The Affordable Care Act's Impact on Employer-Sponsored Insurance, Employers, and Employees: The Case of The Langdale Company

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ABSTRACT

On March 23, 2010, President Barack Obama signed a sweeping healthcare legislation into law, the *Patient Protection and Affordable Care Act* (PPACA), and, just a week later, the *Health Care and Education Reconciliation Act*. The final amended version of the law is commonly known as the "Affordable Care Act" (the ACA). The ACA is the first comprehensive health care reform in the history of the United States (U.S.). The new law introduces profound changes to the U.S. healthcare system particularly in the health insurance industry, including employer-sponsored insurance (ESI).

The following analysis' purpose was to investigate the ACA's impact on a Southeastern Georgia employer, The Langdale Company, and its employees. Specifically, the researcher investigated the ACA's impact on the Company's benefit philosophy and bottom line and employee satisfaction with health coverage offered by the Company (the Plan) in the post-ACA environment.

For this case study, the researcher utilized an employer questionnaire and a survey of employees who, at the time of the study, had health insurance through the Company (845 employees). The researcher used statistical tests such as cross-tabulation, *Gamma*, *Pearson's Chi-square,* and *t test* to test the significant difference between two dependent variables and multiple independent variables and to further explore the variables, when needed.

The case study results revealed that The Langdale Company plans to maintain the Plan and keep offering health benefits to its employees. The Company is anticipating a significant cost increase, though, and is considering different cost-containment measures

(i.e., strengthening its wellness and disease management programs and Consumer-Driven Health Plan design). The vast majority of the employees are satisfied with their Plan (89.1 percent) and disapprove of the ACA (65.9 percent). The independent variables, including employee health care expenses, had little to no effect on employee satisfaction with the Plan. Furthermore, the results revealed that the vast majority of employees (97.7 percent) would like to maintain their health coverage.

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LIST OF ACRONYMS

ACA – Affordable Care Act
AFL-CIO – American Federation of Labor and Congress of Industrial Organizations
CBO – Congressional Budget Office
CDHP – Consumer-Driven Health Plan
CHROME – ContinuousHealth Reform Optimizer and Management Environment
DM – Disease Management
DV – Dependent Variable
ESI – Employer-Sponsored Insurance
GAO – the U.S. Government Accountability Office
HDHP – High-Deductible Health Plan
HIX – Health Insurance Exchanges
HRA – Health Reimbursement Account
HRA – Health Risk Assessment
HSA – Health Savings Account
IRS – Internal Revenue Service
IV – Independent Variable
JCT – Joint Commission on Taxation
OECD – Organisation for Economic Co-operation and Development
p - Probability
PEPY – Per Employee Per Year
PPACA – Patient Protection and Affordable Care Act
RCT – Rational Choice Theory
SCOTUS – Supreme Court of the United States
SD – Standard Deviation
x^2 – Pearson's Chi-Square

GLOSSARY[1]

Actuarial Value – a measure of the average value of benefits in a health insurance plan. It is calculated as the percentage of benefit costs a health insurance plan expects to pay for a standard population, using standard assumptions and taking into account cost-sharing provisions. Placing an average value on health plan benefits allows different health plans to be compared. The value only includes expected benefit costs paid by the plan and not premium costs paid by the enrollee. It also represents an average for a population, and would not necessarily reflect the actual cost-sharing experience of an individual.

Adverse Selection – people with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

Affordable Care Act – the Patient Protection and Affordable Care Act (PPACA), commonly called Obamacare, is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it is known as the Affordable Care Act and represents the most significant government expansion and regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

COBRA – when employees lose their jobs, they are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Consumer-Directed Health Plans – consumer-directed health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These health plans usually have a high deductible accompanied by a consumer-controlled savings account for health care services. There are two types of savings accounts: Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).

Cost Containment – a set of strategies aimed at controlling the level or rate of growth of health care costs. These measures encompass a myriad of activities that focus on reducing overutilization of health services, addressing provider reimbursement issues, eliminating waste, and increasing efficiency in the health care system.

Cost-Sharing – a feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, coinsurance and annual deductibles.

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[1] *Source: The Henry J. Kaiser Family Foundation. 2010. "Glossary of Key Health Reform Terms." http://www.kff.org/healthreform/upload/7909.pdf (March 28, 2013).*

Cost Shifting – is an economic situation where one group pays a smaller share of costs than before resulting in another group paying a larger share of costs than before.

Employer Mandate – an approach that would require all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.

Federal Poverty Level (FPL) – the federal government's working definition of poverty that is used as the reference point to determine the number of people with income below poverty and the income standard for eligibility for public programs.

Grandfathered Health Plan – a health plan that was in existence on March 23, 2010, when the Affordable Care Act was signed into law. Grandfathered status protects plans from certain mandates under the ACA.

Group Health Insurance – health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.

Health Insurance Exchange/Connector – a purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers would select their coverage within this organized arrangement. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006.

High-Deductible Health Plan – health insurance plans that have higher deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services), but lower premiums than traditional plans. Qualified high-deductible plans that may be combined with a health savings account must have a deductible of at least $1,150 for single coverage and $2,300 for family coverage in 2009.

Individual Mandate – a requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified individuals. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.

Minimum Creditable Coverage – the minimum level of benefits that must be included in a health insurance plan in order for an individual to be considered insured. Minimum creditable coverage standards have been established in Massachusetts as part of that state's health reform law. The Affordable Care Act requires minimum creditable coverage as defined by the States.

Out-of-Pocket Costs – health care costs, such as deductibles, co-payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.

Out-of-Pocket Maximum – a yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.

Pay-or-Play – an approach that would require employers to offer and pay for health benefits on behalf of their employees, or to pay a specified dollar amount or percentage of payroll into a designated public fund. The fund would provide a source of financing for coverage for those who do not have employment-based coverage. Prior to the ACA's passage, two states, Massachusetts and Vermont, and the City of San Francisco already imposed pay-or play requirements on employers.

Premium Subsidies – a fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income.

Self-Insured Plan – a plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employer sponsored self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the plan.

Tax Preference for Employer-Sponsored Insurance – under the current tax code the amount that employers contribute to health benefits are excluded, without limit, from most workers' taxable income and any contributions made by employees toward the premium cost for health insurance are made on a tax-free basis. In contrast, individuals who do not receive health insurance through an employer may only deduct the amount of their total health care expenses that exceeds 7.5 percent of their adjusted gross income.

Wellness Plan/Program – employment-based program to promote health and prevent chronic disease. Goals of these programs include: reducing health care costs, sustaining and improving employee health and productivity, and reducing absenteeism due to illness.

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DEDICATION

To my amazing daughter, Emma Frances Sparks.

"This is an unprecedented time in health care. The decisions employers make now—to take a fresh look at health benefit plans and programs and determine long-term needs and direction—will have a profound impact on the health of their organizations."

Aon Hewitt (2012)

Chapter I

INTRODUCTION

National health reform discourse in the United States (U.S.) is over a century old. Since the Progressive Era, the idea of universal health coverage emerged whenever a demand arose to fix the healthcare system. Despite the demand for reform, strong opposition would always defeat the measure, that is, until the historic day of March 23, 2010. On this day, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. A week later, the Health Care and Education Reconciliation Act (HCERA), a bill amending PPACA, was also signed into law. The final amended version of the law is commonly known as the "Affordable Care Act" (ACA).

The ACA is the first comprehensive health care reform in the history of the U.S. The legislation introduces major changes to the system by regulating insurer health care spending[2], mandating minimum essential (to be defined by the States) and other health benefits, expanding Medicaid[3], creating Health Insurance Exchanges (HIX), requiring U.S. citizens to obtain health insurance by 2014 (the Individual

[2] The Medical Loss Ratio (MLR) provision mandates that insurance providers spend at least 80 percent of paid premiums on health services.

[3] On June 28, 2012, the Supreme Court ruled that the federal mandate requiring States to expand Medicaid is unconstitutional. So, currently Medicaid expansion is voluntary.

Mandate), and mandating that starting in 2014 employers offer employer-sponsored health insurance (ESI; the Employer Mandate, also known as *Pay or Play*).

ESI is a leading source of health insurance in the U.S. and covers about 149 million nonelderly people (The Kaiser Family Foundation and Health Research & Education Trust 2012). It is the backbone of the U.S. health insurance system. The first attempt at establishing ESI was undertaken by the Dallas school teachers in 1929. The teachers paid 50 cents a month or $6 per year for 21 days of hospital care at Baylor Hospital following the patient's first week in the hospital. The Dallas school system did not contribute to the teachers' health plan, though (Fronstin and Erwin 2012). ESI, as we know it today, developed in the early 1940s. In 1942, in an effort to regulate inflation, the government limited employers' freedom to raise wages. However, it allowed for the expansion of benefits, such as health insurance. Many employers seized this opportunity to offer health insurance in order to attract scarce workforce at the time. By 1948, when President Harry S. Truman decided to revive the concept of the national health insurance, private health insurance industry was already strong and meeting needs of the public. Several federal rules released in the 1940s and 1950s established incentives for offering ESI such as tax preferred treatment for employer and employee contributions (Blumenthal 2006).

Today, most employers offering health plans contribute to their plans significantly – on average, 82 percent and 72 percent for single and family coverage, respectively (Fronstin and Erwin 2012, The Henry J. Kaiser Family Foundation 2012c). The ACA's reforms focus predominantly on the health insurance market and place many demands and burdens on ESI. Inevitably, these reforms increase employer health care costs and

indirectly, the employees whose premiums and cost-sharing are growing as a result of the changes. The impact of the ACA is so profound that, for the first time in the history of employment-based health insurance, the future of ESI is uncertain.

Overview of Case Study

This case study seeks to evaluate the impact of the ACA on a southeastern Georgia employer, The Langdale Company (the Company) and its employees. The Company is a large employer with approximately 1,100 employees. In 2012, on average, 802 employees have had health insurance through the Company. The Langdale Company Employee Health Plan (hereafter, the Plan) is self-insured and self-administered. This means that the Company pays for incurred claims from its own assets and that the entity administering health benefits is a part of the Company, in this case an affiliate.

This study assesses the ACA's impact on the Company's bottom line and employee benefit strategy as well as employee satisfaction with the Plan. The researcher used an employer questionnaire and the Company's health care and administrative costs data for the calendar years 2009 through 2012. Furthermore, the researcher surveyed the Langdale Company employees in order to gauge employee opinion of the ACA and examine their satisfaction with the Plan following the implementation of reform-mandated provisions effective January 1, 2011 and later. To compliment this data, the researcher also looked at the Plan design reflecting changes in employee financial responsibilities.

This study is unique because it surveys employees in addition to obtaining the employer perspective. Most of the major studies assessing the impact of the ACA on ESI, such as Kaiser Family Foundation and Health Research & Educational Trust *2012*

Employer Health Benefits survey and the surveys done by McKinsey & Company, Towers Watson, Mercer, and the National Federation of Independent Businesses (NFIB), rely on employer surveys only. The literature shows that the ACA indirectly increases employee health care costs, but less is known about how employees feel in regards to the reform. This study attempts to gauge employee satisfaction with the ACA and the Plan. When deciding whether to keep the ESI in 2014 and beyond, competitive employers should seek employee opinions of the post-ACA ESI and take such data into account. The Langdale Company's strategy for 2014 will be assessed based on the employer questionnaire. The nature of this study does not allow for generalizations regarding all employers and employees in the United States, but its findings and recommendations can be found applicable for employers similar to The Langdale Company.

Project Objectives

The study encompasses three primary objectives, which are as follows:

1. First objective – to measure the ACA's impact on The Langdale Company's bottom line and its employee benefit ideology.
2. Second objective – to assess The Langdale Company's employee opinion of the health reform and to gauge employee satisfaction with their Plan in the post-ACA era.
3. Third objective – to investigate the ACA's impact on employee health care costs (defined as premiums, deductibles, copayments, coinsurance, and prescription drug expenses).

Research Questions

This study seeks to answer three specific research questions and investigate corresponding hypotheses, which are as follows:

Research Question 1: Will The Langdale Company continue offering ESI to its employees? Why or why not? Is the Company considering implementing some other cost containment measures?

Research Question 2: Are The Langdale Company employees satisfied with their post-ACA ESI?

Hypothesis 2a: Employees who say they have excellent knowledge of the ACA are more likely to say that they are satisfied with their Plan than employees who have poor knowledge of the ACA.

Null Hypothesis 2a: There is no relationship between employee knowledge of the ACA and employee satisfaction with the Plan.

Hypothesis 2b: Employees who say they know a lot about what the Plan covers are more likely to say that they are satisfied with their Plan than employees who say they know hardly anything about what the Plan covers.

Null Hypothesis 2b: There is no relationship between how much employee knows what the Plan covers and employee satisfaction with the Plan.

Hypothesis 2c: Employees who approve of the ACA are more likely to say that they are satisfied with their Plan than employees who disapprove of the reform.

Null Hypothesis 2c: There is no relationship between employee approval of the ACA and employee satisfaction with the Plan.

Research Question 3: What is the ACA's financial impact on The Langdale Company employees?

Hypothesis 3a: Employees who said that their health care costs increased in the years 2011 and/or 2012 are less likely to say that they are satisfied with their Plan than employees who said that their health care costs decreased.

Null Hypothesis 3a: There is no relationship between employee health care costs post-ACA and employee satisfaction with the Plan.

Hypothesis 3b: Employees with lower household incomes are more likely to say they will drop ESI and obtain insurance through Health Insurance Exchanges (HIX) than employees with higher household incomes.

Null Hypothesis 3b: There is no relationship between employee household income and employee willingness to drop ESI and obtain insurance through HIX.

Significance of the Study

The literature on the effects of ACA on ESI and employers is ample. Many research groups and professional organizations, such as Towers Watson, Mercer, and the Society for Human Resources Management (SHRM), have surveyed employers, human resources staff, and company executives on how they are responding or planning to respond to the law. Other research organizations, such as Kaiser Family Foundation, the Deloitte Center for Health Solutions, and the Employee Benefit Research Institute (EBRI), regularly survey U.S. adults on their opinions of the ACA.

Nevertheless, there appears to be a gap in the literature on the new law that says little about the perspectives of employees. In this critical time for ESI, competitive employers should consider employee opinions. Specifically, there is a need for research

that examines employee satisfaction with their post-ACA ESI and whether the health reform has affected employee willingness to participate in ESI. Employee opinion on the ACA, health insurance cost, and insurance design will help guide employer business strategy and inform current and future health policies. The researcher also hopes that this research will help establish the need for the continued assessment of the ACA's impact on The Langdale Company employees until the law's full implementation and beyond.

Summary

The ACA is changing the ESI market and forcing employers and employees to make critical decisions about their health benefits. More than ever, both groups are considering alternatives such as obtaining insurance through Health Insurance Exchanges. The choices they make in 2014 and beyond will significantly impact the wellbeing of businesses and their employees. In this study, the researcher will assess the scope and magnitude of the ACA's impact on ESI and discuss possible actions by employers and employees based on a theoretical framework laid out in Chapter 2.

In the literature review, the researcher will present a short overview of the national health reform efforts in the U.S. She will then proceed to a discussion of the ACA and its implications to employers and employees. Since the law's passage several studies predicting employer behavior in 2014 and beyond have been released. This literature review will heavily rely on the Government Accountability Office's 2012 report, *Patient Protection and Affordable Care Act: Estimates of the Effect on the Prevalence of Employer-Sponsored Health Coverage,* which reviews and summarizes findings of 27 independent and original studies examining impact of the ACA on

employers. These studies comprise of statistical models and national employer surveys published between January 1, 2009 and March 30, 2012.

Furthermore, in Chapter 2, the researcher will establish a theoretical framework for this study. The researcher will propose that Rational Choice Theory can predict employer and employee perceptions and behaviors and also inform employer benefit practices. In Chapter 3, the methodology behind assessing the ACA's impact on the employer's bottom line and benefit philosophy will be discussed. Additionally, the researcher will discuss the survey instrument she used to obtain data on employee opinions of the ACA, their current health insurance, and their actual and perceived health care expenses in the calendar years 2011 and 2012.

Analysis of results will follow in Chapter 4. The researcher will begin by discussing findings from the employer questionnaire. A figure for visual presentation of environmental pressures affecting the Company and illustrating measures the Company plans to take in 2014 was created. Then, the researcher will discuss the validity of each of the hypotheses. Statistical tests, such as cross-tabulation, *Gamma*, and *Pearson's Chi-square* were used in order to assess whether a relationship exists, what is the direction of the relationship, and whether the relationship is statistically significant.

Lastly, in Chapter 5, the researcher will discuss findings in the context of the existing literature, present recommendations for The Langdale Company, and discuss the implications of this study to the entire ESI market. The researcher found that The Langdale Company and its employees have experienced higher health care costs since the law's passage. Nevertheless, the Company wants to keep offering ESI. Most employees are satisfied with ESI and also want to keep their coverage. Approximately two-thirds of

the employees disapprove of the ACA, but most employees have a favorable view of the majority of individual provisions. The researcher will argue that the Rational Choice Theory framework can explain the differences between employee perceptions of the entire law and of the individual provisions. The framework can also be useful to explain employer responses to the ACA. The researcher hopes to demonstrate that a theoretical framework is needed to provide employers with knowledge and understanding of what employees want, need, and value in their compensation packages so that they can achieve a competitive advantage.

Chapter II

REVIEW OF LITERATURE

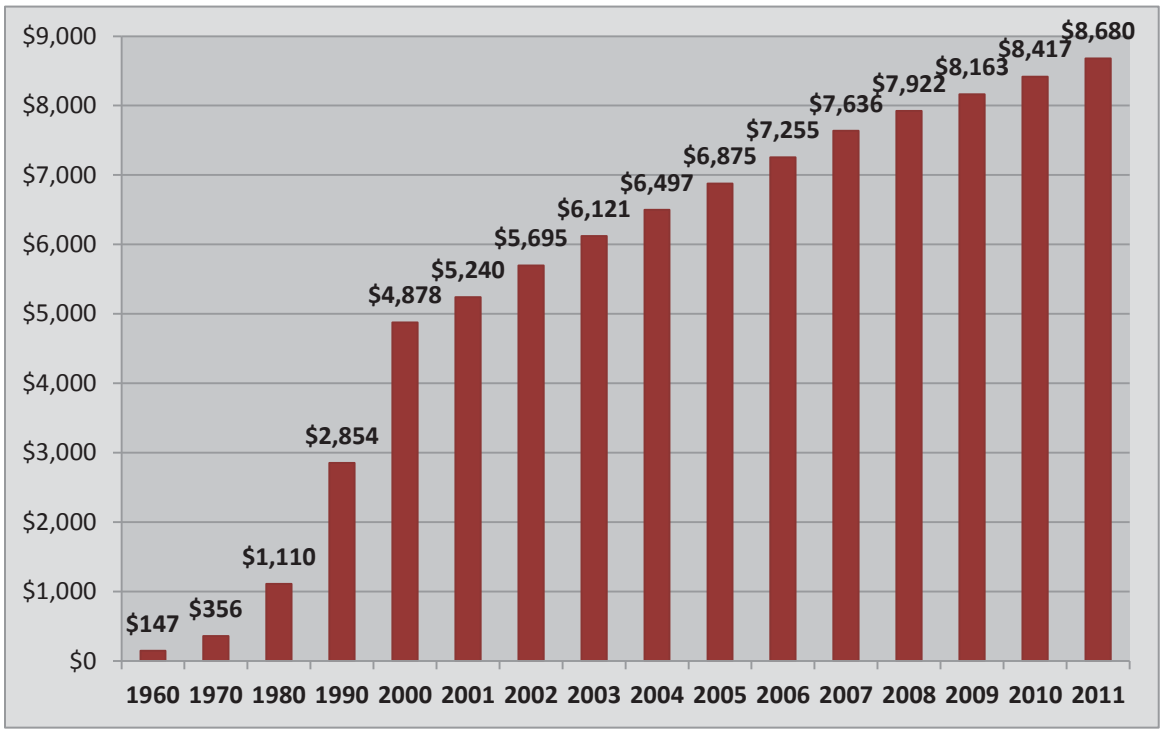
Problem Statement and Overview

One of the goals of the ACA is to make health care in the U.S. affordable. In 2011, the U.S. spent nearly 18 percent, or $2.7 trillion, of the nation's gross domestic product (GDP) on health care (Center for Medicare & Medicaid Services 2012; See Figure 1 for national expenditure per capita), and the Congressional Budget Office projects that health expenditures will increase to almost 25 percent of GDP by 2037 (2012d). In comparison to OECD countries, in 2010, the U.S.'s health care share of GDP was 88 percent higher than the OECD average health care share of GDP (about 9.5 percent) (OECD Health Data 2012). The U.S. spends more per capita on health care than any other nation. Nevertheless, in comparison to OECD countries the quality of health care in the U.S. is poor. The U.S. lags behind other industrialized nations on several quality health care indicators (Kenen and Okrent 2012). Studies also found that about 30 to 40 cents of every U.S. health care dollar is spent on poor quality care (Kenen and Okrent 2012).

Unfortunately, the promise of reducing health care costs and making health care affordable has not been yet fulfilled, and health care cost projections for the next few years do not predict the desired cost reduction outcomes. Literature shows that the ACA fails to slow down health care spending, the primary factor in setting health insurance premiums, and that it increases, among others, employer and employee shares of

premium and other costs (Appleby 2011; Fronstin and Erwin 2012; Humo 2010; Miller 2010a; Miller 2010b; Miller 2010c; The Kaiser Family Foundation and Health Research & Educational Trust 2012).

Figure 1. National Health Expenditures per Capita, 1960-2011, CMS 2012



Source: Centers for Medicaid and Medicare Services. 2012. "National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2011" https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf (September 24, 2012).

In 2012, the average annual single coverage premium increased 3 percent to $5,615, and the average annual family coverage premium increased 4 percent to $15,745 (The Kaiser Family Foundation and Health Research & Educational Trust 2012). Since 2002, the average annual single and family premiums increased 82 percent and 97 percent, respectively (The Kaiser Family Foundation and Health Research & Educational Trust 2012). Moreover, in the last four decades, the average annual health care spending per capita has outpaced the growth of the economy by between 1.1 and 3.0 percentage points (The Henry J. Kaiser Family Foundation 2012c).

Escalating and unjustified health care costs are not the only factors driving ESI costs up. The ACA places several new requirements on health insurance providers which introduce additional administrative costs. These provisions of the law include a requirement to provide preventive care benefits at 100 percent of coverage with no cost-sharing, and also a mandate to develop and distribute a uniform health plan description called the Summary of Benefits and Coverage (SBC) annually and at other specified times.

On average, employers pay 82 percent and 72 percent for single and family coverage, respectively (The Kaiser Family Foundation and Health Research & Educational Trust 2012). With employer responsibility nearing what they would pay a low-income employee in wages, the situation forces both employers and employees to put their health benefits into perspective. Among several critical questions, probably the most important is: Will employers continue providing ESI?

For employers, the ACA has transformed the health insurance from an employee benefits supplement to a strategic business tool. Now, more than ever, employers are estimating the impact of ESI on market competitiveness, the bottom line, and their employees. Most employees who already have health insurance through their employers want to keep it. About 83.7 percent of employees are happy with their ESI in the post-ACA era (Fronstin and Erwin 2012). Generally, the employee portion of health care costs in ESI is lower than premiums in the private insurance market. Additionally, most ESI plans offer a comprehensive level of health benefits and include emergency care, hospital care, in-patient rehab, nursing facilities, and hospital care (Fronstin and Erwin 2012). Employees will be closely watching their employers' decisions in 2014 and beyond.

Overall, the ACA is transforming ESI. In 2014, the key mandates, the Employer Mandate and the Individual Mandate, will take effect. The two mandates introduce a system of penalties for employers who do not provide health insurance or whose health plans fail to pass the affordability and minimum value tests. They also introduce penalties for U.S. citizens who do not purchase a qualified (as defined by the regulations) health insurance. Employers and employees are facing tough decisions concerning their health insurance coverage. These decisions will have profound effects on the health of employees and that of the businesses. The following literature review will: (1) provide a short overview of the national health reform efforts to lay a background for this study and to emphasize the importance of the law; (2) outline major ACA provisions affecting employers and employees; (3) present relevant literature on the impact of the ACA on employers and employees; and (4) form a theoretical framework for this study.

The Patient Protection and Affordable Care Act of 2010

The amended Patient Protection and Affordable Care Act (the ACA) is the first comprehensive national health care reform in the U.S. The law is a centerpiece of President Barack Obama's administration and is commonly referred to as "Obamacare." Since its passage in March 2010, the ACA has captured a steady attention of the media, politicians, research organizations, health care industry, and the public. Kenen and Okrent (2012, 2) explain that Washington health reform debates "are not always about health care per se, but about politics, power, and the size and reach of government." They add: "it is because of these factors that the debate goes on well after passage of the law" (Kenen and Okrent 2012, 2). Over two and a half years since the ACA's passage, the public remains nearly equally divided on their support of the law, with 45 percent saying

they have a favorable view and 40 percent saying they have an unfavorable view of the reform (The Kaiser Family Foundation 2012e).

The ACA is designed to be implemented over a nine year period: from the enactment date of March 23, 2010 to January 1, 2018 when the last major provision goes into effect. It is a hybrid of private and public solutions, but it does not contain a proposed public option, a government-run insurance program that was to be offered along the private health insurance market[4]. The reform affects individual and group[5] health insurance markets as well as public programs. The ACA contains provisions that expand Medicaid[6] and cut Medicare costs through pay cuts to the providers. It also includes improvements to fraud detection programs. One of the objectives of the ACA is to reduce the number of uninsured individuals, which the law hopes to achieve mainly through the expansion of Medicaid.

The primary goal of the reform is to put American consumers back in charge of their health coverage and care and to ensure quality and affordable health care (HealthCare.gov 2012). The ACA introduces several consumer protections which are outlined in the new *Patient's Bill of Rights,* a part of the law. The Bill*:*

- Provides Coverage to Americans with Pre-existing Conditions through a new Pre-Existing Condition Insurance Plan,
- Protects Choice of Primary Care Doctors,
- Keeps Young Adults under 26 Covered,
- Ends Lifetime Limits on Coverage of Essential Health Benefits,
- Ends Pre-Existing Condition Exclusions for Children under 19,

[4] Public option was erased due to a strong opposition from the private insurance industry.
[5] Group health insurance is the same as employer-sponsored insurance (ESI). Group health plans encompass both fully insured and self-insured plans.
[6] The Supreme Court's June 28th decision made the expansion of Medicaid a voluntary instead of a mandatory provision of the ACA. It is up to the States whether they will expand Medicaid.

- Ends Arbitrary Withdrawals of Insurance Coverage,
- Reviews Premium Increases over 10%,
- Helps You Get the Most from Your Premium Dollars via the Medical Loss Ratio provision,
- Restricts Annual Dollar Limits on Coverage and Eliminates it Completely in 2014, and
- Removes Insurance Company Barriers to Emergency Services (HealthCare.gov 2012).

Since the *Patient's Bill of Rights* was enacted, the ACA has expanded these rights and protections. Today, the law also:

- Guarantees Preventive Care at No Cost,
- Guarantees Right to Appeal Denial of Payment,
- Requires Health Insurance Issuers and Health Plans to Provide an Easy-to-Understand Summary about a Health Plan's Benefits and Coverage, and
- Establishes Eight New Preventive Services for Women (HealthCare.gov 2012).

The law is complex and controversial. Kenen and Okrent (2012, 2) stated: "Health care reform is difficult because it's big and complicated, with lots of moving parts and potential unintended consequences." The most publicized and challenged ACA provision, known as the Individual Mandate, is set to become effective January 1, 2014. The mandate is the first ever federal requirement that U.S. citizens buy adequate insurance coverage for themselves. However, the idea that all citizens should have health insurance is not new. Republicans promoted an individual mandate law during President George H.W. Bush's administration (Kenen and Okrent 2012). Massachusetts implemented a state individual requirement on July 1, 2007 (Healthinsuranceinfo.net 2009).

Additionally, the ACA requires that, in 2014, employers either provide insurance coverage that meets standards set by the law or pay penalties. This provision is often referred to as the Employer Mandate, or *Pay or Play*. In the same year, states are required

to start operating the Health Insurance Exchanges (HIX), transparent insurance markets where citizens and small businesses can shop for insurance[7]. Overall, the year 2014 will bring about historic changes in the U.S. healthcare system. A list of major ACA mandates by year is presented in Figure 2.

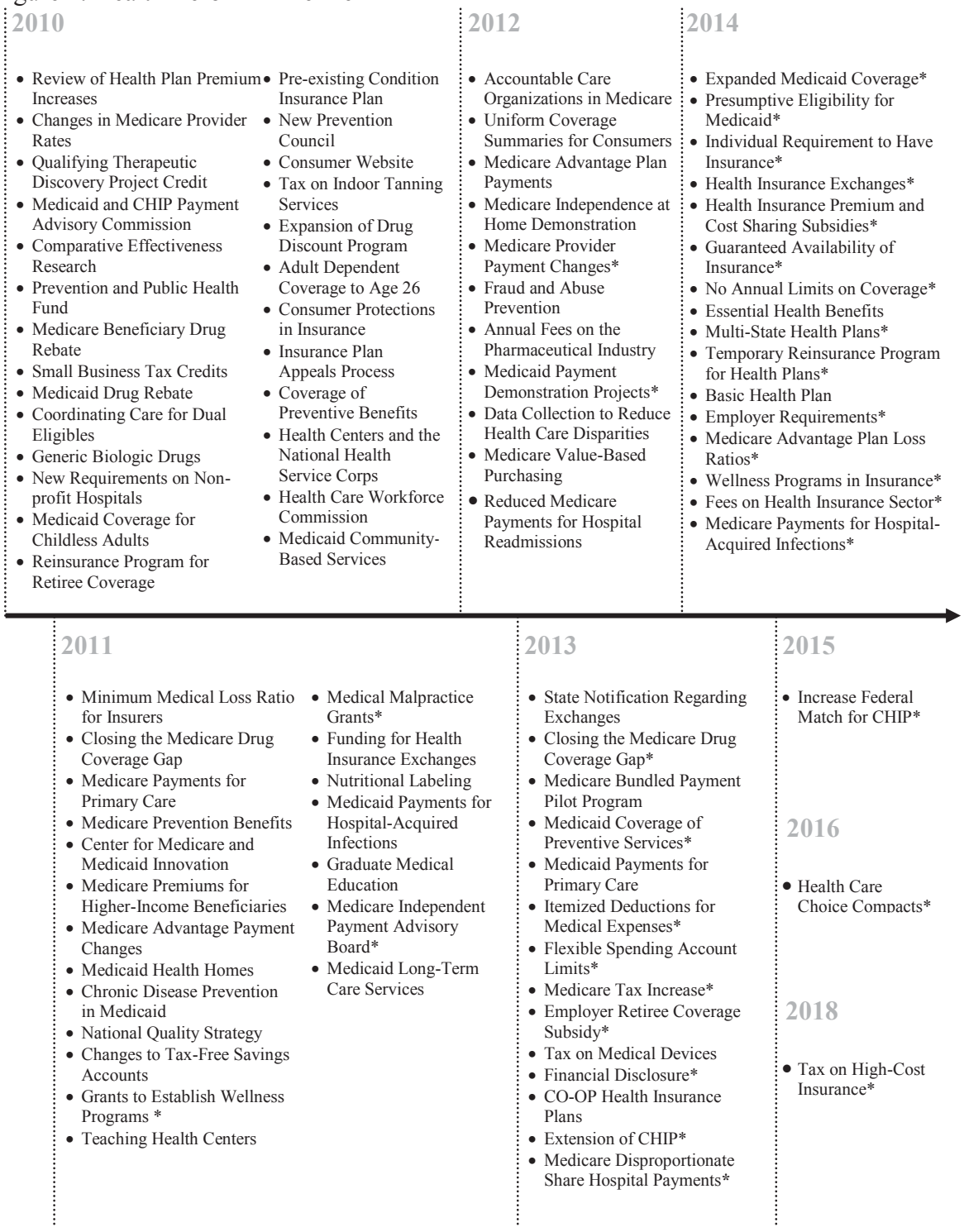
A Brief Overview of National Health Insurance Efforts in the United States

The United States is the only industrialized and democratic country without some form of national health insurance. Some researchers argue this phenomenon is a result of the "American exceptionalism,"[8] a premise based on the American values of individuality, freedom, liberty, and the anti-statist sentiment. Others have blamed the U.S. political system and the political fragmentation, which stagnates and kills many bills during the legislative process (Steinmo and Watts 1995). Quadagno (2004) takes a different approach and proposes a theory of *stakeholder mobilization* as the primary obstacle to national health insurance. She argues that since the New Deal of the 1930s, organized medicine (most notably the American Medical Association and the American Hospital Association), insurance companies, and organized labor (primarily, The American Federation of Labor and Congress of Industrial Organizations) have successfully defeated national health insurance bills by using their superior resources and shaping public perceptions (Quadagno 2004).

Figure 3 illustrates the key proposed health care reforms in the 20th and the 21st centuries. Since President Lyndon Johnson's 1965 success in passing Medicare and Medicaid, the politics in healthcare shifted to a safe, incremental approach. Almost as in

[7] If a state fails to establish HIX, the federal government will establish and operate it for that state.
[8] The term "American exceptionalism" was coined by Alexis de Tocqueville. Seymour Martin Lipset, a political sociologist, devoted much of his academic work to studying what makes America different from other countries, and expanded on the idea of American exceptionalism (See http://www.seymourmartinlipset.org/).

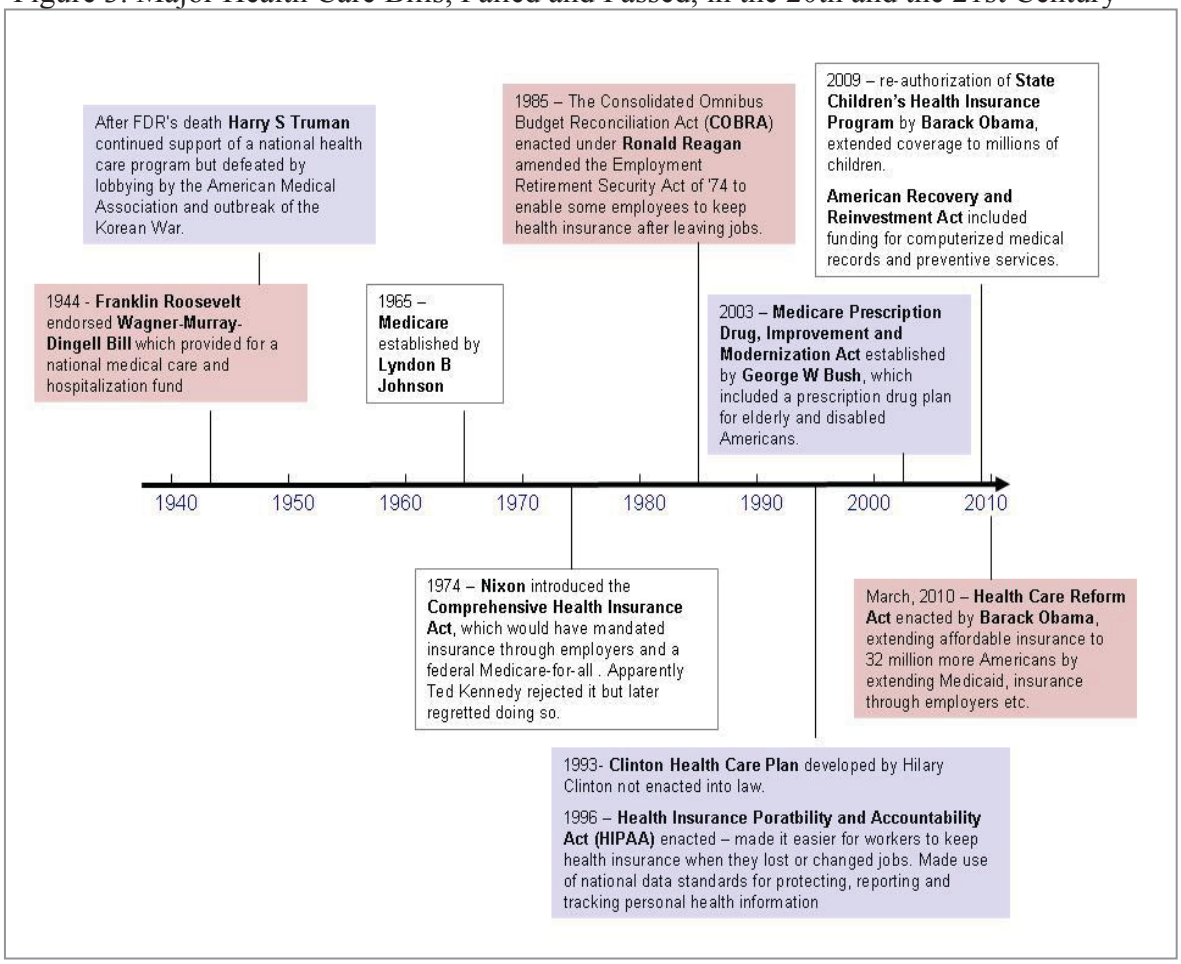
Figure 2. Health Reform Timeline



** Provisions not in effect*

Source: The Henry J. Kaiser Family Foundation. 2012d. "Implementation Timeline." http://healthreform.kff.org/timeline.aspx (September 27, 2012).

Figure 3. Major Health Care Bills, Failed and Passed, in the 20th and the 21st Century



Source: Data, Mandrita. 2010. "Health Care Reform & You." Division of Medical Sciences Bulletin (April). http://dmsbulletin.hms.harvard.edu/?p=391 (October 4, 2012).

a script, when health care costs rose, politicians "rediscovered" a health care crisis and proposed socialized reforms; particular stakeholder groups mobilized against the reform and came up with their own solutions to the problem. Lastly, reformers adopted one or a combination of proposed alternatives (Oberlander 2010; Quadagno 2004). The 2003 Medicare Prescription Drug legislation is one example of this process. The benefit was tailored to accommodate claims by major health industry stakeholders such as the Pharmaceutical Research and Manufacturers of America (PhRMA) (by prohibiting government from negotiating drug prices), the managed care plans (by creating the

"doughnut hole"[9]), and physicians (by increasing their payments). The result was a benefit that preserved and benefited the private market (Quadagno 2004).

What was different about the 2010 health care reform efforts than those of any other time in the history of the U.S.? There is no definite answer to this question, especially since the odds were clearly against the ACA. In 2010, President Obama had Democratic majorities in the Senate (59 Democrats) and in the House of Representatives (257 Democrats), but these majorities were not as sizable as the Congress that passed Great Society[10] and New Deal programs (Oberlander 2010). Moreover, the Republican Party was in strong opposition to the law. At the same time, the national economy was in one of the worst downturns in the U.S. history, which created unfavorable circumstances for passing a one trillion dollar law.

The author contends that the ACA passed because the interests of the public, stakeholders, and the government aligned. The American society has finally embraced the principle of social solidarity, slightly shifting their views from health care as a commodity to health care as a right (Quadagno 2010). In 2009, most Americans (83 percent) supported some form of a public-plan option: about 53 percent strongly supported the availability of a public plan, while another 30 percent somewhat supported it. In 2012, public support for a public-plan option is as strong as it was in 2009 with 80 percent supporting it (Employee Benefits Research Institute 2012). Furthermore, in 2009, most Americans supported allowing uninsured into a federal government plan (83 percent), employer mandate (77 percent), expansion of Medicaid and Medicare (79

[9] Medicare pays 75 percent up to $2,250 for drug costs in a year. Then, the benefit stops, and a beneficiary has to spend another $3,600 before Medicare picks up again. After beneficiary satisfies the "doughnut hole," Medicare pays 95 percent of subsequent drug costs.
[10] Lyndon Johnson's 1965 bill.

percent), guaranteed issue (80 percent), and that health plans offer coverage on a national basis (88 percent). In 2012, public support for these provisions remains almost equally strong (Employee Benefits Research Institute 2012).

Wide public support is only one of multiple critical pieces that enabled the passing of the law. The resourceful and powerful healthcare system stakeholders such as PhRMA, the American Hospital Association (AHA), and the American Medical Association (AMA) also supported the law. The Obama administration took a different approach to handling health industry stakeholders than administrations of the past. The Obama administration worked with the stakeholders through negotiations. This strategy has been criticized by the Republicans because negotiations with major stakeholders often took place behind closed door (Oberlander 2010). Nevertheless, dealing with the stakeholders was essential to the law's passage. It neutralized a major obstacle in the U.S. legislative process: the interest-group opposition. The law also incentivized the insurance industry which will gain millions of new enrollees because of the expansion of Medicaid and the Individual Mandate.

Organized labor did not play a significant role in passing the ACA mostly due to a decrease in membership and available funds. Since the late 1960s, American trade unions advocated for national health insurance through a single federal program. The AFL-CIO supported Senator Ted Kennedy's 1971 Health Security bill, which organized labor's Committee of 100 for National Health Insurance (CNHI) drafted. However, when Kennedy announced his own plan in 1974 without consultation with the trade unions, organized labor removed itself from the national health insurance discourse and did not support any national health reform plan including Nixon's Comprehensive Health

Insurance Act, which contained an employer mandate. Due to the lack of grassroots movements and lobbying on the part of the AFL-CIO and other stakeholders, the proposed health reforms did not gain enough support among the public and the politicians to pass (Quadagno 2004).

When the national health insurance debate resurfaced again in the early 1990s, the AFL-CIO pledged support for President Bill Clinton's 1993 Health Security plan. Nevertheless, organized labor failed to support the plan because it became involved with fighting NAFTA. Clinton's proposal was the most comprehensive reform since 1965 and included an employer mandate. Small business owners opposed an employer mandate and mobilized grassroots efforts against Clinton's plan along with the insurance industry. Health Insurance Association of America (HIAA) was the key political opponent to health reform at the time.

Organized labor continues supporting national health insurance efforts including President Barack Obama's 2009 plan, but it is no longer a critical stakeholder due to limited resources and divisions within the group. The association successfully delayed until 2018 a 40 percent tax on "Cadillac" insurance plans but was not able to force it out of the bill altogether. The association was also split on the issue of the public option. Moreover, organized labor was once again distracted when health reform was in the making by trying to preserve the Employee Free Choice Act (EFCA), at which it failed (Iglehart 2010; Patel and McDonough 2010).

Probably the most critical factor that enabled the ACA's passage was the 2008 election of a President with a plan and commitment to reform health care. Altogether, the changing ideology, wide public and stakeholder support, and change in the Presidential

office opened a "policy window"[11] that allowed the placement of health care reform high on the government's agenda. In the subsequent stages of the *policy cycle,* the stakeholders and the government shaped the law in the context of the predominant ideology (policy formulation stage), and the government officially enacted the ACA into law (decision-making stage). Currently, the law is in the implementation stage and evaluation stage of the policy-cycle. The reelection of President Barack Obama means that the law is here to stay. In fact, the ACA is already moving forward. Only two weeks following the Presidential election, the Department of Health and Human Services issued three proposed rules: essential health benefits (EHBs), premium pricing rules, and the wellness rule for comments. These rules are to become effective January 1, 2014.

To sum up, the predominant ideology, institutions, and the interest groups enabled the passage of the most comprehensive health care reform in the U.S. to date, shaped the bill, and continue to affect its implementation. The federal agencies tasked with the implementation of the ACA, the Departments of Health and Human Services, Labor, and the Treasury, are significant stakeholders during the implementation stage. The Departments are responsible for translating the ambiguous ACA language into practical guidance and enforceable mandates. Their role in the health care reform process should not be overlooked.

The ACA Is Here to Stay

Immediately following the passage of the ACA, the State of Florida filed a lawsuit against the Secretary of the Department of Health and Human Services (*Florida*

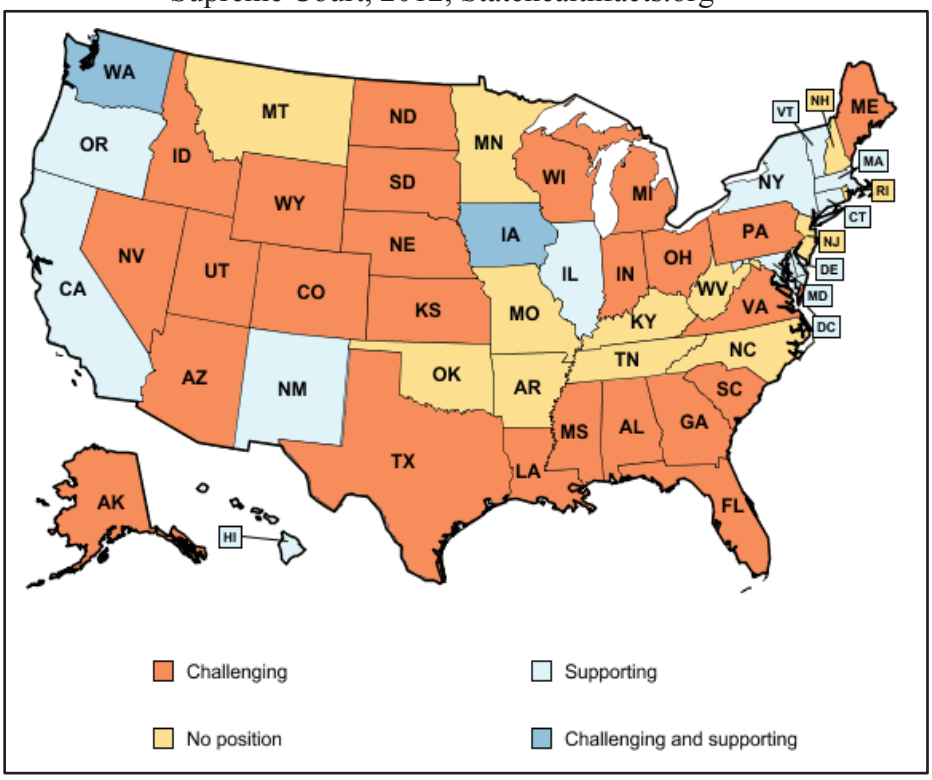
[11] The term was coined by John Kingdon in the 1980s. Kingdon developed an analytical framework for agenda-setting that consists of three streams: the problem stream, the policy stream, and the political stream. When the three streams come together they open "policy windows" where problems become public issues requiring government action. "Policy windows" do not guarantee that issues will be addressed (Howlett, Ramesh, and Perl 2009).

et al v. United States Department of Health and Human Services). Within a year of the ACA's passage, 25 states, including Georgia, joined Florida and two more filed separate suits challenging the new law. The primary argument was that the individual mandate exceeds the power granted to Congress under the commerce clause. Several individuals who do not have health insurance and the National Federation of Independent Business have also challenged the individual mandate and the Medicaid expansion provisions of the law. In the fall of 2011, the Department of Justice petitioned the Supreme Court of the United States (SCOTUS) to decide the constitutionality of the individual mandate. Five District Courts reached decisions prior to the U.S. Supreme Court ruling resulting in two courts upholding the law and the individual mandate, two rulings against the individual mandate, and one decision finding the individual mandate unconstitutional and potentially the entire law invalid (Dolgin and Dieterich 2011).

SCOTUS agreed to hear the Florida case and a case known as *National Federation of Independent Business v. Sebelius* to consider the constitutionality of the individual mandate and the Medicaid expansion. Additionally, SCOTUS chose to address two other issues: (1) whether the Anti-Injunction Act, a law which prohibits suing the federal government for the imposition of a tax until after the tax has been paid, bars SCOTUS from ruling on the individual mandate until 2014 when the provision goes into effect, and (2) whether the mandate can be severed from the remainder of the law or whether the law must be struck down in its entirety if one of the provisions is found unconstitutional (The Henry J. Kaiser Family Foundation 2012b).

On June 28, 2012, SCOTUS ruled in a 9-0 vote that the Court has jurisdiction to decide the case prior to the individual mandate's implementation. Then, in a 5-4 vote, the

Figure 4. States' Positions in the Affordable Care Act case at the Supreme Court, 2012, Statehealthfacts.org



Source: Statehealthfacts.org. 2012. "States' Positions in the Affordable Care Act case at the Supreme Court, 2012." The Henry J. Kaiser Family Foundation. http://www.statehealthfacts.org/savemap.jsp?ind=1040&cat=17&sub=201&yr =255&typ=5&sort=a&o=a&sortc=1 (November 28, 2012).

Court found that the individual mandate is a constitutional exercise of Congress' power to tax. Nevertheless, the Court found Medicaid expansion unconstitutional, agreeing that the Congress does not have the power to withhold all existing Medicaid funds from the state if they chose not to expand their Medicaid programs. SCOTUS did not have to address the issue of severability since it found the individual mandate constitutional (The Henry J. Kaiser Family Foundation 2012b). Now that the U.S. Supreme Court has upheld the federal health care reform law, President Obama was reelected, and the Democrats retained the control of the Senate, employers can no longer take a wait-and-see approach towards the ACA implementation. As the Speaker of the U.S. House of Representatives, John Boehner, stated: "Obamacare is law of the land."

Major Provisions Affecting Employers and Employees

In 2011, 60 percent of employers in the U.S. offered health insurance coverage to their employees. Their number has been steadily declining since 2001 when 68 percent of employers offered ESI. Still, about 149 million of nonelderly people obtain health insurance through their employers, which makes ESI the leading source of health insurance in the U.S. (The Kaiser Family Foundation and Health Research & Educational Trust 2012). Several studies, such as those discussed in recent U.S. Government Accountability Office's (GAO) report[12], predict that certain ACA provisions creating other sources of health insurance coverage, especially Medicaid expansion and subsidized coverage in the HIX, may further discourage employers from offering ESI. On the contrary, some researchers argue that the two key provisions of the ACA, the Employer Mandate and the Individual Mandate, are likely to encourage employers to continue providing or start providing ESI (The U.S. Government Accountability Office 2012). A summary of major provisions effecting employers and employees is presented in the Appendix C.

The ACA's Financial Impact on Employers and Employees

The ACA has increased employer and employee costs in ESI plans. In an employer survey conducted by the Midwest Business Group on Health (MBGH 2012), employers reported the cost impact of the ACA in 2011 to be anywhere between less than two percent and up to five percent. The results varied based on employer size, with large employers (those with 1,000 and more employees) reporting a lesser cost impact

[12] The U.S. Government Accountability Office. 2012. "Patient Protection and Affordable Care Act: Estimates of the Effect on the Prevalence of Employer-Sponsored Health Coverage." http://gao.gov/products/GAO-12-768 (September 25, 2012).

(Midwest Business Group on Health 2012). In 2011, on average, the cost of premiums increased 8 percent for single coverage and 9 percent for family coverage (Appleby 2011). Then, the premium costs decreased to 3 and 4 percent in 2012 (Appleby 2012), but, in 2013, per capita premium cost is predicted to increase 5.5-6 percent (PricewaterhouseCoopers Health Research Institute 2012). Many researchers explain the modest increase of only 4 percent in 2012 as a result of a small decline in the utilization of medical care and the uncertainty over the future of the healthcare industry in the Presidential election year (Appleby 2012; PricewaterhouseCoopers Health Research Institute 2012).

Employer health insurance share of payroll has been steadily rising reaching 12.8 percent (the reported median) in 2010, which is up 4.4 percent from the median employer contribution in 2000 (The Henry J. Kaiser Family Foundation 2012c). Most employers anticipate that under the ACA the cost of health benefits will continue to increase. Employers have already experienced high increases in family premiums of 9 percent in 2011 (Appleby 2011). They have also reported increased workload and other costs associated with managing their plans such as consultant/attorney fees (Midwest Business Group on health 2012). On average, employers contribute 82 percent to single coverage premiums and 72 percent to family coverage premiums, which in 2012 accounted for $4,664 and $11,429, respectively (The Kaiser Family Foundation and Health Research & Educational Trust 2012).

Most employers say that they will continue providing ESI in 2014[13] (The U.S. Government Accountability Office 2012). Most employers have already or are planning

[13] The number of employers who will continue providing ESI varies substantially per different studies. The next section in this dissertation will address this topic in more detail.

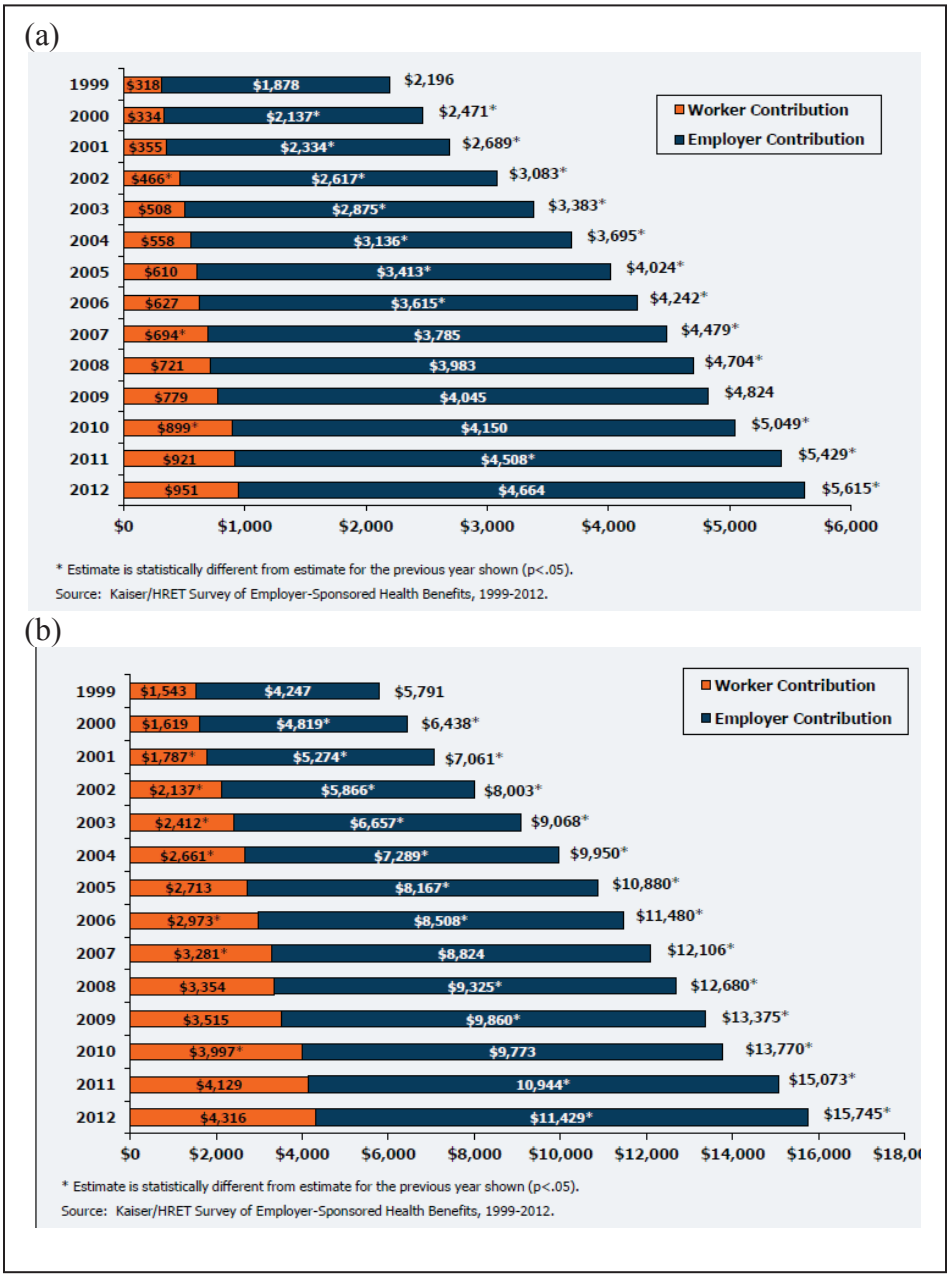
to redesign their health benefits in order to contain rising health care costs. Among popular cost containment tactics are offering of high deductible or consumer-driven health plans (with health savings accounts or health reimbursement accounts), implementing wellness and disease management programs and offering incentive for employees to participate (usually a reduction in employee premium share), promoting a "culture of health," and any other methods aimed at changing employee behavior (Aon Hewitt 2012).

Sixty-two percent of employees obtain their health insurance through their own employers. In 2012, most employees, 81 percent, who were offered ESI elected to enroll in it. About 46 percent elected single coverage, 17 percent elected single plus one coverage, and 36 percent elected family coverage. The distribution of enrollment by type of coverage has stayed nearly the same in the last decade. In terms of health plan type, the percentage of workers enrolled in CDHPs has more than doubled from 2009 (8 percent) to 2012 (19 percent). Enrollment data for the other health plan types shows that 65 percent of covered workers are enrolled in PPOs, 16 percent in HMOs, 9 percent in POS, and < 1 percent in conventional plans (The Kaiser Family Foundation and Health Research & Educational Trust 2012).

Employees pay on average 18 percent for single coverage and 28 percent for family coverage, which in 2012 equaled to $951 and $4,316 annually, respectively. The average annual employee and employer premium contributions since 1999 are presented in Figure 5. Premium increases are hurting employee finances because they outpace inflation and the growth in employee earnings, which means that each year employees pay a higher percentage of their income for health coverage (The Henry J. Kaiser Family

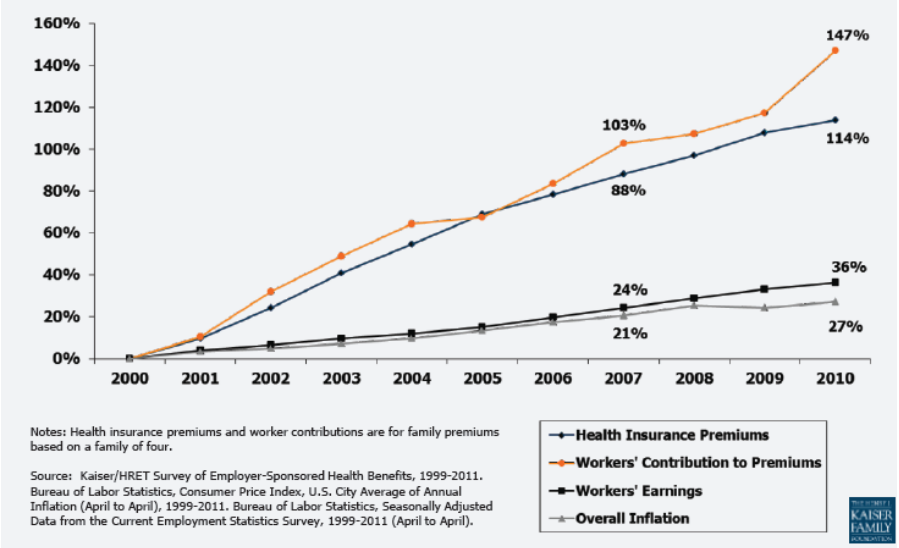
Foundation 2012c). Moreover, employees' premium share is growing faster than employers' share (The Kaiser Family Foundation and Health Research & Educational Trust 2012). Figure 6 illustrates the growth in premiums, employee premium share, inflation, and employee earnings.

Figure 5. Average Annual Employee and Employer Contributions to Premiums and Total Premiums for (a) Single Coverage and (b) Family Coverage, 1999-2012



Source: The Kaiser Family Foundation and Health Research & Education Trust. 2012. "Employer Health Benefits 2012 Annual Survey." http://www.http://ehbs.kff.org/ (October 8, 2012).

Figure 6. Cumulative Increases in Premiums, Employee Premium Share, Inflation, and Employee Earnings, 2000-2010



Source: The Kaiser Family Foundation. 2012c. "Health Care Costs: A Primer." http://www.kff.org/insurance/upload/7670-03.pdf (September 28, 2012).

Escalating premium costs are not the only worry for employees. Their cost sharing responsibilities (copayments, deductibles, and coinsurance) are also increasing. One explanation is that more employees are offered and enroll in consumer-driven health plans (CDHPs). Currently, CDHP is a second most common ESI plan design. CDHPs save employers money because they require employees to pay more out-of-pocket (The Kaiser Family Foundation and Health Research & Educational Trust 2012). The high deductible design is also expected to make employees use their benefits efficiently and to be more involved in their health care decisions, which is expected to decrease wasteful and unnecessary treatments.

Health care costs have a significant impact on employees' income and may have dire consequences for employees and their families. According to the Kaiser Health Tracking Poll September 2012 edition, 50 percent of American families cut back on medical care in the past 12 months (The Henry J. Kaiser Family Foundation 2012g). About one-third of surveyed individuals said they relied on home remedies or over-the-

counter drugs instead of seeing a doctor, and a quarter said they did not fill a prescription for medicine because of the costs. Moreover, 17 percent said that family medical bills caused them serious financial problems (The Henry J. Kaiser Family Foundation 2012g).

What Lies Ahead: The Future of Employer-Sponsored Insurance

To contain escalating health care costs, employers have adopted or are planning to adopt different coping mechanisms. These mechanisms can be classified into two general approaches: (1) abandoning ESI; or (2) implementing cost-containment strategies. Under the first alternative, employers may go away with ESI without increasing employee compensation, or they may increase employee compensation based on employee health care costs in the HIX or some other formula. In July 2012, the U.S. Government Accountability Office (GAO) released a report, "Patient Protection and Affordable Care Act: Estimates of the Effect on the Prevalence of Employer-Sponsored Health Coverage," that reviews findings of 27 separate and original studies forecasting the ACA's impact on ESI. The report found that up to 20 percent of employers may drop health coverage in 2014. The GAO's findings will be discussed in more detail in the following subsections.

The second alternative encompasses numerous solutions. Some of the most common cost-containment strategies are:

- Increasing employee share premiums;
- Increasing employee cost-sharing payments (i.e., co-payments, deductible, out-of-pocket limits);
- Modifying/adding tiers to cost-sharing structure;
- Shifting to high deductible health plans (HDHPs) or consumer-driven health plans (CDHPs);
- Increasing employee proportion of dependent coverage cost;
- Implementing wellness programs and disease management programs; and

– Creating a "culture of health" (Aon Hewitt 2012).

One of the most popular cost-containment strategy employers are currently utilizing or considering is a Consumer-Driven Health Plan (CDHP) design. In 2012, CDHPs have surpassed health maintenance organizations (HMOs) in prevalence, 58 percent to 38 percent, making CDHPs the second most offered health insurance design after preferred provider organizations (PPO) (Aon Hewitt 2012). CDHPs are high deductible health plans with, on average, $1,923-$2,190 deductible for single coverage and $3,666-$4,068 deductible for family coverage. These plans incorporate savings options such as health reimbursement arrangements (HRAs) and health savings accounts (HSAs). Employers contribute to CDHPs through their contribution to premiums and through their contributions to savings account options. CDHPs are popular with employers because they shift responsibility for efficiently utilizing the insurance to the employees. Furthermore, employers with CDHPs report a two percent lower trend cost versus PPOs. Aon Hewitt (2012) predicts that CDHPs will continue growing in popularity among employers and employees in the next few years.

Review of Microsimulation Models Estimates

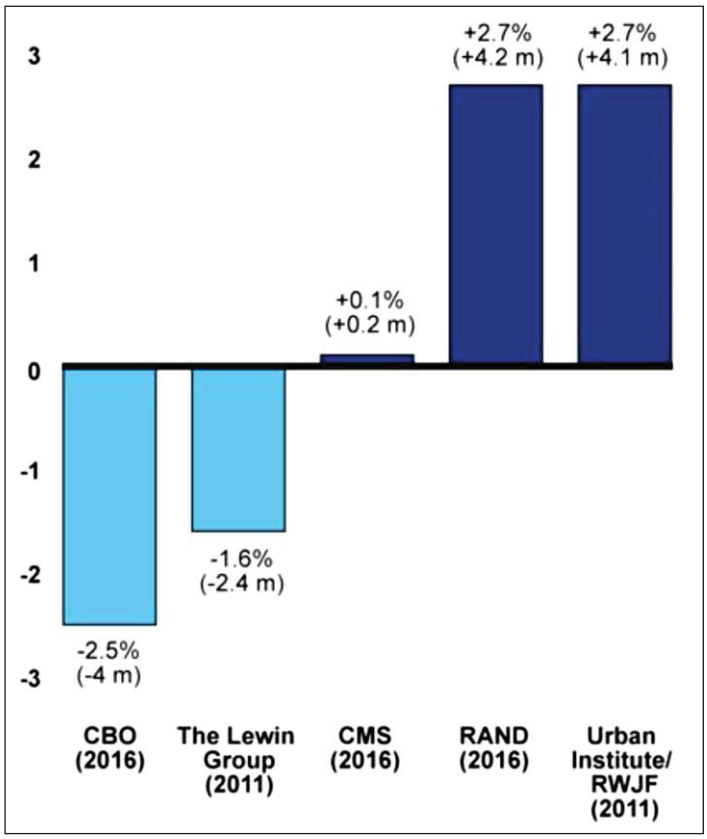
Studies that utilize microsimulation models predict that the ACA has a negligible effect on ESI rate of coverage and its costs. The GAO (2012) reviewed 12 microsimulation studies published from January 1, 2009 through March 30, 2012. The studies were conducted either by the staff or using statistical models from five organizations: Centers for Medicaid and Medicare Services (CMS), Congressional Budget Office, The Lewin Group, RAND Corporation (RAND), and The Urban Institute/Robert Wood Johnson Foundation (RWJF).

In terms of coverage, the GAO (2012) found that ESI can experience a net decrease of 2.5 percent to a net increase of 2.7 percent in the number of individuals with coverage in the near term (usually defined as the years 2014-2016). Figure 7 illustrates findings by the organization. The CBO predicts the highest net decrease of 2.5 percent or about 4 million individuals. The studies by the RAND and the Urban Institute/RWJF estimate the highest net increase of 2.7 percent or about 4 million individuals.

The latest report from the Urban Institute, which is not included in the GAO report, predicts the same ESI coverage trend in 2012 that the organization predicted for 2011, 2.7 percent increase (The Urban Institute Health Policy Center 2012). The report also addresses estimates of ESI cost trend and contradicts studies that predict the ACA will burden employers and erode ESI. The study found that under the ACA the total employer spending, for all employer sizes, will increase a small 2.2 percent, from 553.4 million to 565.8 million. Small employer health care costs will decrease, mostly due to small business tax credits and the competition in the HIX market. Mid-size and large employer health care costs will increase 9.5 percent and 4.3 percent, respectively. However, the main driver of these costs will be increased enrollment. Employers will not see a substantial change in their per capita health care costs. The Urban Institute argues that:

> "The future of employer-sponsored coverage is overwhelmingly determined by the state of the economy and by the growth in health care costs. As long as health care costs grow faster than inflation, the proportion of the population ESI covers will continue to drop. **That trend should not be confused with or attributed to the impact of the ACA**." (Emphasis added; The Urban Institute Health Policy Center 2012, 6).

Figure 7. Microsimulation Model Predictions of the ACA's Effect on ESI Coverage for 2016 and 2011 (assuming implementation of key PPACA provisions), GAO Analysis



Source: The U.S. Government Accountability Office. 2012. "Patient Protection and Affordable Care Act: Estimates of the Effect on the Prevalence of Employer-Sponsored Health Coverage." http://gao.gov/products/GAO-12-768 (September 25, 2012).

Examining Employer Surveys Predictions

Employer surveys examined by the GAO show a wide range of results. When employers were asked whether they will keep or drop ESI in 2014, the surveys revealed that 2 to 20 percent of employers may drop it. The GAO (2012) explains this phenomenon can be attributed to the variation in survey methodologies, and the survey's reliance on individual opinions and knowledge, which are specific to one's circumstances. Nevertheless, all studies are valid and should be given full consideration. Figure 8 shows 16 organizations whose findings were compared. The chart shows the size of employers surveyed and the percentage of employers likely to drop ESI in the near term (generally, defined as a period from 2014 to 2016).

Figure 8. The GAO's Analysis of Employer Surveys, January 1, 2009 through March 30, 2012

Organization	Size of employers surveyed	Percentage of employers likely to drop coverage in the near term
National Federation of Independent Business	Small (50 or fewer employees)	2
Towers Watson	Midsize and large: from 2,000 to 10,000+ employees	2
International Foundation of Employee Benefit Plans (IFEBP)	Small and large employers from IFEBP membership: employers with annual revenues ranging from less than $1 million to over $1 billion	3
Benfield Research	Jumbo (5,000+) employees only	4
Mercer	All sizes: 10+ employees	5
Willis	All sizes. Fewer than 500 employees, 25 percent; 500 to 4,999 employees, 43 percent; and 5,000+ employees, 33 percent	5
HR Policy Association	Large employers (not defined) drawn from the organization's membership	6
Midwest Business Group on Health	58 percent were employers with 500+ employees; 25 percent had 50 to 500 employees	6
PricewaterhouseCoopers	All employers	7
Market Strategies International	All sizes from at least 2 employees	9
McKinsey & Co.	All sizes from < 20 employees to > 10,000 employees	9
GfK Custom Research North America	N/A	12
Ceridian	N/A	19
Lockton Companies	N/A	19
Fidelity Investments	N/A	20
HighRoads	N/A	20

Notes: "Likely" responses include employers that stated they were "likely," "definitely likely," or "very likely" to drop coverage, or were "seriously considering" dropping coverage. For two surveys (Benfield Research and IFEBP), "likely" responses included those "considering" dropping coverage because there was no other affirmative response available. Near term is defined as generally within 2 years of implementation of key PPACA provisions. Surveys are for different time periods.
N/A means that the size of employers surveyed could not be obtained.

Source: GAO analysis of employer surveys.

Source: The U.S. Government Accountability Office. 2012. "Patient Protection and Affordable Care Act: Estimates of the Effect on the Prevalence of Employer-Sponsored Health Coverage." http://gao.gov/products/GAO-12-768 (September 25, 2012).

Many employers are not certain how to measure the impact of the ACA on their health care costs, especially the impact of the individual provisions (Midwest Business Group on Health 2012; Willis 2013). In 2010, the MBGH survey respondents' perceptions of the ACA cost impact were approximately 3 percent higher than the actual

trend in 2011, up to 5 percent vs. less than 2 percent. It appears that employers tend to exaggerate the ACA's cost impact on their bottom line. In 2014, employers predict to experience a cost trend increase of less than 2 percent (11 percent), of 2-5 percent (22 percent), 6-10 percent (12 percent), or over 10 percent (13 percent)[14]. About 33 percent of very small employers[15] anticipate seeing increases of 10 percent or more. About 40-45 percent of mid-size, large, and jumbo employers expect to experience increases in the health care cost of up to 5 percent.

Clearly, there is no agreement on the cost impact of the ACA on employers and employees. The MBGH's (2012) findings present radically different outcomes than the Urban Institute's (2012) microsimulation model discussed earlier. Microsimulation studies are more objective and thus more reliable than employer surveys. In both studies, the results strongly varied by the size of employer. The author also observed that business's benefit ideology is a critical factor in determining the coverage and cost impacts of the ACA.

[14] The remainder of employers reported "Don't know."
[15] In this survey "very small employers' are those with 50 or less employees.

Theory Behind Employer and Employee Behavior in the Post-ACA Health Care Market: The Rational Choice Theory

> *"Rather, all human behavior can be viewed as involving participants who maximize their utility from a stable set of preferences and accumulate an optimal amount of information and other inputs in a variety of markets."*
>
> Gary S. Becker ([1978] 1990)

This research draws on *Rational Choice Theory* (RCT). There are several assumptions that can be made about the U.S. healthcare system:

1. The U.S. healthcare system is market-based,
2. Selling and purchasing health insurance along with obtaining and giving medical care are economic activities,
3. The stakeholders in the healthcare system are self-interested, and
4. The stakeholders want to maximize their utility by increasing their profits (tangible and intangible) and avoiding costs.

RCT is known as the economic approach to human behavior. Considering the above listed axioms, this theory has a potential for explaining stakeholder behavior in the post-ACA healthcare market. In this section, the author will use RCT to explore employer-employee relationship and explain their individual choices in the post-reform healthcare market. The author will begin with a short overview of the theory. Then, the author will discuss the applicability of these ideologies to the employer and the employee behavior in the post-reform healthcare system. The author will end this section with a brief summary.

Rational Theory Origin and Key Postulates: An Overview

To begin with, it is imperative to define a fundamental term in RCT - "rationality." RCT relies on a specific and narrow definition of "rationality," which is different from the common usage of this term. In RCT, "rational" choices/actions are

based on the premise of utility maximization. Ultimately, a "rational" actor acts upon his or her preferences and makes choices that benefit him or her most. The theory recognizes that actors do not necessarily know all alternatives or everything about solutions they are considering. Thus, the optimal choices actors make are based on their limited knowledge and may not be uniform to all similarly situated actors (Becker [1978] 1990; Green 2002).

The roots of RCT can be traced to the work of Adam Smith and his idea of market self-regulation and individuals acting on their self-interests (Lynch and Cruise 2005). Originally, the theory and rational choice models were utilized by economists. But, in the second half of the 20th century, RCT experienced a spill-over effect to a variety of disciplines such as Sociology, Psychology, Political Science, and Anthropology (Becker [1978] 1990; Green 2002). Suddenly, other disciplines realized the appeal of RCT. Becker ([1978] 1990, 5) explains: "(…) the economic approach is uniquely powerful because it can integrate a wide range of human behavior." In 1975, Azzi and Ehrenberg developed a rational choice model of church attendance. Other scholars used RCT to construct models of suicide, auto safety regulation, addiction, racial profiling, Congressional influence on military assignments, political revolutions, megafauna extinction, the predictability of consumption spending, the rules of debate, and many others (Becker [1978] 1990; Green 2002).

A wide range of application is not the only advantage of RCT. The theory is capable of generating non-tautological predictions, that is, predictions that are testable and can be validated. Additionally, RCT can lead to "novel predictions"[16] (Green 2002, 18). These predictions are important because if they support the theory, the researcher

[16] Novel predictions are phenomena that were not accounted for when formulating the theory.

can be certain the theory is not flawed. The researcher's confidence in the theory can be further strengthened if novel predictions are testable and can be confirmed (Green 2002).

The theory has several limitations that need to be addressed. Primarily, RCT has been criticized for a lack of empirical validity. An argument has been made that the theoretical assumptions are not always congruent with reality. For example, Rational Choice models in economics often assume perfect market conditions and complete information. The second criticism is that RCT's unit of analysis, the individual decision-maker, is inappropriate. Some scholars argue that groups should be the primary unit of analysis. Also, several studies[17] discovered that individual choice behavior does not always follow the theoretical assumptions. The third issue surrounding RCT is whether institutions dictate preferences or vice versa. Similarly, there is concern about whether power relations and political questions influence preferences or vice versa. Another major criticism is that some rational choice models do not take into account that individuals may not have complete information about available alternatives. Additionally, individuals may not be able to perform mathematical and/or statistical analyses used by scholars to arrive at their decisions. The last major criticism of RCT purports that not all individuals (at least not at all times) behave selfishly. Thus, utility maximization can be misleading and the theory may prove invalid (Green 2002).

Rational Choice Framework

This research will attempt to develop a theoretical framework that can help explain study findings, employer and employee attitudes towards the ACA and its separate mandates, and employer and employee anticipated behaviors when the two key

[17] The author refers to studies by the psychologist Amos Tversky in collaboration with other scholars, as mentioned in Green (2002).

provisions, the individual mandate and the employer mandate, take effect on January 1, 2014. The ACA's financial impact on employer and employees is an important variable in this analysis because based on the RCT assumption that individuals try to avoid costs, it is safe to say that both employers and employees will act in ways that minimize their health insurance expenses. Some consulting companies have developed tools to help employers quantify the ACA's impact on their and the employees' bottom lines so that employers can make informed decisions about their ESI. The CHROME, one of the tools available to employers, monetizes costs to an employer and its employees for few possible scenarios, including when the employer maintains its ESI and three other scenarios (see Figure 9). Estimating the ACA-related costs creates a basis for the framework.

Monetizing the ACA's Impact is Critical to Understanding Attitudes and Behaviors: CHROME.

CHROME (ContinuousHealth Reform Optimizer and Management Environment) Compass software is a comprehensive and probably the most sophisticated model currently available to employers. Eric Helman, Founder and CEO of ContinuousHealth, LLC, stated during a phone conversation in September 2012 that about 700 employers across the U.S. use CHROME. The software enables employers to perform a *Pay or Play* analysis by modeling the potential employer costs based on employee data, organizational philosophy, and preferences. Various variables are considered such as salary and employee demographics, medical plan enrollment, plan design, and unique data obtained through the executive questionnaires (reflecting organizational philosophy

and preferences). Additionally, the model incorporates fixed data tables such as tax rates. All variables can be adjusted at any time to provide context-based results.

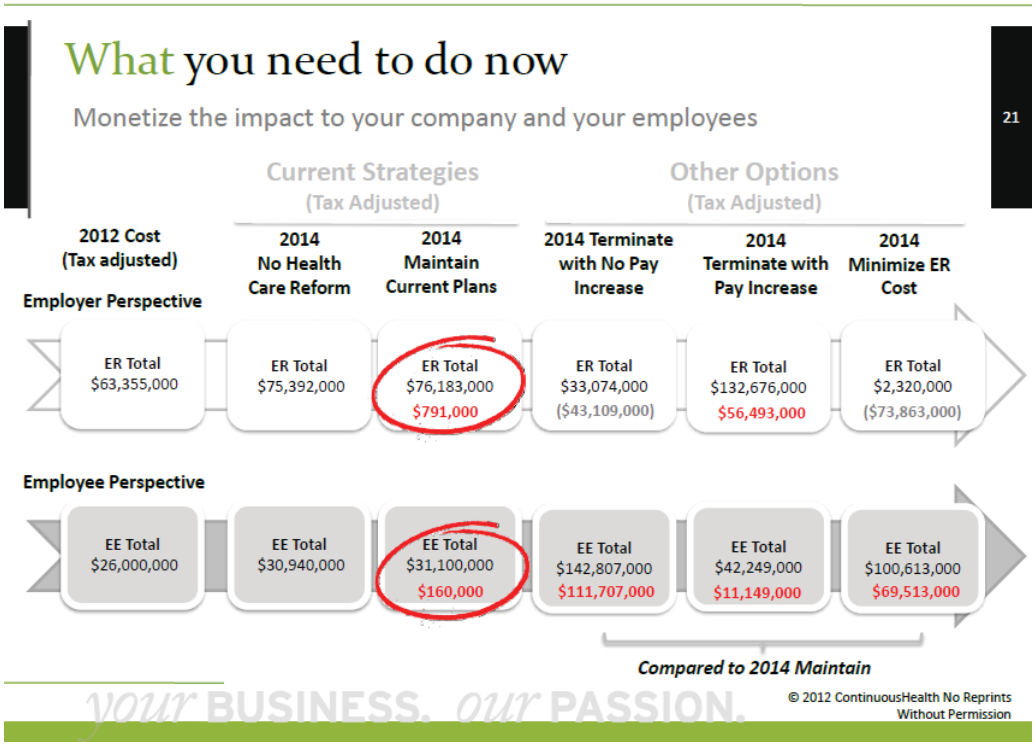
CHROME is a strategic tool. For Helman, the health care reform transformed how employers think about health care benefits. Health insurance is no longer just a part of an employee benefit package. Employers need to think about how to allocate compensation for health care to fulfill the employer's strategic objectives. Employers need to ask themselves: Do we want to provide health care coverage to the employees or do we want to send them to the Exchanges and subsidize? Do we want to cut our health care expenses down at all costs including increasing employee health care costs? Do we want to eliminate health care benefit and increase employee compensation? How will our decisions affect employees and their families?

Figure 9 illustrates CHROME results from a real case example. It shows that the XYZ employer's choices under the "Other Options" will substantially increase employee annual health care costs. In 2014, employees could expect an increase of $160,000 in their health care costs if the XYZ employer maintains its current plans. However, if this particular employer eliminates ESI and does not offer pay increases, the employee costs could increase almost 700 times up to $111,707,000. The XYZ employer can save up to $73,863,000, in 2014 by minimizing its health care costs and shifting more financial responsibilities to employees (for example, by offering High Deductible Health Plans). In this scenario, the employer keeps the benefit and cost-sharing levels high enough to maintain the affordability and minimum coverage requirements under the law. By doing so, the employer[18] avoids a $3,000 penalty for each employee who goes to the Health

[18] Penalties apply to employers with 50 or more full-time employees or full-time equivalents (full-time is defined as at least 30 hours a week).

Insurance Exchanges and receives government subsidy. CHROME presents the monetized effect of four alternatives outlined in Figure 9 to the employer. The employer will choose behavior most optimal to the organization based on its business strategy and the expected utility. If the employer wants to continue offering ESI and the utility of providing ESI exceeds that of scenarios under "Other Options," the employer will certainly preserve ESI.

Figure 9. CHROME Compass Real Case Results Example



Source: Optum. 2012. "Health Reform: What Lies Ahead?" E-panel Presentation. Presented August 28, 2012.

Note: Used with permission from ContinuousHealth, LLC.

RCT Implications for Employers and Employees

RCT has a potential to explain employer and employee behavior in the healthcare market and inform future predictions. Two major assumptions can be made about the stakeholders in the healthcare system. The first is that stakeholders are utility maximizers who want to obtain more goods/services at the lowest price possible in an effort to

increase profits and lower costs. The key stakeholders include physicians, government, lobby groups, medical associations (such as American Medical Association and American Hospital Association), hospital systems, pharmaceutical companies, pharmacies, pharmacy middlemen, employers and employees, healthcare insurance companies, and all U.S. citizens. The second assumption is that stakeholders have a stable set of preferences that guides their choices. The author posits that employers want to contain their health care costs, but at the same time they also want to see employees happy and healthy. An employer's business strategy will determine which direction the employer favors. Employees, on the other hand, are simply seeking to minimize their health care costs.

Based on the above assumptions, the author makes the following predictions about the impact of the ACA on employers and employees. Most employers will continue providing health insurance to their employees in 2014 and beyond because its utility exceeds that expected from the other three scenarios identified in the CHROME Compass model (See Figure 9). Employers who abandon their health benefits in 2014 with no intention to compensate employees and those who shift most of their costs to employees will be better off financially, but their employees will suffer substantial health care cost increases. The available literature shows that ESI is an important benefit to both employers and employees. It is also a strategic tool that employers highly value. Thus, the predominant business strategy among employers will be to continue offering health insurance coverage to employees.

A different approach to ESI is anticipated for employers who have not been providing health benefits. The author predicts that, in 2014, most of these employers will

opt for paying a penalty. These employers either do not regard health benefits as important to their organizations' wellbeing or simply cannot afford them, or both. Small employers (with 200 or less employees) have the lowest rate (61 percent) of providing ESI among the U.S. employers (The Kaiser Family Foundation and Health Research & Educational Trust 2012). Small firms cite the cost of health insurance as the primary reason they do not offer ESI. Still, some small employers have provided funds to their employees to purchase insurance in the private market, which shows their willingness to helping employees with their health care costs (The Kaiser Family Foundation and Health Research & Educational Trust 2012).

The decisions employers will make are far more complex than they initially appear. There are other hidden costs and benefits, some unique and some common to the employers. Unique components, which are also probably the most difficult to capture in the RC frameworks, are the organizational philosophy and culture. Employers need to ask themselves how important is it to them and their employees for health insurance to be included in the benefit package? How will their decisions financially affect employees and in terms of productivity and absenteeism? The common and often overlooked costs of abandoning ESI for employers are a loss of tax deduction for an employer, a possible loss in productivity, an increase in absenteeism, and an increase in workforce turnover[19]. An organization's human resources office can trace and supply data on these and other metrics.

Under the new law, individuals with household incomes less than 400 percent of the Federal Poverty Level (FPL; $44,680 for an individual and $92,200 for a family of

[19] Cost per Hire is involved.

four in 2012[20]) and whose share of the insurance premium exceeds 9.5 percent of the household income[21], or whose ESI des not meet a minimum value requirement[22], will qualify for government subsidies designed to help low income individuals with their health care expenses. Nevertheless, most individuals will find ESI cheaper. The literature and the CHROME model show that employees who obtain health insurance in the private market in 2014 will face substantially higher health care costs. Using a microsimulation model, the Congressional Budget Office (CBO) and the Joint Commission on Taxation (JCT) estimated that, in 2014, many workers and their families will not be eligible for Medicaid, the Children's Health Insurance Program (CHIP), or generous subsidies in the HIX (Congressional Budget Office 2012b).

In addition to the findings by the CBO and the JCT, one of the key considerations for employees is that employee premiums in an ESI arrangement are tax-exempt. Secondly, employers tend to pay a majority of the premiums, on average 82 percent for single coverage and 72 percent for family coverage (The Kaiser Family Foundation and Health Research & Educational Trust 2012), making employee's share of premium low. Also, employers purchase insurance policies as a group, which spreads the risk for the insurer, and enables employers to obtain lower premiums than an employee could get on his or her own in the commercial health insurance market. Finally, employers who self-insure their health benefits, that is, pay medical claims from their own general assets, are generally able to keep premiums even lower than employers who fully insure. Overall,

[20] FamiliesUSA. 2012. "2012 Annual Federal Poverty Guidelines." http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html (November 28, 2012).
[21] There are three safe harbors employers can use to verify the affordability of their coverage. One such measure is to use 9.5% of employee's W-2 income as the affordability threshold.
[22] The minimum value provision requires that employers pay at least 60% of total costs of benefits.

employees will obtain better utility from the ESI arrangement. It follows that in 2014 a vast majority of employees will keep or enroll in ESI.

Exploring Employer Choices: Stay, *Pay or Play*?

In 2014 employers will be faced with a decision of whether to eliminate employer-sponsored health insurance (or continue without it) and pay a penalty ("pay") or provide/continue providing ESI to their employees ("play"). The ACA introduced a number of penalties and fees that employers need to consider when deciding how to proceed. The *Pay or Play* provision is one of those penalties. Other ACA changes that employers need to be aware of include provisions that affect benefits design such as the requirement to cover preventive care with no cost-sharing and benefits administration such as the Medical Loss Ratio that requires fully-insured plans to spend at least 80 percent of their premium revenue on medical services (All major provisions affecting ESI are listed in the Appendix C*)*. Whether employers are purchasing health insurance coverage from the third party or are self-insuring, due to ACA's requirements and its, so far, poor performance in controlling health care costs, they are facing higher health insurance costs. Employers may find it easier and more convenient to pay a fixed penalty each month they do not offer health insurance benefits to their employees than to provide ESI. The ACA by design tries to deter employers from this action. Here is where the *Pay or Play* provision comes in.

As the law stands now, in 2014, many employers will find the penalty to be less than their cost of health insurance coverage. Employers with 50 full-time employee or full-time equivalents who fail to offer health insurance coverage to their employees will be assessed a $2,000 annual penalty multiplied by the number of full-time employees (reduced by the first 30 employees). If employers offer health insurance coverage but the

insurance is either unaffordable (employee premium share is over 9.5 percent of employee's household income) or does not meet minimum value (the insurance's share of total costs of benefits is less than 60 percent of the costs), they will have to pay the lesser of $3,000 per each employee who obtains coverage and subsidy in the HIX or $2,000 multiplied by the number of all employees (less the first 30). The penalties are substantially lower than the 2012 national average employer premium share for a single coverage of $4.664 (The Kaiser Family Foundation and Health Research & Educational Trust 2012).

There are three general courses of action employers can take in 2014: "Stay the course," "Pay and exit," and "Pay differently." The last category encompasses two approaches: "Play by new rules," and "Play on a new field" (Aon Hewitt 2012). Figure 10 illustrates the four likely actions by employers and the factors employers may take into consideration when making their decisions.

"Stay the course" option may be the most difficult to take. Grandfathered health plans, those plans that were in effect on March 23, 2010 and were not substantially altered since the law's passage, fall under this category. Employers with grandfathered ESI can make limited benefit design and cost sharing changes. Ultimately, over years, these employers have to assume a higher share of the cost increase. Employers who abandoned the grandfather status can shift more of the cost to the employees in a form of higher premiums, deductibles, or an increase in other employee responsibilities. Nevertheless, even this approach poses a risk of eventually exhausting employee cost sharing capabilities and making ESI unaffordable. The next option, "Pay and exit," describes a scenario in which employer drops ESI and pays a federal penalty. Employers

who choose this path will need to investigate the effects of their decision on business's competitiveness and employees' health (Aon Hewitt 2012). The CHROME *Pay or Play* analysis illustration demonstrates that employee health care costs in this scenario are likely to skyrocket.

Figure 10. Employer Choices in 2014 under the ACA

Source: Aon Hewitt. 2012. "2012 Health Care Survey." http://www.aon.com/attachments/human-capital-consulting/2012_Health_Care_Survey_final.pdf (September 28, 2012).

The "Play differently" option will be utilized by employers who want to continue offering health insurance but in a cost-efficient manner. This approach is the most innovative of all the options and introduces infinite health insurance design and cost containment measures possibilities (most common cost-containment strategies were listed

earlier in this chapter). Aon Hewitt (2012) distinguishes between the emphasis on preventive and wellness measures enforced through an incentive program ("Play by new rules") and a new revolutionary defined contribution model of ESI ("Play on a new field"). The last solution draws from the reforms in the retirement benefits that transformed from the defined benefit pensions to defined contribution 401(k) and other plans that shift most of the financial responsibility on employees. Employers using this model can send employees to purchase health insurance in the HIX and offer them flat-dollar subsidies. They can also keep their ESI and subsidize employees who purchase health insurance through it.

Exploring Employee Choices: *Pay* for Health Insurance or *Pay* a Tax?

Healthcare system reformers have long recognized that people make rational choices in the health care market. People often do not purchase health insurance until they need it. This is especially true for young people. This phenomenon is the sole reason why insurance protections such as the Pre-existing Condition Exclusion were designed and why insurers could deny insurance to the sick prior to the reform. In 2014, the ACA will prohibit insurers from denying coverage based on health and will completely eliminate the pre-existing condition exclusion[23]. These and other provisions will guarantee equal health insurance access to all, healthy and sick. But, the new consumer protections pose a problem of adverse selection. More sick individuals obtaining insurance at any time may result in higher health care premiums and even make the insurance issuers financially insolvent.

[23] Currently, pre-existing condition exclusion is eliminated for policyholders/plan participants under 19 years old only.

To protect insurers in the post-ACA era, the law introduces the Individual Mandate. The mandate requires individuals to purchase a qualifying health plan[24] by 2014. Those who do not purchase insurance, with some exceptions for low-income individuals and other exceptions, will have to self-report their lack of health insurance on the tax return and pay a tax. The objective of the tax is to encourage people to buy insurance based on the assumption that a rational individual would try to avoid the tax and thus choose to purchase insurance. It is debatable whether the tax will be able to accomplish its objective. First of all, the tax is set at $95 or 1 percent of taxable income for an individual in the first year (2014) and then rises to $695 or 2.5 percent of income in 2016 (in the following years, the tax will be adjusted for inflation), which is substantially lower than purchasing a health insurance policy (Wolters Kluwer Law & Business 2010). A (rational) healthy individual could easily opt to pay the tax instead of purchasing insurance.

Most importantly, however, the IRS has recently announced that it will not enforce the tax because the law does not grant the IRS any powers in this domain (Gleckman 2012). Gleckman (2012) explains: "The ACA bars the IRS from bringing a criminal enforcement case against someone who refuses to pay the non-insurance penalty. And it makes it very difficult, if not impossible, for it to enforce a tax lien." Essentially, individuals are given a choice to purchase health insurance or pay an "optional tax." Assuming that individuals act rationally, the Individual Mandate is doomed for failure because "most people who really want to game the system will

[24] Qualifying health plan is a health insurance policy or an employer-sponsored plan that meets minimum essential benefits and affordability requirement (as discussed previously).

probably get away with it" (Gleckman 2012). The following section introduces the concept of a *free rider* to the discussion.

The Problem of a *Free Rider* under the ACA.

A related, and often discussed, phenomenon in RCT is *free riding*. In his theory of group solidarity, Michael Hechter argues that "it is rational to consume public goods without contributing to their production" (Turner 2003). In the healthcare market, *free riders* can be identified as individuals who go without health insurance until a need arises. The category of *free riding* can also include the use of emergency departments by the uninsured. *Free riding* is a rational choice because it maximizes one's utility of medical care at the lowest cost (contribution) possible. Nevertheless, the behavior develops adverse selection in the healthcare system with more sick individuals purchasing insurance than the healthy, resulting in higher costs to insurers. Some if not all of the costs then are transferred to the individuals who have health insurance in a form of higher premiums and/or cost-sharing. One of the objectives of the Individual Mandate is to eliminate the *free rider* problem by punishing those who do not have health insurance in 2014 and beyond. It appears that the problem will persist, though, because the intended deterrent, the tax, is optional. A rational individual would either pay a tax instead of purchasing health insurance because the tax would be lower than an average health insurance premium for most individuals or choose not to purchase health insurance and not to self-report the lack of insurance coverage and thus avoid paying an "optional tax."

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that only 20 percent, or 6 out of 30 million, uninsured people in 2016 will pay the penalty tax (Congressional Budget Office 2012c). About 18 to 19 million

uninsured people are predicted to qualify for one or more of the following exemptions: unauthorized immigrant, income too low to file tax return, Indian tribe member, and premium share of income too high. That leaves 11 to 12 million uninsured people, of which some will be exempted from the tax because of hardship or religious beliefs, and others will simply avoid paying the penalty (Congressional Budget Office 2012c). CBO findings confirm that some individuals will avoid tax payments and validates the theoretical rational choice framework for this study and the concept of a *free rider* discussed above.

Assessing the Effects of Health Insurance Exchanges (HIX).

A majority, about 260 million (or 84 percent), of individuals in the U.S. has health insurance coverage (U.S. Census Bureau 2012). More than a half, about 149 million, obtains their health insurance through their employers (The Kaiser Family Foundation and Health Research & Educational Trust 2012). The benefits of ESI to employees were discussed earlier in this chapter. To sum up, the author concluded that a rational working individual would prefer ESI over purchasing commercial health insurance policy. The effects of the Health Insurance Exchanges (HIX) coming in 2014 have not been taken into the account, though. These are difficult to assess because presently not much is known about insurance issuers and their insurance plans that will be participating in HIX and what is known is an array of minimum benefits to high coverage level plans and non-profit and for-profit organizations.

Initially, states had to decide how they will set up and operate their HIX by submitting their letter of intent to the HHS by November 15, 2012. This deadline was extended to December 14, 2012. In January, the Secretary of Health and Human Services waived the deadline for states to opt to create their own HIX or to join with the federal

government in establishing HIX. To date, 24 states have received conditional approval to operate a state-based or state-partnership exchange. The following is a list of states by the type of HIX:

State-based exchange	State-partnership exchange	Federally-facilitated exchange
CA, CO, CT, DC, HI, ID, KY, MA, MD, MN, NM, NV, NY, OR, RI, UT, VT, WA	AR, DE, IA, IL,NH, MI, WV	AK, AL, AZ, FL, GA, IN, LA, KS, ME, MO, MS, MT, NC, ND, NE,NJ, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY

■ *Democratic* ■ *Republican* ■ *Independent*
Source: Deloitte. 2012a. "Health Care Reform Memo: March 11, 2013." Deloitte Center for Health Solutions. http://www.deloitte.com/view/en_US/us/Insights/Browse-by-Content-Type/Newsletters/health-care-reform-memo/c12c55b75685d310VgnVCM3000003456f70aRCRD.htm (March 17, 2013).

For employers and employees in states that decided to let the HHS run their HIX, including Georgia, the effect of the HIX on their ESI, at this time, is close to impossible to determine. Little is known about how the federal government will set these Exchanges, operate them, or finance them. There is also a fear that federal Exchanges will not provide subsidies to enrollees because the ACA does not allow them to do so (Scandlen 2012).

Based on available literature (Congressional Budget Office 2012b), some observations and predictions can be made. Lacking the public option, HIX are solely private, and market-based. The reformers' idea behind the HIX is that competition will lower health insurance prices, but the savings obtained through HIX may still be lower than what employees save through ESI. Especially, as discussed earlier, when self-insurance arrangements offer cheap premiums and overall cost to the employee. So, when faced with a choice to keep employer-based insurance or purchase insurance through Exchanges, a rational employee will choose to keep/get ESI. Some employees who

qualify for government subsidies in the HIX will have lower costs in HIX than in the ESI, and thus will obtain health insurance through HIX.

Summary

The future of ESI in 2014 and beyond is uncertain. In 2011, employers experienced high health premium increases of 8-9 percent that were almost triple the rate of price inflation in the U.S. This trend was expected to continue into the year 2012. Surprisingly, health premiums rose on average only about 3-4 percent. This sudden change can be contributed to a slow economy and a slight decline in the rate of medical care utilization (Appleby 2012). A study by the Urban Institute argues that the decrease in health care spending is also attributable to the cost-containment provisions of the ACA (Zuckerman and Holahan 2012). However, the ACA has not yet been fully implemented and its effects on health spending are subject to change. A report by PricewaterhouseCoopers (PwC) estimates that, in 2013, premiums will increase, on average, 5.5 percent (Appleby 2012).

The microsimulation model analyses demonstrate that the ACA's impact on ESI coverage and costs is trivial. Employer surveys, on the other hand, predict that up to 20 percent of employers could drop ESI in 2014 due to increased costs under the ACA. The MBGH (2012) survey found that in 2011 employer health care cost increased only less than 2 percent and not 5 percent employers anticipated in 2010. Thus, the microsimulation models appear to be more reliable than employer surveys. Employer surveys rely on self-reported data from employer representatives with different knowledge and experience, which allows for bias.

The ACA is often compared to the Massachusetts health reform of 2006, named Romneycare after the state Governor Mitt Romney. Romneycare requires that

Massachusetts employers offer ESI or pay a penalty, which is lower than employer health care costs. Contrary to predictions that employers would simply abandon ESI, currently, more people have ESI than before the 2006 reform (Wolters Kluwer Law & Business 2010). This analogy validates the predictions of studies discussed in this literature review and those derived from the RC framework. It also validates the researcher's assertion that in making their (rational) decisions employers will also consider factors other than the monetary cost of health insurance.

Rational choice theory can create a useful framework for explaining employer and employee behavior in the post-ACA health insurance market. Microsimulation models analyzing the impact of the ACA often use economic theory as one of their data elements (The U.S. Governmental Accountability Office 2012). RCT can produce valid predictions on a national scale. However, the best use for RCT is on the individual employer basis. RCT assumes that employers hold certain preferences stable. These preferences, often expressed in the business strategy, are unique to employers. Also, employers face different financial and political pressures. The environment in which employers and employees operate needs to be assessed and accounted for in the RC frameworks. This approach can help predict employer and employee behavior in the post-ACA era.

Chapter III

METHODOLOGY

This study utilized an employer questionnaire, the Plan cost analysis, and a trend survey design in order to conduct a descriptive case study of The Langdale Company (the Company) and a quantitative analysis of employee attitudes towards the ACA and their ESI. The study objectives are: (1) to measure the ACA's impact on The Langdale Company's bottom line and its employee benefit ideology; (2) to assess The Langdale Company's employee opinion of the health reform and to gauge employee satisfaction with their Plan in the post-ACA era; and (3) to investigate the ACA's impact on employee health care costs (defined as premiums, deductibles, copayments, coinsurance, and prescription drug expenses).

This project consists of five stages. The first stage was completed in the Fall of 2011. In this stage, the researcher surveyed all employees who had health insurance through the Company (801 employees). The researcher used a questionnaire designed by her using a web-based survey development tool, *SurveyMonkey*, and then analyzed collected data using descriptive and inferential statistics: *cross-tabulation, Gamma,* and *Pearson's Chi-square*. The author investigated relationships between (1) employee health care cost change and their satisfaction with the Plan, (2) employee knowledge of health care reform and their satisfaction with the Plan, (3) how much employees know what plan covers and what it doesn't and their satisfaction with the Plan, and (4) employee

approval of the 2010 health care reform and their satisfaction with the Plan. The above relationships were again investigated in the 2012 follow-up study.

The second stage of this research consisted of a follow-up survey, which was distributed in December 2012. A *survey notification* was included in the Company quarterly Newsletter, which was mailed in October. In this stage, the researcher used the same survey tool that she used in stage 1 with certain modifications. The researcher analyzed collected data. Then, in the third stage, she compared the 2011 findings to the 2012 findings. This analysis investigated differences between the groups in order to assess the ACA's impact over time. In the fourth stage, the researcher developed and administered an employer questionnaire which asked the Vice President of Human Resources (Barbara Barrett) what the Company is doing and planning to do in response to the ACA. Lastly, in the fifth stage, the researcher compared the Company's health benefit costs from financial data for years 2009 through 2012.

Case Study Participants

This study surveyed the entire population of The Langdale Company employees who have health insurance coverage through the Company. At the time of this study, November 2012, 839 employees had regular health insurance coverage, and six employees had continued health insurance coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA)[25], together 845 employees. The researcher used the census as the sample in order to obtain the most accurate results. In the 2011 pilot study,

[25] The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan (U.S. Department of Labor 2013).

only 103 employees with ESI responded to the survey, which yielded a 13 percent response rate.

Study Instrumentation

Instrumentation

The study utilized a survey questionnaire designed by the researcher via the online tool *SurveyMonkey*. In the first stage, the survey was mailed via U.S. mail to all eligible employees (employees enrolled in the health Plan) in late October 2011, approximately two weeks following a mailing of a post card announcing survey. The survey included a cover letter describing the project, ensuring anonymity, and informing study participants that the study was exempted from review by the Institutional Review Board (IRB) (see Appendix B). The cover letter also informed study participants that the survey was available online via the Company's website. The researcher used *SurveyMonkey* to collect responses and to export data in the Statistical Package for the Social Sciences (SPSS) format. A statistical analysis was then conducted using PSPP[26].

In stage two of this study, the researcher used the same tool to gather data and the same methods of distribution. The researcher modified the survey in order to address voluntarily given concerns and suggestions by the 2011 pilot survey respondents and also to eliminate questions that were not pertinent[27] to this study. Additionally, the researcher added few new questions, one of which was critical to assessing employee willingness to maintain their ESI in 2014: How likely are you to drop your health insurance coverage through the Langdale Company and purchase insurance in the Health Insurance

[26] PSPP is a free software application, nonproprietary version of SPSS, for analysis of sampled data.
[27] Some collected data such as responses to questions about use and type of news media were not utilized in the pilot study and were not needed for stage two of the project. These questions were removed from the survey.

Exchanges?

The survey is divided into five dimensions: the first dimension assesses the employee overall familiarity with the PPACA law; the second dimension measures the employee knowledge of and attitudes towards health benefits offered by the Langdale Company; the third dimension assesses the employee health care costs; the fourth dimension asks for comments regarding their health insurance in the form of an open-ended question; and the fifth dimension collects employee demographics.

The researcher designed an employer questionnaire for the VP of HR. Lastly, the researcher examined the 2009-2012 health Plan cost data in order to assess the financial impact of the ACA. This data was compiled and updated by the Benefits Coordinator at TLC Benefit Solutions, Inc, a company that administers the Plan. The years 2009 and 2010 served as a baseline in the analysis. The Company health Plan is a calendar year plan, so the ACA requirements became effective for the Company January 1, 2011. Additional analysis will illustrate an estimated cost of specific ACA provisions to the Plan.

Variables

For the quantitative component of this study, the employee survey, the dependent variable (DV) is *Satisfaction with the Plan.* Initially, this variable had eight categories: *Very Satisfied, Satisfied, Somewhat Satisfied, Neither Satisfied nor Dissatisfied, Somewhat Dissatisfied, Dissatisfied, Very Dissatisfied,* and *Don't Know*. Due to small cell count in the frequency table in the 2011 pilot analysis, the researcher recoded DV values into six categories (*Very Satisfied*, *Satisfied, Neither Satisfied nor Dissatisfied, Dissatisfied, Very Dissatisfied and Don't Know*). In the 2012 study, the researcher added

an additional DV, *Willingness to Maintain ESI* with the following categories: *Very Likely, Likely, Somewhat Likely, Not at all Likely (I will drop my health benefits effective January 1, 2014),* and *Don't Know.*

In the 2011 analysis, independent variables and their corresponding values (IVs) were: *Health Care Cost Change in 2011(Increased a Lot, Increased Some, Stayed the Same, Decreased Some, Decreased a Lot, and Don't Know); Knowledge of Health Care Reform (Excellent, Good, Fair, Poor, and Don't Know); Knowledge of the Plan (A lot, Some, Not Very Much, Hardly Anything, and Don't Know); Approval of the ACA (Approve, Neither Approve nor Disapprove, Disapprove, and Don't Know* – recoded*).* The 2012 follow-up study used these variables and their corresponding values. A new IV, *Employee Household* with values ranging from $12,500 to $150,000 or more, was created to test hypothesis 3b. In order to reduce the number of cells in the analysis, the variable was recoded into approximate federal poverty levels of less than 100 percent, less than 200 percent, less than 300 percent, less than 400 percent, and 400 percent and over.

Due to low variability in both DVs, the researcher introduced two control variables to the study: *Job Category* and *Gender*. Originally, the *Job Category* variable had seven categories: *Executive, Senior Management, Management or Supervisor, Non-management Technical/Professional, Clerical or Administration, Hourly Employee,* and *Don't Know*. For purposes of the analysis, this variable was recoded into two categories: *Management and Other Professional* and *Hourly.*

Study Procedures and Statistical Analysis

Reviewed literature revealed mixed effects of the ACA on ESI. This case study will assess the ACA's impact on The Langdale Company, its health Plan, and its

employees. Study procedures consisted of five stages: the 2011 pilot study, the 2012 study, comparative analysis of the two studies, the Plan cost analysis, and an employer questionnaire. The researcher used the following descriptive and inferential statistics in order to analyze the hypotheses: *cross-tabulation, Gamma,* and *Pearson's Chi-square*. A *t test* for independent samples was used in an additional analysis examining employee 2012 health care expenses by enrollment category (Participant Only or Family).

Study Limitations

There are several limitations to this study. First and foremost, the survey component of this study is based on a researcher-designed instrument, which questions the reliability and validity of the tool. The researcher utilized a scale analysis on 33 questions about the ACA's individual provisions. Cronbach's Alpha revealed strong internal reliability ($\alpha = .95$) for these items and thus validated the instrument. Additionally, the comparison analysis between the 2011 and the 2012 groups yielded similar results[28], indicating that the tool is reliable as well. The survey has face and content validity. The researcher has experience in the field as a compliance officer for the Plan. Furthermore, survey questions were modeled on questions asked by various reputable consulting and research organizations, particularly from The Kaiser Health Tracking Poll, a product of a leader in health policy analysis, The Henry J. Kaiser Family Foundation.

Other limitations include: a low cell count in the cross-tabulation analyses, which may have skewed the results, specifically the results of *Pearson's Chi-square* (x^2) significance test; low variability of the two studied DVs; low response rate of 12 percent;

[28] Some variation between the 2011 study and the 2012 study results was expected as a result of the ever-changing political and health care environment, along with employees' exposure to more information about the ACA prior to the 2012 follow-up survey.

and the self-reported nature of the survey which might have introduced error or bias into the findings. Lastly, similar to actuarial *Pay or Play* modeling tools, this research assumes that the employers and the employees will make informed decisions and have perfect information. In reality, this study will show that the knowledge of the ACA varies widely. Furthermore, individuals do not always act selfishly. Thus, we can expect more variability in the behavior choices employers and employees make than the conclusion of this study will suggest.

Summary

This research is a case study of The Langdale Company supplemented with an employee survey. The ACA has changed the health insurance industry as employers and employees have come to know it. With the ESI being the backbone of health insurance in the United States, it is important to understand the impact the ACA has on employers and employees. Specifically, will the ACA bring the end to the employment-based insurance or will it fundamentally transform it? What effects will employer behavior have on employees, and what do the employees think about the ACA and plan to do in response to it? This study focuses on a single employer, The Langdale Company, and hopes to help the Company gain a better understanding of the actions it can take and of the employee perspective on the ACA and their ESI. Additionally, the research will utilize a theoretical framework developed in Chapter 2 that can help other similar employers understand and predict their and their employee responses to the ACA, thus broadening application of this study.

Chapter IV

RESULTS

As explored in depth in the literature review, Chapter 2, now is the time employers examine their health plans or consider offering health insurance to their employees, if they have not yet done so. The January 1, 2014 deadline for the two crucial health care reform mandates, the Individual Mandate and the Employer Mandate, is quickly approaching. The Company is facing an array of changes to its health plan. In addition to facing the *Pay or Play* provision, the Company's Plan will lose Grandfathered Status and thus will have to adopt several other requirements such as preventive care with no cost-sharing, eight new women's wellness benefits, and contracting with three Independent Review Organizations for external review. The following chapter examines The Langdale Company employees' satisfaction with their ESI in connection with the 2010 health care reform. This chapter also presents an employer perspective on health care reform and what it means for the Company and its employee benefits package. Lastly, the Plan cost data for years 2009-2012 is explored.

Demographic Analysis: Survey Respondents vs. Study Population

The following analysis compared demographic characteristics and health plan enrollment data of employees who responded to the survey with the overall employee population who had the Company health insurance on December 12, 2012, the date the survey mailing list was created. The Company has a diversified workforce. One hundred and three out of 845 surveyed employees responded to the survey resulting in a 12

percent response rate. In this analysis, the researcher investigated how representative the 12 percent was of the entire population. The following variables and their corresponding values were utilized for the analysis: *Age (17 or younger, 18-20, 21-29, 30-39, 40-49, 50-59, 60-65, 66 or older) , Enrollment Category (Participant Only, Full Family), Gender (Male, Female),* and *Job Category (Executive, Senior Management, Management or Supervisor, Non-Management Technical/Professional (includes Sales), Clerical or Administration, Hourly Employee).*

Table 1 presents the frequency and percent of survey responses to each of the four variables' values and the frequency and percent for the entire sampled population for the same categories. The percent differences between survey responses and population data ranged from 0.4 percent difference (*Executive*) to 25.6 percent difference (*Hourly Employee*). The following was observed: (1) study population age 39 and younger was underrepresented (10.9 percent difference for 30-39, 8.9 percent for 21-29, and 0.9 for 18-20), and the population 50 years old to 65 was overrepresented (13.7 percent difference for 50-59 and 8.3 for 60-65); (2) population with Participant Only coverage was underrepresented (13.7 percent difference) and the population with Family coverage was overrepresented (13.9 percent difference); (3) Male population was underrepresented (12 percent difference), and female population was overrepresented (12 percent difference); and (4) Hourly Employee population was underrepresented (25.6 percent difference), and Management or Supervisor and Senior Management were both overrepresented (18.9 and 3.3 percent difference, respectively). In sum, this analysis suggests that the survey results may not accurately represent opinions of the entire population. Nevertheless, the survey respondents and study population were found

Table 1. Distribution of Survey Respondents vs. Study Population by Age, Enrollment Category, Gender, and Job Category

Variables	Values	Survey Respondents		Study Population*	
		f	%	*f*	%
Age	17 or younger	0	0	0	0
	18-20	1	1.0	16	1.9
	21-29	6	6.1	127	15.0
	30-39	10	10.1	177	21.0
	40-49	27	27.3	231	27.3
	50-59	37	37.4	200	23.7
	60-65	17	17.2	75	8.9
	66 or older	1	1.0	19	2.2
	Total	103†	100.0	845	100.0
†4 cases were missing; all skipped the question.					
Enrollment Category	Participant Only	35	34.7	409	48.4
	Family	66	65.5	436	51.6
	Total	103†	100.0	845	100.0
†2 cases were missing; one of these skipped the question, one of these answered "Don't know."					
Gender	Male	76	76.0	744	88.0
	Female	24	24.0	101	12.0
	Total	103†	100.0	845	100.0
†3 cases were missing; all skipped the question.					
Job Category	Executive	1	1.0	5	0.6
	Senior Management	4	4.2	7	0.8
	Management or Supervisor	33	34.4	127	15.1
	Non-Management Technical/Professional (includes Sales)	12	12.5	126	15.0
	Clerical or Administration	10	10.4	49	5.8
	Hourly Employee	36	37.5	527	62.7
	Total	103†	100.0	841	100.0
†7 cases were missing; six of these skipped the question, one of these answered "Don't know."					

** Source: The Langdale Company Human Resources data; Participant Information Listing as of 12/12/2012.*

Notes:

a. Table is based on data as of December 12, 2012.
b. Age for the Study Population was determined as of December 27, 2012, an approximate date employees received the survey booklets, in order to allow for adequate comparison.
c. Job Category data is current as of January 14, 2013.
d. Percentages may not add up to 100 due to rounding.

similar in regard to frequency and percent distribution: variable categories with highest counts/percent for the population also had highest counts/percent for the survey

respondents.

Survey Respondents

Survey respondents were predominantly male (76 percent) and White (86 percent). The respondents' household income varied widely with a mean of approximately $64,903. Most of the respondents were 50 to 59 years old (37.4 percent) with an average age of approximately 49 years. Additionally, most of the respondents had a college degree (42 percent), 22 percent had some college but no degree, and 31 percent had a high school degree or equivalent. A majority of the respondents were married (73 percent) and described their political ideology as conservative (70.6 percent). Most of the survey respondents were hourly employees (37.5 percent) and management or supervisor (34.4 percent). Table D-1 presents the distribution, means and standard deviations (where applicable) of collected respondent demographics (see Appendix D).

The Langdale Company's Response to the PPACA

Results of Research Question 1

Research Question 1 asked whether the Company will continue offering ESI to its employees, and why or why not. In addition, the research question asked whether the Company will implement some additional cost containment measures. The Company's Director of Benefits responded to an employer questionnaire that asked about the Company's employee benefits philosophy and the future of its health benefits in the post-ACA era. The employer questionnaire is attached in the Appendix F.

The Company finds it very important to continue providing health benefits to employees, and currently it plans to continue offering health benefits in 2014. "The Company philosophy has always been that if the Company takes care of the employees

then the employees will take care of the Company," stated Ms. Barrett. The Company's goal is to keep employees healthy and happy. In order to encourage employees to take care of themselves, the Company offers a variety of programs and incentives. Ms. Barrett mentioned the following incentives available to the employees: "wellness benefits, lower copays for medication to treat chronic disease, and health risk assessments and flu shots free to employees." Moreover, the Company realizes that health benefits have become a strategic tool that is crucial to recruitment, retention, and employee morale and productivity.

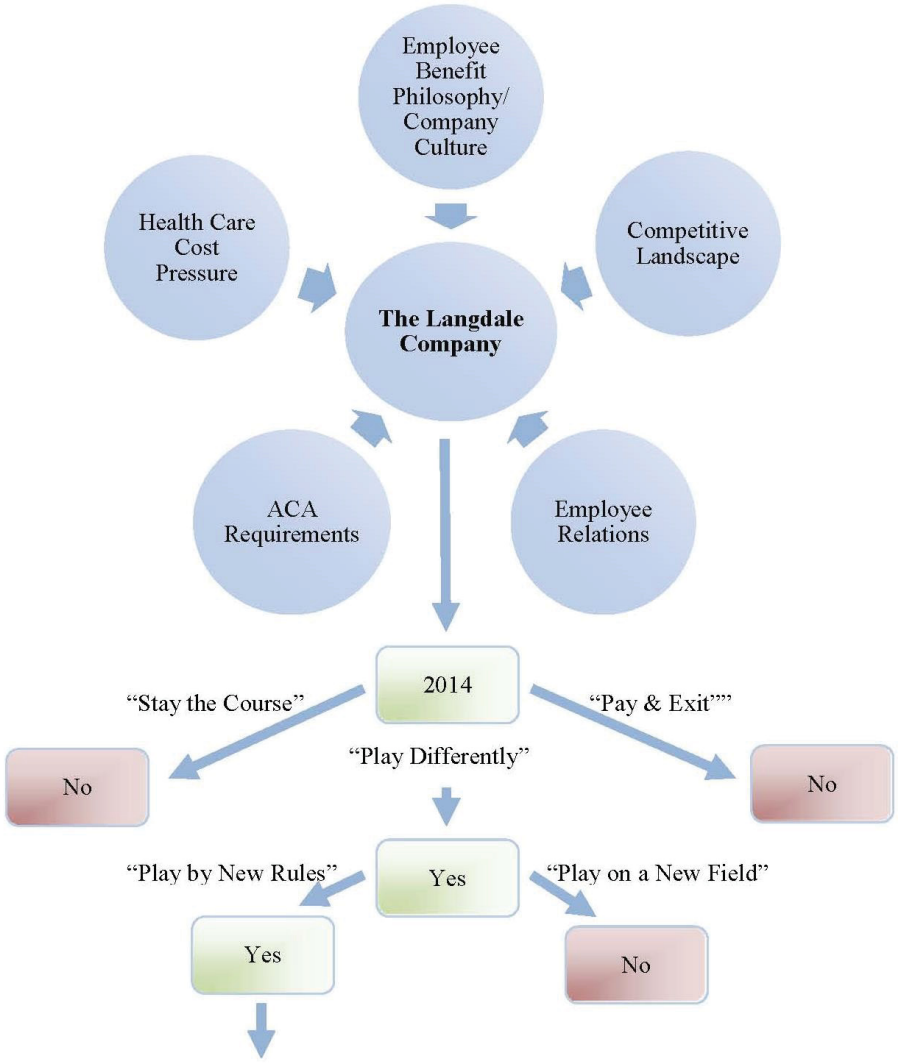
When asked about the impact of the ACA on the Company's health plan, Ms. Barrett stated that the health reform will greatly increase cost to the Plan. Currently, the Plan is in the process of being evaluated by an actuary in a *Pay or Play* modeling analysis. This analysis, Ms. Barrett emphasized, will help the Company better plan for the future. At this time, the Company is considering offering a High Deductible Health Plan with an HRA/HSA account. However, it is also "open to looking at all available options." The results of the actuarial study will have a significant impact on the type of cost-containment measures the Company will take. In evaluating the competitors, Ms. Barrett stated that employers she spoke with are planning to continue to offer health benefits to their employees. Figure 11 illustrates the employer questionnaire analysis based on the employer options model by Aon Hewitt that was introduced in Chapter 2.

Significance Results between Independent and Dependent Variables

Results of Research Question 2

The second research question asked, "Are The Langdale Company employees satisfied with their post-ACA ESI?" Table E-1 (Appendix E) presents distribution of the

Figure 11. The Context The Langdale Company Operates in and the Company's Response to the ACA



variable *Sati* aid that they are satisfied with the Plan with 27.7 percent saying that they are *very satisfied* and 38.6 percent stating that they are *satisfied*. Furthermore, the researcher is 95 percent confident that the true value of the parameter lies between 83 percent and 95 percent for the Plan satisfaction. In the 2011 study, 84.8 percent of survey respondents said they

were satisfied with the Plan with 21.9 percent saying they were *very satisfied* and 33.3 percent saying they were *satisfied*. In the following analyses, the researcher investigated whether and how *Knowledge of the ACA*, *Knowledge of Plan Benefits,* and *Approval of the ACA* have an effect on employee satisfaction with the Plan. The following hypotheses were tested:

Hypothesis 2a: Employees who say they have excellent knowledge of the ACA are more likely to say that they are satisfied with their Plan than employees who have poor knowledge of the ACA;

Hypothesis 2b: Employees who say they know a lot about what the Plan covers are more likely to say that they are satisfied with their Plan than employees who say they know hardly anything about what the Plan covers; and

Hypothesis 2c: Employees who approve of the ACA are more likely to say that they are satisfied with their Plan than employees who disapprove of the reform.

Cross-tabulation and *Pearson's Chi Square* (x^2) were utilized for the analyses.

Relationship between Knowledge of the ACA and Satisfaction with the Plan.

Hypothesis 2a argued that employees with excellent knowledge of the Health Care Reform would be more likely to be satisfied with the Plan than employees with poor knowledge of the ACA. The analysis revealed moderate positive association between the variables (Gamma = .35). The observed percent differences between three *Knowledge of the ACA* categories, *excellent*, *fair* and *poor*, were small (under 5 percent). *Good* is the only category that showed moderate difference (between 23.1 and 13.3) in comparison with other categories. *Pearson's Chi Square* (x^2) indicated that the relationship between the variables was not significant ($x^2 = 18.90$, $p = .22$). Hypothesis 2a was rejected.

Employee knowledge of the ACA had negligible effect on employee satisfaction with the Plan, and the findings could not be generalized to the population. Table 2 illustrates the findings.

Table 2. Cross-tabulation of Knowledge of the ACA and Satisfaction with the Plan (Column %)

		Knowledge of the ACA			
		Excellent	Good	Fair	Poor
Satisfaction with the Plan	Satisfied	77.8	100.0	86.7	76.9
	Neither satisfied nor dissatisfied	11.1	0.0	2.2	7.7
	Dissatisfied	11.1	0.0	11.1	15.4
	Total	100.0	100.0	100.0	100.0
	(Count)	(9)	(31)	(45)	(13)

Notes:

a. $x^2 = 8.60$, $p = .198$ (Some low cell count may have skewed the final result).
b. Gamma = .35
c. Percentages may not add up to 100 due to rounding.
d. Five cases were missing.

Relationship between Knowledge of Plan Benefits and Satisfaction with the Plan.

The second hypothesis predicted that employees who know a lot about Plan benefits would be more likely to be satisfied with the Plan than employees who know hardly anything about their benefits. The analysis indicated moderate positive association (Gamma = .42) between variables. However, no significant statistical difference was found ($x^2 = 7.28$, $p = .30$). There was a significant observed difference in the satisfaction between categories "a lot" and "not very much" (21.6 percent) and between "some" and "not very much" (17.7 percent). Hypothesis 2b was partially supported. Employee knowledge of their benefits had a small effect on their satisfaction with the Plan. Table 3 illustrates the findings.

Table 3. Cross-tabulation of Knowledge of Plan Benefits and Satisfaction with the Plan (Column %)

	Knowledge of Plan Benefits

		A lot	Some	Not very much	Hardly anything
Satisfaction with the Plan	Satisfied	94.3	90.4	72.7	100.0
	Neither satisfied nor dissatisfied	2.9	1.9	0.0	0.0
	Dissatisfied	2.9	7.7	27.3	0.0
	Total	100.0	100.0	100.0	100.0
	(Count)	(35)	(52)	(14)	(2)

Notes:

a. $x^2 = 7.28$, $p = .296$ (Some low cell count may have skewed the final result).
b. Gamma = .42
c. Percentages may not add up to 100 due to rounding.
d. Three cases were missing.

Relationship between Approval of the ACA and Satisfaction with the Plan.

Hypothesis 2c stated that employees who approve of the ACA would be more likely to be satisfied with the Plan than employees who disapprove of the ACA. In 2012, approximately two-thirds (65.9 percent) of The Langdale Company employees disapproved of the Health Care Reform law (See Table E-2, *Appendix E*). This analysis is critical to the case study. It is important to understand how disapproval of the new law affects employee satisfaction with the Plan in the post-ACA era. The analysis showed strong negative association between the variables (Gamma = -.51). The relationship was statistically significant ($x^2 = 39.66$, $p = .00$). As stated, the hypothesis was rejected because the direction of the association between the two variables was not supported. The findings revealed that employees who disapprove of the ACA were more likely to be satisfied with the Plan than employees who approve of the ACA. This relationship can be generalized to the study population. Table 4 illustrates the findings.

Table 4. Cross-tabulation of Approval of the ACA and Satisfaction with the Plan (Column %)

	Approval of the ACA

		Strongly approve	Approve	Neither	Disapprove	Strongly disapprove
Satisfaction with the Plan	Satisfied	75.0	100.0	41.7	93.8	100.0
	Neither satisfied nor dissatisfied	25.0	0.0	16.7	0.0	0.0
	Dissatisfied	0.0	0.0	41.7	6.3	0.0
	Total	100.0	100.0	100.0	100.0	100.0
	(Count)	(4)	(14)	(12)	(32)	(28)

Notes:

a. $x^2 = 39.66$, p = .000 (Some low cell count may have skewed the final result).
b. Gamma = -.51
c. Percentages may not add up to 100 due to rounding.
d. 13 cases were missing.

Examining Approval of the Individual Provisions.

In addition to asking employees their opinion of the ACA in general, the survey asked employees their opinion of the ACA's 33 major provisions. More respondents approved than disapproved of 27 of these individual provisions with more than 50 percent of the respondents approving of 24 of these provisions. Table 5 illustrates approval percent total and by political ideology of 15 selected provisions, in descending order.

Results of Research Question 3

Both the 2011 survey and the 2012 survey asked respondents: (1) to estimate their 2011/2012 health care expenses ("How much do you think you will have spent out of your own pocket for health care in 2011/2012? [Include premiums, deductibles, co-pays, co-insurance, and prescription expenses]") and (2) to report their health care cost change in 2011/2012 ("How have your overall health care costs changed in 2011/from 2011 to

Table 5. Percent Who Say They Approve of the Individual Provisions of the Law, Total and by Political Ideology

Selected Individual Provisions	Total	*Political Ideology*		
		Liberal	Moderate	Conservative

Medicare Prescription Drug Discounts	80.6	100.0	81.8	76.4
Medical loss ratio	80.0	100.0	90.9	77.5
Tax credits to small businesses	78.1	100.0	86.4	75.5
Pay physicians based on quality of care	73.5	100.0	63.7	68.4
Guarantee issue	71.0	100.0	72.8	68.4
Essential Health Benefits requirement	70.5	100.0	71.4	62.5
Require uniform summary of benefits and coverage	69.0	100.0	72.8	66.7
No cost-sharing for preventive services	68.4	100.0	81.8	57.9
Dependent Coverage up to age 26	54.5	100.0	63.7	45.7
State Health Insurance Exchanges (HIX)	54.4	100.0	70.0	43.4
Increase Medicare payroll tax on upper income	47.4	100.0	63.7	37.5
Federal premium subsidies in the HIX	39.8	50.0	45.5	29.1
Employer mandate/penalty for large employers	29.6	66.7	50.0	19.0
Expand Medicaid	27.9	66.7	28.6	21.1
Individual mandate/penalty	24.5	66.7	31.8	21.0

2012 calendar year?"). The researcher began with an overview of the reported health care expenses and an analysis of the relationship between *Health Care Expenses* and *Satisfaction with the Plan*. Then, the author proceeded to investigate Hypothesis 3a by examining the relationship between Health Care Cost Change, as perceived by the employees, and Satisfaction with the Plan.

In 2011, the two most common responses to question (1) were $2,000-$2,999 (15.6 percent) and $3,000-$3,999 (15.6 percent) (Sparks 2011). The mean statistic showed that in 2011 respondents spent, on average, $3,405 out of pocket for health care. In 2012, the two most common responses were $3,000-$3,999 (15.2 percent) and $5,000-$7,499 (15.2 percent). Approximately two-thirds of the respondents (62.0 percent) spent

between $3,000 and $3,999 and lower on their health care. The remainder of the survey respondents (38.0 percent) spent $4,000 or more on their health care with 5.4 percent spending between $10,000 and $12,499 and approximately 1.1 percent spending between $12,500 and $14,999. None of the respondents reported health care expenses of $15,000 or higher in 2012. The mean statistic showed that in 2012 respondents spent, on average, $3,915 out of pocket on health care, which is a 15 percent increase from the previous year. Table E-2 illustrates distribution, means, and standard deviations for this variable for 2011 data and 2012 data (see Appendix E).

Additional analysis of collected data revealed that employees with *Participant Only* coverage spent, on average, $2,598 on health care in 2012, and employees with *Family* coverage spent $4,780. The independent-samples *t test* showed that the relationship is significant at the level $p \leq .01$. Table 6 demonstrates findings of this analysis.

Table 6. Descriptive Statistics and Independent Groups Design t test for Participant Only Coverage and Full Family Coverage Groups

2012 Health Care Expense				
Enrollment Category	N	x	sd	*t*
Participant Only	33	$2,598	1,726	-3.25*
Family	57	$4,780	3,303	

* $p \leq .01$

Relationship between Health Care Expenses and Satisfaction with the Plan.

The analysis of the relationship between *2012 Health Care Expenses* and *Satisfaction with the Plan* showed weak negative association between the variables (Gamma = -.26). The majority of respondents in each health care expense category said that they are satisfied with the Plan (ranging from 72.7 percent to 100.0 percent). The

relationship was not statistically significant at the level $p \leq .95$ ($x^2 = 10.68$). Knowledge of employee health care expenses was of little help in predicting their satisfaction with the Plan. Results of cross-tabulation of the two variables are presented in Table 7.

Table 7. Cross-tabulation of 2012 Health Care Expense and Satisfaction with the Plan (Column %)

Satisfaction with the Plan	*2012 Health Care Expenses*							
	$1 - $499	$500 - $999	$1,000 - $1,499	$1,500 - $1,999	$2,000 - $2,999	$3,000 - $3,999	$4,000 - $4,999	$5,000 - $7,499
Satisfied	100.0	100.0	72.7	90.9	81.8	92.9	90.0	92.9
Neither satisfied nor dissatisfied	0.0	0.0	9.1	0.0	9.1	0.0	10.0	0.0
Dissatisfied	0.0	0.0	18.2	9.1	9.1	7.1	0.0	7.1
Total (Count)	100.0 (5)	100.0 (4)	100.0 (11)	100.0 (11)	100.0 (11)	100.0 (14)	100.0 (10)	100.0 (14)

	$7,500 - $9,999	$10,000 - $12,499	$12,500 - $14,999
Satisfied	100.0	100.0	100.0
Neither satisfied nor dissatisfied	0.0	0.0	0.0
Dissatisfied	0.0	0.0	0.0
Total (Count)	100.0 (5)	100.0 (5)	100.0 (1)

Notes:
a. $x^2 = 10.68$, $p = .95$ (Some low cell count may have skewed the final result).
b. Gamma = -.26
c. Percentages may not add up to 100 due to rounding.
d. 12 cases were missing.

The researcher explored this analysis further by controlling for *Enrollment Category*. Multiple regression analysis (MRA) confirmed that 2012 health care expenses had little impact on employee satisfaction with the Plan (beta = -.08). It also revealed that an employee's enrollment in a *participant only* coverage versus a *family* coverage had an

even weaker effect on satisfaction than health care expenses (beta = -.02). Table 8 presents the results of the MRA.

Table 8. Multiple Regression Analysis of Satisfaction with the Plan by 2012 Health Care Expenses and Enrollment Category

Independent Variable	B	SE_b	Beta	t	p
2012 Health Care Expenses	-.016	.023	-.081	-.703	.484
Enrollment Category	-.020	.116	-.020	-.172	.864

Notes:
a. $R^2 = .076$, F = .250, p = .779
b. Enrollment category variable was transformed into dummy variable.

Relationship between Health Care Cost Change and Satisfaction with the Plan.

The following analysis examined Hypothesis 3a, which predicted that "employees who said that their health care costs increased in the years 2011 and/or 2012 are less likely to say that they are satisfied with their Plan than employees who said that their health care costs decreased." The survey asked employees to report how their health care costs had changed in 2011 (for the 2011 survey) and from the 2011 to 2012 calendar year (for the 2012 survey). In 2011, over three-quarters (80.7 percent) of survey respondents said that their health care costs increased with 62.4 percent saying the costs *increased some* and 18.3 percent saying the costs *increased a lot*. Approximately 16 percent of respondents reported that their health care costs *stayed the same*, and three percent said their costs *decreased* (Sparks 2011).

In 2012, the percent of individuals who said their health care costs increased had dropped to 71.6 percent (57.9 percent said the costs *increased some*, and 13.7 said their costs *increased a lot*). In this year, more individuals stated that their health care costs *stayed the same* (24.2 percent vs. 16.1 in 2011). There was also a small increase in the percent of respondents who reported that their health care costs *decreased* in 2012 (4.3

percent vs. 3.3 percent in 2011). Table E-2 shows distribution of this variable for the 2011 and 2012 data (see Appendix E).

Table 9. Cross-tabulation of the 2012 Health Care Cost Change and Satisfaction with the Plan (Column %)

		2012 Health Care Cost Change				
		Increased a lot	Increased some	Stayed the same	Decreased some	Decreased a lot
Satisfaction with the Plan	Satisfied	91.7	92.7	87.0	66.7	100.0
	Neither satisfied nor dissatisfied	0.0	3.6	4.3	0.0	0.0
	Dissatisfied	8.3	3.6	8.7	33.3	0.0
	Total (Count)	100.0 (12)	100.0 (55)	100.0 (23)	100.0 (3)	100.0 (1)

Notes:
a. $x^2 = 5.30$, $p = .726$ (Some low cell count may have skewed the final result).
b. Gamma = .28
c. Percentages may not add up to 100 due to rounding.
d. Nine cases were missing.

The analysis of the relationship between *2012 Health Care Cost Change* and employee satisfaction with the Plan revealed weak positive association between variables (Gamma = .28). Respondents who said that their 2012 health care costs increased were more likely to say that they are satisfied with the Plan than respondents who experienced a decrease in health care costs. The test of significance found that the relationship was not significant ($x^2 = 5.30$, $p = .73$), and therefore it could not be generalized to the population. Hypothesis 3a was rejected. The analysis is summarized in Table 9.

Relationship between Household Income and Willingness to Maintain ESI.

When asked how likely are they to maintain their ESI in 2014, the vast majority of respondents (97.7 percent) said they are likely to maintain it, with 77 percent saying that they are *very likely* and 19.5 percent saying that they are *likely* to keep their ESI (Variable distribution is illustrated in Table E-1, Appendix E). Examining the impact of

the household income on employee decision to maintain employer-provided health insurance is crucial to the case study. If employees whose household incomes are below 400% of FPL choose to drop ESI and purchase health insurance through the HIX, The Langdale Company may be liable for a federal penalty.[29]

Table 10. Cross-tabulation of Household Income (Recoded into Percent FPL for a Family of Two) and Willingness to Maintain ESI (Column %)

Willingness to Maintain ESI	*Household Income (Percent FPL* for a Family of Two)*				
	Less than 100% FPL	Less than 200% FPL	Less than 300% FPL	Less than 400% FPL	400% FPL and over
Very likely	100.0	80.0	81.8	61.5	83.8
Likely	0.0	0.0	18.2	30.8	16.2
Somewhat likely	0.0	0.0	0.0	7.7	0.0
Not at all likely (I will drop my health benefits effective January 1, 2014)	0.0	20.0	0.0	0.0	0.0
Total (Count)	100.0 (1)	100.0 (5)	100.0 (22)	100.0 (13)	100.0 (37)

**Source: Families USA. 2013. "2013 Federal Poverty Guidelines." http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html (February 9, 2013).*

Notes:

a. $x^2 = 22.61$, $p = .03$ (Some low cell count may have skewed the final result).
b. Gamma = -.09
c. Percentages may not add up to 100 due to rounding.
d. 25 cases were missing.

The analysis revealed weak negative association between household income and willingness to maintain ESI (Gamma = -.14). The relationship was significant at the level $p \leq .05$ ($x^2 = 63.27$). The findings indicated that employees with lower household incomes were more likely to say they will drop ESI effective January 1, 2014. Two additional analyses tested the same relationship with household income recoded into

[29] Employer mandate also known as *Pay or Play* provision was discussed in Chapter 2.

percent of FPL for a family of two and a family of four[30]. Both analyses yielded weak negative association and found the relationship significant. Observed percent difference showed that 100 percent of respondents in all but Less than 200% FPL categories said they are likely to maintain their ESI, and 80 percent of those in the Less than 200% FPL said they are likely to maintain their ESI. Hypothesis 3b, which stated that "employees with lower household incomes are more likely to say they will drop ESI and obtain insurance through HIX than employees with higher household incomes," was rejected. Table 10 illustrates the analysis with household income as a percent FPL for a family of two.

Additional Analyses: Examining the Effect of Job Category and Gender on the Results

The demographic analysis revealed significant overrepresentation of the management and underrepresentation of the hourly employees among the survey respondents. The following are additional analyses the researcher conducted to measure the effect of *Job Category* on the final results. Due to the limited number of cases, the researcher was not able to use *Job Category* variable as a control variable. Instead, the researcher used a dichotomized *Job Category (Management and Other Professional, Hourly)* as an independent variable in the cross-tabulation analyses with the following six variables: *Satisfaction with the Plan*, *Knowledge of the ACA, Knowledge of the Plan, Approval of the ACA, Health Care Cost Change,* and *Willingness to keep ESI*[31].

Satisfaction with the Plan remains high among the employees regardless of job category; 96.7 percent of management and other professionals and 77.1 percent of hourly

[30] The two criteria were chosen because 73.0 percent of respondents said they are married indicating household size of at least two individuals. The 2012 survey asked employees to report how many individuals live in the household, but only two respondents answered the question.
[31] Some variables were recoded in order to reduce the number of cells.

employees said they are satisfied with their health benefits. The epsilon difference of 19.6 percent indicates a weak to weakly moderate relationship between the two variables. The *Chi-Square* test showed that the relationship is significant at $p \leq .01$. In regards to knowledge of the ACA, management and other professionals were more likely (52.6 percent) to say they have excellent and good knowledge than the hourly employees (20 percent). The relationship was found significant at $p \leq .01$. Furthermore, management and other professionals were also more likely to say they know a lot about the Plan (43.3 percent) than the hourly (25.7 percent). This relationship was also found significant at $p \leq .05$.

The vast majority of management and other professionals, 83.3 percent, said they disapprove of the ACA, and 11.1 percent said they approve of the ACA. Hourly employees were more equally split between disapproval (40.0 percent) and approval of the law (33.3 percent). The epsilon differences ranged from 21.1 percent (Neither) to 43.3 percent (Disapprove) indicating moderate to strong relationship between job category and the approval of the ACA. The findings revealed significant difference between the management and other professional group and the hourly group in regards to approval of the ACA ($p \leq .001$). Table 11 illustrates the findings.

Hourly employees were more likely to experience an increase in their health care cost from prior year than management and other professionals (81.3 percent vs. 66.7 percent). The epsilon difference indicates weak correlation between the two variables, and the relationship was found not significant. Lastly, job category had little to no effect on employees' willingness to keep ESI. The vast majority of management and other professionals (98.1 percent) and hourly (96.7 percent) said they are likely to keep their

Table 11. Cross-tabulation of Job Category and Approval of the ACA (Column %)

		Job Category	
		Management and Other Professional	Hourly
Approval of the ACA	Approve	11.1	33.3
	Neither	5.6	26.7
	Disapprove	83.3	40.0
	Total	100.0	100.0
	(Count)	(54)	(30)

Notes:

a. $x^2 = 16.90$, p = .000 (One cell has expected count of less than 5).
b. Phi and Cramer's V = .45
c. 19 cases were missing.

current ESI.

Gender was used as a control variable for the above analyses in order to gauge the effect that overrepresentation of females and underrepresentation of males may have on the results. The Langdale Company workforce is predominantly male (88 percent). Male representation in the sample was 12 percent lower than the population. The exploration of the relationship between job category and satisfaction with the Plan revealed that there is no variation in the satisfaction for females. All females said that they are satisfied with the Plan. Thus, gender had little effect on the relationship.

The epsilon difference indicates a weak effect of gender on the relationship between job category and knowledge of the ACA. More males (60 percent) than females (36.9 percent) in the management and other professional category said that they have excellent or good knowledge of the ACA. Slightly more females (25 percent) than males (19.4) reported the same in the hourly category. Nevertheless, gender had a strong effect on the relationship between job category and knowledge of the Plan with 68.4 percent and 50.0 percent of females in management and other professional category and in the

hourly category, respectively, saying they know a lot about the Plan versus 31.7 percent and 22.6 percent of males.

In regards to the approval of the ACA, for male respondents, the analysis was strengthened. For females, on the other hand, job category did not significantly affect their approval of the ACA. Both female management and other professional employees and female hourly employees largely disapproved of the law (70.6 percent and 66.7 percent, respectively). However, there were only three females in the hourly group, thus limiting the accuracy of the analysis. Table 12 demonstrates the findings.

Table 12. Cross-tabulation of Job Category and Approval of the ACA, by Gender (Column %)

Gender			*Job Category*	
			Management and Other Professional	Hourly
Male	*Approval of the ACA*	Approve	8.1	37.0
		Neither	2.7	25.9
		Disapprove	89.2	37.0
		Total	100.0	100.0
		(Count)	(37)	(27)
Female	*Approval of the ACA*	Approve	17.6	0.0
		Neither	11.8	33.3
		Disapprove	70.6	66.7
		Total	100.0	100.0
		(Count)	(17)	(3)

Notes:

a. *Male* $x^2 = 19.46$, $p = .000$, *Female* $x^2 = 1.33$, $p = .515$ (Some low cell count may have skewed the final result).
b. *Male* Phi and Cramer's V = .55, *Female* Phi and Cramer's V = .26
c. 19 cases were missing.

Gender had little to no effect on the relationship between job category and health care cost change and on the relationship between job category and the willingness to maintain ESI.

Overall, the above analyses indicate that the two variables do not affect the dependent variables (*Satisfaction with the Plan* and the *Willingness to Maintain ESI*) and

that they do not change the original cross-tabulation analyses. Although with different results, the two factors affect the independent variables. They are an integral part of a contextual background that shapes employee attitudes and responses.

Trend Analysis: 2011 Study Results vs. 2012 Study Results

The 2011 study investigated four relationships, which are as follows: (1) the relationship between *Knowledge of the ACA* and *Satisfaction with the Plan*; (2) the relationship between *Knowledge of Plan benefits* and *Satisfaction with the Plan*; (3) the relationship between *Approval of the ACA* and *Satisfaction with the Plan*; and (4) the relationship between *Health Care Cost Change* and *Satisfaction with the Plan*. The 2012 study followed up on the four relationships. The following analysis sought to spot a trend in the Langdale employees' satisfaction with the Plan in the four relationships in the years 2011-2012.

Table 13 compares statistical results of the 2011 analyses and the 2012 analyses of the four relationships. All 2012 analyses showed stronger associations between variables than the 2011 analyses. In 2011, the relationship between *Knowledge of the ACA* and *Satisfaction with the Plan* was found to be significant ($p \leq .05$), but it showed no association between variables. In 2012, the results showed moderate association but the relationship was not significant. The relationship between *Approval of the ACA* and *Satisfaction with the Plan* was weak and lacked significance in 2011. The 2012 analysis found strong negative association between the variables. Moreover, the relationship was significant at the level $p \leq .001$.

Tabular and visual presentations of percent distribution changes between the 2011 study and the 2012 study of the four relationships are illustrated in the following Figures

12a – 12d.

Table 13. Comparison of Statistical Results of the 2011 Analyses and the 2012 Analyses, Cross-tabulation of Independent Variables and Satisfaction with the Plan

Independent Variable	*2012 Study*			*2011 Study**		
	Gamma	x^2	p	Gamma	x^2	p
Knowledge of the ACA	.35	8.60	.198	.00	14.27	.03**
Knowledge of Plan benefits	.42	7.28	.296	.27	6.04	.42
Approval of the ACA	-.51	39.66	.000**	.10	5.70	.22
Health Care Cost Change	.28	5.30	.726	-.12	11.44	.18

**Source: Sparks, Ewelina. 2011. "Employee Satisfaction with the Langdale Company Health Benefit Plan after 2010 Health Care Reform." PADM 9050 – Program Evaluation, Valdosta State University.*

** Findings are significant.

Figure 12a. Comparison of Percent Distribution of the 2011 and the 2012 Cross-tabulation of Knowledge of the ACA and Satisfaction with the Plan (Column %)

		Knowledge of the ACA			
		Excellent	Good	Fair	Poor
2012	Satisfied	77.8	100.0	86.7	76.9
	Neither	11.1	0.0	2.2	7.7
	Dissatisfied	11.1	0.0	11.1	15.4
2011	Satisfied	66.7	89.5	86.1	83.3
	Neither	33.3	2.6	2.8	0.0
	Dissatisfied	0.0	7.9	11.1	16.7

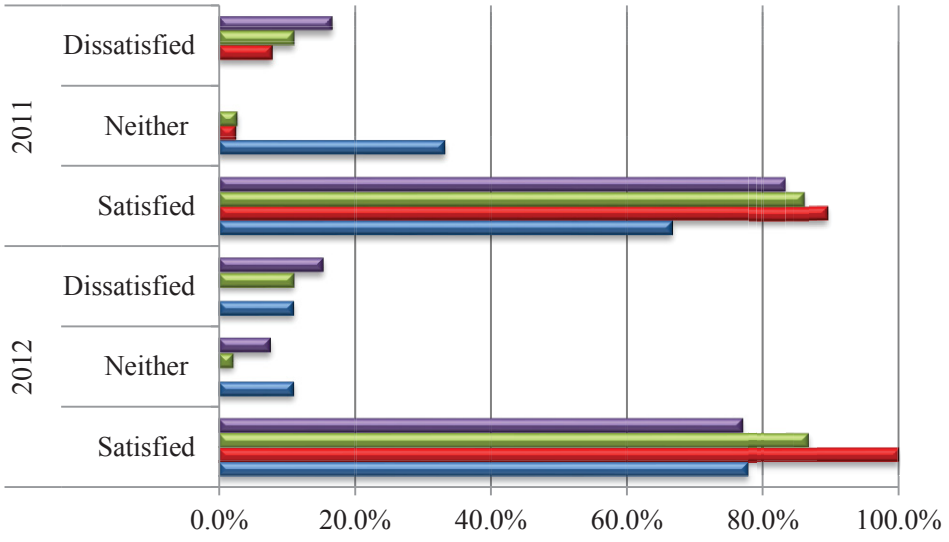


Figure 12b. Comparison of Percent Distribution of the 2011 and the 2012 Cross-tabulation of Knowledge of Plan Benefits and Satisfaction with the Plan (Column %)

		Knowledge of Plan Benefits			
		A lot	Some	Not very much	Hardly anything
2012	Satisfied	94.3	90.4	72.7	100.0
	Neither	2.9	1.9	0.0	0.0
	Dissatisfied	2.9	7.7	27.3	0.0
2011	Satisfied	89.2	81.8	78.6	66.7
	Neither	5.4	4.5	7.1	33.3
	Dissatisfied	2.0	13.6	14.3	0.0

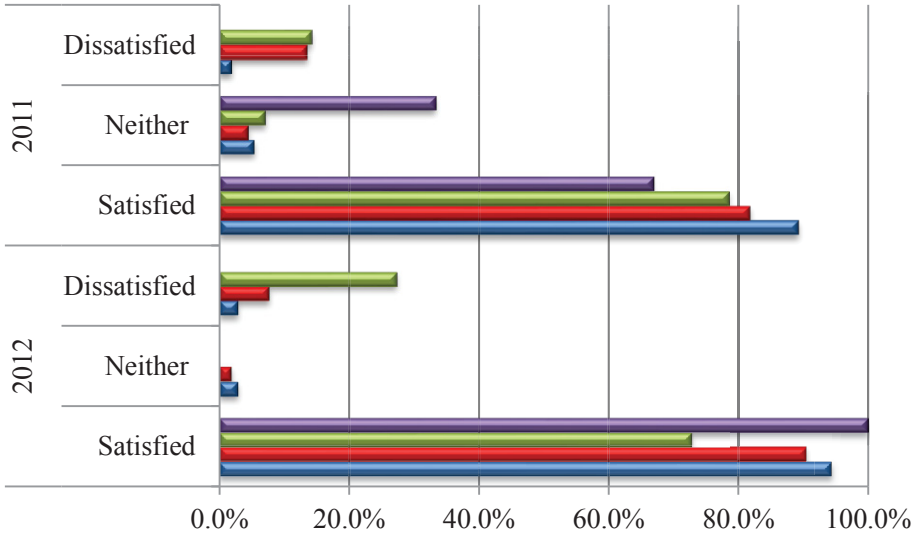


Figure 12c. Comparison of Percent Distribution of the 2011 and the 2012 Cross-tabulation of Approval of the ACA and Satisfaction with the Plan (Column %)

		Approval of the ACA				
		Strongly approve	Approve	Neither	Disapprove	Strongly disapprove
2012	Satisfied	75.0	100.0	41.7	93.8	100.0
	Neither	25.0	0.0	16.7	0.0	0.0
	Dissatisfied	0.0	0.0	41.7	6.3	0.0
2011	Satisfied	77.8	92.9	75.0	78.3	90.6
	Neither	11.1	7.1	0.0	4.3	0.0
	Dissatisfied	11.1	0.0	25.0	17.4	9.4

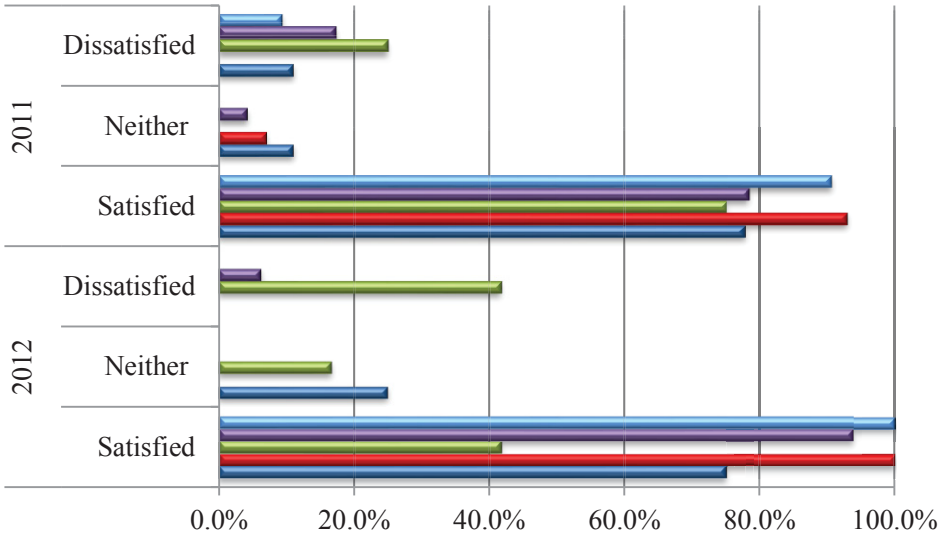
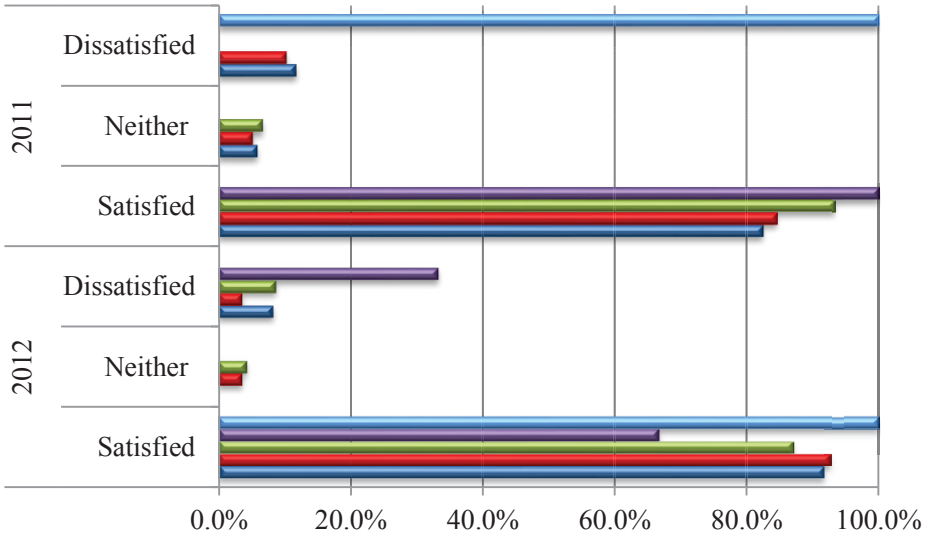


Figure 12d. Comparison of Percent Distribution of the 2011 and the 2012 Cross-tabulation of Health Care Cost Change and Satisfaction with the Plan (Column %)

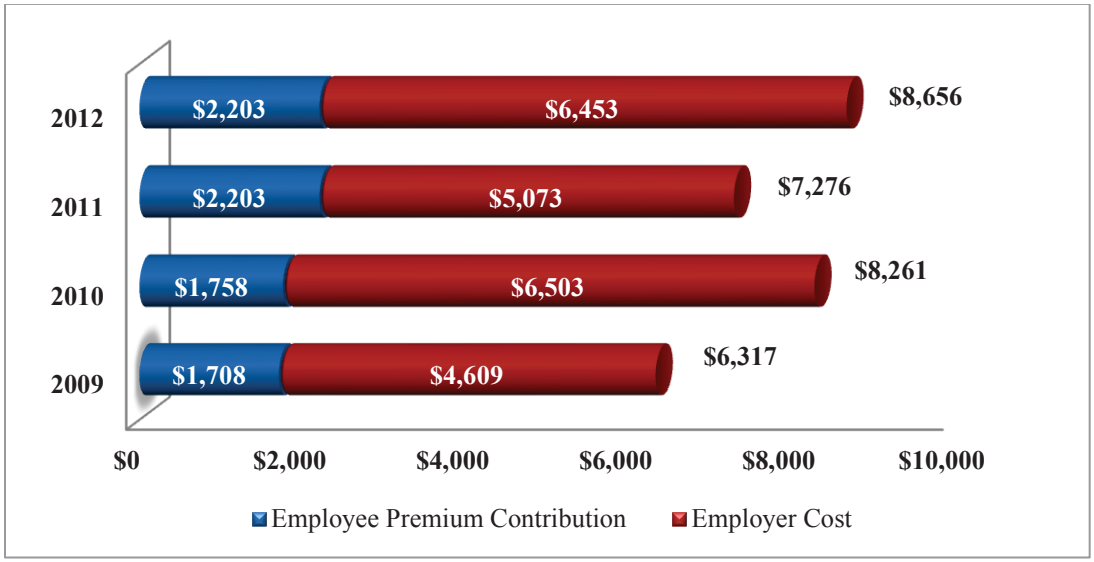
		Health Care Cost Change				
		Increased a lot	Increased some	Stayed the same	Decreased some	Decreased a lot
2012	Satisfied	91.7	92.7	87.0	66.7	100.0
	Neither	0.0	3.6	4.3	0.0	0.0
	Dissatisfied	8.3	3.6	8.7	33.3	0.0
2011	Satisfied	82.4	84.5	93.3	100.0	0.0
	Neither	5.9	5.2	6.7	0.0	0.0
	Dissatisfied	11.8	10.3	0.0	0.0	100.0



Plan Cost Data: 2009-2012

This analysis explored the Plan cost data for years 2009-2012. The years 2009 and 2010 are pre-ACA years for The Langdale Company Plan. The health reform's passage in March 2010 did not affect the Plan until January 1, 2011. Furthermore, the effect of the ACA on the Plan in 2011 through 2012 was modest because the Company decided to keep the Plan *grandfathered* and thus avoid compliance with some major mandates, such as preventive care without cost sharing, until 2014. The data for years 2011 and 2012 represents the Plan cost in the post-ACA era. For this case study, the "Plan cost" means total fixed and medical (including pharmacy) claims cost. Figure 15 illustrates average employee premium contribution and employer share of the cost for years 2009-2012. The average employee premium increased $50 or 3 percent in 2010. In 2011, the premium increased $445 or 25 percent from $1,758 to $2,203. In 2012, the premiums stayed the same. The Company did not increase premiums in 2012 due to the *grandfather clause* limits.

Figure 13. Average Annual Employee Premium Contribution and Employer Cost, 2009-2012

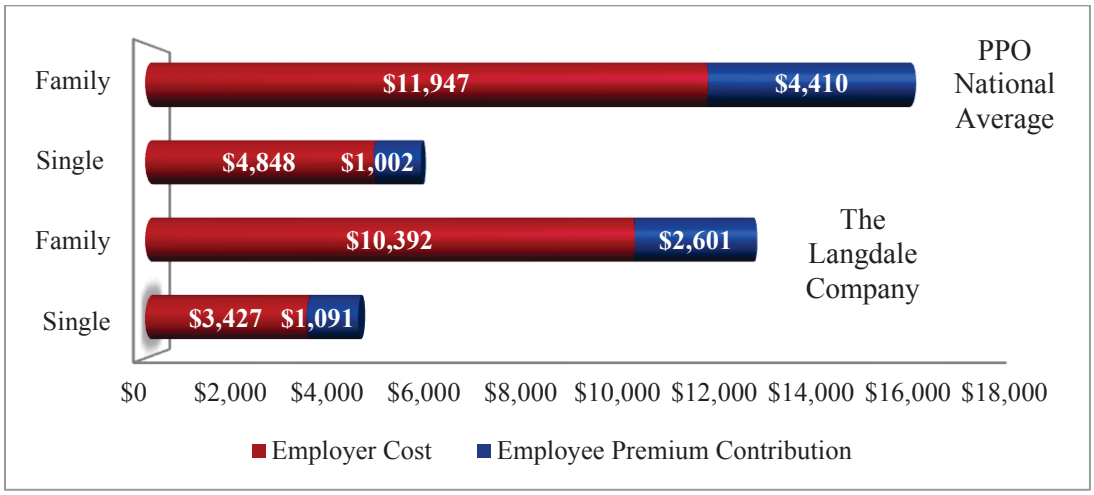


Source: TLC Benefit Solutions, Inc. 2013a." Fixed and Claim Expense, 2005-2012."

It is important to note that for employers who self-insure their health plans, their annual per employee per year (PEPY) costs are a direct result of claims experience for that particular year. Thus, the employer costs often fluctuate, whereas the employee premiums stay the same or gradually increase. This observation held true for the Company. The Company PEPY health costs increased $1,894 or 41 percent in 2010. Then, in 2011, PEPY cost decreased $1,430 or 22 percent (about one-third of the decrease can be attributed to higher premiums). In 2012, the PEPY cost increased again by $1,380 or 27 percent. The 2012 Langdale Company Health Plan cost share stayed below the PPO national average (See Figure 16).

As mentioned earlier, the Company will drop the *grandfathered status* effective January 1, 2014. There are several benefit changes required by the ACA with which the Company will now have to comply. Moreover, due to the individual mandate, more employees are expected to enroll in the Company's health plan. It is certain that the Company's health costs will increase. The researcher developed a spreadsheet with the Company-specific data (based on the 2012 plan design and the January 2013 employee and dependents census) and the ACA requirements the Company is required to meet in order to monetize the ACA's impact on the Company. Figure 17 presents a part of the primary worksheet titled *PPACA Cost Drivers*. In 2013, the ACA will cost the Company approximately $264,855. In 2014, the ACA can potentially increase the cost of the Plan by $2 million. This is a significant cost increase to the Plan taking into consideration that the 2012 Gross annualized Plan cost is currently estimated at $7.2 million.

Figure 14. Average Annual Premium Contribution and Employer Cost for Single and Family Coverage, by PPO National Average and The Langdale Company Plan, 2012



Sources: The Kaiser Family Foundation and Health Research & Educational Trust. 2012. "Employer Health Benefits: 2012 Summary of Findings;" TLC Benefit Solutions, Inc. 2013b. "Total Plan Costs by Enrollment Level."

Notes:

a. The Langdale Company employer cost excludes pharmacy expenses.
b. The Langdale Company employee premium contribution assumes semi-monthly single and family rate. Tobacco and spousal surcharges are not included.

Summary

This analysis provided valuable data related to the three research questions. It evaluated the impact of the ACA on The Langdale Company and its employees. Future continued assessment, especially of the years 2014-2016, will assist the Company in keeping the Plan satisfaction level high while containing the costs and complying with the ACA. The chapter began with a comparison of the demographic characteristics of the survey respondents and the study population. Then, the researcher described the study participants in more detail. Next, the researcher examined each research question, beginning with a qualitative analysis of the employer questionnaire and moving to the statistical analyses of six different relationships.

The first research question determined that the Company will continue offering health benefits to its employees in the year 2014. However, the exact cost-containment measures

Figure 15. Estimated Cost of the ACA Compliance for The Langdale Company, 2013-2016

Requirements	2013	2014	2015	2016
Patient-Centered Outcomes Research Institute (PCORI) program (2013 - $1 per covered life; 2014 through 2019 - $2)	$1,703.00	$3,406.00	$3,406.00	$3,406.00
Transitional Reinsurance Program (2014 - $63 per covered life; 2015 - $42; 2016 - $26.25)		$107,289.00	$71,526.00	$44,703.75
Eliminating $35 co-pay for preventive care		$59,605.00	$59,605.00	$59,605.00
Contracting with 3 IROs for the external appeal process		$2,100	$2,100	$2,100
New mandated preventive care benefits including eight new women's benefits and eliminating annual dollar limit		$1,277,250.00	$1,277,250.00	$1,277,250.00
Coverage up to age 26	$263,151.84	$263,151.84	$263,151.84	$263,151.84
Coverage for routine costs for clinical trial participants (I,II,III,IV)		?	?	?
Eliminating pre-existing condition		$195,453.24	$195,453.24	$195,453.24
Total	**$264,854.84**	**$1,908,255.08**	**$1,872,492.08**	**$1,845,669.83**

that will be utilized to offset the cost increase have not yet been determined, pending an actuarial *Pay or Play* analysis. The second research question tested the impact of three variables: knowledge of the ACA, knowledge of the Plan, and approval of the ACA on employee satisfaction with the Plan. The findings revealed that the first two relationships could not be generalized to the population. However, the last relationship, between approval of the ACA and satisfaction with the Plan, was strong and significant. Interestingly, the association statistic showed the opposite direction of the relationship than the researcher hypothesized. As a result, the researcher found that employees who disapprove of the ACA are more likely to be satisfied with the Plan than employees who approve of the ACA.

The last research question examined the impact of health care expenses and health care cost change, as perceived by the employees, on satisfaction with the Plan. It also evaluated the relationship between employee household income and willingness to maintain ESI. All relationships showed weak associations. The last relationship was found to be significant; nevertheless, the hypothesis 3b was rejected.

Chapter 5 will examine in detail the importance of the findings to the Company and similar employers, in general. It will also discuss the applicability and importance of the theoretical framework established in Chapter 2.

Chapter V

DISCUSSION

This research yielded informative data about the impact of the ACA on The Langdale Company and its employees. Results revealed that the Company plans to continue offering health benefits to its employees in 2014. The Company is committed to keeping employees healthy by offering affordable health insurance and wellness and disease management (DM) programs. Consistent with Fronstin and Erwin (2012), who reported that 83.7 percent of employees are happy with their ESI in the post-ACA era, the vast majority of the Company employees (89.1 percent) said they are satisfied with their Plan. The percent of employees who said they disapprove of the ACA, 66 percent, was significantly higher than public opinion, 39 percent (The Henry J. Kaiser Family Foundation 2012f). This inconsistency will be explained later in this chapter.

The analysis of the impact of five variables knowledge of the ACA, knowledge of the Plan, approval of the ACA, health care expenses (in dollars), and perceived change in health care costs, on employee satisfaction produced mixed results. It revealed that knowledge of the ACA and the Plan has positive moderate effect on employee satisfaction. This effect was stronger in 2012 than in 2011 (see Table 13) and may explain an increase in employee satisfaction with the Plan from 84.8 percent employees reported in 2011 to 89.1 percent. The relationship between approval of the ACA and satisfaction with the Plan was the only strong and statistically significant relationship. It indicated that employees have different opinions of their insurance and the ACA with the

majority disapproving of the ACA but reporting satisfaction with their Plan. Lastly, the health care expenses and cost change had little effect on employee satisfaction. A detailed analysis of the statistical tests will be presented later in this chapter.

Employers experience the effects of the ACA differently because of the different size, different population demographics, the type of industry, and their employee benefit philosophy, among other factors. For the Company, the ACA may result in a 28 percent increase to the Plan cost based on the researcher's ACA compliance analysis (Figure 17). This increase is substantially higher than an estimated 4.3 percent increase for large employers by the Urban Institute (The Urban Institute Health Policy Center 2012). This chapter will examine the impact of the ACA on the future of The Langdale Company Health Plan and what it means for the employees. Then, the researcher will discuss the importance of the rational choice (RC) framework in the ACA modeling analyses. Recommendations and the conclusion will follow.

The Future of The Langdale Company Health Plan

In 2014, the Company will be "Playing by New Rules." The decision to continue offering health benefits in the new ACA landscape is consistent with what studies found most employers will be doing in 2014 and beyond (The U.S. Government Accountability Office 2012; MBGH 2012; Willis 2013). What sets the Company apart from most employers is that the Company continually assesses the ACA's financial and plan design impact upon the Plan. In the employer perception survey of the impact of the ACA on health benefits, Willis (2013) found that more than half (51 percent) of employers have not yet determined the cost of ACA compliance. Particularly, the Company is investigating the impact of the ACA in the year 2014. The researcher conducted a study

of the effect of the individual compliance requirements on the cost of the Plan. Additionally, the Company has contracted with one of its business associates to conduct an actuarial *Pay or Play Modeling* study with results due to the Company this Spring.

Utilizing Wellness and Disease Management (DM) programs

In 2012, 63 percent of large employers offering health benefits offered at least one wellness benefit. Moreover, 60 percent of this group of employers offered wellness benefits to spouses or dependents. Improving the health of the employees and reducing health care costs were among the primary reasons employers offered wellness benefits (The Kaiser Family Foundation and Health Research & Educational Trust 2012). Since the ACA's passage, employer interest in wellness benefits and DM programs has been steadily increasing with 70 percent of employers striving to increase utilization of wellness and prevention and 55 percent wanting to increase participation in disease management in late 2011 (Aon Hewitt 2012).

Currently, the Company offers a variety of wellness benefits and a disease management (DM) program. Under the wellness program, the Company offers free annual on-site Health Risk Assessments (HRAs) with biometric screening to the employees who have health insurance through the Company. The Company offers lower premiums to HRA participants and there is nearly a 100 percent participation rate. Employees and their primary care physicians are then mailed the HRA results, which in 2012 caused 23 percent of employees to see their doctors, and approximately one-third of the HRA participants received a feedback on the HRA results from their primary care physicians (results from the 2012 survey). The Company also offers gym membership subsidies, free smoking cessation program, free on-site flu shots, annual exam reminders,

and a wellness newsletter with healthy tips and recipes.

The Company DM program was initiated in 2000 and modified into an opt-out program in 2004. As an opt-out arrangement, the program retained nearly 100 percent of all enrolled individuals (those with one or more major and usually chronic conditions) and continues to show a return on investment (ROI). From January 2010 through September 2012, the program ROI was 6.8 : 1 resulting in $2.5 million estimated savings for the Plan (Doctors Direct Healthcare, Inc. 2012). Moreover, in 2011, The Company DM program was part of a qualitative evaluation by Emory University Cancer Prevention & Control Research Network (CPCRN), which found that the Company DM program employs many Chronic Care Model (CCM) constructs and delivers quality chronic disease care.

Towards Two C's: Cost-Shifting and Consumerism

Two of the most common cost-containment strategies in the post-ACA era are increasing employee share of the cost (cost-shifting) and offering High Deductible Health Plans or Consumer-Driven Health Plans (consumerism) (Aon Hewitt 2012). Both tactics aim at increasing employee involvement in their own health care and encouraging them to make better informed decisions. While premium increases are a possible tactic the Company will employ in 2014, it is not the Company's intention to simply shift the cost to the employees. Through utilization and strengthening of wellness and DM programs and changes in plan design, the Company will strive to keep the cost increases as low as possible for both the employees and the Company. Employees in this case study and nationwide may see more offerings of rewards as well as consequences as part of their ESI makeovers.

Employer offerings of CDHPs have increased in recent years resulting in 19 percent enrollment among covered employees, in 2012, and making CDHP a second most popular ESI plan (The Kaiser Family Foundation and Health Research & Educational Trust 2012). Evidence reveals that employers with CDHPs have, on average, 2 percent lower costs than with PPOs (Aon Hewitt 2012). In this case study, the majority of respondents (56.6 percent) said they would likely enroll in a High Deductible Health Plan if the Company offered it. Ms. Barrett expressed the Company's interest in this plan arrangement. However, no decisions have been made at this time.

Rational Choice Theory Revisited

Becker ([1978] 1990) argued that people are rational, calculating, and resource-maximizing actors. They weigh the benefits and costs of their behavior, including material and nonmaterial factors. In the context of health care, it can be argued that employers weigh the benefit of healthier and happier workforce and tax deductions of their cafeteria plans with the monetary cost of offering health insurance to the employees. The employees, on the other hand, want to purchase health insurance that provides generous benefits and broad provider networks at the lowest price possible. The following is a discussion of the case study findings in the context of the rational choice theory (RCT).

The RC framework predicts that both employers and employees will act rationally in regards to health insurance benefits in the post-ACA era and select options that, based on their knowledge, will benefit them the most. The literature and this case study show that for employers the cost of providing health benefits is not the sole most important factor in response to the new law. Most employers, including The Langdale Company,

want to keep providing affordable health insurance to their employees because they recognize the adverse moral and financial impact dropping benefits would have on the employees. Moreover, there appears to be an agreement among employers that health benefits are central to employee benefit packages and in the long run will help employers recruit and retain talent. Of course, for employers who can not afford providing health benefits, which may be the case for many smaller employers (with 50-200 full-time employees), the cost of health insurance may be the determining factor in their health benefit decisions. Nevertheless, these employers can adopt some other mechanisms in order to maintain a competitive advantage, such as increasing employee compensation. The findings from the Company employer questionnaire validate the RC framework as a predictor of employer behavior in the post-ACA era. Moreover, they emphasize the importance of a firm's benefit philosophy in the employer's rational decision-making. The following paragraphs will discuss the RC framework's effectiveness in predicting employee behavior.

Employee opinion of the ACA and the Plan, their health care costs, and their willingness to maintain ESI are critical pieces in the rational choice theory (RCT) assessment. The ACA modeling analyses for employers, such as those offered by ContinuousHealth LLC (*CHROME*) and Medcom (*Pay or Play Modeling*), and microsimulation model predictions for the entire U.S. ESI sector (The U.S. Government Accountability Office 2012) assume that individuals will act "rationally," as defined by the rational choice theory (see Chapter 2). This study revealed that most employees (66 percent) disapprove of the ACA, yet the majority approves of 24 out of 33 individual provisions of the law investigated by the researcher. This contradiction between opinions

of the ACA as a whole vs. its components is consistent with the national trend since the law's passage (The Henry J. Kaiser Family Foundation 2012e).

On the surface, these findings appear irrational. However, closer examination of collected data revealed that the majority of respondents are against government involvement in health care with 68 percent saying that health care should be delivered solely by the private industry and only 3 percent saying government alone should deliver health care. Moreover, approximately 70 percent of respondents identified themselves as conservative. Conservative ideology prevails in the South. In 2009, Georgia ranked 14th on the most net conservative list compiled by Gallup (Saad 2009). Historically, conservatives have been against "big governments" and welfare states. Thus, the opinion of the ACA appears to be based on the respondents' view of the size and reach of the government and its role in health care more than on the law itself.

The following paragraph takes a closer look at the employee opinion of the ACA. In 2012, approximately 66 percent of the employees said they disapprove of the ACA, and 20.9 percent said they approve of the law. These findings are significantly different from the November 2012 Kaiser Health Tracking Poll, showing that 39 percent of the public has an unfavorable view of the ACA and 43 percent has a favorable view (The Henry J. Kaiser Family Foundation 2012f). These differences can be explained by a dominant Romney voter[32] population (73.7 percent) among the case study survey respondents. In the case study, the support for Romney is similar to the support in the region. In the 2012 Presidential election, Romney won in the state of Georgia with 53 percent of the popular vote. In the southern region, support for Romney was higher than

[32] Eight in ten Romney voters and only one in four Obama voters reported unfavorable view of the ACA in the November Kaiser Health Tracking Poll (2012). There appears to be strong association between being a Romney voter and having an unfavorable view of the ACA.

the statewide results, ranging from 55 percent in Lowndes County to 83 percent in the neighboring Echols County (NBCNews.com 2012).

Clearly, employee political ideology is an important external factor that should be considered in employee attitudes surveys. Additional analyses that accounted for the job category and gender proved that some external factors can influence the independent variables in this study and have a potential to significantly influence studied relationships. One could argue that such factors become lenses through which employees perceive their own reality and upon which they base their preferences and make rational choices. In this case study, the external factors had little to no effect on the studied relationships. However, low variability of the DVs has hindered such explorations. Future studies should take in account external factors such as political ideology, job category, income, and gender, especially when there is variability in the DVs.

Employees in this case study are acting rationally, based on their political ideology and party affiliation, to disapprove of the law as whole. The health reform, in its entirety, is often overwhelming and hinders any efforts at cost-benefit analysis of the law as a whole. Approximately 66 percent of employees said they do not know enough about the ACA to understand how it impacts them personally. The March 2012 edition of the Kaiser Health Tracking Poll found that 59 percent of the public feels the same way (The Henry J. Kaiser Family Foundation 2012f). However, most individuals are capable of assessing the impact of the law's individual mandates, and they act rationally to approve of the majority of them. The benefits of lower health care costs and improved access to health care as well as expanded benefits associated with these provisions (e.g., no cost-sharing for preventive services and dependent coverage up to age 26) are driving up their

popularity among the employees and the public.

Another consistency with the public opinion is the low approval rate of the individual mandate: 32 percent nationwide vs. 24.5 percent for this case study (The Henry J. Kaiser Family Foundation 2012e). The clear majority opposition to the individual mandate may be a result of the respondent's view of the government as overstretching its constitutional regulatory privileges. That reasoning was the rationale behind the lawsuits described in Chapter 2. This sentiment may be dictating public and employee opinion. Nevertheless, as a highly personal mandate to many citizens, the explanations for disapproval of the individual mandate may be drawn from the RC framework. Even though the majority of citizens have health insurance, public and employees alike may want to avoid the probability of being subjected to penalties associated with the individual mandate.

Employee health care expenses and perceived change in health cost in 2012 had little effect on employee satisfaction with the Plan. These findings may be a result of lower than national average family coverage premium and single coverage premium at the national average level (see Figure 14). Moreover, most employees said that the co-payments (78.8 percent), network deductible (60.2 percent), and out-of-pocket limit (56.3 percent) are reasonable or very reasonable. In this case study, health care costs were not a decisive factor in analyzing employee satisfaction. Nevertheless, the importance of employees' health expenses and cost change should not be overlooked in the future studies. Since the Company maintained its Plan *grandfathered* in 2011-2013, its employee premiums, deductible, and out-of-pocket limit increased slightly in 2011 and 2012, but there were no changes in employee responsibilities in 2013. Due to losing the

grandfathered status in 2014, employees may experience significant increases in their responsibilities (mainly in premiums). Approximately 72 percent of respondents said they are very concerned that the ACA will harm their budget, and an additional 23 percent said they are concerned or somewhat concerned, indicating that the cost of health care is central to employee budgets. According to Deloitte (2012b), per-capita discretionary expenditures totaled $2,898 in 2010.

Overall, the survey results and the analysis indicate that since the law's passage, employees have not experienced significant increases in their health care costs, and thus their satisfaction with the Plan was not affected. However, the 2014 Plan changes will increase the employee responsibility and the author predicts that the overall satisfaction with the Plan will decrease resulting in more individuals being dissatisfied with the Plan. Additionally, in 2014 the correlation between employees' cost change and satisfaction may result in a moderate to strong adverse relationship. Deloitte Center for Health Solutions' *2012 Survey of U.S. Health Care Consumers* found that satisfaction with all health plans (ESI, government programs, and direct purchase) decreased from 52 percent in 2011 to 44 percent in 2012. Additionally, 16 percent of individuals reported switching health plans, with 47 percent of those citing cost as the reason. In the context of health care expenses and perceived health care cost change, this case study did not produce enough evidence to support or to reject the applicability of the RC framework in predicting employee behavior. Nevertheless, due to substantial Plan changes in 2014, sufficient evidence can be obtained from the continued assessment into years 2013 and 2014.

Since the Company will be increasing employee health care costs, will the

employees be switching coverage? This case study investigated employee willingness to maintain the Plan in 2014 based on what they currently know about the ACA. This is of concern to the Company for two reasons: (1) if the employee qualifies and receives subsidy in the HIX, the Company can be liable for a penalty; and (2) the Company has to offer coverage to at least 95 percent of its full-time workforce, which can potentially increase the employee population with coverage from 802 to 1130. Knowing how many employees want to keep/enroll in the Company Plan will help estimate the total Plan cost in 2014. Currently, the Company's approach is to keep the Plan affordable (premium cannot exceed 9.5 percent of employee's household income) with minimum value (at least 60 percent actuarial value). The researcher tested the Plan for both affordability and minimum value and found that the Plan premiums are affordable (on average, 5 percent of employee's W-2 earnings) and that the Plan has approximately 81 percent actuarial value. Thus, it is unlikely the Company will be liable for employer penalties in 2014.

To address the second issue, the Company will likely experience an increase in the number of employees enrolled in the Plan. Only two survey respondents said that they will drop their current health coverage, with one stating that the reason for switching health plans was the inability to add the spouse to the Plan.[33] The other respondent did not state the reason for dropping ESI. Due to the ACA, the Company will no longer be able to keep the Plan "closed." Thus, the first employee who planned on dropping coverage effective January 1, 2014 may now stay on the Plan and add his or her dependents. The individual mandate is forcing individuals to purchase health insurance or pay a fee. For those who decide to purchase health insurance in 2014, many may decide

[33] The Plan is a closed plan, meaning that employees and dependents can be added when the employee is hired or if there is a qualifying event (as defined by Health Insurance Portability and Accountability Act), but not during an open enrollment period.

to enroll in ESI. It is safe to say that health insurance premiums in the HIX (and outside of the HIX) will be higher than premiums in the group health plans for similar levels of coverage. Moreover, if the Company Plan remains affordable and meets the minimum value requirement, which is the Company's intention, employees will not be able to obtain government subsidies in the HIX.

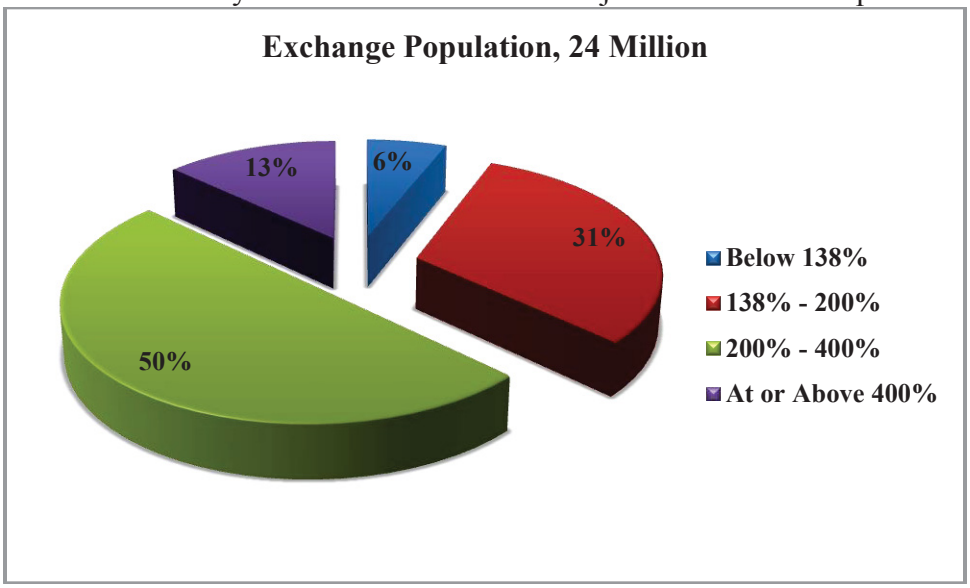
When deciding whether to purchase health insurance in 2014 or pay a penalty (or avoid both), and whether to purchase ESI or go to the Exchanges (if the employee does not qualify for a government insurance program), employees will likely examine their out-of-pocket expenses (including premiums) and nonmaterial benefits (such as types of benefits offered) in each scenario. Based on these and other factors, they will decide on the most optimal option. The researcher predicts that employee household income and the availability and the amount of federal subsidies will be critical to the employee decision-making in the Fall of 2013. This particular analysis failed to prove a relationship between employee household income and their willingness to maintain the Plan and, thus, support the RC framework in this context. Nevertheless, the continued assessment of the Company and other future studies may yield contrary findings and provide additional support for the RC framework.

Impact of Demographic Factors on Employees' Decisions in 2014 and Beyond

In 2014, the Exchanges will provide health coverage to an estimated 12 million individuals and approximately 29 million individuals by 2021 (PricewaterhouseCoopers Health Research Institute 2013). This case study and the literature (The Henry J. Kaiser Family Foundation 2011; PricewaterhouseCoopers Health Research Institute 2013) argue that employee household income and availability of federal subsidies will constitute

principal factors in employee decision-making in 2014 and beyond. The Exchanges will offer considerable financial incentives for employees who qualify for federal subsidies to obtain health insurance through the Exchanges. In its study, *A Profile of Health Insurance Exchange Enrollees*, the Henry J. Kaiser Family Foundation (2011) predicted that approximately 37 percent of the HIX population will have household incomes below 200 percent of FPL in 2019 (see Figure 16).

Figure 16. Federal Poverty Level Distributions for Projected 2019 HIX Population



Source: The Henry J. Kaiser Family Foundation. 2011. "A Profile of Health Insurance Exchange Enrollees." http://www.kff.org/healthreform/upload/8147.pdf (March 29, 2013).

Employees who have household incomes below 200 percent of FPL will be eligible for significant subsidies, allowing them to enroll in health plans with high actuarial values (87-94 percent) at a low cost with premiums ranging from 2 - 6.3 percent of household income (The Henry J. Kaiser Family Foundation 2012a). In 2014, nine out of 10 individuals in the Exchanges will receive federal subsidies (PricewaterhouseCoopers Health Research Institute 2013).

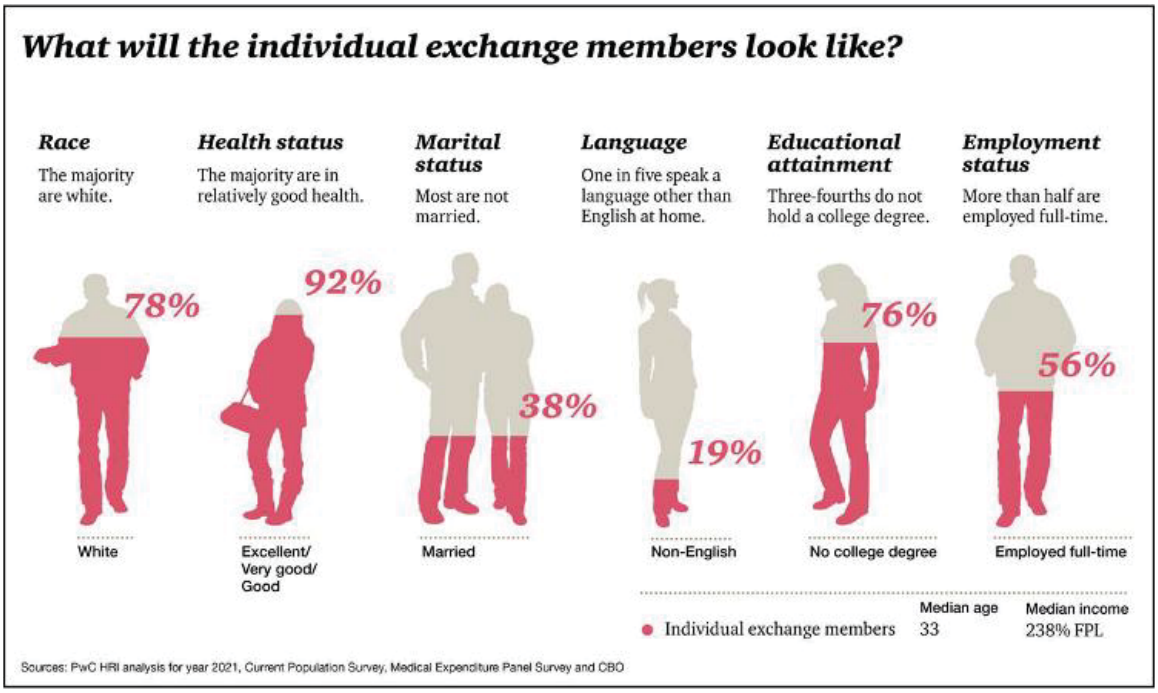
Furthermore, available data shows that by 2021 individuals in the Exchanges will be predominantly White (78 percent) and lacking college degree (76 percent); with

median age of 33 years old and median income of 238 percent of FPL. Figure 17 illustrates the profile of individuals in HIX. In comparison, Medicaid population will be more racially and ethnically diverse (74 percent White), less educated (89 percent lacking college degree), younger with median age of 31 years old, and having lower incomes (median income of 65 percent of FPL) than the HIX population (See Figure 18). Based on the 2021 education attainment and income predictions, it is safe to say that employees in low socioeconomic strata are more likely to seek health coverage in the HIX than employees in middle and high socioeconomic strata.

The concept of the socioeconomic status (SES) introduces two other factors that can potentially affect employee decision-making, occupation and race/ethnicity. Occupation is a reflection of both income and educational attainment that was shown in the previous paragraph to impact an employee's decisions. Low-skilled workers will be more likely to purchase health insurance from the HIX than employees in the positions such as supervisor, senior management, or executive. Historically, racial and ethnic minorities have been associated with low SES (American Psychological Association 2013). Thus, employees who belong to a racial or ethnic minority group will be more likely to purchase insurance from the HIX than from their employers, unless they qualify and enroll in one of the government insurance programs instead.

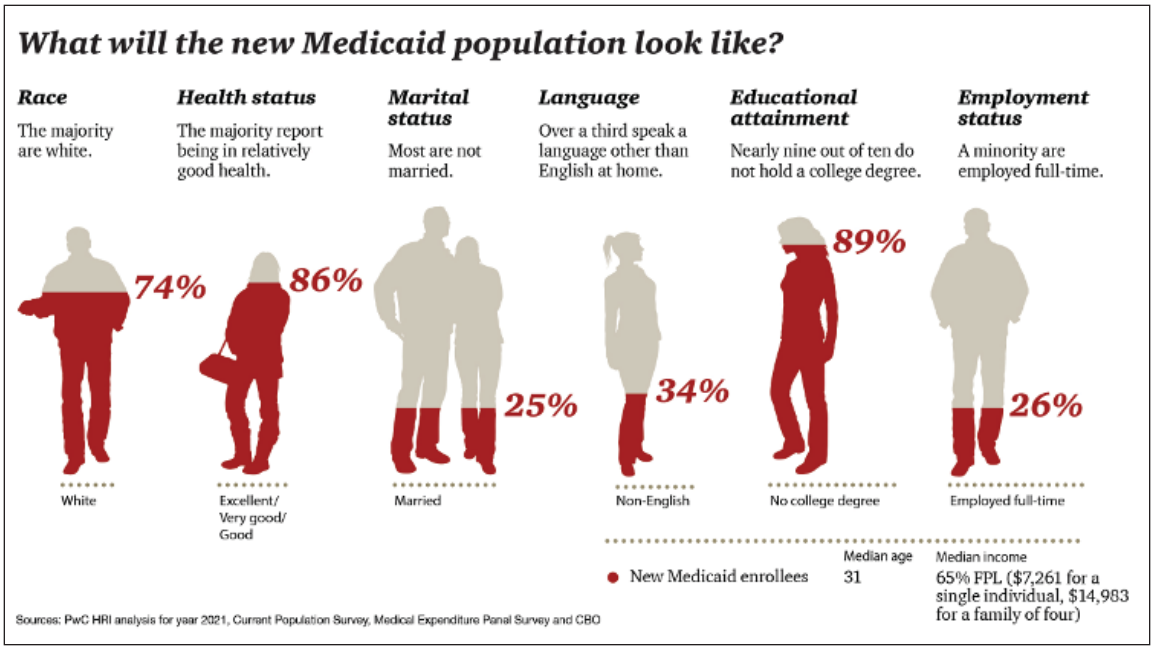
It is important to note that the above discussed behavior of the employees in 2014 is conditional on the availability of affordable ESI. As previously discussed in Chapter 2, employees who are offered affordable and of at least minimum value ESI will not qualify for federal subsidies in the HIX (except in rare situations). Furthermore, as it stands now, the predictions are that health plans in the HIX will be more expensive than ESI. In an

Figure 17. Exchange Population Characteristics, 2021



Source: PricewaterhouseCoopers Health Research Institute. 2013. "30 Million Newly-Insured under the Affordable Care Act: Who Are They?" http://www.pwc.com/us/en/health-industries/publications/health-insurance-exchanges-and-medicaid-expansion.jhtml (March 29, 2013).

Figure 18. Medicaid Population Characteristics, 2021



Source: PricewaterhouseCoopers Health Research Institute. 2013. "30 Million Newly-Insured under the Affordable Care Act: Who Are They?" http://www.pwc.com/us/en/health-industries/publications/health-insurance-exchanges-and-medicaid-expansion.jhtml (March 29, 2013).

essence, employers will become gatekeepers to HIX subsidies for the employees. Unless employees qualify for one of the government insurance programs, such as Medicaid, or decide not to purchase health coverage, their behavior will be largely determined by the actions of their employers.

Employee migration to the HIX can be triggered by employers eliminating their ESI; by providing unaffordable and/or not satisfying minimum value requirements; or by targeting low-wage employees and making health insurance premiums unaffordable to this group only. The last option can produce win-win results because low-wage employees will realize savings in the HIX due to generous subsidies, and the employer will pay a penalty instead of a share of premium or cost of health insurance, which is significantly higher. Overall, this discussion validates and expands the RC framework by introducing the concept of SES and showing its impact on employee decision-making in connection with the 2014 changes and its implications for employers.

Recommendations and Conclusion

On March 9, 2010, Nancy Pelosi, then Speaker of the House, said these famous words: "We have to pass the (health care) bill so you can find out what is in it." Today, three years later, the public knows more about the ACA than it did in 2010, but misconceptions about the law and uncertainties about the future of the U.S. healthcare system are ample. Approximately two-thirds of the citizens report they do not know enough about the ACA to understand its impact on them and their families. Moreover, states with federal HIX, including Georgia, know little about the structure or the plans that will be part of their state Exchange. Meanwhile, the HIX open enrollment period starting in October of this year is quickly approaching.

All employers, those who do and those who do not offer ESI, should be actively evaluating impact of the ACA on their bottom line and that of their employees, as well as rethinking their health benefit strategy. Following the 2012 Presidential election, Speaker of the House, John Boehner, said: "Obamacare is law of the land." While challenges in the courts and efforts to underfund/repeal parts of the law still persist, the Obama administration has won major battles and defended the ACA successfully. The 2012 reelection of President Obama assured the public that the ACA is here to stay.

In addition to the rising health care costs, employers are now faced with requirements to expand/offer ESI to essentially all full-time employees and their dependents[34], including young adults up to age 26, and to expand benefits with employers taking in a higher share of the cost. Now is the time employers begin planning their responses to the ACA for the January 1, 2014 deadline, the date when major mandates take effect, if they have not yet started doing so. One popular approach to managing employer health costs is offering Consumer-Driven Health Plans. Moreover, the literature (Aon Hewitt 2012) reveals heightened employer interest in wellness and disease management programs. The Langdale Company's success with these programs has proven their potential for controlling health plan costs.

Finally, employee views and perspectives on the ACA and their ESI should be an integral part of any employer planning for the future of their health benefits. A 360-degree evaluation of the ACA's impact on the Company can help employers determine their strategy for better health, improved bottom line, and a competitive advantage. Most employees nationwide and in this case study are satisfied with their ESI, and they want to keep these health plans. Since the passage of the 2006 Massachusetts' health reform, the

[34] The ACA does not mandate coverage for spouses, only children.

vast majority of Massachusetts' residents (79 percent) continue to be enrolled in ESI (Henry J. Kaiser Family Foundation 2012h). The same trend can be expected nationwide when the 2014 reforms take effect. Thus, it is safe to say that generally any actions employees take in 2014 will be in direct response to what their employers do. If employers stop offering or decide not to offer health benefits, employees will likely purchase health insurance from the Exchanges, unless they qualify for one of the government programs. However, it is very unlikely for employees to go to the Exchanges if they are offered affordable ESI. Employers need to recognize the continued need for ESI and take advantage of this opportunity to improve their health benefits, engage employees, and reduce the waste.

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APPENDIX A:

The Langdale Company Health Benefit Plan Satisfaction Survey 2012

(Hard copy version)

2012

THE LANGDALE COMPANY

The Langdale Company

The Langdale Company Health Benefit Plan Satisfaction Survey

Dear Participant,

I am a graduate student seeking my Doctoral degree in the Department of Public Administration at Valdosta State University. I am conducting a study of The Langdale Company Health Benefit Plan administered by TLC Benefit Solutions, Inc. The purpose of this research is to assess employee satisfaction with the Health Plan in connection with the 2010 Health Care Reform changes.

This survey is anonymous. No one, including the researcher, will be able to associate your responses with your identity. Your participation is voluntary. You may choose not to take the survey, to stop responding at any time, or to skip any questions that you do not want to answer.

I am also an employee of The Langdale Company. The Company has given me permission to contact you about this study. If you choose to participate, you should know that I will only share general, aggregate results with The Langdale Company management for Health Benefit Plan improvement and development purposes. No one will have access to individual surveys nor will know who responded and who did not.

I would greatly appreciate your completing the enclosed survey and returning it to me in the enclosed postage-paid envelope. This survey should take 15 to 25 minutes to complete.

You must be at least 18 years of age to participate in this study. Your completion of the survey serves as your voluntary agreement to participate in this research project and your certification that you are 18 or older.

Enclosed you will also find a postcard that you can fill out and return for a drawing of 10 gift card prizes ($25 each). Winners will be contacted the day of the drawing and announced in the newest edition of the company Newsletter. ***It is important that you return your postcard separate from the survey.***

If you have any questions regarding the purpose or procedures of the research, you may contact me at (229) 249-0940 (Monday

through Friday 8am-5pm) or at ebgad@valdosta.edu. This study has been exempted from Institutional Review Board (IRB) review in accordance with Federal regulations. The IRB, a university committee established by Federal law, is responsible for protecting the rights and welfare of research participants. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 229-259-5045 or irb@valdosta.edu.

Thank you again for your help!

E-Survey is Available!

For your convenience, this survey is also available online through The Langdale Company website: Go to www.houze.org/langdale for easy access instructions.

If you choose to do e-survey, you can discard the enclosed hard copy of the survey.

Remember to mail your postcard for the prize drawing.

Sincerely,

Ewelina Sparks

Ewelina Sparks
Graduate Student
Department of Public Administration
Valdosta State University

2010 Health Care Reform

Do you approve or disapprove of the 2010 Health Care Reform overall? (Please check one response).

- ☐ Strongly approve
- ☐ Approve
- ☐ Neither approve nor disapprove
- ☐ Disapprove
- ☐ Strongly disapprove
- ☐ Don't know

If you disapprove of the 2010 Health Care Reform, would you say it is mostly due to:

- ☐ What you know about the health reform law
- ☐ Your general feelings about the direction of the country and what's going on in Washington right now
- ☐ Both equally
- ☐ Don't know

Where do you rank Health Care Reform among national priorities?

- ☐ Top priority
- ☐ Top three
- ☐ Top ten
- ☐ Not a priority
- ☐ Don't know

How do you rate your knowledge of Health Care Reform?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

Should health care be insured and delivered by government or the private industry?

- ☐ Government
- ☐ Private industry
- ☐ Both
- ☐ Don't know

Do you think that government currently has too much influence, too little influence or the right amount of influence on the health care industry?

- ☐ Too much influence
- ☐ Too little influence
- ☐ The right amount of influence
- ☐ Don't know

How concerned are you that Health Care Reform will harm our national economy and budget?

- ☐ Very concerned
- ☐ Concerned
- ☐ Somewhat concerned
- ☐ Not concerned
- ☐ Don't know

How concerned are you that Health Care Reform will harm your budget?

- ☐ Very concerned
- ☐ Concerned
- ☐ Somewhat concerned
- ☐ Not concerned
- ☐ Don't know

Please indicate whether you **1 - Strongly Agree; 2 - Somewhat Agree; 3 – Neither; 4 - Somewhat Disagree; or 5 - Strongly Disagree** with the following statements:

	1	2	3	4	5
The Health Reform has benefited me and my family	☐	☐	☐	☐	☐
The Health Reform has negatively affected me and my family	☐	☐	☐	☐	☐
The Health Reform has not affected me and my family	☐	☐	☐	☐	☐
I favor the changes made by the Health Reform that benefit me and my family	☐	☐	☐	☐	☐
I favor the changes that do not personally benefit me and my family	☐	☐	☐	☐	☐
I know enough about the Health Reform to understand how it impacts me personally	☐	☐	☐	☐	☐

The Langdale Company Health Benefit Plan Satisfaction Survey

Please describe how the Health Reform has benefited you and your family or has had a negative impact on you and your family.

How has the Health Reform benefit you and your family?

What negative effects has the Health Reform had on you and your family?

2012 Presidential Election

Who did you vote for in November Presidential election?

- ☐ Barack Obama
- ☐ Mitt Romney
- ☐ Someone else
- ☐ Did not vote

For each of the following please indicate if it was a major factor in your vote for president, a minor factor or not a factor at all in your vote for president.

	Major factor	Minor factor	Not a factor	Don't Know
The economy	☐	☐	☐	☐
The 2010 health care law	☐	☐	☐	☐
The future of the Medicare program	☐	☐	☐	☐
The future of the Medicaid program	☐	☐	☐	☐
The candidate's views on women's health issues, including birth control and abortion	☐	☐	☐	☐
Whether the candidate is a Democrat or Republican	☐	☐	☐	☐

	Major factor	Minor factor	Not a factor	Don't Know
Mitt Romney's background as a businessman	☐	☐	☐	☐
Barack Obama's job performance over the last four years	☐	☐	☐	☐
The direction the country is headed	☐	☐	☐	☐
The candidate's views on the size and role of government	☐	☐	☐	☐
The candidate's ability to relate to the middle class	☐	☐	☐	☐
Foreign policy	☐	☐	☐	☐
Barack Obama's handling of the response to Hurricane Sandy	☐	☐	☐	☐

Which of the above factors was <u>the biggest factor</u> in your vote for president? (Choose one).

- ☐ The economy
- ☐ The 2010 health care law
- ☐ The future of the Medicare program
- ☐ The future of the Medicaid program
- ☐ The candidate's views on women's health issues, including birth control and abortion
- ☐ Whether the candidate is a Democrat or Republican
- ☐ Mitt Romney's background as a businessman
- ☐ Barack Obama's job performance over the last four years
- ☐ The direction the country is headed
- ☐ The candidate's views on the size and role of government
- ☐ The candidate's ability to relate to the middle class
- ☐ Foreign policy
- ☐ Barack Obama's handling of the response to Hurricane Sandy
- ☐ Other (please specify): _____

Do you approve or disapprove of the following major Health Care Reform mandates? Please rate each scale from 1 (Approve) to 5 (Disapprove).

Require individuals to purchase basic health insurance coverage or pay a fee, known as ***Individual Mandate***

Require employers to offer health insurance coverage or pay a penalty, known as ***Play or Pay provision***

Expand ***Medicaid***

Establish Affordable ***Insurance Exchanges***, competitive insurance marketplaces in each state

Provide ***federal premium subsidies*** to lower premium payments for the Exchange participants whose household income is between 100% and 400% of the federal poverty line

Provide ***cost-sharing subsidies*** - reduced copayments, co-insurance, and deductibles - to eligible participants in the Exchanges

Provide ***small business tax credits***

Expand coverage for ***Early Retirees***

Provide access to insurance for the ***uninsured with Pre-Existing Conditions***

Prohibit denial of coverage to children with ***Pre-Existing Conditions***

Require all qualified health insurance plans to offer ***essential health benefits***

Expand ***dependent coverage*** for young adults up to age 26

Eliminate ***lifetime limits***

1 – Approve	2 – Somewhat Approve	3 – Neither Approve nor Disapprove	4 – Somewhat Disapprove	5 – Disapprove	Don't know
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
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☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐

The Langdale Company Health Benefit Plan Satisfaction Survey

Do you approve or disapprove of the following major Health Care Reform mandates? Please rate each scale from 1 (Approve) to 5 (Disapprove).
Increase Medicare payroll tax on upper income individuals
Eliminate ***annual/calendar year maximums*** (2014)
Provide ***free Preventive Care***
Eliminate ***Pre-Existing Condition Exclusion*** (2014)
Establish ***Grandfather clause*** that frees qualified health plans from compliance with some Health Reform provisions
Prohibit insurance companies from ***retroactive cancellation of coverage***
Require ***Automatic Enrollment*** into employer's health plan
Provide consumers with expanded process to ***appeal insurance company decisions***
Guarantee ***availability and renewability of coverage***
Require a uniform ***summary of benefits and coverage***
Hold insurance companies accountable for ***unreasonable rate increases***
Reduce waste, fraud, and abuse in ***public programs***
Introduce ***Medicare Prescription Drug discounts***

1 – Approve	2 – Somewhat Approve	3 – Neither Approve nor Disapprove	4 – Somewhat Disapprove	5 – Disapprove	Don't know
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
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☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐

Do you approve or disapprove of the following major Health Care Reform mandates? Please rate each scale from 1 (Approve) to 5 (Disapprove).

Expand the number of ***primary care doctors, nurses and physician assistants***

Strengthen ***Community Health Centers***

Increase payments for ***rural Health Care Providers***

Increase Medicaid payments for ***Primary Care Doctors***

Extend funding for the ***Children's Health Insurance Program (CHIP)***

Base physician payments on the ***quality of care*** they provide

Introduce ***Accountable Care Organizations (ACOs)***, where your primary care doctor and the specialists you see work together and coordinate your care

---

Your Health Insurance

Who is covered under your ***Medical*** Insurance through The Langdale Company Health Benefit Plan?

- ☐ Employee only
- ☐ Employee and spouse
- ☐ Employee and child/ren under 19 years of age
- ☐ Employee and child/ren including Adult Children (19 up to 26)
- ☐ Employee, spouse, and child/ren under 19 years of age
- ☐ Employee, spouse, and child/ren including Adult Children
- ☐ Don't know
- ☐ I don't have Medical Insurance with The Langdale Company

1 – Approve	2 – Somewhat Approve	3 – Neither Approve nor Disapprove	4 – Somewhat Disapprove	5 – Disapprove	Don't know
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐

How long have you been covered under the Medical Insurance through The Langdale Company Health Benefit Plan? (Include COBRA coverage and any breaks in coverage shorter than 63 consecutive days).

- ☐ Six months or less
- ☐ From six months to one year
- ☐ From one year to two years
- ☐ From two years to three years
- ☐ From three years to five years
- ☐ More than five years
- ☐ Don't know

Did you know that your Health Insurance is Grandfathered under Health Care Reform? ***Grandfathering*** *means that your Health Insurance is not required to comply with some Health Reform provisions.*

Yes ☐ No ☐

Your Health Insurance Benefits

How much do you know about what your Health Insurance covers and what it doesn't?

- ☐ A lot
- ☐ Some
- ☐ Not very much
- ☐ Hardly anything
- ☐ Don't know

How do you rate your knowledge of the changes your Health Insurance made due to the Health Care Reform Act effective January 1, 2011?

Excellent	Good	Fair	Poor	Don't know
☐	☐	☐	☐	☐

Do you consider the following Health Care Reform requirements that apply to your Health Insurance important or unimportant? Please rate them on the following scale: ***1 - Extremely Important; 2 – Important; 3 – Somewhat Important; 4 – Neither important nor unimportant; 5 - Not important.***

	1	2	3	4	5	Don't know
No Lifetime Limit	☐	☐	☐	☐	☐	☐
Limited Annual Maximum ($2 mil in 2013)	☐	☐	☐	☐	☐	☐
Coverage for Adult Children up to Age 26	☐	☐	☐	☐	☐	☐
No Pre-Existing Condition Exclusion up to Age 19	☐	☐	☐	☐	☐	☐
Eliminating Student Status Requirement	☐	☐	☐	☐	☐	☐
Prohibiting Retroactive Cancellation of Coverage	☐	☐	☐	☐	☐	☐

Which of these requirements is **the most important** to you? (Choose one.)

- ☐ No Lifetime Limit
- ☐ Limited Annual Maximum
- ☐ Coverage for Adult Children up to Age 26
- ☐ No Pre-Existing Condition Exclusion up to Age 19
- ☐ Eliminating Student Status Requirement
- ☐ Prohibiting Retroactive Cancellation of Coverage
- ☐ Other (please specify): _____

Do you approve or disapprove of the mandated Health Care Reform changes your Health Insurance has made overall?

- ☐ Strongly approve
- ☐ Approve
- ☐ Somewhat approve
- ☐ Neither approve nor disapprove
- ☐ Somewhat disapprove
- ☐ Disapprove
- ☐ Strongly disapprove
- ☐ Don't know

Your Health Care Costs

How much do you think you will have spent out of your own pocket for health care in 2012? (Include premiums, deductibles, copayments, coinsurance, and prescription expenses).

- ☐ $0
- ☐ $1 - $499
- ☐ $500 - $999
- ☐ $1,000 - $1,499
- ☐ $1,500 - $1,999
- ☐ $2,000 - $2,999
- ☐ $3,000 - $3,999
- ☐ $4,000 - $4,999
- ☐ $5,000 - $7,499
- ☐ $7,500 - $9,999
- ☐ $10,000 - $12,499
- ☐ $12,500 - $14,999
- ☐ $15,000 - $17,499
- ☐ $17,500 - $19,999
- ☐ $20,000 - $24,999
- ☐ $25,000 - $29,999
- ☐ $30,000 or more
- ☐ Don't know

How have your overall health care costs changed from 2011 to 2012 calendar year?

- ☐ Increased a lot
- ☐ Increased some
- ☐ Stayed the same
- ☐ Decreased some
- ☐ Decreased a lot
- ☐ Don't know

In your opinion, how reasonable are your 2012 Health Insurance expenses? Please rate them on the following scale: ***1- Very reasonable; 2- Somewhat reasonable; 3 - Neither reasonable nor unreasonable; 4 - Somewhat unreasonable; 5 - Not at all reasonable.***

	1	2	3	4	5	Don't know
Premiums	☐	☐	☐	☐	☐	☐
Copayments ($35 in-network)	☐	☐	☐	☐	☐	☐
Deductibles ($550 in-network)	☐	☐	☐	☐	☐	☐
Family deductible ($1,650 in-network)	☐	☐	☐	☐	☐	☐
Out-of-pocket limit ($3,000 in-network)	☐	☐	☐	☐	☐	☐
Annual limit ($1,250,000)	☐	☐	☐	☐	☐	☐

Your Overall Satisfaction

How satisfied are you with your Health Insurance overall?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Somewhat satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied
- ☐ Don't know

What would you like to see Congress do when it comes to the health care law? They should **expand the law, they should keep the law as is, they should repeal parts of law, they should repeal the law and replace it with a Republican-sponsored alternative, or they should repeal the law and not replace it?**

- ☐ Expand the law
- ☐ Keep law as is
- ☐ Repeal parts of law
- ☐ Repeal and replace with Republican alternative
- ☐ Repeal and NOT replace
- ☐ Don't know
- ☐ Other (please specify): _____

Your Opinions

If you could change some things about the way your Health Insurance works, what would those things be?

How important is it for you that The Langdale Company continues to offer health insurance to the employees?

- ☐ Very important
- ☐ Important
- ☐ Somewhat important
- ☐ Not at all important
- ☐ Don't know

High Deductible Health Plans (HDHPs)* are becoming very popular these days. If The Langdale Company offered this option to the employees, how likely would you be to enroll in a HDHP?

****HDHPs have higher deductibles, but lower premiums. Under a HDHP, you would pay nothing for preventive/wellness exams. Co-pays may apply to some benefits such as sick office visits and emergency room visits. In all other cases, deductible applies. After you meet your deductible, the plan will cover most of your cost, for example 80%.***

- ☐ Very likely
- ☐ Likely
- ☐ Somewhat likely
- ☐ Not at all likely
- ☐ Don't know

Looking into the Future: 2014

Based on what you know about the Health Reform changes in 2014, how likely are you to maintain your current health insurance with The Langdale Company in 2014?

- ☐ Very likely
- ☐ Likely
- ☐ Somewhat likely
- ☐ Not at all likely (I will drop my health benefits effective 1/1/2014)
- ☐ Don't know

If you are planning to drop your health benefits effective 1/1/2014, what are the major reasons behind your decision?

Your Health

How do you rate your current health status?

Excellent	Good	Fair	Poor	Don't know
☐	☐	☐	☐	☐

Have you taken any of the following steps to reduce your health care costs? (Choose all that apply).

- ☐ Tried to take better care of myself
- ☐ Went to the doctor only for more serious conditions and symptoms
- ☐ Delayed going to the doctor
- ☐ Skipped a recommended doctor's visit
- ☐ Used programs offered by The Langdale Company that help me do things like lose weight, stop smoking, etc.
- ☐ Participated in the Health Risk Assessment offered by The Langdale Company
- ☐ Did not fill or skipped doses of prescribed medication
- ☐ Talked to the doctor more carefully about affordable treatment options
- ☐ Looked for less expensive health care providers
- ☐ Switched to over-the-counter drugs
- ☐ Have not taken any steps to reduce my health care costs
- ☐ Other (please specify): _____

If you participated in the **Health Risk Assessment (HRA)** provided by The Langdale Company, would you say that you benefited from it, or not? Please describe how you benefited (or not) from the HRA.

Please answer the following questions about your Health Risk Assessment results:

	Yes	No
Did your HRA results cause you to see your doctor?	☐	☐
Did your doctor contact you regarding your HRA results he/she received from The Langdale Company?	☐	☐
When you went to your doctor's office for your wellness exam or a sick visit, did he/she give you feedback regarding your HRA results?	☐	☐

About You

Are you male or female?

Male ☐ Female ☐

Are you Spanish, Hispanic, or Latino?

Yes ☐ No ☐

Are you White, Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or other Pacific Islander, or some other race?

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ From multiple races
- ☐ Some other race (please specify):

What is your total **family income** from all sources, before taxes?

- ☐ $12,500 - $14,999
- ☐ $15,000 - $19,999
- ☐ $20,000 - $24,999
- ☐ $25,000 - $29,999
- ☐ $30,000 - $34,999
- ☐ $35,000 - $39,999
- ☐ $40,000 - $44,999
- ☐ $45,000 - $49,999
- ☐ $50,000 - $59,999
- ☐ $60,000 - $69,999
- ☐ $70,000 - $79,999
- ☐ $80,000 - $89,999
- ☐ $90,000 - $99,999
- ☐ $100,000 - $124,999
- ☐ $125,000 - $149,999
- ☐ $150,000 or more

Which category below includes your age?

- ☐ 17 or younger
- ☐ 18 - 20
- ☐ 21 - 29
- ☐ 30 - 39
- ☐ 40 - 49
- ☐ 50 - 59
- ☐ 60 - 65
- ☐ 66 or older

What is the highest level of school you have completed or the highest degree you have received?

- ☐ Less than high school degree
- ☐ High school degree or equivalent (e.g., GED)
- ☐ Some college but no degree
- ☐ Associate degree (including technical college degree)
- ☐ Bachelor degree
- ☐ Graduate degree

Are you now married, widowed, divorced, separated, or never married?

- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Never married

Generally speaking, would you say your views in most political matters are liberal, moderate or conservative??

- ☐ Liberal
- ☐ Moderate
- ☐ Conservative
- ☐ Don't know

What best describes your position with The Langdale Company?

- ☐ Executive
- ☐ Senior Management
- ☐ Management or Supervisor
- ☐ Non-Management Technical/Professional (includes Sales)
- ☐ Clerical or Administration
- ☐ Hourly Employee
- ☐ Don't know

Thank you for your participation!

APPENDIX B:

Valdosta State University Institutional Review Board (IRB) Approval Letter

Institutional Review Board (IRB)
for the Protection of Human Research Participants

PROTOCOL EXEMPTION REPORT

PROTOCOL NUMBER: IRB-02729-2011 **INVESTIGATOR:** Ewelina Gad Sparks

PROJECT TITLE: Employee Satisfaction with the Langdale Company Health Benefit Plan after 2010 Health Care Reform

DETERMINATION:

☑ This research protocol is exempt from Institutional Review Board oversight under Exemption Category(ies) 2. You may begin your study immediately. If the nature of the research project changes such that exemption criteria may no longer apply, please consult with the IRB Administrator (irb@valdosta.edu) before continuing your research.

☐ Exemption of this research protocol from Institutional Review Board oversight is pending. You may **not** begin your research until you have addressed the following concerns/questions and the IRB has formally notified you of exemption. You may send your responses to irb@valdosta.edu.

ADDITIONAL COMMENTS/SUGGESTIONS:

Although not a requirement for exemption, the following suggestions are offered by the IRB Administrator to enhance the protection of participants and/or strengthen the research proposal. If you make any of these suggested changes to your protocol, please submit revisions so that IRB has a complete protocol on file.

Barbara H. Gray Date: 10/19/11 ***Thank you for submitting an IRB application.***
Barbara H. Gray, IRB Administrator ***Please direct questions to irb@valdosta.edu or 229-259-5045.***

cc: Dr. James Peterson (Dept. Head)
Dr. George Merwin (Advisor)

Form Revised: 09.02.2009

Institutional Review Board (IRB)
for the Protection of Human Research Participants

PROTOCOL EXEMPTION REPORT

PROTOCOL NUMBER: **IRB-02729-2011** **INVESTIGATOR:** **Ewelina B. Gad Sparks**

PROJECT TITLE: **Employee Satisfaction with the Langdale Company Health Benefit Plan after 2010 Health Care Reform**

INSTITUTIONAL REVIEW BOARD DETERMINATION:

This research protocol is **exempt** from Institutional Review Board oversight under Exemption Category(ies) 2. You may begin your study immediately. If the nature of the research project changes such that exemption criteria may no longer apply, please consult with the IRB Administrator (irb@valdosta.edu) before continuing your research.

ADDITIONAL COMMENTS/SUGGESTIONS:

Although not a requirement for exemption, the following suggestions are offered by the IRB Administrator to enhance the protection of participants and/or strengthen the research proposal:

SPECIAL NOTE: This protocol was originally titled "Employee Satisfaction with the Langdale Company Health Benefit Plan after 2010 Health Care Reform." Proposed changes, including the revised title, do not affect the exemption status; this exemption report is provided to document continued exemption of the protocol under the new title.

☐ If this box is checked, please submit any documents you revise to the IRB Administrator at irb@valdosta.edu to ensure an updated record of your exemption.

This is a revision of the original form dated 12/6/12. The only revision made to this form was a change in name of the researcher from Ewelina B. Gad to Ewelina B. Gad Sparks. The exemption status remains: Exempt under Category 2.

Barbara Gray 3/19/13

Barbara H. Gray, IRB Administrator Date

Thank you for submitting an IRB application.

Please direct questions to irb@valdosta.edu or 229-259-5045.

Revised: 08.02.2012

APPENDIX C:

Major ACA Provisions Affecting Employers and Employees

Provision	Description	Effective Date
1st Implementation Phase		
Small Employer Health Insurance Tax Credit	An eligible small employer with no more than 25 full-time employees and the average annual compensation of these employees is equal to or less than $50,000 may claim a 35 percent tax credit for premiums it pays toward health coverage in tax years beginning in 2010 through 2013. For the tax years 2014 and 2015 the tax credit is increased to 50 percent.	Tax years beginning after December 31, 2009
Automatic Enrollment	Employers who have more than 200 full-time employees and who offer at least one health benefit plan are required to automatically enroll new employees in a plan. Employees may opt out of coverage. Written notice at the time of hiring (and to current employees no later than March 1, 2013) is required.	No effective date*
Essential Health Benefits Package	Qualified health plans must provide at least essential health benefits (as described by the Dep. of Health and Human Services) and the scope of these benefits must be equivalent to the scope of benefits provided under a "typical" employer-sponsored plan (to be established by the Dep. of Labor).	No effective date*
Free Preventive Care	Qualified health plans must provide recommended preventive services at no cost.	September 23, 2010**
Reporting on Premiums	In 2010, health insurance plans were required to report the proportions of premium dollars spent on clinical services, quality, and other costs and maintain certain minimum medical loss ratios (MLR). A process was established for reviewing increases in health plan premiums and requiring plans to justify increases of 10 percent or more.	January 1, 2011
Extension of Dependent	Group health plans and health insurers offering group or individual health insurance with dependent child coverage must make available optional coverage	September 23, 2010**

Coverage	for the enrollee's adult children who are younger than age 26, regardless of marital status of the adult child.	
Elimination of Lifetime Limits	Individual and group health plans are prohibited from placing lifetime limits on the dollar value of coverage (applies to "essential health benefits" only).	September 23, 2010**
Annual Limit Restrictions	Annual limits on the dollar value of benefits are limited to $750,000 (or the previous lifetime limit amount, if greater) in the first year, $1,250,000 (on or after September 23, 2011), and $2,000,000 (on or after September 23, 2012) (applies to "essential health benefits" only).	September 23, 2010**
Prohibition on Rescission	Health insurance issuers in the group and individual markets may not rescind an enrollee's coverage, except where an individual has engaged in fraud or made an intentional misrepresentation of material fact as prohibited under the terms of the plan or coverage. Prior notice to the enrollee is required.	September 23, 2010**
Elimination of Pre-existing Condition Exclusion for Children	Pre-existing condition exclusion on individuals under the age of 19 is prohibited.	September 23, 2010**
Establishing New Standards for Internal Claims and Appeals and External Review	Non-grandfathered plans and issuers must establish external review processes that comply with either an approved State external review process or the Federal external review process.	September 23, 2010** (delayed to July 1, 2011)

2nd Implementation Phase		
Uniform Summary of Benefits and Coverage and Uniform Glossary	All health plans and issuers must provide a Summary of Benefits and Coverage, along with a uniform glossary of terms, to shoppers and enrollees upon request and before they buy coverage. SBC must have clear, consistent and comparable information about health plan benefits and coverage. SBC six-page template has been issued.	Initially March 23, 2012; (Currently unknown)
3rd Implementation Phase		
Penalty	Employers with 50 or more employees who (1) do not offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, or (2) offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, but the coverage is unaffordable or does not provide minimum value (within the meaning of the Code) will pay a penalty for any month that any full-time employee is certified to receive a federal premium tax credit or cost-sharing reduction. The penalty under (1) is based on all (excluding the first 30) full-time employees (which is 1/12 of $2,000 for any month multiplied by the number of full-time employees reduced by 30), while the penalty under (2) is based on the number of full-time employees certified to receive a premium tax credit or cost-sharing reduction (which is 1/12 of $3,000 for any month multiplied by the number of full-time employees who receive a premium tax credit or cost-sharing reduction). Under scenario (2), employers may choose to pay the LESSER of (2) OR (1) penalties.	January 1, 2014
Free Choice Voucher	Employers that offer coverage will be required to provide a free choice voucher equal to the employer's contribution to its own plan to employees with income less than 400 percent of the federal poverty level if their share of the premiums exceeds 8 percent of their household income and is less than 9.8 percent. Employers who provide free choice vouchers will not be subject to penalties for	January 1, 2014 *Repealed Apr. 15, 2011***

	employees that receive premium credits in the new state-based Exchange.	
Tax Penalty	Citizens and legal residents are required to have "qualifying health coverage." Those without coverage will pay tax penalty, so called "shared responsibility payment." This provision does not apply to persons who are not applicable individuals. Exemptions are granted to applicable individuals for whom the lowest cost plan option exceeds 8 percent of their household income and to those with incomes below the tax filing threshold.	January 1, 2014
Premium Assistance	Qualified individuals whose household income is at least 100 percent but not more than 400 percent of the federal poverty line can receive a refundable premium assistance credit.	Tax years ending after December 31, 2013
Limits on Cost-sharing	Annual cost-sharing (which includes deductibles, copayments, and coinsurance) with respect to the essential health benefits may not exceed the amount applicable to health saving accounts (HSAs) for self-only and family coverage for taxable years beginning in 2014.	January 1, 2014
Elimination of Pre-existing Condition Exclusion	No group health plan or any health insurance issuer may impose a pre-existing condition exclusion to limit or deny coverage.	January 1, 2014
Waiting Periods Limits	Waiting periods for coverage are limited to 90 days.	January 1, 2014
Insurance Exchanges	State-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges will be established through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Beginning in 2017, states can allow businesses with more than 100 employees to purchase coverage in the SHOP.	January 1, 2014

4th Implementation Phase		
Excise "Cadillac" Tax	High-cost health plans (defined as costing more than $10,200 for an individual or $27,500 for a family) must pay a tax equal to 40 percent on the amount of premiums above the thresholds.	January 1, 2018

Sources: U.S. Department of Labor 2011; Wolters Kluwer Law & Business 2010.
Notes:
**When no effective date is provided, a provision is considered effective on the day of enactment.*
*** For plan/policy years beginning its first new year on or after September 23, 2010.*
***** U.S. Congress. 2011. *Department of Defense and Full-Year Continuing Appropriations Act, 2011.* 112th Cong., 1st sess., H.R.1473. *http://www.gpo.gov/fdsys/pkg/BILLS-112hr1473enr/pdf/BILLS-112hr1473enr.pdf* (July 28, 2011).

Source: Sparks, Ewelina. 2011. "Employee Satisfaction with the Langdale Company Health Benefit Plan after 2010 Health Care Reform." PADM 9050 - Program Evaluation Research Paper, Valdosta State University.

APPENDIX D:

Table D-1. Distribution, Means and Standard Deviations of Respondent's Demographics

	f	%	Mean	sd
Gender				
Male	76	76.0	N/A	N/A
Female	24	24.0		
Total	103†	100.0		
† 3 cases were missing; all skipped the question.				
Race/Ethnicity				
White	8	86	N/A	N/A
Black or African-American	6	14		
Total	14 103†	100.0		
† 3 cases were missing; all skipped the question.				
Household Income				
$12,500-$14,999	1	1.1	$64,903	35,490
$15,000-$19,999	3	3.3		
$20,000-$24,999	1	1.1		
$25,000-$29,999	5	5.5		
$30,000-$34,999	8	8.8		
$35,000-$39,999	9	9.9		
$40,000-$44,999	8	8.8		
$45,000-$49,999	6	6.6		
$50,000-$59,999	9	9.9		
$60,000-$69,999	11	12.1		
$70,000-$79,999	4	4.4		
$80,000-$89,999	4	4.4		
$90,000-$99,999	6	6.6		
$100,000-$124,999	9	9.9		
$125,000- $149,999	2	2.2		
$150,000 or more	5	5.5		
Total	103†	100.0		
† 12 cases were missing; all skipped the question.				
Age				
18-20	1	1.0	49	11
21-29	6	6.1		
30-39	10	10.1		
40-49	27	27.3		
50-59	37	37.4		
60-65	17	17.2		
66 or older	1	1.0		
Total	103†	100.0		
† 4 cases were missing; all skipped the question.				
Highest Level of School or Degree				
Less than high school	5	5.0	N/A	N/A
High school degree or equivalent (e.g.,	31	31.0		

GED)	22	22.0		
Some college but no degree	19	19.0		
Associate degree (including technical college degree)	20	20.0		
Bachelor degree	3	3.0		
Graduate degree	103†	100.0		
Total				
† 3 cases were missing; all skipped the question.				
Marital Status				
Married	73	73.0	N/A	N/A
Widowed	3	3.0		
Divorced	14	14.0		
Separated	0	0.0		
Never married	10	10.0		
Total	103†	100.0		
† 3 cases were missing; all skipped the question.				
Political Ideology				
Liberal	3	3.5	N/A	N/A
Moderate	22	25.9		
Conservative	60	70.6		
Total	103†	100.0		
† 18 cases were missing; four of these skipped the question, 14 of these answered "Don't know."				
Job Category				
Executive	1	1.0	N/A	N/A
Senior Management	4	4.2		
Management or Supervisor	33	34.4		
Non-Management Technical/Professional (includes Sales)	12	12.5		
Clerical or Administration	10	10.4		
Hourly Employee	36	37.5		
Total	103†	100.0		
† 7 cases were missing; six of these skipped the question, one of these answered "Don't know."				

Notes:

a. The other Race/Ethnicity categories had no responses (Spanish, Hispanic or Latino; American Indian or Alaskan Native; Asian; Native Hawaiian or other Pacific Islander, or some other race).

b. Percentages may not add up to 100 due to rounding.

APPENDIX E:

Table E-1. Distribution of Dependent Variables

Table E-2. Distribution of Selected Independent Variables

Table E-1. Distribution of Dependent Variables

	f	%	*Cum %*
Satisfaction with the Plan (2012)			
Very satisfied	28	27.7	27.7
Satisfied	39	38.6	66.3
Somewhat satisfied	23	22.8	89.1
Neither satisfied nor dissatisfied	3	3.0	92.1
Somewhat dissatisfied	5	5.0	97.0
Dissatisfied	3	3.0	100.0
Total	103[†]	100.0	
[†] Two cases were missing; one skipped the question, one answered "Don't know."			
Satisfaction with the Plan (2011)			
Very satisfied	23	21.9	21.9
Satisfied	35	33.3	55.2
Somewhat satisfied	31	29.5	84.8
Neither satisfied nor dissatisfied	6	5.7	90.5
Somewhat dissatisfied	5	4.8	95.2
Dissatisfied	4	3.8	99.0
Very dissatisfied	1	1.0	100.0
Total	110[†]	100.0	
[†] 5 cases were missing; three skipped the question, 2 answered "Don't know."			
Willingness to Maintain ESI			
Very likely	67	77.0	77.0
Likely	17	19.5	96.6
Somewhat likely	1	1.2	97.7
Not at all likely (I will drop my health benefits effective 1/1/2014	2	2.3	100.0
Total	103[†]	100.0	
[†] 16 cases were missing; two skipped the question, 14 answered "Don't know."			

Note: Percentages may not add up to 100 due to rounding.

Table E-2. Distribution of Selected Independent Variables

	f	%	*Cum %*
Approval of the ACA(2012)			
Strongly approve	4	4.4	4.4
Approve	15	16.5	20.9
Neither approve nor	12	13.2	34.1
disapprove	32	35.2	69.2
Disapprove	28	30.8	100.0
Strongly disapprove			
Total	103[†]	100.0	
[†]Six cases were missing; all answered "Don't know."			
Approval of the ACA(2011)			
Strongly approve	9	8.9	8.9
Approve	29	28.7	37.6
Neither approve nor	6	5.9	43.6
disapprove	24	23.8	67.3
Disapprove	33	32.7	100.0
Strongly disapprove			
Total	110[†]	100.0	
[†]Nine cases were missing; one skipped the question; eight answered "Don't know."			
2012 Health Care Expenses			
$0	0	0.0	0.0
$1-$499	6	6.5	6.5
$500-$999	4	4.4	10.8
$1,000-$1,499	11	12.0	22.8
$1,500-$1,999	11	12.0	34.8
$2,000-$2,999	11	12.0	46.7
$3,000-$3,999	14	15.2	62.0
$4,000-$4,999	10	10.9	72.8
$5,000-$7,499	14	15.2	88.0
$7,500-$9,999	5	5.4	93.5
$10,000-$12,499	5	5.4	98.9
$12,500-$14,999	1	1.1	100.0
$15,000 or more	0	0.0	
Total	103[†]	100.0	
[†]11 cases were missing; all answered "Don't know." Mean = $3,915, sd = 3,017			

	f	%	*Cum %*
2011 Health Care Expenses			
$0	1	1.1	1.1
$1-$499	10	11.1	12.2
$500-$999	9	10.0	22.2
$1,000-$1,499	6	6.7	28.9
$1,500-$1,999	12	13.3	42.2
$2,000-$2,999	14	15.6	57.8
$3,000-$3,999	14	15.6	73.3
$4,000-$4,999	8	8.9	82.2
$5,000-$7,499	9	10.0	92.2
$7,500-$9,999	4	4.4	96.7
$12,500-$14,999	1	1.1	97.8
$15,000-$17,499	1	1.1	98.9
$25,000-$29,999	1	1.1	100.0
Total	103†	100.0	
†13 cases were missing; eight of these answered "Don't know." Mean = $3,405, sd = 3,795 *Source: Sparks, Ewelina. 2011. "Employee Satisfaction with the Langdale Company Health Benefit Plan After 2010 Health Care Reform." PADM 9050 project paper. Valdosta State University.*			
2012 Health Care Cost Change			
Increased a lot	13	13.7	13.7
Increased some	55	57.9	71.6
Stayed the same	23	24.2	95.8
Decreased some	3	3.2	99.0
Decreased a lot	1	1.1	100.0
Total	103†	100.0	
†Eight cases were missing; seven of these answered "Don't know."			
2011 Health Care Cost Change			
Increased a lot	17	18.3	18.3
Increased some	58	62.4	80.7
Stayed the same	15	16.1	96.8
Decreased some	2	2.2	98.9
Decreased a lot	1	1.1	100.0
Total	103†	100.0	
†Ten cases were missing; seven of these answered "Don't know. *Source: Sparks, Ewelina. 2011. "Employee Satisfaction with the Langdale Company Health Benefit Plan After 2010 Health Care Reform." PADM 9050 project paper. Valdosta State University.*			

Note: Percentages may not add up to 100 due to rounding.

APPENDIX F:

Employer Questionnaire

The Langdale Company: Barbara Barrett, Director of Benefits & VP of HR

February 7, 2013

1. How would you describe the Company's employee benefit philosophy, overall?

   The Company philosophy has always been that if the Company takes care of the employees then the employees will take care of the Company. The Langdale Company's benefit philosophy is to encourage employees to stay well by providing wellness benefits, lower copays for medication to treat chronic disease, and health risk assessments and flu shots free to employees. We also engage centers of excellence with which to refer employees.

2. How important is it for the Company to continue providing health benefits to employees, and why?

   Very important.

a. Does the Company plan to continue providing these benefits now that the major health care overhaul law was passed?

   Yes, at this point in time. We are having an actuarial study performed to determine ACA's impact to the Plan.

3. Has the ACA changed how the Company views/approaches health benefits?

   Yes, ACA requirements will greatly increase cost to the Plan.

a. Has health benefits become a strategic tool? (Recruitment, retention, effect on employee morale and productivity, etc.)

   Yes, the Company's benefit package provides a well rounded variety of benefits available to employees.

4. What changes will the Company make to its health benefits due to the ACA?

   Of course, we will comply with all requirements of the Act by 1-2014. Once we receive the actuarial study we will be in a better position to answer this question.

a. Are specific cost-containment measures being considered? (i.e. switching to High Deductible Health Plan, increasing employee out-of-pocket costs).

   We are in the process of evaluating whether a High Deductible Health Plan is a viable option in our benefit packet. We are basically open to looking at all available options.

5. What do you think your competitors are doing/planning to do with their health benefits due to the ACA? Will they drop health coverage and increase pay/keep offering coverage/switch to defined contribution plan/buy health coverage through the Exchanges, etc.?

   In discussing this issue with other employers, their current plan is to continue to offer health coverage to their employees