American Slavery, Sentiments, and Efficacy of the Affordable Care Act

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November 16, 2021

Abstract

The fact that the Patient Protection and Affordable Care Act (ACA) was passed during the presidency of the first African American President, Barack Obama, provides a unique opportunity to study the relationship between former American slavery, sentiments surrounding ACA, and its efficacy. The results using data from the Cooperative Congressional Election Survey (CCES) merged with the historical slave concentration in 1860 show that higher dependency on past slavery is associated with pro-ACA sentiments among Black Southerners in states that expanded Medicaid but is positively associated with preferences to repeal ACA among both Black and White Southerners in non-expansion states. To estimate the impact of slavery on insurance coverage, we use a difference-in-difference-in-differences framework that compares insurance coverage in local areas with low vs. high slave concentration in 1860, before and after the policy implementation, and by states' participation in ACA's Medicaid expansion. The results suggest that past slavery posed impediments in reducing uninsured rate among Black Southerners in expansion states and White Southerners in non-expansion states. The results are driven by lower take-up of Medicaid coverage among Black Southerners in slave intense areas within expansion states.

Keywords: Patient Protection and Affordable Care Act (ACA), American slavery, ACA opinions, ACA efficacy, Politics

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1 Introduction

Passed and implemented during the historic presidency of the first African American president, Barack Obama, the Patient Protection and Affordable Care Act (ACA) has been met with turbulent opposition from Republican congressmen and lawmakers, governors, Republican candidates and the right-wing media. But nowhere in America has the opposition been as strong as in the American South – twenty one out of thirty four House Democrats who voted against ACA in the Senate were from south and many southern states have defaulted to federal health insurance exchange.[1] Ironically, Southerners as a group of people have relatively poor health outcomes that result in lower life expectancy and also suffer from higher levels of uninsured rate (Arias et al., 2021; RWJF, 2020). Although these geographic patterns go hand-in-hand with socio-economic disparities such as lower levels of education and higher rates of poverty in the American South, SES alone cannot fully explain why some areas of south are still lagging behind.

In this study, we investigate whether former slavery in the American South can impede institutional changes in the health care sector that are redistributive and equitable in nature by focusing on ACA – the most sweeping health care reform in the United States. The goal of ACA was to obtain nearly universal health insurance coverage in the U.S. through various provisions, including but not limited to the individual mandate, subsidies in health care exchange markets, employer mandate and Medicaid expansions. Although several provisions of ACA are similar to the past health policies that were designed but not fully passed,[2] one crucial difference is that ACA was drafted and passed during the presidency of the first African American president. This itself is likely to exacerbate racial polarization and shape preferences regarding ACA.[3]

While early provisions of ACA such as the dependent coverage and removal of copay on preventive cure went into effect in 2010, more comprehensive provisions such as Medicaid expansions and individual mandate were not fully implemented by states until 2014. Following the 2012 supreme court decision that allowed states to decide on Medicaid expansion by making it optional, 29 states participated in 2014 Medicaid expansion, with an addition of 7 states joining over the next several years. So far, only 7 out of 16 southern states have implemented Medicaid expansion.[4] Past studies have examined the effects of ACA on a wide array of outcomes including but not limited to access to health care, health and labor market outcomes, crime, education, and marriage (Frean et al.,

[1] See https://ballotpedia.org/Obamacare_overview

[2] An example of the universal health coverage bill is the Health Security Act, proposed during the presidency of Bill Clinton, which was defeated by 1994.

[3] Knowles et al. (2010) provide evidence that racial prejudice predicted both reluctance to vote for Obama and opposition against the health care reform plan attributed to Obama, whereas racial prejudice was not associated with preferences regarding the same health care plan attributed to Bill Clinton. Tesler (2012) shows that racial attitudes were an important variable influencing White Americans' health care opinion in 2009-10, while this relationship only increased in magnitude as the reform progressed. More importantly, the author argues that presence of Obama as the president seems to have driven differences in Black-White policy opinions even farther apart with the racial divide in 2009-10 being 20 percentage points more than the time of Clinton's plan in 1993-1994.

[4] Southern states in this study include Texas, Louisiana, Arkansas, Missouri, Tennessee, Mississippi, Kentucky, Alabama, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, Maryland, and Delaware; chattel slavery was still legal in these states in 1860.

2017; Courtemanche et al., 2017; Wen et al., 2017; Jung and Shrestha, 2018; Hampton and Lenhart, 2019; Peng et al., 2020; Miller et al., 2021). However, impediments to the adoption of Medicaid expansion within the ACA have yet to be explored.

The existing studies discuss three main reasons driving opposition against ACA. First, the racial-resentment theory, shaped around the principles of symbolic racism, is based on a perception that Blacks do not epitomize core American values and lack work ethic to pull themselves by the bootstrap (Kinder et al., 1996; Sears and Henry, 2003). Second, the self-interest theory links ACA as a redistributive reform that transfers "resources from hardworking American to underserving individuals" (Williamson et al., 2011). As Whites are relatively at a better socio-economic position compared to minorities, opposition against welfare programs and reforms beneficial to Blacks can be driven by self-interest (Gilens, 1995). Third, the party affiliation theory argues that ACA opposition is not related to racial prejudice but strictly driven by political preferences (e.g., small government involvement) and it just so turns out that Republicans are less trusting of the government compared to Democrats (Williamson et al., 2011).

We first evaluate the relationship between antebellum slavery and preferences regarding ACA using a pooled cross-sectional data from the Cooperative Congressional Election Study (CCES – 2014, 2016, 2018) merged with county level slave concentration in 1860 (interpolated to match current boundaries) in states with (expansion states) and without (non-expansion states) Medicaid expansion. Using suitability measure of cotton farming as an instrument for allocation of former slaves across the geographic landscape of south, we show that both White and Black Southerners from non-expansion states living in areas with high concentration of slaves in 1860 are more likely to be opposed to ACA and favor repealing ACA entirely. In contrast, Black Southerners residing in high slave concentration areas are more likely to support ACA in states with Medicaid expansion. To explain the former results, we show that the broadcast of anti-ACA political television ads were concentrated in areas more dependent on former slavery. This could have acted as strong political cues to shape preferences against ACA.

To empirically evaluate the relationship between former slavery and access to health care among Black and White Southerners following the ACA, we use publicly available data from the American Community Survey (ACS) for years 2012-2018 and focus on uninsured status as well as the breakdown of insurance by types (e.g., current or former employer coverage, privately purchased insurance, Medicaid, other insurance). Since the finest level of geographic location reported in the publicly available ACS files are Public Use Microdata Areas (PUMAs), we use across PUMA variation in 1860 slave concentration measure aggregated using the county level files. Following previous studies that utilize local area pre-reform uninsured rate (Miller, 2012; Courtemanche et al., 2017), our identification strategy adapts a difference-in-difference-in-differences framework by using three levels of variation for identification: *i*) time (pre vs. post ACA); *ii*) geographic variation in slave concentration in 1860 (interpolated at local areas defined by 2010 PUMA boundaries); and *iii*) ACA's framework, based on the variation in states' Medicaid expansion status (expansion vs. non-expansion states).

Our results suggest that the former slavery impeded potential impacts of Medicaid expansions within ACA; uninsured rate decreased at a higher rate in areas that were less dependent on former slavery. In non-expansion states, higher slave concentration in 1860 has no differential effects on Blacks' insurance status following ACA but is associated with relatively lower reductions in uninsured rates among White Southerners. These effects are modest in magnitude. In expansion states, areas with higher concentration of slaves in 1860 experienced lower rise in insurance coverage among both Black and White Southerners compared to relatively low slave intense areas. The point estimate suggests that one standard deviation of a reduction in slave concentration in 1860 from the average results in an increase in Black Southerners' insurance rate by 2.2 percentage points. This result is driven by relatively higher take-up in Medicaid coverage among Blacks living in low slave concentration areas compared to areas more dependent on past slavery within expansion states.

We hypothesize that former slavery may have shaped preferences regarding ACA and thus affected its efficacy through the transfer of values, political attitude and cultural traits across generations (Boyd and Richerson, 1996; Bisin and Verdier, 2011). After the abolition of chattel slavery, White landowners dependent on slaves as labor capital faced exorbitant economic losses (Ransom and Sutch, 2001; Ager et al., 2019). While both high and low-slave areas supported policies to expand slavery prior to 1865, events of emancipation, reconstruction, and redemption increased anti-Black sentiments and fostered racist attitudes in areas more dependent on slavery. A gradual absence of the federal intervention gave White Southerners power to form institutions restricting economic and sociopolitical inclusion of Blacks through racially targeted violence, Jim Crow laws and state constitutions supporting Black disenfranchisement (Naidu, 2012; Acharya et al., 2016). Using across county variation in slave concentration in 1860, Acharya et al. (2016) show that past slavery still shapes political preferences in the American South – White Southerners residing in higher slave concentration areas in 1860 are more likely to currently identify themselves as Republicans, be opposed to affirmative action, and express anti-Black racial sentiments. Such persistence in political beliefs through intergenerational socialization may have spilled over informing preferences regarding ACA.

One alternative explanation for our results is that socioeconomic and geographic differences across areas that led to high and low dependency on past slavery may elicit differential responses to ACA. To account for differences in factors leading to variation in chattel slavery, we control for the interaction between the post ACA indicator and local area level variables in 1860 interpolated to current geographic boundaries. The set of historical controls include the proportion of farms under 50 acres, log of population, average farm value per improved acre of land, the total acres of improved land, proportion of counties in PUMA with access to water and railways in 1860 (respectively), and land ruggedness. Similarly, the model specifications also include triple interactions between post Medicaid period, an indicator for expansion states, and 1860 local area characteristics. To account for the possibility of varying effects on insurance coverage following ACA implementation due to availability of providers, the preferred specification additionally controls for state-specific number of insurance providers along with average premium level (for an individual).

We use a number of different strategies to increase confidence that the estimates presented in this study are causal. First, we use county level data of uninsured rate from the Small Area Health Insurance Estimates (SAHIE) for years 2008-2018 and conduct an event-study exercise.[5] These estimates provide supporting evidence that there are no pre-trend differences in uninsured rate across high vs. low slave concentration areas prior to Medicaid expansion year, while reductions in uninsured rate are relatively lower in high slave concentration areas following the expansion. Second, we conduct a placebo exercise using 2012 and 2013 ACS data, by artificially implementing the policy year as 2013. Most of the estimates in the placebo exercise are close to zero. Next, we randomly assign 1860 slave concentration values across local areas and construct an alternative placebo exercise using ACS data (2012-2018). Here, the actual estimate is largely different from the distribution of artificially constructed estimates that are obtained from 500 replications.

This study is related to different strands of studies in the literature. First, it contributes to a handful of studies emphasizing the role of path dependency in determining future health policies and reforms following critical junctures (Jacobs and Skocpol, 2011; Haeder, 2012; Fouda and Paolucci, 2017). While Jacobs and Skocpol (2011) and Haeder (2012) argue that ACA serves as a critical juncture in the U.S. health care system since it has significantly altered the trajectory of health policies, we take a different position and explore the possibility of whether former institution with discriminatory practices may have persistent effects on determining preferences and efficacy of more pro-equity health reforms such as ACA. Second, our study is also related to the growing literature evaluating the impacts of slavery on economic and political outcomes (Lagerlöf, 2005; Naidu, 2012; Bertocchi and Dimico, 2014; Hornbeck and Naidu, 2014; Acharya et al., 2016; Williams, 2017). Finally, and more broadly, this study builds on previous work demonstrating the long-term effects of institutions, historical events and episodes (Nunn, 2008; Nunn and Wantchekon, 2011; Acharya et al., 2016; Dell et al., 2018).

The study proceeds as follows. Section 2 provides a brief history of health care reforms in America followed by discussions of ACA and its opposition. Section 3.1 documents various data sources used in this study, whereas section 4.1 discusses the methods. Section 5.1 describes the results, while Section 6 provides additional robustness tests. Results from heterogeneous analysis are presented in Section 7, and Section 8 concludes the study.

2 Background

2.1 Affordable Care Act and its Opposition

ACA has been best described as a three-legged stool, designed to expand health insurance coverage in America (Gruber, 2011). The first leg focuses in improving equity in non-group insurance setting by outlawing insurance provision based on pre-exisiting conditions, providing guaranteed access, fixing limits on insurance pricing by health status, and ensuring a minimum coverage standard.

[5] We are unable to conduct the event study exercise using ACS data since the PUMA boundary prior to 2012 survey year depend on older PUMA demarcation (year 2000).

One theoretical critic of the first leg is that such laws would increase premiums due to inclusion of relatively unhealthy individuals in the pool, while contributing to adverse selection death spiral. To counterbalance such possibility, the second leg imposes an individual level mandate that requires the U.S. residents to have insurance coverage. The third leg aids enforcement of the second by: *i*) increasing affordability of insurance coverage mainly through government subsidies using tax credits that caps the portion of income spent on health insurance based on poverty level, and *ii*) statewide Medicaid expansions. ACA also established the Federal Exchange market to improve insurance coverage among small businesses and individuals who qualified for subsidies. More importantly, states were presented with an option of establishing state oriented exchange market individually or through coalition of a group of states. The implementation of tax credits and cost sharing subsidies went into effect on January 1, 2014 along with implementation of Medicaid expansion for all non-elderly adults with income upto 138% of the federal poverty level in states opting for expansion.[6]

As passed by the Democratic Congress, ACA has received turbulent opposition from Republican congressmen, governors, Republican candidates and the right-wing media. To further increase partisanship, Republicans dubbed ACA as "Obamacare" and polls have consistently shown evidence that less than 50% of Americans actually support ACA (Dalen et al., 2015). Dalen et al. (2015) argue that opposition is specifically honed towards the individual mandate because of the perception that it goes against one's freedom of choice. The opposition against ACA is heavily driven by American Whites; over 60% of White populace were opposed to ACA, while only 30% were in favor in January 2014.[7] Not surprisingly, 82% of Republican voters were against ACA in 2014 compared to 13% of Democrats.

The current literature spanning across multiple disciplines discusses three different drivers of opposition: *i*) racial resentment; *ii*) self-interest; and *iii*) affiliation to party principles.[8] The racial resentment theory is built on the premise that Blacks do not try hard enough to pull themselves "by the bootstrap" and they take what they have not earned (Kinder et al., 1996).[9] Scholars have argued that the form of symbolic racism (racial resentment) is different from old-fashioned racist beliefs that have portrayed Blacks as an inferior race and anti-Black sentiments in more recent decades revolve around the notion that Blacks violate core American values (Sears and Kinder, 1971; Sears, 1988; Kinder et al., 1996; Sears and Henry, 2003). Gilens (1995) shows that Whites' racial attitude against Blacks are good predictors of cultivating opposition against welfare policies. In a more recent study, Banks (2014) argues that the content of racial polarization is further aggravated by anger, which has been shown to increase partisanship regarding ACA.

The self-interest theory dates back to 1960s and argues that middle class Americans resent

[6]See https://www.kff.org/interactive/implementation-timeline/ for timelines regarding different components of ACA.

[7]This is based on KFF Health Tracking Poll regarding ACA, which can be found https://www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/.

[8]These theories are not specific to ACA but are generally applicable to a range of welfare policies.

[9]This view, strikingly different from Europeans' perspective that poor are poor because they have been unfortunate and not because they are lazy, is termed as American exceptionalism (Lipset, 1996).

paying taxes that benefits only the poor (Campbell et al., 1980). With minorities highly over-represented among the poor Americans, redistributive policies will disproportionately favor minorities. Williamson et al. (2011) argue that the debate around ACA created similar assessment as opponents viewed the reform as redistributing resources from hardworking Americans to undeserving populace. Although more recent studies have identified that economic self-interest does not play as big of a role in determining preferences regarding welfare policies (Gilens, 1995; Fong, 2001), anecdotal evidence suggest that people are still supportive of entitlement programs based on self-interest. For instance, the majority of Americans support long-standing federal policies such as Medicare and social security but are yet against Medicaid and ACA. Next, the theory of party affiliation advocates that public's resentment over ACA reflect conservative principles (e.g., small government, strict adherence to the U.S. constitution) or political beliefs and are not driven by racial prejudice.

2.2 How can former slavery determine ACA's efficacy?

Even after 150 years from the emancipation proclamation, nowhere in America was the opposition against ACA as turbulent as in American South. Only two out of 16 southern states have operated their own exchanges and many have defaulted to the option of Medicaid expansion. Rick Perry (Republican governor of Texas) and Rick Scott (Republican governor of Florida) are well-known to have posed vehement opposition against ACA. Moreover, Florida's Republican attorney general was the first to file suit against ACA, which eventually turned out as a Supreme Court case. Overall sentiments regarding ACA has been congruous with political opinions directed towards president Obama.

Figure 1 shows simple representation of the possible relationship. To explain the link between former slavery and ACA, the pathway traced by the red arrows depict persistence of racial sentiments and political attitudes through intergenerational socialization. A huge body of work in economics and political science has highlighted the transfer of political attitudes, values, and preferences from parents and older relatives to children (Bisin and Verdier, 2011; Nunn and Wantchekon, 2011; Voigtländer and Voth, 2012; Charnysh, 2015; Acharya et al., 2016). Cultural anthropologists Boyd and Richerson (1996) and economists Bisin and Verdier (2011) argue that one reason why cultural changes happen so slowly is due to the transfer of cultural traits from parents to children. Past studies have also demonstrated empirical evidence regarding the persistence of political, cultural traits and values over generations. Voigtländer and Voth (2012) show that areas with higher concentration of plague-era pogroms also demonstrated higher levels of anti-Semitism in the 1920s. In a more recent study, Charnysh (2015) argues that anti-semitic cues disseminated by populist elites in Poland in years leading up to the 2003 EU referendum resonated strongly with voters who were predisposed to anti-semitism. Also, Nunn and Wantchekon (2011) show that African families who were raided during the period of Transatlantic and Indian Ocean slave trades are less trusting today.

The history of American slavery and racial resentment in the South is no exception to the

pattern of cultural persistence. Scholars have linked the origins of racial resentment against Blacks to threats imposed on Whites' economic and political factors following emancipation (Du Bois, 1935; Ransom and Sutch, 2001; Foner, 2011; Naidu, 2012; Acharya et al., 2016). The abolition of slavery exacerbated economic loss in the American South due to the civil war, which was mainly borne by White Southerners. Specifically, the new-found Black males' enfranchisement threatened White elites' political status. This influenced racial politics in the American South, designed to exclude Blacks from social, economic, and political settings through means of racial violence, Jim Crow laws and state imposed legal laws. Laws such as poll taxes and literacy test disproportionately subdued Blacks' political influence through systematic disenfranchisement (Naidu, 2012), while historical lynchings are shown to have persistent impacts in reducing contemporary political participation among Blacks (Williams, 2017).

We hypothesize that racial resentment, tied to the events of slavery (emancipation, reconstruction era, and redemption), may have transferred over generations in forms of political attitude to shape more recent opposition against ACA. In fact, during the Jim Crow segregation era, White children were constantly exposed to rhetoric of White supremacy at home as well as public schools and were active witnesses of racial violence in public spaces. These pieces of evidence portray the desire to teach racial beliefs to the younger generation (DuRocher, 2011). However, we argue that emancipation did not have an uniform effect across the southern landscape; since areas with higher dependency in chattel slavery faced deeper burden of economic and political loss, these areas also fostered higher levels of racial resentment against Blacks (Du Bois, 1935; Foner, 2011). More importantly, the domestic political elites can also manipulate public opinion regarding ACA by using cues to increase persuasiveness of their arguments, which may disproportionately resonate to both Black and White race groups residing in high slave dependent areas. Contextually, our work builds on the findings of Acharya et al. (2016), who show that *i*) areas with high dependency on past slavery are more likely to have White residents that show racial resentment against Blacks and oppose policies that benefit minorities; and *ii*) the effects of racial resentment following emancipation has been transferred in forms of contemporary political attitude over generations.

People's predisposed beliefs and attitudes can interact with the type of information received about the reform from the political officials and insurance marketers. Locally broadcast news media coverage are known to have contributed in shaping public opinions regarding the reform (Gollust et al., 2020). Both Republican and Democrat leaders have expressed crystallized polarizing views regarding ACA that were dispensed through television ads for House and Senate races (Gollust et al., 2014, 2020). Since people may choose to accept or reject these partisan cues based on their political predisposition Druckman et al. (2013), which varies across high vs. low slave dependent areas, anti-ACA cues may resonate more with White Southerners in high slave intense areas.

The political cues can also play a salient role in shaping opinions independent of a person's predisposed political beliefs due to confusion surrounding ACA. In fact, a large body of literature highlights the importance of political cues in shaping public opinions regarding complex reforms with long term consequences (Carey and Burton, 2004; Druckman et al., 2013; Bolsen et al., 2014;

Golman et al., 2017). ACA is a reform that largely aroused confusion in public and it was heightened due to the opposing and contradictory opinions constructed by several competitive parties, motivated by their own self-interest. In such environments, people may simply accept political cues that they are exposed to. Gollust et al. (2014) demonstrate that discouraging sentiments regarding ACA were highly concentrated in states that relied on federally sponsored insurance market, which embeds the majority of southern states. More importantly, the tone of political cues also may vary across local areas' dependency on slavery. These strong political cues used during the time of public confusion can shape opinions regarding ACA that are independent of one's predisposed political opinions. For instance, Black Southerners in Black belts who are constantly exposed to discouraging political cues regarding ACA may develop anti-ACA sentiments.

Alternatively, former slavery can also shape preferences regarding ACA through contemporaneous measures, depicted by the green arrows in Figure 1. To explain racial resentment, scholars have highlighted the concept of *racial threats* based on demographic heritage (Ogburn and Grigg, 1955; Blalock, 1967b; Giles, 1977; Blalock, 1967a). As the size of the subordinate group (minority group in most cases) grows to be considerably large, the dominant group recognizes the potential of competition. Thus to counteract such threats the dominant group responds with racial hostility and adapts repressive strategies. In the context of American South, this is emphasized by Key (1984), "...To maintain its own status the ruling group must oppose any political program that tends to elevate or excite the masses, Black or White." Figure A8 demonstrates that the 1860 slave concentration measure is highly correlated with southern demography and predicts the share of Black population even in current days. Hence, racial resentment associated with the current size of Black population, determined due to persistence in demography, can shape political preferences and affect efficacy of ACA in the American South. As shown in Figure 1, this channel operates independently from the mechanism of intergeneration transfer through socialization.

The next channel, documented by the dotted green arrows in Figure 1, demonstrates that other peculiar differences across high vs. low slave dependent areas can itself influence current day political sentiments, including ACA. For instance, antebellum economic characteristics can predict whether counties became highly dependent on slavery; these characteristics may also determine current sentiments regarding ACA. Similarly, political, social and geographical differences across high vs. low slave dependent counties in the antebellum south can determine preferences regarding ACA. One example is that of pre-abolition racial attitudes, which can directly shape current day political beliefs without going through the channels related to slavery. As will be discussed in the next section, these factors can confound the relationship between former slavery and ACA if omitted from the analysis.

3 Data

3.1 Contemporary Variables of Interest

The study focuses in the American South and includes 16 states: Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia. Our first set of dependent variables include perceptions regarding ACA, which are traced using the Cooperative Congressional Election Study (CCES) of 2014, 2016 and 2018. The primary aim of CCES is to understand Americans' perspective on the Congress, political representatives, voting behavior and their views regarding social policies. The survey includes a large enough sample, which enables us to isolate Southern region alone and still have enough sample size for precise estimations. Specifically, we use a question regarding ACA that is consistently reported in 2014 and 2016 survey years: *Would you vote to repeal the Affordable Care Act if you were in Congress today?* Based on this question, we construct an indicator representing "against ACA," which include people who are inclined to repeal the reform.

The questionnaires pertaining to preferences regarding ACA are not consistent in CCES 2018 compared to the past two survey years. ACA questionnaires in 2018 are more detailed and asks whether the respondent would: i) repeal the entire ACA, ii) repeal the part of ACA that requires that most individuals have health insurance, and iii) partially repeal ACA, including repealing individual and employer mandates and cut Medicaid payments. We use whether respondents are in favor of repealing the entire ACA to construct a more conservative preference against ACA.[10]

Next, the study uses information on detailed insurance coverage in years leading upto ACA and also period following the implementation of ACA from the American Community Survey (ACS) one year sample files of years 2012 to 2018. Several attributes favor using ACS files compared to other database. First, and more importantly, ACS consistently reports information about health insurance coverage starting from 2008, further broken down by types of insurance (e.g., private, current or former employer, Medicaid, Medicare, Tricare, Indian reservations, VA). These information facilitate analysis of ACA across the spectrum of available health insurance coverage types and enables a researcher to identify secondary (but important) effects such as potential crowding out of private insurance due to policies governed towards improving public insurance coverage. Second, ACS include local level area identifiers in forms of PUMA, which is very important to operationalize the identification strategy of this study. As PUMA's boundaries change in every 10 year period based on population estimates of the Census, we use 2012 as the starting year to avoid inconsistency across PUMA demarcations.[11] Third, variations at the PUMA level has been increasingly used by the research community, including but not limited to studies of Courtemanche et al. (2017) and Frean et al. (2017), who use across PUMA variation in independent variables to identify the effects of ACA on insurance coverage.

[10] However, robustness exercises after taking i), ii), and iii) together as being against ACA yield similar results.

[11] This is because ACS 2012 and over rely on 2010 PUMA, whereas years before 2012 are based on 2000 PUMA classification. Some major changes in PUMA boundaries over the decade has occurred. Using ACS 2012 as the starting year avoids such inconsistency. See https://usa.ipums.org/usa/volii/pumas10.shtml for more detail.

Using information provided in ACS, we create binary variables representing whether an individual had: *i*) any insurance coverage (uninsured status), *ii*) employer sponsored insurance coverage, *iii*) Medicaid coverage, *iv*) private insurance coverage, or *v*) other forms of insurance. In alternative specifications, we utilize individual-level controls from ACS including gender, age, age square, education, marital status, and income level.[12]. We also include contemporary county level controls such as urban-rural classification of counties from the National Center for Health Statistics (NCHS) in 2013, and state-level unemployment rate from the Bureau of Labor Statistics.

Using ACS from 2012-2018 does not allow to properly access pre-existing trends in outcome variables across local areas with low vs. high dependency in slavery. Additionally, we use county-level uninsured rate from the Small Area Health Insurance Estimates (SAHIE) from 2008 to 2018 to complement our analysis pertaining to ACS files.[13]

3.2 Historical Variables of Interest

We use county-specific proportion of slaves in 1860 as a measure of local areas' dependency on slavery. The count of slaves come from the 1860 U.S. Census and presents the last record of slavery before emancipation. To account for changes in county demarcation over the years, an area-weighting method is used to depict 1860 slavery counts to the current county boundaries.[14] The county level data on historical variables are extracted from Acharya et al. (2016) replication files. To comply with PUMA, the finest level of geographic area reported in the publicly available American Community Survey files, we first use a crosswalk that maps current counties to 2010 PUMA's boundaries.[15] Next, we aggregate the county level proportion of slaves to PUMA level using population weights (portion of interpolated population of a county contributing to a PUMA's total population), which allows merging of slavery and other historical variables with ACS files using PUMA. In summary, we rely on two forms of adjustments: *i*) interpolation that maps historical county-level variables to the current county boundaries based on areal weights; and *ii*) aggregation that translates county based statistics to PUMA level using population weights to merge historical variables with ACS data using PUMAs as local area identifiers.

Figure 2a shows 1860 slave concentration across counties in south mapped to the current county boundaries. The figure presents some distinct patterns of slavery, particularly concentrated in the Black Belt region and stretching from Virginia to Mississippi. The next evident concentration is the cluster alongside Mississippi river, starting from the Southeast border of Missouri and continuing

[12] We also present a parsimonious model not accounting for any individual level controls as past research has pointed out that ACA affects education and marital status (Jung and Shrestha, 2018; Hampton and Lenhart, 2019)

[13] One drawback using SAHIE database is that insurance coverage by types of insurance divided by race groups are not publicly available.

[14] This method uses areal weighting to interpolate county specific slavery counts and population based on 1860 county boundaries fitted to the current period county demarcation. The weights include the proportion of county land area in 1860 that make up current county area. The areal interpolation is favored instead of population-weighted interpolation as both proportions and levels (e.g. total population) are interpolated. For more detail, please see Acharya et al. (2020), pages 218-219.

[15] The crosswalk that maps counties to 2010 PUMA boundaries is extracted from the Geocorr 2014 app through https://mcdc.missouri.edu/applications/geocorr.html.

down to Louisiana. Figure 2b presents the map of 1860 slave concentration, aggregated at the 2010 PUMA level. The patterns of slave concentration in Figure 2a are well preserved in Figure 2b. The map portrays wide within and across state variations in dependency on former slavery. This is consistent with previous works showing a wide variation in Southern slavery, dependent on factors such as climate, geography, soil suitability for crops, and demand for crops (Lagerlöf, 2005). For example, 92 percent of people in Sharkey county, Mississippi were enslaved, whereas the proportion was only 12 percent in Jones county, Mississippi. We utilize variations in slave dependency of 1860 interpolated at the local area (PUMA) level while identifying the impacts of slavery on ACA.

To account for differences across local areas with high and low dependency on slavery, we control for historical characteristics of local areas that may explain development of slave based economy in south. These variables include latitude and longitude of a county (including their squared terms), whether a county had access to waterways or railways respectively, total population, average farm value per acre of improved land, total acres of improved farmland, land ruggedness, and land inequality coefficients.[16] Next, we also account for changes in past healthcare policies by including local area controls regarding the total expenditure involved in Hill-Burton project between 1947 and 1971 and county-level health departments (CHDs) between 1908 and 1933, respectively. The data for Hill-Burton project and CHDs come from the Hill-Burton project register and the History of County Health Organizations in the United States published in U.S. Health Bulletin 222.[17] Similar to slave concentration in 1860, these historical variables are aggregated at the PUMA level and are merged with ACS data files using the PUMA identifiers.

4 Method

The empirical analysis is divided into two parts to: *i*) understand the relationship between slavery and preferences regarding ACA, and *ii*) evaluate the effects of ACA on health insurance coverage based on former dependency on slavery. Throughout the main analysis the sample is restricted to 16 southern states and analyses are conducted for Black and White race groups separately. Among various other provisions of ACA (e.g., subsidies for private coverage, employer mandate, and the establishment of health insurance marketplace), we design model specifications focused on Medicaid expansions due to two main reasons. First, previous studies show that Medicaid expansion largely contributed to increases in health insurance coverage following ACA, not only through more generous expansions but also due to increased take-up among previously eligible populace (woodwork effect) (Frean et al., 2017; Courtemanche et al., 2017). Second, seven southern states participated in Medicaid expansion, which provides us with an additional layer of variation to identify the impacts of slavery on health insurance coverage following ACA.[18]

[16] These variables are similar to the vector of controls applied in (Acharya et al., 2016). Data for these variables are extracted from the replication files.

[17] We thank Heidi L Williams and Lauren Hoehn-Velasco for providing the digitized format of Hill-Burton and CHDs data.

[18] Although seven southern states (Arkansas, Louisiana, Kentucky, Virginia, West Virginia, Maryland and Delaware) out of the 16 states adopted Medicaid expansion, Louisiana did not implement the expansion until July 1, 2016. More-

4.1 Effects of Slavery on ACA Sentiments

To analyze the relationship between slavery and preferences regarding ACA by race groups, we first estimate the baseline OLS model.

$$Y_{icst} = \alpha + \beta_1 \times slave1860_c \times Medicaid_s + \beta_2 \times slave1860_c \times NoMedicaid_s + \gamma_1 \times G_c \times Medicaid_s + \gamma_2 \times G_c \times NoMedicaid_s + \kappa_1 \times X_c \times Medicaid_s + \kappa_2 \times X_c \times NoMedicaid_s + \sigma_s + \eta_t + \epsilon_{icst} \quad (1)$$

Here, Y_{icst} represents whether an individual i in CCES survey, who reside in county c belonging to state s (during the survey year t), is in favor of repealing ACA. The variable of interest, $slave1860_c$, represents interpolated slave concentration mapped from 1860 county boundaries to the modern day county c. The slave concentration measure is interacted with an indicator of whether the state s expanded Medicaid along with a separate interaction with non-expansion states. This allows for differential effects of former slave concentration on ACA sentiments between expansion vs. non-expansion states. β_1 and β_2 shows the relationship between 1860 slave concentration and current preferences regarding ACA in expansion and non-expansion states, respectively.

G_c represents a vector of geographic controls in county c, including longitude, latitude, squared terms of longitude and latitude, ruggedness of land, log of county area, and access to water. Alternatively, specifications also add vector X_c, which includes measure of county characteristics in 1860 such as the proportion of farms under 50 acres, farm value per capita, log of the total improved acreage, log of total population, access to railways, Gini coefficient of inequality, and proportion of free Blacks used as a proxy for anti-slavery sentiments. Both G_c and X_c are interacted with indicators for expansion and non-expansion states separately to let the effects of historical variables vary across states with and without Medicaid expansions. σ_s include a vector of state fixed effects that capture unobserved time invariant heterogeneity within states and η_t represents survey year fixed effects. In some specifications we also account for individual characteristics in 2014 such as age, age squared, gender, education, family income, and marital status. The standard errors are clustered at the county level to account for correlation in error terms within the local areas.

There are two main concerns in the model specification given by equation 1. First, the historical measure of slaves may be misreported, and if the misreporting is of a classical type, the coefficients will be biased towards zero.[19] Next, and more importantly, there might be other factors unaccounted for that may influence both slave concentration in 1860 and current racial attitude, which confounds the causal interpretation. For example, areas with high vs. low slave dependency may have historical differences in political attitude, and such differences could have determined recent

over, Virginia implemented Medicaid expansion only in 2019, which falls beyond the sample years of this study. All other states implemented Medicaid expansion on January 1, 2014, in congruent with a bulk of other states across U.S. who opted for Medicaid expansion. Missouri has adopted the expansion but has not yet implemented it. See https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

[19] Due to data limitation, we have to rely on 1860 slave concentration measure throughout the study.

political preferences including ACA sentiments. Although inclusion of state-fixed effects accounts for such differences to an extent, they fail to account for differences across local areas with a state. This is pertinent since the level of variation utilized to identify equation 1 is at the county level.

As an alternative and a preferred strategy in this context, we estimate an IV specification using environmental suitability of growing cotton as an instrument for slave holdings in 1860. Following the invention of cotton gin in 1794 – a machine that revolutionized cotton farming – cotton plantation expanded in the American South. This led to a Second Middle Passage (the second largest forced migration in the American history), when slaves were bought from the upper South to work in cotton plantation fields in the deeper South. It is approximated that one million enslaved people were forced to migrate from the upper South to the deeper South to fuel cotton production (Johnson, 2009). As such, the cotton boom determined allocation of slaves.

The cotton suitability measure is constructed by using data from the UN Food and Agriculture Organization (FAO). The IV strategy is motivated by the fact that the majority of slaves were employed in cotton farms. In the first stage, we estimate the county-level dependency on slavery using more recent measure of cotton suitability index. Alternatively, we use malaria stability index, devised by Kiszewski et al. (2004)[20] and used by Esposito (2019) to show that the introduction of malaria led to enslavement of African workers in malaria-prone areas, as an additional instrument along with cotton suitability index. The second stage traces the relationship between past slavery and current attitude against ACA by using the predicted value of county-specific slave concentration measure from the first stage.

The validity of IV estimates is governed by two main assumptions. The first, and more general one, is that of exclusion restriction – cotton suitability affects current day preferences regarding ACA only through antebellum slavery once other observed county characteristics are accounted for. Next, the specification uses more recent cotton suitability measure to predict slavery outcomes of the past, which invites concerns regarding changes in soil quality overtime. Although we do not dispute the possibility of changes in soil quality, we assume that these changes happen uniformly across the southern landscape. Moreover, we argue that the estimates in the first stage should provide some evidence regarding this assumption.[21]

4.2 Slavery and ACA's efficacy

The next econometric objective is to evaluate whether former slavery affected the efficacy of ACA in expansion vs. non-expansion states. The model specification is given as:

[20] This measure predicts malaria transmission using interaction between mosquitoes' characteristics with climate, including long-run temperature and precipitation.

[21] Many scholars have notified the importance of slavery in cotton farming (Hammond, 1897; Ransom and Sutch, 2001). If changes in soil quality are systematically driven (e.g,. areas that were highly suitable in the past lost suitability), then the first stage will present a weak relationship between cotton suitability measure and slavery.

$$Y_{icst} = \alpha + \beta_1 \times slave1860_c \times Post_{2014} + \beta_2 \times slave1860_c \times Medicaid_{st} + \delta \times Medicaid_{st} + \zeta \times PostLA_{st} + \lambda_1 \times Uninsured_{c2013} \times Post_{2014} + \lambda_2 \times Uninsured_{c2013} \times Medicaid_{st} + \gamma_1 \times G_c \times Post_{2014} + \gamma_2 \times G_c \times Medicaid_{st} + \kappa \times X_{icts} + \sigma_c + \phi_t + \epsilon_{icst} \quad (2)$$

where, Y_{icst} measures insurance related outcome (i.e., whether insured, Medicaid coverage, private insurance coverage, employer's insurance, and others) of an individual i residing in local area c (PUMA in the case of ACS data) of state s in year t. The specification interacts 1860 slave concentration (interpolated to 2010 PUMA boundaries) with the $Post_{2014}$ indicator, which represents period following January 1, 2014 and marks the timing of ACA implementation. $Medicaid_{st}$ is an indicator representing whether a state s implemented Medicaid expansion in year t or before.[22] Although all five out of seven states that participated in ACA's Medicaid expansion implemented expansions on January 1, 2014, Louisiana implemented Medicaid expansion only on July 1, 2016 (regarded as 2017 in the model specification) and Virginia implemented in 2019; the timing of Virginia's Medicaid implementation exceeds the sample years in the ACS data. $Medicaid_{st}$ is interacted with local area slave concentration in 1860 to capture the effect of Medicaid expansion across local areas' dependency level on past slavery. $Medicaid_{st}$ is also included by itself to allow for differential trends in insurance coverage between expansion vs. non-expansion states following the timing of ACA in 2014. To account for the fact that Louisiana expanded Medicaid only in mid-2016 (separate from all other expansion states in south), $PostLA_{st}$ is an indicator for Louisiana representing years 2017 and 2018.[23]

Following Courtemanche et al. (2017), we also include interactions between local area specific uninsured rate in 2013 ($Uninsured_{c2013}$) and $Post_{2014}$ along with the interaction between $Uninsured_{c2013}$ and $Medicaid_{st}$. All model specifications also account for the local area and year fixed effects given by σ_c and ϕ_t. The standard errors are clustered at the local area level (PUMA).

In equation 2, the coefficients of interest include β_1 and β_2. β_1 represents the relationship between past slave dependency and the outcome variable in non-expansion states, whereas β_2 captures the relationship between slavery and outcomes in expansion states. The model represents a difference-in difference-in differences framework given the interaction between slave concentration ($slave1860_c$) and $Medicaid_{st}$. While identifying the relationship between slavery and ACA's efficacy in non-expansion states (β_1), the identification hinges on an assumption that in absence of ACA, there would be no systematic difference in outcomes between local areas with high and low

[22] This is similar to interacting the post Medicaid implementation period ($Post_M$) with a dummy representing states with Medicaid expansion.

[23] Louisiana's implementation of Medicaid expansion in later year creates a staggered treatment framework with treatment effects varying by time. Goodman-Bacon (2021) demonstrates that this may be problematic in difference-in-differences framework if the units treated early on that are in a different trajectory because of treatment act as control for units that are treated later. Although there still exist an additional layer of variation (local area slave concentration) in this difference-in-difference-in-differences framework, including $PostLA_{st}$ captures change in insurance coverage in Louisiana as a whole following the Medicaid implementation compared to other states and accounts for late implementation. We also provide results from the robustness exercise by dropping Louisiana.

dependency on past slavery. Next, the identifying assumption for states with Medicaid expansion is that even if insurance outcomes would have changed systematically between states with and without Medicaid expansions, these changes at the local area level would not be systematically correlated to local areas' dependency on slavery if not for ACA. It has to be noted that this identification relies on a weaker assumption compared to a difference-in-difference setup, which would require that there would be no systematic changes in outcomes across states with and without Medicaid expansion. Any differences in outcomes between states with and without Medicaid is absorbed by the term $Medicaid_{st}$.

One of the main concerns while evaluating the long-term impacts of slavery is that areas with high vs. low dependency in chattel slavery have different attributes (e.g., political preferences, economic and geographic characteristics) from the get-go. Such variables may have both influenced dependency on slavery and also independently shaped contemporary political beliefs and views regarding ACA. This channel is depicted by the green arrows in Figure 1, which demonstrates an omitted variable bias problem. The time invariant differences across local areas will be captured by local area fixed effects (σ_c) in specification 2. Nevertheless, it is still possible that historical differences in characteristics between high and low slave dependent areas may elicit differential responses to outcome variables following ACA. To allow for varying effects of ACA and Medicaid expansion based on historical characteristics, we control for the interactions between historical variables of local areas dating back to 1860 (vector G_c) and $Post_{2014}$ as well as $Medicaid_{st}$. Specifically, vector G_c include proportion of farms under 50 acres, farm value percapita, log of the total improved acreage, log of the total population in 1860, access to railways and waterways, Gini coefficient of inequality, proportion of free Blacks and land ruggedness, all measured in 1860.[24] Additionally, specifications also control for arguably exogenous individual characteristics (contemporary vector X_{icts}) obtained from ACS data.

Although it is not possible to assess the validity of the underlying identifying assumptions, we conduct applicable tests that are helpful in providing suggestive evidence regarding the assumption. As a first test, we restrict our analysis to the pre-expansion period (years 2012 and 2013) and construct placebo measure of the post period as year 2013. Then using this placebo setting, we estimate equation 2. Next, we conduct an event study exercise by using data of county specific uninsured rate from SAHIE between 2008 and 2018. The event study specification is given as follows:

[24] High and low slave dependent areas differed in several aspects. For instance, large plantations generally involved production suited to labor intensive cash crops (e.g., cotton, rice, tobacco), whereas small farms were more directed towards self sustenance. The proportion of free Blacks in 1860 portray sentiments regarding slavery, with lower concentration of free Blacks indicating strict views in favor of slavery. Slave dependent areas were also generally flat. These controls variables used are very similar to Acharya et al. (2016).

$$Uninsured_{cts} = \alpha + \sum_{k=-6}^{-2} \gamma_k \times slave1860_c \times I(t = 2014 + k) + \sum_{k=0}^{4} \gamma_k \times slave1860_c \times I(t = 2014 + k) + \sum_{k=-6}^{-2} \eta_k \times slave1860_c \times I(k) \times Medicaid_{st} + \sum_{k=0}^{4} \eta_k \times slave1860_c \times I(k) \times Medicaid_{st} + \delta \times Medicaid_{st} + \lambda_1 \times Uninsured_{c2013} \times Post_{2014} + \lambda_2 \times Uninsured_{c2013} \times Medicaid_{st} + \gamma_1 \times G_c \times Post_{2014} + \gamma_2 \times G_c \times Medicaid_{st} + \sigma_c + \phi_t + \zeta \times I(k) + \epsilon_{icts} \quad (3)$$

The event study specification given in equation 3 mimics equation 2 but the analysis is performed at the county level. The measure of interpolated slave concentration in 1860 is interacted with a set of indicators $I(t = 2014+k)$ representing year/years away from 2014, the ACA implementation year. The omitted category is year 2013, when $k = 1$. Next, $I(k)$ is a vector of indicators representing if year t is k year/years away from the implementation of Medicaid expansion year. For example, $I(-4)$ would represent four years prior to the Medicaid expansion year. The magnitude on η_k for $k < -1$ will track pre-policy differences in uninsured rate across counties with high vs. low dependency in past slavery. If the magnitude on η_k $(k < -1)$ is close to zero, it would suggest that uninsured rates were not changing differently across areas with high vs. low dependency on past slavery compared to the omitted period (one year prior to the expansion year) within expansion states. Similar interpretation can be drawn for non-expansion States from estimates of γ_k for $k < -1$. The standard errors are clustered at the county level to account for within county correlation in the error term when estimating specification 3.

5 Results

5.1 Past Slavery and ACA Sentiments

Figure 3a shows associations between ACA sentiments among Black Southerners in the past decade and *i*) slave concentration in 1860 across counties (states) (top panel), and *ii*) political identity (bottom panel). The best-fit lines shown in two sub-figures on the top (using county and state level aggregation) show that 1860 slave concentration is not related with Blacks' preferences to repeal ACA. The sub-figure on the bottom left shows that Blacks living in counties that accrued higher proportion of votes for Trump in 2016 presidential election are slightly more in favor of repealing ACA. The sub-figure on the bottom right indicate that Blacks' preference against ACA decreases with rise in Whites' vote share for Obama in the 2008 presidential election. This provides some evidence that preferences regarding ACA varies even among Black Southerners; Blacks living in democratic areas favor ACA compared to those living in more Republican areas.

Figure 3b replicates Figure 3a but focuses on White Southerners. The top-left figure suggests that anti-ACA sentiment is prevalent even in counties with relatively low levels of slavery – close

to 60% of White Southerners residing in areas with slave concentration below 10% are in favor of repealing ACA. Moreover, the positive best-fit line suggests that higher dependency on past slavery is associated with larger fractions of individuals in favor of repealing ACA. The figure on top-right, aggregated at the state level, highlights this finding with an upward sloping best-fit line.[25] The figures in the bottom panel show that anti-ACA sentiments increases with proportion of votes for Trump in 2016 presidential election and decreases with an increase in White voters for Obama (in 2008 election). These figures depict the well-publicized relationship between political preferences and ACA.

One explanation to trends shown in Figure 3b is that racial tensions increased during the 2008 presidential election involving the first elected Black president and remained high in the following decade, which may have aggravated the relationship between political inclination and ACA. However, Figure 4 suggests that political attitude going back to 1900s predicts preferences regarding ACA. The sub-figures indicate that increases in Democratic voters before the civil rights movement, while Democratic party was still preferred by White conservatives, is positively associated with anti-ACA sentiments. In contrary, following the mass exodus of White Southerners from the Democratic party, expedited in the Spring of 1963 (Kuziemko and Washington, 2018), the democratic vote share in the 1964 election is negatively associated with the proportion of people choosing to repeal ACA.[26] This suggests that the trends in Figure 3b are not just motivated by current political beliefs but are also explained by historical political attitudes.

Table 1 presents OLS estimates from estimating specifications given by equation 1. Panels A and B pertain to Black and White Southerners, respectively. Columns 1-5 portray the relationship between the proportion of slaves in 1860 and current preference regarding ACA (repeal vs. support), whereas Columns 6-10 show the reduced form estimates using cotton suitability measure as the explanatory variable. All specifications control for the state and year of survey fixed effects. Column 1, the most parsimonious specification, additionally controls for geographic characteristics along with a vector of county specific economic and demographic variables dating back to 1860. These factors, explained in section 3.1 and emphasized at the bottom of Table 1, are likely to have determined local areas' dependency on slavery as well as past political attitude. The estimate in Column 1 shows that a 1 percentage point increase in slave concentration in 1860 is associated with an increased probability of Blacks being against ACA by 0.107 percentage points in non-expansion states. In other words, one standard deviation of an increase in 1860 slave concentration is associated with an increased probability of wanting to repeal ACA by 2.03 [19×0.107] percentage points in non-expansion states. In contrast, the coefficients for the expansion states are negative, hinting that Blacks in high slave concentration areas are in favor of ACA within expansion states,

[25] Although the red text markers show that states below the median slave concentration in 1860 were more likely to participate in Medicaid expansion, sub-figures in Figure A1 display wide variations in interpolated 1860 slave concentration measure at the local level (county) across both expansion and non-expansion states.

[26] Using high frequency data from contemporaneous media and surveys, Kuziemko and Washington (2018) identify Spring of 1963 as a critical turning point in party dealignment (realignment), timeframe associated with president Kennedy's proposed legislation against discrimination in public accommodations that put the issue of Civil Rights infront of the majority of Americans.

although these coefficients are imprecisely estimated.

Columns 2 to 5 add other appropriate controls interacted with expansion and non-expansion states, respectively. Column 2 adds the proportion of free Blacks in 1860 to proxy for variation in sentiments regarding slavery across southern counties prior to emancipation. This does not alter the magnitude of the coefficient on slave concentration in 1860 across both panels. To address the racial threat hypothesis suggesting that Whites living in areas with high concentration of Blacks at current times may have developed a contemporary racial threat, which might dictate preferences regarding ACA, Column 3 controls for county-specific proportion of Blacks in 2000, interacted with expansion and non-expansion indicators respectively.[27] The magnitude on the point estimates are stable when accounting for the proportion of contemporary Black population. Column 4 excludes the proportion of Blacks in 2000 and adds income inequality measure (log of White-Black median income ratio in 2014) to address whether preferences regarding ACA is being driven due to contemporary inequality in income. The magnitude of the coefficient on slave concentration is comparable to the parsimonious specification illustrated in Column 1 in both panels. Column 5 excludes income inequality measure but adds arguably exogenous individual level variables from CCES including age, age squared and gender. We refrain from adding other economic and demographic variables as these individual level controls may be directly affected by slavery and thus may introduce posttreatment bias in estimation (Rosenbaum, 1984).

Even after accounting for the specified covariates as shown in Columns 1-5 of Table 1, it is highly possible that the model specification fails to control for other omitted variables that predict both past slavery and current sentiments regarding ACA. Moreover, an additional concern with specifications using the measure of slave concentration (a limitation throughout the study) is that this measure could be misreported. To address some of these concerns, we conduct an instrumental variable (IV) analysis by instrumenting slave concentration with county level cotton suitability measure based on environmental factors. Before we move to the IV results, Columns 6-10 in panels A and B, Table 1, present results from the reduced form specifications evaluating the relationship between cotton suitability and preferences regarding ACA. This segment of the table is structured similar to Columns 1-5. The results show that improved conditions for cotton farming is positively associated with opposition against ACA in non-expansion states across both race groups. However, Blacks residing in areas suited for cotton farming within expansion states are more likely to advocate ACA.

Table 2 shows the effects of 1860 slave holdings on ACA sentiments from the IV analysis. Column 1 presents the first stage estimate from the specification that additionally accounts for state fixed effects and a vector of geographic controls including longitude, latitude, squared terms of longitude and latitude, log of county area, ruggedness of the land, and whether the county had access to waterways. The estimate in Column 1 suggests that cotton suitability measure is a strong predictor of slave holdings in antebellum South. The F-statistic based on a Wald test that compares

[27] Although this is one convenient approach to account for contemporary racial demography, it is not the preferable way as former slavery dictates the current day demography in the American South. See Figure A8. We conduct other robustness exercise to evaluate the potential of racial threat driving the main results.

the restricted vs. unrestricted model specifications is greater than 10 – a widely used cut-off value to gauge the strength of the instrument (Staiger and Stock, 1997).

Columns 2-6 (7-11) use the predicted values of slave concentration from the first stage and test several alternative specifications for Blacks (Whites). The estimate from Column 2 indicates that an increase in proportion of 1860 slave holdings by 1 percentage point is associated with a reduction in anti-ACA sentiments by 0.56 percentage points among Blacks in expansion states but is associated with an increased probability of repealing ACA by 0.29 percentage points in non-expansion states. A finding that stands out when comparing the effects across two race groups is that while increases in 1860 slave concentration is associated with an increased support for ACA among Blacks in expansion states, results pertaining to Whites are inconclusive (Column 7, estimate=-0.143, s.e.=0.208). However, White Southerners in high slave intense areas are more opposed to ACA and are willing to repeal it entirely (Column 7, estimate=0.257, s.e.=0.155). The addition of proportion of free Blacks in 1860, interacted with indicators representing expansion and non-expansion states respectively, does not affect the size of the coefficients in Column 3 (8). Column 4 (9) controls for the interaction between expansion and non-expansion indicators with the proportion of Blacks in 2000 to test whether the results are being driven by contemporary differences in Black population across counties. The size of the coefficient pertaining to non-expansion states increases slightly in Column 9. Next, Column 5 (10) controls for the interaction between expansion and non-expansion indicators with income inequality measure between Blacks and Whites in 2000, whereas Columns 6 (11) account for other individual level controls from CCES data (education, family income dummies, and marital status). The coefficients across both race groups pertaining to expansion vs. non-expansion states are stable across all reported columns.

The exclusion restriction underlying the IV approach assumes that the effect of cotton suitability measure on current ACA sentiments is driven through slavery. This is a strong assumption as the relationship between cotton suitability measure and ACA preferences may be driven by other factors common to areas favoring cotton farming. For example, areas with better cotton suitability measure may have remained relatively rural, which may have influenced political attitude regarding ACA. Hence, an alternative explanation to the IV results is that factors common to cotton growing areas other than slavery are driving the results. Although the test accessing the validity of exclusion restriction is not feasible, we conduct a falsification exercise similar to Nunn and Wantchekon (2011) and Acharya et al. (2016) by focusing on non-Southern counties and replicating Columns 6-10 presented in Table 1. Since slavery was legally outlawed in the North, if factors common to cotton growing areas other than slavery are driving the results then the relationship between cotton suitability measure and ACA preferences outside the South should mimic the results shown in Table 1, Columns 6-10. These results presented in Appendix Table A1 show no relationship between cotton suitability measure and ACA preferences.[28] To an extent, this increases credibility of the IV estimates.[29]

[28] Specifications used in Table A1 do not evaluate the effects across expansion vs. non-expansion states as cotton suitable areas outside of south mostly all belong to states that expanded Medicaid.

[29] Alternatively, Table A2 shows the results when using both cotton suitability and malaria suitability indices as

Figures 5 and 6 plot the IV estimates based on education levels (years in college) and income (median income by race groups). Figure 5 show that Blacks' opposition against ACA in high slave concentration areas within non-expansion states is in fact driven by the subgroup with relatively low levels of education and income, while support on behalf of ACA in high slave intense areas within expansion states is concentrated among Blacks with relatively higher levels of education and income. Figure 6 for White Southerners demonstrate an uniform effects across the reported subgroups, indicating lack of heterogeneous effects based on demographic variables.

In summary, one finding highlighted in section 5.1 is that Blacks with higher levels of education in high slave intense areas within expansion states are relatively strong proponents of ACA, whereas Blacks residing in non-expansion states are opposed to ACA. As shown in Table 2, the coefficients on 1860 slave concentration for Blacks in non-expansion states are in fact positive and similar to Whites; opposition is more concentrated among Blacks with lower levels of education. An explanation to these results is that political cues against ACA may have been highly publicized specifically among counties with high dependency on past slavery in non-expansion states that were also politically more opposed to ACA. In fact, Gollust et al. (2014) show that locally broadcast ACA news coverage were significantly more discouraging in states with federally operated insurance exchange market. In an environment of public confusion and distrust, this might have fostered anti-ACA sentiments even among Blacks living in high slave dependent areas within non-expansion states.

To evaluate the relationship between former slavery and television broadcast of political ads, we use data from Kantar Median/CMAG and focus on the total number of ads that sent a discouraging message against ACA in 2014 gubernatorial elections, aggregated at the county level.[30] Table 3 replicates 1 in structure and conducts the analysis at the county level where the outcome used it the log of the total number of ads that sent discouraging message regarding ACA. The point estimate pertaining to non-expansion states across all specifications consistently suggest that anti-ACA political ads are concentrated in counties with high dependency on former slavery. For instance, one percentage point of an increase in 1860 slave concentration is associated with an increase in anti-ACA political ads by 2 percent. To evaluate whether these results are spuriously driven by other characteristics that are unique to slave dependent areas (e.g., attitude regarding welfare policies), we replicate Table 3 by focusing on political ads dispensed against other welfare policies except ACA (e.g., childcare, health care not related to ACA, prescription drugs not related to ACA, Medicare, and social security). The results shown in Table A3 show that the magnitude of point estimates are very close to zero across all specifications pertaining to both expansion and non-expansion states. Overall, these findings provide evidence that concentration of anti-political cues in high slave intense areas is likely to have increased opposition against ACA in non-expansion

instruments in the first stage. Column (1) shows that both indices predict 1860 slave concentration – coefficient of malaria stability index is similar to Esposito (2019). The findings from this IV specification are consistent to Table A2, although the IV magnitudes are higher.

[30] To identify the total number of political ads within a county we construct a crosswalk that maps the Designated Market Area (DMA) codes to respective counties. This crosswalk is available upon request.

states.

5.2 Slavery and insurance coverage following ACA

Figure 7 shows the trend in proportion of uninsured population and insurance coverage by types in the American South. As illustrated, over 18.5 percent of non-elderly individuals living in south were uninsured in 2012 – about 2 percentage points higher than the country-wide statistic. Moreover, Blacks were approximately 5 percentage points more likely to be uninsured compared to Whites. There has been a noticeable decrease in uninsured rate starting from 2014, with rates decreasing proportionately among Black and White race groups. Figure 7b shows that take-up of private insurance has increased for both race groups. Figure 7c demonstrates large gaps in proportion of individuals covered through employer sponsored insurance between Black and White race. In 2012, White Southerners were close to 17 percentage points more likely to be covered through employers sponsored insurance compared to Blacks. This gap has reduced to 14.4 percentage points in 2018. Figure 7d shows that Medicaid is an important source of insurance for Black Southerners, with close to 30 percent of non-elderly Blacks receiving coverage through Medicaid while only 14 percent of Whites were covered by Medicaid in 2013. Medicaid coverage among Whites increased by about 1.5 percentage point following 2013, whereas there is no such discernible pattern among Blacks.

Tables A6 and A7 present summary statistics in expansion and non-expansion states from ACS 2012 and 2013 sample (years prior to ACA implementation), which are further divided by race groups. Table A6 shows that Blacks residing in high slave dependent areas are on average 5 percentage points more likely to be uninsured compared to Blacks in low slave dependent areas in expansion states.[31] Such difference is driven by lower Medicaid coverage in high slave dependent areas. The pattern of insurance coverage is similar across White Southerners living in high vs. low slave dependent areas prior to ACA implementation but Whites in slave dependent areas have higher wages, a finding consistent to Lagerlöf (2005). Table A7, pertaining to non-expansion states, show no difference in insurance pattern across high and low slave dependent areas among Blacks but uninsured rate is 4 percentage points lower in high slave dependent areas compared to Whites in low slave dependent areas.

Table A8 shows that high and low slave intense areas differ across several historical characteristics measured prior to emancipation in both expansion and non-expansion states. Specifically, areas more exposed to former slavery are also more suitable for cotton farming, are less rugged, and have easier access to waterways. These findings concur with Lagerlöf (2005), suggesting that factors such as climate and soil suitability, which determine the growth of staple crops, are important determinants of slavery. It is noticeable that high and low slave intense areas also differ in other 1860 characteristics such as farm value per capita, total improved acres, and Gini coefficients of land holdings. We allow for the local area specific 1860 characteristics to have differential effects on insurance coverage following ACA in both expansion and non-expansion states by including the interaction terms between: i) the post ACA dummy (year 2014 and after) and 1860 variables, ii)

[31] High and low slave dependency areas are based on median value of 1860 slave concentration.

the post Medicaid implementation dummy, expansion state indicator, and 1860 characteristics of local areas. Additionally, we estimate propensity score matched difference-in-difference-in-differences specification, which is discussed in section 6.

Table 4 shows estimates from specification 2 when the dependent variable used is an indicator for whether an individual is uninsured. Columns 1-5 and 6-10 pertain to Blacks and Whites, respectively. All specifications include the local area (PUMA) and survey year fixed effects along with a vector of 1860 controls and their interaction terms as discussed in the previous paragraph. Columns 2 and 7 add log of expenses pertaining to past health policies (the Hill Burton project and county health departments (CHD)) along with ACA controls, both interacted with post ACA indicator and Medicaid status ($Medicaid_{st}$). Columns (3) and (8) include state specific linear time trends to capture unobserved ongoing linear trends within states. Columns (4) and (9) include individual level controls from ACS data that are arguable not directly influenced by slavery (e.g., age, age squared, and gender). Next, Columns (5) and (10) exclude the individual level controls but include: i) metropolitan status in 2013 interacted with the post ACA indicator as well as $Medicaid_{st}$ to control for varying effects of ACA and Medicaid implementation based on rural-urban divide across expansion vs. non-expansion states, and ii) state unemployment rate.

Results in Table 4 show that Blacks' uninsured rate in slave dependent areas decreased at a lower rate compared to areas less dependent on former slavery following ACA Medicaid expansion in expansion states but no such discernible pattern is detected for non-expansion states. In Column (1), coefficient on the interaction term between 1860 slave concentration and the post ACA indicator are close to zero and statistically insignificant at conventional levels (estimate=-0.007, s.e.=0.012). The result pertaining to expansion states, depicted by the triple interaction term between the proportion of slave in 1860, whether the state participated in ACA Medicaid expansion and post Medicaid implementation indicator is positive, suggesting that uninsured rates were systematically higher in high slave intense areas compared to low slave dependent areas following Medicaid expansion. An increase in 1 percentage point of slave concentration in 1860 is associated with a relative increase in uninsured rate by 0.203 percentage points (s.e.=0.035). This translates to one standard deviation of an increase in slave concentration associated with 3.86 percentage points [19×0.203] increase in relative uninsured rate.

Controlling for the interaction terms (as described above) including past health policy intensity (captured by the log of expenses) and ACA controls do not significantly alter the magnitude of coefficients for both expansion and non-expansion states. Including the state-specific linear time trends in Column (3) slightly lowers the magnitude on the interaction term pertaining to expansion states (estimate=0.136) but does not change the inference (s.e.=0.037). The coefficients of interest are also not affected by the addition of individual level controls (Column 4) or urban-rural and state level unemployment controls (Column 5). Consistent with Courtemanche et al. (2017), the coefficients on the interaction terms between uninsured rate in 2013, post Medicaid implementation, and expansion states are negative and statistically significant at the 1 percent level across all specifications. These results indicate that although Medicaid expansion did improve insurance status

among Blacks residing in areas with higher pre-reform uninsured rates, benefits were comparatively lower in area more dependent on former slavery.

Results pertaining to Whites, as shown in Columns 6-10, are somewhat different from the findings for Blacks. Column 6 suggests that areas with higher dependency on past slavery experienced a lower reduction in uninsured rate following the ACA implementation in 2014 (for non-expansion states) and Medicaid implementation (expansion states). The point estimates suggest that 1 percentage point increase in 1860 slave concentration is associated with 0.01 and 0.024 percentage points increase in relative uninsured rate in non-expansion and expansion states respectively, although the coefficients are quite imprecisely estimated. The addition of interaction terms pertaining to past health policy expenses and ACA controls slightly increases the coefficient's magnitude pertaining to non-expansion states. The results for non-expansion states remain similar across Columns (8)-(10) with additional controls, suggesting that insurance rate improved at a lower rate in slave intense areas within non-expansion state following ACA. However, such claim cannot be made for expansion states given the imprecision of point estimates (e.g., Column (8), estimate=0.027, s.e.=0.021).

In summary, the findings presented in Table 4 provide evidence that slavery impeded Blacks' insurance coverage following Medicaid implementation but such patterns are indistinguishable within non-expansion states. However, Whites residing in low slave concentration areas within non-expansion states benefited more from ACA implementation in terms of higher reduction in uninsured rates.

One concern is that differences in pre-policy uninsured rates across local areas can affect the estimates if pre-policy uninsured rates are systematically correlated with 1860 slave concentration. For example, Courtemanche et al. (2017) and Miller (2012) provide evidence that local areas with higher baseline uninsured rate prior to the reform benefited the most from universal coverage provisions of ACA. Following Courtemanche et al. (2017), all specifications control for: i) the interaction between area specific uninsured rate in 2013 and post ACA indicator, and ii) the triple interaction term between area specific uninsured rate in 2013, indicator for Medicaid expansion states, and post Medicaid implementation indicator. Although the magnitude of coefficients pertaining to expansion states ($uninsured$ 2013 $\times$ $Post$ $\times$ $Medicaid$) are similar across two race groups in Table 4, the results pertaining to non-expansion states ($uninsured$ 2013 $\times$ $Post$) are close to zero for Blacks and only appear to be statistically significant for Whites. While the results indicate no disproportionate reduction in uninsured rate among Blacks in high vs. low slave dependent areas within non-expansion states, the findings pertaining to Whites, although not meant to represent the whole U.S., are consistent with the findings presented in Courtemanche et al. (2017) study.

Additional findings indicate that lower levels of reduction in uninsured rate in slave dependent areas within expansion states are driven by relatively low Medicaid take-up in such areas. Table 5 shows the relationship between past slavery and different types of insurance coverage following ACA, where specifications 3 (for Blacks) and 8 (for Whites) from Table 4 are chosen for estimations. Columns 1-4 and 5-8 pertain to Black and White race groups, respectively. The results in

Columns 1-4 show that reported types of insurance coverage (ESI, private insurance, Medicaid, other) among Blacks did not change systematically across varying levels of slave dependency areas in non-expansion states following ACA implementation. The coefficients on the interaction terms between slave concentration in 1860 and post ACA indicator are close to zero and not statistically significant for any insurance types (e.g., ESI, estimate=0.00001, s.e.=0.014). Similarly, within expansion states, ESI, private insurance and other types of insurance did not change systematically with 1860 slave concentration following the Medicaid expansion. However, the point estimate in Column (3) for expansion states suggests that 1 percentage point of an increase in 1860 slave concentration is associated with 0.11 percentage points less of a reduction in Medicaid coverage compared to average increase in Medicaid coverage following the expansion. To put this in context, Medicaid coverage increased by 5 percentage points among Blacks following the expansion. But the point estimate in Column (3) suggests that areas that are one standard deviation away from the mean of 1860 slave concentration experienced only 2.91 percentage points of an increase in Medicaid coverage.

We are unable to uncover any statistically significant effects of past slavery on insurance coverage across various insurance types for Whites. Columns (5) and (6) in Table 5 show no effects of former slavery on employer sponsored insurance coverage and private coverage in both non-expansion and expansion states. Column (7) also shows that Medicaid coverage improved uniformly in areas with varying levels of past dependency on slavery following ACA implementation in non-expansion states. The estimate pertaining to expansion states indicates that a 1 percentage point of an increase in 1860 slave concentration is associated with 0.031 percentage points of reduction in Medicaid coverage relative to the average increase. However, the coefficient is statistically insignificant (s.e.=0.020) at the conventional levels.

In summary, findings from Tables 4 and 5 indicate that uninsured rate for Black Southerners decreased at a higher rate in low slave intense areas compared to high slave intense areas following Medicaid expansion. Such results are driven by lower take-up of Medicaid coverage in high slave dependent areas. Although findings for White Southerners suggest that Whites in low slave dependent areas within non-expansion states benefited from higher reductions in uninsured rate following the ACA implementation, such an effect is not driven by any specific insurance type.

The identification of specification outlined in equation 2 for the non-expansion states hinges on an assumption that insurance coverage across areas with low and high slave concentration would not vary systematically in absence of ACA. Similarly, the identification for states with Medicaid expansion is based on the assumption that although insurance coverage may have changed differently between states with and without Medicaid expansions, insurance trends would not have changed systematically across low and high slave concentration areas within expansion states if not for ACA's Medicaid expansions. Any differential changes in insurance coverage overtime across expansion and non-expansion states are captured by the interaction between indicator representing expansion states and post Medicaid expansion indicator ($Medicaid_{st}$).

Although it is not possible to test the given identification assumptions, we provide several

evidence that advocates the identification used in this study. First, we conduct an event study analysis to provide suggestive evidence that the findings reported in Tables 4 and 5 are not spurious. To conduct the event study analysis, we estimate specification given by equation 3 and use the county-level data of uninsured rate from SAHIE (2008-2018).[32] Figure 8a shows the correlation between slave concentration and baseline uninsured rate in 2013, while Figure 8b shows the event-study estimates of γ_k from equation 3. Figure 8a indicates that there is no correlation between past slave concentration and uninsured rate in 2013, although the spread in uninsured rate is higher at the lower spectrum of slave concentration. In Figure 8b, the estimates of γ_k for years $k \in \{2008, ..., 2012\}$ are very close to zero compared to the omitted category 2013. In contrast, there is a sharp rise in the magnitude of coefficient pertaining to year 2014, after which the point estimates fall gradually back to zero. The coefficients of γ_k for $k \in \{2014,\ 2015,\ 2016\}$ clearly shows that the reduction in uninsured rate is lower in local areas with higher slave concentration within states that expanded Medicaid. The finding that coefficients concerning pre-policy years are very close to zero is suggestive of no pre-existing differential trends in uninsured rate between areas with high and low slave concentration. To an extent, these suggestive findings improve credibility of the identification strategy used in the study.

Next, we present results from a falsification exercise, presented in Table 6, that uses data for the period prior to ACA (2012, 2013) to re-estimate Table 5, except that 2013 is used as the placebo policy period. There are no consistent patterns in the reported coefficients that describe the relationship between past slavery and insurance status in this falsification exercise. The estimates for both expansion and non-expansion states are close to zero and statistically insignificant at any conventional levels. In fact the estimates on Medicaid coverage are negative, although insignificant (estimate=-0.027, s.e.=0.068). Almost all the coefficients pertaining to past slavery across both expansion and non-expansion states are close to zero among Whites (Columns 6-10), except for Medicaid coverage in expansion state, which is significant at the 5 percent level (estimate=0.046, s.e.=0.019). If anything, this show some evidence that Medicaid coverage increased relatively more for White Southerners residing in high slave concentration area a year prior to the implementation. However, this falsification exercise is somewhat limited since we are unable to include past years prior to 2012 due to inconsistency in PUMA demarcation in ACS years prior to 2012.

As an additional exercise, we randomly allocate 1860 slave concentration across local areas (PUMA) in the sample and estimate specifications outlined in Table 4, Columns (3) and (8), for Blacks and Whites, respectively. This process is repeated 199 times, which yields a distribution of pseudo estimates. Figure A3 shows that the actual estimates (shown by the blue dotted line) are beyond the entire distribution of pseudo estimates for Blacks in expansion states (Panel B). This further adds to the evidence that the main results are highly unlikely to be occurring by chance.

[32] One limitation using aggregated SAHIE data is that race based uninsured rate is only available at the state level. As our identification requires uninsured rate at the local level, we use the overall uninsured rate for all race at the county level. The publicly available files only provide county level data for uninsured rate as a whole, and breakdown by insurance types are unavailable.

5.3 Contemporary demographics as a mechanism?

We explore whether the modern day *racial threat* hypothesis, discussed as an alternative mechanism in section 2, can explain the current findings. Due to persistence in demographics, Figure A8 shows that variation in former slavery is highly correlated with present-day Black concentration. An alternative argument is that the efficacy of a redistributive reform can be suppressed simply because of it being perceived as disproportionately beneficial to minorities in areas with high concentration of Blacks.

Alternatively, we argue that if racial threat hypothesis is a significant factor framing political preferences regarding ACA, then efficacy of ACA should vary systematically with Blacks' concentration both in south and non-Southern regions. An obvious difference across the two regions is that the origin of threat in south can be traced back to its subculture of slavery – as economic burden following emancipation fell heavily on White Southerners in slave intense areas, racial hostility increased disproportionately in those areas. However, the argument of contemporary racial threat applied in the context of U.S. south often overlooks its origin but focuses more on contemporary concentration of minorities.

Tables A12 and A13 provide results after using contemporary concentration of Blacks (in 2000) to assess whether the effects of ACA varies with Blacks' population both in Southern and non-Southern U.S. regions. Any relationship between present-day fraction of Black population and insurance status in non-southern U.S. would not be driven due to dependency in slavery but through other factors that are commonly shared among areas with high proportion of Blacks. The findings for U.S. south shown in Table A12 are similar to the main findings that uses 1860 measure of slave concentration – uninsured rate among Blacks fell by a lower magnitude in areas with high concentration of present-day Blacks within expansion states. However, findings pertaining to non-Southern region are close to zero for outcomes that uses uninsured status and Medicaid coverage. These results suggest that the present-day Black concentration in south may be acting as a proxy for former slave concentration;[33] if contemporary demographics were mainly influencing the findings, one would expect to see similar pattern of lower reductions in uninsured rate following Medicaid expansion in areas with high concentration of Blacks even outside of south.

Following the event of the Great Migration of African Americans between early 1900s and 1970, places with higher proportion of drop in the share of Black population are also more likely to experience reductions in contemporary racial threats. Figure A9 shows the relationship between 1860 slave concentration measure and changes in concentration of Black population between 1870 and 1970. It is evident that higher proportion of Blacks migrated out of more slave intense areas. The figure on the right restricts the sample to counties that experienced more than 10 percentage points or more drop in proportion of Blacks between 1870 and 1970. According to the hypothesis of racial threat, modern day racial threat should have lowered in areas that experienced high drop in Black concentration. The results based on the sample of PUMAs with high reduction in Black concentration (10 percentage points or more) shown in Table A14 are similar to the main findings.

[33] In fact, Lagerlöf (2005) uses present-day Black concentration as a proxy for former slavery.

This provides additional evidence that the results of this study are unlikely to driven mainly due to modern day racial threat.

6 Threats to Validity

The expansion of Medicaid through ACA will not have affected take-up of Medicare coverage.[34] Figure A4 shows that Medicare coverage did not differ across low and high slave concentration areas following Medicaid expansions across both race groups. The figure also shows that the sample composition is similar in pre and post ACA periods across low and high slave concentration areas based on the reported variables.

Next, Goodman-Bacon (2021) demonstrates that the time-varying treatment effects due to staggered timing in implementation of treatment can bias difference-in-differences estimate. This is because treatment units, who are in a different trajectory due to the treatment, can serve as control groups for units that receive treatment later on. Among the states that expanded Medicaid in the time frame used by this study, Louisiana is the only state that expanded Medicaid in June 2016 (coded as 2017). As an auxiliary exercise, we drop Louisiana from the sample and re-estimate the main specifications. The results shown in Figure A5 are similar to the main findings.[35]

Additionally, Figure 9 presents results from additional robustness exercises based on alternative specifications and sub-samples. Row 1 in both sub-figures in Figure 9 plots the preferred estimates for expansion and non-expansion states from Table 4, Columns 3 (Blacks) and 8 (Whites). The vertical dashed lines show the main estimates. Row 2 uses specification that drops the 1860 controls, past health policy as well as ACA controls. Row 3 restricts the sample to 1860 slave concentration between the 10^{th} and 90^{th} percentile to exclude the extreme values. Row 4 replicates row 3 except includes areas with slave concentration between the 20^{th} and 80^{th} percentile. Row 5 demonstrates the weighted least square estimates using person's weight from ACS. In these different specifications or sub-samples, the point estimates obtained are similar in magnitude to the main estimates for both expansion and non-expansion states across Black and White race groups.

Next, as intensity of slavery was primarily dependent on factors promoting the growth of staple crops such as cotton, we use the propensity score matching method to create a trimmed sample of low slave intense areas that have similar propensity score as slave dependent areas.[36] Table A9

[34] Although Medicare program went through some changes over the sample period of this study, these were countrywide changes and are not related to the timing of Medicaid expansions. Carey et al. (2020) find that Medicaid expansion increased healthcare utilization among Medicaid beneficiaries but did not affect utilization of Medicare beneficiaries. See Carey et al. (2020) for more details.

[35] Arkansas's Medicaid expansion differed from general expansion as Medicaid funds could be used to purchase private health insurance. Medicaid enrollees can pick from available silver plans while Arkansas Medicaid would pay premiums. The findings obtained from analysis after dropping Arkansas produce results that are unchanged from the main findings. These results are not reported but are available upon request.

[36] Specifically, we first construct an indicator of high slave dependent area based on the median value of slave concentration in 1860. Then we estimate a logit regression on the high slave indicator that uses cotton suitability measure, land ruggedness, access to waterways in 1860, and state dummies as the covariates. We use the single-nearest-neighbor matching, which retains observations from the low slave intense pool that are closest in propensity score to each unit in the high intense pool.

and A10 present summary statistics of the propensity score screened ACS sample (years 2012 and 2013). The tables show that the averages of most of the variables, including fractions of uninsured and with Medicaid, are similar across high and low slave intense areas in the trimmed sample for both race groups. The results obtained after estimating specification 2 when using uninsured status as the dependent variable are shown in Row 6, Figure 9. The figure shows that the point estimate obtained from the propensity score matched sample are similar to the preferred estimate. This exercise further increases confidence regarding validity of the main estimates.

7 Heterogeneity by Categories

Results focused on sub-samples divided by several categories suggest that former slavery impeded efficacy of Medicaid expansion among Black individuals with education less than associate's degree, low income groups, and relatively younger subgroups. Tables 7 and 8 restrict the sample to individuals with less than associate level education vs. associate level or more who are above 25 years of age but below 65 (surpassed the college-going-age but not yet reached Medicare eligibility), respectively. Table 7, comprising of individuals without an associate degree, shows no effects of past slavery on insurance coverage following ACA implementation in non-expansion states for both race groups. While uninsured rate decreased at a higher rate in areas less dependent on past slavery compared to more dependent areas following Medicaid implementation (Column (1), estimate=0.15, s.e.=0.049), this effect is mainly driven by lower take-up of Medicaid coverage in high slave intense areas (Column (4), estimate=-0.156, s.e.=0.048). Column (9) provides some evidence of relatively lower take-up of Medicaid in high slave concentration areas for Whites as well. Although Table 8 suggests that uninsured rate decreased at a lower rate in high slave concentration areas within expansion state even among Blacks with associate degree or more (Column (1), estimate=0.085, s.e.=0.042), the result on Medicaid coverage (Column 4) are indistinguishable from zero.

Figure A6 shows the relationship between former slavery and Medicaid coverage by income bins of $5,000 intervals constructed from reported wages or salary in the past 12 months. The figure shows that the coefficient for non-expansion states are quite precisely estimated at zero for both Black and White race groups across all income bins. In contrast, for expansion states, past slavery impacted Medicaid coverage of low income Blacks with earnings below $15,000 (in past 12 months), after which the coefficients increase in magnitude and hover around zero. The findings that slavery's effects on Medicaid coverage may be concentrated among individuals from the lower end of the earnings distribution is consistent with previous findings that families from poor socioeconomic background primarily benefited from Medicaid expansions.

Figure A7 presents results based on four age subgroups – 18-30, 31-40, 41-50, and 51-64. The sub-figures on the top and bottom pertain to Blacks and Whites, respectively, with circle and triangle markers representing estimates for expansion and non-expansion states. Sub-figure A shows that the point estimates for non-expansion states are close to zero across all age subgroups.

While effects of past slavery on uninsured rate are more pronounced for Blacks in age groups 18-30, 31-40, and 41-50 within expansion states, the estimate pertaining to age group 51-64 is close to zero. Sub-figure D shows that these results are primarily driven by lower take-up of Medicaid coverage among age groups 18-30, 31-40, and 41-50. Similar patterns emerge for uninsured rate among Whites in sub-figure E (compared to sub-figure A). Although the magnitude of estimates pertaining to employers insurance for expansion states increases by age in sub-figure F, the coefficients are statistically insignificant at the 95 percent level. Sub-figure H shows that effects of slavery on take-up of Medicaid coverage are close to zero for subgroups 18-30 and 31-40 but decreases in magnitude for older age groups. This indicates that Medicaid coverage increased at a higher rate among older White Southerners in areas less dependent on slavery compared to slave intense areas.

8 Conclusion

This study first evaluates whether former American slavery affected present-day sentiments regarding ACA among Black and White Southerners in states with and without Medicaid expansion. Next, it explores the potential relationship between past slavery and efficacy of ACA by focusing on health insurance outcomes.

The results show that both Black and White Southerners living in slave intense counties within non-expansion states are more in favor of repealing ACA. We argue that vehement backlash and anti-ACA cues dispensed by politicians, locally broadcast ACA-related media coverage, and insurance marketers may have resonated more among people from slave intense areas in states that voluntarily chose not to expand Medicaid. In fact, we show that the broadcast of political ads discouraging ACA in 2014 gubernatorial elections were more concentrated in counties with high slave concentration in 1860. In contrast, Blacks living in higher slave concentration areas within expansion states are more supportive of ACA, while findings for Whites are inconclusive and imprecisely estimated in the preferred specifications.

When analyzing the relationship between past slavery and efficacy of ACA, the results indicate that although uninsured rate decreased in the American south following ACA, the reduction was disproportionately higher among Black Southerners living in low slave intense areas compared to slave dependent areas within states that expanded Medicaid. Additionally, we show that this pattern is driven by lower take-up in Medicaid coverage among Black Southerners living in high slave intense areas. In non-expansion states, findings indicate that uninsured rate among White Southerners decreased at a higher rate in less slave intense areas compared to slave dependent areas. These findings point out that former American slavery may have impeded efficacy of ACA.

To account for the possibility that variables influencing former slavery may also result in differential responses to ACA implementation, we control for a vector of historical variables in the regression framework. This approach accounts for differences in economic, political and geographical factors across high vs. low slave intense areas before slavery was abolished that might have affected both intensity of slavery and present-day ACA sentiments. We conduct a battery of ro-

bustness tests to assess the validity of our findings; the results from these tests are consistent with the main findings of the study. Additionally, we provide an argument that the theory of modern day racial threat is unlikely to be influencing our results. Specifically, we show that the relationship between slavery and ACA's efficacy is stronger in local areas that experienced high reductions in Blacks' share of population during the Great Migration period, which is inconsistent with the argument of modern racial threat driving the findings. Also, we show that results are unlikely to be driven due to selective sorting of Blacks and White Southerners following the Great Migration.

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9 Figures and Tables

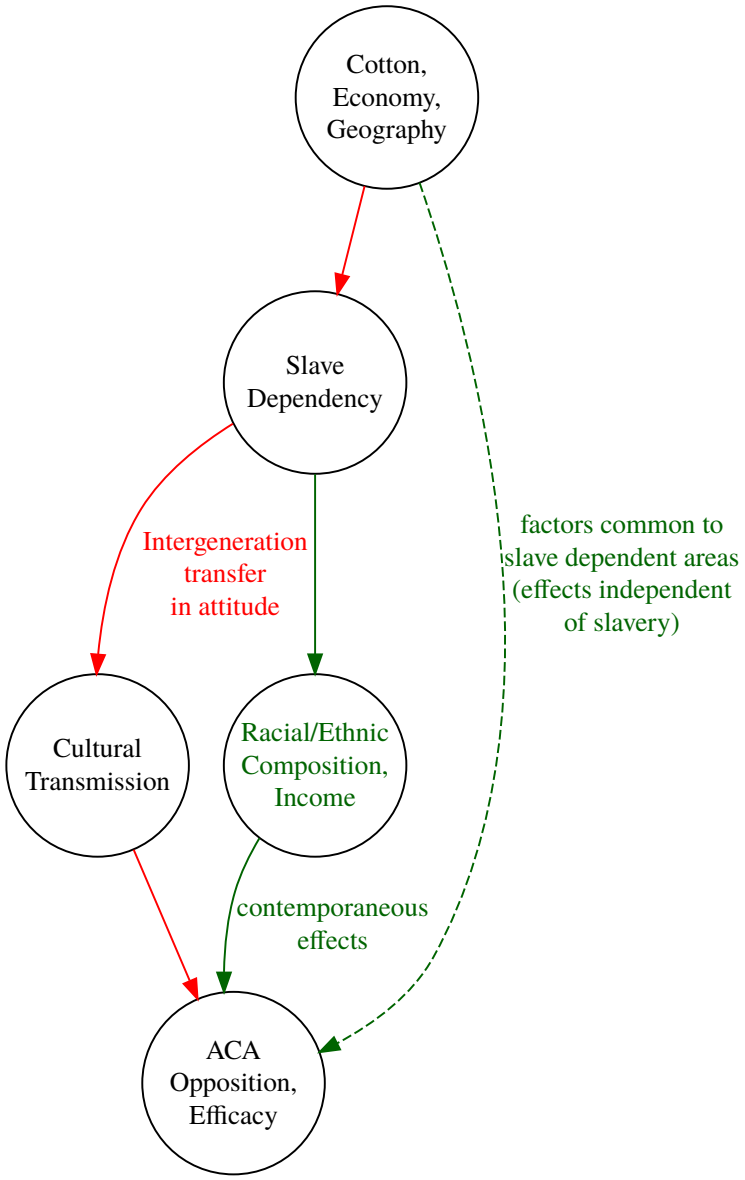
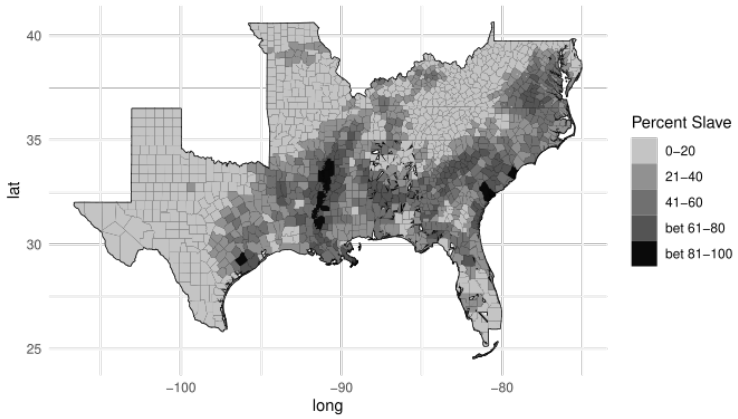
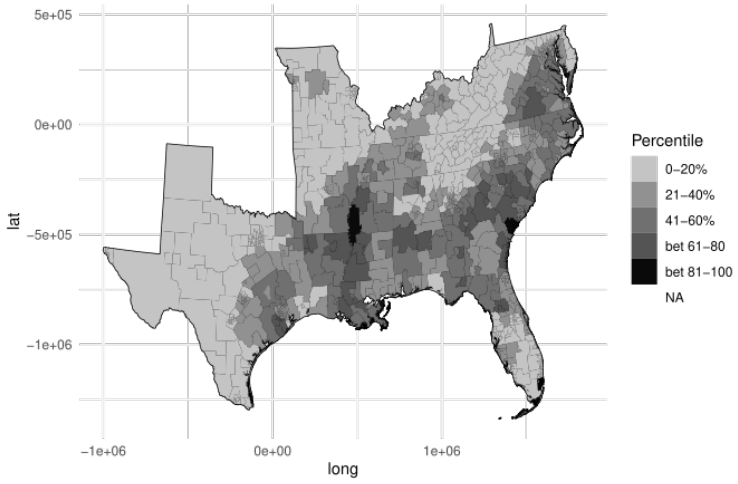


FIGURE 1: Possible Channels – Slavery and ACA

Geographic, economic and soil suitability determined the intensity of slave dependency. A disproportionate increase in racial hostility against Blacks in slave intense areas following the emancipation (reconstruction and redemption) can have persistent effects on social norms and political attitudes through intergeneration socialization. As documented by red arrows, this can shape preferences regarding ACA and thus affect its efficacy. Past slavery also determines present-day socio-economic variables and have persistent effect on ethnic composition. The efficacy of ACA may vary differentially across these contemporaneous variables, which is shown by the green solid arrows. Next, the effects of ACA can also vary across historical variables that influenced slavery. This is shown by the green dashed arrow.



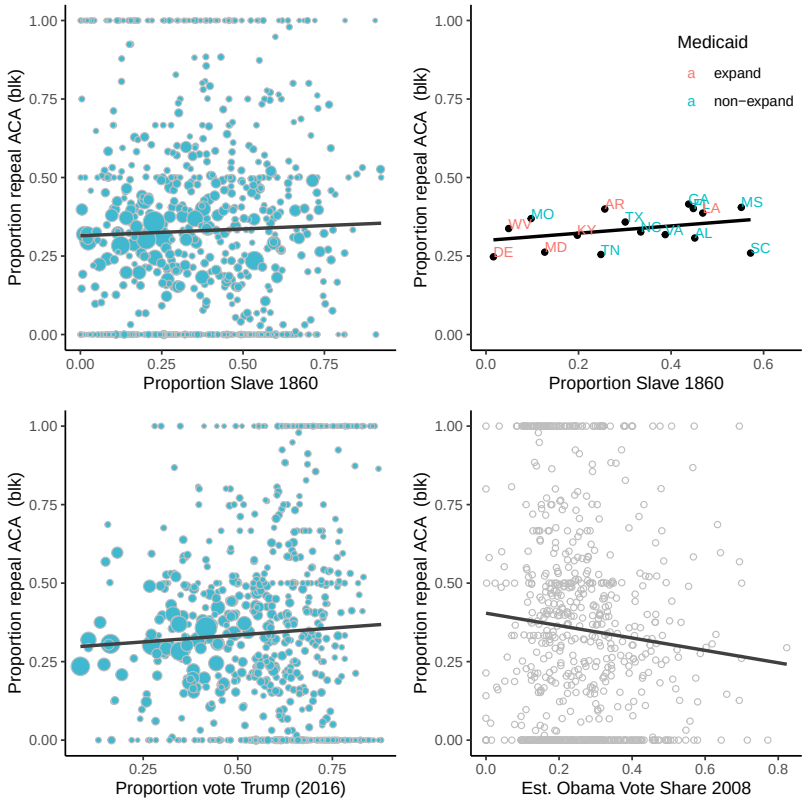
(A) Proportion Slaves 1860 (County)



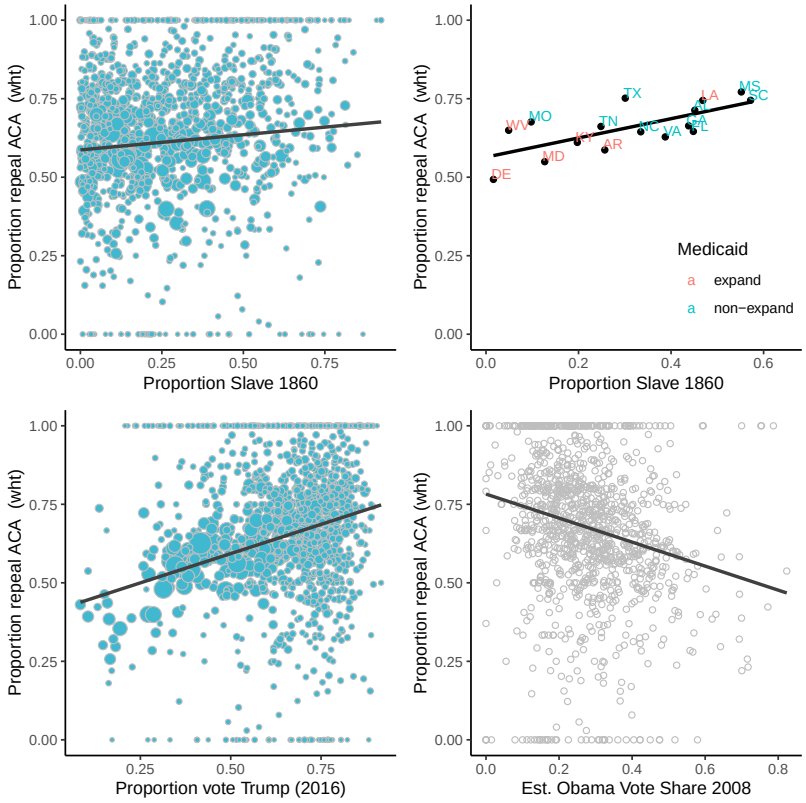
(B) Proportion Slaves 1860 (PUMA)

FIGURE 2: 1860 Slave Concentration by County and 2010 Puma Boundaries

Source: Census 1860. PUMA demarcation is based on 2010 assignments and is extracted from the Geocorr 2014 app through Missouri Census Data Center.



(A) Slavery in 1860 and Blacks' ACA Preference



(B) Slavery in 1860 and Whites' ACA Preference

FIGURE 3: 1860 Slave Concentration, ACA Sentiments and Current Political Preferences

Note: The sub-figures at the top of each panel use CCES data (2014, 2016, 2018) at the county-level (left) and aggregated at the state-level (right). In each panel, the bottom-left figure shows the relationship between the proportion of Trump's votes in 2016 presidential election and proportion in favor of repealing ACA, whereas the figure in the bottom right shows the relationship between the proportion of Whites who voted for Obama in 2008 presidential election and proportion in favor of repealing ACA. The size of the markers in top and bottom (left) sub-figures pertain to county specific number of people in the CCES sample.

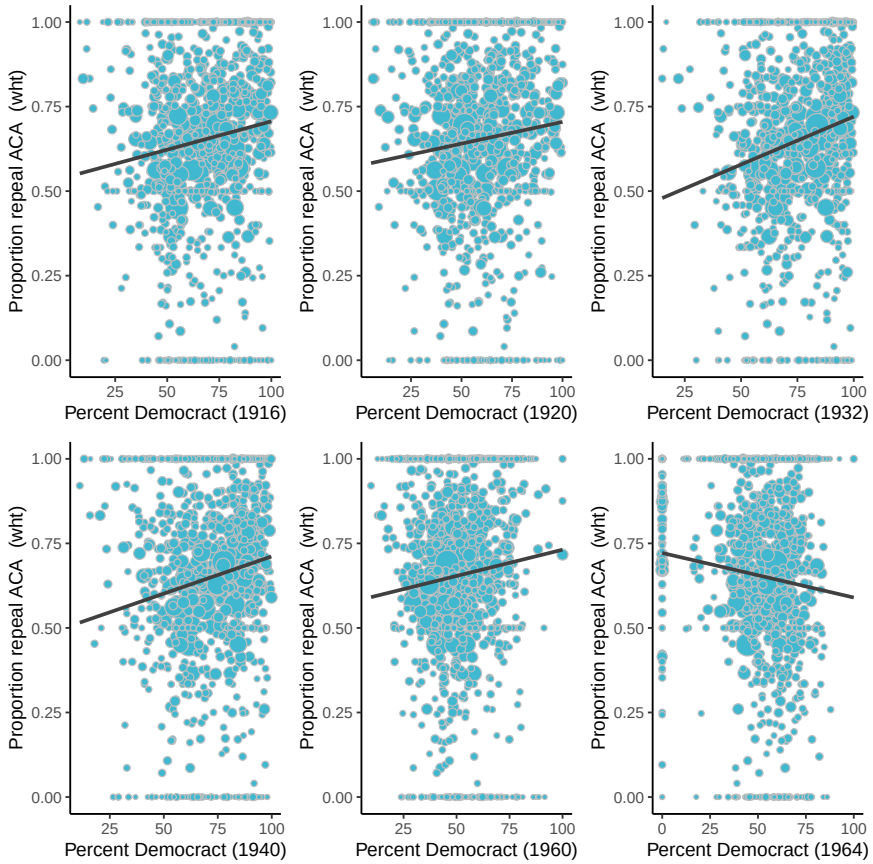


FIGURE 4: Past Political Preferences and ACA

Note: CCES 2014, 2016, 2018; author's calculations. The size of the markers in figures pertain to county specific number of people in the CCES sample. The *percent democrat* variable represents the percent of total votes attributed to the Democratic presidential candidate. The last year shown is 1964, a year prior to the Voting Rights Act of 1965.

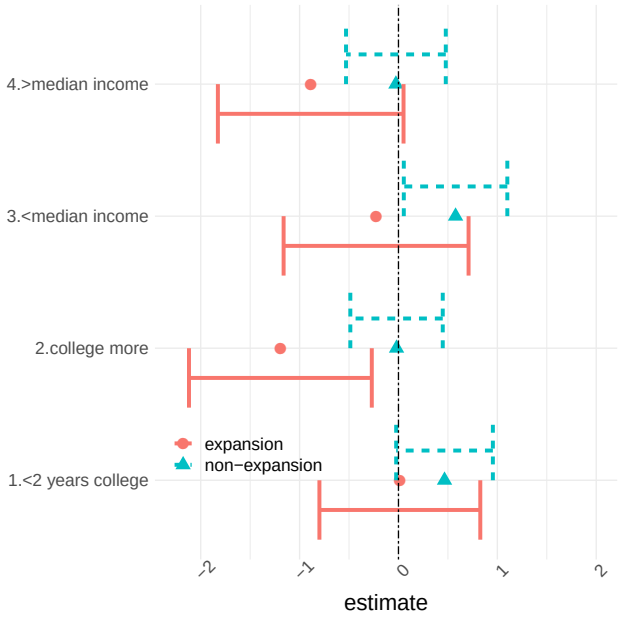


FIGURE 5: Past Slavery and Blacks' ACA Sentiments (Heterogeneous Effects)

Note: The figures use CCES data (2014, 2016, 2018). IV coefficients are estimated using the specification similar to Columns (3) in Table 2. Median family income is between $60,000 and $70,000 for Black Southerners in CCES sample.

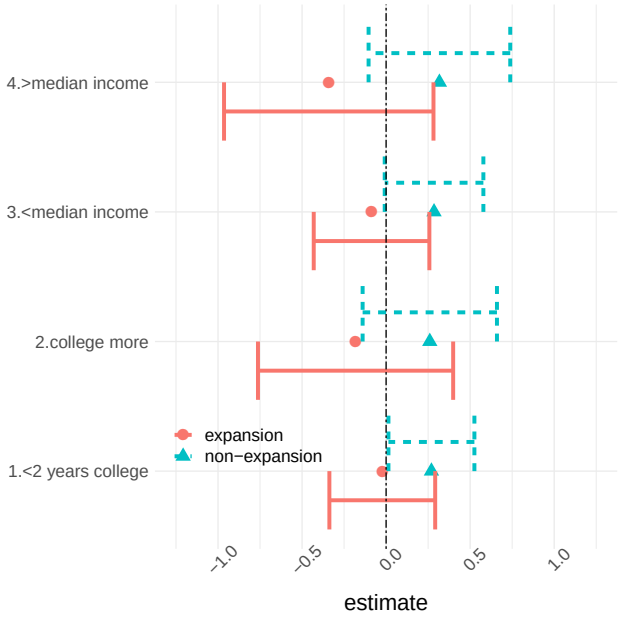
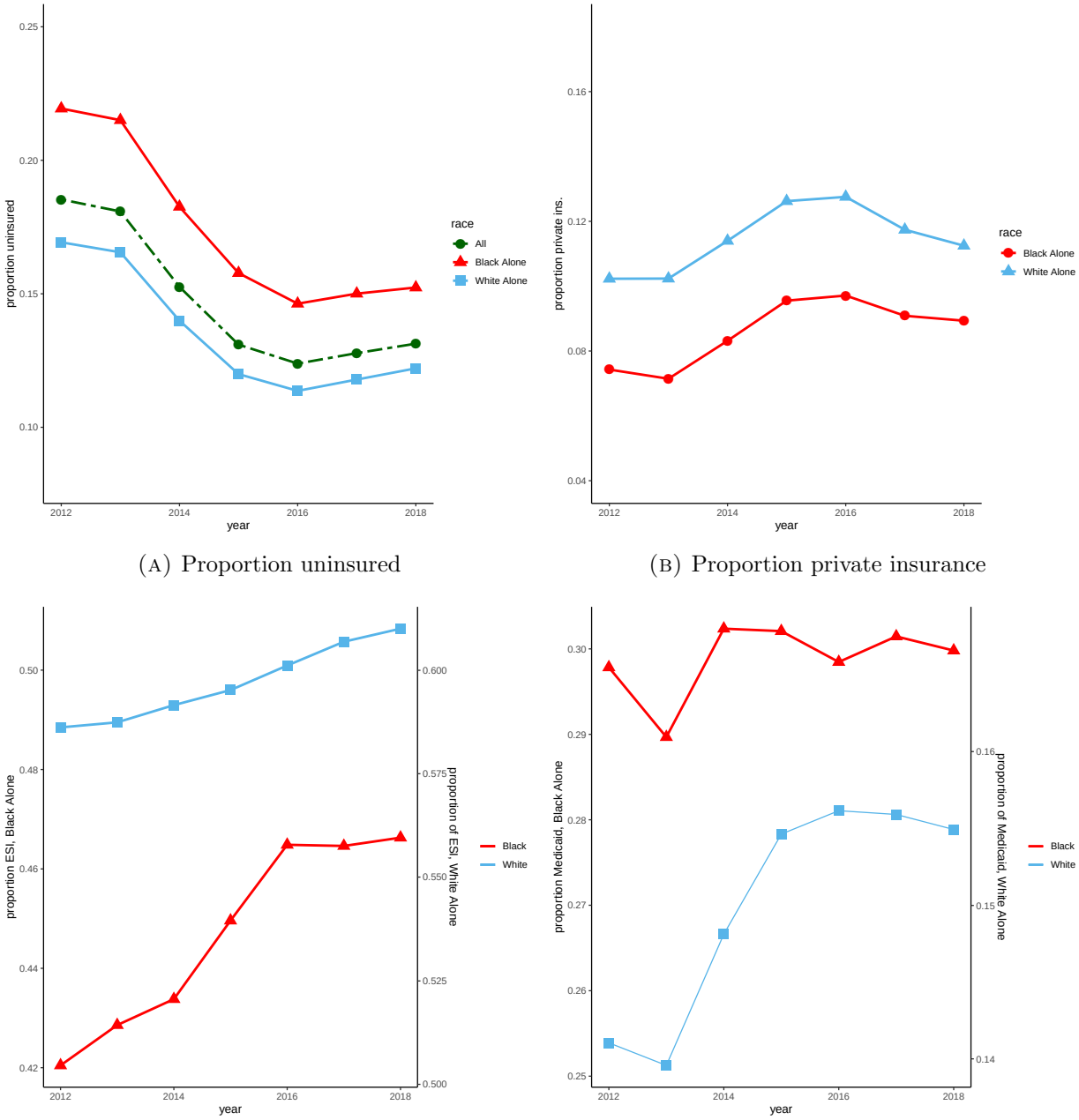


FIGURE 6: Past Slavery and Whites' ACA Sentiments (Heterogeneous Effects)

Note: The figures use CCES data (2014, 2016, 2018). IV coefficients are estimated using specifications similar to Columns (8) in Table 2. Median family income is between $60,000 and $70,000 for White Southerners in CCES sample.



(A) Proportion uninsured

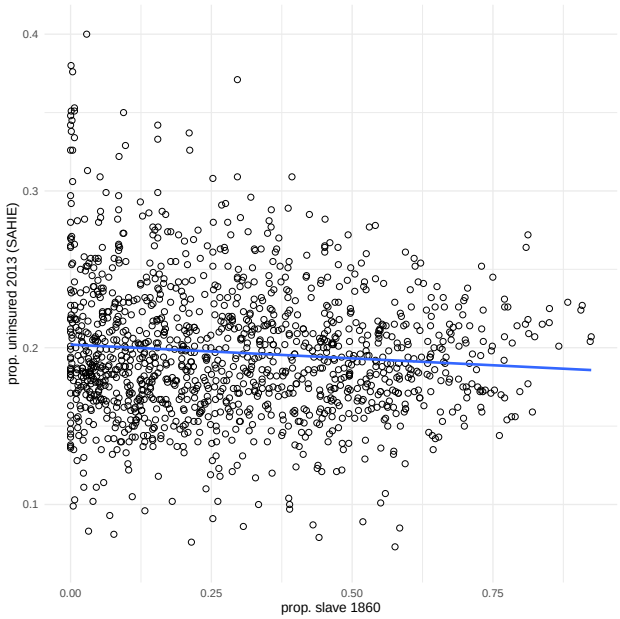
(B) Proportion private insurance

(C) Proportion employer insurance

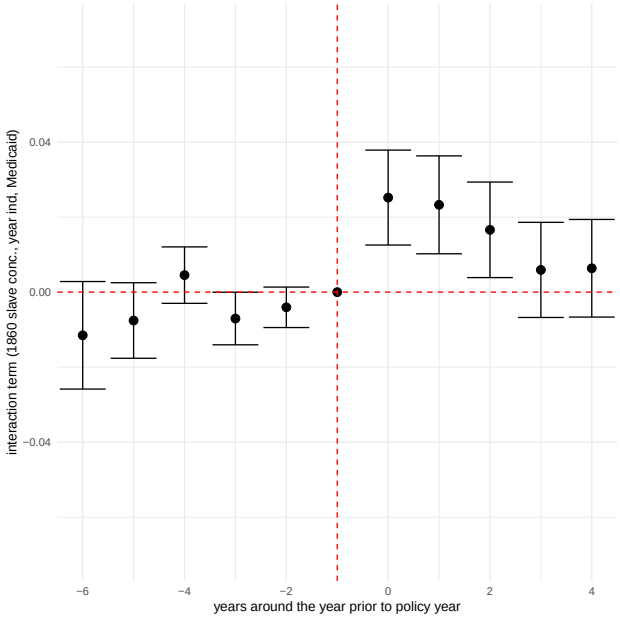
(D) Proportion Medicaid

FIGURE 7: Insurance Time Trends by Coverage Types

Source: American Community Survey, ACS 2012-2018. The sample is restricted to individuals between ages 18-65.



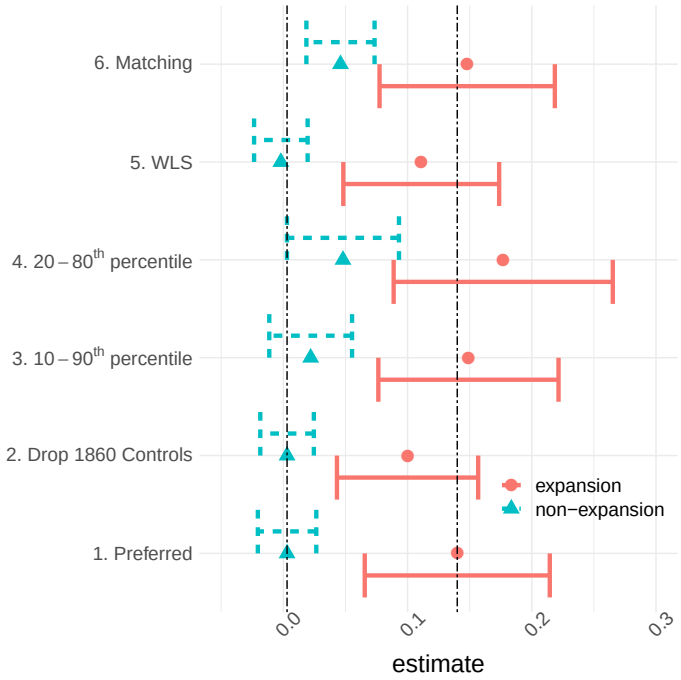
(A) Proportion Slaves 1860 and Uninsured in 2013



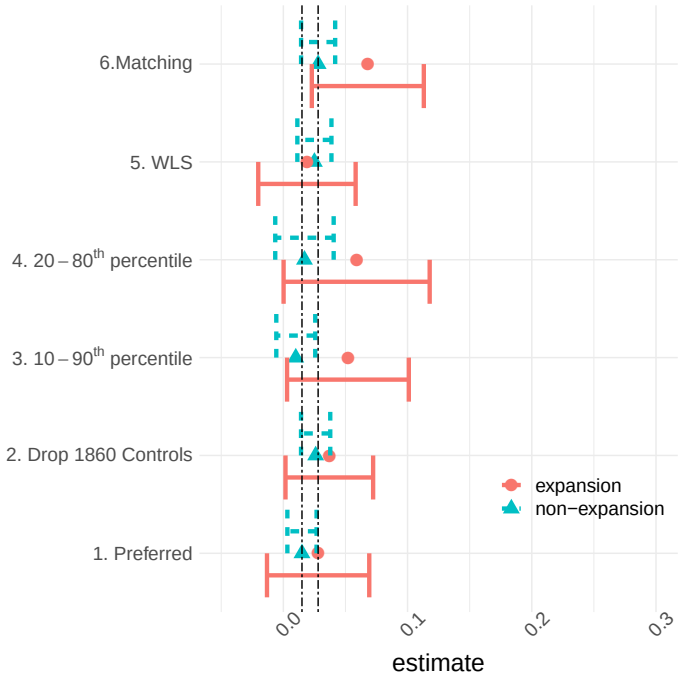
(B) Event Study Estimates

FIGURE 8: Event Study Results using SAHIE Data

Note: Small Area Health Insurance Estimates (SAHIE) and Census 1860. The top figure plots the correlation between county-specific slave concentration and proportion uninsured in 2013. The bottom figure shows estimates of γ_k from the event study specification given in equation 3 pertaining to expansion states.



(A) Blacks



(B) Whites

FIGURE 9: Additional Robustness Checks

Note: The circle and triangle markers represent coefficient estimates from equation 2 for expansion and non-expansion states respectively, when using uninsured status as the dependent variable. Row 1 plots the preferred estimates from Table 4, Columns 3 (Blacks) and 8 (Whites). The vertical dashed lines represent the preferred estimates for both expansion and non-expansion states. Row 2 drops all 1860 controls, past health policy controls, as well as ACA controls from the model specification. Row 3 restricts the sample to areas with slave concentration between the 10^{th} and the 90^{th} percentile to trim out the extreme values of 1860 slave concentration. Row 4 replicates Row 3 but further narrows the sample to include areas with slave concentration between the 20^{th} and the 80^{th} percentile. Row 5 presents the weighted least square estimates by using person's weight from ACS. Row 6 uses propensity matching to trim the sample, which is then used to estimate equation 2.

TABLE 1: Past Slavery and ACA Sentiments in South

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Panel A. Individual Against ACA (CCES, Blacks)										
prop. slave 1860×Medicaid	−0.042	−0.086	−0.093	−0.097	−0.089					
	(0.099)	(0.117)	(0.128)	(0.118)	(0.113)					
prop. slave 1860×No Medicaid	0.107*	0.105*	0.105*	0.105*	0.117**					
	(0.056)	(0.056)	(0.056)	(0.056)	(0.056)					
cotton suitability×Medicaid						−0.365**	−0.382**	−0.384**	−0.385**	−0.336*
						(0.172)	(0.177)	(0.179)	(0.176)	(0.177)
cotton suitability×No Medicaid						0.116*	0.113	0.112	0.117*	0.129*
						(0.069)	(0.070)	(0.070)	(0.070)	(0.070)
Observations	10,672	10,672	10,672	10,672	10,672	10,672	10,672	10,672	10,672	10,672
Panel B. Individual Against ACA (CCES, Whites)										
prop. slave 1860×Medicaid	−0.235*	−0.226*	−0.154	−0.222*	−0.228*					
	(0.129)	(0.128)	(0.124)	(0.125)	(0.128)					
prop. slave 1860×No Medicaid	0.111**	0.111**	0.132***	0.120**	0.106**					
	(0.050)	(0.050)	(0.049)	(0.049)	(0.050)					
cotton suitability×Medicaid						−0.111	−0.123	−0.122	−0.099	−0.131
						(0.116)	(0.115)	(0.110)	(0.114)	(0.114)
cotton suitability×No Medicaid						0.122**	0.129**	0.180***	0.146***	0.130**
						(0.054)	(0.054)	(0.056)	(0.054)	(0.054)
state and year FE	X	X	X	X	X	X	X	X	X	X
Geography variables	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X	X	X
prop. free blk. 1860		X	X	X	X		X	X	X	X
Proportion Black 2000			X					X		
Log white-black income ratio, 2014				X					X	
Other 2014 Controls					X					X
Observations	43,693	43,693	43,693	43,693	43,693	43,693	43,693	43,693	43,693	43,693

Note: The analysis is restricted to Black and White Southerners in Panels A and B. All specifications include controls for state and year fixed effects, geographic controls including longitude, latitude, sq. terms of longitude and latitude, log of county area in sq. miles, whether the county has access to waterways, and other 1860 control variables (proportion of farms under 50 acres, farm value per capita, log of total improved acreage, log of total population in 1860, whether county had access to railways, Gini coefficient of land inequality in 1860). Additionally, Columns (2, 7) control for the proportion of free Blacks in 1860. Columns (3, 8) and (4, 9) include controls for proportion of Blacks in 2000 and log of White-Black median income ratio in 2014. The addition of county level control variables in Columns(1-4 and 5-9) are interacted with indicators for expansion and non-expansion states, respectively. Columns (5, 10) include individual covariates including age, age squared, and gender from CCES. The standard errors are clustered at the county level and presented in parenthesis. *p<0.1; **p<0.05; ***p<0.01.

TABLE 2: Past Slavery and ACA Sentiments in South – IV Approach

	Dependent variable:										
	First Stage	Against ACA (CCES 2014, Blacks)					Against ACA (CCES 2014, Whites)				
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
cotton suitability	0.394***										
	(0.066)										
prop. slave 1860×Medicaid		−0.555	−0.577*	−0.581*	−0.580*	−0.505	−0.143	−0.158	−0.135	−0.118	−0.179
		(0.339)	(0.345)	(0.347)	(0.344)	(0.348)	(0.208)	(0.206)	(0.199)	(0.201)	(0.203)
prop. slave 1860×No Medicaid		0.294	0.283	0.282	0.289	0.307	0.257*	0.288*	0.375**	0.331**	0.293*
		(0.193)	(0.194)	(0.194)	(0.195)	(0.195)	(0.155)	(0.155)	(0.154)	(0.155)	(0.152)
State FE	X	X	X	X	X	X	X	X	X	X	X
Year FE		X	X	X	X	X	X	X	X	X	X
Lon. Lat. + sq terms	X	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls			X	X	X	X		X	X	X	X
Proportion free blacks 1860			X	X	X	X		X	X	X	X
Proportion Black 2000				X					X		
Log(wht-blk inc ratio 2014)					X					X	
Other 2014 Controls						X					X
F-stat	95.84										
Observations	1,122	10,672	10,672	10,672	10,672	10,672	43,693	43,693	43,693	43,693	43,693

Note: *p<0.1; **p<0.05; ***p<0.01

Column 1 represents the first stage results from a specification that controls for state fixed effects and geographic variables, including longitude, latitude, squared terms of longitude and latitude, log of county area, land ruggedness, and access to waterways. Columns 2-6 and 7-11 show results from the IV specification for Black and White Southerners, respectively, when using the predicted values of 1860 slave concentration from the first stage. The county level variables additionally included in Columns 2-5 and 7-10 are interacted with indicators representing expansion and non-expansion states. Column 2 includes similar controls as Column 1. Column 3 adds other control variables pertaining to 1860 (proportion of farms under 50 acres, farm value per capita, log of total improved acreage, total population, access to railways, Gini coefficient of inequality, and proportion of free Black). Column 4 also includes proportion of Blacks in 2000, and Column 5 instead controls for the ratio of White to Black median income in 2014. Column 6 include individual level controls from CCES including age, age squared and gender. Columns 7-11 are structured similar to Columns 2-6. The standard errors are clustered at the county level and presented in parenthesis.

Table 3: Past Slavery and Anti-ACA Political Ads

	Dependent variable:									
	Log(Anti-ACA Political Ads) (2014)									
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
prop. slave 1860×Medicaid	0.005	0.002	0.005	0.006	0.005					
	(0.016)	(0.016)	(0.015)	(0.016)	(0.015)					
prop. slave 1860×No Medicaid	0.027***	0.027***	0.024***	0.021***	0.022***					
	(0.008)	(0.008)	(0.009)	(0.008)	(0.007)					
cotton suitability×Medicaid						0.015	0.019*	0.019*	0.012	0.016
						(0.012)	(0.011)	(0.011)	(0.014)	(0.012)
cotton suitability×No Medicaid						0.027***	0.027***	0.024***	0.027***	0.029***
						(0.008)	(0.008)	(0.008)	(0.007)	(0.007)
state FE	X	X	X	X	X	X	X	X	X	X
Geography variables	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X	X	X
prop. free blk. 1860		X	X	X	X		X	X	X	X
Proportion Black 2000			X					X		
Log white-black income ratio, 2014				X					X	
Log 2010 population					X					X
Observations	1,313	1,313	1,313	1,138	1,256	1,262	1,262	1,262	1,106	1,206

Note: *p<0.1; **p<0.05; ***p<0.01

Note: The dependent variable used is the log of anti-ACA political ads from 2014 gubernatorial elections. All specifications include controls for state and year fixed effects, geographic controls including longitude, latitude, sq. terms of longitude and latitude, log of county area in sq. miles, whether the county has access to waterways, and other 1860 control variables (proportion of farms under 50 acres, farm value per capita, log of total improved acreage, log of total population in 1860, whether county had access to railways, Gini coefficient of land inequality in 1860). Additionally, Columns (2, 7) control for the proportion of free Blacks in 1860. Columns (3, 8) and (4, 9) include controls for proportion of Blacks in 2000 and log of White-Black median income ratio in 2014. The addition of county level control variables in Columns(1-4 and 5-9) are interacted with indicators for expansion and non-expansion states, respectively. Columns (5, 10) include individual covariates including age, age squared, and gender from CCES. The standard errors are clustered at the county level and presented in parenthesis. *p<0.1; **p<0.05; ***p<0.01.

TABLE 4: Past Slavery and Uninsured Status following ACA

	Dependent variable:									
	Uninsured									
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
prop. slave 1860×$Post_{2014}$	−0.007	0.001	0.006	0.004	0.001	0.011*	0.016***	0.015***	0.013**	0.015***
	(0.012)	(0.012)	(0.012)	(0.011)	(0.012)	(0.007)	(0.006)	(0.006)	(0.005)	(0.006)
prop. slave 1860×Medicaid×$Post_M$	0.203***	0.175***	0.136***	0.135***	0.127***	0.033	0.024	0.027	0.028	0.023
	(0.035)	(0.037)	(0.037)	(0.036)	(0.038)	(0.021)	(0.022)	(0.021)	(0.020)	(0.020)
uninsured 2013×$Post_{2014}$	−0.038	−0.050	−0.064*	−0.060*	−0.083**	−0.192***	−0.209***	−0.215***	−0.200***	−0.217***
	(0.040)	(0.038)	(0.038)	(0.036)	(0.038)	(0.017)	(0.016)	(0.016)	(0.015)	(0.016)
uninsured 2013×$Post_M$×Medicaid	−0.434***	−0.412***	−0.389***	−0.357***	−0.345***	−0.466***	−0.435***	−0.443***	−0.414***	−0.389***
	(0.109)	(0.107)	(0.107)	(0.106)	(0.107)	(0.067)	(0.068)	(0.066)	(0.063)	(0.065)
PUMA+year+$Post_M$×Medicaid	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X	X	X
Past H. Policies+ACA Controls		X	X	X	X		X	X	X	X
Ind. Controls+st. Linear Trends			X	X	X			X	X	X
Income+Unemp+Educ+Marital				X					X	
2013 Metro Status+st. Unemp					X					X
Observations	832,332	832,332	832,332	832,332	832,332	3,607,358	3,607,358	3,607,358	3,607,358	3,607,358

Note: *p<0.1; **p<0.05; ***p<0.01

Columns 1-5 and 6-10 pertain to Black and White Southerners, respectively. $Post_{2014}$ refers to period following the ACA implementation (2014 and after), whereas $Post_M$ refers to period following the Medicaid expansion year. All specifications control for PUMA and year fixed effects as well as the interaction between $Medicaid$ and $Post$ ($Medicaid_{st}$). Column 1 (5) adds a vector of 1860 covariates including proportion of farms under 50 acres, log of the total improved acreage, log of the total population in 1860, access to railways and waterways, Gini coefficient of inequality, proportion of free Blacks in 1860, and ruggedness of the land. All these variables are at the PUMA level and are interacted with: *i*) post ACA indicator (year 2014 and above), and *ii*) indicator representing whether a state has implemented Medicaid expansion in a given year. Additionally, Column 2 (6) include log of expenses associated with past health policies (Hill Burton and CHD) and the vector of ACA controls (whether adopted state based exchange, number of networks, and premium for an individual plan), which are also interacted with: *i*) post ACA indicator (year 2014 and above), and *ii*) indicator representing whether a state has implemented Medicaid expansion in a given year. Column 3 (7) include a vector of individual controls such as age, age squared, and gender as well as state specific linear time trends. Additionally, Column 4 (8) include individual level controls such as income, employment status, education and marital status from ACS. Columns 5 (10) excludes individual level controls in Columns 4 (9) and adds control for the state unemployment rate as well as 2013 metropolitan status; the latter is interacted with both post ACA indicator and a dummy for if a state has implemented Medicaid expansion in the given year. The standard errors are clustered at the PUMA level and presented in parenthesis. *p<0.1; **p<0.05; ***p<0.01.

TABLE 5: Past Slavery and Insurance Coverage following ACA

	Dependent variable:							
	ESI	Priv.	Medicaid	Other	ESI	Priv.	Medicaid	Other
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
prop. slave 1860 × $Post_{2014}$	0.00001	−0.003	0.003	0.002	−0.004	−0.007	−0.0001	0.002
	(0.014)	(0.010)	(0.011)	(0.008)	(0.007)	(0.005)	(0.005)	(0.003)
prop. slave 1860 × Medicaid × $Post_M$	−0.024	0.029	−0.107***	−0.027	−0.006	0.002	−0.031	0.003
	(0.041)	(0.025)	(0.038)	(0.022)	(0.023)	(0.015)	(0.020)	(0.014)
$Post_{2014}$×uninsured prop. 2013	0.052	−0.002	0.011	0.010	0.123***	0.069***	0.015	0.007
	(0.036)	(0.025)	(0.028)	(0.020)	(0.018)	(0.011)	(0.011)	(0.008)
Medicaid × $Post_M$ × uninsured prop. 2013	0.174	−0.086*	0.312**	0.035	0.066	−0.007	0.395***	0.038
	(0.116)	(0.052)	(0.127)	(0.049)	(0.070)	(0.048)	(0.072)	(0.033)
PUMA+Year FE+$Post_M$×Medicaid	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X
Past Health Policies+ACA Controls	X	X	X	X	X	X	X	X
Ind. Controls+st. Linear Trends	X	X	X	X	X	X	X	X
Observations	832,332	832,332	832,332	832,332	3,607,358	3,607,358	3,607,358	3,607,358
Note:	*p<0.1; **p<0.05; ***p<0.01							

The analysis is restricted to southern states. Columns 1-4 and 5-8 pertain to Blacks and Whites, respectively. The specification used is similar to Column 3 (7) in Table 4. The standard errors are clustered at the PUMA level and presented in parenthesis.

TABLE 6: ACA, Slavery, and Insurance Types – Placebo Test

	Dependent variable:									
	uninsured	ESI	Priv.	Medicaid	Other	uninsured	ESI	Priv.	Medicaid	Other
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
prop. slave 1860 × $Post_{2014}$	0.015	0.005	−0.018	−0.018	−0.007	0.009	−0.014	−0.002	−0.002	0.011*
	(0.017)	(0.018)	(0.012)	(0.016)	(0.011)	(0.008)	(0.011)	(0.007)	(0.005)	(0.006)
prop. slave 1860 × Medicaid × $Post_M$	0.037	−0.013	−0.001	−0.011	0.005	−0.011	0.013	−0.024	0.037***	−0.002
	(0.039)	(0.055)	(0.031)	(0.046)	(0.027)	(0.019)	(0.027)	(0.020)	(0.014)	(0.017)
$Post_{2014}$×uninsured prop. 2013	0.154***	−0.098*	−0.037	−0.040	−0.003	0.062**	−0.001	−0.059***	−0.031***	−0.020*
	(0.052)	(0.054)	(0.030)	(0.043)	(0.032)	(0.025)	(0.027)	(0.016)	(0.012)	(0.011)
Medicaid × $Post_M$ × uninsured prop. 2013	0.207	−0.219	−0.199**	0.007	−0.125	0.140**	−0.153	0.064	−0.038	−0.010
	(0.131)	(0.153)	(0.092)	(0.133)	(0.082)	(0.064)	(0.108)	(0.064)	(0.046)	(0.044)
PUMA+Year FE+$Post_M$×Medicaid	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X	X	X
Past Health Policies	X	X	X	X	X	X	X	X	X	X
ACA Controls	X	X	X	X	X	X	X	X	X	X
Ind. Controls	X	X	X	X	X	X	X	X	X	X
Observations	245,977	245,977	245,977	245,977	245,977	1,024,127	1,024,127	1,024,127	1,024,127	1,024,127

Note: *p<0.1; **p<0.05; ***p<0.01

The analysis is restricted to southern states and only includes 2012 and 2013 survey years. Columns 1-5 and 6-10 pertain to Blacks and Whites, respectively. Post here refers to year 2013. The specification used is similar to Column 3 (7) in Table 4. The standard errors are clustered at the PUMA level and presented in parenthesis.

TABLE 7: Past Slavery and Insurance Coverage – Less than Associate's Degree

	Dependent variable:									
	uninsured	ESI	Priv.	Medicaid	Other	uninsured	ESI	Priv.	Medicaid	Other
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
prop. slave 1860 × $Post_{2014}$	0.009	−0.008	−0.010	0.015	−0.004	0.015*	−0.001	−0.007	0.002	−0.002
	(0.015)	(0.017)	(0.012)	(0.015)	(0.011)	(0.009)	(0.009)	(0.006)	(0.007)	(0.005)
prop. slave 1860 × Medicaid × $Post_M$	0.149***	−0.013	0.037	−0.156***	−0.030	−0.004	−0.008	0.021	−0.034	0.019
	(0.049)	(0.052)	(0.028)	(0.048)	(0.033)	(0.026)	(0.031)	(0.017)	(0.024)	(0.017)
$Post_{2014}$×uninsured prop. 2013	0.022	−0.012	−0.017	−0.014	−0.0004	−0.137***	0.107***	0.019	−0.009	−0.005
	(0.050)	(0.045)	(0.029)	(0.039)	(0.026)	(0.023)	(0.022)	(0.012)	(0.016)	(0.011)
Medicaid × $Post_M$ × uninsured prop. 2013	−0.352**	0.160	−0.092	0.270*	0.015	−0.548***	0.031	0.037	0.502***	0.119**
	(0.144)	(0.137)	(0.067)	(0.161)	(0.062)	(0.084)	(0.092)	(0.052)	(0.094)	(0.046)
PUMA+Year FE+$Post_M$×Medicaid	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X	X	X
Past Health Policies	X	X	X	X	X	X	X	X	X	X
ACA Controls	X	X	X	X	X	X	X	X	X	X
Ind. Controls	X	X	X	X	X	X	X	X	X	X
Observations	493,799	493,799	493,799	493,799	493,799	1,797,236	1,797,236	1,797,236	1,797,236	1,797,236

Note: *p<0.1; **p<0.05; ***p<0.01

The analysis is restricted to southern states and the sample include individuals less than associate's level of education. The sample only includes individuals who are 25 years and over (but below 65) to capture individuals who had surpassed the college-going-age (but below Medicare eligibility criteria). Columns 1-5 and 6-10 pertain to Blacks and Whites, respectively. The specification used is similar to Column 3 (7) in Table 4. The standard errors are clustered at the PUMA level and presented in parenthesis.

TABLE 8: Past Slavery and Insurance Coverage – Associate's Degree or More

	Dependent variable:									
	uninsured	ESI	Priv.	Medicaid	Other	uninsured	ESI	Priv.	Medicaid	Other
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
prop. slave 1860 × $Post_{2014}$	−0.025	0.028	0.002	−0.010	0.025	0.009	−0.001	−0.006	0.002	0.001
	(0.017)	(0.023)	(0.016)	(0.013)	(0.015)	(0.005)	(0.008)	(0.007)	(0.003)	(0.005)
prop. slave 1860 × Medicaid × $Post_M$	0.085**	0.007	0.023	−0.009	−0.026	0.023	0.0001	0.004	0.005	−0.015
	(0.042)	(0.071)	(0.043)	(0.040)	(0.051)	(0.015)	(0.025)	(0.024)	(0.017)	(0.016)
$Post_{2014}$×uninsured prop. 2013	−0.183***	0.111**	0.059	0.0001	0.021	−0.139***	0.026	0.066***	0.033***	0.028**
	(0.042)	(0.052)	(0.039)	(0.032)	(0.037)	(0.016)	(0.022)	(0.018)	(0.008)	(0.011)
Medicaid × $Post_M$ × uninsured prop. 2013	−0.206**	−0.034	−0.069	0.372***	0.040	−0.158***	0.042	−0.015	0.115***	−0.024
	(0.101)	(0.162)	(0.091)	(0.111)	(0.111)	(0.041)	(0.070)	(0.065)	(0.042)	(0.039)
PUMA+Year FE+$Post_M$×Medicaid	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X	X	X
Past Health Policies	X	X	X	X	X	X	X	X	X	X
ACA Controls	X	X	X	X	X	X	X	X	X	X
Ind. Controls	X	X	X	X	X	X	X	X	X	X
Observations	199,187	199,187	199,187	199,187	199,187	1,326,435	1,326,435	1,326,435	1,326,435	1,326,435

Note: *p<0.1; **p<0.05; ***p<0.01

The analysis is restricted to southern states. The sample includes individuals with associate's level or more. The sample only includes individuals who are 25 years and over but below 65 to capture individuals who had surpassed the college-going-age. Columns 1-5 and 6-10 pertain to Blacks and Whites, respectively. The specification used is similar to Column 3 (7) in Table 4. The standard errors are clustered at the PUMA level and presented in parenthesis.

A.1 Appendix

A.1.1 Health Care Reforms for Minorities – A Brief History

Although discrimination in health care sector has become less overt over time, health disparity continue to plague vulnerable populations. Several health care reforms targeted towards minorities or vulnerable populations have been passed in Congress since 1865, and they have served as an inspiration for ACA.[37]

One of the earliest policies addressing minority's health care needs was the Freedmen's Bureau legislation (known as the Bureau of Refugees, Freedmen and Abandonded Lands), created on March 3, 1865 within the war department. The Bureau's responsibility was to provide freedmen with food, clothing and attend to general welfare needs. Following the emancipation, plight of former slaves to the cities and congestion within the refugee camps led to health crisis. To address the need for medical attention, a medical division was established within the Bureau on June 16, 1865, whose role was to provide temporary health care to former slaves and refugees.

While the Bureau established hospitals and medical dispensaries across the South, the role of the Bureau in improving access to health care for Blacks came with several challenges. Due to lack of cooperation from the civic authorities, dearth of physicians, blatant racial discrimination from the local physicians refusing treatment of Blacks, White Southerner's hostility towards the Bureau, and reduced funding from the federal government, the Bureau fell short of providing quality health care to the majority of former slaves (Foster, 1982; Pearson, 2002; Dawes, 2016). Moreover, southern state officials used budgetary and administrative controls to undermine the efficacy of the program. The racial bias in health care is demonstrated by Whittlessey's (North Carolina's assistant commissioner)[38] account that many "White refugees .... in sick condition" were admitted in the hospital "as soon as possible," whereas Blacks were denied of such services (Foster, 1982). Similarly, several historians have pointed out that White Southerners regarded Black's suffering as the price for freedom, emphasizing racial animosity at the time (Legan, 1973; Raphael, 1972). Finally, succumbing to racial politics at the time, Congress voted to shut down the Bureau in June 1872.[39]

The advent of County Health Department (CHD) movement in the early part of the twentieth century, led by the United States Public Health Services (USPHS), Rockefeller Sanitary Commissions (RHCs) and other related organizations, aimed towards combating rural health problems.[40] The first roll-out of CHDs began in 1908; by 1933 CHDs were distributed across 38 states spanning around 600 counties. Although not particularly targeted towards vulnerable subgroups, County Health Departments (CHDs) were widely placed in the Southern states as well as other regions of the country. Hoehn-Velasco (2018) finds that the adoption of CHDs in rural areas improved in-

[37] Dawes (2016) in his book *150 Years of Obamacare* discusses the importance of past health policies in passage of ACA.

[38] Assistant commissioners were selected for Bureau's agency in the confederate states, who were in-charge of developing their own program to help freedmen (Pearson, 2002).

[39] As of now, we are unaware of any empirical studies accessing the efficacy of the Bureau's efforts.

[40] See Hoehn-Velasco (2018) and Hoehn-Velasco (2021) for more details.

fant mortality, with such effects more pronounced among non-Whites, indicating that CHDs were disproportionately more beneficial to more vulnerable subgroups.

One of the major early policies to address discrimination in health care was the Hill-Burton Act (Hospital Survey and Construction Act) that was signed into law in 1946. Following the depreciation of health care facilities due the Great Depression and WWII, Hill-Burton was enacted to facilitate modernization of hospitals and health care facilities and is the largest federal legislation to provide subsidies to construct non-profit hospitals. Between July 1947-1971, funding of $28 billion (in 2012 $) has been deployed in strengthening hospital infrastructure in America on a need-based process, which meant that rural areas and areas in the American South (where the baseline medical resources were scarce) mostly benefited from this act. Although segregation was still ongoing, the law attested that refusal or provision of inadequate treatment based on race was not permitted. Chung et al. (2017) estimate that the program accounted for over 70,000 hospital beds across America, improved health care utilization and the effects of subsides have persisted over 20 years from the year of distribution.

The option of legal discrimination in health care ended with the advent of the Civil Rights Act of 1964, which "prohibited excluding, denying benefits, or discrimination against individuals based on race, color or national origin under any program or activity receiving federal funding" (Dawes, 2016). Introduction and implementation of Medicare and Medicaid further emphasized the gravity of the situation as hospitals that resisted desegregation were excluded from receiving payments. A handful of studies have shown the positive impacts of both Medicaid and Medicare laws on health care utilization and health outcomes (Goodman-Bacon, 2018, 2016; Card et al., 2008; Finkelstein, 2007).

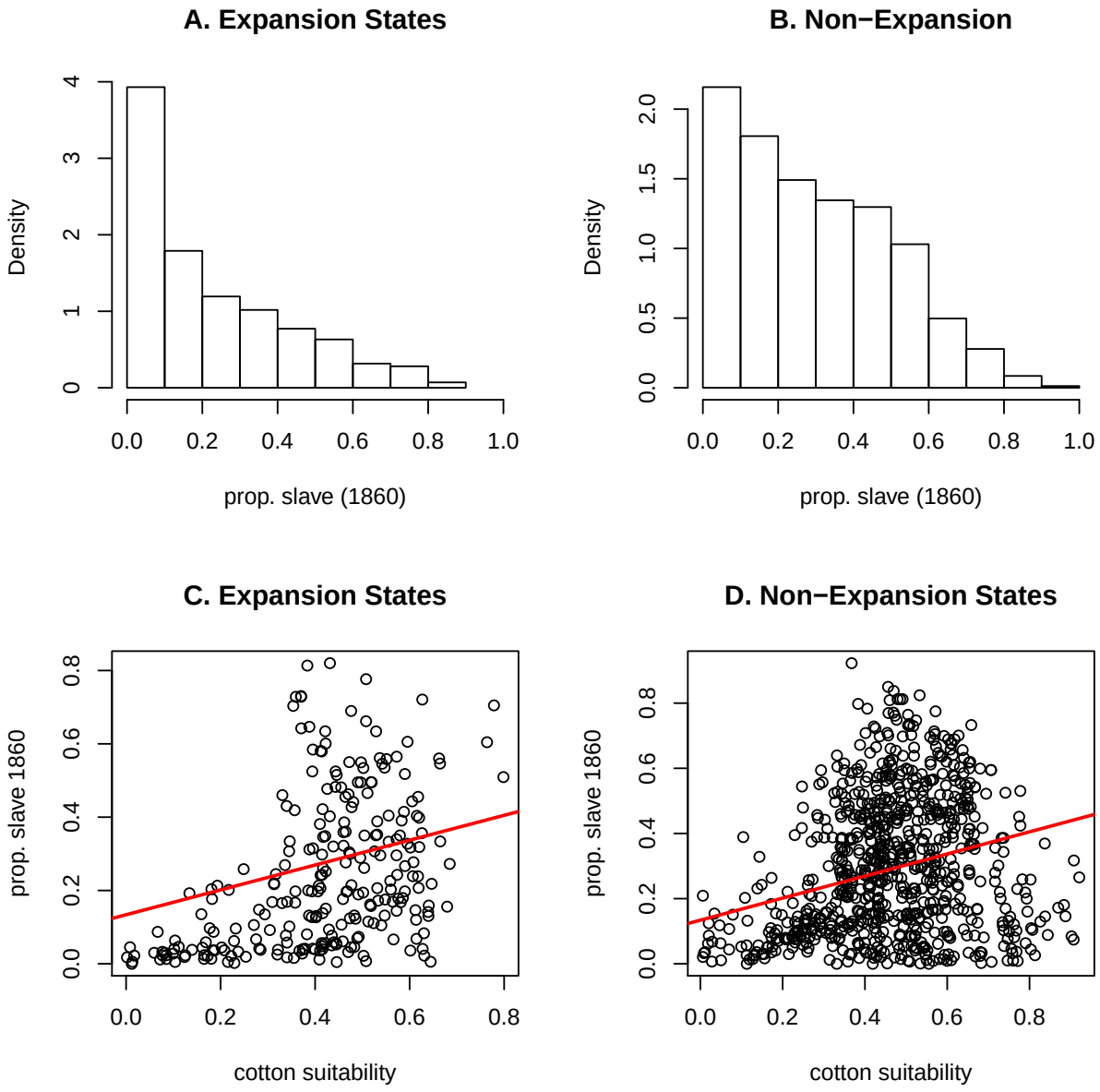
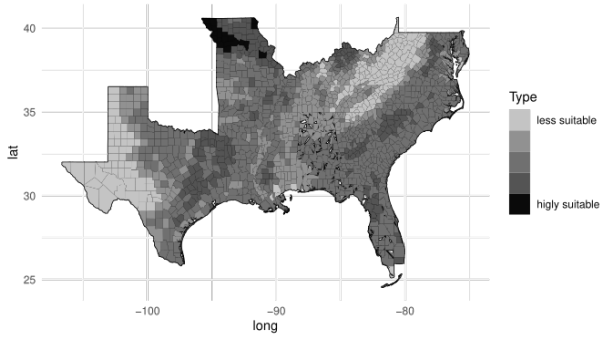
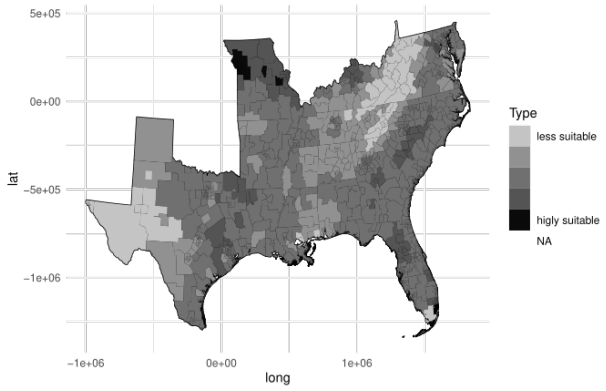


FIGURE A1: Slavery in 1860 and ACA

Note: Panels A and B show the distribution of 1860 slave concentration in expansion and non-expansion state groups. Panels C and D show correlation between cotton suitability measure and 1860 slave concentration across two groups.



(A) Cotton Suitability Measure (County)



(B) Cotton Suitability Measure (PUMA)

FIGURE A2: Slavery and Cotton Suitability at PUMA

Source: Census files and FAO (replication files from Acharya et al. (2016).)

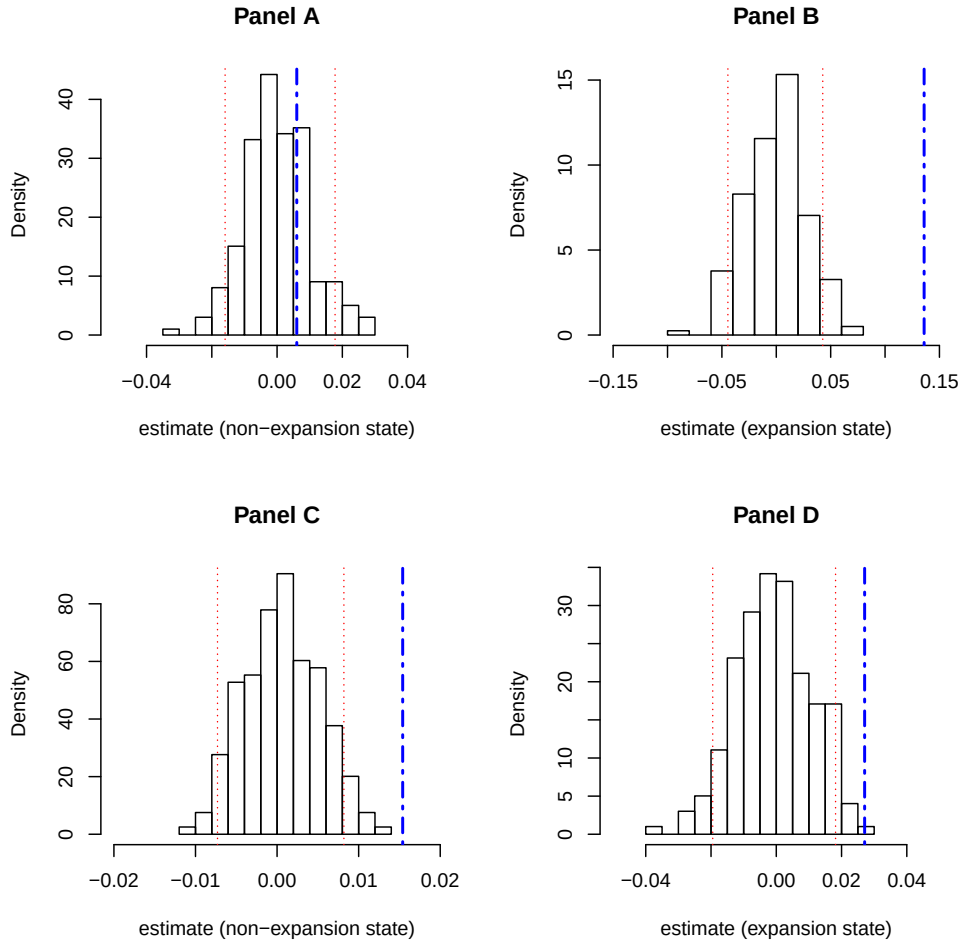
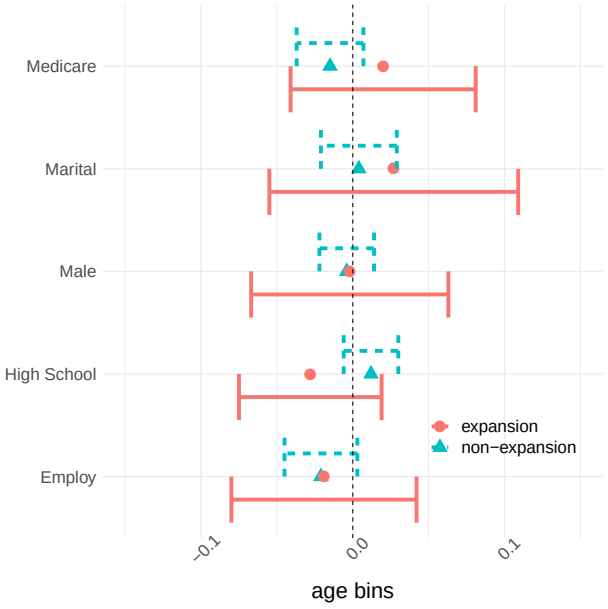
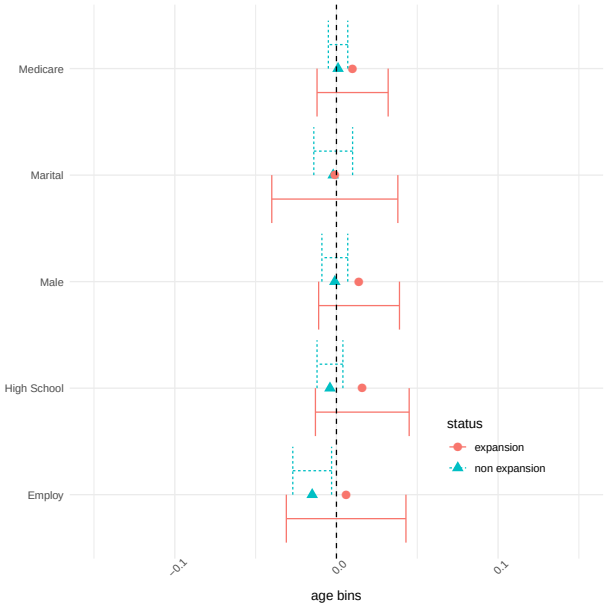


FIGURE A3: Estimates using random assignments of proportion of slaves in 1860

The sample is restricted to Blacks in the top panels and Whites in the bottom panels. The figures plot histogram of the estimates obtained on the interaction terms for expansion and non-expansion states similar to Table 4, Column 3, when an indicator for uninsured status is used as the dependent variable. The estimates are obtained after randomly assigning proportion of slave in 1860 across local areas from 500 replications. The red dotted lines represent the 5^{th} and 95^{th} percentiles of the replicated estimates, whereas the blue dashed line represent the actual estimates from Table 4, Column 3.



(A) Blacks



(B) Whites

FIGURE A4: Tests for Sample Composition – Pre and Post ACA

Note: The circle and triangle markers represent coefficient estimates when variables reported on the y-axis are used as the dependent variables in a regression framework defined by specification 2 but without individual level controls. The error bars represent the 95% confidence intervals.

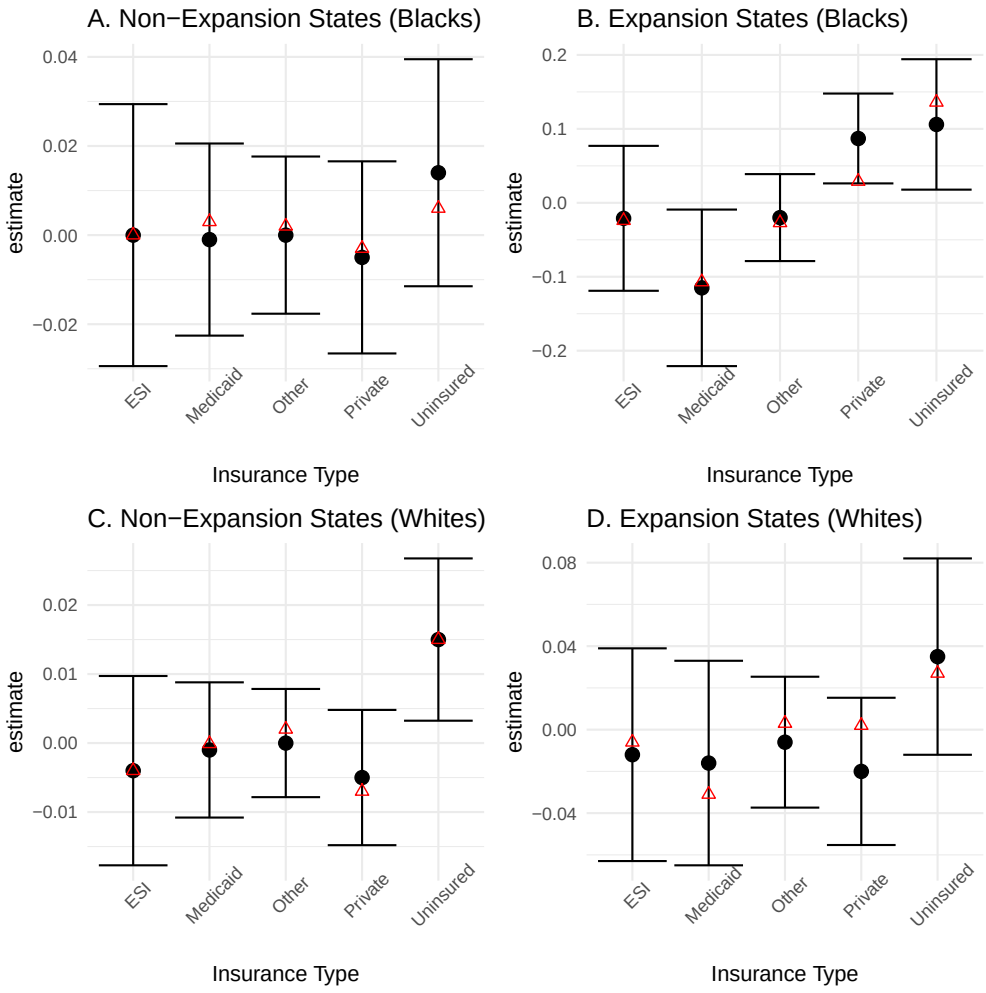
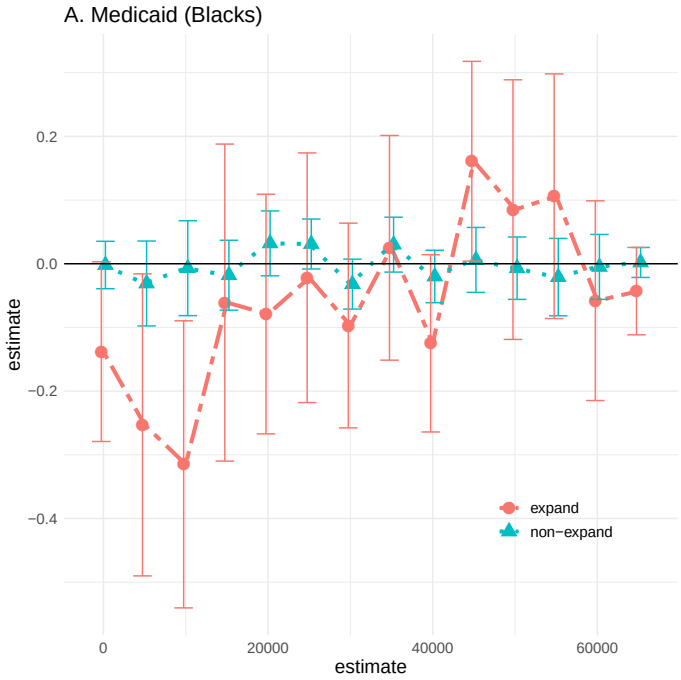
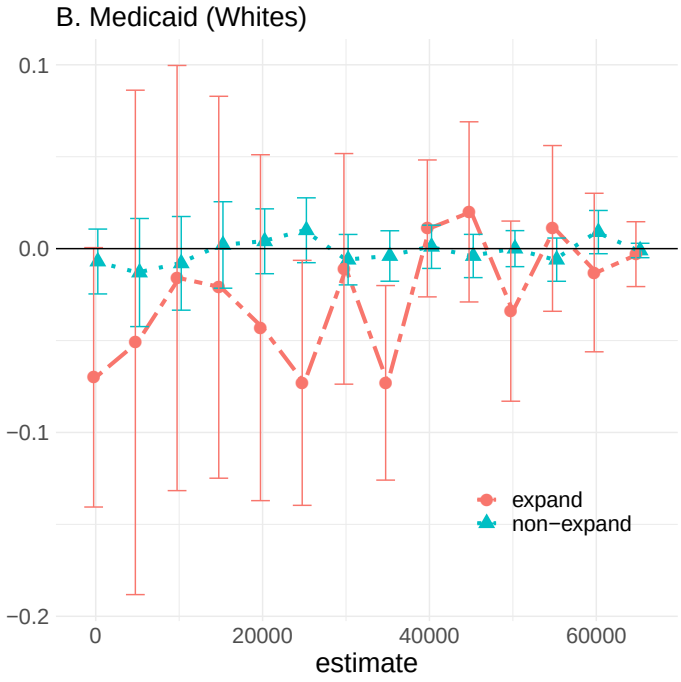


FIGURE A5: Slavery and Insurance Status after Dropping Louisiana

Note: The sample is restricted to Black and White Southerners in the top and bottom panels, respectively. The figures plot estimates obtained on the interaction terms for expansion and non-expansion states similar to Table 4, Column 3 (8), but after excluding Louisiana from the sample. The triangle markers represent the magnitude of preferred estimates for comparison.



(A) Blacks



(B) Whites

FIGURE A6: Estimates based on Income Bins

Note: The figure plots estimates using the specification used to estimate Columns (3) and (7) in Table 5 for Blacks (top) and Whites (bottom), respectively, when using Medicaid status as the dependent variable. Here, the sample is divided according to income in past 12 months (wages or salary) in intervals of $5,000 bins. For instance, the first bin comprise of individuals earning between 0 to $4,999. The error bars represent 95 percent confidence intervals, constructed from standard errors clustered at the PUMA level.

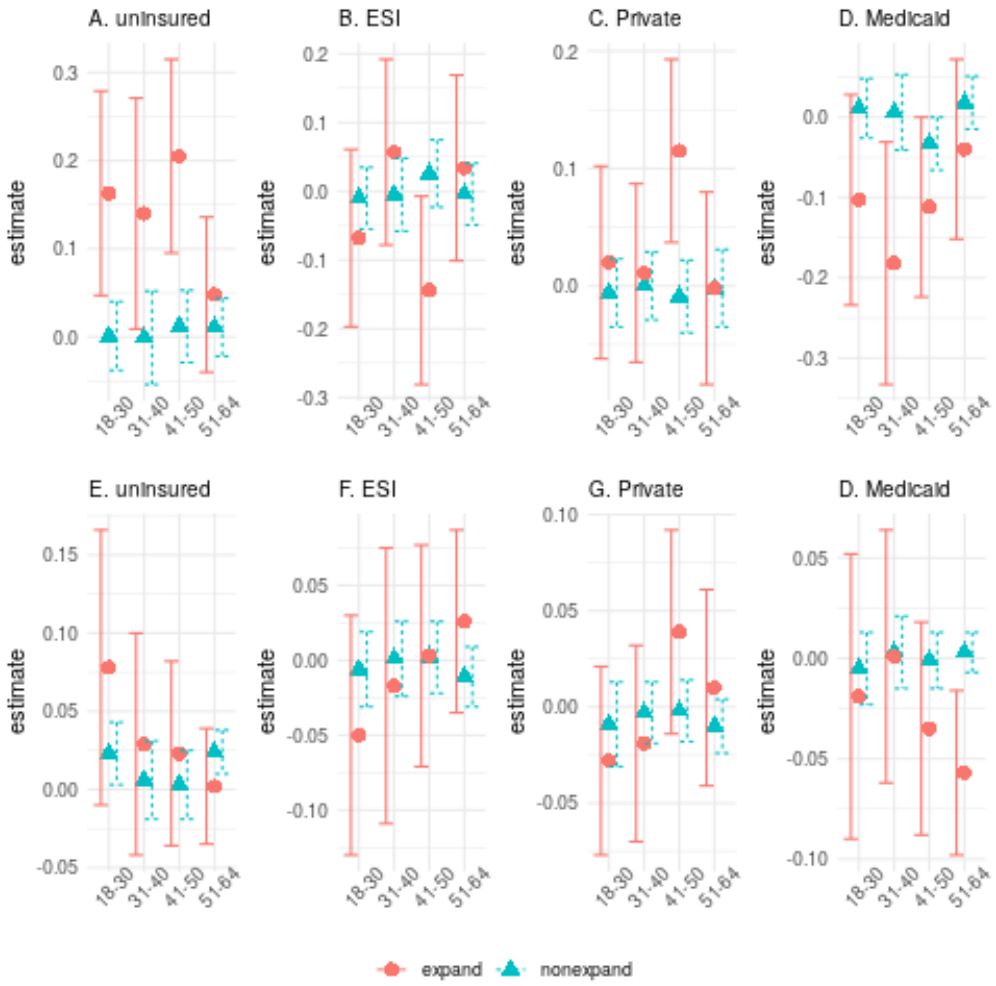


FIGURE A7: Estimates by Age Groups

Note: The sample is restricted to Blacks in the top panels and Whites in the bottom panels. The figures plot the magnitude of estimates on the interaction terms for expansion and non-expansion states similar to Table 4, Column 3, but from sub-samples restricted to given age groups. The error bars represent the 95 percent confidence intervals, constructed from standard errors clustered at the PUMA level.

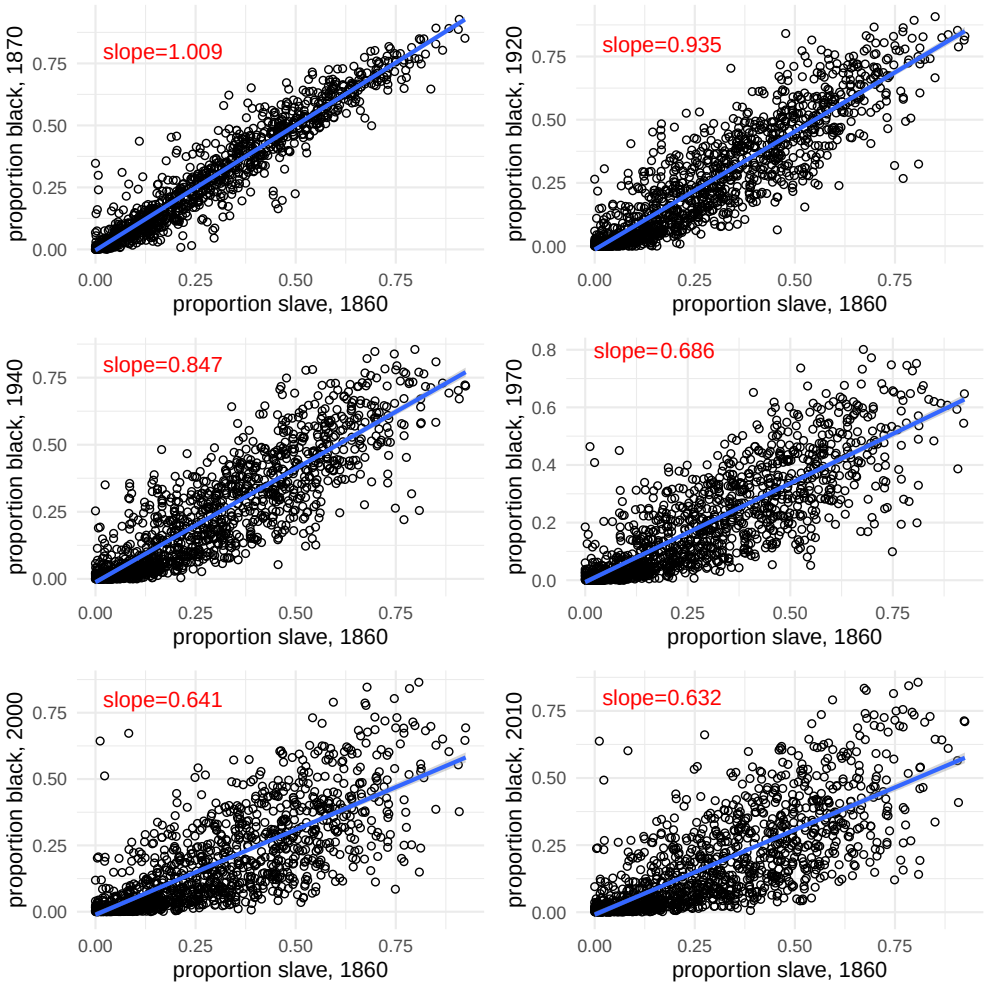


FIGURE A8: Slave Concentration in 1860 and Proportion of Blacks

Note: The sub-figures show the relationship between slave concentration in 1860 and proportion of Blacks in 1870, 1920, 1940, 1970, 2000, and 2010. The best fit line in 1870 show strong correlation between 1860 slave concentration and proportion of Blacks in 1870. This relationship weakened during the period of The Great Migration (1920-1970). However, the relationship in more recent years (2000 and 2010) still mimics that in 1870.

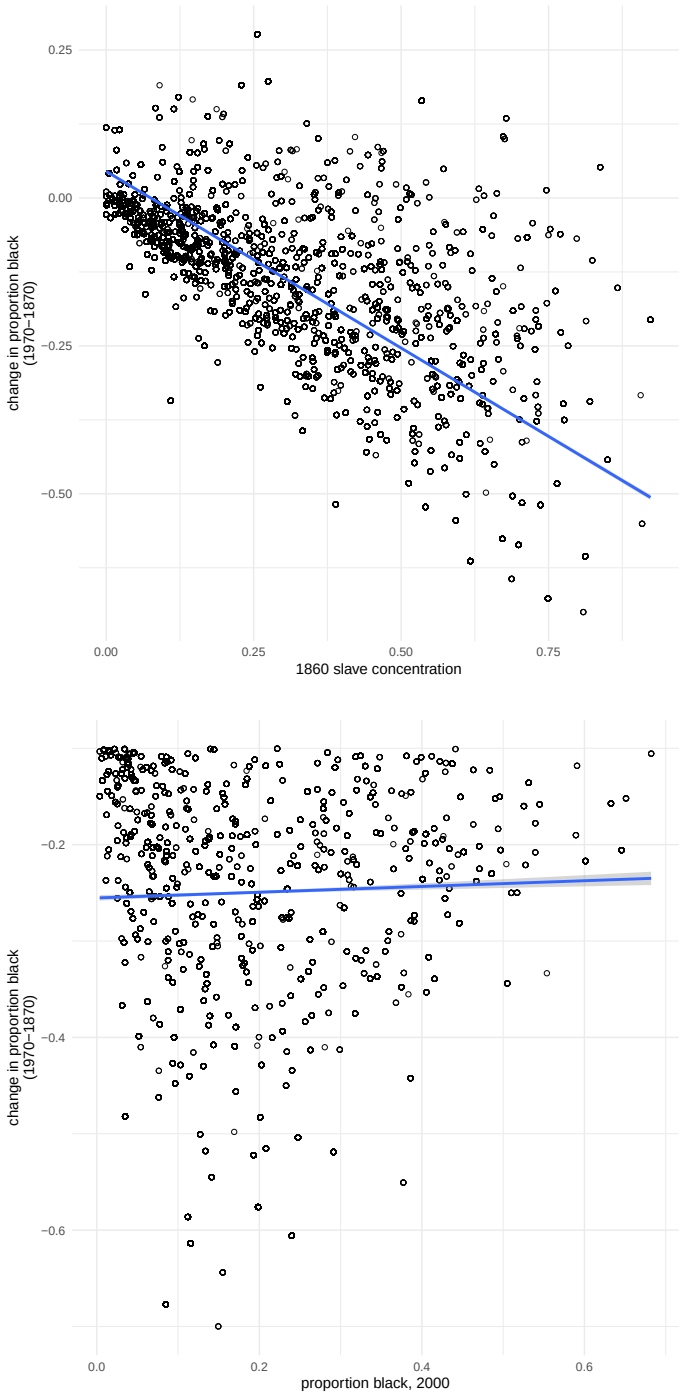


FIGURE A9: Change in Proportion of Blacks (1870-1970)

Note: The figure on the top shows the relationship between 1860 slave concentration measure and the change in concentration of Blacks between 1870 and 1970. The bottom figure is restricted to PUMAs where the share of Blacks dropped by 10 percentage points or above and shows the relationship between present-days Black concentration and change in concentration of Blacks between 1870 and 1970.

TABLE A1: Cotton Suitability Measure and ACA Sentiments Outside of South

	Dependent variable:									
	Individual Against ACA									
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
cotton suitability	−0.022	−0.022	−0.028	−0.002	−0.023	0.004	0.004	0.009	−0.002	0.003
	(0.052)	(0.052)	(0.051)	(0.054)	(0.053)	(0.042)	(0.042)	(0.037)	(0.039)	(0.042)
state and year FE	X	X	X	X	X	X	X	X	X	X
Lon. Lat. + sq terms	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X	X	X
prop. free blk. 1860		X	X	X	X		X	X	X	X
Proportion Black 2000			X					X		
Log white-black income ratio, 2014				X					X	
Other 2014 Controls					X					X
Observations	4,498	4,498	4,498	4,498	4,498	25,267	25,267	25,267	25,267	25,267

Note: *p<0.1; **p<0.05; ***p<0.01

Columns 1-5 and 6-10 show results for Black and White race groups, respectively. All specifications include controls for state and year fixed effects, geographic controls including longitude, latitude, sq. terms of longitude and latitude, log of county area in sq. miles, whether the county has an access to waterways, and other control variables pertaining to 1860 (proportion of farms under 50 acres, farm value per capita, log of the total improved acreage, log of the total population in 1860, whether county had access to railways, Gini coefficient of land inequality in 1860). Additionally Columns 2 (6) control for the proportion of free Blacks in 1860. Columns 3 (7) and 4 (8) include controls for the proportion of Blacks in 2000 and log of White-Black median income ratio in 2014, respectively. Columns 5 (10) include individual covariates including family income, education, and marital status from CCES survey. The standard errors clustered at the county level are presented in parenthesis.

TABLE A2: Past Slavery and ACA Sentiments in South – Alternative IV Approach

	Dependent variable:										
	First Stage	Against ACA (CCES 2014, Whites)									
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
cotton suitability	0.303***										
	(0.055)										
malaria stability	0.114***										
	(0.033)										
prop. slave 1860×Medicaid		−1.353**	−0.910	−0.908	−0.883	−0.837	−0.435	−0.698*	−0.757*	−0.582	−0.668*
		(0.541)	(0.595)	(0.596)	(0.595)	(0.592)	(0.296)	(0.408)	(0.387)	(0.388)	(0.406)
prop. slave 1860×No Medicaid		0.446*	0.410	0.410	0.420	0.416	0.459**	0.468**	0.534***	0.509**	0.456**
		(0.233)	(0.255)	(0.255)	(0.257)	(0.261)	(0.219)	(0.214)	(0.205)	(0.216)	(0.211)
state and year FE	X	X	X	X	X	X	X	X	X	X	X
Lon. Lat. + sq terms	X	X	X	X	X	X	X	X	X	X	X
temp. + prec. + elevation	X	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls			X	X	X	X		X	X	X	X
prop. free blacks 1860			X	X	X	X		X	X	X	X
Proportion Black 2000				X					X		
Log(white-black income ratio 2014)					X					X	
Other 2014 Controls						X					X
F-stat	20.025										
Observations	1,122	10,672	10,672	10,672	10,672	10,672	43,693	43,693	43,693	43,693	43,693

Note: *p<0.1; **p<0.05; ***p<0.01

Column 1 represents the first stage results from a specification that controls for state fixed effects and geographic variables, including longitude, latitude, squared terms of longitude and latitude, log of county area, land ruggedness, average temperature (1950-1961), average precipitation (1950-191), elevation and access to waterways. These controls are similar to those used in Acharya et al. (2016) and Esposito (2019). Columns 2-6 and 7-11 show results from the IV specification for Black and White Southerners, respectively, when using the predicted values of 1860 slave concentration from the first stage. The county level variables additionally included in Columns 2-5 and 7-10 are interacted with indicators representing expansion and non-expansion states. Column 2 includes similar controls as Column 1. Column 3 adds other control variables pertaining to 1860 (proportion of farms under 50 acres, farm value per capita, log of total improved acreage, total population, access to railways, Gini coefficient of inequality, and proportion of free Black). Column 4 also includes proportion of Blacks in 2000, and Column 5 instead controls for the ratio of White to Black median income in 2014. Column 6 include individual level controls from CCES including age, age squared and gender. Columns 7-11 are structured similar to Columns 2-6. The standard errors are clustered at the county level and presented in parenthesis.

TABLE A3: Past Slavery and Other Anti-Welfare Political Ads Excluding ACA

	Dependent variable:									
	Log(Other Political Ads) (2014)									
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
prop. slave 1860×Medicaid	−0.023	−0.026	−0.018	−0.025	−0.024					
	(0.027)	(0.025)	(0.027)	(0.029)	(0.025)					
prop. slave 1860×No Medicaid	−0.004	−0.004	−0.004	−0.007	−0.006					
	(0.011)	(0.011)	(0.010)	(0.010)	(0.011)					
cotton suitability×Medicaid						−0.007	−0.003	−0.002	−0.016*	−0.004
						(0.007)	(0.008)	(0.008)	(0.010)	(0.009)
cotton suitability×No Medicaid						0.009	0.009	0.010	0.009	0.011
						(0.009)	(0.009)	(0.009)	(0.008)	(0.009)
state FE	X	X	X	X	X	X	X	X	X	X
Geography variables	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X	X	X
prop. free blk. 1860		X	X	X	X		X	X	X	X
Proportion Black 2000			X					X		
Log white-black income ratio, 2014				X					X	
Log 2010 population					X					X
Observations	1,313	1,313	1,313	1,138	1,256	1,262	1,262	1,262	1,106	1,206

Note: *p<0.1; **p<0.05; ***p<0.01

Note: The dependent variable used is the log of number of anti-welfare political ads excluding ACA during the 2014 gubernatorial elections. All specifications include controls for state and year fixed effects, geographic controls including longitude, latitude, sq. terms of longitude and latitude, log of county area in sq. miles, whether the county has access to waterways, and other 1860 control variables (proportion of farms under 50 acres, farm value per capita, log of total improved acreage, log of total population in 1860, whether county had access to railways, Gini coefficient of land inequality in 1860). Additionally, Columns (2, 7) control for the proportion of free Blacks in 1860. Columns (3, 8) and (4, 9) include controls for proportion of Blacks in 2000 and log of White-Black median income ratio in 2014. The addition of county level control variables in Columns(1-4 and 5-9) are interacted with indicators for expansion and non-expansion states, respectively. Columns (5, 10) include individual covariates including age, age squared, and gender from CCES. The standard errors are clustered at the county level and presented in parenthesis. *p<0.1; **p<0.05; ***p<0.01.

TABLE A4: Past Slavery and Insurance Coverage following ACA–expansion States

	Dependent variable:									
	Uninsured	ESI	Priv.	Medicaid	Other	Uninsured	ESI	Priv.	Medicaid	Other
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
prop. slave 1860 × Medicaid × Post	0.130***	−0.037	0.047**	−0.093**	−0.021	0.029	−0.008	0.002	−0.029	0.011
	(0.039)	(0.038)	(0.024)	(0.040)	(0.023)	(0.020)	(0.023)	(0.014)	(0.020)	(0.013)
Medicaid × Post × uninsured prop. 2013	−0.437***	0.219*	−0.098**	0.311**	0.055	−0.629***	0.167**	0.058	0.409***	0.046
	(0.101)	(0.112)	(0.047)	(0.121)	(0.046)	(0.067)	(0.068)	(0.046)	(0.072)	(0.033)
PUMA and Year FE+Post	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X	X	X
Past Health Policies+ACA Controls	X	X	X	X	X	X	X	X	X	X
Ind. Controls+st. Linear Trends	X	X	X	X	X	X	X	X	X	X
Observations	156,705	156,705	156,705	156,705	156,705	576,092	576,092	576,092	576,092	576,092

Note: *p<0.1; **p<0.05; ***p<0.01

The analysis is restricted to southern states that expanded Medicaid through ACA. Columns 1-5 and 6-10 pertain to Blacks and Whites, respectively. The specification used is similar to Column 3 (7) in Table 4. The standard errors are clustered at the PUMA level and presented in parenthesis.

TABLE A5: Past Slavery and Insurance Coverage following ACA–non-expansion States

	Dependent variable:									
	Uninsured	ESI	Priv.	Medicaid	Other	Uninsured	ESI	Priv.	Medicaid	Other
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
prop. slave 1860 × Post	0.015	0.00004	−0.006	−0.002	−0.001	0.015**	−0.004	−0.005	−0.0001	0.0002
	(0.013)	(0.015)	(0.011)	(0.011)	(0.009)	(0.006)	(0.007)	(0.005)	(0.005)	(0.004)
uninsured prop. 2013 × Post	−0.071*	0.056	0.005	0.015	0.011	−0.216***	0.121***	0.071***	0.018	0.007
	(0.039)	(0.037)	(0.026)	(0.028)	(0.021)	(0.017)	(0.018)	(0.011)	(0.011)	(0.007)
PUMA and Year FE+Post	X	X	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X	X	X
Past Health Policies+ACA Controls	X	X	X	X	X	X	X	X	X	X
Ind. Controls+st. Linear Trends	X	X	X	X	X	X	X	X	X	X
Observations	675,627	675,627	675,627	675,627	675,627	3,031,266	3,031,266	3,031,266	3,031,266	3,031,266

Note: *p<0.1; **p<0.05; ***p<0.01

The analysis is restricted to southern states without Medicaid expansion through ACA. Columns 1-5 and 6-10 pertain to Blacks and Whites, respectively. The specification used is similar to Column 3 (7) in Table 4. The standard errors are clustered at the PUMA level and presented in parenthesis.

TABLE A6: Summary Statistics (ACS data, Expansion states)

variables	high slave (Blacks)	low slave (black)	high slave (Whites)	low slave (Whites)
uninsured	0.25	0.2	0.16	0.16
	(0.43)	(0.4)	(0.37)	(0.36)
health ins. employer	0.5	0.49	0.64	0.64
	(0.5)	(0.5)	(0.48)	(0.48)
health ins. private	0.08	0.09	0.11	0.1
	(0.27)	(0.28)	(0.31)	(0.3)
health ins. Medicaid	0.17	0.24	0.08	0.1
	(0.38)	(0.43)	(0.27)	(0.3)
health ins. other	0.12	0.12	0.1	0.09
	(0.32)	(0.32)	(0.29)	(0.29)
schooling	17.37	17.43	18.15	18.12
	(3.32)	(3.23)	(3.34)	(3.23)
gender	0.47	0.47	0.49	0.49
	(0.5)	(0.5)	(0.5)	(0.5)
wages or salary (12 mo.)	28837.33	25689.65	43161.81	38228.23
	(36496.93)	(32408.39)	(59191.43)	(50486.8)
married	0.34	0.31	0.59	0.57
	(0.47)	(0.46)	(0.49)	(0.49)
employed	0.59	0.56	0.68	0.67
	(0.49)	(0.5)	(0.47)	(0.47)
age	41.16	40.91	42.55	42.68
	(13.82)	(14.02)	(13.67)	(13.64)

Note: Data from ACS 2012-2013 is restricted to states that expanded Medicaid. High slave areas are those with 1860 slave concentration above the median.

TABLE A7: Summary Statistics (ACS data, Non-Expansion states)

variables	high slave (Blacks)	low slave (black)	high slave (Whites)	low slave (Whites)
uninsured	0.27	0.29	0.18	0.22
	(0.44)	(0.46)	(0.38)	(0.41)
health ins. employer	0.46	0.46	0.62	0.59
	(0.5)	(0.5)	(0.49)	(0.49)
health ins. private	0.09	0.08	0.11	0.1
	(0.28)	(0.27)	(0.32)	(0.31)
health ins. Medicaid	0.18	0.17	0.07	0.08
	(0.39)	(0.38)	(0.26)	(0.28)
health ins. other	0.14	0.11	0.11	0.09
	(0.35)	(0.32)	(0.31)	(0.28)
schooling	17.27	17.53	18.3	17.95
	(3.29)	(3.28)	(3.26)	(3.51)
gender	0.47	0.48	0.49	0.49
	(0.5)	(0.5)	(0.5)	(0.5)
wages or salary (12 mo.)	22019.38	23906.99	39382.01	37945.66
	(29579.49)	(31128.16)	(54201.13)	(54771.52)
married	0.33	0.33	0.59	0.57
	(0.47)	(0.47)	(0.49)	(0.49)
employed	0.53	0.57	0.66	0.67
	(0.5)	(0.5)	(0.47)	(0.47)
age	40.97	40.46	42.53	42.61
	(13.97)	(13.68)	(13.7)	(13.58)

Note: Data from ACS 2012-2013 include states that did not expand Medicaid. High slave areas are those with 1860 slave concentration above the median.

TABLE A8: Summary Statistics (Historical Data)

variables	high slave (expand)	low slave (expand)	high slave (non-expand)	low slave (non-expand)
1860 slave concentration (%)	43.42	8.74	40.86	12.64
	(13.18)	(6.45)	(13.72)	(6.75)
cotton suitability	0.52	0.42	0.49	0.47
	(0.08)	(0.12)	(0.11)	(0.16)
county area	1314.58	1193.61	1280.73	1534.98
	(1348.45)	(1195.39)	(1147.89)	(2530.58)
land ruggedness	18.85	47.12	27.59	45.2
	(11.46)	(29.84)	(24)	(45.18)
waterway access 1860	0.85	0.77	0.49	0.46
	(0.27)	(0.37)	(0.46)	(0.48)
railway access 1860	0.33	0.57	0.49	0.25
	(0.44)	(0.49)	(0.46)	(0.42)
proportion of farms under 50 acres 1860	0.36	0.44	0.43	0.6
	(0.21)	(0.21)	(0.2)	(0.2)
farm value per capita 1860	327.93	198.1	189.47	114.46
	(139.04)	(135.13)	(111.97)	(93.67)
farm value per improved acres 1860	60.18	65.87	37.72	53.14
	(32.75)	(48.02)	(22.83)	(35.72)
total improved acres 1860	167140.21	156962.98	154625.81	58844.66
	(137214.56)	(131864.99)	(186373.57)	(98710.22)
Gini coefficients land holdings	25090.33	59945.5	24792.9	15124.17
	(16384.55)	(57950.82)	(23572.34)	(26578.64)
proportion free blacks 1860	0.04	0.06	0.02	0.01
	(0.05)	(0.06)	(0.02)	(0.02)

Note: Data from various sources and from Acharya et al. (2016) replication files. High slave areas are those with 1860 slave concentration above the median.

TABLE A9: Summary Statistics (ACS data, Expansion states)

variables	high slave (Blacks)	low slave (black)	high slave (Whites)	low slave (Whites)
uninsured	0.26	0.24	0.18	0.15
	(0.44)	(0.43)	(0.39)	(0.36)
health ins. employer	0.49	0.51	0.62	0.65
	(0.5)	(0.5)	(0.49)	(0.48)
health ins. private	0.08	0.08	0.11	0.1
	(0.28)	(0.27)	(0.31)	(0.31)
health ins. Medicaid	0.18	0.18	0.09	0.08
	(0.38)	(0.38)	(0.28)	(0.28)
health ins. other	0.12	0.12	0.1	0.09
	(0.32)	(0.32)	(0.29)	(0.29)
schooling	17.24	17.65	17.8	18.33
	(3.31)	(3.27)	(3.33)	(3.28)
gender	0.46	0.49	0.5	0.49
	(0.5)	(0.5)	(0.5)	(0.5)
wages or salary (12 mo.)	28119.54	27550.99	37710.4	43572.37
	(35427.41)	(36553.21)	(48580.27)	(61675.37)
married	0.34	0.33	0.57	0.6
	(0.47)	(0.47)	(0.49)	(0.49)
employed	0.59	0.58	0.66	0.68
	(0.49)	(0.49)	(0.47)	(0.47)
age	41.27	40.69	42.36	42.87
	(13.82)	(13.98)	(13.74)	(13.54)

Note: The PUMA sample with 1860 characteristics is first screened using the propensity score method to match each high slave area with the closest propensity score from the group of low slave dependent areas. The screened historical (1860) sample is then merged with ACS 2012-2013 sample (restricted to states that expanded Medicaid) to produce the summary statistics presented above. High slave areas are those with 1860 slave concentration above the median.

TABLE A10: Summary Statistics (ACS data, Non-Expansion states)

variables	high slave (Blacks)	low slave (black)	high slave (Whites)	low slave (Whites)
uninsured	0.27	0.28	0.18	0.2
	(0.45)	(0.45)	(0.39)	(0.4)
health ins. employer	0.44	0.48	0.61	0.61
	(0.5)	(0.5)	(0.49)	(0.49)
health ins. private	0.08	0.08	0.12	0.12
	(0.28)	(0.27)	(0.32)	(0.32)
health ins. Medicaid	0.19	0.16	0.07	0.08
	(0.4)	(0.37)	(0.26)	(0.26)
health ins. other	0.14	0.11	0.11	0.08
	(0.35)	(0.31)	(0.31)	(0.28)
schooling	17.18	17.55	18.27	18.23
	(3.3)	(3.3)	(3.27)	(3.38)
gender	0.47	0.47	0.5	0.49
	(0.5)	(0.5)	(0.5)	(0.5)
wages or salary (12 mo.)	20930.36	24441.63	38122.79	40724.12
	(28246.61)	(31620.87)	(53201.88)	(58264.16)
married	0.32	0.35	0.58	0.58
	(0.47)	(0.48)	(0.49)	(0.49)
employed	0.52	0.58	0.65	0.68
	(0.5)	(0.49)	(0.48)	(0.47)
age	40.8	40.78	42.11	43.01
	(14.01)	(13.67)	(13.81)	(13.47)

Note: The PUMA sample with 1860 characteristics is first screened using the propensity score method to match each high slave area with the closest propensity score from the group of low slave dependent areas. The screened historical (1860) sample is then merged with ACS 2012-2013 sample (restricted to non-expansion states) to produce the summary statistics presented above. High slave areas are those with 1860 slave concentration above the median.

TABLE A11: ACA, Slavery, and Insurance Types (Other Race Groups)

	Dependent variable:				
	uninsured	ESI	Priv.	Medicaid	Other
	(1)	(2)	(3)	(4)	(5)
prop. slave 1860 × $Post_{2014}$	0.035*	−0.023	−0.017	−0.008	−0.005
	(0.020)	(0.023)	(0.015)	(0.010)	(0.011)
prop. slave 1860 × Medicaid × $Post_M$	0.135**	−0.119*	0.055	−0.072	0.029
	(0.056)	(0.066)	(0.047)	(0.044)	(0.034)
$Post_{2014}$×uninsured prop. 2013	−0.224***	0.157***	0.031	0.005	0.026
	(0.040)	(0.047)	(0.030)	(0.020)	(0.019)
Medicaid × $Post_M$ × uninsured prop. 2013	−0.051	−0.118	0.131	0.167	−0.003
	(0.166)	(0.163)	(0.099)	(0.108)	(0.086)
PUMA and Year FE+$Post_M$×Medicaid	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X
Past Health Policies+ACA Controls	X	X	X	X	X
Ind. Controls+st. Linear Trends	X	X	X	X	X
Observations	405,623	405,623	405,623	405,623	405,623

Note: *p<0.1; **p<0.05; ***p<0.01

The analysis is restricted to southern states and comprise of individuals who are not of Black or White racial ethnicity. The specification used is similar to Column 3 (7) in Table 4. The standard errors are clustered at the PUMA level and presented in parenthesis.

TABLE A12: Past Slavery and Insurance Coverage – Using Proportion Blacks, 2000

	Dependent variable:							
	uninsured	ESI	Priv.	Medicaid	uninsured	ESI	Priv.	Medicaid
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
prop. black 2000 × $Post_{2014}$	0.0001	−0.005	0.002	−0.001	0.042***	−0.015	−0.020***	−0.012**
	(0.013)	(0.015)	(0.009)	(0.011)	(0.008)	(0.009)	(0.007)	(0.006)
prop. black 2000 × Medicaid × $Post_M$	0.095***	−0.005	0.018	−0.077**	−0.008	0.021	0.026	−0.037*
	(0.030)	(0.035)	(0.019)	(0.032)	(0.023)	(0.024)	(0.018)	(0.021)
$Post_{2014}$×uninsured prop. 2013	−0.104***	0.054*	0.026	0.017	−0.287***	0.127***	0.124***	0.029***
	(0.034)	(0.033)	(0.023)	(0.027)	(0.022)	(0.017)	(0.017)	(0.010)
Medicaid × $Post_M$ × uninsured prop. 2013	−0.373***	0.175	−0.113**	0.322**	−0.391***	0.057	−0.056	0.402***
	(0.107)	(0.115)	(0.050)	(0.125)	(0.064)	(0.070)	(0.051)	(0.070)
PUMA+Year FE+$Post_M$×Medicaid	X	X	X	X	X	X	X	X
Other 1860 Controls	X	X	X	X	X	X	X	X
Past Health Policies	X	X	X	X	X	X	X	X
ACA Controls	X	X	X	X	X	X	X	X
Ind. Controls	X	X	X	X	X	X	X	X
Observations	849,374	849,374	849,374	849,374	3,685,514	3,685,514	3,685,514	3,685,514

Note: *p<0.1; **p<0.05; ***p<0.01

The analysis is restricted to southern states. Columns 1-5 and 6-10 pertain to Blacks and Whites, respectively. The specification used is similar to Column 3 (7) in Table 4. The standard errors are clustered at the PUMA level and presented in parenthesis.

TABLE A13: Effects in Non-Southern Region– Using Proportion Blacks, 2000

	Dependent variable:			
	uninsured	ESI	Priv.	Medicaid
	(1)	(2)	(3)	(4)
prop. black 2000 × $Post_{2014}$	−0.009	−0.056	0.105**	−0.019
	(0.054)	(0.070)	(0.043)	(0.065)
prop. black 2000 × Medicaid × $Post_M$	0.014	0.051	−0.116***	0.020
	(0.056)	(0.071)	(0.043)	(0.068)
$Post_{2014}$×uninsured prop. 2013	−0.184**	0.070	0.030	0.061
	(0.076)	(0.109)	(0.075)	(0.102)
Medicaid × $Post_M$ × uninsured prop. 2013	−0.276***	−0.057	−0.001	0.365***
	(0.084)	(0.111)	(0.076)	(0.109)
PUMA+Year FE+$Post_M$×Medicaid	X	X	X	X
Other 1860 Controls	X	X	X	X
Past Health Policies	X	X	X	X
ACA Controls	X	X	X	X
Ind. Controls	X	X	X	X
Observations	443,863	443,863	443,863	443,863
Note:	*p<0.1; **p<0.05; ***p<0.01			

The analysis is restricted to non-southern states. Columns 1-4 pertain to Black Southerners. The specification used is similar to Column 3 (7) in Table 4. The standard errors are clustered at the PUMA level and presented in parenthesis.

TABLE A14: Racial Threat Hypothesis

	Dependent variable:									
	uninsured	ESI	Priv.	Medicaid	other ins	uninsured	ESI	Priv.	Medicaid	other ins
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
prop. slave 1860 × $Post_{2014}$	−0.038*	0.023	0.005	−0.003	0.017	0.014	−0.009	−0.004	0.004	0.004
	(0.021)	(0.027)	(0.017)	(0.021)	(0.014)	(0.009)	(0.011)	(0.008)	(0.007)	(0.007)
prop. slave 1860 × Medicaid × $Post_M$	0.293***	−0.094	−0.014	−0.129	−0.049	0.032	−0.036	0.001	−0.012	0.048**
	(0.071)	(0.058)	(0.035)	(0.083)	(0.030)	(0.033)	(0.039)	(0.022)	(0.030)	(0.021)
$Post_{2014}$×uninsured prop. 2013	0.018	0.059	−0.054	−0.017	0.014	−0.144***	0.073**	0.075***	−0.030	0.017
	(0.057)	(0.059)	(0.036)	(0.042)	(0.033)	(0.029)	(0.030)	(0.019)	(0.020)	(0.012)
Medicaid × $Post_M$ × uninsured prop. 2013	−0.261	0.171	−0.023	0.069	−0.004	−0.362***	0.171**	−0.104	0.345***	0.030
	(0.226)	(0.174)	(0.101)	(0.223)	(0.087)	(0.078)	(0.079)	(0.074)	(0.089)	(0.048)
PUMA+Year+$Post_M$×Medicaid	X	X	X	X	X	X	X	X		
Other 1860 Controls	X	X	X	X	X	X	X	X		
Past Health Policies+ACA Controls	X	X	X	X	X	X	X	X		
Observations	379,513	379,513	379,513	379,513	379,513	1,481,018	1,481,018	1,481,018	1,481,018	1,481,018

Note: *p<0.1; **p<0.05; ***p<0.01

The analysis is restricted to PUMAs that experienced a drop in Blacks' population share by 10 or more percentage points between 1870 and 1970. Columns 1-4 and 5-8 pertain to Blacks and Whites, respectively. The specification used is similar to Column 3 (7) in Table 4. The standard errors are clustered at the PUMA level and presented in parenthesis.