The Revealing Case of the Affordable Care Act

The Affordable Care Act (ACA) presents a remarkably useful case study for examining the broader dynamics of GOP antipathy to redistribution. *NFIB v. Sebelius* (an unanticipated Supreme Court ruling in 2012) generated something of a natural experiment. States suddenly needed to decide whether to expand Medicaid enrollment. The expansion would have been supported by heavy subsidies from the federal government. Because the program would have largely benefitted low-income residents, the ensuing political dynamics were highly suggestive.

As written, the ACA was extremely redistributive toward heavily Republican "red" states. These states pay considerably lower federal taxes per capita. They pay an even lower share of the main tax sources for ACA expansion, which targeted affluent Americans. Even more important, low-income households are far more prevalent in red states (and especially Southern states), and existing Medicaid rules there were far more restrictive. Therefore, these states stood to receive huge inflows of money from the ACA's Medicaid expansion as well as its income-tested subsidies for private insurance. The Supreme Court's controversial decision on the ACA—ironically relying on five Republican appointees for its majority—gave states the option of rejecting Medicaid expansion. This development unexpectedly jeopardized much of that massive redistribution from Democratic "blue" states to red states.

It is difficult to exaggerate what a bad deal this new option is for the states. The individual states were being asked to make a very modest contribution to Medicaid expansion—in return, they would get a huge flow of resources. Moreover, much of the expected inflow would go not just to low-income households that would now hold insurance, but also—through that insurance—to health-care providers, including hospitals, which will be financially squeezed in the absence of these anticipated resources.

Despite these extremely powerful financial incentives, as of 2014, 24 states had rejected Medicaid expansion. The list of rejectionists included almost all the states that stood to gain the most financially. Acceptance would not only provide insurance coverage for more than 7 million people. It would also bring in an estimated $423 billion in federal funding over a decade, providing almost $170 billion in reimbursements to hospitals as well as increased state employment. Even though states would have to modestly increase Medicaid expenditures (one dollar for every 13.4 contributed by the federal government) the *net* effect on state budgets would have been positive (Dorn, McGrath, and Holahan 2014).

This opposition has been concentrated in the old states of the confederacy, only one of which (Arkansas) has accepted Medicaid expansion. Of course, there is a long history of Southern ambivalence about national redistributive programs. Substantial research has suggested the significance of racial antipathies in driving that resistance (Lieberman 2001). Yet even against that historical backdrop, the political opposition within red states to the ACA is stunning. While racism and the desire to sustain the Jim Crow racial order played a considerable role in the history of Southern resistance to the welfare state, a reasonable politico-economic logic was at work. Social policies like Aid to Families with Dependent Children, Social Security, or a higher minimum wage threatened to increase the reservation wage of the poor—that is, the lowest wage at which they would be willing to accept a

particular job. About the early 1970s proposal for a national minimum income, Louisiana senator Russell Long famously complained: "I can't get anyone to iron my shirts." Raising the reservation wage in low-wage states would make it harder for businesses in those states to gain a competitive advantage.

Yet this logic of wage competition hardly applies to the ACA. Providing access to health insurance is unlikely to have much impact on reservation wages. How do we explain why states like Texas, South Carolina, and Mississippi would turn down improved access to health care for millions of their residents as well as tens of billions of dollars for local hospitals and health-care providers, all paid for by taxpayers from other states? Indeed, it is hard to find a parallel, either historically or comparatively, for the current refusal of poor states to accept such a favorably-structured influx of funding. The puzzle is underscored by the presence of politically influential concentrated interests (doctors, hospitals, insurance companies) that have a large financial stake in expansion as well as substantial organizational capacity to make sure policymakers hear their concerns (Hertel-Fernandez and Skocpol 2016).

Understood as a matter of color-blind political economy, that refusal makes little sense. It is, however, consistent with an account that stresses the highly racialized politics in ACA-rejecting states. Even among red states, the most intense opposition to the ACA has been concentrated in areas with a large minority population.[3] States that are "red" but have smaller minority populations, such as Montana, Wyoming, Utah, and Indiana, have been much more likely to accept or at least seriously consider Medicaid expansion. In the states of the old confederacy, the Republican Party is an overwhelmingly white party, voting is more polarized on racial lines than it is in the rest of the country, and the parties have become increasingly racially polarized in recent years (Stewart, Persily, and Ansolabehere 2013). In the new political economy of many red states, subsidies perceived to benefit "other people" may be intrinsically objectionable. These sentiments may carry the day, even if millions of lower-income whites in the region would benefit directly from the program, and the entire state would gain from the fiscal flows that would accompany Medicaid expansion.

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Public opinion research supports the possibility that racial frames are fueling political resistance to the ACA (Tesler 2012). Racial antipathy seems to play a significant role in evaluation of the program, reinforced by the identification of health-care reform with President Obama. As Tesler argues, there is now strong evidence that if policies can be identified with particular groups, voters may transfer their evaluation of the groups to the policies. This can be true even if the actual association of the group with the policy is tenuous at best. The racial divide on health-care reform is not only far greater today than it was with Clinton's proposals in the 1990s; whites are more hostile to the *same* described proposal when it is attributed to Obama rather than Clinton.

CONCLUSION: RACE AND TOP-END INEQUALITY

Critics (e.g., the Soss and Weaver contribution to this taskforce) are correct. Investigations of rising inequality have too often downplayed the significance of racial divisions. In this brief analysis, I have sketched out two of the pathways through which racially grounded conflict very likely contributed to the startling shift of income to a relatively small cluster of very affluent Americans. Both pathways work through the GOP, whose sharp rightward movement on economic issues has been a key contributor to rising top-end inequality.

Evidence concerning the first pathway—race as a key driver of political realignment, consolidating the nation's most conservative elements in a single party—is strong. Evidence on the second pathway—racial antipathies as a key feature expanding the electoral base (and hence the political practicality) for extremely antiredistributionist policy stances in the GOP—is more circumstantial.

Indeed, the nature of dog-whistle politics may mean that such evidence is necessarily circumstantial—that the alternative hypothesis is essentially unfalsifiable. It will almost always be possible to posit "ideological" rather than racially grounded rationales for opposition to particular policies—even if those ideological positions are riddled with inconsistencies.

12 Nonetheless, the circumstantial evidence available is considerable. Much of it is grounded in behavioral research that has used innovative techniques to highlight the presence of racial antipathies in conservative white electorates, especially in the South. In this chapter I have sought first to draw a plausible connection between these sentiments and support within the GOP (including among those on relatively low incomes) for a "Randian" stance toward redistribution that is largely absent from partisan politics outside the United States. Second, I have deployed policy-grounded evidence derived from the case of the ACA's Medicaid expansion rules, post *NFIB v. Sebelius*. Comparative evidence bolsters the case for racial antipathy playing a role. I am unaware of any prior example of a poor region rejecting such huge transfers when they are packaged in a way that would not significantly raise reservation wages. ▪

NOTES

1. Including my work with Jacob Hacker (Hacker and Pierson 2010).
2. Of course such stances need not be philosophically consistent. Indeed, despite the popularity of such rhetoric in "red" states, those states actually contribute far less in federal taxes than they take out in benefits, while the reverse is true of "blue" states (Lacy 2009).
3. In this respect resistance to Medicaid expansion parallels recent GOP-led efforts to raise hurdles to voting. A recent study found evidence that these restrictions "are highly partisan, strategic, and racialized affairs." All other things being equal, new restrictions became considerably more likely where there was a large minority population, where minority turnout had increased, and where Republicans control legislatures. These findings, the authors conclude, "are consistent with a scenario in which the targeted demobilization of minority voters and African Americans is a central driver of legislative developments" (Bentele and O'Brien 2013).

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