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African Americans' Understanding of the Provisions of the Affordable Care Act

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Abstract

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Dissertation Submitted in Partial Fulfillment

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Abstract

African Americans as a group tend to have numerous health issues, and by the time they seek healthcare, the conditions often advance into more serious ailments. Researchers have shown that cultural distrust of the U.S. healthcare system coupled with some discriminatory practices has hindered African Americans seeking care and taking full advantage of the healthcare system. With the introduction of the Patient Protection and Affordable Care Act (ACA), there is some confusion about the application of the law, resulting in many intended beneficiaries misinterpreting it, and not accessing quality healthcare. This interpretive phenomenological study explored how African Americans in the Washington D.C., metropolitan area understand and interpret ACA provisions related to their healthcare needs. A sample of 10 African Americans adults participated in in-depth interviews that generated data for this study. Critical communicative methodology provided a framework for exploring the phenomenon. Study findings highlight the themes of interpreting the ACA to mean having more individual control and responsibility for healthcare decisions and having fewer perceived restrictions acting as barriers to access healthcare. Study results contribute to social change by providing knowledge to those who implement healthcare policy on optimal policy delivery to intended beneficiaries. This knowledge may also apply to other new social policy dissemination, thus ensuring policies reach their intended target populations, facilitating optimal utilization.

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Dedication

This study is dedicated to my wife Marion who carries more than half the load in our relationship and dedicates herself to ensuring our happiness. Without you, my Franchise, I don’t know how I would have mustered the courage to undertake this higher education study. You continuously motivate me to fight for the underrepresented and give our sons and me the courage to tackle any challenges. Your commitment to us makes us pursue endeavors without fear because we know you are the force that drives us towards success. I also dedicate this study to my boys, Therion and Jelani, who patiently calmed me down when literature fatigue caused my mood swings. Thanks for being troopers helping me conduct literature research and affording daddy the time to analyze the literature and write my qualitative study. To my darling mother, Lucy, who guided my educational path with the backing of her faith and her ability to make me confident even under the most challenging circumstances. To my dad, James, who challenged me to aim higher and pursue knowledge in everyday interactions and my siblings, Helen-Beatrice, Emmanuel, Caven, Basil, and Joseph, for fostering a strong educational etiquette and encouraging me when I encountered difficulties. To my Pah-Ben and mommy-Liz who gave me the necessary confidence to face all challenges head-on and to my Mbambah, Anna Maria Nzelle Ewang (RIP), who lit the curiosity flame in me from a very young age because of her wits and subtle book-smarts.

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I want to acknowledge my wife Marion for her commitment towards my success and who together with my boys Therion and Jelani created an environment conducive for me to complete my doctoral study. My wife also provided me with a set of objective eyes to catch potential errors that I may have otherwise overlooked due to being engulfed in my study.

I would also like to acknowledge my chair Dr. Benoliel for guiding me through this arduous process and for her commitment towards my success. She pushed me to surpass set timelines and ensured that I produced a quality study. You served not just as my guide but also as my friend and provided me with a much needed objective set of eyes. I would like to acknowledge my second committee member and my URR, Dr. Hershberger for also providing me with much needed extra set of objective eyes. You provided me much needed insight on ways to improve this study while encouraging me to remain motivated. I also wanted to acknowledge the School of Social and Human Sciences at Walden University for creating an environment that fosters student growth and development.

The participants and facilities that voluntarily took part in this study deserve acknowledgement because they helped bring to light challenges in social policy dissemination. They could also help facilitate the creation of a stable and sustainable channel through which benefitting social policies could be optimally transmitted.

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Chapter 1: Introduction to the Study

Introduction

Throughout U.S. history there have been various attempts undertaken to provide healthcare coverage for all Americans (Loker, 2012). These attempts coincide with the clearly outlined disparities in healthcare coverage in the United States (Danaei et al., 2010). Proponents of healthcare reform have outlined the consequences of these healthcare disparities for African Americans and other racial minorities (Williams, 2011). Disparities in quality healthcare affordability and access have been identified as significant contributors to African Americans receiving lower quality care when compared to their Caucasian counterparts (National Center for Health Statistics, 2012). The lack of quality healthcare coverage leads to greater misdiagnosis and/or delayed diagnosis of health conditions for African Americans (Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010). Because of the challenges African Americans encounter in getting quality healthcare coverage, there has been a tendency for these individuals to present with more significant health conditions such as diabetes, obesity, high blood pressure, hypertension, and HIV/AIDS (Williams, 2011). According to the study by Denning and DiNenno (2010), which was used by the Center for Disease Control (CDC; 2012), African Americans utilize preventative care at much lower rates than Caucasians.

The National Center for Health Statistics (2012) reported that existing inequalities within the U.S. healthcare system, in conjunction with provider biases, enhanced the disparities in quality healthcare affordability and access. Such inabilities to gain access to or even afford quality healthcare coverage may worsen medical conditions and, in conjunction with built-in system access challenges, may result in exacerbated medical conditions, thus impacting life expectancy and infant mortality rates for African Americans (Levine et al., 2011). According to Kim, Kumanyika, Shiver, Igweatu, and Kim (2010), the inability to afford and access quality healthcare coverage can impact life and family dynamics because it could result in the proliferation of preventable diseases and illnesses within communities. Levine et al. (2011) stated that the low life expectancy and high infant mortality rates in the African American community can be attributable to low-quality healthcare coverage. This information is also supported by data collected by the National Center for Health Statistics (2012).

Many health professionals and policy makers have stated that documented healthcare coverage disparities and their impact on the overall health of communities justify the need for more affordable and accessible healthcare for all U.S. citizens (DeNavas-Walt, Proctor, & Smith, 2012). Davis (2009) stated that legislators in favor of comprehensive healthcare reform have argued that such reform would mitigate disparities in affordability and access to quality healthcare coverage for all Americans. The United States does not provide universal healthcare to its citizens, but the Affordable Care Act (ACA; 2010), which was signed into law in 2010, was aimed at addressing the growing healthcare disparity gap (Leigh, 2012). When signing ACA into law in 2010, President Obama stated that this marked the success of decades of health reform attempts (Williams, 2011). Comprehensive healthcare reform is aimed at providing quality healthcare affordability and access through a mandate for over 30,000,000 uninsured U.S. citizens and permanent residents (DeNavas-Walt et al., 2012). The law’s mandate states that everyone eligible to buy health insurance must do so either on the individual market or through their employer and be subject to a penalty if they fail to have health insurance.

The signing into law of healthcare reform and its affirmation by the Supreme Court as a constitutional law was only the first step in combatting racial disparities in the U.S. healthcare system (Andersen, Davidson, & Baumeister, 2013). For this law to work as intended, it has to be better understood and appropriately interpreted for beneficiaries to take full advantage of all its provisions (Andersen, Rice, & Kominski, 2011). As outlined below, there have been numerous studies undertaken that have identified potential causes of racial disparities in the U.S. healthcare system. Other studies have highlighted factors necessary in overcoming racial disparities in healthcare such as health literacy, health insurance affordability, and health reform. Exploring how African Americans understand and interpret the provisions of ACA could foster positive social change in social policy dissemination. This is because it would facilitate gaining insight into African Americans' understanding of the law that could enable legislators to make appropriate adjustments in the education of the public on the law and subsequent social policies.

Background of the Problem

Williams (2011) stated that the great variations in health insurance plan options also contribute towards widening the racial disparities in healthcare coverage gaps. Another area of significance in the racial healthcare disparities in the United States is the tremendous disparity in the quality of healthcare the different racial groups received (Braveman et al., 2010). In the National Academies Press, Smedley, Stith, and Nelson

(2003) explored the role race and other factors played in determining the quality of healthcare Americans received. Their study was also reviewed in the Journal of American Medical Association (JAMA, 2010). In addition to the lower quality healthcare minority groups receive, they also partake in less preventive healthcare, receive less specialized healthcare, and are less likely to undergo more intensive and technical procedures than their Caucasian counterparts (Andersen, Davidson, & Baumeister, 2013).

Numerous studies have outlined the racial disparities in healthcare coverage in the United States, and healthcare disparities have been recognized by various presidential administrations, including President Pierce, who vetoed a mental health bill in 1854; President Teddy Roosevelt, who called for national healthcare in 1912; President Franklin Roosevelt, who signed social security into law in 1935; President Johnson, who signed Medicare and Medicaid into law in 1965; and President Obama, who signed ACA into law in 2010 (Loker, 2012). In recognition of historical vast disparities in healthcare, the U.S. Congress commissioned a study on unequal treatment in healthcare (Smedley et al., 2003). A key recommendation from this study was improving health literacy, which is a field that has its documented origins in the early 1990s as a close association between education and health developed (White, 2008). Additionally, historical studies conducted by Sogie-Thomas (2006), Montori (2005), Schwartzberg, VanGeest, and Wang (2005), and Cutilli and Bennett (2009) stated that patients with limited education were found to experience greater challenges in understanding health issues and did not take active roles in their healthcare decision-making process. As a result of this linkage between education and healthcare coverage, the importance of health literacy continues to gain momentum (Sørensen et al., 2012).

In addition to health literacy, public policy literacy is also considered an integral part in the fight against racial and ethnic disparities in healthcare (Gould, 2011). ACA advocates identified limited utilization as a key contributor in widening the racial healthcare disparity gap, which the law was designed to overcome (ACA, 2010). While research has demonstrated the importance of healthcare literacy in utilization, I have not found any studies that have addressed the question of whether African Americans understand and interpret ACA for their own health benefits. Health reform policies such as ACA are public policies, and failing to understand these policies can result in limited utilization (Williams, 2011). Limited utilization would then contribute to widening the racial healthcare disparity gap that the public policy was designed to overcome (ACA, 2010).

Statement of the Problem

The effects of a lack of understanding of the healthcare system on overall quality of health for African Americans have been extensively researched and documented (Phillips, 2012). This lack of understanding of health information and the healthcare system has been linked to health conditions such as diabetes, high blood pressure, and cardiac disease, according to the National Center for Health Statistics (2012). Research has also exposed the impact that lack of knowledge has on creating racial disparities in healthcare coverage (Hodgetts, Chamberlain, Tankel, & Groot, 2013). The problem is that the patients who might benefit the most from health-reform policies such as ACA may not understand or be aware of the benefits they may derive from them (Williams, 2011). Given this lack of understanding and the recent changes in healthcare coverage brought about by ACA, African Americans may be more vulnerable to misinterpreting and not benefiting from access to quality healthcare. Notwithstanding the existing research, I had not found research that explored how African Americans understand and interpret ACA provisions so that these individuals can take advantage of the law and attain quality healthcare coverage. While studies had noted a significant racial disparity in healthcare coverage for African Americans, I found very limited to no research into how African Americans understand the healthcare system and health reform policies.

As the complexity in healthcare delivery increases, health literacy has to be emphasized to ensure that everyone takes full advantage of the policies in place to facilitate equity in healthcare coverage. The entrenched African American cultural distrust of the healthcare system has to be overcome to enable greater interaction between healthcare providers and African American patients. This could make the experiences of African Americans within the healthcare system on par with Caucasians and could facilitate greater participation in preventative healthcare coverage. Outlined in the following section is a listing of question that would facilitate assessing how African Americans understand the provisions of ACA.

Purpose of the Study

This study was intended to expand on current knowledge regarding how African Americans understand ACA provisions in relation to their own healthcare needs. In reviewing the available literature, I found many studies on racial healthcare disparities but very limited to no studies on how African Americans understand, interpret, and utilize the health reform law. As previously noted, there appears to be a correlation between health literacy and public policy literacy in narrowing the disparity gap in healthcare. An examination of all available literature on racial disparities in healthcare showed that African Americans constitute the most studied racial group that suffers from racial disparities in healthcare coverage. The results from this study provide insight into African Americans' experiences with ACA as their actual experiences were investigated through the use of an IPA approach. The research approach measures, research questions, and study participants are further discussed in Chapter 3.

Research Questions

I employed the research question outlined below in this study and participants' responses to this question informed the development of probing questions by the researcher to capture in-depth data from participants' shared experiences.

- RQ: How do African Americans describe their understanding and interpretation of ACA provisions and how to utilize these provisions to gain better healthcare coverage?

Theoretical Framework

Critical communicative methodology (CCM), developed by Jesus Gomez (J. Gomez, Latorre, Sanchez, & Flecha, 2006), provided the framework for this study. CCM proposes that a communications rationale may be employed in building social knowledge through discourse. As societies have evolved, there has been more scientific discourse on the challenges facing society, which resulted in the creation of CCM (J. Gomez et al., 2006). CCM’s development has propelled significant change in combatting social segregation and discrimination (A. Gomez, Puigvert, & Flecha, 2011). Studies of social phenomena conducted using CCM processes facilitate collaboration between communities and researchers, with researchers contributing scientific knowledge and participants contributing their lived experiences. This uncovers novel understandings that help develop solutions to various social challenges. These newer perspectives to existing social problems then serve as templates for social advocates to use when lobbying policy-makers on developing effective social policies (A. Gomez et al., 2011). CCM credits everyone with cultural intelligence, which contributes to knowledge building and thus combats the stereotypical elimination of certain groups from academic contribution. CCM falls in line with Freire’s (1998) theory, which credits everyday people with the ability to understand their experiences and facilitate changing said experiences through critical consciousness. This was the essence of what I wanted to capture by evaluating how African Americans understood and interpreted ACA provisions.

Dearing (2009) stated that the dissemination of new concepts over time among members of a social class constitutes the unique communication process termed *diffusion*. Rogers’s (2003) diffusion of innovations model is optimal for researching the diffusion and adoption of knowledge or innovative concepts. ACA is a novel healthcare concept in the United States, and this model provided great insight on how ACA was diffused and adopted by the beneficiaries. I employed Rogers’s diffusion of innovations model to understand how ACA provisions were communicated in the African American community. The diffusion of new concepts model contains four main parts: (a) the innovation, (b) communication channels, (c) time, and (d) the social system (Rogers, 2003, p. 36). Rogers explained that for new concepts to be readily accepted, they must present benefits, meet the needs of the beneficiaries, be simple, be easily tested, and produce visible results in the social framework. Hedman and Valo (2015) further stated that communication enables information sharing to facilitate consensus with outlets providing general knowledge of the concept. Interpersonal conduits, on the other hand, influence perceptions of the concept, thus facilitating the concept's acceptance or rejection. Time is an integral element within all levels of the diffusion and adoption of the new concepts model. The social system embodies the realm within which new concepts are generated, diffused, and adopted or rejected. Rogers identified five classes of individuals in the timeline of innovation adoption: the innovators, the early adopters, the early majority, the late majority, and the laggards. African Americans' distrust of the U.S. healthcare system has caused them to fall in the laggard class in new healthcare concept adoption. This distrust was founded through numerous atrocities carried out under the name of medical research such as the 40-year syphilis experiments in Tuskegee, Alabama (Lang & Bird, 2015). The nearly half century of forced sterilization of mainly African American females in North Carolina (Gardella, 1995) also contributed to the distrust, which makes the adoption of healthcare innovations a challenge for African Americans.

I also employed Andersen et al.'s (2011) behavioral model of healthcare utilization as the conceptual framework for this study. This model delineates the central elements that contribute to health services utilization; the three main elements are predisposing, enabling, and need factors (Andersen et al., 2011). Access is the central focus of this model with categories such as potential access, realized access, and equitable and inequitable access. Access is a central facet of ACA, which was created to make healthcare services available to all Americans when needed (potential access) and enable them to actually use (realized access) the services. Additionally, one of ACA’s key goals is to prevent demography or need (equitable access), and social class or beliefs (inequitable access) from continuing to serve as hindrances to securing quality healthcare coverage. This facet of ACA is aimed at establishing a platform for equitable access and affordability to quality healthcare coverage for all American residents.

I examined how African Americans understand and interpret ACA provisions and how to take advantage of them. Study findings are expected to significantly contribute knowledge in filling the gap within existing studies on African Americans’ public policy literacy and health literacy regarding ACA. Addressing the problem of how African Americans understand and interpret ACA provisions and how to use them could help shape how public policy is disseminated and to ensure greater comprehension and limited misinformation. Bauer, Thielke, Katon, Unützer, & Areán (2014) stated that the lack of appropriate requisite knowledge on public policy facilitates the spread of misinformation about public policies which leads to greater confusion, as the implementation of ACA has demonstrated. Williams (2011) stated that individuals ACA could have benefited the most were bombarded with excessive misinformation, causing most of them to vote against their perceived best interest. Voting against one’s best interest further emphasizes the importance of public policy literacy and health literacy in combating the increasing racial disparities in healthcare.

Nature of the Study

In exploring how African Americans understand and interpret ACA provisions, I used an IPA approach developed by Smith for this qualitative study. IPA’s foundation is rooted in phenomenology developed by Husserl (1859-1938) when he sought to develop a philosophical science of consciousness through interpretation (Biggerstaff, & Thompson, 2008). This approach represents an optimal methodology in exploring African Americans’ personal experiences and affords the researcher the opportunity to capture detailed lived experiences with ACA. This health reform law was passed to combat the extensive racial disparities in healthcare coverage experienced by African Americans in the United States. Comprehensive health reform has been studied as one potential solution to the racial disparities in healthcare challenge. However, a 2010 World Health Organization report stated that health reform on its own does not significantly impact racial disparities but can play a major role in conjunction with several other factors such as literacy, social determinants of health, and socioeconomic factors. Based on existing studies, literacy could serve as the focal point from which all solutions for overcoming racial disparities in healthcare could be developed. This was what prompted the decision to explore how African Americans understand and interpret ACA provisions.

I explored how a sample of African Americans in the greater Washington, D.C. metropolitan area understood and interpreted ACA provisions to enable them to take advantage of the provisions in acquiring quality healthcare coverage. I employed semistructured interviews to capture study participants’ personal experiences with ACA. This interview format afforded me the ability to optimally capture detailed descriptions of

African Americans’ personal experiences with ACA. Once all data were collected, I extracted themes from them and used the software programs NVivo and Microsoft Word to analyze the data. These themes facilitated coding all data and subsequently analyzing the collected data to accurately present participants’ experiences with ACA.

Definitions

Health literacy: How health and medical information is understood by patients and the general public (Cutilli & Bennett, 2009).

Health disparities: Refers to differences in healthcare coverage provided to African Americans and other races/ethnic groups (D. B. Smith, 2015).

Racial disparities – refers to inequalities in healthcare based primarily on race (Yearby, 2015).

Assumptions

One of the assumptions in this study was that all study participants would give honest, candid, and overt answers to all questions they were asked. A second assumption was that the absence of health literacy could lead to a lack of understanding of health information and contribute to health disparities (K. Davis, 2009). The importance of health literacy in healthcare delivery has been researched and documented by Cutilli and Bennett (2009), Cunha et al. (2015), and numerous others. The third assumption for this study was that the historical exploitation of African Americans in medical research has resulted in their distrust of the healthcare system and any medical procedures. McNeil et al. (2014) investigated a link between apprehensions about the healthcare system and its low usage by African Americans over their Caucasian counterparts.

Scope and Delimitations

The scope and delimitations of this study were also defined by the specific subject of the study, and, therefore, no other racial groups were included in the study. As noted earlier, this study was on how African Americans understood and interpreted ACA provisions for their personal health benefit. The study involved the use of African Americans aged 27 to 64 years because ACA affords all children the opportunity to remain on their parent's health insurance policy until age 26 and adults aged 65 and older are eligible for healthcare coverage under Medicare.

Additionally, this study involved an exploration of seven to 12 African Americans' understanding and interpretation of ACA provisions for their personal health benefit.

Limitations

The study was limited to African Americans within the greater Washington D.C. area. The selection of Washington, D.C. was to limit the impact of influencers such as state policies on ACA implementation. The sample for this study consisted of a small purposive sample of African Americans aged 27 to 64 years to explore their personal experiences with ACA. Given that the sample was not comprehensive, results may not be transferrable to all African Americans. Qualitative methodologies afford participants the opportunity to share in their own words their lived-experiences with the phenomenon under investigation (Marshall & Rossman, 2014). Additionally, in exploring participants' descriptions of their experiences, the researcher is afforded the opportunity for interpretation, which presents replicability challenges (Maxwell, 2013).

Employing a qualitative methodology through an IPA approach with the use of open ended questions under semi structured interview guidelines warrants significant time dedication to collect, transcribe, and analyze data (Shinebourne, 2011). According to Ritchie, Lewis, Nicholls, and Ormston (2013), unlike quantitative methodologies, qualitative methods of inquiry afford researchers interpretation abilities that may present credibility and replicability challenges. Additionally, Patton (2001) stated that the opportunity to inject personal bias in qualitative studies is higher than in quantitative studies. Another criticism of qualitative methodologies is the perceived absence of procedural and processual transparency in data analysis (Shenton, 2004).

Significance of the Study

A key significance of this study was that it contributes knowledge to help fill the gap in research on how African Americans understand and interpret ACA provisions and how they take advantage of the provisions for their health benefits. What I wanted to accomplish through this study was an examination of African Americans' experiences and perspectives on how they understand ACA provisions. This in turn provided their perspectives on how they interpreted the provisions in order to take advantage of them for their personal health benefit. Over time, taking advantage of ACA provisions could help reduce racial disparities in healthcare (Cantor, Monheit, DeLia, & Lloyd, 2012). As previously noted, many U.S. presidents have attempted to close the racial disparity gap in healthcare, but the health-disparity gap continues to widen (CDC, 2012; Denning & DiNenno, 2010). Results from the study provide needed insight on African Americans' health and their public policy literacy and possibly determine some key factors that contribute to the widening healthcare gap.

In 2008 Margaret Chan, the director general of the World Health Organization, presented a report by the Commission on Social Determinants, which stated that the principal prediction of good or bad health and quality of life was the communal environment in which people were born into, lived, and worked. Birn (2009) stated that health equality could be attained by taking action on the social determinants of health that Director Chan presented. African Americans have historically been at the lower end of the socioeconomic ladder. There is a link between health/public policy literacy and socioeconomic status (Cunha et al., 2015), and, as previously stated, health/public policy literacy impacts information understanding and utilization. As such, assessing African Americans' understanding of ACA provisions provides knowledge on potential policy dissemination challenges and facilitates solutions for enhancing policy diffusion and adoption by Americans.

The significance of this study stems from the fact that it provides rich details of African Americans' described understanding and interpretation of ACA provisions. The study is also significant because I explored African Americans' interpretation of ACA provisions and how they take advantage of these provisions for their personal health benefit. Additionally, the study could inform on ACA utilization, which could provide a gauge on ACA as an intervention strategy to combat the extensive history of health disparities in the United States. In keeping with the old adage "knowledge is power," understanding ACA provisions could empower African Americans to demand equitable quality healthcare coverage.

Summary of Chapter 1

Disparities in quality healthcare affordability and access have been identified as significant contributors to African Americans receiving lower quality care when compared to their Caucasian counterparts (National Center for Health Statistics, 2012). The lack of quality healthcare coverage leads to greater misdiagnosis and/or delayed diagnosis of health conditions for African Americans (Braveman et al., 2010). Because of the challenges African Americans encounter in getting quality healthcare coverage, there has been a tendency for these individuals to present with more significant health conditions such as diabetes, obesity, high blood pressure, hypertension, and HIV/AIDS (Williams, 2011). According to the CDC (2012), African Americans utilize preventative care at much lower rates than Caucasians.

Understanding ACA provisions could facilitate better utilization of healthcare services by African Americans. Taking full advantage of ACA provisions could play a significant role in minimizing racial disparities in healthcare coverage in the United States (Andersen & Davidson, 2007). Additionally, understanding the provisions within ACA would facilitate more informed utilization which could enhance African American’s health and resilience to crises and disasters.

Chapter 1 is followed by a review of the relevant literature informing this study. In Chapter 2, I review available literature on health disparities and health policy utilization and the various strategies employed thus far to overcome these disparities.

Additionally, in Chapter 2, I describe the theoretical and conceptual frameworks that guided the study. In Chapter 3, I delve into the research design, methodology, and rationale chosen for the study to include the mechanisms for selecting study participants and how data were collected, transcribed, stored, and analyzed. In Chapter 4, I present the collected data, the analysis of this collected, data and the results from the study. In Chapter 5, I present an interpretation of the findings from the study, limitations of the study, recommendations from the study, and implications for social change from the outcomes of the study.

Chapter 2: Literature Review

Introduction

A literature review in IPA studies provides an expansion of the researcher's knowledge given that the principal research question and all subsequent interview questions in IPA studies are normally not theory-driven (J. Smith, Flowers, & Larkin, 2009). As such, the literature review in IPA studies facilitates identifying existing gaps in research that the research question will seek to address (Shinebourne, 2011). The success of any program primarily depends on how the program is understood, as understanding facilitates opportunities for full program usage. ACA has been plagued by extensive misinformation, and gaining insight on how this program was understood could clarify why African Americans underutilize it. The lack of understanding regarding healthcare policies contributes to disparities in healthcare coverage in the African American community. The National Center for Health Statistics (2012) identified the limited understanding of healthcare policies as a key component in the lack of preventative healthcare coverage usage for African Americans. Despite being an increasingly affluent population, African Americans still carry elements of distrust for the healthcare system, and these, in addition to entrenched racial biases, contribute to the increasing racial disparities in healthcare coverage. Additionally, physician biases and cultural norms place African Americans at the lowest levels of healthcare comprehension and utilization. ACA was designed to overcome all these hindrances and facilitate the attainment of optimal healthcare coverage for all Americans. However, failing to properly understand its provisions could contribute to the racial disparities that the law was aimed to overcome.

Numerous studies have detailed the racial disparities in healthcare that African Americans and other minorities suffer, but there was very limited literature on how African Americans understand and interpret ACA provisions. There is even more limited literature on how African Americans take advantage of ACA provisions to attain optimal personal healthcare benefits. Gaining added insight into how African Americans perceive, understand, and interpret ACA provisions could facilitate better understanding of how the law is utilized and provide insights on its effectiveness, especially among the African American population. This study contributes knowledge that could increase attention on how African Americans understand ACA provisions and how they interpret them to secure quality healthcare coverage.

The pursuing literature review began with an overview of the research strategies used to retrieve articles referenced in the review. The key focus was on studies that captured how African Americans understood and interpreted ACA provisions and how they used them to secure quality healthcare coverage. Insights on African Americans' personal experiences with the U.S. healthcare system were also provided as well as a discussion of Rogers's diffusion of innovation theory, which I used to analyze how ACA contents were disseminated to African Americans. I conclude with an examination of Andersen's behavioral model of healthcare utilization to provide insights on how African Americans understand and interpret ACA provisions.

Research Strategy

The absence of research on how African Americans understand and interpret ACA provisions has resulted in the use of current and historical sources for the literature review. Many information sources were employed to inform this literature review. Google Scholar was searched using the terms *African Americans' understanding of the Affordable Care Act*, *African Americans' interpret provisions of the Affordable Care Act*, *the Affordable Care Act utilization*, *the Affordable Care Act Implementation*, *African Americans health literacy*, *literacy on the Affordable Care Act*, *disparities in healthcare*, *racial disparities in healthcare*, *African Americans' literacy on the Affordable Care Act*, *contributing factors to racial disparities in healthcare*, and *culture and racial disparities in healthcare*. Several scholarly articles were discovered using these search terms. Additional sources of references were identified in these articles, and optimal matches for this study were further evaluated. I delved into several university libraries such as Walden University, Berkeley, and online journals such as *Journal of American Medical Association*, which also served as information sources for this review. Additional sources for literature included the Van Dorn Library database at Fort Belvoir, Virginia, the CDC database, the National Institute of Health Statistics database, PsychInfo, SocIndex, the Library of Congress, the *Journal of Psychology and Health*, the *Journal of Social and Administrative Science*, and other online sources. However, none of the searches produced studies on how African Americans understand and interpret ACA provisions. Neither was there literature on how African Americans use ACA provisions to secure quality healthcare coverage for their personal health benefit. As such, health literacy and other factors that impact or contribute to health literacy in urban and minority populations were the focus of the following review.

Lack of understanding of the basic tenets of healthcare coverage have contributed to African Americans not using the healthcare system to the same extent as their Caucasian counterparts (Wright, 1998). As such, African Americans have poorer quality of health overall because of their limited participation in preventative healthcare coverage. The following literature review includes an examination of the factors that contribute to disparities in healthcare coverage and health literacy standards. ACA was designed to address disparities in healthcare coverage, including racial disparities. It was still a new law at the time of this study, and few studies were available on it. As such, I employed material with more of an historical focus for contextual purposes as well as more current sources to affirm the need for the study.

Theoretical and Conceptual Framework

J. Smith et al. (2009) stated that phenomenology, interpretation, and ideography constitute core theoretical perspectives in IPA. Phenomenology is the philosophical approach focused on the exploration and understanding of human experiences (J. Smith & Osborn, 2008). Interpretation centers on drawing out meanings from texts while ideography deals with unique experiences of specific people and the circumstances under which these experiences take place (J. Smith & Osborn, 2008). As outlined earlier, the study was grounded in exploring African Americans’ understanding and interpretation of ACA provisions and how they took advantage of the provisions for their own health benefit. The frameworks that guided this study included CCM developed by Jesus Gomez

(J. Gomez et al., 2006). For this study, J. Gomez's CCM and Rogers's diffusion of innovations model were employed as theoretical frameworks that guided the study.

The CCM developed by Jesus Gomez (J. Gomez et al., 2006), provided the framework for this study, as stated earlier. CCM proposes that a communications rationale may be employed in building social knowledge through discourse. As societies have evolved, there has been more scientific discourse on the challenges facing society, which resulted in the creation of CCM (J. Gomez et al., 2006). CCM's development has propelled significant change in combatting social segregation and discrimination (A. Gomez, Puigvert, & Flecha, 2011). Studies of social phenomena conducted using CCM processes facilitate collaboration between communities and researchers, with researchers contributing scientific knowledge and participants contributing their lived experiences. This uncovers novel understandings that help develop solutions to various social challenges. These newer perspectives to existing social problems then serve as templates for social advocates to use when lobbying policy-makers on developing effective social policies (A. Gomez, et al., 2011). CCM credits everyone with cultural intelligence, which contributes to knowledge building and thus combats the stereotypical elimination of certain groups from academic contribution. CCM falls in line with Freire's (1998) theory, which credits everyday people with the ability to understand their experiences and facilitate changing said experiences through critical consciousness. This was the essence of what I wanted to capture as I evaluated how African Americans understood and interpreted ACA provisions.

Dearing (2009) stated that the dissemination of new concepts over time among members of a social class constitutes the unique communication process termed *diffusion*. Rogers’s (2003) diffusion of innovations model is optimal for researching the diffusion and adoption of knowledge or innovative concepts. ACA is a novel healthcare concept in the United States, and this model provided great insight on how it was diffused and adopted by the beneficiaries. I employed Rogers’s diffusion of innovations model to understand how ACA provisions were communicated in the African American community. The diffusion of new concepts model contains four main parts: (a) the innovation, (b) communication channels, (c) time, and (d) the social system (Rogers, 2003, p. 36). Rogers explained that for new concepts to be readily accepted, they must present benefits, meet the needs of the beneficiaries, be simple, be easily tested, and produce visible results in the social framework. Rogers further stated that communications enable information sharing to facilitate consensus with news outlets providing general knowledge of the concept. Interpersonal conduits, on the other hand, influence perceptions of the concept, thus facilitating the concept’s acceptance or rejection. Time is an integral element at all levels of the diffusion and adoption of new concepts.

The social system embodies the realm within which new concepts are generated, diffused, and adopted or rejected. Rogers (2003) identified five classes of individuals in the timeline of innovation adoption: the innovators, the early adopters, the early majority, the late majority, and the laggards. African Americans’ distrust of the U.S. healthcare system has caused them to fall in the laggard class in new concept adoption. This distrust was founded through numerous atrocities carried out under the name of medical research such as the 40-year syphilis experiments in Tuskegee, Alabama (Lang & Bird, 2015). The nearly half century of forced sterilization of mainly African American females in North Carolina also contributed to the distrust, which makes the adoption of healthcare innovations a challenge for African Americans.

I also employed Andersen et al.'s (2011) behavioral model of healthcare utilization as the conceptual framework for the study. This model delineates the central elements that contribute to health services utilization; the three main elements are predisposing, enabling, and need factors (Andersen et al., 2011). Access is the central focus of this model with categories such as potential access, realized access, and equitable and inequitable access. Access is a central facet of ACA, which was created to make healthcare services available to all Americans when needed (potential access) and to enable them to actually use (realized access) the services. Additionally, one of ACA's key goals is to prevent demography or need (equitable access), and social class or beliefs (inequitable access) from continuing to serve as hindrances to securing quality healthcare coverage. This facet of ACA is aimed at establishing a platform for equitable access and affordability to quality healthcare coverage for all American residents.

I examined how African Americans understood and interpreted ACA provisions and how they took advantage of them. Study findings would significantly contribute to filling the gap in existing studies on African Americans' public policy literacy and health literacy regarding ACA. Addressing the problem of how African Americans understand and interpret ACA provisions and how to use them could help shape how public policy is disseminated and ensure greater comprehension and limited misinformation. Bauer et al. (2014) stated that the lack of appropriate requisite knowledge on public policy facilitates the spread of misinformation on said public policies, which leads to greater confusion, as demonstrated by the implementation of ACA. Williams (2011) stated that the people ACA could have benefited the most were bombarded with excessive misinformation, causing most of them to vote against their perceived best interest. Voting against one's best interest further emphasizes the importance of public policy literacy and health literacy in combating the increasing racial disparities in healthcare.

Built-In Distrust and Role of Culture in Healthcare Disparities

All the literature within this section addresses the fact that African Americans have learned over time not to trust the current healthcare system. Throughout history there have been numerous instances in which healthcare systems and programs that were touted as beneficial to such minority groups as African Americans, Native Americans, and Latinos were actually lethal (Elders, 2012). Prominent examples include the more than 40-year-long syphilis experiments in Tuskegee, Alabama, in which the promise of free healthcare lured an estimated 400 African American men to take part in the study (Elders, 2012). Another notable case involved the targeted sterilization of African American and other disparate groups of women for nearly 50 years in the state of North Carolina.

In line with investigating the causative factors behind the built-in distrust of health and other institutions, Wright (1998) explored how the myth of HIV/AIDS originating from Africa has deepened African Americans' mistrust of proposed healthcare strategies. This was attributable to the fact that a majority of African Americans perceive themselves to be targets of the powers that be. This perception was affirmed by Randall’s (1995) exploration of African Americans’ opinions of existing and past healthcare policies and strategies. What the exploration uncovered was the fact that African Americans viewed the healthcare system and medical research as experiments with a specific objective to eradicate the Black race as evidenced by historical facts. All these attempts to exploit minority groups have subsequently resulted in presidential apologies once their true purpose was uncovered (Mays, 2012). Examples of presidential apologies included that issued by President Clinton to African Americans over the Tuskegee experiments and President Obama to Native Americans over exploitative studies at the hands of the government.

Current patient and research participant protection laws are very important measures instituted to combat exploitative medical practices, and Elders (2012) stated that ACA strengthens these protection laws. ACA seeks to foster the creation of collaborative healthcare delivery as evidenced by Elders’s (2012) exploration of the role ground-roots-centered and community-directed health reform can play in eradicating racial healthcare disparities. He highlighted the importance of ACA’s improved bioethics approaches towards medical research and how these improved ethical standards could be employed to eliminate exploitative studies detrimental to ethnic and racial minorities. Findings from Elders’s study highlight the importance of getting everyone within communities involved to enhance healthcare and combat health disparities. Patients’ family members become part of the treatment team to ensure that patients adhere to agreed treatment protocols and medication guidelines. Studies such as Elders (2012), Wright (1998), and others reviewed within this section provide an historical context of racial disparities in healthcare and the need for varying approaches in overcoming these disparities. Unfortunately, they do not provide any insight on African Americans' understanding of health-reform policies and how they interpret these policies to secure quality healthcare coverage.

In most studies exploring the roots of African Americans' distrust for the healthcare system, researchers reviewed the information within the existing framework. To that effect, Randall (1995) presented an African American's point of view on bioethics through an evaluation lens of the historical influencers of African Americans' distrust of government and healthcare policies. He concluded that the poor bioethics standards appear to have contributed significantly to African Americans' distrust of the healthcare system. This conclusion was based on the fact that a majority of the medical studies that were touted as beneficial to African Americans were intended to use them as research "pigs" and harm them (Randall, 1995). As a result of these nonbeneficial studies, African Americans became very suspicious of the government and would rather avoid any government studies. Over time, this suspicion and the outwardly accepted bigotry against Africa Americans led to the development of institutions which contributed in promoting the racial divide (Randall, 1995). These suspicions have deterred African Americans from willingly taking part in medical studies. Shavers-Hornaday, Lynch, Burmeister, and Torner, (1997) investigated the factors contributing to African Americans' limited representation in medical research. Shavers-Hornaday et al.

identified factors such as inept recruitment strategies, historically poor relationships between African Americans and medical personnel, inadequate access to medical facilities, lack of African American health professionals, and cultural barriers as potential contributors to African Americans' low participation in medical research.

While the earlier stated studies explored the controllable systemic and institutional causes of African Americans' distrust of the healthcare system, other studies looked at less controllable contributors such as genetics. In their exploration of the hindrances to health promotion for hypertensive African American men, Huntley and Heady (2013) highlighted predisposition and social and economic factors as elements to consider in promoting African American health. This aligns with the National Center for Health Statistics's (2012) report that African Americans are genetically predisposed for hypertension and that failing to incorporate culture-specific remedies in treatment, further exacerbates the racial disparities in healthcare. The determination of African Americans' predisposition was determined through medical research which has historically been perceived as untrustworthy within the African American community (Mays, 2012). These studies are significant because they present a basis for attributing African Americans' distrust of health and social policies, which contributes to existing disparities in healthcare coverage. However, these studies fail to address how African Americans understand and interpret health and social policies, thus providing the premise on which this study was developed.

There have been numerous studies undertaken that explore the relationship between race and health disparities as outlined herein. One such study involved Lillie-

Blanton, Brodie, Rowland, Altman, and McIntosh (2000) surveying a nationally representative sample of 3,800 individuals about public perceptions on the role of race and ethnicity in healthcare coverage. Their findings highlighted differences in Caucasians’ perceptions compared to African Americans and Latinos. Most Caucasian participants stated that the healthcare system was fair and equitable to all races while African Americans and Latinos believed they received lower quality healthcare than Caucasians. Study findings made it clear that developing solutions to racial disparities in healthcare coverage required improving public awareness. This public awareness has been identified as a very important factor in identifying the causative factors of racial disparities in healthcare (Lillie-Blanton et al., 2000). Lillie-Blanton et al. found that increased awareness made it possible for the public to acknowledge existing challenges even those not directly impacting them. However, their survey was not intended to investigate how participants understand existing healthcare policies or how to interpret them in accessing quality healthcare coverage.

Most Caucasians fail to acknowledge the existence of the problems that African Americans encounter in gaining healthcare coverage in the U.S. (McCormick et al., 2015). They further postulated that just because something does not affect someone directly that does not mean that it doesn’t exist. Devi (2012) explored the underlying facets contributing to America’s entrenched racial inequalities in healthcare and viewed ACA as a tool that could hopefully play a significant role in overcoming these inequalities. She identified lack of knowledge and deliberate refusal to accept racial inequities as contributing factors to political disagreements, which hamper solutions to these disparities. These disagreements have resulted in unequal allocation of resources with African Americans being at the losing end thus perpetrating the continuous racial disparity in healthcare coverage. In supporting her assertions, Devi (2012) employed statistical data from the CDC and other institutes regarding variations in mortality rates between African Americans and Caucasians. Devi concluded that more collaboration between all parties involved (African American patients, health providers, community leaders, and government officials) could provide one vital facet in solving the racial healthcare disparity challenge.

Another important facet in the exacerbation of distrust of the healthcare system is lack of financial resources. Financial resources facilitate the acquisition of health insurance and this in turn promotes using the healthcare system. While most of the literature agrees that financial resources afford access to the U.S. healthcare system some of the literature argues that financial resources may in fact compound health disparities. Quaye (2005) explored the relationship between African Americans' socioeconomic status and the decisions they make on healthcare. Data from the U.S. Census Bureau were employed in highlighting the progressively widening gap in income between African Americans and the rest of the United States America. Quaye compared the type and value of medical care to social class and opportunities with the latter playing a more prominent role in determining quality of life. He noted that these socioeconomic gaps have further isolated African Americans and propagated the distrust of social systems thus augmenting racial disparities in healthcare.

In exploring the role culture plays in promoting racial disparities in healthcare Askim-Lovseth, & Aldana (2010) investigated the influence of race, social class, economic status, insurance or the lack of insurance in a Latino minority group. Askim-Lovseth and Aldana explored the relationships between Latinos and their healthcare providers to the quality of healthcare they received. From this exploration they raised the concern that lack of appropriate culture-based approaches may propagate disparities in healthcare coverage. The absence of tailored actions to combat racial disparities in healthcare coverage means that generic approaches are employed but while these approaches may succeed for certain groups they may not necessarily work in others (Askim-Lovseth & Aldana, 2010). As such, treatment methods that are not patient-directed may not work as intended. The concern of inappropriate healthcare coverage and its potential impact on healthcare outcomes could also apply to the African American community. What this does is bring attention to the employment of new and/or untried approaches in combatting racial disparities in healthcare. As important as these studies are in highlighting the existing distrust and the role culture plays in racial disparities in healthcare they fall short in exploring health policy literacy.

Racial Disparities in Healthcare

There are extensive and highly complex factors that contribute to racial disparities in healthcare. These factors are deeply rooted in American society and include clinician biases, institutional biases, systemic racism, and numerous others (Smedley, Stith & Nelson, 2003), (D. B. Smith, 2005 & 2015), (Peek et al., 2012). According to Nelson (2002) and in the *Journal of the American Medical Association*, (2010) there is extensive literature on current racial disparities in healthcare coverage in the United States noting that African Americans and other minorities groups were at the losing end of the disparity spectrum.

Most of the literature reviewed in this section highlights the existence of racial disparities in healthcare despite the claims by some Caucasian Americans that racism does not exist. Yearby (2015) examined the historical perspective on racial bias in the U.S. healthcare system since the Civil War and also presented a thorough examination of the health system's structure. Following the Civil War, the U.S. Congress deliberated on a universal healthcare system but rejected it primarily because it would have covered freed Blacks. This action led to the development of private medical facilitates that catered to Caucasians who could afford health insurance and resulted in the private healthcare system still in existence in the United States (Yearby, 2015). African Americans who could afford insurance were not treated in the same facilities as their Caucasian counterparts because of the segregation carried over from slavery.

Examining existing government policies and their impact in combatting health disparities revealed several factors warranting further investigation. Yearby (2015) also explored legislation such as the Title VI of the Civil Rights Act of 1964 developed to stop segregation and inequity in the U.S. healthcare system. The role of the government in instituting racial bias within the healthcare system, institutional and structural racial bias and personal bias were examined. According to Yearby the government created segregated healthcare facilities, and the medical facilities designated for African American use were limited, very poorly built and equipped. Medical facilities catering to

African Americans were also staffed with limitedly trained medical providers who lacked the tools needed to perform their duties (Yearby, 2015). On the other hand, medical providers catering to Caucasians were provided with all the necessary equipment and training needed to optimally perform their duties. Additionally, restrictions were imposed on the type of medical services and procedures African Americans could receive. The systemic racial bias against African Americans was also infused into the services they received. This systemic racial bias was compounded by provider personal biases in propagating the racial divide in healthcare coverage. Yearby noted that over 4,000,000 African American lives have been needlessly lost since 1964 due to racial disparities in healthcare. Additionally, these disparities in healthcare are also financially costly to the United States government. African Americans continue to be subjected to lack of preventative care, misdiagnosis, inept and low quality medical care, and overwhelmed and poorly-trained medical providers. All of these factors impact the type and quality of healthcare coverage African Americans receive. While no value could be placed on life, it was estimated that the financial costs of racial bias within the U.S. healthcare system would surpass 500,000,000 dollars by 2018 (Yearby, 2015). These costs led Yearby to conclude that racial bias is not just detrimental to African Americans but to the entire United States.

Access to quality healthcare in the United States is based on socioeconomic status, and this, coupled with institutional, structural, and personal biases, has limited African Americans' access to life enhancement opportunities. This limited access then translates into substandard education and poor healthcare coverage for African

Americans and further propagates the racial divide in accessing and receiving quality healthcare (Alegria et al., 2008). Bowser (2015) explored the extent to which race has contributed to the rationing of healthcare services throughout U.S. history. Costs have influenced the ability to purchase health insurance, and also healthcare providers' determination of the services that would benefit patients, and these factors have ensured that African Americans continue to suffer racial discrimination in receiving quality healthcare coverage (Bowser, 2015). While purposeful racism played a role in laying the foundation for rationing services based on race, the outcry against racism resulted in more subtle discriminatory practices such as policies influencing resource allocation from African American communities (Bowser, 2015).

In investigating the basis for racial disparities in healthcare, Lang and Bird (2015) employed constrained choice methodology to explore the interactions between agencies, social institutions, and social policies by examining the influence of race, ethnicity, and sexual orientation on heart disease and HIV/AIDS. African Americans showed increased mortality from cardiac disease and HIV/AIDS whereas Caucasians and other groups showed a steady decline in deaths from the same diseases (Lang & Bird, 2015). Lang and Bird's focus on structural contributions to racial health disparities identified segregation and other societal constraints as principal contributors to racial disparities in healthcare in conjunction with social decisions that impact individual health status (Lang & Bird, 2015). Manipulating social welfare programs such as food assistance plays significant roles in individual health status and could contribute to the propagation of racial healthcare disparities.

As stated earlier, there have been several approaches proposed to combat healthcare disparities. Lang and Bird (2015) recommended education and increase in food and housing programs as means for combating institutional and social contributions to racial disparities in healthcare. ACA is a social reform policy and in line with Lang and Bird's recommendation that educating the public would contribute in reducing racial disparities. Prior to educating the public, however, gauging the public's understanding of social policies should be done to better target areas for focus. This could enable beneficiaries to receive optimal benefits from the social policy because they would have a better understanding of the policy and be able to use that knowledge to take full advantage of the policy's provisions.

Along the same lines, D. B. Smith (2015) investigated the role federal funding has played in propagating and/or reducing the racial disparity gap in healthcare. He undertook an examination of the role political protection and social urgency can play in overcoming racial health disparities. The need for ground roots support has been identified as integral in the appropriate allocation of government resources (D. B. Smith, 2015). Smith also used an historical context to investigate how government funds enhanced structural and institutional biases that extended racial segregation and disparities in healthcare coverage. The creation of segregated hospitals and schools propagated the racial divide and these discriminatory practices became infused into the systems that cater to citizens (Mathew, 2015).

In further investigating the inherent racial biases in healthcare, Mathew (2015) explored the context of healthcare delivery with legal and social systems reform presented as key facets in combating racial disparities in healthcare. The impact of racial disparities in healthcare has been significant regarding racial/ethnic minorities with an estimated 90,000 deaths reported in 2005 by former Surgeon General David Satcher, who claimed these deaths as directly attributable to racial disparities in healthcare. Mathew examined a 2011 U.S. Health and Human Services Department report on national healthcare quality and disparities, which noted that minimal progress has been made on racial disparities in quality of health-care coverage from 2002 to 2008. In her exploration, Mathew investigated the role of implicit bias in propagating racial bias in healthcare coverage and cited social science research that outlined the pervasiveness of racial minority bias in the American health system and society. Mathew employed research by Green that linked healthcare providers’ implicit biases and racially unequal health treatments to emphasize the implicit role racial bias played in promoting racial disparities in healthcare.

There are several factors that have been identified as contributors to the racial disparities in healthcare as stated earlier. These factors included socioeconomic status and geographic location. Hodgetts et al. (2013) evaluated the methods employed in addressing urban poverty and health. They assessed the link between urban poverty and health inequalities by studying the challenges that 100 families living in poverty experienced in the city of Auckland, New Zealand. Study findings highlighted the need to incorporate the families’ lived experiences in the public discourse on health inequalities and urban poverty. Additionally, community dynamics were identified as helpful influences on study participants’ impressions of many facets of life, with healthcare coverage being one such facet. Shi and Singh (2014) carried out an in-depth exploration of the U.S. health-care delivery system and the factors driving it by conducting a comparative analysis of the U.S. healthcare system to systems in other developed nations. Shi and Singh identified that by paying for their own insurance patients incurred high costs and that the absence of health insurance mandates prior to ACA served as potential contributing factors to the expanding racial disparities in U.S. healthcare.

In the studies discussed here, the factors contributing to racial healthcare disparities were explored but participants' understanding and interpretation of health policies were not researched. Results from these studies confirm the existence of racial disparities in the United States and how they are proliferated. Some of the researchers presented solutions to curbing these racial disparities but none examined how minorities understand and interpret the provisions of health reform or healthcare policies.

Health Literacy

One of the factors that have been identified as contributing to health disparities is health literacy or a lack of health literacy (Parker et al., 1995). Health literacy entails the degree to which health information is understood and how this impacts how health programs are utilized (Kirgiz, 2015). In exploring what measures increase health literacy, Chung and Nahm (2015) assessed the role information technology could play in increasing health literacy and facilitating health management. This could be accomplished by evaluating how the ease of information relay created by modern technology could be employed in health education and health management. Information can be relayed much faster and more easily today than in years past, and this ease could be beneficial in disseminating health information. Chung and Nahm stated that the ease with which technology can facilitate information transfer makes it easier to educate people on health issues and on how to manage their health information. Bau (2011) also highlighted the importance of incorporating modern technology into health information relay. Additionally, Bau identified measures already underway such as those in the American Recovery and Reinvestment Act of 2009 popularly known as the stimulus bill that provide financial incentives to hospitals and physicians to expedite the digitization of U.S. medical records. This would facilitate better care by making patient records easier to access. The ease of access to patient records would give physicians more time to better relay health information to patients and thus increase their health literacy (Bau, 2011).

The absence of adequate health literacy has been identified as a contributor to health disparities (Parker et al., 1995). To further explore the previous assertion Paasche-Orlow, Parker, Gazmararian, Nielsen-Bohlman, and Rudd (2005) evaluated a study by the Institute of Medicine on the enormity of limited health literacy and the need to promote health-literate communities. They employed the definition of health literacy, which focuses on the extent to which people are capable of obtaining, processing, and understanding simple health data and tools vital in proper health decision-making. Paasche-Orlow et al. concluded that education, ethnicity, and age played a role in limited health literacy. They called for simplifying health services as a means of improving health knowledge and concluded that these improvements could potentially enhance Americans’ overall health and minimize existing health disparities.

The importance of health literacy is not only essential in the U.S. healthcare system but globally as several studies such as those undertaken by Cunha et al. (2015), Kirgiz (2015), Bauer et al. (2014), Lyles and Sarkar (2015), Roselli et al. (2011), and Mayer and MSLM (2007) have highlighted. Cunha et al. (2015) evaluated the impact of economic and sociodemographic environments on health literacy by conducting a descriptive and transversal study of 508 Portuguese citizens through a European health survey. Lower income, lower social status and lower education played roles in determining health literacy. Cunha et al. concluded that education impacts health literacy, which in turn is very important in promoting healthier lifestyles. Results in the above discussed highlighted the need for improving health literacy in the fight against health disparities and identified socioeconomic status, education, and geographical location as factors potentially contributing to health literacy. Despite identifying health literacy as a potential contributing factor to racial disparities in healthcare coverage, none of the researchers investigated how any of the racial groups subjected to healthcare disparities understood existing healthcare policies.

How can health literacy be measured or determined? Parker, Baker, Williams, and Nurss (1995) sought to develop legitimate and trustworthy measurement instruments for determining patient health literacy. They created the Test of Functional Health Literacy in Adults, which proved a valid tool for measuring health literacy. In their study, Parker et al. noted that the majority of patients did not know how to read basic information and concluded that further research was needed to assess functional health literacy and its impact on personal experiences in healthcare. Schillinger et al. (2002) examined the relationship between health literacy and outcomes in patients with Type II diabetes. They noted that health literacy reflects patients' reading level as well as their ability to comprehend and follow medical guidelines. The premise of Schillinger et al.'s study was that poor health literacy was prevalent among ethnic and racial minorities in public settings. Study conclusions from their study highlighted the link between limited health literacy and the prevalence of Type II diabetes among racial minorities. Recommendations included focusing on improving interventions with patients who have limited health literacy. Both of these studies resulted in data that identified a correlation between low health literacy and health status but patients' levels of understanding of existing health policies were not investigated.

In line with the need for collaboration from all ranks in society Kirgiz (2015) assessed the need for media literacy in fostering the formulation of health literacy. Kirgiz evaluated the role media literacy could play in developing health awareness among Turkish citizens. Turkey was used for the study because it ranks as one of the most social-media-active nations. This made turkey a prime location to assess the influence of social media penetration on health literacy. Kirgiz concluded that there was very high public awareness on all issues because social media was used to relay information and people use this information to push for socially responsible policies. Once a policy is enacted, the government uses several social media outlets to share this information with the public (Bauer et al., 2014). The Turkish government also uses social media to promote its agenda and based on feedback from citizens, the bills are adjusted as needed to meet social enhancement standards. Bauer et al. (2014) evaluated how health service delivery strategies could be matched with information technology to develop health literacy and chronic disease management. Health literacy could be improved by exploring the role of health reform in pushing health information technology utilization and reshaping healthcare delivery mechanisms. Additionally, Bauer et al. highlighted the role of health reform in encouraging collaborative care and healthcare delivery mechanisms. Patient- and population-centered care and accountability were two key factors identified as central to health service delivery. The literature synthesized in this segment identified the importance of health literacy and how adequate health literacy could play a significant role in combatting existing racial health disparities.

The need for using internet resources to improve health literacy by organization and treatment facilities has also been investigated. Rosselli et al. (2011) explored the importance of online websites to health facilities in promoting prevention measures. In investigating the value of online websites Roselli et al. assessed the degree to which websites are being used and identified limited utilization. The unused potential of Internet websites and related tools as instruments health authorities was identified as potential tools that could be employed to increase health literacy and assist in disease prevention. Local health authorities in Italy were evaluated on their use of online tools in preventative healthcare and were found to be using these tools inefficiently. A conclusion from the Rosselli et al. study led to the development of a more efficient and effective online information relay tool that health systems could use to improve health literacy and foster preventative approaches to healthcare. These improvements fostered increase health literacy and have assisted in increasing equity in healthcare coverage (Roselli et al., 2011)

The researchers previously discussed investigated the benefits of incorporating modern technology in the health delivery system and as a means of improving overall health literacy. Results from their studies provide potential solutions for improving health literacy, but these researchers failed to determine how minorities understand healthcare policies. They also did not investigate how racial minorities interpret existing healthcare laws to secure quality healthcare.

Additional studies supporting the need for this study include the prospective cohort study of Baker et al. (2007), who tested the notion that people with low health literacy possess less health knowledge, exhibit inferior chronic disease health management, take part in fewer preventive health services, and present with poorer health. Baker et al. concluded that reading fluency determined the level of health literacy, which serves as a direct prediction of death from heart disease in elderly people living in community settings. Nutbeam (2000 & 2008), proposed the use of three major domains of health literacy – functional, interactive, and critical – as appropriate measurement tools in health promotion. Results from his study highlighted the need for instructive courses to tackle the challenges social and economic factors impose on health by assessing the importance of health education. These instructive courses would explore the three domains stated earlier to gain in-depth knowledge on health literacy beyond the mere transmission of health information. Nutbeam identified that tailored or personal communication, and community-based health education approaches were excellent methodologies that could be used to enhanced health literacy. Access to health information and effective use of this information were identified as essential elements in optimal health literacy.

The importance of health literacy in helping patients navigate the complex healthcare system in the best way possible is well documented (Hernndez et al., 2011). Hernandez and Landi (2011) presented findings from a 2011 Institute of Medicine roundtable noting that the prevention of disease and overall wellness are simply intertwined with health literacy. This roundtable focused on integrating health literacy in initial and post-prevention approaches to healthcare through discussions and presentations. Discussions resulted in 10 recommendations for improving health literacy, which ranged from developing and implementing health literacy mechanisms to the need for the U.S. government to set up health literacy protocols through the Surgeon General's office. These recommendations have been identified by Smith et al. (2009) as core elements that could lead to better targeted approaches in improving health literacy and in so doing empower racial minorities and other disparate groups to demand quality care from their providers. All of the recommendations included calls for federal, state and local governments to promote health literacy through community involvement. Participants in this scientific forum explored solutions to limited health literacy but did not assess how current health policies and laws were understood.

Health literacy cannot be adult-centered because if children are educated properly they would grow having the requisite skillsets necessary to optimally utilize the healthcare system and demand equitable healthcare coverage (Flecha, Garcia, & Rudd, 2011). To explore the need for using school-led health literacy enhancement mediums Flecha et al. assessed the key role schools could play in enhancing health literacy, which would then serve as a vital tool in combating inequalities in healthcare coverage and delivery. Data were collected from five primary schools and a preprimary school that serviced racial minority students in five European countries. From these data, Flecha et al. identified the significant impact community-based programs and supportive environments can have on enhancing family health literacy and overcoming health inequities.

Flecha et al. (2011) found that collaboration was vital in health literacy, and instead of forcing information down to people the needs of the family have to be taken into consideration. Health literacy programs have to be tailored to meeting family needs if people are to buy into the benefits of health literacy in improving overall healthcare. Another solution from the investigation conducted by S. Smith et al. (2009) highlighted the importance of relations – patient/provider, provider/patient, patient/health information – in conjunction to other factors like socioeconomic status, and education had on their health literacy in minority groups studied. This study and the others discussed here focused on empowering minorities through improved health literacy and community-based approaches to their health data. None were focused on investigating how African Americans and other minorities understand health reform policies.

The popular adage “knowledge is power” makes the case for appropriate knowledge as an empowering tool. Kickbusch (2002) postulated that the objective of health literacy as a health promotion tool is to afford patients greater control of their health and its determinants. This led him to identify and record the elements that enhance people taking control of their health in the healthcare system and in everyday living. His assessment of Nutbeam's (2000) proposal focused on how to improve the personal, social, and structural elements that can be modified to affect the determinants of health. He concluded his analysis by identifying health promotion as a central element in the push for improving health literacy. As evidenced in these studies health literacy in collaboration with other identified aspects can play an important role in curbing racial disparities healthcare. One aspect that has not been investigated in existing studies is exploring how beneficiaries of healthcare and social programs understand existing program.

The tools that are available to overcome existing disparities in healthcare coverage have not been fully and honestly explained to citizens (Bauer et al., 2014). Janiak, Rhodes, and Foster (2014) evaluated usage data and literacy demands of a website developed as part of state-level healthcare reform in Massachusetts. The site was developed to help young women understand the offerings of newly available health insurance products. Following Janiak et al.'s evaluation, modifications were made to the website to make it more usable and comprehensible to women of all health literacy levels and recommendations were made for culturally suitable educational materials. This study assessed information by individuals with access to electronic communication but the vast majority of disparate populations do not have such access according to Janiak et al. (2014) and as such other measures have to be employed to optimally relay messages to these underrepresented groups.

Janiak et al. (2014) found that once people attain health literacy, they will make appropriate decisions regarding health insurance selection. They noted that these decisions would then move people from accessing appropriate healthcare to actually using it. Janiak et al. regarded the passing of ACA as the conduit for millions of previously uninsured reproductive-age women to reproductive services. This supports the rationale to solve higher post-partum obesity rates for African American and minority women reported by Davis, Zyzanski, Olson, Stange, and Horwitz (2009).They noted the lack of insurance and patient health literacy as the principal rationales given by most women for not using preventative reproductive services. The Janiak et al. (2014) study comes closer to the focus of this study by presenting findings on how improved health literacy can impact insurance choices. However, Janiak et al. also did not investigate how existing health policies are understood. Not understanding health policies could facilitate poor choices in insurance and healthcare coverage options.

Getting everyone involved in health service delivery has been identified as vital in ensuring programs succeed and appropriate healthcare coverage is enforced. This means that patients, their families and support systems, have to work in concert with healthcare providers which according to Speros (2011) will facilitate the delivery of optimal healthcare to patients. Speros (2011) explored the role nursing could play in improving health literacy standards. Speros identified the promotion of research and education as essential in helping nurses deliver patient-specific health information in clear and unambiguous language. Speros also explored the importance of health literacy as a standard practice for nurses and noted that it could be integrated into each patient’s care plan. This health literacy incorporation in care delivery could empower patients and make them partners in managing their health instead of outsiders receiving instructions on how to manage their health (Speros, 2011).

As earlier noted health literacy is very essential in proper health service utilization which would lead to the deduction that poor health literacy could be detrimental to optimal healthcare management. To explore this assertion, Mayer and Villaire (2007) investigated the impact poor health literacy has on health management and highlighted strategies such as shared healthcare decision-making, and provider trust, that could help healthcare providers optimally manage the health of their patients with low health literate. According to Clarke et al. (2011), the importance of optimal health information communication with patients has continually grown in the United States given that patients here are principally responsible for covering their healthcare costs. The National Center for Health Statics (2012) study brought attention to the fact that many Americans lacked basic understanding of the health information they received from providers. This lack of understanding has been identified as a contributing factor to the growing racial disparity in healthcare coverage. Despite this knowledge, there is still a gap in the understanding of how African Americans and the American public in general understand health policies, including ACA.

Strategies for Improving Health Literacy

As the review of literature this far has shown, many researchers have addressed the health literacy crisis among racial minorities. African Americans have endured persistent disparities in many social settings, including healthcare. With the passage of

ACA, it is believed that this long-standing disparity will be progressively reduced (Black, 2013). Various researchers have also presented strategies to improve health literacy; however, many of these strategies have not been tailored to African Americans, which have resulted in the failure of the one-shoe-fits-all approach (McNeil et al., 2014). The distrust African Americans have of the healthcare system based on past experiences has significantly limited their reception of intervention and preventive strategies. Wright (1998) noted social workers' disproportionate perceptions of African American patients with HIV/AIDS. Despite drug effectiveness in treating AIDS patients, African American patients have failed to enjoy the same benefits, and the infection/mortality rates from HIV/AIDS have continually increased in the African American community (Wright, 1998). In highlighting the failures of intervention strategies regarding HIV/AIDS within the African American community, Wright did not delve into the literacy of African American patients regarding intervention policies. This lends further support for the need to undertake this study as it brings to mind the relevance of understanding and interpreting intervention measures before such measures' effectiveness can be assessed.

Several measures have been implemented and attempted to combat racial disparities and inequities in health service delivery and management. D. B. Smith (2015) examined intervention successes such as the implementation of Medicare from Title VI of the Civil Rights Act of 1964 and how these could be employed in ACA implementation to reduce racial healthcare disparities. He conducted a historical review of the U.S. healthcare system prior to the Civil Rights movement and how this movement impacted intervention measures development to reduce racial healthcare disparities. As a result of the Civil Rights movement, federal funding was directed toward healthcare facility integration, injecting accountability measures in the healthcare system, and more community-based intervention approaches (Smith, 2015). The Civil Rights movement highlighted the need for developing ground-roots solutions for handling racial disparity challenges and racial inequity in U.S. healthcare delivery.

D. B. Smith (2015) focused on the role of financial motivations in providers promulgating racial disparities in healthcare service delivery. Understanding the financial incentives in healthcare delivery could contribute a different perspective on the fight against racial disparities in healthcare coverage (D. B. Smith, 2015). The measures identified by D. B. Smith included those incorporated into ACA's healthcare cost control provisions which provided directives to health insurers on how to mitigate potential profit-based customer exploitations. Andersen, Davidson, and Baumeister (2013) stated that ACA was designed to target intentional discriminatory policies in healthcare delivery but some States' resource allocation policies still appear to support racial disparities. A clear example of this is the expansion of Medicare and Medicaid provisions in ACA. States may opt in or opt out of the expansion, which can reduce access to quality care for African Americans and members of other minority populations (Bowser, 2015).

Additional studies that explored various intervention measures include the study by Birn (2009) that stipulated the relevance of social policies in narrowing the health equity gap through social welfare policies, community involvement, and universal health-care services coverage. In her assessment, Birn identified the need for greater global involvement in overcoming health challenges and improving health literacy. She challenged governments around the world to pay greater emphasis to global health crises and not allocate resources toward less globally beneficial personal/corporate agendas. Birn also called for greater collaboration between local and national activities in combating health inequalities given their potential impact on all nations.

Approaches to Address Inequities in Healthcare

There is extensive literature on interventions to address racial disparity in U.S. health but very little literature on how African Americans understand and interpret the provisions of health reform laws to secure quality healthcare coverage. Hodgetts (2012) emphasized the need for collaborative partnerships between communities and service providers in tackling urban poverty to improve the overall health and wellness of the poor. He stressed the need for civic involvement in facilitating positive social change by broadcasting social determinants in health news reports. He stipulated that news outlets' focus on disease epidemics, treatment breakthroughs, and healthcare practices undermine the relevance of social determinants in promoting a vivacious public health forum. Hodgetts highlighted homelessness as a significant health concern that could be used as rallying tool for bringing civic-minded reporters, underrepresented groups, and social scientists together for potential solutions. Bringing all these groups together would facilitate greater civic-centered news reports, which would in turn impact social policies and promote greater health equality and improved health literacy.

The World Health Organization (WHO; 2010) drew attention to the significance of exposing healthcare inequities in urban settings as the essential factor in overcoming disparities in healthcare coverage. Study authors pinpointed the uneven distribution of resources such as health facilities, emergency response units, and other advantages in urban settings and that the growth of urban dwellings presents significant health challenges to governments. An essential recommendation was the need for collaboration between the health sector, local governments, and urban communities to combat health inequities and urban health challenges. Local and city governments were urged to improve living and working conditions, which directly impact urban health statistics (WHO, 2010). Study authors also warned against comparing urban and rural health conditions because of each setting’s unique elements and stated that a targeted approach would help create health equality in urban settings.

Clarke et al. (2013) undertook a systematic inspection of available literature on racial healthcare disparity intervention measures. They intended their study to inform policy makers and healthcare providers on strategies for improving minority health and reducing racial disparities in health coverage. They recommended further investigation into improving systems serving minority groups, community-centered intervention strategies, educational intervention strategies, and the effects of policy reform on racial disparities in healthcare coverage.

McNeill, Hayes, and Harley (2014) explored a community-based approach to overcoming racial health disparities, citing the Jackson Heart Study, which highlighted noncompliance by study participants as a central cause of poor health. Along the same lines, a study used by the CDC (2012) explored the benefits of community health workers in improving overall health in disparate populations (Denning & DiNenno, 2010). According to McNeill et al. (2014), having everyone of importance to the patient collaborating with healthcare providers increased the patient’s adherence to treatment protocols and improved health overtime while reducing healthcare disparities (McNeill et al., 2014). The Jackson Heart Study in the state of Mississippi investigated the potential for improvements in health and faithfulness in following medication guidelines for African Americans through education and targeted health intervention strategies (McNeill et al., 2014). These recommendations highlight the need for education and an all-involved strategy in combatting racial disparities in health. However, the focus of these studies was not to explore how African Americans and other disparate populations understand existing laws and intervention measures creating a gap which my study aims to fill.

Many researchers have focused on approaches for addressing racial disparities in U.S. healthcare. Peek et al. (2012) conducted a cross-sectional study to explore national physician group efforts to combat healthcare disparities. They confirmed the existence of racial and ethnic disparities in healthcare across various health conditions and settings. In examining efforts by various organizations to reduce racial disparities, Peek et al. found that more than half of the organizations studied undertook few to no measures to address the racial disparity problem. Peek et al. recommended collaborative efforts with minority-based organizations to improve identified strategies developed to combat racial disparities in healthcare.

Kocher, Emanuel, and DeParle (2010) explored how ACA affords health-care providers greater options in the delivery of quality healthcare. They explored the unique opportunities and challenges ACA provides by making healthcare coverage more affordable and accessible to all Americans and how practitioners could reduce personal and institutional biases thus reducing racial health disparities. Based on their study, Kocher et al. concluded that physicians who are more receptive to the opportunities ACA presents, could redirect the U.S. healthcare system towards more equitable health delivery by providing quality care to patients. Additionally, working collaboratively with other health providers will augment patient health delivery outcomes and enhance the delivery of health services to patients (Kocher et al., 2010).

As presented earlier, there are significant disparities in healthcare delivery and patient outcomes in the United States. These disparities create barriers to quality care delivery resulting in disparate populations experiencing different medical care delivery outcomes. In line with intervention strategies, Natale-Pereira, Enard, Nevarez, and Jones (2011) explored how patient navigators can play an invaluable role reducing racial disparities in healthcare coverage. Patient navigators are individuals who have been diagnosed with significant medical findings navigate the often convoluted medical delivery system. The assistance of patient navigators ensures that patients receive timely diagnosis and treatments (Natale-Pereira et al., 2011). They presented a historical documentation of the racial inequities within the U.S. healthcare system and cited identified contributors to these inequities such as patients distrust of medical providers and of the healthcare system, as well as systemic and personal biases. Potential solutions explored included patient navigators assisting patients overcome language and cultural barriers to improve health literacy and reduce healthcare coverage disparities (Natale-Pereira et al., 2011). Overcoming barriers within the healthcare delivery system will empower patients which will result in them demanding equitable healthcare from providers.

The role of social workers in fully implementing ACA provisions has also been studied. Frauenholtz (2014) investigated how social workers could lead ACA implementation by helping up employee assistance programs. Social workers could play a key role in helping people make optimal health insurance choices, which would ensure greater ACA benefits (Frauenholtz, 2014). This further emphasizes the importance of collaboration and getting everyone onboard in overcoming the entrenched racial health-care disparity problem in the United States and giving disparate populations a stake in developing healthcare management plans.

The state of New Jersey enacted a policy in 2005 mandating physicians to complete cultural competency training as a requirement for state licensure (Like, Barrett, & Moon, 2008). This was a measure aimed at addressing the increasing ethnic/racial disparity in healthcare coverage in conjunction with the rising diversity in the state's population. In their examination, Like et al. (2008) reviewed New Jersey's cultural climate and identified African Americans as a racial group that suffered considerable disparities in healthcare, especially in AIDs treatment. One significant conclusion from their study was that physicians could not solve racial disparities in healthcare by themselves. A more comprehensive approach involving patients and considering legal and political factors in conjunction with socioeconomic, regional and public health factors would present a better option for solving these disparities. The role of culture in a person's perceptions of health and healthcare is significant, and healthcare providers need to understand this aspect to facilitate optimal healthcare coverage.

The Intended Impact of ACA

> It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new order of things… Whenever his enemies have the ability to attack the innovator, they do with the passion of partisans, while the others defend him sluggishly, so that the innovator and his party alike are vulnerable.
>
> (Niccolò Machiavelli, *The Prince,* 1513).

ACA's implementation falls in line with the quote above because it represents a comprehensive reform of the U.S. healthcare system or change from the norm in U.S. healthcare delivery. Following World War II, one's ability to pay for healthcare was the principal determinant of healthcare coverage in the United States. People who could not afford health insurance had to rely on charitable causes for healthcare coverage (D. B. Smith, 2015). African Americans were forced to seek care in extremely inferior medical facilities from minimally qualified providers due to racial segregation, and in every instance providers would see African Americans last regardless of reason (Andersen & Davidson, 2007). At that time, the few African American providers who existed were barred or restricted from pursuing career enhancing opportunities, which directly impacted the level and quality of care they could render to patients (D. B. Smith, 2015). African American healthcare providers also served in under-resourced healthcare facilities and could not offer their African American patients many of the medical services available to Caucasians (Clarke et al., 2013).

Despite the U.S. Congress blocking universal healthcare implementation following the Civil War due to entrenched bias against African Americans, several presidential administrations pushed for change. President Truman used federal funding as a tool to forcefully eliminate segregation in Veteran's Administration healthcare centers, medical schools, and charitable healthcare facilities seeking federal funding (Smith, 2005). These victories laid the foundation for all hospital desegregation, which was further enhanced by the passage of Medicare. The core principles of ACA stem from such victories over time and provide the justification for its addressing entrenched racial disparities in the U.S. healthcare system (D. B. Smith, 2015).

Access to healthcare coverage through insurance was found to increase prostate cancer survival, and ACA aims to expand insurance coverage for millions of Americans who would otherwise not be able to afford such coverage (Mahal et al., 2014). African Americans and the underserved population in the United States have been identified as the populations living under financial constraints and would benefit the most from the provisions in ACA's Medicare/Medicaid expansion (Devi, 2012). Owning health insurance was found to contribute to an increase in the chances of African Americans surviving from prostate cancer or receiving early detection, which increases rates of survival (Mahal et al., 2014). ACA also aims to reduce healthcare spending across all racial groups. Health insurance has been identified as a major determinant of quality care affordability and access, and ACA provides a level playing field for everyone (Chen, Bustamante, & Tom, 2015). By making health insurance more affordable to all in conjunction with other provisions to overcome disparate treatment, ACA reduces racial healthcare disparities by significantly reducing healthcare cost outlays for young African American adults aged 19 to 26 years old (Chen et al., 2015). While these provisions may help African Americans attain equitable healthcare coverage, the provisions may be inconsequential if African Americans fail to understand them.

As previously discussed, racial disparities in healthcare have been exhaustively investigated and confirmed and the underlining factors contributing to the disparity extensively presented. Potential solutions to mitigate the impact of structural, institutional, personal and other biases on these racial disparities have been explored. Huntley and Heady (2013) called for developing more culturally specific biomedical research to cultivate strategies that would benefit African Americans in their quest for equitable healthcare coverage. ACA provisions promote this facet in research and treatment outcomes as it would help mitigate the impact of racial disparities in healthcare coverage. According to Leigh (2012), during the first quarter of 2009 one fifth of all African American women were uninsured, which translated into lower access to healthcare coverage and increased potential for illness. Leigh examined the historical barriers to quality care for African American women and the potential role ACA could play in improving their healthcare needs. She concluded that the ACA provisions aimed at reducing racial disparities in healthcare access and affordability would benefit African American women who have historically been subjected to racial and sex disparities in healthcare as reported by Davis et al. (2009) and Janiak et al. (2014).

One central theme in all literature investigated for the present study’s review was that African Americans and other minorities continue to fall at the bottom of the racial disparity sphere. In the United States, there have been numerous attempts made to target racial disparities in healthcare with ACA being the most comprehensive attempt thus far. The goal of this health reform law is to make health insurance available to all Americans with an emphasis on healthcare cost controls, preventative healthcare, and equity in quality healthcare access. Susman (2012) stated that ACA could potentially create a significant decline in the number of uninsured Americans. He called for an end to political grandstanding by elected officials and a greater emphasis on the best interest of patients and American communities (Susman, 2012).

ACA was designed to target racial disparities in healthcare coverage and to control healthcare costs. The prevalence of certain chronic diseases such as HIV/AIDS and diabetes in the African American community is attributable to numerous social challenges (Denning & DiNenno, 2010). ACA is aimed at mitigating the impact of these social challenges by making health insurance more affordable and quality care more accessible to African Americans.

When African American HIV patients are concerned there is a disproportionate correlation between improved treatment options and their rising mortality rates from the disease (Owen, 2012). Owen (2012) explored how ACA provided insurance to African American HIV patients, exposing them to all available treatment options and educating them on lifestyle changes to better manage the disease. Prior to ACA, many African

Americans could not access Medicare or Medicaid treatment until the HIV virus completely disabled them, but under ACA they have access to treatment (Owen, 2012).

ACA also mitigates the potential for financial hardship and bankruptcy due to illness by ensuring that health insurers cannot place healthcare coverage caps. What this means is that families will no longer be prevented treatment from a diagnosis because of increasing costs. Prior to the implementation of ACA, there have been numerous documented cases of families having to file for bankruptcy because of exorbitant medical expenses as a result of a medical illness (DeNavas-Walt et al., 2012). DeNavas-Walt et al. also stated that insurers could deny insurance protection to someone due to a preexisting condition and ACA put an end to all such practices. Fontugne (2014) explored ACA's benefits in enhancing collaborative efforts between legal and medical professionals in fully implementing ACA to benefit all people in the United States. From her examination, Fontugne concluded that ACA provides greater potential for positive social change with optimal collaboration between doctors and lawyers.

ACA continues to encounter political challenges despite the numerous attempts to repeal it, and it continues to garner support as various phases are implemented (Kersh, 2011). The law provides subsidies to businesses and individuals to increase access and affordability to quality health insurance and these subsidies could be expanded to existing healthcare delivery programs to increase the number of people covered. Kersh (2011) examined challenges to ACA and its intended benefits and concluded that while challenges lay ahead as ACA's provisions were rolled out the law's benefits continue to gain support among U.S. citizens. Some of these benefits include access to quality care for all, especially disenfranchised minorities, tax credits for small businesses, new coverage options with no denial for preexisting conditions, the elimination of insurance caps, mandates for at least 80% premiums used for coverage or refunds to patients, coverage of children till age 26 years under parents' policies, funds for community health centers, and greater emphasis on preventative care (Kersh, 2011).

The use of ACA in combatting various health service discriminatory practices continues to be examined. On this track, Alegria et al. (2012) investigated ACA's impact on reducing racial and ethnic disparities in behavioral health services by examining data from national studies on estimated service disparities for patients with and without insurance coverage. Study findings showed the importance of educating patients and having local clinics in conjunction with health insurance coverage as the optimal elements needed to curb healthcare service disparities across racial and ethnic clusters. Despite these findings, Alegria et al. concluded that an estimated 10% fewer African Americans than Caucasians with identified needs for behavioral health services would not receive said services. Latinos showed no disparity, and Alegria et al. proposed alternate intervention measures to combat racial disparities.

As previously discussed, fewer African Americans participate in health research and healthcare treatment procedures due to the long standing record of poor and egregious treatment such as the Tuskegee syphilis studies (Mays, 2012). The undervaluing of African American lives contributed to the establishment of the Institutional Review Board and other accountability measures in human research. Mays (2012) explored the role ACA could play in combating the deeply rooted racial disparities in healthcare research, access, and quality healthcare coverage. Mays also evaluated the role President Clinton's apology for the atrocious syphilis experiments in Tuskegee, Alabama, could play in optimally implementing health reform in ACA. President Clinton's apology involved the acknowledgment of wrongdoing by the government under the false benefit of medical science and ACA has provisions to prevent such experiments from ever occurring again. One such provision in ACA is a robust bioethics standard in medical research to prevent the exploitation of underrepresented and/or minority populations during medical research and to ensure ethical practices are followed (Sorrell, 2012). These provisions constitute some enhanced benefits as a result of ACA in combating racial disparities at all levels within the healthcare research and delivery system (Mays, 2012).

In determining healthcare service utilization, Hofer, Abraham, and Moscovice (2011) estimated yearly utilization of primary care services and the number of primary care providers needed to cover increased use by reviewing surveys with the aid of multivariate models. They estimated that primary care utilization could increase by over 24,000,000 at the high end and 15,000,000 on the low end by 2019. Prior studies they reviewed supported their assertions that vigorous primary care systems could reduce racial disparities, reduce healthcare costs and increase the quality of care delivered to patients (Hofer et al., 2011). By mandating insurance coverage, ACA would increase the number of patients with health insurance coverage, and as such is predicted to increase the utilization of primary care services. Hofer et al. proposed strategies for expanding the primary care system so that it could handle increased utilization and for strengthening measures to reduce racial disparities in healthcare.

In assessing how ACA would impact African Americans, Leigh and Wheatley (2010) explored ACA provisions and how they could help improve the health delivery system and attain racial equity. They explored how ACA could shrink the health insurance gap and if cost control provisions could negatively impact African Americans' access to quality healthcare. Leigh and Wheatley also examined the impact of required race and ethnic data gathering and sharing within the healthcare system in conjunction with increased funding aimed at increasing diversity in healthcare providers and local healthcare centers. They also explored if cost containment provisions could make providing coverage to Medicare and Medicaid recipients less attractive to providers thus impacting care options and quality. Based on the findings from their study, Leigh and Wheatley concluded that ACA provides a significant step in overcoming racial disparities in health delivery in the United States. They also cautioned that cost containment provisions in ACA could serve as disincentives to some medical provision centers which cannot maximize profits.

African Americans may rely more on Medicare and Medicaid and, as such, their access and quality of care may be impacted (Leigh & Wheatley, 2010). Based on their investigation, Leigh and Wheatley (2010) recommend building on ACA by placing greater emphasis on preventive measures and the social determinants of health to attain equity in healthcare coverage.

Cantor, Monheit, DeLia, and Lloyd (2012) evaluated the ACA provision affording young adults the option to remain under their parent's insurance coverage until the age of 26 years. Data sources from population surveys from 2005 to 2011 were employed with multivariate controls to investigate the impact of ACA on insurance coverage for young adults in comparison to older adults. Their investigation revealed substantial dependent coverage increases for young adults directly attributable to ACA with a reduction in the rates of uninsured and underinsured young adults. While findings spanned all race groups, there was a significant increase in eligible young African American adults who otherwise would have been uninsured (Cantor et al., 2012).

Evidence from investigating other healthcare reform laws, such the one in Massachusetts that served as the template for ACA, indicates that health reform on its own does not eliminate racial disparities (Albert et al., 2014). In their study, Albert et al. (2014) explored the impact of Massachusetts health reform on reducing racial and socioeconomic disparities in cardiovascular care. They examined data from hospital claims to investigate coronary bypass rates and cardiac interventions by race, ethnicity, sex and education for Massachusetts residents aged 21–64 years released from heart disease between November 2004–July 2006 and December 2006–September 2008 (Albert et al., 2014). Results from their exploration revealed that while healthcare reform may have reduced barriers to health insurance it has yet to eliminate existing disparities in obtaining cardiac procedures.

Other studies such as McCormick et al.'s (2015) investigated the impact of Massachusetts's healthcare reform on hospital admissions stemming from race and ethnicity. While healthcare reform may have increased the number of insured residents, especially in disparate groups, it had minimal impact on hospital admission disparities (McCormick et al., 2015). Healthcare reform on its own has had minimal impact on racial and ethnic disparities in healthcare according to Clark et al. (2011), who explored the impact of Massachusetts healthcare reform on addressing the healthcare needs and costs for the state’s disparate population. A result from their investigation was that nearly one fourth of adults in fair/good health encountered challenges accessing healthcare services and providers during the implementation phase of health reforms. Additionally, low-income earners ($25,000 or below) were found to receive fewer cardiac and cancer preventative services than higher-income earners (Clark et al., 2011). Based on their exploration, Clark et al. (2011) called for novel services to better address barriers to equitable healthcare for underrepresented populations.

The researchers of the above studies focused on examining the effects of healthcare reform on access, affordability, and utilization of health services, and how they impacted racial disparities. However, their intent for the stated studies was not to explore how disparate groups understood the health reform policies, thus creating the gap towards which this study intends to contribute knowledge. This factor could indicate lack of appropriate utilization of the provisions of the health reform policies, which informs the premise for this study.

Through ACA, African Americans would attain significant healthcare benefits such as women receiving maternity care without paying half the costs, all preventative healthcare screenings, increased funding to local health facilities, better chronic disease management, healthcare support services, health interventions guided by the patient’s condition and not broad diagnosis, funding for minority healthcare provider training, and children covered under their parents insurance to age 26. These benefits would also include every other ACA provision and highlight the potential benefits of ACA to the African American community and in the fight against racial disparities in healthcare coverage. Jacobs (2011) investigated one facet of ACA that directly targets insurance companies’ discriminatory coverage policies by monitoring whom insurers cover and the specific benefits they provide to the insured. This ACA provision aims at combatting entrenched institutional biases on the part of the health insurance providers by making them subject to oversight on the percentage of premiums dedicated to healthcare services or issuance of refunds should the set percentage not be employed in insured healthcare coverage (Jacobs, 2011). Another disparate group is the prison population, with African Americans constituting a significant percentage of the prison population (Phillips, 2012). ACA aims to reduce prison healthcare costs and reduce racial disparities in incarcerated healthcare coverage by expanding preventative services coverage and mitigating medical illness incarcerations (Phillips, 2012).

All the studies discussed here focused on investigating ACA’s impact on curbing disparities in healthcare coverage and highlighted African Americans as an excluded group even with expanded coverage. Potential benefits of ACA are in the process of being fully implemented, which makes it vital to investigate how well African Americans understand the law. While recommending alternate intervention strategies to benefit all racial groups in overcoming the racial disparities all available studies focused on causes of and potential solutions to combat racial disparities in healthcare coverage. As such, there appears to be a gap in investigating how African Americans and other disparate groups understand and interpret the provisions in ACA to secure equitable quality healthcare coverage to Caucasians and other racial groups.

Summary and Conclusion

In this section, existing literature was examined and the overarching themes from available literature centered on the existence of significant disparities in the U.S. healthcare system. The studies reviewed also presented the long and extensive history of racial disparities and the factors that contributed to these disparities. Several potential solutions to overcome these disparities were presented and explored such as systemic institutional and personal biases and the roles of socioeconomic status and education. The need for reforming the U.S. health system was also explored and the potential impact comprehensive healthcare reform in ACA could have on existing health deliveries inequities. The extensive literature confirms the existence of health disparities in the U.S. and presents potential solutions. ACA is accepted as a major step in the right direction for overcoming healthcare disparities by providing everyone with the same access and affordability of healthcare. However, a gap exists in the literature on how African Americans and other disparate populations understand and interpret existing healthcare policies to demand equitable health coverage to Caucasians.

Based on the literature review outlined herein, I selected an optimal methodology to explore how African Americans understand and interpret ACA provisions. I the next chapter, I delved into the research design, methodology, and rationale chosen for this study to include the mechanisms for selecting study participants and how data would be collected, stored and analyzed. Through the use of the selected methodology explained in the coming chapter, this study contributes knowledge towards filing the gap in limited studies exploring how African Americans understand and interpret ACA provisions.

The absence of research on how African Americans understand and interpret ACA provisions and how to take advantage of these provisions for their personal health benefit leaves a knowledge gap which this study aims to fill. Furthermore, this study provides insight into the effectiveness of current policy dissemination strategies and facilitates the development of more efficient approaches.

Chapter 3: Research Method

Introduction

This study is intended to expand on current knowledge regarding how African Americans understand and interpret ACA provisions and how they take advantage of the provisions to gain insight into access and utilization of the healthcare system. In reviewing the available literature, I found many studies on racial healthcare disparities but no studies on how African Americans understand, interpret, and use ACA provisions. As previously noted, there appears to be a correlation between health literacy and public policy literacy in narrowing disparity in healthcare. An examination of all available literature on racial disparities in healthcare showed that African Americans constitute the most studied racial group suffering from racial disparities in healthcare coverage. The results from this study will provide insight into African Americans' experiences with ACA provisions as their actual experiences will be explored using an IPA approach.

In Chapter 1, I presented the documented challenges African Americans encounter within the U.S. healthcare system and how these challenges have contributed to existing racial disparities in healthcare. In that section, the various attempts at creating greater equity in healthcare coverage between African Americans and their Caucasian counterparts were outlined with ACA being the most comprehensive law. I also outlined the need to investigate how African Americans understand and interpret the provisions of ACA and how they take advantage of said provisions to attain quality healthcare coverage for themselves. In Chapter 2, I delved into existing literature that documents the relevance of health literacy in combating disparities in healthcare coverage. This section also established the link between poverty, and socioeconomic status coupled with education to attaining health literacy, which bears significant implications on gaining access to and utilizing health services. What these two prior chapters addressed was the justification for investigating the unknown facet of how African Americans understand and interpret ACA provisions and how to take advantage of them to demand equitable quality healthcare coverage. This chapter covers the qualitative methodology that I employed to garner greater insight into African Americans' experiences as they pertain to understanding and interpreting the provisions of ACA.

In this chapter, I provide in-depth information on the research design and rationale for the study, my role in the study, the methodology that was employed for the study, the sources from which data were collected, and how these data were collected, stored, analyzed, and used. I also address any credibility concerns for the study. In the research design and rationale section, I presented the overarching research question, which set the foundation for developing follow-up questions based on participants' responses. I also discuss the research approach and the reason for selecting that approach. IPA methodology was employed for the study to explore how African Americans understand and interpret ACA provisions to secure quality healthcare coverage. The principal objective of IPA is to understand participants' lived experiences and how they interpret these experiences. According to J. Smith (1996), and Shaw (2001), IPA has its origins in phenomenology, which is built on the philosophy of individual consciousness given that IPA's aim is to explore individual perceptions of a phenomenon. J. Smith et al.

(1997) stated that IPA delves into the meanings that lived experiences hold for participants.

I served as an observer/facilitator and addressed how I mitigated the injection of personal bias in the study and the level of interaction with study participants. I also address any potential ethical concerns that could have arisen as a result of undertaking this study and what measures I employed to handle these potential ethical challenges. I provide detailed parameters of the methodology to facilitate the study’s replicability, and in this section, I outline how participants were recruited, handled, and protected. I also explore the tools I used in collecting, securing, and analyzing study data, and address all measures that I employed in ensuring internal validity of the study.

This study’s focus was on how African Americans understand and interpret ACA provisions and how to take advantage of these provisions to attain equity with their Caucasian counterparts in healthcare coverage. Study results significantly contribute to filling the gap of limited literature research on public policy literacy and African Americans’ health literacy regarding ACA. Addressing the problem of how African Americans understand and interpret ACA provisions and how to use them could help shape how public policy is disseminated to ensure greater comprehension and limit misinformation. The lack of appropriate public policy knowledge can facilitate the spread of misinformation about public policies, which can lead to greater confusion. Williams (2011) stated that the people who could have benefited the most from ACA were bombarded with excessive misinformation, causing most of them to vote against their best interest. This further emphasizes the importance of public policy literacy and healthcare literacy in combating the increasing racial disparities in healthcare.

Research Design and Rationale

The research question developed to guide this study was as follows: How do African Americans describe their understanding and interpretation of ACA provisions and how to utilize these provisions to gain better healthcare coverage? During the recruitment phase, I employed ACA awareness as the gauge for potential study participants because being aware of ACA determined participants' eligibility for the study. The recruitment flyer stipulated the eligibility criteria, and interested participants called or talked to me in person during my onsite presence.

A qualitative approach was chosen for this study because it facilitates investigating phenomena in under investigated populations. The lack of investigation allows for the nonexistence of clearly defined variables, and this absence of clear-cut variables favors the use of qualitative methods of inquiry (Silverman, 2001 & 2010). I used qualitative methodology through IPA to add knowledge to existing literature by exploring the limitedly known area of how African Americans understand and interpret ACA provisions to secure affordable, quality, and equitable healthcare coverage. Several techniques can be employed to analyze collected data in qualitative inquiry methods. The use of these techniques could trim down the abundant data that qualitative studies often produce (Marshall & Rossman, 2014). This is essential in determining the usefulness of the data or for prioritizing collected data to meet study objectives. Given that qualitative data are collected from interviews, observations, or other written information, these data are unique. Qualitative data capture many nuances that quantitative numbers cannot, and it is vital that appropriate methods are employed to collect, analyze, and safeguard this information (Miles, Huberman, & Saldana, 2013). If qualitative data are not properly analyzed and secured, they could be extremely difficult to replicate and it could be almost impossible to duplicate the exact data (Ritchie et al., 2013).

I employed critical communicative methodology as outlined by J. Gomez, et al. (2006) given that a communications rationale may be employed to build knowledge through discourse. In conjunction, I also employed Andersen’s behavioral model of healthcare utilization as outlined by Andersen et al. (2011) as the conceptual framework for this study. In reviewing the available literature, there are many studies outlining racial healthcare disparities but very limited to no studies on how African Americans understand, interpret, and utilize ACA. As previously noted, there appears to be a correlation between health literacy and public policy literacy in narrowing the disparity gap in healthcare. An examination of literature on healthcare showed that African Americans constitute the largest studied racial group suffering from racial disparities in healthcare coverage.

Social phenomena benefit from qualitative research because this approach allows research participants to tell the story in their own words and for researchers to collect the data directly from the participants. As previously noted this study was qualitative in nature and employed an IPA methodology through semi structured interviews to investigate how African Americans understand and interpret ACA provisions and how to utilize them. J. Smith et al. (2009) stated that a phenomenological study affords individuals the ability to share their personal experiences about a shared common event. J. Smith (1996) stated that IPAs fully assess how participants understand their personal and social world. Employing IPA methodology facilitated identifying principal themes that better reflect participants' lived experiences and their meanings of these experiences (Cooperrider, Fleischer, & Cotton, 2015). The participants for this study were African Americans who ranged in age from 27 to 64 years old living in the Washington, D.C. area. The reason for this location choice is because there is no state government interference on the education and implementation of ACA in this area. This age group was also chosen as it encompasses the age group that the National Health Statistics Center (2012) identified as most in need of preventative healthcare coverage.

Using IPA in research studies makes it possible to uncover the experiences of African Americans regarding their understanding and interpreting ACA provisions and provides insights on their lived experiences regarding ACA. According to J. Smith (1996) IPA entails all elements needed in an effective approach for gathering this type of information. This is the reason why I employed IPA methodology in exploring how African Americans understand and interpret ACA provisions to secure quality healthcare coverage. The principal objective of IPA is to understand participants' lived experiences and how they interpret these experiences. According to J. Smith (1996), IPA has its origins in phenomenology, which is built on the philosophy of individual consciousness given that IPA's aim is to explore individual perceptions of a phenomenon. J. Smith et al. (1997) stated that IPA delves into the meanings that lived experiences hold for participants. Interpretation constitutes an integral facet of IPA that provides researchers with the best tools to appropriately analyze collected data.

Additional methodologies were considered, but they would not have provided the same insights as IPA. Ethnographical studies afford describing the experiences of a culture-sharing group, meaning they benefit a study of a large, isolated group. An ethnographic approach would not have provided the specific insights that IPA provides because the population for this study was not an isolated group. ACA is a law designed to benefit everyone residing in the U.S. However, since this study was limited to less than a dozen participants, it did not fit the guidelines for an ethnographic study.

A biographical study as outlined by Roberts (2014) was also considered, but this approach would have provided too targeted a view of how African Americans understand and interpret ACA provisions. The experiences of several African Americans were explored for this study; as such, a biographical method of inquiry would not have been optimal. Given that the purpose of this study was not on developing a new theory, a grounded theory approach also would not have been appropriate. Investigating African Americans’ understanding and interpretation of ACA provisions from a case study perspective would also not have been appropriate because interpretations of ACA over time were not relevant to this study’s purpose.

Role of the Researcher

I played the role of the data collection tool as outlined by Patton (2002) from an outside or *etic* perspective. This facilitated maintaining a great degree of objectivity in the study, which also required recognizing my personal biases and taking steps to mitigate them. I asked the interview question, focused on listening to participant's responses, and then asked probing questions to facilitate participants divulging more in-depth experiences. I also employed a broad range of sources to garner ideas and notions from which to create a mosaic on the phenomenon under investigation. Researchers must also develop optimal recruitment plans that can be feasibly executed as well as give participants all information necessary to establish trust and facilitate their granting informed consent (Sorrell, 2012). Additionally, I tapped into personal experiences as an African American to develop optimal study samples, construct probing questions, undertake interviews, and organize and analyze data collected. The researcher has to provide all necessary information to participants to establish trust and facilitate participants' granting informed consent.

Researchers must be cognizant of their role in ensuring quality in research, and given the interactions necessary in qualitative studies, researchers must strive to minimize the impact of personal biases. Biases include body language, appearance, voice tones, and facial expressions, which can influence the study. I presented myself in a professional manner by being properly groomed and dressed in business attire with neutral colors. I also focused on keeping out personal opinions from the study and maintained a natural tone in voice while asking unbiased questions. Additionally, I used common language in asking clear and succinct questions to facilitate participants' understanding of the questions and enabled them to freely describe their perspectives. Another approach I employed to mitigate injecting personal biases into the study was to journal the thoughts of participants and their responses to facilitate engaging in self-reflection. I built on this self-reflection to facilitate the suspension of passing judgment and dedicated all resources to analyzing participants' described experiences. This process is termed *bracketing* as presented by Tufford and Newman (2012).

Another potential influence on a study is the power dynamic because as the facilitator of the study there is an inherent position of power that accompanies the role. Ensuring that this power imbalance between researcher and participants does not negatively impact the data collection process is vital in carrying out a quality study. To mitigate the impact of the power imbalance, I ensured that I presented myself in such a way as to tone down the power that comes with my role and enhance participants' comfort with me. Engaging in peer review is another valuable tool to help mitigate injecting researcher biases in studies (Creswell, 2013). This study was aimed at exploring how African Americans understand and interpret ACA provisions and how to use these provisions to secure quality healthcare coverage. Based on this factor, I had to apply special care in recruiting appropriate participants and in collecting and analyzing the data to ensure the participants' perspectives were presented as intended. To ensure that this study was useful, I needed to maintain credibility in the study (Patton, 2002).

Methodology

Participant Selection

As noted, African Americans in the Washington, D.C. area were recruited as study participants for this study to explore their understanding and interpretation of ACA provisions. As such, African Americans who could freely express themselves, present and were aware of ACA served as the best qualified participants for the study, and no other criteria could disqualify them except their age and location. The sample size for the study was determined by the nature of the study, quality of the data needed, and other factors (Bracchetti, Deeks, & McCune, 2011). The final number of study participants who took part in this study was 10 which aligned with the earlier justified number of needed participants. IPA provides rich data by affording the researcher the opportunity to collect detailed information about a phenomenon as experienced by participants (Shinebourne, 2011). J. Smith (1996) stated that saturation is attained using a smaller sample size because data collected through IPAs provide great detail. There are numerous factors such as population heterogeneity, budget, and data collection methodologies that impact the potential sample size for a study (Mason, 2010). Given that African Americans constitute a homogenous racial group, the sample size needed to attain saturation does not need to be large. Individuals aged 27 to 64 years who visit and live around the study site in greater Washington, D.C. were recruited. This means all visitors to the study site, from guests to workers, were potential recruits. Other age groups were not optimal for this study given the National Center for Health Statistics (2012) report that identified this group as having the greatest need for preventative healthcare coverage. Additionally, ACA provisions allow younger African American children to be covered by their parents' healthcare coverage up to age 26 while older (65 and over) African Americans receive Social Security medical benefits.

As noted, participants were recruited from the selected location in greater Washington, D.C. once permission had been secured from the center administrator and the IRB. I recruited with the use flyers placed in the visitor's lounge and welcome desk.

Interested participants contacted me using the contact information on the flyers and also in person during my visits to the center. Participants constituted everyone visiting the study site who met study criteria. Study site administrators and the designated liaison personnel were given an overview of the study along with a request for authorization to carry out the study at the site. A meeting was scheduled and carried out with center administrator office personnel and study details were discussed to ensure that everyone had the same information. I presented a letter of cooperation to the center administrator and their designated representative. Center administration personnel assisted in selecting appropriate study sites within the study location and also informed me on available interview space. This provided study participants with a sense of familiarity which made them more receptive to actively participating in the study. Understanding that potential participants’ preferences were different, I discussed interview locations with participants. I also secured participants’ authorization to use open spaces outside the study site for the interviews. I communicated the intent and the potential benefits of this study with participants when I secured their permission to use available locations as interview sites for this study. I had secured permission to recruit and interview potential participants on selected study site premises however; I was responsible for selecting all study participants. A letter seeking authorization is attached (Appendix A) and a sample recruitment flyer (Appendix A) was made available to the site administrator.

Sampling

As stated earlier this study was of African Americans living in greater Washington D.C. and study participants were recruited from a selected community recreation center. I employed criterion purposive sampling as outlined by Patton (2002) to fill my sample size of seven to 12 African Americans. This narrow sampling approach facilitated controlling saturation because a larger focus using IPA methodologies would have provided more data than necessary for analysis (Shaw, 2001). This sample size also facilitated the development of themes and commonalities while not being overwhelming (Mason, 2010). Additionally, qualitative research is aimed at in-depth assessment of small groups and using large samples could result in losing the meaning of restrained reflections (Mason, 2010). Criterion purposive sampling is essential when detailed information is needed from a sample based on personal involvement with the phenomenon under investigation (Patton, 2002).

I employed criterion purposive sampling as outlined by Patton (2002) and Robinson (2014) to fill this study's required sample size range of seven to 12 African Americans. Criterion purposive sampling entails case selection based on predetermined adherence to a valuable criterion (Robinson, 2014). The predetermined criterion for this study was the selection of Washington D.C. as my study site to avoid state legislative influence and ACA awareness. As earlier noted, I asked interested participants about their awareness of ACA in determining their eligibility to take part in the study. J. Smith et al. (1997) stated that IPA samples need to represent closely defined groups for whom the study holds significance or from a population with comparable socioeconomic backgrounds. During the recruitment phase I used a simple ACA awareness inquiry through the flyers to gauge potential participants' awareness of ACA and determined if interested parties constituted good potential fits for the study. The sample size stated earlier facilitated the development of themes and commonalities while not being overwhelming (Bacchetti, Deeks & McCune, 2011).

IPA focus is in understanding specific phenomena under specific circumstance and as such a small sample size suffices (J. Smith et al., 2009). The selected sample for this study was 10 participants which depicted the actual number at which data saturation was attained under the methodology framework. According to Barratt, Ferris, and Lenton (2015), purposive sampling facilitates preliminary comprehension of a condition and identifying the requirements of a group or groups. Criterion purposive sampling is essential when detailed information is needed from a sample based on personal involvement with the phenomenon under investigation (Patton, 2002). This sampling method would ensure answers are derived from a lived experience and informed perspective rather than from conjecture.

Instrumentation

Semi structured interviews of African Americans would be conducted to learn of their experiences and views as possible users of services outlined in ACA. The sources of data that provided the background and basis for this study were scholarly literature on health literacy, and racial disparities in healthcare. The semi structured interviews were of 10 African Americans in the Washington D.C. metropolitan area. As noted, IPA entails the employment of a data collection tool that affords participants the opportunity to provide detailed, first-hand experiences of the phenomenon under investigation (Shinebourne, 2011). Additionally, IPA provides a mechanism for giving collected data appropriate relevance.

Semi structured interviews serve as conduits for participants to provide first-hand accounts of how they make sense of their lived experiences. Through semi structured interviews the researcher and participants take part in a back and forth conversation during which follow-up questions could be developed based on responses to get more in-depth experiences of participants. Smith (1996) stated that IPA exploratory methodologies afford researchers the possibility of delving into participants' social and psychological world in exploring participants' experiences. This gives the researcher leeway to follow the path of the interview participants carve because participants may introduce an area through their responses that the researcher had not considered. Smith, Flowers, and Osborn (1997), view semi structured interviews as optimal tools for following unpredicted responses which will lead to further explore participants' experiences. This flexibility of semi structured interviews in data collection is what makes qualitative methodologies optimal for exploring social phenomena because it affords the researcher the ability to follow the participants' lead in developing best questions.

One essential facet of IPA methodologies is the ability to allow participants to share their experiences in their own words. As such, I used audio recording equipment to ensure that I completely captured participants' description of their experiences with ACA. This means I had to secure approval from participants to audio record them which resulted in some participants' refusing to take part in this study. To mitigate this I infused the establishment of rapport with participants into the recruitment and study process. I provided participants with details of thestudy to give them all the necessary information to garner their informed consent. I also made it clear to participants that I wanted to explore their experiences with ACA and as such I wanted to accurately process their descriptions of the lived experience. The best way to let their descriptions of the experience to be properly recorded was through audio recording because manually writing down their descriptions could result in inaccuracies. Shienbourne (2011) stated that jotting down notes during the data collection process is inefficient in IPA studies because it could be distracting and result in key descriptions being left out. While audio recording served as the primary data collection mode, I also used a ledger and pen to write down observations during interviews. These observations assisted in comprehensive reflections on the study and helped in developing themes.

In ensuring credibility in this study, I adhered to the interview protocol parameters outlined by J. Smith et al. (2009). I went over all interview parameters with participants and ensured that they understood every aspect of the study and addressed all concerns they presented. I also secured consent from participants to audio record their interviews using a digital audio recorder and as noted. In addition, I recorded my observations on a ledger. I employed the use of the open-ended question: How do African Americans describe their understanding and interpretation of ACA provisions for their personal health benefit? Based on the responses given, I asked probing questions to further explore participants’ experiences. Cooperrider et al. (2015) stated that an interview protocol enables the researcher to guide the interview to ensure participants remain on topic. So, if participants’ responses deviated from the study subject, I used the interview question developed through interview protocols to steer participants back on topic. I also discussed interview expectations with participants and ensured interviews lasted no longer than 45 minutes per session to mitigate fatigue for participants and myself.

Study Procedures

Study procedures chronicled the order which the study followed and the data collection phase of the study commenced with a visit to the study site. I submitted a study proposal including all clearly outlined facets of the study to participants and the study site administrator. During this phase I provided an overview session on the study to designated study site personnel who conferred the authorization to recruit potential participants. I also expressed a desire to recruit participants around the site location and premises and secured collaborative intent. Following this step, I sought authorization to utilize the study site's premises to conduct the one-on-one, in-person interviews. One of the first steps I undertook was to provide the researcher's contact information to all involved parties and clearly outlined the expected timeline for the study.

When study participants were identified and selected, I carried out an informational session with them to present the scope of the study, obtain all necessary consent, and address any potential concerns. I also collaborated with participants to determine best interview location, and scheduled interview times while making every effort to accommodate participants and adhere to set timeline. Participants' consent to audiotape the interviews was also secured and any potential complications eliminated. As stated earlier, an overview of the scope of the study was provided to participants while their informed consent was secured and their confidentiality protections documented.

Once all forms were signed and verified the interviews were scheduled during which time exploring participants' experience with ACA with focus on the overarching question "How do African Americans describe their understanding of the provisions of ACA and how to utilize these provisions to secure quality healthcare coverage?" was recorded.

The use of open-ended questions as noted earlier enabled participants to descriptively recount their experiences. J. Smith et al. (2009) stated that this approach would facilitate participants to open up and talk comfortably. During the interview the researcher sought to gain more in-depth knowledge on the described understanding and interpretation of ACA provisions based on probing questions developed from the responses given during the interview. In the course of the interview, the researcher's observations of participants were recorded to facilitate the determination of their comfort levels with questions and make any necessary adjustments. I also ensured clarity in the questioning and exhibited confidence in their delivery to reassure participants of the objective intent to only explore their experiences with ACA.

Only one interview was scheduled in keeping with IPA interview protocols but while permission was sought for a potential telephonic follow-up call if needed, it was never used. This telephonic follow-up call was to occur within a couple of days of the interview and it was to be used only to clarify any unclear information from the recorded interview. At the completion of the interviews, the researcher required nealy two weeks to transcribe all data.

Data Collection

The responses given to the research question guided the development of additional interview probing questions to fully capture participants' experiences. Additionally, through the interview schedule a range of topics was developed which guided exploring participants' experiences (J. Smith et al., 2009). These topics were organized in an appropriate sequence as they were formulated during the open-ended interview session. To ensure suitability of probing questions I used clearly outlined IPA guidelines to assess their quality as recommended by Shinebourne (2011). If the expected number of participants was not attained within the two week recruitment window, I could have extended the timeline and sought other recruitment locations such as community health centers. I also employed snow ball strategies to reach as many potential participants as possible to attain the desired number. I used data collected from the semi structured interviews of African Americans to uncover how they understood the provisions of the health reform law ACA and how they utilized those provisions for their personal health benefit.

J. Smith et al. (2009) suggested creating an interview schedule to enable establishing rapport and a level of comfort for participants. This rapport and participant comfort will create an opening for them to divulge in depth accounts of their experiences with the subject being explored in the study. The interview schedule enables the researcher to commence interviewing participants with a question that urges them to extensive share their experiences (Shinebourne, 2011). Assumptions and leading questions should be avoided because they may guide participants towards specific responses discrediting the study (Shinebourne, 2011). Additionally, I developed prompts as recommended by Shinebourne (2011) to propel participants to share greater details of their experiences should the question be perceived as abstract.

I employed semi structured interviews with an IPA methodology because this afforded the researcher an opportunity to adjust the line of questioning based on answers provided by participants to collect detailed personal experiences (J. Smith et al., 1997). The flexibility facilitates detailed information gathering in exploring how individuals understand the personal and social circumstances under which they are subjected (J. Smith et al., 1997). I employed communicative qualitative techniques for data collection which proposed the use of three techniques; communicative daily life story, communicative focus groups and communicative observations (Cooperrider et al., 2015). All these data collection procedures center on creating change through collaborative ventures between the researcher and the participants. I employed the communicative daily life story procedure because it allowed study participants the ability to reflect on and interpret the social phenomenon ACA which was under investigation. A. Gomez et al. (2011) stipulated that collecting data through communicative daily life story brings forth insightful descriptions of the participant’s life experiences which highlighted their take on ACA in this study. Semi structured interviews of African Americans uncovered how they understood and interpreted ACA provisions and how they utilized those provisions in securing quality healthcare coverage.

Interviews were conducted in person and because data was verified accurate by participants no telephonic clarification was needed. The in-person interviews served as the baseline for further developing affinity with participants and gaining additional insight on their experiences through initial and probing questions. I also ensured I stated appreciation to participants for taking part in the study. The overarching primary question was outlined above but no telephonic follow-up clarification questions needed to be generated because they were not needed. As noted earlier, the center from which participants were recruited also served as the location for in-person interviews with participants' concurrence. Because the study site was located within a greater Washington, D.C. community, it gave participants a sense of familiarity and security while placing the least constraints on them. The study site premises and surrounding grounds served as the interview location based on participants' stated preference for more open spaces and they did not want to be limited to restricted settings.

As previously stated, the interviews were audio recorded with notes taken minimally. The digital audio recorder was positioned in clear sight of study participants and the taking of notes was as discreet as possible to minimize interference. I served as the data collection tool from interviews and all interviews took place at the designated location for reasons outlined earlier. Given that the study focused on healthcare/public policy, the community center served as an optimal location for the study. Alternate locations were reserved if participants preferred but all participants accepted the use of study site grounds as the interview location. There was one interview conducted and there was no need for a telephonic follow-up for clarification purposes. All interviews were audio recorded and all interviews took no more than 45 minutes. At the end of the interviews, I reassured participants of their rights and expectations of privacy for their information and also answered any questions or concerns that may have arisen in accordance with interview protocols stated by Biggerstaff and Thompson (2008). Audio recordings were transcribed post interview and linked with handwritten notes to specific participants. These interviews provided the primary means of data collection for the study and once completed the collected data was organized in clearly identified participant folders to facilitate analysis as recommended by Dworkin (2012). The organized folders with all related study material were safeguarded in a Sentry safe in the researcher's secure office.

Data Analysis

Data analysis software such as NVivo and Microsoft Office 365 was employed to identify themes from the data and these themes were validated with guidance from my committee. NVivo and Microsoft Office 365 software facilitated data analysis by uncovering themes in the data which enabled better representing participants' described experiences. NVivo utilizes auto-coding to generate codes and themes from collected data while it also queries the data and codes in one location. Additionally, NVivo makes it easier to annotate, connect and uncover relationships from data versus the cumbersomeness of manual coding. Larkin and Thompson (2012) stated that data analysis in IPA studies starts at the individual level through a line-by-line analysis of participants' experiences with the phenomenon under investigation. In analyzing the collected data the researcher should continually read and reread the data to uncover themes that would facilitate garnering a clear picture of the experience with the phenomenon under study (Miles et al., 2013).

Data collected through semi structured interviews provided firsthand accounts of African Americans' understanding and interpretation of ACA provisions and how they used them to secure quality healthcare coverage. Following data collection, the semi structured interviews were transcribed and reviewed for analysis. J. Smith et al. (2009) stated that the researcher's role is significant in making sense of the meanings of participants' experiences. This requires researchers to be responsive to data and eliminate all preconceptions ahead of data collection (Smith, 1996). According to Shinebourne (2011), the analysis framework provided by IPA is very flexible to facilitate the researcher to reflectively engage with participants' descriptions and meanings of experiences. I listened to the audio recordings several times and transcribed them into word documents to gain greater familiarity with the data. I also reviewed observational annotations to assess participants' nonverbal cues and made comments on the transcribed data as recommended by Shinebourne (2011). Shinebourne (2011) further recommended paying attention to content, context, and language while keeping notes on initial interpretations.

Following the latter processes, I began the development of emerging themes from the transcribed narratives which Smith, Flowers, and Larkin (2009) stated would facilitate the clustering and labeling of similar themes. From this clustering and labeling, a table of themes was developed which signified detailed interactions with data. Shinebourne, (2011) also stated that this in-depth interaction with collected data ensures preservation of participants' shared experiences which also provides a map that an outsider can follow to track the study. Ritchie et al. (2013) stated that the development of such maps enhances the integrity of a study. I carried out this process for all participants and actively worked to maintain objectivity throughout the study to facilitate identifying new themes from each participant. At the end of the data analysis, a table of themes was developed which Shinebourne (2011) stated enabled the development of a comprehensive narrative of the entire study. This comprehensive report lays out the back and forth interaction of the researcher's interpretation of participants' report. Using the words of participants with notations of the researcher's interpretation would facilitate retaining the participants' voice with researcher's interpretations (Cooperrider et al., 2015). As noted earlier, all data collected would be primarily analyzed using NVivo software to code and identify all emerging themes from the data.

I also used thematic analysis as presented by Fereday, and Muir-Cochrane (2008) to analyze collected data because of the flexibility this approach offered and it enhanced other qualitative data analysis methods. Gomez et al. (2011) assessed that social sciences centered on promising and feasible concepts based on Freire's "Prophetic thought" concept must also create and promote avenues for conquering social inequities. Communicative data analysis could be exclusionary and transformative in nature and once analyzed could facilitate positive social change. This mode of data analysis identified transformative elements that could facilitate positive social change based on outcomes from the study. In doing so, the study could facilitate the development of more effective alternatives in social policy dissemination and identifying elements that could propel effective social change. Following the collection of data, the researcher organized the collected data to facilitate identifying nuances for improved analysis. Gaining an understanding of the experiences shared by research participants laid the foundation for understanding the meanings communicated in the collected data.

Given the earlier stated purpose of the study, analyzing the collected data entailed pinpointing information that was directly connected to the study. IPA data analysis entails the development of codes from the data as opposed to employing existing theories to assign applicable codes to collected data (Larkin & Thompson, 2012). Identifying the elements that assign meaning to social inequalities as described by participants facilitated gaining added insight to develop measures to overcome said inequalities (A. Gomez et al., 2011). In analyzing data collected, it was essential to not only list the various groups, subgroups and characteristics but to outline the "exclusory and transformative dimensions of the situation being studied" (J. Gomez et al., 2006, p. 100). Exclusion categories prevent specific individuals or cohorts from benefiting from the phenomenon under investigation which in this study was the healthcare system. In this study, the transformational facets included ACA which facilitates individuals and cohorts overcoming barriers to enjoying the full benefits of the healthcare system. In analyzing data in this critical communicative IPA study, I mentioned a transformative facet to counteract any exclusionary facets identified. This enhanced the possibility of drawing attention to all available alternatives that could be employed in overcoming and improving social inequities (A. Gomez et al., 2011).

Issues of Trustworthiness

Validity checks in IPA research are not aimed at producing unique truths but to make sure credibility of developed themes is maintained (Shinebourne, 2011). Also acknowledging the subjective facet of IPA as a qualitative methodology makes it nearly impossible for separate researchers to produce the exact themes and codes from the same data (Miles et al., 2013). Burnard et al. (2008) explained that in qualitative studies, the presentation and analysis of qualitative data could be very confounding because it is demanding and warrants a lot of time. Many social scientists have argued that a clear-cut, objective analysis of social veracity is inexistent and as such the analysis of qualitative data is more subjective (Burnard et al., 2008). The latter statement supports the need for verification of qualitative study findings by a third party to mitigate the injection of bias and augment the credibility of the study. For this study I employed inter-rater reliability or peer review as outlined by Hartling et al. (2012). Peer review entails the independent verification of findings from the study by another qualitative researcher which for this study was another qualitative researcher and editor. I provided the data to them and asked them for extracted themes, then, I compared their themes for homogeneity with the themes I extracted and those extracted by NVivo.

Inter-rater reliability could be employed as a strengthening tool in a phenomenological studies as verified by Marques and McCall (2005), and Griffiths, Schweitzer, and Yates (2011). They argued that in a phenomenological study the researcher serves as the principal data collection tool thus making bias elimination challenging. The inter-rater reliability measure serves to address the issue of consistency because it allows two or more raters to analyze data consistently (Griffiths et al., 2011). Researchers like Pyett (2003), Braun and Clarke (2006), and Fereday, and Muir-Cochrane (2008), have argued against inter-rater reliability being used in qualitative inquiry given the subjective nature of social phenomena. However, the need for validity and reliability in qualitative studies has pushed for the development of tools to verify study findings and ensure consistency. To be considered as a solidification tool of findings inter-rater reliability has to be applied immediately following theme identification but prior to drawing conclusions from said themes (Marques & McCall, 2005). In their study Marques and McCall (2005) presented that utilizing inter-rater in this manner serves a more constructive function than an after-the-fact function. This according to Griffiths et al. (2011) would facilitate maintaining consistency and enable substantiation of findings.

Another safeguard that was employed in verifying findings was the employment of participants’ validation immediately following data collection to ensure that described lived experiences were accurately reflected (J. Smith et al., 2009). This participant validation had to take place immediately following collection to mitigate potential researchers’ inaccurate reflective analysis of participants’ descriptions (Shinebourne, 2011). The provision of in-depth descriptions of results and findings would also facilitate reliability because results could be replicated (Ritchie et al., 2013). Reporting of findings was exactly as given by participants without any alterations in context or grammar. Additionally, any peer review notations and researcher notes were provided to give added detail to the interpretative phenomenological exploration of how African Americans understood and interpreted the provisions of ACA and how they took advantage of said provisions to secure quality healthcare coverage.

Following the study, participants underwent a debriefing during which an overview of the study and their recorded shared experiences were made available. The complete study will be presented as a final doctoral dissertation study for Walden University with refereed versions made available for publishing in scholarly journals.

Ethical Considerations

Prior to beginning the data collection phase for this study, I requested and obtained Institutional Review Board (IRB) approval. Keeping in mind the personal nature of the study, some participants were skeptical about taking part in the study. However, after addressing all interested participants' concerns, those selected freely and willingly volunteered to take part in the study. All study participants opted to participate and were free to opt out of the study at any time. Additionally, all privacy laws were adhered to and participant confidentiality was upheld as mandated by research ethics. While participants shared their personal experiences, no detriments to participants for taking part in the study were identified. Still, local mental health resources will be identified and made available in case any participants expressed experiencing harm from study participation. Participants' expressed consent was attained and their confidentiality maintained unequivocally. All research material was protected and secured by the researcher in a Sentry safe located in the researcher's office as earlier noted and access to collected data was controlled by the researcher only. The IRB recommends destroying all audio and video recordings immediately following their transcription unless otherwise mandated by the research. I destroyed all digital audio recordings once they were transcribed and continued to secure all transcripts and study notes in the Sentry safe as earlier noted. Before data was validated all identifying information was removed from the transcripts. Consent forms and confidentiality statements were secured in line with Walden University protocols.

Summary

In this chapter I delved into the research design, rationale and methodology for this study which explored how African Americans understand and interpret ACA provisions and how they use these provisions to secure quality healthcare coverage. I detailed the role the researcher would play in this study and how participants were recruited, selected and interviewed. I also examined the data collection mechanism (IPA) which was employed for the study and how participants and their described experiences were protected. I also presented the procedures this study followed and how collected data were analyzed. Methods for ensuring credibility and trustworthiness in this study were also explained and how any potential ethical concerns were mitigated and/or addressed. This laid out the background on which the data were represented as chapter 4 details.

Chapter 4: Results

Introduction

This phenomenological study was intended to record African Americans' understanding and interpretation of the provisions of ACA and how they use them for their personal health benefit. The lived experiences of 10 African Americans aged 27 to 64 years formed the core around which this study was designed with African Americans sharing their personal experiences with ACA. The results of this study contribute knowledge on the existing disparities in healthcare coverage from a health literacy perspective based on African Americans' understanding and interpretation of ACA provisions. ACA is the current comprehensive healthcare law of the United States, and the findings of this study shed some light on how this healthcare law is employed by those at the disparate end of the healthcare disparity gap.

Chapter 4 is the results chapter in which I provide participant demographics, data collection with procedural details, data collection sites, and data storage and analysis. During recruitment, several potential participants wanted to know what financial benefit they would be getting if they participated in the study. When informed there was no monetary compensation, most of them lost interest.

Research Question

For this study, I employed one research question: How do African Americans' describe their understanding and interpretation of ACA provisions and how to utilize these provisions to gain better healthcare coverage? Based on the responses given by participants to this question, probing questions were developed to capture greater detail on the responding African Americans' experiences with ACA. Following the interviews, there was no need for telephonic follow-up calls because participants' responses were authenticated by them at the interview and transcribed verbatim with clarity.

Setting

Participants for this study were recruited from the greater Washington D.C. area, through the use of flyers posted at the study site and at the time of the study, all participants presented as sound in judgment. Participants' economic status was not taken into consideration because their experiences needed to be captured as described. This means that socioeconomic influencers were not segregated given that they contributed to how participants experienced the phenomenon being investigated.

Participant Demographics

Potential participants interested in taking part in the study contacted me directly, and people also approached me during the times I was present at the center if they sought more information on the study. After receiving clarification and more detail on the study, those who wanted to take part in the study were either then scheduled for an interview time convenient to them or they were interviewed immediately if they chose that option.

I used specific criteria to select optimal candidates for this study. All participants chosen to take part in the study had to be African American, ranging in age from 27 to 64 years, were aware of ACA and lived in the Greater Washington D.C. area. The age bracket was to capture all individuals who were not still under their parents' policy because ACA allowed children to stay on their parents' policy until age 26, and adults 65 years and over receive MEDICARE. All participants made the informed choice to take part in the study, and no one was coerced and/or forced to take part in or continue participating in the study. There were 10 African American participants in the study, of which five were women and five were men. The participation of everyone in the study was absolutely voluntary, and to protect their identity, I coded their names. The codes used are KRC-1, KRC-2, KRC-3, KRC-4, KRC-5, KRC-6, KRC-7, KRC-8, KRC-9, and KRC-10. All interviews happened on or around the study site grounds at a secluded bench for privacy. The participants' demographics as presented at the time of the interview are shown in Table 1.

Table 1

Participant Demographics

Participants	Gender	Age	Education level	Job status
KRC-1	M	42	Masters	Working
KRC-2	F	35	Working on Associates	Working
KRC-3	F	44	Bachelors	Working
KRC-4	F	52	Masters	Working
KRC-5	F	29	Bachelors	working
KRC-6	M	61	Bachelors	Working
KRC-7	M	56	Masters	Working
KRC-8	M	44	Bachelors	Working
KRC-9	F	29	GED	Working
KRC-10	M	37	Some College	Entrepreneur

Below is a brief overview of each participant as they presented themselves, and I employed their own descriptions to represent them.

Circumstances Encountered

According to the information presented by the participants, 90% had some college experience. Specifically, 30% stated they had Masters Degrees, 40% stated they had

Bachelor’s Degrees, 20% stated they had some college experience, and 1% stated that they had a High School equivalency degree. I assessed what factors could account for this skew in reported education levels from the surrounding demographics. One such factor is the high level of federal government employees within the Greater Washington, D.C. region. Another factor identified could be the extensive social benefits programs that the Washington, D.C. government implements. All these factors could account for the high percentage of reported college educated personnel who volunteered for this study.

KRC-1

Participant KRC-1 is a 42-year-old African American male social worker who serves full time as a case manager in the Washington D.C. area. He provides housing placement for low income families and creates skill development programs to get them self-reliant by providing job training and other career development avenues. He helps low income families get housing and social welfare benefits such as food subsidies and MEDICAID, but he also assists working families who need some social assistance. He stated that he has a Master’s Degree in Social Work and he is married with children: one currently in college and another who has a medical condition. He stated that his family gets their health insurance coverage through his wife’s employer.

KRC-2

Participant KRC-2 is an African American female who informed me that she is a 35-year-old single mother of three children and that she is currently working on her Associates Degree. She also stated that she works but has to rely on the D.C. Welfare program for housing, food stamps, and medical care. She stated that she gets D.C. MEDICAID for her and her children

KRC-3

Participant KRC-3 is a 44-year-old African American female living in the Greater Washington, D.C. area. She informed me that she works as a Mental Health Case Manager in Washington, D.C. and she has a Bachelor's Degree in Social Work. She also volunteered that she has is married and has no children and that she gets Tricare health insurance coverage through her husband.

KRC-4

Participant KRC-4 presented as a 52-year-old African American female who lives and works in the Greater Washington, D.C. area. She further volunteered information that she is divorced with two children, and one of them was in college while the other was working. She stated that she gets Tricare health insurance coverage for her and her college child through her employer.

KRC-5

Participant KRC-5 stated that she is a 29-year-old African American female who lives and works in the Greater Washington, D.C. area. She volunteered the information that she is single with no children and that she has a Bachelor's degree and is working on a Master's. Additionally, she volunteered that she gets her healthcare coverage through her employer.

KRC-6

Participant KRC-6 presented as a 61-year-old African American male. He volunteered the information that he is a federal employee and that he gets his health insurance coverage through his employer. He further volunteered that he is married with three children but that all his children are independent and on their own. He stated that he has been living and working in the Greater Washington, D.C. area for the last 30 years.

KRC-7

Participant KRC-7 stated that he is a 56-year-old African American male who lives and works in the Washington, D.C. area. He stated that he has a Master’s degree and numerous professional certificates. He volunteered that he is a divorced father of two daughters and that he is retired from the military. He further stated that he gets all his health insurance coverage from the VA but he also has Tricare insurance through his current employer.

KRC-8

Participant KRC-8 reported that he is a 44-year-old African American male who lives and works in the Greater Washington, D.C. metropolitan area. Voluntarily, he stated that he has an advanced degree; he is married with two children, and one of those children falls within the autism spectrum. He further stated that he bought health insurance for his entire family through the health insurance exchange under ACA.

KRC-9

Participant KRC-9 presented as a 29-year-old African American female who resides in the Washington, D.C. area, which she described as the Southside of D.C. She voluntarily stated that she is a High School graduate; single mother to one child, and that although she worked she does not earn enough income and as such has to rely on government assistance. She stated that she receives D.C. MEDICAID that covers all the healthcare needs for her and her daughter.

KRC-10

Participant KRC-10 described himself as a 37-year-old African American entrepreneur who has launched several ventures to include a music label. He stated that he is married with three young children and that while his wife works, he stays home to look after the children. He further volunteered that his family benefits from the D.C. government’s assistance to working families. He stated that this program provides his family with medical coverage through MEDICAID and that while his family does not receive housing assistance, they do not make enough income to afford health insurance. He also stated that he has some college education but could never concentrate in class.

Data Collection

The codes listed above were assigned to protect all study participants’ identities. All interviews were conducted around the study site at a reserved secluded bench at the side of the building with minimal to no traffic. All participants who volunteered to take part in the study were briefed on the study and given the opportunity to review all consent forms, and every question they asked was addressed to their satisfaction before the interviews. At the beginning and throughout the interview process, each participant was reminded of their rights to withdraw from the study should they so choose and for any reason. No compensation was offered to any participant for accepting to take part in the study. All interviews were recorded on a digital recorder and the duration of the interviews ranged from 30 to 45 minutes. Participants gave their first names only and their phone numbers in case I needed some clarification during transcription. At the conclusion of each interview session, I played the recording so the participants could check for accuracy, and none of the participants made any response changes. I also recorded nonverbal cues presented by participants throughout the interview.

Once the interviews were completed, I transcribed all recordings, and the digital copies and phone numbers were destroyed in accordance with Walden University policies. I employed manual transcription in conjunction with Dragon Naturally Speaking version 11.o software to transcribe the interviews. I also purchased a 128 GB Iron Key secure thumb drive to store all the interview data with the use of a 32 bit passcode. Additionally, all documents pertaining to the research are stored in a security safe for which only I have the access codes. The data are securely stored and will be subsequently destroyed per Walden University policy.

All transcribed data were then evaluated using thematic analysis to identify patterns and develop themes from the data. These themes, according to Miles et al. (2013), represent patterns identified across data sets that are valuable in exploring described lived experiences with the phenomenon under investigation. The collected data in conjunction with observation annotations were uploaded into NVivo software, which helped in the identification of patterns within the data following transcription. Throughout the interview process, no disruptive events occurred thanks to the professionalism of all participants and staff at the study site.

Data Analysis

Qualitative data analysis is the phase following the collection of data in which the researcher seeks to examine the meaning of the data through interpretation and understanding of the participants' shared experiences. Larkin and Thompson (2015) stated that IPA analysis starts at the individual phase with a step by step analysis of each participant's claimed experiences, understandings, and concerns of the phenomenon under investigation. Qualitative research is the tool that affords social researchers the ability to explore the meanings and lived experiences of participants with a social phenomenon through the use concepts which facilitate understanding (Marshall & Rossman, 2014). This interpretative phenomenological analysis study was aimed at producing results from participants' sharing their experiences. For the researcher to focus on extracting the lived experiences of study participants, they must suspend their personal preconceptions (J. Smith et al., 2009). The data collected were analyzed, and interpreted, and all produced results were discussed. The use of qualitative research was to afford the researcher the ability to collect rich, detailed data that could be overwhelming to analyze (Cooperrider et al., 2015). To capture participants' experiences as they describe them, collected data had to be transcribed verbatim so that nothing was subject to guesswork.

Preliminary data analysis began with the single open ended interview question and from responses given to that question, additional probing questions were developed which helped in the acquisition of precise information. An inductive data analysis approach was employed in analyzing the data by grouping data to establish data relationships through the use of emergent frameworks (Miles et al., 2013). For content, the participants' responses were the primary area of focus, and all participants shared personal experiences but others included what they believed to experiences shared by related groups. I used summary notes from interviews and nonverbal recordings to augment the analysis of collected data which in conjunction with other factors mentioned earlier facilitated areas of focus when the collected data was being analyzed.

I utilized an exploratory framework in analyzing the data and this framework was guided by the data collected. I also employed interpretative data analysis tools by developing a systematic approach to identifying relationships in collected data, grouping similar points to identify emerging themes, grouping and labeling related information using codes, grouping similar codes from different sources into one, and indexing the word lists (Dey, 1993). I employed content analysis to describe the data and interpret the meaning of the data in conjunction with narrative analysis by sorting, reflecting, enhancing, and presenting the interviews and observations of participants. Narrative analysis facilitated the ability to present the individual lived experiences of participants under varying contexts.

Evidence of Trustworthiness

There are certain core concepts that highlight the trustworthiness of a qualitative study such as transferability, dependability, confirmability and credibility (Creswell, 2013). Transferability refers to the generalization of findings across different groups or situations supported by evidence. Generalization is extremely limited in qualitative research because of the fact that the method of data collection in qualitative studies defines the data and its interpretation (Larkin & Thompson, 2015). To address this issue of transferability I employed criterion purposive sampling by emphasizing specific information instead of generalized information by taking into account each participant's characteristics. Dependability asserts that similar findings would be uncovered if the study were repeated however, given the ever evolving social dynamic with people this would be extremely difficult to attain.

In IPA studies, dependability is enhanced by collecting rich details, triangulations and inter-coder utilization. The use of triangulation afforded me the opportunity to ask the same research question to different participants in the study, using different sources to collect data and employ varying methods to answer research questions. Confirmability refers to the exertion of control over researcher bias and maintaining objectivity throughout the study and credibility entails how believable the findings are from the qualitative study. Larkin and Thompson (2015) stated that member checking was less effective in IPA studies because of their interpretative nature. However, I replayed the interview recordings to participants to ensure that their experiences were captured as they intended them to be captured. I employed an across transcript analysis to test the coherence of the analysis and I also employed an audit check through an independent auditor. I also utilized data reduction, data display and conclusions drawn as presented by Huberman and Miles (2013) as a means of enhancing the credibility of this study.

Results

Following data transcription, participants' described experiences were compared to the verified recordings before deletion to ensure accurate reporting. The transcriptions were read and reread and relevant statements specific to their described experiences were highlighted. The highlighted experiences were then described to better capture their lived experiences. This facilitated the development of themes that enabled exploring their understanding and interpretation of ACA provisions for their own health benefit. This thematic development was undertaken for each participant and then similar themes were grouped for all participants. Following data analysis, more than 100 coded statements were produced and out which there were five core themes identified which further expanded into detailed subthemes. I them categorized the themes based on their weighted averages from participants' descriptions of their shared experiences.

As noted earlier, this study was intended to explore the understanding and interpretation of ACA provisions by African Americans aged 27 to 64 years old living within the greater Washington, D.C. area. The study also sought to contribute knowledge towards developing a basis from which sustainable solutions could be developed to combat existing disparities in healthcare. Below is a description of identified themes and detailed subthemes included within each core theme to represent the meaning of the findings for all study participants.

Insurance

All participants acknowledged that ACA mandated that everyone have insurance coverage. There were three primary insurers identified in the study: TRICARE, D.C. MEDICAID, and other Employer provided insurance. While all participants were familiar with ACA, the type of insurance coverage each participant possessed impacted the degree to which they understood and interpreted ACA provisions. Participants' KRC-1, KRC-5, KRC-6, and KRC-8 all purchased private insurance through the open market established by ACA. Participants' KRC-3, KRC-4, KRC-7, and KRC-10, all utilized Tricare as their health insurer while participants' KRC-2 and KRC-9 benefitted from D.C. Medicaid. Participants KRC-1, KRC-5, KRC-6, and KRC-8, all had a deeper level of understanding and interpretation of ACA provisions because they had to purchase health insurance on their own. These participants compared insurance plans before settling on the best plans for themselves and their families. This afforded them the opportunity to be able to research ACA in more detail.

Participants KRC-3, KRC-4, KRC-7, and KRC-10, stated that they had no need to fully understand and interprete ACA provisions because they benefitted from Tricare insurance coverage through their employer. They all stated the ease of using this insurer because they did not have to shop for their own insurance or compare insurance plans. All they stated they had to do was select a primary care manager at whatever location they were assigned to work. Participants KRC-2 and KRC-9, benefitted from D.C. Medicaid and they demonstrated the least understanding and interpretation of ACA provisions. They also expressed the ease of obtaining Medicaid because there was less paperwork complete and they did not have to compare plans and/or shop for insurance. They expressed the fact that Medicaid covered everything for them and their families. Additionally, Medicaid afforded them the services of a Case Manager who was responsible for processing the health insurance needs and coverage while also assisting them with other life's challenges such as housing, job training and more.

Costs

Having to purchase insurance was identified by many of the participants as an area of concern because for the group that purchased insurance through the exchanges and open market established because of ACA, costs impacted their decision. For the group of participants that benefitted from Medicaid, they also identified costs as the reason for them not being able to afford insurance. The Medicaid recipients also identified the absence of resources as a key deterrent to their interaction with ACA. KRC-2 and KRC-9 stated that they could not access ACA websites because they did not have access to computers. Additionally, KRC-3 and KRC-5, work as social workers and their jobs gave them insight to highlight the lack of resources as key influencers on how low income Americans perceived ACA. They mentioned the absence of flexible transportation as limiting to the potential association of these low income families with ACA.

The costs of insurance plans through ACA were a concern for participants who purchased insurance through ACA exchanges. There was some difference between some participants' perceptions in that KRC-1 considered ACA insurance costs to be agreeable because of the incentives and discounts their family benefitted from which made the costs affordable. However, KRC-3 stated that the costs of insurance plans through ACA were expensive because they could not benefit from the discounts and added incentives to reduce costs given that they were a couple without children. Despite these factors, KRC-3 stated ACA was still a valuable law in the fight for social equity. ACA has spread the responsibility of healthcare coverage to all because of the mandate which means that the insured will no longer bear the burden of the uninsured due to insurers passing over costs.

Another key element in the ability of participants to understand and interpret ACA provisions for their personal health benefit was their education. The two participants on Medicaid had high school diplomas or their equivalency and they demonstrated interest in understanding and interpreting ACA provisions because as KRC-2 stated “I don’t have the time or the money nor do I want to know about Obamacare because D.C. Medicaid covers everything for me and my kids”. They viewed the process as to arduous and not worth the effort. The amount of paperwork required to gain insurance through ACA exchanges also presented a challenge for some participants because the Medicaid recipients listed the ease of applying for Medicaid as one positive facet that ACA insurance plans lacked. This created an added barrier for them pursuing full understanding and interpretation of ACA provisions and the desire they expressed in remaining under Medicaid. The Tricare beneficiaries also expressed the ease of using Tricare because they only had to choose a provider in their location and did not have to compare insurance plans. Also, some participants expressed the benefit of gating insurance through their employers because of the reduced costs most of these plans carried when compared to those plans in the ACA insurance exchanges.

Providers

One key theme that was presented was the concern that many participants expressed with not being able to retain their providers under insurance plans acquired through ACA. Some participants stated that they lost their medical providers because the insurance company they selected under ACA exchanges wanted them to utilize providers within their network. A positive facet that some participants expressed about ACA was that it now requires providers to work more closely with patients in developing treatment plans. An important theme highlighted was that ACA now mandates that insurers utilize no less than 80% of premiums towards patient care instead of growing profits. As a result of this mandate, if the insurer does not use80% of premiums to provide health coverage to the insured, the insurer must issue premium refunds at the end of the year to the insured.

Control

All participants with the exception of the Medicaid and Tricare beneficiaries expressed their increased control over their own healthcare decisions primarily due to ACA. The Medicaid recipients stated that the availability of a case manager handling their cases made it easier for them to meet up with their healthcare needs because the case managers oversaw all aspects of their healthcare needs. They did not have to pay anything out of pocket and just had to report to their doctors for medical care. However, the Medicaid and Tricare recipients did not identify having greater control over their own healthcare. Of all the participants, KRC-5 expressed that because of ACA, she is taking greater control over her healthcare decisions by playing an active role in the development of treatment plans. This participant further stated that this added control over her healthcare has extended into other aspects of her life which has boosted her confidence and made her medical provider extremely thrilled. This is a depiction of self-efficacy for this participant.

Many participants identified ACA as a very transformational law which is leveling the healthcare field by creating greater equity in care amongst all groups in America. ACA mandates that everyone have insurance coverage and sets controls over insurance companies’ processing of healthcare coverage claims. As a result of ACA, insurance companies can no longer deny anyone insurance coverage because of an existing medical condition or charge exorbitant rates. One important control theme that participants highlighted was the fact that ACA has now stopped families from going bankrupt as a result of a medical diagnosis. ACA has also eliminated coverage caps that insurers placed on coverage meaning that insurance companies must now cover the full costs of all medical treatments. Under ACA, children can remain under their parents’ policies up to age 26 which affords them the opportunity to complete their education before taking on insurance responsibilities.

Restrictions

In addition to the above stated themes, restrictions were also identified as overarching concepts pertaining to understanding and interpreting ACA provisions for personal health benefits. These restrictions were broad in scope as identified by study participants from restrictions on how insurance companies handled healthcare coverage to removal of restrictions set by insurance companies to deny coverage to some individuals. ACA was identified as a law that forces health insurance costs to now match the level of care received because in the past insurance companies could increase rates if healthcare coverage demanded extensive medical coverage. Also, the restrictions set by insurance companies on coverage provided to certain ethnic groups were now removed meaning everyone can now have access to the same quality of care. The elimination of the barrier to insurance coverage that insurers placed on pre-existing conditions or gender and ethnic groups was identified as a key benefit of ACA. The removal of these restrictions because of ACA has now increased the number of people with insurance coverage and increased the access to healthcare coverage for all. This latter facet has made preventative care a common practice in healthcare coverage which means increased doctors' visits and medical conditions are now diagnosed before they become medical emergencies.

One important theme that was highlighted during this study was the numerous barriers established by legislators to increased understanding and interpretation of ACA provisions. Congress members used the law to foster their political agenda and those who did not vote I favor of the law started a campaign of misinformation about the law as stated by KRC-4. This participant stated that legislators who benefitted from the law spread false information on the law to foster personal political agendas. These extensive campaigns to mislead on ACA enabled some State governments to restrict the full implementation of ACA and create barriers for their citizens thus restricting the full potential of ACA.

Summary

This IPA study's central highlight was to explore African Americans' understanding and interpretation of ACA provisions for their own healthcare benefit. The study was intended to contribute knowledge towards the development of solutions to combat the documented disparities in healthcare coverage across the various groups in

America. To attain that objective, the health literacy of participants had to be explored by affording them the opportunity to share their experiences with ACA provisions and how they use them for their personal health benefit. I utilized one research question and based on responses to that question; probing questions were developed to capture rich data. The interview responses were analyzed and coded into patterns and themes and subthemes were developed from these coded patterns. The following core themes: insurance; costs; providers; controls; and restrictions, were developed and these were further expounded to yield numerous subthemes. Evidence of participants' understanding and interpretation of ACA provisions for their personal health benefit was captured in the data collected.

Chapter 5 houses the interpretation of the findings, limitations of the study, recommendations for further research, implications for igniting appropriate level positive social change and conclusions capturing the key facets of the study.

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Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The history of vast disparities in healthcare in the United States is well documented, and several proposals such as universal healthcare, patient-driven care, institutional change, improving health literacy, and many more have been provided and some implemented. However, there significant disparities in healthcare delivery across the various ethnic groups in the United States still exist. African Americans have been highlighted in past research as a group at the disparate end of the healthcare disparities challenge, and the impact of these disparities has been identified as influencing the poor health diagnoses African Americans receive and for their cynical view of the healthcare coverage and health research systems.

To address these healthcare concerns, ACA was passed by Congress and signed into law by President Obama in 2010. The law's principal objective is to make quality healthcare accessible to all Americans regardless of ethnicity, socioeconomic status, or class. In doing so, the law combats the extensive healthcare disparities in the United States by facilitating greater equity in healthcare access, delivery, and coverage. This interpretative phenomenological analysis study was intended to explore African Americans' understanding and interpretation of ACA provisions for their own personal health benefit. In this chapter, I present the interpretation of the study findings, make recommendations for further studies, and highlight potential positive social change avenues based on the results. Based on an interpretation of the study findings, I relate them back towards the existing gap identified in current literature. I also present an overview of the entire study with limitations and assumptions in this chapter followed by a personal reflection on what I have learned from this study.

Study Overview

As noted earlier, I used this study to explore African Americans' understanding and interpretation of ACA provisions for their personal health benefit. I wanted to capture African Americans' lived experiences with ACA and how they described those experiences in their own words. ACA is the most comprehensive healthcare reform law in the history of the United States, and it is aimed at overcoming the vast and long history of disparities in the U.S. healthcare system. As stated earlier, African Americans have been identified through extensive research as being at the disparate end of healthcare disparities. Therefore, capturing their understanding and interpretation of ACA provisions, contributes knowledge towards the development of solutions to overcome disparities. Williams (2011) stated that the difficulties African Americans experienced in securing quality healthcare coverage has contributed to them being diagnosed with significant health complications such as hypertension, diabetes, high blood pressure, obesity, and AIDS, at much higher rates than other ethnic groups.

One area that ACA is also targeting in creating equity within the U.S. healthcare sphere is increasing the frequency of preventative healthcare, which a 2012 Center for Disease Control report had identified as being rarely used by African Americans. I identified a gap in existing research literature on African Americans' understanding of existing healthcare policies and connected that to the development of another approach in the development of solutions to combat healthcare disparities in Chapter 2. Additionally, Bleich, Jarlenski, Bell, and LaVeist (2012), detailed existing inequalities in the U.S. healthcare system which coupled with healthcare provider bias as highlighted by the National Center for Health Statics (2012) as significant contributors to existing quality care disparities. The impact of these challenges in quality healthcare coverage delivery on African Americans has been researched and documented (Kim et al., 2010). These healthcare disparity challenges, according to DeNavas-Walt, et al. (2012), have been the founding premise for ACA, and its impact is something I sought to contribute knowledge towards.

For this study, I employed the use of three theoretical frameworks: CCM formulated by Jesus Gomez, Roger's diffusion of innovations model, and Andersen's behavioral model of healthcare utilization. The foundation on which this study was premised is Freire's (1998) theory that recognizes people as capable of understanding their experiences and using critical consciousness to alter those experiences. CCM aligns with this theory, and because I wanted to explore African Americans' experiences with ACA, I employed the use of CCM as presented by J. Gomez et al. (2006). A communications approach proposed under CCM could serve as a foundation on which social knowledge is built in the fight against social inequities and unfair practices (A. Gomez et al., 2011). Using CCM as a theoretical foundation facilitates the interactions of researchers who contribute scientific knowledge, and participants, who share their lived experiences, which propel the optimal development of viable solutions.

I also employed the use of Roger's diffusion of innovations concept to explore the diffusion of ACA provisions within the African American ethnic group in the

Washington, D.C. community used for this study. This concept outlined the core tenets that promote the acceptance of new concepts such as their perceived benefit, ease of understanding, and ability to produce visible results and be testable (Rogers, 2003). Optimal communication has been identified as essential in consensus building with personal interactions fostering the reception of a new concept (Hedman & Valo, 2015). This study was aimed at uncovering the effectiveness in ACA dissemination within the study population to communication knowledge as noted earlier. As participants stated, the presentation of ACA by legislators created a barrier to unadulterated understanding of its provisions.

The third concept employed was Andersen's behavioral model of healthcare utilization (Andersen et al., 2011). This concept defines the core factors that impact how health services are utilized. Andersen et al. (2011) outlined three distinguishing elements: predisposition, enabling, and need factors, which influence access to and use of health services. Access to quality healthcare services is a core tenet of ACA, and provisions within ACA were tailored to overcome inequities and disparate treatment of certain groups in the healthcare system. Thus, exploring how African Americans understand and interpret ACA provisions gives insight into their utilization of healthcare services under ACA.

The question employed for this study was as follows: How do African Americans describe their understanding and interpretation of ACA provisions and how to utilize these provisions to gain better healthcare coverage? Subsequent probing questions were developed based on responses given to that question. The research question was tailored with an IPA methodology as a guide to facilitate the capturing of rich data through the exploration of African Americans' understanding and interpretation of ACA provisions. The rationale that informed the selection of IPA methodology was the newness of ACA, and the discussions and challenges with ACA can be optimally captured through an exploration of lived experiences. I used flyers to solicit volunteers from the population pool at a specific site in greater Washington, D.C.

Responses given by participants to the research question and any subsequent probing questions reflected their understanding and interpretation of ACA provisions and how they used the provisions for their personal health benefit. The participants' experiences informed their understanding and interpretation of ACA provisions and how they used them for their personal health benefit. All participants in the study possessed some knowledge of ACA, but their health insurance plan, educational, and financial status influenced the extent of their understanding and interpretation of ACA provisions. Participants who did not have to shop for their health insurance through the exchanges established under ACA expressed limited to no personal experiences with understanding and interpreting ACA provisions. This included participants who benefitted from social welfare programs such as Medicaid and participants who received health coverage through their employer such as Tricare. The participants who demonstrated in-depth understanding and interpretation of ACA provisions were those who had to enter the insurance market and compare insurance plans before selecting the best match for them.

Research has shown that African Americans have been a socioeconomically distressed class throughout U.S. history, and this has been the same within the healthcare arena. These experiences have shaped how African Americans view and interact within the healthcare field as documented in Chapter 1. The cynical and suspicious view held by most African Americans has been documented in existing research as being driven by their prior experiences. Some participants expressed their pleasure in ACA being a great equalizer in making the healthcare field more accessible and affordable to all. Participants also expressed the need for fair presentation of ACA to the general public so it can be accepted or be rejected on its own merit. The interest levels demonstrated by participants in seeking understanding and interpretation of ACA provisions were linked to their education and socioeconomic status. As such, using easily relatable information delivery mechanisms was deemed by most participants as the way to enhance their understanding and interpretation of ACA provisions.

Interpretation of the Findings

This study was intended to explore how African Americans understand and interpret ACA provisions for their own personal health benefit. In the previous chapter, I recorded the shared experiences of the study participants and analyzed and described the emergent themes from the data collected. These themes were extracted from the participants' lived experiences as they described them using their own words.

Insurance

The ability to purchase health insurance was identified from the data analysis as a core theme impacting African Americans' utilization of the healthcare system. This ability also influenced their level of understanding and interpretation of ACA provisions for their own health benefit. Participants who benefitted from Medicaid and Tricare did not have to learn about ACA and its provisions. These participants expressed the ease with securing healthcare coverage through their programs because Medicaid and Tricare did not require beneficiaries to compare healthcare plans. Once they are accepted into the health coverage programs, participants stated they only had to choose a provider for Tricare beneficiaries and follow the guidance of their case manager for Medicaid beneficiaries.

The participants who shopped for their health insurance shared different experiences than their Tricare and Medicaid counterparts with ACA provisions. These participants explored available insurance plans and made their insurance choices based on costs and overall benefit for them and their families. Participants purchasing their own insurance also expressed greater input in their healthcare choices and decisions. However, what all participants expressed was the high level of access they experienced due to their ownership of health insurance. Participants who benefitted from Medicaid, Tricare, or other insurance coverage stated that all their healthcare needs were being fulfilled. One participant actually stated that they were getting more bang for their money spent purchasing insurance because of ACA.

Costs

Participants who had to enter the ACA exchanges or health insurance market stated that costs informed on their decision in selecting the type of insurance to purchase. Some participants shared that they experienced higher costs while others stated that they benefitted from the various incentives and discounts to reduce their overall costs. These cost saving measures increased their understanding of ACA provisions because they researched more insurance plans. In so doing, they learned more about ACA provisions and garnered a better understanding of the law and could then interpret it for better healthcare coverage options. Even the participants who stated the high costs of insurance plans under ACA expressed their appreciation for its provisions in combatting overall costs through making insurance companies better manage premiums. Other cost saving measures highlighted by participants were the provisions in ACA that prevent families from ever going bankrupt due to health crises and the bar on skyrocketing costs when families receive significant medical diagnoses.

Even for participants who did not have to purchase their own health insurance because of financial constraints and benefitted from Medicaid, they expressed satisfaction in knowing that ACA expanded Medicaid coverage, thus providing greater security for families. Additionally, under ACA participants on Medicaid expressed they enjoyed more benefits such job placement services in conjunction with other benefits they already received such as housing and transportation assistance. One of the participants stated that "Obamacare is giving many more black families better quality of life." This was one of the main talking points many ACA proponents expressed when the bill was passed in 2009 and also when it was signed into law by president Obama in 2010.

Providers

Healthcare providers have always had the power in making healthcare decisions for patients, and this impacted treatment outcomes, especially within African American families given their lack of confidence in the healthcare system (Fontugne, 2014). What ACA aims to do is make healthcare decisions a collaborative effort between providers and patients. ACA also advocates for social workers to engage communities to increase the health literacy for everyone especially the poor to enable them make better health choices (Frauenholtz, 2014). What this does is opens up communities that would be otherwise closed off to health and provides a forum through which health concerns within communities can be addressed (Elders, 2012). This collaborative effort in health decisions have been verified as more effective through research in patient adherence to treatment plans (Fontugne, 2014). This is because patients have a stake in ensuring that the treatment plans they help develop actually work. This empowers patients to seek a better understanding of the healthcare system by openly discussing treatment options with providers. Some of the participants in this study credited having to understand and interpret ACA provisions for giving them the opportunity to take control of their healthcare decisions.

Control

One participant stated that her healthcare provider was extremely pleased with her increased interest in taking control of her health decisions. She further stated that by gaining control over her healthcare decisions, she is also taking control of other aspects of her life, which has boosted her confidence and outlook in life. Health literacy affords people the ability to gain greater control over their health decisions, and having a greater understanding and the ability to properly interpret ACA provisions is a very powerful tool. ACA provisions are also aimed at reining in increasing healthcare costs for patients by eliminating caps on coverage set by insurance companies. Additionally, ACA provisions afford young adults 26 years old and younger to remain on their parents’ policy, thus saving young adults insurance expenditures (Cantor et al., 2012). Participants in this study also expressed their satisfaction with ACA provisions mandating insurance companies to use no less than 80% of premiums for patient health coverage. This now ensures that insurance companies focus on effective handling of patient premiums instead of building up their profits.

Most participants expressed dissatisfaction with the lack of control over the dissemination message when ACA was enacted. They stated that legislator who did not vote for the bill wanted to discredit it and those who voted for it were afraid to stand for it all for political gain. One participant stated that their initial perception of ACA was impacted by the “bad press” it received and it’s only after they understood the law that they realized legislators were using it as a political toy. The experiences shared by this participant led me to view another important factor in African Americans’ understanding and interpretation of ACA provisions: interest and education.

The role of education in fostering socioeconomic progress can never be understated (Kirgiz, 2015). In this study, all participants with at least a college degree described a better understanding of ACA provisions or an interest to research them further. The participants with only high school diplomas demonstrated minimal understanding and less interest in garnering greater understanding of ACA provisions. This was evident in their expressed lack of desire to understand and interpret ACA provisions for better healthcare outcomes. According to Lyles and Sarkar (2015), education has been identified as predictor of health literacy with the two sharing a linear relationship. This means the more educated a person is, the higher their level of health literacy and the more empowered they will be in taking control of their healthcare decisions (Cunha et al., 2015). The confidence that participants with more education exuded was evident in their interactions with me and their responses to questions presented during the interviews. The data collected by this study confirmed that education does have influence over health literacy and the confidence needed in having greater input in their health decision.

The theme of control entails varying subthemes such as education, income, and accessibility which either hindered some participants exposure and/or interest in understanding and interpreting ACA provisions for their own health benefits. Some participants cited lack of computer access as a justification for not wanting to understand ACA provisions. Other participants expressed the possibility of comparing health insurance plans as a deterrent because they did not have time for such requirements instead preferring the easier path of Medicaid and Tricare. Individuals who engaged in actively participating in ACA health insurance acquisition expressed a level of increased confidence in their healthcare choices and decisions. These views were confirmed in the study. Increased self-efficacy was another benefit that gaining greater control over health decisions facilitated for participants. Additionally, the increase in preventative healthcare coverage which is a core element of ACA, gives beneficiaries greater control over their healthcare decisions. This prevents health conditions from becoming health emergencies by allowing them to be caught earlier. Several participants confirmed this assertion and expressed great satisfaction with the control this ACA provision afforded them over their health.

Restrictions

As stated earlier, ACA provisions removed several restrictions such as costs, caps, and preexisting conditions that placed barriers on people receiving quality healthcare coverage. Several participants identified this removal of restrictions as a one of their favorite benefit from ACA. Two participants stated that because of ACA provisions their children with preexisting health conditions now get quality healthcare coverage without them being afraid of suffering financial hardships or enduring exorbitant healthcare costs. Other participants identified the benefit of expanded coverage through ACA in getting them complete healthcare and the removal of caps set by insurance companies as enhancing their social and family dynamics.

One requirement that several participants identified as benefitting their healthcare coverage was the requirement in ACA provisions that mandates insurance companies to spend no less than 80% of premiums on healthcare coverage. This sets restrictions on insurance company profits from beneficiary payments. In Chapter 1 I discussed how insurance companies could deny coverage to people based on ethnicity but that discriminatory practice was now eliminated by ACA provisions. These provisions have eliminated the discriminatory practice by insurance companies of denying certain ethnic groups insurance or hiking up insurance rates for certain ethnic groups because or preconceived biases about these groups. An example would be charging African Americans higher insurance premiums because of the false preconceived notion that they suffer from high blood pressure and diabetes.

In interpreting study results, one thing stood out: the influence of ACA on participants' understanding of provisions. ACA expanded MEDICAID but the MEDICAID participants and Tricare beneficiaries demonstrated limited to no interest in understanding ACA provisions. This could be considered an unintended impact of ACA because individuals benefiting from prepackaged insurance coverages such as MEDICAID and Tricare had no incentives to understand ACA provisions because their coverages required minimal effort on their part.

Limitations of the Study

The small sample size could be viewed as a limitation for the study but J. Smith (1996) stated that a small sample size allows for greater depth of data collected for analysis. Engaging in deeper interpretative analysis through IPA could potentially draw the researcher away from intended meaning however S. Smith et al. (2009) embolden researchers to go beyond obvious meanings. IPA's core aim is in centering findings from participant accounts by explaining, informing and mastering themes (Shinebourne, 2011). The selection of the recruitment site for the study in greater Washington, D.C. could be viewed as a limitation because a less restricted recruitment area would have a made a larger potential sample accessible. However, Washington, D.C. was purposefully selected to eliminate the impact of state legislation on study participants' understanding of ACA provisions. This therefore means that this study in its current scope cannot be generalized. As noted earlier, IPA methodology recommends smaller sample sizes for capturing rich data (J. Smith et al., 2009).

The selection of African Americans as the specific sample group for this study could be viewed as a limitation of the study. Capturing rich data and practicing transparency while connecting this study to existing literature could facilitate transferability (J. Smith et al, 2009). The freedom and creativity afforded researchers by IPA is especially beneficial in healthcare research and where participants' views may not be as expected (Biggerstaff & Thompson, 2008). The time demand warranted in IPA studies could also be viewed as a limitation however the potential to capture deep and rich data is considered a benefit. Another potential limitation of the study could be the willingness of college graduates to take part in the study versus those without college degrees. This is because education levels influence health literacy as stated by Cunha et al. (2015).

Recommendations

Bauer et al (2014) stated that the lack of health literacy is a significant concern in the U.S. and not just for African Americans and other disparate populations within the healthcare disparity realm. Recommendations from this study would be to research the impact of providers dedicating time to improve patient's health literacy in an effort to get them actively involved in their own health decisions. The findings from this study highlighted the different levels of health literacy of participants and education level had input on this but deliberate actions by providers could mitigate that educational barrier. This would be applicable for all healthcare services recipients from Medicaid to Tricare and private insurance owners.

Based on the findings from this study, Medicaid and Tricare beneficiaries demonstrated limited interest in understanding and interpreting ACA provisions for their health benefits. One recommendation would be to investigate what other factors contributed to Medicaid and Tricare recipients not needing to better understand and interpret ACA provisions for their health benefit. A reduction in the complexity of the steps to take part in ACA was identified by some participants as a hindrance. So one recommendation could be to investigate what measures could simplify ACA enrollment procedures.

As stated earlier, there were different degrees of understanding and interpretation of ACA provisions demonstrated by participants in this study. This then leads to a recommendation for future studies targeting active users of ACA to explore their understanding and interpretation of the provisions. In this same light, a future study could investigate if the unintended impact of ACA on study participants stated above is attributable to MEDICAID, Tricare, and other prepackaged insurance coverage beneficiaries.

This study was limited to African Americans who visit the selected site in greater Washington, D.C. Expanding the scope of the study could enable future studies to better explore the understanding and interpretation of African Americans. Future studies could also be expanded to other ethnic groups to better capture how Americans understand and interpret ACA provisions for their own health benefit. In line with this all inclusive study, a comparative analysis study could also be conducted on how different ethnic groups receive information and how said information is filtered into the different groups.

Findings from this study showed that active engagement in the ACA health insurance exchanges improved participants' understanding and interpretation of ACA provisions. Recommendations would be for future studies to take this a step further and comparatively investigate how families understand and the interpret ACA provisions versus single adults and couples without children. Another future study could be investigating the correlation between improved health literacy and overall self-efficacy.

Reduce complexity of ACA because this was cited as a major deterrent by most participants. Given the requirements to understand ACA provisions to enhance quality of healthcare, education played impacted my study results. As noted in Chapter 4, some potential participants lost interest in the study after I informed them they will not be receiving any monetary benefit. The interactions I had with and observations I made of these participants informed me that they may not have education at or beyond the high school level. This could account for the majority of participants for this study being college educated.

Based on the outcomes of this study, recommendations could inform on additional research in different areas. Future studies could setup added measures to improve on the potential to capture data from participants with varying educational backgrounds. Educational level contributes to socioeconomic status which in turn affects spending power. Results of this study also highlighted costs as an avenue of relevance to participants, future studies could investigate the impact of costs on the ability of health insurance beneficiaries to understand and interpret ACA provisions.

The inability to retain healthcare providers was presented as influencing participants' desire to take part in retaining healthcare coverage through the ACA health insurance market. A future study could investigate the impact providers have on people's healthcare decisions. Some groups such as military personnel and their families readily change providers while some Americans perceive this as an inhibitor to them engaging in securing healthcare coverage through ACA.

This study did not explore how healthcare providers understand and interpret ACA provisions in healthcare service delivery. A recommendation would be for future studies to explore how providers understand and interpret ACA provisions and how this understanding and interpretation impacts their healthcare delivery.

Implications for Positive Social Change

McNeil et al (2014) stated that change is needed in the healthcare system of the U.S. and ACA is a first step towards overcoming the deeply rooted disparities in the healthcare system. Exploring the understanding and interpretation of ACA provisions would give insight into the effectiveness of the law in combatting healthcare disparities in the U.S. This exploration would also contribute knowledge towards the development of strategies to improve health outcomes through improves health literacy and practice implications. As the findings of this study demonstrated, understanding and interpreting ACA provisions for personal health benefits empowered some participants to play active roles in their health decisions. This fact has been shown to improve self-efficacy which lends to adherence to health treatment plans because patients have a vest interest in ensuring the success of established treatment strategies (McNeil et al, 2014).

Additionally, ACA provisions encourage community engagement in improving health outcomes for the community. This means that health decisions are not restricted to providers and patients but extended to those important to patients so that a support system is in place to encourage conformity to healthcare strategies. The sea change intended by ACA is to enhance equity in the U.S. healthcare system. This is a potentially transformational law if it is supported and improved by legislators and it could finally get the U.S. out of its entrenched healthcare disparity across racial groups (Black, 2013).

Conclusion

I employed open ended questions in the semi-structured interviews utilized in this interpretative phenomenological analysis study to explore African Americans' understanding and interpretation for ACA provisions for their own health benefit. African Americans aged 27 to 64 years old who resided in greater Washington, D.C. and visited the selected recruitment site served as the population from which the study sample was pulled. I employed one research question in keeping with IPA recommendations and developed probing questions based on responses to the interview question to elicit participants sharing in-depth experiences. In the course of the interview, I probed for them to share details about their experiences with ACA by expressing their understanding and interpretation of ACA provisions. The intention of this approach was to uncover how their understanding and interpretation of ACA provisions impacted their utilization of the provisions for their own health benefit.

The conclusions drawn from the study are that ACA increased access to quality healthcare coverage for African American participants. However, findings from the study also led to the conclusion that the extent of participants' understanding and interpretation of ACA provisions was impacted by several other factors. These factors included type of healthcare participants benefitted from, education levels of participants, financial status of participants and their personal interests in taking greater control over their healthcare decisions. As outlined earlier three central theoretical frameworks guided this study. From the collected data it showed that increased interactions with ACA provisions improved participants' understanding and interpretation of them for their own health benefit. This exposure also gave participants greater control over their healthcare decisions and encouraged them to actively engage in their health treatment choices thus improving their self-efficacy. Based on these findings the expectation is to uncover what factors influence patient's interest in taking active roles in their health decisions. Also investigating the correlation between increased health literacy and improved overall self-efficacy would be valuable.

Given the limited literature on African Americans' understanding and interpretation of ACA provisions this study could be connected to any existing studies. However, there are numerous studies on health literacy which were referenced to provide a lens through which this study was informed. The data supports the conclusion of study participants' understanding and interpretation of ACA provisions being influenced by socioeconomic class which impacted their education and health literacy levels and the type of healthcare coverage they utilized.

Community involvement in healthcare activities could provide the support that many within the African American community could rely on for optimal healthcare outcomes. This aligns with Andersen’s behavioral model of health utilization that was discussed in Chapter 2. ACA provisions seek to encourage this community practice from families to social workers and providers within communities collaborating in improving health outcomes for patients. Through participants’ shared experiences, the desire for greater involvement by legislators and citizens to improve ACA provisions was evident. Thus healthcare decisions should not be used for personal political gain but instead to benefit the American public especially the disparate populations that have suffered extensive healthcare disparities.

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Appendix A: Letter to Center Administrator

Community Partner Administrator Date: February 18, 2016
Address

Dear sir/ma'am,

My name is xxx and I am a doctoral candidate at Walden University. I am conducting dissertation research on how African Americans understand and interpret the provisions of the Affordable Care Act (ACA) and how to take advantage of these provisions to gain quality healthcare. There are numerous studies outlining the vast disparities in healthcare suffered by African Americans and the impact on their general health. However, there is limited to no research on how African Americans understand and interpret the provisions of ACA and how to take advantage of these provisions to secure quality healthcare coverage. This research is intended to provide insight into how African Americans understand and interpret the provisions of ACA and how to take advantage of them to secure quality healthcare coverage.

Your assistance in conducting this much needed research is extremely warranted. If you agree to participate in this study, I would like for you to provide me with authorization to recruit African Americans between the ages of 27 to 64 within the D.C. metropolitan region who visit your center. Identification of African Americans that meet the latter criteria will provide a sample pool from which suitable candidates for the study will be selected. Once identified, I would like to meet with them to discuss the nature of this study. The participants are free to choose whether or not to participate and can discontinue participation at any time. Information provided by the participants will be kept strictly confidential.

I would welcome a telephone call from you to discuss any questions you may have concerning this study and your role in identifying research participants. I can be reached at Phone # or emailed at Email Address xxxx@waldenu.edu.

Sincerely,

Researcher Name
Doctoral Candidate
Walden University

Recruitment Flyer

*****VOLUNTEERS NEEDED****
AFRICAN AMERICAN PARTICIPANTS AGED 27 TO 64 YEARS OLD NEEDED FOR INTERVIEW ON THE AFFORDABLE CARE ACT

I am looking for volunteers to take part in a research study on
“Knowledge of the Affordable Care Act (aka - OBAMA CARE)”

As a participant in this study, you would be asked in an interview to describe your knowledge of the Affordable Care Act and its provisions and how you take advantage of the provisions for your personal health benefit.

Your participation is voluntary and would involve 1 interview session, which will last approximately 30 to 45 minutes.

This study is aimed at contributing knowledge that would help create solutions to overcome the racial disparities in healthcare.

For more information about this study and to volunteer to take part in the study I’ll be present in the entrance hall next to the welcome desk from the date……. to ……. (Inserted when used) during the time window of 1pm to 6pm and you can also use my contact info below to reach me:

Name of Researcher
Department of Social & Behavioral Science (Human Services)
Walden University
@
Phone
Email: **()**

The study has been reviewed and approved by the
Institutional Review Board for ethics, Walden University.

****VOLUNTEERS NEEDED****

Appendix B: Interview Protocol

Complete study overview and address all concerns participants may have pertaining to study. Clearly stipulate my interests for undertaking study and provide details. Go over study length which should be no more than 45 minutes and the use of digital recorder to capture participants' described experiences. Clearly define sample size range and establishment of rapport with participants. Use digital recorder for interviews and take notes sparingly during interview.

Date: ____________________________

Location: _________________________

Name of Interviewer:

____

Name of Interviewee:

____

Primary Interview

RQ1: How do African Americans describe their understanding and interpretation of ACA provisions and how to utilize these provisions to gain better healthcare coverage?

Interview Protocol

Date: ____________________________

Location: _________________________

Name of Interviewer:

____

Name of Interviewee:

____

Telephonic Follow-up (if needed)

A telephonic follow up would be done only if clarification is needed on responses given to primary interview question and probes.