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The Persistence of Racialized Health Care Attitudes: Racial Attitudes among White Adults and Identity Importance among Black Adults

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Abstract: This study evaluates the emergence and persistence of the racial divide on health reform in public opinion using survey data from 2008 through 2017. The findings support existing work showing a consistent relationship between racial resentment and attitudes on the Affordable Care Act among White adults. However, the study also builds on existing work by evaluating the relationship between strength of racial identity among Black adults and health care opinion during President Barack Obama's Administration. The paper investigates the implications of the findings for future health policy in the post-Obama era using survey data on the Republicans' attempt to pass the American Health Care Act in 2017. The results underscore the conditions that make the "spillover" of racial attitudes into seemingly non-racial policy areas more or less likely to occur. The findings also provide suggestive evidence for how future health reforms may receive different levels of support from both White and Black adults.

Keywords: race, health care, Obamacare, racialized, attitudes.

The racial divide in American politics is a "divide without peer" (Kinder and Sanders 1996, 27). Across a number of studies, Black American adults are consistently more Democratic in party identification and vote choice and more likely to prefer policies that benefit racial minorities than

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White American adults. Moreover, numerous scholars have shown that implicating race through political cues can activate racial resentment among White adults in voting decisions in policy areas that are seemingly unrelated to race. In the Obama era, where President Obama's own race served as a cue that activates racial considerations (Tesler 2012; 2015, 2016), scholars have shown that race-based divisions "spill over" into several non-racial policy areas, particularly on the issue of health care. However, it remains unclear how lasting and pervasive these spillover effects can be. Will the spillover of racialization persist in health policy even when Obama is no longer a leader at the center of the policy issue?

To help answer this question, this study traces the persistence of race-based divisions in opinion on health care policy from 2008–2017 using multiple sources of cross-sectional survey data. While the literature on the spillover of racialization primarily focuses on changes in the attitudes of White adults in the United States, this study examines the racialization of opinion among both White and Black respondents. In particular, I evaluate whether strength of attachment to racial identity is associated with Black respondents' attitudes toward health policy, while accounting for other socioeconomic, partisan and ideological considerations.

The findings suggest that racial resentment among White Americans and racial identity among Black Americans have both contributed to the racial divide on The Patient Protection and Affordable Care Act (ACA), the major health reform law passed in 2010. Further, the relationship between racial attitudes and opinion on the ACA persisted throughout Obama's time in office. In addition, the study also evaluates if racial divisions in opinion on health policy continued into the early period of the Trump Administration by comparing the racial divide on the ACA in 2017 to the divide on the Republican-led effort to repeal and replace the ACA during the summer of 2017 with the American Health Care Act (AHCA). While racial divisions on the ACA remained, the results show that the repeal policy had a substantially smaller racial gap in opinion than the ACA during this time period, even though both policies experienced a large partisan divide.

The findings contribute to the literature in important ways. First, the analysis builds on the study of race and public opinion on health care to include a focus on Black public opinion. The results show that both out-group resentment among White adults and in-group identification among Black adults are activated in the same issue context. The results also provide initial evidence on how the spillover of racialization may

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take shape in the post-Obama era. Experimental studies have shown that policy preferences experience a greater racial divide when Obama is made more salient in connection to the policy (Knowles et al. 2010; Maxwell and Shields 2014; Tesler 2016). What this study shows is how this effect may manifest in health care attitudes over time for new policy proposals related to, but distinct from the ACA and its connection to Obama. This study suggests the potential for health care policy to experience less of a racial divide. For example, this means that Democratic efforts may face less resistance due to racial resentment, but it also means that Democrats might receive less support from Black adults.

WHITE RACIAL ATTITUDES AND PUBLIC OPINION

Racial attitudes among White adults have been shown to exert a powerful influence on contemporary American policy attitudes across several policy domains, using experimental and survey-based evidence, and accounting for several non-racial political and demographic factors (see Hutchings and Valentino 2004 for a review). Kinder and Sanders (1996) find that racial divisions are particularly pronounced on issues with explicit racial content. In surveys from 1986–1992, Black respondents are more than 40 percentage points more supportive than White respondents on racial policies from school desegregation, to preferential hiring, and federal spending on programs that assist Black individuals (Kinder and Sanders 1996, Table 2.2).

However, the influence of racial attitudes on political preferences also extends into policies without explicit racial content—those with "unstated" or "covert" racial content (Kinder and Sanders 1996, 31). For example, Kinder and Sanders (1996) find that Black adults are more than 30 percentage points more supportive of food stamps than White adults, about 20 percentage points more likely to oppose capital punishment, and nearly 20 percentage points more supportive of welfare policies. Importantly, Kinder and Sanders (1996) find that these racial differences, indeed, appear to be related to race—they subsist even when accounting for class differences between White and Black respondents.

To explain racial divisions on non-racial issues, White (2007) argues that these issues can become racialized in contexts where implicit racial cues prime out-group *racial resentment* among White individuals. Tesler describes this pattern as the "spillover of racialization" (Tesler 2012;

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2016; Tesler and Sears 2010). Issues without explicit racial content can become racialized when coded racial language, Black imagery, and source cues—such as race as a salient social background characteristic of an elite issue advocate—are connected to the policy in mass communications (Tesler 2012; 2016). Moreover, the relationship between racial attitudes and views on non-racial policies generally seems to be growing. Enders and Scott (2019) suggest that racial resentment has become an increasingly strong predictor of a wide range of non-racial attitudes since the late 1980s.

BLACK IDENTITY AND PUBLIC OPINION

In addition to racial resentment among White adults, racial considerations among African Americans have also shaped the way in which Black individuals participate in politics and influence voting decisions, party identification, and public opinion. Black adults are highly unified politically, with more than 80% identifying with the Democratic Party. Dawson's (1994) concept of linked fate, or the Black utility heuristic, attributes this unity to the shared historical experiences of discrimination, segregation, and extensive in-group mechanisms for communication, which have made it more efficient for African Americans to use the welfare of the racial in-group as a shortcut for understanding how political outcomes will affect the individual. Beyond linked fate, more recently, scholars have argued that non-traditional ideologies and strength of identity can help to further explain unified Black political behavior (Dawson 2001; Gay et al. 2016; Hutchings and Jefferson 2014). In particular, Hutchings and Jefferson (2014) find that Black adults' preference for a larger role for government, as well as the importance of being Black to an individual's identity predict Democratic party identification.

Strength of in-group identification also helps to explain unified preferences of Black adults across several policy areas with racial content (Dawson 1994; Kinder and Winter 2001). However, in-group identification cannot explain Black preferences across all policies (Kinder and Winter 2001; Tate 1993). Just as the "spillover of racialization" into preferences among White voters is limited to certain contexts, the activation of racial identity for Black public opinion only occurs when certain conditions are met. Specifically, White (2007) argues that explicit racial cues that directly implicate "Blacks" or "African Americans" can prime racial identity among Black individuals.

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RACIALIZATION OF HEALTH CARE ATTITUDES IN THE OBAMA ERA

Both the theory of racialized spillover and strength of Black in-group identification can help explain why President Barack Obama's tenure in office has corresponded with persisting and sometimes increasing racial divisions in public opinion across a wide range of racial and non-racial policy areas. Hutchings (2009) found that the racial gap in opinion on racial policies in 2008 remained about the same as it was in 1988. While strength of identification with one's own racial group among Black adults may not generate the equivalent force for public opinion as the strength of hostility or resentment toward an out-group, both concepts may work in opposing ways to contribute to increasing divisions in public opinion between racial groups.

In non-racial policy areas, scholars have argued that Obama's race has served as a source cue that heightens the impact of racial attitudes among White adults on preferences when non-racial policies are closely connected to Obama as an actor (Tesler 2012; 2015). For example, Tesler (2012; 2015) finds that racial attitudes predict support and opposition for tax policies that are attributed to Obama in experimental settings. In addition, Tesler finds that among individuals interviewed in the period soon after Obama's announcement of support for same-sex marriage, racial attitudes became more predictive of opposition to the issue.

This "spillover of racialization" became especially pronounced and well-documented on the ACA. In 2009–2010 during the passage of the law, Black respondents were more than 40 percentage points more supportive of the law than White respondents in public opinion polls. This gap is more than 10 percentage points greater than the racial division on health care during Bill Clinton's presidency (Tesler 2012).

It is not surprising that racialized spillover occurred on health reform given Obama's close connection with health reform during his term in office. Even prior to his election as president, Obama spoke in-depth about health care reform on multiple occasions, including two campaign events early in 2008. First, a significant portion of the Democratic primary debate held on February 26, 2008 in Cleveland, OH put a spotlight on Hillary Clinton and Obama's health care plans.[1] By 2009–2010, President Obama treated health care as a centerpiece of his first-term agenda—supporting Congress in its passage of the ACA legislation. Finally, post-2012, the ACA has colloquially come to be known as "Obamacare", further entrenching the close connection between

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Obama—and the source cue of Obama's race—with health care as an issue.

Obama also *explicitly* mentioned "Blacks" as potential beneficiaries of health care reform, which could also not only activate White racial resentment but also activate in-group identification among Black voters. For example, on March 18, 2008 in Philadelphia, PA, Obama gave a speech largely focused on race.[2] The speech followed an *ABC News* report on March 13, 2008 about Obama's then-pastor, Reverend Jeremiah Wright, who delivered remarks that denounced America, in part, due to the country's treatment of Black Americans (Ross and El-Buri 2008). Obama's message in the March 18th speech articulated the need to foster unity across racial lines to help everyone in the country succeed. Throughout the speech, Obama made several explicit mentions of specific racial groups as potential beneficiaries of his policy agenda, including health care. This means that as early as February and March 2008, explicit and implicit cues could have primed racial attitudes on health care among both Black and White adults.

Survey data reveal moments in this timeframe where a racial divide on health reform emerges during the 2008 presidential campaign. Using rolling cross-sectional data from the National Annenberg Election Study (APPC 2010),[3] Figure 1 displays the difference in the 7-day moving average for support for government involvement in health reform for Black Democrats and White Democrats over time, by days away from March 18, 2008, the date that marked President Obama's speech on race. (For example, Day 0 corresponds to the average from March 15–21, 2008.) Positive values mean that Black Democrats were more supportive of government involvement in health care than White Democrats, on average.

The survey asks respondents whether they would prefer "having one health insurance program covering all Americans that would be administered by the government and paid for by taxpayers" (=1), "keeping the current system where many people get their insurance from private employers and some have no insurance" (=0), or neither system (=.5).[4] At Day 0 in Figure 1, a divergence emerges in the opinion of Black and White Democrats. During the timeframe immediately after March 18th, there is an increase in preference for government health care among Black Democrats and a moderate decrease among White Democrats.[5] These data represent a moment very early in Obama's campaign where public opinion on health care behaves in ways that correspond to Obama's salient association with the issue.

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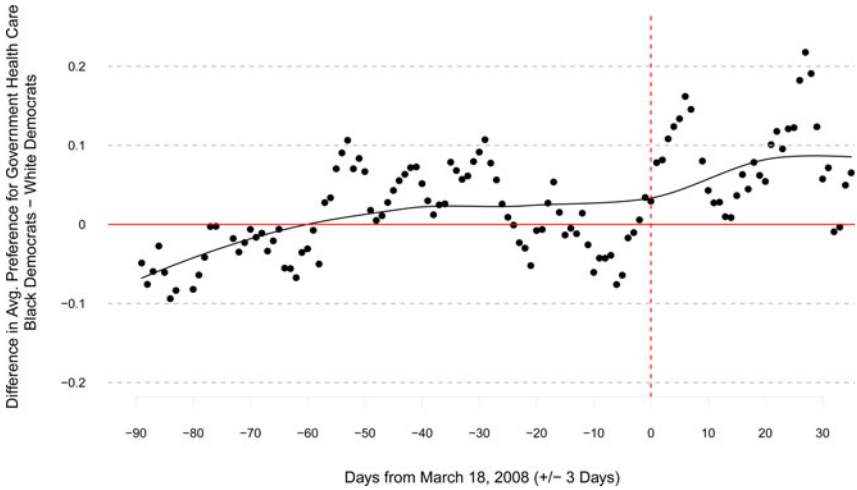

FIGURE 1. Racial divide in support for Government involvement in health care over time.

Note: 2008 NAES. Points are the difference in 7-day averages between Black Democratic and White Democratic respondents. Figure displays a loess curve of the averages over time using data from all dates where the survey question is available. Dashed vertical line at "0" represents the day of Barack Obama's speech on race.

This early racial divide aligns with the findings from Lundberg et al. (2017) that racially charged evaluations of Obama emerged prior to the 2008 presidential election and continued to have a strong relationship with attitudes on Obama's performance and policies throughout the president's tenure. Henderson and Hillygus (2011) similarly find that racial attitudes among White adults predict health care policy attitudes as early as September 2008 and became more impactful by 2010. In a set of experiments, Knowles et al. (2010) and Maxwell and Shields (2014) also show that the presence of Obama as the source or leader associated with health care reform is what activates the relationship between racial attitudes and health care opposition among White adults.

Thus, a considerable body of work supports the claims that health care is a policy area that experienced a growing racial divide between White and Black adults, that this racial gap in opinion appears to be at least partially tied to negative racial attitudes among White adults (and not reduced to other factors that may be correlated with race), and that Obama's close association with health reform and the ACA appears to correspond with and may partially explain the elevated relationship between racial

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resentment and attitudes toward health reform among White adults during Obama's tenure in office.

What this study seeks to contribute to the literature is twofold. First, the study evaluates public opinion on health care to assess if health care also became "racialized" among Black adults, in the sense that in-group identification led Black adults to become more supportive of health reform. Just as Obama's persistent, close association with health reform provided cues that activated negative racial attitudes among White individuals, Obama's association with the law and references to how Black Americans may benefit from the law, might have also activated in-group identification among Black adults. Second, I assess if health care opinion appears to become less racialized once a set of conditions that are "ripe for spillover" (Tesler 2012) are less salient in contemporary health reform. In particular, I assess if a new health care policy in the post-Obama era, which is, arguably, less tied to Obama as an actor, appears to have less of a racial divide than the ACA over the same time period.

DATA AND METHODS

The analysis contains two components. In the first component, I assess the relationship between opinion on health reform and race and racial attitudes using two nationally representative American National Election Study (ANES) surveys from 2012 and 2016. The 2012 ANES is a two-wave panel survey containing a pre- and post-election wave in the fall of 2012. The survey includes both face-to-face and online interviews. The 2016 ANES is a similar two-wave survey conducted before and after the 2016 presidential election. The analysis will include only respondents who identify as non-Hispanic White or identify as non-Hispanic Black. In addition, the primary outcome variable was asked in the pre-election wave, but because multiple covariates of interest are asked in the post-election waves, the sample will include only respondents who completed both waves. The resulting sample from 2012 includes 3275 White and 959 Black respondents, and the 2016 sample includes 2631 White and 343 Black respondents. The 2012 ANES had an oversample of Black/African American respondents. Because of this oversample, analyses of Black respondents in 2012 have greater statistical power than analyses from 2016. Analyses of both surveys apply ANES-provided sampling weights.

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The primary dependent variable in these analyses is respondents' favorability toward the ACA. This question was asked during the pre-election waves, only, in 2012 and 2016. The question wording was "Do you favor, oppose, or neither favor nor oppose the health care reform law passed in 2010? This law requires all Americans to buy health insurance and requires health insurance companies to accept everyone." Respondents were coded on a seven-point scale (scaled from 0 to 1) from 0 = "Oppose, a great deal" to 1 = "Favor, a great deal" with "Neither favor nor oppose"/Don't know as the midpoint of the scale.

The primary independent variables in the analysis are partisanship, race, and racial attitudes. The race measure *Black* versus *White* is a dichotomous indicator for whether a respondent identifies as Black (=1) or White (=0). The partisanship measure will rely on the traditional ANES seven-point branching question (scaled from 0 to 1), which classifies respondents from "Strong Democrats" to "Strong Republicans" with "pure" independents and unaffiliated respondents at the midpoint.

To assess racial attitudes among White respondents, the analysis will use a four-question racial resentment measure, scaled from 0 to 1 (see Supplementary Materials for question wording). To assess the strength of identity among Black respondents, I use a measure of linked fate and a measure of identity importance. The linked fate question is on a four-point scale (scaled from 0 to 1) based on the question, "Do you think that what happens generally to Black people in this country will have something to do with what happens in your life? Will it affect you a lot, some, or not very much?" The importance of being Black to identity wording is: "How important is being Black or African-American to your identity?" Responses are on a five-point scale (scaled from 0 to 1 from "Not at all important" to "Extremely important"). In addition to the primary independent variables, the multivariate regression analyses will adjust for several other political, socioeconomic, and health-related covariates described in the Results section.

The second component of the analysis compares public opinion on the ACA to public opinion on the AHCA, a short-lived Republican proposal on health reform in the summer of 2017. To do so, I evaluate three surveys from the Kaiser Family Foundation monthly tracking polls from May, June, and July 2017.[6] These are nationally representative telephone-interview surveys that track public opinion on health reform. The analyses in the results examine these three surveys separately and in a pooled analysis. Both the separate and pooled analyses use sampling weights provided by the Kaiser Family Foundation (KFF) (2017) to

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weight the data to be nationally representative. These weights were developed to make a single, cross-sectional survey representative, but due to the similarities in the samples over the short timeframe in 2017, I apply the same weights in the pooled analysis.[7]

In each of the three KFF polls, respondents were asked questions about both the ACA and the AHCA.[8] Favorability toward both the ACA and AHCA is asked on a five-point scale from "very unfavorable" to "very favorable." Those who indicate "don't know" are coded at the midpoint of the scale. The variables are rescaled from 0 to 1. For the analysis, the AHCA variable is reverse coded so that the stereotypical most Democratic or liberal position for both measures is "1" ("very favorable" for the ACA, and "very unfavorable" for the AHCA).

Like the analysis of the ANES surveys, the primary explanatory variables in this analysis are race (*Black* versus *White*, coded as 1 = Black, 0 = White) and partisanship. The KFF polls do not use the same seven-point branching question for partisanship. Instead, in these analyses, partisanship is on a more limited five-point scale with "pure" independents and unaffiliated respondents as the midpoint. The analyses will also adjust for several political and demographic covariates. However, these surveys do not include measures of racial attitudes, which means the KFF analyses are limited to assessing the racial gap in opinion on the ACA and AHCA and not differences within racial groups. Thus, the analyses using the ANES data from 2012 and 2016 provide more direct evidence on whether racial attitudes and strength of racial identity underlie health care attitudes.

RESULTS

The first analysis evaluates the racial divide in opinions on health reform. To do so, I examine the two cross-sections of data from the ANES (2012) and ANES (2016) in which respondents were asked both their opinions on the ACA and race-related questions. Tables 1 and 2 present the results of a regression of attitudes toward the ACA on race (*Black* versus *White*) and partisanship. In Table 1, the regressions include a 7-point scale for partisanship as a covariate (from 0 = Strong Democrat to 1 = Strong Republican). In columns 3–4, the analysis is subset to Democrats only, which means partisanship in the data only ranges from a stronger to weaker Democrat. The regressions presented in Table 2 add covariates for ideology, preference for big government,[9] region

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Table 1. Racial gap in opinion on ACA, 2012 and 2016

	2012 all respondents	2016 all respondents	2012 Democrats	2016 Democrats
Intercept	.778***	.739***	.772***	.754***
	(.012)	(.013)	(.012)	(.015)
Black vs. White	.075***	.098***	.054**	.040
	(.016)	(.026)	(.017)	(.025)
Partisanship	−.644***	−.603***	−.439***	−.469***
	(.016)	(.019)	(.060)	(.080)
Deviance	351.183	277.086	174.436	122.247
Dispersion	.083	.094	.082	.093
Num. obs.	4,212	2,957	2,127	1,319

Note: ANES 2012 and 2016. Weighted. ***$p < .001$, **$p < .01$.

Table 2. Racial gap in opinion on ACA, 2012 and 2016, with covariates

	2012 all respondents	2016 all respondents	2012 Democrats	2016 Democrats
Intercept	.662***	.543***	.627***	.523***
	(.041)	(.053)	(.050)	(.075)
Black vs. White	.077***	.104***	.095***	.105***
	(.018)	(.025)	(.020)	(.029)
Partisanship	−.386***	−.347***	−.369***	−.352***
	(.025)	(.027)	(.058)	(.075)
Controls included	Yes	Yes	Yes	Yes
Deviance	279.992	221.536	135.646	98.040
Dispersion	.070	.079	.067	.078
Num. obs.	4,016	2,803	2,028	1,257

Note: ANES 2012 and 2016. Weighted. ***$p < .001$.

(South or otherwise), homeownership, employment, political knowledge, age, income,[10] education, marital status, whether the respondent is a born again Christian, gender, overall health and ability to pay for health care costs, health insurance, and survey mode. (Full regression results for Table 2 are available in Supplementary Materials Table S1.)

In both 2012 and 2016, Black respondents hold significantly more favorable views toward the ACA as compared to White respondents. This is true among all respondents in analyses with (Table 2) and without

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(Table 1) full covariates, and true among Democrats only in 2012 in Table 1. The racial divide is significant when evaluating Democrats only in 2012 and 2016 in the analysis with covariates (Table 2). Partisanship is also consistently related to ACA views, with stronger Democrats more favorable of the ACA.

To examine if race-related attitudes underlie the relationship between race and views toward the ACA, I evaluate the relationship between racial resentment and White respondent attitudes on the law, as well as the extent to which strength of racial identity influences opinions among Black respondents.

Tables 3 and 4 first present regression results among White respondents only. Table 3 includes only partisanship and racial resentment as covariates. Table 4 adds the set of demographic and political covariates from Table 2. (See Supplementary Materials Table S2 for full regression results from Table 4.) Consistent with previous work on the spillover of racialization, the results show that controlling on ideology and partisanship among other covariates, racial resentment is a significant predictor of health care attitudes among White respondents. This holds true in analyses of both 2012 and 2016, and when evaluating attitudes among White Democrats, only. Ideology and preference for big government are also significantly related to views on the ACA, among other covariates.

In Tables 5 and 6, the analysis is applied to Black survey respondents, only. The tables present regressions of attitudes toward the ACA on the importance of Black identity and linked fate, along with partisanship. As with the previous analyses, regressions in Table 5 include a limited set of covariates, while Table 6 adds a set of covariates, including ideology and preference for big government (see Supplementary Materials Table S3 for full results).

The results in Tables 5 and 6 reveal that in 2012 and 2016, in the full sample of Black respondents, identity importance is significantly associated with support for the ACA. Black respondents who feel "being Black" is an important part of their identity tend to hold more favorable views of the ACA than Black respondents who place less importance on racial identity. The coefficient on identity importance remains positive among the sample of only Democrats, but the coefficient is not significant in the analyses with full covariates. These results could suggest that having a stronger attachment to racial identity is more influential for attitudes among those who are not already predisposed to support the ACA from their political predispositions (non-Democrats). However, the differences in the coefficients in the regression with all Black respondents versus

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Table 3. White respondent attitudes on the ACA, 2012 and 2016

	2012 all respondents	2016 all respondents	2012 Democrats	2016 Democrats
Intercept	.967***	.892***	.983***	.921***
	(.019)	(.015)	(.026)	(.016)
Partisanship	−.560***	−.492***	−.399***	−.385***
	(.019)	(.024)	(.070)	(.079)
Racial resentment	−.351***	−.363***	−.392***	−.431***
	(.031)	(.031)	(.046)	(.042)
Deviance	262.768	226.068	106.431	88.095
Dispersion	.081	.087	.082	.086
Num. obs.	3,254	2,603	1,292	1,029

Note: ANES 2012 and 2016. Weighted. ***$p < .001$.

Table 4. White respondent attitudes on the ACA, 2012 and 2016, with covariates

	2012 all respondents	2016 all respondents	2012 Democrats	2016 Democrats
Intercept	.794***	.671***	.763***	.636***
	(.048)	(.053)	(.064)	(.082)
Partisanship	−.344***	−.306***	−.336***	−.283***
	(.029)	(.032)	(.073)	(.083)
Racial resentment	−.218***	−.226***	−.239***	−.238***
	(.033)	(.034)	(.049)	(.050)
Ideology	−.315***	−.277***	−.222***	−.259***
	(.043)	(.044)	(.064)	(.060)
Pref. for big gov.	.186***	.204***	.112***	.119***
	(.019)	(.021)	(.031)	(.035)
Controls included	Yes	Yes	Yes	Yes
Deviance	215.894	190.507	84.988	75.785
Dispersion	.069	.077	.069	.077
Num. obs.	3,116	2,470	1,234	983

Note: ANES 2012 and 2016. Weighted. ***$p < .001$.

only Democrats are not statistically significant. In addition, the sample with only Democrats has fewer respondents and less statistical power.

In Table 6, preference for big government is also associated with support for the ACA. This aligns with Hutchings and Jefferson's (2014)

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Table 5. Black respondent attitudes on the ACA, 2012 and 2016

	2012 all respondents	2016 all respondents	2012 Democrats	2016 Democrats
Intercept	.701***	.554***	.718***	.663***
	(.051)	(.097)	(.053)	(.092)
Partisanship	−.405***	−.218*	−.251*	−.338*
	(.067)	(.094)	(.100)	(.167)
Linked fate	.021	.079	.014	.014
	(.032)	(.068)	(.032)	(.071)
Identity importance	.138*	.187*	.109·	.128
	(.055)	(.084)	(.061)	(.091)
Deviance	56.991	25.873	44.883	19.656
Dispersion	.062	.078	.056	.070
Num. obs.	920	333	809	280

Note: ANES 2012 and 2016. Weighted. ***$p < .001$, *$p < .05$, ·$p < .1$.

Table 6. Black respondent attitudes on the ACA, 2012 and 2016, with covariates

	2012 all respondents	2016 all respondents	2012 Democrats	2016 Democrats
Intercept	.628***	.317*	.649***	.556**
	(.094)	(.154)	(.106)	(.166)
Partisanship	−.318***	−.201*	−.255**	−.392*
	(.057)	(.084)	(.095)	(.163)
Linked fate	.006	.064	−.014	−.006
	(.030)	(.056)	(.031)	(.062)
Identity importance	.103*	.174*	.083	.129
	(.045)	(.072)	(.051)	(.083)
Ideology	−.091·	−.013	−.070	−.071
	(.049)	(.083)	(.052)	(.082)
Pref. for big gov.	.227***	.197**	.127**	.104·
	(.046)	(.057)	(.049)	(.056)
Controls included	Yes	Yes	Yes	Yes
Deviance	46.338	20.185	37.665	16.191
Dispersion	.053	.064	.049	.061
Num. obs.	874	318	774	267

Note: ANES 2012 and 2016. Weighted. ***$p < .001$, **$p < .01$, *$p < .05$, ·$p < .1$.

work that shows that preference for an active government can help explain Black political unity and complement explanations based on in-group identification. Linked fate has a smaller and non-significant relationship

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Table 7. Racial gap in attitudes toward AHCA versus ACA

	Model 1	Model 2	Model 3	Model 4
Intercept	.737***	.758***	.750***	.771***
	(.010)	(.019)	(.012)	(.020)
Black vs. White	.084***	.115***	.075***	.106***
	(.017)	(.017)	(.017)	(.017)
AHCA vs. ACA	.176***	.176***	.150***	.151***
	(.009)	(.009)	(.015)	(.014)
Partisanship	−.557***	−.458***	−.583***	−.482***
	(.011)	(.013)	(.016)	(.017)
Black (White) vs. AHCA (ACA)	−.125***	−.127***	−.106***	−.108***
	(.023)	(.023)	(.025)	(.024)
Partisanship × AHCA (ACA)			.050*	.048*
			(.022)	(.022)
Controls included	No	Yes	No	Yes
R^2	.371	.402	.371	.403
Adj. R^2	.370	.400	.371	.401
Num. obs.	5,730	5,696	5,730	5,696
RMSE	.277	.271	.277	.271

Note: KFF data from May, June, and July 2017. Weighted. ***$p < .001$, *$p < .05$.

with attitudes toward the ACA, which aligns with recent work that shows weak and inconsistent relationships between linked fate and attitudes and behavior (Gay et al. 2016). The results are similar in models that include only linked fate or identity importance, but not both (Tables S4–S7).[11]

PUBLIC OPINION ON HEALTH REFORM POST-OBAMA

Will the racial divide on health care continue in a post-Obama policy era? To answer this question, the final analysis compares public opinion of the ACA to the AHCA in the summer of 2017. The first set of analyses combine the three KFF surveys in regressions using survey fixed effects. To directly assess if the racial divide is significantly greater for the ACA than the AHCA, I append answers to both questions as the outcomes in a single regression where race (Black = 1 versus White = 0) is interacted with an indicator for whether the respondent's answer is to the ACA (=0) or AHCA (=1) question. (Respondents were asked both questions.)

Table 7 presents the regression results. Model 1 includes a limited set of covariates, while Model 2 adds covariates for health insurance, gender,

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income, age, education, employment status, ideology, and health. (See full results for Table 7 in Supplementary Materials Table S9.) First, examining the "main effects" of the Black versus White coefficient, consistent with the ANES analyses, the results show that Black survey respondents hold significantly more positive views toward the ACA than White respondents, controlling on partisanship and other factors.

Moving to the comparison of the ACA and AHCA, the interaction between race and health policy measure is negative and significant. Recall, AHCA favorability is reverse coded, such that higher values for both the ACA and AHCA indicate support for the stereotypical liberal, Democratic position on the issue. To help interpret the interaction results, Figure 2 displays the estimated attitudes toward health reform from Model 1 for four types of respondents: where the covariates are set to a Democrat in the analysis who is Black or White and answering the question about the ACA or AHCA. Black survey respondents are significantly more supportive of the ACA than White respondents. In contrast, White survey respondents hold more unfavorable views of the AHCA than Black respondents. Thus, while Black respondents hold views more stereotypical of liberals and Democrats on the ACA, this does not hold for the AHCA, where the racial gap is smaller overall and in the opposite ideological direction.

One reason the racial gap may be smaller for the AHCA is that it was a new policy proposal, that was generally less popular, and about which the public had little information and few elite cues. Thus, individuals might not have known how to map predispositions onto their preferences on the AHCA in the same way that they do for the ACA. To assess this possibility, I evaluate the association of another more stable consideration—partisanship—with the ACA versus the AHCA by interacting partisanship with the indicator for whether the response is to the ACA or AHCA in regressions presented in Table 7, columns 3 and 4.

The results show that partisanship is consistently a strong, and significant predictor of support on the ACA (interpreting the main effect of partisanship). Going from a Democrat to a Republican is associated with about a 60-percentage-point shift in ACA support in Model 3 and nearly a 50-percentage-point shift in support in Model 4 (which includes additional covariates). The results do reveal a significantly weaker partisan gap on the AHCA relative to the ACA—5 percentage points less of a partisan gap on the AHCA in Models 3 and 4. Thus, another predisposition shows a diminished association with the AHCA compared to the ACA. However, this represents a 10% reduction of the relationship between

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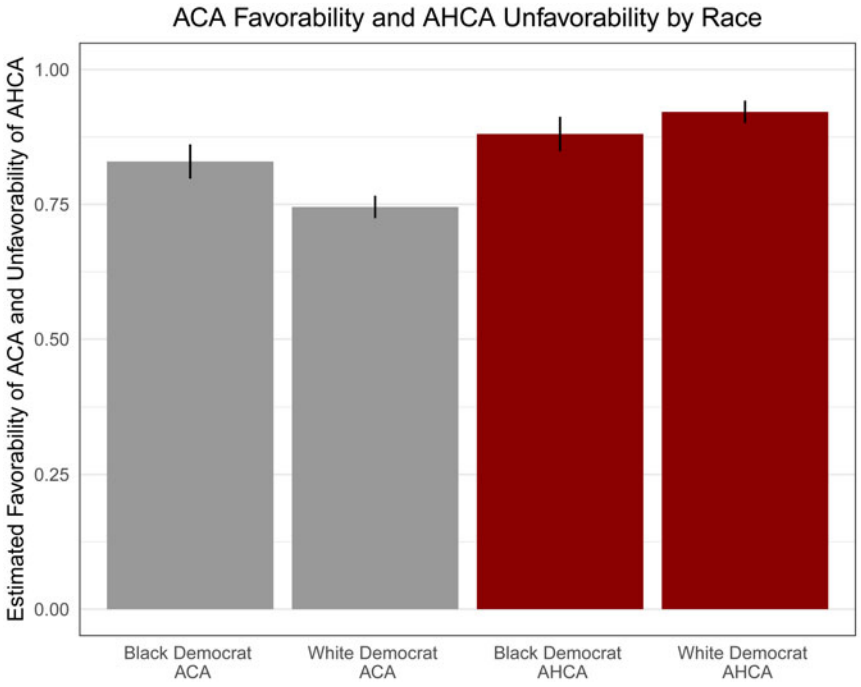

FIGURE 2. Favorability on the ACA and unfavorability on the AHCA by race.
Note: KFF data from May, June, and July 2017. Estimates and 95% confidence intervals based on regressions in Model 1 of Table 7. Month of survey fixed to June 2017 for estimated values.

partisanship and health care attitudes. In contrast, the racial gap on the ACA is generally negated on the AHCA.[12]

The last results disaggregate the data by survey month and health policy measure. Figure 3 displays the coefficient for race (Black versus White) and 95% confidence intervals from regressions of health care views on race and the set of covariates from Table 7, column 2. The separate regression analyses reduce the statistical power to detect significant differences in the relationship between race and health care views on the ACA and AHCA, but will help reveal if the patterns vary greatly across surveys. As Figure 3 shows, the differences between the coefficients on race for the ACA and AHCA are largest in July 2017, but the overall pattern is consistent across surveys. The results show that the racial divide for the ACA is positive (suggesting greater support among Black respondents) for each survey and significantly different from zero in June and July 2017 at the $p < .05$ level. In contrast, the coefficient on race for the AHCA is generally smaller and is not distinguishable from zero in each survey.

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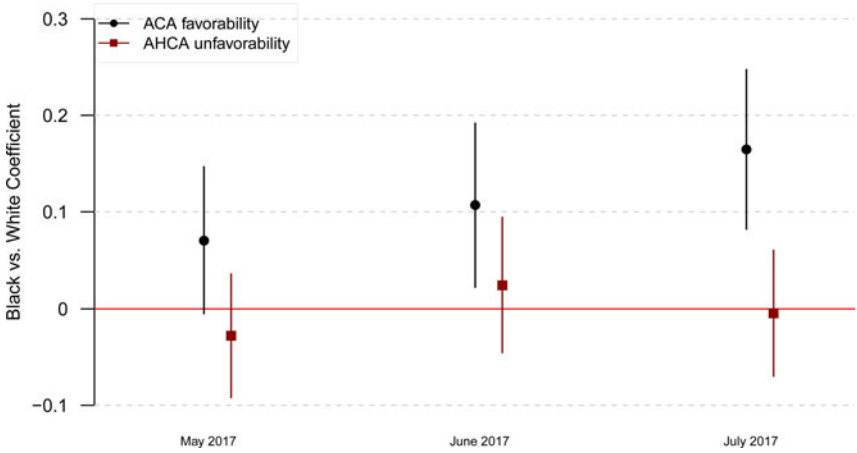

FIGURE 3. Racial differences in ACA and AHCA opinion by survey.
Note: KFF data from May, June, and July 2017. Figure displays coefficient estimates for Black versus White and 95% confidence intervals from separate regressions of ACA favorability and AHCA unfavorability on race (Black versus White) and covariates.

CONCLUSION

The findings of this study first highlight the importance of accounting for public opinion among both Black and White respondents in analyses of race-related considerations on public policy. Using ANES data from 2012 and 2016 and KFF data from 2017, the results show a persistent racial divide on opinion towards the ACA, where Black adults are more supportive of the law than White adults. Consistent with previous work, racial resentment among White respondents is significantly associated with lower support of the ACA. However, the study shows that race-related considerations may also have been activated among Black survey respondents, leading to greater support of the ACA. In the 2012 and 2016 ANES, identity importance among Black respondents was significantly associated with support of the ACA.

The results from the ANES analyses provide evidence that both racial resentment among White respondents and identity importance among Black respondents have been associated with favorability toward the ACA. That said, it is not necessarily the case that these factors have influence of equal magnitude. Going from low to high values of racial resentment typically had a somewhat larger negative association with ACA favorability among White respondents than going from low to higher values of identity importance among Black respondents. Still, analyses

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of the racial divide in public opinion should not neglect strength of in-group identity, as these results show that it may contribute to at least some part of the difference in attitudes between racial groups.

These findings have implications for understanding how public opinion may shift on political issues in the post-Obama era. If policies become less connected to Obama as a leader, the results suggest that the racial gap in opinion on those political issues may narrow, holding other considerations equal. As initial evidence, the KFF data show a weaker racial divide on the Republican-led health care effort in 2017 as compared to the ACA over the same time period. Though the data cannot directly speak to this possibility, the results from the ANES would suggest that a change in the racial divide on an issue may be a result of less support of Republican policies among White voters in the absence of racialized spillover, and potentially less opposition among Black voters.

It is important to emphasize that results which suggest a reduced role for racialized spillover on health care in a post-Obama era do not say anything about the level of racial animus in society. In fact, the results underscore the unique barriers that Black elected leaders may face from White voters when trying to advance a policy agenda. The absence of a racial divide on the recent Republican-led health care effort helps to reinforce work that argues that the racial divide on the ACA can be traced, in part, to negative racial attitudes among White voters as Obama emerged as a face of health care reform (Tesler 2016; Henderson and Hillygus 2011; Knowles et al. 2010; Maxwell and Shields 2014). Moreover, if rhetoric surrounding future legislation provides implicit or explicit racial cues, then a racial gap in opinion might still emerge on non-ACA health policies. Enders and Scott (2019) argue that opinion on non-racial issues has become more racialized among White adults since 1988 and cannot be reduced to an effect of the Obama era. President Obama's race might have provided a source cue that activated racial animus, but the authors point out that Obama's tenure was a "component" of a long-term trend in the relationship between racial attitudes and political opinions and behavior. In a society where negative racial attitudes are prevalent, the use of cues that activate these attitudes may continue to influence public opinion on a range of policy areas even in a post-Obama period.

SUPPLEMENTARY MATERIAL

The supplementary material for this article can be found at https://doi.org/10.1017/rep.2019.20

NOTES

1. The transcript for the February debate is available at: "The Democratic Debate in Cleveland." The *New York Times*. http://www.nytimes.com/2008/02/26/us/politics/26text-debate.html

2. The speech transcript is available at: "Barack Obama's Speech on Race." *The New York Times*. http://www.nytimes.com/2008/03/18/us/politics/18text-obama.html

3. The 2008 NAES is a telephone survey that contains a rolling cross-section beginning in December 2007 and asked the health care question throughout the primary campaign.

4. The response options generally reflect the preferences of the partisan elites at the time. During the 2008 campaign, both Obama and Clinton, among other Democratic candidates, spoke about increasing the government's role in health care to expand the number of people insured, reaching the ideal of universal coverage, and providing a public insurance option. Republican candidates advocated for improving the health care system within the private market. The figure focuses on Democrats only, because these events occurred during the course of the Democratic primary.

5. It is not possible to distinguish whether this divergence is due to the leaking of the Reverend Wright tapes on March 13th, the speech, or coverage of the speech on March 18th. This analysis is not meant to show that racial divisions emerged and persisted over time as an effect of this speech, but rather, point to moments very early in Obama's campaign where public opinion on non-race-related policies appears to respond to Obama's association with the policy.

6. The May survey includes 835 White and 144 Black respondents. The June survey includes 830 White and 130 Black respondents, and the July survey includes 794 White and 132 Black respondents.

7. Descriptive statistics for the KFF surveys are available in Supplementary Materials Table S8.

8. The ACA question wording is: "As you may know a health reform bill was signed into law in 2010, known commonly as the Affordable Care Act or Obamacare. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?" The AHCA question wording is: "As you may know, Congress is currently discussing a health care plan that would repeal and replace the Affordable Care Act. Given what you know about this proposed new health care plan, do you have a generally favorable or generally unfavorable opinion of it?"

9. See Supplementary Materials for the three questions that comprise this scale.

10. The income measure in the ANES contains 5–10% missing data across samples. To account for this, I impute values for income using the "hot deck" method with covariates for region, homeownership, employment, age, education, marital status, born again Christian, gender, and health and health insurance. Listwise deletion is used for all other covariates, which have minimal missing data. A similar "hot deck" procedure is used in the KFF data with the available covariates.

11. These supplementary analyses were conducted to assess potential multicollinearity issues. When identity importance is not included in the regression models, linked fate remains weakly related to ACA attitudes. In models in which linked fate is not included, identity importance continues to be a significant predictor of ACA attitudes in models with all Black respondents.

12. There is 9 percentage points less of a partisan gap in unweighted regressions presented in Table S10, representing a 17% reduction in the effect of partisanship.

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