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Determinants of State Level Support for the Patient Protection and Affordable Care Act

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Abstract

What accounts for variance in public opinion support for the PPACA? The political science (and social science in general) literature is relatively sparse on this question. This paper suggests that state level support for the PPACA has a largely political, rather than economic, motivation. Multivariate models are estimated, with support measured at the state level using 2010 data from Gallup; explanatory variables (per capita where necessary) include uninsured percentage, change in uninsured, unemployment, Medicaid recipients, state GDP, poverty rate, percents African-American and Latino, and the state PVI. A bivariate relationship is counter-intuitive; as the rate of uninsured in a state increased, so does opposition to the PPACA. Multivariate models estimate a more nuanced picture, with partisanship, religiosity, and race being consistent significant predictors of state level support for the PPACA across three models. In other words, judgment of the PPACA as policy is mediated by pre-existing partisan attributes rather than economic indicators.

Introduction

The Patient Protection and Affordable Care Act (PPACA), passed by Congress and signed by the President in March 2010, and subsequently surviving a series of legal challenges with the Supreme Court upholding it in a narrow 5-4 vote in June 2012 (*National Federation of Independent Business v. Sebelius*) represents the most sweeping domestic legislation enacted since the Great Society programs. Furthermore, it is the largest single overhaul of health care provision and regulation in the United States since the passage of Medicare and Medicaid in 1965.

Success of the PPACA through the legislative process was tenuous, with Democrats in the U.S. Senate requiring the use of a parliamentary end-run around Republicans' use of the filibuster. That it passed at all would have been viewed as something of a surprise in the immediate wake of the failure of President Clinton's initiative in 1993-94. Those opposed to broad health care policy reform had a playbook readily to hand (Skocpol 1996), which indeed predicted that any foreseeable subsequent advance in this area would be piecemeal, and no thorough reform of health care would be possible in the United States lacking any fundamental transformation in the underlying politics.

However, that fundamental transformation did not occur. While Obama enjoyed similar institutional advantages as Clinton (with both Houses of Congress of his party), public opinion on the issue hadn't dramatically shifted. Shapiro and Arrow (2009; cited in Gelman

et al. 2010) examined the responses to 18 survey questions in 1994 and 2009. Of the 18, they found that five were more favourable to Obama's effort, five less, and nine either unchanged or ambiguous. Notably, the five items that improved in the intervening 15 years measured vague notions about the *idea* of health care reform (e.g. "does the health care system need to be rebuilt") while those items where support decreased were about specifics regarding the need for increased taxation, federal spending on health care reform, and whether or not the government should guarantee universal coverage.

Pass it did, but "debate on the issue was deeply divisive" without the support of a single Republican vote in Congress (Clarke et al. 2010:141). One result is that health care was transformed from a valence issue to a positional one, and it's not difficult to suggest that the polarisation in the legislative branch reflected to some degree the state of public opinion, which was, and remains likewise polarised. According to the Kaiser Foundation tracking poll, the PPACA is currently (September 2013) supported by 39% of respondents, and held as unfavourable by 43%. Since the PPACA was passed in March 2010, there has been some variability in support and opposition nationally, with the favourable range being 34% to 50%, and unfavourable 35% to 51%, the current top line of 39/43 compares with the spread of 46/40 with passage three years ago. These figures are consistent with AP polling during the period that the bills were debated in Congress prior to passage, with support between 40% and 50% from September 2009 through March 2010 (Gelman et al. 2010).

What accounts for variance in public opinion support for the PPACA? Tesler (2012) finds that race is a factor in determining support; given that President Obama is regarded as an African American, support for his health care reform initiative is mediated by racial attitudes amongst the white population. This is a phenomenon known as racialization, which is conceptually and empirically easy to understand regarding policies that have an explicit racial component to them (e.g. affirmative action), but more complex and difficult to pin down for policies that are not, at first blush, concerned with race. This trait can be extended to parties through issue ownership. Parties and the candidates attached to the parties are associated with positions favourable or in opposition to issue positions that themselves have been racialized. Ownership of an issue position that has been racialized by a segment of the population could pass that effect on to the candidate or party. At the extreme, this can be personalised, as in the oft discussed faux pas of President Ford biting into an unshucked tamale while campaigning in San Antonio in April 1976. This likely served as a decision cue for some Latinos; here's a candidate who understands neither their culture nor their concerns (Popkin 1994). Hence, it doesn't require a leap of imagination to extend the cue of racialization directly to the politician him or herself, as in the case of President Obama.

Relying on data no more current than 2004, Gelman, Lee, and Ghitza (2010) find opposition to be concentrated among those with higher incomes, and those over the age of 65, with some degree of geographic variation as well (support is stronger on the coasts, lower in the south and Midwest). Variance in support is more sophisticated than simply a breakdown in demographics. Partisanship serves as a significant mediating factor in determining levels of support (or opposition).

That partisanship shapes attitudes towards policy is nothing new in political science; indeed it's traced back to the earliest groundbreaking rigorous analysis of voting behaviour (Campbell et al. 1960). The heuristic utility of partisanship, discussed above, is the most efficient means of communicating this effect, both in terms of its function for voters as well as well as for this narrative (Downs 1957; Shively 1979). While the nature and substantive relationship between partisanship and specific issue attitudes vary in the literature, a

consensus does exist that there is a strong relationship between the former on the latter (Achen 2002; Bartels, 2000, 2002; Fiorina 1981; Jacoby 1988; Miller & Shanks 1996).

Beyond the two papers cited above (Gelman et al. 2010; Tesler 2012) the social science literature exploring variance in public opinion on the PPACA is virtually non-existent. However, the two cited above perhaps unintentionally are informed by distinctly different theoretical frameworks for explaining policy support at the individual and mass levels. On the one hand, a classic approach to predicting policy support would be a basic economic analysis: does this policy explicitly help or hurt a given citizen? The Gelman et al. analysis of support for health care reform fits this narrative. Those over the age of 65, in addition to being more conservative on average, are more likely to have existing coverage, which at the very minimum will be Medicare. It's not difficult to imagine their either the issue of health care reform maintains a relatively low salience in the policy preference baskets of the over 65 set, or that health care reform is interpreted as a direct threat to their extant coverage.

Building on from this line of reasoning, economic incentives to support, rather than oppose, the Affordable Care Act are not difficult to imagine. First would be status of one's health insurance. Put another way, states with higher levels of uninsured should be expected to be more supportive of the PPACA as there is a clear economic benefit to the policy. Likewise, for similar reasons, unemployment should also be associated with the rate of support, as too would the Medicaid rate and the poverty rate in a given state.

This suggests several testable hypotheses:

H1: The uninsured are more likely to support the PPACA

H2: The unemployed are more likely to support the PPACA

H3: The higher the state-level poverty rate, the higher the level of support for the PPACA.

There are two additional theoretical narratives that can be used to predict or at least explain support for policy positions, both where the policy itself is perceived, filtered, and interpreted endogenously through pre-existing attitudes or traits, both based on heuristics of varying efficacy. Likewise, these emanate from partisanship. In the American context, it is well known that partisanship provides an influence or cue on both candidates and which positions to take on issues of policy (Bartels 2000; Miller & Shanks 1996; Jacoby 1988). This can be extended as a policy heuristic through either a) the result of clever framing of an issue in question through trait ownership, or b) an explicit association in the minds of citizens that the policy belongs to either "their team" or "the other team", thus serving as an effective short cut for staking out a personal position on a policy.

The first, issue / trait ownership, builds on Petrocik's notion of issue ownership (1996) and its extension to trait ownership (Hayes 2005). Yet, as applied to policy outputs, this is flipped around. With issue ownership, a Presidential candidate frames the decision as a problem or problems facing the country that his or her candidacy or party are best equipped to address. If a given policy, such as health care reform, is successfully framed as a salient problem facing the country, knowing that this candidate and her or his party is perceived as better able to handle it, the candidate enhances the probability of their success. Trait

ownership can be simplistically construed as similar to issue ownership, with the point of departure being that traits are more general qualitative topics, rather than discrete issues: “Republicans will be perceived as stronger leaders and more moral than Democrats. At the same time, Democrats are likely to be viewed as more compassionate and empathetic than Republicans” (Hayes 2005:911) but like issue ownership, these are ultimately strategically arrived at on the part of the candidate. Indeed, Hayes suggests that a feedback function exists between party / candidate and voter to the extent that voters use trait ownership as a decision heuristic in judging candidates: the partisan brand owned by the candidate establishes a base line of trait expectations. Should the candidate explicitly not fulfil these expectations in some manner, electoral consequences can ensue.

How does this apply to the perception of a policy in the process of, or already, adopted? It does not require too much of a theoretical leap to suggest that the traits “owned” by the two parties are likewise shared by their policies, especially if a given policy fits the trait expectation well, as health care reform fits the “compassionate, empathetic” trait ascribed to the Democrats.

Likewise, large percentages of those *habitually* supporting one party or the other still do so out of some level of conscious self-selection. Assuming that the trait ownership of their chosen candidate or party is a salient decision rule, then we can assume to some degree that a feedback loop exists regarding these traits. In other words, while some level of projection might be going on between the target voters of a given party and the party itself (e.g. Democrats strategically choose to appear compassionate as they want to appeal to voters who consider themselves so and rank it as a salient trait) likewise, those choosing a given party projects some of the traits that they perceive their choice to possess back upon themselves. To an extent, their owning their choice by owning the traits inherent to that choice. This is best understood as a likability heuristic (Brady and Sniderman 1985). If a group is “liked” by a given voter, the perceived proximity of that group to a given policy position affects the individual’s perception of the policy position. Extending this as a source cue (Mondak 1993), the Republican Party’s strenuous opposition to the PPACA is interpreted by those identifying with the party to likewise oppose the PPACA. This is not an efficient heuristic when the source cue is nonexistent, but in this example, there wasn’t much doubt.

If a policy is perceived as having compassionate or empathetic traits, support for it should vary in public opinion by the concentration (or lack there of) of the perceived importance of these traits. Put another way, the confirmation bias might operate in overdrive in terms of policy judgment: “because human beings process information, political or otherwise, in ways that tend to confirm what they already believe (Abelson 1959), persuasion is a difficult endeavour, and candidates who focus only on drawing voters close to their issue positions face a daunting challenge.” (Hayes 2005:909).

H4: All else being equal, the partisan makeup of a given state, examined through different measures, is associated with support or opposition to the PPACA.

There are two ways that race can be considered a lens through which the PPACA in particular is perceived. First, similar to a pre-existing partisan attribute, race, both one’s own and one’s perception of the motivations of the other, have been demonstrated to condition perceptions of policy outputs and discrete policies. Hero and Tolbert (1996) find that the racial / ethnic dynamic of a state is associated with both policy perception and policy outputs that favour minorities (Latinos and Blacks) ranging from neutral to poor. Hetherington and

Globetti (2002) find that trust as an exogenous factor conditions white acceptance for policies perceived as favouring minorities. In both cases, the perceived beneficiary group of the policy, i.e. minorities, is a filter through which the policy itself is judged. In the case of the PPACA, it could be possible to hypothesise that health care reform is perceived to assist the poor, and minorities are more closely associated with poverty than the white population, therefore the PPACA might be perceived as a minority policy.

The other way that race can be construed to condition support for policy is if that elite issue advocacy for that policy is associated directly with a political leader who is a member of an ethnic minority. Tesler (2012) offers compelling evidence to suggest that perceptions of the PPACA are more racially polarised (by about 20%) than the 1993-4 Clinton policy proposal. Tesler suggests that race-based evaluations of President Obama condition both minority support for the PPACA, as well as a portion of white-based opposition.

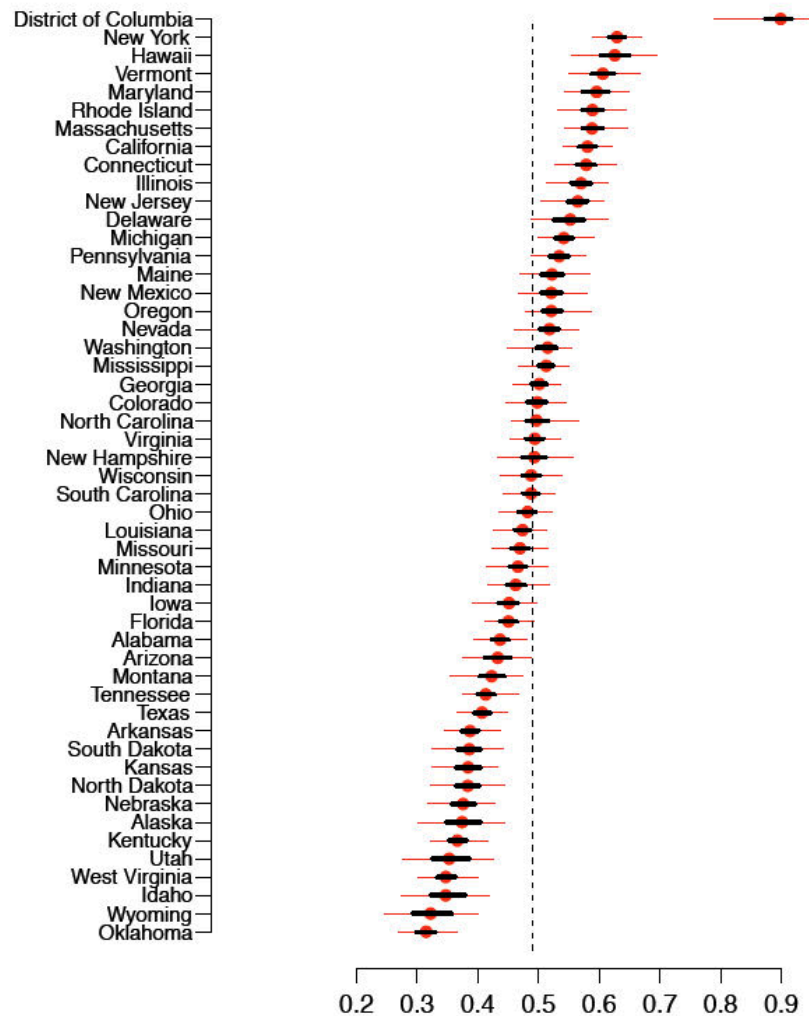
H5: The higher the minority percentage in a state, the higher the level of support for the PPACA.

Data and Methods

Data are all gathered at state level. While data are available for several non-states (e.g. the District of Columbia, Puerto Rico), these are dropped from the analysis, resulting in an N of 50.

The dependent variable is state level public opinion support for the PPACA. The source for state level PPACA support is an extrapolation estimate of state level support from national Gallup data over a six month period: September 2009 to March 2010 (Gonzales 2011). As this is an estimate, it does introduce an additional layer of uncertainty into the model, yet it is the best state level data available. The point estimates and error bands appear sound in terms of face validity (Figure 1); the highest levels of support are found in New York, Hawaii, and Vermont, with the lowest in Oklahoma and Wyoming. The public opinion data are old, but public opinion on the PPACA has been relatively stable (Kaiser Foundation 2013). While the primary dependent variable is an estimation extrapolated from standard Gallup polling data on the question, the distribution of support across the states satisfies a *prima facie* test, as illustrated in Figure 1.

Figure 1: Average State Level for Health Care Reform, September 2009 to March 2010



Note: Red lines indicate 95% confidence regions, solid black lines indicate 50% confidence regions. National average level of support indicated by dashed line.

(Source: Gonzales 2011).

Most of the independent variables, used to either examine specific hypotheses or to provide control variables, are sourced from the US Census, including state per-capita GDP, average unemployment from 2008-10, the rate of Medicaid recipients expressed as a percentage, the poverty rate, again expressed as a percentage, and the percentages Black and Latino. I calculated from Census data the percentage change in the uninsured rate, from 2008-2010, based on the assumption that a larger rate of change (in either direction) might have as strong an effect on public opinion as the baseline rate of uninsured (percentage point change, to be specific).

Gelman (2010), in an analysis of voting patterns at the state level, suggests that a strong determinant of voting behaviour in both presidential and congressional elections, is religiosity, which in part helps explain the apparent paradox identified by wealthier states tending to support Democratic candidates, yet wealthier individuals supporting Republican candidates. Religiosity at the state level is derived from Gallup (2009), using an item which

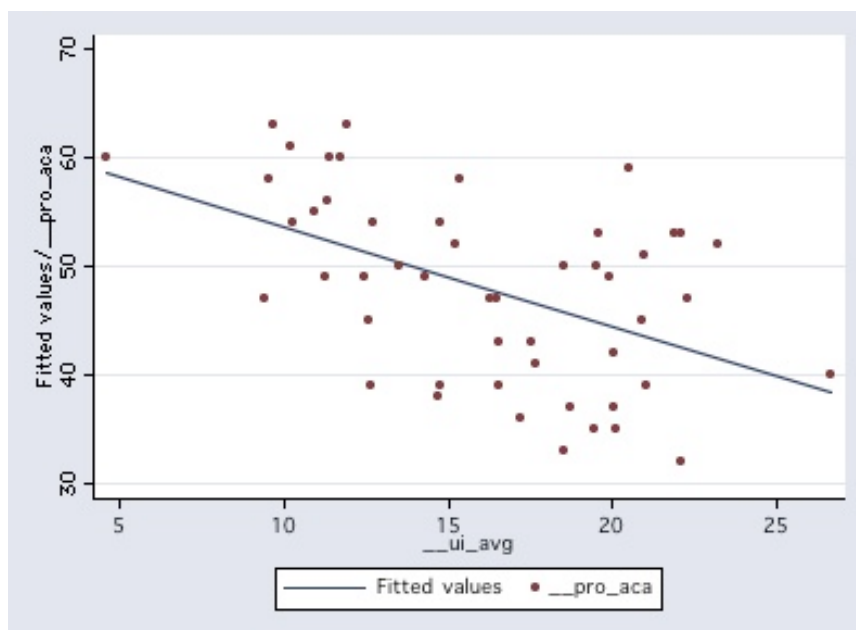
asked respondents “is religion an important part of your daily life?” This question was asked as part of their daily tracking poll throughout 2008, resulting in an N of over 350,000.

Finally, three different measures of the pre-existing political composition of the state are included. First, the state-level PVI (Cook 2012), the percentage of the vote received by Obama in the 2008 election, and the “average poll rating” (unadjusted) for Barak Obama during a period in the 2012 election campaign (Silver 2012).

Results

The first pass at examining the data is a simple bivariate relationship of the percentage uninsured in the state and the level of support for the PPACA.

Figure 2: Average Uninsured and State Level Support for the PPACA



A bi-variate relationship was the exact opposite of what we would expect with a strict economic analysis: as percentage uninsured increased, support for the PPACA declined. Believing that isn’t an accurate story, standard OLS regression models are estimated, including the range of variables discussed above.

Some brief explanation first: “partisanship” is the respective partisan lean variable for each of the three models in turn: in Model 1, it’s the polling average; Model 2, the PVI; Model 3, Obama’s percentage of the vote in 2008. Three discreet models are estimated here as, unsurprisingly, these three partisan indicators covary at an unacceptably high rate (all over .90).

Table 1: State Level Determinants of Support for the PPACA

	Model 1	Model 2	Model 3
Partisanship Measure	.60 ^{***} (0.08)	.69 ^{***} (0.09)	.66 ^{***} (0.06)
Religiosity	-0.27 ^{**} (0.09)	-0.23 [*] (0.09)	-0.25 ^{***} (0.07)
GDP per capita	0.00	0.00	0.00
Average uninsured 08-10	-0.38 [*] (0.16)	-0.25 (0.17)	-0.27 [*] (0.13)
%change uninsured 08-10	-0.01 (0.32)	.02 (0.31)	-0.11 (0.25)
Average unemp. 08-10	.22 (0.24)	.05 (0.24)	.16 (0.19)
Medicaid Rate (%)	-5.18 (14.75)	-5.17 (14.67)	-2.32 (11.55)
Poverty Rate (%)	.28 (0.27)	.19 (0.27)	.37 ⁺ (0.22)
% Black	.37 ^{***} (0.07)	.38 ^{***} (0.07)	.38 ^{***} (0.06)
% Latino	.10 ⁺ (0.05)	.11 [*] (0.05)	.08 ⁺ (0.04)
R²	.91	.91	.94

The model fit is strong across the board: between 91 and 94 percent of the variance in public opinion support for the PPACA is explained, with the model including the % vote for Obama in 2008 being the strongest, but only marginally so.

Four variables are consistently significant across the three models: the partisan measure, religiosity, and both race measures. Before discussing the others, a further comment needs to be made regarding conventional significance levels. The industry standard, however arbitrary, is .05; it is permissible to stretch this to .10 but only in cases where we have an *a priori* theoretical reason to not only expect a relationship, but also to expect the *direction* of the relationship. In the cases where this paper is treating an estimate as significant at the .10

level (specifically, the percentage Latino in Models 1 and 3) we have an a-priori theoretical expectation for the estimate to be significant in the direction indicated.

In terms of the hypothesis clusters, the first group, the economic hypotheses (H1-H3) were mixed. The uninsured are not only not more likely to support the PPACA, but rather from the evidence we have here, they are, if anything, less likely to support the PPACA, with estimates significant at the .05 level in two of the three models. What might account for this counterintuitive finding? Two possibilities come to mind. First, a large component represents the young uninsured, who see no need for a government policy essentially forcing them to purchase insurance when they're young and healthy. Second, it is possible that predominantly red states have atypically huge pockets of poverty and uninsured citizens, but the model should account for this through the other variables. The latter explanation is somewhat confirmed by the inclusion of an interactive term in the third model (not reported here) between religiosity and percentage uninsured. Red states are noted for higher levels of religiosity (Gelman 2010), and when this interactive term is included neither the interactive term nor the average uninsured estimates retain significance.

The only other economic indicator with any level of significance reported in the models is the poverty rate, which is a significant positive predictor of support for the PPACA in only one model and at the .10 level. Neither Medicaid rate nor the rate of unemployment report significant estimates.

The second cluster, partisanship, is highly associated with support for the PPACA. Taken in total, all three have highly substantive estimates on variance in support: average polling data in support of President Obama in September 2012, the state PVI, and the state level support for Obama in the 2008 election all strongly predict higher levels of support for the President's policy of health care reform. Likewise, higher levels of religiosity in a given state predict lower levels of support for the PPACA.

Finally, the third cluster, race, is consistently associated across all three models with positive support for the policy. Regardless of the measure of partisanship in the model, the higher the percentage of African-American in the state, the higher the level of support for the President's policy; likewise, stable support for higher levels of Latinos per state, with the latter only varying slightly in terms of significance level.

Conclusions

Of the three hypothesis clusters, two consistently yielded results supporting the predictions. Partisanship, both through the various measures as well as through religiosity, is associated with support (or opposition) to the PPACA in the predicted direction. Democratic states, and states with less of a religious inclination, are more likely to be supportive of the policy. Likewise, race is a consistent predictor of support as well, with states having higher levels of African Americans and Latinos being more supportive on average when other state level attributes are accounted for. Somewhat surprisingly, not only are economic indicators largely not predictive of support or opposition for the policy, those that did return with significant estimators (average uninsured twice, poverty rate only once) did so in a mixed manner. As discussed above, in two of the three models higher levels of uninsured in the states is associated with lower levels of support for the policy, while an increased level of poverty is only associated with increased levels of support in one model.

I tried several methods of isolating the swing states in advance of the 2012 election (of which I included NV, NM, CO, OH, WI, IA, NH, VA, NC and FL) on the assumption that perhaps heightened campaign activity in such states would have increased awareness of, and debate about, the PPACA. I ran models with those states only, which resulted in little more than null findings, but then an N of ten isn't going to afford any real statistical power. I also ran interactive terms in the model isolating whether or not these states as a group had a unique estimate for uninsured %, unemployment, Medicaid and poverty rate, likewise with no significant results of note.

What lessons can we take away from this little exercise? I have several ideas. Politically, it's evident why health care was not a major issue in the campaign. First, obviously, Romney would find it difficult to run against something that he supported in Massachusetts. Second, less obvious, it was not going to make a difference. Romney states were largely predisposed to oppose, while Obama states were in favour. The ten swing states identified above have a much tighter distribution of support for the PPACA (45%-53%) than the nation writ large (32%-63%), but adopting a strident anti-PPACA strategy had risks. Iowa and Florida show 45% support in this dataset, so these would be good targets to attack the PPACA, but one would risk losing support in Nevada and New Mexico (both 53%), and the other six (all at 49% or 50% in favour). In addition to the obvious risk of appearing inconsistent or hypocritical on the issue, the Romney campaign likely calculated that he stood more to lose than to gain by going after the PPACA in the swing states. While nine of the ten swing states specified above did end up in the incumbent's column (only North Carolina of the ten voted for Romney), Romney's own internal polling predicted a much closer race in those states, including winning three that he ultimately did not: Colorado, New Hampshire, and Iowa (Scheiber 2012). Thus, while in retrospect it might appear that making a strong issue out of the PPACA would have been a necessary gamble for Romney (and one that might have paid off), the campaign's own flawed picture of the race precluded such a risk.

The story here is clear, with the usual caveats about the ecological fallacy. Support for the PPACA is mediated both through a pre-existing political prism, and through a racial heuristic. Rather than expend the effort to consider the economic rationale for the policy in a complex profit and loss statement, support for Obamacare as public policy is a predominantly partisan issue.

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