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Public perception of the United States' Affordable Care Act

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ABSTRACT

Background/Objective: Implementation of the Affordable Care Act (ACA) in the US has given opportunity to obtain health insurance for thousands who were previously uninsured. Many believe that the ACA is an improvement over previous insurance, while others view it as making health care more costly. The purpose of this study was to survey individuals regarding knowledge and perceptions of the ACA.

Methods: Researchers in public health, physician assistant studies, pharmacy and medical education developed a survey to assess the impact of the ACA. The survey included demographic questions and statements which assessed ACA support, and perspectives of the ACA's impact on pharmaceutical and medical coverage and personal out of pocket costs. A convenience sampling was used to recruit participants at a public venue in an urban setting.

Results: Demographics of the 179 surveyed include: median age 31 years; 84% Caucasian; 37% married; 58% completed a minimum of four years of college; and 45% with income exceeding $50,000. 13 (7%) were uninsured before the ACA, and 8 (4%) after. 130 (73%) had prescription coverage before the ACA with 107 (60%) reported no change in coverage, 22 (12%) better coverage, and 21 (12%) less coverage after the ACA. An association for ACA support was found based on political affiliation with more Democrats than Republicans supporting the ACA ($p < .001$). 71 (71%) who support the ACA, reported insurance did not improved after the ACA.

Conclusions: These findings identify that in a sample of upper middle class individuals, a majority support the ACA despite a lack of improvement in their own insurance indicating that personal sacrifice for the general population is occurring.

Key Words: Affordable Care Act, Healthcare, Public perception, United States

1. INTRODUCTION

Passed in 2010, the Patient Protection and Affordable Care Act (ACA) resulted in significant changes to the health care system in the United States (US).[1–3] The ACA brought in the most comprehensive changes to the American health care system since the creation of Medicaid and Medicare in 1965 with the intention to address three main areas in health care: access to health insurance, costs of health care, and the delivery of health care.[1–5] Certain elements of the law became active soon after its passage, but most provisions took effect in 2014.[3] By 2016, the percentage of people without health insurance coverage was 8.8% which decreased since 2015 when the uninsured was reported to be 9.1%. Despite the implementation of a government market place to obtain insurance, private health insurance coverage in 2016 continued to be more prevalent than government coverage, 67.5% compared to 37.3%, respectively. Although a majority of Americans were covered by private health insurance by 2016, the number of individuals covered by Medicare increased by 0.4% and the number covered by Medicaid increased

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by nearly 2% when comparing coverage before the ACA implementation to coverage in 2016.[6]

No other law in recent history has generated such passionate response across the political spectrum. According to an October 2013 Gallup poll of adults in the US, 45% approve the ACA, while 50% disapprove.[7] The Gallup poll highlighted variation in attitude toward the law by party affiliation, with 85% of Republicans disapproving the law, and 83% of Democrats approving the law.[7] Two years later in 2015, Wilensky reported similar support for the ACA based on political affiliation in a forum where she reported that only 8% of Republicans approved the ACA, while 74% of Democrats voiced their approval of the ACA. Wilensky also reported that approval rate among political independents is at 33%.[8] A person's political affiliation plays a major role in shaping an individual's opinion on certain policies, and the ACA has been no exception.[9] A partisan history has existed in health care reform over fifty years before the ACA implementation with Democrats favoring government involvement over Republicans.[9–12]

The political identification of a person is not the only thing that impacts approval or disapproval of the ACA. Legerski found that a person's age and education level also impact the acceptance of the ACA.[13] The older, wealthier populations of the US tend to disagree with the implementation of the ACA, while younger populations that either had a higher education or had not completed high school were more likely to welcome the ACA into the American health system.[13] Race has also been reported to impact approval of the ACA with 54% of nonwhites positively viewing the impact of the ACA.[8] There has been a shift towards ACA disapproval with the nonwhite population, as a Gallup poll in 2013 originally reported that 74% of this population approved the ACA.[7] Blendon also identified a shift in support for the ACA over the past 10 years.[14] In 2007, public support for the view that the federal government should assure that all Americans have health insurance coverage was at 64%, and in 2014 Blendon reported that the percentage dropped to 47% in support of federal government involvement in ACA.[14,15] During these same years Blendon identified that the trust in the federal government fell from 51% in 2012 to 40% in 2014.[14] Wilensky hypothesizes that the cause of the shift in support for the ACA may be due to President Obama's job approval ratings, which the Gallup poll reported to be 44% in December 2015, down from 68% in 2008.[8] While this is not a definitive reason for the shifts in the approval of the ACA approval, it is a hypothesis identifying potential factors that contribute to fluctuation in the support for the ACA.

The literature also shows that insurance coverage before and after the ACA influenced an individual's current opinion of the ACA. Williams reported that as of 2015 only 11.7% of Americans remain uninsured and even with the number of insured citizens increasing, there are some changes in people's coverage that causes them to reject the ACA.[16] When analyzing the 2015 Gallup poll, Williams concluded that the data collected in 2015 was unevenly distributed across states and did not accurately reflect the population of individuals uninsured. Of those individuals who were uninsured, approximately 48% said they remained uninsured after the ACA was implemented because they could not afford health insurance, while 9% said they chose to be uninsured because they did not approve the ACA before it was put into effect.[16] Other factors contributing to the number of uninsured were lack of employment, self-employed, or just not able to afford health insurance.[9] Of those individuals who are insured, Blendon and Benson reported that 56% of families saw no effect of the ACA on their health insurance, while 27% said it had negatively affected them and 14% said it had positively affected them.[14] Additional information regarding how attitudes of the ACA are affected by insurance status comes from a cross-sectional and panel survey done that found that people who experienced a negative change in health insurance because of the ACA were more likely to disapprove of it, while people who saw no effect on their health insurance or were positively impacted by it were more likely to approve of it.[17]

Though general population surveys reveal the fractious political debate surrounding the law, insights on the public's perspectives on the ACA are lacking in the literature. The purpose of this study was to assess the public's perspectives on the ACA and determine whether their past/present insurance coverage, political affiliation, or income influence with their perception of the ACA, as well as determine the effect the ACA has had on their personal insurance coverage. Utilizing a graduate public health course in program development, this study incorporates the input from a multidisciplinary team (nurse, public health, pharmacist, medical school educator, and physician assistant) into the development, distribution and analysis of the survey, that assessed the impact of the ACA. This approach was employed for the purpose of allowing individuals with different backgrounds to work with each other and benefit through understanding another's roles, and coordinate a team approach to evaluating a program.[18]

2. METHODS

2.1 Survey development and review

Survey development was initiated through a meeting that included faculty from a college of human medicine (PhD

trained Medical Physiologist), college of pharmacy (Doctor of Pharmacy faculty), and college of health professions (PhD Nursing faculty, Physician Assistant Master's Program faculty, and PhD trained Public Health faculty). The initial meeting focused on the impact of the ACA that each profession viewed as important within their professional practice. Each profession identified themes in regard to how the ACA impacted their profession. For example, the pharmacist identified that coverage of prescriptions under the ACA has changed and anecdotally identified that individuals were commenting on concern regarding the cost of prescriptions. Therefore, a section in the survey was developed to obtain data in this area. Other areas of the survey were developed based on each professions expertise in how the ACA has impacted their field. This approach to survey development incorporated multiple perspectives, and allowed for content validity in the development of the survey. In addition, items pertaining to the demographic component of the survey were developed based on information obtained from the literature. Based on both content experts and literature review, the survey included items to assess perceptions on how the ACA affected changes in the following: pharmaceutical coverage (less or greater), changes in insurance coverage (better or worse), information and knowledge of the ACA, support for the ACA (yes or no), political affiliation, age, income, education status, and employment.

2.2 IRB proposal development and submission

The study was submitted to the university's IRB and approved (#16-043-H-GVSU).

2.3 Procedure for participant recruitment and consent

Recruitment of participants to complete the survey occurred during a two-week time period (October, 2016) during a national festival (ArtPrize). The purpose for this time period was to randomly recruit individual's representative of the public who were walking on sidewalks in an urban setting. The area of the festival was divided into nine geographical areas. Researchers worked in pairs to recruit participants within their designated geographic area. Potential participants were greeted by the Researchers and a script was read explaining the study, which was followed by obtaining verbal consent. If individuals stated "No" in response to willingness to participate, they were thanked for their time. If the individuals stated "Yes" in response to willingness to participate, they were given the option to complete the handwritten survey or to have the statements read to them by the Researchers. Individuals who agreed to participate in the study but later stated that they did not want to complete the survey were allowed to withdraw from the study and their survey was not included in the analysis.

3. RESULTS

3.1 Data analysis

Descriptive analysis on study variables was performed. Means (standard deviations) were calculated for continuous variables, and frequencies (percentages) were determined for categorical variables. Chi-squared analyses were performed to determine if there was a difference in support for the ACA based on demographic and political affiliation. When assumptions were not met, the Fisher's Exact Test was used, and in analyses where there were missing data.

Table 1. Demographic characteristics of survey respondents

Characteristic	N (%)
Age in Years	
Mean (SD)	37.5 (17.6)
Median	31
Age Groups, number	
18-26 years	64 (36%)
27-40 years	45 (25%)
41-64 years	54 (30%)
65+ years	13 (7%)
Did not respond	3 (2%)
Gender	
Male	71 (40%)
Female	108 (60%)
Marital Status	
Married	67 (37%)
Not Married	96 (54%)
Other	14 (8%)
Did not Respond	2 (1%)
Race	
White/Caucasian	150 (84%)
Non-White/Caucasian	19 (11%)
Did not respond	10 (6%)
Political affiliation	
Republican	51 (28.5%)
Democrat	60 (33.5%)
Independent	56 (31%)
No political affiliation	5 (3%)
Did not respond	7 (4%)
Education	
High School	15 (8%)
Some College	60 (34%)
Four Year Degree	55 (31%)
Graduate School	49 (27%)
Income*	
< $20,000	47 (26%)
$20-40,000	27 (15%)
$40-50,000	14 (8%)
$50-75,000	24 (13%)
> $75,000	57 (32%)
Did not respond	11 (6%)

Note. * Median household income in 2016 was $58,000 with a range of $96,000 to $51,000[6].

3.2 Demographic characteristics

A total of 179 surveys were completed and included in the study analysis (see Appendix). Table 1 includes the demographic characteristics. The average age of the participants was 37.5 years with the age group of 18-26 years having the highest percentage (36%). A majority of the sample was female (60%), not married (54%), white/Caucasian (84%), politically affiliated with the democratic political party (33.5%), had some form of college education (92%), and reported an annual income over $40,000 (53%).

Table 2. Statistical analysis on the support for the ACA and demographic characteristics

Characteristics*	Response to the statement "Do you support the ACA?"*		Significance (Chi-Square)
	Yes	No	
Age Groups			
18-26 years	39	16	
27-40 years	25	14	$p = .781$
41-64 years	33	20	
65+ years	8	5	
Gender			
Male	32	35	$p < .001$
Female	75	21	
Marital Status			
Married	43	21	$p = .313$
Not Married	57	28	
Other	6	7	
Race			
White/Caucasian	89	47	$p = .296$
Non-White/Caucasian	14	4	
Political affiliation			
Republican	16	32	
Democrat	52	4	$p < .001$
Independent	34	17	
No political affiliation	3	1	
Education			
High School	5	8	
Some College	29	21	$p = .018$
Four Year Degree	36	18	
Graduate School	37	9	
Income			
< $20,000	28	11	
$20-40,000	18	7	$p = .789$
$40-50,000	8	6	
$50-75,000	13	8	
> $75,000	34	19	
Insurance before the ACA			
Yes	94	53	$p = .222$ (Fisher's Exact)
No	11	2	
Insurance coverage at time of survey			
Yes	102	50	$p = .444$ (Fisher's Exact)
No	4	4	
Improvement in personal insurance as a result of the ACA			
Yes	29	4	$p = .003$
No	71	47	

Note. * Individuals who did not respond to either support for the ACA or the item under characteristics were not included in the statistical analysis.

3.3 Statistical analysis

Chi-squared analysis was performed to determine if there was a difference in support of the ACA based on demographic information. There was no difference in support for the ACA based on age group (p = .781), race (p = .296), marital status (p = .313), income (p = .789), or whether they had insurance prior to the ACA or after the ACA, p = .222 and p = .444, respectively (see Table 2). There was a significant difference in support for the ACA based on gender (p < .001) with a greater percentage of females in support of the ACA compared to males. In addition, there was a significant difference in support of the ACA based on political affiliation (p < .001) with a greater percentage of Democrats in support compared to Republicans. Level of education also had a significant difference in support of the ACA, which showed that individuals with the greater number of years of higher education had a greater percentage of support for the ACA (p = .018) (see Table 2). In addition, there was a significant difference in support for the ACA based on whether there was improvement in personal insurance after the ACA (p = .003). Only 8% of those who did not support the ACA had improvement in their personal insurance, while 29% of those who support the ACA reported having improvement in personal insurance after the ACA, indicating that there is an association between support for the ACA and improvement in personal insurance.

Because the literature has indicated that the acquisition of insurance influences an individuals' support for the ACA, a crosstab analysis of the following statements was completed: "Did you have insurance prior to the ACA?" and "Do you currently have insurance?" There was no statistically significant difference between those who had insurance before the ACA and those who had insurance after the ACA (p = .113). As identified in Table 3, a large number of individuals had insurance both before and after implementation of the ACA (N = 154) with only six individuals (4%) having no current insurance but had insurance before implementation of the ACA. Of the 13 individuals who did not have insurance before the ACA, 11 (85%) currently have insurance.

Table 3. Statistical analysis between insurance before the ACA and after the ACA

Characteristics*	Frequency of responses to "Did you have insurance before the ACA?"		Significance
	Yes	No	
Response to "Do you currently have insurance?"			
Yes	154	11	p = .113 (Fisher's Exact)
No	6	2	

Note. * Individuals who did not respond to either statements were not included into the statistical analysis.

Table 4. Statistical analysis of support for the ACA and pharmaceutical coverage

Characteristics*	Frequency of responses to "Do you support the ACA?"		Significance
	Yes	No	
Response to "Did you have prescription coverage before the ACA?"			
Yes	86	44	p = .171
No	16	12	
Response to "How did your prescription coverage change with the ACA?"			
No Change	72	35	p = .372
Better Coverage	17	5	
Less Coverage	12	9	
Response to "Are you satisfied with your pharmaceutical coverage?"			
Satisfied	79	34	p = .056 (Fisher's Exact)
Neutral	18	18	
Not satisfied	8	2	

Note. * Individuals who did not respond to either statements were not included into the statistical analysis.

Analysis of pharmaceutical coverage before and after the ACA was performed. There was no statistical significance between support for the ACA and prescription coverage prior to the ACA (p = .171) (see Table 4). When asked how their prescription coverage changed with the ACA, 71% (107/150) reported no change, 15% (22/150) reported better coverage, and 14% (21/150) reported less coverage (see Table 4). When stratified by support for the ACA, there was no difference in support for the ACA based on better or less coverage (p = .372). There was a weak association between satisfaction with pharmaceutical coverage and support for the ACA (p = .056), which identified that there is a greater percentage of individuals who support the ACA who are satisfied with their coverage than individuals who do not support the ACA, 75% compared to 63% respectively. These findings indicate that satisfaction with pharmaceutical coverage may be a factor that could influence support for the ACA.

4. Discussion

The landscape of health care in the United States has changed dramatically in the last four years. In January 2014, the Affordable Care Act's individual mandate for insurance saw the state exchanges and federal marketplace go into effect.[19] Implementation of the ACA has increased the number of individuals with insurance, but the perception of the coverage of insurance has received little investigation.[20] The purpose of this study was to determine the perception of the ACA in a graduate program evaluation course where they were required to apply the principles of program evaluation to assess a national program, the ACA.

Before diving into the discussion of the findings, it is necessary to address the importance of the approach used in this study. By involving professionals from a variety of backgrounds to develop the survey, researchers were able to appreciate each professions' view on how the ACA has influenced their profession. Researchers were able to experience how anecdotal experiences of a health professional could be validated through research. An example of this involved the pharmacist who anecdotally expressed personal experiences where pharmaceutical coverage was negatively affected by the ACA. The survey identified that a majority (71%) of individuals did not report a change in coverage. This type of experience allowed the Researchers to witness the process for taking anecdotal events to evidence-based knowledge.

The findings of the survey identified items consistent with current literature, as well as items that were not consistent with current literature. In 2015, Wilensky reported that 8% of Republicans, 33% of Independents, and 74% of Democrats approved of the ACA.[8] We found similar findings with 87% of self-reported Democrats supporting the ACA; however, 31% of self-reported Republicans in our study supported the ACA reflecting a shift of Republicans toward supporting the ACA after implementation of the program.

Our study did not find a difference in support for the ACA based on age. 61% of individuals 18-26 years, 55% of individuals 27-40 years, 61% of individuals 41-64 years of age, and 62% of individuals greater than 65 years of age supported the ACA. There was no significant difference between the age groups in their support of the ACA in our study. These findings differ from Legerski and Berg who reported in 2016 that older individuals disapproved of the ACA compared to younger individuals.[9] In fact, individuals greater than 65 years of age had the highest percentage who support the ACA in our study. Although Legerski and Berg reported that the older individuals disapproved of the ACA, they did not report the specific ages, making the comparison to our study difficult.[9] Support for the ACA by individuals greater than 65 years of age will most likely continue based on a mandate stating that insurers cannot insure adults age 65 or older for more than three times the premium they charge a 21-year-old: the frequently used ratio is currently a 5:1 ratio.[21,22]

Legerski and Berg (2018) also reported that individuals with a college degree, as well as individuals who did not finish high school approved of the ACA compared to other educational categories.[13] Our study found a significant difference in support of the ACA based on education with those holding a graduate degree having the greatest support for the ACA at 76% compared to those with a high school education, who supported the ACA at 33%. The findings in our study are in alignment with the Pew Research Center findings in 2014 where they reported that 50% of college graduates approve of the ACA compared to individuals with no college experience who have the lowest approval rating of the ACA (36%).[23]

Income level has previously been reported to be associated with support for the ACA. Legerski and Berg reported that the wealthy individuals disapproved of the ACA compared to individuals with lower incomes.[13] Our study did not find a statistical difference in support for the ACA based on income (p = 0.789). Both categories of individuals in the wealthiest category (> $75,000) and the lowest category (< $20,000) had the same percentage of individuals (60%) who supported the ACA. The Pew Research Center (2014) identified that there was a higher percentage of individuals with a family income of less than $30,000 that approved of the ACA compared to individuals with a family income of $75,000 or more, 45% compared to 41% respectively.[23]

In this study, there was significant difference in support of the ACA based on gender with a greater percentage of females

in support of the ACA compared to males, 69% compared to 45% respectively. In a review of the literature, a comparison between gender and support for the ACA has not been reported. The support by females could be speculated based on the change in coverage for preventative health such as contraception coverage under the ACA. The ACA provides a variety of evidence-based preventative services to females with no out-of-pocket cost to women who have certain health plans which has the potential for improvement in health outcomes.[24–28]

Williams previously reported that having insurance influences support for the ACA and Macabe reported that individuals who experienced a change in health insurance coverage where their coverage was changed unfavorably were more likely to disapprove of the ACA.[11,16] We found no statistical difference in support for the ACA based on a change in coverage. This finding indicates that in our sample, there was support for the ACA despite personal improvement or impediment.

As varied as the types of insurance plans available, pharmaceutical coverage is also varied based on the plan.[29] Due to ACA, total pharmaceutical coverage increased and copayment decreased.[33,35] Medicaid-paid prescription increased by 19 percent in expansion states in compare to states that did not expand the coverage, more over the ACA reduced Opioids Prescription to Medicaid enrollees.[30,36] The prescription assistance programs (PAPs) is still important to cover prescription drug costs for eligible patients.[31] However, to make the plan efficient and reduce waste, fraud and abuse the Department of Health and Human Services and Centers for Medicare & Medicaid Services enforced some measures like new guidelines.[32]

We found that there was no difference in support for the ACA based on pharmaceutical coverage before the ACA, nor did we find that there was difference in support of the ACA whether their pharmaceutical coverage had changed. It should be noted, however, that 10% of those that did not support the ACA had better coverage while 17% of those who supported the ACA had better coverage after the ACA. This suggests a trend that support for the ACA may be influenced by improvement in pharmaceutical coverage.[34] When asked whether they were satisfied with their pharmaceutical coverage, a greater percentage (75%) of individuals who support the ACA were satisfied with their coverage compared to the individuals who did not support the ACA (63%).

5. Conclusion

The results of this study both supports and negates prior studies regarding support for the ACA. In support of the literature, we found a strong association of support for the ACA and having a Democratic affiliation. However, we also showed that there is an increase in the number of individuals who identify as Republican who support the ACA. Contrary to the literature, our study did not find an association with age or income and support of the ACA where others identified that the older adults do not support the ACA and the younger adults do support the ACA. This contradiction may be the result of the small sample size in this study, as well as the sample of participants which were recruited based on their attendance at a public venue. We also found that there was no difference in support for the ACA based on income, whereas others have found support of the ACA to be linked to those with lower incomes compared to higher incomes. Additionally, others have reported that insurance status affects support for the ACA, but we did not find any difference in support of the ACA based on current insurance status. Based on our results it is evident that implementation of the ACA is evolving and as United States Citizens are utilizing the ACA, there will be changes in the perception of this system.

Conflicts of Interest Disclosure

The authors declare no conflicts of interest.

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