The Spillover of Racialization into Health Care: How President Obama Polarized Public Opinion by Racial Attitudes and Race

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This study argues that President Obama's strong association with an issue like health care should polarize public opinion by racial attitudes and race. Consistent with that hypothesis, racial attitudes had a significantly larger impact on health care opinions in fall 2009 than they had in cross-sectional surveys from the past two decades and in panel data collected before Obama became the face of the policy. Moreover, the experiments embedded in one of those reinterview surveys found health care policies were significantly more racialized when attributed to President Obama than they were when these same proposals were framed as President Clinton's 1993 reform efforts. Dozens of media polls from 1993 to 1994 and from 2009 to 2010 are also pooled together to show that with African Americans overwhelmingly supportive of Obama's legislative proposals, the racial divide in health care opinions was 20 percentage points greater in 2009–10 than it was over President Clinton's plan back in 1993–94.

What I'm saying is this debate that's taking place [over health care reform] is not about race, it's about people being worried about how our government should operate. —Barack Obama, *Meet the Press,* September 2009

As the epigraph indicates, the role of racial prejudice in mass opposition to President Obama's health care reform proposals was regularly debated during the summer and fall of 2009. Liberal political commentators often asserted in those months that at least some of the uproar sparked by Obama's policies was a product of race-based opposition to a black president's legislative agenda (e.g., Hannania 2009; Krugman 2009; Robinson 2009). This belief gained some public traction too. A Pew Survey from November 2009 revealed that 54% of adults thought that race was at least a minor reason why "people oppose Barack Obama's policies," with 52% of African Americans saying it was a major factor (Pew Research Center 2010). The president, along with many other political figures, reached a much different conclusion, though. Obama repeatedly rebutted claims that hostility toward his health care plan was rooted in racial animus. He suggested instead that the media was merely pursuing this prejudiced opposition narrative because race continues to evoke such powerful emotions in American society.[1] The racism debate continued up until the Affordable Care Act's passage in March 2010 with neither side providing much evidence in support of their contrasting positions about racial attitudes and mass health care opinions.[2]

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[1] See, for example, Silva (2009).

[2] The debate became especially heated in the immediate aftermath of passage when health care protestors allegedly shouted racist slurs at black congressmen on their way to vote for the bill. For more, see Kane (2010).

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This study helps fill that empirical void by documenting the impact of race and racial attitudes on health care opinions before and after Barack Obama became the face of the policy. The findings presented show that racial attitudes were both an important determinant of white Americans' health care opinions in the fall of 2009 and that their influence increased significantly *after* President Obama became the face of the policy. Moreover, results from a nationally representative survey experiment show that racial attitudes had a significantly greater impact on health care opinions when framed as part of President Obama's plan than they had when the exact same policies were attributed to President Clinton's 1993 health care initiative. Obama also appears to be driving the policy preferences of blacks and whites farther apart. With over 80% of African Americans consistently supporting Obama's health care reform plan, the 2009–10 racial divide in health care opinions was roughly 20 percentage points larger than it was for President Clinton's health care plan back in 1993–94.

All told, then, the evidence suggests that Obama's legislative proposals have the potential to polarize issue opinions by racial attitudes and race. Before presenting these findings, I first turn my attention to some plausible explanations for why the president's strong association with health care would increase the influence of race-based considerations on public opinion.

Theoretical Background and Empirical Expectations

An expansive body of research focuses on how racial attitudes come to influence white opinion about governmental policies. This process of *racialization,* whereby racial attitudes are brought to bear on political preferences, is rather straightforward for race-targeted policies like affirmative action and federal aid to minorities. Those issues are thought to readily evoke racial predispositions because there is a natural associative link between policy substance and feelings toward the groups who benefit from them (Sears 1993). Most public policies lack such clear-cut racial content, though. How, then, have racial attitudes been implicated in a wide variety of nonracial policy preferences—issues as diverse as welfare, Social Security, crime, taxes, and the Iraq War (Gilens 1999; Gilliam and Iyengar 2000; Hurwitz and Peffley 1997, 2005; Sears and Citrin 1985; White 2007; Winter 2008)?

Prior research suggests that this racialization of issues with no manifest racial content results from mass communications that heighten the association—either consciously or unconsciously (Winter 2008, 147–51)—between African Americans and government policies. Overtime observational studies, for example, show that the emergence of media coverage linking welfare benefits with "undeserving blacks" helped white Americans bring their racial antagonisms to bear on opposition to this policy (Gilens 1999; see Winter 2008 for a similar analysis of how Social Security became symbolically associated with race).

Several experiments provide even stronger evidence that political messages can link racial groups with public policies. These studies convincingly demonstrate that race cues as subtle as coded words (i.e., "inner city"), black imagery, and especially some combination of the two often make racial attitudes a more central determinant of political preferences (Hurwitz and Peffley 2005; Mendelberg 2001; Valentino, Hutchings, and White 2002; White 2007; Winter 2008). Or, as Hurwitz and Peffley conclude, "When messages are framed in such a way to reinforce the relationship between a particular policy and a particular group, it becomes far more likely that individuals will evaluate the policy on the basis of their evaluations of the group" (2005, 109). Those subtle race cues are especially effective in activating racial attitudes because they connect African Americans to political evaluations without audience members consciously knowing the message violates strong societal norms of racial equality (Hurwitz and Peffley 2005; Mendelberg 2001; Valentino, Hutchings, and White 2002; though see Huber and Lapinsky 2006).

Along with such established avenues, source cues provided by the background characteristics of elite issue advocates may also foster connections between governmental policies and social groups. In fact, a series of findings indicates that prominent position takers' races, religions, and genders can all activate group-specific attitudes in mass opinion formation. Jacobson (2007, 161), for instance, suggests that George W. Bush's strong identification as a born-again Christian contributed to white evangelicals' unwavering support for both the Iraq War and the premises upon which it was based. Even more relevant for our purposes, experiments show that Americans' willingness to embrace elite views depend in part on whether the positions are attributed to black or white sources (Domke n.d.; Kulkinski and Hurley 1994; Peffley and Hurwitz 2010, 164–65). Winter (2008, 130–31) also concludes that gender attitudes influenced health care opinions during the 1993–94 reform debate in part because of the policy's strong association with a gendered figure in Hillary Clinton. And in an analysis most similar to the one in this study, Knowles, Lowery, and Schaumberg (2010) argue that Obama activated implicit

racial prejudice in opposition to his health care reform plan.[3]

If, as these studies indicate, the salient social characteristics of elite sources have the potential to activate considerations in the realms of race, religion, and gender, then President Obama's legislative initiatives should be especially ripe for racialization. For, as Kinder and Dale-Riddle assert about the 2008 campaign, "Whatever Obama said about society and government and about problems and policies, at the end of the day, every time American voters caught a glimpse of him, he *was* black" (2011, 25). That embodiment of race, combined with the profound racial symbolism surrounding Obama's position as the first black president, is often cited as the reason why racial attitudes had a significantly stronger impact on mass assessments of him in both the 2008 campaign and in the first year of his presidency than they had on evaluations of previous presidents and presidential candidates (Kam and Kinder 2011; Kinder and Dale-Riddle 2011; Piston 2010; Tesler and Sears 2010). Given the importance of elites' background characteristics in the studies referenced above, the salience of Obama's race in public perceptions of him should also spill over into public opinion about his visible policy positions. More specifically, source cues that connect racialized public figures to specific issues are expected to activate racial considerations in mass opinion much the way that code words and other subtle race cues have linked African Americans with public policies in prior research. This hypothesis, which I call the *spillover of racialization*, therefore situates Obama's race—and the public's race-based reactions to him—as the primary reason why public opinion about health care opinions racialized in the fall of 2009.

The president's racial background, however, is certainly not the only explanation for health care racialization. One plausible alternative is that Obama's party affiliation was responsible for polarizing public opinion by racial considerations. After all, partisan politics at both the elite level and in the mass electorate was increasingly divided by racial issues before Obama became president (Carmines and Stimson 1989; Laymen and Carsey 2002; Valentino and Sears 2005). Racial attitudes and race may have been stronger determinants of health care opinions in the fall of 2009, then, because the policy was more closely connected to the racially liberal political party than it was before the visible reform debate. That party-specific hypothesis seems unlikely to fully account for the increased effects of racial attitudes and race in the fall of 2009, however. Winter (2008, 132), for example, found that thermometer ratings of African Americans were not implicated in health care opinions during the Clintons' 1993–94 reform efforts, and prior experiments suggest that African Americans are more supportive of positions attributed to black Republicans than they are of white Democrats (Kuklinski and Hurley 1994).

Nevertheless, the fact that there are readily available alternatives to the spillover of racialization from a black president to his policies underscores the need to unpack the causal effects of Obama's race in polarizing public opinion by racial considerations. The next section, therefore, focuses on how the data and methods utilized in the study help disentangle the influence of Obama's race from other confounding factors like his party identification.

Method

Public opinion about health care offers a critical test of the spillover of racialization hypothesis. After receiving little media attention during the first half of 2009, the debate over health care reform was one of the most reported on news stories in America every single week from early July through the remainder of the calendar year.[4] As a result of that sustained media coverage, up to 49% of Americans reported following the health care reform debate "very closely" in 2009 (Pew Research Center 2009). If, as the spillover of racialization hypothesis contends, Obama's connection to the issue helped racialize white Americans' policy preferences, then the effect of racial attitudes on their issue opinions should have increased from before to after his reform plan was subjected to such intense media scrutiny.

Observational Data

This study utilizes observational data from repeated cross-sectional surveys and panel reinterviews to test that hypothesis. The cross-sectional data come from the American National Election Study (ANES). Starting in 1988, the ANES has regularly measured both respondents' preferences for governmental health insurance and their racial resentment levels in the same surveys. That standard ANES health care question asks respondents to place themselves on a 7-point government-to-private insurance scale (see supporting information for question wording

[3] The study below differs substantially, however, in its use of explicit racial attitudes, more control variables, more detailed health care items, and nationally representative samples.

[4] This is based on the Project for Excellence in Journalism's weekly content analyses in their series of News Coverage Indexes. See http: //www.journalism.org/news_index/99.

and coding of all survey items). The same item also appeared in the September 2009 wave of the 2008–2009 ANES Panel Study.[5] My first test of the spillover hypothesis employs these cross-sectional data to compare the relationship between racial resentment and health care opinions during the fall 2009 debate over Obama's reform proposals to their association in previous ANES surveys. It is important to note, however, that sampling and mode differences between the time series and the 2009 ANES may complicate such comparisons.[6]

Fortunately, we can augment those less precise cross-sectional analyses with two different panel studies that recorded the same respondents' health care opinions before and after the reform debate heated up in the summer of 2009. Panel reinterviews offer a number of advantages over repeated cross-sectional surveys in determining the changing impact of considerations like racial attitudes. For starters, we need not worry about differences in sample compositions between surveys because these changes are taking place within the same individuals. Panels also mitigate concerns about reverse causality by testing the effects of racial attitudes, as measured in one panel wave, on health care opinions at two different points in time. In other words, we can be more confident that the changing effects of racial attitudes over time were not an artifact of corresponding changes in their underlying distributions (e.g., Lenz 2009).

The first panel data are from the 2008–2009–10 ANES. The March 2009 and September 2009 waves of that study each included the above-referenced health care item and an additional 7-point scale, which asked how much more or less the federal government should spend on health insurance for adults. The two items form a reliable 14-category government insurance scale (Cronbach's $\alpha \approx .65$ in both waves). The January 2008 and July 2010 ANES panel waves also contain questions about governmental health care. However, those corroborating results are relegated to the supplemental appendix (see Table A1) because the questions were not identically worded in both waves.[7]

Aside from the ANES panel data, I also commissioned a nationally representative panel study in November 2009 to test whether Obama's health care reform proposals racialized Americans' issue opinions (see Tesler and Sears 2009; funding provided by the NSF [SES-0968830]). That original survey reinterviewed 3,147 participants from the Cooperative Campaign Analysis Project's (CCAP) six-wave panel study of registered voters (Jackman and Vavreck 2009). Like other surveys conducted by YouGov-Polimetrix, the CCAP utilized a matching algorithm to produce an Internet sample that closely approximates the demographic makeup of the high-quality random sample carried out by the U.S. Census Bureau in the American Community Study (Rivers 2006; Vavreck and Rivers 2008). Previous Polimetrix surveys perform well in predicting public opinion and vote choice (Vavreck and Rivers 2008), and all of the analyses are weighted to the general population to foster comparability between different sampling designs.

Experimental Data

The observational data, however, cannot tell us whether the racialization of health care opinions was *caused* by Obama's association with the policy or by another factor like his partisanship. So with that in mind, we randomly assigned our November 2009 CCAP respondents to receive three different cues about who proposed specific health care reform policies.[8] The three survey groups are described as (1) the neutral condition, (2) the Clinton-framed condition, and (3) the Obama-framed condition. Respondents in all three conditions were asked whether they favored or opposed the federal government guaranteeing health care for all Americans (i.e., universal coverage) and if they supported or opposed a government-administered health insurance plan to compete with private insurance companies (aka "the public option"). Individuals in the neutral condition, however, were only told that "some people" had proposed these policies. The Clinton-framed condition, on the other hand, explained that these policies were a part of President Clinton's 1993 reform efforts; and the Obama-framed condition described the initiatives as President Obama's current health care proposals (see the supplemental appendix for exact wording of all three versions). We then asked each group four follow-up questions about the consequences of passing these two policies, which the questions explained were proposed by either "some people," President Clinton, or

[5] The 2008–2009 ANES Panel Study is merged with an Off-Panel file, whose content was not controlled by the ANES. The dependent variable of interest was asked in the March and September 2009 off-panel waves fortuitously fielded by Mark Schlesinger of Yale University.

[6] The ANES is typically constructed by area probability sampling with face-to-face interviews. The 2008–2009 ANES used random dialing sampling and was conducted over the Internet.

[7] Those panel results presented in Table A1, in fact, suggest a much bigger racializing effect of the 2009–10 debate over Obama's health care reform plan than any other results in the study.

[8] The survey contained four forms, three of which were used for this experimental test.

President Obama. A final question asked the subjects if passing these proposals would make them feel happy, hopeful, angry, and/or afraid. Taken together, the seven health care questions form a highly reliable (Cronbach's $\alpha = .90$) 26-category support scale.

This approach of randomly assigning different contextual information about policy endorsements has been effectively utilized in previous studies to establish the causal influence of elite cues on public opinion (Kuklinski and Hurley 1994; Levendusky 2009; Lupia and McCubbins 1998; Peffley and Hurwitz 2010; Tomz and Sniderman 2005). Similarly, telling one group of respondents that Bill Clinton proposed universal coverage and the public option in 1993 and another one that the exact same initiatives were Barack Obama's proposals is especially important for our purposes because it varies the race of these policies' presidential sponsor. The partisan cues provided in both conditions, however, are held constant because Clinton and Obama are easily identifiable Democrats. Any difference in the effects of racial attitudes between the Obama and Clinton conditions, then, cannot simply be attributed to health care's increased association with the more racially liberal political party.

Racial Attitudes

The measurement of white Americans' racial attitudes is one of the most contentious issues in public opinion research (see Sears, Sidanius, and Bobo 2000 for review). Multiple measures of racial attitudes are therefore utilized in this study. My focal explanatory variable is Kinder and Sanders's (1996) racial resentment scale. Much like its closely related predecessor, symbolic racism, racial resentment presumably taps into subtle hostility toward African Americans with four questions about black work ethic, the impact of discrimination on African American advancement, and notions of black people getting more than they deserve—themes thought to undergird the symbolic racism belief system (Sears and Henry 2005; see the supplemental appendix for information on scale construction). Symbolic racism and racial resentment have become the focal constructs for explaining the role of racial attitudes in contemporary American politics (see Hutchings and Valentino 2004 for a review), and their effects on mass assessments of Barack Obama were significantly larger in 2008 and 2009 than they have been for previous presidents and presidential candidates (Kinder and Dale-Riddle 2011; Tesler and Sears 2010).

Some political scientists, however, have argued that symbolic racism confounds racial animus with ordinary political conservatism, so that its strong political effects may only reflect relatively unprejudiced aversion to liberal big government (Hurwitz and Peffley 1998; Sniderman, Crosby, and Howell 2000; Sniderman and Tetlock 1986). As a result of that critique, our CCAP reinterview survey also asked respondents to rate how hardworking and intelligent racial and ethnic groups are on 7-point stereotype scales. Unlike racial resentment, these stereotype ratings provide a direct measure of attitudes about African Americans—one that is less confounded with political ideology. The more blatant nature of stereotype assessments, however, is also a weakness. Stereotypes are especially susceptible to misreporting due to social desirability pressures to rate all racial groups equally (Huddy and Feldman 2009).

Like these past disputes, the inferences one makes about how strongly racial attitudes influenced health care opinions in 2009 depends fundamentally on how these attitudes toward African Americans are operationalized. More importantly, though, both measures indicate that President Obama's association with health care polarized public opinion by racial attitudes.

Control Variables

Previous studies of elite cues and mass cue taking show that the signals provided to ordinary Americans by a president's issue positions often activate partisan attitudes in public opinion (e.g., Berinsky 2009; Levendusky 2009; Zaller 1992). It is imperative, then, to distinguish how Obama's health care proposals increased the impact of racial attitudes on policy preferences from the more familiar mechanism of partisan/ideological activation. As such, all regression models include a standard seven-category measure of party identification, ranging from strong Democrat to strong Republican, and a five-category measure of ideology in which respondents rated their positions from most liberal to most conservative. In addition to this base model, I control for other relevant factors whenever possible. These controls include attitudes about the size of government and self-interested concerns about out-of-pocket medical expenses.

Observational Evidence of the Spillover of Racial Attitudes

The highly visible debate over the government's role in providing health care touched off by the White House's proposal of policies like universal coverage and the public option in the summer of 2009 should have provided the American public with important information about

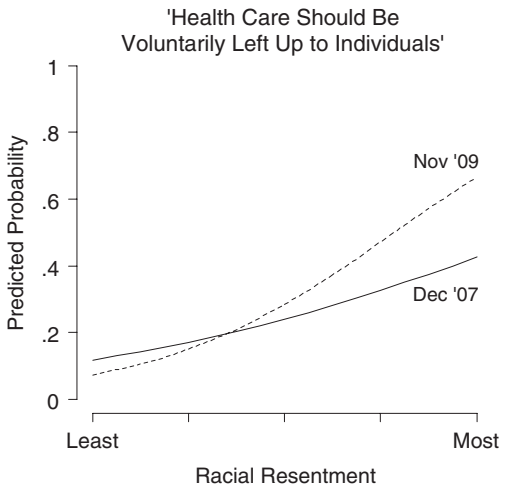
Obama's issue position. The spillover of racialization hypothesis, therefore, posits that the impact of racial attitudes on white Americans' health care opinions increased from before to after Barack Obama became the leading spokesperson for the policy.

Our first test of that hypothesis compares the relationship between racial resentment and health care opinions in the September 2009 wave of the ANES Panel Study to their association in prior ANES surveys. The baseline coefficients presented in Table 1 show that racial resentment had a substantively small and nonsignificant independent influence on white respondents' 7-point health care placements (recoded from 0 to 1) in every previous ANES survey except 1994. The interaction term Resentment*September 2009, however, indicates that racial attitudes were strongly linked to health care opinions in that post-Obama survey. With ideological self-placement and party identification held constant, changing from least to most racially resentful decreased white support for governmental insurance by 20% of the scale's range in September 2009. As can be seen by comparing the baseline resentment coefficients to their September 2009 interactions, that effect was roughly three times larger than the relationship produced in every year other than 1994 and almost twice the size of its influence in the 1994 survey conducted shortly after the Clintons' proposed health care reform legislation.

The overtime coefficient comparisons in Table 1 would therefore suggest that racial attitudes were more closely aligned with health care opinions in 2009 than they were in earlier surveys. Yet, while the negative resentment coefficient in September 2009 is significantly larger than it was in nearly every earlier survey, it is important to note that racial attitudes were not a statistically stronger predictor of health care opinions in that survey than they were in 1994 ($p = .14$). Moreover, the aforementioned sampling and mode differences between the September 2009 wave and earlier ANES surveys might bias the overtime comparisons. All told, then, Table 1 offers a potentially informative snapshot of the differing racial dynamics in 2009; but more work is needed to confidently determine whether racial attitudes were a significantly stronger predictor of health care opinions after Obama's issue position was highlighted and if that racialization was caused by the president's race or another factor.

The 2008–2009–10 ANES panel study is particularly well suited to address the former of those two concerns. Not only does that study gauge the exact same panelists' preferences for governmental health insurance before and after the debate over Obama's proposals heated up in the summer of 2009, but it also contains excellent measures

FIGURE 1 White Americans' Health Care Opinions as a Function of Racial Attitudes



Note: Predicted probabilities are based on logistic regression coefficients in Table A2 of the supplemental appendix. Probabilities were calculated by setting ideology, partisanship, and tax-policy preferences to their sample means. All explanatory variables were measured in March 2008.
Source: CCAP panelists interviewed in both December 2007 and November 2009.

of limited government and self-interested anxiety about out-of-pocket medical costs—control variables not available in the Table 1 comparisons. The results from these March 2009 and September 2009 ANES panel waves are presented in Table 2. The first column of that table shows that with partisanship, ideology, limited government, and medical cost anxiety held constant, moving from least to most racially resentful decreased white support for governmental insurance by about 10% of the scale's range in March 2009 and 18% in September 2009—a statistically significant difference ($p = .02$). The third column further shows that antiblack stereotypes, which had no independent influence whatsoever on March health care support, were also a significantly stronger predictor of governmental insurance preferences in September 2009 ($p = .04$).

The significant overtime racialization results in the ANES panel study were replicated in the November 2009 CCAP reinterviews. These panelists were originally asked back in the December 2007 CCAP whether health care should be provided by the federal government, government subsidized, or voluntarily left up to individuals. Figure 1 examines whether the impact of racial resentment on this pre-Obama baseline assessment of health

TABLE 1 (OLS) Predictors of White Americans' Health Care Opinions, 1988–2009

	1988 Baseline	1992 Baseline	1994 Baseline	2000 Baseline	2004 Baseline	2008 Baseline
Racial Resentment	−.013	−.061	−.110	−.067	−.041	−.066
	(.043)	(.034)	(.048)	(.090)	(.055)	(.069)
Racial Resentment*	−.186	−.139	−.090	−.133	−.159	−.134
Sept 2009	(.059)	(.052)	(.062)	(.098)	(.068)	(.080)
Partisanship	−.229	−.252	−.280	−.187	−.154	−.199
	(.031)	(.026)	(.031)	(.064)	(.047)	(.056)
Partisanship*Sept 2009	−.060	−.030	−.003	−.095	−.129	−.083
	(.046)	(.042)	(.046)	(.072)	(.058)	(.066)
Ideology	−.116	−.190	−.265	−.226	−.437	−.444
	(.057)	(.043)	(.055)	(.097)	(.077)	(.078)
Ideology*Sept 2009	−.145	−.071	.004	−.035	.176	.184
	(.070)	(.059)	(.069)	(.105)	(.087)	(.089)
September 2009	.197	.051	.043	.123	−.010	−.028
	(.041)	(.031)	(.039)	(.073)	(.043)	(.049)
Pooled Observations	2896	3240	3030	2042	2453	2246

Note: Dependent variable is a 7-point private insurance to government insurance scale recoded from 0 (private insurance) to 1 (government insurance). All variables are coded 0–1, with 1 representing the most conservative position. The interaction terms denote the difference in effects between September 2009 and the baseline effect in each prior ANES survey. Regression analyses utilize sampling weights with robust standard errors that account for design characteristics.
Source: ANES Cumulative File; 2008–2009 ANES.

care opinions increased in November 2009. The display plots the probability of saying health care should be voluntarily left up to individuals as a function of racial resentment at these two points in time.[9] Consistent with the results in Tables 1 and 2, health care opinions were more racialized after Obama became the most visible spokesperson for reform. With partisanship, ideology, and tax policy preferences (used here as a proxy for limited government) held constant, moving from least to most racially resentful increased the predicted proportion of white respondents saying that health care should be left up to individuals by just over 30 percentage points in December 2007. The same change in these panelists' resentment levels, however, increased their support for private insurance by nearly 60 percentage points in November 2009—a statistically significant difference in overtime effects ($p = .01$: see Table A2 of the supplemental appendix).

Interestingly enough, though, the effects of partisanship and ideology did not grow significantly over that same time period. In fact, their impacts were nearly identical in both the 2007 and 2009 CCAP surveys (see Table A2 of the supplemental appendix). Despite the wide schism between Democratic and Republican elites in support of health care during the latter half of 2009, Table 1 also shows that the effects of party and ideology on ANES panelists' health care opinions were similar in March and September of that year. Those results stand in stark contrast to the aforementioned research on how past presidents' most visible policy positions tended to polarize public opinion by partisanship and ideology.

In sum, whether using ANES panel data from March and September 2009 or CCAP reinterviews from December 2007 and November 2009, the debate over President Obama's health care proposals appears to have altered the ingredients of mass opinion about this issue: racial attitudes became more important in white Americans' beliefs about health care relative to nonracial considerations like partisanship and ideology.

Experimental Evidence of the Spillover of Racial Attitudes

Concluding from those results that Obama's race was responsible for the increased effects of racial attitudes on white Americans' health care opinions in 2009 is problematic, however. There is simply no way of knowing whether the growing polarization of public opinion by racial attitudes shown in Table 2 and Figure 1 was *caused* by the president's race or another factor like his party affiliation. The Clinton and Obama experimental conditions help disentangle those two potential influences, though,

[9] This three-category variable is dichotomized into voluntary health care or not because respondents were unclear whether Obama favored a single-payer or a subsidized system.

Table 2 (OLS) Predictors of White Support for Government Health Insurance in March and September 2009

	Weighted	Unweighted	Weighted	Unweighted
Racial Resentment	−.096	−.088		
	(.027)	(.024)		
Racial Resentment*	−.078	−.080		
Sept 2009	(.039)	(.034)		
Partisanship	−.174	−.174	−.188	−.184
	(.023)	(.020)	(.023)	(.023)
Partisanship*Sept 2009	.012	.008	.011	.007
	(.033)	(.028)	(.033)	(.028)
Ideology	−.102	−.102	−.118	−.120
	(.028)	(.025)	(.028)	(.025)
Ideology*Sept 2009	−.044	−.031	−.058	−.047
	(.040)	(.036)	(.040)	(.035)
Limited Government Scale	−.381	−.386	−.394	−.401
	(.030)	(.025)	(.030)	(.025)
Limited Government Scale*	−.025	−.035	−.015	−.024
Sept 2009	(.041)	(.035)	(.041)	(.035)
Medical Costs Anxiety	.196	.194	.188	.188
	(.025)	(.022)	(.025)	(.023)
Medical Costs Anxiety*	−.013	−.004	−.016	−.009
Sept 2009	(.036)	(.032)	(.036)	(.032)
September 2009	.040	.038	.042	.034
	(.038)	(.034)	(.046)	(.041)
Antiblack Stereotypes			.003	.002
			(.044)	(.036)
Antiblack Stereotypes*			−.127	−.117
Sept 2009			(.061)	(.051)
Antiwhite Stereotypes			.054	.025
			(.057)	(.048)
Antiwhite Stereotypes*			.029	.031
Sept 2009			(.081)	(.068)
Pooled Observations	3233	3233	3213	3213

Note: Dependent variable is a two-item, 14-category government insurance scale (0 = least support; 1 = most support). All variables are coded 0–1. Racial resentment and antiblack stereotypes were measured in August 2009; party and ideology were measured in October 2008; limited government was measured in November 2008; and medical cost anxiety was measured in March 2009. Weighted regression analyses utilize robust standard errors that account for design characteristics.
Source: 2008–2009 ANES panelists interviewed in both March and September 2009.

as discussed earlier. The spillover of racialization's second major hypothesis, then, is that racial attitudes should be brought more heavily to bear on health care opinions among respondents who were told that policies like universal coverage and the public option were a part of President Obama's reform efforts. In other words, much the way that subtle race cues activated racial predispositions in prior experiments, the strong link between Obama and these two policy proposals experimentally established in that condition should *cause* racial attitudes to spill over into health care opinions.

This hypothesis test, however, is complicated by the fact that many respondents probably did not need the Obama cue to connect the president—and their racial attitudes as a consequence—to health care reform. We saw above that with Obama's health care plan dominating the headlines at the time of our November 2009 survey, the CCAP panelists' opinions about the governmental health insurance were already strongly influenced by racial resentment even without additional information about Obama's position. "This baseline racialization," as Winter discusses with an analogous case, "creates a

ceiling effect that limits the additional framing that might be possible in the race condition" (2008, 66). Ceiling effects might have thus inhibited the experimental cues provided in the Obama condition from further enhancing the impact of racial attitudes on health care opinions. As a result, any differences produced between conditions are likely conservative estimates of Obama's causal potential in racializing public opinion.

That being said, the experiments embedded in our November 2009 CCAP reinterviews still yielded significantly stronger racial attitude effects on health care opinions in the Obama condition. Those results are graphically displayed in Figure 2. The points on the display denote the impact of racial resentment and antiblack stereotypes on the aforementioned 7-item, 26-category health care support scale (recoded from 0 to 1) in all three experimental conditions. That is, each dot represents the change in health care support scores associated with moving from most racially liberal to most racially conservative with partisanship, ideology, and tax policy preferences held constant. The coefficients presented on the left-hand side, therefore, show that moving from least to most racially resentful decreased support for health care by 23% of the scale's range in the Clinton condition and 40% in the Obama condition—a statistically significant difference in effects ($p = .01$: see Table A3 of the supplemental appendix). The negative relationship between antiblack stereotypes and health care support was also significantly larger in the Obama group than it was in the Clinton condition ($p < .01$), as shown on the right side of the display.

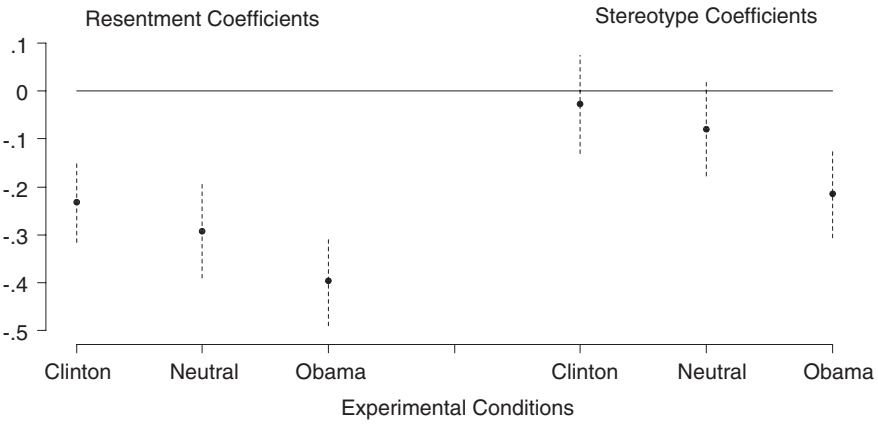
Figure 2 further indicates that differences in racial attitude effects were not as pronounced between the Obama and neutral conditions as they were between the Obama and Clinton conditions. Racial resentment's impact on health care opinions among Obama-group respondents was not quite statistically different from its neutral-condition impact ($p = .14$: see Table A3), although antiblack stereotypes had a significantly larger negative relationship with health care support in the Obama condition than they had for neutral-group respondents ($p = .05$). The most plausible reason why both measures of racial attitudes had larger effects on health care opinions in the neutral condition than they had in the Clinton condition is that neutral-group respondents connected Obama to their health care opinions even when no cue was provided. Indeed, recall that racial attitudes were already a powerful determinant of ANES and CCAP panelists' preferences for private health insurance *after* the 2009 summer months in which Obama's reform efforts dominated the news. The Clinton frame, however, should have caused some respondents to shift their point of reference on health care reform from Obama to the less racialized Clinton, thereby *deactivating* the impact of racial attitudes on their opinions.

An additional three-condition experiment from our November 2009 CCAP reinterviews—one of whose groups framed the $787 billion stimulus package as legislation passed in 2009 by congressional Democrats—produced an even more dramatic pattern of deracialization. With President Obama's stimulus package receiving heavy media coverage during the first half of that year (Project for Excellence in Journalism 2009), the left panel of Figure 3 predictably shows that racial resentment was a powerful independent determinant of support for the policy among respondents who received the Obama-framed and neutral versions of this stimulus question. Those substantial resentment effects, however, almost completely vanished in the second panel of the display for the subset of respondents who were asked if they thought the economic stimulus package *approved by congressional Democrats* was a good or bad idea. In fact, racial resentment had a significantly larger negative impact on stimulus support in *both* the Obama and neutral conditions than it had among the Cong-Dem-group respondents (see Table A4). Shifting the responsibility for the stimulus away from President Obama toward these less racialized Democrats (Tesler and Sears 2010, Figure 8.2), therefore, appears to decrease the influence of racial attitudes on public support for this policy.

That deactivation in Figure 3 is reminiscent of how counterstereotypical cues in previous racialization experiments (i.e., white criminals or welfare recipients) neutralized the impact of racial predispositions on political evaluations (Gilliam and Iyengar 2000; Mendelberg 2001; Valentino, Hutchings, and White 2002). Combining those prior results with the deracializing impact that the Clinton, and especially the congressional Democrats, cues had on support for two of Obama's most visible policy proposals—health care reform and the stimulus package—seems to offer an important corollary to the spillover of racialization hypothesis: much the way that Obama's association with legislative proposals primes race, shifting responsibility for those policies away from Obama to less racialized political actors like Bill Clinton and congressional Democrats can potentially dampen the effects of racial predispositions.

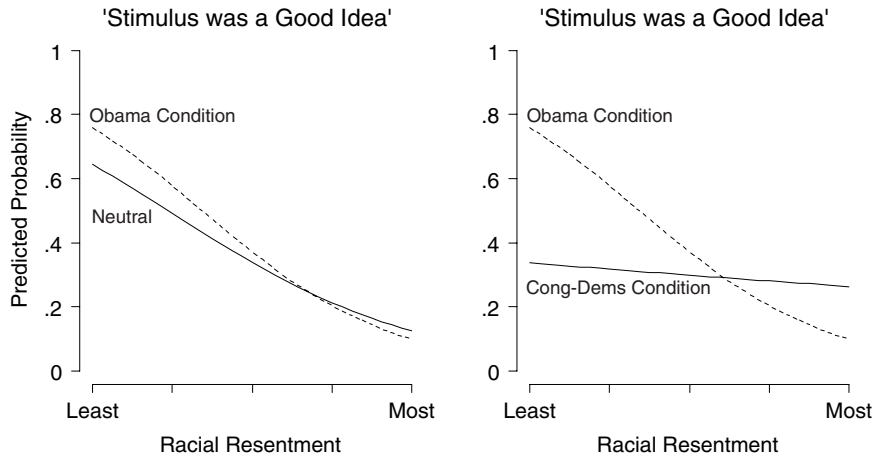
Dampening the effects of racial predispositions, however, does not necessarily mean greater public policy support. Recent research, for example, suggests that racialization can be brought about not only by racially conservative opposition to policies and candidates, but by racially liberal support as well (Hurwitz and Peffley 2005; Tesler and Sears 2010; Winter 2008). These *two*

FIGURE 2 Impact of Racial Attitudes on White Health Care Support Scores by Experimental Condition



Note: The points on the display are based on OLS regression coefficients reported in Table A3 of the supplemental appendix with partisanship, ideology, and tax-policy preferences included in the model. Each point represents the change in health care support scores (coded 0–1) associated with moving from least to most racially conservative, and the dashed lines denote the 95% confidence interval around the point estimates. Racial resentment, partisanship, and ideology were measured in both March 2008 and November 2009 and averaged across waves. Tax preferences were only measured in March 2008 and stereotypes were only measured in November 2009. *Source*: CCAP Reinterviews, November 2009.

FIGURE 3 White Americans' Opinions about the Stimulus as a Function of Racial Resentment and Question Frame



Note: Predicted probabilities are based on logistic regression coefficients in Table A4 of the supplemental appendix. Probabilities were calculated by setting ideology, partisanship, and tax-policy preferences to their sample means. Racial resentment, partisanship, and ideology were measured in both March 2008 and November 2009 and averaged across waves. Tax-policy preferences were only measured in March 2008. *Source*: CCAP Reinterviews, November 2009.

sides of racialization are particularly noticeable in Figure 3, where we see predicted support for the stimulus was greater among racial liberals in the Obama condition than it was for the Cong-Dems group but weaker among the most racially resentful. Obama's activation of racial liberals also helps explain why health care support was not statistically higher in the Clinton condition than it was in the Obama condition despite the fact that health care opinions were significantly more polarized by racial attitudes when these policies were attributed to President Obama.

Finally, and consistent with the results from the observational data, the effects of such nonracial factors as partisanship and ideology were not larger in the Obama condition than they were in the other two experimental groups. Respondents, therefore, used different considerations in expressing their health care opinions depending on whether specific policy proposals were attributed to President Clinton, President Obama, or no one in particular: the Obama frame caused racial attitudes to be a more important determinant of health care opinions relative to nonracial considerations.

Black Support and the Racial Divide in Health Care Opinions

Aside from polarizing the electorate by racial attitudes, our first African American president may also drive the political opinions of blacks and whites farther apart. As Kinder and Winter put it, "Issues can be formulated and framed in such a way as to light up or downplay racial identity, and therefore, in such a way as to expand or contract the racial divide in opinion" (2001, 452). Attributing policies to black sources seems likely to "light up" racial identity and therefore expand the racial divide in public opinion. Prior experimental research, in fact, shows that ascribing positions to such black elites as Jesse Jackson and Colin Powell expanded the black-white racial divide in public opinion, with African Americans increasingly likely to adopt those viewpoints (Kulkinski and Hurley 1994; Peffley and Hurwitz 2010). We should expect a similar result for Obama's positions, especially given his unprecedented popularity among African Americans during his first two years in office.[10] My final hypothesis, then, is that health care opinions should be more divided by race in 2009 than they were before Obama became the Democratic nominee for president, with African Americans particularly supportive of the president's health care proposals.

Just like the enhanced polarization of white Americans' health care opinions by racial attitudes from 2007 to 2009, however, Obama's party affiliation rather than his race could easily be responsible for that suspected rise in black support for health care reform. Indeed, with African Americans being the party's most consistently loyal constituency, any Democratic president's reform efforts might be expected to galvanize black support. Fortunately, this alternative explanation is testable because several polling firms repeatedly asked about President Clinton's health care plan in 1993–94 and used similarly worded questions to gauge support for President Obama's proposals in 2009–10.[11] If the racial divide in 2009–10 is simply a party-specific phenomenon, then we should see a similar gap between blacks and whites in their approval of both Democratic presidents' health care plans.

The evidence presented in Figure 4, however, suggests that President Obama possesses a unique potential to polarize public opinion by race. Four survey firms continuously monitored public support for President Clinton's health care reform plan in 1993 and 1994.[12] Because of the small number of African Americans in the typical media poll, the surveys are aggregated to create a pooled sample for each of the four firms. From these four pooled samples, the results in Figure 4 show that the differences between black and white Americans in support for President Clinton's health care plan ranged from a low of 20 percentage points in the *LA Times* sample to a high of 30 percentage points in the *Gallup* surveys.

These large differences in the health care opinions of black and white Americans in 1993 and 1994, however, grew noticeably larger in 2009 and 2010.[13] As the 2009–10 results in Figure 4 show, the black-white racial divide in

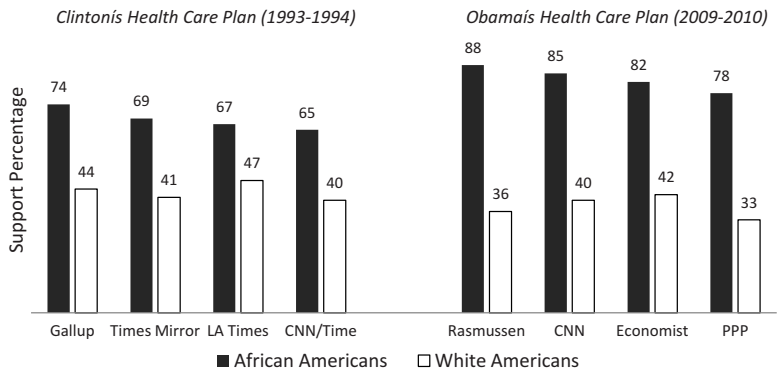
[10] President Obama's black approval rating held consistently at 90% throughout his first two years in office (see http: //www.gallup.com/poll/121199/Obama-Weekly-Job-Approval-Demographic-Groups.aspx). President Clinton, on the other hand, had only a 74% approval rating in the 1993–94 National Black Politics Study and a 70% approval rating in a February 1994 survey of African Americans by Time/CNN.

[11] The small number of African American respondents in each experimental condition did not produce significant differences in black support between groups in the CCAP reinterviews.

[12] These surveys were found by searching the ipoll databank under the topic of health for "Clinton" and "support" of "favor." All datasets were then accessed from Roper's data archive.

[13] The CNN results are based on analyses of datasets accessed from Roper's data archive. *The Economist* and PPP publish all of their results by race, and Rasmussen does so for their premium members. These results were accessed from Pollster.com's link to every survey on health care reform since 2009 (http: //www.pollster.com/polls/us/healthplan.php).

FIGURE 4 Support for Health Care Proposals by Presidential Sponsor and Respondents' Race



Survey Information:

- Gallup: 14 surveys from September 1993 to July 1994, pooled black sample = 1019
- Times Mirror: 4 surveys from September 1993 to June 1994, pooled black sample = 420
- LA Times: 4 surveys from September 1993 to April 1994, pooled black sample = 492
- CNN/Time: 13 surveys from September 1993 to August 1994, pooled black sample = 1,337
- Rasmussen: 27 surveys from June 2009 to March 2010, pooled black sample ≈ 2,700
- CNN: 6 surveys from June to November 2009, pooled black sample = 516
- Economist: 24 surveys from August 2009 to March 2010, pooled black sample = 2,803
- PPP: 9 surveys from August 2009 to March 2010, pooled black sample ≈ 850

Note: All survey questions are similarly worded, asking respondents whether they favored or opposed Bill Clinton's health care reform plan and whether they favored or opposed Barack Obama's health care reform plan.

support for President Obama's proposals ranged from a low of 40 percentage points in the pooled *Economist* sample to a high of 52 percentage points in the *Rasmussen* surveys. Averaging across the four pooled 1993–94 and 2009–10 samples in the display, 69% of African Americans favored Bill Clinton's health care plan compared to 43% of whites. That 26-point racial division in 1993–94 expanded into a 45-point gulf in 2009–10, with 83% of blacks supporting President Obama's health care proposals and only 38% of whites doing the same.

The deep divide in black and white Americans' support for a number of policies ranging from affirmative action to governmental health care was well established long before Obama's presidency (Bobo and Kluegel 1993; Kinder and Sanders 1996; Kinder and Winter 2001; Schuman et al. 1997; Tate 1994). With African Americans so supportive of Obama and his policies, however, that profound divide is likely to grow even wider during his presidency.

Conclusion

The spillover of racialization into health care could have significant implications for American politics in the Obama era. Since the president's association with health care racialized Americans' issue positions, one might even assume that mass political decision making in general would become increasingly polarized by racial attitudes and race during his presidency. There are a number of points to take into consideration before leaping to that conclusion, though.

Several factors thought to facilitate the spillover of racialization into health care are unlikely to be as prevalent in other instances. First and foremost, it is hard to imagine that there will be another issue during Obama's tenure in office that he is as closely associated with as health care. That policy, after all, will surely be described as *Obamacare* for the foreseeable future. Issues that are not as easily connectable to the president should

necessarily be less susceptible to his racializing influence. Second, Americans did not have particularly stable health care opinions prior to the 2009 debate.[14] More crystallized political attitudes—even ones that are strongly associated with Barack Obama like identification with the Democratic Party—might show more resistance to the spillover of racialization. Third, racial attitudes were not significantly implicated in health care opinions prior to 2009, at least not in the ANES data. The spillover of racialization into Obama administration policies that already evoke strong racial predisposition (e.g., immigration: Kinder and Sanders 1996, 122–23) may therefore be limited by ceiling effects. Finally, and as alluded to earlier, the spillover of racialization works because the public viewed Obama through a racial prism. If Obama becomes a less racialized figure during his time in office, which research on black mayors suggests he might (Hajnal 2007), then the spillover of racialization from the president to his policies should dissipate in kind.

Despite those qualifications, the spillover of racialization from Obama into his health care proposals should still have some important implications. Perhaps most importantly, the evidence indicates that source cues provided by the background characteristics of elite issue advocates offer another avenue to activating race-based considerations in political evaluations. In fact, that newly established path to racialization might be even more effective in polarizing public opinion by racial predispositions than the well-documented effects of subtle race-coded communications in previous racial priming research. Implicit racial appeals have to walk a very fine line to avoid violating strong societal norms of racial equality, and even then they can lose their effectiveness if criticized for playing the race card (Mendelberg 2001, 2008). Moreover, the priming effects from such subtle race appeals are thought to be short lived, losing much of their impact when communications make new considerations salient (Kinder and Sanders 1996). In contrast, there is nothing necessarily untoward about communications that point out a racialized public figure's policy positions. Source cue racialization should also be longer lasting than campaign appeals that prime race if the media persistently highlight the racialized source's position (i.e., Obamacare).

To be sure, more work is required to determine how portable the spillover of racialization is to both other issues and to other public figures. The above-referenced studies showing that the races, religions, and genders of prominent elite sources can all activate group-based considerations in mass opinion formation, however, suggest that spillover effects are not simply unique to our first African American president—a conclusion that could be increasingly important as the demographic composition of elected officials changes in the decades ahead. In fact, in what might be called the original spillover of racialization finding, Sears, Citrin, and Kosterman (1987) showed that the increased association between the Democratic Party and African Americans, which presumably resulted from Jesse Jackson's 1984 presidential campaign, immediately accelerated the polarization of Southern partisanship by both racial attitudes and race.

Obama's presidency surely situates black leadership at the forefront of American politics more powerfully than Jackson's failed nomination bid. The focal position that President Obama now occupies in the political system naturally links him to such important political evaluations as partisanship, congressional voting, and other policies beyond health care. For reasons just mentioned, we should not expect racial spillover effects to be as pronounced in these domains as they were for health care opinions. Yet, the potential for race-based evaluations of Obama to spill over into his visible positions, as documented by the health care example in this study, suggests his presidency could usher in a new contemporary high point for the influence of racial considerations in American politics.

[14] The test-retest correlation between support for governmental health care in the 2006–2008 General Social Survey Panel study was only .35.

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Supporting Information

Additional Supporting Information may be found in the online version of this article:

Table A1: (OLS): Predictors of Whites' Health Care Opinions in January 2008 and July 2010

Table A2: (Logistic Regression): Predictors of Whites' Saying Health Insurance Should Be Voluntarily Left Up to Individuals in December 2007 and November 2009

Table A3: (OLS) Predictors of Health Care Support Scores

Table A4: (Logistic Regression): Predictors of Saying the Stimulus Was a Good Idea

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