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Lived Experiences of the Individual Mandate of the Affordable Care Act

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Abstract

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MBA, University of Phoenix, 2004

BS, Houston Baptist University, 1998

Dissertation Submitted in Partial Fulfillment

Of the Requirements for the Degree of

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Abstract

In 2014, the individual mandate of the Affordable Care Act (ACA) came into effect. More than 7 million Americans paid a tax penalty for not carrying insurance during the previous tax year. Millions of others were forced to purchase a health insurance plan to avoid that penalty. This study filled a gap in public health policy research by incorporating qualitative data to offer narratives along with statistical data that could help explain health outcomes to make successful policy changes in 2019. The purpose of this study was to research the use of market competitive theory by learning people's lived experiences and how they made the decision to participate in the ACA. The theoretical foundation was based on the social justice theory when mandating that citizen's purchase or pay. The method for this research was a qualitative interpretive phenomenological thematic approach with triangulation using the snowball effect and the hermeneutic circle method of analysis. The sample size included 6 volunteers who identified as either purchasing health insurance or paying the individual mandate penalty during a recorded interview. The findings answered the first research question by showing that the 6 participants found reason to carry health insurance based on their lived experiences and desire to maintain wellness overall. Findings for the second research question indicated that the individual mandate penalty did not increase the likelihood that the 6 participants would purchase healthcare insurance based on their lived experiences. This study supports the need for continued ACA qualitative research to identify more themes on how people make decisions regarding their health care that could provide positive social health policy change for the future.

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Chapter 1: Introduction to the Study

Millions of Americans have faced challenges accessing affordable healthcare because of the rising costs of health services and high insurance premiums (Komisar, 2013). Since 1965, politicians have worked to initiate health care reform for Americans by implementing essential health policies such as the Social Security, Medicare, and Medicaid, all of which are designed to help citizens in need afford access to affordable and necessary healthcare services. The implementation of the Affordable Care Act (ACA) of 2010 further added to previous healthcare efforts by guaranteeing taxpayers access to affordable health insurance and quality healthcare services. Although the ACA has created dramatic changes in the country's healthcare system, parts of the law impose a financial burden on the individual. One difference of the ACA health policy from previous health policies included an individual mandate to purchase insurance or pay a penalty. In this study, I investigated the question of whether or not the penalty incentivized people to purchase health insurance by interviewing people to qualitatively study lived experiences and how they made healthcare decisions.

The shift in health policy, which now mandates that citizens must purchase insurance independently, qualify for state-managed health insurance coverage, or pay a penalty at the end of the tax year, has had an impact and should be researched further in order to promote social change for healthier outcomes (CDC, 2011). A purchase-or-pay policy defies the idea of social justice for taxpayers. In this study, I sought to highlight how some people make the personal decision to purchase health insurance, while others

pay the penalty. This study may provide valuable information for policymakers that can help promote health policy reform that benefits all stakeholders in the following years.

Health Policy Background

Medicare and Medicaid are some of the first public health policies in the United States. Unfortunately, the programs are not designed to provide relief for millions of uninsured and underinsured people who do not qualify for those benefit programs (O'Brien, 2005). Although both of these programs were effective for a time, continued changes in the healthcare industry now threaten cost containment and disease management; the need to address the uninsured and underinsured population has become a national problem in America (Moon, 2005 and O'Brien 2005).

Medicare

Medicare was established in 1965 as an extension to the Social Security Act (SSA). It was designed to protect the aging population against being denied continued coverage from private insurance companies due to declining financial status of the recipients and their inability to pay for rising healthcare costs (Social Security Administration, n.d.). Davis and Collins (2005) examined Medicare beneficiaries' satisfaction ratings and reported that most felt that they did gain affordable access to medical services. However, these beneficiaries also expressed concern with the future satisfaction due to the increased aging population, rising healthcare costs, and the addition of Medicare coverage choices. Later, Komisar (2013) indicated a need for further research as future Medicare beneficiaries may have to endure extraordinary costs

for long-term services as more out-of-pocket costs are incurred and a large population remains underinsured.

Medicaid

The Medicaid program was also established in 1965 as an extension to the SSA to provide essential healthcare services to the disadvantaged, poor, and disabled population in America (Rowland & Garfield, 2000). Rosenbaum (2006) found that "with each passing year, the status of Medicaid coverage as a legally enforceable federal right grows increasingly precarious," thereby indicating a need for health policy change (p. 47). That statement was supported by the newest federal health policy law, ACA, in which states were asked to expand Medicaid coverage, but also given the right to decline the expansion, leaving many citizens without healthcare coverage in those states.

Affordable Care Act

The ACA was created for several reasons ranging from preventative health care to and cost containment. The number of uninsured citizens had soared to about 43 million by 2007 and continued climbing to approximately 53 million by 2010 (Boukus & Cunningham, 2011). More recent research reported that "more than half of people with low incomes and 20 percent of those with middle incomes were either underinsured or uninsured in 2014" after the ACA effective date, likely due to states such as Texas that refused to expand Medicaid or offer a state-initiated market exchange program instead of the Federal Market Exchange (FME; Schoen et al, 2014, p iii). Although these issues are concerning whether or not citizens' have access to affordable care in Houston, Texas, the

policymakers there have yet to make any changes regarding the affordability of health insurance and the individual mandate.

The current study was important because most health policies are written using the market competition theory which focuses on supply and demand to regulate prices as opposed to social justice theory, which supports equality and liberty against freedom from oppression regarding health care (Enthoven & Kronick, 1991; Kronick, Goodman, Wennberg, & Wagner, 1993). Furthermore, theories such as the managed market competition and market competitiveness are based on the commerce clause with the idea that if the benefit to society outweighs the cost, then the policy stands as the Supreme Courts decided regarding the ACA's individual mandate of the ACA (McDonough, 2012). However, social justice theory is based on citizens' rights to equality, which is an important factor when any health policy mandates the purchase of a commodity or face a penalty. Thus, it is valuable to have research information from citizens regarding their personal experiences to assess the policy's effectiveness to create healthier outcomes for societies in the future.

It is also important to understand the benefits of scientific health policy research concerning people's participation and how they perceive the policy based on their idea of social justice. Chapter 2 includes literature on social justice theory, the policy that was put in place in Massachusetts that was reportedly benefiting those state residents, the Clinton policy that was suggested in 1993, and the ACA that was signed by President Obama in 2010.

Problem Statement

The problem is that thousands of Americans are required to purchase health insurance or pay a penalty and the policymakers do not yet know how people make that decision. The ACA policymakers and most researchers do not yet know about people's lived experiences of this phenomenon or how those lived experiences can lead them to make decisions about healthcare coverage. Latham (2012) theorized that one possible reason so many people paid the tax penalty in 2014 could be that the "mandate forces currently healthy people to subsidize others' healthcare costs" (p. 14).

Challenges occurred when the ACA provides rights such as promised access to affordable health insurance, but that access was difficult to obtain in some states and premiums continued to increase each year from 2014 to 2016. The Supreme Court ruled that the individual mandate clause within the ACA was protected and constitutional under the Commerce Clause, and this disregards social justice for those that cannot afford health insurance or feel they do not need it because they are currently healthy (McDonough, 2012). That ruling meant that taxpayers above 138% of the federally recognized poverty level, regardless of age, now had to purchase health insurance or pay a penalty by law.

Manchikanti, Caraway, Parr, Fellows, and Hirsch (2011) suggested that public opinion continued to be against health insurance reform when polled as a global question and should be researched further. In this research study, I offered a qualitative interpretive perspective to understand how people make meaning of the healthcare phenomenon, the individual mandate, and how people made the decision to purchase

health insurance or pay the penalty. I used Heidegger's interpretive (hermeneutic) phenomenology design for this study because it allowed me to gather word-of-mouth interviews on how people made decisions based on their lived experiences.

Purpose of the Study

The purpose of this study was to understand how a group of people in Harris County, Texas make meaning of their healthcare decisions when it comes to their participation in the ACA given the individual mandate penalty. More specifically, this phenomenological qualitative study allowed me to examine the ACA public health policy and participants' personal experiences living with the individual mandate. In addition, most employers must offer health insurance or pay a similar penalty, otherwise known as a tax (Manchikanti et al, 2011). The ACA penalty can range from about $695 for individuals with lower incomes to $2,500 for individuals with higher incomes, or 2.5% of gross income, whichever is greater (Manchikanti et al, 2011).

I conducted this study regarding the ACA and the individual mandate in order to close the health policy research gap through a qualitative study to understand how people's personal experiences lead to their decision to buy or not buy health insurance. The underlying factors in how people make health decisions beyond qualitative empirical data warranted this quantitative research to learn why people had affordable access to insurance policies but still paid the penalty since 2014.

Research Questions

I used the following research questions to gain insight into people's lived experiences that contributed to their decision to purchase healthcare insurance or pay a penalty.

Research Question 1 (RQ1): How do taxpayers make the decision whether to purchase health insurance or pay a penalty each year based on their lived experience?

Research Question 2 (RQ2): Does the penalty increase the likelihood that citizens in Harris County, Texas, will purchase healthcare insurance based on their lived experience?

Theoretical Framework

The theoretical framework that I used for this study was social justice theory. The specific phenomenon was the individual mandate, which requires the purchase of health insurance for those above the federal poverty level. Failure to do so would result in individuals paying the mandated penalty at the end of each tax year. Baker (2011) purported that many citizens attempt to define the "penalty" as something other than a tax even though it must reported to the Internal Revenue Service (IRS) for collection and reporting purposes. The framework of this public policy research study is social justice theory because "it is viewed as so central to the mission of public health that it has been described as the field's core value" (Gostin, 2008, p.21). In addition, Gostin and Powers (2006) stated that social justice is important in health policy creation to reduce socioeconomic disparities. Social justice theory will be discussed in greater detail in Chapter 2.

I used social justice theory to understand how citizens made the decision to purchase health insurance or pay the penalty based their personal lived experiences. This policy research was unique because I used a phenomenological approach with social justice theory as opposed to the routinely accepted ethnography approach that policymakers have relied on for years. This study of the individual mandate researched gap on the ACA's individual mandate by offering narratives that later can be correlated with statistical data, which could help explain health outcomes to make successful policy changes in the future.

Studying personal experiences and their effect on the decision to purchase or pay was further supported by other research in order to gain a better perspective on the number of enrollees expected in the future. The theoretical basis for this research topic is the idea to present a conception of justice when mandating that citizen's purchase or pay as opposed to the market competition, which could leave many patients susceptible to extraneous healthcare costs, which they may not be able to afford.

This study included the sample population who participated in the ACA by purchasing health insurance through the FME, uninsured participants who were above the 138% of poverty, and people who had paid the penalty anytime between 2014 through 2016. The sampling method included an interview that lasted no longer than 20 minutes and the data collection period included tax year 2014 through 2016. The participant population was six volunteers to maintain research construct validity and to produce a reliable study that justifies the recent policy change regarding the individual mandate for 2019.

Assumptions

Assumptions are beliefs that are presumed to be true for the purpose of building a theory (Simon and Goes, 2013). The first assumption was that participants would answer honestly during the interview. Another assumption was that the inclusion criteria was appropriate and assured that participants had experienced the same phenomenon of the individual mandate. In addition, my assumption was that some citizens in Houston, Texas made the decision to purchase or pay based on their personal lived experiences. Key assumptions I made were that some people are not aware of the financial penalty, some people above Harris County, Texas poverty level, but could not afford the monthly premiums, people personally chose to pay the penalty do, and people made the decision to purchase health insurance for health-related purposes.

Limitations

Limitations are constraints that are beyond my control largely because of the qualitative interpretive study design I chose, which can be difficult to replicate. Texas was one of 24 states that chose not to fully participate in the ACA, which excludes Texans citizens from subsidies, and denied Medicaid expansion for citizens 138% of poverty level, leaving many still uninsured at this time (Baker, 2011; Schoen et al, 2014). Those states decided not to implement the major elements of the ACA to benefit all citizens, such as the expansion of Medicaid and the implementation of a state-based exchange program. It should be noted that research of citizens with Medicaid or FME coverage and provider participation also remains understudied (Chang & Davis, 2013; Header & Weimer, 2012; McKennan, 2012; Richardson & Yilmazer; 2013). Therefore,

one limitation to the study was that it had a limited number of study participants and the research focused on only one county in Texas.

One unexpected limitation arose when I moved from Texas to Tennessee during the research project. The move limited my ability to gain more volunteers through personal interaction, and the travel involved made it difficult to accommodate participants' schedules.

Nature of the Study

This was a qualitative interpretive phenomenological study in which I explored how people's experiences influenced their decisions to purchase health insurance or pay the tax penalty respective to the new healthcare policy. In this study, I researched the lived experiences of individuals affected by the ACA's individual mandate phenomenon of the ACA. I chose a qualitative interpretive phenomenological approach so that I could gather information on the participants' lived experiences and not on data that can only be quantified. The data that I was able to gather during the study were thematically analyzed in order to achieve saturation and identify themes among the participant pool.

I selected the nature of the study after researching two philosophers: Edmund Husserl and Martin Heidegger who were best known for expanding the foundation of phenomenology. Heidegger was known for his work in interpretive phenomenology and Husserl was known for his work in descriptive phenomenology (Lopez & Willis, 2004). Heidegger's interpretive phenomenological approach is the best research method to learn how people made healthcare decisions based on their lived experiences.

Delimitations

Delimitations in my study consisted of the conscious decision to only include a certain population in a specified location to provide some insight on how those people made health decisions. This study was delimited to examining the lived experiences of 6 participants residing in Houston, Texas to assess their opinions on the individual mandate of the ACA since 2014. I focused on whether the tax penalty encouraged participation or purchase of health insurance. This focal point was important to identify how people's personal opinions play a role in this current healthcare reform initiative when mandating participation.

Further delimitations were that all participants were 18 years of age and Older. Reinhardt (2016) discussed why insurance companies are losing money by participating in the ACA when he reported that the policy will generate big losses because young healthy people have a choice to purchase health insurance, which does not the support increasing costs of caring for the sickest Americans.

Significance

The significance of this study was that it revealed participant's perspectives regarding the individual mandate of the ACA to identify what lived experiences contributed to the decision to purchase health insurance or pay the penalty. The data I was able to collect in this study can contribute to the success of the ACA as policymakers consider making amendments. Furthermore, it was important to understand citizens' opinion when considering changes to public health policy laws in order to create social change. If people continue to face challenges when trying to access healthcare services

due to financial constraints or personal citizens' opinions, then the law fails to promote healthy outcomes and cost containment as intended.

Summary

The ACA mandates that all U.S. citizens subscribe to healthcare insurance coverage or pay a penalty when filing federal taxes each year. This new healthcare policy affected all Americans because health policies in the United States have never included a mandated purchase or pay program. The IRS reported that millions of Americans paid the penalty in 2014 as opposed to purchasing a health insurance policy. The purpose of this study was to gain insight into why people made the decision to pay the penalty based on their personal lived experiences. The framework of this study was based on social justice theory. This study is important because the phenomenon of the ACA and people's perspectives to purchase or pay can ultimately determine whether or not this law will create social change and healthier outcomes for Americans. In Chapter 2 I will discuss social justice theory while offering an overview of a previously proposed health policy, the Massachusetts Health Plan that has been implemented, the current ACA and citizen's perspectives on the ACA.

Chapter 2: Literature Review

Introduction

The literature review begins with social justice theory and progresses to a historical overview of healthcare reform to provide information regarding policy changes since the 1960's. The review also includes information regarding personal perspectives of the ACA and affordable access to healthcare services.

Problem Statement

The problem is that people in the United States are mandated to purchase health insurance or pay a tax penalty at the end of each year. Galewitz (2015) documented that around 7.5 million Americans paid this penalty in 2014 and that begs the question as to what lived experiences led to that decision by taxpayers. The purpose of this study was to identify the ACA's individual mandate and peoples' lived experiences since 2014. This qualitative study is relevant because there are very few studies on social justice theory and the ACA individual mandate phenomenon is deficient.

Currently, there are very few studies, dissertations, or conference proceedings about the lived experiences that affect people's decisions to purchase health insurance and retain the policy for 12 consecutive months or pay the penalty at the end of the year when filing federal tax returns. I investigated previously implemented federal health policies, a previously proposed policy, a similar policy that was implemented on the state level, and research on people's perceptions of the ACA.

This chapter includes the current research on social justice theory and the idea healthcare as a right, while reviewing past attempts of healthcare reform in the United

States. There is also information about current health policy law, and the review concludes with a discussion of the ACA and the individual mandate. The review will allow readers to review the similarities and differences of a previously proposed national health policy, the proposed Clinton healthcare plan that was not implemented, the Massachusetts health insurance policy that was implemented, the ACA national policy that was implemented, and people's current perceptions of the current policy.

Social Justice Theory

John Rawls's (1971) book brought of social justice theory to a next level when he introduced his book *A Theory of Justice*. Rawls did not specifically include healthcare in his theory (Ekmekci & Arda, 2015). "John Rawls's theory of justice, which is considered as a contemporary reflection of egalitarian ethical theories, addresses the issue of fair distribution of social goods" (Ekmekci & Arda, 2015, p. 228). Although Rawls never mentioned healthcare specifically, researchers state that healthcare should be recognized as a right to be considered part of Rawls's theory of social justice because any healthcare system is a form of distribution of social goods per the ACA (Daniels, 2001; Gostin & Powers, 2006; Ekmekci & Arda, 2015; Rasanathan, Norenhag, & Valentine, 2010).

In his application of social justice theory to healthcare, Daniels (2001) highlights three pertinent questions. Those three questions Daniels (2001) discussed in his study included: is there a special morality about healthcare when considering distribution; when are health inequalities unjust if socially controllable factors are not addressed; and how can citizens meet their reasonable healthcare needs within reasonable constraints. He posits the specialty of health care and whether health care is morally important as it has

been seen by many societies who distribute it as a social good. Likewise, Daniels questions the unjustness of health inequalities, especially when many socially controllable factors besides access to health care affect the levels of population health and the degree of health inequalities in a population. This leads to the final question which aligns with the basis of this study about how society can meet competing for health care needs fairly under reasonable resource constraints. (Daniels, 2001).

Gostin and Powers (2006) examined the following issue:

> How public health based on social justice gives rise to important policy imperatives such as improving the public health system, reducing socioeconomic disparities, addressing health determinants, and planning for health emergencies with an eye on the needs of the most vulnerable (p. 1054).

Ekmekci and Arda (2015) and Rasanathan, Norenhag, and Valentine (2010) found that the idea of social justice is also based on the idea of personal responsibility. Both studies showed that fundamental and freedom right based endeavors are the challenges with today's changing health care needs and health policies. Ekmekci and Arda (2015) stated that healthcare should be on the primary list of social goods in the United States because of its current high cost. According to Rasanathan, Norenhag, and Valentine (2010) subscribed to the idea that "the right to health is often recognized as a powerful reason for addressing disparities, but appreciation of the advances in rights-based approaches that can be applied in policy seems limited" in America (p. 51). In these two different studies, both sets of researchers noted that further research is required in for social justice theory to be used as an effective tool to help policymakers create better

health outcomes, reduce disparity, and gain public support. Therefore, the theory is based on social justice that citizens will make the decision to purchase health insurance or pay the penalty based their personal lived experiences because the ACA asserts that affordable health is a right and not a privilege based on market competition or lack of state participation in the ACA.

Historical Overview of Healthcare Reform

The need for some kind of healthcare delivery system was realized early in the 1900s by Congress, when they implemented a health maintenance organization (HMO), which was started by Western Clinic in Tacoma, Washington, offering patients services for a 50-cent monthly premium (McIntyre, Rogers, & Heier, 2001). McIntyre, Rogers, and Heier (2001) speculated on the future success for healthcare management in HMOs including, but not limited to, performance measurement and quality management, patient advocacy, and collaborative delivery of services.

Providers' perspectives on changes to healthcare policy are relevant because providers have to accept patients into their practice. Stephens (2001) began by defining health reform and ended with explaining why primary care physicians are instrumental in disease management and assisting in cost containment. All of these themes discussed continue to echo concerns from citizens today for policy-makers to take significant strides towards continued healthcare reform in the future. Stephens (2001) defined reform as "a process by which societies attempt to achieve their best ideals for the welfare of their citizens" (p. 248). Although Medicare and Medicaid have existed in the United States since 1965, these programs have age and income restrictions. They

therefore do not help people pre-retirement age people living above the poverty level or in the middle class with cost-effective health coverage. Stephens (2001) noted several issues in the US healthcare system, including "an unmet need for services, health manpower shortages, escalating costs, increased complexity of medical care, outdated arrangements for practice, embarrassing indices of public health, the need for better distribution of knowledge derived from new research" (p. 249).

Given the societal need to improve disease management, prevention, and control costs, further research was necessary to review health insurance affordability prior to the ACA implementation in order to identify the consumer's needs and consumption of healthcare services (Schoen et al., 2014). Schoen et al. (2014), examined the affordability of health insurance before the implementation of the ACA. They found that "at least 79 million people were at risk for not being able to afford needed care before the major reforms of the ACA took hold" (p. ix). Therefore, it can be deduced that 79 million people are not able to access affordable care under the ACA, which can results in citizen's utilizing using emergency hospital services as a source of primary care. Furthermore, Schoen et al. (2014) stated that "new marketplaces offer plans that include substantial cost sharing and annual caps on out-of-pocket patient costs that apply to in-network providers only" (p. 14).

The Clinton Plan

Medicare and Medicaid provide benefits for designated poverty-level citizens and for the elderly population. However, both continue to struggle given the currently uninsured and underinsured population need and cost containment for necessary

healthcare services as mentioned previously. In the mid-1990s, President Clinton proposed a very similar health care policy to the ACA, but it was ultimately rejected for several reasons, one being the individual mandate approach that was not perceived to be reasonable at that time (Zelman, 1994).

Although the Clinton plan was rejected, it did provide some valuable information about the need for healthcare reform and also gained widespread agreement from stockholders to control certain areas of healthcare such as cost containment of services and consumer-consciousness, in order to achieve health policy changes that would benefit all Americans in the future (Zelman, 1994). Moreover, the Clinton Plan can be argued to assert social justice for Americans to access affordable healthcare as a federal right and not a privilege based on the assumption of guaranteed health coverage relating to household income levels for qualifying individuals and families.

Zelman (1994) outlined the following nine essentials of the Clinton Plan:

> First, replace competition between health plans based on risk selection with competition based on quality, service, and price; second, equitably spread risk by moving from experience to community rating, thus eliminating differences in premiums based on health status or employment; third, maximize consumer choice of physicians and plans, in part so that consumers can reward those providers who offer better service and quality at lower prices; fourth, strengthen the power of purchasers by consolidating purchasing power and better informing them; fifth, simplify and clarify choices for consumers; sixth, increase consumers' cost-consciousness by making them responsible for the differences in cost

> between less and more expensive plans; seventh, reduce high administrative costs of buying, selling, and administering insurance policies, especially for small and mid-size employers; eighth, enhance the portability of insurance by enabling workers to change jobs or family circumstances without having to change health plans; and ninth, eliminate coverage restrictions such as preexisting condition exclusions and waiting periods. (p. 17)

However, the Clinton plan did not pass into law, so it is impossible to know whether or not that plan would have worked as intended. However, the creators of the ACA used the Clinton Plan as an operational template while using the Massachusetts Healthcare law as a financial guide for success.

Massachusetts Healthcare Reform

In 2006, Massachusetts implemented statewide legislation mandating that all residents of the state have health insurance coverage either through employment, via Medicaid, or purchased through the state-implemented online health insurance market (Shapiro, 2015). Based on the reported performance and analysis of that health policy, Gruber and Shapiro (2011/2015) called this the “three-legged stool” model of healthcare management. According to Shapiro (2015):

> The first leg consists of changes to the non-group private health insurance market, such as limiting price discrimination against individuals with pre-existing conditions, guaranteeing issuance and renewal of insurance, and prohibiting medical underwriting. The second leg of the stool aims to keep the insurance market from unraveling due to elements of the first leg. For instance, with the

> guaranteed issuance, healthier people may find it in their best interest to wait to buy insurance until they ultimately need healthcare. The third leg aims to make sure that people with lower incomes are able to purchase insurance. This took the form of government subsidies to health insurance plans sold on the online exchange. (p. 1)

The Massachusetts Healthcare Reform law has many of the same criteria now included in the federal law, the ACA, which was established years after this particular law was passed in 2006. .

The Affordable Care Act 2010

The ACA was signed into law in 2010 by President Obama. The law was intended to reduce the number of uninsured and underinsured Americans and to help contain spiraling healthcare costs (Manchikanti et al., 2011). In addition, the ACA has increased the coverage age for children up to 26 years of age, allowing young adults to continue using their parents' or guardians' insurance plans (Antwi, Moriya, & Simon, 2013). One of the most important aspects of this legislation was doing away with insurance companies' ability to deny coverage based on pre-existing conditions, thereby allowing people to receive treatment for chronic conditions without high out-of-pocket costs. Another critical piece of the ACA is the call to expand Medicaid up to 138% of poverty level in each state to help lower income citizens and residents obtain health insurance coverage. However, this portion of the law was left up to each state to implement, and the states that did not expand Medicaid continue to have a significant population of uninsured citizens (Angier et al, 2015). One of the most controversial parts of the ACA

for consumers and policymakers was the individual mandate for citizens to maintain health insurance coverage or pay a penalty at the end of every year (Jones, Bradley, & Oberlander, 2014).

The ACA included several different obligation dates and changes to the FME website before full implementation. This can become a challenge for researchers studying the effectiveness and efficiency. According to Manchikanti et al (2011:

> One, a mandate for individuals and businesses requiring as a matter of law that nearly every American have an approved level of health insurance or pay a penalty; two, a system of federal subsidies to completely or partially pay for the now required health insurance for about 34 million Americans who are currently uninsured – subsidized through Medicaid and Exchanges; three, extensive new requirements on the health insurance industry; and four, numerous regulations on the practice of medicine. (p. E35)

Although this is only one rendition of a summary regarding the ACA, others mimic the same information offered but in greater detail (Dpc.senate.gov, n.d.).

Though there are other critical aspects to the ACA as a law in whole, the individual mandate is most pertinent to the research study because of its effect on people facing financial hardship and an inability to obtain health insurance in many states. The disparities people face in accessing affordable health insurance in states such as Texas include the lack of Medicaid expansion and the inability to mandate small businesses to provide employer-based insurance coverage for citizens and residents (Brown, Wyn, & Teleki, 2000).

The Public's Perspectives on the ACA

The perspectives of citizens are critical in the evaluation of the ACA to determine future outcomes of the law and to see if it has created positive change for America since 2014. Although several studies have been published about provider opinions of the ACA and opinions of various racial and ethnic groups. However, there is little peer-reviewed research on patients' perspectives in general (Donovan, 2015). However, that gap should not diminish the importance of investigating the opinions of all who are or will be impacted by the ACA in order to gain information that could lead to positive change later.

In a legislative opinion poll involving women of color, Johnson (2014) found that subjects were concerned with the political struggle involved in allowing states to choose which parts of the ACA would be implemented and what would not. Johnson (2014) also found that 29% of North Carolinians perceived positive outcomes with the ACA in place, while 50% think that the ACA will make healthcare less accessible or affordable. Furthermore, according to Johnson (2014), a significant number of Americans are still without affordable access to care because some states refuse to expand their Medicaid program. This article review is valuable and further supports the existence of a gap in researching citizens' opinions because of the limitation in only surveying a specific ethnic group.

Donovan (2015) studied medical students' opinions on the ACA, including whether or not they felt they were able to interpret the law accurately and what level of support they had toward the policy regulations for health management. This research is

valuable because the most-discussed aspects of the ACA is only one part of the overall health policy law. The full title of the law is the Patient Protection and Affordability Care Act (PPACA). The patient protection portion of the law focuses on encouraging students to become healthcare providers through incentives and loan forgiveness programs available to those who qualify. Therefore, it is important to gain provider opinions on whether or not they feel they will be able to fulfill the requirements of the law in caring for an increased number of patients.

In Donovan's (2015) study, 2,761 medical students were surveyed and the statistics of that research indicated that 63% of the medical students were in support of the ACA, while about 75% confirmed that they understood both the ACA and the expectations of providers. This information is positive because it shows that providers are realizing their obligations toward a successful outcome for the current health policy. Bhattacharjee and Petzold (2014) argued that online social media networks like Facebook or Twitter are viable sources for data mining and collection because of their popularity and support of freedom of speech in verbal expression of current events or phenomenon taking place at that time. Therefore, the authors called for further research in order to study people's perceptions of the ACA's ability to offer affordable healthcare to all citizens and residents of the United States.

More recently, Kirzinger et al (2017) found that while people are aware that the individual mandate is still in effect in spite of President Trump's declarations, few participants stated that the mandate was a strong motivator to buy their own coverage. More specifically, Kirzinger (2017) reported that 55% of the marketplace enrollees say

that the penalty was “not a reason” why they chose to purchase health insurance, while 26% stated that the fine was a “major reason” (p. 11). This study also revealed that 37% of the uninsured population stated that the main reason they do not have coverage is because they cannot afford the cost of purchasing healthcare insurance.

Summary

This chapter contains a review of the literature about previously implemented major health policies in order to compare them with the newly implemented Affordable Care Act to support my research questions regarding participation or be penalized at the end of each year. I also wanted to support the fact that the individual mandate is a phenomenon as this is the first time that the federal government has mandated that citizens purchase a commodity or pay a tax penalty on an annual basis.

I chose the idea of social justice as my applied theory because the ACA affects all federal taxpayers, and the Supreme Court’s finding that the ACA would have a greater benefit for healthcare social change if the individual mandate remained does not seem socially justified as a federal health policy. Instead, the court seemed to be saying that people needed to take personal responsibility for their own healthcare maintenance in order to reduce rising costs and manage health conditions through preventative care. In addition, the proposed Clinton health care bill was reviewed due to the similarities that were noted when studying the ACA for this research paper.

Thus, this literature review is important and has value because it identifies the individual mandate of the ACA as a current phenomenon in the history of health policy. In addition, the lack of research found for review was a clear indication that this study

proposal is relevant and has value when considering a social change. So, my research intends to provide an enhanced view of people's perspective on the individual mandate phenomenon within Harris County, Texas. In conclusion, Chapter 3 will provide a methodology to help fill the gap in the literature review using a qualitative interpretive phenomenological approach with triangulation and the hermeneutic circle in order to answer my questions on how people make the decision to purchase health care insurance or pay based on their lived experiences.

Chapter 3: Methodology

Introduction

In this study, I used a the phenomenological approach to investigate people's lived experiences of the individual mandate portion of the ACA to determine the future success of the new healthcare law ensuring that ensured that all citizens and residents have had health insurance coverage starting beginning in 2014. My study contains data about participants' lived experiences in making the decision to purchase health insurance or pay the penalty. The results of my study can help support Congressional tax decisions and make a significant change to the ACA for greater social change in Healthy People 2020 outcomes (CDC, 2013). The major sections in this chapter include research design, population and sampling, appropriateness of the design, data procedures, rationale, confidentiality, informed consent, instrument, validity and reliability, interview process data analysis, and finally, the chapter summary.

Research Design

I used Heidegger's interpretive (hermeneutic) phenomenology design because the focus of the study was how people experience the ACA individual mandate rule (Lopez & Willis, 2004; Wojnar & Swanson, 2007).

Moran (2002) stated that despite his foundational contribution to phenomenology, Husserl is often overlooked in favor of Heidegger's philosophical approach to understanding how people make choices based on their lived experiences. Lopez and Willis (2004) stated that Heidegger, a student of Husserl, challenged his theories on how phenomenology could help offer meaningful inquiry by using hermeneutics. Lopez and

Willis (2004) describe Husserl's transcendental concept, in which researchers' biases are excluded completely from the descriptive data interpretation process when researching personal experiences regarding a phenomenon. Groenewald (2004) stated that Husserl's phenomenology focused more on how objects or situations appear to one's consciousness, as opposed to how outside experiences are related to a phenomenon.

Lopez and Willis (2004) explained that Heidegger took the idea of phenomenology further by asserting the importance of hermeneutics. Lopez and Willis (2004) discussed the importance in understanding why people make the personal decisions they make based not only on how they interpret a phenomenon experienced, but also on how the freedom to express that phenomenon is seen from their personal experience or "lifeworld" for nurse scholars and clinicians.

Descriptive Phenomenology

Reiners (2012) asserted that descriptive phenomenology involves researching how people's "everyday conscious experiences can be described", leaving out "preconceived opinions" that people and or society attain (p. 1). Therefore, descriptive phenomenology according to Reiners (2002) allows researchers to ask questions based on personal knowledge through experience and not opinions of a person. Other researchers state that descriptive phenomenology is eidetic, meaning that it involves mental images retained in a person's memory that was created through subjective personal experiences and knowledge that is personally gained (Moran, 2002; Lopez & Willis, 2004).

Lopez and Willis (2004) stated that Husserl's introduced descriptive phenomenology, along with "bracketing" techniques, focused on the commonalities of

experiences based on the idea that everyone experienced the same phenomenon at a given time. Using descriptive phenomenology allows a researcher to ask questions such as what is it like to participate in a particular lived experience, like experiencing a heart attack.

Interpretive Phenomenology

Although Heidegger was a student of Husserl, he had different ideas about how to understand phenomena based on personally lived experiences by using hermeneutics. My understanding of Heidegger's perspective is to study the people who control the outcome, rather than study how to achieve the desired outcome. Groenewald (2004) stated that "Heidegger introduced the concept of 'Dasein' or 'Being there' and the dialogue between a person and her world" (p. 43). Additionally, Rafique and Hunt (2015) went on to verify that "interpretive phenomenological analysis focuses on lived experiences of participants by incorporating dual components: phenomenology and interpretation" of the data collected (p. 2).

Using interpretive phenomenology allows researchers to focus on hermeneutics or the study of interpretation of a person's experiences and knowledge (Lopez & Willis, 2004; Reiners, 2012). Heidegger introduced interpretive phenomenology as part of a philosophical movement to understand "being in the world rather than knowing the world" (Reiners, 2012, p. 1). In other words, interpretive phenomenology gathers detailed verbalized and written personal experiences and decision-making perspectives during a phenomenon such as the newly implemented ACA individual mandate.

By using this method I was able to review the my participants' descriptions of their lived experience regarding the phenomenon, while further describing the person's

interactions and freedom to make choices (Lopez & Willis, 2004; Peitkiewicz & Smith, 2014). In my research, I used interpretive phenomenology to guide me as I asked subjects to describe in detail their personal experience without researcher intervention or guidance. I kept my potential biases in mind while pursuing an understanding of the participant's personal experiences in regard to making personal decisions.

Appropriateness of Design

I chose the qualitative phenomenological approach for this particular study because I wanted to find out why people made certain decisions based on their personal experiences. It is important to understand behaviors and can most effectively be researched by asking people about the lived experiences that guided the behavior (Holloway, 2005). Therefore, I researched people's personal lived experiences of ACA, and subjective knowledge regarding, the individual mandate of the ACA. I believe that my qualitative interpretive phenomenology study closed a gap in ACA research by introducing people's lived experiences as opposed to only looking at the qualitative data.

The interview technique of using thematic analysis was the best data collection tool for this study because it gave participants the freedom to describe their personal experiences, interpretations, and perspectives in detailed summary regarding the individual mandate phenomenon as some researchers have made (Holloway, 2005; Rafique & Hunt, 2015). Through the identification of themes in the behavior of purchasing health insurance or paying the penalty, an understanding of how people make the decisions they make regarding healthcare the individual mandate. In this chapter I

will discuss the ethical procedures, data collection process, informed consent, and confidentiality measures used in this study.

Rationale

The rationale behind this study was to introduce a different scientific method to better understand how people make health decisions when researching the individual mandate using qualitative analysis as opposed to quantitative data. Little research has been conducted on people's lived experiences regarding the ACA's individual mandate using the theoretical framework of social justice theory as opposed to managed competition theory. In this study I investigated how people make healthcare decisions about purchasing insurance based on real-life experiences.

Validity and Reliability

The validity and reliability of this study rested on the qualitative method and thematic saturation in order to study social behavioral while researching individual's healthcare decision-making after much research (Gostin 2008; Latham, 2012). The reasons why more than seven million taxpayers paid the penalty at the end of the tax year 2014 has not been widely studied to date. This research was important to understand how people make the decisions they make to conform to purchasing a commodity or paying a penalty.

The validity of the qualitative method to employ interpretive phenomenology relied on another research study that focused on personal experiences and decision-making processes. Greenfield and Jensen (2010) used the approach to research patients and ethics, Grundy (2014) chose this method "for its emphasis on gaining access to

meaning through examining concrete activities in the contexts in which they take place" in peoples' lives at during a specific time (p. 556). Triangulation using and the hermeneutic circle provided further validity to this research. Triangulation was the way of achieving saturation of themes in order to further validate the chosen method for this particular study. The transferability of information relied on the population of participants who independently purchased health insurance or paid the penalty without variance.

The study is reliable because of the interpretive data collection processes that I used. I collected interview data on decisions related to healthcare decisions information on the outcomes that were reviewed in my study; more specifically, why did people pay the penalty instead of purchasing health insurance. The data collection approach provided dependability on the themes that were collected. The reliability of this study is enhanced by its use throughout social psychology to study why people make decisions. Lastly, the reflexivity of the method approach was based on the systematic attitude that all taxpayers are impacted by the ACA.

Ethical Procedures

Following ethical procedures is the most critical part of any research design. In this research project, I followed Walden University's Institutional Review Board's (IRB) protocol and procedures to meet ethical standards to protect human participation, the participants' rights, the confidentiality and usage of the data collected as well as its dissemination. In this section, I will discuss the sample population, data collection, data usage, who can view the data, and how the data will be stored confidentiality during and after the research study.

Population and Sampling

Choosing the correct sample size for a phenomenological qualitative research study is the most critical piece in order to gain pure data on the lived experiences of the population being studied (Dworkin, 2012; Groenewald, 2004). A smaller sampling size allows the researcher the opportunity to conduct an in-depth analysis to gain an understanding of the phenomenon under while focusing on the meaning or themes found in the study through personal experiences. For this study, the sample size was six participants.

I used purposeful sampling for this study. The requirement for participation was either the purchase of health insurance or the payment of the penalty since 2016. I had intended to interview 10 participants that purchased insurance and 10 participants that paid the penalty. However, the volunteer pool consisted of only six participants who purchased insurance and no participants who paid the penalty. To ensure triangulation through sampling, a secondary method called snowballing included some participants who were referred by other participants who joined my study. Furthermore, the population size was determined based on a research review of the appropriate participant pool who had personally experienced the phenomenon of dealing with the ACA's individual mandate to taxpayers (Groenewald, 2004; Rafique & Hunt, 2015). The six participants were from Harris County, Texas, who had personally experienced in the phenomenon of the ACA. I interviewed the participants in one-on-one, semi structured, tape-recorded interviews based on a written outline of questions with follow-up

opportunities for valid saturation and to achieve reliable triangulation for transferability purposes.

Data Collection Procedures and Confidentiality

I collected data from qualified participants about their decision to purchase health insurance. Volunteers were qualified if they purchased insurance from the FME or paid the penalty for not doing so between 2014 and 2016 while residing in the Harris County district of Houston, Texas.

I focused on the time between 2014 and 2016 because the individual mandate went into effect in 2014 and 2016 was the most recent date that my subjects would have reported their health insurance status. Houston, Texas was the geographical area because the IRS statistics indicated that a significant number of Texans paid the penalty and I wanted to understand how that happened.

I solicited participants first through social media outlets such as LinkedIn and Facebook by posting the IRB approved flyer along with the IRB approved consent form. Additionally, Paper flyers were on cars and handed them out in person, while in public areas of Houston, Texas. The researcher was the primary instrument for interview data collection with one-on-one tape-recorded sessions. To ensure that each participant was interviewed consistently, a list of questions (see Appendix A) was used, which included three sections for discussion.

The data collection included three sections for each participant to answer during a one-on-one interview process lasting about 20 minutes in duration while being tape-recorded using a portable tape recorder. Additionally, the confidentiality of each

participant is maintained by applying a six character code rather than a name to each interview when entering data into NVivo 11. The six characters were transposed onto the consent form and mentioned in the audio file for data validity purposes. This means that data associated with specific interviews was protected for each participant while analyzing the data in NVivo 11.

Informed Consent

For each participant, an informed consent approved by the Walden University Internal Review Board (09-2817-0179615) was provided in order to review the ethical rights of the survey population interviewed. Therefore, each participant was informed of his/her voluntary participation, the data collection and handling process, and his/her right to privacy regarding how the tape-recorded information will remain secure during and after the research activity. The consent form was to notify participants of their voluntarily status to participate in the tape-recorded interview lasting on average 20 minutes or less and to notify them that the data will only be collected one time during the interview process, however my contact information was offered in the event the volunteers had further questions, concerns, or input. Furthermore, each participant's interview and recording will remain protected information and will not be shared outside of the appropriate people at Walden University in order to fulfill the necessary requirements for graduation in the Public Policy and Administration Ph.D. program.

Furthermore, each signed informed consent form remains stored in a locked cabinet located in a secured setting. In addition, each consent form was labeled with a six-character identification code for future research reference.

Instrument

The instrument used was created by the researcher in order to address specific questions regarding lived experiences and decisions to purchase or pay for health insurance after thorough research of literature did not yield any viable instruments available for this research topic. The researcher was the primary instrument for interview data collection with one-on-one tape-recorded sessions. A list of questions was used to ensure that each participant was interviewed the same and captured all of the relevant information to answer the research questions. The interview outline (see Appendix A) created includes three sections of discussion. The first section requested demographic information about the participant, as well as information about whether or not the participant was currently insured. The second section covered questions about the participant's personal experiences regarding the ACA, more commonly known as "Obamacare". Section two questions related to each participant's family size, economic status, and current financial obligations. Lastly, section three asked if the participant had any concerns about the individual mandate of the ACA and was offered an opportunity to include any other information he/she felt relevant, which was not asked during the interview process.

Each participant's interview was archived using a six-character identification code as mentioned earlier. The recorded interviews were uploaded to the NVivo 11 program and then transcribed for qualitative analysis. All measures of security regarding participant participation and personal information were kept confidential while adhering to all research ethical standards. Additionally, the NVivo 11 program was chosen because

of its ability to secure information, its ability to reliably analyze qualitative data, and its ability to manage uploaded tape recordings from various sources along with the capability to assist in transcribing the information appropriately for reliable results.

Interview Process

I conducted interviews conducted in person, using FaceTime, and via telephone. I used the questions found in Appendix using the questions outlined, while the interview was recorded using a handheld recording device. The recording device was equipped with a portal allowing all recordings to be downloaded into a secure file, including NVivo 11.

As mentioned earlier in this chapter, there were two approaches that were considered for this phenomenology research study, the descriptive and interpretive methods. The interpretive method was identified to be the best because the descriptive phenomenology approach looks at individuals' personally lived experiences and eidetic structures through commonalities while reducing the effects of researcher biases and preconceptions through a process called bracketing (Lopez & Willis, 2004). Whereas the interpretive method considers the researcher's biases and does not exclude them from the study, which is more applicable to this phenomenological study.

Therefore, the research interview process conducted in this study was focused on the interpretive phenomenology approach because "it will focus on describing the meanings of the individuals' being-in-the-world and how these meanings influence the choices they make" (Lopez and Willis, 2004, p.729). Additionally, the interview process was designed to "explore respondents' perceptions of what is important in relation to the

phenomenon" of the individual mandate and how they made decisions regarding their health (Fade, 2004, p.648).

Data Analysis

The goal of this study was to examine how people make meaning of their experiences regarding the phenomenon of the ACA mandates that people purchase a health insurance plan or pay a penalty at the end of every year since 2014. With that in mind, the data analysis approach was thematic because it is "a method for identifying, analyzing, and reporting patterns (themes) within data", which is a critical approach in determining how people make the decisions they do regard public policy (Braun & Clarke, 2006, p. 79). By using the NVivo 11 program, I was able to code from the transcriptions and run reports based on thematic analysis and word frequency.

Thematic Analysis

Thematic analysis was the ideal interpretive phenomenological approach to this research study because it is important to identify themes in how people make the decision to pay a penalty or purchase health insurance. In other words, people cannot be made to take personal responsibility in their healthcare maintenance, so, researchers are forced to rely on philosophical guidance to determine how people make the decisions they make based on the phenomenon that impacts their personal lives today (Gostin, 2008). Thus, the information obtained will help guide future health policymakers to determine if using consumer-market theory as opposed to social justice theory will maximize individual participation and to achieve a successful outcome by creating healthy outcomes with social change.

Furthermore, Braun and Clarke (2006) described thematic analysis as a form of data collection that allows for the identification of patterns that can be further formed into themes. Therefore, the themes from this research project included people who people who had to pay the penalty or made the decision to purchase health insurance. The assumed themes included people who were not aware of the financial penalty, people that could not afford the monthly premiums, people who personally choose to pay the penalty, and people who made the decision to purchase health insurance for health-related reasons.

Analysis Program

I used the NVivo 11 software to upload the tape-recorded interviews, provide compatible transcription downloads, and then helping code the data for effective qualitative analysis. This software was chosen for its user-friendliness and the ease of uploading audio recordings of the interviews. NVivo 11 is also a good program to enhance the reliability and validity of qualitative research when all of the data is collected and entered correctly (Welsh, 2002). The software license was purchased from the company directly for the completion of this dissertation.

Chapter Summary

The methodology for this study was a qualitative interpretive phenomenological analysis using a thematic approach for saturation and triangulation to achieve reliability and validity of the data collected. I chose this method because the goal of this study was to understand how people make the decision to purchase health insurance or pay the tax penalty at the end of the year. The ACA is a phenomenon to citizens and residents alike

because no other health policy in U.S. history has ever mandated the purchase of a health commodity. Hence, Chapter 3 I discussed the research design, the phenomenological approach as the appropriate design, the sampling population, the instrument designed for interviewing the sample population, the validity and reliability of the methodology, and the data analysis process. In the next chapter, I will discuss the data analysis process, the NVivo 11 program in more detail, along with the results of the data.

Chapter 4: Results

Introduction

This chapter contains the results of my interpretive phenomenological research study, structured into four sections. In the first section, I describe how volunteers were recruited and how the data were recorded and analyzed. In the second section, I describe how I looked for developing patterns and common word themes. In the third section, I discuss how my findings relate to my two research questions. The last section includes the procedures followed to assure validity and reliability of the data.

Restatement of the Purpose of the Study

The purpose of the study was to learn how citizens of Harris County, Houston, Texas made decisions about purchasing to purchase health insurance or pay the individual mandate penalty at the end of each tax year from 2014 through 2016. In addition, the purpose is to research the current health policies and recommend implementing social justice theory in future health policy as opposed to the current managed competition theory. This study highlights a need for healthcare policy change guided by qualitative research and lived experiences.

Recruitment and Data Procedures

The Walden University IRB approved my research study on September 28, 2017, at which time I started to recruit participants through social media outlets and via snowball sampling using already interested participants. By using social media outlets such as Facebook and LinkedIn, I was able to obtain four volunteers. The remaining two volunteers were referred to me by others through the social media outlets I used to

advertise my research project. The volunteers were obtained exclusively from Harris County, Texas. The data I collected were not meant to be generalizable across the entire state of Texas.

I conducted my recruitment process through social media by posting my IRB-approved consent form and the IRB-approved flier (Appendix B) on social media, leaving fliers on parked cars in public areas, and personally handing out fliers in public areas. Participants were over the age of 18, were residents of Harris County, Texas, and reported during the interview that they either purchased health insurance or paid the tax penalty at any time from 2014 through 2016 IRS tax period.

Once I recruited participants, they acknowledged receipt and full understanding of the research consent form and further consented to being recorded using a handheld tape recorder. The six interviews occurred either in person or by phone. The questions and data collection procedures were consistent for all participants as described in Chapter 3. Each participant was assigned a six-character data number, which was used during the recording and listed on their consent form. However, in NVivo 11, I labeled the audio files as Volunteer 1, Volunteer 2, etc.

Data Collection

The interviews had three sections. Section one included demographic information such as age, biological sex, family size, annual net income, and whether or not the volunteer had health insurance. Section two included volunteers' personal knowledge and experiences regarding the individual mandate and how they made personal decisions about health insurance. In section three, I sought out the volunteer's personal opinion on

the ACA individual mandate and asked if there was anything they would like to express that I had not covered in the interview. I intended to have a total of 20 volunteers, 10 who purchased health insurance and 10 who paid the penalty. Unfortunately, only six people volunteered to participate in this study and all six had purchased insurance. All interview participants were able to seek further clarification via email if any questions had arisen.

Participants

Participants were residents of Harris County, Texas who had filed a federal tax return during the years 2014 through 2016. They were all at least 18 years old and willingly volunteered to participate in the study. Table 1 gives a brief description of the six individuals who volunteered to participate in my research project to learn how people make the decision they make regarding their healthcare based on their lived experiences.

Table 1

Section One: Volunteer Description

Participants	Age	Biological Sex	Harris County Resident	Family Size	Annual Income	Currently Insured
Volunteer 1	53	Female	Yes	1	$30,000	Yes
Volunteer 2	44	Female	Yes	3	$150,000	Yes
Volunteer 3	27	Female	Yes	1	$14,000	No
Volunteer 4	48	Female	Yes	3	$58,000	Yes
Volunteer 5	34	Female	Yes	1	$48,000	Yes
Volunteer 6	34	Female	Yes	1	$60,000	Yes

Volunteer 1

Volunteer 1 was a 53-year-old single woman living alone on an estimated $30,000 annual income. She purchased health insurance from 2014-2016 from the FME

market. Her knowledge of the individual mandate was that the cost of insurance was based on one's income level if an employer does not provide it. She only knew of two policies offered in Harris County, which was only two from her experience. She chose a policy based on the promise that she would be able to keep her regular provider, and the government quoted her a price minus a government subsidy toward that amount per month that costs her $225.00 per month. She purchased the insurance and later found out her provider was not on the participating provider list, so she had to change providers as her new insurance contract required.

When asked how she made the decision to purchase health insurance, Volunteer 1 indicated the need for cost-effective prescription payment coverage first, and then the importance to continue her desired health outcomes through cost-effective outpatient provider visits in order to achieve her wellness and disease maintenance goals. Volunteer 1 stated that her annual estimated cost excluding premiums was about $3,500. She further indicated that the higher cost was because she pays out of pocket to continue to see her previous primary care provider (PCP) after unsuccessful attempts at finding an in-network provider through her insurance company. In addition, Volunteer 1 indicated that the overall cost of her healthcare maintenance personally impacted her negatively because the only thing the health insurance did for her was cover high prescription costs and keep her from being penalized at the end of the year.

In the third and final section of the interview, Volunteer 1 explained her personal opinion regarding the ACA mandate and she stated that while she knew something had to be done, she did not agree with the current health policy based on her personal

experience. She stated that, given where she can only buy policies from the FME in Texas, she faced challenges because so many insurance companies had backed out of it, her options were limited. She could not find an insurance company that was in network with her personal doctor. When asked if there was anything she likes to include that was not asked during the interview, Volunteer 1 stated the FME system is kind of difficult to work with. She had paid the amount, but somehow it did not get posted and the insurance company canceled her plan. She stated it was just a difficult system to work with and she was very unhappy with the whole process.

Volunteer 2

Volunteer 2 was a 44-year-old woman from Harris County, Texas, living with one adult and one child on an estimated $150,000 annual income, who purchased health insurance from 2014 through 2015 through the FME. Volunteer 2 stated that she had had employer-sponsored health insurance since 2016. She stated that her understanding was that if you do not have health insurance through an employer, you do not qualify for Medicaid or Medicare, you have to go to the marketplace to select healthcare or you will get a fine on your taxes. She stated that she personally chose to purchase health insurance through the FME because it was cheaper than what her employer was offering, so she could opt out of her employer's coverage without having to pay the penalty at the end of the tax year.

Volunteer 2 indicated that her decision was not based on any existing health concerns, but more for the preventative health services that would keep her family healthy. Her goals for her family's health were to make sure they can get annual exams,

to make sure that they have proper prescription plans should they need any medication, to make sure that they have access to quality care, and to have hospitalization coverage just in case because her son plays sports. When asked to estimate the cost of healthcare, she stated that from 2014-2015, her annual cost was about $6000. Volunteer 2 further stated that she saved money during that period because it was cheaper to purchase insurance through the exchange market than it was to use her employer-sponsored healthcare coverage plans.

In the third and final section of the interview, Volunteer 2 was asked about her personal opinion regarding the ACA mandate, and she stated that she had mixed feelings about it. She stated that she thought, on one hand, all Americans should have access to care. However, she stated that she also thought that the transition was more difficult than she expected, so that left her with negative feelings about the FME. She further stated that during the initial rollout, the process was very convoluted and took many hours and many phone calls for people to effectively complete the application task. Volunteer 2 concluded the interview if there was anything she would like to add that was not already addressed during the interview process. She stated that she was happy that there were no have restrictions on pre-existing conditions and she knew several people who benefitted from that clause. Volunteer 2 thought that was one positive about the act but she closed by stating she has mixed feelings about it because there are good qualities about it and there are bad qualities about it, but she stated “that's just kind of how things are going to transition, we just have to work out the kinks”. Volunteer 2 stated that she experienced long waiting times for care, and that was the main reason why she decided to return to her

employer-sponsored health insurance plan instead of continuing to subscribe in the FME plan.

Volunteer 3

Volunteer 3 was a 27-year-old woman living alone on an estimated $14,000 annual income. She purchased health insurance in 2015 through the FME. Volunteer 3 stated that she was previously covered under her parents plan until she turned 26 because of the ACA. Volunteer 3 stated that her understanding of the mandate was that one must pay a penalty if one does not have employer-sponsored plan and chooses not to purchase insurance through the Affordable Care Act, one is required to pay a penalty. She went on to say that she believed that if one became uninsured, one must pay a prorated penalty. She stated that last year, she considered not buying insurance because she did not think she could afford it. She believed that the penalty at the time was $600 for the full year. She also stated that the situation was a lot for her at the time.

Volunteer 3's decision to buy health insurance had two parts. The first part was based on healthcare service needs due to a number of health issues that were costly in 2014, estimating around $12,000 a year. The second part of her answer was thinking that she cannot be the only one subjected to high healthcare costs and she felt a personal need to participate in the ACA. When asked to estimate the cost of her healthcare, she stated that from 2015-2017, her annual cost was about $6000. Volunteer 3 further stated that this cost impact during that time was positive because it provided affordable coverage and provided a reasonable deductible. Additionally, she stated that it did not matter what

the coverage was as long as she had something in place given her financial situation and health status.

Volunteer 3 stated that the cost of healthcare derailed her career for a year. She had to stop auditions and had to stop taking lessons in order to pay for medical expenses because the treatment was not covered under any insurance. She also had to take extra jobs just to pay for the monthly cost of the healthcare. Every month, she stated that she had to choose between paying for that and paying for auditions. Missing auditions meant losing the potential for jobs. Volunteer 3 closed that question by stating that the cost affected her greatly and was a frustrating experience overall.

In the third and final section of the interview, Volunteer 3 was asked about her personal opinion regarding the ACA mandate, and she stated that she thought this was really hard for a lot of people in her position to understand. She further stated that the question was not hard, but the individual mandate. Volunteer 3 went on to say that it was hard for people in her position to understand the pay or purchase mandate. She stated that a lot of young people think that it is a terrible idea, and she is feeling frustrated enough to agree with that at this point. She went on to say that she does think that it is necessary in order to have socialized healthcare. Volunteer 3 described the mandate as similar to Social Security. When asked if there was anything she would like to add that I did not already ask, Volunteer 3 stated that she felt she said everything she needed to say during the interview process, and so the interview was concluded at that time.

Volunteer 4

Volunteer 4 was a 48 year old woman who resided in Harris County, Texas with a family of three. She had an annual income of around $54,000 to $60,000 from 2014-2017. She stated that she did not have health insurance for about 12 months starting in 2016. She did not pay the penalty because she had not filed her 2017 IRS taxes at the time of the interview. When asked about her knowledge regarding the individual mandate, Volunteer 4 simply stated that she did not know very much, only that she was aware of the requirement to purchase health insurance or pay a penalty. She stated that she made the decision to purchase health insurance from 2014-2016 because it was harder to not have insurance because of her health conditions.

Accessing affordable healthcare to manage chronic conditions was most important to her. Volunteer 4 also stated that it was a very difficult decision for her to not purchase health insurance in 2017 because she needed stable healthcare but could not afford the cost. She estimated her healthcare costs to be about $40,000 a year since 2014, which has negatively affected her credit and led to her contemplating bankruptcy proceedings. Thus, when asked what her personal opinion was about the ACA's individual mandate, Volunteer 4 concluded by stating that she did not think it was right to impose a mandate on people with fixed incomes, further stating "that a lot of people, such as herself cannot afford health insurance".

Volunteer 5

Volunteer 5 was a 34 year old Female Harris County, Texas resident living with two roommates but otherwise independently on an estimated $48,000 annual income. She

purchased health insurance for herself only from 2014-2017 through the FME. From 2017 onward, Volunteer 5 paid for herself and two others through the FME. She stated that her personal knowledge of the individual mandate was that insurance coverage was supposed to be available to anyone who did not have other means such as employer-sponsored insurance. She also stated that she was aware of the federal-only credits available to Texans based on IRS reported income, and the penalty involved if you did not sign up for insurance or qualify for any credits.

Volunteer 5 made the decision to purchase health insurance since 2014 based on health maintenance priorities and without any current health problems guiding that decision. When asked what was important during that decision-making process, she stated she based her decision on a risk versus reward analysis. She went on to clarify that her purchase price was the same as the tax penalty, so that was not a factor in her decision. Instead, she believed that the sense of security in knowing there was healthcare coverage available for her was more beneficial than worrying about how to pay out-of-pocket should something happen. Volunteer 5 stated that her estimated healthcare cost was around $3,500 a year since 2014. When asked how that cost affected her personally, she stated that it was terrible for healthy people to pay high premiums, which leads to lack of consumer competitiveness in other market industries.

In the third section of the interview, Volunteer 5 was asked her personal opinion of the ACA's individual mandate and she responded that she did not think it was right because everyone cannot afford to purchase health insurance and she felt they should not be penalized if that is the determining reason for their personal decision. When asked if

there was anything else regarding the ACA individual mandate that she would like to share, which was not asked during the interview, she stated that she wished health policy was better regulated from a federal standpoint regarding costs and cures from companies such as pharmaceutics and durable medical, as opposed to regulating individual state's decision on participation. Volunteer 5 concluded by stating that a better tax would have been to apply funds to lowering costs and finding cures as opposed working with insurance companies, who she feels has a monopoly over the health industry.

Volunteer 6

Volunteer 6 was a 34 year old woman living alone on an estimated $60,000 annual income. She stated that she was uninsured, but she did participate in a Christian-based Samaritan Industry program in 2017, which was considered an exempt share plan by the IRS. When asked about the time period from 2014 to 2016, she indicated that during a portion of that time she had employer-sponsored coverage and otherwise she did not purchase insurance or pay a tax penalty.

When questioned about her knowledge of the individual mandate, Volunteer 6 stated that she knew you had to have a certain level of healthcare coverage in order to not have to pay the tax penalty. Therefore, she made the decision to purchase coverage based on costs, her goals for her health, but not based on any current health issues. More specifically, she stated that the cost to participate in the current share plan was more beneficial for her health goals and less expensive than paying the tax penalty.

In section three, Volunteer 6 was asked her personal opinion about the ACA's individual mandate. She stated that she did not believe the government was going to fix

health care through intimidation via the tax penalty. She went on to say that she felt "it was not the government's place to regulate healthcare providers or health insurance providers". Volunteer 6 clarified through her analogy of being a bad driver and car insurance increases, to folks making bad health decisions and the cost of health services increasing. She concluded the interview by saying that she felt there was nothing affordable about going through the FME, stating that there are many requirements such as maternity and pre-existing conditions coverage for all, which increased the premium costs exponentially. She stated that she could not afford that cost, and so she decided to participate in a tax-exempt health program as opposed to purchasing from the exchange market.

Data Analysis

Once the interview data were recorded and then transcribed, the files were uploaded into NVivo 11 Pro for coding and analysis. I chose the NVivo software over other qualitative data analysis tools because of the reliability of its data mining capabilities. NVivo 11 allowed me to upload the tape recorded interviews, send those files out for transcription and the upload the transcribed volunteer interviews in order to code the data based on themes and units of observation. These features were important because my data analysis relied on the thematic approach and the information that allowed me to complete the hermeneutic circle method of analysis.

Coding

I used the coding convention outlined by NVivo 11 for reliable analysis of themes; this convention has also been used in other studies (Basit, 2003; Bailey et al,

2018). The coded items included the Source, the Nodes, Sister Nodes, and Cases to determine units of inductive theme observations. The sources and case classifications were not further coded because the interviews were the only sources used for this study.

The source data consisted of six audio interview recordings, which were transcribed once the recordings were uploaded into NVivo 11. The transcription of the audio was essential in the coding process. Once transcribed, the data were able to be coded into Nodes that are containers of volunteer responses verbatim. Three sets of Node containers were created, Demographic, Lived Experiences, and Personal Opinions, which represented the three sections of the interview. The Node data were then thematically coded by using Sister Nodes that drilled the interview data into recurring decision-making scenarios based on the volunteers' stated lived experiences.

Findings

The data were analyzed in sections in order to document the findings and then identify the themes. The interview process was divided into three sections in order to provide accurate themes from the findings to answer the research questions. Section one of the findings consisted of demographic information, shown in Table 1 above. The second section identified the findings based on lived experiences, and the third section of the interview was based on the participants' personal opinions.

Section Two

During section two of the interviewing process, volunteers were asked about their personal knowledge of the ACA, whether they paid the tax penalty or purchased health insurance, if there were any health problems that guided their decision, what was

important to them for their health, their health goals, and how the cost affected them personally.

The transcript findings show that all six volunteers had limited information on the ACA individual mandate. In addition all six volunteers indicated on the recorded interview that they had purchased health insurance; however, two volunteers informed me, off recording that they did not pay the penalty because they did not inform the IRS that they were not covered by health insurance.

The breakdown of coded results for this section can be seen in Table 2 below.

Table 2

Section Two: Lived Experiences

Participants	Personal Knowledge	Paid or Purchased	Health Problems	What Was Important	Health Goals	Financial Impact
Volunteer 1	Limited	Purchased	Yes	Provider	Wellness	Negative
Volunteer 2	Limited	Purchased	No	Cost	Wellness	Positive
Volunteer 3	Limited	Purchased	Yes	Cost	Wellness	Negative
Volunteer 4	Limited	Purchased	Yes	Coverage	Wellness	Negative
Volunteer 5	Limited	Purchased	No	Coverage	Wellness	Negative
Volunteer 6	Limited	Purchased	No	Cost	Wellness	Positive

Section Three

During this section of the interview process, volunteers were asked about their personal opinion of the ACA based on their lived experiences. They were also asked if they had any further comment, which was not asked during the interview processes. The breakdown of coded results can be seen in Table 3 below.

Table 3

Section Three: Decision-making and Personal Opinion

Participants	How Decision Was Made	Personal Opinion
Volunteer 1	Needed Insurance	Negative
Volunteer 2	Wanted Insurance	Mixed Feelings
Volunteer 3	Wanted Insurance	Necessary
Volunteer 4	Needed Insurance	Negative
Volunteer 5	Wanted Insurance	Negative
Volunteer 6	Wanted Insurance	Negative

Themes

After coding the findings, I found several themes in the data. Only women participated, and all made the personal decision to subscribe to either a self-paid insurance plan or an employer plan for tax years 2014 through 2016. Other themes included that participants had limited knowledge of the ACA, but were aware of the penalty if they did not participate. The main theme discovered was that all volunteers stated that their wellness was the key factor in how they made the decision to purchase insurance. However, the theme for how they made their decision was based on the fact that four out of the six stated that they wanted health insurance, while the other two indicated a need for health insurance mostly due to prescription discounts. All participants indicated that they experienced negative financial effects, and most participants held negative feelings toward the ACA's individual mandate.

Triangulation

Triangulation was achieved first through snowballing in that four out of the six volunteers were referred to the study by someone else. However, the main triangulation technique used was the hermeneutic circle method (see Figure 1). This method starts with the phenomenon of the ACA individual mandate then moves to the initial question as to how people made the decision to purchase or pay. The circle then continues to identify the second research question on the likelihood of participation due to the penalty. The next link identified the participant's engagement through participation followed by the understanding of engagement. The last link included the greater understanding as to how participants made the decision to purchase or pay, which then links back to the whole phenomenon of the ACA and understanding of participation.

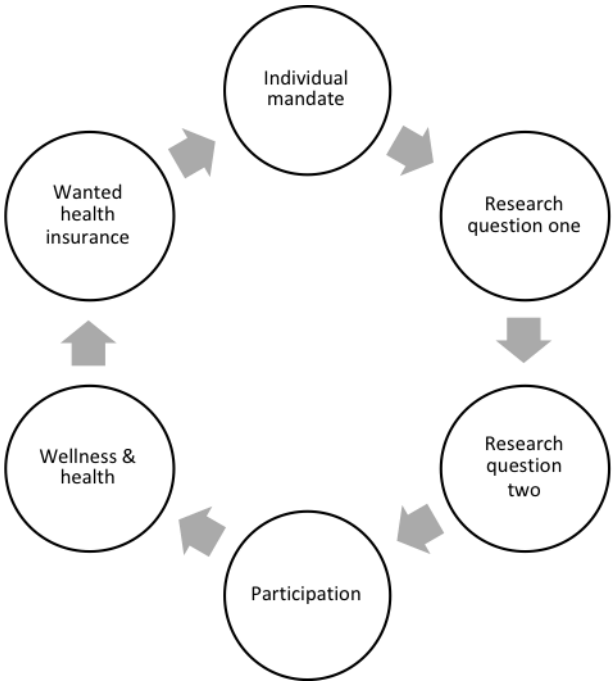

Figure 1. Hermeneutic circle method.

Evidence of Trustworthiness

Trustworthiness, as described in Chapter 3, was achieved by establishing reliability, transferability, dependability, and conformity through reflexivity in the research study. Reliability rests on the qualitative interpretive phenomenological approach to discover how people make the decision to purchase or pay based on their lived experiences as discovered from the identified themes. Triangulation was achieved by the use the hermeneutic circle. In addition, transferability relies on the phenomenological research approach focused on the Harris County volunteer population. Also, dependability was established by using the thematic approach, snowballing effect, and the hermeneutic circle approach from the interview transcriptions and coding conventions used in NVivo 11. Finally, conformity through reflexivity was established based on the identified systemic attitudes relative to the limited knowledge in the ACA individual mandate phenomenon.

Results

The results are based on the NVivo 11 analysis that created themes from the data and I was able to provided triangulation for each research question through the hermeneutic circle methods. The research questions and results are discussed in further detail below.

Research Question 1

How do taxpayers make the decision whether to purchase health insurance or pay a penalty each year based on their lived experience? The data revealed that the participants made the decision to purchase health insurance for health and wellness

purposes. Their main goals were to receive free annual preventative services and disease maintenance with regard to prescription plan discounts.

Research Question 2

Does the penalty increase the likelihood that citizens in Harris County, Texas, will purchase healthcare insurance based on taxpayer's lived experience? The data revealed that the individual mandate did not play a role in how the volunteers made the decision to purchase or pay. In fact, the data revealed that even though the volunteers felt they were negatively affected financially and held a negative opinion on the ACA as a whole, they still made the decision to purchase health insurance based on their personal experience of want and need.

Summary

The purpose of this research study was to learn how people made healthcare decisions and to see how social justice theory can benefit citizens in healthcare reform. Several themes were identified using the interpretive phenomenological method and NVivo 11 was used to create and code these themes in order to answer the research questions. The first research question, concerning why participants chose to purchase healthcare, was answered by the volunteers' desire to maintain wellness and/or maintain current health conditions. The second research question, concerning the individual mandate, found that people were not motivated by a tax penalty, but more so by the desire to maintain wellness. The volunteers did express that health insurance had a negative financial impact on their household, and that they held a negative opinion of the ACA in general. These volunteers participated based on their desire receive preventative

healthcare and prescription health maintenance care and that the consumer-market theory should be readdressed when applying to the ACA health policy. Further discussion summarizing the research and results continues in Chapter 5.

Chapter 5: Interpretations, Limitations, Recommendations, and implications

Introduction

This chapter contains the discussion, conclusions, and recommendations based on this type of phenomenological research study. This was a qualitative interpretive phenomenological study of how people made the decision to purchase health insurance or pay the penalty between the years 2014 and 2016. Additionally, the chapter contains the interpretations of findings and the limitations of the study as well as recommendations, implications, and conclusions for future research.

The problem that I addressed in this study was that over 7.4 million people paid a tax penalty rather than buy health insurance at the end of the tax year 2014, and researchers still do not know why or how people made that decision (Galewitz, 2015). The ACA was designed by lawmakers using the managed competition theory, which subscribes to the idea of patient competition amongst healthcare providers, instead of social justice theory, which strives to govern rights, equality, duty, and distribution of social and economic advantages (Daniels, 2001; Gostin & Powers, 2006; Ekmekci & Arda, 2015; Rasanathan, Norenhag, & Valentine, 2010; Rawls, 2009). Previous researchers suggested that there has been a distinct decline in primary care and specialty care providers available to patients since 2010 (Bodenheimer & Pham, 2010). This may be caused partially by the failure of managed competition in areas where there are too few participating providers for consumers to have meaningful choices. For the purposes of this study, “participating provider” refers to a medical professional who is considered in-network for health plans on the FME.

The purpose of this study was to learn how people made healthcare decisions when faced with a purchase or pay situation following the implementation of the ACA. The interpretive phenomenological approach by Heidegger (2008) was chosen in order to study six Harris County residents' concepts of being mandated to participate in the ACA as opposed to conducting a study on what they knew about the ACA. This study provided information on individual perceptions of the mandate to buy health insurance; more specifically, it pointed to how the volunteers' lived experiences might have led to their decision to purchase health insurance or pay a penalty at the end of each tax year. The benefits of this study also to identified the individual impact of the individual mandate in order to identify areas for improvement in health policy related to the ACA. The findings of this study were that the individual mandate played a small role in how people made the decision to purchase health insurance; it had little impact on incentivizing the six volunteers when they decided to purchase as opposed to paying a penalty at the end of the tax year.

Interpretation of the Findings

The interpretive phenomenological approach was the most appropriate qualitative method for this study because using it allowed me to focus on the lived experiences of the volunteers and to learn how they made healthcare decisions (Lopez & Willis, 2004). The theoretical framework for this study was the version of social justice laid out in *A Theory of Justice* by John Rawls (2009). In this project, I questioned whether mandating the purchase of a commodity is truly just—viewing healthcare through the lens of managed competition theory could leave many people susceptible to healthcare costs they may not

be able to afford. As noted in Chapter 2, Kirzinger et al. (2017) discovered that "when the uninsured are asked about the main reason they do not have coverage, the most common response offered is that it is too expensive and they cannot afford it" (p. 11).

This study confirmed the need for health policy reform based on the findings that people care about their health and are willing to take personal responsibility in their own healthcare maintenance when given access to affordable health insurance. The fact that people chose to purchase insurance is why social justice theory should be considered as the predominant force in providing health reform, which will help to achieve the goals described in the CDC's Healthy People 2020 (CDC, 2011). The ACA is the first national health policy in the United States, and further research can help it to meet its intended health outcome goals.

Interpretations of How Taxpayers Make Healthcare Decisions

My first research question was about how taxpayers make the decision to purchase health insurance or pay a penalty each year based on their lived experiences. Analysis of the interviews indicates that the volunteers made the decision to purchase health insurance because they wanted to maintain their current health status and because of the free preventative care services. The majority of the volunteers indicated that they had had insurance prior to the 2014 individual mandate and that they were happy with those plans. Further thematic analysis indicated that people made the decision to continue to purchase insurance based on personal reasons such as their need for low-cost maintenance medication to control chronic illnesses and the desire to keep their current

provider. All volunteers stated that they did not pay the tax penalty at any time between 2014 through 2016.

Interpretation of Whether the Penalty Played a Role in Participants' Decisions

The second research question asked if the penalty increased the likelihood that citizens in Harris County, Texas, would purchase health insurance. The theme that came up the most in all the interviews was that the volunteers did not purchase health insurance to avoid the tax penalty. Instead, the volunteers purchased health insurance because they wanted to take personal responsibility for their own health outcomes and having insurance helped to reduce their financial risks if a catastrophic event were to occur.

However, four out of the six volunteers did indicate that the cost of healthcare overall has had a negative effect on them personally. They further indicated that their buying power in other consumer products had declined because of health insurance costs. All six volunteers indicated that they were not happy with the cost, stating that for most plans on the FME, the benefit package was not worth the premium they paid for it. All volunteers indicated that they believed a health policy was necessary, but should be more affordable.

Limitations of the Study

One of the study's limitations was its focus on just one county in Texas. Another limitation was that I was only able to recruit six volunteers, all of whom were women that chose to purchase health insurance. Therefore, the results may not be generalizable to men who purchased insurance or persons who paid the penalty. In the process of recruiting participants, I found that potential volunteers were reluctant to be recorded

during the interview. This reluctance significantly decreased the sample for offering lived experiences of citizens in Harris County, Texas. This limitation was illustrated by one volunteer who, once the interview concluded and the tape recorder turned off, stated that she did not tell the IRS that she did not have health insurance one year. When asked why she did not include this information during the interview, she stated that she did not pay the penalty, so the answer was truly no for that question.

The second limitation of the study was caused by my move to a different state after the study had already begun. Therefore, a set schedule had to be created and the amount of time I had available to promote the research study and potentially gain more volunteers. My out of state status further limited the number of volunteers because of the limited amount of time I was able to spend recruiting in Harris County. Another limitation to conducting a qualitative interpretive phenomenological research study long distance was the need to conduct more telephone interviews than face-to-face interviews. I would have preferred the face-to-face interviews because the personal interaction would have allowed me to observe body language and nonverbal communication that could have been misinterpreted or missed during a phone interview.

Researcher bias was mitigated by reviewing the volunteers' transcribed interviews and learning how they made the decision to purchase insurance based on their desire for wellness. The results from the six volunteers indicate a call for policymakers to reform and not fully repeal the ACA. It is necessary for everyone to have access to healthcare, access and research is the way to truth and social change for future health policy.

Recommendations

In this study, I examined how some citizens in Harris County, Texas citizens made healthcare decisions in order to better understand the needs of people when mandating the purchase of a commodity for the betterment of society. With the interpretations and limitations of this study in mind, it is recommended to conduct more research on the impact and outcomes of ACA to make a greater social impact on health outcomes in America and manage cost containment of necessary healthcare services. I also recommend that this study be conducted again, using a fill-in the blank questionnaire as opposed to a recorded interview so that volunteers can be more confident in the confidentiality of the information they provide.

As noted in Chapter 2, there are currently limited studies provided information on how people make the decision to purchase health insurance or pay the tax penalty, prompting which highlights the need for further research on this subject. My recommendation is to continue to research lived experiences when studying the current health policy and the need for policy reform. Research on lived experiences regarding how people make decisions to purchase health insurance or not to purchase is still necessary understood when policy-makers are the mandating participation of all qualified citizens. Other research studies such as case studies would be beneficial in documenting lived experiences on a case by case basis. This could provide additional information on how people make healthcare decisions based on their current health status.

Finally, more research surrounding the FME and the Medicaid expansion program continues to be promoted by many researchers in order to support the reliability of the

information to offer discoveries that will determine gaps in the ACA and its implementation (Baker, 2011; Chang & Davis, 2013; Roland & Garfield, 2000). With that in mind, this study is a model for health policy studies in order to examine how most Americans feel they are personally affected by the phenomenon of the fiscal mandate of the ACA.

Implications

The findings of this study provide evidence-based research from a small homogenous population for policymakers to make the appropriate change to the current ACA health policy by implementing the theory of social justice and terminating the individual mandate portion of the current policy. Although these findings are specific to only six volunteers, the fact that none of the six volunteers purchased health insurance out of fear of the penalty further supports the idea that the individual mandate is unnecessary. In addition, implications for change to the current policy were found as it pertained to the commerce clause. All participants agreed to the need for health policy but further indicated that the current policy was too expensive, thereby having a negative financial impact on their ability to purchase other commodities such as entertainment, dining, and non-essential purchases they used to make in the past.

Another implication was the need for policy review and reform to remove the managed competition theory from the current policy and replace it with social justice theory. Thereby, removing the mandate to participate in what is said to be a cost-effective health policy for all because the ACA indicates that health insurance is a right and should be affordable to all citizens. The fact remains that the policy is not having the intended

results for all citizens in states like Texas, who did not participate in any aspect of the ACA. The result left many without insurance due to the lack of Medicaid expansion and providing state subsidies to qualified recipients. Thus, the implication for further research in order to make sound policy changes is essential in creating an affordable health policy that Democrats, Republicans, and the people can agree on.

Conclusion

This qualitative interpretive phenomenological study was conducted to inquire about people's lived experiences and how health insurance decisions were made based on those experiences. In particular, I wanted to understand This study asked the question of how those people made the decision to purchase health insurance or pay the tax penalty after learning that 7.4 million were reportedly penalized in 2014 (Galewitz, 2015). The findings were clear in that all volunteers purchased health insurance because they wanted to be healthy and to have that health coverage even though the cost was a burden. Therefore, this study indicates that most people will purchase health insurance to maintain wellness, but the cost is reducing their overall purchasing power overall, which will no doubt affect the rest of the economy going forward. Although a complete repeal of the ACA is impossible for a host of practical reasons, this study provides some justification to reexamine the individual mandate.

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Appendix A: Interview Questions

Section One:

1. Age: _____
2. Biological Sex: Male Female
3. Harris County resident: Yes No
4. Family size (Please explain):

   _____

5. Annual net income in dollar amount (After taxes. take home pay):

   _____

6. Do you have health insurance? Yes No

Section Two:

1. What is your personal knowledge about the individual mandate?
    a. Have you had to pay the individual mandate penalty, or did you personally purchase health insurance?
        i. How did you make that personal decision?
            1. Were there any health problems that guided your decision?
            2. What was important to you when you made the decision to purchase health insurance or pay taxes?
            3. What are your goals for your health?
2. With or without insurance, estimate how much health care cost you since 2014? Please break down by year. (Premiums, copays, coinsurance, RX, DME, etc.)
3. How did that cost impact you personally?

Section Three:

1. What is your personal opinion about the ACA's individual mandate to purchase health insurance or pay a penalty?
2. Is there anything else regarding the ACA individual mandate you would like to share that I did not cover in this interview?

Appendix B: Public Flyer

VOLUNTEERS NEEDED FOR

RESEARCH STUDY ON THE AFFORDABLE CARE ACT (OBAMACARE) INSURANCE PENALTY

I am looking for volunteers to be interviewed about the Affordable Care Act (Obamacare) insurance penalty. If you personally purchased health insurance or paid the penalty, I would like to interview you. The interview will take approximately 20 to 30 minutes.

Thank you!

This study has been reviewed and approved by the Research Ethics Review Board, Walden University. IRB# 09-2817-0179615