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Rising Cost of Medicare and its Effect on Recipients 65 and Older

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Abstract

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MA, University of Phoenix, 2015

BS, University of Phoenix, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The rising cost of Medicare is a growing concern for recipients. Beneficiaries are often forced to implement a host of strategies to meet rising out-of-pocket expenses. This qualitative study was conducted to address a research gap in methods used by senior citizens to manage rising Medicare coverage costs. Garmezy's resilience theory was used to contextualize the rising costs of Medicare premiums and copays and strategies used to manage healthcare needs. The purposive sample of □2 socioeconomically diverse respondents included eight women and four men ranging in age between 65 and 77, for an average age of 70.2 years. Participants completed a semi structured interview that consisted of close-ended and open-ended questions that were thematically analyzed using the modified van Kaam method popularized by Moustakas. While most respondents reported being satisfied with their Medicare coverage, nearly half (4□7%) reported difficulty financing the rising costs of premiums and copays, and half used a strategy to meet those costs, including forgoing other bills, limiting care to free clinics, receiving free nutritional benefits, and simply avoiding clinical visits to meet rising costs. Nearly all (9□ 6%) felt that dental and eye care should be covered and that elders should not be forced to work after retirement to meet the portion of Medicare not currently covered by the government. This study confirmed the difficulty of meeting rising Medicare costs and may lead to positive social change by increasing awareness and informing policy makers about the need to reform Medicare cost-sharing policies to assure healthcare access for this highly vulnerable population.

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Dedication

This degree is dedicated to my two granddaughters, Taylor and Nyla. Grandma wants you to remember to never give up on your dreams and remember you can do all things through Christ that strengthens you. I would also like to dedicate this dissertation to my husband, Norris, for your endless support during this journey, and my children, Tyrikka, Roderick, and Garrett, for cheering me on. I wanted you all to see me finish.

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Jeremiah 29:11 For I know the plans I have for you," declares the LORD, "plans to prosper and not to harm you, plans to give you hope and a future." I would like to give God all the glory and honor for the completion of this study. Through Him this journey was possible, and I was often on autopilot as He ordered my steps. Thank you to my family and friends who encouraged me, supported me, and allowed me to miss out on attending numerous functions and gatherings because I had to complete my work. Guilford Watson, thank you for prophesying this status over my life almost immediately upon getting to know me. Alexandra Salter, you were an inspiration throughout this journey, thank you! Angela Thomas, thank you for your encouragement. Thank you to my sister Nakenya Baker-Lewis for not letting me give up towards the end. Angiloo Grecia, thank you for countless days and nights encouraging me to finish strong. My best friend for life, Arlice Larkin, you're amazing and saved my day; thank you for your expertise and support all the way to the finish line. Dr. Lisa Molina, I thank you for support, encouragement, reminder texts, and phone calls to make sure I completed this study.

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To God be the Glory!

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Chapter □: Introduction to the Study

Healthcare spending in the United States accounted for approximately □8% of economic spending or approximately $□8 trillion in 20□9; (Center for Medicare and Medicaid Services, 2020). Financing of healthcare in the United States far exceeds the per capita spending of every industrialized nation (Camillo, 20□6; Kesselheim et al., 20□6; Olson et al., 20□6; Papanicolas et al., 20□8). The enormous impact of healthcare spending on the national economy has caused it to be a leading policy concern. The system is comprised of a complex mix of stakeholders: the government, insurance and pharmaceutical industries, healthcare organizations, medical providers, and patients from a myriad of socioeconomic backgrounds (Camillo, 20□6; Chaufan, 20□5; Deal, 20□7; Kesselheim et al., 20□6; Kocher & Chigurupati, 20□6). The fragmented structure of the United States system has been cited as an important factor in high per capita costs that surpass single-payer systems characteristic of most industrialized countries (Chaufan, 20□5; Olson, et al., 20□6; Papanicolas et al., 20□8).

The Patient Protection and Affordable Care Act of 20□0, commonly referred to as the Affordable Care Act (ACA), was established to increase the proportion of citizens with health insurance and to reduce healthcare spending in the United States (Obama, 20□6). The success of the ACA was contingent upon compulsory enrollment of employers and employees in health insurance programs with the goal of providing healthcare coverage to all Americans (Manchikanti et al., 20□7; Obama, 20□6).

The strategies employed under the ACA to improve the healthcare system have centered on increasing private insurance enrollment, improving healthcare quality, and

reducing healthcare costs (Cohn, 20□4; Kocher & Chigurupati, 20□6; Orszag, 20□6). The ACA increased the percentage of people covered with health insurance to 9□5 % by 20□9 (Berchick et al., 20□9; Keisler-Starkey & Bunch, 2020). Although the ACA intended to reduce Medicare spending, out-of-pocket copayments have increased over time (Colla et al., 20□6; Cubanski, et al., 20□7; Cubanski et al., 20□8; Neuman et al., 20□5).

In 20□9, Centers for Medicare and Medicaid Services reported that there were 59.9 million Medicare beneficiaries in the United States. This figure suggests that approximately □5% of the U.S. population depends on the Medicare system for their healthcare (CMS, 2022). Medicare expenditures accounted for 20% of U.S. healthcare spending or approximately $799.4 billion in 20□9 and are projected to reach approximately $□7 trillion by 20□0 (Blumenthal et al., 20□5). As the population ages, Medicare enrollment will continue to increase, causing the projected rate of healthcare spending to rise exponentially over time (Colla et al., 20□6; Dielman et al., 20□6; Iyengar et al., 20□6; Neuman et al., 20□5).

The standard premium for Medicare Part B increased to $□44.60/month in 2020, up from $□□5.50/month in 20□9 (Govinfo.gov, n.d.). The Social Security cost of living adjustment was 5.9% for 202□, which increased the average retiree's total benefit by about $24 per month (SSA.gov, 202□). This paltry increase has the potential to greatly affect those dependent on fixed incomes. The Medicare program is closely linked to the larger problem of U.S. healthcare spending (Blumenthal et al., 20□5; Hartman et al., 20□8). Researchers have reported that many seniors with chronic medical conditions will

require ongoing medical attention supported by Medicare. However, many Medicare recipients are elderly, retired, and survive on a fixed income (Cubanski et al., 20□8; Deal, 20□7). According to the supplemental poverty measure, approximately 7 million seniors, age 65 and older, live below the poverty level threshold. The supplemental poverty measure takes into consideration variables including financial resources, liabilities, taxes, and out-of-pocket medical expenditures.

This qualitative phenomenological study was designed to explore and understand how Medicare recipients are affected by premium increases and how they manage their healthcare needs in a climate of rising healthcare costs. The results of the study add to the body of health policy literature and can assist policy makers in addressing the effects of out-of-pocket costs of seniors dependent on Medicare for healthcare. This study, therefore, carries significant social implications.

This chapter addresses the background of the study, problem statement, purpose statement, research questions, theoretical foundation, nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and summary.

Background of the Study

The Medicare health insurance program was implemented under the Social Security Act Amendment of □965 with a goal of providing healthcare coverage to seniors 65 and older and people with certain disabilities. The Act also established healthcare coverage for the poor under Medicaid (Bauchner, 20□5; National Archives, n.d.) The Medicare program is significant because it is the second largest federal program in the

country. Approximately □8% of the population relies on Medicare benefits for healthcare coverage (Bauchner, 20□5; Dean et al., 20□7).

Individuals enrolled in Medicare, can enroll in Medicare Part D for their prescription drug coverage. Medicare Part D is an outpatient drug benefit approved by the government and provided through private plans (KFF, 202□). This study sought to learn how Medicare recipients are affected by premium increases and how they manage their healthcare needs in a climate of rising healthcare costs. The financial implications linked to Medicare Part D are well-documented. Olson et al. (20□6) conducted a study to examine the efficiency of Medicare Part D in □998, 200□, and 20□5. The study showed that financial hardship from purchasing medications rose from □9% in □998 to □6% in 20□5 (Olson et al., 20□6). Seniors also reported high insurance premiums, cost sharing, and out-of-pocket copayments as the cause of financial difficulties (Olson et al., 20□6). Additional studies supported these findings and concluded that the cost of maintaining Medicare Part D may impact a patient's decision to forego necessary pharmaceutical treatment (Doshi et al., 20□6)

The ACA was made into law to provide affordable healthcare to U.S. citizens, improve the quality of U.S. healthcare, and reduce costs related to healthcare (Obama, 20□6). According to Orszag (20□6), the average spending for each Medicare beneficiary declined, and quality care delivery improved. However, Orszag's findings have been challenged by several researchers who have suggested that the ACA continues to fall short in making healthcare accessible and affordable to seniors (Butler, 20□6; Chaufan, 20□5; Manchikanti et al., 20□7; Wilensky, 20□7).

The ACA was instrumental in establishing Accountable Care Organizations (ACOs) to assist in carrying out ACA goals and objectives (McWilliams et al., 20□6). ACOs have implemented cost-containment strategies that financially incentivize healthcare providers with a reduction in patient visits and hospital stays (Burwell, 20□5). However, financial reward strategies have been found to have a measurable negative impact on quality of healthcare delivery (Kocher & Chigurupati, 20□6). The Medicare program is a major focus of ACOs because of its complexity and overall share of government healthcare expenditures (Colla et al., 20□6; Hartman et al., 20□8; McWilliams et al., 20□6).

Healthcare policy research is a broad topic. This review of the literature has revealed a gap in the research related to exploring how Medicare recipients manage their healthcare needs. Significant studies have highlighted the struggles that seniors encounter in addressing their healthcare concerns (Arpey et al., 20□7; Blanco et al., 20□5; Campbell et al., 20□6; Iyengar et al., 20□6). However, through the lens of resilience, in this study, I sought to explore and understand the strategies seniors use to maintain their health on a fixed income. This topic is critical as the population 65 years of age and older rapidly increases. It has been projected that by the year 20□0, approximately □8% of the population will be senior citizens (Blumenthal et al., 20□5). An aging population is correlated to a rise in the prevalence of chronic health conditions and higher healthcare costs (Hosseini, 20□5; Iyengar et al., 20□6; Neuman et al., 20□5). Rising costs are further complicated by a decrease in income (Blanco et al., 20□5; Cubanski et al., 20□8; Dean et al., 20□7; Polivka & Luo, 20□5). As such, in this study, I offer experiential insights into

the perceptions and experiences of seniors who survive in a climate of rising healthcare costs. A more detailed review of the literature is provided in Chapter 2.

Problem Statement

The rising cost of healthcare has profoundly impacted seniors who rely on Medicare to address healthcare concerns (Biggar & Hood, 20□5; Camillo, 20□6; Wilensky, 20□7). The Medicare Program served an estimated 6□million enrollees at an annual cost of approximately $776 billion CMS, (2022). The growing concern regarding the high cost of healthcare has resulted in accountability measures designed to control increases in Medicare copayments (Collica-Cox, 20□5; Dickman et al., 20□6). When financial responsibility is transferred to Medicare recipients, the ability to maintain adequate health on a fixed income becomes compromised (Applebaum & Cummings, 20□7; Camillo, 20□6). Medicare coverage is essential for the health and well-being of many people 65 and older. However, changes in Medicare policy have made it progressively complex and costly (Bradley et al., 20□6; Collica-Cox, 20□5; Hosseini, 20□5). A wealth of literature covering Medicare research has failed to address the direct impact of changing policies on financial constraints experienced by recipients.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore, understand, and describe the lived experiences of adjusting to rising Medicare costs among recipients 65 and older. Resilience theory was used to guide the exploration of how Medicare recipients manage their healthcare needs on fixed incomes. To describe

this phenomenon, I gathered data through semi structured interviews from a total of □2 Medicare recipients who resided in Henry, Clayton and Dekalb counties, Georgia.

Research Questions

This study contained two central research questions: (a) How do the rising costs of Medicare premiums and copayments impact the ability of recipients to manage their healthcare needs? and (b) What strategies do Medicare recipients use to address their unmet healthcare coverage needs?

Theoretical Foundation

The resilience theory was selected as the theoretical lens by which to explore, understand, and describe the lived experiences of Medicare recipients 65 and older who manage their health. Garmezy pioneered his work on formalizing resilience among adolescents as a viable theoretical construct (Garmezy, □987; Shean, 20□5). At the time of its inception, the resilience theory was used primarily in the field of psychology (Masten et al., □999; Shean, 20□5; Zolkoski & Bullock, 20□2). However, resilience as a theoretical construct has been successfully applied to a broad spectrum of academic disciplines due to its flexibility (Ayala & Manzano, 20□4; Gulbrandsen & Walsh, 20□5; Hart et al., 20□6; Terrill et al., 20□4; Welsh, 20□4).

The primary premise that characterizes resilience is its value in exploring how people, groups, and organizations overcome or manage adverse conditions and circumstances (Ayala & Manzano, 20□4; Capano & Woo, 20□7; Ungar, 2005). While Olson et al. (20□5) reported that the resilience theory is not well-defined and indicated that caution should be exercised in its application and interpretation, the dominate

literature on the topic has emphasized that resilience theory applies to exploring variables that differentiate how one person can manage and overcome adversity in contrast to another succumbing to circumstances (Bolton et al., 20□7; Hart et al., 20□6; Ledesma, 20□4; Marici, 20□5).

The resilience theory applied to this study because the central phenomenon of interest was how the rising cost of Medicare has impacted the ability of recipients to manage their healthcare needs. The assumption was that adverse conditions and circumstances are the primary factors considered in selecting resilience as a theoretical lens (see Campbell et al., 20□6; Hosseini, 20□5). The review of the literature supported the application of the resilience theory in similar studies to address an important gap in researching the topic of aging and healthcare policy (see MacLeod et al., 20□6; Phillips et al., 20□6; Randall et al., 20□5; Schembri & Ghaddar, 20□8; Terrill et al., 20□4; Tkatch et al., 20□7).

Nature of the Study

The nature of this study required a qualitative phenomenological research approach. A phenomenological approach was suitable for conducting a deep exploration into the perceptions and experiences of people with the objective of understanding the phenomenon under study (see Eddles-Hirsch, 20□5; Moustakas, □994). Quantitative and mixed method research designs were considered, but the qualitative approach was congruent with the exploratory nature of the study (see Maxwell, 20□□; Padilla-Diaz, 20□5; Patton, 2002).

Through the lens of resilience theory, the phenomenon of how the rising costs of Medicare impact recipients' abilities to manage their healthcare needs was explored. Cubanski et al. (20□8) reported that approximately 7.□million or as many as □0% of elders are believed to live below the poverty line. Aging is correlated to chronic health conditions and increased spending of out-of-pocket copayments to access care (Baylis et al., 20□5; Campbell et al., 20□6). Many researchers have agreed that increased Medicare costs exacerbates concerns for recipients already living under economic constraints (Blumenthal et al., 20□5; Cubanski, et al., 20□7; Dean et al., 20□7; Hosseini, 20□5; Neuman et al., 20□5).

The number of semi structured interviews needed to conduct phenomenological research varies between research authorities. Creswell (20□4) recommended five to 25 interviews while Moustakas (□994) suggested at least six interviews to conduct phenomenological studies. In this study, I collected data from □2 subjects. A purposive sampling method was used and criteria inclusive of age, Medicare eligibility, and residency within Henry, Clayton and Dekalb Georgia, were applied. Semi structured interviews provided the structure and flexibility necessary to fully explore the research questions within the context of the phenomenological approach (see Padilla-Diaz, 20□5).

The interview included a set of close-ended and open-ended questions crafted to align with the research questions. Each interview was digitally recorded and transcribed. Respondents were offered the opportunity to review the transcript for accuracy. This method, known as member checking, helped to further validate the findings (see Smith, 20□5).

The transcribed data were manually coded and analyzed according to Moustakas's (□994) modified van Kaam method. The 7-step data analysis process was used to identify and categorize participant responses into themes (see Creswell, 20□□; Eddles-Hirsch, 20□5; Lewis, 20□5; Moustakas, □994). The data collection commenced after approval was received from the Walden University Institutional Review Board (IRB). A more detailed description regarding the methods used for this study is provided in Chapter □.

Definitions

The terms explained below are central to this study and are commonly used in healthcare literature.

Accountable care organizations (ACO): ACOs are organizations established under the Patient Protection and Affordable Care Act of 20□0 to improve healthcare quality and reduce healthcare spending (McWilliams et al., 20□6).

Bracketing: A strategy used in phenomenological research that requires the researcher to harness preconceived beliefs and describe participant perceptions and experiences as reported (Eddles-Hirsch, 20□5).

Fee for service payments: A payment model that reimburses healthcare organizations and providers for services rendered, which differs from a value-based payment structure (Buntin & Ayanian, 20□7).

Medicare Advantage: A Medicare program identified as Medicare Part C. Medicare Advantage offers recipients the ability to select health insurance providers from a pool of companies under the principle that the more people enrolled, the lower the costs. (Jacobson et al., 20□5).

Reflexivity: A term used in qualitative research literature that denotes a researcher's ability to maintain self-awareness throughout the process of gathering data, analyzing data, and reporting findings (Palaganas et al., 20□7).

The Patient Protection and Affordable Care Act of (2010): A statutory law that was propagated by former President Barack Obama to expand healthcare coverage, improve healthcare quality, and lower costs. The Act is commonly referred to as the ACA (Auerbach, 20□9; Olson et al., 20□6;).

Traditional Medicare: A term that is synonymous with original Medicare, identified as Medicare Part A, which covers inpatient hospital stays, and Medicare Part B, which covers outpatient medical visits. Medicare Part D is a prescription drug plan that is separate (Blumenthal et al., 20□5).

Assumptions

The identification of assumptions serves to document the potential for bias within the research framework (Smith, 20□5). The assumptions I identified to obtain necessary data in this research project included the following:

- Participants had sufficient experience with the phenomenon under investigation.
- Participants were open, honest, and willing to share their experiences.
- Interview questions were adequate to explore the phenomenon under investigation.
- The experiences and perceptions of the participants are generalizable to the populations from which the sample was drawn.

- The study outcome will benefit elderly Medicare recipients.
- The research study will facilitate positive social change.
- The phenomenological approach was effective for exploring the research question.
- The assumptions associated with this research study are necessary because the phenomenological approach is exploratory and documenting the assumptions supports the reflexivity process (see Roulston & Shelton, 20□5).

Scope and Delimitations

The scope of this study was to explore, understand, and describe the perceptions and experiences of older Medicare recipients with managing rising coverage costs. Resilience theory was used as the theoretical lens to examine challenges associated with rising Medicare coverage costs. This research project was important because existing research has failed to address how Medicare recipients manage their health within the context of the resilience theory framework.

The study included participants over 65 years of age who have received Medicare benefits for 2 years or more. Medicare recipients with less than 2 years of coverage and those who were employed, self-employed, or had multiple streams of income did not meet the purposive sample criteria. The catchment area of residence was limited to Henry, Clayton and Dekalb counties, Georgia. Demographics such as race, and gender did not factor in the participant selection process. The purposive sampling criteria assured that the selected participants were characteristic of the population needed to meet the objectives of this study (see Alase, 20□7).

The goal of this study centered on exploring how participants met the rising financial costs of healthcare coverage. The adaptation theory was initially considered because it appeared to be contextually like the concept of resilience (see Ritter et al., 20□6). However, a review of the literature revealed that resilience and adaptation are not interchangeable theoretical constructs (see Wong-Parodi et al., 20□5). The adaptation theory is applicable to spontaneous or random situations, which differs from the prolonged conditions that characterize the application of the resilience theory (see Ritter et al., 20□6; Wong-Parodi et al., 20□5). Although qualitative research is limited in its ability to generalize findings, documenting the rationale used to make scientific decisions improves the transferability and credibility of the research project (see Cypress, 20□7; Leung, 20□5; Smith, 20□5).

Limitations

Limitations are inherent in quantitative and qualitative research projects, and the reliability of the results improve when the limitations are identified, mitigated, and reported (Cypress, 20□7; Queiros et al., 20□7). The inability to generalize qualitative research results is considered a limitation in response to sample size and geographic constraints (Leung, 20□5). However, Leung (20□5), posited that a trend is developing where generalizability in qualitative research may be assessed within the context of replicated research procedures, sample criteria, and rigor in data analysis to promote the transferability and dependability of this research project, the problem, purpose, theoretical framework, and research questions were congruently aligned. The purposive sample criteria assisted in assuring that the participant sample reflected the population of

interest, which is necessary when exploring the phenomenon within the context of the phenomenological research design (see Padilla-Diaz, 2015).

The need to mitigate bias in qualitative research has been addressed in several studies (Eddles-Hirsch, 2015; Queiros et al., 2017; Roulston & Shelton, 2015; Smith, 2015). To aid in addressing bias, reflexivity techniques were used to remain cognizant of the role of a researcher. Reflexivity is an ongoing process of introspection, which requires the researcher to maintain an understanding of personal values and assumptions (Palaganas, et al., 2017; Roulston & Shelton, 2015).

During contact with the participants and throughout the data analysis process, a bracketing strategy was used to facilitate the transmission of participant perceptions and experiences devoid of any personal preconceived positions. Bracketing is a practice used in phenomenological research that requires insightful separation (Eddles-Hirsch, 2015; Padilla-Diaz, 2015). Interview data were analyzed from verbatim transcripts and verified by the participants to support the credibility of the findings (see Alase, 2017; Smith, 2015). To further address the potential for bias and methodological weaknesses, research procedures were reviewed by the Walden University doctoral committee and IRB.

Significance of the Study

This study is significant because the rising costs of financing Medicare coverage is an issue that impacts seniors and taxpayers alike (see Kane, 2016; Neuman et al., 2015; Polivka & Luo, 2015). The projected increase in Medicare as a substantial part of the federal budget is an increasing concern as the population ages (Blumenthal et al., 2015; Dean et al., 2017). Kane (2016) reported that Medicare is financed through employer and

employee payroll taxes, general tax revenue, and premiums from supplemental medical insurance. It is important to note that general tax revenue is necessary to cover Medicare because dedicated sources are not sufficient (Kane, 20□6). According to Polivka and Luo (20□5), more than 8.5 million seniors rely on social security and Medicare to manage their daily lives. Even though Medicare is a widely studied research topic, exploring methods used by Medicare recipients on a fixed income to manage their health is lacking.

Academic research is invaluable for policy practitioners. According to Neuman et al. (20□5), academic research is useful to inform the policy process. However, the significance of this research is for the purpose of accountability. This study addressed the challenges of Medicare cost-sharing policies from the perspectives of recipients.

This study was designed to advance social change by exploring the problem of cost through the lens of a vulnerable population. The aim was to explore participant experiences and perceptions within the context of resilience. Researchers have confirmed that seniors are confronted with many challenges related to health and financial well-being (Blumenthal et al., 20□5; Campbell et al., 20□6; Cubanski et al., 20□8; Keohane et al., 20□5; Neuman et al., 20□5). As the challenges associated with Medicare are considered, the political process affecting societal change must be engaged (Polivka & Luo, 20□5; Wilensky, 20□7).

Summary

The Medicare program is projected to grow exponentially soon as the population rapidly ages (Blumenthal et al., 20□5; Hosseini, 20□5). According to Dean et al. (20□7), approximately two-thirds of Medicare beneficiaries are afflicted with chronic medical

conditions, with half surviving on incomes below $26,000 per year. Increased out-of-pocket costs for medication, premiums, and inpatient and outpatient office visits place a significant financial burden on recipients (Cubanski et al., 20 7; Doshi et al., 20 6; Jacobson et al., 20 5; Keohane et al., 20 5).

The ACA is at the forefront of responding to the need for high quality, accessible, and affordable healthcare (Auerbach, 20 9; Obama, 20 6;). The ACA uses ACOs to manage the Medicare Advantage plans, with the aim of meeting its cost containment goals and objectives (Keohane et al., 20 5). ACOs utilize a cost containment strategy that rewards medical providers with financial incentives to reduce patient visits and hospital stays, while increasing patient out-of-pocket costs (Jacobson et al., 20 5). Under the ACO strategy, medical providers are penalized if the number of patient visits and return hospitalization stays increase (Boccuti & Casillas, 20 5). The implementation of ACOs appears to work in a way that is not in a patient's best interests, with cost savings being the primary objective.

In this qualitative phenomenological study, I explored methods used by Medicare recipients to manage their healthcare needs. Through the lens of resilience theory, the lived experiences of the participants were explored and reported. In Chapter 2, I provided a detailed picture of the literature by covering the theoretical foundation, the literature search strategy, and relevant research on the United States healthcare system, Patient Protection and Affordable Care Act, and Medicare. This is followed by a summary and transition to Chapter . Chapter three addresses trustworthiness through transparent research procedures that encompass credibility, transferability, dependability,

confirmability, and ethical domains. As the safety of the research participants is a primary area of concern, IRB approval was secured, informed consent was provided, and follow-up procedures were created. This is followed by a summary and transitions to Chapter 4. Chapter four was completed after the data collection procedure finished. Chapter four contains a discussion in addition to information on the research setting(s), demographics of the participants, data collection process, data analysis process, evidence of trustworthiness, and results. Chapter four ends with a summary and transitions to Chapter 5. Chapter five includes an introduction, interpretation of the findings, limitations of the study, recommendations for future research, implications of positive social change, and a conclusion.

Chapter 2: Literature Review

The rising cost of healthcare presents challenges to seniors who rely on Medicare to address their healthcare concerns. In 20□7, an estimated 58 million people were enrolled in Medicare, at an annual cost of approximately $700 billion (CMS.gov, 20□9). The ACA was designed to respond to growing concerns regarding the high cost of healthcare and Medicare spending (Collica-Cox, 20□5; Dickman et al., 20□6). While Medicare coverage is essential for the health and well-being of many senior citizens, changes in Medicare policies have made using the entitlement program progressively complex and costly (Bradley et al., 20□6; Collica-Cox, 20□5; Hosseini, 20□5).

Many scholars have examined the complexities of the rising cost of healthcare and have reported that Medicare accounts for 20% of all healthcare spending in the United States (Biggar & Hood, 20□5; Bradley et al., 20□6; Dickman et al., 20□6; Stegeman et al., 20□4). By contrast, the direct impact of changing policies and the financial obligations on recipients has not been well studied. The purpose of this qualitative phenomenological research study was to address this gap by exploring, understanding, and describing the lived experiences of Medicare recipients who are directly impacted by changing Medicare policies and spending requirements. The resilience theory guided the study on how Medicare recipients manage their healthcare needs on a fixed income within a climate of rising healthcare coverage costs.

This chapter provides a comprehensive review of healthcare literature with a focus on the research gap investigated. This chapter also includes an introduction, the literature search strategy used, and theoretical foundation. Topics address spending in the

U.S. healthcare system, spending in other industrialized nations, ACA, Medicare, Medicare, and their impact on seniors. The chapter ends with a summary.

Literature Search Strategy

The literature search strategy was developed with a focus on the problem to be examined, purpose, overarching research questions, and the theoretical framework used to frame the study. Several databases were accessed through the Walden University Library, including PsycARTICLES, ProQuest Central, SAGE Premier, Political Science Complete, Academic Search Complete, Business Source Complete, and Thoreau. Google Scholar, PubMed, and government websites were used as additional research sources. The search terms included *resilience theory, rising healthcare costs, Affordable Care Act,* and *Medicare coverage,* and reference lists from selected peer-reviewed articles assisted in identifying additional relevant literature.

The literature was limited to peer-reviewed articles published between 20□5 and 202□. Publications were also required to be written in English and relevant to the research topic. Any articles included in this review that fell outside the search parameters were considered classic or determined to be substantive to the research topic at-hand. The preliminary search uncovered a total of □5□articles. After the inclusion criteria were applied, □□4 were considered appropriate for this review.

Theoretical Foundation

Resilience theory was selected as the theoretical lens because the research premise is linked to exploring human characteristics associated with overcoming and managing adversity. Resilience theory argues that it is not the nature of adversity that is

most important, but how we deal with it. Resilience helps humans survive, recover, and even thrive in the wake of misfortune. Research associated with the concept of resilience was pioneered by Garmezy (□987) and centered on the field of psychology. However, over time, resilience theory evolved to be applied across the social sciences, healthcare, education, and business domains (Ayala & Manzano, 20□4; Dahles & Susilowati, 20□5; Gulbrandsen & Walsh, 20□5; Hart et al., 20□6; Terrill et al., 20□4; Thrasher, 20□6; Welsh, 20□4).

Theoretical Propositions

The resilience theory framework can be applied to people, groups, and organizations. The functional definition associated with resilience theory cannot be absent of adverse conditions or circumstances. It attempts to explain the variables that shape a person's ability to manage and overcome adversity (Garmezy, □987; Hart et al., 20□6; Marici, 20□5; Masten et al., □999; Weichselgartner & Kelman, 20□5; Zolkoski & Bullock, 20□2). Although resilience theory is dynamic and can be applied across a range of academic disciplines, the underlying precept of successfully dealing with adverse and challenging circumstances persists (Bolton et al., 20□7; Marici, 20□5; Welsh, 20□4).

Some researchers have contended that resilience theory presents challenges in its application and interpretation. For instance, Olson et al. (20□5) proposed that resilience theory is not a definitive theory even though the theory provides considerable benefits to researchers. They also posited that caution should be exercised when using resilience as a theoretical construct in policy design because it can unintentionally minimize the causes that facilitate adverse conditions. Weichselgartner and Kelman (20□5) appeared to

support Olson et al.'s conclusions. However, they cautioned that although resilience theory is flexible enough to apply across several academic disciplines, the theory has less effect if its application is not clear. The value of resilience theory in guiding research designed to explore humanistic questions has been well-documented (Bolton et al., 2017; Hart et al., 2016; Ledesma, 2014; Marici, 2015).

Theoretical Analysis

This qualitative phenomenological research study addressed exploring, understanding, and describing the lived experiences of Medicare recipients who are directly impacted by changing Medicare policies and spending requirements. Transitioning to Medicare from an employer covered plan can be difficult for this population. Researched literature of previous studies identified theories that were applied and explored amid this population. Campbell et al. (2016) conducted a qualitative study using the grounded theory approach to explore how financial barriers impact patient health. The data were based on 14 semistructured interviews with a focus on the role of resilience on the ability to navigate financial barriers. Even though they examined the connection between financial barriers and patient resilience, the potential impact of Medicare costs on seniors was not addressed. Campbell et al., (2016) data did not explain the gap of the lived experiences of this population amid an era of rising costs and how they manage their healthcare needs.

Resilience has shown evidence of usefulness in understanding this phenomenon at various stages and across age groups. In a comprehensive literature review, Allen et al. (2016) conducted resilience research in children and adolescents. They identified the

many psychological ways young people respond to adversity including anxiety, maladaptive coping, and depression. In a phenomenological study conducted by Thrasher (20□6), the perceptions and experiences of African American graduate students within a framework of resilience were explored. The data gathered from focus groups and interviews conducted with this group of young adults revealed that perceptions of success and external support profoundly increased personal resilience.

Aging and resiliency amid a climate of rising healthcare and a vulnerable population necessitated additional studies. Gulbrandsen and Walsh (20□5) investigated resilience in the context of aging and coping. A qualitative grounded theory approach was used to identify self-perceptions and experiences among a sample of older women. Gender differences were highlighted, and it was noted that women's experiences differed by age and their stage in life and development. In a qualitative study of older adults by Tkatch et al. (20□7), perceptions of a variety of medical conditions were explored. The data were based on interviews conducted with □2 male and female participants between 66 and 80 years of age. The researchers were unable to correlate a relationship between chronic illnesses and the perceived ability to manage health-related setbacks (Tkatch et al., 20□7). This literature was helpful as it provided insight on how these participants managed their health-related setbacks, but it did not address how they manage the rising cost of their healthcare needs amid rising healthcare costs.

In addition to learning how this population was coping with aging in the context of managing their healthcare, I sought to explore how other researchers examined resilience amid aging and navigating adversity. Phillips et al. (20□6) conducted a

longitudinal study of 8□2 men and 9□□ women, from 64 to 75 years of age. The study included participants from four countries. The quantitative results concurred with most qualitative-based research results that address resilience, aging, and navigating adversity. Terrill et al. (20□4), however, analyzed □,862 older adults dealing with disabilities and secondary medical conditions. They found that the level of resilience among infirmed respondents was significantly associated with depression, pain, and fatigue (Terrill et al., 20□4). These studies were instrumental on describing the lived experiences of this population and how they managed aging, adversity, depression, fatigue, and pain. However, these studies did not provide data regarding how they manage their healthcare amid a climate of rising cost.

I explored and evaluated other studies through the theoretical lens of resilience and this aging population. In a mixed-method comparative analysis, Randall et al. (20□5) examined how older adults story their lives in a framework of resilience. The data were based on □□0 questionnaires followed by 45 interviews. The researchers concluded that the participants who held a positive self-image had a more descriptive, resilience-based narrative than the participants who held a less than positive self-image, demonstrating the multiplicity of resilience as a theoretical concept (Randall et al., 20□5). The examination of the data included the lived experiences of this population and offered perceptiveness on how these participants self-image through the theoretical lens of resilience, within this changing climate was affected. However, the data failed to describe how this population managed the rising cost of their healthcare needs.

Resilience is centered on a person's ability to navigate ongoing challenges in contrast to adaptation, which focuses on how an individual manages situations that create stress (Wong-Parodi et al., 20□5). I examined how resilience was applied amid my focused population encompassing positive experiences. Wilson and Saklofske (20□8) conducted a mixed-method study exploring mental health, resiliency, and emotional intelligence in older adulthood, including the mediating role of savouring. Savouring is defined as "the process of attending to positive experiences, as a mediator in the relationships between resiliency, trait emotional intelligence (EI), and subjective mental health in older adults" (Wilson & Saklofske, 20□8, p. □). A sample size of □49 participants ages 65 and older were recruited from community groups and retirement homes. The responses of the participants were captured in online and paper formats. The theoretical implications of the researchers' conclusion encompassed the simple association of psychology exercises that may be effective in improving quality of life and resiliency in older adults. Though savouring is present in the broadening effect of positive emotions, it did not mediate a relationship amid mental health and emotional intelligence (Wilson & Saklofske, 20□8). Additionally, this study did not describe or explain how this population manages their healthcare amid a climate of rising cost.

Theoretical Rationale

Resilience theory has been applied across a myriad of academic disciplines. A comprehensive review was conducted to identify the best theoretical framework. Adaptation theory was initially considered to be a viable framework. However, Wong-Parodi et al. (20□5) contended that resilience and adaptation are not aligned in their

applications. They further explained that resilience is centered on a person's ability to navigate ongoing challenges in contrast to adaptation, which focuses on how an individual manages situations that create stress (Wong-Parodi et al., 20□5). Ritter et al. (20□6) supported conclusions made by Wong-Parodi et al.20□5, which emphasized that adaptation theory is a framework used to study questions associated with how people cope with periodic stressful events. I concluded that adaption amid my target population is valuable to my research and examined additional studies to strengthen my efforts to examine the lived experiences of this population.

Resilience theory was the chosen theoretical framework applied to this research study because the aim was to explore, understand, and describe the role resilience plays in the lived experiences of Medicare recipients. In addition, the resilience theory suggests that two people faced with the same set of adverse conditions can have very different responses to their circumstance (Gulbrandsen & Walsh, 20□5; Ledesma, 20□4). The central research question guided the study as follows: How do the rising costs of Medicare premiums and copayments impact the ability of recipients to manage their healthcare needs? and (b) What strategies do Medicare recipients use to address their unmet healthcare coverage needs?

By exploring the research problems using resilience as the theoretical lens, the findings offered insights into how Medicare recipients have managed their healthcare needs within the context of rising healthcare costs. Hart et al. (20□6) endeavored to explore the concept of resilience and its use in policy design. The researchers provided a description that underscored the government's role in shaping economic and social

policies. The researchers communicated from a social justice perspective by emphasizing how healthcare policy has facilitated an increase in recipient financial responsibility without ignoring the individual's role in making positive healthcare decisions (Hart et al., 20□6). I found the research relevant because it demonstrated the value of the resilience theory in responding and adjusting to policy design. The data I examined amid this study adds to the relevancy of healthcare cost amid this population. The study failed to demonstrate how this population manages their healthcare amid a climate of rising healthcare cost.

Seniors and Healthcare

Seniors are faced with being restricted in the way they live and manage their health, which are important factors in how they cope with life stressors. Bauger and Bongaardt (20□6) conducted a phenomenological study to research the lived experiences of older adults in retirement. The study consisted of two males and seven females between 62 and 7□ years of age. The interviews included an open-ended question that asked the participants to describe an experience of well-being associated with retirement. The researchers described the importance of a healthy body, the ability to participate in new experiences, and maintaining productive relationships and resilience (Bauger & Bongaardt, 20□6).

I sought to explore how seniors managed their healthcare in a climate of rising cost. Duckett (20□8) conducted an interpretative, phenomenological analysis of the perceptions and lived experiences of male seniors who resided in a rural region of the northeastern United States. Duckett sought to explore the essence of how the participants

managed and lived their lives in an area that did not contain adequate healthcare services, A thematic analysis was conducted on the text of □0 interviews. The study identified lack of access to local health resources, transportation, economic restrictions, and self-medication as specific challenges for achieving well-being. Duckett's study added to learning the lived experiences of this population and how they are managing their healthcare amid a climate with limited resources. However, Duckett's study did not provide data on how this population manages their healthcare amid a climate of rising cost.

Additionally, I sought to understand the experiences of seniors in securing comprehensive healthcare, and how they are managing their costs. Deal (20□7) conducted a qualitative phenomenological research study to explore the challenges that retired seniors face in securing comprehensive healthcare. The study included □2 participants over the age of 65 who resided in northeast Georgia and did not retain supplemental health insurance. The researcher was able to demonstrate that Medicare coverage for this population is inadequate, Medicare benefits are difficult to understand, and Medicare is not adequate for maintaining health concerns. Additionally, Deal underscored the impact that high insurance deductibles and copayments have on seniors who survive on limited incomes. Deal's study provided rich data on the lived experiences of this population and challenges they face securing comprehensive healthcare; however, the study did not contain data on how this population manage their healthcare during rising cost.

I examined additional literature encompassing the senior population and how they manage their healthcare amid a climate of rising costs. Blanco et al. (20□5) used focus

groups to examine how the behaviors of older African Americans and Latinos are driven to navigate their expenses, including covering healthcare expenses and unanticipated expenses. A synopsis of the results revealed that 69% received social security, 24% received a pension, and 64% of the group was able to save on a consistent basis. The researchers also noted that 89% of the participants had some form of health insurance with Medicare or Medi-Cal although many of the participants lived with chronic health conditions, and the saving behaviors were challenged by living on a fixed income. These results highlight the importance of adequate and manageable healthcare coverage (Blanco et al., 20□5). Healthcare for seniors is an important consideration for this population when retiring. Managing healthcare amid higher cost and on a fixed income is both necessary and challenging with chronic health conditions.

Many individuals retire at the retirement age set by the Social Security Administration. However, numerous seniors work long past retirement age for different reasons. I sought to examine the experiences of seniors transitioning from work to retirement and their preparation for their healthcare expenses. Landon and Ritz (20□6) conducted a mixed method research study to explore factors that contribute to contentment in people who classify themselves as retired. The study sample consisted of 5,000 men and women between 50 and 70 years of age. The study centered on the exploration of income and financial resources, age and life circumstances, and how people transition from work to retirement (Landon & Ritz, 20□6). While the results were mixed, they showed that participants who planned for retirement were better able to retire in response to life circumstances rather than rely on social security. The researchers also

found that participants who were better educated, planned for retirement, and had sufficient social support, fared better than the participants who were marginalized (Landon & Ritz, 20□6). With an increase in people reaching retirement age, understanding how older people transition their lives in a climate of financial uncertainty provides fruitful ground for further research (Landon & Ritz, 20□6; Silver, 20□6). The retirement system is required to be stanch to handle the inflow of individuals approaching retirement and sustaining their healthcare needs throughout retirement.

The effect of the economic landscape on the U.S. retirement system is an area of concern. A continuous decline in economic stability (reduced wages, reduced home equity, reduced personal savings, and increased debt) has been noted as individuals move closer to retirement. Private industry's drive to generate profit and the government's failure to control spending have contributed to creating a vacuum for the aging population as they enter retirement age. It has been further contended that approximately 8.5 million seniors 65 and older rely on Medicare and social security benefits to stay above the poverty line. Over the past □0 years, the prosperity of the U.S. workforce has declined because of private and government cutbacks. The changes make it difficult for people nearing retirement age to make meaningful adjustments for survival on a fixed income (Deal, 20□7; Polivka & Luo, 20□5). The information the researchers shared caused pause for concern. This population has experienced reduced wages and increased debt. Now coupled with a fixed income and survival adjustments for maintaining healthcare can be challenging.

The U.S. Healthcare System

The rising cost of healthcare in the U.S. is a phenomenon that impacts the government, healthcare delivery systems, and patients that require care. In a retrospective analysis, Aldridge and Kelly (20 5) projected that by 2040, one in three U.S. dollars will be allocated for healthcare. This finding underscored the need for policy adjustments associated with the costs of providing chronic and end of life healthcare (Aldridge & Kelly, 20 5). Camillo (20 6) noted that the U.S. system consists of an intricate mix of government and private sector financing pools making the system more complicated than most other industrialized countries. The inferences made by Camillo (20 6) were reinforced by Grogan (20 5) who discussed the role of politics in shaping healthcare policy decisions that contribute to a disparity in how funds are allocated, and how healthcare services are delivered to marginalized populations. The need for healthcare policy approaches to assure access is well established in the literature (Casalino et al., 20 6; Hampson et al., 20 8; Papanicolas et al., 20 8). This study provided rich data on the healthcare system in the United States. Examining data of other healthcare systems provided a robust scale for comparison.

International Comparisons

I pursued additional studies to learn how the healthcare system compared in other countries in contrast to the United States. Olson et al. (20 6) examined the efficacy of healthcare systems across eleven industrialized countries including Canada, Germany, France, Sweden, the Netherlands, Switzerland, Norway, the United Kingdom, the United

States, Australia, and New Zealand. A randomly selected sample of adults from each country completed a telephone survey. The researchers cited several limitations intrinsic to conducting a cross-cultural study which included adjusting the interview to the characteristics of each country. After completing a comparative analysis of the data, the study revealed that adults in the U.S. are more prone to go without healthcare due to increased costs compared to 0 out of the countries surveyed (Osborn et al., 206a). Olson et al. (206) emphasized the value of analyzing information from people who experience the impact of healthcare policies. They highlighted the effects that higher healthcare costs have on the U.S. population compared to other industrialized nations (Olson et al., 206). The study provided robust data in explaining the healthcare system in other countries in contrast to the U.S., the data did not identify how the senior population managed their healthcare amid rising cost.

I explored data from other researchers on healthcare spending in other countries with plans to examine the differences between U.S. and their system. Papanicolas et al. (208) conducted a comparative study to explore best practices in healthcare spending within 0 high income countries: Canada, Germany, Australia, Sweden, Switzerland, Japan, France, Denmark, the United Kingdom, and the Netherlands. The results revealed that the U.S. allocated 7.8% of its gross domestic product on healthcare. This figure was substantially higher than other industrialized countries where approximately one tenth of the GDP was committed to healthcare. It was also found that labor, supplies, pharmaceuticals, and administrative costs contribute to the higher costs in the United States. Although U.S. healthcare utilization rates were comparable to other countries,

expenditures were nearly double (Papanicolas et al., 2018). I concluded from this data that in comparison to other countries, the rate for healthcare is comparable. However, the out-of-pocket expenses are far more expensive for individuals of the United States. Improvement for the discrepancy in expenditures raises alarm.

I explored data of physicians practicing healthcare in countries other than the United States. I sought to understand how the rising cost in healthcare affects individuals ages 65 and older. Osborn et al. (2015) explored the outcome of the Commonwealth Fund International Health Policy Survey of Primary Care Physicians. The survey collected data from physicians practicing in Canada, Germany, Sweden, the Netherlands, Switzerland, Norway, the United Kingdom, the United States, Australia, and New Zealand. The study confirmed that each participant country met the chronic healthcare needs of the aging population and expressed a need for the coordination of care to control spending and maximize access (Osborn et al., 2015). Osborn's study confirms the need to explore healthcare spending and how individuals ages 65 and older manage their health amid rising cost with emphasis of coordinating care.

Domestic Spending

Explored research of the rising cost of healthcare steered me to scrutinize data from other researchers. Bradley et al. (2016) conducted a longitudinal retrospective study to understand patterns of healthcare and social service spending in the 50 States and District of Columbia between 2000 and 2009. The study revealed that states with higher ratios of social to health spending experienced better health outcomes in comparison to states with lower rates of spending (Bradley et al., 2016). Meisel et al. (2016) examined

healthcare price transparency and its role in providing consumers with pertinent information that can assist in decision making. The researchers indicated that price transparency in the healthcare industry is a controversial topic. It was found that consumers would like to know their out-of-pocket costs before a procedure or test. However, hospital leaders and other financial administrators suggest that providing estimates beforehand are often not realistic. The arguments explored by the researchers revealed that healthcare pricing data is made available to insurance carriers and medical providers, but often fails to inform patients. The researchers noted that in the current climate of cost sharing where consumers incur more of the costs for healthcare services, price transparency becomes increasingly relevant (Meisel et al., 20□6). Not only is transparency relevant, knowing what a procedure should cost would assist in helping seniors manage their healthcare cost amid a climate of rising cost.

Challenges for policy makers to implement new programs and initiate change appears simplistic to individuals in need. Hampson et al. (20□8) conducted a qualitative study to explore the benefits of using real world evidence (RWE) to address U.S. healthcare challenges. The researchers conducted interviews with nine subject matter experts (SMEs) in the academic, insurance, and the pharmaceutical industries. The study centered on exploring the significance of RWE as communicated by the SMEs during the interviews. The researchers proposed that RWE has value in meeting many common challenges in the healthcare industry that can be used to inform policy, industry, and consumer decisions (Hampson et al., 20□8). Hampson's study is invaluable as the

examined data proposed utilizing the lived experiences of these individuals to inform change and reduce many of the challenges amid the healthcare industry.

Along with utilizing real world evidence to inform policy, consumer, and industry decisions. I sought to understand how individuals are coping with their cost for medications. Kesselheim, et al., (20□6) conducted a comprehensive literature review that covered the period between 2005 and 20□6 with a focus on exploring U. S. prescription drug pricing and higher patient costs. The researchers reported that U.S. per capita spending of $858 on prescription drugs far exceeds the average spending of $400 among □9 other industrialized nations. The researchers concluded that the Food and Drug Administration regulations make it difficult for insurance companies to negotiate better pricing structures. The need for a policy adjustment that facilitates generic drug choices offers a solution to this issue (Kesselheim et al., 20□6). Alternative drugs that contain a smaller cost in contrast to a name brand drug that is equally effective, should be made available to all.

Drug choices for individuals should be readily available and alternative options with a lower cost in price as a viable option. As drug choices should be optional for the patient, efficiency in literature for those options should be readily available and easily accessible by all. Rahurkar, et al., (20□5) implemented a systematic literature review to ascertain the efficiency of the health information exchange (HIE) or the portability of electronic patient information across a broad spectrum of medical institutions. The research centered on identifying whether the HIE provided cost savings, improved patient care, and/or improved healthcare quality. Based on the review of 27 peer reviewed

articles published between 1980 and 2014, it was concluded that the benefits of the HIE are not well-documented because full implementation has not been accomplished. The researchers also noted that although the Health Information Technology for Economic and Clinical Health Act of 2009 was initiated a decade ago, increased efficiency of healthcare remains unfulfilled (Rahurkar et al., 2015). Technologies implemented for economic and clinical health are in place as a variable in linking patient information and improved quality healthcare. The efficiency of its effect the individual patient experience has not fully been met.

Healthcare spending in the U.S. has been found by most estimates to be increasing (Camillo, 2016; Casalino et al., 2016; Papanicolas et al., 2018). Cohn's report discusses the political landscape, which favors transferring costs to the consumers to make healthcare more affordable for the government and healthcare delivery system. Kocher and Chigurupati (2016) examined cost saving measures implemented within the healthcare service delivery system. The rise of ACOs and their role in reducing costs and managing risk was highlighted as a driver in reshaping how healthcare providers deliver care (Kocher & Chigurupati, 2016). The scholars reported that ACOs strongly influence the reduction of expenditures for primary care physicians (PCPs) (Kocher & Chigurupati, 2016). PCPs often operate within a framework that involves costs that reduce access to services. For example, PCPs may be required to reduce referrals to specialists, order fewer diagnostic tests, reduce the length of stays in treatment facilities, and exercise other measures that can have a direct and negative impact on patient health (Kocher & Chigurupati, 2016). Policies to reduce healthcare spending in the U.S. are often

implemented at the expense of compromising the health and well-being of patients (Camillo, 2016). The cost for healthcare increases and the patient receives less access to services poses a problem for all. The implementation of policy is necessary to reduce and or eliminate a negative impact on patient health.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (ACA) was implemented by former President Barack Obama with congressional approval. The ACA is also known as Obamacare and continues to be a controversial topic that spans policy implementation, healthcare delivery, private industry, insurers, the insured, and those individuals who remain without care (Chaufan, 2015; Manchikanti, et al., 2017; Obama, 2016; Wilensky, 2017). While ACA legislation was crafted to increase affordable healthcare to over 20 million U.S. citizens, reduce healthcare spending, and improve healthcare quality, the ACA increased healthcare coverage. However, it also has caused approximately six million middle-income people to lose health insurance, negating part of its overall policy goals (Manchikanti et al., 2017). The ACA's goal of quality improvement created unintended consequences that exacerbated both cost- saving efforts and quality care delivery (Manchikanti, et al., 2017). For example, Casalino et al. (2016) found that physicians spend upward of $15.4 billion annually to maintain ACA regulatory reporting requirements. Quality control within the healthcare industry has many benefits, but careful consideration for the impact of costs to support policy is beneficial (Casalino et

al., 2016). With six million middle income people losing healthcare, readdressing the components of the goals of the plan necessitated additional research.

The literature review of the impact of Obamacare on the U.S healthcare system is prudent. The ACA had a tremendous impact on the U.S. healthcare delivery system in several important and controversial ways. According to Obama (2016), the ACA was transforming the U.S. healthcare system through the implementation of Affordable Care Organizations (ACO) and bundled payments that assisted in reducing costs. Obama's reference to Medicare's transformation and the reduction in spending through ACOs mirrors the assumptions presented by Kocher and Chigurupati (2016), albeit in a different way. For example, Kocher and Chigurupati (2016) made the case that ACOs provide cost savings for insurers and financial incentives for primary care physicians at the expense of patient care. To the contrary, Obama's research upholds ACOs as a positive cost saving reform measure without reporting on the impact that cost saving strategies have on quality care delivery (Obama, 2016). The decline in the number of uninsured was also cited as a positive ACA outcome with an increase of approximately 20 million persons insured between 2010 and 2015 (Obama, 2016). The reduction in the uninsured was linked to a sizable increase in Medicaid patients as reported by Kocher and Chigurupati (2016). Obama advocated that the ACA's role in attempting to address the complex challenges that are intrinsic to the U.S. healthcare system was undeniable and policy makers should improve the ACA by addressing problematic areas that are evident (Obama, 2016). Affordable healthcare for all and reducing the number of individuals without health insurance encapsulates milestones which can be attributed to the

implementation of the ACA. As with all policies not everyone is completely satisfied with the components of the policy.

I assessed data from earlier researchers to gain understanding of how the healthcare systems of other countries paralleled to the ACA. According to Chaufan (20□5), the ACA was touted as a panacea for a burgeoning U.S. healthcare system, but arguments prevailed regarding the benefits and pitfalls of the Act. Chaufan (20□5) reported that the U.S. healthcare system was considerably more expensive than other industrialized nations, yet health outcomes and vital statistics ranked far lower than industrialized nation averages. In addition, Chaufan (20□5) touted the benefits of a single payer system as an alternative to the ACA. The researcher reported that a single payer healthcare system has been applied in many industrialized nations with favorable results. Chaufan (20□5) also noted that when drawing a comparison between the ACA and a single payer healthcare system, the benefits around cost savings, access and quality care appear to be better than the disjointed construct that is characteristic of the ACA. It was concluded that the ACA is conjoined with the private insurance industry via ACOs, which maintain a profit-seeking focus. To ensure a return on investment, ACO strategies must be designed to minimize financial risk and promote profit. A promote profit shifting to a single-payer healthcare system was offered as a solution to a complex problem because implementation has the potential to reduce the confusion and take away the profit-seeking motive that is paramount in the U.S. healthcare industry (Chaufan, 20□5; Kocher & Chigurupati, 20□6). The ACA embraces a benefit that affords millions of

individuals to have affordable healthcare. The plan's void of not containing the functionality to a single-payer healthcare system is deemed as a drawback.

Examined literature of other researchers provided positive insight and benefits of the ACA. Orszag (20 6) acknowledged former President Obama's contribution to research on the healthcare gap. Orszag indicated that Obama's research emphasized the positive aspects of the ACA, such as an increase in U.S. healthcare coverage, a decline in healthcare costs, and an improvement in healthcare quality (Orszag, 20 6). However, Obama's arguments were countered by scholarly evidence that suggested that the downside of the ACA was more prominent than reported (Orszag, 20 6). An important aspect of the ACA is the increase in Medicare Advantage enrollment, which was thought to decline in response to insurer payment reductions (Obama, 20 6). The focus on mandatory bundled payments as a cost containment plan for Medicare was also addressed by Orszag. Many of the steps implemented to move the ACA agenda forward appear to have cost savings as the primary driver with quality care delivery floundering as an unintended consequence (Camillo, 20 6). For example, hospitals are penalized if patient readmissions rates are not reduced because insurers can deny reimbursing hospitals when patients are required to return after surgeries or procedures. The readmission policy can also influence medical decisions that are contrary to the health and well-being of the patient (Kocher & Chigurupati, 20 6; Orszag, 20 6).

The implementation of the Affordable Care Act came with advantages and disadvantages. Policy implementation is necessary, however; not all effected by the policy are satisfied with all the intricacies of the policy. Butler (20□6) explored many of the nuances associated with the implementation of the ACA. The researcher indicated that Medicaid and the Children's Health Insurance Program (CHIP) enrollment far exceeded projected ACA forecasts at approximately □7 million new enrollees in 20□6 (Butler, 20□6). The increased Medicaid and CHIP enrollments significantly surpassed the ACA forecast by approximately □0 million persons (Butler, 20□6). By contrast, exchange program enrollment was considered unattractive to low and middle-income groups because the plans provided uncertain benefits and out-of-pocket costs (Butler, 20□6). The unattractiveness of the ACA to the low and middle-income groups sought a response from the upcoming republican party.

The political approach to repeal the ACA and sign into law a change in federal commitments paying insurance plans, subsidies, pain ease through Medicaid expansion funds, and the individual mandate (Newkirk, 20□7), prompted me to explore how this political approach affects my studied population. Wilensky (20□7) discussed the political landscape that led up to the 20□6 election. The Republican Party's goal to repeal the ACA and the Democratic Party's desire to maintain the ACA was underscored as an area of political tension (Wilensky, 20□7). The Independent Payment Advisory Board (IPAB) was implemented in response to the ACA and proposed a reduction in reimbursement rates for healthcare facilities and providers if Medicare expenditures continued to grow at a pace beyond the gross domestic product (GDP) (Wilensky, 20□7). The need to reduce

Medicare rates was offset by a reduction in Medicare expenditures that can be correlated to existing cost saving measures (Wilensky, 20□7).

Numerous challenges must be navigated to make the ACA more beneficial to the public. Congress has the responsibility to address the problematic systemic areas (Wilensky, 20□7). Replacing the ACA with a single payer system may be a practicable option because the change would provide a balance between cost savings and improved quality care. However, the interdependence that is maintained between the government, drug companies, insurers, and healthcare providers are important factors that hinder the value of a single payer system (Chaufan, 20□5). The explored data regarding the healthcare for seniors revealed this population mirror those of hinderances of the Affordable care Act.

Medicare

Medicare is a unique government health insurance program because it is partially funded by income tax and further subsidized by government expenditures (Duckett, 20□8). Medicare has evolved into a complicated health insurance program that requires recipients to make health coverage selections that are considered difficult to understand (Blumenthal, et al., 20□5; Trivedi, 20□6). The Medicare health insurance program has expanded significantly since the inception of the Social Security Act Amendments of □965 (Archives.gov, □965; Ginsburg, & Rivlin, 20□5). Medicare offers health insurance to eligible participants 65 and older, certain disabled persons, and individuals with end stage renal disease (Duckett, 20□8). According to a review conducted by Blumenthal et al., (20□5), Medicare enrollment is projected to increase from 52.□million in 20□□to

approximately 8□8 million by 20□0. In 20□7, Medicare cost approximately $709.4 billion or approximately □4% of the U.S. government's spending (Duckett, 20□8). Data on how these plans are broken down and how an individual eligible for this coverage attains this coverage required further investigation.

The Medicare program is broken up into four parts. Part A covers inpatient hospital, nursing home, home health, and hospice care. Part B covers outpatient hospital care, end stage renal disease, laboratory services, medical equipment, relevant home health, and other medical services. Part C is identified as the Medicare Advantage Program, which includes private insurance providers under a cost sharing arrangement that includes a fixed fee monthly payment to cover services under Parts A and B. Prescription drug coverage is only covered under Part C if included in a selected plan. Part D covers prescription drugs (Duckett, 20□8). Trivedi (20□6) reported that there are approximately□8 plans under Medicare Part C and □0 additional plans under Medicare Part D. Complexity is further exacerbated by the recipient's lack of aptitude to examine each plan for both pitfalls and benefits (Blumenthal, et al., 20□5; Trivedi, 20□6). The projected growth of the Medicare program has contributed to changes that were initiated to sustain and reduce costs (Ginsburg & Rivlin, 20□5; Rother, 20□7). With this data in hand, I sought to learn how Medicare impacts seniors obtaining this coverage and the ease of purchasing these plans.

Medicare's Impact on Seniors

As seniors reach retirement age, they are automatically enrolled in Part A. Parts B and D are necessary if the individual requires prescription drug coverage. Olson, et al.,

(20□6) conducted a study to investigate the experiences of adult seniors 65 years and older with purchasing medications prior to the implementation of the Medicare Modernization Act of 200□and after the Patient Protection and Affordable Care Act of 20□0. The researchers used a data collection strategy that consisted of U.S. based, randomly mailed surveys in □998 and 200□followed by a national online survey in 20□5. The data analysis involved descriptive statistics and logistics regression to explain the relationship between the results and study variables (Olson et al., 20□6). The results showed that although the proportion of seniors without health insurance declined from □2% in □998 to 9% in 20□5), reports of financial hardship with purchasing essential medications rose from □2% to □5% during the same research period. The rise in out-of-pocket costs, which were correlated to higher insurance premiums, cost sharing, and medication prices, was a significant factor in the findings (Olson et al., 20□6). The implementation of these programs for seniors failed to combat the cost for seniors enrolled in these plans. Doshi, et al., (20□6), investigated Medicare Part D cost sharing and its influence on patient decisions to follow through with recommended treatment to extend life. The researchers retrospectively analyzed Medicare Chronic Condition fees for service data covering the period 20□□to 20□□, which consisted of □,05□cancer patients. The researchers found that the average out-of-pocket costs, associated with important cancer treatment medication, exceeded the monthly median income of the Medicare recipients, who mostly relied on social security income to survive. The structure of Medicare Part D cost sharing was determined to be an important factor to influence patient decisions to delay necessary specialty drug treatments. It appears that

research lends credence to the need for a Medicare policy adjustment that takes into consideration the effect that increased out-of-pocket costs have on recipients who survive on a fixed income (Olson et al., 20□6); Doshi et al., 20□6). This data of these researcher provided robust information to conduct this study, I continued to examine data to learn more about the healthcare policy and the benefits for seniors.

Medicare advantage plans or Part C is an option individuals can enroll in for their healthcare coverage. Keohane, et al., (20□5) examined Medicare Advantage policy and its impact on patient out-of-pocket spending for skilled inpatient medical services. The study sample was taken from a 20□□Medicare Advantage Healthcare Information data set of 8.□7 million beneficiaries across □,84□plans that met the inclusion criteria (Keohane et al., 20□5). The study outcomes highlighted that cost sharing under Medicare Advantage reduces redundant services, which is viewed as an important cost saving outcome. The researchers also reported that uncontrolled out-of-pocket expenses hindered patient decisions to use skilled inpatient medical services even though they may be necessary. The cost sharing requirement is problematic when Medicare Advantage plans contain cost sharing limits because patients who live on fixed incomes are marginalized when healthcare decisions are made at the expense of daily survival choices (Deal, 20□7; Doshi et al., 20□6; & Keohane et al., 20□5). Medicare supplement plans are viable options for individuals to have for their healthcare coverage. I sought to explore how the coverage amid the plans differed.

In a comparative analysis by Baker, et al., (20□6), pay differences between Medicare Advantage and traditional Medicare insurance plans were explored. The

researchers analyzed 40 million records from the healthcare Cost Institute and Medicare claims data. Price differences in inpatient hospital claims between 2009 and 20□2 were calculated (Baker et al., 20□6; Zolkoski & Bullock, 20□2). It was concluded that Medicare Advantage plans, under the auspices of ACOs, paid approximately 5.6% less for inpatient medical services than traditional Medicare. The researchers inferred that a gap existed regarding investigating pay differences between the two programs. The leveraging power of Medicare Advantage plans was a contributing influence in the price differences, which was also identified as an important public policy concern (Baker et al., 20□6). Additionally, Lewis, et al., (20□9) conducted a qualitative research study to understand the changes that ACOs initiated to improve quality care delivery and reduce costs. Data was gathered from semi-structured interviews with executives from □0 ACOs (Lewis et al., 20□9). The sample was required to have secured ACO contracts including the Medicare shared savings program, which is a component of Medicare Advantage. The data analysis resulted in themes that highlighted four primary areas targeted for cost savings: transforming healthcare delivery through a team-based approach, reducing emergency room visits, improving patient management, and expanding networks to increase collaboration (i.e., boundary spanning) (Lewis et al., 20□9). These findings relate to Baker et al.'s (20□6) findings because both studies found that cost savings were the primary driver behind the development and implementation of the ACO model with an inference of improved quality care. However, patient out-of-pocket costs were important in ascertaining value from the perspective of the patient.

The Centers for Medicare & Medicaid Services implemented a chronic care management (CCM) payment policy in 20□5, which was designed to create a new payment paradigm (Marici, 20□5). The implementation of the chronic care management policy gave medical providers the ability to bill for services under a tele-health construct that did not require the patient to report to the office. The healthcare management process was, therefore, allowed to begin after the patient received their first in-office visit, at which time, a 20-minute tele-health visit would be allowed once a month. The out-of-office visits were paid for under a fixed fee model with a 20% co-pay or out-of-pocket payment expected of the patient. Managing patients with chronic conditions was identified as an area of importance because many of the conditions characterized as chronic require a higher level of medical attention resulting in higher costs (Buntin & Ayanian, 20□7; O'Malley et al., 20□7). I included the results of this study as the data provided insight on policy implementation that affects the experiences of this population amid rising cost.

Seniors are probable for aging and might require additional services for chronic care. I explored data to provide insight on chronic care and the elderly. O'Malley et al. (20□7) conducted a qualitative study to explore provider experiences correlated with Chronic Care Management (CCM) services and fees. The researchers collected data via semi-structured telephone interviews with 60 healthcare providers and □□professional society representatives (O'Malley et al., 20□7). The outcome of the study revealed that the CCM model, on the surface, appeared to offer benefits, such as facilitating a medical management structure designed to contain costs and improve service delivery (O'Malley

et al., 2017). However, the results were not consistent among providers. Several providers experienced challenges in sustaining the CCM model because it required an increase in staffing and quality assurance reporting, which resulted in higher administrative costs. Findings by Casalino et al. (2016) corresponded to participant reports captured by O'Malley et al. (2017). The researchers noted that providers had concerns about patients with low incomes because of the difficulty in meeting the CCM copayment requirement (O'Malley et al., 2017). The inability to afford sufficient staff to offer quality care to individuals raises concern. I sought to understand how individuals with lower incomes receive and or manage their care with chronic conditions.

The divide between low-income Medicare recipients and people who can afford private insurance raises concerns when low-income individuals with chronic medical conditions are identified as burdens on the healthcare system in terms of cost and access to quality care (Buntin & Ayanian, 2017; Ginsburg & Rivlin, 2015; Hosseini, 2015). Buntin and Ayanian (2017) explored social risk factors related to Medicare payment disparities. The researchers analyzed data from providers, health plans, and patients with dual eligibility for Medicaid and Medicare. The outcomes of the study showed that healthcare providers can be marginalized when social risk factors are omitted from Medicare quality reporting in relation to the reward payment structure (Buntin & Ayanian, 2017). This contention was identified because providers who serve a disproportionate number of disadvantaged patients could be penalized for factors that are not relative to quality care. The Medicare and Medicaid payment systems were reported

as inadequate and created a disparity in access and quality for patients who did not possess sufficient financial resources (Buntin & Ayanian, 20□7).

Political concerns remain regarding higher Medicare costs for treating chronic medical conditions that are characteristic of older individuals (Baylis et al., 20□5; Hosseini, 20□5; Rother, 20□7). The primary recipients of Medicare are adults 65 and older who rely on Social Security and other fixed income assets to manage life. Many of the strategies used to reduce Medicare costs do not appear to consider out-of-pocket costs (Applebaum & Cummings, 20□7; Doshi et al., 20□6; Keohane et al., 20□5; Lewis et al., 20□9; Polivka & Luo, 20□5). According to 20□6 Centers for Medicaid and Medicare data, recipients without co-insurance were required to pay a $□,288 deductible for an inpatient hospital event lasting from one to 60 days (Duckett, 20□8). A gap appears to exist between the policies that are being implemented to contain the growth of Medicare costs and the recipients' abilities to keep up with rising out-of-pocket healthcare expenses (Blumenthal, et al., 20□5; Perlis & Perlis, 20□6; Rother, 20□7).

Summary

The literature review was structured to align with the research problem, study purpose, study theoretical foundation, and research questions. Several topics proved pertinent to the study including resilience theory, seniors and healthcare, the U.S. healthcare system, the Patient Protection and Affordable Care Act, and Medicare. By conducting a comprehensive examination of the literature within the context of the study

design, an understanding was gained of relevant research concerning the problem and what remains to be investigated.

The U.S. healthcare system to Medicare is a significant public policy concern because of current and projected costs that are compounded by competing priorities between the government, the insurance industry, pharmaceutical industry, and healthcare providers (Baylis et al., 20□5; Buntin & Ayanian, 20□7; Doshi et al., 20□6; Hosseini, 20□5; Lewis et al., 20□9; Rother, 20□7). The literature revealed that healthcare costs in the U.S. far exceed the healthcare expenditures of other industrialized nations (Camillo, 20□6; Olson et al., 20□6; Papanicolas et al., 20□8). The cost gap between the United States and other countries is linked to the multiplicity of the United States healthcare system, which is different from the single payer systems utilized by other nations (Camillo, 20□6; Papanicolas et al., 20□8). The rise in United States healthcare expenditures has ushered in policy changes designed to reduce and sustain healthcare costs over time (Kocher & Chigurupati, 20□6; Meisel et al., 20□6; Rahurkar, et al., 20□5).

The ACA was presented by former President Barack Obama with Congressional approval, to provide healthcare coverage to all Americans (Congress.gov, 20□0; Manchikanti et al., 20□7). However, research has shown that the implementation of the ACA has been fraught with challenges in enrollment, quality improvement, and cost containment (Chaufan, 20□5; Manchikanti et al., 20□7; Obama, 20□6; Wilensky, 20□7). Studies conducted to explore the effectiveness of the ACA have focused on quality improvement and cost reduction efforts (Butler, 20□6; Casalino et al., 20□6; Orszag, 20□6; Wilensky, 20□7). The utilization of ACOs was implemented under the ACA to

improve healthcare quality and reduce healthcare costs within Medicare Advantage programs. ACOs use a cost sharing strategy that rewards providers when costs are reduced. The cost reduction strategy has the potential to negatively impact Medicare patients because a financial incentive exists for doctors to limit care even though care may be needed (Kocher & Chigurupati, 20□6; Orszag, 20□6). Medicare is a primary area of importance within the realm of U.S. healthcare spending because of its impact on the budget and the projected growth of the aging population (Baylis et al., 20□5; Blumenthal, et al., 20□5; Hosseini, 20□5; Rother, 20□7).

The literature explored the nuances associated with healthcare delivery, quality, and cost reduction (Doshi et al., 20□6; Ginsburg & Rivlin, 20□5; Lewis et al., 20□9; Rother, 20□7). However, research also reveals that Medicare is an unstable system that continues to evolve with cost savings being a primary focus (Baker et al., 20□6; Keohane et al., 20□5; Olson et al., 20□6; O'Malley et al., 20□7;). Several scholars have affirmed that qualitative research on the human experience is useful for informing policy decisions and impacting outcomes (Chouinard, 20□□; Richardson, 20□4; Saetren, 20□4). A gap exists in the research regarding how Medicare recipients are impacted by healthcare policy changes. As such, this qualitative phenomenological research study was designed to address this gap by exploring how Medicare recipients manage their healthcare needs on fixed incomes. Chapter three will explain the methods that will be used to initiate the data collection and analytic processes.

Chapter 3: Research Method

The purpose of this qualitative phenomenological study was to explore, understand, and describe the essence of the lived experiences of Medicare recipients 65 and older who may be directly impacted by Medicare coverage cost-sharing policies. The resilience theory guided the study to explore the phenomenon of how Medicare recipients manage their healthcare needs. The data were gathered through semi structured interviews from 12 respondents who were Medicare recipients and resided in Henry, Clayton, and Dekalb counties, Georgia. Chapter 3 outlines the research methods, which comprises the research questions, design and rationale, role of the researcher, methodology, and issues of trustworthiness. The chapter ends with a chapter summary.

Research Design and Rationale

This subsection includes the research questions and the phenomenological design rationale.

Research Questions

Medicare recipients face rising out-of-pocket costs necessary to secure medication, inpatient, and outpatient care (Cubanski et al., 2017; Hosseini, 2015; Keohane et al., 2015; Olson et al., 2016). According to Dean et al. (2017), approximately 66% of Medicare recipients are afflicted with two or more medical conditions, and half survive on incomes below the poverty level. In this study, I sought to answer two research questions: How do the rising costs of Medicare premiums and copayments impact the ability of recipients to manage their healthcare needs? and (b) What strategies do Medicare recipients use to address their unmet healthcare coverage needs?

Phenomenological Approach

The phenomenon central to this study was strategies used by Medicare recipients 65 and older to manage healthcare needs. After reviewing qualitative research approaches, the phenomenological approach was determined to align with the aim to explore the phenomenon through the perceptual experiences of the participants (see Eddles-Hirsch, 20□5).

Several researchers have agreed that the phenomenological approach is applicable when there is a need to understand a phenomenon within the limits of the participant's reality as reported (Alase, 20□7; Creswell, 20□□; Moustakas, □994). The process of identifying the best qualitative approach involved a review of the benefits and drawbacks associated with ethnography, grounded theory, narrative, and case study research methods. The ethnographic and grounded theory approaches were ruled out because this study did not involve an exploration of cultural characteristics, and my use of the resilience theory negated the need for a grounded theory approach (see Creswell, 20□□; Fusch et al., 20□7; Nagel et al., 20□5). The narrative approach was considered, but a review of its application proved incongruent with my use of semi structured interviews as the data gathering instrument (see Creswell, 20□□).

The case study approach appeared to be suitable because of its application in examining a specific case in conjunction with multiple data sources (see Creswell, 20□□; Yazan, 20□5). In contrast, this study required an exploration into the perceptions and experiences of a group of participants to gain a deep and rich understanding of the

phenomenon (Eddles-Hirsch, 20□5; Moustakas, □994; Patton, 2002). The latter solidified my rationale for using a phenomenological approach.

Role of the Researcher

The role of the researcher was to examine and interpret the lived experiences of the participants. Because behavior could have a positive or negative impact on the data gathering activity, professional boundaries problems were always maintained (see Alase, 20□7; Roulston & Shelton, 20□5). The aim was to create an atmosphere conducive for the participants to discuss their lived experiences within the context of the semi structured interview questions (see Alase, 20□7). Bias is a concern regarding qualitative research projects because data gathering involves contact with the participants and interpretations of the content (Leung, 20□5; Smith, 20□5). To mitigate bias, no person was allowed to participate in the study who I knew personally or professionally.

I was acutely aware that personal opinions about the topic of Medicare could have been an influential factor during my meetings with the participants and in my analysis of the findings (see Smith, 20□5). My opinion remained separate, and bracketing was used to ensure that the participant experiences were captured and analyzed from verbatim reports (see Eddles-Hirsch, 20□5). Informed consent is an important ethical requirement regarding research that involves human subjects (Hallinan et al.., 20□6). Thus, to adhere to ethical standards, IRB approval and informed consent was secured before the interviews were conducted and the data were gathered (see Hallinan et al., 20□6). Informed consent was validated through documented participant acknowledgements and signatures (see Hallinan et al., 20□6). Because the sample consisted of elders, care was

exercised to ensure that the selected participants were able to participate in the study at a functional level (see Padilla-Diaz, 20□5).

The Sample Selection Methodology

This section covers the participant selection logic, instrumentation used, procedures for recruitment, data collection process, and data analysis process. The van Kaam method of thematic analysis involves multiple steps. The multistep method was described by Moustakas (□994) and consists of a qualitative methodology to conduct a thematic analysis as described by Creswell & Creswell, (20□8). In this study, I specifically followed the modified van Kaam method popularized by Moustakas to create themes for analysis. Van Kaam's method includes (a) Horizontalization: All quotes and excerpts are considered equal in importance. All quotes that are relevant to the experience or phenomenon are grouped; (b) a list of quotes is separated by importance to the phenomenon; (c) themes are explored for latent meaning and grouped into themes; (d) themes are examined to make sure they are representative of the lived experiences; (e) an individual textural description is created for each participant; (f) a structural description is created to examine the emotional, social, and cultural connections between participants; (g) a composite description is created to relay common themes; (h) a composite structural description examines the emotional, social, and cultural connections experienced across all the participants; and (i) both the textural and the structural themes are merged to give a comprehensive understanding about the lived experience of the phenomenon (see Moustakas, □994). The modified Van Kaam analysis allows qualitative researchers to

explore the participants' lived experiences to understand the essence of the phenomenon through the voices of those who lived the experience (see Moustakas, □994).

Participant Selection Logic

This study included □2 participants 65 years of age and older who were enrolled in Medicare and resided in Henry, Clayton, and Dekalb counties, Georgia. The purposive sample selection logic linked to the need to explore and understand how Medicare recipients manage their healthcare needs. The participant sample was defined in this manner because research has confirmed that many Medicare recipients are impacted by financial constraints caused by the rising out-of-pocket costs necessary to maintain health and wellness (see Cubanski et al., 20□7; Doshi et al., 20□6; Jacobson et al., 20□5; Keohane et al., 20□5).

The purposive sample comprised adults 65 and older who received Medicare during the interview period. The Medicare program consists of traditional Medicare under Parts A and B and Medicare Advantage under Part C. Medicare Part D covers prescription drugs and is separate (CMS, 2022). The purposive sample criterion was specific to Medicare enrollment. Participants were required to draw their incomes from social security, retirement benefits, savings, and/or other nonworking subsistence. The purposive sample criterion aligned with the phenomenological research approach and resilience-based theoretical lens (see Alase, 20□7; Hart et al., 20□6).

For this study, □2 participants were estimated to be adequate to explore and understand the essence of the phenomenon if the selected participants met the purposive sample criterion (Creswell, 20□□; Padilla-Diaz, 20□5; Patton, 2002). Potential

respondents were sent an invitation via email, phone, social media posting or in person to participate using a purposive recruitment strategy. According to Patton (2002) and Taherdoost (20□6), using nonprobability sampling methods such purposive sampling is a viable strategy for efficiently overcoming recruitment obstacles and identifying participants with similar characteristics. Purposive sampling, also known as judgmental sampling, is a selective and subjective process used to assure that the units to be studied reflect the population of interest. Participants are self-selecting, and therefore can choose to take part in research on their own accord. Thus, in this study, I used self-selection and purposive nonprobability sampling techniques.

After securing the consent of the IRB, potential participants were given an informal overview of the study followed by the purposive recruitment question: Have you received Medicare coverage for the past two or more years? If the potential participant answered yes and agreed to participate, informed consent was secured via phone or email before an interview was scheduled. Researchers do not agree on what constitutes a sufficient sample size for a phenomenological research project, which ranges between three and 25 participants (Alase, 20□7; Eddles-Hirsch, 20□5; Patton, 2002). The need for saturation in relation to participant reports has been consistently cited by scholars (Alase, 20□7; Eddles-Hirsch, 20□5; Fusch et al., 20□7; Patton, 2002).

Instrumentation

Data were obtained through semi structured interviews conducted by phone or video chat using an interview guide (see Appendix B). Research on qualitative study approaches has demonstrated that completing open-ended response options requires a

greater amount of time and mental effort than most close-ended questions (Dillman, 2007). The burden of providing open-ended responses may fall more heavily on certain populations than others and can result in study abandonment. It is also suggested that interviews begin with open-ended questions that require the respondent to voice their opinions (Horr & Heimlich, 20□8). In consideration of negative bias, I carefully crafted the interview to contain a combination of easier to answer closed-ended questions as well as open-ended questions to provide the opportunity for individuals to describe their lived experiences.

Overall, it has been found that while a great deal of information can be gained from open-ended survey questions, some groups are more likely than others to provide responses, and these differences should be kept in mind when designing studies and interpreting qualitative study results. Adjustments were made to maximize response rates to each question in the interview instrument. The interview instrument designed for this study, therefore, included a combination of close-ended questions that were analyzed for frequencies as well as open-ended questions that were analyzed for themes to describe the phenomenon under study.

The interview guide was developed to promote consistency throughout the data collection process (see Camillo, 20□6). An interview guide can be instrumental in aligning the research questions with the interview questions for the purpose of exploring the phenomenon within the context of the research design. The interviews were digitally recorded, transcribed, and submitted to the participants for validation prior to the data analysis. No other data collection instruments, except the field notes, were used for this

study. The guide incorporated resilience as the theoretical lens. For example, Questions through 4 were designed to address the central research question, while Questions 5 through 7 covered the sub question. Considering that the study design was qualitative, the interview guide was designed to explore the phenomenon as proposed (see Dikko, 20□6). The semi structured interview questions ensured that the same criteria were used for each participant to support replication and reliability (see Castillo-Montoya, 20□6; Leung, 20□5).

Assessment of the tool was acquired before using it for interviewing the study participants. The Agree II assessment tool was used to create a measure of the level of agreement between the raters to assess content validity of the interview questions (see Brouwers et al., 20□0). A panel of four evaluators read and graded the quality of the written interview tool for studying the research questions and describing the phenomenon of interest. The panel also provided comments regarding the interview questions to ensure that the questions were aligned with the research purpose (see Castillo-Montoya, 20□6; Dikko, 20□6; Leung, 20□5). The panel consisted of four stakeholders and included a (a) primary care practitioner, (b) director of operations for elder healthcare services, (c) doctoral level public health research methodologist, and (d) a Medicare recipient.

The level of agreement regarding clarity and appropriateness of interview questions was explored, and the content validity of the interview questions was estimated. An interrater reliability statistic of alpha = .8□was measured, indicating a rater agreement level well above the minimum alpha of .70 was needed to confirm the validity and reliability of the interview tool.

Procedures for Recruitment and Participation

The data were collected from □2 respondents who were Medicare recipients aged 65 and older. Once IRB approval was secured, the sample was acquired using a continuous process of circulating mail, email, social media posts and personal contact to viable candidates who met the inclusion criteria. Local senior citizen centers and churches were contacted through telephone, email, and flyers to identify potential candidates. The invitation to participate was included as part of the initial communication (see Appendix A). As the participants were located and recruited, informed consent was secured before an interview was scheduled. According to Alase (20□7), nonrandom recruitment strategies are appropriate when the need to identify participants who meet the inclusion criteria are enforced.

Data Collection

After informed consent was secured, the process of scheduling interviews began. Each semi structured interview was conducted using the interview guide to support the reliability of the findings (see Appendix A). To ensure confidentiality, participant names were not recorded. Instead of recording personal information, each respondent was assigned an identification code, which contained a letter and a number. The respondent had the choice to conduct the interview by telephone or Zoom video chat. The semi structured interview took between □0 and 45 minutes to complete. A total of □2 semi structured interviews were conducted between March □8 and 26, 202□ There was a slight delay in completing all interviews due to unanticipated COVID-□9 constraints.

Each interview was digitally recorded and transcribed with the consent of the participant. Interviews were member-checked by each participant who reviewed the transcripts for accuracy before the data were used for the analysis. The member-check technique helps to ensure accuracy, credibility, validity, and transferability (internal validity) of the data and to affirm or dispute the conclusions to decrease the possibility of incorrect entry or interpretation of data (Creswell & Creswell, 20□8; Smith, 20□5).

Data Analysis Plan

The data analysis plan aligned with the data collection procedure. The interview questions were linked to the central and sub research questions. For example, close-ended questions addressed the recipients' abilities to manage their healthcare expenses while the open-ended interview questions corresponded to strategies used to address their healthcare needs (see Appendix C).

The data was manually coded using the modified van Kaam method. Each interview was recorded, transcribed, read for clarity, and thematically analyzed (Eddles-Hirsch, 20□5; Syed & Nelson, 20□5). Any discrepant cases were identified during the preliminary grouping stage of the modified van Kaam method (Moustakas, □994).

Data analysis in phenomenological research involves the suspension of judgment because the method of analysis must capture the essence of participant experiences devoid of the perceptions of the researcher (Eddles-Hirsch, 20□5; Moustakas, □994). Moustakas' (□994) modified van Kaam method was used to identify themes gleaned from the participant interviews (Moustakas, □994). The modified van Kaam method involved horizontalization, preliminary grouping, reduction and elimination, and clustering, which

culminated into thematic descriptions that captured the lived meanings of the phenomenon (Moustakas, 1994; Padilla-Diaz, 2015).

The analysis of emergent coding was applied utilizing field notes along with the transcription of the interviews. Coding field notes line by line guided recollections and observations of the participant such as body language, verbal cues, or gestures during the interview. Each transcript was read thoroughly and was used to create preliminary groupings of the participant reports. The preliminary groupings were used to identify discrepant cases as warranted. The next step involved the reduction and elimination of overlapping statements. The horizons that were consistent and could be labeled were used for the next step, which involved clustering participant statements to form core and sub themes. After the development of these themes, the data were analyzed to extrapolate individual textural and composite descriptions that will highlight each participant's perception of the phenomenon. The data analysis integrated textural and structural description of data for the purpose of describing the phenomenon (Eddles-Hirsch, 2015; Moustakas, 1994).

Issues of Trustworthiness

Trustworthiness in qualitative research is a prerequisite to advancing the tradition in support of expanding knowledge (Leung, 2015; Queiros et al., 2017; Smith, 2015). Trustworthiness is promoted through transparent research procedures that encompass credibility, transferability, dependability, confirmability, and ethical domains (Cypress, 2017; Dikko, 2016; Gunawan, 2015; Leung, 2015; Smith, 2015). The scope of qualitative

research demanded that a measurable level of consistency be integrated into each research study (Cypress, 20□7; Gunawan, 20□5; Hammerberg et al., 20□6).

Credibility

Credibility is necessary regarding promoting trust in the research outcome (Cypress, 20□7; Hammerberg et al., 20□6). Because semi-structured interviews were the primary data collection method for this study, validation of the verbatim transcripts were incorporated into the research procedures (Smith, 20□5). To further promote the credibility of the findings, the data collection process was not complete until saturation, or the point in which new information was discovered, had been reached. Several researchers have confirmed that the validation of the transcribed data and saturation are procedures that support credibility in qualitative studies (Fusch et al., 20□7; Hammerberg et al., 20□6; Palaganas et al., 20□7; Smith, 20□5).

Transferability

Transferability was a necessary factor concerning this study because it offered opportunities for the findings to be correlated to similar circumstances, places, and contexts (Henry, 20□5; Leung, 20□5). Even though qualitative research results are not generalizable across populations, transferability expands a study's value to the larger academic community (Hammerberg et al., 20□6; Leung, 20□5). Transferability was confirmed through the implementation of Moustakas' modified van Kaam method of analysis. The data analysis procedures described the process used to address discrepant reports to include explaining the thematic outcome (Moustakas, □994). According to

Hadi and Jose Closs (2016), transferability can be evidenced by thick descriptions, which afford researchers the opportunity to ascertain how conclusions were reached.

Dependability

Dependability is commonly reported in academic literature and is primarily associated with qualitative research (Cypress, 2017; Leung, 2015). It is necessary when attempting to provide a level of authenticity that can be verified through each phase of the study design (Leung, 2015). Dependability was realized using a documented audit trail, which supports replication (Cypress, 2017). A study conducted by Henry (2015) revealed that many researchers agree that an audit trail is an important measure in validating rigor in qualitative research.

Confirmability

Confirmability in a qualitative study addresses how bias and researcher-imposed subjectivity are mitigated (Roulston & Shelton, 2015). According to Palaganas et al. (2017) and Alase, (2017), reflexivity and bracketing are techniques that are paramount in neutralizing researcher bias and both strategies apply to this study. Reflexivity is the practice of maintaining self-awareness throughout the research process (Palaganas et al., 2017). Bracketing was used during the data gathering and data analysis processes to assist in separating personal perceptions from the perceptions of the participants (Alase, 2017).

Ethical Procedures

Special permission was not needed to gain access to the participants or data because the data collection process was conducted outside the purview of a government or private institution. The participants were recruited as private citizens, which required

informed consent. IRBs are established to monitor and support research endeavors with the goal of preserving research integrity (Hallinan, et al., 20□6). The IRB review process was an important step intended to safeguard participants and the data was not collected until IRB approval was secured (Alase, 20□7). In preparation to conduct research on human participants, Walden University's IRB application was completed and submitted for review as required. Approval was confirmed with an IRB number to identify the study document.

It was ensured that everyone asked to participate in the study met the study criteria prior to being asked to complete the consent form. The participants were selected using a purposive sample criterion and located through a self-selection recruitment strategy. Participants were able to complete the interview by phone in the comfort of their home.

Securing informed consent prior to conducting the participant interviews was paramount to make sure that the participants are fully aware of the research purpose of the study, voluntary nature of their participation, confidentiality of the study, and ability to withdraw consent at any time (Hallinan et al., 20□6). The risks to the participants were ascertained to be minimal; however, the exploratory nature of the interview questions leaves room for concern (Alase, 20□7). I was prepared to discontinue the interview and contact emergency medical assistance if required, however, this was not needed during the interview process. All (□00%) of the interviews were conducted by phone to accommodate social distancing mandates during the COVID-□9 pandemic.

The participants were informed that the interviews would be digitally recorded and that they would not be identified in the recordings. They were also reminded that they could skip a question or withdraw from the study at any time. To support participant anonymity, each participant was assigned a number that corresponded to their entry into the study. For example, the first participant was identified as participant number one. The interviews were recorded and transcribed by a professional transcription service. Names of the participants were not recorded to maintain confidentiality and anonymity (see Appendix D).

The interview guide, interview recordings, transcripts, consent forms, IRB application, emails, and notes were safeguarded in a locked file cabinet. No other person had access to the data storage area. All the data related to this study will be kept for at least □years as required by the university and the Department of Health and Human Services under 45 CFR 46.□□5. The study has no connection with any personal interests nor were financial incentives offered for recruitment purposes. The IRB approval number for this study is 02-08-2□-065826□

Summary

The purpose of this qualitative phenomenological study was to explore, understand, and describe lived experiences of Medicare recipients who may be impacted by rising Medicare cost-sharing policies. The resilience theory was used to guide the study and the phenomenon of interest. The data were gathered through semi-structured interviews with a group of N=□2 participants over the age of 65, who currently receive Medicare benefits and reside in Henry and Dekalb counties, Georgia.

The participants for this study were selected using a purposive sampling process. A self-selection sampling strategy was used to recruit participants who met the inclusion criteria. The interviews were digitally recorded, transcribed, and analyzed to maintain participant confidentiality. The data analysis utilized Moustakas' modified van Kaam method, which involves preliminary grouping, reduction and elimination, and clustering before culminating into thematic descriptions that capture the meaning of the phenomenon (Moustakas, □994).

Chapter three addresses trustworthiness through transparent research procedures that encompass credibility, transferability, dependability, confirmability, and ethical domains. As the safety of the research participants is a primary area of concern, IRB approval was secured, informed consent was provided, and follow-up procedures were created. Chapter four was completed after the data collection process concluded. That chapter contains an introduction as well as information on the research setting(s), demographics of the participants, data collection process, data analysis process, issues of trustworthiness, results and ends with a summary.

Chapter 4: Results

This qualitative phenomenological study was conducted to bridge a gap in knowledge by exploring, understanding, and describing the lived experiences of Medicare recipients 65 and older who are directly impacted by Medicare coverage cost increases. To describe the phenomenon, data were gathered through semi structured interviews from a total of □2 Medicare recipients who resided in Henry, Clayton, and Dekalb counties in Georgia. The interviews included open and closed-ended questions to receive different experiences and insights that led to the discovery of the lived experiences of the □2 participants.

The resilience theory was used to guide the exploration of how Medicare recipients manage their healthcare needs on fixed incomes. Resilience theory was applicable because the central phenomenon of interest was how recipients could manage their healthcare needs in the face of climbing costs while on a fixed income, which requires a high degree of resilience. A review of the literature supported the application of the resilience theory to address an important gap in the topic of aging and healthcare policy (see MacLeod et al., 20□6; Phillips et al., 20□6; Randall et al., 20□5; Schembri & Ghaddar, 20□8; Terrill et al., 20□4; Tkatch et al., 20□7).

The study was conducted in accordance with Walden University's IRB to ensure ethical protection for each respondent. Each participant received an electronic consent form and offered their consent electronically. After obtaining the electronic consent, each participant was contacted by phone to set up an interview time and date convenient for them. Each respondent was interviewed over the phone and was asked □0 interview

questions, which required approximately □5 minutes to complete. The interviews were recorded and transcribed for analysis. All data will remain securely stored for 5 years, as required by Walden University.

Research Questions

This study contained two central research questions: (a) How do the rising costs of Medicare premiums and copayments impact the ability of recipients to manage their healthcare needs? and (b) What strategies do Medicare recipients use to address their unmet healthcare coverage needs?

Setting

Healthcare in the United States accounts for over □8% of the entire economic budget and far exceeds the per capita spending of any other industrialized nation (Camillo, 20□6; Kesselheim et al., 20□6; Osborn et al., 20□6a). The enormous impact of healthcare spending on the national economy has caused it to be a leading policy concern. The ACA has employed a range of strategies to improve healthcare quality, reduce healthcare costs, and increase access (Cohn, 20□4; Kocher & Chigurupati, 20□6; Orszag, 20□6). However, spending for senior citizens has continued to increase exponentially over time (Colla et al., 20□6; Dielman et al., 20□6; Iyengar et al., 20□6; Neuman et al., 20□5). The standard premium for Medicare Part B increased to $□44.60/month in 2020, up from $□□5.50/month in 20□9. The Social Security Cost of Living Adjustment was □6% for 2020, which increased the average retiree's total benefit by about $24/month. However, the cost of healthcare to seniors continues to grow. The rising costs

can profoundly impact those who rely on Medicare to address healthcare concerns (Biggar & Hood, 20□5; Camillo, 20□6; Wilensky, 20□7).

This qualitative phenomenological study was designed to explore and understand how Medicare recipients are affected by premium increases and how they manage their healthcare needs in a climate of rising healthcare costs. Two specific questions were explored: (a) How do the rising costs of Medicare premiums and copayments impact the ability of recipients to manage their healthcare needs? and (b) What strategies do Medicare recipients use to address their unmet healthcare coverage needs?

The results of the study add to the body of health policy literature and can assist in addressing the effects of out-of-pocket costs to seniors dependent on Medicare for healthcare.

Demographics

A purposive sample of □2 individuals completed a semi structured interview, and the data were analyzed to answer the two main research questions. Findings from the questionnaire indicated that each respondent's education encompassed a high school education, and two of the participants had graduate degrees. Two in three respondents were female (66.7%) versus male (□□.□%). The ages ranged between 65 and 77, for a mean of 70.2 years of age. Half of the respondents were under 70, half were over 70, and most respondents received benefits for less than 5 years, followed by 5 to □0 years, and then over □0 years. Respondents reported their general health as either good (75%) or fair (25%) and were most likely to report having diabetes, high blood pressure, and high

cholesterol. Study respondents were relatively younger than national figures (See Table □).

Table 1

Sample Demographics

Descriptor	Frequency	Percentage
Gender		
Female	7	66.7
Male	5	□□.□
Education		
High school	□	25.0
Trade school/some college	□	50.0
College degree	□	8.□
Graduate degree	2	□6.7
Age group		
Under 70	6	50
Over 70	6	50
Medicare beneficiary		
Under 5 years	4	□□.□
5-□0 years	□	25.0
Over □0 years	5	4□7
Health status		
Good	9	75.0
Fair	□	25.0
Health conditions		
Diabetes	□	25.0
High blood pressure	□	25.0
High cholesterol	2	□6.7
Arthritis	□	8□8

Data Collection

The 10-item semi structured study instrument included a 15-minute semi structured questionnaire. The survey captured the basic demographics and lived experiences of the 12 participants. Flyers requesting study participation were placed in several locations. Each participant was 65 or older, was enrolled in Medicare, and resided in Henry, Clayton, or Dekalb counties, Georgia. Each interview was conducted telephonically and was audio-recorded, transcribed, and member-checked for accuracy. Each participant was given the opportunity to review the interview transcript and make any necessary corrections before their data was included in this study.

Data Analysis

The thematic analysis was based on the recorded interviews conducted with 12 participants. Creswell (2014) outlined six steps of qualitative data analysis to include (a) transcribing interviews, (b) organizing and preparing the data, (c) reading and examining all the data, (d) compiling different categories that can be used to present themes for analysis, (e) interpreting the data, and (f) presenting the findings of the study. The purposive sample criteria assisted in delineating the participant sample, which is necessary when exploring the phenomenon within the context of the phenomenological research design (see Padilla-Diaz, 2015). The resilience theory was selected as the theoretical lens by which to explore, understand, and describe the lived experiences of Medicare recipients 65 and older who manage their health and survive on a fixed income. The primary premise that characterizes resilience is its value in exploring how people, groups, and organizations overcome or manage adverse conditions and circumstances

(Ayala & Manzano, 20□4; Capano & Woo, 20□7; Ungar, 200□). The resilience theory applied to this study because the central phenomenon of interest was exploring how the rising cost of Medicare impacts recipients' abilities to manage their healthcare needs while on a fixed income.

Evidence of Trustworthiness

In this qualitative research study, the validity and reliability were established using credibility, transferability, dependability, confirmability, and ethical domains. Credibility was established by ensuring that the responses recorded were clear throughout the study. Verbatim experiences of each participant were incorporated into the research procedures. In addition, the interviews with participants were not interrupted or ended prematurely eliminating the possibility of miscommunication. An electronic copy of the responses was sent to each participant within □week after their interview to review for accuracy before the data were included in this study. Transferability was established through note taking throughout each phase of the research process. All logs and notes will be kept secured for 5 years, as required by Walden University.

Credibility

Credibility is necessary regarding promoting trust in the research outcome (Cypress, 20□7; Hammerberg et al., 20□6). Semi structured interviews were the primary data collection method used for this study; validation of the verbatim transcripts was incorporated into the research procedures (see Smith, 20□5). To further ensure the credibility of the findings, the data collection process continued until saturation was reached. Several researchers have confirmed that the validation of the transcribed data

and saturation support credibility in qualitative studies (see Fusch et al., 20 7; Hammerberg et al., 20 6; Palaganas et al., 20 7; Smith, 20 5).

Transferability

Transferability was necessary because it offered opportunities for the findings to be correlated to similar circumstances, places, and contexts (see Henry, 20 5; Leung, 20 5). Even though qualitative research results are not generalizable across populations, transferability expands a study's value to the larger academic community (Hammerberg et al., 20 6; Leung, 20 5). Transferability was confirmed through the implementation of Moustakas's (994) modified van Kaam method of analysis. The data analysis procedure describes the process used to address discrepant reports to include explaining the thematic outcome (Moustakas, 994). According to Hadi and Jose Closs (20 6), transferability can be evidenced by thick descriptions, which afford researchers the opportunity to ascertain how conclusions were reached.

Dependability

Dependability is commonly used in qualitative research (Cypress, 20 7; Leung, 20 5). It is necessary when attempting to provide a level of authenticity that can be verified through each phase of the study design (Leung, 20 5). Dependability was realized in this study through a documented audit trail, which supported replication (see Cypress, 20 7). A study conducted by Henry (20 5) revealed that many researchers have agreed that an audit trail is an important measure in validating rigor in qualitative research.

Confirmability

Confirmability in a qualitative study addresses how bias and researcher-imposed subjectivity are mitigated (Roulston & Shelton, 20□5). According to Alase (20□7) and Palaganas et al. (20□7), reflexivity and bracketing are techniques that are paramount in neutralizing researcher bias, and both strategies applied to this study. Reflexivity is the practice of maintaining self-awareness throughout the research process (see Palaganas et al., 20□7). Bracketing was used during the data gathering and data analysis processes to assist in separating personal perceptions from the perceptions of the participants (see Alase, 20□7).

Ethical Procedures

Ethical procedures in this study were carefully followed. Each participant was provided with an informed consent letter and required to provide their consent in written form electronically. No contact was made with the participants prior to approval from the IRB. IRBs are established to monitor and support research endeavors with the goal of preserving research integrity (Hallinan et al., 20□6).

Results

Respondents completed a series of close-ended and open-ended questions to assess their experience with financing Medicare expenses. Close-ended answers were reported as frequencies and percentages and repeated themes or patterns to respond to open-ended questions were examined. Summaries of responses to questionnaires are listed below:

Participant 00□was a76-year-old female who had been enrolled in Medicare for □□years. She was an educator/consultant before retiring. She was enrolled in Medicare

Parts A & B with Part D prescription drug coverage and rated her satisfaction with her benefits as fair and very expensive. She did not report experiencing any difficulties affording the monthly premiums or her medical coverage and did not practice any strategies to manage her healthcare costs.

Participant 002 was a 77-year-old male who had been enrolled in Medicare for 2 years. He was an educator before retiring. He was enrolled in Medicare Parts A & B with Part D prescription drug coverage and was extremely satisfied with health coverage and was not having any difficulty affording his monthly premiums. He did not practice any strategies to manage his healthcare costs.

Participant 00 was a 66-year-old male who had worked as a warehouse worker before retiring. He was enrolled in Medicare Parts A & B with Part D prescription drug coverage and reported being somewhat satisfied with his current Medicare coverage but was having extreme difficulties affording the rising cost in monthly premiums. He used a range of resources and drug discount programs to cover the rising costs of his medications.

Participant 004 was a 72-year-old female. She was a college graduate and was an appeals officer with the Internal Revenue Service before retiring. She was enrolled in Medicare Parts A & B and had Part D prescription drug coverage. She described being extremely satisfied with her current health coverage, was not experiencing any difficulties affording her monthly premiums, and did not use any strategies to overcome the rising costs of her healthcare coverage.

Participant 005 was a 72-year-old female enrolled in Medicare for 9 years. She was a high school graduate and was a Communications officer at Fulton County 9□□ before retiring. She was enrolled in Medicare Parts A & B and Medicare advantage plan or Part C, and Part D prescription drug coverage. She described being extremely satisfied with her current Medicare coverage. She did not experience any difficulty to maintain her coverage, and she did not practice any strategies to meet the rising costs of healthcare premiums.

Participant 006 was a 70-year-old male enrolled in Medicare for 5 years. He completed one year of college and was a Traffic Control supervisor with the Department of Transportation before he retired. He was enrolled in Medicare Parts A & B, a Medicare supplement plan, and a Part D prescription drug plan. He described his Medicare coverage as excellent but is not satisfied with the costs for premium and deductible coverage. He explained that his healthcare costs are barely covered by his monthly social security benefit and finds it extremely difficult to afford the rising costs. He explained that he tries to maintain good health and avoid medical visits to control the rising costs of healthcare. He described how seniors have served the country by paying into social security to keep this country going and need more than what is currently offered to survive.

Participant 007 was a 68-year-old female who was an office Manager for the National Federation for the blind before retiring. She was enrolled in Medicare Parts A & B and a Medicare advantage plan or Part C which encompasses a prescription D drug plan. She described satisfaction with her current Medicare coverage and does not

experience any difficulties affording the rising cost in Medicare premiums or healthcare coverage and does not have to practice any strategies to meet her healthcare needs.

Participant 008 was a 72-year-old male who was a Truck Driver and Warehouse worker before retiring. He was enrolled in Medicare Part A only and was not enrolled in Part B or a prescription D drug plan because he receives all his healthcare needs through the Veterans Administration. He described his Medicare coverage as "Fair" and used the Veterans Administration to meet his medical needs. He has not experienced financial challenges, and he does not practice any strategies to meet the rising costs of healthcare coverage.

Participant 009 was a 68-year-old female who was a Clerk at the United States Postal service before retiring. She was enrolled in Medicare Parts A & B and a Medicare Part C advantage plan and Part D prescription drug plan. She described her experience as extremely satisfied with her current Medicare coverage and is not experiencing any difficulty affording the monthly premiums. She explained not practicing any strategies to meet the rising cost in healthcare coverage.

Participant 0□0 was a 69-year-old male who worked as a mixer for Sara Lee Bakery before his retirement. He was enrolled in Medicare Parts A & B and was unsure if he had prescription drug coverage. His general health was fair and reported somewhat satisfied with the current Medicare coverage he has. He is not having any level of difficulty affording his monthly premiums and does not practice any strategies to meet the rising cost of healthcare coverage.

Participant 0□□was a 70-year-old female who was a Medical Assistant before retiring. She was enrolled in Medicare Parts A & B, Medicare Advantage Part C and Medicare Part D prescription drug coverage. She described her satisfaction with her current Medicare coverage as extremely high but having trouble paying for her Medicare premiums because food is expensive, and she does not qualify for food stamps. She described not having many necessities in her home to meet the rising Medicare costs. She cannot afford to keep up with the rising cost of living with the social security income she receives monthly.

Participant 0□2 was a 68-year-old female who was a Nurse's assistant before retiring. She was enrolled in Medicare Parts A & B, Medicare Advantage part C, and Medicare Part D prescription drug plan. She described her extreme satisfaction with her current Medicare coverage and is not worried about the cost of doctor visits or prescriptions. She did not report any financial challenges related to her Medicare coverage and did not use alternatives to meet her healthcare costs. However, she received $50.00 per month from her health plan to pay for food. In addition, the center where she resides provided free meals to residents on a weekly basis. She explained that not having to worry about food helps relieve the rising costs of healthcare.

Discrepant Case

Eleven of the twelve respondents reported satisfaction with their Medicare coverage except for one respondent (Respondent 006) who was not satisfied with his current coverage. This one respondent can be defined as a "discrepant case" or "outlier" case in which their experiences differ from the other respondents (Welch & Patton,

20□□). His dissatisfaction was a result of the high cost of financing the monthly premiums, deductibles and copayments, leaving him little left of his monthly social security benefit on which to survive. He further stated that his costs for medications tripled over the last year. According to this participant "we seniors have served our country, maybe not in the Military, but we have worked and paid into social security and kept this country going all our working lives and we need more than what Medicare is currently offering us to survive. "

Insurance Coverage

Traditional Medicare insurance consists of Part A, which covers hospital services, and Part B, which covers expenses including physician appointments, laboratory tests and X-rays. Among the □2 respondents, three quarters (75%) reported receiving Parts A and B. Half reported receiving Part C, and the majority (8□□%) reported receiving Part D, or prescription drug coverage (See Table 2).

Table 2

Medicare Benefits Received

Part	Frequency	Percent
Part A	9	75.0
Part B	9	75.0
Part C	6	50.0
Part D	□0	8□.□

Covering the Rising Cost-Share

Satisfaction with Medicare benefits was described as Excellent (58.□%), Good (□□.□%), and Poor (8.□%). However, over forty percent (4□6%) reported having difficulty meeting the rising costs of their Medicare premiums and copays. Over half reported at least one strategy used to meet the increasing cost of healthcare coverage. Responses seemed to suggest that although the coverage received was adequate for most beneficiaries, cost-sharing presented difficulties for nearly half of the respondents.

Difficulty Paying Increases

A small majority (58.□%) reported not having a problem with paying for the premium increases or co-pays, nearly half provided an example of what they did to meet the rising costs of Medicare coverage. Over four in ten respondents reported substantial difficulty and half described at least one strategy for meeting Medicare premium and copay expenses.

Table 3

Beneficiary Experience With Medicare

Experience with Medicare	Frequency	Percent
Satisfaction		
Excellent	7	58.□
Good	4	□□.□
Poor	□	8.□
Financial difficulty		
No	7	58.4
Yes	5	4□6
Alternative strategies		
No	6	50.0
Yes	6	50.0

The statements for strategies used to pay or cost sharing are listed below in Table 4.

Table 4

Thematic Analysis of Strategies Used for Meeting the Rising Cost of Medicare

Statements	Themes
I use different medication discount cards	Do not pay other bills
I do whatever I can to avoid going to the doctor	Avoid Clinical visits
I get all of my care from the Veterans Administration	Use Free Clinics
I must rob Peter to pay Paul	Less food/Nutrition
Prioritize what bills will be paid	
Avoid-eating or paying bills in order to afford medication	
Humana gives me 50 dollars a month for food	

Summary

The purpose of this qualitative phenomenological study was to bridge the gap in examining the lived experiences of Medicare recipients 65 and older who may be impacted by increases in cost-sharing. Each participant completed a semi-structured interview by phone and was provided a transcript of their responses to member-check for accuracy. During the study, I found that 9□6 % were satisfied with the coverage received through Medicare. However, nearly half experienced difficulties covering the rising costs of premiums and copays and practiced a host of strategies to compensate for rising financial costs. A thematic analysis identified (□) not paying other bills, (2) avoiding

clinical visits, (□) depending on free care clinics and (4) receiving food supplements, as thematic patterns to describe the survival strategies. Respondent needs for improving current Medicare spending policies as well as recommendations for future studies are discussed in Chapter 5.

Chapter 5: Discussion

The purpose of this qualitative phenomenological study was to explore and describe the lived experiences of Medicare recipients 65 and older who may be directly impacted by healthcare cost increases. The resilience theory was used to guide the exploration of how Medicare recipients manage their healthcare needs on fixed incomes. To describe the phenomenon, data were gathered through semi structured interviews from a total of □2 Medicare recipients who resided in Henry, Clayton, and Dekalb counties in Georgia. The interviews were audio-recorded and comprised open-ended questions to receive different experiences and insights that led to understanding the lived experiences of □2 Medicare recipients. Data for this study were based on semi structured interviews completed with the participants. I sought to describe the lived experience of meeting rising Medicare costs among this population.

Key Findings

While most of the respondents (58.4%) reported that they did not have a problem with paying increases for the premium or copays, it was noted that rising costs were difficult for four in □0 (4□6%) of the respondents. and half listed at least one method used to meet the rising costs. Strategies used by Medicare recipients to meet their financial needs included receiving care clinics, receiving nutritional benefits, using discount cards for pharmaceuticals, forgoing other less important bills, or forgoing clinical visits to avoid copays. The vast majority (9□6%) recommended that a higher proportion of medical costs should be covered by the Federal government, and while some suggested that all healthcare coverage should be free for seniors, □00% of the

respondents believed that Medicare should cover more of the healthcare costs of retired citizens and retired elders should not be forced to work to meet uncovered out-of-pocket healthcare expenses.

Interpretation of the Findings

The purpose of this qualitative phenomenological research study was to address this gap by exploring, understanding, and describing the lived experiences of Medicare recipients who are directly impacted by Medicare policies. The resilience theory was used to guide the exploration of how these □2 Medicare recipients managed their healthcare needs on a fixed income within a climate of rising healthcare costs. Findings of this small study found that four in □2 respondents were having trouble with cost-sharing, which suggests that as many as □0% of all Americans may currently have trouble meeting their financial obligations for meeting cost-sharing of Medicare premiums and copays.

In addition, strategies used to meet the rising costs place the recipient in danger of not receiving appropriate healthcare and place them at higher risk of chronic disease or premature death. It is important to recognize that the sample was about 70 years of age and relatively younger than the average life expectancy of 79 years. Findings carry tremendous implications for diminishing the quality of health and life expectancy of up to half of the 6□2 million Americans currently dependent on Medicare benefits.

Recommendations for Policy Change

A □00% of the respondents believed that Medicare should cover more of the healthcare costs of retired citizens. The themes regarding recommendations are summarized in Table 5.

Table 5

Respondent Recommendations for Medicare Policy Changes

Statements	Themes
We have worked and paid into the SS system our whole lives	Entitled
We seniors have served our country … maybe not in the military.	Entitled
but we kept this country going all our working lives.	Entitled
We have earned the right to have free Medicare coverage	Entitled
Medicare should cover costs of doctor visits and diagnostics.	Entitled
Medicare should cover more of the costs of low-income seniors	Fixed -Income
Lower the amount participants must pay for doctor visits.	Fixed -Income
Make medication affordable without having to work	Labor
Many seniors are not able to work.	Labor
We need more to survive.	Survival
Do not force us not to eat in order to pay bills for medication.	Survival

The respondents provided a host of conclusions and recommendations regarding changing policies to improve access to healthcare amid a climate that is dire for the aging population. The lived experiences of the study participants warrant the attention of policy makers and hold considerable importance to achieving social change. Entitlement was a

key theme shared by the respondents. Seniors who have contributed to the Social Security system throughout their working years expressed their right to retire comfortably on a fixed income. They expressed that the system currently causes difficulties and that they should not have to forgo necessities such as eating because they cannot afford their Medications, high deductibles, and copayments. The sample size used for this study was small, but it does represent the characteristics of the 80 million individuals who will be dependent on Medicare for their healthcare by 20□0 (see CMS, 2022). The lived experiences and demands of this population need to be considered when revising practices, policies, and regulations that affect the livelihoods and well-being of the aging population.

Medicare is the foundation of healthcare for millions of Americans and similarly is a major player in the nation's health system. Many scholars have examined the complexities of the rising cost of healthcare. Although the impact of Medicare costs on Federal spending is well understood, the potential impact of changing cost-share obligations on recipients have not been well studied (Biggar & Hood, 20□5; Bradley et al., 20□6; Dickman et al., 20□6; Stegeman et al., 20□4). This study was an opportunity to address rising costs from the perspective of recipients.

Limitations of the Study

Limitations are inherent in both quantitative and qualitative research projects. The reliability of the results improves when the limitations are identified, mitigated, and reported (Cypress, 20□7; Queiros et al., 20□7). The inability to generalize qualitative research results is considered a leading limitation. Leung (20□5) posited that

generalizability in qualitative research may be determined within the context of replicated research procedures, sample criteria, and rigor in data analysis. In order to promote transferability and dependability concerning this research project, the problem, purpose, theoretical framework, and research questions were congruently aligned. The purposive sample criteria assisted in delineating the participant sample, which is necessary when exploring a phenomenon (see Padilla-Diaz, 20□5).

The need to mitigate bias in qualitative research is covered in several studies (Eddles-Hirsch, 20□5; Queiros, et al., 20□7; Roulston & Shelton, 20□5; Smith, 20□5). To aid in addressing bias, reflexivity techniques were used to remain cognizant of my role as a researcher. Reflexivity is an ongoing process of introspection, which requires the researcher to maintain an understanding of personal values and assumptions (Palaganas, et al., 20□7; Roulston & Shelton, 20□5).

During my interaction with the participants and throughout the data analysis process, the bracketing strategy was applied to facilitate the transmission of participant perceptions and experiences devoid of any personal preconceived positions. Bracketing is a practice employed in phenomenological research that requires insightful separation (Eddles-Hirsch, 20□5; Padilla-Diaz, 20□5). Interview data were analyzed from verbatim transcripts and verified by the participants to address the potential for basically weaknesses and ensure the credibility of the findings (see Alase, 20□7; Smith, 20□5).

Recommendations

This research provides insight on the lived experiences of Medicare recipients ages 65 and older who may be directly impacted by healthcare cost increases. Medicare

accounts for 20% of all healthcare spending in the United States (Biggar & Hood, 20□5; Bradley et al., 20□6; Dickman et al., 20□6; Stegeman et al., 20□4). Information from this study can be used to inform policy makers. It is recommended that future studies on this subject include a larger number of randomly selected individuals who reside in other parts of the country. The experience of different socioeconomic segments of the population could provide more robust data.

Implications

Social change is the core belief of Walden University; this is not just as a subject matter but as a part of who we are as visionaries, individuals, and community members. As a social change agent, I am steadfast to grow in knowledge, understanding, and the scope of the communities, professional world, and global world. Through this process, I am provided a platform to allow the participant's voice to be heard and to deliver their perspective. In this study, I have attempted to not merely collect the data and analyze the data but to open the door for other positive social change-makers.

Positive Social Change

This study was designed to advance positive social change by exploring the problem of rising Medicare costs through the lens of a vulnerable population. The aim was to explore participant experiences and perceptions within the context of resilience. Researchers have confirmed that seniors are confronted with many challenges related to their health and financial well-being (Blumenthal et al., 20□5; Campbell et al., 20□6; Cubanski et al., 20□8; Keohane et al., 20□5; Neuman et al., 20□5). Challenges associated with Medicare are considered part of a political process that affects each member of

society (Polivka & Luo, 20□5; Wilensky, 20□7). The goal is to initiate positive social change by informing legislators and administrators who can shape Medicare policy decisions.

Conclusion

Transitioning into retirement is a major life event, where one is no longer paid employment and left more or less to one's own devices. Healthcare insurance is a means of financing a person's healthcare expenses. Many individuals have private health insurance through an employer while others depend on their health coverage through programs offered by the government. The impact of Medicare spending in the U.S. government and private citizens is of critical importance as the aging population continues to increase (Baylis et al., 20□5; Blumenthal et al., 20□5; Hosseini, 20□5; Rother, 20□7). This study confirmed the difficulty of meeting rising Medicare costs and has social value for increasing awareness and informing policy makers about the need to reform Medicare cost-sharing policies to assure healthcare access for this highly vulnerable population.

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Appendix A: Invitation to Participate

Dear Medicare Beneficiary.

My name is XXXX, and I am a doctoral student at Walden University. I am conducting a research study titled "Rising Cost of Medicare and its Effect on Recipients 65 and Older". The study is being conducted to examine the effects of Medicare policy, rising costs, and its effect on recipients. The results will be used to address a gap in knowledge and to inform future policy decisions. I am seeking participants 65 and older who have retained Medicare coverage for two years or more. If you fit the criteria, I would truly appreciate your participation.

If you decide to participate you will be required to provide written consent but have the right to withdraw your consent at any time. The study requires completion of a half-hour interview consisting of a combination of short close-ended and open-ended questions; the interviews will be digitally recorded and transcribed to allow for analysis. You can elect to complete the interview via video chat or by phone. You can choose to complete the interview in a private meeting room at a library location within the vicinity of your home or by phone at your convenience.

Once the interview has been completed and transcribed, you will be given an opportunity to review your answers for accuracy. No harm is expected to come from your voluntary participation. Respondents will not be financially compensated for their participation.

If you agree to participate, your involvement will be kept strictly confidential. You will have the opportunity to review your responses and provide feedback before the data is used. You will not be asked to report your name or any other identifying information. Data will only be reported in the aggregate (as a group) to assure that you will not be identified. All data will be safeguarded for a period of five years at which time it will be destroyed according to Walden University guidelines.

If you have any questions or concerns about the study or would like to schedule a time to be interviewed, please feel free to contact me at XXX@waldenu.edu or give me a call at XXX.

I thank you in advance for your assistance with my research project.

Sincerely,

Walden University

School of Public Policy & Administration

Appendix B: Medicare Policy Interview Script

During the interview, please think about your experiences and respond to the questions to the best of your ability. You can skip any question you choose not to answer. The session will be audio recorded and transcribed. You will have an opportunity to review the transcript for accuracy before the information is included in the study. Please note that all data will be analyzed in the aggregate (as a group) and there is no way of identifying you or any other respondent. All information is confidential, and participation is voluntary. Check if the respondent read and agrees to the above statement. •

Phone Interview
In Person Interview
Contact Phone: _____-_____
Participant ID NU: _____-_____
Date: _____ Start Time: _____ End Time: _____
Gender:
Male
Female

What is your highest level of formal education?

Some High School
High School/GED Graduate
Trade School
Some College
Associates Degree
Bachelor's Degree
Graduate Degree

What was your occupation before retiring? _____
What is your current age? _____Years NA
How many years have you been eligible for Medicare? _____Years NA
What type of Medicare coverage do you have?

Traditional Medicare
Medicare Advantage
Other _____

□ Do you have Medicare Part D Prescription Drug Coverage?

Yes
No
Not Sure

2. How would you rate your experience signing up for Medicare?

Excellent
Good
Fair
Poor

What is the main reason for rating your experience signing up for Medicare this way?

4. How would you describe your general health?

Excellent

Good
Fair
Poor

Please list/describe any health condition(s) you are currently experiencing

5. Please rate your satisfaction with the Medicare coverage you currently receive?
   Extremely Satisfied
   Somewhat Satisfied
   Not at All Satisfied
   Please describe why you chose this level of satisfaction with your Medicare coverage.
6. In 2020, the Standard premium for Part B increased to $144.60 a month up from $135.50 per month in 2019. The average retirees' total benefit increased about 6% or $24 per month. How difficult is this increase in premiums for you to afford?
   Extremely Difficult
   Somewhat Difficult
   Not at All Difficult
7. Have you experienced any financial challenges related to your Medicare coverage?
   Yes
   No
   Unsure
   Please describe any financial challenges you are experiencing with your Medicare coverage (e.g., premiums, deductibles, or co-pays).
8. Do you practice any strategies to manage your healthcare?
   Yes
   No
   Unsure
   What strategies, if any, do you use to manage your health?
9. If you could, what changes would you make to your Medicare policy?
10. Is there any other information you would like to add regarding your Medicare or healthcare coverage?

Appendix C: Confidentiality Agreement (Transcription Service

In providing transcribing services for a doctoral study by XXXXX titled "Rising Cost of Medicare and its Effect on Recipients Aged 65 and Older," I will have access to information that is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of the confidential information can be damaging to the participants and the researcher. By signing this Confidentiality Agreement, I acknowledge and agree that:

I will not disclose or discuss any confidential information with others, including friends or family.

I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.

I will not discuss confidential information with the client where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.

I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information. Information will be always safeguarded.

I agree that my obligations under this agreement will continue after termination of the work that I will perform.

I understand that violation of this agreement will have legal implications.

I will only access or use systems or devices that I am officially authorized to utilize, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

By signing this document, I acknowledge that I have read and agree to comply with the terms and conditions stated above.

Printed Name: _____

Signature: _____ Date: _____