# **Opposition to Obamacare: A Closer Look**

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#### Abstract

Prior telephone surveys have reported two main reasons for opposition to the Affordable Care Act (ACA): distrust of government and opposition to the universal coverage mandate. The authors set out to elucidate the reasons for this opposition. This article describes how the authors used qualitative methods with semistructured interviewing as a principal investigative method to gather information from people they met while bicycling across the United States from April through July 2016. During this time, the authors conducted open-ended,

semistructured conversations with people they met as they rode their bicycles from Washington, DC, to Seattle, Washington. Informants were chosen as a convenience sample. One hundred sixteen individuals participated as informants. The majority of comments were negative toward the ACA. Conversations were categorized into four themes, which included the following: (1) The ACA has increased the cost of health insurance; (2) government should not tell people what to do; (3) responsibility for ACA problems is diffuse; and (4) the ACA should not pay for other people's

problems. These face-to-face conversations indicated that opposition to the ACA may be due to the fact that many Americans have experienced an increase in the cost of insurance either through increased premiums or greatly increased deductibles. They blame this increase in cost on the ACA, President Obama, the government or insurance companies, and the inclusion of "others" in insurance plans. The authors discuss how these findings can influence medical education curricula to better prepare future physicians to discuss health policy issues with patients.

The Affordable Care Act (the ACA, also known as "Obamacare") was passed by a Democratic congress and signed by a Democratic president over the objection of virtually all Republican lawmakers in 2010. It continues to be a highly partisan issue. Opposition has continued even though at least 20 million Americans have gained health insurance since the passage of the ACA, and several of the most unpopular features of U.S. health insurance, such as denial of insurance to those with "preexisting conditions," were outlawed by the legislation.

The conversation about U.S. health care continues to evolve rapidly. As of this writing in early 2017, the GOP has introduced the American Health Care Act as a replacement for Obamacare. The debate is ongoing, and we emphasize that our article reflects the situation at the time it was written.

The reasons behind opposition to the ACA are complex. Although

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the opposition is due in part to the complexity of the legislation, another large part is driven by negative press accounts.1 Multiple telephone surveys of the U.S. public since the law was passed in 2010 until early 2017 have shown that a majority of Americans continue to oppose the ACA. Because of their multiple-fixed-choice formats, however, these telephone surveys have neither clarified the underlying reasons that Americans oppose mandatory health insurance and the government's role in health care, nor elucidated other potential reasons for opposition to the ACA, including problems related to underinsurance.3

We set out to enhance our understanding of people's thoughts and opinions about Obamacare. Using qualitative methods to engage with participants across the country, we as academic physicians envisioned that this new information would enrich our role as educators.

#### **What We Did**

To gain this insight, we reimagined standard research methodology. Three of the authors (P.R.G., L.G., A.H.) rode their bicycles over 3,000 miles along a rural northern route from Washington, DC, to Seattle, Washington, between April and July, 2016, with one request: "Tell me your thoughts about Obamacare." We sought personal and authentic conversations

with people along our route to deepen the understanding gained through earlier surveys. We chose to avoid urban centers to move beyond our own urban-based understanding of people's thoughts about the ACA and to include the voices of those living in rural areas of the United States.

We used qualitative description<sup>4</sup> as our principal methodology and semistructured interviewing as our principal investigative method.<sup>5,6</sup> We used these techniques in an attempt to gather information, rather than as a formal research study. To support the analysis process, we borrowed constant comparison from the tradition of grounded theory tradition.<sup>7</sup>

Three authors engaged in 116 interviews, which occurred during breaks for food or overnight lodging. Our presence on bicycles and a "Bike Listening Tour: Talk to Me About Obamacare" logo on our jerseys facilitated entry in public meeting places in small towns along the route. On arriving in a community, we introduced ourselves to a convenience sample of informants: those persons present at the local gathering spot (café or otherwise). We explained, "We're riding our bikes across the country to learn what people think about Obamacare," and further clarified, "This is a listening tour; it's about you—we want to hear your thoughts and experiences in relation to the ACA."

Just as commonly, however, individuals approached us to inquire about the "Talk to Me About Obamacare" logo, and we introduced the project idea in response.

After obtaining oral consent from each participant as required by the project's IRB-exempt status from the University of Arizona, we conducted semistructured interviews with the intent to learn the views of people along the route. As such, we listened without correcting any inaccurate comments or challenging informants' perceptions, allowing participants to share their comments freely without fear of being judged.<sup>8</sup>

The interviews lasted 15 to 30 minutes, each at a rhythm appropriate for informants to express their experiences and opinions at their own pace.<sup>8</sup> Although we had a set of prompt questions at the ready if needed to maintain conversation (List 1),<sup>9</sup> we guided interviews using indirect prompting ("uh-huh," "tell me more," and "that's interesting") and silent gestures of encouragement (head nodding and maintaining eye contact).

All informants were identified by gender, and pseudonyms were used to protect anonymity. A demographic summary of our informants is provided in Table 1. County-level data come from the U.S. Census and the American Community Survey, which we obtained from the National Historical Geographic Information System.<sup>10</sup> The lead author (P.R.G.) recorded the cross-country route using a bike computer with GPS. Figure 1 depicts this route with the symbol

type indicating the set of interviewing authors (A.H. was present for only two interviews). The majority of participants lived near the bike route, fulfilling our desire to speak with people along our chosen path; however, a small number of participants were out-of-state visitors. County of residence was not used as an exclusion restriction for participation.

Immediately following each interview, we dictated ethnographic field notes as a voice recording, reporting pertinent information relating to the interviewee, location of interview, direct quotations, and reflective observations. These notes were maintained in a blog site that all five authors continuously reviewed. During approximately 15% of the interviews, we took contemporaneous written field notes. $^{6,11,12}$  The authors present at each interview would review each other's notes at the time of the voice recording to ensure accuracy. Beginning in the second month, interviews were analyzed using a codebook developed by one of the authors (L.G.) based on standard qualitative coding principles.8 Disagreements in coding analysis between the first coder (L.G.) and second coder (P.R.G.) were resolved by discussion between them. Constant comparison13 was used to iteratively compare each new interview with prior interviews. At the beginning of our last week of travel, when we entered Washington State, we purposely increased the numbers of interviews to ensure that we were not missing any themes. We used qualitative description and borrowed the technique of constant comparison from the grounded theory tradition for analysis.7 Finally, we recognize reflexivity as a factor in our interpretation of participant interviews. <sup>6,14</sup> We are all employees of academic medical centers. Acknowledging the potential role of our background in the research, we made the work a "Listening Tour" as stated and did not correct any of the misinformation from participants. Nonetheless, we realized that our background influenced the way we heard the participants' stories and observations.

# **People's Stories: What We Found**

Twelve themes emerged from our interviews (Table 2). Positive comments focused on the ACA guaranteeing people's ability to insure children up to age 26 and the restrictions against people being denied insurance because of preexisting conditions. Negative comments, however, were more common. Of the eight negative themes we identified, four dominated in terms of importance of message and rate of occurrence.

# Theme 1: The ACA has increased the cost of health insurance

Dana (42 years old, northern Idaho) revealed that her premium increased with Obamacare and the deductible rose from \$700 to \$1,200. "I don't go to the doctor anymore since I can't afford the deductible."

Claire (43 years old, western Minnesota), saddled with a hefty deductible, commented, "and I have to pay for all of that out of pocket before my insurance kicks in?"

Josh (43 years old, eastern Minnesota) believed that premiums increased and "struggled to find the 'Affordable' in the Affordable Care Act."

Sally (45 years old, central South Dakota) said, "After having health care included in my job for over 20 years, I had no idea how much health insurance would cost me. It makes you wonder if it's even worth having insurance, if they're going to nickel and dime you for everything."

Irene (60 years old, central Washington) said, "Obamacare helped the people who were previously unable to afford insurance, but now working people ... are struggling."

As part of the ACA, people purchasing individual insurance whose incomes are

#### List 1

# Interview Questions Used If Needed to Maintain Conversation During 116 Interviews About Individuals' Opinions on the Affordable Care Act, April–July 2016

- 1. Introduction: I'm riding my bike across the country to meet people like you and learn what they think about Obamacare.
- 2. Framing: There's a lot of political stuff going on; lots of experts tell us what's what—but I'm here to listen to you, not to all the TV and online people who call themselves experts.
- 3. Demographics (at end of encounter): I hope you don't mind, but I need to ask a few questions about you:
  - How old are you?
  - How would you identify yourself in terms of ethnicity?
  - Do you have any ongoing medical problems?
  - Do you think of yourself as ill?
  - Are you getting medical care at this time?
  - Do you have insurance now or have you had it before?
  - How far did you go in school?
  - What kind of work do you do?

Table 1
Characteristics of 116 Individuals Interviewed About Their Opinions on the Affordable Care Act, April–July 2016

		Participant
Characteristic	Interview participants	counties of residence
ACA sentiment		_
Positive, no. (%; SD)	53 (46; 50)	·····
Demographics		
Age in years, mean (SD)	52.91 (15.90)	39.60 (5.54)
Male, no. (%; SD)	62 (53; 50)	N/A (50; 1)
White, no. (%; SD)	109 (94; 0.24)	N/A (85; 15)
African American, no. (%; SD)	2 (2; 13)	N/A (4; 6)
Asian and Pacific Islander, no. (%; SD)	1 (1; 9)	N/A (5; 7)
Hispanic or Latino, no. (%; SD)	4 (3; 18)	N/A (6; 9)
Total population, mean (SD)	<u> </u>	456,000 (143,300)
Rural, % (SD)	<u> </u>	47 (37)
Education		
High school dropout, no GED, 25+, % (SD)	<del>-</del>	10 (4)
Completed college or above, 25+, % (SD)	_	36 (10)
Income and employment		
Per capita income in dollars, mean (SD)	_	27,300 (5,980)
Below poverty line, % (SD)	_	14 (5)
Unemployment rate, mean % (SD)	<u> </u>	7 (4)
Insurance		
Currently without insurance, no. (%; SD)	5 (4; 20)	N/A (12; 5)
Previously insured, no. (%; SD)	101 (87; 34)	_
Employer-based insurance only, no. (%; SD)	59 (51; 50)	N/A (46; 9)
Insurance bought via ACA marketplace, no. (%; SD)	15 (13; 34)	_
Received subsidy given marketplace purchase, no. (%; SD)	10 (67; 49)	_
Medicaid only, no. (%; SD)	2 (2; 13)	N/A (11; 5)
No. of observations	116	49

Abbreviations: SD indicates standard deviation; GED, general educational development test; ACA, Affordable Care Act.

between 100% and 400% of the Federal Poverty Level are eligible for a subsidy to offset the cost of insurance premiums. None of these five respondents received a subsidy.

# Theme 2: Government should not tell people what to do

John (55 years old, southern Michigan) said, "It's wrong for the government to tell you that the insurance has to pay for things you don't believe in." As a business owner who does not believe in abortion, why should he have to pay for insurance that covers abortion?

Shirley (68 years old, western Maryland) said, "People don't like being told what

doctor to go to." She reported that since Obamacare, people in her area were no longer able to continue with their doctor because s/he would no longer accept the insurance. "But Obama said we could stay with our doctor."

Frank (67 years old, western Pennsylvania) remarked that people should have health coverage but should not be forced to get it. "Being forced to get it is wrong ... and it's wrong to penalize people for not having it."

Zach (35 years old, northern Ohio), a musician, reported that he is not a fan of the individual mandate. "You can choose whether or not to drive a car, but you can't choose whether or not to be alive

and need health insurance." He felt forced to get insurance.

Henry (68 years old, eastern South Dakota) said, "We don't want the government in health care," and emphasized that the government should not offer handouts. "The government shouldn't take care of you womb to tomb. There isn't enough money in the budget."

Although she believed "the government should not tell people what to do," Sally (47 year old, western Minnesota) commented, "I have no idea how to fix it. I just don't get sick," exemplifying another common refrain we heard.

# Theme 3: Diffuse responsibility for ACA problems

Insurance companies are to blame. Jeff (49 years old, central Maryland) believed that "it's not Obamacare but just the greedy insurance companies."

Joan (64 years old, western Pennsylvania) told us, "Maintaining the private insurance industry was a mistake. As for-profit companies, their first priority is to deliver dividends to their shareholders and secondarily to deliver health care. Obama made a pact with the devil."

George (45 years old, central Minnesota), when talking about the high costs, said, "it's because the insurance companies are taking advantage, but that's all because of Obamacare."

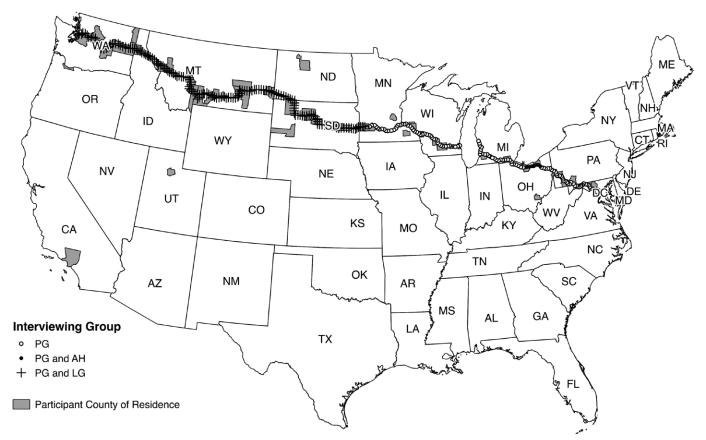
Penny (63 years old, eastern Montana) viewed insurance companies as having too much control: "Who's in charge here? When your health insurance determines your medical care, that's a problem."

Politicians are to blame. Derek (36 years old, western Pennsylvania) said, "it's all the regulations. When you have politicians trying to make health policy, it's never going to work. Too many politicians and too much regulation—2,000 pages of regulation."

Sean (69 years old, western Wisconsin) told us, "It's not perfect, since the politicians made it."

President Obama is to blame. Karen (48 years old, eastern South Dakota) summed it up by saying, "It would have been a lot better if Obama's name wasn't in the title.

<sup>&</sup>lt;sup>a</sup>Values reported in the participant counties of residence column are averages across the 49 participant counties of residence.



**Figure 1** The authors' bicycle route across the United States, during which they interviewed 116 people about their opinions of the Affordable Care Act. Symbols indicate the interviewing group present at each point along the trip: Paul Gordon (PG), Laurel Gray (LG), and Alex Hollingsworth (AH). Participant counties of residence are shown in light gray. The majority of participants lived near the bike route; however, a small number of participants were out-of-state visitors. *Sources*: Map shapefiles are from the National Historical Geographic Information System (NHGIS).<sup>10</sup>

Maybe they could have just called it New Care."

Ami (51 years old, eastern Maryland) told us, "people are just opposed to anything from the Democratic party."

Mike (73 years old, northern Oregon) said, "Republicans did an outstanding job in their marketing campaign to lead people to distrust the government and hate Obamacare."

Betty (43 years old, central Minnesota) offered the sentiment, "its good he only has one year left."

# Theme 4: The ACA should not pay for other people's problems

Margaret (62 years old, eastern Minnesota) stated, "Obamacare encourages people to take advantage of the system." Growing up without running water and working all her adult life, she feels that she made it the hard way; why can't everyone else? "Those [people's tattoos] cost money—why don't they use their money for health care or food? Why do the others ask for disability; why don't they continue working?"

Laura (69 years old, western Pennsylvania) objected to paying for those "other" people. Comparing car insurance with health insurance, she commented, "Why should I pay for motorcycle riders who don't wear helmets?"

Joe (72 years old, central Wisconsin) told us when talking about contraception, "That's a lifestyle choice, it's not a medical problem—the government shouldn't have to pay for that."

Karen (48 years old, eastern South Dakota) concluded, "he just gives all of the taxpayers' money away to poor people."

Jose (67 years old, central Montana) deeply valued hard work and believed government handouts are wrong: "You need to earn everything."

Ray (53 years old, western Montana) believed that Obamacare "encourages people to take advantage of the system. People should go out and get an education and get a job where they are covered by insurance."

Bob (70 years old, eastern Washington) asked, "Why should I have to pay for other people's problems? For example, take a man. Why should he have to pay for childbirth?"

# **Understanding These Stories**

Through this study we learned of two overarching themes, both filled with anger: (1) People were unhappy with regard to many of the administrative aspects of the ACA (Themes 1–3 above), and (2) people identified "others" as undeserving of health insurance through the ACA (Theme 4).

# Unpacking anger

The administrative aspects of the ACA. As to the administrative aspects of the

Table 2

# Common Themes From 116 Conversations About Individuals' Opinions on the Affordable Care Act, April–July 2016

Category	Themes
Increased costs	<ol> <li>Rates have increased since the advent of the ACA, and coverage has decreased.</li> <li>Deductibles are too high.</li> </ol>
	Fear of potential costs.
	Financial.
	Emotional.
	Psychological.
	4. Result: I'm not going to use my insurance.
Concerns about the role of government	Government shouldn't tell people what to do/people shouldn't be told what to do.
	What doctor they can (or can't) see.
	That they have to have insurance.
	<ul> <li>Shouldn't get penalized for not having insurance.</li> </ul>
	2. Government should provide social assistance for some things, but only the "right" things.
	Assistance tied to personal ethos:
	<ul> <li>How you were raised by your family.</li> </ul>
	<ul> <li>Your personal moral fiber.</li> </ul>
	No discussion of the "other."
	<ul> <li>Discussion was centered on the role of government and how funds should be allocated.</li> </ul>
Who is responsible?	1. Insurance companies are greedy.
	• Insurance companies are partly to blame for the increased costs.
	<ul> <li>Insurance companies are taking advantage of the requirement that everyone is required to have health care.</li> </ul>
	2. Politicians (in general) have created too many regulations.
	3. Opposition is along partisan lines.
	• Explicit mentioning of either party opposed to the other.
	Explicit anti-Obama sentiment.
	<ul> <li>Reference to large geographical areas of the country as having "negative responses" (alluding to "Republican territory").</li> </ul>
	Republicans are opposed to anything from the Democratic party.
Lack of generosity (i.e., concern for fellow citizens)	1. Government should pay but only for the "right things."
	2. Why do I have to pay for others?
	3. Why should I have to pay for something I don't believe in?

Abbreviations: ACA indicates Affordable Care Act.

ACA, much of the expressed unhappiness was related to (1) the individual mandate, (2) an increased cost of health insurance, and (3) government and insurance company control of the ACA.

The first two of these unpopular features of the ACA are closely linked. The individual mandate was required in order to make sure that all Americans, including those with preexisting conditions, would have access to health insurance. For the first time in the United States, the ACA prevented insurance companies from refusing to insure or

charging increased premiums for patients with "preexisting conditions." Health insurance providers were obligated to offer policies within a given territory at the same price to all persons regardless of their health status or history of illness.

Undoubtedly, patients with preexisting conditions are very likely to have increased health care expenditures. These increased health care costs can be covered in part only if healthier people are required to have insurance—hence, the individual mandate. Under the ACA, this requirement that all Americans

must have health insurance added many young, healthy patients to the insured population.

Unfortunately, if under this mandate the addition of young healthier patients did not offset the increased expenses of those with preexisting conditions in a given insured population, some insurers would accrue a deficit. Many responded by increasing premiums, increasing deductibles, or discontinuing offering insurance altogether.

Conversations also demonstrated that many people harbored a generalized anger at "the government." Many believed that all health care is controlled by the ACA. This is incorrect, as the majority of U.S. health care is covered by employmentbased private insurance (55.4%). Although Medicare (16% of U.S. health care) and Medicaid (19.5%) are government run, they are not part of the ACA.15,16 ACA insurance purchased via the marketplace was intended for those who did not qualify for the previous three entities—about 10.4% or 33 million people in 2014.16 Many others said that government simply should not be involved in health care. This is surprising given that Medicare, which is mandatory health insurance controlled by the federal government, is highly rated by the public.17

**Disregard for "others."** The lack of empathy for "others" and an unwillingness to help fellow citizens was a surprising finding, especially in that the bicycling authors—complete strangers in their own right during the trip—were frequently approached by people with offers of roadside assistance and invitations for meals or lodging. Many conversations were filled with deep vitriol and a profound unkindness directed at those perceived to be lazy, stupid, or financially irresponsible. Comments like, "Why should I have to pay for those people?" typified such judgments. These expressions were often accompanied by the comment, "Obamacare encourages people to take advantage of the system," and were coupled with complaints of having to pay increased premiums.

Common to many conversations was that the ACA wasted government assistance on "others." Poor people and people who make life decisions that adversely affect their health were commonly identified in this context.

## Understanding blame

Although our study was designed to listen to people's opinions rather than explore in depth their underlying reasoning, these conversations provided us with the opportunity to link articulations of anger with overtly expressed explanations. We heard over and over that health care is complicated, premiums and deductibles have risen, and networks have narrowed. When faced with these often costly and inconvenient consequences, particularly during an economic downturn, and fed by misinformation that is amplified by a partisan political process, the blaming of President Obama, "big" government, "greedy" insurance companies, and "others" became acceptable coping strategies.

These sentiments are quite different from those expressed in countries that offer publicly supported universal health care coverage. As stated by Health Minister Ulla Schmidt, German health care is based on the concept of "social solidarity.... Everyone in Germany should have guaranteed access to state-ofthe-art medical care and contribute to the financing of this guarantee on the basis of the household's ability to pay."18 The core principles of the National Health Service, which has provided universal health care to the United Kingdom since 1948, are that it (1) must meet the needs of everyone; (2) must be free at the point of entry; and (3) must be based on clinical need, not one's ability to pay.19

Albeit at times misinformed, our informants' voices were loud and clear, and they conveyed a strikingly similar negative sentiment across the geographic breadth of the United States: The ACA is seriously flawed. Rather than having any concrete ideas as to how to fix it, however, many informants resorted to blaming others: those who created the ACA and those who benefit from its implementation. This blaming was accompanied by a palpable anger. Although certainly a real and deeply felt emotion, in relation to beneficiaries, it represented a particularly unfortunate and disturbing theme of exclusion: "Others" were not worthy of health insurance.

#### Limitations

This work suffers from four limitations. First, our quotations may have been

richer had interviews been audio recorded, and such recordings might have helped us illuminate themes more fully. Second, we were not able to conduct follow-up interviews, which would have helped us clarify aspects of informants' comments and explore their significance in more depth. Third, although qualitative descriptive methodology supports investigation of surface aspects of human reasoning around specific questions,4 it does not allow for the kind of inquiry into individual understandings and group cultures that more thorough ethnographic studies offer. Fourth, as with any study involving in-person interviews, our work is limited by potential researcher bias. In our study, the researchers conducted the interviews, analyzed the responses, and determined representative themes. It is possible that a bias held by any researcher prior to the study could impact any stage of the research process. We attempted to minimize the possibility of researcher bias in a variety of ways, such as having multiple interviewers both conduct and review the interviews, but it was not possible to completely eliminate the possibility of researcher bias.

### **Conclusions and Reflections**

As academics in medicine (P.R.G., E.C.S., J.E.D.) and health economics and health policy (A.H.), we were most surprised at the bitterness and anger directed at the government and others. This needs to inform our teaching. We need to let our learners anticipate and prepare for this and be attentive to patients' thoughts, experiences, and emotions. We must help our students learn how to engage their patients in conversations about health policy. Although the short patient encounter cannot provide adequate time for a thorough education on health policy, encouraging our students to listen to patients' concerns will allow them to make more informed recommendations to their patients.

From a student's perspective (L.G.), it is in our third and fourth years that we have the most time with patients, which extends vastly beyond the time that our residents or attendings can spend with patients. We cannot use this time to offer our patients medical counsel, as we are unqualified to do so. However, if we are politically informed and aware of health care insurance systems, we

can answer some of the most important questions our patients ask. The profound desire for answers about the ACA and frustration at lack of information were universal during our bike tour. Given the opportunities they have to interact with patients, medical students have an obligation to be politically informed, and their institutions should be held equally accountable to this task. Our patients seek, and deserve, answers that extend beyond their symptoms. We must be able to answer questions about the system in which we play a role.

The themes that emerged from our interviews have reinforced the importance of covering the ACA in the curriculum as apolitically as possible. Realizing that many students may be arriving in the classroom with their own biases and misconceptions has been particularly illuminating to us. In response to this we must devote more attention to a thoughtful discussion of the ACA with the intention of enabling students to form an opinion of the law based on facts.

We were not surprised by what we heard. Our interviews confirmed that there is significant dissatisfaction with the ACA and increased our understanding of this unhappiness: While superficially related to money (and access), it was supported by profound anger at the federal government, insurance companies, politicians, President Obama, and people who were deemed unworthy of insurance. This broad discontent suggests it is unlikely that minor changes in the ACA will be sufficient to change people's views.

Two reasons for the Republican victories in the 2016 election were dissatisfaction and anger with the ACA and with the federal government. One of the promises of the Republican campaign was to repeal and replace the ACA. Now that the GOP controls the executive and legislative branches of government, it remains unclear how they will address this promise. The American Health Care Act has so far not received the support it would need to be passed by Congress, in part because it is projected to cause up to 24 million people to lose their insurance coverage over a 10-year period.<sup>20</sup> After all, 20 million additional people have obtained insurance since 2014, and certain aspects of the ACA are very popular with U.S. voters. Unfortunately, our interviews demonstrated that many people do

not understand the complexity of the legislation or the necessity of maintaining the unpopular parts (individual mandate) to fund the more popular parts.

Whether or not it is repealed or changed, the question remains: Will profound structural changes to the ACA allow it to be acceptable to a majority of people while also accomplishing its stated aim: providing insurance for all Americans at an affordable price? Can we learn from other high-income countries that have single-payer insurance plans, with improved health outcomes at lower proportional costs? Some have recommended adding a public option to the ACA, others have suggested moving to a publicly supported national health insurance, and still others promote scrapping the ACA altogether and returning to a pre-2010 status quo.  $^{21-23}$ 

The ACA will change. Review and revision seems far more likely than repeal. Whether it is repealed or revised, the ACA, like Medicare, is very complex legislation. Just as with Medicare, the ACA will require constant review with revisions where indicated. We see the future as an ongoing battle between the voters' wishes for improved coverage and the challenge of funding them.

However, we seriously doubt that moving backward in time will, in any way, rectify problems of cost and access to health care. Yet, whatever other changes we might imagine occurring, it is clear from our study that people's anger will need to be acknowledged. Many Americans feel left behind as the ACA has taken effect, and they are quick to lay blame at others' doorsteps without knowing how to improve a complicated and complex problem. The challenge of recognizing, understanding, and addressing such anger will be an important consideration to deal with whatever direction the future of U.S. health care and its provision take.

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