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Aaron Spaulding

University of North Florida, aaron.spaulding@unf.edu

Hanadi Hamadi

University of North Florida, h.hamadi@unf.edu

D Rob Haley

University of North Florida, rhaley@unf.edu

Mei Zhao

University of North Florida, mzhao@unf.edu

Clark (Moody) McCall

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Perceptions of the Changing Healthcare Environment: A Florida Perspective

Aaron Spaulding, PhD, MHA, Hanadi Hamadi, PhD, D. Rob Haley, PhD
Mei Zhao, PhD, Clark (Moody) McCall, MHA

ABSTRACT

This study reviewed public perceptions of healthcare, including the public's opinions of healthcare reform. The study's objective was to examine how opinions are affected by individual differences such as age, income, race, and current insurance. It used telephone survey responses from the citizens of Florida to provide a more empirical look at the views of the population. Overall, the study findings provided important insight into the perceptions of Floridians of important components of the Patient Protection and Affordable Care Act (ACA) including cost, affordability, Medicaid expansion, and universal access to care. The results of this study indicate that whereas income, type of insurance held, race, education, and age have some impact on response to the statements posed, party affiliation is the best indicator of individuals' perceptions of the policies. In addition, results suggest that policymakers should consider more effective and targeted ACA educational campaigns for those populations that are older, more educated, and with higher incomes. They also should consider identifying and implementing opportunities to expand the Medicaid program because there is such broad support for its expansion.

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BACKGROUND

Advocating that health is a right and not a privilege, The Patient Protection and Affordable Act (ACA) of 2010 was passed and enacted on March 23, 2010. Its intent was to improve healthcare quality, lower costs, and improve access to services. However, whereas most Americans agree that changes to our healthcare system are needed, the mechanisms for promoting that change are still hotly debated. In short, we seem to be caught between two altering views of responsibility: Actuarial Fairness, and Solidarity.

Actuarial fairness is based on the idea that members of society should be responsible for their own needs (Landes, 2015). Individuals are acutely responsible for the risks that are incorporated and experienced in their daily lives, and if some evil does occur, the individual assumes responsibility and should have been more cognizant of the ramifications of their day-to-day decisions (Dubois, 2007; Nichols, 2000). For instance, if individuals involve themselves in risky behaviors, it is not up to anyone else to cover the costs associated with those activities, nor is it up to those person to bear the cost for someone else's activities.

However, knowing that adverse events do occur, and that innocent individuals are often the recipients of unjust injury promotes the view of the solidarity

principle. The solidarity principle pulls the focus from the individual and aligns it with the needs of the community in which benefit is measured by maintaining the vitality of all (Nichols, 2000). In other words, all should pay the same amount for health insurance regardless of the actual need (Glazer & McGuire, 2011).

Obviously, there are great disparities in political opinions within the government on the future of American healthcare. As a major political swing state, Florida contains a population that provides an overview of the ideas and opinions that are held in both northern and southern states (Strömberg, 2008; Beachler, 2011). Therefore, the purpose of this study is to explore perceptions of healthcare in Florida, including opinions of healthcare reform and how those opinions are affected by individual differences such as age, income, race, and current insurance held.

Healthcare reform was a central focus of debate for both the 2008 and 2012 presidential elections (Blendon, Altman, Benson, Brodie, Buhr, Deane, & Buscho, 2008; Jones 2012). Despite victories in both, President Obama found his proposals met with additional debate and political resistance. During his first term in office, the ACA narrowly passed the

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House of Representatives and the Senate with little to no bipartisan support (Oberlander, 2010). The individual mandate provision, on which the ACA draws its power to require all individuals within the United States to carry health insurance, also has been challenged in the Supreme Court (Balkin, 2010). Furthermore, challenges to the law have continued into Obama's second term as political gridlock over healthcare and budgetary expenses resulted in an overall shutdown of the government. Out of the 50 states and District of Columbia, 15, including Florida, have rejected Medicaid expansion. However, Governor Rick Scott's (R-FL) statement on February 20, 2013, "I cannot in good conscience deny Floridians access to healthcare," illustrates the difficulties policymakers faced in deciding whether to accept federal aid to expand Medicaid under the ACA of 2010 (Barrilleaux & Rainey, 2014; Jost 2014).

Previous research has sought to measure the population's knowledge and understanding of the ACA. Much of it focused on political affiliation and an individual's sources of information regarding the ACA. Regional variations in public opinion of the ACA were examined via data collected from polls conducted by the Kaiser Family Foundation in February and March 2011. Results showed that 42% of the people in the United States found the ACA to be favorable, whereas 47% found it unfavorable. The New England, Pacific, and East-North Central areas all found the ACA more favorable than unfavorable, whereas the Mountain, Middle Atlantic, West-South Central, West-North Central, South Atlantic, and East-South Central areas found it more unfavorable. The researchers attributed the favorability differences among regions to the political cast of the residents in that region (Brodie, Deane, & Cho, 2011).

Over 70% of Americans favored healthcare reform in February 2009 when President Obama was inaugurated; but, by August 2009, support for reform fell to 45% (Jacobs & Mettler, 2011). Shifts of this sort are often attributed to "framing," where precise words, phrases, and images of speech are used to affect individuals' perceptions in particular situations (Jacobs & Mettler, 2011). Terms like "government takeover of healthcare" and "death panels" are used not to sway opinions, but to prime beliefs about big government and trigger partisan affiliations (Lenz, 2009; Tesler, 2014). However, it is believed that over time more and more Americans will improve their understanding of the ACA. With additional understanding and experiences with the law, it is likely that opinions and feelings toward the ACA will change.

Similar to framing, there is some belief that party affiliation has a large impact on public perception of

healthcare reform. Through a panel study by the Associated Press between 2008 and 2010, Henderson and Hillygus (2011) found that opinions of both Republicans and Democrats had moved in slightly negative directions. Data showed that more Republicans than Democrats who favored the law in 2008 were more likely to oppose it in 2010. Whereas only 52% of Republicans held their party's position in 2008, this number jumped to almost 75% in 2010 (Henderson & Hillygus, 2011). These movements within each party as well as disagreements relating to funding mechanisms, expansions of existing programs, and greater powers exercised by the President have led to greater party polarization (Thompson, 2013; McDonough 2012). However, there is no agreement on whether party polarization has influenced the mass electorate's opinion on issues related to health insurance and reform.

For instance, Lenz (2009) found that individuals tend to utilize the positions that the party they associate with use. However, Henderson and Hillygus's study (2011) found that on an individual level, people's opinions were affected more by fundamental considerations and not just political affiliation. Furthermore, one study on priming found that individuals' long held beliefs are likely to remain consistent despite political communications (Tesler, 2014). As such, we do not have a richer understanding of the results that the polarization of the political parties have had on the public's perception on issues related to health reform (McDonough, 2012).

What seems obvious is that individuals are predisposed to certain views regarding fairness as the healthcare system changes. This study seeks to determine if there are any actual differences related to perceived fairness or ideas relating to actuarial fairness or solidarity among persons residing in Florida.

METHODS

Adding to the current body of literature, this study seeks to determine how individuals view healthcare reform and their opinions relating to current and proposed legislation. To determine Florida's public opinion of the current healthcare environment, a telephone survey was conducted. This telephone survey used random-digit-dialing and included land-line and cell phone samples (Gundersen, ZuWallack, Dayton, Echeverría, & Delnevo, 2014). The state was pre-weighted into seven strata to ensure geographic diversity, and conducted in English and Spanish, based on the respondent's preference. The survey was conducted between September 30, 2013 and October 8, 2013.

Dependent Variables

The four dependent variables used for this study were: (1) “I would be willing to have fewer healthcare options if the costs were lower;” (2) “I feel that the Affordable Care Act (Obamacare) will improve my access to care;” (3) “I feel that the State of Florida should expand the Medicaid program to cover more Floridians;” and (4) “I would pay more for healthcare so that everyone may have access to care in the State of Florida.” Each survey response was coded as either agreeing (0) or disagreeing (1) with the statement or statement provided. All missing responses were dropped; however, each dependent variable was analyzed separately, allowing variability in the responding populations.

Independent Variables

The independent variables for this study included seven categorical variables: age, education, race, insurance, income, gender, and party affiliation. The age variable was divided into four categories: 18-24, 25-44, 45-64, and 65 and older. The education variable was divided into four categories of highest education obtained: High School Graduate, Some College Experience (No Degree), College Graduate, and Post-graduate Degree. The race category was divided into more specific races; however, there were not enough members of each race to support good statistical practices; therefore, they were collapsed into the following binary categories: Caucasian and non-Caucasian.

The insurance category specifies which type of insurance the responder possessed and was divided into four categories: (1) private insurance through an employer; (2) private insurance that they purchased themselves; (3) Medicaid or Medicare; and (4) no insurance. Originally, there was also a category for individuals who were not sure if they had insurance or not; however, those responders were too few to study properly, and thus, were dropped from the study. We also collapsed the Medicaid and Medicare categories as there were not enough within the sample to provide analysis while keeping them separate.

Next, the income category was based on household income and divided into five categories: (1) less than \$23,000; (2) between \$23,000 and \$35,000; (3) between \$35,000 and \$65,000; (4) between \$65,000 and \$95,000; and (5) above \$95,000. The gender variable was divided into males and females. Finally, the party affiliation variable was divided into three categories (1) Democrat; (2) Republican; and (3) No Party or Other. The third category was originally separated into No Party or Other as distinct categories;

however, there were not enough responders within each to maintain them separately.

Data Analysis

To analyze the responses to each of the dependent variables, we used logistic regression (Long & Freese, 2006). Each independent variable was treated as binary with a standard referent (Long & Freese, 2006). STATA 12 was used to run all analyses, and models were estimated through maximum likelihood and rate ratios with 95% confidence intervals reported. Variables that did not have p-values below 0.25 in unadjusted models were excluded from the final model (Mickey & Greenland, 1989).

RESULTS

We used descriptive statistics demonstrating the percent agreement of each demographic variable to provide an understanding of the survey population and its healthcare opinions (Table 1). These statistics indicate that overall there is a mix of opinion regarding each topic. The dependent variable asking: “I would be willing to have fewer healthcare options if the costs were lower” received majority agreement from those aged 18-24. Sixty-five and older were split, whereas both other age groups indicated disagreement. Those with a high school education or those that graduated college agreed with the statement, whereas those with some college or post-graduate education disagreed. Non-Caucasians were split in their agreement; a small majority of Caucasians disagreed, and males were more likely to agree than females. All insurance categories other than private insurance provided by an employer were split to slightly more likely to agree with the statement. Finally, those making less than \$23,000 as well as those making between \$35,000 and \$65,000 were more likely to agree than those in the other income categories.

The dependent variables stating: “I feel that the Affordable Care Act (Obamacare) will improve my access to care” and “I would pay more for healthcare so that everyone may have access to care in the State of Florida” received more negative responses than positive in almost all categories. The groups that indicated positive response to each statement were those of age 18-24, non-Caucasians, those with no insurance, those making less than \$23,000, and individuals who identified as Democrats. College graduates and individuals on Medicare/Medicaid also were more likely to indicate that they would pay more for everyone to have access to care.

The dependent variable: “I feel that the state of Florida should expand the Medicaid program to cover more Floridians” had much more agreement than any

of the other dependent variables. There were only two groups that had a greater number of responders disagree” – those who made above \$95,000, and identified with a Republican party affiliation.

The initial logistic model indicates that several variables are influential across the different statements (Table 2). These variables include non-Caucasians vs. Caucasians, Republicans vs. No Party/Other Affiliation, and to a lesser degree, income level of greater than \$95,000 vs. income of \$23,000 or less. All model fit statistics were significant except for “I would be willing to have fewer healthcare options if the costs were lower.”

To improve fit statistics and determine how influential certain variables truly are, we used backward stepwise regression. The final models are present in Table 3, and all models improved fit statistics (Table 3).

The variables which remained for the statement: “I would be willing to have fewer healthcare options if the costs were lower” include: income and party affiliation. However, only the income variable demonstrated significant difference among responders. Specifically, respondents who make \$65,000 to \$95,000 or \$95,000 and above are approximately twice as likely to disagree with this statement than persons making less than \$23,000.

Most variables remained in the final model for “I feel that the Affordable Care Act (Obamacare) will improve my access to care.” The variables that significantly distinguished responders include: age, education, race, income, and party affiliation. Responders who are 65 and older were approximately four times more likely to respond negatively to the statement than those who were 18-24. College graduates were 0.4 times as likely (therefore, less likely) to respond negatively as high school graduates; however, those with a post-graduate degree are not included in the final model. Non-Caucasians were 0.3 times as likely (much less likely) to respond negatively than Caucasians. Responders who make \$95,000 or more were three times more likely to disagree with the statement than those who make less than \$23,000. Finally, responders who identified as Republican were 14 times more likely to disagree than Democrats, and individuals with No Party/Other affiliation were four times more likely to disagree.

Income is no longer an influential variable for responses to: “I feel that the State of Florida should expand the Medicaid program to cover more Floridians.” Responders who have Medicaid/Medicare or no insurance were 0.5 and 0.3 times less likely to disagree than those with private insurance through and employer. In addition, those who indicated they were

Republican were five times more likely to disagree with the statement than those identifying as Democrats, whereas those with No Party/Other affiliation were two times more likely to disagree with the statement.

Finally, race, party, and insurance are important variables for responses to the statement: “I would pay more for healthcare so that everyone may have access to care in the State of Florida.” Non-Caucasian responders were 0.5 times less likely to disagree as responders who are Caucasian. Those who have either Medicaid/Medicare or no insurance were 0.5 or 0.4 times less likely respectively to respond negatively compared to responders who have private insurance through their employer. Finally, Republicans were approximately five times more likely, and those who identified with No Party/Other were two times more likely, to disagree with the statement than Democrats.

DISCUSSION

The current political environment promotes many theories on how the American population views healthcare reform. However, many of these views are anecdotal. This study uses responses from citizens of the State of Florida to provide a more empirical look at the views of the population. Overall, this study provides important insight into the perceptions of Floridians in terms of important components of the ACA, including cost, affordability, Medicaid expansion, and universal access to care. Although the traditional American ideology of individual freedom and responsibility seems to embrace the idea of actuarial fairness, the United States is currently wrestling with what is best for the community as a whole. The results support this assertion as we find differences in opinion among income levels, types of insurance the responders hold, race, education, age, and party affiliation.

It appears party affiliation defines the perspectives most Floridians pursue in relation to healthcare reform and change. Whereas party affiliation by itself is not concerning, the fact that party affiliation is significant without additional significance involving other variables indicates that individuals may not be considering how changes in healthcare affect their own lives. Individuals may be allowing their party affiliation to determine their perceptions of the policy, when in fact the policies may indeed provide them with benefits they otherwise would not have. For instance, we would expect that those with no insurance would be less likely to disagree with the statement that the Affordable Care Act (Obamacare) would improve their access to care. Because we do not see results indicating significant differences in perceptions

Table 1. Descriptive Statistics

	I would be willing to have fewer healthcare options if the costs were lower?		I feel that the Affordable Care Act (Obamacare) will improve my access to care.		I feel that the state of Florida should expand the Medicaid program to cover more Floridians.		I would pay more for healthcare so that everyone may have access to care in the State of Florida.	
	% Agreement	Pop (373)	% Agreement	Pop (361)	% Agreement	Pop (362)	% Agreement	Pop (375)
Age								
18-24	57.50%	40	60%	40	70%	40	55%	42
25-44	44.71%	85	38.37%	86	59.76%	82	46.59%	88
45-64	47.92%	144	35.56%	135	56.93%	137	43.26%	141
65 and older	50.00%	104	28%	100	57.28%	103	44.23%	104
Education								
High School	52.88%	63	42.62%	61	72.58%	62	45%	60
Some College	48.23%	141	34.85%	132	59.70%	134	42.96%	142
College Graduate	51.85%	108	41.12%	107	55.24%	105	51.79%	112
Post Graduate	40.98%	61	27.87%	61	50.82%	61	40.98%	61
Race								
Caucasian	48.63%	292	27.60%	279	52.33%	279	40%	290
Non-Caucasian	50.00%	80	68.29%	82	81.93%	83	64.29%	84
Insurance								
Private Insurance (Employer)	44.79%	163	33.33%	156	50.66%	152	40.24%	164
Private Insurance (Self-Purchase)	50.79%	63	29.23%	65	55.56%	63	38.71%	62
Medicaid/Medicare	50.47%	107	38.61%	101	65.09%	106	50.93%	108
None	57.50%	40	58.97%	39	80.49%	41	63.41%	41
Income								
Less than \$23,000	62.50%	56	61.11%	54	70.91%	55	60.34%	58
\$23,000 - \$35,000	46.55%	58	42.59%	54	66.07%	56	44.64%	56
\$35,000 - \$65,000	54.74%	95	38.71%	93	60.82%	97	41.24%	97
\$65,000 - \$95,000	42.11%	76	30.67%	75	56.76%	74	45.45%	77
Above \$95,000	40.91%	88	21.18%	85	46.25%	80	41.38%	87
Gender								
Male	51.83%	191	32.97%	182	62.15%	177	45.74%	188
Female	45.86%	181	40.78%	179	56.22%	185	45.16%	186
Party								
Democrat	47%	117	68.22%	107	78.15%	119	65.22%	115
Republican	52.17%	138	12.32%	138	35.61%	132	27.66%	141
No Party/Other	43.56%	101	36.63%	101	59.14%	93	46%	100

Table 2. Initial Logistic Model

	I would be willing to have fewer healthcare options if the costs were lower?	I feel that the Affordable Care Act (Obamacare) will improve my access to care.	I feel that the state of Florida should expand the Medicaid program to cover more Floridians.	I would pay more for healthcare so that everyone may have access to care in the State of Florida.
	OR 95% CI	OR 95% CI	OR 95% CI	OR 95% CI
Age				
18-24			Reference	
25-44	1.822 (0.769, 4.316)	2.284 (0.767, 6.8)	1.302 (0.488, 3.47)	1.257 (0.506, 3.122)
45-64	1.532 (0.696, 3.374)	1.837 (0.671, 5.035)	1.188 (0.484, 2.915)	1.059 (0.457, 2.455)
65 and older	1.265 (0.465, 3.438)	3.184 (0.826, 12.269)	1.210 (0.383, 3.827)	1.071 (0.362, 3.174)
Education				
High School			Reference	
Some College	1.023 (0.531, 1.97)	0.860 (0.363, 2.041)	1.588 (0.743, 3.392)	0.872 (0.42, 1.809)
College Graduate	0.780 (0.384, 1.585)	0.361 (0.142, 0.917)	1.451 (0.647, 3.254)	0.507 (0.232, 1.108)
Post Graduate	1.178 (0.518, 2.678)	0.859 (0.285, 2.585)	2.204 (0.879, 5.527)	0.749 (0.305, 1.835)
Insurance				
Private Insurance (Employer)			Reference	
Private Insurance (Self-Purchase)	0.922 (0.47, 1.806)	1.451 (0.621, 3.387)	0.851 (0.415, 1.746)	1.048 (0.51, 2.151)
Medicaid/Medicare	1.134 (0.524, 2.454)	0.625 (0.214, 1.827)	0.473 (0.197, 1.137)	0.580 (0.25, 1.348)
None	0.923 (0.391, 2.182)	0.499 (0.172, 1.446)	0.325 (0.118, 0.892)	0.405 (0.162, 1.013)
Income				
Less than \$23,000			Reference	
\$23,000 - \$35,000	1.881 (0.834, 4.245)	1.625 (0.585, 4.511)	0.786 (0.306, 2.022)	1.684 (0.706, 4.021)
\$35,000 - \$65,000	1.408 (0.647, 3.064)	2.993 (1.098, 8.16)	0.871 (0.364, 2.084)	1.933 (0.85, 4.4)
\$65,000 - \$95,000	2.454 (1.048, 5.746)	2.819 (0.957, 8.305)	0.710 (0.275, 1.835)	1.297 (0.534, 3.148)
Above \$95,000	2.660 (1.113, 6.36)	4.343 (1.399, 13.488)	1.021 (0.39, 2.672)	1.491 (0.601, 3.701)
Caucasian				
Caucasian			Reference	
Non-Caucasian	0.856 (0.476, 1.538)	0.272 (0.132, 0.558)	0.336 (0.166, 0.681)	0.500 (0.268, 0.931)
Gender				
Male			Reference	
Female	1.245 (0.795, 1.95)	0.883 (0.488, 1.599)	1.374 (0.831, 2.272)	1.091 (0.675, 1.763)
Party				
Democrat			Reference	
Republican	0.698 (0.405, 1.202)	13.826 (6.561, 29.136)	4.932 (2.677, 9.088)	4.626 (2.571, 8.324)
No Party/Other	1.054 (0.588, 1.89)	3.745 (1.886, 7.435)	2.075 (1.071, 4.019)	1.942 (1.06, 3.555)
Model Fit Statistics				
LR Chi2	17.67	137.47***	74.05***	59.68***
Pseudo R2	0.0367	0.311	0.1604	0.1244

*p < .10, **p < .05, ***p < .01

Table 3. Final Adjusted Logic Model

	I would be willing to have fewer healthcare options if the costs were lower?		I feel that the Affordable Care Act (Obamacare) will improve my access to care.		I feel that the state of Florida should expand the Medicaid program to cover more Floridians.		I would pay more for healthcare so that everyone may have access to care in the State of Florida.	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Age								
18-24				Reference				
25-44			2.245	(0.779, 6.47)				
45-64			1.957	(0.734, 5.214)				
65 and older			3.993	(1.109, 14.371)				
Education								
High School				Reference				
Some College								
College Graduate			0.398	(0.209, 0.758)			0.602	(0.363, 1)
Post Graduate					1.598	(0.835, 3.057)		
Insurance								
Private Insurance (Employer)				Reference				
Private Insurance (Self-Purchase)								
Medicaid/Medicare			0.444	(0.173, 1.143)	0.493	(0.285, 0.852)	0.513	(0.304, 0.865)
None			0.429	(0.161, 1.146)	0.327	(0.133, 0.806)	0.370	(0.164, 0.833)
Income								
Less than \$23,000				Reference				
\$23,000 - \$35,000								
\$35,000 - \$65,000			2.118	(0.995, 4.51)			1.429	(0.834, 2.45)
\$65,000 - \$95,000	1.781	(1.028, 3.086)	1.990	(0.877, 4.512)				
Above \$95,000	1.890	(1.111, 3.216)	2.931	(1.245, 6.903)				
Caucasian								
Caucasian				Reference				
Non-Caucasian			0.272	(0.135, 0.548)			0.501	(0.28, 0.894)
Gender								
Male				Reference				
Female					1.419	(0.872, 2.31)		
Party								
Democrat				Reference				
Republican	0.713	(0.459, 1.108)	13.738	(6.573, 28.712)	4.985	(2.743, 9.062)	4.646	(2.618, 8.246)
No Party/Other			3.898	(1.987, 7.647)	2.070	(1.091, 3.927)	2.004	(1.122, 3.581)
Model Fit Statistics								
LR Chi2	9.2**		135.32***		70.76***		57.37***	
Pseudo R2	0.019		0.3061		0.1532		0.1195	

*p < .10, **p < .05, ***p < .01

between this group and those with private insurance (a group we would believe would disagree with the Act improving their access to care) we are led to believe that this group either does not need access, does not understand the policy, or that the results are explained by some other variable. In this case, it is likely that party affiliation better describes the opinions shared.

Implications for Public Health Practice

Public health practitioners should consider that the ACA was targeted to expand healthcare to those who were more likely to be uninsured or underinsured. The perception of the ACA lowering costs and improving access was more positive for those who are younger, non-Caucasian, and who lack a college education. It is likely that education about the benefits of the ACA targeted these vulnerable populations more effectively than those more likely to be insured. Therefore, additional educational efforts should be considered with a direct focus on developing more effective and more targeted ACA campaigns for those populations who are older, more educated, and with higher incomes.

In addition, this research identified that most Floridians are supportive of expanding Medicaid. But Florida's Medicaid program is undergoing a transition toward managed care to control costs and improve quality. It is difficult to expand a program while it is experiencing such a transformation. However, Florida's policymakers should consider identifying and implementing opportunities to expand the Medicaid program because there is such broad support for its expansion.

Limitations

Whereas this research provides important insight into Floridians' perceptions of the ACA, it is not necessarily generalizable to populations in other states. Furthermore, some populations in the state may be under-sampled because the survey was conducted only in English and Spanish. Finally, we cannot discount the effect the statement set may have had on individual responses. These survey statements were asked as part of a larger survey, which covered a number of topics that affect Florida residents.

Conclusion

Because Florida continues to see a greater migration rate than many other states, the results do provide an interesting view of the ACA and a more robust assessment of how different individuals view it than what might be available when looking at other state populations. On the one hand, it would seem that society does not want to be responsible for an individual's unhealthy habits – habits where

consequences are most certainly assured; but, discussions and examples describing the limitations for an individual to know what unexpected or hidden consequences might occur have promoted new policy and greater debate. The results of this study provide us with a clearer picture of the populations that agree or disagree with the recent political policies and healthcare changes the State and Federal governments have enacted. As such, we gain a better understanding as to how these and future policy and healthcare changes may be perceived, accepted, and challenged.

REFERENCES

- Balkin, J.M. (2010). The constitutionality of the individual mandate for health insurance. *New England Journal of Medicine*, 362(6), 482-483.
- Barrilleaux, C., & Rainey, C. (2014). The politics of need: Examining governors' decisions to oppose the "Obamacare" Medicaid expansion. *State Politics & Policy Quarterly*, 14(4), 437-460.
- Beachler, D.W. (2011). Barack Obama and the South: Demography as electoral opportunity. *Patterns of Prejudice* 45(1/2), 155-175.
- Blendon, R.J., Altman, D.E., Benson, J.M., Brodie, M., Buhr, T., Deane, C., & Buscho, S. (2008). Voters and health reform in the 2008 presidential election. *New England Journal of Medicine*, 359(19), 2050-2061.
- Brodie, M., Deane, C., & Cho, S. (2011). Regional variations in public opinion on the Affordable Care Act. *Journal of Health Politics, Policy and Law*, 36(6), 1097-1103.
- Dubois, M. (2007). The individual or the institution? Ethics and behavioural responses to social insurance. *Journal of Applied Philosophy*, 24(3), 316-328.
- Glazer, J., & McGuire, T.G. (2011). Gold and silver health plans: Accommodating demand heterogeneity in managed competition. *Journal of Health Economics*, 30(5), 1011-1019.
- Gundersen, D.A., ZuWallack, R.S., Dayton, J., Echeverría, S.E., & Delnevo, C.D. (2014). Assessing the feasibility and sample quality of a national random-digit dialing cellular phone survey of young adults. *American Journal of Epidemiology*, 179 (1), 39-47.
- Henderson, M., & Hillygus, D.S. (2011). The dynamics of health care opinion, 2008-2010: Partisanship, self-interest, and racial resentment. *Journal of Health Politics, Policy and Law*, 36(6), 945-960.
- Jacobs, L., & Mettler, S. (2011). Why public opinion changes: The implications for health and health policy. *Journal of Health Politics, Policy and Law*, 36(6), 917-933.

Jones, D.K. (2012). The fate of health care reform — what to expect in 2012. *New England Journal of Medicine*, 366(4), e7.

Jost, T.S. (2014). Implementing health reform: Four years later. *Health Affairs*, 33(1), 7-10.

Landes, X. (2015). How fair is actuarial fairness? *Journal of Business Ethics*, 128(3), 519-533.

Lenz, G.S. (2009). Learning and opinion change, not priming: Reconsidering the priming hypothesis. *American Journal of Political Science*, 53(4), 821-837.

Long, J.S., & Freese, J. (2006). *Regression models for categorical dependent variables using Stata*. College Station, TX: StataCorp LP.

McDonough, J.E. (2012). The road ahead for the Affordable Care Act. *New England Journal of Medicine*, 367(3), 199-201.

Mickey, R.M., & Greenland, S. (1989). The impact of confounder selection criteria on effect estimation. *American Journal of Epidemiology*, 129(1), 125-137.

Nichols, L.M. (2000). State regulation. What have we learned so far? *Journal of Health Politics, Policy & Law*, 25(1), 175-196.

Oberlander, J. (2010). Long time coming: Why health reform finally passed. *Health Affairs*, 29(6), 1112-1116.

Strömberg, D. (2008). How the electoral college influences campaigns and policy: The probability of being Florida. *American Economic Review*, 98(3), 769-807.

Tesler, M. (2014). Priming predispositions and changing policy positions: An account of when mass opinion is primed or changed. *American Journal of Political Science*. doi: 10.1111/ajps.12157.

Thompson, F.J. (2013). Health reform, polarization, and public administration. *Public Administration Review*, 73(s1), S3-S12.

United States Census Bureau. (2015). State and County QuickFacts. Retrieved July 16, 2015 from <http://quickfacts.census.gov/qfd/states/12000.html>.

Aaron Spaulding (corresponding author) (aaron.spaulding@unf.edu) is Assistant Professor, Department of Public Health, Brooks College of Health, University of North Florida, Jacksonville, FL. **Hanadi Y. Hamadi** (n00968253@unf.edu) is Assistant Professor, Department of Public Health, Brooks College of Health, University of North Florida, Jacksonville, FL. **D. Rob Haley** (rhaley@unf.edu) is Associate Professor, Department of Public Health, Brooks College of Health, University of North Florida, Jacksonville, FL. **Mei Zhao** (mzhao@unf.edu) is Professor, Department of Public Health, Brooks College of Health, University of North Florida, Jacksonville, FL. **Clark (Moody) McCall** (n00602563@unf.edu) is an anesthesia intern at University of Florida Health, Jacksonville, FL. Copyright 2015 by the *Florida Public Health Review*.