

Introduction

Racial identities and attitudes play a strong role in shaping public opinion towards policies (Abramowitz and McCoy 2018; Benegal 2018; Kam and Burge 2019). Likely reinvigorated by Barack Obama's 2008 presidential campaign and terms in office, the role of race and racial resentment applies to a myriad of policies. This "spillover" of racial resentment is well documented in attitudes toward the Affordable Care Act (ACA) which remains not only a politically polarizing policy but one fraught with racial tension (Lanford, Block, and Tope 2018; Maxwell and Shields 2014; Tesler 2012; C. J. Tolbert and Steuernagel 2003). This study employs an expanded measure of racial resentment which captures racial resentment toward Blacks, Latinos, and immigrants and its impact on attitudes toward healthcare reform and the ACA using a nationally representative survey of non-Hispanic Whites, Blacks and Latinos.

The majority of studies on racial resentment focus on the role of Whites' racial resentment toward Blacks in attitudes toward healthcare reform. Whites with high levels of racial resentment toward Blacks are less likely to support healthcare reform and the ACA (Maxwell and Shields 2014; Tesler 2012). This is not surprising, given that racial tensions in this country historically fall along Black and White divisions. Yet, shifting demographics mobilize racial tensions that go beyond the Black and White dichotomy (Huber 2016). Therefore, it is necessary to explore race and expand racial resentment to consider the evolving racial tensions among Whites, Blacks, and Latinos.

I address this issue in two ways. The first expands the racial resentment battery to capture resentment toward Latinos and immigrants in addition to Blacks. I do not argue that immigrants are a racial/ethnic group but that it is necessary to include them in the racial resentment battery upon reviewing pervasive anti-immigrant sentiments which often correlate with racial resentment (Hooghe and Dassonneville 2018). The second addition I make tests the role of racial resentment among Blacks, Latinos and Whites. These two extensions provide a more robust measurement of racial resentment which is useful in a political climate heavy with racial division that go beyond the Black-White dichotomy.

The second part of this study applies this robust version of racial resentment to attitudes toward healthcare reform and the ACA. The majority of studies that document the spill-over of racial resentment focus on the "Obama effect" (Maxwell and Shields 2014; Stein and Allcorn 2018; Tesler 2012). Many voters viewed Obama through a racialized lens, and because of his close ties to the ACA, they also racialized the policy.

The spillover of racial resentment and race is well documented in the context of healthcare reform and the ACA among Whites, yet, there is less examination on how racial resentment and race spill over into attitudes toward healthcare reform and the ACA in the post-Obama era and whether or not the racialization of the ACA continues after his presidency. I examine the extent to which racial resentment spills over into views about healthcare reform broadly and the ACA, showing that high levels of racial resentment are strongly associated with unfavorable views toward healthcare reform and the ACA. These findings contribute to the growing body of scholarship on attitudes toward healthcare reform and the ACA.

Literature Review

Racial Attitudes and Public Opinion

Racial conflicts and animosity have afflicted the United States from its very early stages, mainly driven by racial prejudice against Blacks. The early versions of racism, now referred to as old-fashioned racism, heavily relied on notions at the core of traditional prejudice (Hughes 1997). Traditional prejudice considered Blacks to be inherently inferior to Whites based on biological and innate differences which justify segregation and discrimination (Kinder and Sears 1981). Old-fashioned racism gave rise to policies such as the Jim Crow laws from the 1880s to the 1960s enforced by the majority of states (Fremon 2000). Jim Crow laws were a compilation of state and local statutes and legalized racial segregation (Fremon 2000).

The civil rights movement, which gained traction in the 1950s and peaked in the 1960s, eliminated Jim Crow segregation and catalyzed a shift in racism. It also liberalized Whites' opinions about many racial issues (Schuman et al. 1997). For example, 68% of Whites favored segregated schools in 1942 but by 1995, only 4% of Whites shared that position (Schuman et al. 1997, p.107). This trend extends to Whites' attitudes toward their children attend school where half the students were Black and racial integration of neighborhoods (Schuman et al. 1997).

A series of studies confirm the liberalization of Whites' attitudes post-civil rights movement using the Borgardus Social Distance Scale, which measures people's psychological attitudes of closeness toward other members of social, ethnic and racial groups (Bogardus 1933). Studies among White college students found significant declines in social distance attitudes and greater tolerance toward Blacks and Native Americans from 1926 to 1977 (Owen, Eisner, and McFaul 1981; T. W. Smith and Dempsey 1983). Using this scale, Whites' attitudes became less

prejudice and more tolerant concerning racial integration in schools, neighborhoods, and other informal social activities (L. D. Bobo et al. 2012; Samson and Bobo 2014).

Despite the demise of Jim Crow laws, racial prejudice and inequality did not disappear (L. D. Bobo, Kluegel, and Smith 1997; Sears and Henry 2003; Yearby 2018). The civil rights movement altered the racial landscape in the United States toward a somewhat more racially desegregated and egalitarian society, but it did not dissolve racial hierarchy or prejudice. In place of old-fashioned racism, a new version of racism evolved to capture modern racial common sense, egalitarian principles, structural inequalities, desire for social dominance, and new forms of prejudice that embody negative feelings toward Blacks and other racial and ethnic minorities. Scholars describe this new form of racism as symbolic racism (Henry and Sears 2002; Hughes 1997; Kinder and Sears 1981; Sears and Henry 2003), modern racism (McConahay 1986; Swim et al. 1995), or racial resentment (Abramowitz and McCoy 2018; Kinder and Sanders 1996). Each of these terms are conceptualized and applied in slightly different ways.

Symbolic racism is characterized by the rejection of old-fashioned racism but still expresses prejudice and discrimination indirectly (Kinder and Sears 1981; Sears and Henry 2003). Kinder and Sears (1981) define symbolic racism as "a blend of anti-black affect and the kind of traditional American moral values embodied in the Protestant Ethic" (p.416). The term *racism* refers to fundamental prejudice and discrimination toward Blacks. The term *symbolic* draws attention to both the way racism impacts Blacks as a collective rather than as individuals and is rooted in abstract morals rather than self-interest or personal experience (Sears and Henry 2003, p.260). For example, Whites' opposition to policies which benefit racial and ethnic minorities, such as affirmative action, is a form of symbolic racism (Hughes 1997).

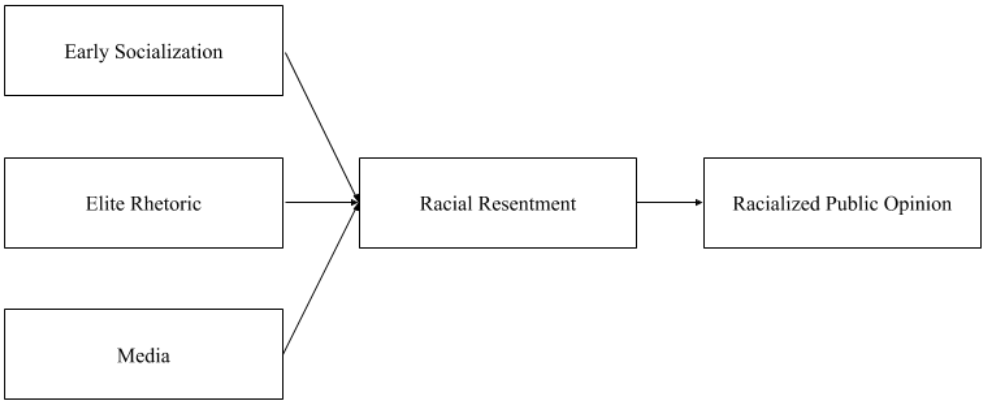
Modern racism denotes old-fashioned racism but believes Blacks function in marketplace free of discrimination, are too demanding, receive more resources than they deserve, and this is ultimately unfair (McConahay 1986, p.92-93). For example, a modern racist denotes racism but uses justifications, such as Blacks receiving too many resources, to act on their negative racial attitudes. A study on conformity to authority found Whites' discriminate when selecting job applicants for an interview based on race (Brief et al. 2000). The crux of modern racism is that when people can attribute ambiguity in policy to a higher authority, people appear to make 'subtle' racist acts which take a considerable toll on racial minorities. In sum, the primary difference between symbolic racism and modern racism is that symbolic racism maintains racism by Blacks' lack of work ethic whereas modern racism justifies racism by claiming Blacks have received more than they deserve and have become too demanding.

Kinder and Sanders (1996) developed a multi-item scale to measure this new form of racism, which they name racial resentment. Racial resentment is the intersection of "Whites' feelings toward Blacks and their support for American values, especially secularized versions of Protestant ethic" (Kinder and Sanders 1996, p.293). Racial resentment and symbolic racism share many of the same tenants and are sometimes used interchangeably throughout public opinion literature (Cramer 2020). The primary difference between symbolic racism and racial resentment is that racial resentment directly ties itself to American individualism (Kinder and Sanders 1996). Of the three terms that help explain 'new' racism, racial-resentment is the most developed, tested, and analyzed over the last few decades (Kam and Burge 2019).

Regardless of the differences between symbolic racism and racial resentment, the mechanisms that lead to the racialization attitudes toward a policy are the same. Early socialization, elite rhetoric, and new media are the three concepts that facilitate racial resentment

(see Figure 1). Early socialization is partially accountable for racial attitudes. Early life experiences and beliefs developed in early years influence many Whites' attitudes that Blacks lack traditional values, such as self-reliance and hard work (Hughes 1997). The early racial socialization manifests itself in adulthood as prejudice and racial resentment, which is largely stable (Kinder and Sears 1981).

Figure 1. Symbolic Racism Theory



The role of media in creating and sustaining racial prejudices garnered a lot of attention over the 20th century (Happer and Philo 2013; Hartmann and Husband 1974; Kellstedt 2003; Oliver, Ramasubramanian, and Kim 2007). Media impacts belief, assumptions, public ideology, and political attitudes. Happer and Philo (2013) find people with prior exposure to information have stronger attitudes on such subjects and are less likely to change their beliefs or opinions. Those who have little exposure to information are less likely to have strong opinions and are more willing to adjust their views. These findings held true even if the information was polarizing or inaccurate (Happer and Philo 2013, p.322). Unlike traditional media, new media platforms provide many different spaces to find information and share information. The high-choice media environment allow individuals to customize the information they receive and share and control whom they interact with on such platforms (Sunstein 2007). Therefore, new media is

often associated with very fragmented, polarized, or different view of the world which reinforce individuals' beliefs (Sunstein 2007).

In the context of race, it appears traditional media reinforces previously held racial beliefs rather than causing dramatic shifts and influences beliefs about the size of racial groups in society rather than attributes of any one racial group (Atkin, Greenberg, and McDermott 1983, p.414). Gilens (1999) finds a strong link between negative racial attitudes and media depictions of poverty. In the new media environment, Maxwell and Schulte (2018) find that social media decreases racial resentment among White millennials. As political scientists Jon Hurwitz and Mark Peffley (2005, p.109) conclude:

> "When messages are framed in such a way to reinforce the relationship between a particular policy and a particular group, it becomes far more likely that individuals will evaluate the policy on the basis of their evaluations of the group."

Elite rhetoric increases associations between racial and ethnic minorities, citizens, and elites amplify the racialization of policies. Elite communication and framing of public policies play a central role in public opinion formation on 'low information' issues (Benegal 2018, p.735). When people evaluate policy issues in low information environments, they frequently rely on trusted elites, thereby, giving political elites substantial influence on public opinion (Carmichael and Brulle 2017).

This became especially salient during Barack Obama's campaign and presidency (L. D. Bobo and Dawson 2009; Kinder and Dale-Riddle 2012; Tesler 2012, 2015; Tesler and Sears 2010). Many voters were quick to identify and view Obama through a racial lens (Kinder and Dale-Riddle 2012). During Obama's campaign race "was the thing always present, the thing so rarely mentioned" (Remnick 2008). In the case of the ACA, Obama's attachment to the policy

activated racial attitudes toward the ACA which resulted in higher levels of racial resentment (Tesler 2012).

Application of Racial Resentment

Kinder and Sanders (1996) establish racial resentment as a strong and robust component that influences attitudes toward highly racialized policies, such as affirmative action and "race-coded" policies such as welfare and crime. The primary measure for racial resentment is a four-item scale administered to survey respondents of the American National Election Study (ANES) since 1986. Survey respondents are asked whether they agree or disagree and how strongly they do so to the following four items:

1. Irish, Italians, Jewish and many other minorities overcame prejudice and worked their way up. Blacks should do the same without any special favors.
2. Generations of slavery and discrimination have created conditions that make it difficult for Blacks to work their way out of the lower class.
3. Over the past few years, Blacks have gotten less than they deserve.
4. It's really a matter of some people just not trying hard enough: if Blacks would only try harder they could be just as well off as Whites.

In the first year that the ANES included the racial resentment battery, it had two additional items. The two items were: "Most Blacks who receive money from welfare programs could get along without it if they tried," and "Government officials pay less attention to a request or complaint from a Black person than a White person" (Kinder and Sander 1996, p.107). The four-item racial resentment scale provides scholars with measurements to view changes in racial resentment overtime and apply the concept broadly (Cramer 2020).

Subsequent work solidified the role of racial resentment in a multiple political attitude arenas (Benegal 2018; Filindra and Kaplan 2016; Gilens 1999; Gilliam and Iyengar 2000; Hancock 2003; Hurwitz and Peffley 1997; Knuckey and Myunghee 2016; Tesler 2012, 2015; Wallsten et al. 2017; Winter 2008). Racialized policies, such as affirmative action (L. D. Bobo 2000; Hughes 1997; Kinder and Sanders 1996), desegregation of schools (Danns 2008; Kinder and Sanders 1996; Kinder and Sears 1981), crime (Carter and Corra 2016; Gilliam and Iyengar 2000; Hurwitz and Peffley 1997; Johnson 2009), tax cuts (Sears and Citrin 1985a), and changes in welfare (Gilens 1999; Hancock 2003), readily prompt racial resentment when people evaluate them. Policies containing explicit racial content elicit racial biases towards the racial/ethnic group perceived to benefit from the policy (Kinder and Sanders 1996; Nelson and Kinder 1996; Sears 1993; Winter 2008).

Racial resentment appears to have strong effects on policies that do not explicitly cue racial content (Benegal 2018; Enders and Scott 2018; Tesler 2012, 2015). Studies on the spill-over of racial resentment gained traction in the years following Barack Obama's 2008 presidential campaign (Kinder and Dale-Riddle 2012; Tesler 2015). As previously stated, the role of elite rhetoric has a strong impact on racial resentment (see Figure 1). Obama being the first Black president cued higher levels of racial resentment relative to previous presidents (Tesler 2015). Benegal (2018) documents the spillover of racial resentment into attitudes toward climate change. Using the 2012 and 2016 ANES, Benegal (2018) finds high levels of racial resentment are highly correlated with low levels of agreement that climate change is occurring, and that climate change is anthropogenic (p.752).

Despite these robust findings, scholars raise questions about the underlying meaning of the racial resentment battery (Carmines, Sniderman, and Easter 2011; Feldman and Huddy 2005;

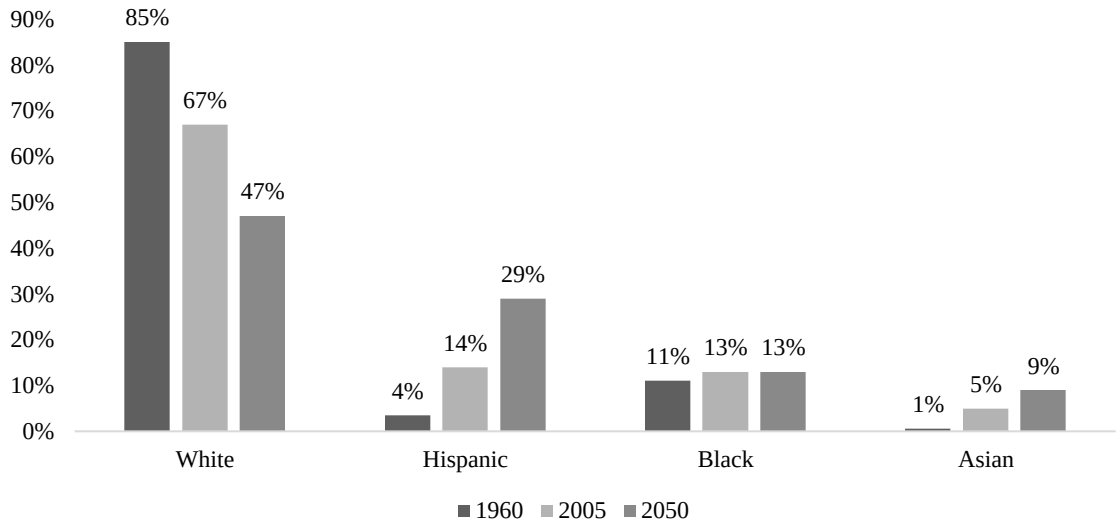
Huddy and Feldman 2009). They assert prejudice plays a minimal role in policy preferences; instead Whites' principles, such as fairness, equality, and the role of government (Schuman 2000; Sniderman and Carmines 1997; Sniderman and Hagen 1985; Sniderman and Tetlock 1986) influence their policy preferences. In addition, some scholars criticize the measure for relying on self-reported attitudes toward racial resentment opposed to unobtrusive measures (Fazio et al. 1995; Fazio and Dunton 1997).

Recent experimental studies speak to both sides of this debate. In a national survey experiment on attitudes toward welfare, DeSante (2013) finds racial resentment correlates with principled ideologies, such as fairness and hard work. However, racial considerations highly condition the relationship. Kam and Burge (2018) unpack the underlying meaning of the racial resentment scale. They capture open-ended reactions to the racial resentment scale and find that both Black and Whites consider negative traits of Blacks are themes of individualism and discrimination are dependent on racial resentment. Respondents with higher levels of racial resentment are more likely to attribute these sentiments to individualism and individual choice and deny or diminish the existence of discrimination in the U.S. Conversely, respondents with lower levels of racial resentment are less likely to point to the character of Blacks and ascertain structural features of discrimination which undermine individualism (Kam and Burge 2018, p.318-319). Despite the limitations of racial resentment, there is a large body of literature that finds the racial resentment scale to be internally consistent and predictive of white attitudes toward racialized policies (Benegal 2018; L. D. Bobo 2000; Henry and Sears 2002; Kam and Burge 2018, 2019; Kinder and Mendelberg 2000; Tesler 2012).

Expansion of the Racial Resentment Scale

The majority of studies on racial resentment focus on racial resentment toward Blacks. Our understanding of Whites' racial resentment toward Blacks is robust, but Whites' racial resentment toward Latinos and Asians has yet to be vigorously studied. This is especially relevant given the shift in racial/ethnic demographics. According to the U.S. Census Bureau (2015), the national population grew "more racially diverse in just the past decade." By 2050 Blacks, Asians, Hispanics and other racial minorities will make up the majority of the population as Figure 2 shows (Colby and Ortman 2015).

Figure 2. Population by Race and Ethnicity, Actual and Projected: 1960, 2005, 2050



Source: Pew 2008

In response to the shift in racial/ethnic demographics in the US, public opinion is mixed. Instead of resolving racism, it appears that modern racism expanded to Latinos and Asians as well as Blacks (Huber 2016; Merenstein 2008). A recent survey by the Pew Research Center found over half of adults, 58%, feel the state of race relations is generally bad (Pew 2019b). When asked to consider the changing racial/ethnic demographics, Blacks and Hispanics were

almost twice as likely to find this shift in demographics as a "very/somewhat good" thing for the country than Whites (Pew 2019a). Conservative pundit Bill O'Reilly of Fox News (2012) summarizes this tension well; when who was asked how we got to Obama's reelection, he replied:

> "It's a changing country. The demographics are changing. It's not a traditional America anymore and there are 50% of the voting public who want *stuff*. They want *things*. And who is going to give them things?... The white establishment is now the minority. And the voters, many of them, feel like this economic system is stacked against them, and they want *stuff*. You're going to see a tremendous Hispanic vote for President Obama. Overwhelming Black vote for President Obama, and women will probably break President Obama's way."

O'Reilly's response is an articulation of a "traditional America," which associates a more racially/ethnically diverse America with a less traditional America. Thereby, racial/ethnic minorities do not contribute to or hold traditional American values such as hard work, individualism and feel entitled to "things" and are dependent on "stuff". When O'Reilly speaks of "things" and "stuff" it is likely he is referring to jobs, healthcare, and education. It is clear that O'Reilly ties the increase of racial/ethnic diversity with a treat to the "white establishment" (Fox News 2012).

These sentiments have only grown under the Trump administration (Abramowitz and McCoy 2018; Huber 2016; Setzler and Yanus 2018; Stein and Allcorn 2018). The Pew Research Center's study on race in America found that a majority of adults, 56%, say that President Trump makes race relations worse (Pew 2019b). This is not surprising upon reviewing President Trump's multiple inflammatory racist statements made and policy stances directed toward

Blacks, Latinos, and Asians during his campaign and presidency (Graham et al. 2019; Rogers, Jakes, and Swanson 2020; Williamson and Gelfand 2019).

Latinos endure racial stereotypes in the media, public discourse, and by larger society (Berg 2002; Branton et al. 2011; Massey 2009; Rodriguez 1989; Timberlake and Williams 2012). These stereotypes lead to discrimination and policies that negatively affect Latinos. Racism toward Latinos has especially heightened over the last few years (Anguiano 2019; Pew 2019b, 2018). One of the catalysts and most notorious moments was during Trump's (2015) announcement that he would run for the presidency, when he said:

> "When Mexico sends its people, they're not sending their best. They're not sending you. They're not sending you. They're sending people that have lots of problems, and they're bringing those problems with us. They're bringing drugs. They're bringing crime. They're rapists. And some, I assume, are good people."

The outrage to the speech was short-lived. Even though media outlets Univision and the NBC Network cancelled broadcasts of televisions content that Trump partially owned (Adolfo Flores 2015; Puente 2015), it was not enough to curtail public support for Trump and prevent him from winning the Republican nomination and the 2016 presidential race (Gallup 2016). Trump continued making disparaging remarks about Latinos and immigrants throughout his campaign and continues to do so through out his presidency (Huber 2016).

The racial tensions between Whites and Latinos manifests itself in anti-immigrant policies that are specifically anti-Latino (Brader, Valentino, and Suhay 2008; Branton 2007; Citrin et al. 1997; De Francesco Soto 2012; Hage 2012; Hajnal and Rivera 2014). Citrin and colleagues (1997) found that Whites' feelings towards Hispanics and Asians drove opposition to immigration more than their personal economic circumstances. Branton (2007) confirmed their

findings that Whites' perceptions of Latinos are inextricably linked to attitudes toward immigration policies, especially in times of heightened intergroup tension.

The trend of opposition to immigration related to anti-Latino sentiments even when compared to negative feelings toward other non-Whites groups. Brader, Valentino, and Suhay (2008) observed the effects of Whites' evaluations of Asians, Blacks, and Latinos and its effect on their attitudes toward immigration. They found that negative feelings toward Latinos have the largest effects on Whites' support for restrictive immigration policies (Brader, Valentino, and Suhay 2008).

When the shifting racial/ethnic demographics, racial tension, and highly polarized context in which researchers study public opinion are taken together, there is reason to believe that the concept of racial resentment may extend to Latinos and immigrants. By no means, do I argue that the racialization of Latinos mimics the racialization of Blacks, but there is reason to apply racial resentment to Latinos and immigrants. Still, I anticipate racial resentment will be strongest among Blacks relative to Latinos and immigrants. The history of oppression that is unique to the Black community endures and shows in multiple facets of society. This leads me to my first hypothesis,

H1: Racial resentment toward Blacks will be higher than racial resentment toward Latinos and Immigrants

Application of the Racial Resentment Scale

There is another theme in the racial resentment literature: nearly all studies on racial resentment focus on White Americans. The paucity of studies of how racial and ethnic minorities respond to racial resentment is surprising given the numerous studies on racial resentment. Kam and Burge (2019) point to four possible explanations for this lacuna. The first is Whites have

been the racial/ethnic majority of not only the U.S. population but also the majority of the electorate. The severity of the Black and White racial tensions throughout U.S. history may also explain this gap. It could also result from outgroup homogeneity bias, which asserts that mostly White public opinion researchers explore heterogeneity among Whites but largely ignore analyses of other racial/ethnic minorities (Judd and Park 1988). Finally, data limitations could also cause this gap in information. Only in the last decade have sample sizes of Blacks, Latinos, Asians and Native Americans been included in nationally representative data sets that can sustain robust statistical analyses (Kam and Burge 2019, p. 768).

Several scholars address the oversight of racial/ethnic minorities in the racial resentment literature (Ditonto, Lau, and Sears 2013; Filindra and Kaplan 2016; Kam and Burge 2018; Tesler and Sears 2010). Ditonto, Lau, and Sears (2013) use the 2008 ANES, which had an oversample of Blacks and Latinos to test the influence of racial resentment on evaluations of Obama and racial policies which explicitly benefit Blacks. They find that racial resentment plays a strong role for Whites, Blacks and Latinos but in different ways. Racial resentment is a strong predictor of Whites' evaluations of Obama and racial policies, whereas, racial resentment is a predictor of Blacks' support for racial policies but not support for Obama. The findings for Latinos are even more complex; racial resentment is a predictor of attitudes toward Obama and policy issues that affect Blacks, and implicit bias more readily affects them than Whites and Blacks (Ditonto, Lau, and Sears 2013).

The remaining studies on the effect of racial resentment beyond Whites are an assortment of policy specific studies. In the context of gun control, Filindra and Kaplan (2016) find racial resentment is negatively associated with support for gun control among Whites, but it is positively related to support for gun control among Blacks. Lanford, Block, and Tope (2018) test

racial resentment among Whites and Latinos in the context of healthcare reform. They find that Latinos and Whites share similar levels of racial resentment toward Blacks, however, the way they impact evaluations of healthcare reform differs. Whites are more likely than Latinos to connect their racial resentment toward Blacks with evaluations of healthcare reform (Lanford, Block, and Tope 2018). In both these studies, Whites have higher levels of racial resentment toward Blacks than Blacks and Latinos overall.

In this study, I apply racial resentment to White, Black, and Latino respondents. This is an important expansion to better understand how Blacks and Latinos operationalize racial resentment. I expect Whites to have higher levels of racial resentment, leading me to my second hypothesis,

H2: Whites will have higher levels of racial resentment than Blacks and Latinos.

Racialization of Healthcare Attitudes

The second part of this study applies the expanded version of racial resentment to attitudes toward healthcare reform and the ACA. A fair amount of research documents the impact of racial resentment on healthcare reform and the ACA. Several scholars suggest that President Obama's African American heritage triggered a racialized view of healthcare reform (Knowles, Lowery, and Schaumberg 2010; Maxwell and Shields 2014; Tesler 2012). Healthcare reform was the primary policy initiative on which President Obama ran his campaign and sought to pass in his first year in office (Obama's Deal 2010). Because of Obama's close ties to healthcare reform, he became innately linked to the ACA, thereby, the ACA was racialized simply because of his race.

Obama also didn't shy away from addressing racial tensions. A prime example of this is President Obama explicitly addressing overcoming racial disparities in the context of healthcare during a campaign speech. He made the following statement:

> "The fact is that the comments that have been made and the issues that have surfaced over the last few weeks reflect the complexities of race in this country that we've never really worked through – a part of our union that we have yet to perfect. And if we walk away now, if we simply retreat into our respective corners, we will never be able to come together and solve challenges like health care, or education, or the need to find good jobs for every American" (NYT 2008).

It is difficult to ignore the inextricable link between President Obama and the ACA. In fact, rather than being known as the "Patient Protection and Affordable Care Act," the ACA is better known as "Obamacare." The Republican Party was the first to relabel the ACA Obamacare as an attempt to generate opposition toward the bill and highlight the racialization of the ACA (Hopper 2015; G. Wallace 2012). Melissa Harris-Perry (2013), a television host on MSNBC, summarized how racially charged relabeling the ACA to Obamacare was:

> "A word [Obamacare] that was originally intended as a derogatory term, meant to shame and divided and demean. The word was conceived by a group of wealthy white men who needed a way to put themselves above and apart form a black man – to render him inferior and unequal and diminish his accomplishments."

The Republican Party successfully created confusion about what the ACA was and generated opposition toward it. In several polls, Americans are more opposed to Obamacare than the ACA (CNBC 2013; NBC 2014). Beyond the role of partisan politics, race clearly had a

strong role in rebranding the ACA "Obamacare" and consequentially lead to less favorable attitudes toward the ACA.

In line with the "if you can't beat them, join them" idiom, the Democratic Party and Obama eventually embraced the label "Obamacare" (Blake 2012). Yet, confusion about ACA and Obamacare did not subside. In 2017, almost a decade after the ACA was enacted, one-third of Americans still did not know Obamacare and the ACA were the same thing (Dropp and Nyhan 2017).

Public opinion literature confirms these trends. Tesler (2012) finds racial attitudes had a strong impact on attitudes towards healthcare reform. This effect is especially heightened when President Obama is tied to healthcare reform compared to tying President Clinton's to his 1993 reform effort. Knowles, Lowery, and Schaumberg (2010) asked participants to evaluate healthcare reform proposals presented by "Obama and the Democrats approach to healthcare reform" opposed to "Bill Clinton's 1993 healthcare reform" and demonstrated that Obama's symbolic connection to several components of healthcare reform. They found that participants with negative racial attitudes are more likely to oppose healthcare reform when framed as Obama's relative to Clinton's.

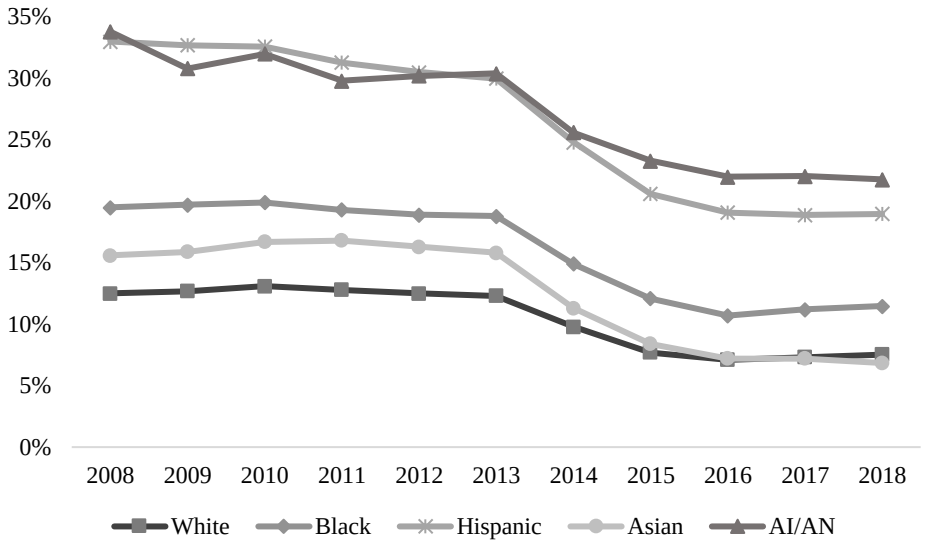
A variety of datasets and statistical approaches confirms Obama's ties to the ACA impacted public opinion of healthcare reform (Byrd, Saporta, and Martinez 2011; Kaiser 2020b; Knowles, Lowery, and Schaumberg 2010; Legerski and Berg 2016a; Maxwell and Shields 2014; Tesler 2012). However, there is little known about how or whether Obama continues to impact attitudes towards healthcare reform and the ACA now that he is out of office. I anticipate that respondents will be more opposed to the ACA when it is referred to as Obamacare than healthcare reform.

H3: Several years after the Obama administration, respondents with high racial resentment will have more negative views towards the Affordable Care Act when it is referred to as "Obamacare" compared to Healthcare Reform.

Outside of the 'Obama Effect,' addressing health inequities based on race and ethnicity also racializes the ACA (Buchmueller et al. 2016). Despite Obama's attempt to advance the ACA in a deracialized environment, the bill itself explicitly sought to address racial disparities (Lewis, Dowe, and Franklin 2013; Michner 2020). The original bill made 34 references to "disparities," 28 references to "discrimination," and 68 occurrences using race, racial, ethnic, or ethnicity (Rangel 2010). The ACA sought to removing financial barriers to care, address disparities in healthcare coverage, facilitate access for people of color and subsidize preventative healthcare services, all of which disproportionately affect racial and ethnic minority communities and ameliorate racial and ethnic health disparities by (Mitchell 2015; Newkirk 2016).

One of the most straightforward ways to measure the efficacy of the ACA in addressing racial/ethnic health disparities is to review the decrease in the percent of uninsured by race/ethnicity (see Figure 3). Since the ACA enactment in 2010, the percent of uninsured decreased across race and ethnicity. However, it is clear that racial and ethnic minorities saw greater decreases in the percent of uninsured nonelderly adults compared to non-Hispanic Whites (Kaiser 2018c).

Figure 3. Uninsured Rates for Nonelderly by Race and Ethnicity from 2008-2018



Source: Kaiser 2018

When framing policies as an underserved federal government handout, people's opinions often become racialized (Gilens 1999; Winter 2008). Such is the case of the ACA. Williamson, Skocpol, and Coggin (2011) find opponents of the ACA generate part of their opposition from concerns that the government redistributes resources from hardworking Americans to underserving individuals. Furthermore, Knoll and Shewmaker (2015) find that this perspective colors attitudes of both Republicans and Democrats, although it is stronger among Republicans.

Since the ACA emphatically sought to address racial and ethnic health disparities and disproportionately benefitted racial and ethnic minority communities, racial resentment likely influences evaluations of the ACA. I anticipate that since the narrative of healthcare reform is closely tied to the ACA racial resentment will play a similar role for respondents' evaluations of health care reform generally. This brings me to my final hypothesis,

H4: Individuals with high levels of racial resentment will be less likely to support healthcare reform expansion and the Affordable Care Act than individuals with low levels of racial resentment.

Methods

Data

I use the Center for Social Policy Social Policy Survey of 2019 (n=2613) to test these hypotheses. The survey was self-administered over an online platform between April 5, 2019-May 2, 2019. The invitation to participate in the survey and survey itself were available to registered and non-registered voters. The full data are weighted within each racial group to match the population of the 2017 ACS-1-year data file for age, gender, education, nativity, ancestry, and voter registration status. A post-stratification raking algorithm was used to balance each category within +/- 1 percent of the ACS estimates. Within the sample, 56.49 percent self-identify as Latinos, 21.66 percent as White and 21.85 percent as Black. Respondents were given a $10-$20 gift card as compensation for their participation. Programming and data collection for the full project was overseen by Pacific Market Research.

Dependent Variables

I use two dependent variables in this analysis, both address evaluations of healthcare reform but the question wording differs significantly. The first dependent variable asks respondents "Given what you know about healthcare reform, do you generally have a favorable or unfavorable opinion of it?" This question has been used by the Kaiser Family Foundation Health Tracking Poll for the last decade (Kaiser 2020b)**.** This variable was coded dichotomously, to capture favorable and unfavorable opinions (1=favorable, 0=unfavorable).

The second dependent variable also captures attitudes toward healthcare reform but uses racialized language. Respondents were asked "Please tell us which comes closer to your view about the Affordable Care Act, passed by Congress and the President in 2010, often referred to as Obamacare." This question significantly differs by explicitly highlighting the Affordable Care Act and the racialized component "Obamacare." As previously stated, Obamacare is a racialized label generated by Republican opposition to encourage aversion to the ACA and create confusion. It is especially necessary to include Obamacare in the question since a third of Americans are not aware that Obamacare and the ACA are the same policy (Dropp and Nyhan 2017). Respondents were given three response categories: repeal the ACA, strengthen the ACA, or neither. This variable was recoded to be dichotomous, only capturing responses that sought to repeal or strengthen the ACA (1= repeal, 0=strengthen).

These two items are useful for determining how racial attitudes impact attitudes toward healthcare reform in a racialized and non-racialized setting. The first dependent variable captures attitudes toward healthcare reform which not racialized. Healthcare reform encompasses many approaches to changing the structure, financing, and healthcare system such as Medicaid-for-all, single payer systems, privatization of the healthcare system (Casalino et al. 2009; Kaiser 2020c). Whereas the second dependent variable which focuses on the ACA and references "Obamacare" which is a racialized term should cue respondents to consider their racial attitudes when evaluating the ACA (see Appendix B for question wording).

Independent Variable

The traditional measure of racial resentment was modified to explore racial attitudes beyond the black and white dichotomy. To do this, the classic measure of racial resentment used by the American National Election Survey (ANES) since 1986 captures respondents' perceptions

of Black individuals' work ethic, experiences with discrimination, and deservingness (Kinder and Sanders 1996). This set of questions was modified to capture racial resentment towards Latinos and Immigrants in addition to Blacks. The racial resentment battery is modified for Latinos simply by replacing 'Blacks' with the term 'Latinos.' The same approach was used to modify the racial resentment battery to capture racial attitudes toward immigrants. Table 1 shows descriptive statistics for racial resentment toward Blacks, Latinos, immigrants, on the four-point racial resentment scale (1= low racial resentment, 4= high racial resentment).

Table 1. Descriptive Statistics for Racial Resentment Battery

	Blacks	*Latinos*	*Imm.*	*Sum*
Irish, Italians, Jewish and many other minorities overcame prejudice and worked their way up. [Blacks/Latinos/Immigrants] should do the same without any special favors	2.28 (1.04)	2.16 (0.99)	2.21 (0.99)	2.21 (1.01)
Over the past few years, [Blacks/Latinos/Immigrants] have gotten less than they deserve	2.59 (1.04)	2.61 (0.98)	2.65 (1.00)	2.62 (1.01)
It is really a matter of some people not trying hard enough; if [Blacks/Latinos/Immigrants] would only try harder they could be just as well off as whites	2.57 (1.06)	2.64 (1.06)	2.65 (1.03)	2.64 (1.05)
Generations of discrimination have created conditions that make it difficult for [Blacks/Latinos/Immigrants]to work their way out of the lower class	2.69 (1.08)	2.73 (0.98)	2.85 (0.99)	2.75 (1.02)
Over the past few years, [Blacks/Latinos/Immigrants] have gotten more economically than they deserve	2.88 (1.01)	2.86 (0.95)	2.73 (1.03)	2.85 (0.99)

Note: Standard deviations in parentheses

To test the role of racial resentment toward Blacks, Latinos, and immigrants, respondents were randomly assigned one of the three racial resentment batteries. For example, if the respondent received the racial resentment battery toward Blacks, the respondent did not receive the racial resentment battery toward Latinos or immigrants. Table 2 shows the distribution and variance of each treatment.

This independent variable is an additive index generated from the five survey items for racial resentment toward Blacks (Cronbach's alpha =0.70), Latinos (Cronbach's alpha=.61), and Immigrants (Cronbach's alpha =.69). The only adjustment to the racial resentment battery was to the "gotten less than they deserve" and "generations of discrimination have created conditions that make it difficult" component to reflect the 1 (low racial resentment) to 4 (high racial resentment) range. A summary variable was also generated to capture overall racial resentment, regardless of which group respondents received.

For the purpose of this analysis, racial resentment is recoded as a dichotomous variable, to high racial resentment and low racial resentment split at the mean, to facilitate a direct comparison, see Table 2. This table demonstrates racial resentment toward Blacks is still very much present and has expanded to Latinos and immigrants.

Table 2. Descriptive Statistics for Racial Resentment Index

	N	Mean	Standard Deviation	Min	Max
Racial Resentment Toward Blacks	884	0.602	0.490	0	1
Racial Resentment Toward Latinos	902	0.587	0.492	0	1
Racial Resentment Toward Immigrants	827	0.545	0.498	0	1
Racial Resentment Overall	2613	0.580	0.494	0	1

Control Variables

Several studies have highlighted the impact of partisan politics on attitudes towards healthcare reform. There is a clear relationship between Democrats who hold favorable attitudes

towards healthcare reform, especially the ACA, compared to Republicans (Brodie, Deane, and Cho 2011; Kriner and Reeves 2014; Sances and Clinton 2019). Moreover, racial resentment has been viewed and critiqued as a manifestation of general liberal and conservative attitudes (Sniderman and Hagen 1985; Sniderman and Tetlock 1986). Party identification is included as two dichotomous variables, Republican (1= Republican, 0= Democrat/other), see Table 3 for descriptive statistics.

I included health insurance status as a control variable. Lerman and McCabe (2017) find that personal experiences with public health insurance programs such as Medicaid and Medicare hold positive sentiments toward the Affordable Care Act. Although, this is not significant in their study their finding suggests health insurance status may play an important role for individuals when evaluating healthcare reform. As a result, I include a control variable for health insurance are coded as 1 and respondents who do not have health insurance are coded as 0.

Beyond health insurance status, I included whether respondents live in a state that expanded Medicaid or not as an additional control. Individuals who live in states that have expanded Medicaid are more likely to have positive attitudes toward the ACA (Clinton and Sances 2018; Hopkins and Parish 2019). This is largely attributed to the larger gains in health insurance in states that chose to expand Medicaid relative to states that did not expand Medicaid (Kaiser 2019b). In line with this research, I anticipate that individuals who live in states that have expanded Medicaid will have more favorable views toward healthcare reform and the ACA because of broad gains their state has made in health insurance. Respondents who live in states that have expanded Medicaid are coded as 1 and states that have not expanded Medicaid are coded as 0. There are three states that have committed to expanding Medicaid in 2019. Since the Medicaid expansion in these states is so novel, they are coded as states that have not expanded.

I also include several demographic controls in these models known to be correlated with socio-political attitudes (Verba and Nie 1972). I include a control variable for income. The income variable asks respondents for their combined household income in 2019 before taxes, the response categories are divided into $20,000 increments. Seemingly, individuals with lower incomes are more likely to be less financially secure and therefore likely to benefit from health insurance expansion provisions under the ACA such as the Medicaid expansion or tax subsidies.

Education is included as a control variable. The educational question asks for the highest degree of educational attainment rather than the number of years. Education is coded at four levels, "High school or less", "Some college", "College graduate," and "Graduate degree." Each education variable is a dummy variable, 1 equals the degree, anything else is coded 0. Gender is another control variable included in this analysis. Women are more likely than men to have more favorable views toward the ACA (Lizotte 2016). Respondents are asked to indicate their gender between Male, Female, and Other. The gender variable is coded as a dummy variable where 1 is equal to female and 0 is equal to male[6]. I anticipate that respondents who identify as female will be more likely to have favorable views toward healthcare reform and the ACA.

The final control variable is race. Racial minorities are more likely to have more favorable views toward healthcare reform and the ACA than non-Hispanic Whites (Kaiser 2020b). Respondents were asked to identify their race. Only individuals who identified as White, Black, or Hispanic/Latino completed the survey. I anticipate that Blacks and Latinos will have more favorable attitudes toward healthcare reform and the ACA.

[6] The survey question allowed respondent to answer Male, Female, or Other. In this sample there were only four respondents who chose Other. I attempted to run my results using Other as the baseline category but because of the small sample size they have been excluded from this analysis which is not ideal.

Table 3. Descriptive Statistics for Weighted Model

Variable	Mean	SD	Min	Max
Racial Resentment Overall	0.460	0.498	0	1
Racial Resentment toward Blacks	0.601	0.490	0	1
Racial Resentment toward Latinos	0.588	0.493	0	1
Racial Resentment toward Immigrants	0.545	0.498	0	1
Race				
Latino	0.565	0.496	0	1
Black	0.219	0.413	0	1
White	0.217	0.412	0	1
Party Identification				
Republican	0.213	0.410	0	1
Democrat	0.553	0.497	0	1
Independent	0.298	0.457	0	1
Income	5.06	3.06	1	12
Education				
High school graduate/Some high school	0.320	0.467	0	1
Some College	0.328	0.470	0	1
College Graduate	0.253	0.435	0	1
Graduate Degree	0.098	0.297	0	1
Female	0.564	0.496	0	1
Has health Insurance	0.852	0.355	0	1
Lives in a state that expanded Medicaid	0.624	0.485	0	1

Results

Expanding Racial Resentment

I begin the analysis with bivariate analyses which provides preliminary support for Hypothesis 1 which anticipates Whites would have more racial resentment relative to Blacks and Latinos (see Table 3). Whites are more likely to have high levels of racial resentment than Blacks and Latinos. Racial/ethnic minority status does not necessarily mean racial resentment operates the same for Blacks and Latinos. As Table 3 demonstrate, Latinos are more likely to have high levels of racial resentment relative to Blacks.

Table 4. Bivariate Distribution of Whites, Blacks, Latinos and Racial Resentment (in percentages)

	Whites	Blacks	Latinos
High Racial Resentment	60.42	38.70	43.22
Low Racial Resentment	39.58	61.30	56.78
N			2,694

In another bivariate analysis, little support is found for Hypothesis 2 which expected racial resentment toward Blacks to be higher than racial resentment toward Latinos and Immigrants see Table 4. However, the difference between racial resentment toward Blacks is barely one percentage higher than racial resentment toward Latinos. This may reflect the deteriorating views towards racial progress in the country, especially toward the Latino community under the Trump administration (Pew 2019b).

Table 5. Bivariate Distribution of Racial Resentment towards Blacks, Latinos, and Immigrants and Racial Resentment Scale (in percentages)

	Racial Resentment Toward Blacks	Racial Resentment Toward Latinos	Racial Resentment Toward Immigrants
High Racial Resentment	48.30	47.23	42.08
Low Racial Resentment	51.70	52.77	57.92
N			2,694

Explaining Attitudes toward Healthcare Reform

Table 6 provides the results from the fully specified logistic regression model, which examines the relationship between racial resentment and attitudes towards healthcare reform while controlling several demographic, political, and healthcare access factors. The purpose of this model is to determine if the relationship between racial resentment and attitudes toward healthcare reform identified at the bivariate level holds when other factors perceived to influence attitudes towards healthcare reform and the ACA are included.

Table 6. Logistic Regression of Racial Resentment on Favorable Attitudes toward Healthcare Reform

	M1	*Odds Ratio*	*M2*	*Odds Ratio*	*M3*	*Odds Ratio*	*M4*	*Odds Ratio*
High Racial Resentment								
Overall	-0.178	0.84						
	(0.111)							
Toward Blacks			0.055	1.05				
			(0.198)					
Toward Latinos					0.045	1.05		
					(0.192)			
Toward Immigrants							-0.156	0.87
							(0.199)	
Party Identification								
Republican	-0.056	0.95	0.067	1.07	-0.288	0.75	-0.063	0.94
	(0.148)		(0.257)		(0.258)		(0.267)	
Independent	0.382***	1.47***	0.355	1.43	0.607***	1.83***	0.202	1.22
	(0.136)		(0.242)		(0.231)		(0.251)	
Race								
Black	0.213	1.24	0.248	1.28	0.391	1.48	0.143	1.15
	(0.162)		(0.293)		(0.281)		(0.287)	
Latino	0.439***	1.55***	0.520*	1.68*	0.585**	1.80**	0.291	1.34
	(0.140)		(0.256)		(0.237)		(0.242)	
Education								
Less than High School Diploma	0.600*	1.82*	0.426	1.53	0.073	1.08	1.269**	3.56**
	(0.331)		(0.616)		(0.054)		(0.617)	
High School	-0.016	0.98	-0.233	0.79	-0.160	0.85	0.304	1.36
	(0.217)		(0.363)		(0.367)		(0.391)	
Some College	0.370*	1.45	0.359	1.43	0.404	1.50	0.337	1.40
	(0.203)		(0.325)		(352)		(0.370)	
College Degree	0.185	1.20	0.078	1.08	-0.126	0.85	0.577	1.78
	(0.197)		(0.322)		(0.345)		(0.356)	
Age	0.237***	1.23***	0.269***	1.30***	0.168*	1.18*	0.266***	1.30***

	(0.055)		(0.092)		(0.097)		(0.095)	
Income	0.016	1.02	-0.016	0.98	0.066*	1.06*	0.000	1.00
	(0.020)		(0.034)		(0.035)		(0.035)	
Female	0.040	1.04	0.013	1.01	0.111	1.12	0.117	1.12
	(0.108)		(0.187)		(0.187)		(0.188)	
Health Insurance	-0.542***	0.58***	-0.454*	0.64*	-0.056*	0.57*	-0.653**	0.52***
	(0.170)		(0.187)		(0.300)		(0.298)	
Medicaid Expanded	-0.093	0.91	-0.257	0.77	-0.142	0.87	0.114	1.12
	(0.113)		(0.194)		(0.194)		(0.203)	
Constant	-1.098***		-1.077*		-1.283**		-1.195**	
	(0.337)		(0.576)		(0.582)		(0.621)	
Pseudo R2	0.032		0.037		0.048		0.038	
N	*1994*		*680*		*679*		*635*	

Note: Dependent Variable is 0 or 1, 1=favorable views
Democrats are the reference category for Republicans and Independents.
Whites are the reference category for race.
Graduate degree is the reference category for education.
Robust standard errors in parentheses.
**** p<0.01, ** p<0.05, * p<0.1*

The effects of racial resentment do not exert statistically significant effects on attitudes toward healthcare reform. When the effects of racial resentment are examined separately, respondents with high racial resentment overall (M1) and respondents with high racial resentment toward immigrants (M4) have less favorable views toward healthcare reform. Whereas for respondents with high racial resentment toward Blacks (M2) and Latinos (M3), the effects are reversed. The lack of significance supports the null hypothesis for H4 which anticipated racial resentment would play a strong role in determining support for healthcare reform.

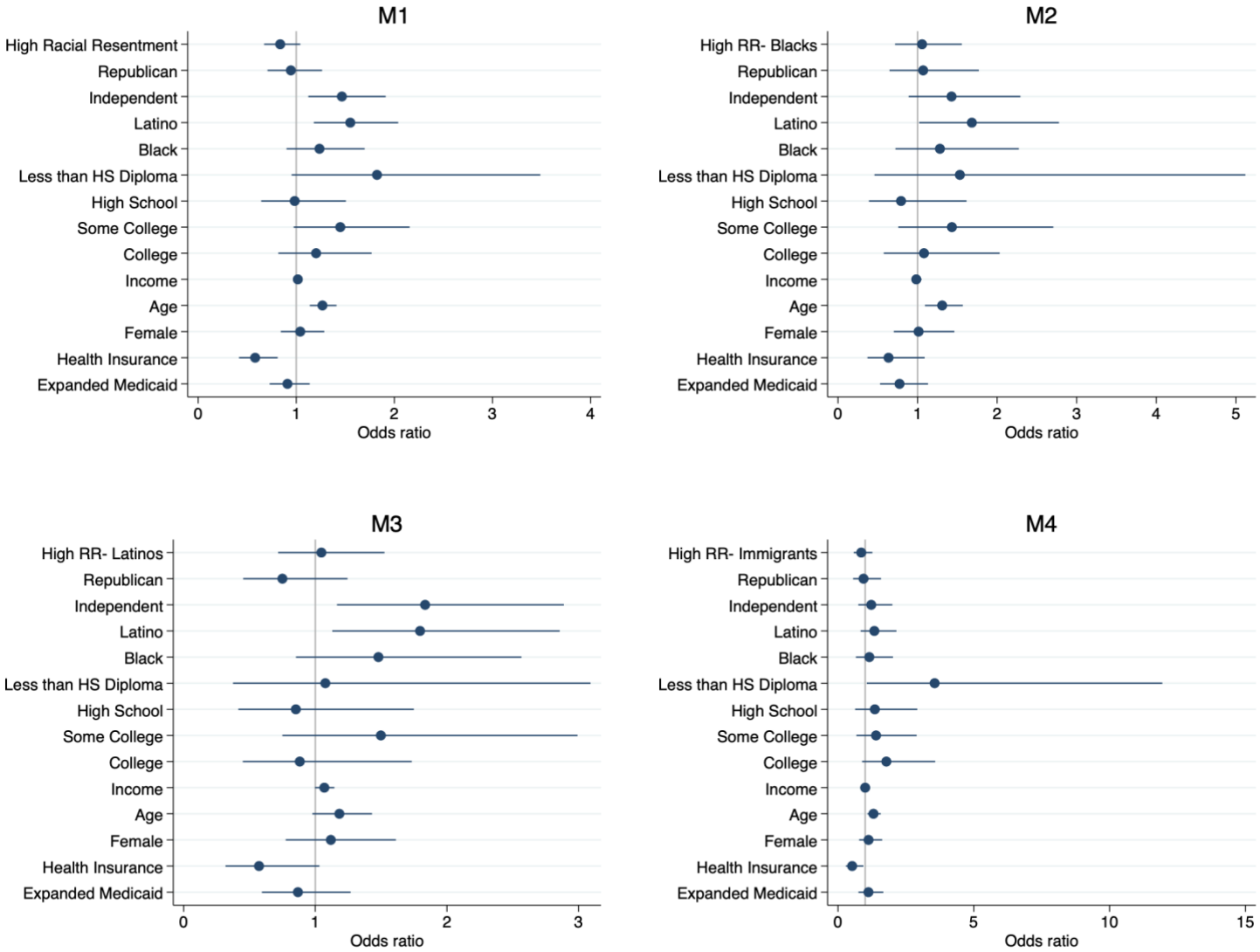
The most consistent predictors of attitudes toward healthcare reform are age and health insurance status (see Figure 4). Older respondents are more likely to have favorable views toward healthcare reform than younger respondents. Health insurance status is also consistently significant throughout all four models but has a negative effect on attitudes toward healthcare reform. Respondents with health insurance are less likely to have favorable views toward healthcare reform. It is important to contextualize this finding in the current healthcare reform environment. 2019 was the first year that there was no federal tax penalty for the individual mandate under the ACA. This survey was run in the spring of 2019. The removal of the federal mandate triggered serious concerns about the growing cost of health insurance premium and co-payments (Kamal et al. 2018). It is possible that people who know about the removal of the individual mandate and have health insurance have unfavorable opinions toward healthcare reform because costs appear to be increasing. More research should be done to better understand the role having health insurance has on attitudes toward healthcare reform.

Race is also a strong predictor of attitudes toward healthcare reform but is not consistent through all models. Latinos and Blacks are more likely to have favorable views toward healthcare reform than Whites. Yet, only in the first three models (M1, M2, M3) are Latinos significantly more likely to have favorable views toward healthcare reform compared to Whites. This finding is backed by many studies done in public opinion and healthcare reform and find that racial/ethnic minorities are more likely to have more positive views toward healthcare reform than Whites (Gallup 2017; Kaiser 2020b).

Party identification which is usually a strong predictor of attitudes toward healthcare reform tells a slightly different story here. There is no significant difference between the attitudes of Republicans and Democrats but in Model 1 (M1) and Model 3 (M3) Independents are significantly more likely to have favorable views toward healthcare reform than Democrats. This is a perplexing finding, the majority on the role of party identification suggests Republicans hold opposing views toward healthcare reform relative to Democrats. Yet in this study, the biggest difference is between Independents and Democrats. The structure of the question did not cue a specific healthcare reform policy nor approach. Therefore, it is possible that there is variation in respondent's operationalization of healthcare reform when adopting favorable or unfavorable views which explains some of the deviation from the literature.

Education is a predictor of attitudes toward healthcare reform when the two ends of the education spectrum are compared to each other. Respondents with less than a high school diploma are significantly have favorable views toward healthcare reform by a factor of 1.82 in Model 1 (M1) and 3.56 in Model 4 (M4) relative to respondents with a graduate degree, holding all other variables constant.

Figure 4. Coefficient Plots for Favorable Attitudes Toward Healthcare Reform



Explaining Attitudes towards the Affordable Care Act

Table 7 provides the results from the fully specified logistic regression model, which examines the relationship between racial resentment and attitudes toward the ACA while controlling several demographic, political, and healthcare access factors. The purpose of this model is to determine if the relationship between racial resentment and attitudes toward the ACA. It is important to highlight that this question asks respondents to evaluate the "Affordable Care Act, also known as Obamacare." The addition of the term "Obamacare" is included in this question to capture attitudes toward the ACA for individuals who do not realize Obamacare and the ACA are the same thing and to test whether the racialization of the term "Obamacare" has continued after the end of Obama's presidency.

Across Table 7, racial resentment is a strong predictor of willingness to repeal the ACA whether taken as an overall racial resentment measure or directed at Blacks, Latinos, or Immigrants. Racial resentment towards Latinos and Immigrants has an even stronger effect than racial resentment toward Blacks when respondents consider repealing the ACA. In Model 3 (M3) the odds of individuals with high levels of racial resentment toward Latinos willing to repeal the ACA increase by a factor of 4.15 compared to respondents with low racial resentment toward Latinos, while all variables are held constant ($p < 0.01$). This effect is slightly stronger in Model 4 (M4) which finds the odds of individuals with high levels of resentment toward immigrants are 4.67 times higher than respondents with low racial resentment toward immigrants, holding all variables constant ($p < 0.01$). This finding supports Hypothesis 3, which expected attitudes toward the ACA to be more racialized than attitudes toward healthcare reform, and Hypothesis 4, which anticipated racial resentment would play a strong role in degerming attitudes toward the ACA.

Table 7. Logistic Regression of Racial Resentment on Repealing the ACA

	M1	*Odds Ratio*	*M2*	*Odds Ratio*	*M3*	*Odds Ratio*	*M4*	*Odds Ratio*
High Racial Resentment								
Overall	1.236***	3.44***						
	(0.120)							
Toward Blacks			0.867***	2.37***				
			(0.218)					
Toward Latinos					0.924***	4.15***		
					(0.223)			
Toward Immigrants							1.543***	4.67***
Party Identification								
Republican	2.170***	8.75***	2.061***	7.86***	2.530***	12.94***	2.04***	7.70***
	(0.151)		(0.261)		(0.268)		(0.271)	
Independent	0.890***	2.43***	1.175***	4.91***	0.643***	1.90***	0.941***	2.56***
	(0.142)		(0.239)		(0.244)		(0.265)	
Race								
Black	-0.604***	0.55***	-0.350	0.70	-0.745**	0.47**	-0.645*	0.52*
	(0.176)		(0.300)		(0.303)		(0.337)	
Latino	-0.610***	0.54***	-0.604**	0.55**	-0.853***	0.43***	-0.318	0.73
	(0.176)		(0.251)		(0.237)		(0.272)	
Education								
Less than High School	0.264	1.30	0.374	1.45	0.784	2.19	-0.204	0.82
Diploma	(0.343)		(0.675)		(0.600)		(0.627)	
High School	0.775***	2.17***	0.568	1.77	1.221***	3.39***	0.684	1.98
	(0.240)		(0.374)		(0.419)		(0.487)	
Some College	0.587***	1.79***	0.367	1.44	0.820**	2.27**	0.685	1.98
	(0.224)		(0.350)		(0.410)		(0.446)	
College Degree	0.644***	1.90***	0.641*	1.90*	0.891**	2.44**	0.540	1.72
	(0.225)		(0.337)		(0.402)		(0.462)	
Age	-0.004	0.99	-0.006	0.99	-0.006	0.99	0.005	1.01
	(0.005)		(0.008)		(0.008)		(0.008)	

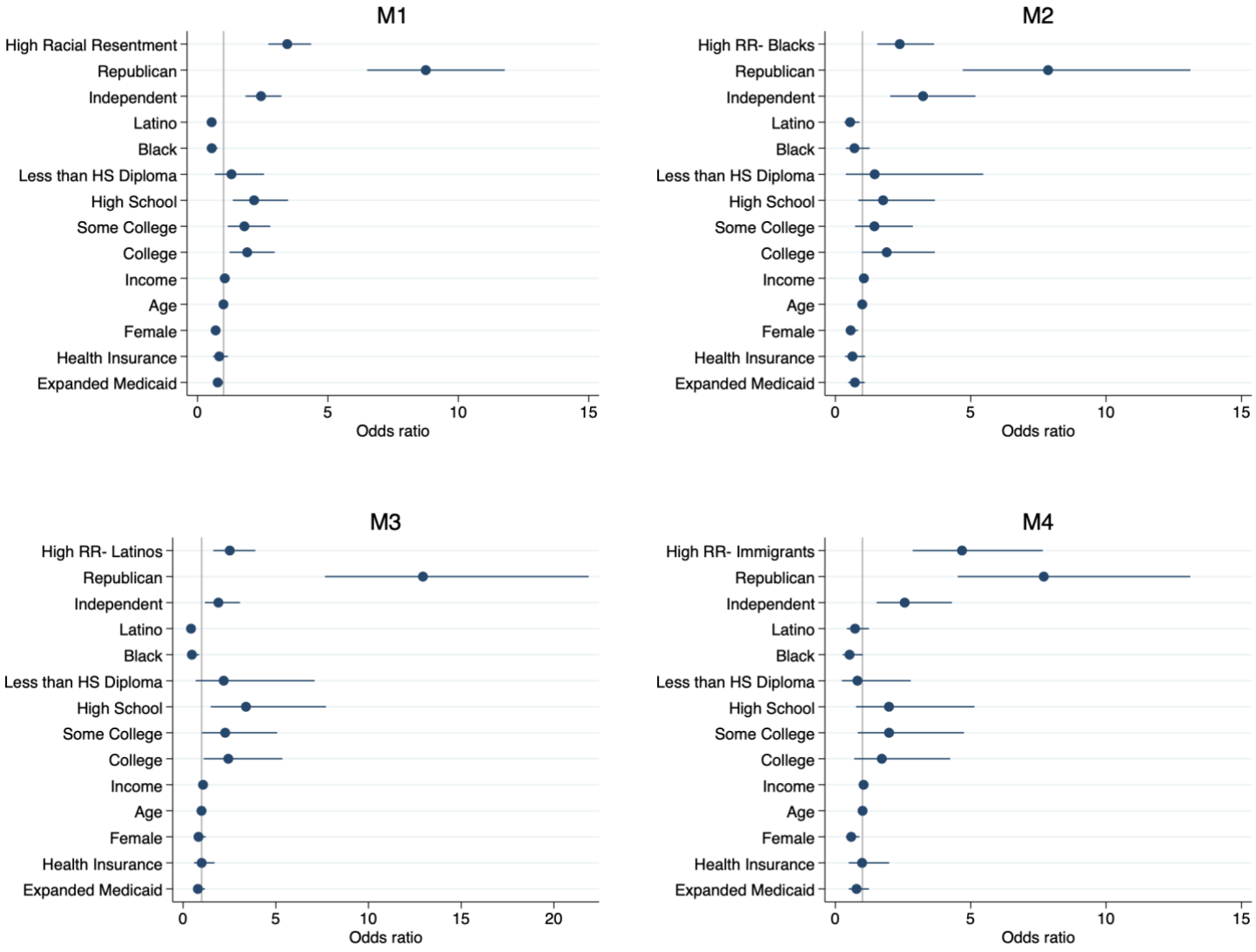
Income	-0.047	1.05	0.053	1.05	0.073**	1.08**	0.042	1.04
	(0.021)		(0.037)		(0.036)		(0.039)	
Female	-0.362***	1.04***	-0.571***	0.56***	-0.185	0.83	-0.535**	0.59**
	(0.115)		(0.200)		(0.197)		(0.211)	
Health Insurance	-0.181	0.83	-0.458	0.63	0.001	1.00	-0.011	0.99
	(0.170)		(0.283)		(0.268)		(0.356)	
Medicaid Expanded	-0.255**	0.91**	-0.325	0.72	-0.227	0.80	-0.245	0.78
	(0.122)		(0.207)		(0.200)		(0.234)	
Constant	-1.923***		-1.370**		-2.198**		-2.996***	
	(0.337)		(0.644)		(0.635)		(0.751)	
Pseudo R2	0.230		0.193		0.241		0.248	
N	*2313*		*786*		*799*		*728*	

Note: Dependent Variable is 0 or 1, 1=favorable views.
Democrats are the reference category for Republicans and Independents.
Whites are the reference category for race.
Graduate degree is the reference category for education.
Robust standard errors in parentheses.
**** p<0.01, ** p<0.05, * p<0.1*

In addition to racial resentment, party identification is a significant and strong predictor of willingness to repeal the ACA. Republicans are consistently more likely to support the repeal of the ACA than Democrats across all models, see Figure 5. Independents are also significantly more likely to support the repeal of the ACA than Democrats across all models, but the effect is not as large as Republicans. This is not a surprising finding given the substantial amount of research on the political polarization of the ACA. The political division falls along party lines, as Republicans have led efforts to repeal the ACA and Democrats have defended and sought to strengthen the ACA (Altman 2014; Cunningham 2013). This political division has extended itself into the publics' attitudes toward the ACA as it relates to their party identification (Kriner and Reeves 2014; McCabe 2016).

Race is a strong predictor of willingness to repeal the ACA. Racial/ethnic minorities are consistently more likely to support efforts to strengthen the ACA compared to Whites. Blacks are significantly more likely to support efforts to strengthen the ACA than Whites with the exception of Model 2 (M2). Similarly, Whites are likely to support efforts to strengthen the ACA than Whites with the exception of Model 4 (M4). These trends reflect many large surveys done on attitudes toward the ACA which find racial/ethnic minorities are more likely to support the ACA than Whites (Gallup 2017; Kaiser 2020b).

Figure 5. Coefficient Plots for Repealing the ACA



Gender has an influence on willingness to repeal the ACA across Table 7. Gender is a significant predictor of willingness to repeal the ACA in all models except for Model 3 (M3). Respondents who identify as female are more likely to support strengthening the ACA than respondents who identify as male across all models. This confirms findings from Lizotte (2016), who studies the gender gap in support for the ACA. Lizotte (2016) attributes women's humanitarianism, social values, and economic vulnerability to partially account for the gender gap in healthcare attitudes.

Education has an interesting influence on willingness to repeal the ACA. Respondents with less than a graduate degree are more likely to support efforts to repeal the ACA compared to respondents with a graduate degree. In Model 1 (M1) and Model 3 (M3), this trend is significant among respondents with less than a graduate degree with the exception of respondents with less than a high school diploma. Legerski and Berg (2018) find educational attainment liberalizes public opinion toward the ACA. This analysis supports their work.

It is worth noting that in Model 3 income is a significant predictor of willingness to repeal the ACA. For each increase in income level, the odds of individuals supporting efforts to repeal the ACA increase by a factor of 1.08, holding all other variables constant ($p < 0.05$). Respondents with high incomes are less likely to benefit from health insurance provisions provided by the ACA. Furthermore, there are significant health disparities that are closely tied to income. Individuals with low incomes are more likely to experience severe medical debt which is associated with lower access and use of healthcare services (D. A. Austin 2014; Pollack et al. 2007). Since respondents with incomes on the highest end of the spectrum are less likely to

experience such debt or lack of financial resources to access healthcare services, they may have an aversion to the ACA since they do not benefit from it.

Finally, respondents who live in states that chose to expand Medicaid are more likely to support efforts to strengthen the ACA rather than repeal the ACA. This relationship is significant in Model 1 (M1). The odds of respondents in states that expanded Medicaid

Conclusion

Healthcare reform solidified itself as one of the most prominent policy issues of contemporary politics and is likely to remain a central issue. This study highlights the importance of taking a robust approach to understanding how individuals develop attitudes toward healthcare reform and the ACA by focusing on the role of racial resentment in the post-Obama era. This study expanded the racial resentment scale beyond the Black-White dichotomy to include Latinos and Immigrants and then apply the modified racial resentment scale to attitudes toward healthcare reform and the ACA. I find that racial resentment, regardless of who it is directed toward, shapes attitudes toward the ACA but not healthcare reform. I attribute this to the racialization of the ACA whereas healthcare reform, which encompasses many definitions, is not necessarily racialized.

Racial resentment toward Blacks, Latinos, and Immigrants are all significant predictors of attitudes toward the ACA. Still, racial resentment toward Blacks is a stronger predictor of attitudes toward the ACA than racial resentment toward Latinos and Immigrants. These findings provide a theoretical foundation to apply the racial resentment scale beyond the Black-White dichotomy. Future research should extend the expanded racial resentment scale to public policies beyond healthcare reform.

Apart from these findings, it is important to recognize the limitations of this study. The Trump administration has invigorated anti-Latino and anti-immigrant sentiments around the country which provide good cause to include racial resentment toward Latinos and immigrants in this study (Pew 2019b). However, the existing narrative often conflates Latinos and immigrants which makes it challenging to differentiate attitudes toward both of these groups. Future research should identify stronger measures to better capture racial resentment toward Latinos and resentment toward immigrants.

One of the most complicated findings of this study was the absence of the political division when respondents evaluated healthcare reform. There was little difference between Republicans and Democrats attitudes but significant differences between Independents and Democrats. Over the last decade, there have been an innumerable approach to healthcare reform. Therefore, it is possible that respondents each have a slightly different definition of what healthcare reform is. Further research should be done to better understand what these do might be and whether or not the ACA reflects their definition of healthcare reform.

Healthcare reform is also an incredibly complicated and convoluted policy that is difficult for individuals who are not content experts to understand (Clouston, Manganello, and Richards 2016; J. Kim, Braun, and Williams 2013). A third of Americans were unaware that Obamacare and the ACA were the same policy (Dropp and Nyhan 2017). The ability to distinguish whether or not individuals have benefitted from provisions under that ACA is even more complex. This study would have benefited from a measure that captured health insurance literacy.

CHAPTER FIVE:

CONCLUSIONS

Healthcare continues to be at the center of contemporary politics, whether it is to strengthen and sustain the system in place or dismantle and rebuild the current system using another approach. This is particularly evident as we approach the 2020 presidential election in the middle of the Coronavirus pandemic. This focus is a reflection of a fractured healthcare system that fails to provide adequate coverage to all citizens, with many continuing to fall through the cracks. This makes the study of the public's attitudes toward healthcare reform even more relevant.

As the racial and ethnic diversity of the US increases, so too does our understanding of attitudes toward the ACA. Traditional theories of the public's attitudes toward healthcare and healthcare reform have been limited as they largely examine the behavior of non-Hispanic Whites. In response, scholars of racial and ethnic politics have examined how these groups might behave differently from traditional expectations, especially when theories such as group identity are taken into account. A fundamental goal of this dissertation has been to expand our understanding of attitudes toward healthcare reform while accounting for race and ethnicity.

This dissertation provides a sweeping account of attitudes toward healthcare reform. This process took the form of applying several theories over the course of three empirical chapters. In Chapter 2, I found that self-interest does not play a strong role in determining Latinos' attitudes toward healthcare reform; rather, party identification explains Latinos' attitudes toward healthcare reform. These null findings set up Chapters 3 and 4 to identify what factors beyond party identification influence attitudes toward healthcare reform. These two chapters conclude that racial resentment and group identity impact attitudes toward healthcare reform, and that

there is substantial variation by race/ethnicity. Through this dissertation, I have both corroborated existing research and added additional clarity and detail to our understanding of attitudes toward healthcare reform and the ACA.

Chapter 2: The Role of Self-Interest on Latinos' Attitudes Toward the Affordable Care Act

In Chapter 2, I test the impact of self-interest on attitudes toward the ACA. My theory hinges on the idea that, regardless of party affiliation, Latinos who are the most likely to be uninsured and face considerable economic hardship are likely to have positive attitudes toward the ACA when they take their self-interest into account. Furthermore, the ACA has significantly invested in assuring the health coverage provisions under the law were accessible to the Latino community. Using the 2018 National Association of Latino Elected Officials (NALEO) and Latino Decisions National Weekly Political Tracking Poll, I designed a survey experiment to test the roles of economic-related self-interest and health-related self-interest on attitudes toward the ACA.

The model reveals that self-interest, regardless of whether it is economic or health-related, does not shape Latinos' attitudes toward the ACA. Instead, it is party identification and age that influences Latinos' attitudes toward the ACA. The only interruption in this narrative is Latinos' prioritization of stabilizing the ACA. Latinos with lower incomes are more likely to prioritize efforts that stabilize the ACA than Latinos with higher incomes. Although this finding does not speak directly to the experiment which cued Latinos to consider their economic-related self-interest, it demonstrates that Latinos with low incomes who may benefit from several key provisions of the ACA, such as Medicaid expansions and subsidized health insurance, rely on a form of economic self-interest.

Because this study fails to provide strong evidence that Latinos' attitudes toward the ACA are shaped by their self-interest, it is necessary to consider what explains the contours of attitudes toward healthcare reform beyond party-identification. To do so, I take a broader approach using the Center for Social Policy Social Policy Survey of 2019 to test the roles of group identity and racial resentment among Blacks, Latinos, and Whites.

Chapter 3: How Linked Fate and Cross-racial Linked Fate Shapes Attitudes Toward the Affordable Care Act

In this chapter, focus is turned to group identity to better understand attitudes toward the ACA. I rely on linked fate and cross-racial linked fate, both measures of group identity, to test whether group identity impacts attitudes toward the ACA. Linked fate relies on heuristics cued by race, gender, or partisan affiliation to make complicated decisions. The traditional measure of linked fate is derived from Michael Dawson's book *Behind the Mule* (Dawson 1995) which created the measure for linked fate: (1) "Do you think what happens generally to Black people in this country will have something to do with what happens in your life?" and (2) "Will it affect you a lot, some, or not very much?" (p.77). High levels of linked fate are correlated with more positive views toward healthcare reform among Latinos (G. R. Sanchez and Medeiros 2016) but not among Blacks (McCabe 2019).

I find that linked fate predicts support for strengthening the ACA among Blacks and Latinos but not for Whites. Blacks and Latinos are both much more likely than Whites to experience barriers to health coverage, access to care and lower health outcomes. Therefore, not only is the ACA especially salient in these groups, but their shared grievances in the context of healthcare may make linked fate especially influential on their attitudes toward the ACA.

Cross-racial linked fate, a relatively nascent concept, measures the levels of linked fate between distinct groups (Dowe, Franklin, and Carter 2018; McCabe 2019). This is a germane line of inquiry when we consider the ACA's success is tied to the collective participation of Americans. I find that cross-racial linked fate shapes Blacks' and Latinos' attitudes toward the ACA but not Whites'. Both Blacks' and Latinos' cross-racial linked fate is correlated with less support for strengthening the ACA.

This relationship is significant for Blacks' cross-racial linked fate with Latinos and Latinos' cross-racial linked fate with Whites. It is possible that the shared status and grievances among Blacks and Latinos are not strong enough to facilitate the role of cross-racial linked fate in the context of healthcare reform. Conditions such as resource competition (perceived or actual) and discrimination may be barriers preventing cross-racial linked fate from being realized among Blacks and Latinos. The effect of Latinos' cross-racial linked fate with Whites is a little more perplexing. It is possible resource competition extends to Latinos' perception of Whites as well. Another explanation relies on the substantial number of Latinos who identity as White. It is possible White identifying Latinos with higher levels of cross-racial linked fate with Whites share Whites' attitudes toward the ACA which are less supportive than those of people of color. Latinos' pan-ethnicity may also play a role in the role of cross-racial linked fate, which should be explored.

Chapter 4: Racial Resentment Beyond the Black-White Dichotomy and its Impact on Attitudes Toward Healthcare Reform

The majority of research on racial resentment has been centered on the Black-White dichotomy to explain Whites' political attitudes and behaviors. Racial resentment is the intersection of "Whites' feelings toward Blacks and their support for American values, especially

secularized versions of Protestant ethic" (Kinder and Sanders 1996, p.293). In this chapter, I extend racial resentment toward Blacks, Latinos, and Immigrants to explain Black, Latino, and White attitudes toward healthcare reform and the ACA.

Racial resentment readily influences attitudes toward racialized policies such as affirmative action, criminal justice, and welfare (L. D. Bobo 2000; Carter and Corra 2016; Danns 2008). Individuals with high levels of racial resentment are generally less supportive of such policies. It appears that racial resentment has also spilled-over into attitudes toward the ACA (Tesler 2012). The language included in the law itself, the framing of the bill by opposition, and its strong ties to the first Black president all facilitated the racialization of the ACA (Michner 2020; Tesler 2012). To test whether the ACA continues to be a racialized policy, I include two dependent variables to capture attitudes toward the ACA and healthcare reform broadly.

I find racial resentment strongly influences attitudes toward the ACA, but not toward healthcare reform. Although racial resentment toward Blacks is the strongest predictor of willingness to repeal the ACA, racial resentment toward Latinos and Immigrants significantly predict willingness to repeal the ACA. These findings provide a theoretical foundation to apply the racial resentment scale beyond the Black-White dichotomy.

Furthermore, it is clear that even after the Obama administration has left office, the racialization of the ACA continues. The Trump administration has invigorated anti-Latino and anti-immigrant sentiments around the country (Pew 2019b). Beyond sentiment, the Trump administration has limited Spanish language resources and disrupted services of cuidadodesalud.gov, the Spanish equivalent of healthcare.gov (Andalo 2017). Clearly, the Trump administration has continued the racialization of the ACA by eliminating resources the Latino and immigrant community rely on.

Conclusion and Avenues for Future Research

A couple broad conclusion drawn from these findings is that there is meaningful variation in the formation of attitudes toward healthcare reform among Blacks, Latinos, and Whites. It is clear there are substantial differences in attitudes toward healthcare reform when group identity and racial resentment are taken into account. As the demographics of the US continue to shift to a minority-majority nation, the importance of this work increases. When it comes to the 2020 elections, it is clear the healthcare is a remarkably salient issue. This highlights the importance of providing a robust understanding to attitudes toward healthcare reform beyond party-identification. This analysis shows that there is still much more work to be done. What has been accomplished here is akin to the metaphor "a journey of a 1000-miles begins with a single step" to demonstrate that there is a long road ahead in the study of race and public opinion. Insights from Chapters 3 and 4 exemplify this.

Chapter 3 demonstrates how group identity impacts attitudes toward the ACA among Blacks and Latinos but not Whites. Linked fate predicts support for the ACA whereas cross-racial linked fate predict opposition toward the ACA. This is an especially meaningful finding when we consider that the ACA's success is determined by collective engagement across race, especially among Blacks and Latinos who are more likely to be uninsured than Whites. The theoretical underpinning that cross-racial linked fate would positively influence Blacks' and Latinos' attitudes toward healthcare reform relied on the shared health inequities. The novel Coronavirus, COVID-19, has underscored the existing racial health disparities. Blacks and Latinos are more likely to be affected by COVID-19 than Whites (Bassett, Chen, and Krieger 2020). Given the acute and severely detrimental impacts COVID-19 has on communities of color, it is possible that cross-racial linked fate may be more readily activated.

The second broad conclusion drawn from this dissertation is that the ACA continues to be racialized in the post-Obama era. A number of scholars attributed the spill over of racialization into attitudes toward healthcare reform to the closeness President Obama had to the law (Kriner and Reeves 2014; Tesler 2012). It is clear the racial attitudes play a strong role when individuals evaluate the ACA beyond the Black-White dichotomy. Chapter 4 confirms that the ACA racial resentment toward Blacks, Latinos, and Immigrants impacts attitudes toward the ACA. The Trump administration is responsible for generating and sustaining a level of racial tension between Whites and Latinos (Pew 2019b; Pew, Research Center 2018) and implemented a series of severely punitive immigration policies which have gravely impacted immigrant communities (Boghani 2019). It is not surprising the extension of the racial resentment battery to Latinos and Immigrants produces similar effects as the racial resentment battery toward Blacks on attitudes toward healthcare reform when contemporary politics are taken into account.

Racial tensions are mounting. Demonstrations in solidarity with the Black Lives Matter movement resurged in May 2020 after the murder of George Floyd, a Black man killed while in Minneapolis policy custody. Race and racial tensions are at the forefront of many Americans' minds (Parker, Menasce Horowitz, and Anderson 2020). Since healthcare reform does not operate in a bubble, it is necessary to consider the impact racial tension may have on attitudes toward healthcare reform.

The landscape of healthcare reform is constantly changing. Right before midnight, June 25th 2020, the Trump administration asked the Supreme Court to overturn the ACA, since the individual mandate was ruled unconstitutional (Stolberg 2020). Currently, the ACA provides coverage to over 23 million Americans, many of whom would not have healthcare during the worst pandemic of the century if the ACA was repealed. Furthermore, the COVID-19 pandemic

forced businesses to close or operate a limited capacity to prevent the spread of the virus, which led to a striking increase in the unemployment rate (NYT 2020). The ACA offers the vast majority of newly unemployed people stopgap health coverage which provides a cushion until they are able to secure a new job or enroll in Medicaid or Medicare. Finally, repealing the ACA dissolves protections for individuals with preexisting conditions.

Understanding attitudes toward healthcare reform and the ACA is especially important during this time of great uncertainty. This dissertation provides a foundation for further exploration of variation by race in attitudes toward healthcare reform, and how group identity and racial resentment impacts the formation of these attitudes.

APPENDIX A

NALEO/LD 2018 Midterm Survey Experiment on Self-Interest

Thinking about the upcoming election, how important are the following healthcare issues to you [A when thinking of your physical health/ B when thinking of your financial health/ C -blank-], on a scale of one (not important at all) to ten (the most important issue).

(A) Continue protections for people with pre-existing conditions

1 2 3 4 5 6 7 8 9 10
Not Important at All — The Most Important Issue

(B) Passing legislation to bring down the price of prescription drugs

1 2 3 4 5 6 7 8 9 10
Not Important at All — The Most Important Issue

(C) Repealing the 2010 Affordable Care Act

1 2 3 4 5 6 7 8 9 10
Not Important at All — The Most Important Issue

(D) Passing Legislation to stabilize the Affordable Care Act

1 2 3 4 5 6 7 8 9 10
Not Important at All — The Most Important Issue

(E) Passing a national health plan, or Medicare-for-all

1 2 3 4 5 6 7 8 9 10
Not Important at All — The Most Important Issue

APPENDIX B

Center for Social Policy Social Policy Survey 2019

1. In order to make sure we have a representative sample of everyone across America, let's start with a few basic demographic questions to ensure this study is inclusive of all Americans: [ALLOW MULTIPLE]
   S2. Race / Ethnicity

   White, not-Hispanic.....1
   Hispanic or Latino.....2
   Black or African American.....3
   Asian American[TERM].....4
   Middle Eastern or Arab [TERM].....5
   American Indian/Native American[TERM].....6
   Other[GO to S2BL].....7

2. Gender

   Female.....1
   Male.....2
   Other [Specify].....3

3. Please select your current state of residence

   Drop down with all 50 states + DC

4. Do you have a favorable or unfavorable view of healthcare reform?

   Favorable.....1
   Unfavorable.....2
   Neither.....3
   Don't know.....88
   Refused.....99

5. Please tell us which comes closer to your view about the Affordable Care Act, passed by Congress and the President in 2010, often referred to as Obamacare.

   The ACA or Obamacare should be repealed……1
   The ACA or Obamacare should be strengthened……..2
   Don't Know…...……88
   Refused…..……99

Linked Fate Questions

6. Do you think what happens generally to Latino people in this country will have something to do with what happens in your life?

Yes....1
No....2
Don't know....88
Refused....99

7. [If 6==1] Will it affect you:

A lot....1
Some....2
Not very much....3
Don't know....88
Refused....99

8. Do you think what happens generally to Black people in this country will have something to do with what happens in your life?

Yes....1
No....2
Don't know....88
Refused....99

9. [8==1] Will it affect you:

A lot....1
Some....2
Not very much....3
Don't know....88
Refused....99

10. Do you think what happens generally to White people in this country will have something to do with what happens in your life?

Yes....1
No....2
Don't know....88
Refused....99

11. [If 11==1] Will it affect you:

A lot....1
Some....2
Not very much....3
Don't know....88
Refused....99

Racial resentment battery: SPLIT SAMPLE: 1/3 12, 1/3 13, 1/3 14

12. Do you agree or disagree with the following statements regarding racial issues in our country?
[Rotate questions and Response Options]
[C] Irish, Italians, Jewish and many other minorities overcame prejudice and worked their way up. Blacks should do the same without any special favors.
[C] Over the past few years, blacks have gotten less than they deserve.
[C] It is really a matter of some people not trying hard enough; if blacks would only try harder, they could be just as well off as white.
[C] Generations of slavery and discrimination have created conditions that make it difficult for blacks to work the way out of the lower class.
[C] Over the past few years, blacks have gotten more economically than they deserve

Strongly agree 1
Somewhat agree..... 2
Somewhat disagree..... 3
Strongly disagree 4
Don't know 88
Refused 99

13. Do you agree or disagree with the following statements regarding racial issues in our country?
[Rotate questions and Response Options]
[C] Irish, Italians, Jewish and many other minorities overcame prejudice and worked their way up. Latinos should do the same without any special favors.
[C] Over the past few years, Latinos have gotten less than they deserve.
[C] It is really a matter of some people not trying hard enough; if Latinos would only try harder, they could be just as well off as white.
[C] Generations of discrimination have created conditions that make it difficult for Latinos to work the way out of the lower class.
Over the past few years, Latinos have gotten more economically than they deserve

Strongly agree 1
Somewhat agree..... 2
Somewhat disagree..... 3
Strongly disagree 4
Don't know 88
Refused 99

14. Do you agree or disagree with the following statements regarding political issues in our country?

[Rotate questions and Response Options]

[C] Irish, Italians, Jewish and many other minorities overcame prejudice and worked their way up. Immigrants today should do the same without any special favors.

[C] Over the past few years, immigrants have gotten less than they deserve.

[C] It is really a matter of some people not trying hard enough; if immigrants would only try harder, they could be just as well off as white.

[C] Generations of discrimination have created conditions that make it difficult for immigrants to work the way out of the lower class.

[C] Over the past few years, immigrants have gotten more economically than they deserve

Strongly agree 1
Somewhat agree..... 2
Somewhat disagree..... 3
Strongly disagree 4
Don't know 88
Refused 99

15. Do you currently have health insurance coverage?

Yes..... 1
No 2
Don't know 88
Refused 99

16. In the past 12 months, have you put off any sort of medical treatment because of the cost you would have to pay?

Yes..... 1
No 2
Don't know 88
Refused 99

17. Do you have a pre-existing condition, defined as a term used by insurance companies to describe an illness or medical condition that a person has before they began looking for insurance, such as a history of asthma, diabetes, high blood pressure, or cancer?

Yes..... 1
No 2
Don't know 88
Refused 99

18. Generally speaking, do you think of yourself as a Republican, a Democrat, an independent, or something else?

Republican..... 1
Democrat..... 2
Independent 3
Other party 4
Don't know 88
Refused 99

19. In what year were you born?

[Drop Down_____Year]

20. What is the highest level of education you completed?

Grades 1 – 8……..1
Some High School……..2
High School graduate or GED……..3
Some college, 2-year degree……..4
4-year college graduate……..5
Post-graduate education……..6

21. What was your total combined household income in 2017 before taxes. This question is completely confidential and just used to help classify the responses, but it is very important to the research.

Less than $20,000……..1
$20,000 to $29,999……..2
$30,000 to $39,999……..3
$40,000 to $49,999……..4
$50,000 to $59,999……..5
$60,000 to $69,999……..6
$70,000 to $79,999……..7
$80,000 to $89,999……..8
$90,000 to $99,999……..9
$100,000 to $149,999……..10
$150,000 to $199,999……..11
$200,000 or more……..12
Did not give any answer……..99

APPENDIX C

Multi-Racial Coalition Committed to Advancing Health Disparities

AIDS Action
American Academy of Pediatrics
American Association of Marriage and Family Therapists
American Cancer Society
American Dental Association
America's Health Insurance Plans
American Hospital Association
American Public Health Association
Asian & Pacific Islander American Health Forum
Cancer Action Network
Child Welfare League of America
Families USA
First Focus
Hispanic Federation
Japanese American Citizen League
National Alliance for Hispanic Health
National Association for the Advancement of Colored People
National Association of Community Health Centers
National Association of Public Hospitals and Health Systems (now known as America's Essential Hospitals)
National Association of Social Workers
National Black Nurses Association
National Coalition for LGBT Health
National Dental Association
National Health Law Program
National Hispanic Medical Association
National Immigration Law Center
National Medical Association
National Partnership for Women and Families
National Urban League
Society for Public Health Education

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