



STRUCTURES OF RESENTMENT: On Feeling—and Being—Left Behind by Health Care Reform

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After her shift at the Dollar General store, Allison visited a social service agency. She was six months pregnant and excited about the baby, but nervous about making ends meet. Though she worked two retail jobs, Allison depended on food aid and could not save enough for a security deposit and first month's rent so that she and her boyfriend could move out of her mother's house. After loading the cereal, bread, and vegetables from the foodbank into her compact car, she sat down for an interview at a picnic table shaded by pines. "Every little bit helps," she said, referring sheepishly to both the groceries and the \$25 interview incentive.

In her interview, Allison—who like most of the clients at this church-affiliated agency in rural Florida was white and poor—reported she had been uninsured for most of her life. She was well into the second trimester of her pregnancy before she received prenatal care by qualifying for Medicaid.¹ Though she was only twenty-two, she suffered from multiple, untreated health problems including nerve issues, recurrent sinus infections, and chronic pain. Allison had tried to sign up for Obamacare a half dozen times, but was unsuccessful. The online calculator estimated she was eligible for coverage at \$20 per month. Yet when she completed

the application and input her personal information, the cost jumped to \$300. “I don’t know anyone who can afford that,” she said, “even my better-off friends.” She did not seem to know that if Florida had expanded Medicaid she would have been eligible for that program, whether or not she was pregnant. Instead, Allison said she did not think too much about insurance now: “It’s something for rich people, who are fortunate enough to be able to pay for it.”



Figure 1. Photo by Kyle Kusz.

In this statement, and at other points in the conversation, Allison expressed resentment that she, as a non-“rich” person, did not benefit from health care reform. Allison worked, but her jobs were insecure, paid little, and did not provide benefits like health insurance. Compounding this situation, the social service and relief programs she could access were temporary, means-tested, and insufficient. Like many other poor individuals, Allison felt disenfranchised and distanced from the possibility of turning the American dream into a reality.

The Affordable Care Act (ACA)—the first major health care reform enacted in the United States in almost fifty years—was meant to address the health and financial well-being of people like Allison. The law, as passed in 2010, contained mandates that required individuals and businesses to obtain health insurance or

pay a penalty; the expansion of state Medicaid programs to include adults with incomes up to 133 percent of the federal poverty level (\$14,404 for an individual, or \$29,327 for a family of four in 2010); subsidies to those with incomes above the federal poverty level to purchase health insurance through online marketplaces; and insurance regulations including preexisting conditions protections and a requirement to fully cover the costs of certain preventative care services. The law succeeded in lowering the number of uninsured people in the United States by twenty million (Garfield, Orgera, and Damico 2019), but its scope remained limited.

Framers of the law had favored incrementalism over more radical system change when they dropped the public insurance option and excluded many immigrants from eligibility, thereby ensuring that only private plans could be sold on the exchanges and that universal coverage would remain out of reach (Halpin and Harbage 2010). These moves, designed to make the law more palatable to those on the right, gained little political goodwill from conservatives. From the day the ACA was passed with no Republican support, it has been endlessly attacked, dismantled, and only ever partially implemented (Starr 2011).

This lack of support for the ACA, and for health care reform more generally, has its roots in resentment: racial resentment that coalesced in attacks on the first Black president (Coates 2017), as well as resentment based on class, gender, sexuality, and immigration status. The law's opponents purposefully employed racially coded language directed at the president and immigrants to fan animus (Tesler 2012; Maxwell and Shields 2014). Yet resentment was also baked into the law itself through its exclusionary *and* equalizing provisions. Means testing—where projected future income determines the cost of coverage in the marketplace—for example, made the law particularly problematic for the working poor, whose income and employment status is subject to frequent changes. Coverage of individuals with preexisting conditions and women's reproductive health services, meanwhile, were cast as a loss for others (i.e., the healthy and men).

During implementation, even more exclusionary features were added, such as state decisions not to expand Medicaid and to limit enrollment assistance. The exclusion from coverage that emerged, combined with the difficulties produced by means testing, fueled resentment among those the law was designed to help.

Allison expressed this resentment in the idea that insurance was “something for rich people.” Allison lived in Florida, the state that initially brought forward a lawsuit challenging the constitutionality of the ACA on the grounds that it coerced states to participate. This lawsuit resulted in a 2012 Supreme Court decision that

made Medicaid expansion optional. In states that opted out of Medicaid expansion, including Florida, most poor adults earning incomes below poverty had no affordable options for health coverage. Thus Allison could not afford insurance on the exchange before her pregnancy: she was too poor to qualify for subsidized insurance and ineligible for Medicaid. The ACA's fragmented and much contested approach to health reform forced Allison to navigate what we call "resentment structures"—social service programs and public policies constructed on the basis of distrust and suspicion that reinforced and reproduced racial and class hierarchies. For white people like Allison, who are already hailed by resentment politics in the media and political discourse, embodied brushes with resentment structures further habituated them to feel resentful of others (be they rich or otherwise).

Borrowing from [Raymond Williams \(1977, 132\)](#), we interpret resentment as an important "structure of feeling," the "characteristic tone" and relational affect that distinguishes this moment from others. Structures of feeling organize dominant discourses from the media and popular culture; they "shape our bodily felt and evaluative response to events and outlooks on the world" ([Banning 2013, 95](#)). But we also contend that resentment is a *feeling that structures*. As resentment spills over from the representational circuits of media pundits, political activists, and policy makers, this red-hot emotion, like molten iron, eventually cools and hardens to produce social policies and structures. The experience of moving through the resulting structures often proves so difficult and off-putting that the structures themselves succeed in creating even more feelings of resentment and frustration.

Viewing policies in this way, as social forces "that have agency and that change as they enter into relations with actors, objects, and institutions" ([Shore and Wright 2011, 20](#)), allows us to see how the ACA, a policy designed to reduce inequality by expanding access to health coverage, has also activated and fanned resentment, particularly among poor, white individuals. As such, this article analyzes the dialectical interplay between resentment as a structure of feeling and a feeling that structures in the contested domains where the ACA was formulated, implemented, and manifested in uninsured people's lives.

RESENTMENT: At the Intersections of Race and Class

Resentment has been an important concept in Western moral and political philosophy at least since [Friedrich Nietzsche \(2018 \[1887\]\)](#) explored it in a *Genealogy of Morals*. A basic definition of resentment is indignation at having been treated unfairly, or as [Marlia E. Banning \(2006, 70\)](#) describes it, "feelings of ill will or anger." As resentment is directed at "others," it also entails an "us-versus-them" view

of the world: “When people perceive that they are not getting their fair share and that others are but do not deserve to, the emotion of resentment is a likely result” (Cramer 2016, 9).

Taking the concept further, Didier Fassin (2013) describes resentment as an emotional reaction to a relational situation, for example, workers who are laid off and then unable to find employment, that results in diffuse animosity toward others in lateral or subordinate positions. Political elites once feared this type of resentment, worrying that this “dangerous” emotion would lead to rebellion (Engels 2015; Nietzsche 2018). But since the 1960s, Jeremy Engels (2015, 20) argues, resentment has been tamed and transformed into a tool for dividing the populace and diffusing resistance.

Each of these definitions, as well as the many others that exist, fundamentally portray resentment as an emotion, albeit one based in a particular social context (in the sense that resentment is not primarily the product of one’s interior state or brain chemistry). As we argue in this article, however, this narrow definition of resentment as an emotion is incomplete.²

In the past decade, resentment has increasingly been recognized as playing a key role in national debates in the United States, including those concerning race, gender, sexuality, immigration, and social welfare (Banning 2006; Engels 2015; C. Anderson 2016, 2017). In Arlie Russell Hochschild’s (2016) *Strangers in Their Own Land*, for example, white southerners felt resentful because, after lifetimes of living “good” lives and doing what was expected of them, “others”—particularly racial minorities, women, and immigrants—were able to cut in front of the proverbial line due to government policies and programs like affirmative action and welfare. Likewise, Theda Skocpol and Vanessa Williamson’s (2012) study of the Tea Party found that its predominantly white, older, and economically well-off members felt passionately about revering the Constitution, while also fearing the decline of America, hating Obama, and detesting “moochers.” Similarly, according to Katherine J. Cramer (2016), economic insecurity, us-versus-them interpretations of the world, and strong rural identities explain why Wisconsinites who might benefit from government help adamantly opposed it. Thus these works portray resentment as an understandable, even natural emotional response to decreasing racial or cultural supremacy and the falling economic power of poor and working-class whites.

In most cases, resentment is portrayed as stemming from those on the political right, including conservatives, men, and whites, and particularly poor members of these groups. In 2016 and 2017, for instance, the *New York Times*, the *New Yorker*,

the *Economist*, and the *Atlantic* all ran major stories on resentment among whites. These pieces depicted poor whites as either unrepentant racists and duped partisans who voted against their class interests, or as sages whose knowledge of economic dislocation and elite snobbery could reinvigorate the Democratic Party (see Rothman 2016). The problem with this framing, as others have pointed out (C. Anderson 2017; Coates 2017), is that focusing the analysis of resentment on poor, white, and male conservatives implies that middle- and upper-class individuals, nonwhites, women, and liberals are not resentful.³ But many are. In fact, far from being non-resentful, middle- and upper-class individuals are the politicians and cultural producers who play key roles in making resentment an integral part of recent politics (Banning 2013). By so doing, they imbue policy programs and social structures with resentment features like strict means testing, more exclusionary and punitive immigration rules, and work requirements for public aid. Resentments do not just appear—they are stoked, amplified, and then institutionalized by a wide spectrum of political actors.

The recent resurgence of resentment, catalyzed by the election of Barack Obama and enflamed by the subsequent election of Donald Trump, has a much longer history. White rage and overt violence like lynching and massacres have long served as tools to enforce white supremacy and racial apartheid in the United States (Feimster 2011; K. Williams 2012; Phillips 2016). Carol Anderson (2016, 3), for example, argues that white rage flares in response to black advancement, which is why it flourished during Reconstruction, after *Brown v. Board of Education*, and during the civil rights movement. Importantly, overt and extra-legal violence was often accompanied by policies like share cropping, red-lining, and anti-miscegenation laws that legitimated and maintained the racial order. In the Jim Crow era and before, white rage and policy agendas were closely and explicitly linked. Rage has often done political and policy work.

As white racial politics shifted in the post-civil rights era and overt shows of racism became less politically palatable, new crops of policies emerged that were racist in their effects, even if segregation and maintaining inequality were not their explicit justification. During the 1970s, with the ascendance of Richard Nixon, dog whistling became the norm and terms like *welfare queens*, *law and order*, and *makers versus takers* largely supplanted more overtly racist language (Haney López 2014a). In the long backlash to civil rights gains, policies based on resentment politics have proliferated. They include tying food-stamp eligibility to work (Dickinson 2016); welfare reform with an emphasis on child support, work requirements,

and term limits (Morgen, Acker, and Weigt 2010); and, most recently, the push to add work requirements to Medicaid (Chokshi and Katz 2018).

While affecting poor, racialized communities directly, these and other resentment policies impact poor whites as well. However, because the policies are situated, at least indirectly, as only biased against nonwhites or non-citizens—as us versus them—observers do not generally appreciate the policies' class-based nature. Hence some scholars argue that the aim of racially based politics is to prevent class-based cohesion and challenges to the status quo that could undermine the hegemony of the wealthy elite (Kawachi, Daniels, and Robinson 2005).

Fassin (2013) takes this idea further by positing a difference between two forms of resentment represented in the examples above: the ideological rancor of the non-oppressed (resentment) and the authentic alienation of the dominated (*ressentiment*). Though Fassin (2013, 260) acknowledges that these can overlap, the contrasting case studies he presents—white police officers in France and black South Africans under apartheid—paint a stark opposition between the two:

The resentful man is not directly or indirectly exposed to oppression and domination, but he expresses discontent about a state of affairs that does not satisfy him. *Ressentiment* results from a historical alienation: something did happen, which had tragic consequences in the past and often causes continuing hardship in the present. Resentment amounts to an ideological alienation: the reality is blurred, leading to frequently misdirected rancor.

According to Fassin's definitions, the resentment described by Hochschild (2016), Skocpol and Williamson (2012), Cramer (2016), and others does not reflect an actual historical loss, but an essentially misguided emotional stance. Fassin's distinction between ideological rancor and anger at genuine oppression becomes problematic when we try to understand the predicaments and political sentiments of poor whites in the United States. An intersectional approach that acknowledges that many poor whites are *both* subjugated by global capital dislocations, the temporalization of work, low wages, lack of health care, the defunding of social services, and eroded public schools *while also being* proponents of white supremacy, Islamophobia, anti-immigrant policies, anti-LGBTQ legislation, and the like is messier—but ultimately more informative.

This article adds to contemporary analyses of resentment by considering how resentment coheres into policies and thereby produces new experiences of disenfranchisement, frustration, and resentful feelings. We do this by examining

the experiences of poor white persons who oppose the ACA, legislation ostensibly meant to help them. In our interviews with uninsured individuals, a diffuse and hybrid version of resentment emerged where poor whites were resentful because they were excluded from meaningful health reform *and* they blamed others for consuming public resources. Respondents talked about and experienced resentment through contradictory tropes about us versus them, deservingness, and personal responsibility. But what was also clear in their stories was how policies based in resentment structured their experiences and political realities.

COLLECTING RESENTMENT NARRATIVES

The narratives presented in this article derive from two independent projects, one conducted in Florida and Rhode Island by Jessica M. Mulligan and the other conducted in Texas by Emily K. Brunson.⁴ Mulligan's research in Florida and Rhode Island centered on the experiences of state residents who sought access to insurance coverage. From 2014 to 2017, 188 health insurance enrollment interactions were observed at the state health insurance exchange and community enrollment events in Rhode Island. In Florida, participants were recruited in 2014 and 2017 from health enrollment sites, social service agencies, and work sites to participate in interviews about insurance coverage. A total of eighty-five participants (fifty from Florida and thirty-five from Rhode Island) were recruited for interviews. Interviews generally took place several months after participants' initial attempts to enroll in coverage and considered their health needs, work histories, and experiences with health insurance.

Contextually, Florida proved hostile to ACA implementation, with no Medicaid expansion and many obstructionist efforts by local politicians to block enrollments. The particular county included in this project was far whiter and older than Florida as a whole, and the county boasted several active Tea Party chapters. Rhode Island in many ways was the opposite. In this reliably Democratic state, leaders embraced the ACA and enthusiastically implemented it. Nonetheless, issues with implementation led to frustration and disenfranchisement (Brugnoli-Ensin and Mulligan 2018; Mulligan, Arriaga, and Torres 2018).

Brunson's research in Texas focused on people's experiences of living without health insurance and how their situations changed over time with ACA implementation. Data were collected in 2013 through interviews with and surveys of health care providers, a survey of two hundred randomly sampled residents, and from interviews with thirty-one persons who had been uninsured for at least six months in the previous year, all of whom lived and worked in a particular county in cen-

tral Texas where demographic characteristics and insurance coverage mirrored the state averages. In the two subsequent years, 2014 and 2015, a subsample of ten interview participants were re-interviewed. Interviews in all three years explored the respondents' health histories, their past and current experiences with health care, and health care access.

Like Florida, Texas was also hostile to ACA implementation. Despite having the highest percentage of uninsured persons in the United States, the state (unsuccessfully) sued the federal government to prevent the legislation from moving forward. Following the failed court case, the state leadership chose to 1) opt out of Medicaid expansion; 2) not develop a state-based insurance exchange; and 3) impose strict regulations on navigators, those hired to assist people in signing up for insurance through the federal marketplace, which resulted in only about five hundred navigators left to serve almost seven million uninsured Texans (Feibel 2014; Michels 2014).

As both of us came to know uninsured and newly insured people who struggled to enroll in, and in some cases use, health insurance, we began to understand that frustrations with the ACA were about more than partisan politics; they were also about a law that did not actually meet the needs of many people it was designed to help. Like Allison, whose story of trying to enroll opened this article, many respondents were left out of affordable coverage. For those who did obtain access to insurance, their experiences were often problematic. So we looked for similarities and patterns across our different research sites to think together about how resentment structured experiences with the ACA and how these played out particularly among poor whites. In doing so, we were cognizant of homogenizing whiteness (Hartigan 1997) and generalizing group responses to poverty (C. Strauss 2018). The case presented here is not an argument for either of these, but rather a nuanced portrayal of commonalities that exist among vast differences.

EXPERIENCING RESENTMENT

For the purposes of this article we have chosen three cases to illustrate how particular resentment structures amplified resentment sentiments among poor whites: difficult-to-navigate means-tested eligibility infrastructures and punishing tax penalties (case 1); the Medicaid gap and the perception of safety-net programs being for racialized others (case 2); and a lack of trained navigators to assist with enrollment into programs that themselves divided populations based on characteristics like disability status, age, and pregnancy (case 3). We chose these particular

cases because they reveal themes that repeated across our interviews while also representing conditions unique to each field site.

Tax Bills and High Deductibles Trigger Resentment of Others

For some individuals, resentment manifested as anger at others—often the poor, immigrants, or people of color—perceived as benefiting from the health law and consuming too many resources. The ACA is a means-tested social program in which each applicant received a different price and level of coverage based primarily on their age, state of residence, family size, and income. Furthermore, instead of providing universal access to comparable insurance, the program provided advanced tax credits to those who income qualified, with the expectation that enrollees would have to pay back any erroneous credits they received after an end-of-year reconciliation with their actual (instead of projected) income. Predictably, this policy structure for determining eligibility and payment generated resentment. Consider the example of Violet.

Violet was a recently widowed sixty-four-year-old, white, retired emergency department nurse. She lived in a small coastal town in Rhode Island in an upscale manufactured home. Violet had signed up for health insurance through the exchange, but ultimately dropped the coverage she received and opted to remain uninsured until Medicare coverage began on her sixty-fifth birthday.

Violet's biggest difficulty with the insurance came in the form of an unexpected tax bill. After her first year in the program, Violet had to pay back \$4,500 to the Internal Revenue Service (IRS). She had earned about \$47,000 that year from her widow's Social Security benefit and from working part-time as a nurse. Therefore, the income estimate that she provided during enrollment proved inaccurate (as predictions of the future often are). When her actual income was reconciled with the projection, she learned that she had been receiving too much in tax credits and hence owed the IRS money.⁵ Violet had signed up for coverage on her own, though she did talk with someone over the phone when it came to picking out the plan. She said she did not understand it was a tax credit, or what that really meant, and no one explained it to her. "Should be called a tax debit, not a credit," she said.

Violet was against Obamacare before she had it, but this experience "really put the stamp on things." Her accountant and her primary care doctor had also told her that Obamacare was terrible. Despite this negative experience and negative feedback from those she trusted, Violet signed up for a second year of coverage through the Rhode Island exchange. In the second year, Violet struggled to

pay the premium for a plan with a large deductible—the only affordable option available to her.

Violet's husband had been a fisherman, and she did not become a nurse until her late thirties. She struggled to pay medical bills when her children were young and the family was uninsured, sometimes paying doctors with quahogs (a type of clam). Given her struggles to obtain medical care for herself and her family, it was surprising when Violet condemned others for their irresponsible use of health resources. She supported adding premiums to Medicaid: "All these people on their welfare and free health care should have to pay something, even if it's just \$15 a month, for a family of four. A few dollars at the doctor's office," she said. "Then people would think twice about wasting it."

Often during the interview, Violet became upset and shifted the conversation to people on welfare who did not work and expected everything for free ("heat assistance, food stamps, medical care, housing, everything"). When asked if she supported Medicare for all, she responded unequivocally:

I don't think so. No. See, I just came from a generation where you worked. My grandparents came over here—my great-grandparents came over from Portugal and the other ones came over from Ireland. They worked. They never got a handout. They never got anything. And there we got all these people—and I'm not saying any one country—but they're all coming over here and they're not working. I was in Social Security . . . waiting in line, you know, in a seat, and this guy ahead of me—he wasn't ahead of me—he was in another booth and he was in there trying to get Social Security because he can't work 'cause his disability? Can't speak English. Well, guess what? Go to night school and learn English. You want to come to this country? Put something back. No.

In this encounter, we see the familiar resentment narrative of blaming others for receiving benefits that one does not receive oneself. Violet even used [Hochschild's \(2016\)](#) image of cutting in line. It is unlikely that Violet's family members received no help: they likely benefited from Medicare, veteran's benefits, strong public schools, and access to low-interest and federally insured home loans. Yet these benefits are often seen as middle-class entitlements, rather than welfare, and therefore not stigmatized.

Violet's anger also stemmed from feeling as though she did not have enough herself—she was currently uninsured and hoping that nothing bad happened to her,

while so many others had coverage. She needed a hernia operation, but was waiting until she turned sixty-five and qualified for Medicare. She clung to the notion that people like her—who worked hard—deserved help, but instead of being helped, Violet felt she had been punished. The tax bill stung because she accepted government help and then was saddled with a bill. If the ACA had not been built with resentment structures in the form of means-tested eligibility, estimated subsidies, and tax penalties, then Violet might have had a much better outcome and a different assessment of health care reform. Instead, each brush with a resentment structure left her claiming that others were receiving benefits that she rightly deserved.

The Medicaid Gap Provokes White Resentment

While Violet expressed resentment of others receiving benefits they did not deserve, some individuals were explicitly resentful based on race. Consider the case of Sharon, a poor, white fifty-six-year-old living in Texas.

In addition to producing policies that excluded many individuals from care, political and public figures in the state assailed the ACA. A senior administrator in the Texas Department of State Health Services, for example, exclaimed, “People in Texas are uninsured because they want to be. Texans don’t want health insurance” (Brunson 2018, 177). These sentiments were, in turn, broadly repeated and reproduced throughout the state through local media and across family dinner tables.

When Brunson first interviewed Sharon in 2013, she was sick with chronic sarcoidosis, an inflammatory disease that caused scarring and thickening of her lung tissues, kidney damage, and intense, chronic pain. Her lack of health insurance meant sporadic care at best. Like Allison, Sharon fell into the coverage gap. Her only option for care was the indigent care program in her county, but the clinic was located nearly forty miles from her house and she did not have money for gas. So Sharon made do, filling her prescriptions when she could, and doing without when she could not, using her elderly neighbor’s Medicare-paid-for oxygen tanks when she experienced difficulties breathing, and seeking care only when absolutely necessary. (At the time of Sharon’s first interview, this had resulted in more than \$60,000 in debt to a local hospital, an amount she had no hope of repaying. By the time of our final interview, Sharon was nearly \$250,000 in debt due to medical expenses.)

Sharon had not envisioned her life this way. When she was young, Sharon attended college and graduated with a bachelor’s degree. She then worked as a respiratory therapist for almost ten years, a job that offered health insurance and other benefits. Because she was young and healthy and had never really used this health

coverage, Sharon did not think twice about a career change that led to a series of jobs without health insurance, and while she accepted the fact that she was “poor,” she never regretted her choice until she developed a chronic health condition.

Over the course of three interviews totaling almost ten hours, Sharon’s focus alternated between her desperation for care and embarrassment over her situation. On a few occasions, Sharon also lashed out at others. The first instance took place during our first interview, when Sharon complained that her whiteness caused her to receive a lower quality of care the few times she was able to use the county’s indigent program. Sharon felt that because the clinic was run by “Mexicans,” and because most of the people who went to the clinic were also “Mexican,” the clinic staff were less sympathetic toward her as a white woman. A second instance occurred at the end of our second interview. As we were leaving, Sharon stopped to explain her shock at the state of her life. While poverty was not entirely unexpected, her diagnosis with sarcoidosis and her inability to obtain care were. “As a *white* woman,” Sharon said, “my life just shouldn’t be like this.”

The following year, before we could even say hello, Sharon apologized for this comment made a year earlier. She wanted to clarify that she was not racist and felt bad for implying that she somehow deserved better because of her skin color. She then went on to explain that she was going to try applying for disability, something she had put off because she had long felt that disability was only for “lazy” people. In the midst of her own mental gymnastics of being resentful about barriers to her care, not knowing what to do, fearing that she could be classified as undeserving herself, and struggling to maintain some semblance of health, Sharon had come to terms with the fact that she was disabled and was finally willing to seek out disability insurance.

Sharon’s case illustrates the interplay between resentment structures and the production of resentment feelings in individuals left out of ACA coverage expansions. Her sense of frustrated white privilege manifested only after she attempted to access care through the ACA and found no options open to her. Boundary expansions that included some groups in health reform (citizens and permanent residents), even as it excluded others (unauthorized immigrants and the poor in non-Medicaid-expanding states), increased the “brightness”—or visibility—of Sharon’s exclusion (Marrow and Joseph 2015). As someone who considered herself liberal and a supporter of the ACA generally, Sharon later expressed shame at her reaction to her own exclusion.

Sara Ahmed (2004b, 51) argues that one’s sense of self often emerges in relation to a hated other: “This other, who may stand for or stand by other others,

presses against me, threatening my existence.” In this vein, Sharon’s sense of self as a white woman emerged in relation to excluded others; she distinguished herself from these others and felt unlike herself when forced to get care at the indigent clinic. Her embodied brush with the resentment policy of the Medicaid gap heightened her sense of whiteness and gave rise to feelings of resentment.

Excluding Men Fuels Familial and Gender Resentments

Expressions of resentment in our research also often involved assessments of deservingness. Sarah S. Willen and Jennifer Cook (2016, 100) argue that “deservingness debates involve conversations, either in public or behind closed doors, in which divergent stakeholders express or enact competing views about whether a particular person or social group deserves a certain kind of attention, investment, or care.” In a country without a strong commitment to universal health care access or a belief in health as a human right, other criteria emerge to explain who did or did not merit health care. In the earlier examples, working, paying premiums, and whiteness all featured in how respondents understood who deserved care. In other words, deservingness was reckoned through ideas about class and race as well as beliefs about personal responsibility. In other cases, gendered and sexual respectability and familial obligations also played important roles in calculations of who deserved care.

In Florida, a divorced, fifty-year-old white woman named Lorie sought coverage for her nineteen-year-old, uninsured son. Lorie was on Medicare for disability since a car accident a few years earlier. She was not aware that the ACA allowed her son coverage on his parent’s insurance until age twenty-six. When we told her this, she planned to contact his father, since he worked for the school department and had “good insurance.”

Lorie’s son had been on Medicaid previously, but lost coverage when he aged out of the program at nineteen. He had multiple medical needs including weight loss, asthma, and a potential heart issue. He sought care, but was unable to pay the associated bills. Lorie had taken her son to the Florida Blue office to get him coverage, but found it was too expensive. The son had no income and therefore fell into the coverage gap, which meant that he had to pay full price for an insurance plan. His mother was not aware that Florida had opted not to expand Medicaid, or that if they lived in an expansion state, her son would have had full coverage.

In considering care for her children, Lorie contrasted the experience of her son, whom she considered deserving of health coverage, with her daughter, whom she derided as dependent and lazy. Lorie criticized her daughter, who had

four children and had given two of them up for adoption. According to Lorie, the daughter lived with her, “sits on her butt all day,” and received \$500 a month in food stamps. Lorie frequently babysat the kids. Her son, on the other hand, was smart and studied. He wanted to be a preacher. He was starting his own lawn-care business—he already had the license. He was not earning any income at the time of our interview, but Lorie insisted that he was a hard worker and was going to make something of himself. He did not want to get married or have kids until he was thirty. According to Lorie, he did not want to be like his sister and definitely did not want to rely on welfare.

In Lorie’s case, gender dynamics (the favored son), condemnation of sexual promiscuity, and ideologies of hard work informed resentment, but it was also expressed in the intimate circuits that run through families where deservingness is reckoned in family stories of who is and is not responsible for their circumstances (and these stories do not always adhere to a racialized or classed us-versus-them narrative). The son was not working yet, but was understood by his mother to have the potential to work hard and create a legitimate family. He, therefore, deserved health insurance, and Lorie was willing to try multiple pathways (her ex-husband, Medicaid, Florida Blue) to help him obtain coverage and care. Her daughter, on the other hand, had a “spoiled identity” in her mother’s recounting, and was not deemed deserving. The mother expressed indignation that her daughter received income supports and health coverage by virtue of being an unwed mother, while her son went without.

Without recourse to a notion of health as a human right or a sense that everyone should have access to care, this family matriarch weighed which of her children was more or less deserving. This example once again shows us how social programs available to some through categorical eligibility rules meant to ration access to coverage and to provide it only to the most deserving (children, the disabled, and parents of young children) generated resentment when they did not align with other conceptions of deservingness (wedded childbearing, hard work). Lorie was not incensed that some people got health care while others did not; she was upset that coverage was going to the wrong people. As with Violet, the ER nurse from Rhode Island, work was seen as the key to deserving insurance, not parenthood or poverty.

STRUCTURED RESENTMENT

As anthropologists of policy have convincingly argued, policies both reflect and create social worlds (Shore and Wright 2011). The resentment narratives in-

roduced in this essay illustrate the creation side of this dialectic. Moving through resentment structures created feelings of resentment for Allison, Violet, Sharon, and Lorie as they reacted to their own exclusion from health care coverage. But how did these policies reflect existing social resentments?

Using the heterodox tools that are the hallmark of the anthropology of policy and “studying up” (Gusterson 1997), we now trace how resentment sentiments informed policy making. Our purpose is to clarify the reflection side of the dialectic, in other words, the ways in which resentment sentiments became incorporated into policy platforms and program structures.⁶ First we examine the media landscape and identify common tropes that major cultural producers and pundits used to articulate resentment narratives. Then we show how these resentment narratives became institutionalized through the creation of policies that contained resentment features such as excluding immigrants, requiring frequent eligibility recertifications, and blocking beneficiary access to information and assistance.

The media landscape, both nationally and locally in areas like Florida and Texas, was populated by attacks against the ACA that targeted coverage expansions and insurance rule changes favoring women, low-income earners, and people of color—all of whom were disproportionately uninsured and/or paid higher insurance rates before the enactment of the ACA. As one example, media coverage widely acknowledged that women were most impacted by coverage limits and insurance underwriting that excluded those with preexisting conditions. In response, Fox News ran segments questioning why young men should have to pay for maternity care, a service they would presumably never need (Franke-Ruta 2013). The Koch Foundation likewise ran outreach and advertisement efforts encouraging college students not to enroll in coverage and instead to “opt out” (V. Strauss 2013), emphasizing that healthy, young adults should not have to enroll in a program that would primarily benefit others. Us-versus-them rhetoric was pervasive and used by media pundits and other ideologues, including political leaders, in their efforts to block and undermine the implementation of the ACA.

Race similarly played a key role in objections to the ACA (Tesler 2012). Much of the media coverage of the legislation directly attacked Obama himself, thereby racializing the law (for examples, consider the much circulated caricature of Obama as a “witch doctor” and the use of the term *Obamacare* itself as a racial provocation [Haney López 2014b]). While many on the right referred to Obama as a socialist, asserting the ACA as a form of socialism, others referred to him as a terrorist (citing both his blackness and his purported ties to Islam), and yet others

suggested that Obama's primary goal with the ACA was to obtain retribution for slavery. Among far-right political pundits, explicit race baiting was common:

Rush Limbaugh: Obama has a plan. Obama's plan is based on his inherent belief that this country was immorally and illegitimately founded by a very small minority of white Europeans who screwed everybody else . . . and it's about time the scales were made even. And that's why this president is lawless, and that's why there's no prosecution of the Black Panthers for voter intimidation, because it's not possible for a minority to intimidate the white majority. It's always been the other way around. This is just payback. This is "how does it feel" time. (Quoted in [Waldman 2014](#))

Glenn Beck: Everything that is getting pushed through Congress, including this health care bill are transforming America. And they are all driven by President Obama's thinking on one idea: reparations. (Quoted in [Waldman 2014](#))

In a move characteristic of white supremacist rhetoric in the United States, Limbaugh and Beck projected hate and divisiveness onto Obama, thereby casting themselves and their audiences as victims and true patriots ([Ahmed 2004a](#), 117–18). The quotes above, along with tropes such as the welfare queen ([Jordan-Zachery 2009](#)), the notion that undocumented immigrants come to the United States for free health care ([Chavez 2013](#)), or the convoluted math that expanding Medicaid would lead to fiscal disaster for state budgets ([Hayes et al. 2019](#)), all rely on the notion that underserving, nonwhite people are syphoning resources from whites and thereby threatening their way of life.

While some of the racial resentment talk was explicit, other commentators (especially politicians on the national stage) relied on more implicit, coded language. Dog-whistle politics, or coded racial appeals, have the appearance of race neutrality but in fact activate and carefully manipulate hostility toward nonwhites ([Haney López 2014a](#), ix). When the speaker of the House at the time, Paul Ryan, characterized the ACA as a program for "takers" ([Craw and Carter 2012](#)), or when Florida governor [Rick Scott \(2012\)](#) invoked states' rights as a reason to reject Medicaid expansion, they dog-whistled.

National and local news media repeated this rhetoric. In Texas, state politicians from then Governor Rick Perry to city council members at town hall meetings likewise continued with the dog-whistling refrains. Sharon had heard

these arguments, repeatedly. In 2010 and 2011, it was nearly impossible in Texas to watch the local news, read a local newspaper, or listen to conversations about health-care reform without exposure to dog-whistling. This environment may well have contributed to Sharon, in her own desperate circumstances, exclaiming in a singular moment that, as a white person, she deserved better. More generally, it also led to broad political and public support for the state government's choice to not expand Medicaid—the policy that led Sharon, who initially supported the ACA, to become resentful.

But how does the emotion of resentment that politicians and pundits mobilize to induce feelings in their constituents and audiences translate into policy and social structures? Carol Anderson (2016, 3) argues that “white rage is not about visible violence, but rather it works its way through the courts, the legislatures, and a range of government bureaucracies. It wreaks havoc subtly, almost imperceptibly.” It is these less visible and less spectacular machinations of white rage that we call resentment policies.

Resentment emotions solidify into resentment policies (which in turn fuel more resentment emotions) when elected officials and private actors (like corporations) promulgate rules, programs, and eligibility criteria that limit access to social services and public goods to only those deemed “deserving”; impose burdens and costs on eligible beneficiaries that discourage the uptake of services; naturalize inequalities and make them seem inevitable; and shame or vilify those in need of services, thereby transforming our interdependencies into “burdens.”

As an example, consider the [American Legislative Exchange Council's \(ALEC\) \(2011\)](#) “The State Legislators Guide to Repealing Obamacare.” This widely circulated and much utilized playbook argued that the health law represented a “federal takeover” of insurance regulation, would lead to higher taxes, and would create “overburdened” Medicaid programs. Using language like “Americans will be subjected to many other Obamacare related taxes,” the guide dog-whistled racism, that is, Americans (read whites) would be subjected to Obama (a Black man). In addition to its guidebook, ALEC held conferences, trained policy makers, and drafted model legislation with the input of major health care interest groups like big pharma and tobacco firms, all to further obstruct the ACA ([Pilkington 2013](#)).

Through their efforts, ALEC and other ideologically similar organizations spearheaded efforts to derail the implementation of the ACA through the courts and through state governments, where much of the work to obstruct implementation of the law occurred ([Jones, Bradley, and Oberlander 2014](#)). These and similar efforts eventually led Florida and thirteen other states, including Texas, to sue the

federal government to block implementation of the ACA in 2010. The Supreme Court decision that resulted from this legal process ultimately allowed twenty-one states to not expand Medicaid coverage, leaving no health-care options for individuals who lived below 100 percent of the federal poverty level. This situation left Sharon and others like her first confused (Wasn't the law supposed to help?) and then resentful (Why am *I* being left out?).

The Medicaid coverage gap is a prime example of a resentment structure. State decisions not to expand Medicaid to poor adults obstructed movements toward greater racial equality. While this policy decision seemingly affected all people living below the poverty line in the same way, Blacks are more likely than whites to live in one of the fourteen states that continue to opt out of Medicaid expansion. In 2019, the majority of Medicaid non-expanding states are located in the south and have large Black populations (Artiga, Orgera, and Damico 2019). In this way the Medicaid gap serves the same function as other racially motivated policies like segregation and Jim Crow laws: it widens racial inequality and limits access to social services.

In a similar vein, the decision to exclude some immigrants from ACA eligibility is another example of a resentment structure. By excluding unauthorized and some lawfully present immigrants from marketplace and Medicaid coverage, the law's framers ensured that applying for health coverage would entail a lengthy verification process during which applicants would be sorted and categorized by submitting immigration status information. In addition to increasing the "brightness" of immigrants' symbolic exclusion from the body politic (Marrow and Joseph 2015), this procedure also created opportunities for exclusion through technical errors and eligibility delays. And even when immigrants were eligible, these policies led some to shy away from coverage, including mixed-status families, where the benefits of coverage were sometimes felt to pale in comparison to the risks involved in obtaining it (Castañeda 2018).

This exclusion did not arise in the law's contested implementation. Drawing xenophobic lines of belonging that issue from an us-versus-them or citizen-versus-non-citizen conception of health care deservingness formed part of the initial framing of the law and demonstrates that Republicans do not have a monopoly on resentment policies. As feelings of disregard for immigrants became concretized in health policy, this created eligibility structures that excluded immigrants, but that also made it more difficult for everyone to access coverage.

In each of the states where we conducted research, we saw resentment policies arise from resentment sentiments, even as the particulars of each state and lo-

cal context mattered in their expression. In addition to Sharon's example in Texas, another instance of an obstructionist resentment policy occurred in Florida, when Rick Scott, then governor, issued an executive order prohibiting ACA enrollments on state property. This meant that where Allison lived, enrollment assistance was only available for a half-day a week in a county-owned building (rather than the state-operated health department) that did not have wireless internet, even though the application for coverage was completely online. The governor claimed the rule protected the privacy of enrollees, but the impact was that it was even harder for Floridians to access coverage. This resentment policy directly influenced the experiences and attitudes of Allison and others like her who were left to navigate a complex and confusing process with inadequate access to trained assistance.

Even in Rhode Island, a reliably Democratic-voting state, resentment structures have found fertile ground. While state policy makers supported the ACA and expanded Medicaid, they also put in place restrictive eligibility processes and even closed the walk-in customer service center in 2015 due to cost overruns and the lack of a budget (P. Anderson 2015). Fiscal conservatism and concerns about fraud led Rhode Island to require multiple, redundant forms of identity verification that left the state exchange malfunctioning and unable to process the enrollments of many eligible individuals and families (Mulligan, Arriaga, and Torres 2018). Applicants' identities were verified through the Rhode Island Department of Human Services, the IRS, Experian (a consumer credit-reporting company), and Homeland Security. When identity did not align among these databases or if the individual did not have a credit history (common for both the young and working poor), their applications often faced delays. Not surprisingly, such policies stoked attitudes of resentment among many of the people we worked with, including Violet, who resented the financial upheaval caused by means testing and her impression that others were able to get care that she had not received earlier in her life.

In all of these ways, resentment has acted as an organizing narrative that directly created policies and social structures that are both based in resentment principles and that perpetuate the idea that the ACA is unfair and benefiting "others." The notions that ACA enrollees should be thoroughly surveilled, are likely to be committing fraud, are not already working, or are simply undeserving of health coverage have come to structure how social policy more broadly is imagined and implemented. In turn, these resentment structures also facilitated the circumstances that led the people we interviewed to become resentful themselves.

Earlier we discussed multiple examples of resentment policies, including the Medicaid gap; barring some immigrants from coverage; limiting access to trained

enrollment assisters; blocking enrollment activities on state property; and requiring multiple, redundant identity verifications to avoid fraud. Other resentment policies that emerged in the politically contested implementation of the ACA include excessive regulations for the certification of in-person assisters; limiting exchange hours during open enrollment; requiring frequent recertification for ACA enrollees; cutting funding for cost-sharing reductions; imposing co-pays and premiums on Medicaid-eligible populations; and, most recently, imposing work requirements on Medicaid eligibility. All of these policies produce structures that in turn fuel resentment among those who must navigate through them.

CONCLUSION

While firmly rooted in their own circumstances and responses to their particular situations, the feelings of resentment expressed by Allison, Violet, Sharon, and Lorie were not unique. We heard similar responses from many people we interviewed. All the middle-class individuals interviewed by Brunson expressed, like Violet, concern about “fairness” and resentment about “undeserving” people receiving access to care when their own access was limited. We also persistently heard poor white respondents repeat the dog-whistle refrains against the ACA that were so common in local and national media. Finally, while willingness to work, responsibility, and family duty emerged as common themes, every conception of deservingness was particularly intersectional to the person describing it. Less individualized was how our interlocutors arrived at their resentment. The experience of moving through the resentment structures of the ACA often proved so difficult and off-putting that the structures themselves created and exacerbated feelings of resentment for individuals seeking health coverage.

In the everyday contexts where people tried to access coverage and care, resentment sentiments were common. Some blamed racial and class others. Some blamed politicians. Some felt that work or respectability should equate with health insurance deservingness. Others were apathetic and felt that the system only worked for rich people. Nonetheless, all the interviewees featured in this article have one thing in common: they moved through resentment structures. They were cut off from Medicaid, blocked from access to trained assisters, and faced a malfunctioning bureaucracy designed for people with stable incomes and predictable lives.

Each of the individuals presented here also experienced unmet health needs because of their exclusion from coverage. Resentment structures thus produced embodied vulnerabilities: Allison’s late entry into prenatal care; Violet’s unrepaired hernia; Sharon’s mounting bills and borrowed oxygen; and Lorie’s uncovered son

with a heart condition. These are real historical exclusions, not just misdirected ideological rancor. In this way, resentment sticks to the ACA, not just because conservative commentators say it is an unfair law but because people know this to be true through their embodied brushes with resentment structures.

Resentment creates and hardens divisions between groups—whites and Blacks, the poor and the middle class, women and men. The dialectic interplay between resentment as a structure of feeling and a feeling that structures also ensures that resentment succeeds in reproducing itself. Of course, none of this is inevitable. Just as policies created on the basis of resentment can foster even more resentment and inequality, policies based in solidarity can create a shared sense that we are all in this together. Medicare is a good example of a policy that emerged from the civil rights movement and fostered greater racial, ethnic, and economic equity through expanding health coverage to the elderly and disabled, as well as desegregating the nation's hospitals (Smith 2016). The ACA could have done this too; it had begun to reduce coverage disparities, before its major provisions were rolled back and sabotaged (Artiga, Orgera, and Damico 2019).

To disrupt the incessant manufacturing of resentment feelings, we need more than concepts of false consciousness and duped racists. We need to consider how policies, like the ACA, themselves result from class- and race-based forces that structure policies and their implementation and thereby create the political, economic, and social realities that individuals experience and come to resent. Turning our analytic attention to how social policies create experiences of resentment helps us understand the continuity of this structure of feeling across time and space, as well as how it has been so effective in blocking greater racial and economic equality (C. Anderson 2016).

ABSTRACT

Described by many as an emotional state rooted in having been treated unfairly, resentment has surged over the past decade. Resentment politics troubled the passage and implementation of the Affordable Care Act (ACA, 2010) in the United States. While some people gained access to health insurance through the ACA, others experienced continued exclusion from affordable coverage. Drawing on ethnographic interviews with poor whites from Florida, Rhode Island, and Texas, we show how uninsured individuals talked about and experienced resentment through contradictory tropes of “us versus them,” deservingness, and personal responsibility. We argue that policies based in resentment, occurring on both national and state levels, structured these individuals’ experiences and amplified their resentment sentiments. Through this case study we argue that resentment is more than an emotion: it is also a force

that structures policies and their implementation. Resentment policies in turn create the social, political, and economic circumstances that generate resentment feelings. [resentment; resentment; Affordable Care Act; Obamacare; health care reform; policy]

NOTES

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1. Pregnant women with income below 185 percent of the Federal Poverty Level (FPL) are temporarily eligible for Medicaid in Florida until two months after giving birth.
2. A considerable anthropological literature exists on affect and its relationship to emotion. The androcentric strains of this literature, which draw heavily on Western philosophical traditions (i.e., [Massumi 2002](#), [Mazzarella 2012](#)), make a hard distinction between affect (defined as corporeal expressions of sensation that are prediscursive) and emotion (located within culture and discourse). In this article, we treat resentment as an emotion, rather than an affect, to the extent that a distinction is useful. By defining affect as prediscursive, scholars place it largely outside of analysis (i.e., [Massumi 2002](#)) and romanticize a prediscursive affective experience as a sign of resistance to modernity ([Mazzarella 2012](#)). This move (and the ontological turn more broadly) strikes us as a way to smuggle ethnographic authority back into treatments of emotion and also tends to ignore the large body of research produced by feminist scholars, such as the anthropology of emotions ([Pedwell and Whitehead 2012](#), 117–18).
3. Further evidence that the poor have been unfairly singled out as the progenitors of resentment politics can be seen in the 2016 U.S. presidential election results. Though poor whites and their racial resentments were often blamed for electing Trump, data do not bear this out. The coalition that voted Trump into office was not disproportionately working class—two-thirds of his support came from people making more than \$50,000 a year ([Carnes and Lupu 2017](#)).
4. Both projects were approved by our universities' Institutional Review Boards; accordingly, confidentiality and privacy were appropriately protected. We have used pseudonyms to protect respondents' identities.
5. Since insurance premiums increase with a person's age (due to the actuarial categories used in insurance rating), older people pay the highest premiums, but they also receive the most in tax credits to bring their premiums down. Therefore, older people will be hit with the largest tax bills if their income is significantly higher than expected. See [Mulligan \(2018\)](#) for a discussion of actuarial rating and means testing in the ACA.
6. In this section we are indebted to the secondary scholarship that documents how organized pressure from Republicans and industry interest groups fomented resentment so as to wrest important concessions from policy makers ([Starr 2011](#); [Light and Terrasse 2017](#)) and later to block implementation and add additional resentment features to the law ([Jones, Bradley, and Oberlander 2014](#)).

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