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# Effects High-Cost Health Insurance and the Uninsured Middle-Class Families of Essex County, New Jersey

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Walden University
2022

Abstract

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Dissertation Submitted in Partial Fulfillment
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# Abstract

Thousands of middle-class families living in Essex County, New Jersey, cannot afford health insurance, but little is known about their experiences regarding this lack. The purpose of this research study was to explore the lived experiences of uninsured middle-class families who could not afford state or any other type of health insurance in Essex County, New Jersey. The theoretical framework for this study was based on Smith's rational choice theory. The research question explored the lived experiences of uninsured middle-class families. Purposeful sampling was used in this phenomenological study to select 10 participants from families residing in Essex County with either a single-parent, two-parent, grandparent(s), or other nonparent(s) who had custody of and were responsible for a child or children. Participants must have resided in Essex County and (a) had a combined income between $50,000 and $80,000 from 2020 to 2022, (b) did not currently and had not had health insurance for at least 1 year prior to recruitment into the study, (c) read and fluently spoke English, and (d) were between 26 and 64 years old. Individual interviews were conducted with Zoom using a researcher-developed instrument. Coding was done using thematic analysis to identify data patterns. The participants repeatedly shared that the premium of health insurance was too high. The potential implications of positive social change from this study include promoting affordable health programs that can provide low-cost to medical care, which could lower death rates, create better health outcomes, and improve the lives of middle-class families in Essex County, New Jersey, to enhance their peace of mind.

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# Dedication

This is dedicated to my son, Jamar. You are my ROCK. You have been with me every step of my educational journey, and I promise to be there for you. I hope my love for learning will motivate you to be a lifelong learner and be the best version of yourself. Grow through education and be the best young man you can be.

# Acknowledgements

I would like to extend my sincere gratitude to Dr. Hilda Shepeard, my committee chair, for her guidance and encouragement throughout this dissertation. You have empowered me to discover my research potential and supported me to the very end.

I am pleased to thank my husband for his support and patience throughout this process. I want to acknowledge my mother for instilling the value of education in me from a tender age. Dad, I know you are looking down and proud of me in heaven. I also want to thank my sister and friend Judith for their encouragement every step of the way.

Finally, thank you to all those who believe in me and positively influence my life.

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# Chapter 1: Introduction to the Study

The United States does not have comprehensive health insurance (Berchick et al., 2019). Under the existing health care system, millions of working but uninsured Americans live in fear of sickness or injury that could leave them bankrupt (Hacker, 2012). The Patient Protection and Affordable Care Act (PPACA; 2010), which became effective in 2014, has reduced the number of uninsured Americans, but the federal government’s failure to reform the health care system has prevented many Americans from obtaining the benefits of those advances were intended bring (Warner et al., 2020). Health care expenditures are funded through numerous sources, contributing to wide inequalities in the reception of health coverage and affordable health care (Probst et al., 2019). According to the U.S. Census Bureau (2019a), approximately 30 million people are uninsured, and most are working-age Americans.

This research explored the experiences of uninsured middle-class families using qualitative methodology and rational choice theory (RCT) as a framework. The PPACA, was created to ensure that all Americans have access to quality and affordable health care (PPACA, 2010). Some in the middle class are considered uninsured and underinsured due to high costs (Hacker, 2012). The information collected from the participants in this study may help to improve policies and programs that make health insurance more affordable.

Social change requires social actors to identify a problem that affects a community and find solutions to address it. This research study provided a better understanding of why uninsured middle-class families are without health insurance to help policymakers develop strategies and programs to support their changing needs.

Effective policies and programs could help the uninsured middle class afford health coverage.

In this chapter, I provide a background to the study, the problem statement, and the purpose of the study. Next, I state the research question, discuss the theoretical framework, and review the nature of the study. Finally, I provide definitions, assumptions, scope and delimitations, limitations, and significance.

## Background

The uninsured are those who lack health insurance coverage from private, government, or any other health insurance program (Sommers, 2020). A growing number of uninsured Americans are middle class, and it is not known how they experience this lack of coverage or what they think could be done to make it more affordable. According to Dickman et al. (2017), the uninsured middle class fear high costs and deductibles. Emanuel et al. (2017) claimed that premiums and deducible expenditures for the middle class are approximately 12% of their median income, which may prevent middle-class American families from accessing the U.S. health care system.

The majority of experts have examined Medicare and Medicaid coverage by looking at programs, costs, and reimbursement methods, and monitoring the quality of services (Adrian et al., 2019; Zimmermann et al., 2016). The aim of this study was to fill a gap in the research by specifically focusing on the experiences of uninsured middle-class Americans in Essex County, New Jersey. This study contributed to the research literature by providing policy makers with information regarding how middle-class families experience the lack of health insurance and their reason for not obtaining it. The findings may help policy makers develop strategies and programs that make health coverage more affordable for more families.

## Problem Statement

Most Americans consider health insurance a fundamental human right (Triono & Sujadmiko, 2021), yet millions are deprived of coverage, and their number continues to grow. Bundort et al. (2021) found that with the unemployment rate at 14.7% in April of 2020, employer coverage rates declined by 0.2% each week during the COVID-19 pandemic. A recent survey by Wammes et al. (2018) found that more than 30% of Americans develop chronic conditions due to the high cost of health care and lack of health care coverage.

Many working middle-class families in Essex County, New Jersey, cannot afford health insurance. This situation is evident in the working middle-income families living in the county earning $50,000 to $80,000, who spend an average of $8,859 each year on out-of-pocket medical expenses, with an average of $456 for individuals per month and $1,152 per family (Data USA, 2021). Even with the benefits of the PPACA (2010), premiums are rising in New Jersey as medical expenses are increasing, and New Jersey failed to enact care reforms (Chacko, 2020) that could have made more individuals eligible for subsidized rates. The problem impacts uninsured middle-class families in Essex County as 16.0% (+/- 1.8) of its 285,154 population are middle class and without health care coverage (U.S. Census Bureau, 2019c).

As previously stated, the research literature for this study primarily addressed problems due to the lack of affordable health care by focusing on the Medicare and

Medicaid programs, cost, reimbursement methods, and monitoring the quality of services (see Adrian et al., 2019; Zimmermann et al., 2016). None of the studies included input from middle-income uninsured families regarding how lacking insurance affected their day-to-day lives. This study helps fill this research gap by contributing new information to help decision makers develop policies and programs that ensure more affordable health care coverage for uninsured middle-class families.

## Purpose of the Study

The purpose of this qualitative study was to explore and better understand the lived experiences of uninsured middle-class families in Essex County, New Jersey, who could not afford state or any other type of health insurance. The goal was to identify the choices and consequences of not having insurance because premiums are not affordable. This study involved either a single parent, two-parent, grandparent(s), or other nonparent(s) who have custody of and are responsible for a child or children with combined household earnings between $50,000 and $80,000 per year.

## Research Question

The following research question guided this study: What are the lived experiences of uninsured middle-class families who cannot afford state or any other type of health insurance in Essex County, New Jersey?

## Theoretical Foundation

The theoretical framework for this study was the RCT, which is a means for understanding and modeling social and economic behavior. The basic premise of RCT is that social behavior can be explained by the way individuals make choices (Rutar, 2019).

RTC is based on the concept that individuals seek to find the most effective method of attaining their goals (Rutar, 2019). The theory also focuses on the determinants of individual choices that will provide them with the greatest benefit (Frank, 2019). RCT asserts that people weigh their options based on alternatives they think serve them best. For example, if Option A is preferred over Option B, and if Option B is preferred over Option C, a collective preference may cycle through one of the sets of possibilities (Rajesh & Deshpande, 2020). Therefore, the assumption is that individuals can maximize their choice of preference to reflect costs and benefits.

Rajesh and Deshpande (2020) argued that a rational agent considers available information, probability of events, potential causes, and benefits; determines preferences; and acts consistently to choose the best choice of action. Rationality is broadly used to predict individuals' behavior in many disciplines, such as the sociological model and human decision-making analysis (Rutar, 2019). Thus, a particular version of rationality is termed *instrumental rationality*, which involves seeking the most effective means to achieve a specific goal (Rajesh & Deshpande, 2020; Rutar, 2019). In RCT, individual behavior is rational when it is goal-oriented, reflective, evaluative, and consistent across time and different choice situations (Rajesh & Deshpande, 2020; Rutar, 2019).

However, RCT does not describe the choice proposed but rather predicts the outcome and pattern of choices (Rajesh & Deshpande, 2020). RCT's premise is that aggregate behavior in society reflects the sum of individuals' choices and the outcome from each possible action (Heckathorn, 2005). As a theoretical framework, RCT is valuable to the study as it was used as a lens to identify patterns in the research, organize data, and find a solution to the research problem (see Jin et al., 2019). With RCT, the findings of this study could provide helpful information and a deeper understanding of the uninsured middle-class population.

## Nature of the Study

The design of this study was phenomenological. The phenomenological approach was the most suitable for this study to address the research question as it facilitated an in-depth understanding of individual uninsured middle-income families and their day-to-day lived experiences due to their choice to go without insurance. This approach highlighted reciprocal interactions in human action processes and allowed analysis of the experiences of individuals' who strive toward meaningful involvement in a knowable world (see Hsia, 2019; Huang et al., 2019). The phenomenological design helped provide structure to the study as well as promoted an understanding of the impact of the lack of health care services on the middle-class population (see Tiu et al., 2018).

The phenomenological design helped me detail participants' experiences of a specific concept, event, or phenomenon (see Tiu et al., 2018). For this study, "family" was defined as one or more adult(s) having custody of and responsibility for one or more children (see St. Vil et al., 2019). Therefore, for this research, a middle-class family was considered a single parent, two-parent, grandparent(s), or other nonparent(s) who had custody of and were responsible for a child or children, with combined household earnings between $50,000 and $80,000 per year. An annual income of $50,000 to $80,000 is defined as middle-class (Data USA, 2021).

Participants were selected using purposive sampling. The technique provided me with the ability to achieved in-depth and detailed information from the participants (see Campbell et al., 2020). The population from which the sample was selected was middle-class families residing in Essex County, New Jersey. I recruited 10 families, who fell under the previous definition, from Essex County who met the following criteria: (a) had a combined income between $50,000 and $80,000 from 2020 to 2022, (b) did not currently and did not have health insurance at least 1 year prior to recruitment for the study, (c) read and fluently spoke English, and (d) were between the ages of 26 and 64. Exclusion criteria were the following: (a) anyone with Medicare, Medicaid, and any other type of health coverage; (b) anyone who does not speak and understand the English language; and (c) participants who did not live in Essex County.

I recruited participants by placing a notice on the county Facebook page, county public library notice board, and urgent care centers. Eligible participants were screened by phone using a guide and scheduled for an interview via Zoom. The virtual platform approached was due to the COVID-19 pandemic. The interviews were audio recorded. After providing consent to participate in the study, data were collected using a researcher-developed instrument. Each interview took approximately 30 to 45 minutes. Data were coded using thematic analysis; themes were developed and analyzed using NVivo 12 Pro research software.

## Definitions

*Affordable health coverage:* Universal coverage plans available for Americans to purchase or provided free of cost despite employment status (Bhatt & Schelhase, 2019; Goldstein, 2019).

*Family:* One or more adult(s) having custody of and responsibility for one or more children, and consisting of either a single-parent, two-parent, grandparent(s), or other nonparent(s) who have custody of and are responsible for a child or children (St. Vil et al., 2019).

*Health insurance:* A health care coverage plan purchased privately or provided by an employer, the state, or the government (Berchick et al., 2019).

*Middle class*: For the purposes of this study, middle class referred to families with a combined household income of $50,000 to $80,000 (Data USA, 2021).

*Uninsured:* The U. S. Census Bureau (2019a) defined the uninsured as individuals who are without any form of health insurance.

## Assumptions

There were several assumptions in this study. The first was that the participants would answer the interview questions honestly. The second assumption was that all participants would answer the screening questions honestly and, therefore, meet the criteria to be eligible for inclusion in the study. In addition, it was essential to assume that the participants in the study were as descriptive and candid in their responses to the interview questions as possible.

## Scope and Delimitations

The scope and delimitations of inquiry set the research boundaries (Seidman, 2019). These excluded Americans and participants who had health insurance. Setting boundaries helps the researcher procure accurate data to address the research question. For this study, I excluded literature that was not related to the uninsured middle-class. I chose to study the uninsured middle-class population because existing research has only addressed the affordability problem by focusing on the Medicare and Medicaid programs, cost, reimbursement methods, and the monitoring of quality of services (see Adrian et al., 2019; Zimmermann et al., 2016). There is a lack of research on middle-income families' perspectives. In this study, I considered transferability and thoroughly described the research content and the critical assumptions (see Daniel, 2019). Therefore, the in-depth descriptions from the study provided patterns that other researchers can generalize or transfer to a different context to contribute to the broader body of research literature.

## Limitations

Part of addressing the trustworthiness of data collection was to realize the boundaries of the study (see Glesne, 2016). The study reached saturation through sampling, collecting, and analyzing data. The sample size of 10 was sufficient for in-depth qualitative studies. However, the low number of uninsured participants from Essex County was a limitation to the study. I should have recruited participants from the neighboring county, which would have provided more interviews, resulting in more information; thus, generalization impacted the study. Getting participants to contact me to be interviewed was another limitation. The COVID-19 ongoing pandemic might have had an impact on the study, as fewer people were going into public places where the recruitment flyers were posted.

Trustworthiness is an essential component in qualitative research that enables confidence in its design, data collection process, and interpretation (Glesne, 2016). A study's ability to produce credible findings is an essential criterion of trustworthiness (Glesne, 2016). Personal bias can affect research trustworthiness (Seidman, 2019); therefore, I took steps to ensure that these did not lead to any conflict of interest during the study. Strategies I used to mitigate the effects of personal bias were (a) clarification and awareness of any bias, (b) prolonged engagement with the participants, (c) persistent observation of the participants' emotions, (d) triangulation, (e) debriefing with experts, (f) a review of the data and its interpretations by experts, and (g) thick descriptions of the data (see Glesne, 2016). I consulted with an authority in the field to assist and confirm theme and pattern development in data analysis. Therefore, there was no prejudice of interest in the study outcome – as my personal bias did not lead to any conflicting interest during the study.

Providing thick, rich descriptions of the interviews allows readers to understand the researcher' claims as a result of the data provided by the participants (Ravitch & Carl, 2021). In addition, trustworthiness strategies, such as honesty, assist in setting standards and increase the likelihood that a study will be more than anecdotal (Glesne, 2016). According to Seidman (2019), for study outcomes to be trusted, they must describe, confirm, expand, question, and inform. Trustworthiness involves the quality and rigor of the study and the criteria used to assess how well the research was carried out (Seidman, 2019). I did not have any affiliations with any trade union, organization, or workplace related to the research topic. As a result, I remained objective in reporting the results.

During data collection, it is essential to understand the research question, listen well, and provide additional insight when possible (Ravitch & Carl, 2021). Recording and transcribing the participant's interviews are essential for accurate data collection (Ravitch & Carl, 2021). I downloaded the audio recorded interviews to my computer for transcription. I utilized the live transcription features provided by Zoom, which appeared during the meeting in real time, to ensure I captured every word. Finally, I asked the participants to verify their transcripts for accuracy.

## Significance

The significance of this study is that its findings help address a gap in the research literature regarding the lived experiences of uninsured middle-class families who cannot afford health insurance. The results may help policy makers better understand barriers to health care accessibility and how the lack of affordable health care affects uninsured middle-income families. Insight from this study may help inform change in current policies to make insurance more affordable (see Hayati et al., 2019).

The findings of the study may also lead to lower health care costs or increased coverage for the participant population. The findings were unique to the literature as they reflected the experiences of those who are directly affected by a lack of health care related to its unaffordability. Implementing policies and programs for uninsured families in Essex County, New Jersey, may encourage social change more broadly in the United States. In this way, the study helped to achieve the objectives outlined by K. Jacobs and

Lucia (2018) and Song and Basu (2019) for a health care system that guarantees all Americans access to comprehensive coverage regardless of employment status, where they live, or history of illness.

In conducting this study, my intention was to bring awareness to the experiences of middle-class uninsured families in Essex County, New Jersey. The state could use my findings to develop and enact innovative programs to provide affordable health care insurance for this population. Data collected could provide insight into areas that prevent these families from having health insurance and help policy makers develop strategies and programs to make health insurance affordable.

The significance of the study also includes creating awareness concerning health policies and programs for the growing uninsured middle-class population who cannot afford health insurance. Being insured is a safety-net for one's well-being. Changing policies and programs to provide affordable health insurance can, therefore, be imperative to human welfare.

## Summary

Health insurance is an essential component of an individual's well-being. This research study may be one way of moving closer to providing affordable health care for all. The purpose of this study was to explore and better understand the lived experiences of uninsured middle-class families in Essex County, New Jersey, who could not afford state or any other type of health insurance. This research could contribute information to the body of literature related to health policies and choices involving diverse ethical issues, including rights and responsibilities of the uninsured middle-class population who cannot afford health insurance. This study may contribute to the research through exploration of the lived experiences of the uninsured middle-class participants who cannot afford employer, state, private, or government insurance. In addition, the data collected could inform policy makers' decisions concerning health care affordability.

In Chapter 2, I provide an in-depth review of the existing research literature regarding the uninsured middle-class population who cannot afford health insurance. I also outline the problem and the theoretical framework that was investigated. In addition, I summarize the literature's significant conclusions, findings, and methodologies that supported the need for this research methodology and the need for the research.

# Chapter 2: Literature Review

It was unknown what the thousands of uninsured middle-class families in Essex County, New Jersey, who cannot afford state or any other type of health insurance experience in terms of how this effects their lives. The purpose of this phenomenological study was to explore and better understand the lived experiences of uninsured middle-class individuals who cannot afford state or any other type of health insurance. In addition, I aimed to understand and gather in-depth information on the uninsured middle-class perceptions through qualitative methods such as participant interviews.

Research has shown that the problem of insurance affordability is relevant and significant (Sacks et al., 2020). With a growing uninsured middle-class population, there is a need to reform the national health care system to provide affordable health insurance for individuals and families. Data from the U.S. Census Bureau (2019a) indicated that approximately 30 million Americans are uninsured. Further research has established that the increase in uninsured middle-class Americans is affected by the high cost of insurance and high deductibles, which leads to a lack of health care services for individuals and family members (Goldstein, 2019).

Lyford and Lash's (2019) and Cogan's (2020) studies demonstrated that the federal government’s failure to reform the country’s health care system prevents many Americans from the benefits of accessing health advances. Despite multiple efforts, the system remains the same as it was in 2010, with slight improvements (Wachter, 2010). Rahman et al. (2019) found that uninsured Americans continue to live in fear of sickness or injury because health insurance is too costly. To ensure the middle class can acquire health insurance, premiums should be affordable for all.

The review of research literature revealed that systematic investigation into health care affordability has chiefly focused on Medicare and Medicaid programs, costs, out-of-pocket expenses, and quality of services (see Adrian et al., 2019; Zimmermann et al., 2016). However, little is known regarding the perspectives of uninsured middle-class families who cannot afford health insurance or what concern this causes them. These perspectives could be important to help make health care in New Jersey more affordable. Through this qualitative research study, I explored the research gap concerning the experiences of uninsured middle-class families in Essex County, New Jersey. In this chapter, I provide an overview of the literature search strategy, theoretical framework, and a comprehensive review of the literature related to key concepts of the study.

## Literature Search Strategy

The strategy to locate research literature for this study included the use of several search engines: ProQuest Dissertations and Theses, ScienceDirect, PubMed, WorldCat, CORE, Academic OneFile, and Google Scholar. Most sources were retrieved from the Walden University Library database, using Thoreau Advanced Search of journals and articles. This provided a wealth of peer-reviewed articles from leading journals worldwide along with doctoral dissertations. I also conducted a search of government agencies, including the Centers for Medicare and Medicaid Services, U.S. Census Bureau, National Center for Health Statistics, and Newark Community Health Center to retrieve relevant information for this study.

Key search terms included *affordable health care*, *health care*, *health care and universal coverage*, *barriers to health care*, *health care eligibility and availability*, *no health care*, *access to health care*, *how people live without health care*, *uninsured middle class*, *uninsured primary care*, *uninsured and underinsured*, *high cost*, *high deductible*, *health plan*, *universal health coverage*, *universal health care*, *U.S. health care system*, *health reform*, *health care reform and policy*, and *why health care reform.*

My search of the literature primarily focused on finding sources concerning middle-class uninsured families. The articles selected were peer-reviewed studies and published dissertations in the field of the health care. When I used Google Scholar and entered the keywords *high cost* or *high deductible* and *health insurance*, *health plan*, *uninsured*, *middle class*, and *families*, this yielded approximately 5,000 articles. To determine whether articles were peer-reviewed, I used ULRICHSWEB, a directory that contains journal information. In my search, I focused on articles published in the last 5 years, from 2017 to 2022. Finally, I looked at how many times the articles had been referenced using Google Scholar's "cited by" feature. I was able to retrieve full-text articles from Google Scholar by clicking on the Find @ Walden link.

I also conducted a search of ProQuest Dissertations and Theses, which stores doctoral dissertations accessible through Walden's library search databases. Search words included *affordable health care*, *health care*, *health care and universal coverage*, *barriers to health care*, *health care eligibility and availability*, *no health care*, *access to health care*, *how people live without health care*, *United States' health care system*, *health reform*, *health care reform and policy*, *why health care reform*, and *uninsured middle-class*.

The WorldCat search engine provided access to library catalogs worldwide. The search terms used were *health coverage*, *universal health care*, *United States' health care system*, *health reform*, *health care reform and policy*, and *why health care reform*. Academic OneFile also allowed me to search globally for peer-reviewed articles from leading journals. The search words or phrases included *health care eligibility and availability*, *no health care*, and *access to health care*. Finally, CORE assisted me in search of open-access journal content. Key search terms were *affordable health care*, *high cost*, *high deductibles,* and *middle-class health insurance*.

I was not able to find sufficient peer-reviewed studies regarding affordable health insurance for the middle class. Therefore, I relied on information regarding middle-class earners and their lack of affordable health insurance from the government websites. Because of the lack of information regarding affordable health insurance for the middle class, further research is needed.

## Theoretical Foundation

### Rational Choice Theory

The theoretical framework that supported this study is based on Smith's RCT. RCT helps explain human action, choice, and interaction. According to Rutar (2019), the basic premise of RCT is that it explains social phenomena as outcomes of individual actions that somehow can be considered rational. Individuals seek to find the most effective method of attaining their goals. Zafirovski (2018) stated that the theory also focuses on the determinants of individual choices and methodological individualism. According to Hodgson (2007), methodological individualism means that one starts from the individual in order to describe certain economic relationships.

The origin of the RTC is in 19th-century utilitarianism, particularly Bentham's (1748–1832) and Beccaria’s (1738–1794) work, which interpreted utility as happiness (Bruinsma, 2018). Economist Samuelson (1947, as cited in Hands, 2014) removed the hedonistic assumptions of utility and argued that RCT had been misrepresented by those who embraced it and misunderstood by those who did not. In addition, Samuelson asserted that RTC is an empty value theory and that one can put almost anything one wishes into utility functions. Samuelson (1947, as cited in Hands, 2014) further explained that human behavior, as patterned outcomes of macrolevel causes based on culture and social structure, impacts individuals and groups who are motivated by self-interest to secure personal gain (Heckathorn, 2005). Friedman and Hechter (1988) asserted that the basic assumptions of RCT depend on the independent contributions of two different kinds of elements. The first element is subjective, involving the actor's (individuals’) utilities. The second is objective and includes external constraints to which the actor is subject. Similarly, Andreoni and Miller (2008) demonstrated that individuals behave as rational actors in making choices, and their choices are in their interest.

RCT, as a framework, often helps provide an understanding of social and economic behavior. A premise of RCT explained by Coleman (1990, as cited in Wittek et al., 2013) aimed to explain the decisions of individuals and the social consequences of their decisions. For example, if Option A is preferred over Option B, and if Option B is preferred over Option C, a collective preference may cycle through one of the sets of possibilities (Rajesh & Deshpande, 2020). Therefore, the assumption is that individuals can maximize their choice of preference to reflect cause and benefit.

Rajesh and Deshpande (2020) argued that a rational agent considers available information, probability of events, potential costs, and benefits; determines preferences; and acts consistently to choose the best course of action. Rationality is broadly used to assume an individuals' future behavior in many disciplines, for example, the sociology model and human decision-making analysis (Rutar, 2019). A version of rationality is called instrumental rationality, which involves seeking the most effective means to achieve a specific goal (Rajesh & Deshpande, 2020; Rutar, 2019). RCT uses the definition of rationality stating that individual behavior is rational when it is goal-oriented, reflective, evaluative, and consistent across time and different choice situations. However, RCT does not describe the proposed choice but rather predicts the outcome and pattern of choices (Rajesh & Deshpande, 2020). Instead, the aggregate behavior in society reflects the sum of individuals' choices and the outcomes that result from each possible action (Rajesh & Deshpande, 2020). Because of RCT's far-reaching impact on research studies, it has been used as a theoretical framework for understanding and formally modeling social and economic behavior.

Zafirovski (2018) demonstrated a broad understanding of RCT and functions, specifically, how individuals make choices. Zafirovski explained that an individual seeks to find the most effective method to attain their goals. RCT is a fundamental approach for understanding ethical behavior and reflects the idea that this behavior is rooted in human nature because it is the individual who ultimately takes actions. Rutar (2019) found that the basic RCT assumes all outcomes are known with certainty. Frank (2019) noted that understanding resource availability explains how individuals make choices and is the most effective method of attaining personal goals.

Zhao et al. (2020) conducted a study with 846 Chinese juvenile offenders to assess the utility of RCT in understanding how they used cost-benefit analyses in their decisions. Findings indicated that RCT can serve as an essential theory for explaining delinquent behaviors in China. Moreover, Nishant et al. (2019) examined the complex relationship between urban management and assessment of compliance to the town with the needs of residents, property and business owners, and investors. The researchers found that on e-government websites, agreement and disagreement between expected and perceived information service quality was positively associated with continued use intention.

Loughran et al. (2016) stated that RCT has emerged as a foundational theory in the field of sociology. Loughran et al. found that the theory has also fueled skepticism in decision making and that people do not often update information rationally and hold nonrational beliefs. On the other hand, the theory revealed that people are often swayed by emotions and assess options differ depending on their mood (Wittek et al., 2013). Thus, RCT aligned with this study’s phenomenological approach to explore whether individuals and families behave as rational beings who self-maximize, and if their actions are the ultimate source of finding the best means to a given end. Therefore, RCT can be used to help answer how individuals behave using empirical methods.

RCT has been applied to multiple problems concerning social interaction and exchange. RCT focuses on incentives for microchoices (individual self-interest) that produce macroeffects (society) suited to policy analysis (Howson, 2019). Vlaev et al. (2019) found that the empirical work on incentive systems can be used to design policies to change behavior in productive ways. Therefore, it is important to explain why one might expect the conditions for RCT to be valid. Travers et al. (2020) posited that humans are rational beings, and rational choice conditions are the only conditions that satisfy the demands for their selective choice. RCT strongly tends to select preferences that satisfy the conditions of the rational actor model. RCT does not presuppose a reason, but it does presuppose adaptivity to an evolutional environment (Wittek et al., 2013).

Fumagalli (2020) stated that it is not always possible for individuals to satisfy all their needs. However, they will choose alternatives that lead to maximization of their interests within situational constraints. Zafirovski (2018) also found that sustained interaction and the emergence of social structure depend on recognizing the ongoing effort to achieve the fulfillment of individual self-interest. Thus, when individuals reflect on their personal values, they strengthen their lives (Wittek et al., 2013).

I used RTC in this study as the theoretical framework and to support its research design. To apply RCT to the topic of this study, I began with the problem of social order. In addition, the study focused on two concepts of RCT: (a) rational actors and (b) self-interest, which emphasize that the key elements of all rational choice explain individuals' preferences, beliefs, and constraints (see Herfeld, 2022). These assumptions formed the basis for the study with a focus in on the lived experiences of uninsured middle-class families. The study addressed two significant areas of research that have informed the development of RCT: (a) the study of individual activities and (b) the study of group activities, which have historically been a significant focus of sociological research. Finally, I used RCT to inform and analyze that individuals are producers of their well-being in terms of need satisfaction. These aspects of RCT have explained and provided a better understanding of individual or groups behavior and why they use self-interest to make confident choices. The theory has informed my research question by directing focus on the factors that influence the choices of uninsured middle-class families in Essex County, New Jersey. The data collected to answer the research question may be helpful to understand the experiences of the uninsured middle-class and inform decisions by policy makers regarding health care affordability.

## Choice of Phenomenology and Theoretical Ideas

Qualitative research has been used to explore several areas of human behavior as an inductive approach to find meanings and insights about a phenomenon (Ravitch & Carl, 2021). Mohajan (2018) stated that it is a social action that emphasizes how people interpret and make sense of their experiences to understand their social and cultural reality. Experience has become a key topic in qualitative research by defining every moment to explain how individuals make decisions (DeJonckheere & Vaughn, 2019).

The choice for the phenomenology related to RCT helps to understand the uninsured family’s rational choices and explore the meaning of their experiences based on their beliefs and actions. Also, this helps to explain why uninsured families use their self-interest to provide them with the most significant benefits. Based on the RCT, individuals’ choices are completed by considering the costs, risks, and benefits of making that decision (Herfeld, 2022). Therefore, one person’s choices may seem irrational to another based on the individual’s desired outcome. Individuals decide what is best for them, dependent on personal preferences. Wittek et al. (2013) found that every individual is enclosed within their own experiences of the world. In addition, Colman (1990, as cited in Wittek et al., 2013) found that all human thoughts and knowledge occurs within this individual experience. Thus, using this phenomenology related to RCT—human beings are thinkers, and they use their experiences to make sense of their actions.

In this phenomenological research, I explored to better understand the lived experiences of the uninsured middle-class families in Essex County, New Jersey, who cannot afford state or any other type of health insurance. Policymakers may use the information to help develop policies and programs that make health care more affordable. By using phenomenology in this study, I may provide a better understanding of uninsured middle-class families’ beliefs, experiences, and meaning from their perspectives as the basis of their social reality lies in the description of their lived experiences (see Wittek et al., 2013).

Phenomenological research is a qualitative design that focuses on understanding individuals’ lived experiences within a geographic location (Neubauer et al., 2019). Therefore, the phenomenological approach was an effective research strategy for exploring uninsured middle-class families’ experiences and life events. The questions that a phenomenological study help answer, and its insight could create a better understanding of the uninsured middle class without health insurance.

McIntosh and Wright (2019) found that by examining an individual’s lived experiences, researchers can find new meanings and form appreciations, which can help inform how they understand the participant’s experience. The interview questions posed to the participants helped provide a better understanding of their lived experiences concerning the lack of any form of health insurance. The interview interactions with participants helped provide specific information about their lived experiences. Phenomenology was an appropriate design for this study as I could ask the participants open-ended questions to explain and elaborate their reason(s) for being without health insurance.

## Studies Using Rational Choice Theory

In the large body of literature concerning RCT, it is apparent that it has made significant contributions within the field of sociology. However, there is skepticism concerning the rationalist assumption of the choice’s individuals make. Steele (2016) found that decisions are affected by an individual’s perceptions and the circumstances in which they find themselves. Steele conducted a qualitative study where 46 offenders in England with different offending backgrounds were interviewed about their lived experiences in the context of evidence to support rationality. The results suggested that rationality varies both within and between individuals. Steele also found that the rational choice perspective identified the offenders as reasoning individuals who weighed the potential costs and benefits of their actions. Therefore, understanding an individual’s needs, concerns, feelings, and circumstances could help identify the goal regulation process that assists with human choice behavior. Steele also found that the views of individuals as decision makers lacked realism and that the justice system criticized the views of the offenders toward their crimes in England as they made mistakes in predicting their future.

Accordingly, Farmer and Dawson (2019) examined the decision-making process and relevance of self-reported profiles of college students involved in petty shoplifting. The purpose of the study was to examine the relevance of criminological theories to self-reported profiles of American college students involved in petty shoplifting and not organized retail theft. The respondents were grouped into two categories: (a) situational-prevention strategies relating to economies and (b) social/psychological prevention and deterrence with the lack of police interest to determine their applicability. The study's results indicated that self-control theory coupled with RCT was relevant to understand low-frequency shoplifters who committed a crime one or two times. However, Farmer and Dawson found some weaknesses related to validity and reliability concerning American college students' self-reported shoplifting, such as frankness, bias, and measurement error. The sample was also small and did not represent all college students. Still, RCT supported the results relevant to the data.

Overall, RCT has shortcomings that prevent making significant generalizations in predicting activities. However, Nishant et al. (2019) explained that RCT infers that people first categorize available options and choose the most favorable selection by comparing costs against benefits and selecting the option that maximizes individual gain. I chose RTC for this study because it allowed me to focus on the quality of experience to understand and describe the nature of social behavior based on the individual actor's decisions. Understanding philosophical roots—using self-interest to make choices—can demonstrate a subjective experience based on constructivism and interpretivism. Goals of this study were to understand, describe, and discover meaning. The rationality assumption ensures that when individuals are presented with an option, they select the best choice if available (see Wittek et al., 2013). Data were collected using researcher-developed interview questions designed to elicit responses regarding the experiences of middle-class families without health insurance.

RCT can be applied to explain the issues that prevent obtaining health insurance for the middle-class family and their choices as well as provide an understanding of individuals as rational actors (see Burns & Roszkowska, 2016). Nishant et al. (2019) added that researchers often use RCT to study choice preferences under various conditions and analyze why individuals make optimal choices. Using a phenomenological approach with RCT as a theoretical lens was suitable for this study to discover the how and why of the research problem.

## Literature Review Related to Key Concepts.

Qualitative research is applied in micro- and macrodescriptions, constructing the concept and theory development, which often overlaps and adds to the complexity of methods (Ravitch & Carl, 2021). The most important is a detailed and relevant description of the contexts in which individuals are rational and self-interested. A qualitative inquiry also involves the inductive development of explanations and concepts. Qualitative studies are driven by observational and interview data or textual data involving concepts, thematic analysis (techniques of verification that assess the trustworthiness of data), replication, and saturation (Ravitch & Carl, 2021).

This literature review will inform readers regarding studies that have contributed to the knowledge of and interest in the experiences of the uninsured middle class. My focus was to investigate the beliefs, values, and experiences of human action and actors' capabilities to make decisions and act rationality based on benefits and costs (see Burns & Roszkowska, 2016). Knowledge of RCT, its theoretical formulations, and where it has been systematically criticized, are areas of research that add value to understanding individuals' choices. Understanding an individual's needs, concerns, feelings, and circumstances could help identify the goal regulation processes to assist with human choice behavior. Several leading contributions and empirical applications have been the result of application of RCT

## Rationale for Selecting Rational Choice Theory

First, the rationale for selecting RCT was focused on the quality of experience to understand and describe the nature of social behavior based on individual actors' decisions. Second, understanding the philosophical roots—using self-interests to make choices—demonstrates a more subjective experience based on constructivism and interpretivism. Third, the study goals were to understand, describe, and discover meaning or generate hypotheses or theories. Fourth, the design characteristics of the study are flexible, evolving, and emergent. Its flexibility was no less disciplined or easier to design and implement. Fifth, researcher-developed interview questions were used to bring meaning and interpretation to the data. Data collection included in-depth interviews, document analysis, and observations.

Few researchers have taken affordable health insurance for middle-class earners into consideration. As members of middle-class families grow, there is a demand to expand the affordability of health care coverage. Pak and Gannon (2021) concluded there are three cornerstones of health care: cost, access, and quality. There is a need for an innovative and universal health care policy that will result in an accessible health care system with relatively low cost for everyone (Pak & Gannon, 2021). Individuals and families need continuous care services as they grow older or develop chronic illness; the call for the health care system to improve should be urgent for all Americans.

## The Unaffordability of Health Care in the United States

The United States has a uniquely complicated health insurance system, unlike any other in the world. Reese (2021) indicated that most developed countries fund their national health insurance programs through general taxes. Similarly, a study conducted by Sacks et al. (2020) with data from the World Health Organization indicated that primary health care should be made comprehensive and high quality to meet all or most individuals' health needs. Over the last 20 years of the 20th century, the American employer-based health insurance model has failed. Although health insurance should be a right for all people, an increasing number of employers have reduced or eliminated employee health care benefits because it is increasingly unaffordable (Goldstein, 2019).

In the United States, the legislative branch is the creator of health policies and allocates the resources necessary to implement them. Making health care policy is a complex process that involves private and public sectors as well as multiple levels of government. These levels include (a) the relationship of the government with the private sector, (b) the allocation of authority and accountability within a federal system of government, (c) the connection between how the policy is formulated and implemented, (d) the basis of the formation of the policy, and (e) incrementalism as the strategy for reform (Fulton, 2017). All three government branches are heath care policy makers. However, the legislative branch is the most involved in this process, which is evident with laws that become policy. Legislators' main goal is to provide policies for their different constituencies (Goldman et al., 2018).

## The Patient Protection and Affordable Care Act

The aim of the PPAC (2010) was to make health care insurance more affordable to individuals and small businesses through significant expansion of the Medicaid system and Marketplace health insurance exchanges organized by the states. The PPACA, commonly referred to as "Obamacare," was passed into law by President Barack Obama on March 10, 2010, and was the most sweeping overhaul of the health care system in the United States since the founding of the Medicare and Medicaid in 1985 (Collins & Saylor, 2018; Legerski & Berg, 2016). The PPACA has continued to undergo periodic changes, largely to respond to cost, access, and quality concerns. The main focus of the PPACA is to develop a better health care plan for approximately 30 million uninsured Americans while stabilizing increasing costs to make the health care system more affordable (U.S. Census Bureau, 2019b).

The PPACA required states to establish health benefit exchanges through Small Business Health Options Program exchanges in which individuals and businesses with up to 100 employers can purchase coverage (DeVries et al., 2016). However, the state of New Jersey did not participate in health care reforms to enable more residents to qualify for subsidized programs. Despite efforts to provide basic health insurance at an affordable rate to every family in the United States, it remains an unrealized goal in New Jersey (McCuskey, 2019). McCuskey (2019) noted that it is unlikely these goals will materialize anytime soon, primarily because expanding access to health care while maintaining current health care costs and levels of quality is a daunting challenge.

## Scope of the Uninsured Problem

Large numbers of people currently remain uninsured in the United States. The U.S Census Bureau (2019a) found that approximately 30 million people in the country are uninsured. The health care system has been criticized for many reasons, mainly because the United States is the only industrialized nation that fails to provide universal access to primary health care. In survey data collected by the Internal Revenue Service, Larrimore and Splinter (2019) found that average premium for employer-sponsored plans is roughly $1,000 higher than those not sponsored. Therefore, affordability is a critical concern. In Essex County, New Jersey, 16.0% (+/- 1.8) of its 285,154 population are middle-class and uninsured (U.S. Census Bureau, 2019c). The rising cost of health insurance leaves many of these families without coverage and therefore without medical care.

### Uninsured Middle-Class Americans

The uninsured middle class continues to grow, and the high cost of health care seems to be the cause associated with this segment of Americans (Goldstein, 2019). Although impoverished people are less likely to have insurance, many of the uninsured are neither unemployed nor poor enough to qualify for federal programs such as Medicare or other types of state assistance (Goldstein, 2019; Ung & Mullins, 2015). The U.S. Census Bureau (2019a) data has shown that approximately one in every three individuals in service occupations have chosen to remain uninsured compared with one in five workers overall. This indicates that the uninsured remain without health coverage.

Lack of insurance hurts the health status of the uninsured. Several studies demonstrated that the uninsured use fewer health care services than the insured (Sen & Deokar, 2021). Even when the uninsured have access to health care, they often find it difficult to pay their bills (Ung & Mullins, 2015). Therefore, the plight of the uninsured affects those who are insured. A survey study by Wammes et al. (2018) showed that high health care costs were associated with higher payments in the United States but lower payments abroad due to the prevalence of mental illness was 30% more in the United States. Keehan et al. (2020) asserted that medical expenditures, which reflect prices for medical services and goods but exclude prices associated with the net cost of insurance, are projected to increase at a rate of 2.4% from 2019 to 2028. Therefore, medical expenditures will account for 43% of the total projected growth in health care spending over this period, most of which will be shared by Medicaid and federal grants to nonprofit hospitals (Keehan et al., 2020). In addition, O’Sullivan et al. (2017) noted that employees with full benefits who become outsourced as contract workers with uncertain income and no benefits might suddenly find income and debt out of balance. Based on data from the U.S. Census Bureau in 2017, within 3 years from when the data was collected, approximately 64 million people would have experienced a time when they had no insurance to cover medical bills, including roughly 9.5 million people who had no health insurance protection at any time from 1995 to 2017 (Fontenot et al., 2018). This demonstrates that medical costs can contribute to the financial struggles of families, who have faced difficulties in paying their medical bills and accumulated medical debt over time.

O'Sullivan et al. (2017) offered a wide range of definitions of the middle-class from the subjective to a specific measure of household income. The government has defined the poverty level; however, no government agency has defined the middle class as class status is not a function of money or other easily identified characteristics. Research shows that Americans determine class using many variables ranging from education, occupation, cultural factors, lifestyle, beliefs, and feelings, as well as the income and wealth gap. Overall, decreased access to health care can result in a higher prevalence of poor health and mortality among the uninsured and their families (Rosengren et al., 2019).

### ***Lack of Insurance Affordability***

Researchers have found that the uninsured no longer only work for low-income employers and the likelihood that middle-class families will be uninsured has increased. Health insurance is now out of reach for low-income families and the growing population of middle-class Americans (Findling et al., 2020). For example, in a Commonwealth Fund survey, Ungar and O’Donnell (2015) found that four in 10 working adults skipped health care services or fell into financial hardship because of health care expenses. This demonstrates that some working adults do not have adequate insurance coverage. Another example of the uninsured middle-class problem comes from Goldstein (2019), who conducted a study with a sample size of $n = 4$ to $n = 722$. Findings showed that the high and increasing cost of health insurance caused middle-class American families to forgo health services ranging from health care to treatment/conditions services. Similarly, a survey by Winkelman et al. (2019) indicated that 9,785 uninsured participants remained uninsured due to high costs. Finally, Bhatt and Schelhase (2019) reported that over half of the uninsured who responded to the question of why they remained uninsured indicated that health insurance was “too expensive” (p. 3). These findings show that the lack of health insurance extends well into the middle-class. The lack of health insurance could lead to serious medical problems, which could be diagnosed earlier if access to health care was affordable (Yabroff, et al., 2019).

### ***Problems Due to Being Uninsured***

If people are not adequately insured, a variety of problems arise. The first problem that researchers have identified is that people without insurance lack access or have delayed access to the services they need. Bhatt and Schelhase (2019) found that 51% of the uninsured do not have a care provider to meet their health care needs. They also reported that 52% of uninsured families delayed seeking health care due to cost. Another problem is that the uninsured are more likely to become ill due to lack of access to care. Wharam et al. (2018) used a controlled pre- and postdesign study to show that breast cancer diagnoses were delayed for up to 2 months in uninsured women aged 25 to 64 due to high deductibles.

Rahman et al. (2019) found that hypertension, hyperlipidemia, diabetes, depression, arthritis, coronary artery disease, and chronic obstructive pulmonary disease were six to 13 times higher among older patients due to high insurance deductibles. Lastly, uninsured Americans are likely to face poor health outcomes. Fernandez-Lazaro et al. (2019) performed a cross-sectional study on medication adherence and barriers with uninsured patients with multiple chronic conditions in Chatham County, Georgia. The researchers found that 150 participants developed a chronic illness because they faced obstacles in obtaining primary medical care. As a result of barriers such as a lack of health care services, their medical needs were unmet.

### *Health Care Reform*

Many studies have indicated a growing need for health care reform in the United States. The goal of this reform is to improve the health care system's performance and to ensure that all or most Americans have access to affordable insurance. Von Wachter (2019) conducted a study on unemployment insurance in which over 40 million workers were insured and found that the system was essentially unchanged since the mid-1970s despite changes in the labor market. Von Wachter showed that health care costs continue to rise because of inflationary trends and technological advances. Papanicolas et al. (2018) found that the cost for health care in the United States was higher than 10 of the highest health care costs in the United Kingdom, Canada, Germany, Australia, Japan, Sweden, France, the Netherlands, Switzerland, and Denmark. However, Papanicolas et al. found that the United States spent 17.8% of its gross domestic product on health care compared to other countries, such as Australia with 9.6% and Switzerland with 12.4%. The percentage of U.S. expenditure to that of other countries shows that its health insurance costs are higher.

Based on data collected in 11 countries, Papanicolas et al. (2018) concluded that life expectancy in the United States was the lowest at 78.8 years. The life expectancy range in the other countries in the study were 80.7 to 83.9 years, with the mean at 81.7. As reported by the National Survey of Employer-Sponsored Health Plans (2017), employers who furnished health care plans found it difficult to continue to provide the level of protection workers had become accustomed to without raising copayments or lowering benefits, which forced them to offer a lower cost health plan. Higher health care costs can result in a higher premium for employees. The National Survey of Employer-Sponsored Health Plans report also indicated that employees' health costs continue to grow and that the per-employee cost of health maintenance organizations in 2015 averaged $12, 388. This was an increase of 2.8% in 2016 or $150.00 more than the year before. Therefore, the cost of employee health insurance has increased.

## Health Care Reform and Well-Being

Affordable health care is important to a family's well-being. Policy decisions and their implementation are significant components of the future direction of the health care system. Notable progress has been gained within the health care system in the United States. The Part D Medicare prescription drug benefit allows individuals to receive drug coverage through private plans (Wu & Raghunathan, 2019). In addition, the Medicare Prescription Drug, Improvement, and Modernization Act (2003) was put in place to help offset medical costs for the unemployed 65 years and older.

During the 1960s and 1970s, most Blue Cross Blue Shield and prepaid group practice plans had small deductibles or low coinsurance costs, and most costs were covered for seeing a physician, laboratory work, X-rays, emergency room visits, and hospital medical and surgical services (Scofea, 1994). As the years progressed, insurers increasingly added coverage for prescription drugs, and the breadth and depth of coverage continued to increase (Scofea, 1994). Currently, the United States is experiencing a significant political change with Joseph Biden as President and the Democratic party gaining the majority in both the House of Representatives and Senate in the 2020 election. The presidential win in 2020 was significant because of considerable concern for improvement in the health insurance to make it more affordable as well as renewed interest in the PPACA. Therefore, dozens of proposals have emerged since the late 1980s, including the PPACA and President Biden’s recent campaign proposal to add more coverage to the Act (Shepard et al., 2020).

## Summary and Conclusions

The literature review revealed a variety of research methodologies used to study the uninsured population. In studies designed to determine improvement of health status, quantitative designs were primarily used (see Farmer & Dawson, 2019; Steele, 2016). However, studies that focused on the quality of life from individual and family’s perspectives are often qualitative (Ravitch & Carl, 2021). Accordingly, the research design criteria differed. The qualitative methodology applied in the literature reviewed included interviewing and case studies. Also, many studies used representative data from government websites and national surveys collected over time (see U.S. Census Bureau, 2019a). Comparable to the research designs, analysis methods covered a broad scope of procedures. Loughran et al. (2016) used descriptive statistics and a survey instrument that combined open-ended and closed-ended questions with integration and analysis of both types of data. Steele (2016) used a systematic review of qualitative data to inform the research question but allowed flexibility for the respondents to talk tangentially. Farmer and Dawson's (2019) used the chi-square test and analysis of variance to identify differences among three groups.

Health insurance protects individuals and families from the financial impact of high-cost medical services; however, uninsured families pay a higher proportion of their health care costs (Cogan, 2020). Consequently, people with severe and chronic health problems are forced to pay higher premiums, which makes them unable to afford health insurance coverage (Goldstein, 2019). Health insurance serves as a protection for individuals from unexpected and financially debilitating health care events (Khera et al., 2018).

The two programs established in 1965, Medicare and Medicaid, brought health insurance protection to most of the elderly and a significant proportion of those living in poverty. However, these did not provide coverage for everyone. Today, approximately 30 million Americans are without health insurance (U.S. Census Bureau, 2019a) despite vigorous attempts and interest in reforming the health care system by policy makers and government officials.

The growing awareness of the size of the uninsured population and the vulnerability of the middle class to unaffordable health insurance have led to a growing dissatisfaction with the health care system. Despite the success of Medicare and Medicaid in insuring millions of Americans, a large percentage are still without health insurance because of costs, while the critics of the status quo remain unable to bring about universal coverage (Andrews et al., 2019). Rahman et al. (2019) concluded that the growing rate of total health care expenditures has created economic strains and concerns. Although health insurance in the United States has evolved since 2010, significant public policy decisions are still needed. The enduring challenge is to formulate policies and programs that can control total expenditures and provide affordable health coverage for all.

The literature reviewed for this study addressed the problem of the millions of Americans who remain uninsured, and the middle-class population that continues to grow without health care coverage. The study addressed the gap in the literature by providing data to describe the experience of the middle-class population who could not afford state or any other type of health insurance. The significance of the study is that it informs the policy changes needed to make current health care coverage more affordable to the middle-class population.

In Chapter 3, I will describe the research design and the role of the researcher. I discuss the methodology used in participant selection, participation, and instrumentation. I also provide a data analysis plan and address issues of trustworthiness and ethics.

# Chapter 3: Research Method

The purpose of this phenomenological study was to explore the lived experiences of uninsured middle-class individuals who cannot afford state or any other type of health insurance. This study involved individuals who (a) had a combined income between $50,000 and $80,000 from 2020 to the present, (b) did not currently have and did not have health insurance for at least 1 year prior to their recruitment into the study, (c) read and fluently spoke English, and (d) were between the ages of 26 and 64. This chapter includes the research design and rationale, role of the researcher, information about the methodology, and issues of trustworthiness and ethics.

## Research Design and Rationale

The qualitative research question addressed in this study is as follows: What are the lived experiences of uninsured middle-class families who cannot afford state or any other type of health insurance in Essex County, New Jersey?

Most Americans think of the uninsured as low-income earners dependent on government assistance (Haley & Wengle, 2021; Shafir, 2017). However, the growing number of uninsured middle-class Americans suggests there is a need to take a closer look at their experiences (Hacker, 2012). More middle-class families are uninsured today because medical costs are higher than they were in 2018 and unaffordable after adjusting for inflation (Shane, 2018). According to White-Williams et al. (2020), education policies, childcare, community revitalization, and the rising costs of housing, food, and transportation to and from work have increased medical costs. Inflation has also risen substantially in many countries over the last 30 years. In the United States, inflation has hit its highest rate in more than 3 decades at approximately 6% in October 2021 due to greater spending (Andre et al., 2021).

Making health care more affordable can help previously uninsured middle-class families obtain coverage. In recent years, researchers have used the term *uninsured middle-class* to describe families and individuals without employer, state, or government health insurance (Berchick et al., 2019). The uninsured middle class, as defined in this study, are working-age adults between 26 to 64 with an annual income above the median household income according to the U.S. Census Bureau (2019c) and without an employer, state, government, or private insurance.

The uninsured middle class is a growing concern in the United States as more middle-class earners are without health insurance (P. D. Jacobs & Hill, 2021). The shift in focus from low-income earners to those in the middle-class is an evolving research topic (Salido & Carabana, 2019). The expansion of health care plans in the United States has remained an important subject of debate, especially as health care remains unaffordable (Gruber, 2017). The free market primarily influences the health care system, limiting how much physicians and other specialists can charge their patients (Adams & Markowitz, 2018). Millions of uninsured Americans continue to live in fear of a sickness or injury that could leave them bankrupt (LiPuma & Robichaud, 2020). In addition, not only are millions of Americans uninsured, but millions also are underinsured and without enough coverage to meet their health care needs (Jiang & McCoy, 2020). The American health care system is broken for the uninsured and underprivileged as well as the uninsured middle class (Haley & Wengle, 2021).

Researchers Johar et al. (2018) have used the term “access” to indicate that society has an ethical obligation to ensure the equal ability to obtain to health care. However, access to care requires that all families and individuals be able to secure an adequate level of care without excessive burdens (Moscelli et al., 2018). A family could be defined as a social group comprised of parents and children tied together by marriage, blood, or adoption in a single household interacting with each other (Bowyer et al., 2018). For the purpose of this study, family is defined as one or more adult having custody of and responsibility for, one or more children (see St. Vil et al., 2019). Thus, the family structure for this research included single-parent, two-parent, grandparent(s), or other nonparent(s) who were responsible for a child or children. In addition, household earnings must have been between $50,000 and $80,000 per year.

The concept of the middle-class is also important to the development of this study as it helps in understanding the research question. Several studies have explained that the middle-class is the aggregate population that divides and ranks individuals from low to high on income, skills, occupation, and education (Barbieri et al., 2020; Sánchez-González & García-Fernández, 2020). For this research, middle class included a combination of independent criteria measured by median range income of $50,000 to $80,000 within socioeconomic needs (Data USA, 2021).

Researchers have advocated for a qualitative approach as an indispensable element for this developing field of obtaining health coverage (Brunson et al., 2018). The purpose of qualitative research is to gain a better understanding of the richness and complexity of social experience by paying close attention to everyday actions, interactions, and social contexts (Shufutinsky, 2020). An in-depth interview involves observing people in their domain (Ravitch & Carl, 2021) or talking with them about their perspectives and experiences. Micro- and macro-descriptions, concepts and theory development, and evaluation are often part of qualitative research (Ravitch & Carl, 2021). These often combine or overlap and add to the complexity of qualitative methods. Multiple qualitative research designs have been developed and formalized, including phenomenology, conversational or discourse analysis, narrative inquiry, case study, grounded theory, and ethnography (Ravitch & Carl, 2021).

Qualitative methodology is the most suitable approach to understand human behavior as it focuses on the reality of individuals' lived experiences. Qualitative research explores the dynamics and textures of everyday life by providing detailed descriptions and a better understanding of subjective experiences. In this study, this method allowed for the exploration and documentation of the lived experiences of middle-class individuals and families without health insurance (see Baldwin et al., 2020; Ravitch & Carl, 2021). I selected qualitative methodology for this study as it allows for the exploration of beliefs, values, responses, and experiences to gain insight into individuals' actions, motivations, assumptions, and challenges (see Ravitch & Carl, 2021).

In contrast, the purpose of quantitative research is to use statistics or numerical data as the basis for making inferences about the phenomenon under study (Queirós et al., 2017). In addition, quantitative research is often influenced by experimental design and is generally a statistical approach to sampling, measurement, and data analysis (Glesne, 2016). Mixed-method research was not selected for this study as I did not believe I needed a combined approach to answer the research question (see Rakic et al., 2020).

The phenomenological approach to research focuses on the subjective and the everyday aspects of human existence (Gephart, 2018). Mohajan (2018) stated that phenomenological research is the investigation of social action, which involves two perspectives of actor and observer everyday world experience by a natural attitude of acceptance. The essence of phenomenology is to arrive at a deeper understanding of human experiences and their given meaning and form (Mohajan, 2018). A phenomenological design was chosen for this study because it is broadly focused and can provide more in-depth understanding of participants' lived experiences.

A phenomenological approach to interviewing allowed me to focus on the lived experiences of the uninsured middle-class participants who cannot afford health insurance and the meaning they make of their experiences (see Seidman, 2019). Seidman (2019) explained that no single approach to interviewing research could be called phenomenological. A phenomenological approach, unlike a basic qualitative study, case study, or ethnography was able to capture the understanding of individuals' experiences from their point of view (see Seidman, 2019).

My adoption of Seidman's (2019) three interview series of creating context, description, and reflective meaning remained intact; however, each participant was encouraged to provide rich data within a single interview to understand that there would be optional future formal or informal contact opportunities. Seidman referred to phenomenological methodology as the specific method used depends mainly on the researcher’s specific talent and skills, the nature of the research question, and the data collected. Therefore, phenomenological methods are adapted to the characteristics of the particular phenomenon being invested. In the case of the uninsured middle-class families who cannot afford any form of health insurance, the phenomenon includes the lived experiences of these families. Saturation was reached through comprehensive, rich, and thematic phenomenological experiences shared in the interview.

Empirical phenomenological research relies on a thick description of experiences, making it incumbent upon the interview to extract the memory of an event in three-dimensional terms (Seidman, 2019). Prior to all interviews, contact was made with each participant via email and phone call to provide them with information and background to the study and an understanding of the purpose of the research and sign consent forms. According to Gephart (2018), this gives participants time to dwell and ponder on the experience and can aid the researcher in getting a more detailed description during the interview. The initial interaction combined with the actual semistructured interview and the participant's opportunity to respond to their data summaries that were emailed to all of them. While depth and reflection upon lived experience is undoubtedly a requirement for phenomenological research legitimacy, the primary purpose of the interview process afforded the uninsured middle-class to express their perspective to capture a detailed description of their experiences as they perceived it (see Seidman, 2019).

## Role of the Researcher

The role of a researcher is to ensure the study’s purpose is clear from the start of the investigation to the end. While conducting the study, I was the primary instrument for collecting data and providing its interpretation. I conducted in-depth interviews with selected participants. As an agent to create positive social change, the information from the study may influence and help develop sustainable solutions to health care affordability. This study could provide data to improve health care policy or programs on a state level to enhance the quality of life for the uninsured middle-class population who cannot afford any type of health insurance.

I conducted the study by inviting participants from uninsured middle-class families in Essex County, New Jersey, who could not afford any type of health insurance. I did not interview anyone who was associated with my place of employment, so the results did not influence by people I know. I also excluded family members and close acquaintances to eliminate ethical issues as this could interject bias into an understanding of the changes in policies and programs. I have no affiliation with any health care industry, or state, government, and insurance enterprise. I work for a Head Start and Early Head Start program as a compliance review administrator.

One way I managed my personal bias was through transparency. I was open regarding the challenges my family faces in being uninsured and underinsured with high copays and the lack of resources and policies to support our middle-class needs. The data collected from the participants could provide information to address the problems surrounding the uninsured middle-class population who cannot afford health insurance. The data that this study might provide regarding the experiences of the uninsured middle-class could help policy makers and state officials better understand the problem and what needs to be done to solve it.

Understanding research bias that can occur during data collection and analysis helps alleviate the possibility of skewing the study's outcomes. Johnson at el. (2020) explained that working with peers on the coding and interpretation of the findings to identify any gaps in the data analysis. I also used an informed consent form to instruct participants on the expectations of the study before they participated. They had the right to discontinue participation at any time during the research process. Some of the topics relating to the middle-class respondents' reasons for being without health insurance were sensitive and may have produced some anxiety or emotional responses. Building trust between the researcher and participant was necessary to developing a welcoming atmosphere where they felt free to share their perspectives (see Black et al., 2018). In addition, all participants were deidentified. I secured Walden University Institutional Review Board (IRB) approval before conducting the research study.

## Methodology

### Participants Selection Logic

The target population for this study was uninsured middle-class families in Essex County, New Jersey, who could not afford any type of health insurance. This included approximately 16.0% (+/- 1.8) of the 285,154 residents of the county (U.S. Census Bureau, 2019c). A purposive sampling strategy was used to reach theoretical saturation in this study, which was when new data no longer brought insight to the research question (see Ames et al., 2019). Weller et al. (2018) stated that a sample size of 10 to 12 is sufficient for an in-depth qualitative research study to reach saturation; however, I recruited 20 currently uninsured middle-class families who had not had insurance for at least 1 year prior to this study. Sample size was a significant factor for trustworthiness of this qualitative study. As researchers attempt to reach saturation, they may increase or decrease the sample size (Vasileiou et al., 2018). Saunders et al. (2018) noted that the saturation is a criterion for discontinuing data collection.

As previously stated, my goal is to recruit 15 to 20 participants. Vasileiou et al. (2018) used a phenomenological approach with semistructured interviews and recommended six to 10 participants to reach saturation. Therefore, following the inclusion and exclusion criteria for this study, I recruited the number of participants needed for saturation.

The criteria for participation in the study included individuals who (a) had a combined income between $50,000 and $80,000 from 2020 to 2022, (b) did not currently have and had not had health insurance for at least 1 year prior to their recruitment into the study, (c) read and fluently spoke English, and (d) were between the ages of 26 and 64. Exclusion criteria are the following: (a) anyone with Medicare, Medicaid, and any other type of health coverage; (b) anyone who did not speak and understand the English language; and (c) participants who did not live in Essex County. In addition, the participants must have been a part of a family household structure that included either a single-parent, two-parents, grandparent(s), or other nonparent(s) responsible for a child or children in the home.

Participants were invited to the study with a flyer (Appendix A) posted in county libraries, urgent care facilities, and Facebook pages. The flyer included the purpose of the study, participation criteria, estimated time requirements, how interviews were to be conducted (e.g., Zoom/Team), voluntary nature of the study, and confidentiality. My contact information was provided, should the potential participant have wanted additional information.

Once potential participants expressed interest, I used a screening guide (Appendix B) to determine if they qualified for inclusion in the study. There were five screening questions to assess if the participants meet the study's criteria. The screening form included a place to mark the participant's responses to the questions with a yes/no option. A response of "no" to any question made the individual ineligible for the study and thanked them and ended the screening. If they answered "yes" to all questions, they were eligible. I asked each qualified participant for their email and telephone number and sent them the consent form for them to reply to the email with the words "I consent," which indicated their agreement to take part in study and interview sessions. I set up a convenient date and time for an interview with participant by phone before sending them the email. Interviews were conducted using Zoom.

## Instrumentation

### *Development of the Instrument*

Data for this study were collected through interviews. No historical or legal documents were used. To access the experiences of the uninsured middle-class participants, I developed semistructured in-depth interview guide (Appendix C). Conducting semistructured in-depth interviews with open-ended questions enabled the participants to provide lengthy and detailed responses (see Seidman, 2019).

Trustworthiness of the data collected during research depends on the strength of the interview questions (Seidman, 2019). The interview questions for this study were based on the key concepts from the research problem and literature review. The approach used in developing the in-depth interview questions was based on assumptions drawn from phenomenology (see Seidman, 2019). The questions were developed to be neutral and to capture the participant's range of experience on the research topic. (e.g., Please describe a day when you or a family member had to go to the emergency room.). I followed Seidman's (2019) recommendation that interview questions should be (a) structured using open-ended questions to avoid leading the participant, (b) ensure that the questions are expressed clearly, and (c) designed to focus on the study topic but have flexibility to explore the participants' views. Because of the depth of subject of the questions, it was important to establish trust with each participant early in the interview and ensure their comfort.

### ***Testing the Research Instrument***

Instrument testing was guided by Ravitch and Carl's (2021) approach to establishing content validity. I established validity of the research instrument by testing it with two individuals who were friends but not part of the study. Massey (2018) noted that pretesting methods identify question defects relating to data collection and instruments. Pretesting a study instrument is essential in identifying how and where the questions fail to communicate with a particular population (Massey, 2018). In addition, a pretest is an effective method to enhance the study's validity through interpretations and findings in the data collection process (see Buschle et al., 2022).

I used the cognitive interviewing technique to pretest and enhance the development of the research instrument (see Meyer et al., 2019). Ravitch and Carl (2021) explained that the purpose of cognitive interviewing is to determine the true meaning of the researcher's questions and that they function as intended. To test the effectiveness of the questions and to meet objectives set for their design in the cognitive interviews, I engaged two individuals to whom I posed questions to test for clarity and understanding. The interviews simulated the data collection process on a smaller scale to identify problems relating to the data collection methodology and instrument (see Manuel et al., 2019). Questions for the cognitive interview were aligned with the research question.

The first steps when using cognitive interviewing to pretest the instrument are (a) identify the objectives of the cognitive interview; (b) determine the time, date, and length of the interviews; (c) select the virtual platforms to use (Zoom/Teams); and (d) the number of interviews needed. This also applied to the 10 participant interviews for this study. Next, I ensured I had all equipment and materials necessary, such as pens, paper, consent forms, record forms, and that the sound and volume on the computer worked correctly. I also practiced recording to ensure that the computer was ready (see Ravitch & Carl, 2021). In addition, I used a digital recorder in case of any technical difficulties. Before the cognitive interview, I then called the two individuals and asked them to check their emails for cognitive interview details. I used the same procedures when conducting the participant interviews using the consent form.

The standard protocol for all the cognitive and the participant interviews in the study was to introduce myself and thank them for meeting with me (in the script used for scheduling the cognitive interview). I established a rapport with the two individuals who participated in the cognitive interviews and study participants by being friendly but genuine to relieve any anxiety they might have had (see Ravitch & Carl, 2021). I also reminded them of the purpose of the research and let them know I was interested in hearing what they have to contribute. Next, I recorded the start time on the cognitive interview recording form, read the cognitive interview consent form aloud to the interviewees, and asked if they had any questions before we began. I reminded them that there are no wrong answers and that none of the questions were designed to hurt their feelings. The cognitive interviews questions were the first five of the 20 questions included in the interview guide (see Appendix D). I asked one question at a time and provided clarity when needed with follow-ups and probes.

1. How long have you been without health insurance?
2. Does your job offer health insurance? If yes, why did you elect to not enroll?
3. Why have you not obtained private insurance?
4. How does not having health insurance affect your family?
5. What are some of the major disadvantages you have experienced by not having health coverage?

To close, I thanked the two interviewees for answering the questions, participating in the cognitive interview, and let them know that their input could help answer the research question. I also asked them to share additional comments relating to the research question. After completing the cognitive interview, I recorded the stop time on the cognitive interview recording form. I also took notes and made comments on the reactions of each individual, such as what went well, what did not go well, and any distractions. Next, I completed all the information on the cognitive interview recording form and reviewed and fill in gaps the interviewee's responses. Next, I debriefed the interviewees to ensure no information was missed and to document what went well, and what could have been improved. I then played back and labeled the recordings with the interviewee's identification number, date of the interview, and my initials, and kept it in a secure encrypted file on my computer. The cognitive interview questions were relevant to this research study as they were a descriptive approach to help identify which questions elicited the intended data as well part of the question development process (see Ravitch & Carl, 2021). I used the same basic procedures when interviewing the study's participants.

The two individuals whom I selected to participate in the cognitive interview were middle-class, uninsured, and without health insurance for approximately 1 year. They also were unable to afford any form of health insurance and resided in Essex County, New Jersey. They were friends who were not eligible to participate in the study. The sample interview data from both individuals was analyzed to determine if any modifications were needed to the interview questions. Comparisons were made during each stage of the cognitive interview to analyze whether the responses were the same (see Boateng et al., 2018). After conducting the cognitive interview, I summarized my notes, compared both responses, and then drew conclusions regarding their feedback.

The findings related to the validity of the instrument were grounded in the two individuals' experiences, which provided insight into constructing codes and themes from the data collected. Peterson et al. (2017) stated that comparative cognitive interviewing can inform data collection and analysis techniques, strategies, and tools. Cognitive interviews allow individuals to express their understanding by verbalizing feelings and thoughts of events from different perspectives. The pretest results provided an interaction between the instrument and individuals similar to the target participants (see Meyer, et al., 2019). In addition, the practice allowed me to be open to learning from unforeseen circumstances and perspectives (see Glesne, 2016).

Qualitative research is a powerful tool for eliciting and communicating the meaning of situations and making sense of life’s complexity as it is lived (Ravitch & Carl, 2021). Qualitative methods have been adopted in sociology and many other applied disciplines (Queirós et al., 2017). Most of the research on affordable health insurance is quantitative in and based on surveys. This qualitative research study provided a deeper understanding of the phenomenon of being in a middle-class family without health insurance. Using in-depth interviews aided in exploring and documenting the study’s problem (see Ravitch & Carl, 2021). The rationale for using cognitive interviewing was to conduct a successful interview (see Willis, 2018). The data collected were analyzed qualitatively to identify problem words or concepts and misunderstood evidence. Establishing the participant's original interpretation of the data or revisions contributed to the validation of the study.

### Procedures for Recruitment, Participation, and Data Collection

I used  the participants responses from the interview questions in the interview guide as well as field notes as sources of data to answer the research question. As the researcher, the interview guide helped steer the study. I conducted only one interview with each participant. Field notes documentation took place within 1 hour after the completion of the interview and all participant interactions, such as follow up interviews. I included the date and time stamp as well as the location of interview. The recorded content covered the participants responses. I also made notes on my observations, details of the interview, description summary of the interview, reflections as the researcher, and emerging questions that raised. Data collection were ongoing for 8 weeks until saturation was reached.

Once the cognitive interview results were been analyzed, it was determined that the optimal length of the interview was approximately 30 to 45 minutes. As described in the consent form, each Zoom interview was audio recorded. I engaged with the participants by listening attentively to their responses and asked follow-up questions to aid in the interview process.

### ***Interview Exit Strategy and Follow-Up Procedures***

Interviews ended with and expression of appreciation for the participants in the study and clarification of any questions they may have had. Participants were reminded to expect an email with a verbatim transcript of their interview to review for accuracy before I began data analysis. Along with the transcript, I also shared any interview notes to confirm that I had interpreted their statements correctly. I also reminded all participants of the confidentiality of their personal information, that the study would not include any personal identifying material, and that all findings would be reported in aggregated form. A copy of the research findings will be shared once the study has been approved for dissemination by Walden University.

Follow-up procedures are considered an essential component of the qualitative research study (Glesne, 2016). During the interview, if there were any new developments, I asked the participants for further clarity. In addition, I conducted a follow-up to thank them for their time.

## Data Analysis Plan

To ensure accuracy, I transcribed each participant's interview recordings. To assist in data analysis, I used NVivo 12 Pro research software to transcribe the interviews and group the responses into codes and categories to discover emerging themes. I also used a frequency distribution table to display the description of the coded materials.

### Procedure for Coding and Data Analysis Software

The coding technique I used in this study was developed by Hassankhani et al. (2018) and included a 6-step process. The process involved (a) becoming familiar with the data collected, (b) generating codes, (c) looking for themes and patterns, (d) defining the themes and patterns, (e) generating reports, and (f) interpreting the themes and patterns related to the phenomenon. The process of coding the themes and patterns required reorganization of the data as the study continued to develop. This approach enabled me to understand the meaning of the data and structure the participants' experiences.

I used a descriptive analysis approach supported by the qualitative research software, NVivo 12 Pro, to analyze the data. I began by coding the data and then grouped the codes into categories. From these categories, I identified themes and patterns. Next, I applied thematic analysis to go beyond the scope of exterior meanings to analyze the data and summarize central themes (see Castleberry & Nolen, 2018; Seidman, 2019).

### Treatment of Discrepant Cases

According to Seidman (2019), any missing data and errors of nonresponse should be addressed as lost data can be viewed as bias and result in a deduction of the sample. If any discrepancies would have been found, they would be reported as a part of the results of this study (see Glesne, 2016); however, there were none. Also, if participants did not complete the interview, I proposed to use the data collected up to that point with the participant's permission, and if they agreed, I would manage the data the same as with any other interview. The participants would have been informed that confidentiality would be maintained, but at their request I would destroy the recordings and notes relating to the discontinued interview and they would not be used. However, no one left the study. Backup copies of all interview recordings were securely stored in a separate encrypted location from the original recordings as suggested by Seidman (2019).

## Issues of Trustworthiness

Trustworthiness of the research allows readers to have confidence in the data collection and interpretation provided by the researcher (Glesne, 2016). I addressed four components to confirm of trustworthiness for this study: credibility, transferability, dependability, and confirmability. Trustworthiness of the data collected is the foundation of good research with evidence-based practice (Glesne, 2016).

## Credibility

Credibility is the process by which qualitative researchers can establish their findings as believable in answering the research question(s) (Seidman, 2019). I used triangulation to demonstrate credibility by comparing my field notes written during the interviews with the audio recordings to check the consistency of the findings (see Forero et al., 2018). In addition, I asked the participants to review their transcripts for accuracy at the end of the interview process and provide feedback regarding any changes needed.

## Transferability

Transferability is the ability to explain the findings in a context other than what was examined (Glesne, 2016). To enhance transferability, researchers should seek to relate the results of their study to similar research available in the literature. I enhanced transferability by providing a thorough, detailed description of the data collection process. I also used thick descriptions from field notes and the recorded interviews to describe the lived experiences of the uninsured middle-class participants. I followed explicit protocols to allow another researcher to perform a similar study.

## Dependability

Dependability is essential to the research findings to establish stability or consistency (Seidman, 2019). The purpose of establishing dependability is to demonstrate that findings are consistent with the data collected (Seidman, 2019). Therefore, I had a research expert in the field perform an external audit to look over the data and see if they arrived at the same findings, interpretations, and conclusions. Additionally, dependability was supported by participants reviewing and ensuring that the transcripts reflected their dialogue accurately.

## Confirmability

Confirmability in qualitative research is the counterpart of objectivity in quantitative research. I provided an audit trail that includes the step-by-step process of conducting the semistructured in-depth interviews, taking field notes, and making recordings. It is imperative to disclose one’s position as a researcher when using a qualitative approach (Rose & Johnson, 2020). The failure to report presumptions could be interpreted as a bias within the qualitative inquiry. Therefore, I kept a reflexive journal to ensure a level of consistency and transparency throughout the study. I achieved confirmability by repeatedly evaluating any possibilities of biases. This helped ensure the findings of the study were the genuine thoughts and experiences of the participants rather than my own.

## Ethical Procedures

After Walden University IRB approval (No. 05-20-22-0997926), data were collected from the participants from middle-class families from Essex County, New Jersey, who met the study’s participation criteria. Ethical procedures are a primary component to maintain trustworthiness in qualitative studies (Seidman, 2019). The recruitment guidelines, policies, and procedures of Walden University’s IRB and the informed consent process guided my work and protected the participants in the study. Following the IRB process ensured that I conducted the research study with the highest level of integrity.

I obtained the Collaborative Institutional Training Initiative certificate to ensure successful and ethical research after receiving the IRB approval (see Appendix E). I have been trained in research ethics, regulatory oversight, and demonstrated I was qualified to conduct this research by earning this certificate. This training covers different aspects of ethical principles and human subject research.

The participants for the study completed a process of informed consent, which ensured they understood the study process and their rights. The participants were informed of the study and their rights both orally and in the consent form they signed. The informed consent document stated that all participants may receive access to the data they contributed to the study and its findings. The contract clarifies how I directed the research and collected and documented data. The purpose of the informed consent was to notify each participant of the study's content (see Glesne, 2016). I informed the participants that they could withdraw from the study for any reason at any time.

Furthermore, the potential participants were aware of all procedures in this study, including the absence of compensation for their participation. In this study I did not intend to make the participants uncomfortable; however, several aspects could have invoked emotional responses. If these circumstances arose, each participant could stop the interview process. Therefore, it was imperative for me to build trust with the interviewees and provide a comfortable discussion environment to allow them to share sensitive information. None of the participants, however, felt uncomfortable and asked me to stop the interview. If specific details regarding the participant's current health status were revealed, I recommended visiting an outpatient clinic or emergency room to seek professional advice; however, this did not occur. The participants did not have to disclose their health information as this was not considered a part of the study and not added to the IRB application.

I maintained the confidentiality of each participant, including any recordings and materials that could identify them (see Glesne, 2016). Data collected were stored on my computer and password-protected in an encrypted format. The password contained alphanumeric characters with uppercase and lowercase numbers, which meet the Critical Security Controls’ encryption research style requirements. The participants’ email addresses were stored in an encrypted Word document; I was the only person who had access to my computer. All files will be destroyed after 5 years of the completion of the study.

## Summary

In this phenomenological study, I explored the lived experiences of the uninsured middle-class participants and their concerns regarding their lack of health insurance. In this chapter, I provided a discussion of the research design and rationale and my role as the researcher. I discussed the study’s methodology, including participant selection logic, instrumentation, and instrument testing, as well as procedures for recruitment, participation, and data collection to assist in answering this study’s research question. I outlined my data analysis plan and addressed issues of trustworthiness, including an ethical plan to ensure the participants’ safety. In Chapter 4, I present the data analysis and research findings.

# Chapter 4: Results

Chapter 4 includes the setting and demographics of the study and a description of the data collection methods. I present an analysis of the data that answered the research question and evidence of trustworthiness. Finally, I provide the results of the data collected from the 10 participants concerning their lived experiences as part of middle-class families who could not afford health care.

## Purpose of This Study

In this study, I aimed to explore and better understand the lived experiences of uninsured middle-class families in Essex County, New Jersey, who could not afford state or any other type of health insurance. This study involved either a single parent, two-parent, grandparent(s), or other nonparent(s) who had custody of and were responsible for a child or children with combined household earnings between $50,000 to $80,000 per year. The qualitative inquiry involved exploring and better understanding the experiences of uninsured middle-class families and focusing on suggestions on how New Jersey can change or improve health policies to help families without health insurance.

## Research Question

The study was guided by the following research question: What are the lived experiences of uninsured middle-class families who cannot afford state or any other type of health insurance in Essex County, New Jersey?

## Setting

The interviews were scheduled based on each participant's availability. The location of each interview was also left for the participant to decide. Primary data collection was done through Zoom interviews. This interview method was selected to ensure participants' safety as the effect of COVID-19 continues. Participants were invited to respond to the interview questions from a quiet place where privacy was available. Virtual interviews were conducted from the privacy of my home office to ensure there were no interruptions during the data collection process. Each interviewee was assigned a number to protect their identity. The numbers were also used during the coding, analysis, and the reporting process. In addition, numbers were used to strengthen confidentiality by making it impossible to trace data back to specific participants (see Surmiak, 2018). Before each interview, the interviewee was given an assigned number. The transcripts and field notes were also labeled with the identifiable interviewee number. During data collection, no unpredictable conditions arose that might have influenced the findings.

## Demographics

Based on the nature of the semistructured interviews and the data collected, there was no need to collect or include a description of the participants' demographics. The demographic details for this study were not required to be obtained or shared in discussing the findings. The study targeted participants who were uninsured middle-class families in Essex County, New Jersey, who could not afford state, government, or any other type of health insurance. Participants’ names, ages, gender, place of work, and marital status were not collected, as this information was irrelevant to the research question.

# Data Collection

## Recruitment

Recruitment flyers to support this study were posted in Essex County urgent care facilities, local libraries, and the county Facebook page. Flyers were posted in over 50 designated locations within Essex County. There were 25 potential participants who contacted me. Ten individuals did not fit the criteria for the study, and five did not respond after they went through the screening process. Ten participants voluntarily agreed to share their lived experiences as uninsured middle-class who could not afford state or another type of health insurance.

## Instrument Procedures

### *Interviews*

The primary instrument used in this study was a researcher-developed interview guide. The interview guide contained questions for the semistructured interviews, which involved the main questions, probes, and individual follow-up interview questions. Data were collected through semistructured one-to-one interviews with each of the 10 participants for 10 interviews. Each interview took 30 to 45 minutes. Interviews were conducted by Zoom and recorded with the participants' permission. At the end of eight interviews, data saturation appeared to be reached. However, two additional interviews were conducted. Data collection took 9 weeks: 6 weeks to recruit the participants, 2 weeks to prepare and send the Zoom links and collect completed interviews, and 1 week for member checking. Each interview was audio recorded and transcribed into a text in Microsoft word.

### *Field Notes*

Handwritten notes captured emotions, tones, and interesting quotes during each interview. I wrote down my interpretations and assumptions of the uninsured middle-class families lived experiences. Directly, after each interview, I spent approximately 30 minutes hand writing notes at my desk on each participant.

### *Data Collection Variations or Unusual Circumstances*

The data collection procedures did not change as initially planned and were approved by Walden’s IRB. Therefore, they were no changes or variations as outlined in the data collection plan listed in Chapter 3. In addition, there were no unusual occurrences identified during the data collection process.

## Data Analysis

### Process

Hassankhani et al. (2018) detailed a 6-step analysis strategy suitable when conducting a qualitative research study. The clearly defined procedure for sorting, grouping, and analyzing data was used to extract codes, categories, and themes from the interview responses. The study consisted of 10 interviews. The interview recording log was the first step using a record sheet. Transcripts were created from audio recordings and then transcribed to text in Microsoft Word where I was able to compare them for accuracy. During each interview, handwritten notes captured nonverbal communication to reflect vocal tones, pauses in speech, and emotions. The notes on the nonverbal cues were important to provide particular emphasis on some of the comments in transcripts.

The notes for each participant were read several times and cross-referenced with notes of initial keywords, ideas, and phrases to ensure familiarity.

A two-cycle coding method was applied to the transcript. Frist, NVivo 12 pro was used, and then I connected first cycle codes with reoccurring focal points to identify the standard codes to emphasize the research question. The way the coding was conducted connected the research question with the uninsured middle-class lived experiences, creating a meaningful interpretation of the data (see Lowe et al., 2018). For the second cycle coding, I used the pattern method. I recorded emerging themes from the first cycle codes and reoccurring focal points in the pattern coding process. Using the second cycle pattern, a rich interpretation of the data collection described the context of the uninsured middle-class influence on this phenomenon.

A list of codes and themes was generated following the second cycle of coding to support the meanings provided by exerts from the transcripts. I followed-up with each participant after the interview, and a copy of their transcript was sent via email requesting feedback. Using email was a safe and easy way to communicate with the participants. All the participants responded and confirmed that no changes were needed to the transcript sent for validation. I made three follow-ups via phone calls, after which the participants' validation was received with no modifications. The immersive process of reviewing the data supported the development of the five common themes: health care is just too expensive, not having insurance is living on the edge, how hopeless people make hope-filled decisions, what is needed to fix the problem (solutions), and sad decisions (of the pragmatic middle class). Table 1 depicts theme development and categories codified from the NVivo codes.

**Table 1**

*Theme Development*

| Codes | Categories | Themes |
|---|---|---|
| Costly<br>Costly basic package<br>Cost saving measures<br>Think twice | Constructivism | Health care is too expensive |
| Home remedies/ Self-identified solutions<br>Infrequent doctor/dental visit<br>Stay in pain<br>Stress and constant worry | Individualism | Not having insurance is living on the edge |
| Rational avoidance<br>Dualism (dyadic decision structures)<br>Hierarchy (of importance)<br>Rational choice | Rational decisions | How hopeless people make hope-filled decisions |
| Universal insurance<br>Free to low cost<br>Cap on insurance<br>Too high deductibles | Self-interest | What is needed to fix the problem (solution) |
| Different treatment<br>Wait time<br>Tax solution<br>Affordable insurance | Utility | Sad decisions (of the pragmatic middle class) |

### *Theme 1: Health Care Too Expensive*

The first theme from the data collected was that health care was too expensive. This theme clarified what influenced the uninsured middle-class family's decision who could not afford state or any other type of health insurance. Each theme was associated with a category. The first category was collectivism, which includes the principle that uninsured middle-class families emphasize the importance of social expectations rather than the individual good. The codes associated with this category were costly, costly basic package, cost-saving measures, and think twice.

### *Theme 2: Not Having Insurance Is Living on the Edge*

The second theme from the data was that not having insurance is living on the edge. The category assigned to this theme was individualism. Individualism is the view that the family's beliefs take precedence over each individual's self-interest for the good of their interdependence. The codes associated with this category were home remedies/self-identified solutions, infrequent doctor/dentist visits, stay in pain, stress, and constant worry.

### *Theme 3: How Hopeless People Make Hope-Filled Decisions*

The third theme from the data was how hopeless people make hope-filled decisions. Rational decisions was the category associated with this theme. Participants expressed their individual decisions for their choices that satisfy the demands of reason. The codes related to this category were rational avoidance, dualism (dyadic decision structures), hierarchy (of importance), and rational choice.

### ***Theme 4: What Is Needed to Fix the Problem (Solutions)***

The fourth theme from the data was what is needed to fix the problem. Self-interest was the category associated with what is needed for this to occur. The uninsured middle-class participants expressed their desire to contribute to what is most vital for them and their families. The codes linked to this category were universal insurance, free to low-cost, cap on insurance, and too high deductibles.

### ***Theme 5: Sad Decisions (of the Pragmatic Middle Class)***

The fifth theme relating to the data collection was sad decisions (of the pragmatic middle class). The category associated with this theme was utility. The participants made rational choices that resulted in outcomes that were in their best interests. The codes aligned with this category included different treatments, wait time, tax solutions, and affordable insurance.

## **Discrepant Cases**

There were no noticeable discrepant cases in the study. All participants met the screening criteria and were uninsured middle-class families living in Essex County, New Jersey. The participant's’ responses were coded and categorized into themes as previously described.

## **Evidence of Trustworthiness**

As outlined in Chapter 3, procedures to ensure trustworthiness were followed during the analysis of data collected. Attention should be given to evidence-based practice, which involves the estimation of the trustworthiness of sources and the credibility of the claims made by the researcher. The findings also need to be believable, and the research method should emphasize the need for a shared language to reduce confusion (Stilwell & Harman, 2021).

## Credibility

To establish credibility, a standard semistructured interview protocol was used. After each interview was conducted and transcribed, the participants took part in member checking, establishing credibility. The participants were able to review the transcript from their interview and my interpretations to determine the accuracy of the data as outlined in Chapter 3. The member checking process was essential to the study as it allowed the participants to make changes to the transcript or clarify and expand on their responses (see Candela, 2019).

The participants' interpretations ensured that I understood and captured what they meant to communicate. Reflexive notetaking was carried out immediately after each interview to maintain the quality of the work. In addition, a journal log was kept in which I recorded my thoughts, assumptions, and emotions during the data collection process to assist with coding.

## Transferability

As outlined in Chapter 3, the participants for the study were the uninsured middle-class families of Essex County, New Jersey, who could not afford state, government, or any other type of health insurance. As Mohajan (2018) suggested, using participants' criteria, description of data collection methods, and probing questions, such collaborative qualitative research requires a detailed description of the research process.

I provided thick and rich descriptions and the transcripts to support transferability and create an experience that allows other readers to connect with the participants, which can apply to other counties and states.

### Dependability

The audit trail was an essential element in contributing to dependability. To ensure that dependability was maintained throughout the study, multiple sources were used in the data collection and analysis process to demonstrate that the findings were credible, and that replication was possible. The audit trail included the transcripts from audio recordings, nonverbal communication through notetaking, and reflexive thought contained in the filed notes.

The participants validation of transcript for accuracy reflected our communication dialogue along with the rationale for merging themes, codes, and categories during data analysis. In addition, to ensure dependability, the data were again analyzed using NVivo 12 Pro. As a result, this allowed me to present the emergent themes with confidence.

### Confirmability

Confirmability was achieved by maintaining a detailed journal throughout the study. The reflexive commentary presented in this study is not mine; it is grounded in the lived experience of the uninsured middle-class participants to support the development of codes and, subsequently, themes. In addition, an audit trail was created by carefully documenting the interviews in my notes, through observation, and interpretation of my notes and thoughts on the uninsured middle-class participants. All these components were collected and recorded in a journal locked in a safe place. The interview recordings are stored with encryption. The careful documentation has allowed me to provide detailed findings for the readers, which reflects the participants lived experiences and not my biased opinions.

## Results

The results of this study are organized according to the themes that emerged to answer the research question. The organization of the results begins with the first set of interview questions to help the reader understand the lived experiences of the uninsured middle-class families who could not afford state or any other type of health insurance in Essex County, New Jersey. The first set of interviews questions were related to the experience and meaning of the interviewees about health policies and suggestions on how New Jersey could change or improve health policies to help their families. The second set of questions was related to the participant's' experiences and meaning of health policies and suggestions on how New Jersey could change or improve health policies to help uninsured families. Five key themes, five categories, and 20 codes emerged as a result of the data collection analysis. The research question that guided this phenomenological study was: What are the lived experiences of uninsured middle-class families who cannot afford state or any other type of health insurance in Essex County, New Jersey?

### Theme 1: Health Care Is Too Expensive

The cost of health care was the prominent prohibitive reason individuals did not have any health care. When asked if there were any other reasons beyond cost, Participant 1 succinctly stated, "No. The cost is the main reason." There were other concerns with the high cost of health care, which affected all participants. The cost limitations were related to individual coverage and identifying and procuring affordable care for the entire family

The problem of cost was not limited to private health care but also included accessing employment-based care offers. There were also concerns related to associated health care expenses, such as deductibles, so that even when the participant considered paying for health care, they were faced with this challenge. The deductibles became a key limiting factor beyond the initial concern for monthly payments for coverage. When asked what role the high deductible played in not having health insurance, nine participants shared that their employer offered health insurance plans based on lower payments, resulting in a higher premium. Participant 7 said, “Even if I could afford the low payment plan, the premium would be so high expensive to afford an insurance plan.” Participants 5, 6, 7, 8, 9, and 10 noted that employer-sponsored health care coverage per paycheck was too high. Participant 4 was able to afford the monthly cost but was stymied by the potential for high deductibles associated with getting insurance. This suggests that high costs influenced decisions beyond acquiring insurance care. Participant 3 stated, "For my family and me, it's tough to find one that the deductible would not be high and one that would cover our preexisting conditions." There are many associated consequences to health care being so high. Because costs are high, the participants utilized emergency services for rudimentary health care and avoided getting regular preventative checks. Participants 3, 4, 5, 6, and 9 shared that deductibles have to be paid upfront before seeing a specialist, making it difficult, especially if they have an underlying illness.

The constructivist approach to social relations is an exploration of how rules shape states, such as New Jersey (see Jung, 2019). States also need to socialize with other nation-states because ideas are intersubjectively shared among them, and ideas can change the interest of nation-states (Lilja, 2018). However, this does not mean that constructivists deny the importance of conflict. Participant 3 stated, “An effective strategy for improving access to health care is to model [what] other nations [have] shared [and the] ideas that [they] have [for] a comprehensive health plan for its [*sic*] citizens. Participants 1, 2, 7, and 10 noted that, office visits and blood tests were completely out-of-pocket and costly, making it hard to provide for the family. As providers for their families, they wanted to ensure they were safe and taken care of.

A key belief is that working individuals should be able to afford health care. Still, the lived experiences of the working middle-class participants suggests that this widespread belief requires deeper investigation. There is also a decision-making limit associated with high health care costs. The decision dynamic is frequently described as *think twice,* which means that participants hesitated to take steps to acquire health care coverage because of the associated cost. Participant 2 indicated, “Not having health insurance affects the family, especially when someone is sick, and we have to think twice about going to the doctor." The participants were aware of the steps required, but because of the associated expense, they reassessed their available options and chose the one they considered best. This process is complex and involves producing a hierarchy of options and other attitudinal concerns. Table 2 lists the codes for Theme 1 from the data obtained from the 10-participant interviews.

**Table 2**

*Codes for Health Care Is Too Expensive*

| | Participants | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Codes | P1 | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 |
| Costly | X | X | X | X | X | X | X | X | X | X |
| Costly basic package | X | X | X | X | X | X | X | X | X | X |
| Cost savings measures | X | X | X | X | X | X | X | X | X | X |
| Think twice | X | X | | X | X | X | X | X | X | X |

### Theme 2: Not Having Insurance Is Living on the Edge

One of the main factors preventing the middle-class from obtaining health insurance is the high cost of health insurance plans. Self-identified solutions, such as home remedies, were commonly used by for participants because of the lack of medical coverage. Participants self-identified with finding solutions in delayed care, self-monitoring, infrequent doctor/dentist visits, staying in pain, stress, and constant worry. When asked how not having health insurance affected their family, Participant 4 said, “Not having health insurance affected the family because sometimes I might not feel well, and I decided not to go to the doctor and use some home remedy.” Participant 2 added,

> It affects the family on every level. Because even when my children get sick with a common cold, I would really love to have them tested, especially for COVID-19, but because the test is no longer free and requires your health insurance, I try not to spend that $250 to go to the urgent care and then you have to sign a waiver

> that you are responsible for any other additional charge because you will be paying for the visit and bill for lab charges.

Each participant agreed that they had difficulty deciding to put other expenses ahead of going to the doctor. This means uninsured middle-class self-pay visits influenced whether a family member visited a primary care doctor or not. Individualism was reflected by the participants who emphasized their right to protect their own interests. Participants 1 through 10 felt strongly about giving their children and the bills precedency if they needed a doctor's visit; if they felt sick, they would, instead, use a home remedy. Individualism is associated with the individual human desire that takes precedence over social values (Lynch & Kalaitzake, 2020). Clark (2021) noted that individualism had shaped public discourse about health insurance. Participant 1 added,

> I am a high-risk patient, but I often have to self-monitor my blood sugar. The money that I would pay to see the doctor, I use it to buy medication, because I have a full knowledge of how to care for my diabetes after so many years

Participants 6, 7, 8, 9, and 10 agreed that taking care of their health should not be a choice. Participant 1 recalled an emotional time when her blood sugar was low, and she was scared because she was home alone. The goal-oriented behavior of the participants reflects the outcome of the purposive pursuit that maximizes their individual self-interest. Table 3 identifies the codes and their frequency used to establish Theme 2.

**Table 3**

*Codes for Not Having Insurance Is Living on the Edge*

| | Participants | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Code | P1 | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 |
| Home remedies<br>(self-identified solution) | X | X | X | X | X | X | X | X | X | X |
| Infrequent doctor/dentist visit | X | X | X | X | X | X | X | X | X | X |
| Stay in pain | X | X | X | X | X | X | X | X | X | X |
| Stress and constant worry | X | X | X | X | | X | X | X | | X |

## Theme 3: How Hopeless People Make Hope-Filled Decisions

The participant's decisions were rational as they made sense of their everyday lives. There were strategies that the participants used in their decision-making processes. When asked, what their experience was in with dealing with using the emergency room and paying the bill afterward, Participant 8 said, "I would try to stay away as much as possible from going to the emergency room unless I really have to go, which I might go once a year." This was one of the strategies the participants used to avoid paying for services. Rational avoidance was also seen in the same participant's response: "So, you know if we get sick, a simple COVID test right now – before you could get a test for free."

Participants also use mystical thinking as one of their strategies, such as an intervention for not having health insurance. When asked what were some of the major disadvantages that they experienced by not having health insurance, Participant 5 explained, "But I try my best to take care of diabetes and thank God I had a checkup a couple of months back, and the doctor said I still do not need to go on medication." All participants used dyadic decision-making by comparing needs versus wants that could not be accomplished simultaneously because of the associated cost. The dualism of rationality was important in shaping the participants’ decision-making process. Participant 5 stated, "Yes. Sometimes I have bills to pay, and other times I might feel sick. Moreover, everything is expensive these days, so sometimes I have to pay the neediest bill at the time." Participant 2 shared,

> I'm trying not to spend $250 to go to the urgent care just to get seen, and then when you get seen at the urgent care here, you will have to sign a waiver that you are responsible for any additional tests that they might do and so you're going to be paying for a visit, and then they are going to be billed for lab charges as well.

The participants also used a hierarchy of needs in their decision-making process by constructing an order that provided a structure that involved looking at the seriousness of an illness. Participant 6 said, “First, I have to think about the seriousness of the illness before going to the family or any family member." When asked why they decided to go to the emergency room, Participant 4 said, "Going to the emergency room is not my first preference, but sometimes the wait is too long, but it works for me at the time, and the experience is not bad." Participants used a decision-making process that involved weighing costs and benefits. The participants’ rational decisions were not randomly selected; they were selected by considering the cost and benefits of different options which were most desirable to their family as Figure 1 demonstrates.

**Figure 1**

*Model of RCT: Rational in the Participants' Choices*

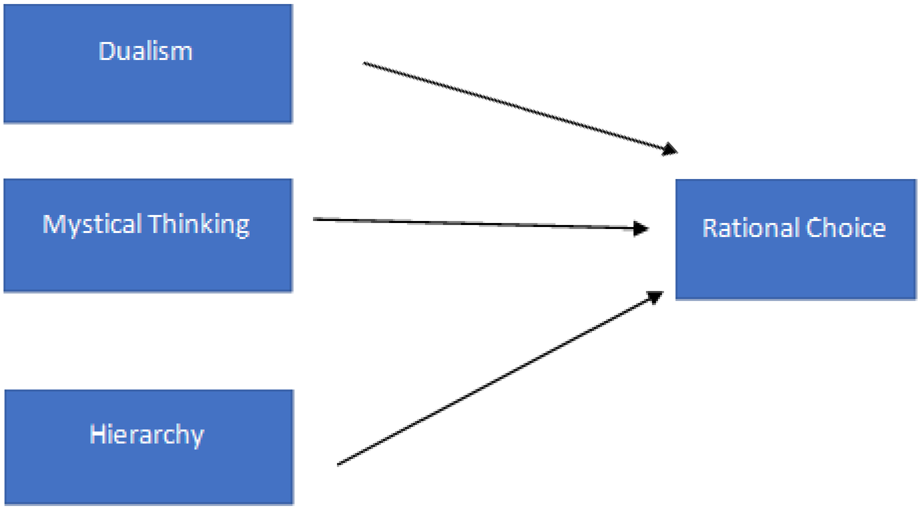

Table 4 provides a list of codes and their frequency that pertain to Theme 3.

**Table 4**

*Codes for How Hopeless People Make Hope-Filled Decisions*

| | Participants | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Codes | P1 | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 |
| Rational avoidance | X | X | X | X | X | X | X | X | X | X |
| Dualism (dyadic decisions structure) | | X | X | X | X | X | X | X | X | X |
| Hierarchy (of importance) | X | X | X | X | X | X | X | X | X | X |
| Rational choice | X | X | X | X | X | X | X | X | X | X |

### Theme 4: What Is Needed to Fix the Problem

Finding ways to make health insurance more affordable was at the forefront of every participant's agenda. The consensus of the participants was to propose universal health care when asked what they would like to see done to New Jersey's state health insurance to make it more affordable. Participants 1, 2, 3, 4, 5, 6, 7, 8, and 10 shared that health insurance should be free or low-cost for all Americans and not only for New Jerseyians. Participant 3 mentioned that other countries, such as Canada, provide universal medical coverage for their citizens. Participants 1, 3, 4, and 6 mentioned that removing the income cap would be an effective strategy for improving access to health insurance. However, all policy makers and legislators must lobby for free insurance, said Participant 7. Participant 2 explained,

> Even the basic package of health insurance is too expensive, and the basic package also limits you to which doctor you can visit, and you end up paying out-of-pocket for many things that do not cover [*sic*] by the insurance. Also, sometimes you are referred to a specialist who does not take your insurance, limiting your stay in your network. Extensive studies should carry out [*sic*] to see how the uninsured working class are being disenfranchised by not having free or very low health premiums.

The idea of universal health insurance based on explicit appeals to solidarity and social justice have emerged periodically, but each time failed to pass into law (Falicov et al., 2020). Participant 3 said, "Not having health insurance not only affects my health, but it also affects my car insurance because the car insurance company gives you a higher rate when not having health insurance." Participant 6 said, "The idea of [*sic*] universal insurance plans should cover most of the doctor's cost, laboratory, X-ray, emergency room, and medical care, and surgical procedures . . . is why I am for universal health insurance."

The purpose of having health insurance is to help people cover their medical costs. The notion of self-interest has application to human behavior in a particular type of human situation (Van de Vyver et al., 2018), which means that human motivation, desires, and passions are driven by self-interest. Participants 1, 2, 3, 4, 5, 6, 8, and 9 noted that if someone was qualified for health insurance based on income, removing the income cap from New Jersey’s current health policy would allow many to receive assistance from health programs that the state already has in place.

Participants 1 through 10 also mentioned that it is essential for New Jersey legislators and policy makers to come together and develop programs and policies to make health insurance affordable for Essex County residents. The participants referred to putting an income cap on insurance premiums as a step in the right direction but not a solution to affordable insurance. Participant 6 recommended to policy makers use “federal and state grants to open a health facility in Essex County where doctors and other health care professionals can work for 5 years and have their student loan [*sic*] forgiven. Participants 4, 6. 7, 8, and 10 added that, student loan forgiveness for services rendered after 5 years should be stated upfront when medical students enroll. Participant 8 noted, "More extensive research on the uninsured middle-class need [*sic*] to be done for policy makers to understand the contributing factors impacting our everyday lives." The participants' preferences were based on self-interest to provide them with the greatest benefits. Table 5 presents the codes obtained from the data of the participants'' interviews pertaining to Theme 4.

**Table 5**

*Codes for What Is Needed to Fix the Problem*

| | Participants | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Codes | P1 | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 |
| Universal insurance | X | X | X | X | X | X | X | X | X | X |
| Free to low-cost | X | X | X | X | X | X | X | X | X | X |
| Cap on insurance | X | X | X | X | X | | X | X | | X |
| Too high deductible | X | X | X | X | X | X | X | X | X | X |

### Theme 5: Sad Decisions (of the Pragmatic Middle-Class)

Rational choice is the decision-making process that involves weighing costs and benefits. Although the participants' decisions were rational, they were the sad decisions of the pragmatic middle-class. Some decisions were based on their mystical thinking, which led to the satisfaction of their rational cost benefit decision that was best for their family. When asked if they ever had difficulty deciding to put other expenses ahead of going to the doctor, and if the response was "yes," to explain that experience and how the decision was made, Participant 5 said, "It is sad, but sometimes the family needs are set aside, and I have to decide what comes first or maybe which bill to pay." The participant defined emotions associated with the processes required to live without health care as "sad." When asked why they decided to go to the emergency room, Participant 2 explained: "Going to the emergency room is not something I love to do because the first question they asked [*sic*] [is], “do you have health insurance?” and obviously, my answer would be no, and what I notice is that they treat you differently." Participant 5 added, "You have to wait a long time for them to attend to your needs." When asked what their experience was with using the emergency room and paying the bill afterward, Participant 4 noted, “Going to the emergency room is not my first preference, but sometimes the wait is so long. But it works for me at the time, and the experience was not bad." Participant 6 stated, "Going to the emergency room can be a pain because of the long wait, but the reward for paying later works for me, so I go there if I have to."

The decisions, while rational, are still sad. Making a rational decision does not necessarily mean it is one someone is happy with, but it is a means to an end. When asked what they would like to see done to New Jersey's state health insurance to make it more affordable, Participant 7 stated: "I would like to see a tax health care program, where you pay a little more tax from your paycheck, which is affordable." Participant 8 added, "The state should consider affordable insurance for all its residents by letting them pay more tax into the state health program." These are critical elements to understanding the rationality of the participants. Although they were willing to pay more tax for affordable health care programs, they could not afford the high cost of health insurance plans. The participants could calculate the benefits (utility) of expected outcomes resulting from their particular interactions. The decision-making order constructed by the participants provides a structure to the decision-making process by evaluating the seriousness of family choices, as illustrated in Figure 2.

**Figure 2**

*Model of RCT: Rationality in How Participants Calculate Benefits (Utility)*

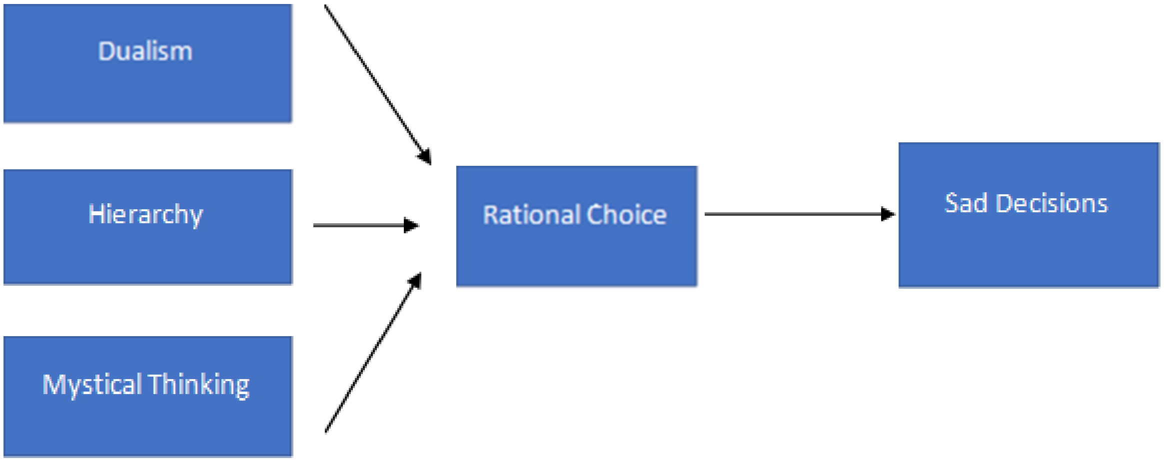

Table 6 includes the codes and their frequency used to identify Theme 5.

**Table 6**

*Codes for Sad Decisions (of the Pragmatic Middle-Class)*

| | Participants | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Codes | P1 | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 |
| Different treatment | X | X | X | X | X | X | X | X | X | X |
| Waist time | X | X | X | X | X | X | X | | X | X |
| Tax solution | X | X | X | X | X | X | X | X | X | X |
| Affordable insurance | X | X | X | X | X | X | X | X | X | X |

## Summary

In this qualitative study, I aimed to better understand and explore the lived experiences of uninsured middle-class families in Essex County, New Jersey, who could not afford state, government, or any other type of health insurance. Data were collected for this phenomenological research through semistructured interviews. Ten uninsured participants from middle-class families voluntarily took part in the study. All the participants met the inclusion criteria of not having insurance from 2020 until the interview. Following the 6-step analysis strategy outlined by Hassankhani et al. (2018), five major themes emerged: health care is too expensive, not having insurance is living on the edge, how hopeless people make hope-filled decisions, what is needed to fix the problem, and sad decisions (of pragmatic middle-class).

Regarding the theme of health care is too expensive, the participants shared that there are self-limiting behaviors based on not having health insurance. Under the theme of not having insurance is living on the edge, the participants shared their experiences of not having health insurance and the solutions to their medical problem by using available personal resources. For theme how hopeless people make hope-filled decisions, the participants use dualism as an ideology choice structure to make sense of their hierarchy of needs. Universal insurance, free to low-cost, cap on insurance, and too high deductibles were codes that developed under the theme of what is needed to fix the problem (solutions). The participants shared their experiences that not having health insurance is a sad decision when they have to think of their family’s needs over going to the doctor. Chapter 5 will address the study findings, limitations of the study, recommendations, and implications for positive social change.

# Chapter 5: Discussions, Conclusions, and Recommendations

In this chapter, I summarize the essential findings of this study and their interpretations. The previous chapter outlined the five thematic categories that emerged: constructivism, interpretivism, rational decisions, self-interest, and utility and their relationship to the theoretical framework. The following chapter features a discussion and interpretation of the study's findings, its limitations, recommendations for future research, and implications for positive social change.

## Purpose and Nature of the Study

The purpose of this study was to explore and better understand the lived experiences of uninsured middle-class families who do not have state or any other type of health insurance living in Essex County, New Jersey who could not afford state or any other type of health insurance. The study involved single-parent, two-parent, grandparent(s), or other nonparent(s) who had custody of and were responsible for a child or children with combined household earnings between $50,000 and $80,000 per year. I aimed to identify the choices and consequences of why uninsured middle-class families do not have health insurance.

This qualitative research study was completed using a phenomenology as its design. The purpose of this phenomenological approach was to identify phenomena through the unique experiences of uninsured middle-class participants due to their choice to go without health insurance. The deductive approach provided the opportunity to test RCT by describing and understanding insights into the uninsured middle-class family's decision making and the impact of the lack of health insurance.

## Summary of Key Findings

The findings from the first-hand accounts of the uninsured middle-class participants aligned with the literature on uninsured middle-class families. All participants stressed the importance of health insurance being free or low-cost for all Americans. Additionally, my study provided information to support the data from the literature that the lack of insurance hurts the health status of the uninsured. Sen and Deokar (2021) found that the uninsured use fewer health care services than the insured. A survey study by Wammes et al. (2018) showed that elevated costs were associated with higher insurance payments in the United States and lower payments abroad because the prevalence of mental illness was 30% higher in the United States. Even when the uninsured have access to health care, they often find it difficult to pay their bills (Ung & Mullins, 2015).

Data from this study have contributed to the knowledge in the discipline by identifying how individual choices based on collectivism and individualism can influence the decision making of uninsured middle-class families. I discovered that decision making was one of the options ranked highly by the participants. My research also addressed how the participants were willing to pay more taxes for state health programs but were not willing to pay high deductibles. Also, the uninsured families' actions may be rational given their beliefs and desires with their decisions; however, they were sad decisions. Decision making is the process by which families make choices that guide their daily operations (Kanto et al., 2020). By applying RCT, I discovered that the uninsured middle-class families did not use a complete rationality approach when making health insurance decisions but used rationality to explain their behavior for basic choices.

## Interpretation of Findings

Humans are rational beings, and the conditions for rational choice are the only conditions that satisfy the demands of reason. In decision making, the uninsured participants addressed the values that were most important to their family’s needs. In simple terms, I studied if the uninsured middle-class families made rational choices based on their family’s needs and how they came to make those decisions.

The findings from the first-hand accounts of the participants support the available literature on uninsured middle-class families. As noted by Kruk et al. (2018), health coverage should be a basic human right, but it is meaningless without a good quality health care system. The theme health care is too expensive applies to collectivism, which was apparent in the uninsured middle-class participants’ emphasis on the importance of meeting social expectations for the group’s good rather than the individual. The codes associated with this category were costly, costly basic package, cost saving measures, and think twice.

Humans are rational beings, and they make rational choice based on the demands of reason, and yet their choices do not violate the rational choice conditions (Burns & Roszkowska, 2016). People make decisions based on their goal-oriented behavior, social interaction, and the development of cultural systems and social structure to reflect the outcome of their individual self-interest. Hence, not having insurance is living on the edge because of high deductible, which was a major finding in the study. Sinaiko et al.

(2016) demonstrated that high deductibles contribute to a greater share of out-of-pocket towards medical costs that discourage the use of outpatient services. The participants in the study felt that if New Jersey removed the income cap on health insurance, it would not fix the high deductible problem, but it would be a step in the right direction.

The theme of not having insurance is living on the edge is also supported by the available literature. All participants stressed that the importance of not having health insurance was linked to stress and constant worry, which could lead to personal health problems. Collectively, the participants expressed there should be no income cap on health insurance, and everyone should have access to free or affordable health coverage. This was evident in the discussions on what were effective strategies for improving access to health insurance. The category assigned to not having insurance is living on the edge was individualism, which is when the family’s beliefs take precedence over each individual’s self-interest for the good of their interdependence. The codes associated with this category were home remedies/self-identified solutions, infrequent doctor/dental visit, stay in pain, stress, and constant worry.

In the case of the participants, each individual appeared as the autonomous subject to their rational choice that protected their primary decisions. The individuals were formally free to exercise choices that added meaning to their lives. Individualism provided these families with a set of answers to the questions surrounding their interests. The participants from uninsured families promoted the idea that all interests are ultimately self-expressed by their rational choice. The theme further represented the individual’s techniques used to address the limits imposed on care access by the lack of insurance.

The participants used rational decisions to explain their choices as patterned outcomes that maximized their individual interest. The participants of the study noted that the importance of their family’s well-being had been affected because of the lack of health insurance. This was depicted in descriptions of these events as the participants retold series of limited doctor’s visits for families as a result of not having health insurance.

The category that was associated with how hopeless people make hope-filled decision was rational decisions. Participants expressed their individual decisions for their choices that satisfied the demands of reason. The codes associated to this category were rational avoidance, dualism (dyadic decisions structure), hierarchy (of importance), and rational choice. The participants cited the importance of individual decision making and how having health insurance will alleviate the burdens of stress, anxiety, and worry. This idea is supported by the findings of the few researchers who have taken health insurance for the middle-class earners into consideration. Pak and Gannon (2021) further supported the findings of the study by asserting that there are three cornerstones of health care: cost, access, and quality.

As mentioned in Chapter 2, health insurance protects individuals and families from the financial impact of high-cost medical services; however, uninsured families pay a higher proportion of their health care costs (Cogan, 2020). The current study highlights that free and low-cost health insurance should not only be for Essex County residents but for all Americans. Self-interested was the category associated with what is needed to fix the problem (solutions). The uninsured middle-class participants expressed their desire to act in their self-interest to affordable health insurance. The codes associated with this category were universal insurance, free to low-cost, cap on insurance, and too high deductible.

As highlighted by the participants, deciding to put other expenses ahead of going to the doctor should not be a choice. The participants discussed that universal health insurance should be a human right and not a choice. The consensus among participants was highlighted in the literature review, that even when the uninsured have access to health care, they often find it difficult to pay their bills. The findings of the study confirm the available literature by Ung and Mullins (2015) and Keehan et al. (2020), which suggested that medical expenditures, which reflect prices for medical services and goods but exclude prices associated with the net cost of insurance, are projected to increase at a rate of 2.4% between 2019 and 2028.

The theme of sad decisions was supported by RCT, which explains the way individuals make choices based on the notion that people attempt to find the most effective method of attaining their personal goals. As previously addressed in Chapter 2, Rutar (2019) found that the basic RCT asserts that all outcomes are known with certainty. Frank (2019) noted that understanding resource availability explains how individuals make choices and is the most effective method of attaining personal goals.

The participants used dualism and rational choice to think about their world. They used dualism as an ideology choice structure to make sense of their hierarchy of importance of what was possible and what was necessary. The participants considered the expected costs associated with their actions to calculate their variable benefits (utility), which maximizes utility. One participant described the emotion associated with the process of living without health insurance as being sad. The findings from the study align with RCT, which explains how individuals make choices in finding the most effective method of attaining their personal goals. The study brings to light that rational actors justify the normative principles that govern their optimal decision making and their descriptive choice caused by desirable or undesirable outcomes (see Wittek et al., 2013).

## Theoretical Framework

The RCT involves understanding that humans are rational beings and that the conditions for rational choice are the only conditions that satisfy the demands of reason (Burns & Roszkowska, 2016). The methods of RCT in qualitative studies are essential to explain human behavior as patterned outcomes of macrolevel causes are related to culture and social structure that affect families. Therefore, RCT focuses on the intentional, goal-oriented behavior of individuals' choices (Wittek et al., 2013).

Social interaction, and the development of cultural systems and social structure, reflect the outcome of the purposive pursuit of individual self-interest (Nishant et al., 2019). By utilizing this approach, the participants shared common reasons why they were uninsured. Subsequently, some uninsured middle-class participants explained how they had to choose to pay rent over getting an annual physical check-up. RCT maintains that individuals are characterized as rational and choose actions to maximize their interests—the satisfaction of their needs and wants (Wittek et al., 2013).

It is important to recognize that other factors, such as the structure of an existing social context, also influence an individual's decision making (Kanto et al., 2020). Within a social context, several factors affect individual choices, and the scarcity of available resources limits societal opportunities. Uninsured middle-class families do not choose one goal over another because of its overall value but because of the resources related to achieving their goals (see Wittek et al., 2013). In the absence of health insurance, the uninsured participants explained behaviors as a response to the value of interests or preferences (see Nishant et al., 2019). One way to characterize the problem of the uninsured middle-class is by collective action.

## Limitations of the Study

The study reached saturation through sampling, collecting, and analysis of the data. However, the small number of uninsured participants from Essex County was a limitation to the study. Additional participants could have been recruited from the neighboring county, which would have provided more interviews, resulting in more information. Therefore, the sample size may have affected generalization of the study's findings. Getting participants to contact me and to interview was another limitation. The ongoing COVID-19 pandemic might have had an impact on the study, as fewer people were going into public places where the recruitment flyers were posted.

## Recommendations

This research study was qualitative phenomenological. The findings depict how participants repeatedly demonstrated that the health insurance premiums are too high. Inflation makes it impossible to pay for health insurance. Therefore, legislators, policy makers, and health advocates need to use this information to create programs and policies that will remove the poverty level guidelines in the state to make health insurance more affordable for middle-class residents. Intensive follow-up research is necessary to understand the effectiveness of new programs and policies of the families and their collectivist and individualist responses to health insurance programs. Future research could include a pilot study of collaborative uninsured middle-class families with all health departments within Essex County.

The information provided from the proposed pilot study should be obtained by the health department through community researchers. The platform would be monitored by rotating researchers collaborating with the health departments to provide open dialogue with the uninsured middle-class population. This could be done by inviting uninsured middle-class participants from across the state of New Jersey to take part in research studies to better understand their lived experience and to share the data collected with health policy makers to create affordable health insurance premiums for the uninsured middle-class population.

The scope of my study did not include how inflation affects uninsured middle-class choices to not obtain health insurance, another area for future research. The final question of the interview guide was how might a policy that puts an income cap on insurance premiums help individuals be able to afford health insurance. Participants reported that health insurance is too expensive to afford, so an income cap would not solve the problem of affordable health coverage, but it would be a step in the right direction. Further research could be conducted to compare and analyze the uninsured middle-class's income with their average spending.

## Implications

### Positive Social Change

Positive social change requires social actors to identify a problem that affects a community and find solutions to address it. The implications of my study can inform policy makers, legislators, and health advisors to promote affordable health programs. These, in turn, will provide low-cost medical care, which could lower death rates, create better health outcomes, and improve the lives of Essex County, New Jersey, citizens by enhancing their peace of mind.

#### *Individual Level*

From the lens of the individual, my study could encourage more families to get involved with their local municipal council and policy meetings open to the public where they will have the opportunity to express their concerns. In addition, families and individuals need to get to know their local legislator, send letters to the committee assigned to the health care bill, and attend hearings and testify on that bill. Families and individuals attending these town hall meetings and offering their opinions echo a sense of synergy and not just individualism. These efforts support the foundation of a more collectivist society. This channel would allow individuals and families to express their thoughts and feelings. In addition, the collective information from the uninsured middle-class population can help create affordable health care for more people.

### ***Society/Policy Level***

Policy makers must understand the premise of individualism and collectivism, which frequently contrast to cover a range of ideas and doctrines that emphasize the individual’s right to protect their interests against society. My study provided information that, from a social perspective, people are interdependent and closely linked to one or more groups, and conformity to group norms is expected, reflecting collectivism. Moreover, individualism was manifested in the participants’ responses in their focus on their family’s welfare as an essential purpose in life. Policy makers at the state level need to consider the relationship between individuals and society, recognizing that these two analytical levels are distinct and may have to be explicated separately. The state of New Jersey can encourage another county other than Essex to conduct similar studies to discover what additional information is needed to change policies and programs for the uninsured middle-class population.

The results of other studies could provide more information to enhance social change, where families feel more involved, and their voice is heard. Furthermore, the state can enhance budgets for county health insurance programs where families can contribute and have the opportunity to visit the doctor without the worry of large health care bills.

## Methodology

My study has shown that qualitative methodology is not widely used when exploring and better understanding the uninsured middle-class lived experiences. The quantitative methodology has been the primary means of exploring and understanding this phenomenon. Quantitative methods are controlled from extraneous influences and generally geared toward statistical approaches to sampling, measurement, and data analysis. Qualitative research on this topic allows the researcher to obtain rich data that is not easily obtainable using quantitative methods. Qualitative research comprises a variety of methodologies, including observation, interviewing, and document analysis, which shape and influence the participants' decisions. Qualitative research, using individual interviews, provides a richer understanding of the participants' behavior by providing real-life examples and the meanings of their experiences on the research topic. The semistructured interview involves direct interaction between the researcher and the participants. The dialogue explores the subjective perceptions, beliefs, and values with the responses and experiences of the participants' and the influence for eliciting the meaning of their situations, for making sense of life as it is lived, and communicated through the uninsured middle-class.

## Practice

Policy making develops when policy makers jointly identify a desirable future situation and then create policies and take actions to move that desired future state, monitoring progress to allow for necessary adjustments. Individuals and the community have the right to be involved in planning and decision-making processes to formulate policies that promote social well-being and positive social change, a course of action to guide responsiveness to public concerns. The shared concerns among all participants in my study was a need to be involved and that their opinions mattered.

The cost-benefit analysis provides relevant information to policy options applicable to the well-being of society with the lack of lived experience references. Community health care programs should align with broader national health care policies and resource allocation (Li et al. 2020). The implications of my study are that it may enable policies and tailored programs to be put in place to consider system improvements with recognition from the uninsured middle-class communities. In addition, the study indicates that policy and system support should optimize community health programs that recognize human rights factors that influence a more comprehensive socioeconomic and community problem relating to society's well-being. Furthermore, the uninsured middle-class families are disconnected from the lack of communication from legislators or local officials regarding public health concerns.

## Conclusion

Health insurance is an essential component of human rights. The United States is the only wealthy democracy that does not provide universal health care for its citizens (Berchick et al., 2019). The growing need for qualitative studies in this discipline is an important indicator that this subject needs more exploration. Quantitative analysis alone cannot put researchers in touch with or create an in-depth understating of the lived experiences of the uninsured middle-class families who do not have state or any other health insurance. The percentage of Americans without health insurance continues to grow, and as reported by the U.S. Census Bureau (2019a), approximately 30% of the population is uninsured.

Affordability is the most important area of conversation recommended by the participants to pressure legislators, policy makers, and the state to hear and understand the struggles of uninsured middle-class families. My study provided a better understanding of why health insurance is not affordable for many, although employers offer it. This study also brings to light that the participants were willing to pay more taxes for state health care programs but were not willing to pay high deductibles. The findings of the study indicate that almost all the participants forgo their medical needs, and especially with high inflation, families cannot afford to pay for health insurance. Affordable health care is essential to our health care needs. The study also shows that not having health insurance affects the participant's well-being that results in stress and worry because uninsured families cannot adequately take care of their family’s medical expenses. The findings from my study are a valuable contribution for legislators and policy makers to use to create programs and policies to make health insurance more affordable.

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Appendix A: Recruitment Notice

# Uninsured Middle-Class Families Living in Essex County, New Jersey, Are Welcome to Participate!!!!

**You are invited to take part in a qualitative study to explore the lived experiences of uninsured middle-class families who do not have state or any other type of health insurance to contribute to what can be done to change current policies to make insurance more affordable.**

## Participants should:

- **Be between the ages of 26–64.**
- **Can read and fluently speak English.**
- **Live is Essex County, New Jersey.**
- **Currently do not have and have not had health insurance for at least 1 year.**
- **Live in a single-parent, two-parent, grandparent(s), or other nonparent(s) household responsible for a child or children.**
- **Have a combined household income between $50,000-$80,000.**

****Participants will be Voluntary**

I am a doctoral student attending Walden University. This research is a requirement to complete my PhD program. The research will explore how the lack of health insurance affects middle-class families. If you do not have any employee, state, private, or government health insurance, I would love to talk to you. If you fall into this category and are interested to participate in this research. The research will take 45–60 minutes via Zoom/Teams Broadcast.
For further information please contact me at XXX or email xxx@waldenu.edu. Thank you!!

****Please Take This Flyer!!**

# Appendix B: Screening Script

Hello,

My name is Janice, and I want to thank you for responding to my recruitment flyer. Thank you for sharing your time with me today. I am a doctoral student conducting research for my dissertation at Walden University. Before we set up an interview time, allow me to ask you five simple screening questions to help me determine if you are a good fit for my research project. If you answer "yes" to all three questions, you will be included in the study. If you answer "no" to any of these questions, you will be excluded from the study. The information you share will be held in confidence. All data collected will be stored in a protected and sealed file.

Before we begin, do you have any questions for me.

Questions:

1. Do you reside in Essex County and live in a household that includes either a single parent, two parents, grandparent(s), or other nonparent(s) who have custody of and are responsible for a child or children? Yes ___ No ___
2. Are you currently without health coverage and have been without coverage for at least 1 year? Yes ___ No ___
3. Do you live in a household with a combined annual income between $50,000 and $80,000 from 2020 to the present? Yes ___ No ___
4. Are you between the ages of 26 and 64? Yes ___ No ___
5. Can you read and speak fluent English? Yes ___ No ___

If any response is "no," end the session, thank them, but inform them they are not eligible. If all responses are "yes": Congratulations, you meet all the eligibility criteria to participate in this study and thank you for agreeing. Please provide your contact information so I may email the Consent Form and do a follow-up to schedule an interview at a time that is convenient for you.

1. Participant telephone number: ________________________________
2. Participant email address: ____________________________________

# Appendix C: Interview Guidelines

Thank you for agreeing to participate in the study. Please feel free to be as descriptive and candid in your responses as possible to the questions. There are no right or wrong answers. If you have any direct concerns about a specific question or need further clarification, please do not hesitate to ask. Before we start, a reminder, the purpose of this research project is to explore the lived experiences of the uninsured middle-class families living in Essex County, New Jersey, who cannot afford state or any other type of health insurance. A quick summary of the Consent Form is that your responses are entirely confidential, including personal information. The interview will be audio recorded and should not take more than approximately 45–60 minutes. It would be best if you were somewhere private so that you can speak freely. Also, you can stop at any time during the interview if needed to get up and stand or stretch. You make also stop the interview if you do not wish to continue.

Research Question: The first set of questions will help me understand your lived experiences of uninsured middle-class families who cannot afford state or any other type of health insurance in Essex County, New Jersey?

**Questions:**

1. How long have you been without health insurance?
2. Does your job offer health insurance? If yes, why did you elect to not enroll?
3. Why have you not obtained private insurance?
    a. Probe: What role did high deductibles play a part in your not having health insurance?
    b. Probe: Where there any other reasons beyond cost?
4. How does not having health insurance affect your family?
    a. Probe: How, if at all, is you/your family's physical and mental health affected because you had no health coverage?
5. What are some of the major disadvantages you have experienced by not having health coverage?
6. What role, if any, has the cost of a self-pay visit influenced whether you or a family member visited a primary care doctor?
    a. Probe: Have you ever had difficulty deciding to put other expenses ahead of going to the doctor? If yes, explain that experience and how you decided.
7. If you have ever used the emergency room for nonemergency issues, approximately how often (e.g., once or twice a year, as needed)?
    a. Probe: Why did you decide to go the emergency room?

    b. Probe: What was your experience with dealing with using the emergency room and paying the bill afterwards?

**Experience and Meaning to the Interviewee related to health policies. I would like to now turn our focus to suggestions on how New Jersey can change/improve health policies to help you are your family.**

1. What would you like to see done to New Jersey’s state health insurance to make it more affordable?
2. What information do you think will be essential to developing programs and policies?
    a. Probe: What type programs would help you and your family?
    b. Probe: Is there a specific section of NJ’s current health policy that has prevented you from receiving assistance from a program or in need of being changed?
3. What do you think will be an effective strategy for improving access to health insurance?
4. What is one recommendation you would give to Essex County policymakers?
5. How might a policy that put an income cap am insurance premiums help you be able to afford health insurance?

That concludes the questions I have. Is there anything you would like to share about your experience that we have not covered?

## Debriefing

Again, thank you for taking the time to participate in the research study. Please feel free to ask any additional questions regarding confidentiality or clarity. I will conduct a follow-up review of the transcripts within 24 hours to confirm if I capture your interpretation correctly. This follow-up will allow you to make any changes if needed and last for about 20–30 minutes. This information once the dissertation is approved, I will share the summary with each participant, elected officials, public health policymakers, and legislatures. Also, if you should need community resources, or someone to talk to because of your acute state, I will provide them via email.

I can be reached by email at xxxx.xxxx@waldenu.edu or call/text XXX. If you want to talk privately about your rights, or any parts of the study, you may call Walden University’s Research Participant Advocate at 612-312-1210. Walden University’s approval number for this study is **05-20-22-0997926**. It expires on **May 19. 2023.**

## Local Community Resources:

As mentioned on the Consent Form, and I state – This study could involve minor discomforts as in any daily life. The interview is confidential. It would pose minimal risk. But should any of the questions/experience revisited present any emotional stress.
These are local community resources to reach out to: Newark NJ – 973 412 2056, 973 268 5184, Irvington – 973 3999 3132, 973, 373 5100, Montclair, NJ – 973 509 9777, 201 986 5000, 973 372 4353 and Hotline # NJ: 866 838 7654.

**Again, thank you for your time.**

# Appendix D: Interview Recording Form

| | |
|---|---|
| Interviewer: | Start time: ________________<br>AM PM |
| Interviewee ID# | Stop time: ________________<br>AM PM |
| Gender: M F | Location: |
| Interview recorded: Yes No | |
| Notes:<br>1. Document any characteristics that impacted the interview (interruptions, background noise, recorder problems, etc.).<br>2. Document any nonverbal communication during the interview (distractions, fidgets). | |

# Appendix E: Collaborative Institutional Training Initiative (CITI Program)

Completion Date 07-Oct-2021
Expiration Date N/A
Record ID 45522422

This is to certify that:

**Janice Fearon**

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

**Student's**
(Curriculum Group)
**Doctoral Student Researchers**
(Course Learner Group)
**1 - Basic Course**
(Stage)

Under requirements set by:

**Walden University**

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wee17412d-28f6-48d7-81dc-1796182f8f3e-45522422