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# Historical Racial Oppression and Healthcare Access: Unveiling Disparities Post-ACA in the American South

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# Historical Racial Oppression and Healthcare Access: Unveiling Disparities Post-ACA in the American South

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#### Abstract

This study investigates geographical disparities in the implementation and effectiveness of the Affordable Care Act (ACA) by linking them to the historical legacy of racial oppression in the American South. Using a cross-border regression discontinuity design that leverages variations in racial oppression intensity, we find that bordering counties in states with less oppressive regime experienced significantly greater benefits from the ACA compared to neighboring counties in more oppressive states. This divergence in insurance outcomes, which did not exist before the ACA, underscores the influence of historical racial regimes on contemporary policy efficacy. Furthermore, we demonstrate that political preferences from the Jim Crow era are correlated with the observed variations in ACA effectiveness. Our findings suggest that the racialization of the ACA is deeply rooted in the historical context of racial oppression in the American South.

Keywords: ACA, Oppressive racial regime, Disparity, American South JEL codes: 110, 114, D02, B15, D02

# 1 Introduction

Although designed as a federal initiative, the implementation of the Affordable Care Act (ACA) was profoundly shaped by state decisions, particularly regarding Medicaid expansion. The 2012 Supreme Court ruling that rendered Medicaid expansion optional led to 29 states adopting the ACA's Medicaid provisions in 2014, with seven more joining over subsequent years. Today, strikingly, eight of the ten states that have opted out of this expansion are concentrated in the American South, underscoring a regional disparity in ACA implementation.

Despite recent research demonstrating the health benefits of Medicaid expansion under the ACA (Miller et al., 2021; Borgschulte and Vogler, 2020), the American South remains notably vulnerable, characterized by high uninsured rates and lower life expectancy (Arias et al., 2021; RWJF, 2020). While socio-economic factors such as lower education levels and higher poverty rates contribute

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to these issues, they do not fully account for the pronounced disparities in healthcare access and health outcomes observed in this region.

In this study, we explore the intersection between historical racial oppression and contemporary healthcare reforms, with a focus on the Affordable Care Act (ACA)—the most significant healthcare reform in the United States. We investigate how the legacy of oppressive racial regimes<sup>1</sup> in the American South influences the effectiveness of ACA implementation. Our analysis employs the Historical Racial Regime (HRR) scale as defined by Baker (2022), which quantifies the extent of historical racial oppression through measures of slavery, sharecropping, disfranchisement, and segregation at the state level. This scale provides insight into each state's historical inclination toward racial inequality.<sup>2</sup>

We utilize a Geographical Regression Discontinuity design to analyze ACA-related outcomes in counties near state borders with varying levels of historical racial oppression. Our findings reveal significant disparities tied to historical racial oppression: counties in states with less oppressive racial regimes experience more substantial reductions in uninsured rates and greater increases in federal Medicaid-CHIP transfers post-ACA. Notably, the gap in uninsured rates widens as the difference in oppression levels between neighboring states increases. Similar trends emerge when examining historical voting patterns for the Democratic candidate in the early 1900s, particularly after the introduction of poll tax laws in many Southern states.

# 2 Conceptual Framework

We propose three pathways linking historical oppression to the implementation of ACA: i) paternalistic culture, ii) persistence in political attitudes and preferences, and iii) differences in contemporary characteristics.

Pathway 1 extends the arguments of Alston and Ferrie (1985, 1993), who explore how Southern paternalism emerged post-Emancipation as a substitute for redistributive policies. This culture, rooted in the Jim Crow era, may shape contemporary attitudes toward public provisions and influence ACA implementation. Pathway 2 leverages research on the intergenerational transfer of political attitudes (Bisin and Verdier, 2011; Nunn and Wantchekon, 2011; Voigtländer and Voth, 2012; Charnysh, 2015; Acharya et al., 2016). In relation to this study, Acharya et al. (2016) find that areas historically reliant on slavery tend to have White Southerners more aligned with the Republican party. This historical alignment may impact the efficacy of the ACA, given its high political polarization. Pathway 3 posits that contemporary socio-economic factors, such as income levels and poverty, linked to past racial oppression, can affect ACA preferences. According to self-interest theory, the Black-White poverty gap, which expands with higher levels of historical

<sup>&</sup>lt;sup>1</sup>Baker (2022) defines a racial regime as a system of rules constructed on the basis of race to promote and sustain racial inequality.

<sup>&</sup>lt;sup>2</sup>The Southern states in this study—Texas, Louisiana, Arkansas, Missouri, Tennessee, Mississippi, Kentucky, Alabama, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, Maryland, and Delaware—were chosen based on their historical context and alignment with Acharya et al. (2016) and Baker (2022) categorizations.

racial oppression (?Baker, 2022), may drive greater opposition to the ACA among Whites in more oppressed regions.

# 3 Data

A measure for historical racial oppression. We assess historical racial oppression using Historical Racial Regime (HRR) scores from Baker (2022). These scores capture the extent of racial oppression at the state level, reflecting both slavery and Jim Crow eras. The HRR measure includes four components: i) the proportion of the enslaved population in 1860; ii) the proportion of Black sharecroppers in 1930; iii) the number of disenfranchisement measures enacted to exclude Blacks from voting; and iv) the proportion of delegates from each state who signed the Southern Manifesto opposing racial integration.

Measures of ACA's efficacy. The study evaluates ACA implementation effectiveness by examining reductions in uninsured rates and increases in federal CHIP-Medicaid funding. We focus on uninsured rates for individuals below 138% of the poverty level, using data from the Small Area Health Insurance Estimates (SAHIE). Federal Medicaid-CHIP transfer data, sourced from the Bureau of Economic Analysis (BEA), reflects the total funding allocated to each county. We calculate the per capita federal Medicaid-CHIP transfer by dividing the total transfers by the county-level population living below the poverty line in 2010. Medicaid-CHIP data is obtained from Olvera et al. (2023) replication files.

### 4 Method

We hypothesize that the efficacy of the ACA varies with the intensity of historical racial oppression across neighboring state pairs. Figure 1 illustrates the variation in Historical Racial Regime (HRR) scores from Baker (2022) and highlights counties within 100 km of the nearest border. For example, comparisons between the Mississippi-Arkansas and Virginia-Kentucky borders reveal differing levels of HRR, with the former showing higher racial oppression.

We focus on bordering counties across states with varying levels of HRR, employing a Geographical Regression Discontinuity (GRD) design outlined as follows:

$$\Delta Y_{cb}^{t-2013} = \alpha + \gamma \times High_{cb} + \kappa_1 \times High_{cb} \times Distance_{cb} +$$

$$\kappa_2 \times Low_{cb} \times Distance_{cb} + \eta_b + \epsilon_{cb}^{t-2013},$$
(1)

where,  $\Delta Y_{cb}^{t-13}$  is the change in uninsured rate (and Medicaid transfers per capita) between year t ( $t \in \{2014, 2015, ..., 2018\}$ ) and 2013 in county c around the border b.



FIGURE 1: HRR Score and Geographical Discontinuities

Note: The figure depicts HRR score from Baker (2022) with respect to the Geographical Regression Discontinuity design of the study. The colored counties are within 100 km of the shortest distance from the centroid to the border, while counties in white are further than 100km. The difference between the bordering states' HRR scores is used to generate variation in racial oppression across contigious counties along the state borders.

The border *b* includes all state borders in the South. For example, for Alabama, *b* includes: *i*) AL-TN, *ii*) MS-AL, *iii*) GA-AL, and *iv*) AL-FL borders. This process gives a total of 26 distinct borders combinations.  $High_{cb}$  ( $Low_{cb}$ ) indicates whether county *c* is on the side of the border *b* with more (less) oppressive HRR measure. These indicators interact with  $Distance_{cb}$ , the shortest distance from county *c*'s centried to border *b*, allowing the relationship between distance to the border and outcomes to vary across sides (states) with high versus low HRR measures.  $\eta_b$  represents border fixed effects. The coefficient  $\gamma_b$  captures the difference in uninsured rate reductions and Medicaid-CHIP transfer increases between counties on the more and less oppressive sides of the border, as shown in Figure 1.

Next, we modify the specification to estimate a GRD design separately for each border b in the South, following the RD design approach used by Althoff and Reichardt (2022). This is given as:

$$\Delta Y_{cb}^{2014-2013} = \alpha + \beta_b \times High_{cb} + \tilde{\kappa}_1 \times High_{cb} \times Distance_{cb} +$$

$$\tilde{\kappa}_2 \times Low_{cb} \times Distance_{cb} + \tilde{\epsilon}_{cb}^{t-2013}.$$
(2)

The specification in equation 2 uses the county-level change in uninsured rates (Medicaid-CHIP transfers per capita) between years 2014 and 2013 as the outcome and is estimated for each border b. This approach yields 26 estimates of  $\beta_b$  for each designated state border b. The magnitude of the border-specific RD estimates are then plotted against the difference in HHR measures between the two states across each border.

#### 5 Results

#### 5.1 Geographic discontinuities in uninsured rates and Medicaid funds

Figure 2 shows the results from estimating the RD design given in equation 1. Figure 2 only includes borders with the difference in HRR of above the median difference across all borders, while borders with the difference in variation in HRR of less than the median value is used for the placebo-type analysis.

Panels A-E in Figure 2 reveal that ACA efficacy, measured by the drop in the uninsured rate post-reform compared to 2013, is higher in magnitude in counties on the side of the border with lower HRR scores. The uninsured rate decreases more dramatically in these counties, with a 6.6 percentage point greater reduction in 2014 compared to those on the side with higher HRR. This discontinuity persists across other years as well. Panel F displays a similar pattern in the 1912 presidential vote share: counties on the side of the border with higher HRR had an average of 13.5 percentage points more vote share for the Democratic candidate.

Figure 3 presents Medicaid transfer per capita as the dependent variable. Panel A indicates that, on average, Medicaid transfers per capita increased by \$1.44 in counties on the border of states with lower HRR score from 2013 and 2014 compared to those in states with higher HRR scores. Additionally, Panel F shows that White Southerners' vote share for Obama in the 2008 presidential election was in fact higher in bordering counties of states with high HRR compared to counties in low HRR states.

Figures A1 and A2 present placebo-type results for both uninsured rates and Medicaid transfers per capita, focusing on borders with HRR differences below the median. The magnitudes of these estimates are noticeably lower than those in Figure 2. Figure A3 shows pre-ACA insurance outcomes, indicating a smooth transition in uninsured rates across low-high HRR state borders (Panels A-D). This suggests that the main findings are not driven due to pre-existing differences in uninsured rates. Panels E and D confirm similar population levels across the bordering counties. Figure A4 include balance checks for additional variables. Panel A shows that bordering counties in the high HRR states had a slightly higher proportion of enslaved individuals in 1860, while pro-



FIGURE 2: Historical Racial Oppression and the Efficacy of ACA Implementation: A GRD Approach Note: The state-specific Historical Racial Regime (HRR) measure is obtained from Baker (2022). The figures show the difference in the level of changes in uninsured rates for the subgroup with income below the 138% of FPL around the border separating low versus high HRR sides. Only across border sides with the difference in HRR magnitude above the median difference are included in the analysis. The state border combination includes the following state pairs: AL—TN, AR—TN, AR—TX, GA—TN, LA—AR, LA—TX, MS—AR, MS—TN, NC—TN, TN—KY, VA—KY, VA—MD, VA—TN, and VA—WV, with the former state representing high HRR. Each point is the average of the outcome variable across counties in a decile of population count (using 2010 county-specific population) away from the border. The GRD estimate is obtained from estimating the specification given in equation 1.



FIGURE 3: Historical Racial Oppression and Allocation of Medicaid Funds: A GRD Approach Note: The sub-figures A-E are constructed similar to the ones in sub-figures A-E except that the outcome variable is the Medicaid funds per capita. The outcome variable in Panel F is the proportion of White votes for Obama during the 2008 presidential campaign.

portion of Blacks and Whites in 2010 are similar across these counties. No dramatic cross-border discontinuities are observed for per-capita income and urban-rural status.

#### 5.2 Past political outcomes and ACA's efficacy

Next, we present the GRD estimates for each Southern state border based on the estimation of equation 2. Panel A in Figure 4 illustrates the relationship between HRR score differences across borders and the respective GRD estimates, with the first state in pair representing more oppressive regime. Despite some noise, the best-fit line suggests that ACA efficacy decreases with



FIGURE 4: HRR and GRD Estimates Using State Border Pairs in the South

Note: The figures in panels A, B and C plot the GRD estimates obtained after estimating the specification given in equation 2 for each state border b. The dependent variable used in Panel A is the county specific change in uninsured rates for the subgroup with income below the 138% of the FPL between 2013 and 2014, Panel B uses changes in federal Medicaid-CHIP funds per capita, and Panel C uses the vote share of the Democratic candidate in the 1912 presidential election. The estimates are then plotted along side with the magnitude of the difference in HRR score between two sides across the state border combination. The first state reported in the state border combination refers to the side with a higher HRR score compared to the latter. Panel D then plots the RD estimates of the respective state border pairs from Panel A and Panel C together.

increases in HRR score differences. For instance, counties near the Virginia-West Virginia border, with significant HRR differences, saw a 15 percentage point drop in the uninsured rate from 2013 to 2014 on the West Virginia side compared to Virginia. Panel B reveals that the difference in Medicaid-CHIP transfers per capita between 2013 and 2014 across bordering states decreases as HRR score differences increase.

Panel C shows that the difference in vote share for the Democratic candidate in the 1912

presidential election increases with greater HRR score differences across borders. Panel D combines the RD estimates from Panels A and C, revealing a positive correlation between the disparity in Democratic support in 1912 and changes in uninsured rates before and after the ACA. The best-fit line in Panel D indicates that a 10 percentage point increase in the Democratic vote share difference across borders in 1912 corresponds to a 1.6 percentage point smaller reduction in uninsured rates between 2013 and 2014.

Figure B5 displays GRD estimates from equation 1, illustrating county-level Democratic vote percentages in presidential election from 1880 to 1964. Cross-border differences increased gradually after Reconstruction, with counties on the high HRR side favoring Democrats, peaking in 1912. Figure B6 plots the slope of the best-fit line relating cross-border RD estimates for ACA efficacy to historical political preferences, similar to Panel D in Figure 4. Panel A demostrates that slope coefficients grow in magnitude, peaking in 1912, suggesting that historical Democratic preferences explain contemporary ACA implementation differences. A similar but less noisy pattern emerges when using changes in federal Medicaid-CHIP transfers per capita, indicating that bordering counties in high HRR states with higher early 1900s Democratic support saw smaller increases in Medicaid transfers between 2013 and 2014. Further details on these patterns are discussed in the Appendix, Section B.2.

# 6 Discussion

Although past studies have explored the racialization of the ACA (Knowles et al., 2010; Tesler, 2012; Grogan and Park, 2017; Lanford and Quadagno, 2016; Michener, 2020), the underlying causes remain less understood. While theories of racial resentment, racial threat, and party principles have been linked to the ACA's racialization, this study introduces a novel perspective: the roots of ACA's racialization can be traced back to the oppressive racial regimes of the American South.

Our findings reveal that variations in HRR across state borders significantly influenced ACA efficacy. The Geographical Regression Discontinuity design shows that counties in states with less oppressive racial regimes experienced greater ACA efficacy compared to adjacent counties in more oppressive states. Moreover, historical Democratic support during the Jim Crow era explains these patterns, highlighting the enduring impact of past oppressive institutions on the implementation of equity-based healthcare policies in America.

This research uncovers a crucial intersection between historical racial oppression and the ACA's implementation, emphasizing how entrenched inequities continue to affect healthcare access. The significant gaps in uninsured rates between counties bordering states with different HRR levels, which emerged only after the ACA, reveal a troubling trend: the benefits of healthcare reform are unevenly distributed, shaped by historical racial inequalities. These disparities may also influence migration patterns as individuals seek better healthcare options. Addressing these gaps requires a thorough understanding of historical injustices to ensure future healthcare reforms bridge these divides and promote equitable access for all.

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# A.1 Additional Results



FIGURE A1: HRR and ACA Efficacy: A Placebo-Type Analysis

Note: The state-specific Historical Racial Regime (HRR) measure is obtained from Baker (2022). The figures show the difference in the level of changes in uninsured rates for the subgroup with income below the 138% of FPL around the border separating low versus high HRR sides. Only across border sides with the difference in HRR magnitude below the median difference are included in the analysis. The state border combination includes the following state pairs: AL—FL GA—AL GA—FL GA—NC KY—WV MD—DE MD—WV MS—AL MS—LA SC—GA SC—NC and VA—NC, with the former state representing high HRR. Each point is the average of the outcome variable across counties in a decile of population count (using 2010 county-specific population) away from the border. The GRD estimate is obtained from estimating the specification given in equation 1.



FIGURE A2: HRR and ACA Efficacy: A Placebo-Type Analysis

Note: The state-specific Historical Racial Regime (HRR) measure is obtained from Baker (2022). The figures show the difference in the level of changes in Medicaid Transfers per capita around the border separating low versus high HRR sides. Only across border sides with the difference in HRR magnitude below the median difference are included in the analysis. The state border combination includes the following state pairs: AL—FL GA—AL GA—FL GA—NC KY—WV MD—DE MD—WV MS—AL MS—LA SC—GA SC—NC and VA—NC, with the former state representing high HRR. Each point is the average of the outcome variable across counties in a decile of population count (using 2010 county-specific population) away from the border. The GRD estimate is obtained from estimating the specification given in equation 1.



FIGURE A3: Historical Racial Oppression and Pre-treatment Variables Prior to ACA

Note: The state-specific Historical Racial Regime (HRR) measure is obtained from Baker (2022). The figures show the difference in the level of changes in reported insurance outcomes prior to ACA around the border separating low versus high HRR sides. Only across border sides with the difference in HRR magnitude above the median difference are included in the analysis. The state border combination includes the following state pairs: AL—TN, AR—TN, AR—TX, GA—TN, LA—AR, LA—TX, MS—AR, MS—TN, NC—TN, TN—KY, VA—KY, VA—MD, VA—TN, and VA—WV, with the former state representing high HRR. Each point is the average of the outcome variable across counties in a decile of population count (using 2010 county-specific population) away from the border. The GRD estimate is obtained from estimating the specification given in equation 1.



FIGURE A4: Historical Racial Oppression and Pre-treatment Variables

Note: The state-specific Historical Racial Regime (HRR) measure is obtained from Baker (2022). The figures show the difference in both historical and contemporary variables prior to ACA around the border separating low versus high HRR sides. Only across border sides with the difference in HRR magnitude above the median difference are included in the analysis. The state border combination includes the following state pairs: AL—TN, AR—TN, AR—TX, GA—TN, LA—AR, LA—TX, MS—AR, MS—TN, NC—TN, TN—KY, VA—KY, VA—MD, VA—TN, and VA—WV, with the former state representing high HRR. Each point is the average of the outcome variable across counties in a decile of population count (using 2010 county-specific population) away from the border. The GRD estimate is obtained from estimating the specification given in equation 1.



FIGURE B5: HRR and State-Border Discontinuity in Democratic Vote Proportion Post-Reconstruction

Note: Only across border sides with the difference in HRR above the median difference are included in the analysis. The state border combination include: AL—TN, AR—TN, AR—TX, GA—TN, LA—AR, LA—TX, MS—AR, MS—TN, NC—TN, TN—KY, VA—KY, VA—MD, VA—TN, and VA—WV, with the former state representing high HRR. Each point plots the RD estimate when using the vote share for the Democratic candidate in the presidential elections between 1880-1964. The RD estimate is obtained from estimating the specification given in equation 3. The error bars represent the 90 percent confidence intervals.



FIGURE B6: Relationship between the past political preferences and measures of ACA efficacy

Note: Each point is the slope coefficient between the RD estimates that measures the across border efficacy of ACA and the RD estimates reporting the difference in the percent of vote attributed to a Democratic candidate during the presidential election in a given year as shown by the x-axis. Panel A uses the change in uninsured rate between 2014 and 2013 as a measure of ACA's efficacy, whereas Panel B uses the change in the federal Medicaid-CHIP transfers per capita (calculated using the number of people living in poverty). RD estimates are obtained from estimating the specification given in equation 2. The error bars represent the 90 percent confidence intervals.

# **B.2** Past Political Outcomes and ACA Implementation Efficacy

This section discusses the relationship between the former oppressive racial regime (as measured by HRR scores) and historical political preferences. It then explores empirical evidence showing how these historical political preferences relate to the efficacy of the ACA in the American South.

Figure B5 plots estimates from the RD design in equation 1, using the county-level percentage of votes for the Democratic candidate in presidential elections from 1880 to 1964 as the dependent variable. The figure illustrates that cross-border differences in Democratic vote share increased gradually after Reconstruction, peaking in 1912.

At the end of the 19th century, White Southern elites implemented measures to suppress the newly enfranchised Black voters (men in 1870), using tactics such as grandfather clauses, literacy tests, and poll taxes. Between 1890 and 1908, seven Southern states—Mississippi (1890), South Carolina (1895), Louisiana (1898), North Carolina (1902), Alabama (1901), Virginia (1902), and Georgia (1908)—adopted constitutional amendments designed to exclude Black voters and restrict poor White Southerners, primarily through literacy tests. This list includes all Deep South states (Mississippi, Alabama, Louisiana, Georgia, and South Carolina) with higher HRR scores. Additionally, by 1904, all Southern states except Kentucky had enacted poll taxes. These systematic voting suppression measures in the late 19th century likely contributed to the increased cross-border differences in Democratic vote share observed in the early 1900s.

The cross-border difference in votes favoring the Democratic candidate gradually decreases from 1928 onwards. By the 1948 presidential election, the estimate even turns negative, reflecting a shift during Harry Truman's campaign. Truman's unexpected support for civil rights, highlighted by the 1948 Democratic Convention's narrow adoption of a civil rights plank, led to a schism within the Democratic Party. Southern Democrats, dissatisfied with Truman's stance, formed the States' Rights Democratic Party (Dixiecrats) and nominated Strom Thurmond for president. As indicated by the triangular marker, votes in bordering counties on the side of higher HRR states strongly favored Thurmond.

Figure B6 shows the relationship between historical political preferences Democratic presidential candidates and the efficacy of ACA in the American South. Panel A plots the slope of the best-fit line of cross-border RD coefficients, using Democratic vote share in presidential elections (x-axis) and the change in uninsured rates between 2013 and 2014 (y-axis). The panel shows that this slope coefficient increases in magnitude through the early 1900s, peaking in 1912. This suggests that cross-border differences in early 20th-century Democratic support can explain contemporary variations in ACA efficacy. Specifically, counties in states with more oppressive racial regimes in the early 1900s, which tended to favor the Democratic Party, also experienced weaker ACA implementation. This relationship diminishes starting from 1928, with coefficients fluctuating around zero. Panel B provides a similar analysis using changes in federal Medicaid-CHIP transfers per capita between 2013 and 2014 instead of uninsured rates. The pattern consistently indicates that counties in states with high HRR, which had higher early 1900s Democratic support, saw lower increases in Medicaid transfers. The relationship also fades post-1928, aligning around zero.