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DETERMINANTS OF ATTITUDES TOWARD THE AFFORDABLE CARE ACT IN KENTUCKY, OHIO,
AND TENNESSEE

by

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A thesis submitted in partial fulfillment of the requirements
for graduation with Honors in the Ethics and Public Policy

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All requirements for graduation with Honors in the
Ethics and Public Policy have been completed.

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**Determinants of Attitudes toward the Affordable Care Act in Kentucky, Ohio,
and Tennessee**

An Honor's Thesis by Nathan Kilian Micatka

The University of Iowa

May 1st, 2018

Abstract

While many scholars have explored the individual determinants of attitudes toward the ACA and healthcare reform more generally, few have concentrated on the policy environment at the state level. This is a significant oversight given that many of the policy specifics of the ACA, such as the creation of insurance exchanges and the expansion of Medicaid, are decided at the subnational level. I take a first step in understanding how the policy design of the ACA influences opinions by looking at Kentucky, Ohio, and Tennessee because they differ in significant ways regarding their policy decisions toward the ACA. Using a policy feedback theory approach, I find significant differences in opinions towards the ACA across the states with citizens in Kentucky being more favorable towards the ACA compared to citizens in Ohio and Tennessee. Additionally, Republicans in Kentucky are more favorable towards the ACA compared to Republicans in Ohio and Tennessee. As such, the effect that subnational policy design has on political behavior and attitudes is key to understanding how individuals react to health reform.

What influences a person's opinions toward the Affordable Care Act (ACA)? While many scholars have explored the individual determinants of attitudes toward the ACA (e.g., Blendon et al. 2012; Brodie et al. 2011; Legerski and Berg 2016) and healthcare reform more generally (e.g., Henderson and Hillygus 2011), few have concentrated on the policy environment at the state level. This is a significant oversight given that many of the policy specifics of the ACA, such as the creation of insurance exchanges and the expansion of Medicaid, are decided at the subnational level. These policy decisions and the ACA's ultimate implementation have the potential to shape attitudes and political behaviors of target populations and other members of the public (Jacobs and Mettler 2017). In so doing, state policy designs are likely to determine subsequent health policy outcomes for years to come.

I take a first step in understanding how the policy design of the ACA influences opinions by looking at Kentucky, Ohio, and Tennessee. These states differ in significant ways regarding their policy decisions toward the ACA. For instance, in 2012, Ohio and Tennessee decided on a federally facilitated marketplace while Kentucky opted for a state facilitated marketplace (although has since applied for waivers) in that same year.

Of utmost importance, Republican elites pushed for healthcare reform in expansive ways in Kentucky while Democratic elites opted for a federally funded program in Ohio. What is particularly interesting about Tennessee is that Republican elites announced the state would default to a federally funded program. So, we see differences in how elites across the two parties addressed policy implementation in their states. I use these partisan differences in policy choice across these three fairly similar states to explore how partisanship influences public opinion among state residents. I find significant differences in opinions towards the ACA across the states with citizens in Kentucky being more favorable compared to citizens in Ohio and Tennessee. Additionally, Republicans in Kentucky are more favorable towards the ACA compared to Republicans in Ohio and Tennessee.

This suggests that the partisan effects of the ACA are influenced by state level politics and variations in policy design. This research further underscores the need for scholars to empirically analyze the ACA at the subnational level.

The paper continues as follows. First, I review the policy feedback literature and discuss the ways that the ACA is likely to influence attitudes toward healthcare reform. Next, I discuss the three surveys—The Ohio Health Issues Poll (OHIP), The Kentucky Health Issues Poll (KHIP), and the Vanderbilt University Poll—used to explore the determinants of mass opinion toward the ACA. I end with discussions for the future of healthcare reform.

Policy Feedback and Healthcare Policy

I use an analytic approach—policy feedback—to better understand attitudes toward the ACA. Campbell (2011) describes this approach as having two components. First, policy design has the ability to influence the attitudes and political behavior of specific target populations as well as the general public. She describes the target population as the individuals who are directly influenced by policy decisions. The second component of the policy feedback approach suggests that attitudes “feedback” into the political system, which subsequently impacts future policy outcomes and mass behavior (Mettler 2002; Campbell 2011). The policy feedback approach has been used to study the effects of various policies, ranging from the GI Bill (Mettler 2002) and social security policy (Campbell 2011), welfare policy (Soss and Schram 2007), immigration policy (Rocha et al. 2015; Maltby 2017), and anti-smoking legislation (Pacheco 2013).

Recently, scholars have focused their attention on using the ACA to better understand the effect of policy on mass behavior and opinion, although scholarship is still in its infancy. Haselwerdt (2017) finds that states that decided to expand Medicaid under the ACA had higher rates of political participation in US House races in 2014 compared to 2012, suggesting that new Medicaid users were prompted to turn out and protect their self-interests. Yet, Haselwerdt (2017) also finds a

backlash effect as a result of conservatives choosing to turn out and vote against the ACA. Pacheco and Maltby (2017), however, show that as implementation of the specific ACA components continues, more public support for the legislation will accompany it. This finding is particularly interesting given the uncertainty of future healthcare reform.

In fact, Jacobs and Mettler (2011) consider the question about the long term attitudinal effects of the ACA to be the lingering puzzle in health care reform. In 2017, we have witnessed multiple battles over the future of healthcare through ACA repeal and replace efforts. Policy effects arise out of consistent messaging toward target population to trigger particular attitudes and beliefs (Jacobs and Mettler 2011). Individuals are becoming more accustomed to having ACA expansion available to them further positing there have been effects from the ACA causing individuals to mobilize toward new policy changes. Moreover, the effects of policy can be attributed to widening sets of policy beneficiaries, and the attitudes of the mass public generally (Jacobs and Mettler 2011). The ACA as a policy has generated effects on the political behavior of individuals in both positive and negative ways furthering the need for more in-depth study of variations across states and individuals.

Central to democracy is the idea that citizens are active in government and participate in decisions. Jacobs and Mettler (2017) argue effects from policy which influence one's political efficacy stem from policy design considerations, political conditions, and motivations. Moreover, they find individuals who experience significant changes in insurance coverage or medical care to have a more benevolent opinion on the effect the expanded insurance access has. When an individual has a personal experience with features of the law, they are more likely to describe better access. This shows that a major consideration of a policy is the self-interest of the target population. Policy will have greater effects on populations who are motivated by self-interest because they are likely to seek out and take advantage of the new policy. Jacobs and Mettler (2017) further support

the self-interest motivation by finding those who reported benefits from the ACA are 1.62 times more likely to view the ACA as being successful with expanding health insurance coverage (pg. 24). As such, policy analysis must also account for motivational differences among individuals because of self-interest driving their responses to policy and government.

Using States to Understand Policy Feedback Effects

Kentucky, Ohio, and Tennessee are ideal states to study how the policy design of the ACA influenced individual opinions because of the different decisions made in the three states. Under Democratic Governor Steve Beshear, Kentucky expanded Medicaid through state facilitated exchanges to help give health insurance access to the roughly 25% (2013) of his state that did not have it. In 2012, Beshear issued executive order 2012-587 clearing the way for a state facilitated marketplace. Kentucky has been the forefront state in terms of reducing its uninsured rate under the ACA as the uninsured rate has waned to 12% (2014) (State Marketplace Profiles: Kentucky). However, in 2016 Kentuckians elected a Republican governor who campaigned on promises to end expansion and state marketplaces in Kentucky leading to ambiguities among individuals in the state because of the ACA success. The section 1115 waiver Kentucky applied for allows them to modify terms of Medicaid coverage in the state, opening the possibility for decreases in Medicaid enrollment and eligibility.

In Ohio, Republican Governor John Kasich chose to expand Medicaid under the ACA to help reduce his state's 17% (2013) uninsured rate. Kasich oversaw expansion while the Ohio legislature was also in Republican control. The state legislature was opposed to Medicaid expansion going so far as to include language in their budget to prohibit expansion. Governor Kasich used his line item veto power to eliminate this. In October 2013, the Centers for Medicare and Medicaid Services approved Ohio's State Plan Amendment (SPA) allowing the use of federal funds to extend Medicaid coverage. Ohio established a federally facilitated marketplace where the federal

government supplied the insurance plans and Ohio retained its control over eligibility specifics. The Ohio Department of Insurance (ODI) is the agency that oversees and regulates the marketplace and plans through ensuring providers are complying with legal provisions.

By 2015, Republicans in the Ohio State Legislature announced they would not be seeking to repeal Medicaid expansion. Legislation was passed that funds Medicaid expansion in Ohio through state fiscal year (SFY) 2017. Studying the policy feedback approach in Ohio will allow us to understand how a consistent partisan landscape effects the behavior of Ohio voters. Furthermore, Ohio experiences a modest but positive uninsured rate decline to 12% (2014) (State Exchange Profiles: Ohio). And, Ohio has implemented a federally facilitated marketplace design, which inevitably increases the number of interactions between citizens and the federal government further influencing political behavior.

In Tennessee, in 2012, Republican Governor Bill Haslam announced that his state would not be expanding Medicaid and instead will default into a federally facilitated marketplace (State Exchange Profiles: Tennessee). Interestingly, before the Governor made this announcement, the state's Department of Finance and Administration set-up an initiative program to advise the Governor and Legislature on the expansion process. The initiative program worked with experts and other interested parties to assemble a report. Their report concluded that there was an overwhelming preference for implementing a marketplace run by the state as opposed to the default option of a federally facilitated one. Importantly, in 2013, Tennessee was experiencing a 17% uninsured rate ("Rankings"). That being said, it appears that Governor Haslam ignored the recommendation of the group convened to advise state elites on expansion.

In early 2015, Tennessee sought to expand their Medicaid program under the Affordable Care Act. The change was subjected to approval by the Centers for Medicaid Services and the State Legislature. Governor Haslam called a special session of the Legislature in February to consider this

change, but the amendment was blocked in committee from moving forward (“Proposed Medicaid Expansion in Tennessee”). And, since then, despite the occasional flirt with the possibility of expansion, Medicaid in Tennessee has remained unexpanded and operates in a federal marketplace. Table 1 displays the policy variations across the three states.

[INSERT TABLE 1 HERE]

To look at how the policy environment in these states influences citizen attitudes toward the ACA, I utilize specific health policy surveys from each state. The Kentucky Health Issues Poll (KHIP) is done by the Foundation for a Healthy Kentucky while The Ohio Health Issues Poll (OHIP) is conducted by the Interact for Health organization. Both organizations seek to improve health in their respective states through developing and influencing policy. And, the Vanderbilt Poll is conducted by the Center for the Study of Democratic Institutions at Vanderbilt University. More importantly, these surveys employ research design strategies so that estimates are representative of the states. I describe the surveys and the data used in the next section.

Kentucky Health Issues Poll (KHIP)

KHIP is a survey conducted over the phone annually on adult residents of Kentucky. The survey was first conducted in the fall of 2008. After the responses are collected, reports are released over the succeeding six to eight months concerning various health related issues asked about in the opinion survey. I use the KHIP surveys conducted between 2010 and 2015. The main dependent variable is an individual’s overall opinion toward the Affordable Care Act (ACA). Specifically, respondents were asked, “Given what you know about the new health reform law, do you have a generally favorable or generally unfavorable opinion of it”? Figure 1 shows trends in ACA favorability opinion for Kentucky from 2010 to 2015.

[INSERT FIGURE 1 HERE]

When the ACA was passed in 2010, there were immediate negative opinions towards the new healthcare law as shown in Figure 1 with only 37% of Kentuckians holding a favorable opinion. However, as time passed, opinion on the law began to stabilize as people became more firmly grounded in their opinion. Overall, the majority of Kentucky residents held an unfavorable opinion (56%) throughout the time period, which is interesting given the success the health law had in Kentucky when former Governor Steve Beshear (D) decided to expand Medicaid.

As shown in Figure 2, I am also interested in opinions beyond ACA favorability. Perhaps most immediately striking is the high percentage of individuals who support expanding Medicaid in Kentucky at roughly 89%. The question asked respondents, “In Kentucky, the state has chosen to expand Medicaid, as the health law permits, to provide health insurance to more low-income people. Do you favor or oppose Kentucky’s decision to expand Medicaid to cover more low-income people?”, then respondents answered on a four-point scale of importance. Moreover, it is interesting that support for such specific components of the ACA is so high when considering Kentucky is regarded as a predominantly conservative state, while the ACA is seen by many as a partisan law implemented by liberals.

[INSERT FIGURE 2 HERE]

These dependent variables all stem from the same survey question in the 2010 KHIP survey. The question began, “Now I’m going to read you a list of specific elements of the health reform law that are scheduled to be implemented this year. For each element I name, please tell me if it makes you feel more favorably toward the law, less favorably toward the law, or it doesn’t make a difference in how you feel about the law.” After this opening, interviewers followed with a series of descriptions for various components of the ACA. I use the questions on the following components in my research: (1) prohibiting insurance companies from denying coverage to children who have a preexisting health problem, (2) creating an insurance option, or high risk pool, for those people

whose preexisting conditions currently make it difficult for them to find and buy affordable health insurance, (3) requiring all new health plans to provide their customers access to basic preventive health care services, such as screenings and immunizations, without charging the customer any co-payment, and (4) Allowing children to stay on their parents' insurance plan until age 26. Survey respondents then ranked each component as either more favorable, less favorable, doesn't make a difference, or don't know.

Additionally, the KHIP 2010 survey asked, "Do you feel that you have enough information about the new health reform law to understand how it will impact you personally, or not?" To which respondents answered with a simple "yes, have enough information" or "No, do not have enough info" response. In the KHIP, 53% of respondents felt they had enough information on the ACA, while the level of support in the OHIP is 39%. Responses from this question are used to help demonstrate the effects on ACA opinions when individuals perceive themselves to be knowledgeable about the policy. Individuals who feel they have enough information about a policy likely have stronger opinions about how a policy will affect them.

Ohio Health Issues Poll (OHIP)

OHIP is a telephone survey conducted on adults in Ohio to gather opinions about health-related issues. OHIP is conducted annually, and first began in 2005. Similar to KHIP, the survey collects opinions on issues ranging from health insurance coverage to tobacco policies. A report on OHIP's annual findings is also produced publicly with access to the datasets.

Unfortunately, the OHIP data set being used did not ask about opinions of the Affordable Care Act in 2010, 2012, and 2013. As shown in Figure 1, there is initially low support for the health law at only 38%, but over time opinions begin to stabilize similar to opinion in Kentucky. Across these years, the unfavorable opinion consistently declined while the favorable opinion increased.

Furthering the notion that individuals became accustomed and attached to the healthcare reform law. Ohioans also had strikingly similar overall opinions of the ACA.

Both Kentucky and Ohio have similar aggregate favorable views. In Kentucky, 43% of individuals had a favorable view of the legislation, and in Ohio 41% of individuals had a favorable view. These moderately low favorable opinions run contrary to the success the ACA had in both Kentucky and Ohio where the uninsured rates dropped rather significantly due to Medicaid expansion. Thus, individuals generally are unsupportive of the law while also signing up for insurance through the expansion. Figure 3 shows other facets of ACA opinion in Ohio.

[INSERT FIGURE 3 HERE]

It is notable in this figure how similar the opinions on the specific components are to each other. The survey questions asking about these components were identical in the OHIP 2011 survey as the ones mentioned above in KHIP. Individuals in Ohio are less supportive of the specific major components of the ACA. Additionally, substantially fewer residents support expanding Medicaid in Ohio than Kentucky with only 65% of Ohioans supporting expansion. Yet, it is still worth noting this is a surprisingly high percentage of residents supporting expansion.

Vanderbilt Poll

The Vanderbilt Poll was launched in 2011 at Vanderbilt University at their Center for the Study of Democratic Institutions (CSDI). The poll is conducted scientifically and in a non-partisan manner to provide public opinion measures for residents in the state of Tennessee. The poll is conducted at least twice a year. Once before the beginning of the state's legislative session and the other at the end of the session. Additionally, the CSDI participates in polling on presidential polling and local issues in the city of Nashville. In efforts to provide unbiased opinion measures, the Vanderbilt Poll is conducted using telephone surveys over both landline and cellular phones. And, the results are weighted statistically to account for demographic differences. The content and

specific issues on the survey are identified by the Poll's Board of Advisors who assist in developing and editing the survey before officially being conducted ("Vanderbilt Poll Snapshot").

Similar to the KHIP and OHIP, the Vanderbilt Poll asked questions on support for the ACA in Tennessee. The question for the dependent variable in this poll was, "Given what you know about the Affordable Care Act that passed in 2010, do you have a generally favorable or generally unfavorable view of it, or have you not heard enough about it to form an opinion?" Respondents were given the choices of generally favorable, generally unfavorable, haven't heard enough about it, don't know, or refused. When aggregated, the data for this question across the years asked show that only 33% of Tennesseans support the ACA. The poll began collecting data on this question in their 2012 surveys. So, there are no observations for 2010 and 2011 for this question.

Unlike the KHIP and OHIP, the Vanderbilt Poll did not ask widely about specific provisions of the ACA very often. However, in 2012, the survey asked, "Do you approve or disapprove of a provision in the Affordable Care Act that allows children to stay on their parents' health insurance until the age of 26?" And, allowed respondents to answer with approve, disapprove, don't know, or refused. Additionally, in 2012 through 2014, the survey asked, "Some states like Kentucky have expanded Medicaid using money from the federal government to provide medical care for low-income people. Other states, like Georgia, have decided not to expand Medicaid. Tennessee has not yet decided whether or not to expand Medicaid. Do you think Tennessee should expand Medicaid coverage for low-income people in the state, or not?", then respondents answered yes expand, no don't expand, don't know, or refused. For the surveys on which this was asked, the aggregate level of support for expansion is high at 61%. Additional summary statistics are shown in Table 2.

[INSERT TABLE 2 HERE]

Individuals in Kentucky, Ohio, and Tennessee are similar in other regards, which is important when studying policy differences across multiple states. In 2013, all three states had approximately 20% of their citizens enrolled in public insurance programs like Medicaid, Medicare, and Military benefits. Moreover, in the same year, 47% of Kentuckians, 52% of Ohioans, and 45% of Tennesseans were enrolled in employer provided health insurance (“Health Insurance Coverage”). And, a year later in 2014, these percentages became even more similar with 46% of Kentuckians on employer provided insurance, 50% of Ohioans now on employer health insurance, and 50% of Tennesseans on employer provided health insurance (“Health Insurance Coverage”). With similar amounts of people enrolled in public insurance and taking up employer provided insurance in all three states, the number of people who would be affected by the ACA is also similar. This leads to a more equivalent evaluation of the effects the ACA had in these states.

Having noted employer provided health insurance is a leading similarity and source of health insurance in these states, it is important to consider the employment landscape in Kentucky, Ohio, and Tennessee. The 2013 unemployment rate in Kentucky was 8.9% meanwhile in Ohio is was 7.5%, and was 7.8% in Tennessee (“Unemployment Rates”). Here again, we see a similar story for residents in all three states in terms of employment, which follows from the data on employer provided health insurance. If individuals are unemployed, they do not have access to employer provided insurance and rely more heavily on government provided programs. As such, it is imperative that the states have similar unemployment outlooks to test the affect the ACA has had. A closely related indicator to employment is the amount of poverty in each state. Kentucky experienced 18.8% of the population living in poverty in 2013. In the same year, Ohio experienced a similar number of persons in poverty at 16%. And, the poverty rate in Tennessee that year was 17.8% (Bishaw and Fontenot 2014). Being in poverty reduces the likelihood an individual has

insurance let alone access to insurance. Similar levels of poverty allow for a more equal comparison of the effects of the ACA in each state.

Finally, it is important that individuals in both states earn roughly the same income because lack of income is often the reason individuals are not enrolled in health insurance. And, in Kentucky, Ohio, and Tennessee, we do see moderately similar median incomes of \$44,811 in Kentucky, \$50,674 in Ohio, and \$46,574 in Tennessee. Additionally, a better indicator of income equally is the per capita median income. This measure proves even more similarity between the states. In Kentucky, the per capita income is \$24,802, in Ohio it is \$27,800, and in Tennessee it is \$26,019 (“Quickfacts”). This income data is reported in 2016 dollars. In sum, the individuals in these states are similar in many regards that lead to determine not only access to health insurance, but overall opinion toward the ACA in their state.

Exploring the Determinants of Opinions in Kentucky, Ohio, and Tennessee

My main goal is to see how attitudes toward the ACA differ in Kentucky, Ohio, and Tennessee with the idea that differences are due to variations in policy design and partisan cues. In these analyses, I control for a variety of other factors that might influence ACA attitudes including gender (1=female), age (18-95), education level (less than high school=1 to college graduate=4), and race (two binary variables to account for black and Latino).

The ACA is a highly partisan issue with Democrats and liberals much more favorable compared to Republicans and conservative (Blendon et al., 2012). I, therefore, include a measure of partisanship (Republican=1, else=0) and ideology (1=conservative, else=0). I also include a variable to identify citizens in Kentucky and Tennessee as well as a linear year variable (when appropriate) to account for time trends in attitudes.

Both the KHIP and the OHIP polls show similar stories in terms of respondents’ favorability of the individual components of the ACA. For example, in the KHIP, 75% of

respondents favored restricting insurance providers from denying coverage to children based on a preexisting condition, and 74% supported creating a high risk pool for those with preexisting conditions. And, in the OHIP, support for restricting coverage for children is roughly 69%, and support for the high risk pool option is 68%. Two other components, children remaining on parents' insurance until age 26 and requiring insurance providers to offer preventive care coverage, follow similar patterns to these components. In the KHIP, 65% of respondents supported the age on children coverage expansion and 78% supported preventive care requirements. The responses in the OHIP are slightly lower, but display this trend with 58% supporting the children age expansion and 66% supporting preventive care requirements. Unfortunately, the Vanderbilt does not ask about any of these specific components of the ACA.

Differences in Support between Kentucky, Ohio, and Tennessee

I start by estimating a logistic regression model for each of the dependent variables mentioned above including overall ACA favorability as well as opinions toward specific policy provisions. Results are shown in Table 3.

[INSERT TABLE 3 HERE]

As shown in Table 3, being from Kentucky is associated with higher support of the ACA compared with being from Ohio. And, being from Tennessee is associated with negative opinion toward the ACA. This is an indication that the political environment and policy design affect levels of support for the law.

Individuals in Kentucky have a more favorable opinion on allowing children to remain on their parent's health insurance until age 26, prohibiting denial of children with preexisting conditions, and requiring insurance providers to offer access to preventive care. Additionally, individuals from Kentucky support expanding Medicaid more significantly than those in Ohio. In

total, being from Kentucky makes an individual more supportive of the ACA, its goal of improving health insurance access, and of specific provisions of the law.

Turning to individual characteristics, there are several that are correlated with overall support for the ACA. Age, race, and level of education all are significantly related to ACA support in a positive direction. Individual determinants also affect favorability for the specific provisions in the ACA.

The provision allowing children to remain on their parent's health insurance until age 26 is broadly popular in Kentucky and Ohio. The model estimates that age, gender, and being black are all significant in explaining opinions toward this provision. Moreover, the model estimating favorability of the provision prohibiting the denial of coverage to children with preexisting conditions suggests age, being Latino, and one's level of education are determinants of support. The determinants of support for the provision on access to preventive care that are significant are gender and level of education.

Finally, the other two policy provisions I am concerned with relate to individuals having enough information on the ACA and whether respondents support Medicaid expansion. Logit models on having enough information over the law is significantly estimated by gender and level of education in Kentucky and Ohio. Meanwhile, support for expanding Medicaid across the three states is significantly estimated by age, being black, and education level.

Also relevant is the role of ideology and partisanship. Republicans and conservatives are much less supportive of the ACA overall, for all the individual provisions, and expanding Medicaid. Interestingly, partisanship and ideology are not significantly related to ACA information.

Taken together, clearly there are particular individual characteristics that lead to differing opinions on the ACA and its specific policy pieces. Importantly, though, in all seven of the estimations, being from Kentucky has a significant effect on an individual's level of support for the

Affordable Care Act compared to being from Ohio. And, for the policy provisions that were minimally asked on the Vanderbilt Poll, being from Tennessee has a significant negative effect on overall favorability and expanding Medicaid, but a positively significant effect on children remaining on their parent's insurance until age 26. This provides evidence that the policy design is important for explaining opinions toward the ACA.

Partisan Differences across States

As noted above, the decisions to adopt a state run health insurance market and expand Medicaid in Kentucky were made by Republicans. It is reasonable to expect for Republicans in Kentucky to have more favorable opinions toward the ACA compared to Republicans in Ohio or Tennessee because the partisan cues from state elites differed. To test this idea, I estimate models with an interaction between the state variables and partisanship to compare the partisan effect on individuals between the states. Results are shown in Table 4. The interaction between Republican and Kentucky shows significance for two estimations. Interestingly, both relate to specific provision of the ACA. The interaction effect is most influential on the opinions over allowing children to remain on their parent's health insurance until age 26 and the option of creating a high risk pool. In the case of the former, Republicans in Kentucky are more supportive of allowing children to remain on their parent's insurance plan compared to Republicans in Ohio. The coefficient for the interaction in the high risk pool estimation also proves to have a positive supporting effect on ACA support for the specific provision. Additionally, and rather interesting, the interaction between Republican and Tennessee shows significance for two of the three estimations. Republicans in Tennessee are less supportive of the ACA compared to Republicans in Ohio, but more likely to support Medicaid expansion.

[INSERT TABLE 4 HERE]

While not all interactions are significant, it is worth noting that in six of the seven estimations for Kentucky, the coefficient is positive. And, two of the three estimations for Tennessee are positive. This conditional effect of partisanship in Kentucky is suggestive for overall ACA support, support over children remaining on parent's insurance until age 26, creating a high risk pool, prohibiting denial of children with preexisting conditions, and access to preventive care. Meanwhile, this conditional effect of partisanship in Tennessee is suggestive of support for children remaining on their parent's health insurance until age 26.

Conclusion

My results suggest that the partisan effects of the ACA are influenced by state level politics and variations in policy design. There are significant differences in opinion towards the ACA with citizens in Kentucky being more favorable compared to Ohioans and Tennesseans. Moreover, Republicans in Kentucky are more favorable toward the ACA than their Republicans counterparts in Ohio and Tennessee. Using a policy feedback approach, I argue that policy design differences at the subnational level affect individuals differently. This is important because policy design decisions shape the political behaviors and attitudes of target populations as well as other members of the public (Jacobs and Mettler 2017). In this case, having the health insurance marketplace be state facilitated appears to serve the motivations of Republican Kentuckians better. This is likely because the conservative ideology of the state views the state facilitated marketplace as more in line with conservative principles compared to conservatives in Ohio viewing their insurance marketplace as the federal government intruding. This partisan effect is even more pronounced among conservatives in Tennessee who strongly dislike the ACA. Policy has the greatest effects on target populations when they are motivated by self-interest as they are likely to seek out and take advantage of the new policy.

Going forward, healthcare policy should be implemented based on individual level determinants that shape the effectiveness of the policy. State governments need to anticipate or be conscious of the partisanship of their states when they implement new policy because by incorrectly designing a policy the government could deter or alienate those who should be taking advantage of the policy and future related policies. Kentucky followed this notion when establishing their ACA marketplace by recognizing the benefits of offering health insurance through the state government to citizens who are conservative versus a marketplace through the federal government.

In Kentucky, the state facilitated marketplace design is feeding back into the political attitudes of the citizen in the state in the form of higher favorability for not only the ACA overall, but specific provisions of the law, and expanding Medicaid to lower income residents. Whereas, this effect is not contributing to the political attitudes of residents in Ohio or Tennessee who are under a federally facilitated marketplace.

The influence that subnational policy design has on political behavior and attitudes is key to understanding how individuals react to policies. Within the current health care system, future policies need to be tailored to the specific needs and views of individuals in a given state. When there is dissonance between the motivations of state residents and the policy design, support for the policy is lower and there are negative effects on political behavior.

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Table 1. Policy Design Variations Between Kentucky, Ohio, and Tennessee

	Expand Medicaid	Marketplace Facilitation	Adult Income Medicaid Eligibility Threshold (without dependent children)	Adult Income Medicaid Eligibility Threshold (with dependent children)
Kentucky	Yes	State	138%	138%
Ohio	Yes	Federal	138%	138%
Tennessee	No	Federal	0%	111%

Figure 1. Percentage of state residents who said they favored the ACA

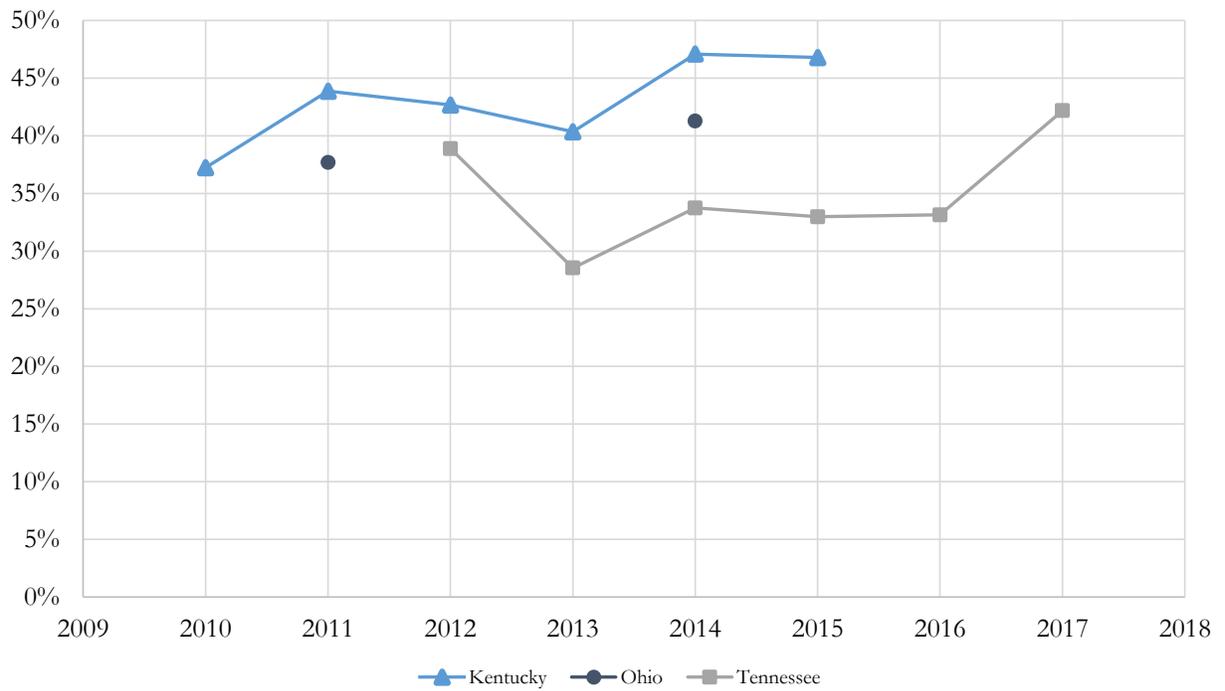


Figure 2. Opinions on Specific Components of the ACA in Kentucky

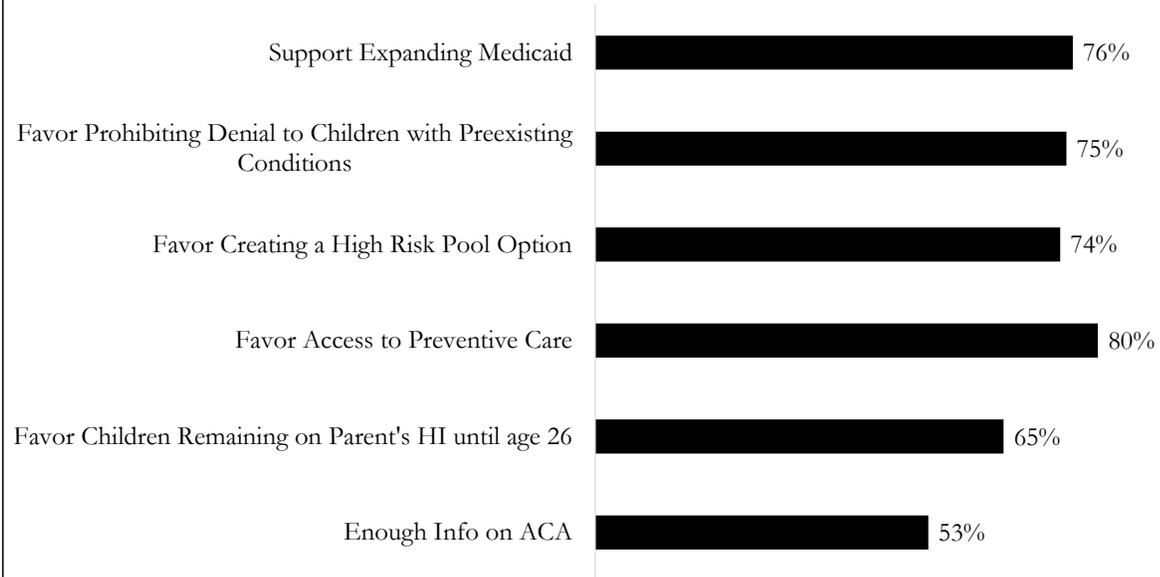


Figure 3. Opinions on Specific Components of the ACA in Ohio

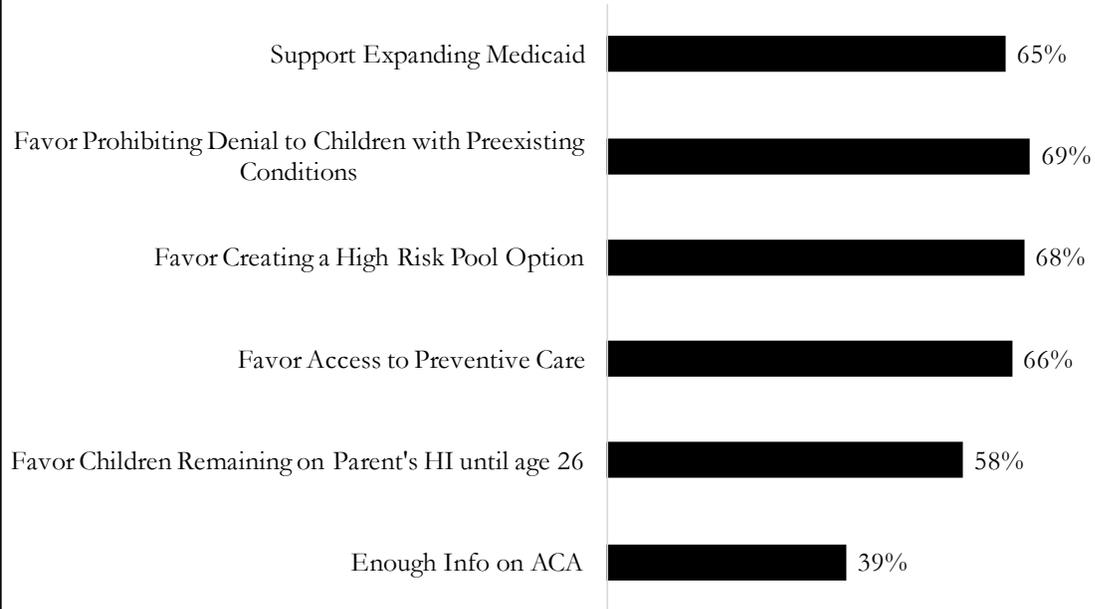


Table 2. Descriptive Statistics of Dependent Variables									
	Kentucky			Ohio			Tennessee		
	N	Mean	Standard Deviation	N	Mean	Standard Deviation	N	Mean	Standard Deviation
Favor Children on parents' HI until age 26	1648	.65	.48	900	.58	.49			
Favor creating high risk option	1624	.74	.44	872	.68	.47	227	.73	.44
Favor prohibiting denial for Children with PEC	1648	.75	.43	889	.69	.46			
Favor access to preventive care	3252	.80	.40	890	.66	.48			
Support Expanding Medicaid	1506	.76	.43	797	.65	.48	3263	.61	.49
Enough information on ACA	796	.53	.50	2523	.39	.49			

	Favor ACA	Favor High Risk Pool Option	Favor Prohibiting Denial of Children with PEC	Favor Access to Preventive Care	Favor Children Remaining on Parent's HI until 26	Enough Info on ACA	Support Expanding Medicaid
Republican	-.168 *** (.053)	-.514 *** (.113)	-.390 *** (.114)	-.824 *** (.098)	-.737 *** (.101)	.027 (.094)	-.947 *** (.073)
Conservative	-1.5 *** (.047)	-.385 *** (.116)	-.480 *** (.117)	-.63 *** (.103)	-.573 *** (.103)	-.097 (.094)	-1.12 *** (.073)
Kentucky	.265 *** (.076)	.226 ** (.102)	.298 *** (.103)	.779 *** (.094)	.345 *** (.097)	.532 *** (.091)	.679 *** (.115)
Tennessee	-.704 *** (.080)				.714 *** (.184)		-.381 *** (.010)
Constant	-.189 (.128)	.602 (.263)	1.110 (.000.27)	2.29 (.237)	1.85 (.249)	-1.28 (.200)	2.19 (.188)
N	13345	2115	2143	3409	2358	2799	4864

*Control variables included are gender, education level, age, Black, and Latino.
 * p<.1, ** p<.05, *** p<.01
 Standard error listed in parentheses

Table 4. Logistic Regression Model on Various ACA Attitudes with Partisan Interaction							
	Favor ACA	Favor High Risk Pool Option	Favor Prohibiting Denial of Children with PEC	Favor Access to Preventive Care	Favor Children Remaining on Parent's HI until 26	Enough Info on ACA	Support Expanding Medicaid
Republican	-1.64 *** .15	-.75 *** .17	-.47 *** .17	-.97 *** .17	-.97 *** .17	.04 .11	-1.24 *** .19
Conservative	-1.50 *** .05	-.37 *** .12	-.47 *** .12	-.63 *** .10	-.57 *** .10	-.10 .09	-1.11 *** .07
Kentucky	.22 ** .09	.04 .14	.24 * .14	.68 *** .14	.18 .13	.55 *** .12	.67 *** .17
Tennessee	-.62 *** .09				.59 ** .24		-.57 *** .14
Republican*Kentucky	.14 .17	.37 * .21	.12 .21	.20 .19	.35 * .20	-.04 .18	.07 .24
Republican*Tennessee	-.59 *** .19				.30 .38		.44 ** .20
Constant	-.19 .13	.72 .27	1.14 .28	2.36 .25	1.96 .26	-1.28 .20	2.32 .20
N	13345	2115	2143	3409	2358	2799	4864
*Control variables included are gender, education level, age, Black, and Latino.							
* p<.1, ** p<.05, *** p<.01							
Standard error listed in parentheses							