

PERSONAL AND COLLECTIVE EVALUATIONS OF THE 2010 HEALTH CARE REFORM

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ABSTRACT

The 2010 health care reform law has been as controversial as any piece of American legislation in recent memory. Although numerous polls have been conducted on the public's views of the reform, we do not know much about how citizens evaluated the policy alternatives. Are citizens more focused on how policy affects them personally or how it affects the nation as a whole? Further, are these evaluations made more on the basis of past experience or assessments of how the policy will affect the future? Using an original survey of public opinion administered during the 2009 Congressional debate, we examine how these evaluative dimensions (and several other factors) shaped public support for overall reform, for associated policy goals, and for available policy tools. We find evidence that retrospective and prospective collective evaluations mattered most, as did personal prospective assessments, but evidence on personal retrospective factors is somewhat mixed.

INTRODUCTION

Health care reform dominated political debate for President Obama's first two years in office, and implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) has been contentious. Although health policy affects every citizen, and the reform debate has been highly salient, the factors shaping public opinion about the reforms are not well understood. Several studies have demonstrated demographic differences and partisan divisions in public views on health care reform (Blendon and Benson 2010; Brady and Kessler 2010; Oakman et al. 2010), but, while informative, these studies do not provide rich explanations about the factors shaping support for the 2010 health care reform effort.

Drawing on theoretical concepts from the literature on economic voting and the role that self-interest has on the formation of an individual's policy judgments, we test hypotheses regarding two evaluative factors that may shape citizens' views of the policy reform: personal versus collective assessments (or in other words, self-interest versus a broader view on how a policy affects the community) and retrospective versus prospective evaluations (or looking backwards versus forwards in assessing a policy change). We argue that these concepts can be used to understand the pattern of citizen support for health care reform. Past research has considered similar ideas descriptively (Blendon and Benson 2009; Jacobs and Shapiro 1994), and to a limited degree to analyze public support for government-sponsored health insurance (Funk 2000; Lau and Heldman 2009; Lynch and Gollust 2010; Sears et al. 1980), but these evaluative factors have not been systematically assessed in terms of how they shape attitudes about a specific reform such as the 2010 ACA.

To test these ideas at the individual level, we developed a survey of citizen attitudes about health care, which was administered in fall 2009 at the height of the Congressional debate

on the ACA. We examine general support for health care reform, as well as several specific policy goals associated with the reform, including reducing the overall costs of health care, improving the quality of health care for the poor, improving access to health care for the uninsured, and guaranteeing access for those with preexisting conditions. In addition, we examine support for several policy tools at the center of the debate, including the individual mandate that everyone have insurance, payment limits to doctors and hospitals, an emphasis on personal responsibility for health care costs, and the reduction of government regulation.

Our results suggest that prospective evaluations, both personal and collective, were important factors shaping approval of the 2010 ACA, its associated policy goals, and several policy tools. Retrospective collective evaluations were also significant contributors to support, but the evidence for retrospective personal evaluations was somewhat mixed. While the strongest determinants of public opinions on the health care reform initiative were political attributes (i.e., partisan identification and political ideology), our analysis shows that the evaluative dimensions were also important factors shaping people's assessments, and that they affected the attitudes of both Democrats and Republicans in a predictable and systematic manner.

In the next section, we review the literature on evaluative dimensions of policy. We then describe our data and methods before turning to the results of the analysis. We conclude with a discussion on the limitations of the study and how the results contribute to the literature.

PERSONAL VERSUS COLLECTIVE POLICY EVALUATIONS

An important question running through multiple streams of the political science literature is whether political behaviors and attitudes are motivated by personal or broader collective evaluations and concerns. That is, when individuals make political decisions, are they based

primarily on an evaluation of how these decisions will affect their own circumstances, or do they base their judgments on an appraisal of how the decision will affect society as a whole?

One important strand of this literature examines the extent to which Americans' perceptions of the economy influence their voting behavior. In general, scholars have found robust evidence of economic voting in U.S. presidential and congressional elections (see Lewis-Beck and Stegmaier 2000 for a relatively recent review). Much of this research focuses on two questions. First, is economic voting based on personal evaluations of the economy (i.e., one's personal financial situation, or pocketbook voting) or, alternatively, collective national assessments of the economy (i.e., national economic conditions, also called sociotropic voting)? Most empirical evidence indicates a stronger role for collective assessments (Kinder and Kiewiet 1979, 1981; Kiewiet 1983; Kinder et al. 1989; Markus 1992; Alvarez and Nagler 1995, 1998).

A second important question in this literature is whether economic voting is retrospective or prospective. Key (1966) and Fiorina (1978, 1981) argue that vote choice is largely a referendum on the incumbent administration, including the president's handling of the economy. Considerable empirical work supports this argument, finding that when the economy is performing poorly, presidents and their co-partisans lose electoral support (Kramer 1971; Tufte 1978; Hibbing and Alford 1981; Alvarez and Nagler 1995, 1998). Other research has found that voters also think prospectively (Fair 1978; Fiorina 1981; Lanou 1994; Lewis-Beck 1988; Lockerbie 1992), consistent with Downs' (1957) argument that voters seek to elect political parties that they believe will do the best job of representing their interests.

These dimensions of economic voting – personal v. collective and retrospective v. prospective – have provided an important theoretical foundation for scholars studying American voting behavior. These concepts have also proven useful in the political psychology and public

opinion literature that examines how individuals formulate preferences about economic policy issues. For example, studies have considered how personal and collective evaluations of the economy shape attitudes and policy preferences about taxes (Grant and Mockabee 2002), free trade (Mansfield and Mutz 2009) and immigration (Pantoja 2006), as well as economic performance itself (Funk and Garcia-Monet 1997; Mutz 1992, 1993).

Beyond economic evaluations, researchers have also examined how personal and collective assessments shape policy preferences on other issues. Motivating much of this literature is the question of the role that self-interest has in shaping citizens' political attitudes. One of the central assumptions of many political science theories, and especially rational choice theory, is that people are motivated primarily by self-interest (Mansbridge 1990), and yet critics have pointed to evidence that people often weigh their perceptions of collective needs as much or even more than their own needs when reaching political judgments (Mutz 1998). Beginning with the work of David Sears and colleagues, public opinion scholars have generally concluded that self-interest is a poorer predictor of policy attitudes than are societal-level assessments (Sears and Funk 1990). This is the case across a wide spectrum of policy domains, including school busing (Sears, Hensler, and Speer 1979), education (Moe 2001; Roch and Wilsker 2010), social services (Funk 2000), and counterterrorism (Joslyn and Haider-Markel 2007), although not always to the exclusion of personal interests (Funk 2000; Roch and Wilsker 2010). In some policy areas such as restrictions on smoking (Green and Gerken 1989), however, research suggests that self-interest influences policy preferences in important ways.

The two objectives of this paper are to determine if personal or collective assessments of health care were influential factors shaping support for the 2010 health care reform effort, and, further, whether individuals were influenced more by retrospective or prospective concerns. In

an assessment of earlier health care reform debates, Jacobs and Shapiro (1994) provide descriptive evidence that personal and collective dimensions affect health care beliefs. Analyzing survey data from the late-1970s to mid-1990s, they concluded that large majorities of the public (between 70%-95%) reported being personally satisfied with the quality and accessibility of health care, yet also expressed doubts about the quality and accessibility of health care for others. Moreover, when evaluating the prospects of the Clinton era reforms, the public believed that their own care would suffer as a result of the policy proposals, while that of others would improve. This type of disconnect fits into a broader pattern of policy attitudes that Mutz (1998) argues are caused by large structural changes in the nature of social interaction and a compartmentalization of personal and collective judgments.

Several studies have more directly examined whether personal or collective interests best explain preferences for government-sponsored health insurance. Analyzing the 1976 American National Election Study (ANES), Sears et al. (1980) found that individuals who did not have health insurance and those with insufficient insurance were more supportive of government-sponsored health insurance. Interestingly, compared to the issues of guaranteed jobs and income, busing of school children, and the rights of people accused of crimes, self-interest mattered the most for health insurance preferences. However, even with health insurance, Sears and his coauthors concluded that “symbolic” politics (i.e., party identification and political ideology) explained much more of the variation in preferences. A recent study by Lau and Heldman (2009) replicated this study using ANES data from 1992 and 2004, with largely the same results.

Two other studies have considered questions beyond whether self-interest matters more than political attitudes. Using ANES questions about government-sponsored health insurance, Funk (2000) considered measures of both self-interest and societal-interest. She found that each

was positively associated with support for government provided health insurance.¹ In a more recent study, Lynch and Gollust (2010) use survey items to measure the concept of fairness as a way to capture collective assessments of the health care system. The authors find that Americans' perceptions about health care inequalities (i.e., the degree of fairness in the system) often more strongly predict support for government-provided health insurance than concerns about one's own personal health care situation and other individual-level attributes.

Our analysis extends existing work in several ways. First, we examine the role of personal and collective assessments in the context of attitudes about a specific health policy reform. Previous research has explored attitudes in the abstract, employing survey questions that ask about policy changes in general. Analyzing the determinants of attitudes during a highly salient debate about health care reform provides a test of the role of these dimensions of public attitudes during a period when they were at the forefront of public discourse.² Second, previous studies have been limited to studying a single dimension of possible reform – government-sponsored health insurance. The primary reason is that researchers have relied almost exclusively on data available in the ANES,³ which does not include multiple relevant questions about health policy. In our study, we examine attitudes along multiple dimensions, including overall support for reform, specific policy goals underlying the reforms, and a set of available policy tools. Last, we consider not just the personal v. collective dimension in our analysis, but also the retrospective v. prospective dimension. Past studies have not distinctly measured and tested the differences between retrospective and prospective evaluations. The potential role for prospective assessments is particularly important given that we are interested in attitudes about specific policy proposals to change the health care system.

Given the preponderance of evidence in the existing literature on the weak role of retrospective personal evaluations and self-interest in driving policy preferences, in general, and with respect to health care in particular (i.e., government-sponsored health insurance), we expect that collective retrospective assessments played a larger role in shaping support for the 2010 ACA. This is not to say that personal considerations were unimportant, but we hypothesize that they were less impactful. We do, however, posit that both personal and collective prospective assessments were important. Considering the salience and duration of the health care reform debate, we hypothesize that individuals had sufficient time and information to formulate judgments about how they and the country as a whole would be impacted by the reform. In the next section, we describe the data and regression models we estimate to test these expectations.

DATA AND METHODS

To examine the individual-level factors associated with support for health care reform, we conducted a survey of 1,000 participants in fall 2009 during the Congressional debate on the bill that became the ACA. The survey was conducted as part of an ongoing effort by a consortium of universities known as the Cooperative Congressional Election Study (CCES) (Ansolabehere 2009, 2010). The CCES is an annual public opinion survey that has been administered by YouGov via the internet since 2006. Each annual survey is composed of two parts: a common section asked of all respondents, and team modules administered to subsamples of 1,000 persons. The questions analyzed in this paper were developed as part of a team module. To generate samples for its surveys, YouGov uses a matched random sample methodology. Specifically, the firm develops a target population from general population studies, and then draws a random set of respondents from this target population to create a “target sample.” Using

a matching algorithm, the firm selects potential respondents from its pool of opt-in participants that match the target sample.⁴ A recent multi-mode study comparing results of the 2010 CCES with a random digit dialing telephone survey and a random sample mail survey found that the 2010 CCES produces estimates similar to those for the other modes, particularly on attitudinal measures (Ansolabehere and Schaffner 2011). All of the regression models we estimate below use the survey weights provided by YouGov.

Support for Health Care Reform and Policy Goals

The health care reform debate was lengthy and involved a number of highly contentious dimensions ultimately resulting in a complex piece of legislation. To capture some of this complexity, we asked questions along three dimensions: support for the reform in general, support for specific policy goals associated with the reform, and support for policy tools that could be used to reform health care.

To measure overall support, we included two questions. The first question asked how strongly the respondent approved of President Obama's health care reform proposal. While answers to this question may be partially influenced by a respondent's view of the President, it was also one of the fundamental questions for political actors in the policy process. As shown in the top half of Figure 1, a small minority of respondents strongly approved of the reform (14%), and slightly more than a third overall approved of the proposal (35%). Meanwhile, over a third strongly disagreed with the reform (37%), and overall disapproval was about 45%. Almost one in five respondents chose neither approve nor disapprove.

[Figure 1 about here]

The other general question regarded the role of the federal government in guaranteeing access to health care. The responses to this question are presented in the bottom portion of Figure 1. Over a third of respondents agreed that the federal government should guarantee access to high quality care for all, and, if the access was only for necessary care, the overall support was about half of respondents. Alternatively, about a third preferred a reduction or elimination of federal responsibility for health care.

The survey also included questions on what we characterize as policy goals. We analyze four goals here that were frequently mentioned as central to the reforms being debated: 1) reduce overall costs for the country; 2) improve the quality of care for the poor; 3) improve access to care for the uninsured; and 4) guarantee insurance for individuals with pre-existing conditions.⁵ The responses to these questions are presented in the top portion of Figure 2. A strong majority of respondents supported the idea that reducing the costs of health care for the country was a very important (60%) or somewhat important goal (30%). About half of the survey respondents also agreed that it was very important that the reform improve the quality of health care for the poor, and another third agreed that it was somewhat important. Similarly, slightly more than half thought it was very important to increase access to health care for the uninsured, and another thirty percent thought it was somewhat important. Support for guaranteed health insurance for those with pre-existing conditions was even stronger with over sixty percent indicating it was very important and another quarter indicating it was somewhat important.

[Figure 2 about here]

The survey also included questions on several policy tools available to reform health care (but not necessarily used in the ACA): 1) require individuals to have insurance, with government support for the poor (the so-called individual mandate); 2) limit payments to doctors and

hospitals; 3) emphasize personal responsibility for health care costs; and 4) reduce government regulation on health care providers. The responses to these questions are presented in the lower portion of Figure 2, and it is clear that there was less overall enthusiasm for these policy tools compared to the policy goals.

About a quarter of the survey respondents agreed that it was very important that the reform require everyone to have insurance, and support reaches a majority if somewhat important responses are included. But, about 45 percent of the sample thought that use of this tool was not very important or not important at all. Exhibiting more support, about a quarter thought it was very important that the reform include limits on payments to doctors and hospitals, and over forty percent thought it was somewhat important. The other third of the respondents did not think that use of this tool was important. A large majority of respondents (about three-quarters) said the idea of emphasizing personal responsibility for health care costs was somewhat or very important, while about two-thirds of respondents believed reducing government regulation on health care providers was somewhat or very important.

Models

In the analysis that follows we examine the factors associated with support for the health care reform, and the specific policy goals and policy tools described above. The regression models we estimate are of the following form:

$$\begin{aligned}
 \text{Policy Support}_{ij} = & \alpha_{ij} + \beta_1 \text{Personal retrospective}_i + \beta_2 \text{Collective retrospective}_i + \\
 & \beta_3 \text{Personal prospective}_i + \beta_4 \text{Collective prospective}_i + \beta_5 \text{Trust in the federal} \\
 & \text{government}_i + \beta_6 \text{Distrust in health care institutions}_i + \beta_7 \text{Political preferences}_i + \\
 & \beta_8 \text{Demographics}_i + \varepsilon_{ij}
 \end{aligned}$$

where i indexes individuals, and j indexes the health care reform questions. The response set to the overall reform support questions is on a five-point scale and the others are on a four-point

scale. *Policy Support* is measured such that higher values indicate more support. It should be pointed out that for all models the variables are coded so that a higher value on the dependent variable is consistent with support for the President's position on reform. The overall reform support and policy goals are fairly straight forward, but the interpretation of the policy tools requires some explanation.

The individual mandate was a crucial component of the ACA so support of this policy tool is likely to be consistent with support of the reform, but such a mandate was also a component of the Massachusetts health care reform enacted under Republican Governor Romney, and such an idea had been endorsed by the conservative Heritage Foundation (Gottschalk 2011). Likewise, limiting payments to doctors and hospitals was a crucial part of the budgetary arithmetic of the health care reform, but some saw the agreement President Obama negotiated with the industry in exchange for their support as a "sweetheart deal" with only "modest concessions" (Hacker 2011). In each of these cases, we would expect models for these policy tools to display similar patterns to the overall support and policy goals models.

The last two policy tools, as originally worded, are likely to exhibit patterns contrary to support for the ACA. The idea of emphasizing personal responsibility for health care costs contradicts the goals of social insurance underlying the reform (Morone 2011), and reducing government regulation was not feasible for such complex legislation so such a preference was at odds with passage of the reform. To ease interpretation, the variables for personal responsibility and regulation reduction were coded so that all models could be interpreted such that higher values mean more support for reform.

The independent variables of central theoretical interest are measured with several items from the CCES survey. Summary statistics for all independent variables are listed in Table 1.

Personal retrospective evaluations are measured using responses to four questions: “In the past 12 months, have you or has anyone in your household decided not to have a medical test, treatment or care because of the out-of-pocket costs?”; “In the past 12 months, was there any time when you or anyone in your household had no health insurance of any kind?”; “How satisfied are you with your access to quality health care?” (with higher values indicating less satisfied); and “Would you say that in general your health is excellent, very good, good, fair, or poor?” (with higher values reflecting poorer health).⁶ Similar questions have been used in prior work examining the role of self-interest in health policy attitudes (Funk 2000; Lau and Heldman 2009; Lynch and Gollust 2010). We measure collective retrospective assessments with the response to a single item: “Thinking about the country as a whole, how satisfied are you with the health care system?” which is measured on a 5-point scale, where larger values indicate lower levels of satisfaction.

[Table 1 About Here]

To measure prospective evaluations, we construct two separate scales, one reflecting personal assessments and the other collective assessments.⁷ With respect to the former, we use a scale based on the respondents’ beliefs about how the reform would affect them and their families in the following nine ways: overall quality, costs, personal financial situation, choice of providers, waiting times for health care, life expectancy, overall health, future taxes, and overall satisfaction.⁸ We capture collective prospective evaluations similarly, using a scaled based on the same set of nine items, except they were framed in terms of affecting the country as a whole.⁹ We would expect that individuals having positive prospective evaluations would be more likely to support reform.

The models also control for several other variables that may have affected individuals' attitudes about the reform. First, we control for trust in government and healthcare institutions. We would expect that citizens with a low level of trust in the federal government would have been less supportive of the reform in general, and particularly for a strong role of the federal government. Trust in government has been shown to be correlated with policy preferences across issues, including health care reform (Hetherington 2005). We use responses to a question on one's trust in federal government to test these expectations, and higher trust is expected to be associated with a greater likelihood of support of reform.

In addition, citizens may have different levels of trust in health institutions, and more distrust of these private sector institutions may lead to greater support for policy reform (Blendon and Benson 2001; Kehoe and Ponting 2003; Mohseni and Lindstrom 2007). If one does not trust such large organizations operating across state boundaries, the federal government may be perceived as the only entity able to regulate health markets. We use a measure that combines responses to three questions that separately ask respondents to characterize their trust in hospitals, insurance companies, and pharmaceutical companies, with a higher score indicating greater distrust in these private institutions.

Finally, the models include respondent political and socio-demographic attributes to control for opinion differences across the population. In terms of political attitudes, we include indicator variables for self-identified Democrats and Independents (Republicans are the excluded category) and political ideology, which is measured on a 7-point scale, such that political liberals are coded as higher values.¹⁰ The expansion of health care access has been pushed by several Democratic presidents over the decades (from Truman, to Kennedy, Johnson, Clinton, and then Obama), and it has been described as "one of the Democratic Party's great canons" (Morone

2011, 377). Given the politically polarized debate over health care reform, and consistent with the findings of past studies (Blendon and Benson 2010; Brady and Kessler 2010; Oakton et al. 2010), we expect that Democrats, and to a lesser extent Independents, to be more supportive of the reform, the related policy goals, and policy tools. The partisan identification and political ideology variables also control for support for President Obama and the Democratically-controlled Congress. We also control for various socio-demographic characteristics, including age, age-squared (to test for a curvilinear relationship), education, gender, employment and income,¹¹ but we do not offer hypotheses or interpretation of the results for these variables.

RESULTS

We first present the results from our two models of general support for health care reform. The response set for each of the dependent variables used a five-point scale so we estimate the models with ordinal logistic regression. The parameter estimates presented in Table 2 provide the regression coefficient with standard errors in parentheses.

[Table 2 About Here]

Consider first the correlates with overall support for Obama's health care proposal. The model estimates indicate that personal retrospective assessments were not associated with approval for the President's reform, as none of the coefficients on the four measures attained statistical significance. By contrast, there was a significant relationship between collective retrospective assessments and attitudes toward reform; the more dissatisfied the respondent was with the health care system, the greater the likelihood that they favored Obama's reform proposal. Personal and collective prospective beliefs about health care were also correlated with

approval for reform. The more respondents believed that reform would improve their family's health care and that of the country as a whole, the more likely they were to support reform.

Trust in the federal government was positively related to approval for Obama's reform proposal, but distrust in health institutions was not a statistically significant determinant. In addition, self-identifying Democrats and Independents (compared to Republicans) were each much more likely to approve of the reform initiative, as were self-ascribed ideological liberals.

The second column in Table 2 reports model estimates for our second measure of general attitudes toward health care reform – the federal role in guaranteeing access to health care. For the personal and collective prospective assessments, the model findings are generally similar to those in the first model. Respondents who believed that health care reform would improve their own and the country's future health care expressed more support for an active federal role in guaranteeing access. Likewise, collective retrospective evaluations mattered. People who were dissatisfied with the existing health care system were more inclined to advocate an expansive role for the federal government. The results for personal retrospective evaluations were mixed. Consistent with expectations, those with poor personal health status were more likely to support the federal role. But, contrary to expectations (and dissimilar to the first model), respondents who lacked personal insurance at some point within the last twelve months were *less likely* to want the federal government to guarantee access to health care for all Americans.

An individual's degree of trust in the federal government was positively associated with approval of the federal government taking an active role in guaranteeing access to health care. Distrust in the health care industry also mattered. The more distrustful respondents were about hospitals, health insurance providers, and pharmaceutical companies (each equally represented in the scale), the more they favored an active role of the federal government. Self-identifying

Democrats (but not Independents) were more likely than Republicans to support the federal government guaranteeing Americans access to health care, as were liberals.

Policy Goals

The next set of results, presented in Table 3, estimate ordinal logistic models for four specific policy goals that were often articulated as part of the reform debate: reduce overall costs for the country, improve quality of health care for the poor, improve access to health care for the uninsured, and guarantee insurance for people with pre-existing conditions. For succinctness, we discuss the relationship between each of the explanatory variables and the different policy goals collectively.

[Table 3 About Here]

We find some evidence that personal retrospective evaluations were related to support for specific policy goals in the expected direction. Respondents who reported that someone in their household had to bypass a medical test, treatment, or care because of the out-of-pocket costs were more likely to support each of the policy goals, except overall costs reduction. In addition, individuals reporting poor personal health were more likely to support the preexisting conditions insurance goal.

The clearest results were for collective retrospective evaluations. Individuals dissatisfied with the overall health care system were more likely to support each of the policy goals. The results for personal and collective prospective evaluations were generally in the expected direction, but not always statistically significant across the different goals. Respondents who believed that reform would improve the health care system for themselves and their family (personal prospective) were more likely to support the reduction of costs, improvement of quality

care for the poor, and improvement in access for the uninsured. Those respondents seeing the reform as good for the country in general were more likely to support each of the policy goals, except for reducing overall costs.

Greater trust in the federal government was associated with a greater likelihood of support for the policy goals of improving the quality of care for the poor and improving access for the uninsured. Distrust in health institutions was generally not associated with support for the goals except that those with greater distrust were more likely to support the goal of improving the quality of care for the poor.

Compared to Republicans, Democrats and Independents were more likely to support most policy goals. Democrats were much more likely than Republicans to support the reduction of costs and the goal of guaranteeing access for pre-existing conditions. Independents were more likely than Republicans to support all of the goals except for the cost reduction. Somewhat surprisingly, liberal ideology was significantly associated with only one goal, improving access for the uninsured.

Policy Tools

In Table 4, we present the results for models of support for various policy tools available for health care reform. Again, the first two tools of an individual mandate and limiting payments to doctors and hospitals were consistent with the reform plan, and the tools of emphasizing personal responsibility and reducing government regulation were coded in reverse so that they would have a consistent interpretation with the other models. The dependent variable in model 3 attains a high value when someone said the goal of emphasizing personal responsibility was *not*

important, and a higher value on the dependent variable in model 4 indicates one thinks reducing regulation is *not* important.

[Table 4 About Here]

Looking across the four models, the results for the personal retrospective variables are mixed. In general, those in poor health and with poor access were supportive of the position consistent with the president's health reform approach. They prefer limiting payments to doctors and hospitals, and not emphasizing personal responsibility, and, in the case of individuals in poorer health, not reducing regulation on health care providers. Conversely, respondents with no insurance at some point in the past 12 months were much *less likely* to support the individual mandate, and were favorable toward more of an emphasis on personal responsibility for health care costs. Clearly, respondents without insurance were very concerned about being compelled to purchase insurance and the cost of doing so.

The results for the other evaluative factors are similar to the previously discussed models. Those dissatisfied with the health care system as a whole (collective retrospective) were more likely to support the policy tools of an individual mandate and limiting payments, and they were more likely to view emphasizing personal responsibility for costs and the reduction of government regulation as not important. While not as strong as in the earlier models, the coefficients on the personal and collective prospective measures are in the expected direction and statistically significant in five of the eight cases. Respondents perceiving positive personal benefits of the reform were more likely to support the individual mandate, limiting payments to providers, and not reducing government regulation. Likewise, those seeing the health care reform as having positive effects for the nation as a whole were more likely to support the individual mandate and to see government regulation as not as important.

There are limited results for the trust and political variables in these models. Trust in federal government was associated with a greater likelihood of support for the individual mandate, but it did not matter for support of other policy tools. Distrust in health institutions was positively related to wanting an emphasis on personal responsibility for costs and maintaining government regulation. These findings are consistent with an argument that citizens with such views see the federal government as an important check on these institutions. Democrats were more likely to support the individual mandate and the payment limits, but they were not significantly different than Republicans on the other two tools. Finally, political liberals were much more likely to support policy tools consistent with the reform.

Understanding the Impact of the Evaluative Dimensions

The results across the models are consistent with our expectations that retrospective evaluations (especially, collective) and prospective evaluations were important factors shaping attitudes about the health care reform. How influential were these factors in explaining opinion? To help interpret the results, we present two additional types of analysis.

First, we examine the amount of variance attributable to the various evaluative factors relative to the other attitudinal, political, and socio-demographic attributes considered in the model. Because this cannot be done directly in ordinal logistic regression, we base this analysis on the results of a series of ordinary least squares regression models, which allows us to compare the amount of variance explained by different sets of variables, using the R-square statistic. The models themselves generate essentially the same pattern of results. We first estimate a base model that includes demographics only, followed by a model that adds the partisanship, political ideology, and trust variables, and then models that serially add the four different evaluative

dimensions. At each step, we calculate the change in R-square, allowing us to see how much these factors add to our understanding of health care reform attitudes. Given the partisan polarization on the health care debate, we would expect much of the variance to be explained by individuals' political orientations. For this reason, any evidence that these evaluative dimensions played a substantial role would be notable.

Figure 3 uses a stacked bar chart to display the results of this analysis, with the R-square attributable to demographics at the bottom, the political and trust variables in the next bar, and the evaluative dimensions at the top. The first column suggests that almost three-quarters of the variance in support for the Obama health care reform is explained by the model, and over 13% of the variance is attributable to the evaluative dimensions (with personal prospective accounting for the largest share). Likewise, the second column suggests that the model accounts for about 60% of the variance in support for a federal role in guaranteeing access to health care, and the evaluative dimensions account for an improvement of over eleven percentage points. As expected, political attributes account for most of the explained variance in all of the models.

[Figure 3 About Here]

In general, our models explain less of the total variance in the policy goals and tools models. In several cases, the political attributes and trust measures do not account for nearly as much of the variance as in the overall support models. That said, once we control for demographics, partisan identification, ideology, and trust, the evaluative dimensions account for a substantial portion of the explained variance in the dependent variables. For the policy goals models, about a quarter of the explained variance is attributable to the evaluative dimensions, and the collective retrospective and personal prospective generally stand out. The total explained variance in the policy tools models range from 13% (emphasizing personal responsibility) to

43% (requiring individuals to buy insurance), with the evaluative dimensions accounting for roughly a fifth of the variance that is explained.

Another way to assess the relationship between support for the health care reform and the evaluative dimensions is to examine the predicted probabilities of different levels of support for different values of the evaluative measures. This is done using the parameter estimates from the ordinal logistic models. Due to space limitations, we present this analysis only for the overall support model (using the estimates from Table 2, Column 1) and the evaluative dimensions (with just one of the personal retrospective variables). In addition, because the results display very strong partisan effects, we examine the change in predicted probabilities separately for Democrats and Republicans. Partisans viewed the reform differently, but if their evaluative assessments changed how would their likelihood of support have changed? In other words, if citizens accepted President Obama's arguments that the policy would be good for them or for the country as a whole, would they have been more likely to support the reform, regardless of partisan affiliation?

[Figures 4 and 5 About Here]

The graphs in Figures 4 and 5 examine the predicted probabilities for self-identified Democrats and Republicans for each category of support for the Obama health care reform for different values of the evaluative factors, holding the rest of the variables in the model constant at their means. Recall from Table 2 that none of the personal retrospective variables reached statistical significance, and the pattern in Figure 4a shows this visually; there is no increase in the likelihood of approval for respondents of either party as dissatisfaction with personal access to health care increases. Figure 4b, however, reveals a pattern for Democrats of increasing approval (and decreasing disapproval) as the collective retrospective variable increases. While

Republican support does not shift as we move to the right in the graph, one can see that strong disapproval decreases substantially, and the indifference category modestly increases.

The graphs in Figure 5a and 5b reveal much stronger patterns. For Democrats, as the belief that the reform will have personal future benefits grows stronger (personal prospective), there is a dramatically greater likelihood of approving or strongly approving President Obama's health care reform proposal (with an associated drop in the "neither" category). Although Republicans never become as supportive as Democrats, the graph in Figure 5A also suggests that the likelihood of strong disapproval greatly diminishes as the expected individual benefits scale increases. And, for large values on the individual benefit scale, the predicted probability of a Republican respondent supporting the reform proposal grows substantially, although it is important to note that there are not that many respondents at the extremes of these scales so the predicted probabilities at these points are estimated with considerable uncertainty.

The general pattern of predicted probabilities for the prospective collective scale is similar. As displayed in the lower panel of Figure 5, the probability of a Democrat approving of the President's reform package was roughly three to four times higher, moving from the low to the high end of the scale. Similarly, their probability of either disapproving or strongly disapproving declined substantially. For a Republican respondent, the change in predicted probability of approving or strongly approving of Obama's health care reform proposal did not change much as views of the national benefits of the proposal increased, but such increases did bring down the probability of strongly disapproving substantially.

In sum, for both prospective evaluative dimensions, more positive assessments are associated with a shift in the more supportive direction. This finding suggests that the battle to frame expectations of the legislation was important for overall support. If President Obama and

his allies could have shifted the expectations of more Republicans to a more positive prospective evaluation, there may have been much less opposition, and a similar shift among Democrats would have increased their strength of support.

DISCUSSION AND CONCLUSION

Our analysis suggests several important aspects of public opinion about the 2010 health care reform debate that previous work has not considered. In addition to the clear and well-documented partisan differences in opinion about the ACA (Blendon and Benson 2010; Brady and Kessler 2010; Oakman et al. 2010), we find that citizens' perceptions of the reform were also partially driven by their collective (and sometimes personal) assessments of the current U.S. health care system, as well as and their expectations about how the reform would affect their future health care, and that of their family and the country as a whole.

There are a couple of important limitations to our analysis that should be noted. First, the study relies on a single cross-sectional survey so we cannot (and do not) make any causal claims, or rule out the possibility that individuals' opinions changed over the course of the protracted health care debate. In addition, we developed several new attitudinal measures to capture respondents' assessments of health care. While many of these ideas were directly adapted from past research on economic voting, some (particularly, the prospective evaluations) have not previously been used in the health policy context. While we believe the measures performed well, future research may want to consider alternative measurements or replications of these measures to further test their validity.

Notwithstanding these important caveats, we would like to highlight what we believe are several notable implications of the analysis. Our finding regarding the relationship between

prospective evaluations and health care policy preferences, both personal and collective in nature, is significant. Prospective evaluations were important correlates of health reform support and a federal role in guaranteeing access to health care, and in general they were associated with a greater likelihood of support for the related policy goals and policy tools. Although this finding is new for the case of health care reform, it is consistent with results for prospective economic voting (Fair 1978; Fiorina 1981; Lanou 1994; Lewis-Beck 1988; Lockerbie 1992). Our research cannot directly speak to how and why citizens formed their prospective evaluations of policy, but one would expect that factors such as news consumption, media influence, and personal predispositions played a role. Future research could consider these and other factors in both assessing the role of prospective evaluations in this specific case, and potentially in shaping attitudes and preferences in other policy domains as well.

A second important finding regards personal retrospective evaluations. An individual's personal health care situation was, more often than not, unrelated to their level of support for the reform. Instead, an individual's societal-level assessment of the health care system was a stronger correlate. On one hand, finding that collective interests mattered more consistently than self-interest is not surprising. Decades of research across a variety of policy areas (Sears, Hensler, and Speer 1979; Sears and Funk 1990; Mutz 1998; Funk 2000; Roch and Wilsker 2010), including government-provided health insurance (Funk 2000; Lynch and Gollust 2010), has found similar evidence that people often reach political and policy judgments with collective interests in mind. On the other hand, we think it is particularly noteworthy that respondents in the survey without insurance were not more likely to support the reform (or its associated goals), and were actually *less likely* to support a Federal role in guaranteeing access to health care and the individual mandate.

One could certainly put a positive spin on these findings, since it would be reassuring if it were the case that these individuals formed their judgments about the ACA with the interests of the nation as a whole in mind, regardless of their own personal challenges with health and the health care system. There is another possible interpretation, however, that might also explain the lack of a role of self-interest in this case. Past work has identified several conditions under which self-interest is most likely to influence individual's political attitudes and policy preferences, including when the effects of the issue at stake are visible, tangible, large, and certain (Citrin and Green 1990; Erikson and Stoker 2011; Sears and Funk 1990). It is possible that for many Americans, the links between their own situation and that of potential benefits of the ACA were unclear, vague, small, and dubious. This divide might be attributable to a failure of communication about the reform (or successful communication from reform adversaries) or a more general skepticism that the President and Democratically-controlled Congress could successfully design a reform package. Regardless of the explanation, the very people that many health care reform advocates believed would benefit the most from the ACA were often unconvinced.

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Notes

¹ The question of particular interest in Funk's paper was whether societal interests moderated the impacts of self-interest. Dissimilar to the other policy areas examined (social welfare and government services), Funk did not find that societal interests moderated personal interest in explaining individual support for government provided health insurance.

² Koch (1998) examined changes in support for government guaranteed health insurance during the Clinton era health care reform debate, but he did not directly study attitudes about the reform.

³ The study by Lynch and Gollust (2010) is an important exception, but they too chose to focus on government-sponsored health insurance as their policy intervention.

⁴ More information on the YouGov sampling methodology is available from Rivers (2007) and Vavreck and Rivers (2008).

⁵ One could argue that the health care reform had other goals. Although not analyzed here, the survey also included items on reducing the cost of Medicaid, reducing the cost of Medicare, improving the quality of care for all, and helping people maintain their current health insurance coverage.

⁶ We do not construct a single scale of personal retrospective evaluations because it is customary in the literature to estimate separate coefficients for each of these measures. The four items also do not fit together well as part of single scale (Cronbach alpha=.45).

⁷ The Cronbach alpha statistic for the items comprising the prospective personal and collective scales were .96 and .97, respectively, suggesting that the items fit together well.

⁸ The question was worded as follows: "If health care reform is signed into law, how do you think it will affect each of the following for *you and your family*? Quality of health care, Health care costs your family pays, Personal financial situation, Choice of health care providers,

Waiting times for health care, Life expectancy, Your overall health, Taxes you pay, Overall satisfaction with healthcare system.” The response options were: Much worse, Somewhat worse, No difference, Somewhat better, and much better.

⁹ The question was worded as follows: “If health care reform is signed into law, how do you think it will affect each of the following for *the country as a whole*? Quality of health care, Health care costs for the country, The economy, Choice of health care providers, Waiting times for health care, Americans’ life expectancy, Americans’ overall health, Government health care expenditures, Overall satisfaction with healthcare system.” The response options were: Much worse, Somewhat worse, No difference, Somewhat better, and much better.

¹⁰ The Democratic and Republican categories include those saying that they lean toward the party.

¹¹ Because about nine percent of the sample did not respond to the income question in the survey, we also include a variable indicating whether a respondent answered this question.

Table 1. Summary Statistics for Independent Variables

	Mean	Standard Deviation	Minimum	Maximum
<i>Personal Retrospective</i>				
Missed Care Due to Out-of-Pocket Cost	0.39	0.49	0	1
No Insurance in Past 12 Months	0.34	0.48	0	1
Dissatisfied with Personal Access to Health Care	2.39	1.37	1	5
Personal Health Status	2.46	1.06	1	5
<i>Collective Retrospective</i>				
Dissatisfied with Health Care System	3.40	1.26	1	5
<i>Personal Prospective</i>				
Health Care Reform Individual Benefit	14.3	9.20	0	36
<i>Collective Prospective</i>				
Health Care Reform National Benefit	15.4	10.6	0	36
<i>Trust and Health Status</i>				
Trust in Federal Government	1.74	0.77	1	4
Distrust Health Institutions	8.60	1.92	3	12
<i>Political Attributes</i>				
Democrat	0.49	0.50	0	1
Independent	0.15	0.35	0	1
Liberal Political Ideology	3.78	1.68	1	7
<i>Demographic Attributes</i>				
Age	46.4	17.0	18	88
Age-squared	2441	1631	324	7744
Education	3.18	1.52	1	5
Female	0.52	0.5	0	1
Full-time job	0.36	0.48	0	1
Income	6.68	4.10	0	14
Income Answered	0.89	0.32	0	1

Table 2. Overall Support for Health Care Reform

	Support for Obama Health Care Reform (1)	Support for Federal Role in Guaranteeing Access to Health Care (2)
<i>Personal Retrospective</i>		
Missed Care Due to Out-of-Pocket Cost	0.098 (0.166)	0.152 (0.160)
No Insurance in Past 12 Months	0.002 (0.171)	-0.462*** (0.170)
Dissatisfied with Personal Access to Health Care	-0.081 (0.062)	0.023 (0.060)
Poor Personal Health Status	-0.113 (0.077)	0.190** (0.075)
<i>Collective Retrospective</i>		
Dissatisfied with Health Care System	0.169** (0.074)	0.372*** (0.070)
<i>Personal Prospective</i>		
Health Care Reform Individual Benefit	0.138*** (0.018)	0.075*** (0.018)
<i>Collective Prospective</i>		
Health Care Reform National Benefit	0.076*** (0.015)	0.049*** (0.015)
<i>Trust in Institutions</i>		
Trust in Federal Government	0.702*** (0.116)	0.398*** (0.115)
Distrust Health Institutions	0.070 (0.045)	0.117*** (0.042)
<i>Political Attributes</i>		
Democrat	1.517*** (0.237)	0.753*** (0.218)
Independent	0.788*** (0.256)	0.148 (0.233)
Liberal Political Ideology	0.186*** (0.063)	0.244*** (0.062)
<i>Demographic Attributes</i>		
Age	0.004 (0.026)	0.083*** (0.026)
Age-squared	-0.000 (0.000)	-0.001*** (0.000)
Education	0.090 (0.057)	0.036 (0.053)
Female	-0.051 (0.149)	-0.177 (0.143)
Full-time job	0.171 (0.175)	-0.217 (0.165)
Income	-0.028 (0.026)	-0.021 (0.025)
Income Answered	-0.305 (0.312)	-0.193 (0.293)
Sample Size	885	880
LR Chi Square (19)	1061.0	737.2
Probability > Chi Square	0.000	0.000

Note: Columns present coefficients from ordinal logit regressions, with standard errors in parentheses.

Significance Levels: *** p<0.01, ** p<0.05, * p<0.1.

Table 3. Support for Health Care Reform Policy Goals

	Reduce Overall Costs for the Country (1)	Improve the Quality of Care for the Poor (2)	Improve Access to Health Care for the Uninsured (3)	Guarantee Insurance Despite Pre-Existing Condition (4)
<i>Personal Retrospective</i>				
Missed Care Due to Out-of-Pocket Cost	0.165 (0.173)	0.459*** (0.171)	0.412** (0.176)	0.421** (0.180)
No Insurance in Past 12 Months	0.069 (0.182)	0.043 (0.177)	0.198 (0.184)	0.128 (0.191)
Dissatisfied with Personal Access to Health Care	0.084 (0.066)	-0.016 (0.063)	0.040 (0.066)	-0.050 (0.069)
Poor Personal Health Status	-0.008 (0.080)	-0.003 (0.079)	-0.014 (0.080)	0.245*** (0.085)
<i>Collective Retrospective</i>				
Dissatisfied with Health Care System	0.338*** (0.074)	0.409*** (0.073)	0.424*** (0.074)	0.418*** (0.076)
<i>Personal Prospective</i>				
Health Care Reform Individual Benefit	0.047*** (0.018)	0.064*** (0.018)	0.034* (0.018)	0.018 (0.019)
<i>Collective Prospective</i>				
Health Care Reform National Benefit	-0.007 (0.015)	0.025* (0.015)	0.043*** (0.016)	0.040** (0.016)
<i>Trust in Institutions</i>				
Trust in Federal Government	-0.004 (0.126)	0.327*** (0.123)	0.229* (0.130)	0.180 (0.131)
Distrust Health Institutions	-0.008 (0.046)	0.078* (0.045)	0.000 (0.047)	0.006 (0.048)
<i>Political Attributes</i>				
Democrat	0.470** (0.234)	0.336 (0.227)	0.354 (0.231)	0.733*** (0.241)
Independent	-0.031 (0.244)	0.619** (0.249)	0.438* (0.246)	0.482* (0.255)
Liberal Political Ideology	0.059 (0.066)	0.063 (0.065)	0.277*** (0.069)	0.020 (0.069)
<i>Demographic Attributes</i>				
Age	0.118*** (0.027)	0.017 (0.027)	0.078*** (0.028)	0.088*** (0.028)
Age-squared	-0.001*** (0.000)	0.000 (0.000)	-0.001** (0.000)	-0.001* (0.000)
Education	-0.080 (0.056)	-0.015 (0.055)	-0.036 (0.056)	-0.093 (0.058)
Female	-0.108 (0.152)	0.303** (0.148)	-0.003 (0.153)	0.234 (0.156)
Full-time job	-0.390** (0.179)	0.020 (0.174)	-0.714*** (0.182)	-0.191 (0.184)
Income	0.010 (0.027)	-0.040 (0.026)	0.003 (0.027)	0.037 (0.027)
Income Answered	-0.034 (0.323)	0.164 (0.319)	-0.225 (0.337)	-0.844** (0.351)
Sample Size	881	881	881	883
LR Chi Square	178.5	432.2	483.2	307.9
Probability > Chi Square	0.000	0.000	0.000	0.000

Note: Columns present coefficients from ordinal logit regressions, with standard errors in parentheses.

Significance Levels: *** p<0.01, ** p<0.05, * p<0.1.

Table 4. Support for Health Care Reform Policy Tools

	Require Individuals to Have Insurance, with Government Support for the Poor (1)	Limit Payments to Doctors and Hospitals (2)	Not Emphasize Personal Responsibility for Health Care Costs (3)	Not Reduce Government Regulation on Health Care Providers (4)
<i>Personal Retrospective</i>				
Missed Care Due to Out-of-Pocket Cost	-0.128 (0.153)	0.058 (0.149)	0.042 (0.149)	-0.090 (0.150)
No Insurance in Past 12 Months	-0.386** (0.161)	-0.135 (0.155)	-0.260* (0.153)	-0.198 (0.155)
Dissatisfied with Personal Access to Health Care	-0.034 (0.057)	0.125** (0.056)	0.152*** (0.056)	-0.067 (0.057)
Poor Personal Health Status	0.052 (0.069)	0.174** (0.068)	0.221*** (0.067)	0.135** (0.067)
<i>Collective Retrospective</i>				
Dissatisfied with Health Care System	0.220*** (0.067)	0.144** (0.065)	0.121* (0.067)	0.227*** (0.065)
<i>Personal Prospective</i>				
Health Care Reform Individual Benefit	0.057*** (0.016)	0.030* (0.016)	0.004 (0.016)	0.030* (0.016)
<i>Collective Prospective</i>				
Health Care Reform National Benefit	0.040*** (0.014)	0.006 (0.014)	0.017 (0.014)	0.030** (0.014)
<i>Trust in Institutions</i>				
Trust in Federal Government	0.348*** (0.107)	-0.026 (0.103)	-0.101 (0.103)	0.046 (0.106)
Distrust Health Institutions	0.017 (0.040)	0.062 (0.039)	0.070* (0.039)	0.220*** (0.041)
<i>Political Attributes</i>				
Democrat	0.735*** (0.210)	0.795*** (0.212)	0.029 (0.205)	0.187 (0.209)
Independent	0.152 (0.227)	0.413* (0.223)	0.077 (0.224)	0.305 (0.222)
Liberal Political Ideology	0.117** (0.058)	-0.040 (0.056)	0.146*** (0.056)	0.097* (0.057)
<i>Demographic Attributes</i>				
Age	0.021 (0.025)	0.077*** (0.024)	-0.056** (0.024)	-0.059** (0.024)
Age-squared	-0.000 (0.000)	-0.001*** (0.000)	0.001** (0.000)	0.001* (0.000)
Education	-0.115** (0.050)	-0.183*** (0.048)	-0.022 (0.049)	0.215*** (0.049)
Female	0.736*** (0.135)	0.444*** (0.132)	-0.111 (0.131)	-0.629*** (0.134)
Full-time job	0.149 (0.159)	0.001 (0.154)	0.111 (0.154)	-0.140 (0.152)
Income	0.072*** (0.024)	-0.059** (0.023)	-0.027 (0.023)	0.027 (0.022)
Income Answered	-0.995*** (0.283)	0.097 (0.281)	0.371 (0.280)	0.506 (0.284)
Sample Size	878	879	875	878
LR Chi Square	484.8	240.1	124.5	302.7
Probability > Chi Square	0.000	0.000	0.000	0.000

Note: Columns present coefficients from ordinal logit regressions, with standard errors in parentheses.

Significance Levels: *** p<0.01, ** p<0.05, * p<0.1.

Figure 1. Support for Health Care Reform

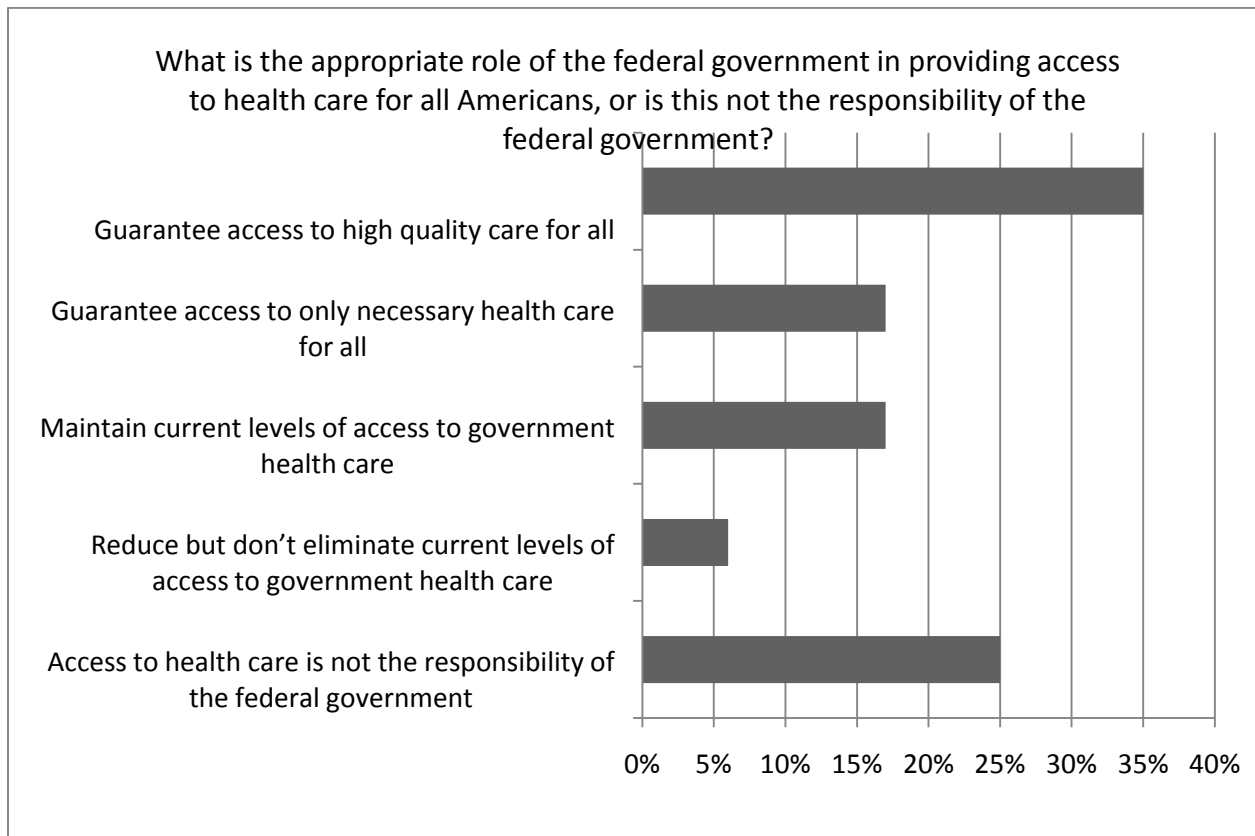
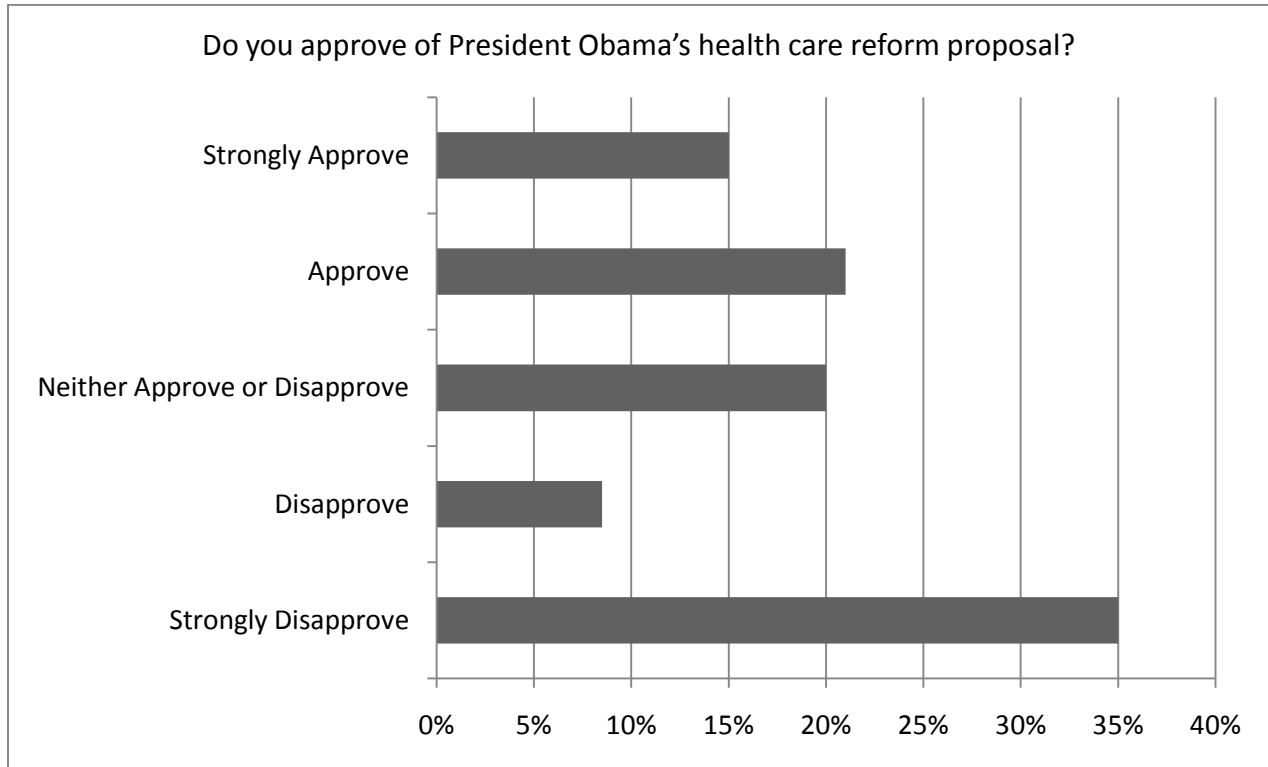


Figure 2. Support for Health Care Reform Policy Goals and Tools

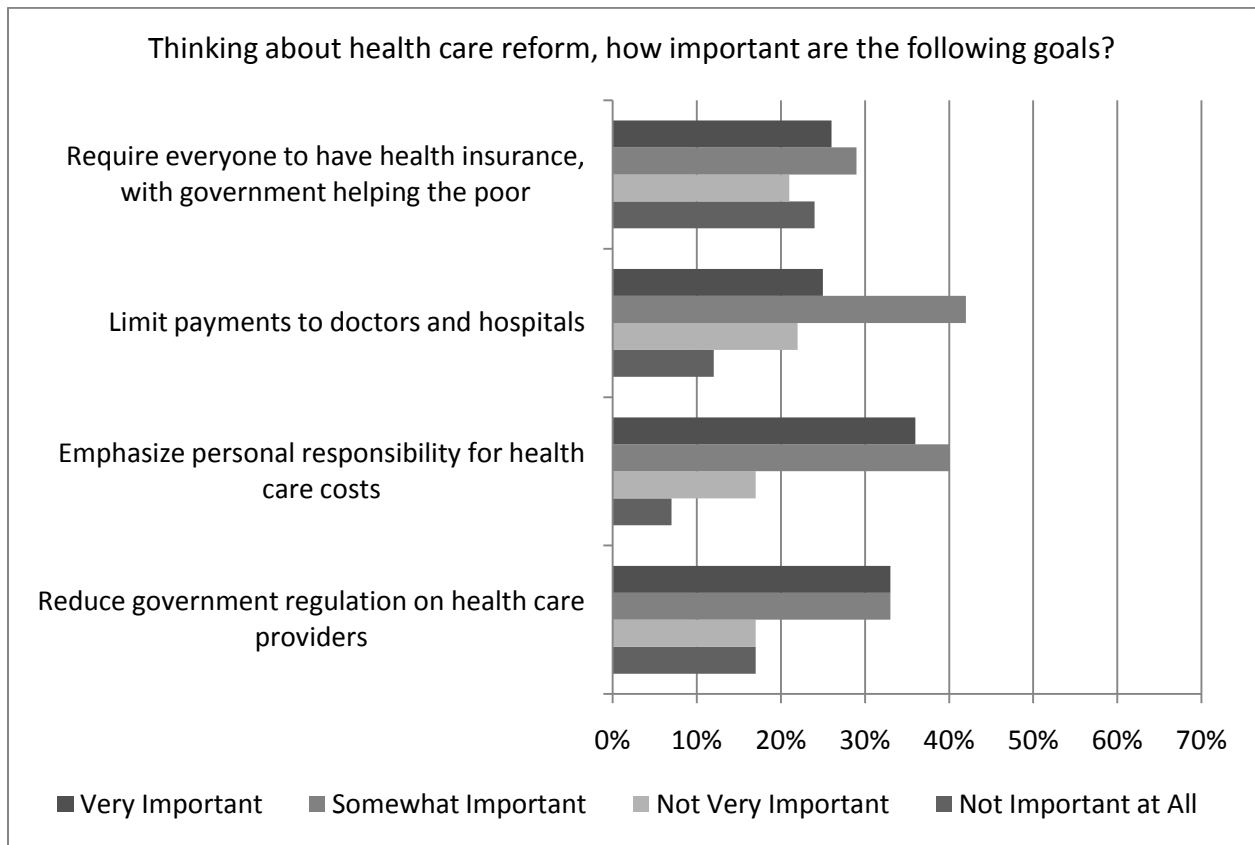
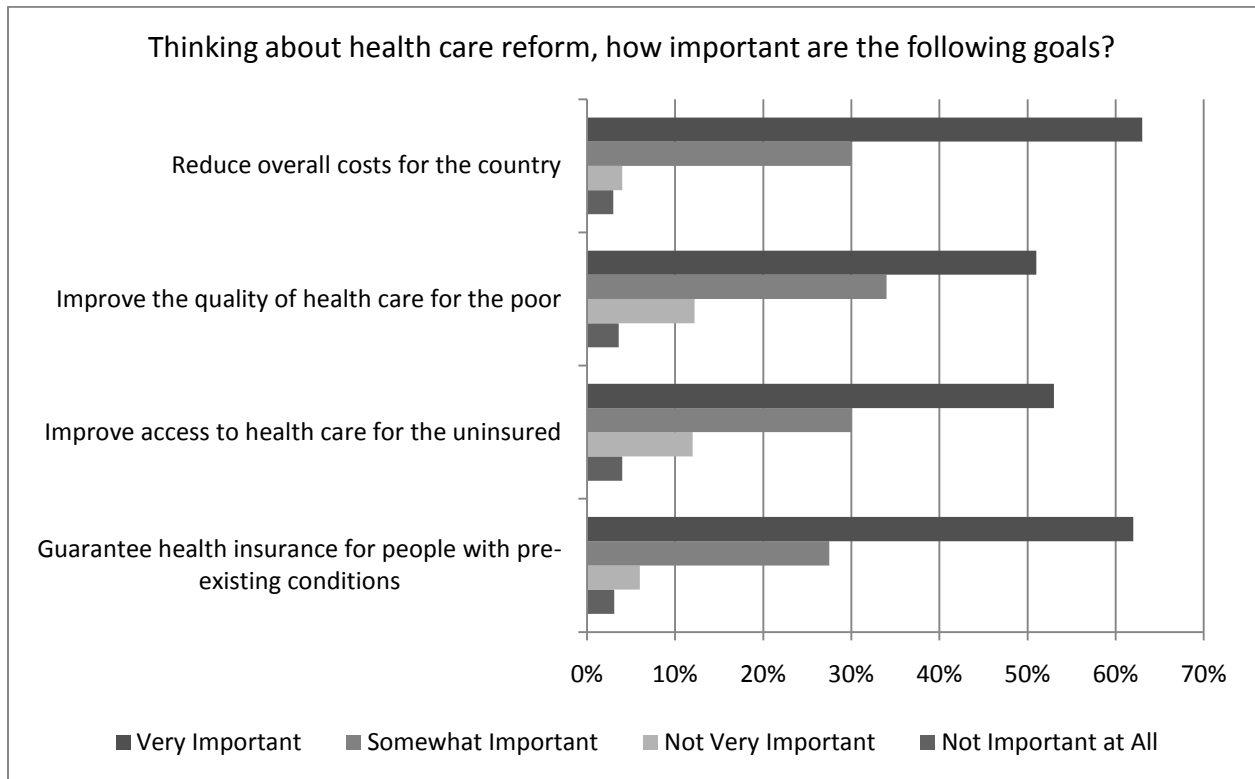


Figure 3. Percent of Model Variance Explained by Evaluative Dimensions

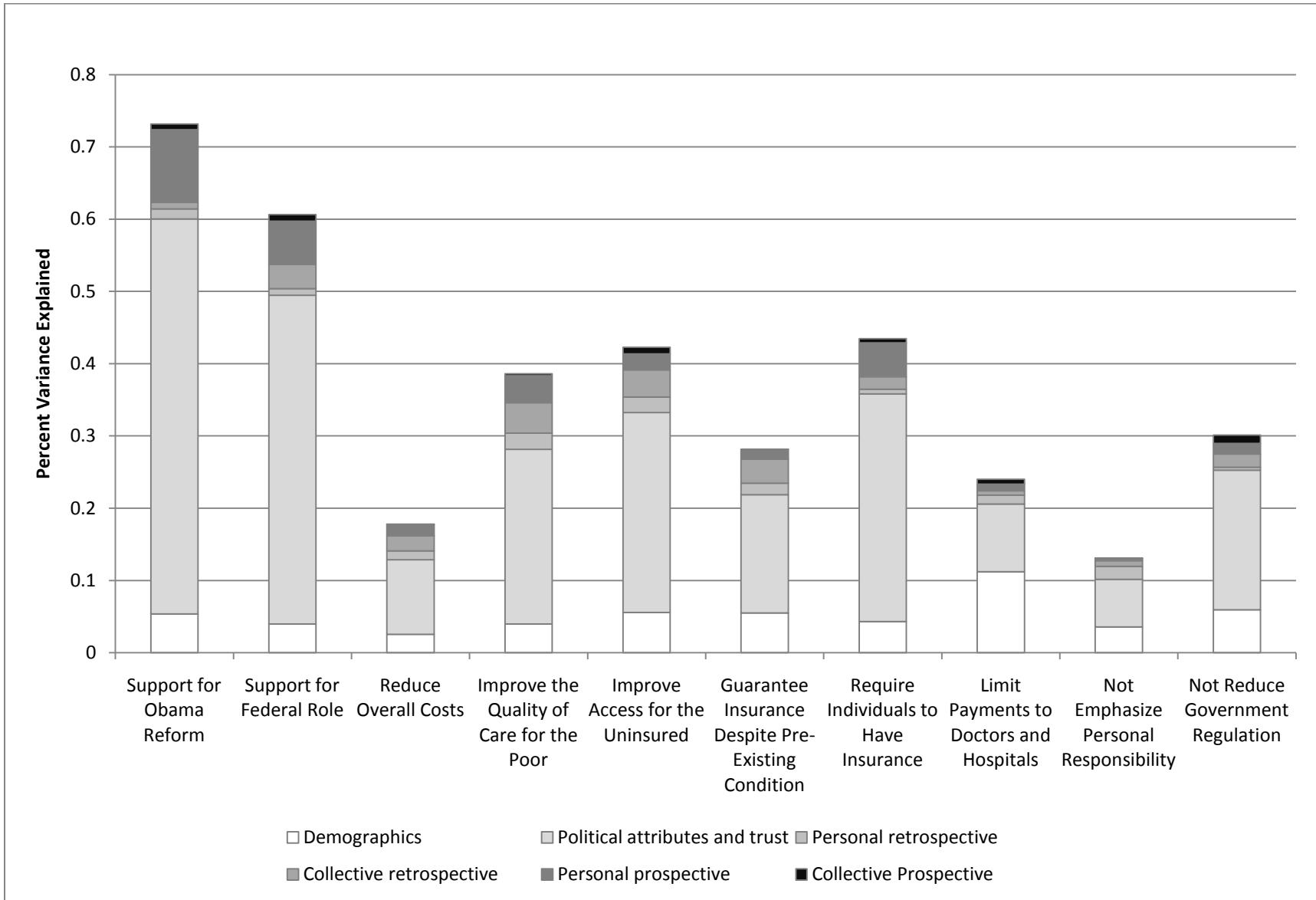
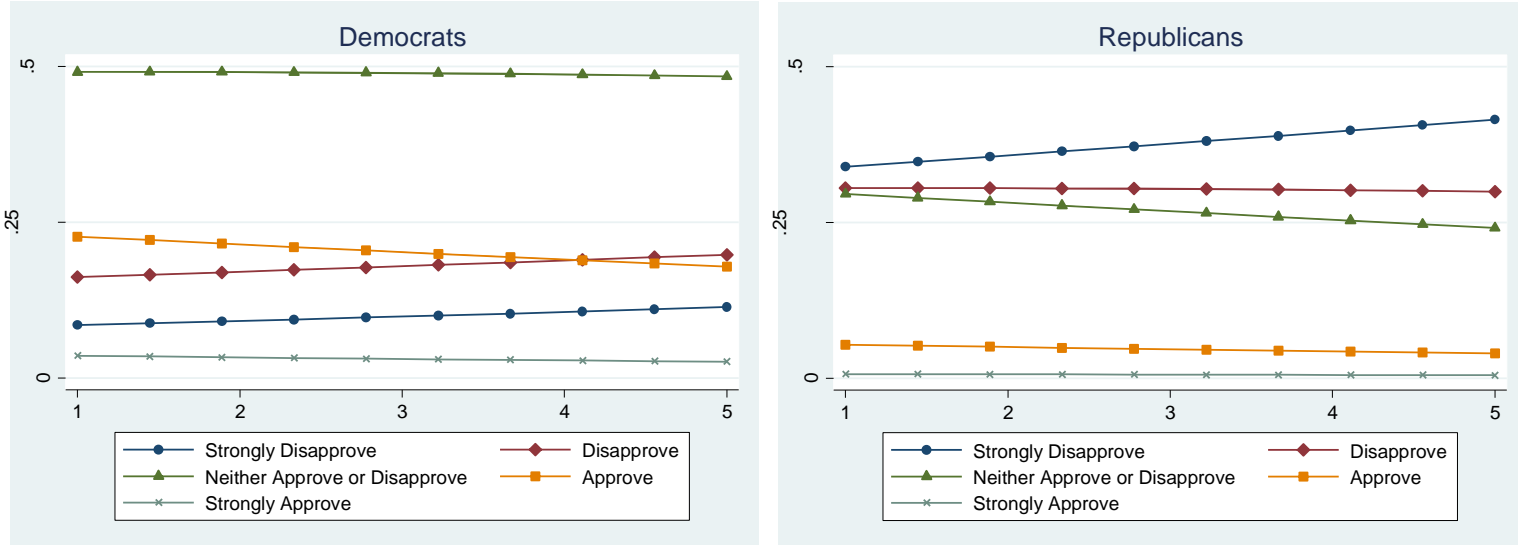
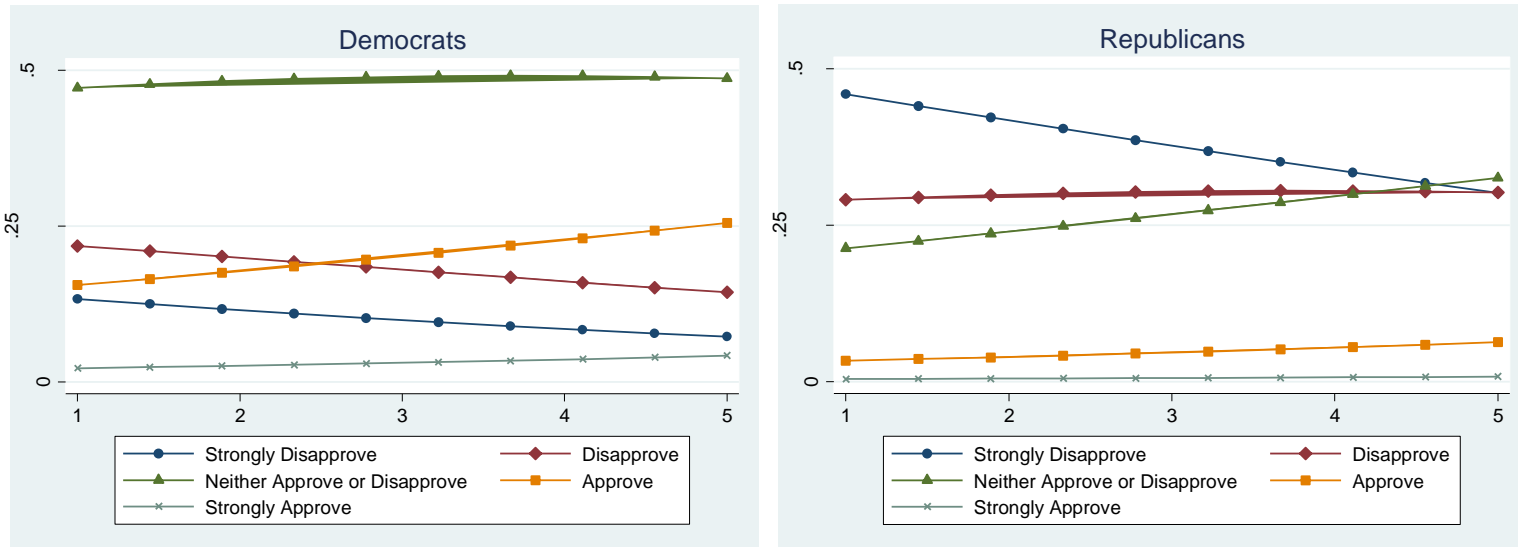


Figure 4. Predicted Probabilities of Support for Health Care Reform for Retrospective Evaluations

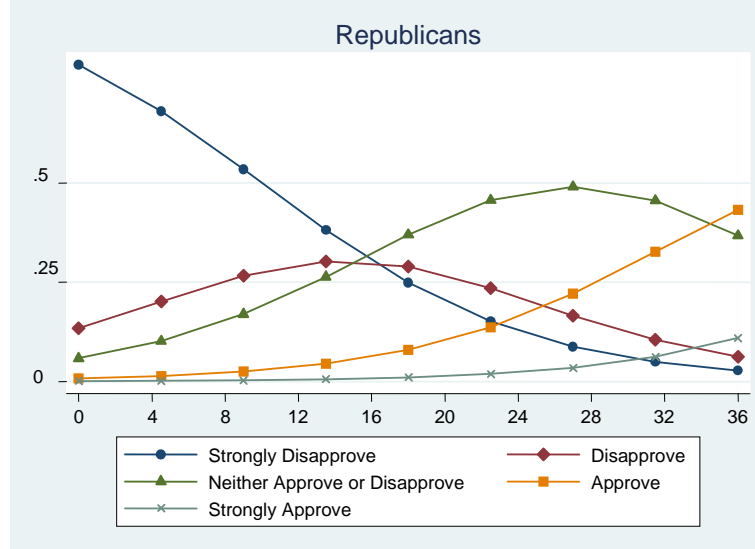
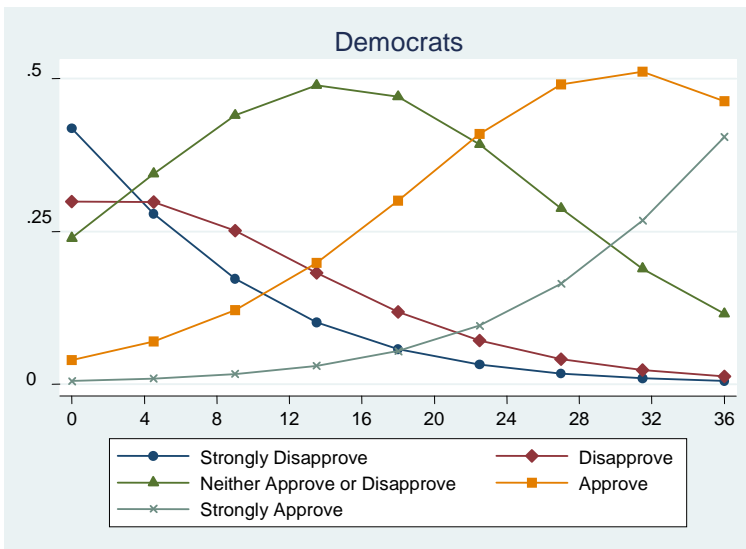


a. Dissatisfied with Personal Access to Health Care

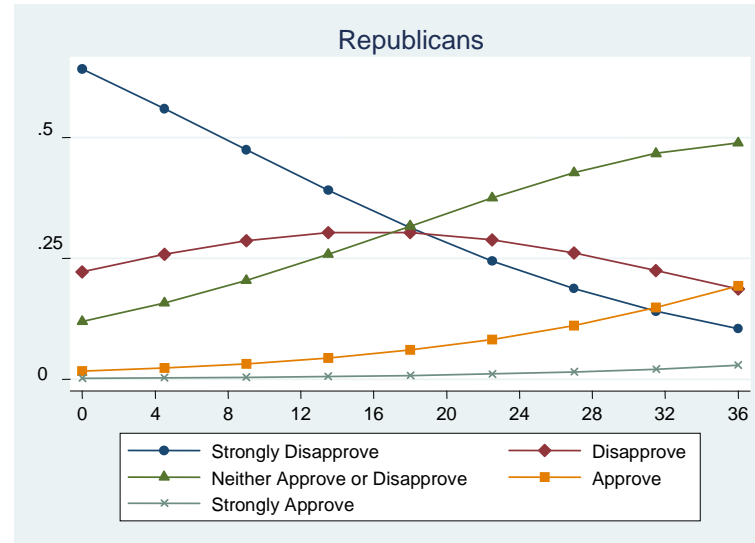
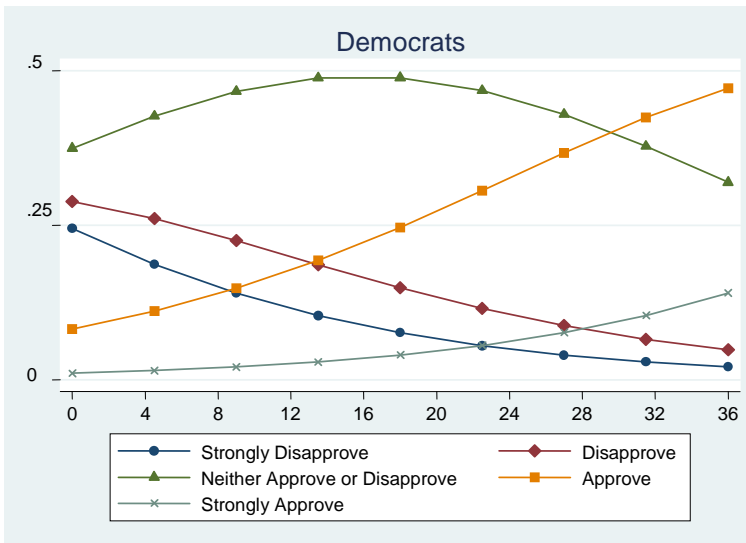


b. Dissatisfied with Health Care System

Figure 5. Predicted Probabilities of Support for Health Care Reform for Prospective Evaluations



a. Health Care Reform Individual Benefit Scale



b. Health Care Reform Collective Benefit Scale