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WORLDS APART: THE IMPACT OF CULTURAL WORLDVIEW ON THE POLICY PREFERENCES OF THE RICH AND POOR

A DISSERTATION APPROVED FOR THE
DEPARTMENT OF POLITICAL SCIENCE

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Abstract

In March 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law amid mixed reviews from the public. The primary research question for this dissertation is: what explains the public's level of support for the ACA? Extant literature on preference formation on complex issues points to the persuasiveness of political elites such as party leaders and policy entrepreneurs (Moore 1987; Delli Carpini and Keeter 1996, Jacobs and Shapiro 2000, Bartels 2005, Jacobs and Mettler 2011) and the way media frames the issues (Iyengar and Kinder 1987, Iyengar 1990 and 1991, Gilens 2000, Kellstedt 2000, Edy and Meirick 2007). Also important is the impact of political knowledge and sophistication (Brady and Sniderman 1985, Lupia 1994, Bartels 2008, Jerit 2009) and the role incomplete information plays in decision making (Simon 1965, Meltzer and Richard 1981, Jones and Baumgartner 2005). Social constructionists posit that a person's mental construction an issue plays an important role in preference formation (Berger and Luckmann 1966, Conrad and Barker 2010). I analyzed preferences regarding the ACA using Cultural Theory, a framework that measures ideological values on two dimensions rather than the typical unidimensional *left-right* model of ideology. My results indicate cultural worldview is the strongest predictor of opinions on more complex questions related to the ACA in which the individual has little factual knowledge. It is not as useful a tool for questions on issues for which the social construction of important elements in the questions supersede the individuals' ideological values as measured by Cultural Theory. The results reveal some important limitations of the theory with respect to highly complex political issues.

Chapter 1: Introduction

The economic problems experienced over the last decade have presented the country with numerous challenges, particularly with regards to an important area of public life – health care. Although substantial reforms to the health care system have been made over the years, the 2010 Affordable Care Act (ACA) presents the most comprehensive changes since Medicare and Medicaid became law in 1965. For all of the effort political elites have put into campaigning for or against the ACA's provisions, the public knows remarkably little about how the law affects them personally but knows enough to express an opinion about it anyway. This dissertation investigates the factors that contributed to opinion formation on the ACA and four other health care-related issues. I analyzed preferences regarding these policies using Cultural Theory, a theoretical framework that measures ideological values on two cross-cutting dimensions rather than the typical unidimensional *left-right* measurement of ideology. I hypothesized that cultural worldview would be more predictive of preference formation than other variables and the results confirmed my suppositions on the more abstract issues for which the individual has very little factual knowledge.

There is an extensive literature base on public opinion that offers several theories for how the public develop opinions on the important issues of the day. Perhaps the most familiar explanation is that partisanship is the determining factor in preference formation (Campbell et al. 1960, Iyengar 1991, Zaller 1992, Carsey and Layman 2006, Jacobs and Mettler 2011). When party elites are unified in their position on an issue, the public should have no difficulty in forming an opinion that matches their party identification. However, what happens when a party's elites are split and an individual must choose between divergent positions? In the summer of 2017, despite

having the majority, Senate Republicans were unable to pass legislation dismantling the ACA because of three recalcitrant Republican Senators who could not be persuaded to vote yea (Parlapiano, Andrews, Lee, and Shorey 2017). Surveys also typically ask respondents to identify as Democrat, Republican or independent (or no party). The increase in independent voters (Gaddie and Goidel 2017) must impact the results of studies that use party identification as a key variable. In light of these facts, party identification may not always be the best predictor of preference formation.

Media influences public opinion by highlighting some aspects of an issue and ignoring others. The media is then able to establish the context within which the public formulates opinions but those opinions are conditioned by an individual's experiences (Delli Carpini and Keeter 1996) and his political values and interest in politics (Zaller 1992). Expert commentary on the issues increases the gap in knowledge between people with low socio-economic status and their more fortunate counterparts but when the media offers historical, social and political information surrounding an issue in order to provide some context, the differences between high and low-income groups decreases (Jerit 2009). It may not be necessary to know all the details about a policy in order to form an opinion (Meltzer and Richard 1981; Iyengar and Kinder 1987). Preferences are rational in that the person makes the best decision he can depending on what he knows (Simon 1965) and depending on the information received from his social connections (Huckfeldt and Sprague 1995). Information presented by the media is weighted by individuals in terms of their experiences and core values (Jones and Baumgartner 2005). In other words, even if the media does its best to provide unbiased,

objective information, the person receiving the information cannot help but be biased. What is the source of that bias and how does it influence opinion formation?

One explanation for why public opinion changes over time is the public *mood* with regard to liberal and conservative policy prescriptions (Erikson, MacKuen, and Stimson 2002). Erikson and his colleagues theorized that liberal policies lead to lower demand for left-of-center ideas and the public makes a conservative swing in response and vice versa (2002). However, political ideology as a predictive variable has its limitations (Feldman 1988). Terms like *liberal* and *conservative* mean different things to different people so a scale asking a respondent to identify as strongly liberal to moderate to strongly conservative may not be the best measure of core values. Where exactly is the middle of the road? What does *liberal* mean? It might mean socially permissive to personally modest survey respondents, in which case they might identify themselves as leaning towards conservatism when that label does not accurately reflect public opinion.

Positivism holds that reality is clear, absolute and independent of an individual's knowledge and experience (Marsh and Smith 2001). I interpret this theory in terms of the ACA thusly: First, I assume health insurance coverage, as a general concept, is a desirable thing. The ACA's regulations increase the opportunity to purchase affordable health insurance and it expands Medicaid in order to cover people; therefore, a person should have a favorable opinion of the ACA because more people will be covered with health insurance (which is demonstrably true). Social constructionists, on the other hand, posit that an individual's construction of an issue is based on his interpretation of reality. His experiences and his ideological values combine to form his own version of

reality in his mind and his preferences are based on that interpretation of reality (Berger and Luckmann 1966). For example, if a conservative Republican survey respondent hears the words 'Affordable Care Act' and immediately associates the ACA with liberal Democrats, loss of insurance coverage, and skyrocketing insurance premiums, he will not have a favorable opinion of the ACA. Even though empirical evidence shows that millions more Americans have health insurance and premium increases have slowed since the ACA's implementation, *reality* for these individuals is independent of factual knowledge. The same can be said for the way ideologically liberal individuals interpret reality.

Wildavsky (1987) hypothesized that an individual's cultural bias has more of an impact on preference formation than political ideology which other scholars confirmed (Kahan et al. 2007A and 2007B). Four distinct cultural worldviews are identified based on the extent to which a person feels their life is defined by group membership and by the degree of authority a person believes those groups should have (Thompson, Ellis, and Wildavsky 1990). Just as individuals on the left and right of the ideological spectrum float between the poles depending on the strength of their attachment to an issue, these four cultural worldviews also wander from their *location* in theoretical space. Cultural Theory has been applied in studies on environmental concern (Song et al. 2012), Supreme Court decision-making (Kahan 2011), nuclear weapons and terrorism (Ripberger, Jenkins-Smith, and Herron 2011), childhood vaccination policy (Song, Silva and Jenkins-Smith 2014) and risk perception (Kahan et al. 2007A and 2007B). This study adds to the existing scholarship by using Cultural Theory to study preference formation for present and future health care legislation.

One of the core tenets of Cultural Theory is that a person's worldview begins to form early in life and is shaped by his life experiences leading to adulthood. It endures over time, should change only as a response to a crisis (e.g. a serious illness) and is not issue-dependent. Did the recession in the previous decade (NBER.org 2017) and the subsequent slow recovery, the rising cost of health care, and the difficulty of securing health insurance at an affordable price influence some individuals, normally ideologically inclined to oppose legislation like the ACA, to change their minds? An individual's cultural worldview is the lens through which he judges his environment and experiences so he can form opinions. It is unavoidably a biased lens and although his views may seem inexplicable to others, they are completely rational to him and therefore, using a simple Likert scale to judge political ideology on a *left-right* continuum may not be particularly helpful in trying to understand how a person can hold seemingly contradicting viewpoints at the same time. Since Cultural Theory measures ideological beliefs on two cross-cutting continuums it is a much better explanatory tool for opinions on complex issues.

Using Cultural Theory helps untangle the differences between those who maintain their cultural worldview's principles yet still approve or disapprove of the legislation and those whose cultural worldviews shifted to another designation. If we can determine what causes a shift between cultural worldviews, political scientists can make better predictions about the public's preferences for future health care legislation as well as other controversial political issues and most importantly, the impact on the electoral process.

I used an empirical study using quantitative methods to analyze which factors were present among people aged 18 to 64 in eight geographically, economically, culturally and politically diverse states to determine public opinion about the adoption of the ACA. Data were collected using anonymous telephone surveys and analyzed using SPSS software. By comparing and contrasting these states' characteristics, including important variables such as cultural worldviews, voting patterns, immigrant populations, knowledge levels, overall health status, percentage of uninsured, unemployment rates, job gains and job losses, we can generalize the results of the study to the rest of the country and perhaps gain some insight into the long-term stability and success of the ACA.

Chapter Two of this dissertation explores the large body of literature on belief systems, ideologies and the origin of preferences which tells us that preferences derive from an individual's cultural worldview (Thompson et al. 1990; Douglas 1970), or their deepest core values (Sabatier and Weible 2007; Kahan et al. 2007) both of which are relatively enduring over time and highly resistant to change. If the theory that a belief system drives preference formation with respect to democratic notions of liberty, equality and distributive justice (Sabatier and Jenkins-Smith 1993), then I should also be able to explain why, in the face of rising income inequality, some income individuals still prefer fewer government interventions that might lift them out of poverty (Frank 2004; Kelly and Enns 2010; Hochschild 1981). The traditional *left-right* continuum of liberal to conservative does not adequately describe someone's ideological point of view although there is a moderate correlation between cultural worldviews and political ideology (Petty 2018; Coughlin and Lockhart 1998).

Hochschild (1981) found that the disadvantaged are often ambivalent about their feelings – they resent people's wealth but respect their ability to earn it and they are angered by welfare fraud but understand why it happens. By differentiating individuals by belief system, we can determine the mix of majority and minority points of view rather than report our results by stating "the lowest income category holds a preference for *Policy X*". The problem is not that these types of statements are untruthful; it is that they are incomplete with respect to public opinion.

"Risk perceptions don't dictate values" – an individual's cultural worldview "will likely influence him or her to construe ambiguous pieces of evidence in a way that fits those conclusions about risk" (Kahan 2008). We will protect our decision-making processes in order to maintain some degree of comfort (Kahan et al. 2007); therefore, a poor individual's preferences may appear to be incongruent with his low socio-economic status, but could be more readily explained if we take his cultural worldview into account. Even in the face of a severe medical condition that overwhelms the family finances, individuals will try to avoid cognitive dissonance by viewing their circumstances through an ideologically biased lens. Belief systems being to form long before we ever amass great fortunes or become mired in poverty so the idea that a change in our financial circumstances would drastically alter our more profound core values seems false if one of the key tenets of Cultural Theory holds. Nevertheless, it also seems reasonable to ask if there are some life-altering events that are so devastating (i.e. serious illness or injury) they change who we are and what we believe about the world. The chapter concludes with a discussion of the advantages and disadvantages of Cultural Theory as an explanatory tool for preference formation.

The concept of income inequality in American society is the subject of Chapter Three. My supposition in this study is that a person's income alone level is not the main driver of preferences for the ACA; however it is still very important. Research indicates that people in the lower income category have had higher approval ratings of the ACA since its adoption (KFF.org 2018) and that should not come as a surprise. The interesting thing about these polls is that the percentage of lower income respondents who disapprove of the ACA is still quite high and approval ratings have varied widely since polling began shortly after the law was adopted. Results for respondents in the middle- and high-income categories have been more consistent.

One reason for focusing on health with respect to income is that researchers often use health status as a class identifier (Deaton 2003; Auguste, Laboissiere, and Mendonca, 2009). Although relying on common sense and experience is an inadequate substitute for real data, we can make some general assumptions about the effects of being in a higher socio-economic category. It stands to reason that wealthier individuals are more likely to move in higher social circles and marry similarly-situated partners, are less likely to be substance abusers and use tobacco products, and less likely to be significantly overweight thus maintaining their fortunate place in society. Healthier individuals not only live longer they tend to be better educated and are financially secure (Deaton 2003; Auguste, Laboissiere, and Mendonca, 2009). Medicaid, a health care program jointly funded by the federal government and the states, is designed to protect eligible low-income adults, pregnant women and children plus elders and disabled persons and thus, mitigate the impact of not having enough money to pay for health care. Although the opportunities for preventative and life-

saving health care should increase a recipient's overall standard of living, it must be acknowledged that poor people, in the aggregate, make risky lifestyle choices such as the decision to smoke cigarettes, being sedentary, as well as being overweight or obese and that accounts for a higher mortality rate compared to the higher socio-economic status groups.

The circumstances surrounding the passage and implementation of the Affordable Care Act and the ensuing challenges faced by patients, insurance companies, states and the federal government are discussed in Chapter Four. The preferences of the respondents in this study reflect the results of national polls regarding the ACA, that is, most disapproved of its adoption. Although overall public opinion on the idea of *free health care for everyone* has been negative over the decades, a Pew Research Center poll in June 2017 showed a shift in attitudes (Kiley 2017) while a poll taken in September 2017 revealed an increase in approval for a single-payer option (Savransky 2017A). There has been a dedicated contingent of activists who have supported universal health care since the Progressive Era but they have never been able to convince the United States Congress to go beyond Medicaid for the poor and Medicare for the elderly. Several theories have been offered to explain why a majority of the public has not demanded universal health care and why Congress has not taken advantage of opportunities to at least offer a single-payer option for Americans who prefer that route. Those explanations are discussed in Chapter Four.

Chapter Five introduces the data, variables, and measures and for the quantitative study. The data were collected via a telephone survey conducted by the University of Oklahoma Public Opinion Learning Lab (OUPOLL) between October 30,

2013 and March 6, 2014. Linear regression analysis was used for all models. The key dependent variables were approval (measured on a seven-point Likert scale) of five different redistributive policies with respect to health care – approval of the ACA, approval of expanding Medicaid to more low-income families, lowering the age for Medicare to 55 so more people can qualify, covering undocumented immigrants with basic health care, and approval of raising taxes on high-income individuals to fund the ACA. Respondents were asked if they had always had the same opinions or if their opinions changed and if so, when did the change occur.

I used typical demographic variables (age, race, gender, income, education, marital status, and minor children) and other indicators helpful for the study – health insurance coverage, health and disability status, ideology, political party, and loyal party voter. I hypothesized that income level would not be as significant a factor as cultural worldview but I expected some economic indicators to be predictive. Employment status, the occurrence of a job loss or pay cut, and whether or not the respondent lives in a union state were included. To determine if respondents' knowledge level of basic political facts affected their approval of the ACA and related issues, respondents answered five questions and the answers were used to build the Knowledge Index. The four cultural worldview designations were determined by responses to a battery of ideological statements. Factor analysis showed these responses loaded into four categories – the cultural worldviews.

Chapter Six shows hypotheses and regression results for the quantitative study. Because politicians and policy experts have focused on the cost of health care and health insurance as being out of reach for too many Americans (hence the need for the

Affordable Care Act) I wondered how significant a person's income level would be in predicting opinions for the legislation. I hypothesized that a person's cultural worldview, rather than income level, would be the determining factor in the approval or disapproval of five health care-related policies: the ACA itself, the expansion of Medicaid, a tax increase on high-income individuals to fund the ACA, health coverage for undocumented immigrants, and lowering the age to qualify for Medicare. A person's income level may not be as significant a factor in preference formation as politicians seem to think it is if their campaign rhetoric is any indication; however, the results of the tests for increasing income taxes to fund the ACA and expanding Medicaid is a strong indicator that Cultural Theory may be better at predicting preferences for abstract concepts that people know very little about. Cultural Theory may not predict as strongly for questions regarding a tax increase which takes real, not abstract, money out of a person's pocket. The Medicaid program, which is very closely associated with race, is also a topic that may uncover latent bigotry that the income variable uncovers when cultural worldview does not. Other independent variables like partisan identification and ideology are important factors but not as explanatory as cultural worldview. Variables such as one's economic outlook for the future, being unemployed, having experienced a job loss or pay cut, living in a union state and being woman with minor children have a strong impact on policy preferences.

The quantitative study's findings are discussed in Chapter Seven. The hypotheses for ACA approval, health coverage for illegal or undocumented immigrants, and lowering the age for Medicare qualification were confirmed – cultural worldview was a stronger predictor of approval than income level and other variables. The

hypotheses that tested approval for increasing taxes to fund the ACA and for expanding Medicaid were not confirmed – income was the stronger predictor. Cultural Theory implies that our worldview is not issue-dependent but I believe the results of these two hypothesis tests reveal there is reason to question that tenet. There is also reason to believe that income is correlated with certain cultural worldview designations because, although our worldviews form early in life, they are also conditioned by our life experiences over time. The link between income and cultural worldview is discussed further in Chapter Seven.

Chapter Eight features the qualitative portion of the study. Thirty-six individuals were interviewed between April 15, 2014 and July 11, 2017. Each respondent completed a questionnaire similar to the telephone survey's section on political knowledge and cultural worldview statements. The purpose of the interviews was to gather information of a more personal type such as family history, family culture, social class and health care experience (i.e. illnesses). Respondents elaborated on their reasons for their opinions on the ACA and health care in general. The respondents lived in the Oklahoma City and Dallas areas and were chosen on the basis of how they fit into a representative group of individuals as I could get considering they were not chosen randomly. The qualitative sample is not representative of the country but it is somewhat representative of red states that have not been particularly optimistic about the ACA.

The Conclusion appears in Chapter Nine. As of late 2017, it has only been a couple of years that the individual and employer mandates have been in effect. I collected names and telephone numbers of respondents in the quantitative study who

agreed to be re-interviewed in the future. Their responses could be very interesting especially in light of the fact that the Democratic Party does not currently have a majority of seats in the House and Senate and we have a first-term Republican President who is pushing for a repeal and replacement of the ACA. Some pundits and scholars have criticized the ACA for being too costly and they point to the increase in insurance premiums in some states. On the other hand, insurance premium increases, on average, have slowed since the passage of the legislation (Mandelbaum 2017) and the ACA's opponents' predictions of massive increases in premiums everywhere have not materialized. Covering everyone in the country with health insurance is expensive but so is having uninsured people flooding emergency rooms for health care that could have easily and more efficiently been handled in a clinic or a doctor's office. The year the ACA passed, 2010, the estimated cost to the country's hospitals of uninsured persons' care was $40 billion and unpaid medical bills are a leading cause of bankruptcies (Groppe 2017). When Michigan expanded its Medicaid program, insurance premiums in the state did not increase but hospitals reported the cost of treating the uninsured decreased by almost 50% (Groppe 2017).

With respect to health care policy, I have proposed that politicians and policymakers speak to Americans in terms of their different ideological perspectives as opposed to dividing them by what they perceive as their economic class. For example, Egalitarians do not need to be sold on the ACA as it stands today and they are already predisposed to favor a single-payer health plan. Too often politicians preach to the converted because, quite frankly, it is easier and they can avoid being confronted with negative feedback from their opposition. Individualists, on the other hand, generally do

not favor government intervention in health care and scolding them for their selfishness will not result in gaining their support. A more successful approach would be to provide Individualists with examples of how having a healthier population is in *their* best interest. If a health care plan can be designed to save money on health care expenses in the long-run, Individualists can look forward to a tax cut, something they will be delighted to receive. It is a valid assumption there is a relationship between income level and cultural worldview. One could argue that being raised in poverty leads a person to develop egalitarian values because they are so much more aware of disparities between the rich and poor. On the other hand, wealthy people who have never experienced depravation can sometimes be very egalitarian in their stated political preferences. The link between income and cultural worldview is an area for further research.

The Affordable Care Act is the most dramatic, impactful health care legislation enacted since Medicare and Medicaid was signed into law in 1965. Many changes have been made to both of these venerable programs in order to improve them and make them work better for the patients. The ACA will continue to evolve as health care professionals, patients and members of government navigate an industry that is expected to grow at an annual rate of 5.6% from 2016 to 2025 resulting in a nearly 20% share of the gross domestic product by 2025 (CMS.org 2016). Understanding the roots of public opinion on this complicated issue is critical to moving forward.

Chapter 2: Cultural Theory as a Belief System

I chose to analyze opinions on the ACA with respect to respondents' ideological worldview because I believe this impactful legislation affects people at a deeply personal level – their property (i.e. money) and their bodies, namely the likelihood of staying in (or perhaps *getting in*) good health. I am certain that ideological views go beyond the *left-right* continuum we are so familiar with and so I chose to apply the tenets of Cultural Theory to my study. We acquire Cultural Theory from the study of anthropology. In the nineteenth century *culture* was synonymous with *civilization* but theorists in the early 20th century sought to operationalize the concept of culture in scientific terms (Gunnell, 2005; Kuhn, 1970). Douglas (1970) argued that an individual's social relationships can be examined on two cross-cutting dimensions, grid and group. The vertical (grid) axis measures the extent that "the individual is personally insulated from the rest of society (Douglas, 2003)" and measures how much his "life is circumscribed by externally imposed prescription" (Thompson et al. 1990, 5) such as existing social mores and institutions that control the way individuals interact with each other. The horizontal (group) axis of the framework represents boundaries around the group and the degree to which "the individual's life is absorbed in and sustained by group membership" (Douglas and Wilsdavsky 1982, 191). The high grid/low group designation corresponds to a very structured social environment and low grid/high group describes an environment that is more amenable to negotiation.

By combining the grid and group dimensions, we are able to characterize an individual has having one of four distinct cultural worldviews that determines the methods by which he defends his preferences, beliefs, and moral arguments (Thompson et al. 1990). For the Egalitarians (low grid/high group), the social norm of fairness is

ensured by equality. Their strong affinity for group associations is an indication of their keen awareness of how some groups' actions affect others and their expectations that government should mitigate the tendency toward an unequal distribution of income and the opportunities that higher incomes make possible – such as health care. The Individualists (low grid/low group) are much more concerned with how other people's actions affect them and resent government's attempts to guarantee economic equality in society. An Individualist is likely to view policies that try to reduce income inequality as inherently unfair. Both cultural worldviews share the low grid dimension; their key differences are represented by the horizontal group continuum.

The Hierarchs (high grid/high group) share the Egalitarians' fondness for groups but fear social disorder and deviation from established rules so the groups will necessarily be stratified. Hierarchs may approve of redistributive policies in general but will push back against the Egalitarians' passionate rhetoric that threatens the authority of those who the Hierarchs respect. Fatalists (high grid/low group) share the high grid dimension with the Hierarchs and have the same disregard for group membership as the Individualists. The Fatalist views life as completely unpredictable and the best he can do is cope with the changes. Fatalists typically do not express policy preferences because from their cultural perspective, all decisions are made for them and policy outcomes are out of their control (Wildavsky 1987).

Figure 2.1 Grid-Group Typology

Fatalist	Grid ↕	Hierarch
Individualist	Group ↔	Egalitarian

If we apply Cultural Theory to the concept of justice (which we will assume, for the sake of argument, each worldview wants), Individualists are concerned with the process of reaching justice – was the process fair? Egalitarians are more results-oriented (Ellis, 1992); fairness notwithstanding. Hierarchs view different outcomes between groups as just if the cause is due to differences in effort, commitment or skill (not *class* in the aristocratic sense). The Fatalists simply accept that sometimes we get justice and sometimes we do not. Setting aside the Fatalists' view, people with different cultural worldviews value liberty, freedom and justice for all but they disagree on the best way to achieve these goals.

The Advocacy Coalition Framework (ACF) characterizes the core values of different cultural worldviews as Hierarchical in nature which allows us to expand the discussion of how cultural biases shape policy preferences. Enduring deep core beliefs reflect the priority of ultimate values, like fairness, equality and the distribution of wealth in society (Sabatier and Weible 2007). We cannot determine what an individual's principles are simply by knowing that he values *doing the right thing* – what does that mean, specifically? I would argue that everyone wants to do what is right but that is not an expression of a core value. Core values are revealed in what the person believes is the right thing to do under certain conditions. We must know how these abstract values reveal themselves in a preference that we can actually evaluate. In the ACF, deep core beliefs manifest themselves in policy core beliefs that determine which policies will receive the highest priority. Both deep core and policy core beliefs are ingrained in an individual's psyche and are difficult to change; together they form the secondary beliefs regarding explicit policy preferences. These beliefs are narrower

in scope and may be adjusted depending on the situation (Sabatier and Jenkins-Smith 1983). For example, two individuals with the same deep core beliefs may share the policy core belief that the government should play an active role in the redistribution of income to pay for health care expenses but one could prefer a greater Earned Income Tax Credit for low-wage earners and the other might prefer an increase in the tax rate for earners in the top category.

Cultural Theory rejects the notion that an individual's preferences are imposed on them from the outside; preferences are endogenous (Wildavsky 1987). Decisions are "culturally rational if they "support one's way of life (Wildavsky 1987, 6). This is important as a possible explanation for why some low-income earners would still prefer less government intervention – their preferences, with respect to a survey instrument anyway, on stingier redistributive policies would be completely reasonable if the respondents are maintaining their conception of the American way of life, which they might hope to aspire to someday. These low-income wage earners – the working poor – obviously know that they make less money than others, but income, wealth, and status are all relative. They might not actually see themselves as stuck in a lower class or even be cognizant of which social class they belong (Campbell et al. 1960) and that could explain why their opinions on income redistribution via welfare programs and other government largess move in the same direction as the opinions of those in the high-income bracket. On the other hand, these people could be keenly aware of their lack of social standing and their high-class preferences are an example of the adage, *fake it till you make it*.

Wildavsky (1987) hypothesized that an individual's cultural bias has more of an impact on preference formation than political ideology which other scholars confirmed (Kahan et al. 2007A and 2007B). There is a moderate correlation between cultural worldviews and political ideology (Coughlin and Lockhart 1998). The horizontal group continuum of the Douglas typology measures some of the same concepts as the *left-right* ideological scale: Egalitarian values align with liberalism, Individualist values are closely associated with conservatism, and Hierarchs demonstrate aspects of both ideologies but tend to lean to the right of center (Coughlin and Lockhart 1998; but see Kahan et al. 2007A). Political ideology is usually self-reported as "liberal – middle – conservative" with varying degrees in between and studies have consistently found that people hold inconsistent preferences and often identify themselves as having one ideological label while not actually holding its views (Stimson 2004; Free and Cantril 1967; Converse 1964). What does the label *strongly conservative* mean? How much difference is there between that and *somewhat conservative*? The answer would depend on how an individual respondent sees himself in relation to others. If a person lives in a state dominated by left-of-center politics, he may consider himself conservative in comparison to others but may actually hold views that would be considered liberal by observers in other states with right-of-center politics. Stimson described respondents who like to think of themselves as conservative yet still preferred relatively higher levels of domestic spending as "symbolically conservative" and "operationally liberal" (2004, 85). Measuring ideological values with two dimensions helps get around the problems related to self-identification.

Conservatives and liberals (nor Republicans and Democrats) are not uniformly distributed across different cultural worldviews but recent research indicates a significant number can be found in each cultural worldview designation (Song et al. 2012). Kellstedt identified Individualism and Egalitarianism as two core values that are "centerpieces of the American ethos" (2000, 249)[1]. Individualism demands that people work hard, do the best they can and avoid relying on the government to help them, a value closely aligned with conservatism. Like liberalism, Egalitarianism conceives of fairness and equality as interchangeable terms, so if some people are trapped in poverty, it is up to the rest of society to help them get out. Individualists are likely to perceive redistributive policies as inherently unfair while Egalitarians will view the vast chasm between the rich and poor as unfair, and indefensible.

While Cultural Theory conceives of culture as a combination of two dimensions, Inglehart (1990) offered the traditional *left-right* orientations: materialist and post-materialist. Materialists are concerned primarily with economic security while post-materialists are more focused on quality-of-life issues. His conception of a belief system is necessarily incomplete because it does not account for the possibility that an individual can value the peace of mind that comes from being economically secure and demonstrate preferences that would indicate he believes there is more to life than having money at the same time. Another concept of culture has the normative values of liberty and equality falling along the continuum of the politics of conscience and the politics of interest (Heineman et al. 2002). The politics of conscience is closely aligned

[1] The concepts underlying these two terms are similar, but not the same, as the cultural worldviews in the Douglas grid-group typology. Kellstedt uses them in place of the typical *left-right* ideological continuum of liberalism-conservatism. The cross-cutting grid dimension is not considered.

with the typical conception of the public good and political liberalism. These ideas conflict with the emphasis on individual liberty that the politics of interest and political conservatism value. Like Inglehart and Kellstedt's one-dimensional concept of core values, the interests-conscience measurement cannot gauge the possibility that an individual could believe that protecting individual liberty *and* freedom at the same time is what is best for the public good in the long run. Although parsimonious, the *left-right* continuum is not as useful for measuring complex concepts as the two-dimensional Cultural Theory paradigm.

If low and high-income earners who share the same belief system judge that people are poor primarily because they are indolent and unmotivated or victims of misguided government interventions, neither group is likely to support a generous social safety net. Conversely, if these two groups both share the view that richer Americans' prosperity is the result of working hard they are more likely to support tax cuts and incentives for wealth building. Social Construction theory is useful in explaining how individuals decide what constitutes a problem that merits government's attention and what is an opportunity to be exploited, in which case, government should step aside. The theory is rooted in the post-positivist belief that all reality, including social problems like income inequality, is socially constructed and subject to interpretation (Ingram et al. 2007). Path dependency dictates which groups receive benefits and which groups will pay the costs of those benefits. The public's evaluations of past policies affect their preferences for new ones (Nakamura 1987) and overtime, policymakers (with the public's tacit approval) who also maintain socially constructed preferences, will inevitably designate more resources than are needed for some groups

while underfunding needier ones, thus widening the gap between socio-economic classes (Cobb and Ross 1997; Schneider and Ingram 1993). Any theory on preference formation must take into account that different people interpret survey questions according to their own biases and construction of reality. For example, 3/1/2 years after the law was implemented, a CNBC poll showed different results for opinions on ObamaCare versus the Affordable Care Act – 46% opposed Obamacare compared to 37% who had negative views of the ACA (Killough and Wallace 2013; Hart Research 2013). Having the former president's name in the question altered the poll's outcome in both directions as 29% approval of ObamaCare compared to 22% for the ACA. The poll also revealed that 30% did not know what the ACA was. Almost four years later, another poll showed that 35% of respondents still did not know that the ACA and ObamaCare were the same legislation (Dropp and Nyhan 2017).

Words like "Individualist" and "Egalitarian" mean different things to different people. To Cultural Theory scholars they are two distinct categories of a belief system but the average person may consider himself to be one or the other or even perhaps both – an Egalitarian Individualist. In order to ascertain a person's cultural worldview, we have to ask him or her about a series of statements that measure the grid and group dimensions. The telephone survey items were very closely modeled after the questions and statements used by Dake's study of the perception of risks (1991) and in several studies from the Cultural Cognition Project at Yale Law School (Kahan et al. 2007A and 2007B). The theoretical basis for the questions is found in the numerous works of Douglas, Wildavsky, Jenkins-Smith and other scholars. Previous research shows these

questions to have Cronbach's Alpha scores that indicate they are reliable measures of cultural worldview.

Table 2.1 Assessing Cultural Worldview

Hierarchical-Egalitarian Scale	***Agreement***
We should increase taxes so we can increase spending on domestic programs.	Low Grid
I think that people with the most experience and expertise should be the decision makers.	High Grid
It is better if the woman cares for the home and family and the man works outside the home.	High Grid
The big problem today is not giving everyone an equal chance.	Low Grid
We should be more tolerant of different moral standards.	Low Grid
Gays should not be allowed to marry.	High Grid
We have gone too far in pushing equal rights.	High Grid
It seems like people on welfare get a lot of free services that the rest of us have to pay for.	High Grid
Individualism-Communitarian Scale	***Agreement***
What is best for society as a whole, not the individual, should be the government's priority.	High Group
The government wastes a lot of tax money.	Low Group
I favor a reduction in spending on domestic programs to cut taxes.	Low Group
The federal government should make it more difficult to buy a gun.	High Group
I favor allowing Social Security funds to be invested in the stock market.	Low Group
It is not that big of a problem if people have an unequal chance.	Low Group
We need a strong national government to solve complex problems.	High Group
Protecting the environment is important to me.	High Group

The table above shows the statements that were included in the telephone survey that collected the data for the quantitative portion of this study. Security and safety are difficult to maintain without money. It stands to reason that money, especially the lack of it over a long period of time, should have some impact on how a person views issues of fairness and equality. I included money-related concepts in the assessment statements in Table 1. I hypothesized that income, though very important, is not the most significant factor in the approval of different redistributive health care-related policies and the results for those questions are shown in Chapter Seven. In this study, egalitarianism, the variable which measures the low grid/high group-orientation, is significantly correlated with the income variable but that is to be expected. The higher the income, the lower the affinity for communitarian ideas. Egalitarians typically line up with the liberal ideological label. As the degree of conservatism goes up, the

strength of egalitarianism goes down. I also expected to see similar affinities with the other cultural worldviews and political ideology. A discussion of these correlations appears in Chapter Six.

The 2016 presidential election between former Secretary of State Hillary R. Clinton (D) and real estate mogul Donald Trump (R) was as contentious as any we have experienced in modern history. One of the most divisive issues in the campaign was the future of the ACA. The Republicans campaigned on the promise to repeal the ACA and replace it with a new health care plan that would, among other things, remove the individual mandate to purchase health insurance and the employer mandate that forces large businesses to offer health insurance to full-time employees. Many pundits have asserted that Donald Trump won the presidency on the basis of these promises which he also wholeheartedly supported. While the House of Representatives passed a replacement package, the Senate failed in its attempt and that should leave even the most casual observer to ask how that happened. Public opinion polls show the country's attitude has shifted towards a more favorable view of the ACA or perhaps, a less favorable view of repealing the law in its entirety (Kiley 2017; KFF.org 2017). Over half of Democrats support a single-payer health care system and, although still in the minority, a full third of Republican voters approve of it (Savransky 2017A). The proponents of *repeal and replace* have a more difficult job ahead of them.

If politicians want to gain support for their policy proposals, such as reforming or repealing the ACA, they should consider speaking to voters in more appealing terms than simply by their class and their income levels; however, the amount of money one has to spend on health insurance and health care should logically have an impact on

one's preferences for the ACA. Cultural Theory implies that the best way to convince the low grid cultural worldviews (Individualists and Egalitarians) to substantially change the ACA is to appeal to their desire for freedom from authoritarian control; therefore, the new legislation must be couched in terms of allowing people to make choices they believe are best for them. The low grid designations differ in terms of their affinity for membership in groups. The best way to persuade an Individualist to support government's intervention in the health care market is to appeal to his natural selfishness. Scolding an Individualist for being self-centered will not be effective. Politicians would be more successful if they put their policy proposal in terms of what is in the Individualist's best interest (i.e. tax cuts if the plan costs less money). Egalitarians will oppose any attempt to repeal the ACA because they will perceive the change as an assault on fairness and scolding them for being too liberal and unrealistic about the limits of government will be ineffective. The better approach would be to convince them that reforming the legislation could provide health insurance to more people at a much lower cost.

The high grid designations (Fatalists and Hierarchs) are typically comfortable with governmental authority as long as members have the expertise necessary for the job so the most effective approach for these cultural worldviews is to convince them that government does, in fact, have the ability to regulate the health insurance and health care industries better than the free market can. These two groups differ with respect to their desire to live in a world bounded by group membership. The Hierarch will respond to appeals that convince him experts will ensure that fairness between different groups will be achieved if the government is in charge of regulating health

insurance and health care. The Fatalist has very little affinity for group membership and generally accepts the authority of experts out of a sense of inevitability – they believe they have no real power in government's decisions and therefore, do not go out of their way to affect the decision-making process. The best approach to fatalistic voters is to remind them that government intervention in the health insurance and health care markets is unavoidable and that the plan to repeal the ACA and replace it with something else is the best option for them.

Another way to view the view the debate on the ACA's future is from the standpoint of risk perception. Risks do not determine an individual's values (Kahan 2008), rather, it is the reverse – a person's values determine how they perceive risks. We will protect our decision-making processes in order to maintain some degree of comfort (Kahan et al. 2007A); therefore, a person not making enough money to pay for health insurance may have preferences that appear to be incongruent with his low socio-economic status, but could be easily explained if we took his cultural worldview into account. While belief systems begin to form at birth, it is reasonable to ask how an individual's personal experiences contribute over time. Our experiences, even traumatic events, are filtered through the lens of our cultural worldview. Even a bankruptcy or the loss of a job should not affect a person's deepest core values (Kahan 2008). "Risk perceptions don't dictate values" – an individual's cultural worldview "will likely influence him or her to construe ambiguous pieces of evidence in a way that fits those conclusions about risk" (Kahan 2008). An Individualist (low grid, low group) will probably interpret his inability to afford health insurance as being caused by the government's attempts at social engineering rather than change his core values and

suddenly prefer communitarian preferences for income redistribution. Kahan (2008) also points out that people do not change one aspect of their cultural worldview and leave the others intact. There is no theoretical basis to support the notion that after expressing a new-found preference for government spending on social programs, an Individualist will also suddenly change his opinion on a host of other issues: global climate change, gun control, gender rights, affirmative action, et cetera. It is more likely that he will explain his approval of government largess in such a way that it he can still maintain his core value of independence from government control. However, if an Individualist without health insurance maintains his values and votes for elected officials who promise to dismantle programs like the ACA, it may be that he views the risks of government wrecking the health care system more than he views his risks of an expensive injury or illness. Of course, it must also be noted that regardless of whether the electorate cast votes for or against the ACA in line with their cultural worldviews, their votes have little to do with their actual use of the program.

One of the benefits of doctoral training is that the student is forced to question all theoretical constructs and hunt for weaknesses. Under what circumstances do the theories hold and when do they break down? Most importantly – what can we learn from the assumptions that were proved false? Two of the first lessons students are taught in their methodology classes is 1) models are only representations of reality – they are not reality itself and 2) hypotheses must be "falsifiable"; we must not craft or search for a theory that reinforces what we already believe to be true (Popper 1959). We have to be prepared to be wrong – that is how we learn.

One important canon of Cultural Theory is that the cultural worldview is not issue-dependent. For example, a Hierarch should always be strongly negative towards policies that tend to level the playing field between different social classes. With respect to a tax increase to support the ACA and providing undocumented immigrants with health coverage, hierarchism was significantly negative as expected but with regards to expanding Medicaid so that more low-income households would be covered, hierarchism was only slightly negative. My quantitative analysis indicates that cultural worldview may, indeed, be affected by certain high-stakes political issues.

Another shortcoming of Cultural Theory is *how* the cultural worldviews are determined. In this study, respondents were asked how much they agreed or disagreed with statements posed to them by human interviewers. Statements designed to elicit deep-seated ideological values about fairness and equality are, by their nature, very personal and the problem of response bias must be acknowledged. Two of the vetted statements in the battery is "It is not that big of a problem if people have an unequal chance" and "We have gone too far in pushing equal rights." I tried to lessen the effects of response bias by asking questions with a battery of sixteen statements instead of just a few. Time constraints on a telephone survey that was already fifteen to twenty minutes long prevented me from asking as many questions as I would have liked but even if I had asked twice as many questions, the results may not have been any different.

No matter how much an interviewer promises an anonymous respondent that his or her responses will be kept confidential, it stands to reason that people will be reluctant to share their true feelings about money, taxes, politics, and the sensitive topic

of race. Other studies utilizing Cultural Theory have used the statement "Blacks should work as hard as everyone else" to capture a person's view on equality. I considered including this statement but decided against it for two reasons. First, I speculated that too many respondents would pick the middle category 'neither agree nor disagree' or disagree with the statement in order to not *sound* racist to the interviewer; either choice might have artificially inflated the Egalitarian category. Second, at the time the survey was in the field, President Obama, our first African-American president, was dealing with the political fallout of having to publicly apologize for the high number insurance policy cancellations (Killough 2013). He famously said "If you like your coverage, you can keep your coverage" but that turned out to not be true for a large number of Americans. I did not want respondents to conflate their opinions about Mr. Obama with their feelings about African-Americans in general.

The most effective way to determine a person's true cultural worldview would be to examine his or her behavior. Do their exhibited, measurable behaviors match the verbally stated preferences? For example, do Egalitarians have racially diverse close social connections? Do they donate their time and money to communitarian social causes? Do they rail against taxes cuts for the wealthy and also instruct their accountants to ignore certain tax breaks that cause them to pay more in taxes rather than less – or do they take the tax breaks but claim they are only doing so because the government would give their extra tax contributions to the wrong interests? Do Individualists who see themselves as *pulling themselves up by their own bootstraps* actually pay their own way in life without assistance from others? Do they take advantage of scholarships to schools when they could actually pay the bills without

help? The limitations of a quantitative telephone survey do not allow us to measure the degree to which preferences and behaviors coincide.

Cultural Theory is derived from the study of anthropology. Kuhn (1970) wrote about the problems we have in determining a person's motives behind his actions. The simple twitch of an eye could mean several different things – it could mean a secret acknowledgement between conspirators; it might be a flirtatious advance; it could mean a person is only joking about something obnoxious they said…or it could just mean an aggravating piece of grit is caught in the eye. We judge a person's behavior through our own biased lens especially when we have to make a judgment quickly.

Everyone, including scholars, sees the world through a culturally biased lens. I chose statements used by Cultural Theory scholars over the last couple of decades and whatever presuppositions these scholars had, I am certain they did their best to use vetted statements to minimize bias. I chose which statements to include in the survey and which ones to set aside so I, too, introduced bias into the study although I also tried to minimize it. Finally, the statements the respondents were asked to judge are open to interpretation even though on the surface they were quite specific. "The government wastes a lot of tax money" could be interpreted by a Hierarch as the *wrong people* spending money on the *wrong things* in which case, they will agree with the statement. On the other hand, an Egalitarian may view the statement as an attack on his or her egalitarian values and feel compelled to disagree with the statement regardless of whether or not there is actual agreement. Cultural Theory has value as an alternative to the traditional *left-right* continuum method of measuring ideology but the shortcomings in the theory must be addressed.

Chapter 3: Income Inequality and Health in America

As Rousseau theorized in his *Discourse on the Origin and Basis of Inequality Among Men* (1754), the minute that man staked his claim to a piece of land and built the first hut, political inequality was set in motion. His new neighbors, inspired by the high-income his industriousness generated, built bigger, better huts which in turn, encouraged our first man to make improvements to his dwelling and the competition for the best hut in the village ensued. Before long, the huts evolved into houses and the houses evolved into mansions. Of course, these homes were very attractive and undoubtedly were the targets of envious residents whose low salaries did not provide them the resources to compete with their social betters. Fearful of losing everything they had worked for, the neighbors formed a social contract whereby they agreed to give up certain liberties in exchange for the protection of their property, which because of improvements over the years, inevitably became unequal (Locke 1690). In a civil society, government, or rather the consent of the governed, maintains inequality by securing private property rights.

We comfort ourselves with the notion that competition makes society better so if some of us win but others lose, it is an acceptable, if not natural, condition. If a man's home is indeed his castle, then his annual salary is the army that protects it. What is the alternative? America's ideological nature, not to mention the Constitution, will not abide the destruction of private property rights nor are we likely to stop celebrating the accomplishments of highly motivated individuals. Why the history lesson? "Inequality among men" has been a vexing problem for governments around the world since the

idea of a 'government' was first conceived. To paraphrase Matthew 26:11 – the poor will always be with us (1984). Is an unhealthy population just as inevitable?

The foci of this dissertation are income inequality and ideological and cultural worldviews and their effects on policy preferences for government intervention in the insurance and health care markets. I chose to research preferences for the ACA because this landmark legislation overhauled the relationship between the citizen, employer, government and the health care provider and gave millions of Americans an opportunity to secure insurance coverage, something previous presidential administrations and Congresses had failed to do in the decades since the passage of the Medicaid and Medicare programs in 1965. The health care industry is expected to grow at an annual rate of 5.6% from 2016 to 2025 resulting in a nearly 20% share of the gross domestic product by 2025 (CMS.org 2016). I also focused on the ACA because of the changes we have observed in the workplace over the last couple of decades. Employees can no longer assume their companies will provide them with insurance benefits due mainly to the fact that increases in premiums have far outpaced the rise in wages over the same period.

Socio-economic status, or class, income inequality and health are inextricably linked. Disabled persons are twice as likely to live in poverty as their able-bodied counterparts because they are far more likely to be unemployed. Income and employment rates have gone down and the poverty rate for disabled persons has increased since the passage of the Americans with Disabilities Act (ADA) in 1990 (Fessler 2015). In the past thirty years, the increasing lifespan has slowed down relative to the gains we made in the past primarily because of obesity (Olshansky et al.

2005). The United States has the highest obesity rate in the developed world (OECD.org 2015).

The generation growing up in America at present was described by former Surgeon General Richard Carmona to be the first generation in history to not live as long as their parents did due mainly to obesity (2004). The Pentagon reported that approximately 71% of adults aged 17 to 24 years are not eligible to serve in the armed service mainly because of health problems such as obesity, lack of a high school diploma or equivalency exam (GED), drug usage or a criminal record (Feeney 2014). The elements of poor health and poverty are essentially the same. I focused on health care legislation, not only because of the changes we have observed in society, especially in our family structures, but also because the ACA is at least as monumental a change in the relationship between Americans and their doctors as the Great Society programs, Medicaid and Medicare, were fifty years ago.

We have dealt with competition between humans since we evolved and today the struggle between unequal income groups is commonly referred to in the media and political campaigns as class warfare, with disparities in access to affordable health care as one of the main areas of dispute between warring factions. War is an armed conflict between two or more societies which generally involves the destruction of private property and institutions and of course, death. The side that wins, if there is such a thing as a declared winner, is the side that comes away from the dispute with more – more resources, more property, and more leverage in future negotiations with other parties. If we apply this notion of a war to our struggle with income inequality, it is implied that one group must win and one group must lose. War between the classes

may not be an appropriate way to conceptualize income inequality especially with regards to Americans' health. However, considering the competition for resources (i.e. doctors, nurses, technicians, hospitals, operating rooms, and pharmaceuticals) is relevant.

The way the media presents political issues regarding social class plays an important role in shaping policy preferences. During good economic times, the media focuses on American rugged Individualism and there is less support for welfare programs and income redistribution but when the economy approaches or slips into a recession, the poor are featured in a sympathetic light and support for public assistance to the needy increases (Gilens 2000). Conversely, Kellstedt describes the process as one in "which a strong economy fuels liberal impulses, which lead to more liberal policies, and hence a conservative backlash" (2000, 257). When the media presents the issue of poverty by featuring the hardships of particular individuals[2] the public assigns responsibility for their circumstances to poor people's irresponsible decision-making or other personal characteristics but when the issue is framed as an outcome of a recession or bad economy[3] the public disperses the responsibility to society (Iyengar 1990 and 1991) and to government's failure to provide an adequate safety net (Iyengar and Kinder 1987).

By examining media frames of the poor during the years leading up to the passage of welfare reform in 1996, studies have found that poverty was often characterized as a Black problem even though most people living in poverty were not

[2] Episodic framing (Iyengar 1991)

[3] Thematic framing (Iyengar 1991)

Black. Perhaps most importantly, Black low-wage earners were rarely featured, which may have led to the notion that redistributive policies were only targeted to individuals who did not work (Gilens 1996; Clawson and Trice 2000). The poor have been commonly portrayed as criminals and substance abusers (Gans 1995) or irresponsible and promiscuous (Parisi 1998). Poor women on public assistance are often characterized as manipulative *welfare queens* who have additional children for increased payments (Coughlin 1989). Does it not stand to reason that if the media or politicians who oppose the ACA portray the uninsured as expensive, bad risks because of their own unhealthy habits and behaviors, the public will not be amenable to paying for a government health plan for them? On the other hand, if their plight is portrayed as being the result of being low-income wage earners, the public should show a higher approval for helping them. In fact, 74% of the public does have a generally positive opinion on Medicaid. Even 61% of Republicans hold a favorable view and 54% want the level of Medicaid spending to stay about the same as current levels (KFF.org 2017C).

Media priming "refers to changes in the standards that people use to make political evaluations" (Iyengar and Kinder 1987, 63). By highlighting some aspects of an issue and ignoring others, the media is able to establish the context within which the public formulates opinions. If the media focuses most of its attention on the economy vis-à-vis high unemployment, growing budget deficits and poverty, the public will judge government officials by their lack of success in how they deal with economic issues. Whatever else has been accomplished will figure very little in the public's evaluations. Zaller (1992) found that elite discourse in the media influences public

opinion but it is conditioned by political interest, political values and predispositions (i.e. age, gender, et cetera.). Political knowledge is also altered by the media. Jerit's study (2009) found that expert commentary on an issue increases the gap in knowledge between people with low socio-economic status and their more fortunate counterparts. When the media offers historical, social and political information surrounding an issue in order to provide some context, the differences between high and low-income groups decreases. Jerit and her colleagues found that media coverage probably conditions the relationship between political knowledge and demographic factors but as in other studies, members in these categories are treated as homogenous (2006).

Jacobs and Mettler found that how the Democrats and Republicans framed the rhetoric surrounding the ACA influenced how those parties' voters responded in public opinion polls (2011). Democrats focused on the Republicans' apparent "callous disregard for human suffering" while Republicans tried to convince the public that the ACA violated the Constitution (2011, 12). The explanation of how budget reconciliation was used such that the legislation could be passed without going through the Conference Committee is still controversial, although it was not unconstitutional. An expanded discussion of reconciliation is included in Chapter Four.

Jerit (2009) found that information presented by experts – that is, highly knowledgeable policy elites – exacerbates the knowledge gap between socio-economic classes. Their paper referenced a study by Moore (1987) that found the knowledge gap increases in a high-information environment, like a political campaign. Specifically, the gap increased for complicated issues that required a good deal of information to describe adequately. The ACA most definitely fits the type of complex policy that

Moore described. Jerit and her colleagues added to Moore's contribution by finding that complex issues are presented by experts whose higher educated audiences can understand while issues that were presented with some contextual information were easier to comprehend by people with less education.

People can only partially "monitor the world", therefore information from multiple sources must be weighted by individuals, but these weights are necessarily imbalanced (Jones and Baumgartner 2005, 85) and that causes individuals to form preferences that are based on incomplete information. This certainly appears to be the case with opinions on the ACA. However, it may not be necessary to know all the details about a policy in order to form an opinion (Meltzer and Richard 1981; Iyengar and Kinder 1987). Preferences are rational in that the person makes the best decision he can depending on what he knows (Simon 1965) but his preferences can seem to run counter to his interests (Frank 2004). Political elites, including policy entrepreneurs and politicians, use their rhetorical skills to persuade the public to adopt preferences they probably would not if they were more sophisticated (Moore 1987; Jacobs and Shapiro 2000). Bartels (2005) refers to this condition as unenlightened self-interest, however, context matters here: "enlightened preferences are based on the conditions under which opinions are constructed" (Delli Carpini and Keeter 1996, 243). Knowledge of economic issues directly impacts preferences for welfare spending as the better informed financially secure individuals expressed less desire for redistributive policies than their uninformed well-off counterparts. Respondents with financial challenges who were well informed preferred more redistribution than their equally strapped but uninformed peers (Delli Carpini and Keeter 1996). The studies that found similar

preferences for redistributive policies between the rich and poor owe the results to several factors, namely, the lack of sophistication among the disadvantaged to realize how bad off they really are. I do not fully accept that interpretation. I understand that higher levels of education are directly related to cognizance, knowledge and of course, income but the idea that the poor are too unenlightened to be aware of their circumstances is unsettling. Perhaps what previous studies have captured is not the lower strata's inability to connect preferences with real needs, but their belief that they can satisfy their needs on their own. Maybe some people's hope for the future is not dependent on the help these kinds of policies could provide.

Kingdon (1995) characterized public opinion has a force that normally constrains policymakers *from doing* something, rather than encouraging them *to do* something. Relating how much the public knows about various policies to the public's preferences for policy outcomes is difficult because opinions "are not crystallized about issue specifics" (Grossback, Peterson and Stimson 2006, 15). Stimson pointed out that "nobody needs to pay attention to everything that stimulates the Washington community" (2004, 15). If we assume that low-income individuals are just too uninformed to be capable of connecting their interests or rather, their needs with their preferences, we will discount explanations for their opinions that help us make sense of their decision-making process. What if respondents in our surveys are expressing preferences *now* that will reflect their interests in the *future*? An individual in the lowest income bracket could assume that generous redistributive policies exacerbate the cycle of dependency ((Delli Carpini and Keeter 1996) and thus, they might not be in his

best interests in the future especially if he also believes that he will not be trapped in the lowest bracket for long (Harms and Zink 2003).

Although formulating a preference and acting on it are two separate processes, Simon's observations on behavior are illuminating. Behavior is explained in terms of the "function it performs" and "behaviors are functional if they contribute to certain goals" (1965, 3), such as the goal of moving into the next higher income bracket.

President George W. Bush's 2001 and 2003 tax cuts, which were targeted to the wealthiest taxpayers, were supported by the lowest income earners. As Bartels points out, this group fully understood that income inequality is undesirable and on the rise yet they failed to comprehend that the tax cut legislation contributed to the problem…or they completely understood but assumed, perhaps incorrectly, the economy would be better off if taxes on the rich were cut. "Sometimes collective policy preferences are significantly influenced by the public's modest level of knowledge about politics, and sometimes they are not" (Althaus 1998, 554), a statement that indicates more research is needed. If we disaggregated these collective preferences by cultural worldview instead of income level, we should be able to better determine the degree to which political knowledge influences the choice of policy alternatives.

Policy alternatives, especially with respect to entitlements, require resources to distribute to various groups in need of those policy options. Entitlement spending (i.e. Social Security, Medicare, and Medicaid) is growing faster than the rest of the economy in general (Peterson and Howe 2004). Health care for all is a laudable goal but it requires resources we may not have. In 1798, Thomas Malthus proposed a theory that the number of objects essentially grow arithmetically but the population of people

grows exponentially. Think about this in terms of the supply of resources: medical doctors, hospitals, drugs and other health related *things*. If the population is growing at a geometric rate but the supply of products and services is not keeping up a similar pace, we will have shortages that no amount of health insurance will be able to mitigate – health insurance and health care are not the same. We have what is often referred to as a *First World Problem* – people do not die at the same rate they did in the past; the American population is increasing at an increasing rate although the problem of obesity, smoking and substance abuse has slowed down the increase in the last three decades (Olshansky et al. 2005). I illustrate my understanding of the Malthusian theory with the following examples: American women rarely die in childbirth today, the infant mortality rate in is low, most children are vaccinated so people no longer die of childhood diseases as they did before, children are more sedentary (at play) plus they do not work in factories so they do not die or suffer catastrophic injuries in accidents as they once did, soldiers do not die on the battlefield as they did in the past because doctors can save their lives with surgery, drugs and treatments, Medicaid pays for health care for the indigent, Medicare enables the elderly to live longer, antibiotics save people's lives so they no longer die of from simple infections, and pharmaceuticals and cancer treatments can extend the lifespan and even cure our sickest people. The point is that technological and medical improvements have extended our lives but they have also overburdened the health care industry's limited resources. If everyone is covered with some form of health insurance, a goal presumably an industrialized prosperous country like ours would strive for, how are we going to provide care for all?

Harold Lasswell's observation that politics is largely about *who gets what* (1936) is particularly appropriate to the discussion of policy preferences for landmark legislation like the ACA. He published his book *Politics: Who Gets What, When, How* in the middle of the Great Depression when the unemployment rate was 16.9%, down from a high of 24.75% in 1933 (Margo 1993). Americans were categorized as "those who get the most are elite; the rest are mass (Lasswell 1936, 295). Considering the richest Americans lost a significant amount of their wealth with the Stock Market Crash of 1929, the top 1% still maintained a large proportion of the national income and did not experience a steady decrease until taxes were increased to pay for President Franklin D. Roosevelt's New Deal programs and for our participation in overseas theaters during World War II[4] (McElvaine 2009). Lasswell observed that "oscillations in economic life" impacted their prosperity and made the elites feel as though they were "under domestic attack" (1936, 342). He suggested these feelings of insecurity could result in non-rational behaviors such as simply switching political parties for no ideological reason. He also alluded to more serious reactions such as overthrowing their government as happened with the German and Russian Revolutions in 1918 after the devastation of WWI. I would not characterize the congressional and presidential elections since the passage of the ACA in 2010, specifically Democratic Party losses in the House, Senate and the Presidency as *revolutionary* behavior by insecure elites but I do believe that the Recession of 2007 – 2009 and the ensuing so-called jobless

[4] Figure 3, "Income Share Going to Richest .01 Percent, 1913-2007", in Robert S. McElvaine's *The Great Depression: America, 1929 – 1941* (2009, xxxii) shows the share of income for the wealthiest Americans did not begin to steadily rise until the President Ronald Reagan's tax policies were implemented, namely the Economic Recovery Act of 1981 and the Tax Reform Act of 1986. Income dipped sharply in 2001 after the *September 11th* terrorist attacks but began to rise again shortly thereafter.

recovery[5] had a distinct, lasting impact on voters that was evident in the election of Donald Trump in 2016.

The number one issue for registered voters a few months before the 2016 election was the economy – 80% for Democrats and 90% for Republicans (Pew Research Center 2016). The issue Donald Trump campaigned on the most was turning the economy around by repealing and replacing the ACA with an improved health care law. According to a Kaiser Health Tracking Poll, just before the election, 45% of adults were in favor of the ACA – 49% for women compared to 40% for men (KFF.org 2017B); however, when we break down polling data by race, the message is clear – people of color account for the most positive attitudes. According to a Pew Research Center Survey in April 2016, 83% of African Americans and 57% of Hispanics favor the ACA compared to only 33% of whites (Leonard 2016).

Exit polls show that of the voters who believed they were worse off financially in 2016 compared to the year before, 77% voted Republican compared to 19% for the Democratic candidate (The Washington Post 2016). Whites account for 70% of all voters, 58% of which voted for Donald Trump in 2016 (Fidel 2016). His populist message appealed especially to white working-class voters who typically distrust government's ability to fairly distribute benefits (Gaddie and Goidel 2017) by promising that a Republican-led unified government would give them better health care options than they could get with the ACA plus increase their job opportunities and wages and these voters responded favorably. Of the voters whose annual household incomes were less than $50,000, 41% voted for Donald Trump compared to 53% for

[5] A jobless recovery is typically defined as state where macro-economic indicators (e.g. Stock Market values) are growing while employment levels are not growing or even on the decline.

Hillary Clinton; the percentage was tied at 47% for incomes over $100,000 (The Washington Post 2016). Exit polling also showed 67% of all white voters without a college education voted for Donald Trump (62% of women and 72% of men) but regardless of education, white women voted for Donald Trump by a margin of 53% to 43% over Hillary Clinton (Fidel 2016). To use Frank's argument (2004), low-income white voters preferred Donald Trump's policies because they tend to respond well to hot-button cultural issues (e.g. abortion) and they are alienated by the rhetoric from the Democrats that is often focused on addressing the hardships of minority groups (Gaddie and Goidel 2017). But while the importance of the white working-class voter in this election should not be ignored and even though most women voted for Hillary Clinton (54%) over Donald Trump (41%), the fact that white women regardless of economic class voted against, by a margin of ten points, the first woman to be the presidential nominee of a major political party is interesting. This is even more remarkable given the release of an audio tape, recorded in 2005, where the married, then fifty-nine-year-old reality TV star was heard making lewd comments about the benefits of his celebrity status and the liberties he felt free to take with women (Carmon 2016).

We have only to observe any past or present political campaign for evidence of how important politicians believe the healthcare/health insurance issue to be – the overwhelming question for candidates and elected officials from any political party is what they will personally do to reduce unfairness *and* increase prosperity for everyone. Their exact plans for achieving such a feat are remarkably different as we would expect, but nonetheless, they are always keenly focused on the economy and delivering messages they believe the electorate wants to hear. In his 2012 State of the Union

Address, President Barrack Obama said the "defining issue of our time" is to ensure that every American can take part in the American dream: "…raise a family, own a home, send your kids to college, and put a little away for retirement" (WhiteHouse.gov). In September 2013, Berkeley Professor of Economics Emmanuel Saez reported that 95% of income gains since 2009 went to the top 1% of earners (Barro), a fact that the President acknowledged in his 2014 State of the Union Address: "…those at the top have never done better. But average wages have barely budged" (WashingtonPost.com). Despite a genuine concern for the plight of the disadvantaged and a host of redistributive policies aimed at improving their lives, income inequality grew under the Obama Administration. Gilens' research shows that policymakers are much more interested in satisfying the policy demands of the wealthy and only become interested in the desires of the middle- and lower-class when an election draws near (2012). Although aware that the fortunate few – the 'one-percenters' – are doing very, very well compared to the rest of the country, the public has note appeared to be at all concerned. For example, according to a Gallup Poll in February 2017 regarding the most important problem facing the nation, only 1% of respondents were concerned about the gap between the rich and poor. The percentage has not changed from the same poll taken in November 2013. Is this disparity due to a breakdown of communication between government leaders and the people? Do the people not know what the *defining issue* of their time is or does the political leadership not understand what the public care about most?

Some political behaviors do correlate with income level as we might expect. Low-income earners financially contribute to political campaigns far less than their

well-heeled counterparts but this is certainly a function of their ability to give, not necessarily their desire; however, if we just consider the donation of time, not money, the well-off are no more generous than lower income individuals to contribute (Verba et al. 1995). On the other hand, taking multiple forms of political participation into account (voting, protesting, volunteering, campaigning, et cetera), the poor, as a group, are significantly less likely than the wealthy to participate (Verba et al. 1995, Keeter, Doherty and Weisel 2015). This disparity has real consequences for political representation. Rigby and Wright found that political parties in states with greater income inequality are more responsive to their affluent and wealthy constituencies (2013). If the last, best hope for the least advantaged members of society is the right to participate in a representative democracy in order to improve their lot in life, increasing inequality would appear to be untenable. If nothing else, the poor's apparent tolerance of inequality is puzzling. Perhaps a more fruitful line of research would be to investigate what personal attributes high- and low-wage earners have in common that influences their policy preferences.

Several explanations have been offered for why low- and high-income earners share the same opinions on many political and economic issues: low-income earners are too unsophisticated to comprehend the gap between their income and that of the highest earners (Kelly and Enns 2010; Bartels 2008; Converse 1964); they are manipulated by the way mass media frames political issues (Edy and Meirick 2007, Gilens 2000; Kellstedt 2000; Iyengar 1990), they mimic the opinions of their more knowledgeable and higher income counterparts (Lupia 1994); they imitate the preferences of the politically strategic groups they admire (Brady and Sniderman 1985);

or they are misled by the persuasive rhetoric of political elites (Frank 2004; Jacobs and Shapiro 2000). All of these explanations assume that it is rational for the rich and poor in the aggregate to respond to increasing levels of income inequality differently because of their socio-economic status: low-income earners will prefer some redistribution while high wage earners will not (Meltzer and Richard 1981). Scholars have delineated different income groups' preferences for government intervention by political party, ideology, race, and gender but the focus has not been on cultural worldviews or core values which, as the literature confirms, is a more complete explanation for these preferences. In doing so, perhaps we can move away from the broad generalization that the rich and poor are best differentiated by how much money they earn and in which social class we think they belong.

Why would low-wage earners have similar opinions regarding redistributive policies that individuals with the highest salaries have? On the surface, it seems counterintuitive but let us ask ourselves why we expect poor people to have vastly different views from the rich on the best ways to improve their circumstances? Categorizing large groups of respondents by income level means we know virtually nothing about how different individuals within a category view the issue of income equality. Poor people's preferences only appear to be irrational and confused or unenlightened (Bartels 2005) if we apply the wrong theory to the questions we want answered. Redistributive democracy theory makes the assumption that the rich and the poor must have divergent interests because the government interventions they require are different. For example, the rich need lower taxes on their income, property and capital gains from investments in order to maintain their high status. People in the

lowest income bracket should desire more government largess such as increased welfare spending and higher tax payments from the wealthy in order to pay for the social safety net. Since the bulk of wage earners will fall well below the mean income in the country, the lowest wage earners will comprise the vast majority of households and should have the power to influence members of government to cede to their demands for redistributive polices and income inequality should fall. However, empirical evidence indicates this is not the outcome (Harms and Zink 2003) because redistributive democracy theory is concerned with *interests* and not *preferences* (Kelly and Enns 2010). If Mayhew's (1974) assertion is correct that elected officials' main goal is to get reelected, then one might assume policymakers are more concerned with the preferences of the poor and not necessarily their interests. Knowing that low-income earners' preferences will move along with those in the highest strata – the contributors – does it not seem reasonable that Congress would respond to the preferences of the rich, with respect to policymaking, while simultaneously appealing to the poor with their campaign rhetoric? "Promise a lot; deliver a little. Lead people to believe they will be much better off, but let there be no dramatic improvement." Wildavsky said these were some of the ingredients for a recipe for violence (1968) but they are also the ingredients for status quo stew. Voters, whether they intend to or not, usually maintain normalcy and elected officials count on that. Only under extraordinary circumstances do voters reverse course and choose against the status quo.

Income inequality has steadily risen since the 1970s[6]. According to the Congressional Budget Office (CBO), between 1979 and 2007, the top 1% of earners

[6] After-tax income is the result after federal taxes have been deducted and government transfer payments such as Social Security and Unemployment Insurance benefits have been added (Congressional Budget Office). The Lorenz

saw their incomes rise by 275% and the next 19% of earners experienced an increase of 65% compared to an increase of only 18% for the bottom quintile of income earners (CBO 2011). The unemployment rate for the same time peaked in 1982, 1992 and 2003 but overall fell steadily until the 2008 recession (BLS.gov 2012). This is noteworthy considering the explanations offered for the rise in income inequality: the loss of high-paying jobs in the manufacturing sector due to productivity and innovation or movement overseas, the influx of low-wage laborers from outside the United States, the rise in salaries of the most prestigious occupations, or tax policies (Noah 2012). Regardless of whether income inequality happens to be increasing or decreasing, it is exacerbated during recessions (Barlevy and Tsiddon 2004). Even though the public's perception of the gap between the rich and poor increased in the early 1990s, there was no appreciable increase in the level of support for new redistributive policies and programs already in place did not become more generous (Kenworthy and McCall 2007). The issue of welfare spending never dominated the public's interest between the 1970s and 1990s but the spike of 12% of the public believing it was the most important problem in 1993 was the impetus behind the passage of sweeping welfare reform in 1996[7] (Jones and Baumgartner 2005).

A leading cause of income inequality stems from differences in access to quality medical care (World Health Organization, 2008). The problem is not only due to a lack of health insurance altogether; part of the problem is related to the rising cost of

Curve represents the cumulative distribution of income. Perfect income equality would exist if 50% of wage earners accounted for 50% of the income generated in the country. The higher the Gini coefficient is, the more unequal the distribution of income in the country will be.

[7] Personal Responsibility Work Opportunity Reconciliation Act signed into law by President Bill Clinton on August 22, 1996.

employees' contributions to their companies' health insurance plans. As their premiums rise, so too does the percentage of their income consumed by insurance costs, prompting many poor workers to forego coverage. In 2005, employers insured 89% of their highest-paid employees while only 22% of their lowest-paid employees were covered (Auguste et al. 2009). The overall percentage of persons covered by employers' insurance plans has gradually declined since 1999 (64.1%) to 55.3% in 2010 (HHS.gov 2011). According to the Henry J. Kaiser Family Foundation (2013), nearly 48 million non-elderly Americans did not have health insurance in 2012, down from 2010's 49.9 million as reported by the 2011 Current Population Survey (HHS.gov 2011). The majority of the uninsured was comprised of the working poor.

Differences in mortality rates are tied to income disparities between socio-economic classes. According to the National Longitudinal Mortality Survey, individuals at all ages in the top 5% of incomes live approximately 25% longer than those in the lowest 5%. There is a myriad of explanations for the difference in outcomes between the rich and poor including but certainly not limited to risky behaviors such as smoking, drug and alcohol abuse, and obesity that affect the lower classes to a greater extent (Deaton 2003).

In a longitudinal study using data from the Americans' Changing Lives survey[8], Paula Lantz and her fellow researchers analyzed the relationship between educational attainment, income and mortality and found that individuals with the least education *and* the lowest income were more than three times as likely to die before the next wave

[8] Americans' Changing Lives (ACL) survey data from the Inter-University Consortium for Political and Social Research (ICPSR) is available at http://www.isr.umich.edu/acl/data.htm.

of surveys[9] than their counterparts with the highest levels of education and income. However, all things being equal, the researchers discovered that income was more predictive of mortality than was education because when socio-demographic variables were controlled, the effect of education on mortality was insignificant. Education had its strongest effect on health choices (1998).

Increases in health insurance premiums have far outpaced the rise in wages over the last couple decades. Cooper and Schone's research of several authors' findings regarding this occurrence offers some compelling reasons for this change: 1) the 28% growth in wages between 1987 and 1993 could not keep up with the 90% increase in insurance premiums over the same time period, 2) employees' contributions to their company benefit packages increased thus making it less likely they would take the insurance offered by their employers, 3) Medicaid eligibility changed substantially for low-income workers which may have made employment-related private insurance less attractive and 4) different states passed legislation aimed at increasing and improving insurance coverage which resulted in an overall increase in premiums (1997). Byron Auguste and his fellow researchers found that in 2005, companies offered better insurance benefits to employees with higher salaries than they did to their lowest paid employees (2009).

The rich are getting richer and the poor are barely getting by – this is nothing new and it is not particularly mysterious either, but the policy preferences of the rich and poor being highly correlated certainly is (Enns and Wlezien 2011; Kelly and Enns 2010; Page and Jacobs 2009; Soroka and Wlezien 2008; Hochschild 1981). Even as

[9] Follow-up surveys took place at 7 ½ year intervals.

income inequality grows, the lowest wage earners, in the aggregate, show an inclination toward a more fiscally conservative government (Petty 2018; Kelly and Enns 2010). This is not to suggest that poor people are more conservative than people who do not qualify as poor; in fact, if we compare individuals with family incomes at or below the poverty threshold, 28% identify as strongly liberal and prefer highly redistributive polices compared to only 16% of the public at large but that means 72% of the poor identify as moderate or conservative and prefer less redistribution to more (Verba, Schlozmon, and Brady 1995).

Health care was mentioned by 6% of Gallup's survey respondents as the nation's number one problem in October of 2012 but after the well-publicized problems with the Health care.gov website, that percentage climbed to nineteen in early-November of 2013 but has since dropped back to 5% as of February 2017. These polling numbers, on their face, do not indicate that Americans tie the issue of health care (or the lack thereof) to the issue of income inequality however, Christina LaMontagne (2013) estimated that almost 10 million Americans between the ages of 19 and 64 will be unable to pay for basic living expenses because of medical bills. In addition, the number of medical bankruptcies continues to increase. Nearly 1.7 million people live in households that cannot pay their medical bills and will have to declare bankruptcy (LaMontagne 2013).

Can we have persistent income inequality without class warfare being necessarily inevitable? According to economists' interpretations of Pareto-optimality, a certain amount of income inequality is itself inevitable. The economic principle of efficiency as proposed by Vilfredo Pareto (1848-1923) states that a society achieves a

natural Pareto-optimality when it is not possible to make anyone better off without making someone else in society worse off. The implication is that the only way to make those individuals in the bottom percentile better off is to take wealth away (e.g. in the form of taxes) from individuals in the top percentile. As for income distribution, it is the case with countries included in the Organization for Economic Cooperation and Development (OECD) that income inequality exists in varying degrees and has increased over the past two decades due mainly to changes in how wages and salaries are distributed across income groups with respect to occupations, education and skills (OECD 2011). For example, the Bureau of Labor Statistics (BLS) reported in its Occupational Outlook Handbook that the median wage for skilled, technical workers in the health care industry was $63,420 annually in 2016 compared to $37,040 for all occupations. Unfortunately, the median annual income for lesser skilled health care workers like home health care aides is only $27,910, far under the median for all occupations (BLS.gov 2015).

The BLS reported that most of the disparity in Americans' wages in the period spanning 1996-2009 took place in the private sector among various occupations, including jobs in the health care industry (BLS.gov 2014). However, health care jobs' overall wage growth has been far above the average for the country, which was 2.4% between 2015 and 2016, even for relatively lower skilled positions such as that of Certified Nursing Assistants whose wages increased by 11% (Picchi 2016). One explanation for the wage inequality in the different health care professions is that older workers with several years of experience are leaving the workforce and younger workers with less time on the job are replacing them. While concerning, not all income

inequality is due to discriminatory factors. The good news is that jobs in the health care industry is expected to grow 19% between 2014 and 2024 (BLS.gov 2015).

Income from wages or salaries is not the only element of inequality found in OECD countries including the United States. Since individuals with higher salaries can afford to invest a portion of their income, they receive a return on their investments so even if their salaries were as stagnant as low-wage workers' income was, this group would still see an increase in their overall income. In fact, in Germany, the United Kingdom and the United States, for the top 1% to 3% of the population, investments rather than salaries constituted the majority share of their total income (Clementi and Gallegati, 2008). People at the bottom of the income ladder do not have the opportunity to invest any portion of their income because they spend most of it on necessities such as rent or house payments. According to the Department of Housing and Urban Development's Report to Congress, almost fourteen million low-income unassisted (i.e. no subsidies) households pay in excess of 50% of their yearly income for a residence when anything above 30% is considered problematic. Very low-income is defined as 50% or less of the area's median income adjusted for family size (HUD 2015). With over half of their income going towards securing a roof over their heads, these families are in danger of not meeting their other needs such as food, clothing, transportation, utilities and health care.

Increases in premiums have far outpaced the rise in wages over the last couple decades. Cooper and Schone's research of several authors' findings regarding this occurrence offers some compelling reasons for this change: 1) the 28% growth in wages between 1987 and 1993 could not keep up with the 90% increase in insurance premiums

over the same time period, 2) employees' contributions to their company benefit packages increased thus making it less likely they would take the insurance offered by their employers, 3) Medicaid eligibility changed substantially for low-income workers which may have made employment-related private insurance less attractive and 4) different states passed legislation aimed at increasing and improving insurance coverage which resulted in an overall increase in premiums (1997). Byron Auguste and his fellow researchers found that in 2005, companies offered better insurance benefits to employees with higher salaries than they did to their lowest paid employees (2009).

Campaign for Tobacco Free Kids, an organization in Washington, D. C. that advocates for public policies that discourage children from smoking and encourages adults to quit, offered some pertinent statistics with regards to tobacco use, poverty and mortality. The most troubling statistics in its 2017 report include 1) only 13.9% of adults living at or above the poverty level smoke but 26.1% of those living below the poverty level smoke, 2) the percentage of individuals who are on Medicaid or are not insured and smoke is more than twice that of individuals with private health insurance, and 3) high school seniors who do not plan to go to college after graduation are more than twice as likely to be smokers than college-bound high school seniors. In a study published in January 2017 by the Centers for Disease Control and Prevention (CDC), researchers found that "fewer than one in 10 smokers overall quit successfully in the past year" [2015] (Babb, Malarcher, Schauer, Asman, and Jamal, 2017). Given the devastating effects of smoking on overall health, a less than 1% success rate is particularly discouraging. Smokers with private health insurance had a cessation rate of 9.4% compared to 5.9% for smokers who were on Medicaid; however, a higher

percentage of smokers on Medicaid received advice to quit than did smokers with private insurance (Babb et al. 2017). Only 44.1% of smokers with no health insurance of any kind were advised to quit by a health professional (Babb et al. 2017). The researchers cited the ACA as a possible source for the increases in advice to quit, cessation attempts, and successful quits since 2010 because more people were covered with some form of insurance.

Obesity is one of the most serious health issues we have in the country today and it disproportionately affects the poor. County-level data shows that the poorest counties have obesity rates many times greater than those of the richest counties (Levine 2011). This is an incredible statistic given the state of hunger around the world. Where else but a wealthy industrialized country could you have a situation where the poor have access to too many calories?

Income inequality is not going to go away. We could take ninety cents out of every dollar a wealthy individual or corporation earns and we would still have class differences in society. We must, regrettably, accept inequality; it is the inevitable result of a culture that values competition and success. Competition creates winners and the Constitution protects their winnings. Rawls (1971) said justice demands we mitigate the damaging effects of competition by compensating the losers just enough to give them an incentive to stay in the game. Perhaps that is what the results of studies showing homogeneous opinions of the rich and poor are telling us (Kelly and Enns 2010). If we are to learn how to govern ourselves better, as Lasswell (1971) advised, political scientists studying public opinion should avoid the assumption that people see themselves the same way others see them.

Survey data shows that people are able to gauge how they are doing financially compared to others, but only the most superficial terms of terms. Although they obviously know they are low-income, a substantial number of people may not see themselves as *poor* and thus, do not favor policies that are designed to alleviate the financial difficulties low-income people face. With respect to the ACA, in March 2018, the Kaiser Health Tracking Poll[10], broken down by income category, showed earners making $90,000 and above as 50% favorable and 48% unfavorable (KFF.org 2018). If we examine the polling data going back to April 2010, this income category was consistently negative until October 2016. In the middle category, $40,000 to $89,999, 48% were favorable compared to 45% unfavorable. Over time, this category was also generally unfavorable towards the ACA until May 2017. There was an eleven point spread in favorability between the middle income category (55% unfavorable) and highest (44% unfavorable) in October 2016. The November 2016 election results revealed 49% of earners in the $50,000 to $100,000 range voted for Donald Trump, who promised to repeal the ACA, compared to 46% for Hillary Clinton (Roper Center 2016). Polling in January 2018 indicated President Trump had lost support amongst his core supporters – working-class white voters (Brownstein 2018) making the results of the Kaiser poll understandable if not expected.

In July 2010, respondents making less than $40,000 annually had the highest level of approval at 56% with only 22% unfavorable. In March 2018, 55% of respondents in this category had favorable opinions of the ACA but a substantial

[10] Respondents were asked the following question: "As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?"

percentage, 38%, were unfavorable. Reviewing the results for this income category shows the results to be much more inconsistent than the middle- and high-income groups'. Whereas the two other income groups' results do not show multiple changes back and forth between favorable and unfavorable, the lowest income category does. It has only been since May 2016 that low-income respondents have been consistently favorable towards the ACA. Considering the fact that millions more Americans are covered with health insurance (or have access to Medicaid because of the expansion), and the ACA's opponents' predictions of the *doubling and tripling* of health insurance premiums have not materialized, we should expect that all income categories would become more favorable towards the ACA and yet, the percentage of people who still disapprove of the ACA are still quite high.

In this study, I addressed the between a belief system measured by cultural worldview and policy preferences. Belief systems possess corresponding preferences for redistributive policies in general, but we do not fully understand what motivates individuals with fewer resources to voice opinions that move in tandem with those of their wealthier counterparts.

Chapter 4: The Long Road to the Affordable Care Act

Government involvement in health care is not a new idea in America. The arguments for its intervention have changed over the centuries but the necessity of relying on the government's organization and vast resources to deal with dire health crises dates to our founding. Today, advocates for a comprehensive health care system that covers everyone argue that good health is essential in a country as highly developed as America. Table 4.1 features the Heritage Foundation's annual list of countries ranked by their degree of economic freedom[11]. The United States sits at #18 (down from #12 in 2015) and the seventeen countries above us have some form of universal health care (Heritage.org 2018; NASDAQ 2017).

Table 4.1 Countries with Universal Health Care

1 Hong Kong	Free treatment, with small co-payments, is available to people with a Hong Kong identity.
2 Singapore	Government keeps costs down through mandatory savings, subsidies and price controls.
3 New Zealand	Mixed public/private system; costs recovered though employers, taxes, energy companies
4 Switzerland	Coverage is universal and mandatory for all residents although not free.
5 Australia	Universal coverage for everyone via a health care tax.
6 Ireland	Mixed public/private system; public system covers everyone.
7 Estonia	Employees are covered if employers pay health care taxes for them.
8 United Kingdom	Publicly funded through the National Health Service.
9 Canada	Publicly funded universal health care
10 United Arab Emirates	Health care free only to UAE citizens.
11 Iceland	Universal free system paid for by taxes and services fees.
12 Denmark	Universal free system paid for by taxes.
13 Taiwan	Single-payer universal system paid for by payroll taxes.
14 Luxembourg	Public/Private system; state-funded system provides basic medical coverage to all citizens.
15 Sweden	Public/Private system; public system funded through taxes.
16 Georgia	Universal system; medical care provided by private facilities funded by taxes.
17 Netherlands	Long-term care provided to all but basic health care insurance must be purchased.
18 United States	Public system for the qualified poor & persons age 65 and older; private system for all others

Although the United States does not have universal health care coverage, certain target populations are covered with health insurance, namely the elderly through

[11] The Heritage Foundation measures economic freedom with twelve exemplars split into four categories: rule of law, government size, regulatory efficiency, and market openness (Miller and Kim 2017).

Medicare and the poor through Medicaid. The Kerr-Mills Medical Assistance for the Aged (MAA) program began in 1960 and was designed to provide health care services to the nation's elderly population which numbered 18 million at the time. Within three years, barely half the states participated in the program (Senate Special Committee on Aging 1963) and by 1965 the number of jurisdictions had supposedly increased to just forty-six with only 551,000 elderly persons receiving any medical treatment under the MMA that year (Bernstein 1975); however, that increase in jurisdictions is misleading. According to the Senate report on the MMA, 95% of elderly persons did not live in a state that had an MMA program (1963). The Senate's conclusion was that MMA would never be able to provide adequate medical services to the nation's growing elderly population.

Medicare is a single-payer (government) insurance program that covers adults aged 65 years and older[12]. Before Congress passed the legislation creating Medicare in 1965, 38% of private doctors in New York state opposed the idea of using Social Security to provide for health care benefits to the elderly and some even threatened to boycott the program (Colombotos 1969) but in less than a year after Medicare was in effect, doctors' approval rating increased to 81%, a far cry from the 20% of doctors in a national poll that approved of the concept in 1961. For its part, the public supported Medicare from the beginning (Colombotos 1969).

The current program is funded by a payroll tax deduction and is comprised of Medicare Part A (hospital insurance), Part B (medical insurance) and Part C, called Medicare Advantage, and Part D for prescription drug coverage. Hospital stays,

[12] Medicare also covers younger individuals that the Social Security Administration has deemed eligible as well as persons with end stage renal failure and Lou Gehrig's disease (amyotrophic lateral sclerosis).

hospice, and some home care are covered but nursing homes are not under Part A. Doctors office visits, outpatient treatment (including limited outpatient prescription drugs that an individual is not likely to give to themselves such as injectable drugs and infusions) and some physical therapy is covered under Part B and a monthly premium is charged (CMS.gov 2017). If qualified individuals paid Medicare taxes while working they probably do not have to pay a premium for Medicare Part A, however, if they paid Medicare taxes for less than thirty quarters, the standard monthly premium is up to $413 ($422 in 2018) and $227 ($232 in 2018) per month if Medicare taxes were paid for thirty to thirty-nine quarters (Medicare.gov 2017). If qualified individuals purchase Part A, they must also purchase Part B. For 2017, standard premiums for Part B are $134 per month (less if the individual is receiving Social Security benefits) for an annual income of $85,000 or below. Premiums go up to $429 for an annual income of $214,000 and above. Parts A and B are referred to as original Medicare plans. Medicare supplement or *Medigap* plans are sold by private insurance companies to cover some of the costs that Parts A and B do not cover, including copayments and deductibles. These supplemental plans do not cover Parts C and D (Medicare.gov 2017).

Medicare Advantage (Part C) plans are offered through private insurance companies that the government approves and pays for Part A and Part B benefits. In addition to Parts A and B, Medicare Advantage plans offer additional benefits such as dental and vision care and most offer prescription drug coverage (Part D) with an additional monthly premium. The average monthly premium for Medicare Advantage in 2016 was $65 (Healthmarkets.com 2017). The prescription drug benefit (Part D)

excludes drugs that are optional under the Medicaid program but covers drugs approved by the Food and Drug Administration (FDA), available by prescription only, and deemed necessary for a "medically accepted indication". If the drug is considered experimental, a covered individual may appeal to Medicare for an exception if there is support for its usage in a peer reviewed medical journal (Medicareadvocacy.org 2017).

There is a problem with Part D called the *donut hole* – the time when there is no drug benefit or the benefit is limited. In addition to monthly premiums, there is a $400 deductible (for 2017) that must be met before the plan starts to pay a share of the costs for covered prescription drugs. Once the deductible is met and the combined costs between the covered individual and Part D reaches $3,700, the individual is in the drug coverage gap where he or she will pay 40% of the costs for brand name drugs and 51% for generic drugs. When out-of-pocket expenses total $4,950, the gap closes and the individual will go back to paying a small co-payment for covered prescription drugs. By January 2020, the prescription drug coverage gap is scheduled to be eliminated (Ehealthmedicare.com 2017).

Although doctors' attitudes on Medicare changed dramatically shortly after the program was in effect, their opinions of Medicaid, also created in 1965, remained negative (Colombotos 1969). Medicaid is jointly funded by the federal government and the states. New York State's first Medicaid program was enacted in 1966 but because of strong opposition, it was replaced with an amended version – incidentally, doctors' opinions did not change after that; approval of Medicaid was 42% before and after (Colombotos 1969). John Colombotos speculated the reasons for the negative views were due to 1) up to four times as many patients using Medicaid than covered by

Medicare in New York state, 2) a bias against "welfare cases" using Medicaid, 3) the fact that Medicaid provided more services than Medicare, and 4) Medicaid paid doctors fixed fees for services rather than the customary fees they would normally charge (1969). Medicaid also cost more than Congress anticipated in 1965 (Tryon, Powell and Roghmann 1970). Opinions on Medicaid varied across geographical regions because in 1969, although Jim Crow laws had been declared illegal, discrimination and segregation remained in place in certain areas of the country.

Is health care a *right*? Betty Bernstein suggested in 1975 that the country (health practitioners, the government, and the citizenry) needed to reach a consensus on this question if a national public health care program was going to succeed. Medicaid, created in 1965, currently covers approximately 68 – 70 million people including pregnant women and children, the disabled and elderly, and other eligible low-income adults (Medicaid.gov 2017A). Qualified individuals have access to inpatient and outpatient care, preventative and diagnostic services, family planning, nursing care and other services required by the federal government. States may opt to cover other services such as prescription drugs, occupational and physical therapy, optometry and dental services, prosthetics, and hospice (Medicaid.gov 2017B). Spending for Medicaid in 2015 was $545.1 billion (CMS.gov 2017). In 1997 the Children's Health Insurance Program (CHIP) began covering children in households that made too much money to qualify for Medicaid but not enough to purchase private health insurance. CHIP expenditures for 2016 were $15.6 billion (KFF.org 2017F). The Department of Health and Human Services (HHS) determines the federal poverty level (FPL) used to qualify eligibility for certain aid programs including Medicaid, CHIP and subsidies for the

ACA's Marketplace health insurance. In 2017, the FPL for a family of four was an adjusted gross annual income of $24,600 (Healthcare.gov 2017B).

Over the decades many changes were made to Medicare and Medicaid but the problem of what to do for the millions of Americans that did not have group health insurance benefits through their employers or did not earn enough money to buy individual health insurance was not resolved. The Health Security Act 1993 was an attempt by the Clinton Administration to establish a universal health insurance plan. The legislation required Americans to purchase health insurance through *alliances* (similar to the ACA's *exchanges*). Aided by a congenial Democratic House of Representatives and Senate, the bill failed mainly because of interest group lobbying against it on behalf of the health care industry (Clymer, Pear and Toner 1994) and concerted opposition from small and large businesses to its mandate that employers provide insurance to their employees (Moffit 1993). As was the case in the 1990s and today, public interest advocacy groups are far outnumbered by private interest groups. They have less ability to marshal resources on behalf of underserved groups to counteract the influence of wealthy, powerful private interests (Callaghan and Jacobs 2016). As Schattschneider famously wrote regarding interest group bias toward the elites, "The flaw in the pluralist heaven is that the heavenly chorus sings with a strong upper-class accent" (1960).

The task force, which eventually numbered over 500 people, led by First Lady Hillary Clinton and President Bill Clinton's chief health care policy advisor Ira Magaziner, was accused of being too secretive about their plans which did not endear the legislation to the public (Clymer et al. 1994). Another problem Clymer and his co-

authors point out is the lack of communication between policy designers on the task force and the economists that could have told them that their plans for generous benefits were not fiscally feasible (1994). Finally, the task force refused to negotiate with Senate Republicans who were working on various health care reform bills of their own. One of those bills was called the Health Equity and Access Reform Today (S.1770; 103rd Congress) which was introduced in late 1993 but never debated. The bill had similarities to the ACA including coverage for pre-existing conditions, an individual mandate, and vouchers for low-income purchasers that were similar to the ACA's premium tax credits (Greenberg 2013).

Former 2012 Republican presidential nominee Mitt Romney signed legislation providing health care coverage to residents of Massachusetts when he was Governor of the state in 2006. The law, called An Act Providing Access to Affordable, Quality, Accountable Health Care and nicknamed RomneyCare, was the model for the ACA (ObamaCareFacts.com 2017) and was sometimes referred to as ObamneyCare (Taylor 2015). The program's state-run exchange is still in effect today for almost every Massachusetts resident although revisions were made to keep the law current with ACA requirements. Six years after the law was implemented, 62% of residents still had a favorable opinion of the program (WBUR.org 2012). For those who do not qualify for Massachusetts' Medicaid program, MassHealth, RomneyCare offers varying premiums based on the income level and provides subsidies to eligible low-income individuals. Although most Massachusetts residents secure health insurance through their employers, RomneyCare has the Health Connector, a type of insurance "clearing house" which is similar in function to the ACA's Marketplace (HealthInsurance.org 2017).

Other similarities include tax subsidies to businesses that offer insurance (and penalties for those with more than ten employees who do not), and a tax penalty for residents who choose not to participate (ObamaCareFacts.com 2017).

For his part, Mr. Romney, as a candidate for the Oval Office in 2012, said that Massachusetts' health insurance plan was for Massachusetts' residents only and not intended to be expanded to the entire country. A few years after the election, in an obituary for Staples Founder Thomas Stemberg, Mr. Romney credited his friend, who made a speech at the 2012 Republican National Convention, for encouraging him to give everyone in Massachusetts access to health care and admitted that RomneyCare was, in fact, the model for the ACA (Taylor 2015).

When the Affordable Care Act was adopted in 2010 it added regulations to the private health insurance market. The ACA did not supplant the private insurance industry. As of 2016, of the total population, 49% secured health insurance through their employers with another 7% getting insurance through a non-group plan (KFF.org 2017D).[13] We have separate government programs for different clients such as Medicare for the elderly and some with qualified disabilities. Veterans receive health care through the Veterans Administration and through Tricare, a program for qualified veterans and their dependents. Those with sufficiently low incomes are covered by Medicaid and qualified children are covered by CHIP – the Children's Health Insurance Program. Nevertheless, we still had 9% of the population – almost 30 million people – who were insured. Prior to January 2014 when the majority of the ACA's regulations

[13] 2016 Health Insurance Coverage of the Total Population (KFF.org 2017D): employer 49%, non-group plan 7%, Medicaid 19%, Medicare 14%, 'other' public plan 2%, uninsured 9%

went into effect (Ehealth 2016), the cost of the uninsured population's medical care[14] was nearly $85 billion in 2013 (KFF.org 2014C). Who picks up the tab for the uninsured? One explanation is that doctors and hospitals simply bill the government for their costs and are reimbursed by the American taxpayers. Another explanation is that patients with cash or patients with insurance are charged higher prices for their own treatment in order to cover the costs of the treatment for the uninsured. The real explanation, however, is found in an examination of who supports the ACA, essentially a private system regulated by the government, and who stands in opposition to a government-run universal health care system.

In 2008, Democrat Barack Obama was elected President over the Republican nominee Mitt Romney. One of his major campaign promises was to reform the health care system and provide health care to all Americans (Obama 2007). How dedicated Mr. Obama was to universal health care is debatable because he certainly did not push Congress hard in that direction (Gordon 2009; Pear and Calmes 2009; Madden 2010). On the other hand, Senator Bernie Sanders (D-VT) estimated there were not more than ten votes in the Senate for a single-payer system so Mr. Obama's reluctance seems understandable (Madden 2010). Rather than focusing on the former president's broken campaign promise, we should examine Congress' motivations for passing the ACA over a single-payer plan or the so-called public option, an optional government-run plan like Medicare. The Senate scrapped both in September 2009 when Democrats realized there was not enough Democratic support to overcome a Republican filibuster (Lothian 2009). Former Democratic Senator Joe Lieberman (I-CT) announced that he would not

[14] "Uncompensated care includes health care services without a direct source of payment. In addition, people who are uninsured paid an additional $25.8 billion out-of-pocket for their care" (KFF.org 2014C).

vote for any legislation that included an expansion of existing government-run health programs, specifically the expansion of Medicare (Pear and Herszenhorn 2009). Former Senator Blanche Lincoln (D-AR) was facing a competitive election in 2010, which she eventually lost to a Republican, and said she could not support an additional government-run system she did not think her constituents would want (Pear and Calmes 2009) although it was reported that Ms. Lincoln received a "great deal of money" from insurance companies (Cook 2009). Former Senator Ben Nelson (D-NE) opposed any new plan that competed with insurance companies that, at the time, covered 200 million Americans. He suggested that type of plan would be too disruptive but it must be noted that Mr. Nelson received over $2 million in donations from health- and insurance-related groups (Grim 2009). Essentially, the single-payer option was never actually up for serious consideration by the Senate. By the end of 2009, Democrats needed sixty votes to avoid a Republican filibuster and Senator Nelson was persuaded to be the sixtieth vote with a permanent deal for Nebraska to receive full reimbursement for expenses related to Medicaid expansion, a deal worth $100 million. After the election of Republican Scott Brown of Massachusetts, Democrats lost their filibuster-proof majority and no longer needed Senator Nelson's cloture vote (Fabian 2010). The so-called "Cornhusker Kickback" was cancelled when the Senate passed the ACA through reconciliation (Reich and Kogan 2016). Max Baucus (D-MT), Chairman of the Senate Finance Committee in 2009, said that a single-payer system was not up for discussion because moderate Republicans would not support it (Weigel 2017) and too many Democrats opposed the idea. It is also the case that he, like others, refused to consider any health care system that would compete with private, for-profit companies and that

he received more money from groups representing health care and insurance company interests than any other member of Congress – about $3.4 million between 2003 and 2008 (Dennison 2009). As Callaghan and Jacobs wrote, private interest advocates are able to bring more "muscle" to the table in terms of sheer numbers and money to outweigh the influence of public advocacy groups at least on the national level; however, when public groups increase their numbers in smaller arenas, such as states, their power and influence also increases (2016). To the surprise and perhaps the frustration of many Senators, Mr. Baucus, who left the Senate in February 2014 to become Ambassador to China, said that he thought Congress should reconsider a single-payer system (Weigel 2017). Democrats had not held the House, Senate and White House since 1994 so their majority in the Senate in 2009 (fifty-eight plus two independents that typically voted with the Democrats) gave them an opportunity to make good on numerous Democrats' promises over the decades to enact universal health care coverage.

The nagging question is this – why did the Democrats choose not to enact a single-payer health care system? Several theories have been offered to explain why a majority of the public has not demanded universal health care, including the lack of an organized electorate and bipartisan political coalitions to push Congress (Greer and Mendez 2015), as well as racism and animosity towards the poor, a group which tends to experience more health problems (Alesina, Glaeser and Sacerdote 2001). This country has also never had as powerful a labor union movement as Western European countries have had (Quadagno 2004). Labor and trade unions in Europe gained political power in the 19th century after the Industrial Revolution but it took the Great Depression

in the 1930s for the labor movement to coalesce. Members of Congress respond to the will of the voters and the institutions of government make the adoption of generous public policies difficult. For example, we employ a winner-takes-all electoral system rather than a system that seats parties by the proportion of votes won which lessens the impact of minority interests (Alesina et al. 2001). The committee system in Congress also makes it unlikely that generous social policies will make their way to the floor for a vote (Immergut 2005). Interest group lobbying is also a contributor to lessening the final output of proposed liberal social policies (Lipset 1996). Private interests including corporations, health care professionals, and insurance companies have a vested interest in not seeing a single-payer health insurance plan implemented in the United States and have donated large sums of money to members of government to ensure their voices are heard (Cook 2009; Grim 2009). Quadagno (2004) posited that when stakeholders mobilize, their "political objectives [mesh] with those of other powerful groups" (29). It seems reasonable to suggest that less powerful or smaller groups can make up for their lack of resources by merging with other likeminded groups and this may be what is happening today.

One explanation for the failure of universal health care that applies to citizen and elected official alike is the fact that many Democrats have made an "ideological shift" to the right to join Republicans in embracing free-market capitalism which is not geared towards social welfare policy (Bonica, McCarty, Poole, and Rosenthal 2013, 104). The Founders were not concerned with income redistribution to alleviate the plight of the poor; indeed, they established the government to protect the rights of private property owners. Anti-statists posit that Americans reject the idea of

government programs controlling large sectors of the economy, like health care but that does not explain Americans' approval for Social Security and Medicare (Quadagno 2004). Previous theoretical frameworks on the issue holds that as the gap between the rich and the poor widens, the median voter increasingly prefers more redistributive policies from the government (Meltzer and Richard 1981); however, empirical evidence shows this to not be the case (Harms and Zink 2003) because redistributive democracy theory is concerned with *interests* and not *preferences* (Kelly and Enns 2010). People caught in the throes of poverty may simply believe they can work themselves out their situation and thus, not vote for redistributive policies that might actually improve their circumstances. Lack of public and private support on ideological grounds for a single-payer system was critical in explaining why there was no real concerted effort to adopt it and it also has important implications for future attempts at nationalizing the health care system.

In the 2008 presidential election cycle, private health companies and organizations, knowing the Democratic nominee had been ahead in the polls for months (Real Clear Politics 2008) and that he supported single-payer, donated $181.8 million to candidates, parties and outside groups with 55% going to Democrats and 45% donated to Republicans (Open Secrets 2017). As predicted by the Princeton Election Consortium two weeks before the election, Democrats maintained control of the House and Senate (Wang 2008). It would be easy to speculate that donations influenced Democrats in Congress to oppose a single-payer or universal plan (and causing them to oppose the president's pledge), because some form of a national health plan had been referenced in the Democrats' presidential platforms since Harry S. Truman's 1948

campaign (American Presidency Project); however, research indicates that determining whether or not campaign donations actually influence an elected official's vote is very difficult to determine. It has been established that donations do have a positive effect on a lobbyist getting inside an elected official's office for a *chat* (Kalla and Broockman 2016). What happens afterwards is subject to speculation. On the one hand, donors with deep pockets tend to give money to like-minded candidates and organizations who will likely support their views regardless of the amount of money given. On the other hand, evidence from the debate over single-payer or even a public option seems to indicate that large dollar donations did have an impact on elected officials' level of opposition.

We may never know for certain how much influence, if any, political contributions had on the demise of a single-payer system and the public option. Interest groups succeed by electing like-minded individuals to office and then lobbying them to support their mutual interests (Mackinder 2011). Another compelling and simple explanation has little to do with money and everything to do with risk aversion – politicians, regardless of party, do not like sweeping change (Madden 2010) which dismantling the for-profit health care system would have required. Once it was evident that neither a single-payer system nor the public option would receive enough Democratic support to pass the Senate, policymakers had to draft legislation that worked with the private insurance industry. In Norm Ornstein's review of the ACA's origins, he pointed out that Mr. Obama avoided the mistakes made by the Clinton Administration and allowed Congress to draft the legislation using his goals and objectives as the starting point. Members of the business community, insurance

companies, health care providers, non-profit organizations, interest groups, and ordinary citizens were consulted in the process. Unified government certainly helped the President and although there was no cooperation from the Republican members of the House, the so-called *Gang of Six*[15] in the Senate (three Republicans and three Democrats) were engaged early in the negotiations. Eventually, former Senate Minority Leader Mitch McConnell (R-KY) convinced the Republican members of the *Gang of Six* to stop cooperating with the Democrats so in the end, there was no bipartisan agreement on a bill (Ornstein 2015).

By the 2012 presidential election cycle, the ACA had been adopted but the Democratic Party lost its majority in the House in the 2010 mid-term elections and the Republicans gained seats in the Senate as well. The Republican nominee promised voters that his first act as president would be to issue waivers to all fifty states granting them the ability to opt out of the ACA (Rovner 2012) which was not actually within his power although he could have significantly altered provisions of the law with executive orders. In this election cycle, the total amount donated by private health companies and organizations was $264.8 million and the percentages were reversed – 44% going to Democrats and 56% going to Republicans (Open Secrets 2017). There is no reason to believe the 12% spread in favor of Republicans was because donors wanted to make certain the Republicans would not repeal the ACA in favor of a single-payer plan; therefore, if their donations were designed to influence votes the purpose would have been to keep the ACA intact or repeal it and go back to the system we had prior to March 2010.

[15] 111th Congress' Senate Finance Committee members: Max Baucus (D-MT), Jeff Bingaman (D-NM), Kent Conrad (D-ND), Mike Enzi (R-WY), Chuck Grassley (R-IA), and Olympia Snowe (R-ME).

For 2016, $280.1 million was donated – 52% to Democrats and 48% to Republicans (Open Secrets 2017). The Democratic nominee, Hillary Clinton, was the favorite in most polls and she had no plans to repeal the ACA unlike the Republican challenger Donald Trump. If donors believed pollsters' predictions signaled Democratic victories in the House and Senate, and the theory that campaign donations influence future voting behavior could be confirmed, then the 4% spread in donations in favor of the Democrats would be a sign that donors wanted the ACA left intact since Democrats, who held both houses of Congress, did not support a single-payer plan or the public option after President Obama was elected.

Bronars and Lott, Jr. warned us to not presume the obvious, that policymakers' votes can be bought with campaign donations. They studied the change in donations during a congressperson's last term and the votes they cast and found that "usually" there is not an effect (1997, 147). Their research indicates donors contribute to politicians who share their ideology and policy goals. Powell finds it difficult to determine exactly how much donations influence politicians' voting behavior because so much of the effects probably occur early in the committee process where bills are in their early stages (2014). If proposed bills never make it out of committee there is no way to determine how the chambers would have voted on a final piece of legislation. Of course, as any investigation of campaign donations would reveal, donors often give money to Republicans and Democrats (Open Secrets 2017) because money buys access to elected official (Kalla and Broockman 2016).

An examination of who bears the costs of the care provided to the uninsured coupled with political donations from health-related companies and organizations points

to some interesting conclusions. First, hospitals pay two-thirds of the costs of uncompensated care (Garthwaite, Gross, and Notowidigdo 2015). These costs are not fully passed on to patients with insurance in the form of higher prices for care. The presumption that *$100 Tylenol tablets* absorb the entire costs of treating patients with no insurance is not supported when we study hospitals' profits. Garthwaite and his colleagues found that when the number of uninsured people increases, either because they lost their private health insurance or their states cut back on Medicaid, hospital profits fall and when hospitals shut down, the hospitals in the surrounding area show an increase in uncompensated care (2015). Non-profit hospitals account for 70% of the private hospitals and receive tax breaks in exchange for providing health care for Medicaid patients and uninsured persons (Garthwaite et al. 2015).

In addition to hospitals and other institutions, doctors, nurses and other specialists also bear the costs of the uninsured by charging reduced fees or by donating their services and unlike hospitals and public clinics, individuals typically do not receive subsidies to offset their costs (NIH.gov 2003). Private organizations, including the American Hospital Association, American Medical Association, American Society of Anesthesiologists, American College of Radiology, and the American Dental Association donate hundreds of millions of dollars to politicians (usually to both Democrats and Republicans) and outside spending groups (Open Secrets 2017). Since members of these groups suffer financial hardships as the proportion of uninsured persons grows, it stands to reason that this is why they donate to politicians and groups that promise to keep the ACA intact. A government-run universal system would seem to solve their problems with uncompensated care, and many practitioners want to see a

single-payer system, but powerful groups have an interest in maintaining private insurance. In the three presidential elections between 2008 and 2016, UnitedHealth Group and Blue Cross/Blue Shield donated millions to the two major parties, with Democrats receiving the majority of the funds (Open Secrets 2017) so it is not likely that these two large insurance companies wanted the ACA repealed. It is more likely that they donated to both parties, which are ideologically opposed on the issue of the ACA, because they want Congress to pass legislation that increases or at least maintains the subsidies that help people afford premiums in the ACA Marketplace.

Then-Speaker of the House Nancy Pelosi (D-CA) led the Democrats to pass a health care bill in November 2009 – The Affordable Health Care for America Act (H.R. 3962). The vote was 219 Democrats and one Republican in favor with 215 members opposed – 39 Democrats and 176 Republicans (CNN.com 2009). The lone Republican affirmative vote was from Joseph Cao, a one-term Representative from Louisiana's 2nd District (New Orleans area) and 31 of the 39 Democrats that voted against it were from congressional districts that were won by Republican presidential nominee Senator John McCain in 2008 (Hossain and Tse 2009).

The Senate Democrats maintained a sixty-seat majority after Republican Arlen Specter of Pennsylvania changed his affiliation to the Democratic Party in April and Al Franken of Minnesota was finally seated in July after he prevailed in a law suit challenging his election. Also, Massachusetts' Governor Deval Patrick (D) appointed Paul Kirk, former chairman of the Democratic National Committee to fill Ted Kennedy's seat after he died in August. They passed their own health care bill on Christmas Eve 2009 – The Patient Protection and Affordable Care Act by 60 – 39. In

January 2010, the special election to fill the seat for the remainder of Senator Kennedy's term went unexpectedly to Scott Brown, a Republican who campaigned against the Democrats' health care legislation. This was surprise to Senate Democrats who had counted on the election to maintain a filibuster-proof sixty vote margin when the House and Senate versions of the bills went to the Conference Committee (Walker and Norbeck 2014).

To solve the problem presented by Brown's election, namely, the loss of their sixtieth vote for the ACA, and since tax bills must originate in the House of Representatives per Article I of the Constitution, the Senate used budget reconciliation, which only requires a simple majority to pass and filibusters are not allowed. 1974's Congressional Budget Act outlined the process of reconciliation, a way to speed up the passage of tax and spending bills that might get bogged down in legislative arguments (Reich and Kogan 2016). First, the health care bill passed in the House the previous October was set aside. The Senate added the health care bill they passed 60 to 39 as an amendment to the Service Members Homeownership Tax Act of 2009, H.R. 3590, which had already passed the House 416 to 0 in October 2009 (House.gov 2009). H.R. 3590 was renamed the Patient Protection and Affordable Care Act and sent back to the House. Second, the House passed the Senate's bill without changes by a margin of 219 – 212 (thirty-four Democrats opposed) and sent it to President Obama who signed his chief legislative accomplishment on March 23, 2010. Next, both chambers of Congress passed the Health Care and Education Reconciliation Act of 2010 (H.R. 4872) to fund the ACA and one week later, President Obama signed the second bill. The ACA, as we know it today, did not receive a single Republican vote in the House or Senate

(Govtrack.us 2010) and for the next seven years, beginning in 2011 with the House bill irreverently titled Repealing the Job-Killing Health Care Law Act, H.R. 2: 112th, (Congress.gov 2011), they would fight to overturn it.

The ACA is not single-payer (i.e. universal) government insurance and the public option was not included in the law. The public option is an insurance plan backed by the government that would compete with private insurance companies. Public opinion polling shows the public option to be somewhat less popular than the single-payer alternative which has gained in popularity since President Trump's election in 2016 (Shepard 2017). By the summer of 2017, the Pew Research Center reported that the majority of Americans said the government has the responsibility to provide everyone with health coverage. The poll results, driven largely by Democrats, should not be interpreted as support for free health care for everyone (PRC 2017). The survey questions said "…make sure all Americans have health care coverage"; it did not say the coverage would be free and paid for by tax dollars.

The ACA increased regulations on the private health care industry with the goal of covering more individuals with policies that best suited their needs. Private companies provide the insurance to most American citizens and legal residents (KFF.org 2014B) but the policies as of January 1, 2014, must meet certain minimum requirements, often referred to as the *ten essential benefits* which include: outpatient care, emergency services, hospital stays, pregnancy, maternity and newborn care, mental health and substance abuse treatment, prescription drugs, rehabilitative services and devices, lab work and preventative care, and pediatric vision and dental care. Plans also must cover FDA-approved birth control methods for women: education and

counseling, barrier and hormonal methods, implanted devices, sterilization and emergency contraception including Plan B® and prescription only ella® (Healthcare.gov 2017C). Coverage for abortion is limited by the Hyde Amendment[16], a law that restricts federal funding for abortion to cases of rape, incest or when the life of the mother is threatened (KFF.org 2014A and 2014B). States that choose to cover abortion beyond the cases referred to in the Hyde Amendment must segregate the premiums paid for abortion services to guarantee that no federal funds were used for pregnancy termination and insurance plans in the Marketplace that prohibit abortion coverage cannot be discriminated against (Kff.org 2014B). Exempt religious employers do not have to offer contraceptive coverage and birth control counseling. Some non-profit religious organizations who have objections to contraception do not have to offer a plan that covers it but the patient will have access from a third-party (Healthcare.gov 2017C). The following table highlights the important features of the ACA.

[16] The Hyde Amendment, originally passed by the House in 1976, is named after Representative Henry Hyde (R-IL). Originally only life endangerment was covered but in 1993 President Bill Clinton signed a bill making abortion for rape and incest allowable. The law must be reauthorized yearly but in January 2017, the House passed H.R. 7 making the Hyde Amendment permanent. As of November 2017, the bill is being considered in the Senate Finance Committee (Govtrack.us 2017). A competing bill called the EACH Woman Act (Equal Access to Abortion Coverage in Health Insurance), H.R. 771, was introduced in the House in January 2017 and as of November 2017, the bill is being considered by the Subcommittee on Health (Congress.gov 2017A).

Table 4.2 Key Features of the ACA

Ten Essential Benefits
1) Ambulatory Patient Services or Outpatient Care: Receiving treatment and walking out of the facility
2) Prescription Drugs: All plans must cover at least one drug in every class/category of the U.S. Pharmacopeia
3) Emergency Care: No charges for out-of-network visits; no preauthorization required
4) Mental Health Services: Patients are billed for ~$40 per session; total number of sessions can be limited
5) Hospitalization: Hospital stays must be covered by the insurer
6) Rehabilitative & 'Habilitative' Services: Therapies to recover from injuries and overcome long term disabilities
7) Preventative & Wellness Services: Vaccinations, Physicals and Well Visits (checkups)
8) Laboratory Services: Lab work, preventative screening tests, scans (including MRIs)
9) Pediatric Care: Dental care and vision tests (including eyeglasses/lenses) for children under 19
10) Maternity & Newborn Care: Prenatal care at no extra costs; childbirth and new born infant care
FDA-approved birth control education and counseling, barrier and hormonal methods, implanted devices, sterilization and emergency contraception; coverage for abortion is limited by the Hyde Amendment; religious and non-profit organizations can be exempt but access from third-parties is required.
Maximum income level to qualify for Medicaid was increased; persons earning 100% to 138% of poverty level can qualify.
Pre-existing conditions must be covered; individuals cannot be turned down for coverage because of a pre-existing condition.
Plans purchased through the Marketplace must cover adult children up to age 26.
The ACA offers consumers the choice of different levels of plans to suit their financial needs (low premiums/high deductibles to high premiums/low deductibles)
Tax credits available for low-income individuals to help with insurance plan costs.
Individual Mandate: individuals who do not cover themselves with health insurance are subject to a financial penalty.
Employers with 50 or more full-time equivalent (30 or more hours per week) employees are required to offer health insurance to workers and their dependents (but not their spouses). Small businesses may be eligible for tax credits.
Employer Mandate: Qualified employers who do not offer health insurance are subject to a penalty.

Source for Ten Essential Benefits: Frank Lalli (2013)

One of the key features of the ACA is an increase in the maximum income level to qualify for Medicaid thus expanding the pool of covered individuals. Medicaid expansion was originally required for all states but the Supreme Court ruled in *National Federation of Independent Business vs. Kathleen Sebelius* (2012) that states could opt out of Medicaid expansion if they chose without losing all Medicaid funding as the ACA had threatened. Approximately 2.4 million adults fall into a "coverage gap" in the states that chose not to expand Medicaid coverage under the ACA (Garfield and Damico 2017). Their income is too high to qualify for Medicaid and many uninsured

persons believe it is not high enough to afford the premiums under the ACA given their other living expenses. In June 2017, a Public Opinion Strategies poll of voters in six states (Alaska, Arkansas, Colorado, Nevada, Ohio, and Tennessee) showed that most wanted the level of Medicaid funding to either increase or stay the same indicating that the Republican *repeal and replace* bills that cut Medicaid funding[17] will not win voter approval (Jacobs 2017).

Pre-existing conditions are covered by the ACA. Originally, these conditions were covered by the Pre-Existing Condition Insurance Plan (PCIP) through a temporary national high-risk pool (KFF.org 2014B). PCIP ended on April 30, 2014 and the current law prohibits insurers from refusing to cover a patient or charge higher premiums because of a pre-existing condition (HHS.gov 2017). In May 2017, a Politico/Morning Consult poll revealed this provision of the law to be popular among registered voters – 52% of Democrats and 48% of Republicans oppose allowing states to drop pre-existing coverage (Savransky 2017C).

The ACA allows parents to cover their children up to the age of 26 on a plan purchased through the Marketplace and they can add children to their existing plans during the annual open enrollment period. These adult children can stay on their parent's plan even if they get married or have a child. Employer-based insurance plans allow adult children to stay on their parent's plan until they turn 26 (some states have different rules regarding the exact age cutoff) and Marketplace plans cover children until December 31 of the year they turn 26 (Healthcare.gov 2017D). An Associated

[17] The Senate's version of H.R. 1628, the Better Care Reconciliation Act, would cut funding to Medicaid by $772 billion by 2026 according to the CBO. The House's version, the American Health Care Act would cut funding to Medicaid by $880 billion (Jacobs 2017).

Press-NORC Center for Public Affairs Research poll in January 2017 showed that 65% of the respondents who opposed the ACA were in favor of keeping adult children on their parent's insurance until the age of 26 (ScienceDaily.com 2017).

The legislation's individual mandate was challenged on the basis that forcing Americans to purchase a product (i.e. insurance) they did not want was unconstitutional. In arguments in front of the Supreme Court, the Obama Administration defended the individual mandate by saying that the 16th Amendment gives the federal government the power to lay and collect taxes and that the "commerce clause" gives the federal government the power to regulate interstate commerce. In *National Federation of Independent Business vs. Kathleen Sebelius* (2012), the Court upheld the individual mandate by a margin of 5 – 4; however, the Court struck down the requirement of states to participate in the expansion of Medicaid (Liptak 2012). Many Republicans viewed the *Sebelius* decision and the 2015 decision in *King vs. Burwell*[18] (Hiltzik 2015) as a betrayal of the conservative values they thought the new Chief Justice, John Roberts, had.

The ACA offers consumers the choice of different levels of plans to suit their financial needs – Bronze (entry level; low premiums/high deductibles), Silver, Gold, and Platinum (high premiums/low deductibles). All plan levels have experienced increases in premiums from 2016 to 2017: Bronze 21%, Silver 17%, Gold 22%, and Platinum 15% (Coleman 2016). Premiums are not the only measure of how expensive (and *usable*) and insurance plan is – deductibles and out-of-pocket expenses are

[18] In *King vs. Burwell* (2015), the Supreme Court ruled that premium tax credits had to go to people residing in states with both state-established exchanges and exchanges established by HHS. The actual ACA legislation said only states with state-operated exchanges could get the tax credits. In a 6 – 3 ruling, the Justices said that it was clear that the majority that Congress meant for all states to get tax credits.

important in the calculation as well. Let us take a look at the cost of the Bronze plan, designed for low-income earners or for people in good health who do not expect to need health insurance in the short term: the average deductible for a single individual Bronze plan enrollee is $6,092 and the out-of-pocket maximum is $6,904. For a family enrolled in the Bronze plan, the average deductible is $12,393 and the out-of-pocket maximum is $13,810 (Coleman 2016). If a person's income is above the level that would qualify him or her for Medicaid and can only afford to purchase the Bronze plan, they may feel at ease because they are covered with insurance, but they cannot use their insurance (aside from emergency room visits) until they have satisfied a $6,092 deductible. These high deductibles act as an incentive to pay the penalty for not purchasing insurance. Having health insurance with affordable premiums but a deductible so high that no low- or moderate-income person can afford to use the insurance is not the same as having *usable* health insurance.

As with any omnibus legislation that completely overhauls an industry, the initial rollout of the ACA was not entirely successful. The ACA's individual mandate required Americans to prove they were covered with health insurance that met the minimum standards allowed by ACA rules or pay a penalty collected by the Internal Revenue Service (IRS). The website, HealthCare.gov, crashed multiple times and consumers were unable to search and enroll in the insurance plans offered (Mortiere 2013). Opponents of the ACA pointed to this problem as an indication that the federal government could not be trusted to run one-sixth of the economy. In 2013 over 90% of Americans that were covered with private health insurance got it through employers (Pauly and Leive 2013). In a speech made to a joint session of Congress in September

2009, President Obama promised Americans that if they were satisfied with their current health insurance plans they could keep them under the ACA (CBSNews.com 2009). In November 2013, shortly after NBC News reporter Lisa Meyers revealed that the Obama Administration had known since 2010 that millions of Americans might lose their existing insurance plans (Todd 2013), he apologized for making a promise that could not be kept (Killough 2013) after an estimated 3.5 to 4.7 million insurance policies were cancelled (Alonso-Zaldivar 2013; 2014). Again, opponents used this as more evidence that Americans could not trust the government's involvement where their health care was concerned. In response to that criticism, President Obama extended the time to replace old policies that did not meet ACA requirements by two years (Alonso-Zaldivar 2014). In 2016, private employer-based health insurance covered 55.7% of the population with direct-purchase insurance (e.g. plans purchased directly from private companies or through the Exchange) covering 16.2% (Census.gov 2017).

One of the goals of the ACA was to expand Medicaid coverage to low-income people who earn 100% to 138%[19] of the federal poverty level. Medicaid is a cost-sharing program with the federal government providing matching funds to individual states. From 2014 to 2016, the federal government would match 100% of the cost of expansion. In 2017 the percentage drops to 95%, 94% in 2018, 93% in 2019 and 90% in 2020. After the Supreme Court ruled that states could not be forced to participate in the Medicaid expansion, several governors opted out because they believed by the year 2020, their costs would skyrocket if the federal government no longer matched funds by

[19] Many sources report the percentage as 133% but the method of calculation shows the percentage to be 138% (healthcare.gov 2017A).

90% (Roy 2012). Of greater concern to the states is what Roy refers to as the "woodwork population" – the people who were already eligible for Medicaid before the expansion but had not yet enrolled. When they *come out of the woodwork* to enroll, their Medicaid costs will not be covered by the ACA's 90% to 100% reimbursement rate. States will have to cover 43% of these enrollees' costs. As of January 2017, thirty-one states and Washington, D.C. adopted the Medicaid expansion and nineteen have not (KFF.org 2017A).

In May 2016, the Department of Health and Human Services issued its rule to enforce Section 1557 of the ACA, regarding nondiscrimination in health programs and activities (Harrington 2016). This was considered a victory by advocates of transgender rights because it paves the way for Medicaid, Medicare and insurance companies to cover sex reassignment surgery and other related health issues. The rule, however, is vaguely worded with regards to insurance companies; it only pressures insurers to cover the surgery, it does not force them to do so. The information on transgender coverage available at Healthcare.gov, the ACA's *information station*, is just as nebulous. The website encourages consumers to investigate the various policies' exclusions before purchasing a (presumably) approved plan but then tells them "these transgender health insurance exclusions may be unlawful sex discrimination".

The ACA's employer mandate requires businesses with fifty or more full-time "equivalent" employees to offer health insurance policies to their employees and their dependents but not to their spouses. Full-time employment is considered now, by law, to be 130 hours in one month or thirty hours per week as opposed to forty hours per week. If companies do not offer plans that meet the minimum standards set by the

ACA, they will have to pay a fine and if a plan costs an employee more than 9.66% of his or her annual salary a penalty is also attached (ObamaCare.net 2016). These rules were implemented to ensure employers offered health insurance that their eligible employees could actually afford but they also could serve as an incentive to cut employees hours to below thirty per week or to restrict growth and expansion.

Smaller companies may be eligible for tax credits so they can offer affordable plans. As of late 2016, roughly 96% of employers are small businesses and not required to participate (ObamaCare.net). The employer mandate was postponed from 2014 to 2015 – 2016 after several influential business leaders complained they could satisfy the reporting requirements in time. The consequences of postponement meant that lower income employees who wanted to purchase insurance through their employers at a price they could afford were not able to do so and had to turn to the Marketplace (formerly called the Exchange) on HealthCare.gov where plans were considerably more than they expected (Pauly and Leive 2013). Even with subsidies for qualified consumers, many Americans chose to opt out of the ACA and simply pay the penalty to the IRS. In 2015 the average penalty was $325 or 2.5% of annual income and in 2016 it rose to $695 or 2.5% of annual income (whichever is higher). In 2016, IRS Commissioner John Koskinen reported to Congress that $3.5 billion of penalties were collected from 6.5 million people who did not have health insurance in 2015 (Galewitz 2017). The backbone of the ACA is the enrollment of younger people in good health who will pay more in premiums than they will take out in benefits, thus subsidizing the older, less healthy enrollees. Costly government subsidies provided to Marketplace enrollees and the refusal of younger people to enroll has resulted in increasing costs for ACA plans by

as much 145% in some markets (Cox, Long, Semanskee, Kamal, Claxton, and Levitt 2016) with an average increase around the country of 60% (Book 2017). Large insurers including Aetna and UnitedHealth have decided to no longer participate in the ACA Marketplace because they cannot afford to serve a "sicker-than-expected customer base" (Howell, Jr. 2016). If it is true that competition brings about lower prices for goods and services, the ongoing trend of companies leaving the Marketplace may be a sign of trouble for ACA premiums. The average number of insurance providers in states that use the Marketplace to enroll consumers has dropped to less than four in 2017[20] with only 57% of Marketplace exchanges offering three or more providers (Cox et al. 2016).

In the early years after the ACA's passage, public opinion polling was consistently negative but that changed in February of 2017 (Kff.org 2017E) after Donald Trump was elected President and promised to sign a new, more affordable health care law. Republican office holders and candidates for office promised to repeal and replace the ACA. With Hillary Clinton's defeat, the Republicans were presented with the opportunity to do exactly that. After fifty-four votes in the House to repeal the ACA prior to the 2016 election (Berenson 2017) the replacement legislation titled the American Health Care Act of 2017 passed the House without a single yea vote from the Democrats but three variations of the bill, including a so-called "skinny repeal" failed in the Senate when three Republicans voted against the legislation[21] (Parlapiano, Andrews,

[20] The number of insurance providers in states with the ACA Marketplace range from one in Alabama, Alaska, Oklahoma, South Carolina and Wyoming and to fifteen in Wisconsin (Cox et al. 2016).

[21] Republican Senators John McCain (AZ), Susan Collins (ME) and Murkowski (AK) voted against the American Health Care Act of 2017. .

Lee, and Shorey 2017). On July 25, 2017 Senator John McCain made an impassioned speech on the floor of the Senate to start over with the process and have both parties work to improve the ACA. He reminded his colleagues that the ACA was passed without any support from the Republicans in 2010 and repeating that mistake by not compromising with the Democrats on its replacement was wrong (Senate.gov 2017). The President used his bully pulpit to blast the Senators, especially Senate Majority Leader Mitch McConnell (R-KY) for allowing the measures to fail. The Senate left for the August recess on August 3, 2017 but not before agreeing to hold pro forma sessions in order to block President Trump's ability to make recess appointments (Killough 2017). Upon their return, three Senators, two Republicans and a Democrat, proffered two new health care bills for consideration. Lindsey Graham's (R-SC) and Bill Cassidy's (R-LA) offering was a plan to block grant the ACA funds to the states so they can decide how to spend the money (Bash 2017). Governors would be the ones to decide how much of the ACA they would keep unchanged. Their bill did not receive enough Republican votes to move to debate and was tabled until after tax reform legislation is accomplished (Mangan 2017A). By contrast, Senator Bernie Sanders' (D-VT) introduced a plan called the Medicare For All Act in September 2017. Senator Sanders had pushed for a single-payer health care plan in 2013 but he had almost no support (Krieg and Luhby 2017).[22] This time, he had the support of one-third of the Senate Democrats (Park and Andrews 2017). In October 2017, Senator Tim Kaine of Virginia (former Democratic nominee for Vice President in 2016) and Senator Michael Bennett (D-CO) introduced a bill adding a public option based on Medicare to the

[22] A similar bill was introduced in the House of Representatives by Congressmen John Conyers (D-MI) in February 2015 and is currently in three committees.

ACA, touting Medicare's low overhead (Sullivan 2017) which is 3% – 5% and there are no high salaries for executives and no stockholders to serve (London 2017). In January 2017, Representative John Conyers (D-MI) introduced a bill in the House for a single-payer health care system. As of April 2018, H.R. 676: The Expanded & Improved Medicare For All Act has 122 Democratic co-sponsors in the House of Representatives (Congress.gov 2018) There are 193 Democrats serving in the House in the 115th Congress so 122 cosponsors accounts for a substantial majority of Democrats.

The health care industry is expected to grow at an annual rate of 5.6% from 2016 to 2025 resulting in a nearly 20% share of the gross domestic product by 2025 (CMS.org 2016). Both Republican Senators and Senator Sanders appeared to be operating under the belief that the 2016 election provided them with a mandate to pass new health care legislation to address that growth. According to Grossback, Peterson and Stimson (2006), mandate elections are infrequent – only three since 1964 beginning with President Lyndon Johnson's *mandate for unity* after President Kennedy's assassination, President Ronald Reagan's election in 1980 thanks in part to White working-class *Reagan Democrats*, and the Republican take-over of the House of Representatives and the Senate which installed Newt Gingrich (R-GA) as Speaker of the House in 1994. Elected officials might believe that they have a mandate from the voters, but that belief only affects their behavior for a short period of time at best (Grossback et al. 2006). Considering how long it takes Congress to pass legislation as impactful as changes to the ACA, we might predict that the perceived mandate from voters will weaken before anything works its way through the committee system. Voters are self-interested but that does not mean they always vote for their own interests

according to others' judgments of what is best for them (Frank 2004). They vote firstly according to their partisan identification (Converse et al. 1960, Wolfinger and Rosenstone 1980, Zaller 1992, Carsey and Layman 2006) but in the current political climate independents' demands figure prominently in election outcomes.

In 1973, roughly five years after Medicare and Medicaid had been implemented, the majority of medical professionals were in favor of some form of national health insurance (Colombotos, Kirchner, Phil, and Millman 1975). In April 1974, 54% of Americans favored a national "comprehensive health insurance program that combined federal government, employer, and employee contributions into one health insurance system that would cover all medical and health expenses" (Erskine 1975). Forty-three years later not much has changed – in June 2017, Kaiser Family Foundation poll showed that 53% of Americans are in favor of a "national health care plan" (Krieg and Luhby 2017). This poll was the topic of conversation in many media outlets after it was made public. There was widespread disbelief on the part of Conservatives in the media as to the results but proponents of nationalized health care (i.e. single-payer) seemed unsurprised. What accounts for the change in the public's tolerance for the ACA or government health care? I asked the question at the beginning of this study, *what explains the public's level of support for the ACA?* The House of Representatives, which was held by a Democratic majority in March of 2010, passed the Senate version of the ACA without Republican support and without support from thirty-four Democrats (CNN 2010). Of course, there was a national campaign led by President Barrack Obama and other policy elites, but voters across America were just as

responsible for the passage of the ACA. Voters will also be responsible for either keeping the ACA as is or replacing the legislation with something else.

We know unhealthy lifestyle choices lead to poor health, negative socio-economic outcomes and higher mortality rates but does health insurance coverage (either private or through a public program for those who qualify) mitigate the effects? This is an issue that must be studied and the results shared with an important segment of the public that has a great deal of influence on future health care legislation – the voters. Public opinion polling on the ACA has consistently been negative until the House of Representatives passed its replacement for it and the proposed legislation was scored by the CBO. According to Kaiser Family Foundation's Health Tracking Poll, as of June 2017, 51% of individuals polled approve of the ACA and 41% disapprove (KFF.org 2017B). Gallup's polling shows the same trend. As of April 2017, 55% of Americans approve of the ACA, 40% would revise the existing law, 30% want the ACA repealed and 26% want no changes (Norman 2017). The ACA has not appeared this favorable in their polling since July 2010, just a few months after the legislation was signed into law (KFF.org 2017B).

We have had opportunities to analyze the results of government health insurance. In 2008, in anticipation of expanding Medicaid eligibility and the likely passage of some kind of federal government health care law, the state of Oregon randomly selected one-third of a 90,000 person waiting list for the Oregon Health Plan Standard, the state's Medicaid program, and offered the low-income lottery *winners* the opportunity to apply for an enroll in the program if they were still eligible. This provided researchers an excellent opportunity for a natural experiment to test if health

insurance led to health *care* and if that care resulted in better health. Katherine Baicker and her research partners studied the effects of health care on health outcomes over a two-year period for individuals selected in the lottery and compared them to the control group, those who were not selected and had no health coverage. The results of their empirical study, published in 2013, showed Medicaid did not have a significant impact in three problematic areas – blood pressure, cholesterol level, and diabetes. These areas were chosen presumably because the results were observable and quantifiable. They did find a greater likelihood that individuals in the test group were more likely to get a diagnosis for diabetes and to use medication for the condition but there was no such effect on diagnoses for high blood pressure or high cholesterol. Their results also showed a decrease in the rate of depression in the test group. Overall, the researchers were able to report that they saw improvements in mental health, health care coverage via Medicaid and in the consumption of health care services, and a reduction in "financial strain" because those in the test group did not have to pay their medical bills (which increased Medicaid spending by $1,172 annually per person in the study). It must be noted that while the test group "self-reported" better health outcomes after receiving Medicaid coverage and utilizing health services, the aspects of health which the researchers could measure (blood pressure, cholesterol and diabetes) showed no significant improvements. These results should concern policymakers and voters who are considering drastic changes to the ACA and Medicaid in 2017. *Feeling* better is good, but *being* better is the goal.

Other studies have reported similar findings with respect to the mitigation of financial hardships due to unpaid medical expenses and to the increase in access to

health care and the utilization of health services via the Massachusetts Health Care Reform Law of 2006[23] and the ACA's Medicaid Expansion (Sommers, Gawande and Baicker, 2017). While access to preventative services is good news, it is not the same thing as measurable differences in health outcomes. Time for studies comparing the health outcomes of people on Medicaid and people without any coverage may be running out as the Republican majorities in the House of Representatives and the Senate consider a replacement for the ACA which cuts $834 billion from Medicaid between 2017 and 2026 and may leave 55 million people without insurance coverage by 2026 (CBO 2017A).

Nestlé Health Science funded a study to determine how obese individuals who had health insurance coverage for non-surgical weight loss treatments compared to program participants who paid out-of-pocket for the treatments. After one year, the results indicated no significant difference in Body Mass Index (BMI) between the covered group and the self-pay group (Ard, Emery, Cook, Hale, Frain, Lewis and Song, 2017).

The Oregon and Nestlé studies' finding are interesting in that they indicate having health coverage is not the same as having good health. Listening to a doctor's advice is not the same thing as following that advice. I do not mean to suggest that these studies' results should be interpreted as the ACA or some other government health care program is doomed to fail. I believe that bad habits (i.e. smoking, over-eating, and substance abuse) are replaced with good habits and that takes time and effort on the part

[23] The actual title is An Act Providing Access to Affordable, Quality, Accountable Health Care. Information for the Commonwealth Health Insurance Connector Authority is located at: http://www.mahealthconnector.org.

of Americans to change. We have valued instant gratification for so long that it has become ingrained in our culture. A few short years of experience with access to health care is not going to change that.

Whether the ACA could change Americans' long-term behavior in a significant way may be a moot question. President Donald Trump's chief campaign pledge was to get "rid of immediately ObamaCare, which is a disaster" (Donovan and Kelsey 2017). In October 2017, he ended the federal government's practice of reimbursing insurance companies for the subsidies that the ACA requires for low- to middle-income purchasers of ACA policies. The Cost Sharing Reduction (CSR) subsidies were written into the law but not appropriated by Congress and their distribution is illegal under the Constitution, according to some legal scholars (Somin 2017). These subsidies were projected to be $10 billion in 2018 (Mangan 2017B). The expectation is that without these reimbursements insurance companies will leave the Marketplace or raise their premiums – the fewer insurers there are in a state, the higher the premiums. Premium hikes may produce lower enrollment which causes premiums to increase more to cover the insurance companies' losses (Cohn 2016). Even with the CSRs, insurers have pulled out of the Marketplace in several states because they failed to anticipate how much the ACA's ten essential benefits, such as maternity care and coverage for preexisting conditions, would affect their pricing structures (Cohn 2016).

Even if Congress had passed legislation appropriating funds for the CSRs and struggling insurance companies figured out how to price their products in order to make a profit, the future of the ACA as it currently exists is in doubt. A tax reform bill, H.R. 1: Tax Cuts and Jobs Act, passed the House on November 16, 2017 (Congress.gov

2017B), with the individual mandate intact but the Senate version stripped the ACA's requirement that everyone carry health insurance or pay a penalty (Haberkorn 2017). Mr. Trump signed the bill into law on December 22, 2017 after the House passed a bill waiving a $25 billion automatic cut to Medicare required by PAYGO[24] (Tumulty 2017). House Minority Leader, Nancy Pelosi (D-CA) is worried about the ACA's survival because the program depends on people purchasing health insurance. She called the Senate's tax bill "Armageddon" (Marcos 2017). To placate those who feared insurance premiums would increase with no individual mandate, Senate Republicans considered a special funding measure for ACA enrollees but House Republicans were opposed to the idea (Haberkorn 2017).

Two months before the tax bill with the individual mandate intact was introduced in the House, public opinion polling by the Urban Institute on repealing the controversial provision was a bit of a surprise with respect to Democrats. Republican results were predictably negative but only 44.8% of Democrats were in favor of keeping the individual mandate with 20.3% supporting its repeal. Independents were 14.5% for keeping the individual mandate and 33.6% against it (Holahan, Karpman, and Zuckerman 2017). In early-December, a Harvard University-Harris poll showed opposition to the tax bill to be 64% overall with support from Republicans at 72% and opposition by Democrats at 89% and 70% among independents (Easley 2017). If Democrats and independents understood that repealing the individual mandate could very well lead to the eventual demise of the ACA, their support for keeping it should

[24] PAYGO stands for pay-as-you-go. It is a budget rule requiring that new legislation for revenues or spending on entitlement programs that add to the budget deficit must be offset by cuts in mandatory spending or tax increases.

have been much higher. One explanation for the disconnect could be that their opinions in December were influenced by discussions in the media regarding the fallout from the Senate's version of the tax bill that repealed the individual mandate. One month prior, the CBO released a report that repealing the individual mandate would increase the number of uninsured by four million in 2019 and thirteen million by 2027 (CBO 2017B). Other aspects of the law, such as Medicaid expansion, federal subsidies for ACA premiums (Mukherjee 2017) and no denial of insurance because of pre-existing conditions (Pear 2017) are still in effect.

Early analysis of the effects of repealing the individual mandate do not show much change in the overall percentage of uninsured persons. National Center for Health Statistics reported that the number of Americans without health insurance coverage was 28.6 million in 2016 compared to 28.9 million in 2017 with insurance premiums remaining largely unchanged (Jula 2018). Prior to the adoption of the ACA, the number of persons with no health coverage was over 47 million (KFF 2014). Most elderly and low-income children are covered by Medicare and Medicaid, leaving non-elderly adults as the largest group of uninsured persons. The cost of health insurance if a person does not qualify for a subsidy is quite expensive and the inability to afford health insurance is the number one reason these non-elderly adults are uninsured (KFF 2014). Another problem facing the uninsured is the fact that they do not have the knowledge necessary to navigate the health care system – 33% do not have a regular doctor and 49% say they have no usual source of medical care. Another problem facing potential ACA enrollees was the fact that the Trump Administration cut the advertising budget for the ACA's enrollment period by 90%. The enrollment window opened on

November 1, 2017 and closed on December 15, 2017. That new enrollment period dropped from three months to six weeks. A Facebook campaign to inform the public of the change was launched amidst a public outcry that the new administration was doing its best to cut the number of people taking advantage of the opportunity for health coverage (Snopes 2017).

It is important to restate that the ACA has become more favorable in the eyes of the public the longer it has been in existence. As of April 2018, more Americans approve of the ACA than disapprove. The critical thing for House members and Senators to glean from these polling results is that it is not only low-income Americans that approve of the ACA, but middle- and high-income Americans also have favorable opinions of the legislation (KFF.org 2018).

Chapter 5: Data, Variables and Measures

This dissertation has two components – a qualitative study consisting of personal interviews with 36 men and women in Oklahoma and Texas. The description and results of the qualitative study are contained in Chapter Eight. The data for the quantitative portion of the study were collected by the University of Oklahoma Public Opinion Learning Lab (OUPOLL), under the supervision of its Director, Dr. Amy S. Goodin, via a telephone survey using Voxco Survey Software of Montreal, Quebec, Canada[25]. The telephone numbers were purchased from Survey Sampling International of Shelton, Connecticut[26]. All interviewers successfully passed their certification requirements specified by the Collaborative Institutional Training Initiative (CITI). The survey was in the field from October 30, 2013 to March 6, 2014. The analysis was completed using IBM's statistical software SPSS (version 19.0)[27].

States included in the sample were: California, Florida, Maine, Minnesota, Missouri, Montana, Nebraska and Oklahoma[28]. For the regression analysis, the states were weighted by party and gender according to each state's voter registration data available at the states' election boards. The purpose of choosing these eight geographically, economically, culturally and politically diverse states was to get as representative a sample of the country as possible. Each state represents other states that shared its demographics and choices with respect to the Affordable Care Act

[25] Voxco Survey Software website: http://www.voxco.com/contact-us.php

[26] Survey Sampling International (SSI) website: https://www.surveysampling.com/

[27] IBM SPSS website: https://www.ibm.com/products/spss-statistics

[28] Oklahoma was oversampled but a comparison regression analysis on the five key models between a full data set and a set with two-thirds of Oklahoma's sample randomly cut showed no material difference in significance and no coefficient's signs changed directions.

(ACA). A description of each state's political and demographic characteristics appears in the section below.

California and Minnesota both voted for the incumbent Democratic presidential candidate, Barack Obama, in 2012 and have Democratic governors who chose to set up the state-based Health Insurance Marketplace (Pear 2012). Their counterparts, Nebraska and Oklahoma, voted for Republican candidate Mitt Romney in the 2012 election and have Republican governors who made the decision to reject the exchange and default responsibility to the federal government (Pear 2012).

No Republican members of the House voted for the Senate's version of the ACA in March 2010.[29] All Democratic California, Florida and Maine House members voted to pass the health care bill. In Minnesota, one Democratic member out of five voted against the bill along with one Democratic member out of four in Missouri. Oklahoma's lone Democrat also voted against the bill. Montana and Nebraska's representatives are all Republican (Govtrack.us 2010).

California has a high immigrant population (27.2%) while by comparison, Minnesota (7.1%), Nebraska (6.1%) and Oklahoma (5.7%) do not (Camarota 2012). These figures prompt me to wonder if a significant presence of immigrants in the sample states played a role in the passage of the ACA. The ACA does not cover unauthorized immigrants but "lawfully present" immigrants are eligible to purchase insurance, apply for tax credits or enroll in Medicaid (NILC.org 2014). The percentage

[29] No Republican members of the House voted for the Senate's version of the ACA in March 2010. See Chapter 4 for a discussion of the reconciliation process and its impact on the passage of the Affordable Care Act.

of mixed-status families, families with members who have different citizenship and immigration designations, has grown (Taylor, Lopez, Passel and Motel 2011).

Florida and Maine have Republican governors who opted out of the exchange (Pear 2012) but each state voted to reelect President Obama in 2012. In both states, all 'nay' votes on the ACA came from Republican House members while all 'yea' votes were cast by Democrats. Florida's immigrant population stands at 19.4% while Maine's population of immigrants is only 3.4% (Camarota 2012). The uninsured rate in Florida in 2009 was 20.9% and in Maine, 10.5% (Newman 2011). These figures suggest that health insurance coverage may have an influence on decision-making.

Montana and Missouri each voted Republican in 2012 and have Democratic governors who represent Republican-leaning populations. These two governors opted to reject the exchange like Nebraska and Oklahoma did (Pear 2012). Montana's one House member, a Republican, voted against the ACA. One Democratic House member out of four from Missouri voted against the ACA along with all five Republicans. Montana's immigrant population is 2% and 3.9% of Missouri's population are immigrants (Camarota 2012). In 2009, Montana's unemployment rate had risen from 4.6% to 6.2% while Missouri's had gone up to 9.3% from 6.1% compared to the national average of 9.3% for the year (BLS.gov 2010). Considering that 50% of the population secured health insurance through their employers in 2013 (KFF.org 2017D), I am curious as to the impact of unemployment on opinions of the ACA.

Interviewers were trained before the survey was put into the field. They were told not to answer respondents' questions about the ACA but they could reread questions for clarification. The policy preference questions (dependent variables),

knowledge, and cultural worldview assessment questions were rotated so that the interviewers would sound fresh each time they interviewed a new respondent. There were no problems or incidences with the survey to report. Interviewers spoke to approximately 485 respondents between the ages of 18 and 64. Persons age 65 and above qualified for Medicare and were not included in this survey although they certainly vote at higher numbers than their younger counterparts. I was interested in the opinions of voters who could be directly impacted by the legislation.

I hypothesized that a person's cultural worldview, rather than income level, should be the determining factor in the approval or disapproval of the ACA and other health care-related redistributive policies. Other independent variables like being a loyal party voter and ideology are important factors but not as explanatory as cultural worldview. In order to support my hypotheses, I have chosen independent variables that I believe play an important role in the decision-making process. Table 5.1 shows the descriptive statistics (weighted by party and gender)[30] for the independent variables and the five key dependent variables (the policy preferences).

Respondents were asked to provide their age in years but for the ten people who refused, they were given an option to choose a range. I substituted the midpoint in that range for their actual age (age^2 was also used in the regressions). The seven-point Likert scale for ideology was collapsed into a three-point scale. For easier analysis, I created binary variables for some of the categorical variables to use in the regressions. Below is a list of the independent variables and the reason they were chosen (not all

[30] Unweighted descriptive statistics are included in Appendix E.

independent variables used in all of the models). The key dependent variables follow afterwards:

- Gender, race, income, education, loyal party voter, and ideology: These are standard demographic variables.
- Cultural worldview: The four cultural worldviews should provide more explanatory power than ideology or income.
- Party loyalty: Always voting with either the Republicans or the Democrats may have an effect on the interest in the ACA. (Party x Party Loyalty)
- Households with minor children: Parents with children should be more concerned with health insurance and health care issues.
- Women with minor children: Women with children should be more concerned with health insurance and health care issues.
- Employed: Employment status should influence the interest in the ACA.
- Job loss or pay cut: Losing a job or taking a pay cut should influence the interest in the ACA.
- Reason for no coverage: Not having health insurance because of the inability to afford it may influence the interest in the ACA.
- Business owner: The ACA's employer mandate should be of interest to business owners.
- Insurance coverage: Having health insurance coverage should influence the interest in the ACA.
- Long term coverage: Having continuous health insurance coverage for five years or longer should influence the interest in the ACA.
- Health status: How healthy a person feels should influence the interest in the ACA.
- Disability status: A disabled person might feel vulnerable to health issues and that should influence the interest in the ACA
- Economic outlook: A person's assessment of their current and future economic status may influence the interest in the ACA.

- Knowledge Index: Political knowledge is not a measure of intelligence but it is a measure of interest in political issues, such as the ACA.

- Primary news source: Where a person gets their news may influence the interest in the ACA. Dummies were created for television, the Internet and printed newspapers and magazines.

- Union State: The eight states were divided into two groups – four with union membership above the national average of 10.7% and four states with union membership below the national average (BLS.gov 2017).

- Change in position: (Position now – Previous position)/Position now

Dependent Variables

- Approval of the Affordable Care Act: Some form of health care legislation will be with us for a long time. How do respondents in eight disparate states feel about the ACA?

- Approval of increasing taxes on incomes of $250,000 or more to fund the ACA: How do respondents in *blue* and *red* states feel about raising taxes for the ACA?

- Approval of expanding Medicaid so more low-income households are covered: Medicaid expansion is fundamental to the ACA although many people do not understand that. How do respondents feel about this aspect of the ACA?

- Approval of the government covering undocumented immigrants with basic health care: The ACA does not cover undocumented immigrants although many people believe that to be the case. How do respondents feel about the possibility of covering them with government insurance?

- Approval of lowering the age for Medicare from 65 to 55 so more people can qualify: Given that this age demographic turns out to vote more than younger people and the mean age of the sample was expected to be middle-aged, how do respondents feel about more people covered by Medicare?

Table 5.1. Weighted Descriptive Statistics (Telephone Survey)

Independent Variables

State	California	9.5%
n = 452	Florida	7.4%

	Maine	8.2%
	Minnesota	14.6%
	Missouri	7.4%
	Montana	13.9%
	Nebraska	9.5%
	Oklahoma	29.4%
Union State Membership	1 Above National Average of 10.7%	
	California	46.3%
	Maine	
	Minnesota	
	Montana	
	0 Below National Average	
	Florida	53.7%
	Missouri	
	Nebraska	
	Oklahoma	
Spanish Language: *n* = 452	1 Florida and California	16.9%
	0 Balance of states	83.3%
Age *n* = 450 Mean = 49.12 Median = 52 Std. Dev. = 12.44	Minimum	18
	Maximum	64
Gender *n* = 451	1 Female	58.4%
	0 Male	41.6%
Marital Status *n* = 451	Single, never married	20.0%
	Married	61.9%
	Divorced	11.9%
	Separated	1.4%
	Widowed	4.1%
	Living with a partner	0.7 %
Unmarried *n* = 451	1 Unmarried	38.1%
	0 Married	61.9%
No Children *n* = 452	1 No children	69.4%
	0 Children at home	30.6%

Women w/Children	1 Woman w/minor children	17.2%
n = 485	0 Not woman w/children	82.8%
Elder w/No	1 50+ w/no minor children	44.9%
Children	0 Not an elder w/child	55.1%
n = 450		
Race	African-American	3.1%
n = 448	Asian	2.2%
	Hispanic	3.3%
	Native American	5.7%
	Non-Hispanic White	85.5%
	Self-Identified as Other	0.3%
	1 Non-White or Mixed	14.5%
	0 Non-Hispanic White	85.5%
Knowledge Index	Nothing correct	3.3%
n = 452	One answer	22.0%
Mean = 2.33	Two answers	33.9%
Std. Dev. = 1.17	Three answers	23.9%
	Four answers	12.9%
	All five answers	4.0%
Education	1 No Diploma	2.1%
n = 451	2 High School Graduate/GED	21.0%
Mean = 4.14	3 Vocational/Technical School	2.6%
Std. Dev. = 1.43	4 Some College/Associate Degree	7.7%
	5 Bachelor's Degree	8.8%
	6 Graduate Degree	7.9%
Income	1 Less than $25,000	9.4%
n = 393	2 $25,000 to less than $50,000	2.2%
Mean = 3.49	3 $50,000 to less than $75,000	8.1%
Std. Dev. = 2.262	4 $75,000 to less than $100,000	5.8%
	5 $100,000 to less than $125,000	6.3%
	6 $125,000 to less than $150,000	6.0%
	7 $150,000 to less than $175,000	2.9%
	8 $175,000 to less than $200,000	3.7%
	9 $200,000 and above	5.6%
Class	Education interacted with Income	
n = 393		
Mean = 15.51		
Std. Dev. = 13.27		

Employment Status:	1 Wage Earner	52.3%
	2 Business Owner or Self-Employed	14.5%
n = 451	3 Disabled	5.0%
Mean = 3.04	4 Retired	1.6%
Std. Dev. = 2.90	5 Unemployed, looking for work	4.7%
	6 Unemployed, not looking for work	2.8%
	7 Student	0.5%
	8 Homemaker	9.9%
	9 Military	8.7%
Unemployed	1 Not employed for wages	32.8%
n = 451	0 Employed for wages	67.2%
Business Owner	1 Business Owner/Self-Employed	14.5%
n = 451	0 Not a Business Owner	85.5%
Current Economic Status	1 Better off	29.8%
	2 About the same	39.2%
	3 Worse off	31.0%
n = 452		
Mean = 2.01		
Std. Dev. = 0.78		
Future Economic Outlook	1 Better off	37.9%
	2 About the same	37.8%
n = 433	3 Worse off	24.3%
Mean = 1.86		
Std. Dev. = 0.78		
Pay Cut	1 Pay cut since 2007	35.9%
n = 449	0 No pay cut	64.1%
Job Loss	1 Lost a job since 2007	32.8%
n = 451	0 No job loss	67.2%
Union State Interacted with Pay Cut	1 Union state w/pay cut	17.5%
	0 Not	82.5%
n = 451		
Union State Interacted with Job Loss	1 Union state w/job loss	13.8%
	0 Not	86.2%
n = 451		

Health Status	1 Very Bad	2.2%
n = 451	2	2.8%
Mean = 5.52	3	6.9%
Std. Dev. = 1.51	4	9.4%
	5	18.4%
	6	28.5%
	7 Very Good	31.8%
Disabled	1 Disabled	10.0%
n = 451	0 Able-bodied	90.0%
Health Insurance	1 Covered continuously	82.9%
n = 452	2 Covered part of the year	4.2%
Mean = 1.30	3 Not covered continuously	12.9%
Std. Dev. = 0.68		
Cannot Afford Insurance	1 Cannot afford health insurance	8.2%
	0 Coverage/None but other reason	91.8%
n = 450		
Length of Time Covered	1 Not covered at present	1.5%
	2 Less than one year	5.1%
n = 391	3 One to two years	7.7%
Mean = 3.53	4 Two to five years	10.3%
Std. Dev. = 0.95	5 Longer than five years	75.3%
	Long term coverage	75.3%
	Short term/no coverage	24.6%
Main Source of Coverage	Private coverage through employer	49.0%
	Private coverage through family	16.6%
n = 383	Other private coverage	13.3%
Mean = 2.30	Medicaid	5.6%
Std. Dev. = 1.65	Military/Veteran's Benefits	7.3%
	Other	8.2%*
	(*Medicare Disability 4.5%)	
Medicaid	1 Medicaid user	5.6%
n = 383	0 Not a Medicaid user	94.4%
Time w/No Coverage	1 month	1.9%
	2 months	23.6%
n = 17	3 months	13.1%
Mean = 5.54	4 months	7.9%

Std. Dev. = 3.24	5 months	7.7%
	6 months	3.1%
	7 months	0.0%
	8 months	27.7%
	9 months	6.8%
	10 months	2.2%
	11 months	0.0%
	12 months	6.1%
Reason for	Lost job	13.6%
No Coverage	Employer didn't offer coverage	7.2%
n = 76	Person w/insurance lost job	1.3%
	Ineligible due to age/left school	0.7%
	Ineligible due to health condition	1.9%
	Couldn't afford insurance	48.4%
	Didn't want to buy insurance	7.0%
	Healthy and didn't need insurance	8.7%
	Other reason	11.1%
	1 Couldn't afford insurance	48.4%
	0 Other reasons	51.6%
Party	Democratic Party	42.0%
n = 452	Republican Party	38.2%
	Independent/No Party	16.6 %
	Other Party	3.2%*
	(*Libertarian 1.6%)	
Party Loyalty	1 Always vote with party	29.7%
n = 377	(Dem 35.8%, Rep 25.1%)	
	0 Do not always vote with party	70.3%
	(Dem 64.2% Rep 74.9%)	
True Party Member	Party interacted with Party loyalty	
n = 377	0 Nominal identifications	70.3%
	1 Loyal Democrat	17.9%
	2 Loyal Republican	11.5%
Ideology	Strongly Liberal	8.0%
n = 443	Somewhat Liberal	12.9 %
Mean = 4.43	Slightly Liberal	9.0%
Std. Dev. = 1.86	Middle of the Road	19.4%
	Slightly Conservative	14.2%

	Somewhat Conservative	22.5%
	Strongly Conservative	14.0%
Three Ideology	Liberal	29.9%
n = 443	Middle of the Road	19.4%
	Conservative	50.8%
Cultural Worldviews	Nominal variables used to compare means only. Factor scores used in regressions.	
n = 452		
	Fatalist	25.5%
	Egalitarian	44.7%
	Hierarch	15.1%
	Individualist	8.2%
Healthcare.gov Website Issues	Technological problems	18.6%
	Too complicated for users	5.5%
	System not tested properly	21.2%
n = 434	Poor planning by HHS	33.5%
	Political Opposition	9.0%
	Other reasons	12.2%
Primary News Source	Cable/Satellite television	41.8%
	Broadcast TV (antenna)	8.5%
n = 452	Radio	7.4%
	Internet (websites)	26.6%
	Social media	0.9%
	Printed magazines/newspapers	13.1%
	Word of mouth, friends, family	1.3%
	Other	0.4%
Changed Mind on ACA	1 Yes	8.0%
	0 No	92.0%
n = 441	Mean value of change = -1.00 (Scale 1 – 7)	
	-35 /35 = -1.00	
Changed Mind on Tax Increase	1 Yes	7.8%
	0 No	92.2%
n = 442	Mean value of change = -1.11 (Scale 1 – 7)	
	39/35 = 1.11	
Changed Mind on Medicaid Expansion	1 Yes	9.1%
	0 No	90.9%
n = 439	Mean value of change = 0.58 (Scale 1 – 7)	
	23/40 = 0.58	

Changed Mind on Coverage for Undocumented Immigrants	1 Yes	5.8%
	0 No	94.2%
	Mean value of change = -0.23 (Scale 1 – 7)	
	-6/26 = -0.23	
n = 442		
Changed Mind on Lowering Age For Medicare	1 Yes	17.9%
	0 No	82.1%
	Mean value of change = 0.49 (Scale 1 – 7)	
n = 416	37/75 = 0.49	
Percentage Change In Position on Five DVs	(Current Position – Previous position) / Current Position	

Key Dependent Variables

Approval of the ACA	Strongly oppose	39.7%
n = 431	Somewhat oppose	6.6%
Mean = 3.46	Slightly oppose	9.3%
Median = 3	Neither support nor oppose	6.9%
Mode = 1	Slightly support	8.7%
Std. Dev. = 2.445	Somewhat support	7.1%
	Strongly support	21.6%
Approval of Tax Increase for the ACA	Strongly oppose	36.0%
	Somewhat oppose	5.8%
n = 445	Slightly oppose	4.8%
Mean = 3.83	Neither support nor oppose	8.9%
Median = 4	Slightly support	8.5%
Mode = 1	Somewhat support	8.6%
Std. Dev. = 2.530	Strongly support	27.4%
Approval of Expanding Medicaid	Strongly oppose	17.5%
	Somewhat oppose	10.3%
n = 441	Slightly oppose	8.7%
Mean = 4.45	Neither support nor oppose	6.4%
Median = 5	Slightly support	17.3%
Mode = 7	Somewhat support	9.8%
Std. Dev. = 2.269	Strongly support	29.9%
Approval of Lowering Age for Medicare	Strongly oppose	31.4%
	Somewhat oppose	11.6%
n = 437	Slightly oppose	7.0%
Mean = 3.65	Neither support nor oppose	10.9%

Median = 3.02	Slightly support	10.5%
Mode = 1	Somewhat support	6.4%
Std. Dev. = 2.368	Strongly support	22.1%
Approval of Gov't Coverage Undocumented Immigrants	Strongly oppose	57.8%
	Somewhat oppose	8.3%
	Slightly oppose	3.7%
n = 446	Neither support nor oppose	7.6%
Mean = 2.49	Slightly support	9.7%
Median = 1	Somewhat support	5.3%
Mode = 1	Strongly support	7.5%
Std. Dev. = 2.068		
Tolerance Index	Tolerance Index: five dependent variables; not used with Cultural Worldview in the regressions.	
N = 404		
Mean = 3.53		
Median = 3.40		
Mode = 1		
Std. Dev. = 1.79		

Table 5.2 Cultural Worldview Measures

Grid: Hierarchical-Egalitarian Scale	***n*=**	**Mean**	**Std. Dev.**	**Agree**
We should increase taxes so we can increase spending on domestic programs.	449	2.76	2.022	Low
I think that people with the most experience and expertise should be the decision makers.	447	4.99	1.917	High
It is better if the woman cares for the home and family and the man works outside the home.	447	2.80	2.089	High
The big problem today is not giving everyone an equal chance.	449	3.87	2.263	Low
We should be more tolerant of different moral standards.	447	4.25	2.241	Low
Gays should not be allowed to marry.	448	3.08	2.505	High
We have gone too far in pushing equal rights.	448	3.31	2.431	High
It seems like people on welfare get a lot of free services that the rest of us have to pay for.	446	4.66	2.331	High
Group: Individualism-Communitarian Scale				
What is best for society as a whole, not the individual, should be the government's priority.	421	4.59	1.720	High
The government wastes a lot of tax money.	451	5.93	1.720	Low
I favor a reduction in spending on domestic programs to cut taxes.	445	4.21	2.226	Low
The federal government should make it more difficult to buy a gun.	447	3.83	2.547	High
I favor allowing Social Security funds to be invested in the stock market.	441	2.59	2.020	Low
It is not that big of a problem if people have an unequal chance.	430	2.84	2.020	Low
We need a strong national government to solve complex problems.	446	5.05	2.121	High
Protecting the environment is important to me.	451	5.87	1.516	High

The scale for the table above is 1/strongly disagree to 7/strongly agree. To form the four cultural worldview labels for the scatterplot graph, I changed the direction of the responses so that the high and low Grid-Group designations could be measured

properly according to Cultural Theory tenets. The "Agree" column refers to whether agreement with the statement ranks the response as high or low grid and high or low group. The Cronbach's Alpha for the included Grid questions (17-24; without 18) is 0.760. The Cronbach's Alpha for the Group questions (25-32) is 0.639.

I did not include statement #18 – "I think those with the most experience/expertise should be the decision makers" to create grid-group coordinates or as factors for the regressions. Factor analysis showed this statement did not load on any of the four dimensions and the SPSS program suggested its deletion. Testing showed no significant correlation between this statement and the four cultural worldviews which was surprising. The Individualists should have disagreed with this statement while the Hierarchs should have agreed. One possible explanation for this occurrence might be the basic distrust of government, especially after the negative media attention regarding the initial rollout of the HealthCare.gov website's online Exchanges. Another major event that may have influenced the responses to this statement was the federal government shutdown between October 1 and October 16, 2013 (Burwell 2013). A Pew Research Center poll taken in late-February 2014 (very close to the end of the survey in the field) showed that only 24% of Americans trust the federal government all or most of the time (PRC 2014).

Cultural Theory requires ideology be measured on two dimensions – vertical (grid) and horizontal (group). To construct the scatterplot of the respondents' grid-group coordinates for Figure 5.1, I had to leave out the individuals whose responses to the groups of Cultural Theory statements placed them directly on the vertical or horizontal axes. The individuals who appear in the graph were ones whose responses

placed them squarely inside one of the four cultural worldview categories. When we examine the scatterplot, we cannot help but notice an upper-left to lower-right diagonal pattern to the observations in this study's sample. There is a continuum running diagonally from the Fatalists (high grid/low group) to their polar opposites, the Egalitarians (low grid/high group). A correlations test between the cultural worldviews and the three-point ideology scale shows that all four of the cultural worldviews have a strong association with ideology. There is no significant correlation between ideology and the Individualists on the seven-point ideology scale and I believe it may be because there are not enough respondents in the Individualist category to be split into seven groups.

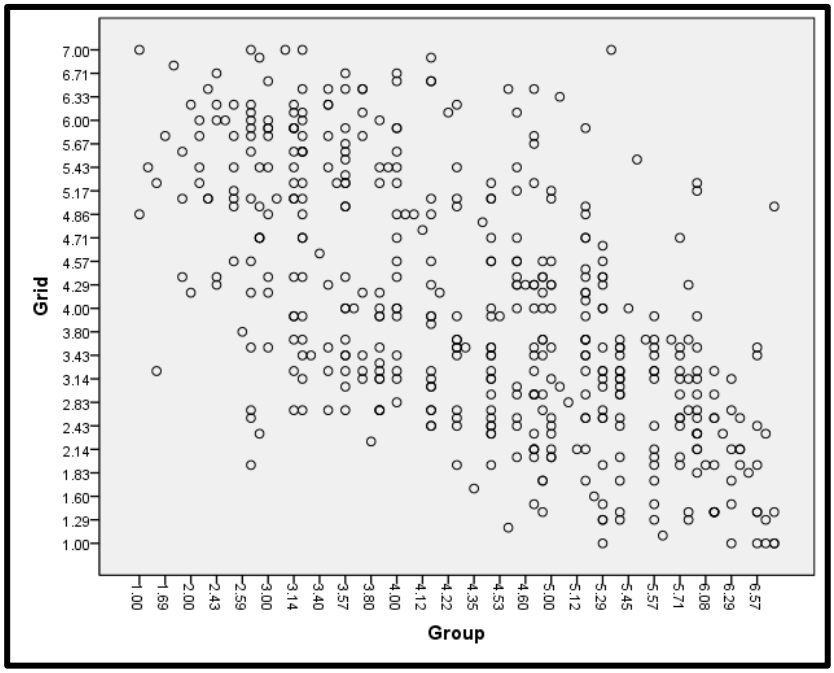

Figure 5.1. Scatterplot of the Cultural Theory assessment statements. Figure 2.1 on page 16 shows the Grid-Group typology.

While categorizing the cultural worldviews according to their grid-group coordinates is a convenient way to present the descriptive statistics for the variables in tables, it does not reveal the degree to which every respondent has some aspect of

various ideological outlooks on life. In all likelihood, no person is a pure ideologue *sitting* on the corners of the grid-group typology. Using SPSS dimension reduction function, I divided the sample into four categories – Fatalism, Hierarchism, Egalitarianism, and Individualism. These factors were used in the regression analysis.

Political ideology, measured as *left versus right*, as a variable is problematic for a few reasons. First, we must rely on respondents to know the definitions of the categories they are presented. What does it mean to be *conservative*? Does it mean *stuffy* and *uptight*? The answer probably depends on the age of the person answering the question. Second, does a respondent calculate the difference between categories the same way the researcher does? What is the difference between *somewhat liberal* and *slightly liberal*? How far are these designations from the *middle of the road*? Third, social desirability bias in survey responses probably plays a role in self-identified ideological labels (Phillips and Clancy 1972). If the majority of respondents do not understand the tenets of political liberalism, they may assume *liberal* refers to *social permissiveness* or *far left-wing*. There is a significant correlation between ideology and political party ($p = 0.01$). Chi-square tests between state and political party do show a strong association between the two variables ($p = 0.05$). Chi-square tests between state and the seven-point ideology scale show a significant association ($p = 0.10$) but that is not the case with the three-point ideology scale.

We know that Egalitarians are left-leaning in their politics and this analysis shows that to be the case. A cross-tabulation analysis shows a majority (53%) of Egalitarians self-identify as liberal while only 21% called themselves conservative. Examining the grid-group typology, we can see that as an individual *moves away* from

the pure Egalitarian position (lowest grid and highest group coordinate) towards the opposite end of the spectrum (highest grid and lowest group coordinate) they become less and less Egalitarian and when they pass the point where the grid and group axes meet (coordinate 0, 0) they become Fatalists. The highest grid and lowest group coordinate is the pure Fatalist position. A cross-tabulation analysis shows that a majority (86%) self-identify as conservatives while only 14% self-identified as liberal or middle of the road. This diagonal continuum represents the familiar *left-right* (liberal-conservative) ideological continuum.

There is also be a diagonal continuum running from the Hierarchs (high grid/high group) and passing through the origin to the Individualists (low grid/low group). Hierarchs, which are high group like the Egalitarians, tend to be somewhat conservative (Song et al. 2012) because of their affinity for dividing groups along a vertical hierarchy (based on social appropriateness and expertise) but unlike the Egalitarians, they are high grid like the Fatalists. The majority of Hierarchs (65%) self-identified as conservative which is far less than the conservative portion of the Fatalists as expected. A slight majority of Individualists (56%) self-identified as conservative. Individualists eschew limits placed on them by authority figures as do the Egalitarians but they have little affinity for groups and therefore, should be the most conservative of the four cultural worldviews. This analysis indicates that claim to be the case.

Table 5.3 has the questions and the correct answers for the Knowledge Index. Respondents were not allowed to change their answers unless they did so immediately and before the interviewer moved to the next question. This rule was put into effect to

make sure people could not use the Internet to look up the correct answer and skew the data.

Three of the questions are typical political knowledge questions and two are specifically about the ACA. The veto override percentage question is commonly used in the General Social Survey and the American National Elections Studies. I also chose it because at the time of the telephone survey the discussion of what it would take for the House and Senate to override President Obama's guaranteed veto of Congress' rescinding his signature legislation was perpetual in the media. Respondents' correct answers were 66%, 67% or two-thirds. They were also allowed to say "about" or "approximately". For the Chief Justice question, they had to say Roberts or John Roberts only. This question was chosen because the discussion of how the conservative Chief Justice voted in the 2012 challenge (*National Federation of Independent Business vs. Kathleen Sebelius*) to the ACA was still occasionally in the news. The budget question was chosen because I felt like respondents who were interested in the future of the ACA might also be aware of how much money the government spends each year. Opponents of the ACA stressed how it would "explode the deficit" so respondents who paid close attention to the news might know that the deficit increased. Respondents needed to answer "no" to the question for ACA coverage of illegal immigrants. This question was important because it provided an opportunity to analyze the responses with respect to political party and ideology. To test whether the respondents knew exactly who the ACA's employer mandate covered, I asked them to choose between the correct answer and an answer that was very close but incorrect. I did this because so

much of the opposition and supportive *voices* in the media were often wrong about the employer mandate.

I changed the "DK/NA" to 0 to reflect the fact that the respondent did not give the correct answer and to calculate the mean value but I kept the original data to show the percentage of people who did not know. This table is in the Appendix.

Table 5.3. Assessing Political Knowledge

Survey Questions	***Answer***
Q12: What is the percentage of votes needed in the House AND Senate to override a veto?	Two-thirds
Q13: Who is the current Chief Justice of the US Supreme Court?	Roberts
Q14: Does the Affordable Care Act, also known as ObamaCare, cover undocumented or illegal immigrants?	No
Q15: Would you say the federal budget deficit is larger, smaller, or about the same as in 2001?	Larger
Q16: Which of the following would you say is the MOST correct statement about the Affordable Care Act's Employer Mandate? --- Employers with 50 or more FULL-TIME employees will be required to offer health insurance ONLY to full-time employees --- Employers with 50 or more employees REGARDLESS of the number of hours worked will have to offer health insurance to all employees.	Full-time

The average knowledge score was moderate (2.27 out of 5.00) among the telephone survey respondents. Delli Carpini and Keeter said that knowledge promotes tolerance, a necessary democratic value (1996). In America, tolerance of others is split along party lines. For decades, Pew Research Center has been asking Americans whether they thought immigrants were a strength or a burden to the country. The country was far less charitable in 1994 with 63% saying immigrants were a burden compared to 33% in 2016 (Jones 2016). Until 2006, Republicans and Democrats and their partisan leaners polled very closely on this question. In 2016 the margin had grown to 78% of Democrats and Democratic leaners viewing immigrants as a strength versus 35% of Republicans and Republican leaners seeing them as strengthening the country (Jones 2016). If some Americans think the ACA covers illegal, undocumented or unauthorized immigrants (which it does not), they are not going to be very tolerant of

the program if they are already not tolerant of undocumented immigrants. The results of the qualitative interviews (discussed in Chapter Eight) show a remarkable lack of specific knowledge about the ACA, particularly with regards to the premiums, deductibles and who is eligible for coverage. Polling data indicates that the lowest income, least educated people are the ones who are the least likely to understand the ACA (Barcellos et al. 2014); however, perhaps they know they are the ones likely to suffer the most if the ACA is repealed without a replacement law because low-income respondents are the most favorable towards the ACA (KFF.org 2018).

Chapter Six discusses the hypotheses and the results of the study. With respect to knowledge, my results confirm existing scholarship – knowledge of the Affordable Care Act (ACA) is very low. Individuals have expressed opinions about the health care law that are not based on reality and they have voted for (or against) candidates for office based on what they *think they know* about the ACA. Former President Barack Obama once said, "elections have consequences" in response to Republicans' complaints about the Stimulus Package in 2009 (Stoltzfoos 2017). The consequences of having an electorate that understands so little about a health care law that has such an impact on their lives could lead to the dismantling of the program if voters do not take action to prevent that.

Chapter 6: Hypotheses and Results

Let us revisit the primary research question: what explains the public's level of support for the ACA? Political knowledge level, while certainly not a good measure of intelligence or even educational attainment, is an indication of how interested a person is in government policies and that interest should lead to preference formation. The following table shows the mean values of key independent variables on the five knowledge questions asked in the telephone survey. Table 6.1 includes the mean values of each question overall and broken down by cultural worldview, political ideology, party affiliation, and annual income. The Knowledge Index is the mean value of the correct answers of the questions divided by five. For ease of presentation, the seven categories for political ideology (strongly liberal to strongly conservative) were collapsed into three groups.

Table 6.1 Political Knowledge Mean Values

	Q12: Veto	Q13: Chief Justice	Q14: Gov't Coverage Immigrant	Q15: Budget Deficit	Q16: Employer Mandate	Index Of Five
Cultural Worldview						
Egalitarian	0.31	0.20	0.48***	0.81***	0.46**	2.24
Individualist	0.33	0.21	0.40	0.91*	0.52	2.38
Hierarch	0.14***	0.10***	0.32***	0.82**	0.53	1.85
Fatalist	0.41***	0.33***	0.29***	0.94***	0.71***	2.65
Ideology (mean = 2.23)						
Liberal (1)	0.41	0.30	0.55	0.80	0.48	2.50
Middle of Road (2)	0.24	0.09	0.45	0.85	0.44	2.03
Conservative (3)	0.29	0.25	0.31	0.90	0.66	2.39
Party						
Democrat	0.35	0.20	0.50	0.80	0.46	2.26
Republican	0.22	0.22	0.30	0.95	0.66	2.34
Independent	0.34	0.24	0.41	0.86	0.54	2.35
Other	0.56	0.50	0.56	0.81	0.88	3.31
Income						
Under $25K	0.15	0.16	0.34	0.80	0.44	1.86
$25 to less than $50	0.24	0.17	0.41	0.88	0.43	2.10
$50 to less than $75	0.26	0.17	0.38	0.90	0.68	2.35
$75 to less than $100	0.37	0.18	0.33	0.87	0.58	2.30
$100 to less than $125	0.37	0.33	0.52	0.81	0.48	2.52
$125 to less than $150	0.40	0.29	0.38	0.86	0.57	2.33
$150 to less than $175	0.29	0.14	0.71	1.00	0.71	2.86
$175 to less than $200	0.30	0.50	0.50	0.90	0.70	2.90
$200K and above	0.65	0.39	0.70	0.96	0.83	3.52
Overall						
Overall	0.30	0.21	0.39	0.85	0.54	2.27

The independent samples T-Test shows a significant difference in means between knowledge questions and cultural worldviews; p = *0.10l, **p = 0.05, *** p = 0.01. The tables appear in the Appendix.

These results are in line with polling data from August 2013, that showed 50% of respondents did not know what the ACA Marketplace (exchange) was and were not capable of working with the HealthCare.gov website (Barcellos et al. 2014). In another poll reported in January 2017, 35% of respondents did not know that the ACA and ObamaCare were the same thing (Dropp and Nyhan 2017). A Kaiser Health Tracking Poll in March 2017 revealed that only one-third of respondents knew the ACA bans federal funding for abortions outside the allowable circumstances in the Hyde Amendment with less knowledge among Republicans (KFF.org 2017G).

As expected, the highest mean knowledge scores on the individual questions and the Knowledge Index are associated with the highest income. As for political party, the two major parties and independent (no party) have similar scores but the "other" category is well above the mean (3.31 compared to 2.27). I attribute this occurrence to the possibility that respondents who have studied the major parties well enough to know they do not identify with them probably pay closer attention to political news than the others. The liberal ideology has a higher mean score than the moderate and conservative ideologies as expected. Bartlels (2008) found that politically liberal individuals are more interested in topics that involve government. The Fatalist cultural worldview has the highest mean knowledge score but I would have expected the Egalitarian worldview to be higher than it is because people with an egalitarian philosophy are more interested in politics (Bartels 2008). Although the sample of states leans right (mean value of 2.23) in terms of self-identified ideology on a three-point scale (liberal, middle-of-the-road, and conservative) there are more than two and one-half times as many liberal Egalitarians as conservative Egalitarians. Also, 102 out of 180 of the Egalitarians who answered this question are Democrats and only fifteen were Republican and three answered "other". The explanation may come down to the annual income of the Fatalists in this case. When I compare the percentages of respondents who had annual incomes in the two lowest categories, only 21% of the Fatalists are represented compared to 44% for Egalitarians. Considering education, 50% of Fatalists have a college degree (undergraduate or graduate degree) compared to 46% of Egalitarians. Since income and education level is strongly associated with political knowledge my findings do not seem so surprising.

Table 6.2 shows the mean values for the responses to the statements for the dependent variables. The Tolerance index is built from five questions regarding various government policies aimed at alleviating the negative effects of income inequality. Respondents answered with 1/strongly oppose to 7/strongly support. Answers were totaled and divided by five.

Table 6.2 Mean Values for Dependent Variables

	ACA Approval	ACA Tax Increase $250K	Expand Medicaid	Government Coverage Undocumented Immigrants	Lower Medicare Age	Tolerance Index of Five Questions
Mean	3.31	3.72	4.35	2.44	2.71	3.46

The policy receiving the highest mean score is Medicaid expansion. Polling in 2013 indicated that about 80% of Americans, regardless of whether they lived in states whose governors announced they would take the federal government's funds for expanding Medicaid, and did not know enough about the topic to say whether the state they lived in would expand the program (KFF.org 2013A). A cross-tabulation between state and Medicaid expansion shows that the states with more liberal politics – California, Maine, and Minnesota, generally had more support for the program. The scale is 1/strongly oppose to 7/strongly support.

Table 6.3 Medicaid Expansion Approval

		Expansion of Medicaid							
		1	2	3	4	5	6	7	Total
State	CA	4	7	3	1	7	6	15	43
	FL	11	1	4	3	4	5	6	34
	ME	6	5	1	5	6	1	11	35
	MN	3	3	5	7	8	6	13	45
	MO	11	0	6	2	5	4	8	36
	MT	16	6	9	4	12	4	9	60
	NB	11	4	4	3	9	3	10	44
	OK	24	10	7	12	20	15	49	137
Total		86	36	39	37	71	44	121	434
Chi-Square test 0.10 level									

The lowest approval ratings are for the government providing basic health care coverage for undocumented or illegal immigrants and for lowering the age to qualify for Medicare from 65 to 55 years of age. As we can see from the table below, none of the eight states in the sample had much support for health care coverage for undocumented immigrants, even states with more liberal politics. There could be several explanations for this occurrence. It could be a proxy measure of prejudice against immigrants coming across the southern border of the United States. It might also be the result of an artifact of the survey's wording on this question. Perhaps the use of the term "illegal" along with "undocumented" in the question influenced the results.

Table 6.4 Basic Coverage for Undocumented or Illegal Immigrants Approval

		Basic Coverage for Immigrants							
		1	2	3	4	5	6	7	Total
State	CA	15	4	3	7	4	4	7	44
	FL	18	4	0	4	3	2	3	34
	ME	19	1	1	5	5	2	3	36
	MN	25	3	5	4	7	1	2	47
	MO	25	1	3	2	5	0	1	37
	MT	39	5	4	4	4	1	4	61
	NB	25	2	2	5	4	3	3	44
	OK	92	12	4	4	5	8	10	135
Total			32	22	35	37	21	33	438
Chi-Square test – no association									

The correlation for the other low-ranking policy, lowering the age to qualify for Medicare, is shown in the table below. The mean age in this sample is 49.32 years. This correlation is significant – the older a person is, the less supportive they are for lowering the qualification age.

Table 6.5 Correlation between Age and Support for Lowering the Age for Medicare

		Age	Lowering Age for Medicare
Age	Pearson Correlation	1	-.155**
	Sig. (2-tailed)		.001
	N	482	429
Lowering age for Medicare	Pearson Correlation	-.155**	1
	Sig. (2-tailed)	.001	
	N	429	430

**. Correlation is significant at the 0.01 level (2-tailed).

The following hypotheses were tested with questions about five different redistributive policies related to health care. Chapter Seven includes the discussion of the results presented here in Chapter Six. Each respondent was asked if and when he or she changed their mind on the issue. A small percentage answered that they did in fact have a change of heart and those responses are shown in tables in the Appendix. For the linear regression analysis, the sample states were weighted by party and gender according to each state's voter registration data available at the states' election boards. The purpose of choosing these eight states was to get as representative a sample as possible. Each state represents other states that shared its demographics and choices with respect to the ACA. Exit polling for the 2016 presidential election indicated that whites accounted for 70% of the votes and 58% of whites voted Republican (Fidel 2017) and by extension, against keeping the ACA intact considering Donald Trump promised voters to repeal the law immediately (Donovan and Kelsey 2017). Donald Trump also captured 51% of the vote from persons with a high school diploma or less

and the vote from whites without a college degree was 66% in his favor (The Washington Post 2016). These poll results pushed me to create proxy variables for union membership. Data from the BLS (2017) provided 2016 membership per state; the average in the country is 10.7%. The eight states in the sample were coded as "membership above" and "membership below". The four states above the average in the weighted sample totaled 46.3% and the four states below the average in the weighted sample totaled 53.7%. The individual state totals are shown below:

California	above	15.9%
Florida	below	5.6%
Maine	above	11.4%
Missouri	below	9.7%
Minnesota	above	14.2%
Montana	above	11.9%
Nebraska	below	7.4%
Oklahoma	below	5.4%

The following two models are for approval of the ACA. Only basic demographic variables are included in Model I and its R^2 is 0.051. Model II includes ideology and the four cultural worldview factors scores are shown in Model III. The factor score indicates the degree to which an individual aligns himself with the cultural worldview tenets as measured by the assessment statements shown in Chapter Two. Full models with all variables are shown in Appendix F. The independent variables shown in the following tables were significant in the models, with the exception of income. The demographic variables included in the mini-models for each dependent variable were: age, race (dummy), gender, education, class, income, disability status and employment status.

Significance levels for all models is *p = 0.10, **p = 0.05, ***p = 0.01.

- Hypothesis #1: *Cultural Worldview will be more significant than Income with the dependent variable: Approval of the passage of the Affordable Care Act.*

- Regression Results: What is your opinion on the passage of the Affordable Care Act?

Table 6.6 Model II – Ideology: $R^2 = 0.722$, Adjusted R^2 0.691

Women w/children	-0.086**
	(0.273)
Unmarried	-0.076*
	(0.220)
Disabled	0.086*
	(0.432)
Income	-0.131
	(0.160)
Party	-0.279***
	(0.192)
Future Econ Outlook	-0.122***
	(0.132)
Changed mind on ACA	0.184***
	(0.172)
Ideology	-0.552***
	(0.066)

Table 6.7 Model III – Cultural Worldviews: $R^2 = 0.772$, Adjusted R^2 0.739

Unmarried	-0.095*
	(0.212)
Disabled	0.086*
	(0.432)
Health Status	0.071*
	(0.074)
Income	-0.179
	(0.156)
Party	-0.181**
	(0.195)
Union State Lost Job	0.143**
	(0.427)
Union State Pay Cut	-0.127*
	(0.215)
Pay Cut	0.182**
	(0.338)
Current Economic Situation	-0.112**
	(0.142)
Changed mind on ACA	0.094**
	(0.163)
Individualism	-0.489***
	(0.112)
Hierarchism	-0.257***
	(0.105)
Egalitarianism	0.292***
	(0.106)
Fatalism	0.187***
	(0.097)

Hypothesis #1 is confirmed – cultural worldview is more significant in the model than income. Although the model with ideology show that variable to be highly significant, the model with cultural worldview have more explanatory power than the model with ideology. Income is not significant in either model for approval of the passage of the Affordable Care Act; in fact, neither is education or class (education interacted with income). Disabled status is slightly significant in both models. Other economic indicators are significant, such as a union state's lost job or pay cut, and economic thermometer readings. Party loyalty (respondents who said they always vote with their political party) is not at all significant in either model but, as expected, party identification is, although less so in Model III.

All four cultural worldviews factor scores have signs in the expected directions and are the most significant variables in the models; however, fatalism often does not show up as significant in models using cultural worldview. Egalitarianism was expected to be the most positive in their feelings for the ACA and individualism was expected to be the most negative, with hierarchism falling between these two groups.

- Hypothesis #2: *Cultural Worldview will be more significant than Income with the dependent variable: Approval of a tax increase on high-income earners if the monies fund the ACA.*

- Regression Results: What is your position on raising federal income taxes on households that earn $250,000 or more per year if the monies were used to help fund the Affordable Care Act?

Table 6.8 Model V – Ideology: R^2 – 0.639, Adj. R^2 = 0.599

Race	0.091**
	(0.340)
Unmarried	-0.109**
	(0.253)
Class	0.377*
	(0.038)
Income	-0.469**
	(0.188)
Party	-0.233***
	(0.204)
Union State Lost Job	0.148**
	(0.515)
Lost Job	-0.139**
	0.378
Ideology	-0.587*** -
	(0.072)

Table 6.9 Model VI – Cultural Worldviews: R^2 = 0.703, Adjusted R^2 0.661

Race	0.124**
	(0.326)
Income	-0.418**
	(0.185)
Party	-0.208***
	(0.210)
Business Owner	-0.100**
	(0.341)
Union State Lost Job	0.146**
	(0.499)
Lost Job	-0.162**
	(0.363)
Pay Cut	0.150**
	(0.390)
Changed mind on Tax	0.199***
	(0.919)
Individualism	-0.428***
	(0.124)
Hierarchism	-0.255***
	(0.121)
Egalitarianism	0.334***
	(0.124)
Fatalism	0.115**
	(0.116)

Hypothesis #2 is partially confirmed – cultural worldview (with the exception of fatalism) performs better than income although the income variable is moderately significant and given the fact that the dependent variable is a tax increase, that should not be a surprise. Other economic indicators are significant, such as business owner, unemployed, union state variables, lost job, pay cut, and economic thermometer readings. Party loyalty, respondents who said they always vote with their political party, is not at all significant although, as expected, party identification is.

The explanatory power of the model with cultural worldview is higher than with ideology. All four cultural worldviews factor scores have the expected signs and are the most significant variables in the model although in Model VI fatalism loses some significance. The factor scores' designations indicate the following: Egalitarians are concerned with issues of fairness so they are agreeable with the idea of raising taxes on high-income households (i.e. those earning $250,000 or more per year) especially if the proceeds are used to provide services to people in need so this result is expected. Individualists, on the other hand, have little tolerance for taxation when it is used to fund domestic programs and the Hierarchs, although more tolerant than Individualists, were probably influenced by the technical problems that occurred with the ACA online Marketplace. The model with basic demographic variables only has an R^2 value of 0.067.

- Hypothesis #3: *Cultural Worldview will be more significant than Income with the dependent variable: Approval of the expansion of the Medicaid program so more low-income households are covered.*

- Regression Results: How do you feel about the expansion of the Medicaid program so that more low-income households are covered?

Table 6.10 Model VIII – Ideology: R^2 – 0.525, Adj. R^2 = 0.472

Knowledge Index	-0.095*
	(0.115)
Class	0.418*
	(0.038)
Income	-0.302
	(0.188)
Party Loyalty	-0.121**
	(0.244)
Party	-0.124**
	(0.207)
Health Status	-0.094*
	(0.087)
Unemployed	0.153**
	(0.282)
Future Economic Outlook	-0.177**
	(0.155)
Ideology	-0.554***
	(0.073)

Table 6.11 Model IX – Cultural Worldviews: R^2 = 0.678, Adjusted R^2 0.632

Education	-0.210**
	(0.152)
Class	0.616**
	(0.034)
Income	-0.516**
	(0.171)
Party Loyalty	-0.127**
	(0.221)
Party	-0.076
	(0.191)
Future Economic Outlook	-0.106**
	(0.140)
Individualism	-0.517***
	(0.114)
Hierarchism	-0.085*
	(0.112)
Egalitarianism	0.459***
	(0.114)
Fatalism	0.141**
	(0.106)

Hypothesis #3 was not confirmed. Income is moderately significant in the model with cultural worldview (though not at all in the model with ideology). Medicaid, a needs-based health care program for the poor, probably influences higher income respondents to be negative towards the idea of expanding the program to more people. Individualism is highly significant and negative as expected and egalitarianism is both highly significant and positive as expected. Fatalism was moderately significant and hierarchism was only slightly significant. Model VII with basic demographic variables had an R^2 value of 0.082.

The model with cultural worldview has much more explanatory power than the model with ideology as I expected. Chapter Seven includes a discussion of the possible reasons why Cultural Theory may not be well-suited to predict preferences on a sensitive issue like Medicaid expansion.

- Hypothesis #4: *Cultural Worldview will be more significant than Income with the dependent variable: Approval of the government providing basic health care coverage to undocumented or illegal immigrants.*

- Regression Results: How do you feel about the government providing basic health care coverage to undocumented or illegal immigrants?

Table 6.12 Model XI – Ideology: R^2 – 0.392, Adj. R^2 = 0.321

Age	0.707*
	(0.063)
Party	0.120*
	(0.215)
Disabled	0.168**
	(0.514)
Income	0.351
	(0.197)
Business Owner	0.109*
	(0.386)
Pay Cut	-0.183*
	(0.417)
Current Economic Situation	0.138**
	(0.178)
Future Economic Outlook	-0.155**
	(0.161)
Ideology	-0.582***
	(0.076)

Table 6.13 Model XII – Cultural Worldviews: R^2 = 0.537, Adjusted R^2 0.469

Knowledge Index	0.103*
	(0.112)
Party	0.231**
	0.213
Disabled	0.120*
	(0.470)
Income	0.293
	(0.184)
Unemployed	-0.115*
	(0.280)
Current Economic Situation	0.104*
	(0.169)
Individualism	-0.592***
	(0.126)
Hierarchism	-0.282***
	(0.122)
Egalitarianism	0.385***
	(0.124)
Fatalism	0.128**
	(0.116)

Hypothesis #4 is confirmed – cultural worldview is more significant than income in predicting support for covering undocumented immigrants with health care; in fact, income was not significant in either model. One thing that immediately comes to my attention is that the explanatory power of the model regarding health coverage for undocumented immigrants dropped dramatically in comparison to models testing the first three hypotheses. The model with cultural worldview is better than the model with ideology. These models have fewer significant variables and the ones that are significant are just barely, with the exception of the cultural worldviews in Model XII. There may be something going on in the minds of the respondents that my survey did not address – perhaps some degree of prejudice against illegal immigrants. The model with cultural worldview instead of ideology has more explanatory power, which is expected. For this dependent variable, government providing undocumented immigrants with basic health care coverage, race was not at all significant in either model. The model with basic demographic variables only had an R^2 value of 0.029.

- Hypothesis #5: *Cultural Worldview will be more significant than Income with the dependent variable: Approval of lowering the age to get Medicare from 65 to 55 so more people can qualify.*

- Regression Results: How do you feel about lowering the age to get Medicare from 65 to 55 so more people can qualify?

Table 6.14 Model XIV– Ideology: R^2 – 0.359, Adj. R^2 = 0.283

Age	1.053**
	(0.074)
Race	0.118**
	(0.425)
Income	0.001
	(0.231)
Knowledge Index	-0.116*
	(0.150)
Education	-0.285**
	(0.287)
Disabled	0.141*
	(0.614)
Business Owner	-0.153**
	(0.462)
Union State Lost Job	-0.166
	(0.672)
Lost Job	0.254**
	(0.475)
Union State Pay Cut	0.183*
	(0.662)
Pay Cut	-0.232**
	(0.513)
Future Economic Outlook	-0.240***
	(0.192)
No Continuous Insurance	0.106*
	(0.771)
Change mind Medicare age	0.130**
	(0.339)
Ideology	-0.240**
	(0.089)

Table 6.15 Model XV – Cultural Worldviews: R^2 = 0.435, Adjusted R^2 0.350, 0.331

Race	0.174**
	(0.423)
Education	-0.358**
	(0.207)
Income	-0.206
	(0.232)
Business Owner	-0.136**
	(0.467)
Unemployed	-0.123*
	(0.351)
Union State Lost Job	-0.212**

	(0.670)
Lost Job	0.292**
	(0.473)
Union State Pay Cut	0.264**
	(0.674)
Pay Cut	-0.212*
	(0.524)
Future Economic Outlook	-0.259***
	(0.196)
Individualism	-0.323***
	(0.161)
Hierarchism	0.021
	(0.155)
Egalitarianism	0.212**
	(0.158)
Fatalism	0.173**
	(0.147)

Hypothesis #5 is partially confirmed in that income was not significant and three of the four cultural worldview factor scores were. For this dependent variable, lowering the age to qualify for Medicare from 65 to 55, income is not significant at all in the models with ideology and cultural worldview. Individualism was highly significant and negative and egalitarianism and fatalism are positive but only moderately significant. Hierarchism is not significant at all. I believe that is a sign of some ambivalence towards lowering the age to qualify for Medicare. Age was significant and positive in the model with ideology; the mean age of my sample is close to the age where the respondents could qualify if this change is made to Medicare. What is surprising is that age was not at all significant in the model with cultural worldview. For the first time, not having continuous health insurance coverage is a significant variable but only in the model with ideology, not cultural worldview. The model with basic demographic variables had an R^2 value of 0.117.

The key hypothesis for the study, ACA approval, was confirmed – cultural worldview was a more significant factor than income level in explaining preferences for

the ACA as were preferences for basic health coverage for illegal or undocumented immigrants. Preferences for a tax increase to fund the ACA and lowering the age to qualify for Medicare were not fully confirmed and the hypothesis testing approval for Medicaid expansion was not confirmed. Chapter Seven offers some possible explanations for why this was the case.

Chapter 7: Discussion of Quantitative Findings

The goal of this research was to learn what factors influenced opinion formation on the Affordable Care Act. I had done enough research with Cultural Theory in my course work to know that income level and cultural worldview were not strongly associated as measured in the studies but that cultural worldview and policy preferences are and I have always suspected that politicians speaking to voters as though the only meaningful thing about them was how much money they made is short-sighted. Anyone can be rich and everyone, probably, can imagine themselves switching places with someone in need of health care and not having the money to pay for it. I believe that explains why public opinion polls in late September 2017 were showing support for improving the ACA as opposed to outright repealing the legislation. The polls were driven in large part by self-identified Democrats but there was also an increase in support for the law among Republicans and independents. Senate Republicans had made repeated attempts to repeal the ACA but have failed and many political pundits observed that if these Senators had really wanted to repeal the ACA they would have done so already. Perhaps they are listening to their constituents at home and realize there is support among conservative voters for a more generous health care system that provides access to health insurance to everyone.

Since political ideology is problematic in that it only measures attitudes that can easily run from the left to the right (liberal to conservative), I decided to use Cultural Theory to test my hypothesis that a person's income level is a poor predictor of his approval for the ACA and related health care issues. The dependent variables included: approval of the ACA, approval of increasing taxes to fund the ACA, approval of

Medicaid expansion, approval of providing coverage for illegal or undocumented immigrants, and approval of lowering the qualification age for Medicare. These issues were covered at length in media outlets at the time telephone survey was in the field. Each of the five dependent variables was used in two models, one testing ideology and the other cultural worldview.

The SPSS statistics program was used for the analysis and the data was weighted by party and gender. The Cultural Theory assessment statements were taken from vetted statements used in well-known academic studies. The high grid and high group statements had good Cronbach's alpha scores. Varimax factor rotation created the worldview variables used in the regression analysis – Fatalism, Egalitarianism, Hierarchism and Individualism.

For purposes of cross-tabulations, comparing means, and testing correlations, the answers to the assessment questions were plotted by their grid-group coordinates. Respondents who had coordinates that fell on the grid or group axis were not counted for purposes of the descriptive statistics. The quadrants the rest of the observations fell into became the Fatalists, Egalitarians, Hierarchs, and Individualists. Individualists only account for 9.2% of the sample compared to 15.8% for Hierarchs, 24.7% for Fatalists and 43.8% for Egalitarians. Since I cannot screen for cultural worldview in advance, I must work with the sample I have. One of the reasons I have such an abundance of Egalitarians may be the social desirability response bias inherent in surveys. We are asking people to admit things to complete strangers on the phone that they may be reluctant to share. Respondents are assured of their anonymity but in the age of Twitter and Instagram, we should expect that a certain percentage of the sample

will not readily confess that they think it is better for the man to work and the woman to stay home or that they do not think gays should be allowed to marry or that people on welfare abuse the system at tax payer expense. These are the types of statements for which support would categorize respondents as low grid/low group – the Individualists. On the other hand, agreement with egalitarian statements like "the big problem today is not giving everyone an equal chance" may make a respondent think he or she looks better in the eyes of the interviewer. Possible solutions to this problem in future research would be to choose more subtle assessment statements and/or include more statements in the survey. My survey included sixteen statements (eight each for grid and group).

Another element at play is the order of the survey questions. Respondents were asked about their health insurance situation before they were given the cultural worldview assessment statements. Given the negative television coverage of the ACA at the time of the survey and the fact that the sample's ideology leans towards conservatism, my unusually large number of Fatalists might be the result. Previous research (Song et al. 2012) showed fatalism to be an insignificant variable because Fatalists do not typically express strong preferences because they are uninterested in public policy. That was not the case with this sample. Fatalism was often the worldview that was not as significant as others in the models that used cultural worldview but it was hierarchism that had a higher incidence of *washing out* in the results. I believe the reason for this is that Hierarchs respect order, expertise, and professionalism. While this survey was in the field, the federal government was experiencing a multitude of challenges – the Marketplace website problems, various

lawsuits over the individual mandate and Medicaid expansion in the states, as well as a constant barrage of attacks coming from the opposition, including the news that a large number of Americans would not be able to keep seeing the same doctors they had been before the ACA went into effect. This is the type of news that would make a Hierarch ambivalent about government health care-related policies.

Two hypotheses in this study were confirmed, two were partially confirmed and the one was not confirmed. Cultural worldview is a better predictor than income with respect to preferences for the ACA and for basic health coverage for illegal or undocumented immigrants – two government health-related policies for which respondents have little knowledge. Cultural worldview is not as appropriate at predicting preferences for less abstract concepts such as income tax increases, Medicaid expansion or lowering the age to qualify for Medicare.

I did not expect income to play as significant role in policy preferences as cultural worldview but I was surprised to see that education and political knowledge were not significant in most of the models. The political knowledge index of five questions, when significant (and usually only slightly) was always negative, indicating, on the surface at least, that the more people know about government the lower their opinion its policies. The Knowledge Index and income were strongly correlated and when income was significant, it was negative too.

Women are more concerned with issues of fairness than men are (Andreoni and Vesterlund 2001; Klinowski 2016) and women were more supportive of the ACA and health-related redistributive policies than men. When I compare the percentages of men and women who gave their level of support (1/strongly oppose to 7/strongly support)

for each of the five dependent variables, I do not see a big difference. A correlation test shows no significant association between income and women with children. In this sample, more than twice as many women with children are married as opposed to being single. A test between unmarried individuals and income shows a negative and significant (0.01 level) association. A cross-tabulation shows that 70.5% of individuals in the two lowest income categories are single and the Chi-Square statistic is significant. Another cross-tabulation between income and marital status and layered by the variable, women with children shows that 52.2% of single women with children 18 and under fall into the lowest income category ($25,000 per year or less).

Race (i.e. non-white) was not significant in the models of approval for the ACA or for extending basic health coverage to undocumented immigrants. Race was significant in the models for lowering the age for Medicare qualification and raising taxes to help fund the ACA. It is interesting that race became insignificant for expanding Medicaid to more low-income households in the model with the cultural worldview variables but not in the model with ideology.

Business owners were not significant at all for ACA approval. They are significant and negative in the models for tax increases on households earning $250,000 a year or more and that is understandable as, in this sample, they would have been the respondents most affected by an increase in their taxes. A cross-tabulation shows 8.2% those making $200,000 or more per year are business owners compared to 5.6% of high-income respondents who do not own their own businesses. Of the five dependent variables, heath care for undocumented immigrants was the least popular; on a scale of 1/strongly oppose to 7/strongly support, the mean score was 2.49. It is surprising that

business owners are positive and moderately significant for extending health coverage to undocumented immigrants in the model with ideology but not in the model for cultural worldview.

For all the effort political parties devote to convincing their constituents to either vote against elected officials who do not support the ACA or vote for them because they do, it is interesting that loyal party voter is not a significant variable in most of the models. Loyal party voter is a dummy variable that represents the 30.4% of respondents who said they vote with their party all or most of the time (0/not loyal and 1/loyal). A correlation test shows a significant ($p = 0.05$) and negative association between party and party loyalty. Since party is identified as 1/Democrat, 2/Republican, 3/Independent, and 4/Other, it would appear that Republicans are less loyal than Democrats in this sample.

The base of the Republican Party, typically middle- to upper-income college educated whites, has changed over the decades since the Reagan Democrats began to switch parties in 1980 and now includes more working-class white voters. White voters without a college education tipped the 2016 election in Donald Trump's favor (Fidel 2016). They are not leaving the Democratic Party and becoming Republicans however; they are joining the ranks of the independent voters (Gaddie and Goidel 2017). The eight states in this study were divided in half between high- and low-union-membership as a proxy variable for union households. Union state was interacted with variables for a pay cut or a job loss. Variables for union state with pay cut or lost job were positive and significant for ACA approval and raising taxes to fund the ACA but were negative and significant for lowering the age to qualify for Medicare.

A cross tabulation shows that independents in this sample tended to identify as middle-of-the-road in their ideology, be non-white or mixed-race, be evenly split between male and female, and have incomes between $75,000 and $150,000. More independents held negative views towards the five health care-related policies than maintained positive perspectives.

The unemployed were significant and positive in the model for Medicaid expansion but only in the model with ideology (not cultural worldview). That is understandable considering they are the respondents who may be the most affected by this policy if they do not get a job that provides insurance benefits or feel like they make enough money to purchase insurance through the Marketplace. The unemployed were significant and negative in the model with cultural worldview for increasing taxes (whites only) and in the model with cultural worldview for coverage for undocumented immigrants, and significant and negative in the models for lowering the age to qualify for Medicare. The unemployed were not significant at all in the models for ACA approval. Respondents who believed he or she would be worse off financially five years from the date they answered the survey were very significant and negative in most of the models except raising taxes on high-income earners.

The ACA was signed into law in March 2010 after a year and a half of debate in Congress. When respondents were interviewed, they already had a few years to learn about the law, form an opinion, and change their minds. Respondents were asked about their current opinion on the ACA and four other policies. Next, they were asked if that opinion had changed and if so, when that change occurred: ACA approval 9.4%, tax increase for ACA 7.3%, Medicaid expansion 10%, and coverage for undocumented

immigrates 5.7%. The most change, 16.1%, occurred with the policy proposal of lowering the age to qualify for Medicare from 65 years to 55 years. Tables showing all changes appear in the Appendix.

I stated at the outset that our cultural worldview begins to develop early in life and is conditioned by our experiences until we reach adulthood, at which point our cultural worldview is generally set and will not change except in response to some kind of crisis. On the one hand, our worldview is formed before we find ourselves to be members of a particular economic class so it seems reasonable to assume that income level and cultural worldview would not be correlated. On the other hand, money problems often lead to financial calamities that have a major impact on worldview development. It stands to reason that there should be a link between income and cultural worldview. With regards to catastrophic health problems, the leading cause of bankruptcy in America has been unpaid medical bills (St. John 2017) so I should probably expect to find some measure of correlation between income and cultural worldview. In fact, income is significantly and negatively correlated with egalitarianism ($p = 0.05$) although not correlated with the other three cultural worldview factors. The factor scores measure the strength of individualism, hierarchism, egalitarianism and fatalism as measured by the cultural worldview assessment statements shown in Chapter Two.

As for the distinct quadrants in the grid-group typology, income is significantly and negatively correlated with the Individualist ($p = 0.01$). Income is also significantly but positively correlated with the Fatalists ($p = 0.01$). Egalitarians and Hierarchs are not correlated with income. Why would income be correlated with some cultural

worldviews but not others? One explanation could be related to the battery of Cultural Theory assessment statements posed to this sample. More broadly speaking, income and cultural worldview may be correlated because the financial circumstances into which we are born and subsequently raised have a powerful impact on how we perceive the world and judge issues related to fairness and equality.

The table below shows a capsulation of the results of the five hypotheses tests with respect to cultural worldview and income.

Table 7.1 Hypotheses' Recap

Hypothesis #1 – Approval for the ACA
Individualism*** (-)
Hierarchism*** (-)
Egalitarianism*** (+)
Fatalism*** (+)
Income (-)

Hypothesis #2 – Approval for Tax Increase to fund the ACA
Individualism*** (-)
Hierarchism*** (-)
Egalitarianism*** (+)
Fatalism** (+)
Income** (-)

Hypothesis #3 – Approval for Medicaid Expansion
Individualism*** (-)
Hierarchism* (-)
Egalitarianism*** (+)
Fatalism** (+)
Income** (-)

Hypothesis #4 – Approval for Coverage of Illegal Immigrants
Individualism*** (-)
Hierarchism*** (-)
Egalitarianism*** (+)
Fatalism** (+)
Income (-)

Hypothesis #5 – Approval for Lowering Medicare Qualifying Age
Individualism*** (-)
Hierarchism (-)
Egalitarianism** (+)
Fatalism** (+)
Income (-)

The primary research question for this study – what explains preference formation for the ACA – was tested with Hypothesis #1 and this hypothesis was confirmed. Cultural worldview factors were stronger performers in the model than the income variable. The cultural worldview factors that disapproved of the ACA were individualism (low-grid, low-group) and hierarchism (high-grid, high-group). Egalitarianism (low-grid, high-group) and fatalism (high-grid, low-group) were the factors that approved of the ACA. The figure below shows the location in theoretical space of the cultural worldview factors.

Figure 7.1 Cultural Worldview Factors

Fatalism	Hierarchism
Individualism	Egalitarianism

The diagonal line that connects individualism and hierarchism represents a continuum that measures the strength of conservatism with Individualists being the most conservative. Both Individualists and Hierarchs self-identify as conservative so the results of the hypothesis test that shows these cultural worldview factors to be significant and negative is expected. The horizontal line that connects Individualism and Egalitarianism represents the traditional left-right ideology continuum, although in reverse. The diagonal line that runs between egalitarianism and fatalism represents the strength of liberalism with Egalitarians being the most liberal. I expected Fatalists to be conservative because they are low-group and in this sample, Fatalists self-identify as conservative; however fatalism, like egalitarianism, is significant and positive in measuring preferences for the ACA.

The income variable is not at all significant in this hypothesis test. I believe the reason cultural worldview factors are so powerful is because the issue being tested – approval for the ACA – is complex and somewhat abstract. Knowledge about this issue is very low so we can be certain that respondents relied on other factors to form their opinions. When Individualists and Hierarchs said they disapproved of the ACA were they really disagreeing with a president they did not support? Did they hear the words 'Affordable Care Act' and immediately associate the law with the myriad of negative media reports? Hierarchs respect expertise and professionalism and the problems with the ACA rollout probably influenced their responses. Individualists resent government intrusion in their lives so they are not likely to approve of far-reaching legislation like the ACA. Egalitarians, in contrast, would approve of legislation designed to expand health insurance coverage to Americans who could not afford it before. Fatalists, who typically believe that factors beyond their control determine their outcomes in life, should *wash out* in the results; they should not be significant in the model and yet they are and in the positive direction. It could be that Fatalists in this sample, with regards to the ACA, believe that the law will benefit them in some way.

Hypothesis #2 tests approval for a tax increase on individuals making $250,000 or more if the monies are used for funding the ACA. Individualism and hierarchism are highly significant and negative as one would expect given these two conservative cultural worldviews do not like tax hikes. Egalitarianism, a liberal worldview, is significant and positive as expected. Fatalism has dropped in significance but it is still positive. This change, however slight, calls into question one of the key tenets of

Cultural Theory – cultural worldviews are not issue-dependent. Fatalism should be just as significant on the issue of a tax increase as it was on the approval of the ACA.

Income is moderately significant and negative in this model. The issue of a tax increase is an easy one to grasp – income taxes go up and a person's net income goes down. Individuals may construct their own view of the ACA (a law they know little about) that does not necessarily align with reality but they do not have to struggle with the concept of a tax increase. This may be why the income variable is significant in Hypothesis #2 which tests a concept, a tax increase, which is not as complex an issue as the ACA.

Hypothesis #3 tests approval for the expansion of the Medicaid program so that more low-income people are covered. Individualism and egalitarianism are highly significant and have signs in the expected direction. Fatalism remains positive and moderately significant. Hierarchism, though still negative, has dropped in significance from high to only slight. Cultural worldviews should not change in significance because the issue being tested has changed. Hierarchs are conservative but less so than Individualists so this cultural worldview's factor is in the expected direction but it is also more approving of expanding Medicaid than it is for increasing income taxes. It is puzzling why Hierarchs would have a higher opinion of Medicaid than tax hikes. Given the general lack of knowledge on the ACA, I find it hard to believe that Hierarchs made the calculation that poor people would be better off with free health care coverage through Medicaid than they would be with subsidized insurance through the ACA Marketplace, something to which the extra tax monies were targeted. It is more likely

that Hierarchs, being high-group, are more approving of a program like Medicaid that seeks to lessen the inequality between groups.

Income is moderately significant and negative as it is in the model testing approval for an income tax increase. Medicaid is a program for poor people who cannot afford to purchase health insurance. Middle- to high-income individuals are less favorable towards social programs than their low-income counterparts so this result should not come as a surprise.

Government providing some kind of basic health coverage is the issue tested in Hypothesis #4. As is the case with Hypotheses #1 and #2, individualism and hierarchism are highly significant and negative and egalitarianism is highly significant and positive. Fatalism is also positive but only moderately significant. Respondents were not told that basic health coverage would involve Medicaid or the ACA so they were free to construct the meaning of 'basic' as they wished. With this complex issue, the cultural worldview factors were the significant performers in the model. Egalitarians should not see a difference between needy Americans and needy immigrants, even if they are in the country without documentation. Conservative worldviews on the other hand, should be opposed to the idea of the government providing health care for noncitizens. Income, as in Hypothesis #1, is not at all significant like it was in Hypothesis #2.

Hypothesis #5 tested approval for lowering the age to qualify for Medicare from 65 to 55 years. The results for this final hypothesis were the most mixed of the five. Individualism was highly significant and negative as it has been in the other four models testing cultural worldview. Egalitarianism, still positive, dropped from highly

significant to only moderately so as is fatalism. Hierarchism is not significant at all in this model. Hierarchism was only slightly significant in approval for Medicaid, another large government program. Hierarchs typically trust people with the expertise and competence to manage large enterprises but in these two cases, especially with Medicare, that does not appear to be the case. Perhaps these results reflect the disdain Hierarchs have for the way the ACA rollout was handled. It could be that they do not believe the government is capable of managing the extra workload that expanding Medicaid and Medicare would cause.

In the model testing approval for Medicaid expansion, income was moderately significant and negative but income is not at all significant in the model testing the expansion of Medicare. For the models where income was not significant, I posited that the issue being tested was complex and that cultural worldview factors were best suited to measure preference formation on issues that the respondents did not fully understand. The results for Hypothesis #5 could be explained by pointing out that the mean age of the sample is 49.32 years. Many of these respondents have parents that are covered by Medicare. Perhaps they simply do not relish the thought of millions more Americans being covered by a health care program that will soon be overwhelmed with aging baby boomers turning 65. The correlation between age and this dependent variable is significant. The older a person is, the less supportive they are for lowering the Medicare qualification age.

National public opinion polling indicates that people earning less than $40,000 per year have higher approval ratings of the ACA than people in the middle- and high-income categories and those results have been consistent over time. I did not find that

in my sample of eight states. I chose eight politically and demographically diverse states in an attempt to represent the entire country but national polls taken during the time the survey was in the field show different results with respect to preferences by income category.

There was no significant correlation between income and preferences for the ACA nor was there a significant correlation between income and the cultural worldview factors except for egalitarianism. That may be an artifact of this sample which is approximately 44% Egalitarian. Social desirability response bias is a problem inherent in telephone surveys because respondents intentionally misrepresent their true feelings on an issue because they are embarrassed to state the truth (Holbrook and Krosnick 2010) perhaps out of fear of being judged by the interviewer. In order to get a better distribution in the cultural worldview categories for future surveys, I should include additional Cultural Theory assessment statements that will elicit more responses outside the low-grid, high-group category. I could also pose the survey to an online sample, perhaps via Qualtrics or some other survey company, and compare my results between the two as self-administered surveys cut down on response bias (Holbrook and Krosnick 2010).

Cultural Theory, like all theories in social science, has its shortcomings but it can be very useful for explaining preference formation; however, its usefulness appears to be conditioned by the issue being posed. It should not matter what the issue being analyzed is and yet in this study, issues did matter, especially in regards to hierarchism. Only individualism maintained the same high level of significance no matter the issue being tested. The other two cultural world view factors also changed in response to the

particular policy being analyzed. This finding is in direct opposition to one of Cultural Theory's key tenets – one's cultural worldview does not depend on the issue being posed to the individual.

If we overlay the four-quadrant grid-group typology shown in Figure 2.1 on the scatterplot graph in Figure 5.1, we can imagine each of those observations (which represent the respondents) moving up or down, right or left and diagonally along the continua that cut through theoretical space. The closer the observation, or rather, the individual is to the origin, the less egalitarian, hierarchical, fatalistic, and individualistic that observation is on the issue posed to them. The closer the individual is to the corners of the grid-group typology, the stronger their affinity for a particular cultural worldview. Would not Cultural Theory be just as useful a framework if we allowed for some movement within and between the cultural worldviews? We readily accept that certain political issues provoke a conservative response from an otherwise middling or liberal survey respondent. Perhaps it is time to adjust the theory to incorporate this new finding.

Chapter 8: Qualitative Study

Hochschild's *What's Fair?* offers some insight into what motivates people who are very fortunate and people who are struggling. Her in-depth interviews with twenty-eight people of various backgrounds and stations in life revealed that they hold conflicting views about power and wealth, fairness and equality, and what role government or society should play in their lives. She made the point that people's preferences are only inconsistent if we are expecting consistency, which is not always a valuable thing to achieve. "Disjunctions that follow an intelligible pattern may be the most subtle response to a highly complex world" (1981, 193).

The telephone survey gathered a great deal of statistical information from over four hundred people but given the time constraints, it was impossible to delve into the reasons behind the respondents' opinions on certain important questions. I interviewed 36 men and women with diverse backgrounds from the states of Oklahoma and Texas between April 15, 2014 and July 11, 2017. My sample was built from contacts I made through my work at the University of Oklahoma and from friends and acquaintances of different family members. I did not interview any member of my family nor did I interview anyone that I thought might be especially knowledgeable about the ACA. I followed Shively's advice to "intelligently" choose my subjects to interview (103, 2005). Most of the respondents secured their health insurance through their employers or their spouses' employers. Several respondents had purchased insurance through the ACA Marketplace but had not used their policies at the time of their interview.

Each respondent completed a questionnaire similar to the telephone survey's section on political knowledge and cultural worldview statements. The purpose of the

interviews was to gather information of a more personal type such as family history, family culture, social class and health care experience (i.e. illnesses). Respondents were allowed to elaborate on their reasons for their opinions on the ACA and health care in general. The respondents lived in the Oklahoma City and Dallas areas and were chosen on the basis of how they fit into a representative group of individuals as I could get considering they were not chosen randomly. Most of the respondents did not have yet have any personal experience with the ACA as yet; however, there was no shortage of strong opinions on the legislation, both for and against. One of the findings in the qualitative study was the fact that knowledge levels on the ACA were very low and that they based their opinions on the ACA on information that was clearly false.

I met each respondent in a public place, usually somewhere on the University campus, a coffee shop or casual restaurant, or their place of employment. As I set up for the interview, the respondents filled out their anonymous questionnaires privately. I sat nearby but they knew I could not see what they were writing on the questionnaire. After they completed their task, I put the questionnaire away because I did not want to know how they felt on certain political issues before I started asking them questions about the ACA and health care in general. Of the respondents who spoke to me while they were filling out their questionnaires, almost all of them expressed embarrassment that they were not sure of the answers to the knowledge questions. I assured them that the purpose of the questions was to gauge how well the media communicates political information to the public but despite my reassurances, I believe several of them felt like the questions were meant to assess their intelligence in some way. The knowledge levels were low but knowledge levels were low in the telephone interviews as well. I

do not believe the questions impacted our discussions but I have to wonder if they had an influence on the Cultural Theory assessment that followed.

Several respondents expressed the opinion that the Cultural Theory statements were "weird" or "hard to answer". One male respondent asked me, "You expect me to answer these?" and laughed. Another respondent asked, "What do you want me to say here?" and another asked, "Can I pass on some of these?" I participated in the telephone interviews while working at the OUPOLL and of course, the respondents were anonymous to the interviewers so it was easier for them to answer questions of a very personal nature without feeling judged by someone they knew, even if casually and only for the purposes of the interview. Despite my assurances that the purpose of the questionnaire was only to categorize the entire group's responses and that none of their identifying information was on their questionnaires, I believe they did not trust that I would not try and figure out who they were. Unfortunately, I realized after I started compiling the responses that many of the respondents chose the midpoint of each of the Cultural Theory assessments which meant that I could not categorize them as Egalitarian, Hierarch, Individualist or Fatalist. The other problem with the questionnaire results was that almost all of the respondents who were able to be categorized, ended up in the Egalitarian group. I attribute this occurrence to social desirability bias. In our political culture, it is not socially acceptable to express anti-gay or anti-minority sentiments nor is it considered appropriate to disparage poor people and the public assistance programs they rely upon for support. Only completely honest answers to the Cultural Theory assessment statements enables researchers to accurately gauge a respondent's degree of egalitarianism, hierarchism, individualism or fatalism.

I made the decision to not use their responses to these statements in my qualitative analysis. If everyone is an Egalitarian, then *no one* is an egalitarian. The following table contains the descriptive statistics for the sample.

Table 8.1. Descriptive Statistics

Gender	Female	22
	Male	14
Age	18-25	7
	26-35	12
	36-45	9
	46-55	6
	56-64	2
Income	Under $25,000	6
	$25,000 – $50,000	10
	$50,000 – $75,000	8
	$76,000 – $100,000	9
	$101,000 – $150,000	3
Race	Non-Hispanic White	20
	African-American	4
	Hispanic	5
	Asian	1
	Native American	6
Education	High School/GED	2
	Some College	16
	College Degree	11
	Graduate Degree	7
Party	Democrat	17
	Republican	13
	Independent/No Party	5
	Other	1
Ideology	Liberal	12
	Middle of the Road	16
	Conservative	8

Given that the telephone survey respondents approved of some aspects of health care reform and not others, I was not surprised that my personal interviews revealed similar opinions. The mean score for expanding Medicaid by allowing people with higher incomes to qualify was 4.35 on a scale of 1/strongly oppose to 7/strongly support. This question also received the highest support of the five questions that built the Tolerance Index (an indication of approval of various redistributive policies). The concept of expanding Medicaid was also approved of by most of the people interviewed. Several people indicated that expanding Medicaid would be easier to manage than the ACA because we have had the Medicaid program for many decades. The interviews also revealed approval of the *idea* of the ACA but several respondents commented that this particular legislation was probably not going to work in the long run because of political opposition.

As with the telephone survey, those interviewed showed a negative attitude towards extending basic health care coverage to undocumented immigrants. The mean value of the question for the telephone respondents was 2.44 – the lowest level of tolerance for any of the five policies included in the Tolerance Index. I was surprised that in both the telephone survey and the personal interviews that there was not more support for lowering the age to purchase Medicare insurance from 65 to 55. The telephone survey mean was 2.71. It is interesting that there was support for expanding Medicaid on the basis that because it was an existing program but the idea of expanding Medicare for the same reason (both were approved by Congress in 1965) was not supported.

With respect to income and education, as with the telephone survey, respondents in the interviews who had lower levels of income and education were more likely to be supportive of the ACA and expanding Medicaid. The strongest supporters were respondents who were more likely to identify as liberal and Democrat. Somewhat less than half of the respondents earning below $25,000 annually actually disapproved of the ACA, the increase in taxes for on high-income earners (i.e. $250,000 or more per year), and expanding Medicaid. These low-income respondents who were the most strongly opposed self-identified as conservative and Republican. The three respondents who have an annual income of over $100,000 were steadfastly against all redistributive policies in the Tolerance Index and they also self-identified as conservative Republicans. As for the respondents in the mid-level income ranges, they were evenly split between ideologies, parties and support (or opposition). This finding supports my hypothesis that income alone does not determine one's approval of redistributive policies.

One of the most fascinating things revealed in the interviews was the lack of specific knowledge about Medicaid, Medicare and the ACA. These respondents have based their support or opposition for redistributive policies on information that is false. During the course of the interviews, I would be asked if something the respondent thought was correct or not and I was careful to not respond or give them any clue as to whether I knew the answer to their question. It was not my place to educate them on American health policy and since the original legislation signed in 2010 in almost 3,000 pages long, there was a very good chance I would have been wrong about something if I

had tried to answer the respondents' questions. Some of the more notable statements the respondents made that were false were:

- Medicaid covers illegal or undocumented immigrants.
- The ACA premiums are thousands of dollars a month.
- The ACA premiums are as low as $20 a month.
- There are no deductibles with the ACA.
- The deductibles are low with the ACA.
- The government will provide a subsidy to pay the penalty for not showing proof of health insurance.
- The penalty for not having health insurance is very low.
- Employers must cover all their employees with health insurance.
- Employers must pay for abortions on demand.
- Women must go to Planned Parenthood to receive health services under the ACA.
- The ACA does not cover children (must use Medicaid).
- American's private health information is on a public database that potential employers can access.
- Medicaid is from the government but Medicare is private insurance.
- Oklahoma does not have ObamaCare because the state refused to set up the Exchange.
- The ACA is what the employers have to cover people with but ObamaCare is what you get from the government.
- ObamaCare is free but you have to pay high premiums to get the ACA insurance.
- Women have to buy insurance that pays for prostate cancer.
- The ACA covers dental and orthodontics.
- When the Republicans repeal ObamaCare, everyone will lose their health insurance immediately.

Another aspect of the interviews that was interesting was how often the respondents used the terms *health insurance* and *health care* interchangeably. I did not attempt to correct them. Some of the Oklahoma respondents who purchased insurance from Blue Cross Blue Shield on the ACA Marketplace had not actually used their policies yet and had no idea what their deductibles were (Blue Cross Blue Shield is the only insurance provider for Oklahoma on the ACA Marketplace as of 2016). Some of them had been ill but they treated themselves with over-the-counter medications rather

than see a doctor just as they had done before they purchased insurance. Respondents with insurance through the ACA and with insurance through their employers expressed relief that at least they were covered with health insurance. This attitude was expressed by people who were covered by an expanded Medicaid program in Oregon (see Chapter 4). People may not have seen an improvement in their physical health while on Medicaid but they reported a decrease in depression and felt their mental health generally improved.

We know that simply expressing an opinion in favor of or against a public policy, like the ACA, is not a perfect indication of whether a person will take advantage of the policy. Several of the respondents in the interviews revealed that they used government health care for themselves, their children, or their parents at some point in their lives. Even some of the most ardent opponents of the ACA took advantage of the opportunity to use government programs because they felt they had no choice. For example, the respondents with elderly parents on Medicare seemed to unable to make the connection that Medicare is a government program. They were completely aware that Medicaid is a government program for the poor but did not understand that the insurance premiums people age 65 and older pay are subsidized by the tax payers nor did they express the understanding Medicaid and Medicare became available at the same time as a means to alleviate the ill effects of poverty.

Cultural Theory holds that a person's ideological worldview is the lens through which they see the environment around them. Whatever problems a person must face are dealt with according to their worldview. I asked respondents questions about how the Great Depression was discussed in their households when they were young. The

majority of older respondents knew the Great Depression was caused by the Stock Market Crash of 1929 and that it ended with World War II. The more conservative respondents tended to blame the government's bad policies in the 1930s. The more liberal the respondent was, the more likely they were to blame the greed of big business for the Great Depression. As far as the ACA and Medicaid are concerned, the respondents who had experience with either one or both programs felt like they had no choice in the matter, regardless of their ideological views. Some respondents believe that fraudulent lawsuits by dishonest patients are responsible for the high cost of medical care and that it is not their fault they must turn to the government for assistance, either by using Medicaid or by qualifying for a subsidy to make the ACA insurance more affordable. Other respondents expressed the view that doctors and hospitals artificially raise the cost of their services so they can make more money and that is why they cannot afford health insurance without assistance. Still other respondents pointed to the fact that advances in medical care have enabled the very sick to live much longer these days and that the cost of their care comes at the expense of affordable health care for themselves. One younger respondent said that 95% of the money a person will spend on their health care is spent in the last year of their life and that it was a waste. These findings are not unexpected according to the Cultural Theory literature. As for the amount spent during the last years of life, the figure is far from 95% but it is still high; approximately one-third of medical spending for persons aged 85 and older occurs in the last years (Alemayehu and Warner 2004).

As for the possibility of repealing and replacing the ACA with a different government health program, the respondents who were most adamant that Republicans

repeal the law were the high-income, conservative respondents who had health insurance through their employers or companies. Respondents who leaned more to the middle or left of center tended to be more supportive of keeping the ACA regardless of their income. This finding reflects much of what was discussed in the media after President Donald Trump's election (KFF.org 2017) and the House of Representatives passed the American Health Care Act of 2017. Public opinion polling was positive for the ACA after years of being consistently negative. The respondents who had insurance through the ACA were extremely anxious at the thought of losing their health insurance. Even the respondents who got their health insurance through an employer expressed some concern that overturning the law would cause a lot of problems that would ripple through the economy.

By comparing and contrasting different respondents' experiences, we get a better understanding of their decision-making process. For example, two respondents, Ann and Lola both have valid reasons for using social services that they could, if they sacrificed enough, have been able to pay themselves. Ann, a 50-something married mother of two active daughters (one high school, one college) had an 86-year-old mother with Alzheimer's Disease and a pulmonary disorder that required constant skilled nursing care (her mother has recently passed). Her mother was rather large and heavy and Ann is very petite and lacks the strength to get her mother up and down and out of bed without assistance. Ann is also a full-time doctoral student and works at her youngest daughter's school. Ann is an only child. Her husband has a well-paying job that requires him to travel and his siblings, for a host of reasons, were neither willing nor able to help with his mother-in-law. This left Ann to shoulder the burden of her

ailing mother by herself. She is very conflicted. Her mother was on Medicare and Medicaid. The state of Oklahoma has several services available to the indigent elderly and with the aid of state counselors Ann was able to secure public assistance funds so that her mother could live in a nursing home rather than live with Ann and her family. Also, Ann's house does not have a room for someone in her mother's condition and even if the girls shared a room, there was no handicap accessible bathroom for her mother to use. Ann told me that she knows she should have taken care of her mother with her own money. Her mother made some bad business decisions after her husband died that left her in poverty. She owed several hundred thousand dollars in unpaid taxes and fees from the family restaurant business and by the time it was over, the Ann's mother had nothing.

Ann's explanation for why her mother relied on public assistance is that the doctors ordered very expensive tests and procedures and other things that were unnecessary and cost a fortune. One night, Ann's mother was running a fever and needed some medication. The doctor's office told Ann the best and fastest way to get her medical attention was to take her to the emergency room. The mother's problem was not an emergency but this was the only way she would see a doctor soon. Ann and her husband could not pay emergency room costs every time her mother needed to see a doctor. Ann believes it was a "grotesque waste of money and resources". Ann said that she would have paid her mother's expenses that Medicaid picked up but the expenses were "ridiculous" and they would have bankrupted her family. Ann has a point. On the surface, it appears she was willing to take government handouts to take care of her mother but that is not the real story. The expenses were so inflated because of the

Medicare/Medicaid system that she could not pay them on her own. It is not an excuse; it is a valid reason.

Lola's story is a little different. She is a single mother of one young daughter. Her child was born seven months before she graduated with her bachelor's degree. She has used food stamps and Sooner Care (an Oklahoma Medicaid program) for her daughter. She comes from a middle-class background. She is a doctoral student working part-time as a college instructor at different colleges. She said that people need help (i.e. welfare, aid, public assistance) because although we say that people will get ahead if they work hard, it generally is not true. The economy is such that poor people cannot make it without help. Lola says her politics are liberal and that she always votes for the Democratic Party. Her parents are much more conservative and she accepts that. She says her parents are very traditional and although she had a traditional upbringing, she has always been different from her parents in terms of politics.

Lola did say that she very much dislikes the "welfare queens". She said she has a friend that is a "Nick Nurse" who works in the neonatal intensive care unit. Parents with seriously ill babies are devastated when the doctors tell them that their insurance company will not cover a certain procedure and they have to pay cash for it if they want to save their child's life. These parents struggle to find ways of paying for medical procedures that are offered at no cost to parents on welfare. Lola was outraged at this, saying it is really unfair. "Babies come into the "'NickQ'" crack addicted and/or with numerous medicals problems and their mothers aren't worried at all about how to pay for their care. These babies get whatever they need but babies with insurance do not." Lola sees this through her Egalitarian lens and uses this circumstance as a reason for

government-funded health care – like single-payer or universal health care. The medical expenses, like the expenses for Ann's mother, are too expensive for an individual to pay on their own. The reason medical costs are high is because of insurance companies, waste and fraud.

Ann votes consistently for the Republican Party but is usually not happy with the choices presented to her. Her opinion of the ACA is mixed. She is not against the idea of the government helping people with health care if they cannot provide for themselves but fears "malingerers will game the system" and people like her will have to pay for it. Lola's opinion of the ACA is very positive although she, too, is worried that some people will abuse the system and ruin it for everyone else. She purchased an ACA policy and she is very happy and quite relieved that she finally has insurance coverage for herself (her daughter is covered by Medicaid). At the time of our interview, she had not used the policy yet and said that as far as she could remember, the deductibles were "reasonable".

Sam and Haj are very similar in terms of opinions health care reform. In every other way, they are complete opposites. Sam grew up in a very liberal household in North Dallas. Both of his parents have graduate degrees as well as "everyone in my family". He is an only child and was fortunate enough to be "raised with money". He attended public schools but since he lived in one of Dallas' best neighborhoods, he received a high-quality education and went to a private university in town. Money was never a problem in Sam's family but serious illness was. His mother's brother was gay and died of AIDS in the mid-1990s. Sam does not really remember him but says his mother has really never gotten over his death. "When Dallas Buyer's Club came out,

my mom cried all the time." This was a film whose plot focuses on the lives of gay people living with AIDS and trying to get medications on the black market. Sam has a couple of gay cousins and a lot of gay friends and worries about them contracting HIV and Hepatitis C. He thinks that the ACA is the only option for a lot of people who have "pre-existing conditions that private insurance companies won't cover". Sam is covered by his father's health insurance policy. His father is a partner in a law firm and Sam says that his father pays an "ungodly" sum of money for health insurance. I asked him what he planned to do when he can no longer stay on his father's insurance and he said he would gladly go onto the Marketplace and buy a plan. He thinks the premiums are very low for the ACA when the subsidies are taken into consideration. I asked him to explain what he knows about the subsidies and he does not really understand the process. Subsidies are given to people based on their income level and from what Sam shared about his family's finances, he may not qualify for any. Sam is especially annoyed with Republicans in Congress that "spread lies about ObamaCare". He has no patience with any of the arguments made about how much the health care law costs. "How much does it cost us to have a sick country?"

Haj and his family came here from India after Haj graduated from high school. His parents are both professionals with college educations and they emigrated so that Haj could go to school in the United States. His father's job brought him to Oklahoma and Haj to OU. His parents were always frugal and "watched their money". "Americans don't know what it's like to be poor; not like India-level poor." His family's attitude towards people in need was simple – "help your brother". Haj's family is Syrian Catholic and charity was important part of life. "Now I'm getting

charity! My parents pay for my school!" He laughed admitted that he has a weakness for the latest gadgets and I could see that he has an expensive MAC computer and the latest iPhone. He is an engineering student and has plans to work in the United States after graduation, but not in Oklahoma. "Oklahoma is, no offense, but kind of backward." He said Oklahoma's politics amaze him and that he has never been around so many "stupid Conservatives". He cannot vote at the present time but says he supports the Democratic Party. His parents support the Republicans. "They think I'm wrong about everything." When we talked about the ACA, he was very positive about it. The insurance he has is paid for by his family and it is very expensive in his opinion. He feels the ACA plans would not be so expensive if the government did not cover "illegals" with it. I asked him what he knows about the provisions of the ACA and he is quite convinced that undocumented immigrants are eligible for ACA coverage, which they are not.

Narciso and Artie have almost everything in common, except for their views on the government's involvement with the health insurance and health care industries. Both are Hispanic males who were born in this country to parents who emigrated from Mexico when they were in their teens and early twenties. Narciso says his parents came here with nothing but their willingness to work hard. They had very little education and only his mother spoke English. He suggested they might have come here illegally and asked me if I wanted to know but I declined. The purpose of my interview was not to out his parents, who by 2014, had been in the country for over thirty years. By the time Narciso was born in 1988, both of his parents spoke fluent English so Spanish is actually his second language. He grew up in an ethnically diverse neighborhood in a

suburb north of Dallas. An older sibling died of a protracted illness when Narciso was in grammar school and he said his family "spent a lot of time at Children's and Parkland" when he was a child. Children's Medical Center is a private, non-profit hospital located near Parkland Hospital, which is Dallas County's public hospital. Narciso is certain they had no "regular" health insurance when he was a child and recalls his mother saying how lucky they were to have "medical aid insurance", which he later assumed was Medicaid. "But we didn't live off welfare," he added. Both of his parents worked full-time until he graduated from high school and his mother quit her job. The family moved to Oklahoma shortly thereafter when his father's employer went out of business and he found a job in the Oklahoma City area. Narciso says that his parents always expected him to go to college. They stressed that he had opportunities his parents and his extended family never had and he was going to make the most of them.

Both of his parents' attitudes towards public assistance was positive unless it was being abused. Other than normal childhood illnesses that could be treated with over-the-counter remedies, Narciso was a healthy child and has remained healthy to adulthood. Both of parents are "mostly" healthy except that his father still smokes cigarettes and his mother continually nags him to stop. Narcisco's attitude about the ACA is very positive. "Poor people can't afford health care. What are they supposed to do? Die?" I asked him if he intended to purchase health insurance through the online Marketplace and his response was a blank stare. "What's that?" I did not explain the process to him but I asked him if he had heard of the ACA website and he had, but only about some of the problems. He was unaware that the website problems had anything

to do with consumers going online to purchase insurance policies through the ACA. As for deductibles and monthly premiums, he is convinced that "ObamaCare is free" if you cannot afford to pay for it. The "Affordable Care Act is the expensive one for people who have money". Narciso said he that he thinks he is covered by his parent's health insurance although at age 26, he may not be. He has not had a reason to go to a doctor in years. He knows that eventually he must buy an insurance policy or pay a fine to IRS. He does not consider himself to be very political and self-identifies as middle of the road. He likes President Obama and does not plan to vote for a Republican in the next election.

Artie, which is short for his father's name, Arturo, has a background very much like Narciso's but has a completely different view on the ACA and politics in general. His parents came to the United States when they were each twenty-one. Most of his close extended family members have come here to work and go to school. Like Narciso's parents, his mother and father had very little education "by American standards" but learned English quickly and got good jobs – good enough to buy their first home before Artie was born. His politics are like his parents – conservative. His parents were raised Catholic but converted to Baptist when Artie was a child. He said about half of his family is still Catholic and the other half is Baptist or not religious. He admits that religion is not that important to him at this point in his life.

When I asked him about experience with public assistance in his family, he said that his older, unmarried sister "has had two kids on welfare" and that his parents are not happy with her. As far as he knows, his family never used public assistance in any form because both of his parents worked from "first day" they came to America. He

said that he knows a lot of Americans think Mexicans only come to the United States to get on welfare but that none of his family has ever done that. Everyone, as far as he knows, has come to the country legally and has either secured American citizenship or legal residence. College was "never optional" for Artie and he graduated in 2012. He has private insurance through his employer. I asked him how likely it is that he would have to go to the online Marketplace to buy an ACA policy and he said he hoped he never had to do that because the premiums are "a couple thousand bucks a month". I asked him if he had done any online shopping and where he saw those premium amounts and he said, quite confidently, that "everyone knows the premiums are insane". As for what he plans to do if his employer stopped offering health insurance, Artie says he will just "pay the fine to the IRS" because it is "far less than even one month's worth of insurance that I probably won't use anyway".

Artie does not like the idea of government regulating any aspect of his life and believes that "people need to take care of themselves without expecting others to do it for them". He votes for the Republican Party and is very, very critical of the Obama Administration, blaming the President and the Democrats for "this piece of crap" (the ACA). Even though Artie and Narciso have very different opinions of the ACA, they each have made up their minds about the health care law based on false information. I did not tell either man they were wrong; that was not my place. Narciso thinks that eventually he will get "free ObamaCare" if he cannot afford the ACA plans. Artie has no intention of purchasing an ACA plan because he thinks the premiums might be as much as $25,000 a year.

Dottie is a young, single mother of two who has been plagued with health problems for most of her adult life. She has allergies that easily turn into bronchitis and admits she was "down for most of the Spring". She is also a smoker and although she knows smoking aggravates her respiratory illness, she has been unable to quit. Both of her parents and most of her family also smoke and "COPD and lung cancer runs in the family". She has been using Medicaid for years and has tried the smoking cessation aids offered by the state of Oklahoma but so far, she has not been successful. She works part-time at a business that is too small to be covered by the ACA's employer mandate. She struggles financially because she receives no child support for either of her daughters who have different fathers. She feels fortunate that she can live with her parents although she wishes she could be financially independent. Her family is somewhat religious although they are not "big church goers". When she and her siblings were young, the family went to church often but something happened that upset her parents and they stopped going. Dottie is not exactly sure what happened but she did say that "churchy people are too judgy". Her family never had a lot of money because her father was unemployed a good bit of the time and her mother was unable to work because of health problems. Her father is 66 and on Medicare and her mother is on disability. This is a family who has had a lot of experience using public assistance to make ends meet. "My mom used to bring a book of paper Food Stamps to the grocery store a long time ago." As far as Dottie knows, they have never had health insurance through an employer or any other private source.

One might think, given her circumstances that she would be a supporter of the ACA or at least the government's involvement in health care but she is adamantly

opposed to it. "It's stupid. It costs too much and it doesn't cover anything." Dottie has never voted but says she considers herself to be a Republican but many of her comments during the interview were inconsistent with that label. She has very negative views on the ACA although it is clear from her comments that she knows very little about the law. She believes that "you can't buy ObamaCare in Oklahoma because Fallin didn't vote for it". Republican Mary Fallin has been the governor since 2010 and Oklahoma chose not to set up the ACA's online Marketplace. She also believes that "ObamaCare covers Mexicans"; presumably she is referring to undocumented immigrants. As a high school graduate without any discernable, marketable skills or a college education, Dottie may never have the need to investigate what the ACA covers or how much it costs. Her political knowledge score was 1 out of 5; she knew (or guessed) the federal budget deficit had increased.

Mike is an example of a person who changed ideological attitudes as he grew older and attributes the change to having a son with an expensive health problem. He had always been a loyal conservative Republican, as was his family. Unlike his family, however, he is not religious at all – in fact he self-identifies as a non-believer. His parents were also quite racist and he "never bought into that". He had a traditional upbringing in a small town in an unpopulated area of northwest Oklahoma. His family's attitude towards poor Whites was not judgmental, as he recalls. "Sometimes people just need help to get back up on their feet." "If they aren't willing to work and help themselves, then too bad." On the other hand, minorities, especially African Americans, were poor because they were lazy; preferring to "live off welfare instead of

get a job". Mike never accepted that line of reasoning. He always believed that many people, regardless of race, were poor because of circumstances beyond their control.

He played sports in high school and eventually played football in college. After he was injured and could no longer play, he finished college and went to work in sales. He maintained his conservative political outlook for years until his second child was born with a serious condition requiring multiple surgeries and treatments to correct and he no longer had a six-figure salary to pay for it all. He decided to go to graduate school and his wife's health insurance, though adequate, was too expensive to cover everyone in the family with only one full-time income. For the first time in his life, Mike had to rely on Sooner Care, or rather Medicaid, for his children. "It was the only option." It was at that time that he said he realized people need a safety net. He became more sympathetic towards people's problems and less judgmental about their circumstances. His politics also changed after coming to the University – he became much more critical of the Republican Party and did not vote for Mitt Romney in 2012. He considers himself to be a moderate Independent. He is "not a fan" of the ACA but admits that it is "better than nothing". He thinks "people who can afford private health insurance do not need the government's help but for people who can't, but also make too much money to qualify for expanded Medicaid, need something".

Dan, 57, owns his own business in the Oklahoma City area and is very successful. He lives in large, expensive house in an affluent neighborhood with his wife and four children, who are homeschooled. He readily admits his politics are "right wing" and he has always voted for the Republican Party. Dan has no tolerance whatsoever for government's involvement in health care and is especially resentful of

the ACA's employer mandate – "They've given me an incentive to cut everyone to twenty-nine hours a week or fire people". He answered four out of five knowledge questions correctly but made comments about the ACA's provisions that demonstrate he does not know that much more about the law than respondents who scored very low.

Pete is also self-employed and although he does not employ a large staff like Dan does, he is highly critical of the ACA's employer mandate. He is 64 and his personal income is "somewhere around $150" and he lives on some acreage outside of Oklahoma City. He was divorced and later widowed and his children are grown. He considers himself to be a "loyal Republican" and supports Congress' efforts to repeal the ACA. He is not hopeful and seems resigned to the fact that "liberals have taken over the country". Like Dan, Pete scored high on the knowledge questions but he does not know much about the ACA. For example, he believes that it covers undocumented immigrants and late term abortion on demand. "Doctors tell women to go to Planned Parenthood if they want health care and the only thing they do is give out free abortions." Dan and Pete have similar backgrounds. Both sets of their parents grew up during the post-World War II economic boom but they were very much affected by their grandparents' stories about the Great Depression. When I asked Pete about the discussions the family had about the Depression years, he said "people took care of themselves in those days, you know, they only took handouts if they absolutely had to. These days people are looking for anything free they can get and we have to pay for them". Dan's response to this question similar but he said that the "so-called Depression" that "liberals blamed" on former President George W. Bush was "nothing

compared to the Great Depression" and added that "poor people today aren't really poor".

Janet grew up very poor in rural Oklahoma, married young, got divorced, and eventually married into a well-to-do family after graduating from college. She has Native American roots and identifies as such but admits she is not "very close to that culture". She is quite conservative and votes for Republican candidates and is especially fond of the Oklahoma governor. As a former smoker in her early fifties, she has a number of health problems but as a wealthy person with continuous health insurance coverage, trips to the doctor have never been a problem. Janet is against the ACA and Medicaid – "that's always been a waste of money" but she is not against Medicare; in fact, she believes Medicare is private insurance. I did not tell her that Medicaid and Medicare began under a Democratic President in 1965 but it was obvious she had no idea the two programs were linked. She scored moderately low on the knowledge questions and was willing to discuss what she knows about the ACA – "it does health care for illegals". I asked her where she got her information and she said she is an avid Fox News Network fan as other conservative respondents claimed to be. Janet alluded to the ACA's requirement that qualified plans must meet certain standards of coverage[31] but, like most ordinary people, could not accurately list what those benefits are. "Women have to pay for prostate exams. Some women might wish they had one but they don't." That comment led to a brief foray into her views on LGBT issues, which were negative to say the least. Janet believes the ACA and Medicaid pays

[31] Minimum Essential Coverage (MEC); requirement that plans approved under the ACA cover ten essential benefits.

gender reassignment surgery and she is partially correct. Federal law prohibits insurance companies (plus Medicaid and Medicare) from discriminating against policyholders on account of gender.[32] While insurance companies may not have to cover the surgery itself, they cannot refuse to cover illnesses, injuries or treatments related to the surgery.

Janet's outlook on the issues surrounding the poor stem from her impoverished circumstances early in her life. She was very critical of her parents' inability to provide for the family. She said she grew up "with nothing" but managed to go to a small college in Oklahoma whereupon graduation, she got a clerical job in Oklahoma City and "married the boss". From her point of view, she worked her way out of poverty and if she can do it, so can everyone else.

James does not understand why "people are so against health care for people". He made the argument that we have health care programs for numerous groups of people, such as active duty military and veterans. "You've got the VA, Medicaid for poor people, Medicare for old people, Aetna for rich people, everybody has something but people like me." James, 38-year old African American, believes that the working-class had been overlooked until the ACA was passed. He has never worked for a company that offered health insurance and has gone without it most of his life. His family used Medicaid throughout his childhood and teens and he says he believes most of his relatives still use it. James purchased an insurance policy about a year before this interview and has been to the doctor twice, once for a basic check-up and once because he had the flu. He thinks he paid approximately $20 for his visits but is not sure and

[32] See Chapter 4 for information on the Department of Health and Human Services regulations regarding transgender patients.

does not know exactly what his premiums are for the plan he has. He is worried that if Republicans are successful in repealing the ACA he will be left with nothing. He is currently single and his children, who live with his former girlfriend, are covered by Medicaid. James is concerned that if he develops a serious health care problem, he will not be able to get treatment because he thinks he makes too much money to qualify for Medicaid but he does not make enough money to buy an individual private health insurance policy. As a Democrat, he blames the lack of options in Oklahoma on Republicans who voted against the ACA.

Respondents from the telephone survey were asked if they could be contacted in the future for a follow-up interview and most agreed, supplying their first name and letting us keep their phone numbers. The main purpose of conducting the personal interviews was to get some insight into the types of follow-up questions that I could ask the telephone respondents a few years after the ACA had been in effect.

Chapter 9: Conclusion

One enduring topic among politicians, the media and ordinary citizens is access to health care. Of the total population, 9% is uninsured – almost 30 million people have no insurance of any kind (KFF.org 2017D) and their health care costs the taxpayers $84.9 billion annually (2014CC). The United States ranks first in health care expenditures per capita among democratic highly developed countries (OECD.org 2015). While emergency care for critical conditions such as heart attacks and long-term treatment for serious illnesses like cancer is very good, preventative health care is poor (OECD.org 2015). For this reason, policy advocates point to the need for health care reform aimed at making preventative care more accessible.

As expected, approval of the ACA was generally negative in the fourth quarter of 2013 through the first quarter of 2014, when the quantitative study was in the field. A large majority of the telephone respondents were covered with private insurance. For the respondents in the qualitative study who approved of the ACA and had purchased insurance, most of them had not had a reason to use the insurance at the time they were interviewed. As of late 2017, it has only been a couple of years that the individual and employer mandates have been in effect so follow up studies should commence soon, especially in light of the fact that the Democratic Party does not currently have a majority of seats in the House and Senate and we have a first-term Republican President who is pushing for a repeal and replacement of the ACA. The Kaiser Health Tracking Poll shows all income categories to have a favorable opinion of the ACA as of March 2018, but the percentages of respondents who remain negative towards the ACA should be studied closely (KFF.org 2018).

Some pundits and scholars have criticized the ACA for being too costly and they point to the increase in insurance premiums. On the other hand, insurance premium increases, on average, have slowed since the passage of the legislation (Mandelbaum 2017). Another criticism of the ACA is that it depends on young healthy people who are less likely to use health care services to pay high premiums in order to subsidize older sicker people and poorer people who pay lower premiums. Also, most people using the ACA qualify for subsidies which must be paid with taxpayer dollars and despite how both political parties behave with the country's checkbook, there is a limit on how much taxation Americans will tolerate. Plus, the infrastructure in terms of hiring enough people to properly manage the paperwork can be costly (Schuman, Chapman, and Alexander, 2014). Covering everyone in the country with health insurance is expensive but so is having uninsured people flooding emergency rooms for health care that could have easily and more efficiently been handled in a clinic or a doctor's office. The year the ACA passed, 2010, the estimated cost to the country's hospitals of uninsured persons' care was $40 billion and unpaid medical bills are a leading cause of bankruptcies (Groppe 2017). When Michigan expanded its Medicaid program, insurance premiums in the state did not increase but hospitals reported the cost of treating the uninsured decreased by almost 50% (Groppe 2017).

At the time the interviews took place, the ACA was still a bit of a mystery. Most people in the country at the time were covered by private health insurance through an employer. That is still the case today, although many Americans lost their health insurance and had to turn to the Health Care Marketplace to purchase insurance. In

2016, the IRS commissioner reported that the agency had collected $3.5 billion in penalties from 6.5 million people who chose not to buy health insurance.

With respect to health care policy, I have proposed that politicians and policymakers speak to Americans in terms of their different ideological perspectives as opposed to dividing them by what *they perceive* as their social class because 1) income level is not as significant as cultural worldview in some models and 2) income and cultural worldview factors are not significantly correlated except for egalitarianism which may be an artifact of this particular sample. For example, Egalitarians do not need to be sold on the ACA as it stands today and they are already predisposed to favor a national health care plan such as the one Senator Bernie Sanders (D-VT) recently offered. Too often politicians preach to the converted because it is easier and they avoid being confronted with negative feedback.

Individualists, on the other hand, generally do not favor government intervention in health care and scolding them for their selfishness will not result in gaining their support. A more successful approach would be to provide Individualists with examples of how having a healthier population is in *their* best interest. If a health care plan can be designed to save money on health care expenses in the long-run, Individualists can look forward to a tax cut.

Hierarchs respect experience and expertise. The best approach for them would be to stress how much better health care will be for everyone if the *right people* are in charge. Costs will go down if the best minds in government have authority over the plan as opposed to lowly paid bureaucrats with no particular expertise in health care policy implementation.

Fatalists, according to Cultural Theory, generally do not express consistent opinions on public policy. In order to persuade them to support an improved ACA or a completely new health care plan, we might simply tell the Fatalists that government involvement in the health care industry is inevitable. A Fatalist may accept that explanation or he may not. Politicians often approach various constituencies with different explanations of the same policy and we have come to expect that. It is not that they are being dishonest, they simply know their different audiences, which they have sold a bit short by focusing on their social class only.

This cross-sectional study was important because it took place before the ACA went into full effect on January 1, 2014 and the subjects are too young to have any experience with another government insurance program, Medicare. A longitudinal study, however, would allow us to follow a panel of subjects over the years to determine 1) the level of approval of the ACA as the program matures, 2) any changes to voting patterns, and 3) any adjustments in cultural worldviews. I expect to see some individuals who hold cultural worldviews that hover near the border of another to show some movement but I cannot predict with certainty which cultural worldviews are most likely to change and in what direction.

The 1929 Stock Market Crash and the ensuing Great Depression is a fruitful example of how different cultural worldviews perceive interventionist policies by the federal government. Individualists typically eschew government meddling in the market and tend to blame the length of the Great Depression on the New Deal's economic policies. Egalitarians on the other hand, assign blame to especially greedy sorts in a dangerously unfettered marketplace. Hierarchs, the worldview formed of

Individualists and Egalitarians, believe the Great Depression was prolonged because the wrong policies were implemented by those in authority who lacked the expertise required to make the proper corrections. Finally, the Fatalists believe the Great Depression was inevitable and nothing could have prevented it or mitigated its damage to the economy. The *correct* view depends on one's cultural bias.

Interviewing individuals before and after they experience the ACA's costs and benefits will tell us several useful things in addition to their level of approval. First, did the cultural worldviews who typically find themselves in opposition to the ACA become more or less opposed after using the program and if so, why? If Cultural Theory holds, positive affirmations of the ACA by worldviews normally opposed to it (and vice versa) should be the result of making sense of their experience through their own biased lens.

I collected names and telephone numbers of the respondents in the quantitative study. We asked them for permission to call them some time in the future to conduct a follow-up survey. After using the program for some length of time, we should try and determine if any of the cultural worldviews actually change designations. If there was a shift in cultural worldviews, what was the reason? According to Cultural Theory, people who changed cultural worldviews should have been strongly affected by a very serious event, in this case, perhaps an illness that was cured because of health care coverage or an illness that was prolonged because of health care rationing (a possible outcome of the ACA proposed by its adversaries).

Most everyone I interviewed in the qualitative study had some ideas about what we could do to improve the ACA – everything from scrapping it entirely to single-payer

national health insurance. We already have a system for government health care – Medicare and Medicaid. If a new Medicare insurance program continues to pay for 80% of the medical costs and the patient is responsible for the other 20%, low-income consumers can qualify for Medicaid to pay the portion Medicare does not cover. This is currently the method used for funding health care for the indigent elderly. Wealthy consumers already have options for Medicare Supplement policies to pay the remaining 20%. For qualified consumers, Medicaid will be their only option but this is currently the program the poor use today. For consumers purchasing Medicare insurance, their premiums and deductibles will vary according to their ability to pay.

This may be a more popular idea among Libertarian and Republican voters but it does provide the opportunity for richer states to have excellent health care for their residents and poorer states to have a far less healthy population. While it is true that we do not prevent people from moving across state lines to seek a better life for themselves and their families, it is also true that making such a move is often difficult and expensive.

The Affordable Care Act is the most dramatic, impactful health care legislation enacted since Medicare and Medicaid was signed into law in 1965. Many changes have been made to both of these venerable programs in order to improve them and make them work better for the patients. The ACA will continue to evolve as health care professionals, patients and members of government navigate an industry that is expected to grow at an annual rate of 5.6% from 2016 to 2025 resulting in a nearly 20% share of the gross domestic product by 2025 (CMS.org 2016).

If we follow a panel of respondents over the decades, we should also be able to see the combined effect of their opinions and their voting patterns and determine the impact on the electoral process, at the state and federal level. Other institutions besides the University of Oklahoma are investigating the policymaking process using Cultural Theory, such as the Cultural Cognition Project at Yale Law School. I believe this long-term project will make an important contribution to the field and expand our understanding of how ideology affects political decision-making. I would like to add my efforts to our other scholars in making the University and OU Poll the *go-to* source for the study of Cultural Theory, political ideology, the electoral and policymaking processes.

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TZONE min=1 max=1 simple1=1
Time Zone (computed from sample)
=>+1
Si 1>0
Newfoundland 1
Atlantic 2
Eastern 3
Central 4
Mountain 5
Pacific 6
Alaskan 7

TIME min=1 max=1 simple 1=8
Imported from sample
=>+1
Si 1>0

FIPS min=1 max=1 simple 1=5
<FIPS> [FILLS FROM SAMPLE]
=>+1
Si 1>0

Question 4 STATE min=1 max=1 simple 1=20
Imported from sample

F11 min=1 max=1 simple 1=1
=>+1
Si 1>0

INTRO min=1 max=1 simple 1=2
Press F11 and look at call history. Be sure to note any messages left on answering machines. [NOTE—this is a call from the following time zone—DO NOT call if out of range: <TIME>]
Regular introduction screen 01

INTR2 min=1 max=1 simple 1=2
Hello, my name is_____. I'm calling from the University of Oklahoma Public Opinion Learning Laboratory. We're conducting a brief survey regarding an important public policy issue. Of the adults who are between the ages of 18 and 64 living in your household, may I please speak to the one who has had the most recent birthday?
[NEW RESPONDENT OR APPT w/NAME]
Hello, my name is _____. I'm calling from the University of Oklahoma Public Opinion Learning Laboratory. We're conducting a brief survey regarding an important public policy issue. Are you the person in your household who has had the most recent birthday and who is between 18 and 64 years of age?
$N
CONTINUE
--Respondent is busy, refuses, other (phone busy, answering machine, etc.) =>/INT

INFM min=1 max=1 simple 1=2
Your phone number was selected at random and we don't know either your name or address. Participation is voluntary, your individual responses will be kept entirely confidential and you are free to refuse to answer any question or withdraw from the survey at any time. There are no foreseeable risks associates with this study beyond those present in everyday life. But please remember, you can always stop participating at any time and may refuse to answer any questions that make you feel uncomfortable. While there is no compensation or direct benefit for participation, you answers will help inform lawmakers on the public's preferences for an important policy issue. Should you have any questions or concerns about our research you can contact our Director, Dr. Amy Sue Goodin at 405-325-7655. If you are ready, let's begin.
[HESITANT] The survey will take no longer than about 15 minutes depending on your answers and most people find it interesting once they start. The survey is about the Affordable Care Act and this is an opportunity for you to express opinions about this important public policy issue. This is not a sales call. Your telephone number was selected at random. This is academic research and all of your answers will be kept confidential. If you have further questions, the telephone number of our Director, Amy Sue Goodin, is 405-325-7655 or her email is amysgoodin@ou.edu. If you have questions about your rights as a participant you can contact the University of Oklahoma Norman Campus Institutional Review Board at 405-325-8110.

Yes	1	
No	0	=>/INT

Q1 min=1 max=1 simple 1=3
First, how old are you? IF NO AGE check box
$E 18-110

No age	0	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q1A min=1 max=1 simple 1=3
In which range does your age fall?
=>Q1A
Sinon =>Q2
Si Q1=0 OR Q1>666

18-26	1	
27-36	2	
37-46	3	
47-56	4	
57-64	5	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q2 min=1 max=1 simple 1=3
Including yourself, how many people currently live in your household? [DO NOT count students who live house part of the year.]
$E 1 25

--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q3 min=1 max=6 simple 1=3
Please tell me which of the following age groups are represented in your household? [READ and check ALL that apply.]

0-5	1	
6-17	2	
18-34	3	
35-54	4	
55-64	5	
65+	6	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q4 min=1 max=1 simple 1=3
How many children under 18 currently live in your household?
$E 1 25
=>Q5
Sinon =>Q4
Si Q3>2

--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q5 min=1 max=1 simple 1=3
As part of the survey, I am required to ask: are you male or female?

Female	1	
Male	0	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q6 min=1 max=1 simple, ouverte 1=3
What is the highest level of education you have completed? [Read scale if necessary.]

High school diploma/GED	1	
Some college/Associate's Degree	2	
Bachelor's Degree/college graduate	3	
Graduate Degree	4	
Vocational/Technical Degree	5	
Other	6	O
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q7 min=1 max=1 simple 1=3
Now I would like to ask you about your OWN health care coverage. Please consider any type of health insurance that you or your employer pay for, as well as insurance or other programs that governments help pay for, such as Medicaid or Veteran's benefits. During the past 12 months were you: [Read all EXCEPT indented options.]

Covered continuously	3	
Covered part of the time, or	2	
Not covered at all	1	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q8 min=1 max=1 simple 1=3
How many months were you without health insurance during the last 12 months?
$E 1 12

--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q9 min=1 max=1 simple 1=3
How long have you had your coverage? [Do not read---Select BEST option; if respondent was uninsured for part of the year in the past but is insured now, ask how long they had THIS coverage.]

Not covered at this time	0	
Less than one year	1	
One to two years	2	
Between two and five years	3	
Longer than five years	4	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q10 min=1 max=1 simple, ouverte 1=3
What is the MAIN reason you did not have continuous health insurance coverage during the past 12 months? [DO NOT READ the options.]
=>Q11
Si Q7=3

Lost or changed jobs	1	
Employer didn't offer coverage	2	
Person providing insurance lost or changed jobs	3	
Ineligible due to age or leaving school	4	
Ineligible due to health condition	5	
Couldn't afford insurance	6	
Didn't want to buy insurance	7	
Health and didn't need insurance	8	
Person with insurance is deceased	9	
Other	10	O
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q11 min=1 max=1 simple, ouverte 1=3
Which of the following is the MAIN source for your health insurance coverage? Is it: [Read all EXCEPT indented options.]
=>SEG1
Si Q9=0 OR Q9=999 OR Q9=888 OR Q7=1

Private coverage through your employer	1	
Private coverage through a family member's employer	2	
Private coverage OTHER than through employment	3	
Medicaid	4	
US Military/Veteran's Benefits (like Tricare)	5	
Other	6	O
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

SEG1 min=1 max=1 simple 1=1
These next few questions are designed to test how well the media communicates political information to the public. To the best of your knowledge:
Continue 1

Q12 min=1 max=1 simple 1=3
Invalide ->Q16
What is the percentage of votes needed in the House AND Senate to override a veto? [DO NOT READ. MUST say two-thirds, 66% or 67%; "About" two-thirds, 66% or 67% is okay.]

Two-thirds or 66%/67%	1		
Anything else	0		
--DK/NA		999	
--Refused		888	
--Dropout		777	=>/DROP

Q13 min=1 max=1 simple 1=3
Who is the current Chief Justice of the US Supreme Court? [Either full name or Roberts, NOTHING ELSE.]

John Roberts or Roberts	1		
Anything else	0		
--DK/NA		999	
--Refused		888	
--Dropout		777	=>/DROP

Q14 min=1 max=1 simple 1=3
Does the Affordable Care Act, also known as ObamaCare, cover undocumented or illegal immigrants?

Yes	0		
No	1		
--DK/NA		999	
--Refused		888	
--Dropout		777	=>/DROP

Q15 min=1 max=1 simple 1=3
Would you say the federal budget deficit is larger, smaller, or about the same as in 2001?

Larger	1		
Smaller---OR---About the same	0		
--DK/NA		999	
--Refused		888	
--Dropout		777	=>/DROP

Q16 min=1 max=1 simple 1=3
Which of the following would you say is the MOST correct statement about the Affordable Care Act's Employer Mandate?
Rotation ->2

Employers with 50 or more FULL-TIME employees will be required to offer health insurance ONLY to full-time employees	1	
Employers with 50 or more employees REGARDLESS of the number of hours worked will have to offer health insurance to all employees.	0	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

SEG2 min=1 max=1 simple 1=1
I'd like to ask you about a few general concepts. For each of the following statements please answer on a scale ranging from 1 to 7, where 1 is strongly disagree and 7 is strongly agree.

Continue	1	

Q17 min=1 max=1 simple 1=3
Invalide ->Q32
We should increase taxes so we can increase spending on domestic programs.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q18 min=1 max=1 simple 1=3
I think that people with the most experience and expertise should be the decision makers.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q19 min=1 max=1 simple 1=3
It is better if the woman cares for the home and family and the man works outside the home.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q20 min=1 max=1 simple 1=3
The big problem today is not giving everyone an equal chance.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q21 min=1 max=1 simple 1=3
We should be more tolerant of different moral standards.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q22 min=1 max=1 simple 1=3
Gays should NOT be allowed to marry.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q23 min=1 max=1 simple 1=3
We have gone too far in pushing equal rights.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q24 min=1 max=1 simple 1=3
It seems like people on welfare get a lot of free services that the rest of us have to pay for.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q25 min=1 max=1 simple 1=3
What is best for society as a whole, NOT the individual, should be the government's priority.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q26 min=1 max=1 simple 1=3
The government wastes a lot of tax money.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q27 min=1 max=1 simple 1=3
I favor a reduction in spending on domestic programs to cut taxes.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q28 min=1 max=1 simple 1=3
The federal government should make it more difficult to buy a gun.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q29 min=1 max=1 simple 1=3
I favor allowing Social Security funds to be invested in the stock market.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q30 min=1 max=1 simple 1=3
It is not that big of a problem if people have an unequal chance.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q31 min=1 max=1 simple 1=3
We need a strong national government to solve complex problems.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q32 min=1 max=1 simple 1=3
Protecting the environment is important to me.

1-Strongly DISAGREE	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7-Strongly AGREE	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

SEG3 min=1 max=1 simple 1=1
Now I would like to change course slightly.

Continue	1

Q33 min=1 max=1 simple 1=3
Rotation [5] ->CONT5
Using a scale from 1 to 7 where 1 strongly oppose and 7 is strongly support, what is your position on the raising federal income taxes on households that earn $250,000 or more per year if the monies were used to help fund the Affordable Care Act? [DO NOT READ the choices. If the respondent needs clarification you can tell them that a '5' corresponds to 'slightly support', for example.]

You strongly oppose	1	
You somewhat oppose	2	
You slightly oppose	3	
You neither support nor oppose	4	
You slightly support	5	
You somewhat support	6	
You strongly support	7	
At this time, you don't know how you feel about	0	
--Refused	888	
--Dropout	777	=>/DROP

Q34 min=1 max=1 simple 1=3
You just told me that <Q33> raising federal income taxes to help fund the Affordable Care Act. Has this always been your position?

Yes	1	=>/CONT1
No	0	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q35 min=1 max=1 simple 1=3
Using the scale from 1 to 7 where 1 is strongly oppose and 7 is strongly support, how would you rate your PREVIOUS view on this issue? [DO NOT READ the choices.]

Strongly oppose	1	
Somewhat oppose	2	
Slightly oppose	3	
Neither support nor oppose	4	
Slightly support	5	
Somewhat oppose	6	
Strongly support	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q36 min=1 max=1 simple 1=3
To the best of your recollection, when did you change your mind?

Less than one year ago	1	
One to two years ago	2	
Between two and five years ago	3	
Longer than five years ago	4	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

CONT1 min=1 max=1 simple 1=3
Skip Control
=>+1
Si 1>0

Q37 min=1 max=1 simple 1=3
Using the scale ranging from 1 to 7 where 1 is strongly oppose and 7 is strongly support, how do you feel about the expansion of the Medicaid program so that more low-income households are covered? [DO NOT READ the choices. If the respondent needs clarification you can tell them that a '5' corresponds to 'slightly support', for example.]

You strongly oppose	1	
You somewhat oppose	2	
You slightly oppose	3	
You neither support nor oppose	4	
You slightly support	5	
You somewhat support	6	
You strongly support	7	
At this time, you don't know how you feel about	0	
--Refused	888	
--Dropout	777	=>/DROP

Q38 min=1 max=1 simple 1=3
You just told me that <Q37> the expansion of the Medicaid program. Has this always been your position?

Yes	1	=>/CONT1
No	0	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q39 min=1 max=1 simple 1=3
Using the scale from 1 to 7 where 1 is strongly oppose and 7 is strongly support, how would you rate your PREVIOUS view on this issue? [DO NOT READ the choices.]

Strongly oppose	1	
Somewhat oppose	2	
Slightly oppose	3	
Neither support nor oppose	4	
Slightly support	5	
Somewhat oppose	6	
Strongly support	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q40 min=1 max=1 simple 1=3
To the best of your recollection, when did you change your mind?

Less than one year ago	1	
One to two years ago	2	
Between two and five years ago	3	
Longer than five years ago	4	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

CONT2 min=1 max=1 simple 1=1
Skip Control
=>+1
Si 1>0

Q41 min=1 max=1 simple 1=3
Using the scale from 1 to 7 where 1 is strongly oppose and 7 is strongly support, how do you feel about the government providing basic health care coverage to undocumented or illegal immigrants? [DO NOT READ the choices. If the respondent needs clarification you can tell them that a '5' corresponds to 'slightly support', for example.]

You strongly oppose	1	
You somewhat oppose	2	
You slightly oppose	3	
You neither support nor oppose	4	
You slightly support	5	
You somewhat support	6	
You strongly support	7	
At this time, you don't know how you feel about	0	
--Refused	888	
--Dropout	777	=>/DROP

Q42 min=1 max=1 simple 1=3
You just told me that <Q41> the expansion of the Medicaid program. Has this always been your position?

Yes	1	=>/CONT1
No	0	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q43 min=1 max=1 simple 1=3
Using the scale from 1 to 7 where 1 is strongly oppose and 7 is strongly support, how would you rate your PREVIOUS view on this issue? [DO NOT READ the choices.]

Strongly oppose	1	
Somewhat oppose	2	
Slightly oppose	3	
Neither support nor oppose	4	
Slightly support	5	
Somewhat oppose	6	
Strongly support	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q44 min=1 max=1 simple 1=3
To the best of your recollection, when did you change your mind?

Less than one year ago	1	
One to two years ago	2	
Between two and five years ago	3	
Longer than five years ago	4	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

CONT3 min=1 max=1 simple 1=1
Skip Control
=>+1
Si 1>0

Q45 min=1 max=1 simple 1=3

Using the scale from 1 to 7 where 1 is strongly oppose and 7 is strongly support, how do you feel about lowering the age to get Medicare from 65 to 55 so more people can qualify? [DO NOT READ the choices. If the respondent needs clarification you can tell them that a '5' corresponds to 'slightly support', for example.]

You strongly oppose	1	
You somewhat oppose	2	
You slightly oppose	3	
You neither support nor oppose	4	
You slightly support	5	
You somewhat support	6	
You strongly support	7	
At this time, you don't know how you feel about	0	
--Refused	888	
--Dropout	777	=>/DROP

Q46 min=1 max=1 simple 1=3

You just told me that <Q45> lowering the age to get Medicare. Has this always been your position?

Yes	1	=>/CONT1
No	0	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q47 min=1 max=1 simple 1=3

Using the scale from 1 to 7 where 1 is strongly oppose and 7 is strongly support, how would you rate your PREVIOUS view on this issue? [DO NOT READ the choices.]

Strongly oppose	1	
Somewhat oppose	2	
Slightly oppose	3	
Neither support nor oppose	4	
Slightly support	5	
Somewhat oppose	6	
Strongly support	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q48 min=1 max=1 simple 1=3
To the best of your recollection, when did you change your mind?

Less than one year ago	1	
One to two years ago	2	
Between two and five years ago	3	
Longer than five years ago	4	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

CONT4 min=1 max=1 simple 1=1
Skip Control
+>+1
Si 1>0

Continue	1	

Q49 min=1 max=1 simple 1=3
Using the scale from 1 to 7 where 1 is strongly oppose and 7 is strongly support, what is your opinion on the passage of the Affordable Care Act? [DO NOT READ the choices. If the respondent needs clarification you can tell them that a '5' corresponds to 'slightly support', for example.]

You strongly oppose	1	
You somewhat oppose	2	
You slightly oppose	3	
You neither support nor oppose	4	
You slightly support	5	
You somewhat support	6	
You strongly support	7	
At this time, you don't know how you feel about	0	
--Refused	888	
--Dropout	777	=>/DROP

Q46 min=1 max=1 simple 1=3
You just told me that <Q49> the passage of the Affordable Care Act. Has this always been your position?

Yes	1	=>/CONT1
No	0	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q47 min=1 max=1 simple 1=3
Using the scale from 1 to 7 where 1 is strongly oppose and 7 is strongly support, how would you rate your PREVIOUS view on this issue? [DO NOT READ the choices.]

Strongly oppose	1	
Somewhat oppose	2	
Slightly oppose	3	
Neither support nor oppose	4	
Slightly support	5	
Somewhat oppose	6	
Strongly support	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q48 min=1 max=1 simple 1=3
To the best of your recollection, when did you change your mind?

Less than one year ago	1	
One to two years ago	2	
Between two and five years ago	3	
Longer than five years ago	4	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

CONT5 min=1 max=1 simple 1=1
Skip Control
+>+1
Si 1>0

Continue	1	

QSITE min=1 max=1 simple 1=3
As you may know, some people have had difficulties signing up for insurance on the government health care website. Regardless of how you feel about the Affordable Care Act, what do you believe is the SINGLE biggest factor that caused these issues to occur? Was it:

Technological problems	1	
The system is too complicated for the users	2	
The system was not tested properly	3	
Poor planning by the Department of Health and Human Services	4	
Political Opposition	5	
Other	6	O
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

SEG4 min=1 max=1 simple 1=1
Now I would like to ask you a few questions about the economy.
Continue 1

Q53 min=1 max=1 simple 1=3
The recession has hit almost everybody pretty hard. Has anyone in your household lost a job since 2007?

Yes	1	
No	0	=>Q57
--DK/NA	999	=>Q57
--Refused	888	=>Q57
--Dropout	777	=>/DROP

Q54 min=1 max=1 simple 1=3
How many members of your household have lost a job since 2007?
$E 1 10

--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q55 min=1 max=1 simple 1=4
What year was that job lost?
$E 2007 2014
=>Q56
Si Q54>1

--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q56 min=1 max=1 simple 1=4
Considering the job loss that had the GREATEST IMPACT on your household, please tell me what year THAT job was lost.
$E 0007 2014
=>Q57
Si Q54<2

--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q57 min=1 max=1 simple 1=3
Has anyone in your household taken a pay-cut since 2007?

Yes	1	
No	0	=>Q61
--DK/NA	999	=>Q61
--Refused	888	=>Q61
--Dropout	777	=>/DROP

Q58 min=1 max=1 simple 1=3
How many members of your household have taken a pay-cut since 2007?
$E 1 10

--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q59 min=1 max=1 simple 1=4
What year did that pay-cut happen?
$E 2007 2014
=>Q60
Si Q58>1

--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q60 min=1 max=1 simple 1=4
Considering the pay-cut that had the GREATEST IMPACT on your household, please tell me what year THAT pay-cut happened.
$E 2007 2014
=>Q61
Si Q58<2

--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q61 min=1 max=1 simple 1=3
In terms of your CURRENT economic situation, would you say you are better off, about the same, or worse off than you were five years ago?

Better off	1	
About the same	2	
Worse off	3	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q62 min=1 max=1 simple 1=3
Thinking about your FUTURE economic situation, do you think you'll be better off, about the same, or worse off five years from now.

Better off	1	
About the same	2	
Worse off	3	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

SEG5 min=1 max=1 simple 1=1
Lastly, I have a few demographic questions for statistical purposes ONLY.
Continue 1

Q63 min=1 max=1 simple 1=3
What is your marital status?
Single, never married 1
Married 2
Divorced 3
Separated 4
Widowed 5
Living with partner 6
--DK/NA 999
--Refused 888
--Dropout 777 =>/DROP

Q64 min=1 max=1 simple, ouverte 1=3
What is your PRIMARY source for news and information? [DO NOT READ the options. If respondent says "FOX, CNN, MSNBC, etc." ask if it is on cable/satellite or the Internet.]
Cable or satellite television 1
Broadcast television (antenna) 2
Radio 3
Internet (websites) 4
Social media, such as Face Book, Twitter or Blogs 5
Printed newspapers and magazines 6
Word of mouth/friends and family 7
Other 8 O
--DK/NA 999
--Refused 888
--Dropout 777 =>/DROP

Q65 min=1 max=1 simple, ouverte 1=3
Which of the following categories best describes your racial or ethnic background? [Multiple responses go in 'Other'.]
American Indian/Native American 1
Asian/Pacific Islander 2
Black or African American 3
Hispanic/Latino 4
Non-Hispanic White 5
Other 6 O
--DK/NA 999
--Refused 888
--Dropout 777 =>/DROP

QHLTH min=1 max=1 simple 1=3
On a scale ranging from 1 to 7, where 1 is very bad and 7 is very good, how would you rate your CURRENT health status?

7-very good	7	
6	6	
5	5	
4	4	
3	3	
2	2	
1-very bad	1	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q66 min=1 max=1 simple, ouverte 1=3
When it comes to political parties, which one of the following do you MOST identify? Is it the: [DO NOT READ the indented options.]

Democratic Party	1	
Republican Party	2	
Are you an Independent or,	3	=>Q68
Is it some other party	4	O
--No party	5	=>Q68
--DK/NA	999	=>Q68
--Refused	888	=>Q68
--Dropout	777	=>/DROP

Q67 min=1 max=1 simple 1=3
Do you ALWAYS vote with your party? [If respondent says “USUALLY”, mark as “NO”. DO NOT READ----If respondent doesn’t vote or hasn’t voted yet, check box.]

Yes	2	
No	1	
--Don’t vote or hasn’t voted yet	0	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q68 min=1 max=1 simple 1=3
On a scale of political ideology, individuals can be arranged from strongly liberal to strongly conservative. Which of the following categories BEST describes your views? Are you:

Strongly liberal	1	
Liberal	2	
Slightly liberal	3	
Middle of the road	4	
Slightly conservative	5	
Conservative	6	
Strongly conservative	7	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q69 min=1 max=1 simple 1=3
Are you currently: [Read all EXCEPT indented options. If more than one---What is your primary status?]

Employed for wages	1	
Self-employed or own your own business	2	
Unemployed and looking for work	3	
Unemployed but not currently looking for work	4	
A homemaker	5	
A student	6	
In the military	7	
Retired, or	8	
Unable to work	9	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

QPHN min=1 max=1 simple 1=3
Do you currently have a land line phone?

Yes	1	
No	0	=>Q70
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

QCELL min=1 max=1 simple 1=3
On a scale ranging from 0 to 10 where 0 is NOT AT ALL likely and 10 is EXTREMELY likely, how likely are you to discontinue the use of you land line phone in the next year?

0-NOT AT ALL likely	0	
1	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7	7	
8	8	
9	9	
10-EXTREMELY likely	10	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q70 min=1 max=1 simple 1=3
Was your estimated annual household income for the past year: [If they volunteer their income, select the correct option.]

Less than $25,000	1	
25 to less than 50	2	
50 to less than 75	3	
75 to less than 100	4	
100 to less than 125	5	
125 to less than 150	6	
150 to less than 175	7	
175 to less than 200	8	
$200,000 and above	9	
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

Q71 min=1 max=1 simple, ouverte 1=3
Thank you for helping us with this important study. Can we possibly call you back in the future for a brief follow-up study? [IF YES, ask for their first name.]

Yes: Enter Name	1	O
No	0	=>GBYE
--DK/NA	999	
--Refused	888	
--Dropout	777	=>/DROP

GBYE min=1 max=1 simple 1=1
Thank you very much for participating in this survey. If you have further questions, the telephone number of our Director, Dr. Amy Sue Goodin, is 405-325-7655 or her email is amysgoodin@ou.edu--If you have questions about your rights as a participant you can contact the University of Oklahoma Norman Campus Institutional Review Board at 405-325-8110.
Goodbye 1

DROP min=1 max=1 simple, ouverte 1=1
Did the respondent choose to end the survey? If yes, enter question number respondent dropped out on in open-ended box.
Yes 1 O
No 0

INT99 min=1 max=1 simple 1=2
Completed interview
Completed interview CO D =>/END

INT min=1 max=1 simple 1=2
END OF INTERVIEW elapsed : $T $D $H
SUMMARY INTERRUPTIONS: NOTE THE REASON Answering machines (remember only 2 messages!) Hello, my name is _____ and I am a student from the University of Oklahoma Public Opinion Learning Laboratory in Norman and we are conducting a brief study pertaining to an important public policy issue. We will call you back in a couple of days. Thank you.

Call back another time	BT		=>CB
Time delay	TD		=>/END
Answering machine	AM		=>/END
Phone line busy	BU		=>/END
No answer	NA		=>/END
Quick hang-up	HU		=>/END
Not eligible	NE	O	=>/END
Disconnected	DS		=>/END
Fax Machine/Modem	FM		=>/END
Cell phone	CP		=>/END
Resident does not accept unidentified calls	UC		=>/END
Not a residential number (business)	BI		=>/END
Language problem (no one eligible in household speaks English or Spanish	LP		=>/END
ER speaks Spanish	SP		=>/END
Health problem (illness, hearing problem, death)	HP		=>/END
Wrong locale	WL		=>/END
Away during survey	AW	O	=>/END
Screened refusal	SR	O	=>/END
Take me off your list	TL	O	=>/END
***Rude/Uncooperative	RU	O	=>/END
(INTRO) Regular introduction screen	01	N	
(INTRO) HU introduction	02	N	
(INT99) Completed interview	CO		=>/END
Dummy call---Eastern	DE		=>/END
Dummy call---Central	DC		=>/END
Dummy call---Mountain	DM		=>/END
Dummy call---Pacific	DP		=>/END
(INTRO) Wrong date	03	N	=>/END

CB min=1 max=1 simple 1-12
Today is $D It is $H questionnaire: $Q
When would be a convenient time for someone to call back?
$CH

Appendix B: Interview Consent Form

University of Oklahoma

Institutional Review Board

Informed Consent to Participate in a Research Study

Project Title: Worlds Apart: The Impact of Cultural Worldview on Policy Preferences

Principal Investigator: Sondra K. Petty

Department: Political Sciences

You are being asked to volunteer for this research study. This study is being conducted at (The University of Oklahoma, Norman Campus). You were selected as a possible participant because you are a male or female between the ages of 18 and 64. Please read this form and ask any questions that you may have before agreeing to take part in this study.

Purpose of the Research Study: The purpose of this study is to examine the factors that determine an individual's preferences for certain public policies.

Number of Participants: 50 people will take part in this study.

Procedures: If you agree to be in this study, you will be asked to answer questions about public policy in a face-to-face, confidential interview.

Length of Participation: One visit that should take no longer than 30 to 45 minutes, depending on how much we talk.

Risks of being in the study: **NONE**

Benefits of being in the study: There are no direct benefits as a result of your participation; however, the information you provide will help lawmakers better understand the policy preferences of Americans.

Compensation: You will not be reimbursed for your time and participation in this study; however I will provide a beverage and light snack during the interview.

Confidentiality: In published reports, there will be no information included that will make it possible to identify you without your permission. Research records will be stored securely and only approved researchers will have access to the records. There are organizations that may inspect and/or copy your research records for quality assurance and data analysis, this includes the OU Institutional Review Board.

Voluntary Nature of the Study: Participation in this study is voluntary. If you withdraw or decline participation, you will not be penalized or lose benefits or services unrelated to the study. If you decide to participate, you may decline to answer any question and may choose to withdraw at any time.

Audio Recording of Study Activities: To assist with accurate recording of the interviews may be recorded on an audio recording device. You have the right to refuse to allow such recording without penalty. Please select one of the following options → I consent to audio recording. ___Yes ___No

Contacts and Questions: If you have concerns or complaints about the research, the researcher(s) conducting this study can be contacted at Sondra Petty, 214-300-8929, **sondrapetty@ou.edu**. Advisor: Dr. Ann-Marie Szymanski, 405-325-6436. Contact the researcher(s) if you have questions, or if you have experienced a research-related injury. If you have any questions about your rights as a research participant, concerns, or complaints about the research and wish to talk to someone other than individuals on the research team or if you cannot reach the research team, you may contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at 405-325-8110 or irb@ou.edu.

You will be given a copy of this information to keep for your records. If you are not given a copy of this consent form, please request one.

Statement of Consent

I have read the above information. I have asked questions and have received satisfactory answers. I consent to participate in the study.

Participant Signature	Print Name	Date
Signature of Person Obtaining Consent	Print Name	Date

Appendix C: Interview Protocol

Personal Interview Questionnaire

Procedures:
Interviewees will answer the Cultural Worldview, Insurance, Knowledge and Demographic questions first. I will give them the paper survey before the interview. I will not know the answers to their questions before the interview.
Survey questions (Most of these questions also appear in the telephone and Qualtrics surveys)**:**

I would like to ask you about your OWN health care coverage. Please consider any type of health insurance that you or your employer pay for, as well as insurance or other programs that governments help pay for, such as Medicaid or Veteran's benefits.

During the past 12 months were you:
3 Covered continuously
2 Covered part of the time, or
1 Not covered at all

How many months were you without health insurance during the last 12 months?

How long have you had your current coverage?
1 Less than one year
2 One to two years
3 Between two and five years
4 Longer than five years

What is the main reason you did not have continuous health insurance coverage during the past 12 months? Was it because you:
1 Lost or changed jobs
2 Your employer didn't offer coverage
3 The person providing the insurance lost or changed their job
4 You became ineligible due to age or leaving school
5 You became ineligible due to a health condition
6 You couldn't afford insurance coverage, or
7 You are healthy and didn't need insurance coverage

Which of the following is the main source for your health insurance coverage? Is it:
1 Private coverage through your employer
2 Private coverage through a family member's employer
3 Private coverage OTHER than through employment
4 Medicaid
5 US Military/Veteran's Benefits (like Tricare)

6 Other_____

These next few questions are designed to test how well the media communicates political information to the public.

To the best of your knowledge, what is the percentage of votes needed in the House and Senate to override a veto?

Who is the current Chief Justice of the US Supreme Court?

Does the Affordable Care Act, also known as ObamaCare, cover undocumented or illegal immigrants?

1 No

0 Yes

Would you say the federal budget deficit is larger, smaller, or about the same as in 2001?

1 Larger

0 Smaller

0 About the same

Which of the following would you say is the MOST correct statement about the Affordable Care Act's Employer Mandate? Is it:

1 Employers with **50** or more FULL-TIME employees will be required to offer health insurance ONLY to full-time employees.

0 Employers who did not receive a waiver from the federal government will be required to offer health insurance to ALL employees.

0 Employers with **50** or more employees REGARDLESS of the number of hours worked will have to offer health insurance to all employees.

I'd like to ask you about some general political concepts. For each of the following statements please answer on a scale ranging from 1 to 7, where 1 is strongly disagree and 7 is strongly agree and you can choose any number in between.

We should increase taxes so we can increase spending on domestic programs.

7 strongly agree

6

5

4

3

2

1 strongly disagree

I think that people with the most experience and expertise should be the decision makers.

7 strongly agree

6

5

4

3

2

1 strongly disagree

It is better if the woman cares for the home and family and the man works outside the home.

7 strongly agree

6

5

4

3

2

1 strongly disagree

The big problem today is not giving everyone an equal chance.

7 strongly agree

6

5

4

3

2

1 strongly disagree

We should be more tolerant of different moral standards.

7 strongly agree

6

5

4

3

2

1 strongly disagree

Gays should not be allowed to marry.

7 strongly agree

6

5

4

3

2

1 strongly disagree

We have gone too far in pushing equal rights.

7 strongly agree

6

5

4

3

2

1 strongly disagree

It seems like people on welfare get a lot of free services that the rest of us have to pay for.

7 strongly agree

6

5

4

3

2

1 strongly disagree

What is best for society as a whole, NOT the individual, should be the government's priority.
7 strongly agree

6

5

4

3

2

1 strongly disagree

The government wastes a lot of tax money.
7 strongly agree

6

5

4

3

2

1 strongly disagree

P27_grp3:
I favor a reduction in spending on domestic programs to cut taxes.
7 strongly agree

6

5

4

3

2

1 strongly disagree

The federal government should make it more difficult to buy a gun.

7 strongly agree

6

5

4

3

2

1 strongly disagree

I favor allowing Social Security funds to be invested in the stock market.

7 strongly agree

6

5

4

3

2

1 strongly disagree

It is not that big of a problem if people have an unequal chance.

7 strongly agree

6

5

4

3

2

1 strongly disagree

We need a strong national government to solve complex problems.

7 strongly agree

6

5

4

3

2

1 strongly disagree

Protecting the environment is important to me.

7 strongly agree

6

5

4

3

2

1 strongly disagree

Please answer the following demographic questions.

How old are you?

Including yourself, how many people currently live in your household?

Please tell me which of the following age groups are represented in your household?

1 0-5
2 6-17
3 18-34
4 35-64
5 55-64
6 65+

How many children under 18 currently live in your household?

What is your gender?

1 Female
2 Male

What is the highest level of education you have completed?

1 High school diploma/GED
2 Some college/Associate's Degree
3 Bachelor's Degree/college graduate
4 Graduate Degree
5 Vocational/Technical Degree
6 Other_____

What is the highest level of education your mother completed?

1 High school diploma/GED
2 Some college/Associate's Degree
3 Bachelor's Degree/college graduate
4 Graduate Degree
5 Vocational/Technical Degree
6 Other_____

What is the highest level of education your father completed?

1 High school diploma/GED
2 Some college/Associate's Degree
3 Bachelor's Degree/college graduate

4 Graduate Degree
5 Vocational/Technical Degree
6 Other_____

What is your marital status?
1 Single, never married
2 Married
3 Divorced
4 Separated
5 Widowed
6 Living with a partner

What is your primary source for news and information?
1 Cable or satellite television
2 Broadcast television/antenna
3 Radio
4 Internet
5 Twitter
6 Blogs
7 Social media, such as Face Book
8 Printed newspapers
9 Printed magazines
10 Word of mouth/friends and family
11 Other_____

Which of the following categories best describes your racial or ethnic background?
1 American Indian/Native American
2 Asian/Pacific Islander
3 Black or African American
4 Hispanic/Latino
5 Non-Hispanic White
6 Other_____

When it comes to political parties, which one of the following do you most identify? Is it the:
1 Democratic Party
2 Republican Party

3 Are you an Independent or,

4 Is it some other party_____

5 No party

Do you always vote with your party?

0 No

1 Yes

What is your mother's political party? Is it:

1 Democratic Party
2 Republican Party

3 Are you an Independent or,

4 Is it some other party_____

5 No party

What is your father's political party? Is it:

1 Democratic Party
2 Republican Party

3 Are you an Independent or,

4 Is it some other party_____

5 No party

On a scale of political ideology, individuals can be arranged from strongly liberal to strongly conservative. Which of the following categories best describes your views? Are you:

1 Strongly liberal
2 Liberal
3 Slightly liberal
4 Middle of the road
5 Slightly conservative
6 Conservative
7 Strongly conservative

How would you describe your mother's political ideology? Is it:

1 Strongly liberal
2 Liberal
3 Slightly liberal
4 Middle of the road
5 Slightly conservative
6 Conservative

7 Strongly conservative

How would you describe your father's political ideology? Is it:
1 Strongly liberal
2 Liberal
3 Slightly liberal
4 Middle of the road
5 Slightly conservative
6 Conservative
7 Strongly conservative

Are you currently:
1 Employed for wages
2 Self-employed or own your own business
3 Unemployed and looking for work
4 Unemployed but not currently looking for work
5 A homemaker
6 A student
7 In the military
8 Retired, or
9 Unable to work

How would you describe your household growing up? Was it:
1 Poor
2 Working Class
3 Middle Class
4 Wealthy

Was your estimated annual household income for the past year:
1 Less than $25,000
2 At least $25,000 but less than $50,000
3 At least $50,000 but less than $100,000
4 At least $100,000 but less than $150,000
5 At least $150,000 but less than $200,000, or
6 $200,000 and above

When you were a child, did your family ever use any type of welfare or public assistance? This includes Food Stamps, AFDC or TANF benefits, rent subsidies, SCHIP, Medicaid or any other type of government-funded service.
1 Yes
0 No

Have you, as an adult, ever used any type of welfare or public assistance? This includes Food Stamps, AFDC or TANF benefits, rent subsidies, SCHIP, Medicaid or any other type of government-funded service.
1 Yes

0 No

If "yes", how long ago did you use these benefits? Was it:
1 Less than 1 year ago
2 One to two years ago
3 Between two and five years ago
4 Longer than five years ago

Open-Ended Questions

Family background:

Regardless of their income, did your parents stress living on a budget?
Did they ever talk about not living beyond their means?
What was their attitude about saving for the future or their old age?

Do you have poor relations?
What was your family's attitude about them? Did they try to help them?

Were the kids in your family expected to go to college or to work directly after high school?

Would you say you have a family history of higher education?

Politics:

Did your family discuss politics in front of you at home?

What was their general attitude towards politics and/or politicians?

What was your family's attitude about the role of government in peoples' lives?

Were they comfortable with government intervention or government regulation?
What did your parents say or do that makes you feel that way?

Poverty:

When your parents discussed politics, particularly regarding the poor or disadvantaged, what was their attitude towards them?

Were they sympathetic to their plight?
Were they hostile or did they blame the poor for their own lot in life?

What was their attitude towards welfare or public assistance in general?

What was their attitude towards single mothers?
What was their opinion on Food Stamps?
What was their attitude about the unemployed?
What did they think about people living on unemployment benefits?

Did they appear to distinguish between the "deserving poor" and the "undeserving"?
Did they seem to be more willing to help people they thought of as poor for reasons beyond their control as opposed to people who were poor because of their own lifestyle choices?

How was the Great Depression discussed in your household?
Who did your parents or grandparents blame for the Great Depression?
Did they blame it on greedy businessmen, their uncontrolled behavior and an unregulated Stock Market?
Or, did they blame Franklin D. Roosevelt (FDR) and his New Deal programs for the length of the Great Depression?

Race:

What was your family's attitude towards different races?
Did you grow up in a bigoted home?

Even if they weren't overt about it, could you tell your parents were prejudiced – or had attitudes that we might deem politically incorrect today?

Did you grow up in a religious household?
What religion or faith?
Did your family attend church regularly?
What was your family's attitude about charity?

Health:

Were you and your family generally healthy while you were growing up?
Did anyone in the family have chronic health problems that required a doctor's care?

Did your family have health insurance?
Do you know what the source of the insurance was? Was it through a parent's job?

Did anyone in the family have to use public assistance for medical treatment (i.e. Medicaid)?

Respondents' beliefs ----
Politics:

In what ways did your family influence your beliefs, opinions, and attitudes today?

In a general sense, is your life today like the household you grew up in?
In what ways is it the same?
In what ways is it different?

What is your attitude about taxes?
Do you think the rich pay too much or too little in taxes?

Poverty:

What is your attitude about welfare or public assistance today?

Have your opinions changed over time?
Are you more or less accepting or sympathetic about public assistance today?
Why do you feel that way?
Did an event trigger your change of mind about welfare?
If so, what was that event?

What is your general attitude about poor people and poverty?
Are you sympathetic and understanding or do you typically expect poor people to work their way out of poverty themselves?
Who or what do you blame for poverty today?

Economics:

How do you view your lot in life?
Who or what is responsible for your current economic condition?
Why do you feel that way?

Are you optimistic about the future or worried?
Why do you feel that way?

What is your reaction when you hear people in the media or in your everyday life talk about poor people or working class?

What do you think when you hear people in the media or in your everyday life talk about the middle class or the wealthy?

Health Care Reform:

What is your opinion on the passage of the Affordable Care Act, also known as ObamaCare?
Do you think it was a good idea or a bad idea?
Why do you feel that way today?
Have your views on the Affordable Care Act changed over time?

When did your views change?
Why did your views change?

Should people be held accountable for their own health situation?

For example, do you have less sympathy for smokers who get lung cancer or COPD than you do for people who get sick but never smoked?

Do you feel the same way about the morbidly obese who are prone to heart ailments and diabetes?

Do you feel the same way about alcoholics who have liver disease?

Are you more sympathetic to children who have severe health issues than you are elderly persons with many health problems?

Do you think the elderly should have unlimited health care no matter their age?

What do you think about rationing health care services because we have a shortage of doctors and nurses?

If you were given the choice, would you raise taxes on high-income households so that the elderly would not be denied life-extending medical services or would you ration care?

Rationing medical services means that some people would be denied health care because of their advanced age.

Do you have the same opinion on rationing care to the obese, smokers and drug abusers?

Why do you think health care costs are so high?
Why do you think the cost of health insurance is so high?

Do you think that health care is a civil liberty or a right guaranteed under the Constitution like freedom of speech or religion?

In that case, you get virtually unlimited health care and the amount you get doesn't diminish the amount of someone else's health care.

If health care is a product, the amount of health care you get is the amount you can afford to pay for. Once you are out of money, you are out of health care.

Appendix D: Government Health Care Web Site Problems

A combination of poor planning and the system not tested properly.
A combination of poor planning because they did not give the people who created the website enough time to find all the bugs. It was a political issue to get the thing live.

All of the above. (15)
A lot of people didn't want to have be forced to purchase insurance.
All of the above. Poor design; poor testing; not good designing of the database.
All of the ones except political opposition.
All the choices except for number two.
An idiot president.
Bad contractor.

Between it being too hard for the users and technological problems.
Combination of a lot of those things, poor planning, technological problems, etc.
Combination of everything.
Combination of the third and fourth options.
Corruption. I believe that people in the government was politically motivated to hire certain contractors in order to funnel money to people who weren't capable of doing the job. I work for the government. I see that a lot in government.
Hired a terrible company.
I blame the President for pushing it to be done so quickly. It was a political issue and they didn't allow for a reasonable time to implement it.
I don't have an answer if I have to pick just one. I think technological, not tested properly and poor planning.
I don't think it was planned to work properly in the first place.
I filled it out and it's just sitting there. What do I do then? We've registered and it's just there.
I think it was not supposed to happen.

I think it's all being forced on everyone and you haven't got a say on whether you want to do it or not.
I think that there was way more people that applied then was anticipated.
I think the whole thing is too complicated for the average person to understand.
I was under the impression that the system was overwhelmed with users as though they weren't prepared for the number of users. The number of people who tried to sign up was too many.
Incompetency on all parties of the government.

It is a little bit of everything. It seems like a big mess. It's terrible.
It is part of all of those; not one specific thing.
It is related to federal contracting regulations that emphasize benefit to the government over quality of service. It is also related to the complexity of connecting disparate software systems together.

It just wasn't completely thought about and planned out like it was supposed to be. It was kind of a push on it, more than anything.
It was a bad idea. Maybe God was telling us it shouldn't happen. It was a combination of a lot of things.
It was a form of sabotage by the opponents of the program. It was people who didn't want it to succeed and maybe a little lack of preparation.
It was a joke to begin with.
It was a number of things.

It was too complicated and a lot people don't have access to the internet (WIFI). You can't access it from your iPhone and I'm sure a lot of people don't have access to computers.
It wasn't very well designed.
It's a silly system.
Lack of knowledge as to what they what they were supposed to do. I live in Maine, a lot of people don't have computers.

Lack of preparation.
Most people that need ObamaCare, they don't have the money to go and buy technology or know how to use it.
Nobody wants it.
Obama not taking responsibility.

ObamaCare scares me to death and the more I learn about it the worse it gets. How anyone in their right mind can even consider allowing the government to be that involved in their health, to let the government know what you do with your body medically.

Part of the users are not capable of doing it. Political - they didn't have it ironed out. They didn't have it usable.
People are not technically capable of using the computer like they think they are, especially in rural areas.
Poor planning all the way around.
President Obama's fault.
Respondent chose other but refused to specify.
So many people tried to sign up for it at once, it just crashed.
Some of the people can't afford it. Some of the people I know aren't working so how are they going to pay for it if they can't find a job.
System not tested properly and poor planning by Dept. of Health & Human services equally.
Technological problems/poor planning 50-50.
Technology was not ready and the system was not tested properly.
The chip being put in people's hands.
The contract was given to a friend of Obama, it didn't go into proper bidding and they rushed into it.
The contractors didn't fulfill their contracts.
The contracts to create the Affordable Care Act were based on political cronyism and not based on those who were the most qualified to create the website.
The Republicans.
The system is a big job and it's really hard to get everybody going on a big system. Programs aren't necessarily always the best.
There are tech problems but the government has to accept the lowest bidder on many contracts. It is the law and it causes many problems.
There wasn't adequate time to get the program together. Too much political pressure to get it done quickly
They hired a company to put up the website and they didn't do a good job.
They used a company outside of the United States which was horrible.
Too many needing insurance at one time.
Too many people trying to do it.
What you have to qualify to get it.

Appendix E: Unweighted Descriptive Statistics

Race - Collapsed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	357	73.6	83.4	83.4
	Non-White	71	14.6	16.6	100.0
	Total	428	88.2	100.0	
Missing	System	57	11.8		
Total		485	100.0		

Which of the following categories best describes your racial or ethnic background?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	American Indian/Native American	20	4.1	4.6	4.6
	Asian/Pacific Islander	6	1.2	1.4	5.9
	Black or African American	11	2.3	2.5	8.4
	Hispanic/Latino	17	3.5	3.9	12.3
	Non-Hispanic White	357	73.6	81.5	93.8
	Other	17	3.5	3.9	97.7
	-- Refused	10	2.1	2.3	100.0
	Total	438	90.3	100.0	
Missing		47	9.7		
Total		485	100.0		

Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Diploma	14	2.9	2.9	2.9
	High School Graduate or GED	106	21.9	22.3	25.2
	Vocational or Tech School	12	2.5	2.5	27.7
	Some College or Associate Degree	132	27.2	27.7	55.5
	Bachelor's Degree	133	27.4	27.9	83.4
	Graduate Degree	79	16.3	16.6	100.0
	Total	476	98.1	100.0	
Missing	System	9	1.9		
Total		485	100.0		

Annual Income

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than $25K	74	15.3	19.9	19.9
	$25 to $50	78	16.1	21.0	40.9
	$50 to $75	72	14.8	19.4	60.2
	$75 to $100	60	12.4	16.1	76.3
	$100 to $125	27	5.6	7.3	83.6
	$125 to $150	21	4.3	5.6	89.2
	$150 to $175	7	1.4	1.9	91.1
	$175 to $200	10	2.1	2.7	93.8
	$200K and above	23	4.7	6.2	100.0
	Total	372	76.7	100.0	
Missing	System	113	23.3		
Total		485	100.0		

Open-Ended Responses to "Other" Race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		456	94.0	94.0	94.0
	African-American and Non-Hispanic White	1	.2	.2	94.2
	American	1	.2	.2	94.4
	American Indian and Asian and White	1	.2	.2	94.6
	Asian and Caucasian	1	.2	.2	94.8
	Caucasian	2	.4	.4	95.3
	Caucasian and Native American	1	.2	.2	95.5
	Caucasian American guy	1	.2	.2	95.7
	European	1	.2	.2	95.9
	Full blooded Asian and Full-blooded Swede	1	.2	.2	96.1
	German	1	.2	.2	96.3
	Irish and French and Chinese	1	.2	.2	96.5
	Middle Eastern	2	.4	.4	96.9
	Mixed	1	.2	.2	97.1
	Multi-Cultured	1	.2	.2	97.3
	N/A	1	.2	.2	97.5
	Native American and White	1	.2	.2	97.7
	Norwegian	1	.2	.2	97.9
	Part White and Part Indian	1	.2	.2	98.1
	Purple	1	.2	.2	98.4
	Swedish and Italian	1	.2	.2	98.6
	White	1	.2	.2	98.8
	White American	1	.2	.2	99.0
	White and American Indian	1	.2	.2	99.2
	White and Black and Native American	1	.2	.2	99.4
	White and Native-American	1	.2	.2	99.6
	White Indian	1	.2	.2	99.8
	White with a little Indian in it.	1	.2	.2	100.0
	Total	485	100.0	100.0	

Business Owner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not a Business Owner	375	77.3	86.2	86.2
	Business Owner or Self-Employed	60	12.4	13.8	100.0
	Total	435	89.7	100.0	
Missing	System	50	10.3		
Total		485	100.0		

Employment Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Employed for Wages	225	46.4	51.7	51.7
	Self-Employed or Business Owner	60	12.4	13.8	65.5
	Unemployed, looking for work	23	4.7	5.3	70.8
	Unemployed, not looking for work	10	2.1	2.3	73.1
	Homemaker	19	3.9	4.4	77.5
	Student	14	2.9	3.2	80.7
	Military	2	.4	.5	81.1
	Retired	41	8.5	9.4	90.6
	Unable to work	41	8.5	9.4	100.0
	Total	435	89.7	100.0	
Missing	System	50	10.3		
Total		485	100.0		

Employed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Employed for wages	287	59.2	66.0	66.0
	Not employed for wages	148	30.5	34.0	100.0
	Total	435	89.7	100.0	
Missing	System	50	10.3		
Total		485	100.0		

Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single, never married	88	18.1	20.3	20.3
	Married	264	54.4	60.8	81.1
	Divorced	52	10.7	12.0	93.1
	Separated	6	1.2	1.4	94.5
	Widowed	19	3.9	4.4	98.8
	Living with a partner	5	1.0	1.2	100.0
	Total	434	89.5	100.0	
Missing	System	51	10.5		
Total		485	100.0		

Unmarried

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	264	54.4	60.8	60.8
	Single	170	35.1	39.2	100.0
	Total	434	89.5	100.0	
Missing	System	51	10.5		
Total		485	100.0		

Minors

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Minor Children	340	70.1	70.1	70.1
	Children under 18	145	29.9	29.9	100.0
	Total	485	100.0	100.0	

Women w/minor children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not a women/w minor children	405	83.5	83.5	83.5
	Women with minor children	80	16.5	16.5	100.0
	Total	485	100.0	100.0	

Health Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Very Bad	9	1.9	2.1	2.1
	2	12	2.5	2.8	4.8
	3	30	6.2	6.9	11.7
	4	39	8.0	9.0	20.7
	5	84	17.3	19.3	40.0
	6	127	26.2	29.2	69.2
	7 Very Good	134	27.6	30.8	100.0
	Total	435	89.7	100.0	
Missing	System	50	10.3		
Total		485	100.0		

Disabled

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Able Bodied	389	74.1	88.8	88.8
	Disabled	49	9.3	11.2	100.0
	Total	438	83.4	100.0	
Missing	System	87	16.6		
Total		525	100.0		

Health Insurance – Collapsed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Covered Continuously	390	80.4	82.8	82.8
	Not Covered Continuously	81	16.7	17.2	100.0
	Total	471	97.1	100.0	
Missing	System	14	2.9		
Total		485	100.0		

Main Source for Coverage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Private coverage through employer	191	39.4	48.0	48.0
	Private coverage through a family member	72	14.8	18.1	66.1
	Other private coverage	46	9.5	11.6	77.6
	Medicaid	29	6.0	7.3	84.9
	US Military/Veteran's Benefits	31	6.4	7.8	92.7
	Other	29	6.0	7.3	100.0
	Total	398	82.1	100.0	
Missing	System	87	17.9		
Total		485	100.0		

Length of time covered with insurance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not covered	6	1.2	1.5	1.5
	Less than one year	23	4.7	5.7	7.1
	One to two years	34	7.0	8.4	15.5
	Between two and five years	41	8.5	10.1	25.6
	Longer than five years	303	62.5	74.4	100.0
	Total	407	83.9	100.0	
Missing	System	78	16.1		
Total		485	100.0		

Long Term Coverage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Short Term-Less than 5 years	104	21.4	25.6	25.6
	Long Term-Five years or more	303	62.5	74.4	100.0
	Total	407	83.9	100.0	
Missing	System	78	16.1		
Total		485	100.0		

Health Insurance Coverage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not covered at all	59	12.2	12.5	12.5
	Covered part of the year	22	4.5	4.7	17.2
	Covered continuously	390	80.4	82.8	100.0
	Total	471	97.1	100.0	
Missing	System	14	2.9		
Total		485	100.0		

Length of time without coverage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 month	1	.2	5.0	5.0
	2 months	3	.6	15.0	20.0
	3 months	4	.8	20.0	40.0
	4 months	2	.4	10.0	50.0
	5 months	2	.4	10.0	60.0
	6 months	1	.2	5.0	65.0
	8 months	4	.8	20.0	85.0
	9 months	1	.2	5.0	90.0
	10 months	1	.2	5.0	95.0
	12 months	1	.2	5.0	100.0
	Total	20	4.1	100.0	
Missing	System	465	95.9		
Total		485	100.0		

Main Reason for No Health Insurance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Lost job	14	2.9	17.7	17.7
	Employer didn't offer coverage	4	.8	5.1	22.8
	Person providing insurance lost job	2	.4	2.5	25.3
	Ineligible due to age or leaving school	1	.2	1.3	26.6
	Ineligible due to health condition	1	.2	1.3	27.8
	Couldn't afford insurance	38	7.8	48.1	75.9
	Didn't want to buy insurance	5	1.0	6.3	82.3
	Healthy and didn't need to buy insurance	6	1.2	7.6	89.9
	Other reason	8	1.6	10.1	100.0
	Total	79	16.3	100.0	
Missing	System	406	83.7		
Total		485	100.0		

Could not afford to buy insurance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Other reasons	41	8.5	51.9	51.9
	Could not afford insurance	38	7.8	48.1	100.0
	Total	79	16.3	100.0	
Missing	System	406	83.7		
Total		485	100.0		

Open-Ended Responses – Main Reason for No Insurance

Changed employers and had to wait for a certain period of time to become eligible.
Cost
Cost and wouldn't cover her.
Couldn't get on the ObamaCare website - Minnesota.
Employer dropped me because of ObamaCare. The price of insurance at my age was too expensive so I let it go.
ER married and her father's insurance didn't allow her to be covered as well
Haven't found one.
I had a divorce and in the divorce, I lost my health care coverage.
I object to insurance in general. I don't want to pay through a middleman.
Independent contractor
Native American, we have free hospital/medical care.
ObamaCare cancelled policy
Self-employed and the cost of insurance is too high and pre-existing - take your pick.
Unable to get insurance.

Political Party

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Democrat	133	27.4	31.7	31.7
	Republican	122	25.2	29.1	60.9
	Independent/No Party	148	30.5	35.3	96.2
	Other	16	3.3	3.8	100.0
	Total	419	86.4	100.0	
Missing	System	66	13.6		
Total		485	100.0		

Other Party

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		469	96.7	96.7	96.7
	Americans Republic	1	.2	.2	96.9
	Conservative	1	.2	.2	97.1
	Green Party	1	.2	.2	97.3
	Libertarian	8	1.6	1.6	99.0
	Moderate	1	.2	.2	99.2
	Socialist Party	1	.2	.2	99.4
	Tea Party	3	.6	.6	100.0
	Total	485	100.0	100.0	

Party Loyalty

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Don't Always Vote w/Party	190	39.2	69.6	69.6
	Always Vote w/Party	83	17.1	30.4	100.0
	Total	273	56.3	100.0	
Missing	System	212	43.7		
Total		485	100.0		

Party * Party Loyalty Crosstabulation

			Loyalty		
			Don't Always Vote with Party	Always Vote with Party	Total
Party	Democrat	Count	85	48	133
		Expected Count	92.4	40.6	133.0
		% within Party	63.9%	36.1%	100.0%
		% within Loyalty	45.0%	57.8%	48.9%
		% of Total	31.3%	17.6%	48.9%
		Residual	-7.4	7.4	
	Republican	Count	88	33	121
		Expected Count	84.1	36.9	121.0
		% within Party	72.7%	27.3%	100.0%
		% within Loyalty	46.6%	39.8%	44.5%
		% of Total	32.4%	12.1%	44.5%
		Residual	3.9	-3.9	
	Independent	Count	1	1	2
		Expected Count	1.4	.6	2.0
		% within Party	50.0%	50.0%	100.0%
		% within Loyalty	.5%	1.2%	.7%
		% of Total	.4%	.4%	.7%
		Residual	-.4	.4	
	Other	Count	15	1	16
		Expected Count	11.1	4.9	16.0
		% within Party	93.8%	6.3%	100.0%
		% within Loyalty	7.9%	1.2%	5.9%
		% of Total	5.5%	.4%	5.9%
		Residual	3.9	-3.9	
Total		Count	189	83	272
		Expected Count	189.0	83.0	272.0
		% within Party	69.5%	30.5%	100.0%
		% within Loyalty	100.0%	100.0%	100.0%
		% of Total	69.5%	30.5%	100.0%

Chi-Square Tests – Party * Party Loyalty

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.351[a]	3	.062*
Likelihood Ratio	8.647	3	.034
Linear-by-Linear Association	6.308	1	.012
N of Valid Cases	272		

a. 3 cells (37.5%) have expected count less than 5. The minimum expected count is .61.

b. *There is slightly enough evidence to suggest an association between party and party loyalty; p = 0.100 level.

State * Party Crosstabulation

		Party				
		Democrat	Republican	Independent/ No Party	Other	Total
State	California	16	6	18	3	43
	Florida	15	9	6	0	30
	Maine	12	8	15	2	37
	Minnesota	20	6	18	1	45
	Missouri	7	10	17	0	34
	Montana	13	12	30	4	59
	Nebraska	10	18	14	1	43
	Oklahoma	40	53	30	5	128
Total		133	122	148	16	419

Chi-Square Tests – State * Party

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	48.595[a]	21	.001
Likelihood Ratio	51.664	21	.000
N of Valid Cases	419		

a. 8 cells (25.0%) have expected count less than 5. The minimum expected count is 1.15.
b. An association exists between state and party; 0.05 level.

Chi-Square Tests – State * Ideology

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	57.592[a]	42	.055
Likelihood Ratio	59.125	42	.042
N of Valid Cases	418		

a. 23 cells (41.1%) have expected count less than 5. The minimum expected count is 2.08.
b. An association exists between state and ideology; 0.10 level.

Correlations

		Party	Ideology
Party	Pearson Correlation	1	.364**
	Sig. (2-tailed)		.000
	N	419	409
Ideology	Pearson Correlation	.364**	1
	Sig. (2-tailed)	.000	
	N	409	418

**. Correlation is significant at the 0.01 level (2-tailed).

Ideology - Collapsed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Liberal	111	22.9	26.6	26.6
	Middle of the Road	98	20.2	23.4	50.0
	Conservative	209	43.1	50.0	100.0
	Total	418	86.2	100.0	
Missing	System	67	13.8		
Total		485	100.0		

Ideology

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Liberal	28	5.8	6.7	6.7
	Somewhat Liberal	44	9.1	10.5	17.2
	Slightly Liberal	39	8.0	9.3	26.6
	Middle of the Road	98	20.2	23.4	50.0
	Slightly Conservative	59	12.2	14.1	64.1
	Somewhat Conservative	89	18.4	21.3	85.4
	Strongly Conservative	61	12.6	14.6	100.0
	Total	418	86.2	100.0	
Missing	System	67	13.8		
Total		485	100.0		

Individualist

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	415	85.6	90.8	90.8
	1.00 Individualist	42	8.7	9.2	100.0
	Total	457	94.2	100.0	
Missing	System	28	5.8		
Total		485	100.0		

Hierarch

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	385	79.4	84.2	84.2
	1.00 Hierarch	72	14.8	15.8	100.0
	Total	457	94.2	100.0	
Missing	System	28	5.8		
Total		485	100.0		

Egalitarian

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	257	53.0	56.2	56.2
	1.00 Egalitarian	200	41.2	43.8	100.0
	Total	457	94.2	100.0	
Missing	System	28	5.8		
Total		485	100.0		

Fatalist

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	344	70.9	75.3	75.3
	1.00 Fatalist	113	23.3	24.7	100.0
	Total	457	94.2	100.0	
Missing	System	28	5.8		
Total		485	100.0		

Correlations between Ideology and Cultural Worldview

		Individualist	Hierarch	Egalitarian	Fatalist	Ideology
Individualist	Pearson Correlation	1	-.138**	-.281**	-.182**	.053
	Sig. (2-tailed)		.003	.000	.000	.283
	N	457	457	457	457	418
Hierarch	Pearson Correlation	-.138**	1	-.381**	-.248**	.124*
	Sig. (2-tailed)	.003		.000	.000	.011
	N	457	457	457	457	418
Egalitarian	Pearson Correlation	-.281**	-.381**	1	-.506**	-.581**
	Sig. (2-tailed)	.000	.000		.000	.000
	N	457	457	457	457	418
Fatalist	Pearson Correlation	-.182**	-.248**	-.506**	1	.488**
	Sig. (2-tailed)	.000	.000	.000		.000
	N	457	457	457	457	418
Ideology	Pearson Correlation	.053	.124*	-.581**	.488**	1
	Sig. (2-tailed)	.283	.011	.000	.000	
	N	418	418	418	418	418

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Correlations Between Collapsed Ideology and Cultural Worldview

		Individualist	Hierarch	Egalitarian	Fatalist	Three Ideology
Individualist	Pearson Correlation	1	-.138**	-.281**	-.182**	.107*
	Sig. (2-tailed)		.003	.000	.000	.029
	N	457	457	457	457	418
Hierarch	Pearson Correlation	-.138**	1	-.381**	-.248**	.155**
	Sig. (2-tailed)	.003		.000	.000	.002
	N	457	457	457	457	418
Egalitarian	Pearson Correlation	-.281**	-.381**	1	-.506**	-.583**
	Sig. (2-tailed)	.000	.000		.000	.000
	N	457	457	457	457	418
Fatalist	Pearson Correlation	-.182**	-.248**	-.506**	1	.426**
	Sig. (2-tailed)	.000	.000	.000		.000
	N	457	457	457	457	418
Three Ideology	Pearson Correlation	.107*	.155**	-.583**	.426**	1
	Sig. (2-tailed)	.029	.002	.000	.000	
	N	418	418	418	418	418

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

As you may know, some people have had difficulties signing up for insurance on the government health care website. Regardless of how you feel about the Affordable Care Act, what do you believe was the SINGLE biggest factor that caused these issues to occur?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Technological Problems	67	13.8	15.8	15.8
	The system is too complicated for the users	23	4.7	5.4	21.3
	The system was not tested properly	86	17.7	20.3	41.6
	Poor planning by the Department of Health and Human Services	143	29.5	33.8	75.4
	Political opposition	31	6.4	7.3	82.7
	Other	73	15.1	17.3	100.0
	Total	423	87.2	100.0	
Missing	System	62	12.8		
Total		485	100.0		

Correlations

		Ideology	Website Issues
Ideology	Pearson Correlation	1	.127*
	Sig. (2-tailed)		.011
	N	418	403
Website Issues	Pearson Correlation	.127*	1
	Sig. (2-tailed)	.011	
	N	403	423

*. Correlation is significant at the 0.05 level (2-tailed).

Open-Ended Responses – Website Issues
A combination of poor planning and the system not tested properly.
A combination of poor planning because they did not give the people who created the website enough time to find all the bugs. It was a political issue to get the thing live.
A lot of people didn't want to have be forced to purchase insurance.
All of the above.
All of the above. Poor design; poor testing; not good designing of the database.
All of the ones except political opposition.
All the choices except for number 2.
An idiot president
Bad contractor
Between it being too hard for the users and technological problems.
Combination of a lot of those things, poor planning, technological problems, etc.
Combination of everything.
Combination of the third and fourth options.
Corruption: I believe that people in the government was politically motivated to hire certain contractors in order to funnel money to people who weren't capable of doing the job. I work for the government. I see that a lot in government.
Hired a terrible company.
I blame the President for pushing it to be done so quickly. It was a political issue and they didn't allow for a reasonable time to implement it.
I don't have an answer if I have to pick just one. I think technological, not tested properly and poor planning.
I don't think it was planned to work properly in the first place.
I filled it out and it's just sitting there. What do I do then? We've registered and it's just there.
I think it was not supposed to happen.
I think it's all being forced on everyone and you haven't got a say on whether you want to do it or not.
I think that there was way more people that applied then was anticipated.
I think the whole thing is too complicated for the average person to understand.
I was under the impression that the system was overwhelmed with users as though they weren't prepared for the number of users. The number of people who tried to sign up was too many.
Incompetency on all parties of the government.
It is a little bit of everything. It seems like a big mess. It's terrible.
It is part of all of those; not one specific thing.
It is related to federal contracting regulations that emphasize benefit to the government over quality of service. It is also related to the complexity of connecting disparate software systems together.
It just wasn't completely thought about and planned out like it was supposed to be. It was kind of a push on it, more than anything.
It was a bad idea, maybe God was telling us it shouldn't happen. It was a combination of a lot of things.
It was a form of sabotage by the opponents of the program. It was people who didn’t want it to succeed and maybe a little lack of preparation.
It was a joke to begin with.
It was a number of things.
It was too complicated and a lot people don't have access to the internet (WIFI). You can't access it from your iPhone and I'm sure a lot of people don't have access to computers.

It wasn't very well designed.

It's a silly system.

Lack of knowledge as to what they what they were supposed to do. I live in Maine. A lot of people don't have computers.

Lack of preparation.

Most people that need ObamaCare, they don't have the money to go and buy technology or know how to use it.

Nobody wants it.

Obama not taking responsibility.

ObamaCare scares me to death and the more I learn about it the worse it gets. How anyone in their right mind can even consider allowing the government to be that involved in their health, to let the government know what you do with your body medically

Part of the users are not capable of doing it. Political - they didn't have it ironed out. They didn't have it usable.

People are not technically capable of using the computer like they think they are, especially in rural areas.

Poor planning all the way around.

President Obama's fault

So many people tried to sign up for it at once, it just crashed.

Some of the people can't afford it. Some of the people I know aren't working so how are they going to pay for it if they can't find a job.

System not tested properly and poor planning by Dept. of Health & Human services equally.

Technological problems/poor planning 50-50

Technology was not ready and the system was not tested properly.

The chip being put in people's hands.

The contract was given to a friend of Obama, it didn't go into proper bidding and they rushed into it.

The contractors didn't fulfill their contracts.

The contracts to create the Affordable Care Act were based on political cronyism and not based on those who were the most qualified to create the website.

The Republicans

The system is a big job and it's really hard to get everybody going on a big system. Programs aren't necessarily always the best.

There are tech problems but the government has to accept the lowest bidder on many contracts. It is the law and it causes many problems.

There wasn't adequate time to get the program together. Too much political pressure to get it done quickly

They hired a company to put up the website and they didn't do a good job.

They used a company outside of the United States which was horrible.

Too many needing insurance at one time.

Too many people trying to do it.

What you have to qualify to get it.

Knowledge Index

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Nothing Correct	24	4.9	5.2	5.2
	1 Answer Correct	109	22.5	23.6	28.9
	2 Answers Correct	146	30.1	31.7	60.5
	3 Answers Correct	102	21.0	22.1	82.6
	4 Answers Correct	59	12.2	12.8	95.4
	All 5 Answers Correct	21	4.3	4.6	100.0
	Total	461	95.1	100.0	
Missing	System	24	4.9		
Total		485	100.0		

Knowledge of Veto Override

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	324	66.8	70.0	70.0
	1 Correct	139	28.7	30.0	100.0
	Total	463	95.5	100.0	
Missing	System	22	4.5		
Total		485	100.0		

Knowledge of Chief Justice

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	366	75.5	79.0	79.0
	1 Correct	97	20.0	21.0	100.0
	Total	463	95.5	100.0	
Missing	System	22	4.5		
Total		485	100.0		

Knowledge of ACA Immigrant Coverage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	281	57.9	60.8	60.8
	1 Correct	181	37.3	39.2	100.0
	Total	462	95.3	100.0	
Missing	System	23	4.7		
Total		485	100.0		

Knowledge of Budget Deficit

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	68	14.0	14.7	14.7
	1 Correct	395	81.4	85.3	100.0
	Total	463	95.5	100.0	
Missing	System	22	4.5		
Total		485	100.0		

Knowledge of Employer Mandate

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	210	43.3	45.9	45.9
	1 Correct	248	51.1	54.1	100.0
	Total	458	94.4	100.0	
Missing	System	27	5.6		
Total		485	100.0		

Correlations

		Knowledge Index	Income
Knowledge Index	Pearson Correlation	1	.306**
	Sig. (2-tailed)		.000
	N	461	372
Income	Pearson Correlation	.306**	1
	Sig. (2-tailed)	.000	
	N	372	372

**. Correlation is significant at the 0.01 level (2-tailed).

Correlations

		Knowledge Index	Education
Knowledge Index	Pearson Correlation	1	.356**
	Sig. (2-tailed)		.000
	N	461	458
Education	Pearson Correlation	.356**	1
	Sig. (2-tailed)	.000	
	N	458	476

**. Correlation is significant at the 0.01 level (2-tailed).

Correlations

		Knowledge Index	Party
Knowledge Index	Pearson Correlation	1	.094*
	Sig. (2-tailed)		.055
	N	461	419
Party	Pearson Correlation	.094*	1
	Sig. (2-tailed)	.055	
	N	419	419

*. Correlation is significant at the 0.10 level (2-tailed).

Correlations between Knowledge Index and Cultural Worldview

		Individualist	Hierarch	Egalitarian	Fatalist	Know Index
Individualist	Pearson Correlation	1	-.138**	-.281**	-.182**	.024
	Sig. (2-tailed)		.003	.000	.000	.610
	N	457	457	457	457	457
Hierarch	Pearson Correlation	-.138**	1	-.381**	-.248**	-.156**
	Sig. (2-tailed)	.003		.000	.000	.001
	N	457	457	457	457	457
Egalitarian	Pearson Correlation	-.281**	-.381**	1	-.506**	-.035
	Sig. (2-tailed)	.000	.000		.000	.453
	N	457	457	457	457	457
Fatalist	Pearson Correlation	-.182**	-.248**	-.506**	1	.171**
	Sig. (2-tailed)	.000	.000	.000		.000
	N	457	457	457	457	457
Know Index	Pearson Correlation	.024	-.156**	-.035	.171**	1
	Sig. (2-tailed)	.610	.001	.453	.000	
	N	457	457	457	457	461

**. Correlation is significant at the 0.01 level (2-tailed).

Q13SCOTUS Q14Immigrant Q16Mandate Q12Veto Q15Budget * Fatalist

Fatalist		Q13SCOTUS	Q14Immigrant	Q16Mandate	Q12Veto	Q15Budget
.00	Mean	.1744	.4302	.4868	.2682	.8343
	N	344	344	341	343	344
	Std. Deviation	.38002	.49583	.50056	.44368	.37235
1.00	Mean	.3274	.2920	.7143	.4071	.9381
	N	113	113	112	113	113
	Std. Deviation	.47137	.45672	.45378	.49348	.24213
Total	Mean	.2123	.3961	.5430	.3026	.8600
	N	457	457	453	456	457
	Std. Deviation	.40935	.48961	.49869	.45990	.34741

Q13SCOTUS Q14Immigrant Q16Mandate Q12Veto Q15Budget * Individualist

Individualist		Q13SCOTUS	Q14Immigrant	Q16Mandate	Q12Veto	Q15Budget
.00	Mean	.2120	.3952	.5450	.2995	.8554
	N	415	415	411	414	415
	Std. Deviation	.40925	.48948	.49858	.45860	.35210
1.00	Mean	.2143	.4048	.5238	.3333	.9048
	N	42	42	42	42	42
	Std. Deviation	.41530	.49680	.50549	.47712	.29710
Total	Mean	.2123	.3961	.5430	.3026	.8600
	N	457	457	453	456	457
	Std. Deviation	.40935	.48961	.49869	.45990	.34741

Q13SCOTUS Q14Immigrant Q16Mandate Q12Veto Q15Budget * Egalitarian

Egalitarian		Q13SCOTUS	Q14Immigrant	Q16Mandate	Q12Veto	Q15Budget
.00	Mean	.2257	.3307	.6087	.2957	.8988
	N	257	257	253	257	257
	Std. Deviation	.41885	.47140	.48901	.45726	.30214
1.00	Mean	.1950	.4800	.4600	.3116	.8100
	N	200	200	200	199	200
	Std. Deviation	.39719	.50085	.49965	.46430	.39329
Total	Mean	.2123	.3961	.5430	.3026	.8600
	N	457	457	453	456	457
	Std. Deviation	.40935	.48961	.49869	.45990	.34741

Q13Chief Justice Q14Immigrant Q16Mandate Q12Veto Q15Budget * Hierarch

Hierarch		Q13 Chief Justice	Q14Immigrant	Q16Mandate	Q12Veto	Q15Budget
.00	Mean	.2338	.4104	.5457	.3333	.8675
	N	385	385	383	384	385
	Std. Deviation	.42378	.49254	.49856	.47202	.33944
1.00	Mean	.0972	.3194	.5286	.1389	.8194
	N	72	72	70	72	72
	Std. Deviation	.29834	.46953	.50279	.34826	.38735
Total	Mean	.2123	.3961	.5430	.3026	.8600
	N	457	457	453	456	457
	Std. Deviation	.40935	.48961	.49869	.45990	.34741

Means Report -Ideology

Ideology Collapsed		Q12 Veto	Q13 Chief Justice	Q14 Gov't Coverage Immigrant	Q15 Budget	Q16 Mandate
Liberal	Mean	.4091	.2973	.5495	.8018	.4775
	N	110	111	111	111	111
	Std. Deviation	.49392	.45914	.49980	.40045	.50176
Middle of the Road	Mean	.2449	.0918	.4490	.8469	.4375
	N	98	98	98	98	96
	Std. Deviation	.43224	.29028	.49995	.36190	.49868
Conservative	Mean	.2871	.2488	.3110	.9043	.6570
	N	209	209	209	209	207
	Std. Deviation	.45349	.43336	.46402	.29488	.47586
Total	Mean	.3094	.2249	.4067	.8636	.5580
	N	417	418	418	418	414
	Std. Deviation	.46278	.41800	.49181	.34359	.49723

Means Report - Party

Party		Q12 Veto	Q13 Chief Justice	Q14 Gov't Coverage Immigrant	Q15 Budget	Q16 Mandate
Democrat	Mean	.3485	.1955	.4962	.7970	.4621
	N	132	133	133	133	132
	Std. Deviation	.47831	.39808	.50188	.40376	.50046
Republican	Mean	.2213	.2213	.2951	.9508	.6557
	N	122	122	122	122	122
	Std. Deviation	.41684	.41684	.45796	.21714	.47709
Ind/NA	Mean	.3378	.2365	.4122	.8649	.5379
	N	148	148	148	148	145
	Std. Deviation	.47458	.42637	.49390	.34303	.50029
Other	Mean	.5625	.5000	.5625	.8125	.8750
	N	16	16	16	16	16
	Std. Deviation	.51235	.51640	.51235	.40311	.34157
Total	Mean	.3158	.2291	.4105	.8663	.5614
	N	418	419	419	419	415
	Std. Deviation	.46539	.42077	.49251	.34068	.49681

Means Report - Income

Income		Q12 Veto	Q13 Chief Justice	Q14 Gov't Coverage Immigrant	Q15 Budget	Q16 Mandate
Less than $25K	Mean	.1486	.1622	.3378	.7973	.4384
	N	74	74	74	74	73
	Std. Deviation	.35817	.37112	.47620	.40476	.49962
25 to 50	Mean	.2436	.1667	.4103	.8846	.4286
	N	78	78	78	78	77
	Std. Deviation	.43203	.37509	.49506	.32155	.49812
50 to 75	Mean	.2639	.1667	.3750	.9028	.6761
	N	72	72	72	72	71
	Std. Deviation	.44383	.37529	.48752	.29834	.47131
75 to 100	Mean	.3667	.1833	.3333	.8667	.5763
	N	60	60	60	60	59
	Std. Deviation	.48596	.39020	.47538	.34280	.49839
100 to 125	Mean	.3704	.3333	.5185	.8148	.4815
	N	27	27	27	27	27
	Std. Deviation	.49210	.48038	.50918	.39585	.50918
125 to 150	Mean	.4000	.2857	.3810	.8571	.5714
	N	20	21	21	21	21
	Std. Deviation	.50262	.46291	.49761	.35857	.50709
150 to 175	Mean	.2857	.1429	.7143	1.0000	.7143
	N	7	7	7	7	7
	Std. Deviation	.48795	.37796	.48795	.00000	.48795
175 to 200	Mean	.3000	.5000	.5000	.9000	.7000
	N	10	10	10	10	10
	Std. Deviation	.48305	.52705	.52705	.31623	.48305
200K and above	Mean	.6522	.3913	.6957	.9565	.8261
	N	23	23	23	23	23
	Std. Deviation	.48698	.49901	.47047	.20851	.38755
Total	Mean	.2938	.2097	.4086	.8683	.5516
	N	371	372	372	372	368
	Std. Deviation	.45612	.40763	.49224	.33864	.49800

Thinking about your future economic situation, do you think you'll be better off, about the same, or worse off five years from now.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Better off	156	32.2	37.3	37.3
	About the same	156	32.2	37.3	74.6
	Worse off	106	21.9	25.4	100.0
	Total	418	86.2	100.0	
Missing					
	System	67	13.8		
Total		485	100.0		

Lost a Job Since 2007

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No lost job	286	59.0	65.4	65.4
	Lost job since 2007	151	31.1	34.6	100.0
	Total	437	90.1	100.0	
Missing	System	48	9.9		
Total		485	100.0		

How many members of your household have lost a job since 2007?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	124	25.6	82.1	82.1
	2.00	23	4.7	15.2	97.4
	3.00	1	.2	.7	98.0
	4.00	2	.4	1.3	99.3
	Don’t remember	1	.2	.7	100.0
	Total	151	31.1	100.0	
Missing	System	334	68.9		
Total		485	100.0		

What year was that job lost?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Don’t remember	2	.4	1.6	1.6
	2007.00	11	2.3	8.9	10.5
	2008.00	22	4.5	17.7	28.2
	2009.00	20	4.1	16.1	44.4
	2010.00	15	3.1	12.1	56.5
	2011.00	18	3.7	14.5	71.0
	2012.00	12	2.5	9.7	80.6
	2013.00	22	4.5	17.7	98.4
	2014.00	2	.4	1.6	100.0
	Total	124	25.6	100.0	
Missing	System	361	74.4		
Total		485	100.0		

Considering the job loss that had the greatest impact on your household, please tell me what year that job was lost.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2007.00	1	.2	3.7	3.7
	2008.00	4	.8	14.8	18.5
	2009.00	6	1.2	22.2	40.7
	2010.00	2	.4	7.4	48.1
	2011.00	5	1.0	18.5	66.7
	2012.00	6	1.2	22.2	88.9
	2013.00	3	.6	11.1	100.0
	Total	27	5.6	100.0	
Missing	System	458	94.4		
Total		485	100.0		

Pay Cut Since 2007

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No pay cut	270	55.7	62.4	62.4
	Pay cut since 2007	163	33.6	37.6	100.0
	Total	433	89.3	100.0	
Missing	System	52	10.7		
Total		485	100.0		

How many members of your household have taken a pay-cut since 2007?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	117	24.1	71.8	71.8
	2.00	42	8.7	25.8	97.5
	3.00	1	.2	.6	98.2
	4.00	2	.4	1.2	99.4
	Don’t remember	1	.2	.6	100.0
	Total	163	33.6	100.0	
Missing	System	322	66.4		
Total		485	100.0		

What year did that pay-cut happen?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Don’t remember	4	.8	3.4	3.4
	2007.00	9	1.9	7.7	11.1
	2008.00	14	2.9	12.0	23.1
	2009.00	19	3.9	16.2	39.3
	2010.00	21	4.3	17.9	57.3
	2011.00	15	3.1	12.8	70.1
	2012.00	18	3.7	15.4	85.5
	2013.00	16	3.3	13.7	99.1
	2014.00	1	.2	.9	100.0
	Total	117	24.1	100.0	
Missing	System	368	75.9		
Total		485	100.0		

Considering the pay-cut that had the greatest impact on your household, please tell me what year that pay-cut happened.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Don't remember	1	.2	2.2	2.2
	2007.00	3	.6	6.5	8.7
	2008.00	6	1.2	13.0	21.7
	2009.00	8	1.6	17.4	39.1
	2010.00	11	2.3	23.9	63.0
	2011.00	5	1.0	10.9	73.9
	2012.00	5	1.0	10.9	84.8
	2013.00	7	1.4	15.2	100.0
	Total	46	9.5	100.0	
Missing	System	439	90.5		
Total		485	100.0		

What is your primary source for news and information?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Cable or satellite television	189	36.0	43.2	43.2
	Broadcast television (antenna)	38	7.2	8.7	51.8
	Radio	26	5.0	5.9	57.8
	Internet (websites)	122	23.2	27.9	85.6
	Social media, such as Face Book, Twitter or Blogs	5	1.0	1.1	86.8
	Printed newspapers and magazines	48	9.1	11.0	97.7
	Word of mouth/friends and family	6	1.1	1.4	99.1
	Other	4	.8	.9	100.0
	Total	438	83.4	100.0	
	Missing System	87	16.6		
Total		525	100.0		

Approval of the ACA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly oppose	176	36.3	41.9	41.9
	2 Somewhat oppose	29	6.0	6.9	48.8
	3 Slightly oppose	34	7.0	8.1	56.9
	4 Neither support nor oppose	34	7.0	8.1	65.0
	5 Slightly support	40	8.2	9.5	74.5
	6 Somewhat support	29	6.0	6.9	81.4
	7 Strongly support	78	16.1	18.6	100.0
	Total	420	86.6	100.0	
Missing	System	65	13.4		
Total		485	100.0		

Changed mind on the ACA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	394	75.0	90.6	90.6
	1 Yes	41	7.8	9.4	100.0
	Total	435	82.9	100.0	
Missing	System	90	17.1		
Total		525	100.0		

Approval of ACA Tax Increase

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly oppose	164	33.8	37.5	37.5
	2 Somewhat oppose	25	5.2	5.7	43.2
	3 Slightly oppose	21	4.3	4.8	48.1
	4 Neither support nor oppose	38	7.8	8.7	56.8
	5 Slightly support	40	8.2	9.2	65.9
	6 Somewhat support	45	9.3	10.3	76.2
	7 Strongly support	104	21.4	23.8	100.0
	Total	437	90.1	100.0	
Missing	System	48	9.9		
Total		485	100.0		

Changed mind on raising taxes for the ACA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	406	77.3	92.7	92.7
	1 Yes	32	6.1	7.3	100.0
	Total	438	83.4	100.0	
Missing	System	87	16.6		
Total		525	100.0		

Approval of Expanding Medicaid

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly oppose	86	17.7	19.8	19.8
	2 Somewhat oppose	36	7.4	8.3	28.1
	3 Slightly oppose	39	8.0	9.0	37.1
	4 Neither support nor oppose	37	7.6	8.5	45.6
	5 Slightly support	71	14.6	16.4	62.0
	6 Somewhat support	44	9.1	10.1	72.1
	7 Strongly support	121	24.9	27.9	100.0
	Total	434	89.5	100.0	
Missing	System	51	10.5		
Total		485	100.0		

Changed mind on Medicaid expansion

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	388	73.9	90.0	90.0
	1 Yes	43	8.2	10.0	100.0
	Total	431	82.1	100.0	
Missing	System	94	17.9		
Total		525	100.0		

Approval of Lowering the Age for Medicare

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly oppose	135	27.8	31.4	31.4
	2 Somewhat oppose	43	8.9	10.0	41.4
	3 Slightly oppose	28	5.8	6.5	47.9
	4 Neither support nor oppose	50	10.3	11.6	59.5
	5 Slightly support	46	9.5	10.7	70.2
	6 Somewhat support	34	7.0	7.9	78.1
	7 Strongly support	94	19.4	21.9	100.0
	Total	430	88.7	100.0	
Missing	System	55	11.3		
Total		485	100.0		

Changed mind on lowering Medicare age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	345	65.7	83.9	83.9
	1 Yes	66	12.6	16.1	100.0
	Total	411	78.3	100.0	
Missing	System	114	21.7		
Total		525	100.0		

Approval of ACA for Undocumented Immigrants

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Strongly oppose	258	53.2	58.9	58.9
	2 Somewhat oppose	32	6.6	7.3	66.2
	3 Slightly oppose	22	4.5	5.0	71.2
	4 Neither support nor oppose	35	7.2	8.0	79.2
	5 Slightly support	37	7.6	8.4	87.7
	6 Somewhat support	21	4.3	4.8	92.5
	7 Strongly support	33	6.8	7.5	100.0
	Total	438	90.3	100.0	
Missing	System	47	9.7		
Total		485	100.0		

Changed mind on government covering undocumented immigrants

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	411	78.3	94.3	94.3
	1 Yes	25	4.8	5.7	100.0
	Total	436	83.0	100.0	
Missing	System	89	17.0		
Total		525	100.0		

Grid 17: We should increase taxes so we can increase spending on domestic programs.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	206	45.7	46.0	46.0
	2	45	10.1	10.1	56.1
	3	40	8.8	8.9	65.0
	4	52	11.5	11.6	76.6
	5	52	11.4	11.5	88.1
	6	19	4.1	4.1	92.2
	7 - Strongly AGREE	35	7.7	7.8	100.0
	Total	449	99.3	100.0	
Missing	System	3	.7		
Total		452	100.0		

Grid 18: I think that people with the most experience and expertise should be the decision makers.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	43	9.5	9.6	9.6
	2	17	3.7	3.8	13.4
	3	36	8.0	8.1	21.5
	4	48	10.6	10.7	32.3
	5	94	20.7	20.9	53.2
	6	77	17.1	17.3	70.5
	7 - Strongly AGREE	132	29.2	29.5	100.0
	Total	447	99.0	100.0	
Missing	System	5	1.0		
Total		452	100.0		

Grid 19: It is better if the woman cares for the home and family and the man works outside the home.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	207	45.8	46.2	46.2
	2	49	10.8	10.9	57.1
	3	32	7.1	7.2	64.3
	4	54	11.9	12.0	76.3
	5	44	9.8	9.9	86.2
	6	18	4.1	4.1	90.3
	7 - Strongly AGREE	43	9.6	9.7	100.0
	Total	447	99.0	100.0	
Missing	System	4	1.0		
Total		452	100.0		

Grid 20: The big problem today is not giving everyone an equal chance.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	104	23.0	23.1	23.1
	2	53	11.8	11.9	35.0
	3	63	13.9	14.0	49.0
	4	44	9.7	9.7	58.7
	5	49	10.8	10.9	69.6
	6	37	8.2	8.2	77.9
	7 - Strongly AGREE	99	22.0	22.1	100.0
	Total	449	99.4	100.0	
Missing	System	3	.6		
Total		452	100.0		

Grid 21: We should be more tolerant of different moral standards.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	83	18.5	18.7	18.7
	2	46	10.1	10.2	28.9
	3	49	10.8	10.9	39.8
	4	47	10.4	10.5	50.3
	5	51	11.2	11.3	61.7
	6	61	13.6	13.8	75.4
	7 - Strongly AGREE	110	24.3	24.6	100.0
	Total	447	98.9	100.0	
Missing	System	5	1.1		
Total		452	100.0		

Grid 22: Gays should NOT be allowed to marry.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	234	51.7	52.1	52.1
	2	24	5.3	5.3	57.5
	3	20	4.4	4.4	61.9
	4	26	5.7	5.7	67.6
	5	28	6.2	6.2	73.8
	6	24	5.2	5.3	79.1
	7 - Strongly AGREE	94	20.8	20.9	100.0
	Total	448	99.2	100.0	
Missing	System	4	.8		
Total		452	100.0		

Grid 23: We have gone too far in pushing equal rights.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	187	41.4	41.8	41.8
	2	46	10.1	10.2	52.0
	3	27	6.0	6.1	58.1
	4	22	4.8	4.9	63.0
	5	48	10.5	10.6	73.6
	6	31	6.8	6.8	80.4
	7 - Strongly AGREE	88	19.4	19.6	100.0
	Total	448	99.2	100.0	
Missing	System	4	.8		
Total		452	100.0		

Grid 24: It seems like people on welfare get a lot of free services that the rest of us have to pay for.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	81	17.8	18.1	18.1
	2	30	6.7	6.7	24.8
	3	37	8.1	8.2	33.0
	4	45	9.9	10.0	43.0
	5	44	9.8	9.9	52.9
	6	40	8.9	9.0	61.9
	7 - Strongly AGREE	170	37.6	38.1	100.0
	Total	446	98.8	100.0	
Missing	System	5	1.2		
Total		452	100.0		

Group 25: What is best for society as a whole, NOT the individual, should be the government's priority.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	63	14.0	15.0	15.0
	2	28	6.3	6.8	21.8
	3	25	5.5	5.9	27.7
	4	63	14.0	15.0	42.7
	5	79	17.5	18.8	61.4
	6	47	10.5	11.2	72.6
	7 - Strongly AGREE	115	25.5	27.4	100.0
	Total	421	93.3	100.0	
Missing	System	30	6.7		
Total		452	100.0		

Group 26: The government wastes a lot of tax money.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	20	4.4	4.4	4.4
	2	15	3.2	3.2	7.6
	3	18	3.9	3.9	11.5
	4	28	6.1	6.2	17.7
	5	50	11.2	11.2	28.9
	6	36	8.0	8.1	36.9
	7 - Strongly AGREE	284	62.9	63.1	100.0
	Total	451	99.7	100.0	
Missing	System	1	.3		
Total		452	100.0		

Group 27: I favor a reduction in spending on domestic programs to cut taxes.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	92	20.3	20.7	20.7
	2	28	6.1	6.2	26.9
	3	48	10.7	10.8	37.7
	4	65	14.5	14.7	52.4
	5	65	14.5	14.7	67.1
	6	29	6.5	6.6	73.7
	7 - Strongly AGREE	117	25.8	26.3	100.0
	Total	445	98.4	100.0	
Missing	System	7	1.6		
Total		452	100.0		

Group 28: The federal government should make it more difficult to buy a gun.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	154	34.0	34.3	34.3
	2	44	9.7	9.8	44.1
	3	22	5.0	5.0	49.1
	4	24	5.4	5.4	54.6
	5	42	9.2	9.3	63.9
	6	33	7.4	7.4	71.3
	7 - Strongly AGREE	128	28.4	28.7	100.0
	Total	447	99.0	100.0	
Missing	System	4	1.0		
Total		452	100.0		

Group 29: I favor allowing Social Security funds to be invested in the stock market.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	225	49.9	51.1	51.1
	2	43	9.4	9.7	60.7
	3	38	8.3	8.5	69.2
	4	53	11.8	12.1	81.3
	5	25	5.5	5.7	87.0
	6	21	4.6	4.7	91.7
	7 - Strongly AGREE	37	8.1	8.3	100.0
	Total	441	97.7	100.0	
Missing	System	10	2.3		
Total		452	100.0		

Group 30: It is not that big of a problem if people have an unequal chance.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	183	40.5	42.5	42.5
	2	42	9.3	9.8	52.3
	3	55	12.2	12.8	65.1
	4	57	12.7	13.3	78.3
	5	36	8.0	8.3	86.7
	6	18	4.1	4.3	91.0
	7 - Strongly AGREE	39	8.6	9.0	100.0
	Total	430	95.3	100.0	
Missing	System	21	4.7		
Total		452	100.0		

Group 31: We need a strong national government to solve complex problems.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	54	12.0	12.1	12.1
	2	26	5.8	5.8	17.9
	3	31	6.8	6.9	24.8
	4	36	8.0	8.1	32.9
	5	54	11.9	12.1	45.0
	6	78	17.4	17.6	62.6
	7 - Strongly AGREE	167	37.0	37.4	100.0
	Total	446	98.8	100.0	
Missing	System	6	1.2		
Total		452	100.0		

Group 32: Protecting the environment is important to me.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - Strongly DISAGREE	13	3.0	3.0	3.0
	2	6	1.3	1.3	4.2
	3	18	4.0	4.0	8.3
	4	33	7.4	7.4	15.7
	5	83	18.4	18.4	34.1
	6	61	13.4	13.5	47.6
	7 - Strongly AGREE	236	52.3	52.4	100.0
	Total	451	99.8	100.0	
Missing	System	1	.2		
Total		452	100.0		

Reliability Statistics

Cronbach's Alpha	N of Items
.792	7

Grid Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
We should increase taxes so we can increase spending on domestic programs.	21.57	89.160	.492	.771
Gays should NOT be allowed to marry.	23.76	79.474	.603	.749
We have gone too far in pushing equal rights.	23.49	79.294	.629	.744
It seems like people on welfare get a lot of free services that the rest of us have to pay for.	22.14	82.579	.569	.756
It is better if the woman cares for the home and family and the man works outside the home.	24.02	92.376	.393	.788
The big problem today is not giving everyone an equal chance.	22.65	90.672	.378	.792
We should be more tolerant of different moral standards.	23.05	83.450	.580	.754

Group Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
The federal government should make it more difficult to buy a gun.	27.28	45.692	.407	.600
We need a strong national government to solve complex problems.	26.10	50.009	.394	.602
Protecting the environment is important to me.	25.29	54.866	.399	.609
The government wastes a lot of tax money.	29.05	54.286	.347	.618
I favor a reduction in spending on domestic programs to cut taxes.	27.38	46.528	.489	.569
I favor allowing Social Security funds to be invested in the stock market.	25.74	55.116	.237	.649
It is not that big of a problem if people have an unequal chance.	25.99	54.145	.274	.638

Reliability Statistics

Cronbach's Alpha	N of Items
.649	7

Rotated Component Matrix[a]

Percent of variance explained is 56.847%	Component			
	1 Indiv	2 Hier	3 Egal	4 Fatal
Gays should NOT be allowed to marry. Hi Grid	.288	.767	-.089	.037
The big problem today is not giving everyone an equal chance. Low Grid	.303	.016	-.685	-.034
We should be more tolerant of different moral standards. Low Grid	.470	.385	-.320	.098
The government wastes a lot of tax money. Low Group	-.715	-.078	-.134	.264
I favor a reduction in spending on domestic programs to cut taxes. Low Group	-.637	-.311	.192	.218
It is better if the woman cares for the home and family and the man works outside the home. Hi Grid	.081	.799	.011	-.028
We have gone too far in pushing equal rights. Hi Grid	.305	.670	-.175	-.243
It seems like people on welfare get a lot of free services that the rest of us have to pay for. Hi Grid	.755	.276	-.036	-.169
I favor allowing Social Security funds to be invested in the stock market. Low Group	-.072	-.108	.014	.826
We should increase taxes so we can increase spending on domestic programs. Low Grid	.681	.125	-.385	.062
The federal government should make it more difficult to buy a gun. High Group	-.336	-.390	.427	-.112
We need a strong national government to solve complex problems. High Group	-.199	-.181	.646	-.029
Protecting the environment is important to me. High Group	.067	-.397	.541	.260
It is not that big of a problem if people have an unequal chance. Low Group	-.247	.019	.167	.557
What is best for society as a whole, NOT the individual, should be the government's priority. High Group	.191	.102	.595	.237

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a. Rotation converged in 10 iterations.

Grid: Hierarchical-Egalitarian Scale	***n*=**	**Mean**	**Std. Dev.**	**Agree**
We should increase taxes so we can increase spending on domestic programs.	449	2.76	2.022	Low
I think that people with the most experience and expertise should be the decision makers.	447	4.99	1.917	High
It is better if the woman cares for the home and family and the man works outside the home.	447	2.80	2.089	High
The big problem today is not giving everyone an equal chance.	449	3.87	2.263	Low
We should be more tolerant of different moral standards.	447	4.25	2.241	Low
Gays should not be allowed to marry.	448	3.08	2.505	High
We have gone too far in pushing equal rights.	448	3.31	2.431	High
It seems like people on welfare get a lot of free services that the rest of us have to pay for.	446	4.66	2.331	High
Group: Individualism-Communitarian Scale				
What is best for society as a whole, not the individual, should be the government's priority.	421	4.59	1.720	High
The government wastes a lot of tax money.	451	5.93	1.720	Low
I favor a reduction in spending on domestic programs to cut taxes.	445	4.21	2.226	Low
The federal government should make it more difficult to buy a gun.	447	3.83	2.547	High
I favor allowing Social Security funds to be invested in the stock market.	441	2.59	2.020	Low
It is not that big of a problem if people have an unequal chance.	430	2.84	2.020	Low
We need a strong national government to solve complex problems.	446	5.05	2.121	High
Protecting the environment is important to me.	451	5.87	1.516	High

Appendix F: Regression Results

Model II – ACA Approval w/Ideology

R2 = 0.722, Adj R2 0.691		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	10.240	1.557		6.579	.000
	Age	-.015	.052	-.076	-.293	.770
	Age Squared	.000	.001	.055	.215	.830
	Race Dummy	-.112	.297	-.014	-.376	.707
	Gender	-.132	.221	-.026	-.595	.552
	Women w/Children	-.572	.273	-.086	-2.095	.037
	Unmarried	-.403	.220	-.076	-1.833	.068
	Knowledge Index	-.120	.099	-.051	-1.206	.229
	Education	.133	.147	.073	.902	.368
	Class	.029	.032	.156	.899	.369
	Income	-.146	.160	-.131	-.910	.364
	Party Loyalty	-.005	.208	-.001	-.022	.983
	Party	-1.091	.192	-.279	-5.679	.000
	Disabled	.728	.432	.086	1.687	.093
	Health	.079	.074	.044	1.063	.289
	Business Owner	.220	.302	.028	.727	.468
	Unemployed	.197	.239	.036	.824	.411
	Union state lost job	.678	.447	.087	1.516	.131
	Lost Job	-.239	.330	-.043	-.723	.470
	Union state pay cut	-.385	.431	-.059	-.893	.373
	Pay Cut	.165	.351	.031	.471	.638
	Current Econ Situation	-.122	.144	-.036	-.845	.399
	Future Econ Outlook	-.394	.132	-.122	-2.995	.003
	Private Coverage	-.234	.326	-.035	-.718	.474
	Not covered continuously	-.558	.565	-.037	-.988	.324
	Changed on ACA	.806	.172	.184	4.682	.000
	Ideology	-.721	.066	-.552	-10.872	.000

a. Dependent Variable: ACA Approval

Model III – ACA Approval w/Cultural Worldviews

R2 = 0.772, Adj R2 0.739		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	7.102	1.487		4.778	.000
	Race Dummy	.070	.282	.009	.248	.804
	Age	-.065	.051	-.328	-1.264	.208
	Age Squared	.001	.001	.322	1.243	.215
	Gender	-.038	.221	-.008	-.173	.863
	Women w/Children	-.352	.265	-.055	-1.328	.186
	Unmarried	-.493	.212	-.095	-2.331	.021
	Knowledge Index	-.032	.095	-.014	-.333	.739
	Education	.079	.142	.043	.557	.578
	Class	.028	.031	.151	.892	.374
	Income	-.196	.156	-.179	-1.254	.211
	Party Loyalty	-.140	.204	-.026	-.686	.493
	Party	-.683	.195	-.181	-3.497	.001
	Disabled	.269	.403	.031	.667	.505
	Health	.130	.074	.071	1.771	.078
	Business Owner	-.006	.288	-.001	-.022	.983
	Unemployed	-.089	.233	-.016	-.380	.704
	Union state lost job	1.053	.427	.143	2.465	.015
	Lost Job	-.477	.316	-.090	-1.512	.132
	Union state pay cut	-.799	.415	-.127	-1.924	.056
	Pay Cut	.936	.338	.182	2.771	.006
	Current Econ Situation	-.365	.142	-.112	-2.571	.011
	Future Econ Outlook	-.176	.129	-.056	-1.365	.174
	Private Coverage	.039	.302	.006	.130	.896
	Not covered continuously	-.713	.523	-.050	-1.364	.174
	Changed mind on ACA	.394	.163	.094	2.413	.017
	Individualism	-1.155	.112	-.489	-10.311	.000
	Hierarchism	-.643	.105	-.257	-6.134	.000
	Egalitarianism	.783	.106	.292	7.364	.000
	Fatalism	.454	.097	.187	4.676	.000

a. Dependent Variable: ACA Approval

Model V – ACA Tax Increase w/Ideology

R2 – 0.639, Adj. R2 = 0.599		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	9.556	1.789		5.340	.000
	Age	.010	.061	.048	.164	.870
	Age Squared	.000	.001	-.104	-.357	.721
	Race Dummy	.725	.340	.091	2.135	.034
	Gender	-.073	.260	-.014	-.281	.779
	Women w/Children	.169	.315	.025	.537	.592
	Unmarried	-.592	.253	-.109	-2.345	.020
	Knowledge Index	.030	.116	.012	.257	.797
	Education	-.146	.171	-.079	-.853	.395
	Class	.072	.038	.377	1.923	.056
	Income	-.540	.188	-.469	-2.874	.004
	Party Loyalty	-.040	.243	-.007	-.164	.870
	Party	-.918	.204	-.233	-4.497	.000
	Disabled	.780	.490	.092	1.591	.113
	Health	-.064	.087	-.035	-.740	.460
	Business Owner	-.298	.356	-.037	-.838	.403
	Unemployed	.281	.280	.049	1.005	.316
	Union state lost job	1.197	.515	.148	2.323	.021
	Lost Job	-.785	.378	-.139	-2.077	.039
	Union state pay cut	-.027	.498	-.004	-.055	.957
	Pay Cut	-.043	.399	-.008	-.108	.914
	Current Econ Situation	.270	.167	.079	1.612	.108
	Future Econ Outlook	-.118	.151	-.035	-.778	.437
	Private Coverage	-.016	.355	-.002	-.045	.964
	Not covered continuously	.960	.665	.061	1.443	.150
	Change mind on Tax	-.014	.009	-.066	-1.616	.107
	Ideology	-.780	.072	-.587	-10.885	.000

a. Dependent Variable: ACA Tax Increase

Model VI – ACA Tax Increase w/Cultural Worldviews

R2 = 0.703, Adj R2 0.661		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	6.349	1.744		3.641	.000
	Age	-.030	.060	-.148	-.502	.616
	Age Squared	.000	.001	.124	.422	.673
	Race Dummy	.958	.326	.124	2.942	.004
	Gender	-.270	.263	-.052	-1.025	.307
	Women w/Children	.230	.308	.035	.746	.456
	Unmarried	-.349	.249	-.065	-1.400	.163
	Knowledge Index	.004	.113	.002	.040	.968
	Education	-.122	.167	-.064	-.728	.468
	Class	.059	.037	.309	1.602	.111
	Income	-.475	.185	-.418	-2.563	.011
	Party Loyalty	-.122	.240	-.022	-.506	.613
	Party	-.797	.210	-.208	-3.800	.000
	Disabled	.263	.463	.031	.569	.570
	Health	.000	.087	.000	-.003	.998
	Business Owner	-.791	.341	-.100	-2.322	.021
	Unemployed	-.211	.276	-.037	-.764	.446
	Union state lost job	1.123	.499	.146	2.250	.025
	Lost Job	-.885	.363	-.162	-2.436	.016
	Union state pay cut	-.457	.480	-.069	-.950	.343
	Pay Cut	.800	.390	.150	2.051	.042
	Current Econ Situation	-.107	.166	-.032	-.645	.520
	Future Econ Outlook	.176	.151	.054	1.161	.247
	Private Coverage	-.172	.330	-.027	-.522	.602
	Not covered continuously	.949	.621	.064	1.528	.128
	Change mind on Tax	4.049	.919	.199	4.405	.000
	Individualism	-1.048	.124	-.428	-8.454	.000
	Hierarchism	-.659	.121	-.255	-5.436	.000
	Egalitarianism	.939	.124	.334	7.560	.000
	Fatalism	.293	.116	.115	2.537	.012

a. Dependent Variable: ACA Tax Increase

Model VIII – Approval of Medicaid Expansion w/Ideology

R2 = 0.525, Adj. R2 = 0.472		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	10.423	1.783		5.847	.000
	Age	.054	.061	.299	.889	.375
	Age Squared	-.001	.001	-.351	-1.048	.296
	Race Dummy	.461	.339	.067	1.361	.175
	Gender	-.145	.258	-.032	-.561	.576
	Women w/Children	-.300	.318	-.051	-.945	.346
	Unmarried	-.302	.251	-.064	-1.201	.231
	Knowledge Index	-.198	.115	-.095	-1.715	.088
	Education	-.223	.171	-.137	-1.305	.193
	Class	.070	.038	.418	1.846	.066
	Income	-.301	.188	-.302	-1.600	.111
	Party Loyalty	-.594	.244	-.121	-2.439	.015
	Party	-.426	.207	-.124	-2.056	.041
	Disabled	.183	.504	.025	.364	.716
	Health	-.151	.087	-.094	-1.737	.084
	Business Owner	.135	.355	.019	.380	.705
	Unemployed	.761	.282	.153	2.695	.008
	Union state lost job	-.843	.525	-.118	-1.606	.110
	Los Job	.568	.385	.115	1.477	.141
	Union state pay cut	.199	.499	.034	.400	.690
	Pay Cut	-.429	.404	-.091	-1.061	.290
	Current Econ Situation	.087	.169	.029	.515	.607
	Future Econ Outlook	-.517	.155	-.177	-3.335	.001
	Private Coverage	-.112	.358	-.019	-.312	.755
	Not covered continuously	.025	.631	.002	.039	.969
	Change mind on Medicaid	.005	.007	.033	.670	.504
	Ideology	-.641	.073	-.554	-8.826	.000

a. Dependent Variable: Approval for Medicaid Expansion

Model IX – Approval of Medicaid Expansion w/Cultural Worldviews

R2 = 0.678, Adj R2 0.632		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	10.086	1.594		6.327	.000
	Age	-.085	.055	-.475	-1.553	.122
	Age Squared	.001	.001	.457	1.496	.136
	Race Dummy	.623	.300	.092	2.075	.039
	Gender	-.063	.238	-.014	-.265	.791
	Women w/Children	.011	.288	.002	.040	.968
	Unmarried	-.309	.225	-.066	-1.374	.171
	Knowledge Index	-.028	.103	-.014	-.271	.787
	Education	-.355	.152	-.210	-2.339	.020
	Class	.103	.034	.616	3.013	.003
	Income	-.513	.171	-.516	-2.991	.003
	Party Loyalty	-.627	.221	-.127	-2.833	.005
	Party	-.257	.191	-.076	-1.342	.181
	Disabled	-.228	.438	-.030	-.521	.603
	Health	-.057	.080	-.035	-.716	.475
	Business Owner	-.022	.312	-.003	-.071	.944
	Unemployed	.138	.256	.027	.537	.592
	union state lost job	-.274	.462	-.041	-.595	.553
	Lost Job	.491	.343	.101	1.429	.155
	union state pay cut	-.091	.444	-.016	-.205	.838
	Pay Cut	.362	.364	.077	.995	.321
	Current Econ Situation	-.058	.153	-.020	-.380	.704
	Future Econ Outlook	-.309	.140	-.106	-2.203	.029
	Private Coverage	-.193	.306	-.034	-.631	.529
	Not covered continuously	-.561	.569	-.043	-.986	.325
	Changed mind on Medicaid	-.002	.006	-.013	-.308	.758
	Individualism	-1.097	.114	-.507	-9.580	.000
	Hierarchism	-.196	.112	-.085	-1.747	.082
	Egalitarianism	1.125	.114	.459	9.841	.000
	Fatalism	.316	.106	.141	2.978	.003

a. Dependent Variable: Approval for Medicaid Expansion

Model XI – Approval of Coverage for Immigrants w/Ideology

R2 = 0.392, Adj. R2 = 0.321		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	1.862	1.852		1.005	.316
	Age	.116	.063	.707	1.845	.066
	Age Squared	-.002	.001	-.837	-2.190	.030
	Race Dummy	.168	.361	.026	.465	.642
	Gender	.424	.271	.102	1.564	.119
	Women w/Children	-.196	.331	-.036	-.593	.554
	Unmarried	.190	.266	.044	.716	.475
	Knowledge Index	.174	.120	.093	1.444	.150
	Education	.249	.179	.170	1.393	.165
	Class	-.060	.040	-.387	-1.509	.133
	Income	.324	.197	.351	1.650	.100
	Party Loyalty	-.092	.256	-.020	-.359	.720
	Party	.377	.215	.120	1.752	.081
	Disabled	1.159	.514	.168	2.255	.025
	Health	-.123	.091	-.084	-1.353	.178
	Business Owner	.713	.386	.109	1.846	.066
	Unemployed	-.310	.291	-.068	-1.067	.287
	Union state lost job	-.294	.543	-.046	-.541	.589
	Lost Job	.072	.398	.016	.181	.857
	Union state pay cut	.455	.538	.084	.846	.398
	Pay Cut	-.795	.417	-.183	-1.908	.058
	Current Econ Situation	.381	.178	.138	2.145	.033
	Future Econ Outlook	-.414	.161	-.155	-2.577	.011
	Private Coverage	.049	.370	.009	.132	.895
	Not covered continuously	-.227	.663	-.019	-.342	.732
	Changed mind on immig.	.814	.495	.088	1.642	.102
	Ideology	-.619	.076	-.582	-8.137	.000
	Spanish Language	.351	.332	.062	1.058	.291

a. Dependent Variable: Coverage for Immigrants

Model XII – Approval of Coverage for Immigrants w/Cultural Worldviews

R2 = 0.537, Adj. R2 = 0.469		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	-1.220	1.725		-.707	.480
	Age	.054	.060	.331	.894	.372
	Age Squared	-.001	.001	-.450	-1.217	.225
	Race Dummy	.280	.335	.044	.838	.403
	Gender	.301	.263	.073	1.146	.253
	Women w/Children	.162	.312	.030	.518	.605
	Unmarried	.394	.247	.092	1.591	.113
	Knowledge Index	.190	.112	.103	1.688	.093
	Education	.227	.167	.150	1.357	.176
	Class	-.059	.037	-.385	-1.599	.111
	Income	.268	.184	.293	1.456	.147
	Party Loyalty	-.130	.243	-.029	-.536	.592
	Party	.706	.213	.231	3.319	.001
	Disabled	.835	.470	.120	1.775	.077
	Health	.075	.087	.050	.860	.391
	Business Owner	-.044	.359	-.007	-.121	.904
	Unemployed	-.530	.280	-.115	-1.895	.059
	Union state lost job	-.055	.506	-.009	-.109	.913
	Lost Job	.005	.368	.001	.014	.989
	Union state pay cut	.332	.507	.062	.655	.513
	Pay Cut	-.287	.393	-.067	-.731	.465
	Current Econ Situation	.282	.169	.104	1.663	.098
	Future Econ Outlook	-.179	.154	-.068	-1.163	.246
	Private Coverage	.122	.332	.023	.367	.714
	Not covered continuously	-.398	.626	-.034	-.636	.526
	Changed mind on Immig.	.559	.504	.057	1.109	.269
	Spanish Language	.192	.306	.036	.628	.530
	Individualism	-1.167	.126	-.592	-9.298	.000
	Hierarchism	-.586	.122	-.282	-4.818	.000
	Egalitarianism	.853	.124	.385	6.886	.000
	Fatalism	.259	.116	.128	2.228	.027

a. Dependent Variable: Coverage for Immigrants

Model XIV - Lowering Age for Medicare w/Ideology

R2 = 0.359, Adj. R2 = 0.283		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	3.552	2.184		1.626	.105
	Age	.193	.074	1.053	2.606	.010
	Age Squared	-.002	.001	-1.033	-2.561	.011
	Race Dummy	.843	.425	.118	1.985	.048
	Gender	-.135	.325	-.029	-.415	.679
	Women w/Children	.037	.392	.006	.093	.926
	Unmarried	-.045	.316	-.009	-.142	.887
	Knowledge Index	-.253	.150	-.116	-1.689	.093
	Education	-.472	.207	-.285	-2.279	.024
	Class	.016	.046	.096	.357	.721
	Income	.001	.231	.001	.003	.998
	Party Loyalty	.110	.305	.022	.360	.719
	Party	-.207	.258	-.057	-.801	.424
	Disabled	1.095	.614	.141	1.782	.076
	Health	-.071	.108	-.043	-.654	.514
	Business Owner	-1.152	.462	-.153	-2.494	.013
	Unemployed	.096	.341	.019	.281	.779
	Union state lost job	-1.201	.672	-.166	-1.788	.075
	Lost Job	1.282	.475	.254	2.697	.008
	Union state pay cut	1.159	.662	.183	1.750	.081
	Pay Cut	-1.155	.513	-.232	-2.252	.025
	Current Econ Situation	.015	.215	.005	.069	.945
	Future Econ Outlook	-.723	.192	-.240	-3.766	.000
	Private Coverage	-.184	.442	-.031	-.416	.678
	Not covered continuously	1.369	.771	.106	1.776	.077
	Changed mind Medicare age	.760	.339	.130	2.239	.026
	Ideology	-.290	.089	-.240	-3.249	.001

a. Dependent Variable: Lower Age for Medicare

Model XV - Lowering Age for Medicare w/Cultural Worldviews

R2 = 0.435, Adj. R2 = 0.350		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	4.936	2.179		2.265	.025
	Age	.063	.075	.352	.839	.403
	Age Squared	-.001	.001	-.300	-.715	.476
	Race Dummy	1.200	.423	.174	2.835	.005
	Gender	.027	.330	.006	.082	.935
	Women w/Children	.539	.395	.092	1.365	.174
	Unmarried	-.081	.318	-.017	-.256	.798
	Knowledge Index	-.053	.150	-.025	-.350	.727
	Education	-.603	.207	-.358	-2.913	.004
	Class	.056	.046	.329	1.206	.229
	Income	-.207	.232	-.206	-.891	.374
	Party Loyalty	-.144	.313	-.029	-.460	.646
	Party	-.037	.270	-.011	-.138	.890
	Disabled	.692	.598	.089	1.158	.248
	Health	-.133	.112	-.081	-1.189	.236
	Business Owner	-.996	.457	-.136	-2.178	.031
	Unemployed	-.624	.351	-.123	-1.778	.077
	Union state lost job	-1.441	.670	-.212	-2.151	.033
	Lost Job	1.422	.473	.292	3.006	.003
	Union state pay cut	1.626	.674	.264	2.413	.017
	Pay Cut	-1.028	.524	-.212	-1.963	.051
	Current Econ Situation	.160	.220	.053	.728	.467
	Future Econ Outlook	-.760	.196	-.259	-3.876	.000
	Private Coverage	-.151	.425	-.026	-.355	.723
	Not covered continuously	1.160	.776	.090	1.494	.137
	Changed mind Medicare Age	.277	.367	.046	.755	.451
	Individualism	-.707	.161	-.323	-4.379	.000
	Hierarchism	.049	.155	.021	.314	.754
	Egalitarianism	.533	.158	.212	3.377	.001
	Fatalism	.395	.147	.173	2.680	.008

a. Dependent Variable: Lower Age for Medicare

Grid: Hierarchical-Egalitarian Scale	Mean	Std. Dev.
We should increase taxes so we can increase spending on domestic programs.	2.70	2.002
I think that people with the most experience and expertise should be the decision makers.	4.86	1.966
It is better if the woman cares for the home and family and the man works outside the home.	2.85	2.112
The big problem today is not giving everyone an equal chance.	3.86	2.288
We should be more tolerant of different moral standards.	4.35	2.223
Gays should not be allowed to marry.	3.09	2.501
We have gone too far in pushing equal rights.	3.38	2.406
It seems like people on welfare get a lot of free services that the rest of us have to pay for.	4.68	2.334
Group: Individualism-Communitarian Scale		
What is best for society as a whole, not the individual, should be the government's priority.	4.47	2.137
The government wastes a lot of tax money.	5.97	1.737
I favor a reduction in spending on domestic programs to cut taxes.	4.17	2.215
The federal government should make it more difficult to buy a gun.	3.69	2.533
I favor allowing Social Security funds to be invested in the stock market.	2.73	2.081
It is not that big of a problem if people have an unequal chance.	2.82	2.054
We need a strong national government to solve complex problems.	4.89	2.218
Protecting the environment is important to me.	5.87	1.550

Hierarchical-Egalitarian Scale	*Agreement*
We should increase taxes so we can increase spending on domestic programs.	Low Grid
I think that people with the most experience and expertise should be the decision makers.	High Grid
It is better if the woman cares for the home and family and the man works outside the home.	High Grid
The big problem today is not giving everyone an equal chance.	Low Grid
We should be more tolerant of different moral standards.	Low Grid
Gays should not be allowed to marry.	High Grid
We have gone too far in pushing equal rights.	High Grid
It seems like people on welfare get a lot of free services that the rest of us have to pay for.	High Grid
Individualism-Communitarian Scale	***Agreement***
What is best for society as a whole, not the individual, should be the government's priority.	High Group
The government wastes a lot of tax money.	Low Group
I favor a reduction in spending on domestic programs to cut taxes.	Low Group
The federal government should make it more difficult to buy a gun.	High Group
I favor allowing Social Security funds to be invested in the stock market.	Low Group
It is not that big of a problem if people have an unequal chance.	Low Group
We need a strong national government to solve complex problems.	High Group
Protecting the environment is important to me.	High Group

Independent Samples Test for Hierarchs

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Q12 Veto	Equal variances assumed	82.988	.000	3.328	454	.001	.19444	.05842	.07964	.30925
	Equal variances not assumed			4.086	125.573	.000	.19444	.04759	.10026	.28862
Q13 Chief Justice	Equal variances assumed	38.947	.000	2.614	455	.009	.13654	.05223	.03391	.23918
	Equal variances not assumed			3.309	131.235	.001	.13654	.04126	.05492	.21817
Q14 Cover Immig.	Equal variances assumed	13.241	.000	1.448	455	.148	.09095	.06279	-.03245	.21434
	Equal variances not assumed			1.497	102.427	.138	.09095	.06076	-.02957	.21146
Q15 Budget Deficit	Equal variances assumed	4.264	.039	1.078	455	.282	.04809	.04460	-.03956	.13573
	Equal variances not assumed			.985	92.505	.327	.04809	.04882	-.04886	.14504
Q16 Employ. Mandate	Equal variances assumed	.203	.652	.264	451	.792	.01712	.06489	-.11041	.14465
	Equal variances not assumed			.262	95.471	.794	.01712	.06527	-.11245	.14669

Independent Samples Test for Individualists

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Q12 Veto	Equal variances assumed	.712	.399	-.454	454	.650	-.03382	.07454	-.18031	.11267
	Equal variances not assumed			-.439	49.003	.662	-.03382	.07699	-.18854	.12091
Q13 Chief Justice	Equal variances assumed	.005	.946	-.034	455	.973	-.00224	.06636	-.13264	.12817
	Equal variances not assumed			-.033	49.408	.974	-.00224	.06716	-.13717	.13269
Q14 Cover Immig.	Equal variances assumed	.054	.816	-.121	455	.904	-.00958	.07937	-.16555	.14639
	Equal variances not assumed			-.119	49.405	.906	-.00958	.08033	-.17099	.15182
Q15 Budget Deficit	Equal variances assumed	3.450	.064	-.877	455	.381	-.04934	.05627	-.15992	.06124
	Equal variances not assumed			-1.007	53.377	.318	-.04934	.04899	-.14759	.04891
Q16 Employ. Mandate	Equal variances assumed	.172	.678	.262	451	.793	.02120	.08087	-.13773	.18013
	Equal variances not assumed			.259	49.508	.797	.02120	.08178	-.14310	.18551

Independent Samples Test for Egalitarians

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Q12 Veto	Equal variances assumed	.525	.469	-.364	454	.716	-.01584	.04347	-.10126	.06959
	Equal variances not assumed			-.364	422.686	.716	-.01584	.04355	-.10144	.06977
Q13 Chief Justice	Equal variances assumed	2.566	.110	.795	455	.427	.03068	.03861	-.04520	.10657
	Equal variances not assumed			.800	437.664	.424	.03068	.03836	-.04471	.10607
Q14 Cover Immig.	Equal variances assumed	24.755	.000	-3.267	455	.001	-.14926	.04568	-.23904	-.05948
	Equal variances not assumed			-3.243	414.730	.001	-.14926	.04603	-.23975	-.05878
Q15 Budget Deficit	Equal variances assumed	30.396	.000	2.731	455	.007	.08883	.03253	.02491	.15276
	Equal variances not assumed			2.644	364.077	.009	.08883	.03359	.02277	.15490
Q16 Employ. Mandate	Equal variances assumed	6.641	.010	3.183	451	.002	.14870	.04672	.05689	.24050
	Equal variances not assumed			3.175	422.962	.002	.14870	.04683	.05664	.24075

Independent Samples Test for Fatalists

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Q12 Veto	Equal variances assumed	20.364	.000	-2.805	454	.005	-.13886	.04951	-.23616	-.04156
	Equal variances not assumed			-2.658	175.520	.009	-.13886	.05224	-.24196	-.03576
Q13 Chief Justice	Equal variances assumed	37.528	.000	-3.489	455	.001	-.15302	.04385	-.23919	-.06684
	Equal variances not assumed			-3.133	162.513	.002	-.15302	.04885	-.24947	-.05656
Q14 Cover Immig.	Equal variances assumed	40.126	.000	2.620	455	.009	.13820	.05275	.03453	.24186
	Equal variances not assumed			2.731	205.453	.007	.13820	.05060	.03843	.23796
Q15 Budget Deficit	Equal variances assumed	37.798	.000	-2.774	455	.006	-.10375	.03740	-.17724	-.03026
	Equal variances not assumed			-3.417	295.388	.001	-.10375	.03036	-.16350	-.04400
Q16 Employ. Mandate	Equal variances assumed	74.751	.000	-4.267	451	.000	-.22748	.05331	-.33224	-.12272
	Equal variances not assumed			-4.484	206.674	.000	-.22748	.05073	-.32749	-.12747