University of St. Thomas, Minnesota
UST Research Online

Education Doctoral Dissertations in Organization Development

School of Education

Summer 7-9-2019

Organizational Implications and Reaction to the Affordable Care Act (ACA) from Firms With Less Than 50 Employees

Paul R. Kuhrmeyer
University of St. Thomas, kuhr0432@stthomas.edu

Follow this and additional works at: https://ir.stthomas.edu/caps_ed_orgdev_docdiss

Part of the Education Commons, and the Organization Development Commons

Recommended Citation
Kuhrmeyer, Paul R., "Organizational Implications and Reaction to the Affordable Care Act (ACA) from Firms With Less Than 50 Employees" (2019). *Education Doctoral Dissertations in Organization Development*. 69.
https://ir.stthomas.edu/caps_ed_orgdev_docdiss/69

This Dissertation is brought to you for free and open access by the School of Education at UST Research Online. It has been accepted for inclusion in Education Doctoral Dissertations in Organization Development by an authorized administrator of UST Research Online. For more information, please contact libroadmin@stthomas.edu.

Organizational Implications and Reaction to the Affordable Care Act (ACA) from Firms With Less Than 50 Employees

A DISSERTATION

SUBMITTED TO THE FACULTY OF THE OPUS COLLEGE OF BUSINESS

OF THE UNIVERSITY OF ST. THOMAS

By

Paul R. Kuhrmeyer

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

DOCTOR OF EDUCATION

May 2019

UNIVERSITY OF ST. THOMAS

We certify that we have read this dissertation and approved it as adequate in scope and quality. We have found that it is complete and satisfactory in all respects, and that any and all revisions required by the final examining committee have been made.

Dissertation Committee

David W. Jamieson, Ph.D., Committee Chair Date

Robert C. Barnett, Ph.D., Committee Member Date

Mark Salisbury, Ph.D., Committee Member Date

ACKNOWLEDGEMENTS

When considering a doctorate, an individual carefully weighs his overall intentions in what it could mean to accomplish such a noble and commendable journey. He reviews the curriculum, checks with his family, and looks introspectively into the possibilities. Finally, if he receives the necessary approvals and accepts the challenge, he knows in advance that a dissertation will ultimately become a capstone to several years of study, classroom participation, and collaborative dialog with cohorts and instructors. In my case, I was seeking, and ultimately attained, the necessary confidence required to lead appropriate and/or essential changes in the businesses I represent. As I reflect on six years of focus and hard work through the OD program at St. Thomas, there are many people to thank. It begins with our original sponsors of Cohort #7, John Conbere, Ed.D. and Alla Heorhiandi, Ph.D., Ed.D. These two individuals led us more than three years, facilitated a great deal of our coursework and directed our activities. Solid dedication to us and their role in preparing us for ever-increasing levels of organizational proficiency have been reserved with gratitude in my DNA. Next I thank my twelve cohorts who inspired my thoughts, offered stimulating dialog, encouraged new ideas, and propped me up me in times of frustration or confusion. We were together on and off for nearly six years and shared a great deal about each other in our collaborative quest to enable organizational/developmental skillsets that fulfill individual aspirations of OD practices or implementations. After John and Alla, Dave Jamieson, Ph.D. and Bob Barnett, Ph.D. guided our work (mostly Dave as Chair) and did an outstanding job. I personally appreciate their encouragement throughout this journey, and their ability to quickly dissect

where I meant to go with a wayward thought or idea. Dave and Bob met with me countless times (with and without notice) and always offered appropriate perspectives and inspirational dialog on where we are, what we need to do, how to do it, and when. They are both beyond talented, and I especially thank Dave for his dedication to the program and its many, many cohorts through uncertain and evolving times at the University of St. Thomas.

Secondly, I thank my wife, Ursula. She introduced me to the idea of pursuing my doctorate beginning in 2010. She had reviewed the OD and Leadership programs at St. Thomas and strongly began suggesting that I look into one or the other. I was working at 3M at the time and she always recognized the opportunity to differentiate/elevate myself professionally through a program like this, versus becoming stagnant or complacent in a large, impersonal arena. For approximately two years I argued with her on the idea, stating that I already have my MBA and MIM, and am doing quite well at 3M without introducing more “stress and unnecessary anxiety” into my life! But she persisted to the point where I agreed to meet with John Conbere and discuss the entire subject of me as an OD student and possibly a Doctor of Education (Ed.D.). Needless to say, we had a good conversation and I successfully completed the curriculum to get me to this point. I thank my wife for her encouragement, patience, and stubbornness. She knew that this would be good for me and that I could accomplish the requirements for the good of ourselves and others.

Most importantly, I thank God. As a 2013 convert to Catholicism, my senses for personal introspection and how things happen have been expanded immensely. My bond to my faith has grown exponentially, which has enhanced my overall awareness in most

everything I do. It helps that the University of St. Thomas is founded in Catholic tradition, however I have witnessed a dilution of our strong faith values on campus over the past several years, which does concern me. I trust we will never lose what helped to build this well-respected, tradition of faith-based education. We must always remember that is through His grace and guidance that our collective examples of gratitude should reside. Clearly, He provided the people who sustained me through this passage, and it is He that supplied the wisdom to complete the curriculum, and it is He who gave me the inner strength to dispel distractions and focus on completing this important life journey.

> *You did not choose me, but I chose you and appointed you that you should go and bear fruit and that your fruit should abide, so that whatever you ask the Father in my name, he may give it to you. (John 15:6)*

Abstract

The Affordable Care Act (ACA) was the signature accomplishment of President Barack Obama in 2010. The ACA was officially launched as active in 2014. The primary objectives of this law is threefold: (1) to reform the private insurance market—especially for individuals and small-group purchasers, (2) to expand Medicaid to the working poor with income up to 133% of the federal poverty level, and (3) to change the way that medical decisions are made. Embedded in the 1296-page ACA are mandates, tax credits, provisions, exemptions, and requirements. Small businesses under 50 employees are affected by the ACA if they approach and eventually breach 50 employees, but there are many more aspects involved when discussing the ACA and small businesses. Specifically, the decision for organizations under 50 employees to offer or not offer health care benefits to its employees is complicated and dependent upon various factors such as cost, regulations, benefits (ROI), and acting upon what is expected as employers. The ACA has challenged employers and employees to examine their respective roles and positions related to providing and receiving health care benefits. Assisting with these discussions is the federal government and the free market. Adding to the decision-making process is the 111th through the 116th United States Congress which is designed to be focused on the best interests of the employee and employer in a free market society. The reactions, organizational implications and responses to the new health care law (ACA) on companies with fewer than 50 employees is interesting and worth learning more about through reading this study.

TABLE OF CONTENTS

CHAPTER 1 - INTRODUCTION

Background 2

Problem Statement 6

Purpose of the Study 7

Research Question 8

Methodology 8

Rationale and Significance 9

Definition of Key Terms 9

CHAPTER 2 - LITERATURE REVIEW

Overview 10

Explanations, Provisions, and Timelines 11

Implementation, Perspectives, and Execution 14

Cost, Impact, and Incentives 18

Early Analysis After the ACA Roll-out 21

Legal Implications, Proceedings, and Challenges 25

Intrinsic versus Extrinsic Motivator Considerations 28

CHAPTER 3 - RESEARCH METHODOLOGY

Research Design 32

Participant Selection 33

Data Collection 34

Data Analysis 35

Researcher Bias 36

CHAPTER 4 - RESEARCH FINDINGS

Interview Process 39

Part I: Organizations >50 Employees That Offer Insurance 40

Interview 1: Twin Cities Golf and Dine (TCGD) 40

Interview 2: Trol-Tek Machine (TTM) 45

Part II: Organizations <50 Employees That Offer Insurance 48

Interview 3: KP Group, LLC 48

Interview 4: Reynolds Marketing Group (RMG) 53

Interview 5: Rysoa 56

Part III: Organizations <50 Employees That Do Not Offer Insurance 59

Interview 6: Eby's Pizzeria 59

Interview 7: Sally's Salon 61

Part IV: Surveys of Seven Participating Organizations 63

Data Analysis 64

CHAPTER 5 - DISCUSSION

Outline of Themes 70

Theme I: Cost Stabilization 71

Theme II: Employer's Reactions 74

Theme III: "Right thing to do" 77

Theme IV: Health Care Coverage Reduces Stress 79

Limitations 81

Implications 81

Future Research 83

Conclusion 84

Personal Reflection 90

REFERENCES 92

APPENDICES

A - Consent form 98

B - Consent for survey 103

C - Letter of permission 105

D - Interview questions-offering insurance 107

E - Interview questions-not offering insurance 112

F - Employee attitude survey 117

TABLES

1 - Domains of legal regulation; comparison of US & OUS 3

2 - Definition of "small" firm in the ACA 16

3 - Interview participants by organization and size 40

4 - KP Group, LLC Traction Organizer 49

5 - Parts I and II: Summary of interviews-insurance provided 58

6 - Part III: Summary of interviews-insurance not provided 63

7 - Summary of interview and survey inputs among companies studied 64

8 - Results-summary of employee surveys among all companies studied 67

FIGURES

1 - Number of articles reviewed 7

2 - KP Group, LLC Star Model 51

Organizational Implications and Reaction to the Affordable Care Act (ACA) from Firms With Less Than 50 Employees: A Multi-Case Study

Chapter 1

Background

In representing its constituents, the United States Congress has debated for decades over the concept of a national health care program that effectively moves an individual's access to affordable, quality health care from a privilege to a basic right. Conservatives traditionally lean towards the premise that it is an individual's responsibility to pay, or at least subsidize, their own health care needs as long as there is a free market approach to competitive options, much like car insurance. On the other hand, liberals will tend to position to society that health care is a shared, basic right and should be controlled and managed through governmental authority. Much like the Social Security Act (1935) dating back to President Franklin Roosevelt, the Affordable Care Act (ACA) was a controversial piece of legislature, but eventually signed into law on March 23, 2010. It is considered the signature accomplishment of President Barack Obama (Glastris & LeTourneau, 2017). This legislative action, often times referred to as "Obamacare," has introduced a broad portfolio of new encounters related to organizational structure and strategic direction of smaller U.S. businesses as it was formally launched on January 1, 2014. Specifically, there are no fewer than eight major modifications to health care as we knew it. A couple of more notable examples include a "no discrimination for pre-existing conditions" clause and the "individual mandate" which requires people to buy insurance or a penalty will be levied against their federal tax statement. As highlighted in Table 1, this legislation as a mandate

on the part of the U.S. Government is embryonic and emulates traditional (non-U.S.) industrialized countries. These are countries whereby health benefits have been provided through interventional means by the government versus voluntary employer participation in the U.S. at the sole discretion of the organization (Pfeffer, 1994).

Table 1

Domains of Legal Regulation of the Employment Relation in the US and OUS Countries

Issue	US Policy	Dominent OUS Policy
At-will employment	Accepted and fought for vigorously	Prescribed by law and limited by regulation
Training expenditures	At the discretion of in-dividual firms	Encouraged by tax incen-tives
Training standards and Practices	At the discretion of in-dividual firms	Frequently established and enforced by government-santioned industry or occupation councils
Co-determination and Employee participation	Not encouraged	Frequently mandated
Employee representation by an organization	Neutral to not encouraged	Encouraged by law and social policy
Use of contract and Temporary workers	Not regulated	Limited in amount and duration of employment
Benefits (e.g., health, retirement)	Provided by employers at their discretion	Provided in many cases by government or by employers under mandate

Adapted from “Competitive Advantage Through People,” by J. Pfeffer, 1994, *California Management Review*, 36(2), p. 9. Copyright 1994.

In addition, a health care exchange has been established to offer choices and facilitate the registration of uninsured or underinsured individuals, which has been estimated as high as 40 million in the U.S. As of March, 2016 the law covered 11.1 people, but that number could actually decrease in 2017 (Bloomberg, 2016) due to more recent departures to support the ACA such as Aetna and United Health Group. In order to remain profitable, insurers like these require healthy members within the plans they offer to offset those in need of health care. In 2010, employee sponsored health care programs covered 55%, or 169 million Americans (Jost, 2012). The availability of health care benefits has always been more efficient and cost effective for large employers versus small due to economies of scale; however, the number of covered employees has been declining for years in direct response to rising premiums. Between 1999 and 2009, employer health care premiums rose 123% (Miller, 2011). In an effort to address this trend through the ACA, federal tax credit provisions were established to incentivize small businesses to participate in offering plans to their employees. This incentive, however, will only be available for up to six years (ending 2020). In the end, small companies who employ fewer than 50 full-time workers are not required or mandated to provide health care to their employees, but in many cases individuals will not carry insurance unless their employer offers it. The ACA offers these federal tax credits to help facilitate the gap in health care coverage for individuals working at small companies. More recent studies show that even with tax credits highlighted above, some states with organizations under 50 employees continue to decline in enrollment an average of 5% per year over the period of 2011-2014 (Lucia, Corlette, Ahn, & Clemans-Cope, 2015). Finally, in addition to all of the variables mentioned above, the most important consideration for small businesses is cost. Choice

and the availability of ancillary health care options, much like large companies can offer to their employees, has always been a challenge for small organizations, but the element of cost explains best why company sponsored plans are declining.

When a company exceeds 50 employees, ACA regulations and requirements open up a whole new set of considerations, one of which would include financial penalties for not offering adequate, affordable coverage. How will organizations formally react to these changes? The 1296-page health care law will influence large and small organizations in their approaches to providing or addressing employee health coverage options.

Small companies, employing less than 50 individuals, will be faced with new questions such as;

1. Can we afford to absorb employee health care costs?
2. If so, what will we, as an organization, need to give up or offset?
3. How will these changes affect our ability to compete in our industry?
4. Can our employees help to offset added costs in exchange for "business as usual"?
5. Are we ready as an organization to accept the health care mandate?
6. In a competitive environment, can we afford not to offer health care benefits?

Since its inception in 2010, several events have altered the implementation of the ACA including delays on the employer penalty for non-compliance and addressing nationwide issues related to setting up state exchanges that function as anticipated. As of 2016, six years after signing the ACA into law, the struggle to implement fundamental components continued. Attempts to explain and clarify the law to millions of people that it affects have

been bewildered by the many changes, delays, and conflicting statements accompanying the ACA (Mullin, 2014). Aside from the more structural and financial modifications related to implementation, organizations will likely question if, and/or how, this new law will be adopted into their current operations without disruption to their productivity and flow.

Finally, and perhaps most importantly, employees and employers are exposed to psychological aspects to receiving, not receiving and/or providing, not providing health care coverage. As indicated, organizations with less than 50 employees are not obligated to offer health care plans to their employees. However, many organizations under 50 employees do offer plans along with larger companies. In these cases employees have a more robust “pay package” than those employees that do not have insurance. There are numerous studies suggesting that there is at least a minor correlation between intrinsic and extrinsic motivators, as well as job satisfaction and job performance. The attributes of job satisfaction include multiple independent variables measures (Harter, Schmidt, & Hayes, 2002) such as job security, clear expectations, benefits/compensation, autonomy, recognition, development opportunities, and growth potential.

Problem Statement

It is unclear how small organizations will react to this new law and the dynamic variables involved. Organizations will need to annually assess their options to provide insurance, abstain from offering anything, or share in partial costs through salary enhancements or other employee benefit options, such as health care. All of these options have both positive and negative effects that an organization will need to consider. The literature that is available on the ACA is broad. Much of what has been studied and written

recognizes the complexity and magnitude of implementing the ACA. In many instances the literature is slanted toward questioning the long-term viability of the ACA and its many moving parts. Of 41 articles gathered thus far as outlined in Table 2, six represent overviews, four discuss specific pitfalls and potentials, eight lean toward explaining the ACA through the lens of companies affected, five are testimonial, six are legal, five are psychological, and the balance are analytical in nature with specific focus on various components of the ACA when considering small organizations and resulting impacts.

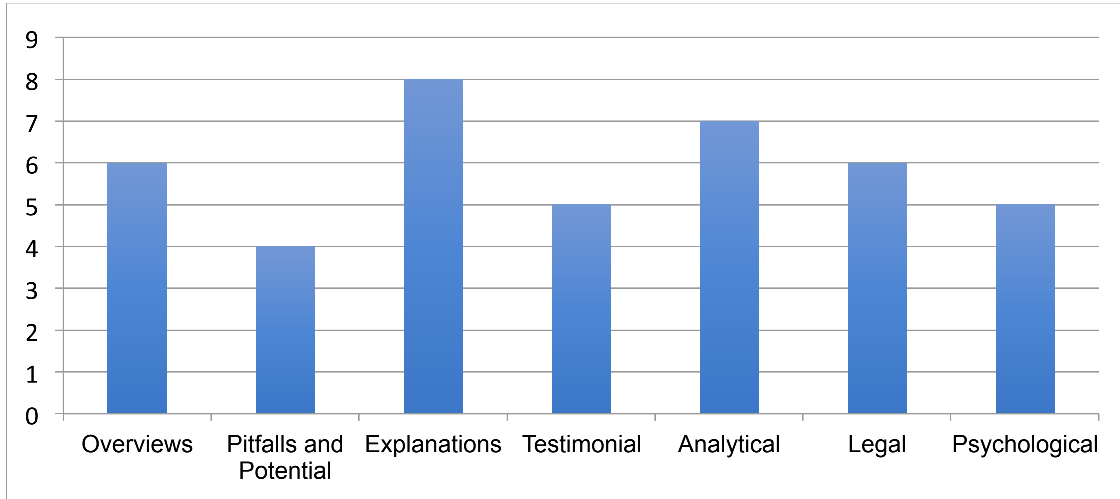

Figure 1. Number of Articles Reviewed

Purpose

The purpose of this study is to report on the real-life impact of this legislation on small company organizational behavior, and gather reactions related to the implementation of the ACA.

Research Question

What are the organizational implications and responses to the new health care law (ACA) on companies with fewer than 50 employees? How does this compare to those with over 50 employees? What values and cultural dynamics are affected and how will the organization react to mandated obligations? Will organizations remain incentivized to grow, will they continue to hire, and are there creative options to universally address perceived concerns with new cost structures? In the end, what can be done to most effectively embrace mandated health care plans for growing organizations?

Methodology

This study is qualitative in nature and conducted through interpretive methodology. Because of the survey included, there will be a quantitative component as well. It focuses on small (<50 full-time equivalent employees [FTEs]), Minnesota-based companies only, who are growing and facing decisions related to government sponsored health care options for their employees. This focus is compared to those companies, both small and large, that do offer insurance. Methodology includes comprehensive interviews with small business owners/influencers responsible for their organization's health care coverage considerations. These targeted small businesses represent perspectives on obtaining and/or providing insurance coverage versus those who do not and/or have already offered health care coverage. Valuable information emerged from these interviews and surveys with respect to organizational choices when mandated health care coverage is introduced into operational equations.

Rationale and Significance

There is a need for more understanding around organizational impact of ACA forces or cause and effect analysis on organizations, both large and small. This study focuses on material that compares and contrasts small company (<50 employees) organizational choices and dynamics versus large company (>50 employees) requirements.

Definition of Key Terminology

Often referred to as **"Obamacare,"** the **Affordable Care Act (ACA)** was signed into law by President Barack Obama on March 23, 2010, and formally launched nationwide on January 1, 2014.

FTE is the acronym for a "**Full-time equivalent**" employee typically defined as working a minimum of thirty hours per week.

LLC is the acronym for a "**Limited Liability Company**" which is defined as a U.S.-specific company with a business structure that can combine the pass-through taxation of a partnership or sole proprietorship with the limited liability of a corporation.

CBO is the acronym for the **Congressional Budget Office** which is the federal agency within the legislative branch of the United States government that provides budget and economic information to Congress.

For the purpose of this study, **Pay Package** is defined as an employee's base pay plus benefits received such as health care coverage, bonus, employer 401K contributions, etc.

Chapter 2: Literature Review

Overview

The availability of literature on the ACA is extensive, evolving, and diverse. There is a psychological and emotional undertone to much of what was written because of the effects on employer/employee relations coupled with an ideological chasm between the degree of a government's role in providing health care. The political arena has stimulated the public and created a springboard for debate from every aspect of the ACA. From 2010-2014, President Obama and a Democratic-led congress positioned this historical initiative as a positive step forward for all citizens whether you are currently insured or not. Those who were already insured could "keep your plan if you like your plan," families on average would "save and average of $2,500/year," and those who were not insured "would finally have access to affordable, comprehensive health care" (Obama, 2009). Republicans on the right and in the minority were skeptical of the ACA as written and voted unanimously to defeat the bill. Republicans posited that any fulfillment of Democratic claims would cost more money and disrupt a system that from their perspective was not perfect, but effective in maintaining the United States as proficient in offering a practical health care system. There are five common themes when reviewing the literature available on the ACA. They are:

1. Explanations/provisions/timelines.
2. Implementation/perspectives/execution.
3. Cost/tax credits/incentives.
4. Legal implications/proceedings/challenges.
5. Psychological considerations.

Explanations, Provisions, and Timelines

As indicated earlier, the ACA was a complicated piece of legislation that has now become a complex law. If people do not understand the basic components or its intricate characteristics, this signature effort of the Obama legacy may forever be cast aside as another failed (and expensive) government program. There has been a great deal written about how the ACA is intended to work, its benefits, and objectives. Many articles reference historical similarities to social security and/or average Americans struggling to manage rising costs associated with basic health care coverage over the past several decades. The overarching purpose of these articles has been to explain the law to those who will need to implement its many new and unfamiliar moving parts. For example, (Miller, 2011) described how pre-existing conditions have been excluded for individual access to insurance, and federal tax credits for small businesses have now become available. This provision applies to companies that employ 10 or fewer full-time employees who individually make $25,000 per year or less. The credit covers up to 35% of the employer's contribution and increases to 50% in the second year. If an employer has 25 employees, the federal tax credit is also available for salaried employees making up to $50,000 per year. Congress has been expected to devote $40 billion per year to small business federal tax credits over the10 year timespan of 2010-2010 (Congressional Budget Office, 2009). For firms with between 25 and 50 employees, there is no credit. It is interesting to note that the total number of firms with 50 employees and less represented over 96% of the cumulative share of all firms in the U.S. or nearly 30 million workers which comprised 26% of total workforce in 2010 (U.S. Census Bureau, 2011). The ACA also included new provisions for Medicare and Medicaid, American Indians, unions,

mental health parity, and noncitizens. Under the law (42 U. S. C., § 300gg-2), insurers must now accept every small employer that applies for coverage, and all of its employees. Ironically, there is no guarantee that the coverage will be "affordable." In many cases, individual small companies when examined on their own for coverage have experienced "sticker shock" due to a lack of bargaining power accompanied with risk factors that have been applied to a limited pool of participants to accommodate fixed costs. In the early stages of the law, no relief was outlined for these instances other than the availability of tax credits (which will be examined later). In an attempt to address small business insurance needs, the ACA initiated health insurance exchanges or SHOP (Small Business Health Options Program). In 16 cases, individual states initiated their own exchanges (like Minnesota), while the other 34 states chose to rely upon the federal government to lead the exchange ownership. For these SHOP exchanges to be successful, they needed to represent something better than what was currently offered, if anything, and be lower in cost if they were offering health insurance. Kingsdale (2012, as cited in Jost, 2012) wrote that "unless exchanges can make a business case for their ability to bring down the cost of insurance, they will not succeed" (p. 271). To offset this concern, the ACA has offered tax subsidies but they are short term and narrow in scope according to Jost (2015).

In addition to the provisions described to date, one of the most formidable or intrusive has been the Employer Penalty from an employer's perspective. As mentioned earlier, if an employer has less than 50 FTEs, they are not obligated to offer insurance and hence not subject to a penalty. Those employers with over 50 FTEs that do not provide adequate or affordable coverage and an employee receives a premium credit through the new exchange are subject to an employer's penalty (Mulvey, 2012). The distinction

between full-time and part-time employees is combined in a standardized calculation to determine FTEs. For example, if an employer has 45 employees working more than 30 hours per week, the casual observer would categorize this organization as not mandated to offer health insurance since they appear to employ fewer than 50 people. However, if that same firm also employees 16 part-time employees working an average of 20 hours per week, their cumulative hours (combined with the 45 above) through formulation would easily place the firm over 50 FTEs and subject this organization to an employer penalty. Further research (Lowry & Gravelle, 2015) on this subject exposed how employers would "do the math" on maintaining their organization's structure at fewer than 50 FTEs to avoid the mandate to provide health insurance. This may include splitting a company approaching 50 employees into two or more smaller, more focused LLCs, choosing not to grow and maintaining operations at a level that will not require new hires, or selling the business altogether. In any case, it was clear that employers could examine options and weigh decisions based on the new 50 FTE threshold. In many of the articles positioned in this section there is a degree of emotion, or at a minimum a justification and promise associated with the ACA in that it would now address many of the issues related to rising health care costs, challenges for small businesses, and accountability to health care providers. As Torres (2013) wrote, "But because of the Affordable Care Act, New Jersey's small businesses and their employees are getting better choices, starting with new protections that limit the outrageous rate hikes many small-business owners faced in the past."

Implementation, Perspectives, and Execution

After its initial development, the 111th Congress provided explanations, timelines, and provisions of the ACA to the American people in March of 2010. As previously mentioned, the law is complex. Jeffrey Pressman of MIT wrote in his seminal book titled *Implementation-How Great Expectations in Washington are Dashed,* that "the great problem is to make the difficulties of implementation a part of the initial formulation of policy. Implementation must not be conceived as a process that takes place after, and independent of, the design of policy" (Pressman, 1973, p. 132). Complexities of the ACA were the responsibility of the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), the Department of the Treasury (IRS), and a (then) newly formed expansion of government to manage the insurance component, the Health Choices Administration. In addition to the federal branches of government, states had also been asked to handle local and unique responsibilities within their jurisdictions. The amount of money exchanged between hospitals, clinics, and patients coupled with the millions of unique situations within the health care arena was staggering. In the early stages of interpreting the law, there was surprisingly little written about how it would be implemented. In other words, there was excitement and focus on the components of the law and its emerging as reality, but how this complex series of reforms would be coordinated successfully was clearly not evident. These observations manifested themselves when the actual implementation of the ACA was formally rolled-out. For example, on October 1, 2013, the federal exchange serving thirty-six states at Healthcare.gov experiences technical difficulties and eventually went offline for just over two months.

Implementation as described above had assumed all qualified parties would be participating, but there was a sizable "sales" component connected to the ACA. Miller (2015) reminds us that despite the availability of subsidies and reduced premium rates, small employers may elect to not sign-on to these incentives due to the arguably small financial assistance, complexity, lack of large penalties, and various state's participation level or support of the ACA. All of these factors in one way or another contributed to the ultimate decision of an employer to offer coverage to their employees or forego the effort altogether. For example, the Congressional Budget Office had estimated back in 2010 that between eight to nine million people covered by predominantly small, low-income businesses would lose their employment-based coverage as a result of the ACA as it was designed.

One other important consideration of the ACA was the elimination of credits over time and the increase in penalties for non-compliance. For example, the Congressional Research Service (2015) outlined to us that beginning back in 2014, the maximum credit for-profit employers was 50% of the employer's contribution toward premiums, and 35% of employer contributions for non-profits. The credit would be entirely phased out as the number of FTEs increased from 10 to 25 and as average employee compensation increased from 42,500 to $50,000. Concurrently, Lewis (2014) described how all individuals in the U.S. would now be required to be covered by a qualified health care plan regardless of affiliation with an employer, otherwise they would face a financial penalty. If an individual was not covered, or paying their portion of coverage through an employer, he or she will face a 1% fee of annual income beginning as of 2014. This penalty was calculated against the average national monthly premium for the bronze plan (least costly of three).

The penalty increased each year thereafter and was managed and processed through an individual's annual tax return. The penalties up-front or in the first three years were minimal and designed to enable individuals to pay the penalty as a less expensive option to participating in a health care plan, but over time this approach will not be economically feasible. Table 2 below summarized important provisions of the ACA.

Table 2

Definition of "Small" Firm in the ACA

ACA Provision	Effective Date	Application to Small Business
Employer Responsibilities Regarding Health Care Coverage		
Employer Penalty	2014	Firms with under 50 full-time equivalent employees are excluded from this provision
Automatic Enrollment in group Health Plans	Awaiting Regulations	Firms with 200 or fewer full-time employees are excluded from this provision
Employer Reporting Requirements		
W-2 Reporting Requirements	2013	Firms with under 250 W-2 form employees (ie.wage earners) granted delayed implementation until further regulations are developed
Reporting Requirements Regarding Health Insurance Coverage	2014	Firms with under 50 full-time equivalent employees are excluded from this provision
Other Incentives to Provide Health Insurance Coverage		
Full Small Business Tax Credit	2010-2016	Firms with 10 or fewer full-time equivalent employees
Partial Small Business Tax Credit	2010-2016	Firms with between 1- and 25 full-time equivalent employees are eligible for a partial credit
Small Business Health Insurance Options Program (SHOP)	2014-2015	States have the option of determining small as either up to 50 or up to 100 full-time employees
	2016 and beyond	Firms with up to 100 full-time employees are eligible to participate

Source: CRS tabulation based on P.L. 111-148 as ammended

Articles to this point related to "implementation" have been more informational and interpretive based on the various authors featured. There were two Congressional hearings that took place in 2013 and 2014 respectively that exhibited emotional and confrontational

behavior between Democratic and Republican party ideologies. The first hearing titled "Affordable Care Act Implementation: Examining how to Achieve a Successful Rollout of the Small Business Exchanges" was heard before the Committee on Small Business and Entrepreneurship of the 113th Congress on November 20th, 2013. Chairwomen and Senator Mary Landrieu (D) from the State of Louisiana opened the hearing with a seven-page endorsement of the ACA to that date. She acknowledged that the roll-out of the individual insurance exchange websites had been disappointing, but beyond that statement, her interpretation of the implementation just needed more time and focused attention to detail. It was clearly Senator Landreau's objective in her opening remarks to put problems aside and identify where and how to initiate solutions. The next speaker at the hearing was Senator James Risch (R) from the State of Idaho. In three pages he essentially renounced everything Senator Landreau had just said and laid out facts and experiences from various states in their efforts to implement the law. At one point Senator Risch stated, "It is really unfortunate that it has come to this. Well, here we are again trying to apply lipstick to this pig; and no matter how many times it is said, the American people are not buying it." The balance of the hearing was dedicated to statements from various Senators, the Small Business Administration (SBA), Health Benefit Exchange Directors, business owners, and entrepreneurial support organizations from all over the country. Questions and answers from all involved in the hearing walked through the multitude of details related to the ACA, limited success stories, and a myriad of challenges. In fact, of the 13 statements and 241 pages of content from that day, seven were positively positioned by the speakers, and six were negative. Interestingly, however, the seven positive were either sponsors of the ACA or assigned to implement the bill, while those that spoke against the ACA that day

were small business owners who had experienced new or additional regulations and requirements, and/or higher costs.

Cost, Impact, and Incentives

Providing health care to employees represents a line item on an employer's profit and loss statement that translates into a percentage of cost. Like all expenses that an organization analyzes, reducing costs—not raising them—is a universal objective. The rising cost of health care forces small organizations to absorb additional costs, pass them on to their employees, or terminate coverage altogether. In a survey of 604 randomly selected small employers (between 3-50 employees), 92% indicated that if coverage was offered through their firm, the premiums would need to be equal to or less than what they are today (Gabel, Whitmore, Sartorius, Stromberg, & Pickreign, 2013). Inherently, and as indicated previously, small businesses are most always at a disadvantage when looking to offer health insurance due to their higher administrative costs and their statistically small base of low-risk participants versus high-risk catastrophic events. This has made cost a more volatile consideration for small employers. In 2012, the average monthly individual policy cost for small employers was approximately $502.00 or $6,029 per year (Gabel et al., 2013). When asked what a monthly reasonable cost would be for individual premiums, employers unanimously indicated less than $502. Fifty-six percent indicated that they could barely afford a $200 per month payment per employee. The question then leans toward the extent of assistance. In other words, would the ACA move towards offering relief of $302 per month ($502 - $200) to small employees, and who would be responsible for this gap?

Efforts to improve the small-group market of the ACA has changed the rules, including the establishment of SHOP exchanges and tax credits. The benefit to small employers of the SHOP exchanges lies in the sharing of administrative costs and providing customized reports related to employee health care activity tracking or claims assistance. The tax incentives to small employers were designed to help offset the relative actuarial disadvantages that large companies overcome though scale and scope. However, if a firm employed more than 24 employees and they made more than $50,000 per year, the small company would not qualify for a tax credit (Blum, 2013). Furthermore, this tax credit was available for only two years. With these stipulations, most companies had adopted a "wait and see" approach which in turn dilutes the impact of the ACA as designed. In New Jersey back in 2014, the cost of health care actually went up by 26-56%. The average cost per employee prior to these increases was $1,093 for an individual plan per month. Costs for 2014 were expected to top $1,500 per month—a 37% increase (Klimley, 2014). Health care expert Dr. Joel Cantor, director of the Center for State Health Policy at Rutgers University, praised the ACA for allowing the previously uninsured to obtain insurance, but also pointed out that small businesses still will have an "affordability issue" that cannot absorb health care increases of 10 or more percent per year, as historically experienced. This position should not be surprising. Boubacar and Foster (2014) found that "an overwhelming majority of Americans recognized the need for health care reform but also expressed their concern about whether the new legislation will properly address the fundamental issues of quality and affordability" (p. 39). They go on to note the dilution of individuals not covered over the past 10 years from 61 million in 2003 to 81 million in 2014. Tanner (2013) noted that the law as written will not achieve its goal of offering

universal health care due to the increases in cost to individuals, businesses, and the government. Hardin (2011) examined the tax effects of the ACA and determined that the new law would create greater tax burdens and greater reporting requirements on both individuals and small business. Furthermore, Collins, Davis, Nicholson, and Stremkis (2010) found that small firms with lower-wage workforces may remove coverage options for between eight million to nine million employees despite the formation of SHOP exchanges.

On the other side, proponents argued the ACA would promote better health care services, strengthen primary care, and deliver more innovative delivery methods. Stremkis, Schoen, & Fryer (2011) concluded that out-of-pocket expenses would be reduced for small employers through the availability of high-performance health systems coupled with lower long-term coverage costs. They also surmised that payment arrangements would improve patient experiences and outcomes.

Interestingly, many businesses had already begun restructuring their organizations in anticipation of breaching 50 employees. The options were eliminating coverage (and pay a penalty if you have over 50 employees), sharing increased costs, cutting hours to part time, reducing overall staff/headcount, and opting not to grow (Legal Monitor Worldwide, 2014). This meant freezing new hires as Muller, Isely, and Levin (2015) found in their article that tracked reactions to the new ACA law. Those employers who would like to continue on the growth curve would likely choose to re-arrange their mix of employee contributions for their premiums. In any case, all articles that referenced cost contained the same theme from an employer's perspective: cost is everything. If costs go up, something else will need to come down, or be eliminated. In other words, there is no room, nor is

there any tolerance to absorb additional expenses. In light of this fact, the authors also noted that government policies may have unintended consequences; at the time of this study, this was a premature prediction. Muller and her team concluded that when considering ACA costs of breaching 50 employees, those employers under 50 employees would most likely limit hiring first, followed by reducing hours, limit expansion, reduce their workforce, and finally, hire temporary workers.

Early Analysis after the ACA Roll-out

Nearly one year after the Senate hearing discussed earlier led by Senators Landreau (D) and Price (R), a House of Representatives sub-committee hearing was conducted on September 18, 2014 to track the progress of ACA. It was titled "An update on the small business health options program: Is it working for small businesses?" Representatives Chris Collins (NY) and Janice Hahn (CA) led this hearing. Not unlike the Senate hearing, the dialog and debate aligned closely with political affiliations. Representative Collins, a Republican from New York, opened the hearing by explaining what the SHOP exchanges are intended to do on behalf of small businesses. This included simplifying the process for obtaining insurance, expanding health coverage options, and lowering costs. Mr. Collins said,

> Unfortunately, the reality of the program is far less than promised. Despite spending vast amounts of time and taxpayer dollars regarding the SHOPs, the program continues to be beset by operational delays and other problems that have undermined their utility as a tool for small businesses. These problems include the inability to utilize web-based portals, limited choice of plans, and a lack of insurance carrier participation in the SHOPs.

Representative Collins went on to cite examples of information that had been requested without answers, higher premiums/deductibles, canceled policies, smaller networks, more paperwork, and onerous reporting requirements. Representative Janice Hahn, a Democrat from California, essentially refuted everything Representative Collins had just stated by citing that families no longer stood at the mercy of the insurance companies, pre-existing conditions would be covered, more Americans than ever would be insured, and that small businesses would take advantage of more options and lower costs. She went on to state that because of the ACA, employer premiums would be rising slower now compared to the past 50 years. Furthermore, the SHOP Exchanges would leverage small businesses as a group to offer high quality, affordable plans with tax credits designed to cut premiums by up to 50%.

The committee then accepted testimony from four panelists who represent both public and private sector observations since the ACA has been enacted. Two panelists described the ACA as largely positive to date (public sector), while two spoke on how the ACA and in particular the SHOP Exchanges were failing (private sector). In reviewing the twenty-five pages of statements, testimonies, and questions, it became clear that there were two very divided sets of perspectives. One side admits there were issues with the ACA to date, but defended its premise and need for America (universal coverage), while the other claimed that what was promised was not working (cost/economics) or sustainable for a multitude of reasons. In September of 2014, there was a great deal of excitement and support of the SHOP programs from the Democratic Party. At the same time these proponents acknowledged the many struggles with early implementation, on-going challenges, and questions that would need answers in the future if the ACA is to be a

success. Dr. Roger Stark, a retired physician and health care analyst, summarized his time in front of the committee by making the following observations:

1. A health-care program that will work and is sustainable would be offered by the individual states (not the federal government) and is patient-oriented, and consumer-driven.
2. A health-care exchange needs to be transparent and simple enough for small businesses to effectively choose a plan that fits their individual needs.
3. Exchanges should not replace existing programs that work, such as association health plans.
4. The insurance providers set the rates and benefits that are market-based outside of government regulations.
5. Each state should function as a laboratory to design the most effective, efficient programs that offer real choices and competitive options.

U.S. House, 113th Congress, 2014, p.7.

Mayra Alvarez, Director of the State Exchange Group for the Centers for Medicare and Medicaid Services, emphasized the many benefits of the ACA as designed and further highlighted new features such as small business administrative efficiencies such as additional plans, premium aggregation, and a dedicated online system for agents and brokers to assist their SHOP small business clients. Additional online system improvements were in the works for individuals and administrative support. The Congressional Hearing went on to both disparage and defend the rollout and status of the ACA.

Just over one year later from this hearing (November of 2015), the ACA was struggling to catch on with small businesses. According to the Congressional Budget Office (CBO), it was expected that one million people would enroll for coverage through SHOP in 2015. Less than 10% of this estimate actually signed up. Some of the reasons aside from everything discussed to this point included:

1. Sixteen state exchanges run their own small business exchanges and most candidates looking for coverage found these exchanges superior to the government SHOP programs.
2. Brokers claimed that SHOP has fewer health plan options and more expensive coverage costs.
3. Several SHOP states had only one choice to choose from for coverage.
4. Many small employers stuck with the plans they had outside of SHOP because the Obama administration gave them the option to wait until 2017.
5. A multitude of software problems in several states made it hard for employers to sign up. (Galewitz, 2015)

More recently, as of October of 2016, more than one million participants covered under the ACA were now faced with losing their plans due to insurers quitting the program literally two years or less after they had signed up (Tracer, Darie, & Doherty, 2016). Two primary providers, Aetna, Inc. and UnitedHealth Group, Inc. negatively impacted 32 states or 1.4 million people when they reduced and/or eliminated the number of available policies. Thus, instead of growing, the ACA was now faced with a dwindling participation rate due to higher premiums (upwards of 50%) and fewer choices. With 11.1 million people covered in 2016, a full 10% would now be forced to re-review their health care

options and/or programs. Interestingly, and despite the dwindling options, the HHS reminded these same people that they would need to sign up for new plans due to the law where those who are uninsured would face a fine. The latest or most up-to-date analysis is dynamic since the 2016 presidential elections. President Trump and the 115th Congress had indicated that changes related to the ACA would occur either through repeal or major modifications. Some modifications, like repealing the individual mandate were already in place by 2018.

Legal Implications, Proceedings, and Challenges

As the ACA entered its fifth full year of formal implementation, Americans and small businesses had heard and been exposed to the explanations, provisions, timelines, and roll out. They had been implementing and executing the various provisions of the ACA based on individual or unique small business perspectives. They had been presented with, and worked through the costs, tax credits, and incentives associated with their health care plans. These steps had been what all Americans, whether individually, through their employers, or as a small business owner, have been processing and applying over the past five to six years (2013-2018). In a landmark 5-4 decision on June 28, 2012, the Supreme Court of the U.S. upheld the (young) ACA from almost certain unconstitutionality. In the decision of *National Federation of Independent Business (NFIB) v. Sebelius,* Chief Justice Roberts ruled that Congress did not have the power to revoke a state's existing Medicaid funding as a penalty for that state refusing to participate in the ACA's Medicaid expansion provisions (Cisneros, 2014). The Chief Justice agreed with the dissenting position that the individual mandate to purchase health insurance exceeded Congress's Commerce Clause

power. This meant that a "penalty" would be considered unconstitutional, but a "tax" would be interpreted as constitutional.

More recently (2015), and in light of all above, new legal dynamics that threaten (near) universal health care have taken root as well. For example, if a state chose not to set up their own health care exchange, the state argues that it is exempt from paying the federally mandated tax credits (Bagley, 2015). ACA § 1311 instructs the states to establish exchanges, but did not anticipate the lack of participation since the federal government did not mandate local exchanges. The federal government then represented the 34 states that did not set up plans, whereby health insurance plans for these states were administered through federal exchanges. These individual states interpreted the link to paying tax credits as voluntary since the language clearly stated that these credits would be payable when "established by the state." Since these states did not establish their own exchanges, they were therefore exempt from paying credits since the federal government was administering the plans as litigated in *King v. Burwell* (Jost, 2015). Unfortunately for the ACA and its original intentions, this example as examined by Adler and Cannon (2013), and cited by Levitt & Claxton (2014), may represent only the beginning of future legal objections related to ACA provisions. Successful evasion of state-derived tax credits created a ripple effect whereby the IRS rule would not apply. The taxes imposed on employers that fail to provide minimum coverage would apply only if one or more employees receive premium tax credits (Jost, 2015). This in turn negates the employer mandate in states where locally derived exchanges were not set up.

Additionally, there was growing anticipation that Employee Retirement Security Act (ERISA)-based claims will increase (Hamby, 2014). As background, ERISA was set

up in 1974 to aid in protections for employees and employers who benefit from, or administer pension plans and welfare plans. The welfare plans related more to health benefits and administration and has traditionally not been subject to much scrutiny or regulation (Rachal & Mobley, 2014). This will likely change with time as the ACA evolves. When a company employs more than 50 employees, they would now be considered as participants (the insured) of the ACA, whereby employees could file claims against their employers through ERISA under the "Pay or Play" mandate. This decision by Congress in 2014 to enable employees to sue their employer for mandate malpractice had also given rise to § 510, which effectively eliminated an employer from reducing hours of an employee to less than 30, from full-time to part-time, for fear of discriminatory behavior to avoid that employee's right or access to ACA coverage under the employer's plan (Baker & Garcia-Yow, 2014). Furthermore, the penalties for employers not providing "adequate" health plan coverage may be assessed a $2000 per employee fine if just one employee was eligible for a tax credit through an exchange. Additional penalties applied if an employer permited an employee to enroll in a plan whereby his or her coverage costs still allow for a tax credit. That cost/amount is 9.5% of a full-time employee's household income as defined on their W-2. Another penalty that employers would be subject to when moving from 49 to 50 employees is called the "whistleblower penalty" (Hamby, 2014). In simplest terms, this penalty would be enabled when an employer discharges an employee as a result of that employee receiving a credit or subsidy by the ACA.

> No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the

> employee) has …received a credit…or subsidy [under ACA]…[29 U.S.C. & 218c]. (Hamby, 2014, p. 14)

The burden of proof is on the employee, but exposes the employer to additional penalties, legal fees, and new policy decisions. In the end, moving to 50 employees and above would spawn new litigation as exemplified in *Inter-Modal (IM) Rail Employee Association v. Atchinson, Topeka, and Santa Fe (ATS) Railway Co.* (Hamby, Journal of Pension Benefits, 2014, p. 15). In this case, IM was interested in maintaining their union labor force but eliminating its costly health care plan. It put its subcontractor work out for bid and was subsequently picked up by ATS, who in turn offered less generous benefits to these subcontractors. Under ERISA § 510 and through the U.S. Court of Appeals for the Ninth Circuit, and eventually the Supreme Court, both retirement and welfare (health care) benefits offered as a "plan" would be protected and not subject to amendment through another employer. In the end, ERISA § 510 would enable multiple and on-going legal claims if employers fail to initiate proper and appropriate communications with employees. Given that up to 30% of all full-time employees would be excluded from health plan coverage, Baker and Garcia-Yow (2014) advised employees to exercise forethought when considering part-time versus full-time requirements in light of ERISA § 510 language and requirements.

Intrinsic versus Extrinsic Motivator Considerations

In light of the ACA and the five sections of literature collected above, there is one additional area of interest, which is motivation when considering health care coverage as a component to employee pay packages. Intrinsic and extrinsic motivators by definition (Herzberg, 1962) are two mutually exclusive components that contribute to levels of job

satisfaction. In simplest form, intrinsic motivators are inherently connected to the job itself as perceived by the employee, and are the foundational, or true motivators linked to levels of job satisfaction. Concepts such as “recognition,” “achievement,” “responsibility,” “advancement,” and “competence” help to describe intrinsic motivators. Extrinsic motivators are rewards provided to employees typically sourced through levels of contribution and quality of work, and are cataloged as the psychological “hygiene of the job.” It is here that employers highlight an employee “pay package” versus “salary” because components of a pay package such as health benefits or a 401k represent building blocks above and beyond a base salary. Characteristic extrinsic motivators include policies, practices, plans, and incentives. Hofstede, Hofstede, and Minkov (2010) note that employees whose jobs demand more education value intrinsic elements higher than those employees with lower education and lower status jobs who value extrinsic elements as more important. The ACA represents a new perspective whereby, if or when small employers elect (or be forced) to offer health care to their employees, it creates strategic, high-level discussions among these business owners and its investors. It further invites “what if” discussions among those small organizations that do versus do not. For example, “if we decide to offer health care, will our sales go up through a more motivated and appreciative employee base?” Or, “if we avoid offering health care by reducing FTEs or splitting the company in two parts as we grow, will our employees leave the company due to lack of hygiene offerings, and seek employment with those who do offer what we will not?” Finally, “as a small organization not offering health care, can we look to larger organizations that already do and determine that the value is justified?” Dating back to Maslow (1954) and other theorists in the 1950’s, human motivation can be partially

explained in terms of needs (as cited in Beckhard, 2006). Unsatisfied needs create tension, which in turn creates motivation. The hierarchy of needs addressed through access to health care is that of safety and security. Does this overlap with organizational dynamics? One angle at this answer may be found through contingencies (Hackman and Oldham, 1980) whereby management of said contingencies between work behavior and organizational rewards can influence employee productivity. At the same time, spin-off effects on the quality of employee's work experiences can be improved. They go on to say that for rewards to be enabled or effective, there is a "value" component to the worker and it is awarded on a "contingent" basis. This means that the employee recognizes that he has earned the benefit, and appreciates its value as a component of his overall motivation equation. For example, when an employee knows that he has health care coverage, is he more motivated in his day-to-day activities? If his daughter falls ill and he has no health care coverage, does his productivity suffer?

Pfeffer (1994) provides another perspective that highlights the competitive advantage that one firm may have over another based on a free-will employee protocol we have in the U.S. For employers that offer health care benefits, that organization is more likely to obtain a higher quality work force, which of course will cost more than an organization that does not offer the same benefits. Which is more competitive? The firm with a higher cost structure and more incentivized/motivated employees, or the firm with a lower overall overhead cost structure and employees who arguably have less incentive or motivational objects in their pay plan? Here we are considering perceived higher value through more motivated employees versus lower overall costs to deliver. As we proceed, and in light of all of the legislation, theory, and experience, what are the overall effects on

an organization that offers health care coverage versus not? Is there a correlation to higher throughput, is the culture more likely to produce favorable business results, will the company ultimately benefit from an investment in health care coverage for its employees, or is it a static, sunk cost? These questions are important. The analysis and answers are even more important. For example, a 2001 meta-analysis demonstrated a substantial relationship between individual job satisfaction and individual performance. The results produced an $r = .30$, a medium effect size (Judge, Thoresen, Bono, & Patton, 2001). From an organizational perspective, it is important because these individual results reflect business-unit level reporting. Would there be a link between job satisfaction and benefit or pay packages? The answer partially lies, or at least is linked to rewards. In the case for health benefits, those that offer coverage view it as a societal requirement, a competitive advantage, and also a reward or benefit for good behavior which leads back to job performance (Judge et al., 2001).

Chapter 3: Research Methodology

This scholarly inquiry will be conducted through multi-case study analysis with a quantitative component. Based on the extensive material, there will be no shortage of inputs related to the ACA to support an interpretive epistemology methodology. In the extensive readings I have studied, there will likely be multiple inputs of interpretation that clearly supports a multi-case study. All interviewees are essentially an experiment, and will have the opportunity to articulate their understanding of the ACA from important three perspectives.

They are:

1. Companies over 50 employees that offer health care benefits,
2. Small organizations that do not offer heath care coverage,
3. Small organizations that do offer health care coverage.

Case study analysis will allow for commonalities and differences in various perspectives in a very diversified subject matter. Despite this observation, the intent of this research is to narrow the focus to information related to organizations experiencing growth, and the prospects of adding more employees to their payroll that breach the mandated benchmark of requiring versus not requiring health care to all FTEs.

Research Design

There was a high level of diversification in responses from employers and employees interviewed. This cross-section of inputs will represent a commonality of sentiment related to common goodwill mixed with a distinct set of positions that are unique to their disciplines and/or circumstances. All information obtained was conducted through personal interviews and surveys. As there are three primary areas of interest (small and

large organizations offering health care, and small not offering), I devised a minimum of twenty questions for each interview. Some of the questions overlapped in an attempt to decipher perspectives unique to each area of interest. The questions were designed to be answered directly and objectively, however, my intent was to draw discussion and deeper meaning from the responses. Follow up questions were appropriate and recorded as required. The goal of the research was to assemble enough critical mass of perspectives, interpretations, and reaction to aid in predicting organizational behavior when faced with government-sponsored programs during a period of growth. Each interview was important in the ultimate synthesis of findings.

Participant Selection

In preparation for selecting participants for this multi-case study, I spoke with two personal friends who are health care consultants and familiar with the ACA. They became familiar with my intentions to study this subject and quickly adopted an interest to assist in identification of qualified organizations that are growing, and employ over/under 50 full-time workers, and do/do not offer health insurance today. Inclusion criteria for employers required a minimum of five years' experience in direct interactions with employee benefit oversight and/or administrative duties related to small business, ACA related health care. During participant recruitment, all received formal Institutional Review Board (IRB) invitations and consent forms as presented in Appendix A, B, and C via e-mail along with the list of questions in Appendix D for employers offering insurance, and Appendix E questions for those employers not offering insurance. Finally, the survey each participant completed is presented in Appendix F. All approved and signed copies reside in the IRB database.

The invitation spelled out the request for a personal interview to last between one and two hours, its purpose, that it will be documented, the content will need to be approved by the interviewee prior to release, and that the results will be shared upon completion. After receiving their informed consent, all participants were pre-screened through a courtesy telephone call prior to the actual interview to initiate the relationship, answer any pre-interview questions, and confirm that their input would align with the goals and objectives of the study.

Data Collection

In order to support an interpretive, multi-case study, interview data derived through a series of linear questioning was appropriate. I focused first on obtaining a solid understanding of the organization's vision, mission, markets, high-level initiatives, and competitive advantage. This helped with setting an overall tone for the interview and provided insight to organizational dynamics. Next I turned to probing on their respective health care plans, whether employer provided or not. This gave insight into how they viewed and/or valued their employees. Some workers were offered insurance through their employer, but chose the local version of the ACA option—MNSure. Interestingly, some organizations provided only one, high-level plan, while others offered two or three options which helped to soften costs for both employee and employer if appropriate. Naturally this came down to a "risk versus reward" equation that the employee had to consider based on their own circumstances. I then moved into how employers link or position their health care offerings to their pay packages. In other words, is offering coverage "advertised" and held as a valuable component to their overall benefits package? Does this element then align with the vision and mission of the organization? If the organization is not offering

health care benefits, is there then an inconsistency with the organization's mission or vision? Additionally, if not offering coverage, are there any other benefits that help to offset the absence of health care, and do they educate their staff on health care options through the ACA? Finally, we then moved into strategy. Is there a strategic component designed to enhance employee satisfaction, productivity, and value? In the absence of coverage, is there a gap in these attributes? In the end, the objective behind the collection of data was to draw out relative information related to offering coverage versus not in light of employee and employer influencers, including the ACA.

Data Analysis

As an interpretive case study, data comprised seven interviews and 50 surveys. The objective in conducting both was to gather employer and employee inputs from both intrinsic and extrinsic motivators. During the employer interviews I took great care in assembling subliminal responses (between the lines) to health care availability in light of organizational dynamics. The overwhelming reactions were sensitized in nature. Six of the seven interviews were rooted in a willingness to provide health care coverage for employees and address potential employee distractions or concerns up-front, in part through an employer's duty. There were other forces involved as well as will be discussed and highlighted in Tables 5 and 6. The interviews were analyzed carefully for commonality, overlap, and dissimilarity, then synthesized into themes. This was then compared to over versus under 50 employees along with offering versus not offering coverage. Secondly, and similarly, the employee surveys were assessed and sorted into sixteen observations that linked back to the themes identified above. For the most part, employees were sympathetic to employer demands as dictated by societal expectations.

The analysis suggests they also considered health care coverage as an important component to their benefits package whether obtained through their employer or through the ACA, and most importantly were willing to contribute more to the benefit if the employer was financially forced to reduce their offerings.

Researcher Bias

As a former 3M Company employee who experienced dramatically high health care costs through MNSure in 2015, I was skeptical of how the federal government implemented the ACA. We heard that we could keep our doctors and that health care costs for families would go down an average of $2,500.00 per year. We also heard that the roll-out for exchanges, though painful and slow, would ultimately represent itself as promised. Finally, we were exposed to Congressional Business Office (CBO) estimates that 20 million new participants to the ACA would fund the program and that all costs would be covered by younger, healthy citizens who would face fines through the IRS if they chose not to participate in the ACA. Therefore, my bias resided in an inability for the government to effectively, and efficiently, manage a national health care system better than the private sector. Secondly, and since I purchased my own small business in 2016, I began to pay even closer attention to the ACA in light of organizational reaction to those not offering health insurance and breaching the 50-employee benchmark. My company employs 10 full-time workers and we do offer insurance. Our monthly cost to provide this benefit is approximately $8,000.00 and is shared by our employees through a 30% incremental payroll deduction. For a full year, this expense/benefit represents approximately 3.6% of top line sales. Fortunately, our business generates just over 20% net income (health insurance cost included), so we can "afford" to offer this coverage to our full-time workers.

My bias emerges when margins are not as attractive. Could that same 3.6% expense of top line sales represent the difference between profitability and loss? What decisions must be made by organizations approaching 50 employees who are exposed to a mandate to now offer health care coverage? Do they decide not to grow any longer to maintain under 50 workers, do they split the company in two and operate under separate entities, or do they decide to hire only part-time employees from this point forward?

Chapter 4: Results

During the course of our classroom studies and essentially throughout the entire Cohort #7 activities from 2012 to 2016, the ACA (2010) had been signed into law, but was incredibly controversial. The House and Senate were divided among party lines, and our collective reality was focused around government control versus free market, and seamless implementation versus delays/issues. States were divided as well. A minimum of 18 states either filed lawsuits in objection, or opted out of participating in the ACA altogether. Names like Kathleen Sebelius, Harry Reid, Nancy Pelosi, John Boehner, and Paul Ryan remind us of a time in history where politicians dug in at polar opposites when it came to agreements on health care responsibilities, expectations, and ownership. It seemed like nothing else mattered, few other news stories or extended coverage on other subjects captured media attention. If either side "lost," the pendulum shift would mean the difference between maintaining capitalistic tendencies versus moving to socialized medicine. It truly was a time of reckoning: U.S. government control versus the free market. Five years after the ACA went into effect, we are reminded of its primary objectives: "(1) Expand the reach of health care against a broader audience, and (2) Reform health care to improve access, lower costs, and improve quality" (Blumenthal, Abrams, & Nuzum, 2015, p. 76). Is this what happened as of 2015, and has it continued to this day? How did individuals and organizations react to these objectives? Has the cost gone down? And finally, did the quality go up? The forces involved include individuals, organizations, states, and the federal government. All of these questions play into decisions that had to be made and continue as the ACA evolves.

Interview Process

I conducted seven employer interviews that lasted nearly two hours each. Each company and the individuals interviewed at the seven companies are identified below with a pseudonym. All interviews in Table 3 were conducted on-site at the company/owner's location, and in most cases the HR/business manager participated with the owner or general manager due to the intricate and detailed nature of the subject matter. There were a total of 27 questions prepared for each interview. All participants were eager to discuss the topic and provide appropriate answers, feedback, opinions, and supporting materials that I had requested. In light of the fact that some organizations do not offer insurance, while the others do, there are two sets of questions that reflected inherent differences in choices, and in offering versus not. This was deliberate and designed to draw out notable points related to how employees and employers view health care in their respective organizations.

Table 3

Interview Participants by Organization and Size

Org. Type	Company Pseudonym and Titles	Focus of Organization	Major Themes
> 50, offering HC	*Twin Cities Golf and Dine (TCGD)* Patrick- General Manager Jamie- Operations Jack- Accountant	Prestigious Private Country Club, Golf Course, Banquets, Fine Dining, Open Year-Round	Family Oriented, Strategic Focus, Well-Managed
	Trol-Tek Machine Steve- President Randy- Human Resources	Industrial manufacturer, specialty refrigeration equipment	Purchased, but Family Owned
< 50, offering HC	*KP Group, LLC* Peter- President Joy- Human Resources	Systems Integrator, controls, UL panels, industrial focus	Family Owned
	Reynolds Marketing Group, (RMG) Tom- President Joy- Human Resources	Digital marketing, strategic planning, full service advertising and promotions	2nd generation, Family Owned
	Rysoa Mike- General Manager Susan- Human Resources	Medical device IPO	
< 50, not offering HC	*Eby's Pizzeria* Eby- Owner	Pizza restaurant offering delivery, take-out and dine-in	Family Owned
	Sally's Salon Sally- Owner Greg- HR	High-end hair salon, coloring, styling, educator	Family Owned

PART I: Organizations >50 Employees That Offer Insurance

Interview #1- Twin Cities Golf and Dine (TCGD). Twin Cities Golf and Dine (TCGD) has roots dating back to 1949 when it originated as an archery range and small clubhouse.

Over the years it has evolved in offerings, capabilities, and size among an exclusive private community. Today it proudly serves as a cornerstone of activity for the community and deservedly has earned the respect of three generations of golfers, residents, and other communities in and around the Twin Cities metro area. It is owned by its 300+ golf and social members, and all major organizational decisions are approved by its elected board of directors. TCGD employs 32 FTEs and 27 part-time employees (30 hours). The industries served are golf, dining, and banquets. In learning more about the organization's health care program and the employees, I met with Patrick, the General Manager, Jamie in Operations, and Jack from the Accounting office. In order to begin the process of gathering information on potential implications of health care on job performance and related psychological insights, I will begin most interview summaries and analysis with the organization's Mission Statement and related proclamations. For TCGD it reads:

> To foster lifelong friendship and a sense of community by serving the needs and desires of our membership through exceptional golf, dining, and social activities in a family-focused atmosphere.

Core values of TCGD are as follows:

> *Family and Friendship.* Creating camaraderie and memories amongst family and friends is at the heart of everything we do.
>
> *Excellence.* We strive to be the very best we can be in everything we do. We maintain the highest standards of quality.
>
> *Service.* We go to extraordinary lengths to create memorable experiences for our members and their guests.

Engagement. We engage our members by offering a diverse array of golf and social experiences. We inform and involve our members on what is happening at their club.

Community. We commit ourselves to being good stewards of the community and environment while being inclusive and welcoming to all.

Integrity. We engender trust and respect, acting ethically and encouraging open and honest communication.

Fiscal Responsibility. We meet the needs of our membership by providing good value in a fiscally responsible manner.

In response to all above, TCGD has chosen a comprehensive $3,600-100 health and dental plan offered by HealthPartners. There is an annual $1,000 HSA deposit for all plan participants provided by the company. In addition, TCGD covers 100% of Group Life and AD&D, and Long-Term Disability insurance premiums. For this entire package, the enrolled employees are responsible for $55.00 per month and this amount is automatically deducted from the employee's bi-weekly pay-checks. It is important to note that the coverage plan is designated for the individual employee only. If he or she has additional family members (spouse/dependents) seeking health insurance, the employee is responsible for 100% of the monthly premium offered through the plan. In terms of eligibility, a new employee who is hired into a full-time position and is not a department head, will become eligible for company paid insurance on the first month following 60 days of employment for all coverages. Department heads (Finance, GM, Program Manager, Golf Pro, etc.) are eligible for full benefits immediately upon arrival.

The next phase of questioning was centered around employee interface and strategic intent. Clearly the leadership of TCGD buy into their organizational mission statement and core values when discussing health care for their employees. The organization's objective is to extend a "family-focused atmosphere" not only to members of the club, but also to its employees. For example, employees are encouraged to play golf on Mondays (at no cost) when the club is generally closed to any/all member activities. This privilege encourages organizational collaboration among colleagues (on and off the golf course) in a relaxed environment. Additionally, employees are encouraged to eat at the club at either 10:30am or 4:00pm for free. There is a communal table in the kitchen where servers, cooks, and related staff can interact and remain updated with food choices they eventually will be serving to guests. Finally, there are two employee parties throughout the year, scholarships, and employee recognition programs to continually remind the staff that they are appreciated. Throughout the year the departmental heads solicit employees input to insure timely, vital insight from their member interactions and/or their experiences as employees. According to Patrick, the General Manager (GM), this invitation for open dialog encourages frequent, essential communications in a competitive environment, which helps TCGD maintain a competitive advantage. The board of directors and departmental heads understand employee dynamics well enough to recognize the relationship of content employees to enhanced productivity. This is no accident. The board of directors in collaboration with the GM, Patrick, have updated the strategic plan with this in mind. This initiative was timely in that Patrick recently came from another club that did not offer health care benefits. He indicated that the prior club was very aware of the >50 requirements under the ACA and they were determined to remain under the

benchmark. As a result, the focus on employee retention was centered on thirteen key employees versus the entire organization. This proved difficult when those not covered by health insurance through the organization exhibited their lack of allegiance and commitment to high standards or quality of work. In the end, those covered (management) found themselves distracted with unnecessary HR issues due to a disconnect between those covered and those not. Strategically, Patrick brought this experience to TCGD and lobbied for the attention required to eliminate employee distractions and unfocused discourse. Employee retention became a vital component to organizational integrity. This is recognized and appreciated despite the cost of benefits, extensive training, and increasing costs with time. According to Patrick, these enhancements to base pay far outweigh the hidden, unaccounted-for expenses related to employee turnover and questionable morale.

TCGD is a family-focused, highly respected country club. They have spent the last several years concentrating on member satisfaction and this, in a large part, begins and ends with a focus on employee dynamics. It is no secret that country clubs can be successful or marginal due to employee experiences, forces, and subtleties on and through the club's members. Developing and maintaining a competitive advantage in this market is critical when your objective is to fulfill available and/or maximize memberships while offering lasting value to the community you serve. TCGD, in demonstrating its commitment to employees, absorbed a 17% increase in health care premiums for 2018. According to all interviewed and the board, this was a strategic decision that was easy to make in light of all above, but at the same time is clearly not sustainable. After all, this organization is demanding value for its members while seeking and attracting the best, brightest, and most committed employees in its quest to fulfill its mission and core values.

When asked if offering health care coverage through the organization is "the right thing to do?," all three interviewed agreed quickly, but independently that the answer is clearly "Yes.".

Interview #2- Trol-Tek Machine (TTM). Like several other businesses featured in this study, the current owner purchased Trol-Tek Machine (TTM) in 2015. The origins of TTM date back to 1983 when several former workers of a Twin Cities industrial engineering firm banded together to form TTM. Their specialty is designing, engineering, and building special order machinery. The default market has been the food and beverage industry, and more specifically, urethane foaming fixtures that are used to produce specialty-use refrigerators. Today the company employs just over 50 employees and works out of a 24,000-foot facility. Half of the employees have been with the company for over twenty years. The company's vision and mission statements reflect some of the reasons for the retention:

> ***Vision.*** To be a world class provider of machinery through innovative ideas and designs that bring value to our Customers and satisfy their needs now and in the future. It's our job to make the Customer look good.
>
> ***Mission.*** TTM's mission is to continually build and maintain a team of honest, hard-working, successful individuals who are committed to service and meeting the Customer's needs. We are committed to providing our employees with meaningful and rewarding work along with advancement opportunities. Our ethics stand on high integrity and use of solid core values in our day-to-day commitment to our Customers and our company. We will continue to uphold a preferred supplier status from our current customers and strive to achieve that status with new customers.

We will service our Customer Base of Manufacturers, OEM's and other Supply Chain Base Customers, as we maintain our industry leading status.

The company offers two health care plans for its employees from HealthPartners. This was arranged so that employees could have greater flexibility in their individual health care options. TTM pays 78% of health insurance costs for individual employees and 50% of an entire family. Overall, TTM estimates that 16% of their fixed costs are dedicated to health care coverage. The plans are reviewed annually and scrutinized for TTM by a broker. To be eligible for health care coverage, an employee must meet the 32-hour per week minimum and be employed for 90 days.

The differences between the two plans are as follows:

1. There is a gold plan that works off of a $1,000 deductible per individual, and $3,000 for family. The total annual out of pocket maximum is $4,750 per individual, and $9,500 for a family. Copays begin after the third visit.
2. The silver plan starts with a $3,600 deductible per individual and a $7,200 family out of pocket maximum on an annual basis. Copays are not required, but the deductible for services is 3.6X that of the gold plan.

When discussing annual reviews with employees, TTM management always presents pay as a package, not as simply salary alone. This is a value conversation with the employee so that they are reminded that there are other components to their pay, and additional costs to TTM.

Interestingly, the company does not conduct strategic discussions among senior management. This is left entirely to the president of TTM. In general terms, management occasionally comes together to talk about expansion efforts, building the core, and

strengthening relations with its customers; however, a formal strategic plan, if written, resides only with the president and is not shared with any other employees. Regardless, the employees maintain their loyalty to the company primarily because they have the ability to work independently and without much intervention from management. For this reason, it should be no surprise that most employees possess multiple capabilities such as design, fabrication, estimating, drafting, and project management. This cross-functional culture has encouraged its workforce to maintain a fresh approach to helping each other, and training newer, less experienced employees. The only strategic link shared within the organization is related to how solid benefits offered by TTM link to productivity, less stress, and few/no distractions. Clearly this organization believes in providing attractive benefits in exchange for attracting talent and maintaining its long-standing employee base. Fabrication and specialty manufacturing are considered somewhat insulated from competitive forces when looking at margins and capabilities. Even so, ensuring that employees are satisfied with their benefits serves as a type of security blanket for TTM in that it is their understanding that removing health care sourcing distractions and related self-procured management issues produces a more focused, dedicated workforce.

Finally, when it comes to whether or not as a U.S. employer TTM supports covering health care benefits from a societal perspective, the answer is “yes.” It has become an expectation that organizations that seek higher levels of talent and profess growth plans provide the necessary benefit packages to maintain existing, and seek new employees. For reasons noted above, TTM has come to include health care coverage and discussions with employees on an annualized basis. This is part of the annual review process and is a protocol for this and many other organizations. Society has helped to

define the employer's responsibility to handle this human requirement and furthermore remove the process almost entirely away from the individual.

Two notable themes from interviews with these two organizations include:

1. Health care coverage is important, but the ACA is not discussed or considered in any analysis or decisions.
2. Despite the mandate, costs are reviewed annually to maintain consistent and acceptable percentage of fixed costs.

PART II: Three Organizations <50 Employees That Offer Insurance

Interview #3- KP Group, LLC. A systems integrator and controls engineering company, KP Group, LLC (KPG) has been in business for 33 years, was recently purchased, and now operates under new management. The company never had a Mission Statement, Purpose Statement, or Vision Statement until the new ownership took control three years ago. The owner quickly enabled the Traction Organizer method (Wickman, 2011) of management and the completed process is summarized below in Table 4.

Table 4

KP Group, LLC Traction Organizer

Vision/Traction Organizer		
Vision	*We believe in contributing to an organization that continually transforms individual capabilities into collective improvements for ourselves and our customers. We seek to preserve an environment where our employees make sound decisions rooted in purpose – which is derived from family values, business ethics, and partnering with customers for mutual benefit.*	5 Year Goal = Double Sales
		12/31/2021 CAGR = 12.5%
Strategy	Achieve superior performance vs. the competition AND capture value (profits) for our organization	Revenue
Core Values	Continuous Ascent	
Credibility	Know what our customers need before they do.	Gross Profit
Improvements	Sell to update/upgrade systems and processes, not to beat quotas.	
Winning	Initiative, Drive, Perseverance.	
Teamwork	Collaboration among ourselves and with customers.	Net Income
Expertise	Continuous Learning.	
Trust	Integrity, Honesty, Ethical Behavior-Always.	
Core Focus	Why does our organization exist?	
	Exhibit employee skillsets, improve customer processes, create value	Measurable Checks and Balances
	What is our niche?	Monthly Business Technical Team Meetings
	Small, nimble, capable, but can play BIG.	
		Weekly Operational / Tracking Meetings
5 Year Target	Double Sales to at 20% Net Income.	
		Quarterly Sales Development Plans
Marketing Strategy	Target Markets	
Penetrate	Municipalities	Job Grade Levels and Descriptions
Expand	Processing	
Maintain	Golf Courses	Semi-Annual Performance /Devt. Plan Reviews
Qualify	Distribution	
Partner	Industrial/Manufacturing	Quarterly Financial Audits
Outsource	Panel Fabrication	
Trusted	Service	Strategic Plan Reviews
Proven Processes	Standard Operating Proceedures (SOP) Required for 3 of 6	
HR Management	Hiring, Capabilities, Structure, Rewards	Scheduled Learning / Training / Trades Shows
Business Development	Strategies, Tactics, Implementation, Marketing, Management	
Time Management	Scheduling, Service, Projects, Hopper	Performance Metrics tied to Bonus
Projects	Bids, Quotes, Tracking, Managing, Billable Hours, Invoicing	
Value Proposition	Competitive Advantage	Networking / Key Account Plan Review
Reviews	Business/Technical Team Meetings, Performance, Development, Operations	

Adapted from "Traction-Get A Grip On Your Business," by G. Wickman, 2011, BenBella Books, Inc., Dallas, TX., pp. 72-73.

Implementing this strategy was instrumental in organizational re-birth. In addition to hiring new employees, a comprehensive strategic plan was developed and implemented, the policy manual was edited and signed off by all employees, and most importantly, all ten employees were strategically brought into (selective) collaborative decision-making roles, which is directly opposite of prior management philosophy. As a result of all above, KPG was a prime candidate to interview and survey in light of ACA mandates and health care offerings within the organization. KPG offers a very good health care/dental plan for its employees. This is consistent with its directive to align employees with offering

customer value and lasting credibility. The organization sources coverage through HealthPartners where there is a $7,350 individual maximum out-of-pocket expense and a $14,700 maximum family expense. The deductible is limited to $1350 for an individual and $2,700 for a family. The plan is comprehensive and attractive to employees. Generic drugs are 100% covered, allergy injections require a $2 co-pay, emergency care requires only a $200 copay, and HealthPartners® general overall feedback has been very positive. As for dental coverage, preventative care is 100% covered, while all basic, specialty, and/or prosthetic requirements are offered at 50% cost to the employee. Single employees enjoy 70% monthly coverage expenses and families are 60% covered by KPG. Since most employees are under the age of thirty-five, and single, annual expenses for this organization are in the $50,000 range, which according to the president is reasonable and represents a solid return on investment. This amount represents approximately 10% of all fixed expenses.

The company's strategy is to focus on competitive advantages in the industrial markets through partnerships and networking. In other words, a "stay small and nimble, but play BIG" approach to market. KPG recognizes that in order to grow, they must enable highly capable employees to demonstrate their skillsets at targeted customers, bring in new, profitable business, and be compensated accordingly for meeting and exceeding goals agreed to by the employee and the president. In addition to the Traction model mentioned earlier, KPG enlists a slightly enhanced (by the president of KPG) Jay Galbraith *Star Model* as identified below in Figure 2. KPG highlights this model with an added understanding of *Strategy* from Michael Porter (Magretta, 2012) at most every monthly employee meeting. It is widely recognized and established by KPG that people, rewards,

structure, capabilities, and processes are the focus for supporting the strategic plan. More importantly, KPG stresses the importance and interaction of all five components working equally to achieve desired results. In return, KPG as an organization reminds employees through the "people" and "rewards" items that the benefits they receive (health care/dental coverage, bonus, 401K, etc.) are designed to contribute directly to enhance capabilities and individual performance on the job. This is accomplished through allowing employees to concentrate efforts on growing the business in an environment largely devoid of health-related distractions and/or medical interferences.

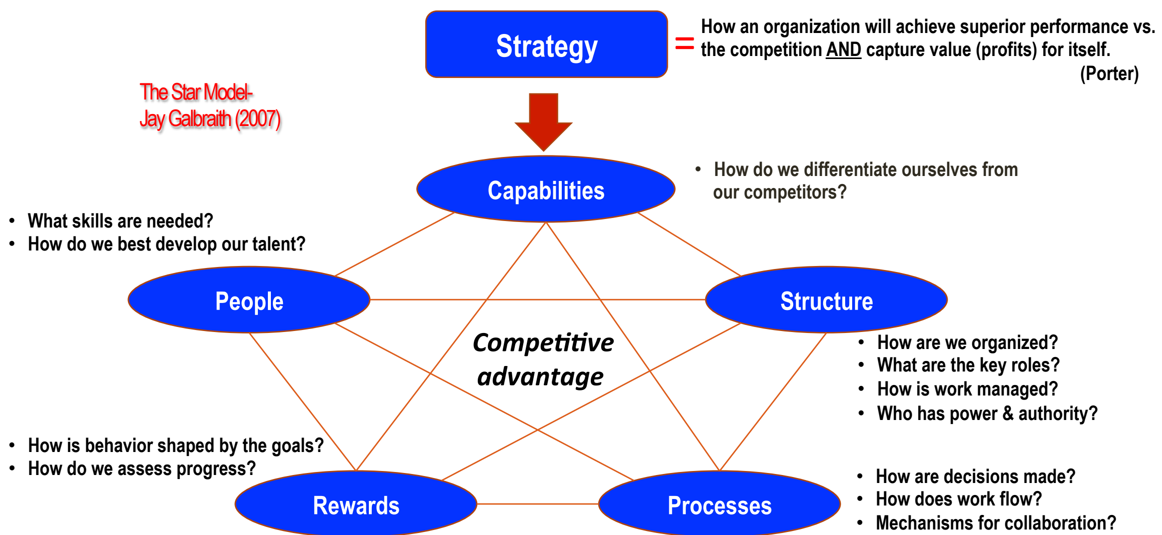

Figure 2. KP Group, LLC – Adopted from The Star Model, Jay Galbraith, 2007.

According to the president of KPG, the investment in health care coverage is not easily measurable to productivity enhancements; however, he contends that without it, employees need to seek and manage their own coverage which takes time and energy away from their measurable objectives at work. He also pointed out that individual coverage is much more

expensive than a group plan that directly affects possible wage and salary negotiations and concerns that would be disruptive, unnecessary, and complicated for both sides. The president of KPG indicated that removing the health care variable from an employee's thought process is strategic in three ways:

1. Competitiveness with other (market) system integrator offerings.
2. Strong belief that offering as a benefit increases day-to-day productivity and effectiveness.
3. Absence of distractions over time leads to loyalty and a more "committed to the cause" employee attitude.

From an employee perspective, access to subsidized health care coverage is communicated up-front through a benefits "pay package." When an employee is hired at KPG, the discussion does not revolve solely around salary. There are six components that comprise an employee's pay package. They are:

1. Base pay. This is typically at or slightly above published market benchmarks.
2. 401K contribution which is company $1 for $1 match up to 4%.
3. Automobile. Each technician receives a Ford Escape or equivalent that represents over $8,000 in annual "savings" to the employee due to the fact that a personal car is largely not required.
4. Health care benefits which can represent annually up to $7,000 per individual or family.
5. Bonus plan for full time employees is dependent on company sales, profitability, new accounts, billable hours, tenure, and discretion. This can rise to $20,000 per year, per employee.

6. Comprehensive tool kits, computer/VPN, software/product training, and travel/expenses are paid by KPG. This is incremental, convenient, and difficult to substantiate, but greatly appreciated by employees.

In the end, KPG is interested in developing employees and retaining those that demonstrate commitment and loyalty. The company is willing to invest in perceived or real elements that contribute to strategic initiatives. The president believes that employers should be in part responsible for the majority of employee health care coverage. In this case he offers between 60-70% and justifies the expense most simply on maintaining a competitive position versus like systems integrators, and the avoidance of general distractions or unproductive complications associated with health care considerations/negotiations. As the president states, "there are tangible, yet immeasurable costs associated with items 1-6 above that are better to avoid and absorb through sales/profits, than to attempt to itemize and justify through operational effectiveness." In other words, if sales and profitability are met or exceeded quarter over quarter, there is little or no incentive to examine incremental variables that may or may not be subject to examination.

Interview #4- Reynolds Marketing Group (RMG). A second-generation marketing firm, RMG is derived from Mr. Reynolds beginning in 1972. He successfully built up a solid base of high-profile customers in and around the Twin Cities area who were aligned with what RMG had to offer. In those days prior to the year 2000, the focus was more on literature generation, advertising, product promotions, and making it easier for sales representatives to connect effectively with prospective customers. As the company evolved and Mr. Reynold's son (Tom) took control in 2006, the marketing focus has transformed dramatically to include internet-based databases and digital marketing. RMG

today employs eighteen FTEs. Their primary objective is to more effectively match clients to customers through creative, innovative marketing.

> ***Vision.*** Reynold's Marketing Group is a data-driven, technology-focused marketing landscape-we develop creative strategies that make meaningful connections and propel business.
>
> ***Mission.*** To help clients excel in a complex and chaotic digital marketing landscape.

The environment in which they work is fun, loose, and free-flowing. There are numerous small and large conference rooms equipped with the latest media options where clients and RMG employees can collaborate and develop meaningful outcomes. There is a workout facility for the employees, a pool table for more casual or open-ended discussions as necessary, and every Friday (late afternoon) there is an on-site employee de-briefing session where all are invited to discuss the week's events, frustrations, or accomplishments over a beer. The company is actively working to establish an "intentional culture" based on good/competitive pay, variety of work, pay for performance, team/problem solving environment, life/work balance, and high-end benefits. To support this, RMG has built an environment that is aligned well with promoting employee-client experiences as the business grows. The organizational objectives are to build an organization from 18 FTEs up to 40-50 FTEs in the coming three years. This will be accomplished through what RMG identifies as the "Digital Maturity Index" initiative that will be rolled out to prospective clients soon. It is designed to establish an organizational profile from which to build a comprehensive, on-going marketing strategy that RMG will manage for the client

over time, not just once. The core markets where RMG concentrates its marketing efforts are consumer, health care, and industrial.

RMG openly recognizes the need for talent in a highly competitive marketing solutions arena. For this reason, RMG offers five different levels of health care options in an attempt to accommodate every employee/family scenario. There is a basic plan for single individuals at a relatively low cost, a high-end plan for families, and other more customizable options in between. The plans are offered through Medica and available to all FTEs and employees working 20+ hours per week on the first day of their employment. RMG pays 70% coverage for individuals, and 50% for families. It is important to note that RMG did not offer health care coverage for its employees until 2006. When initiated by Mr. Reynold's son, the company paid 100% of coverage due to a commitment to secure the highest talent possible and an ill-conceived notion to measure ROI on sales activities and growth plans. By 2008, it was clear that dramatically rising health care costs coupled with an inability to directly track positive attributes associated with offering 100% coverage; as such, RMG settled on the percentages identified earlier.

Strategically, it is interesting to note that RMG does not support employer funded health care coverage. Rather, the company believes that society has essentially mandated the expectation that health care coverage is a responsibility of corporate America. As highlighted throughout this study, employers who manage fewer than 50 employees are not obligated to offer health care coverage. However, in today's highly competitive job markets, RMG maintains that they "must" offer health care coverage to attract talent however difficult that may be. Tom outlined an analogy whereby employers are not responsible for an individual's automobile insurance, lunch, mileage costs, or vacation

expenses; so, why are we (corporations) responsible for health care coverage? He went on to outline how societal expectations for companies to provide health care coverage is "insidious" and can quickly dilute profitability and the opportunity for salary enhancements. To sum up his frustration, Tom shared with me that in over thirteen years of providing 50%-100% subsidies, an employee has never *thanked* him for the health care coverage they receive. In the case of RMG, health care costs represent 25% of fixed costs. This is clearly well above all other organizations interviewed. In the end, however, and at the same time, Tom does understand that there are unforeseen, distractive costs associated with employee-based health care responsibilities. Clearly there is a "peace of mind" benefit that is difficult to measure, yet vital to offer. To maintain a competitive platform among employees and alternative marketing options, RMG will continue to provide above average health care coverage despite the difficulties in demonstrating an ROI.

Interview #5- Rysoa. Rysoa is a medical device IPO that employs four FTEs along with several consultants. Mike Christoph joined Rysoa as president and chief executive officer in June of 2018. He has over 25 years of medical device experience including 15 years at Tronmedic and 11 years across three venture funded startups. Mike was a co-founding executive of a medical company, leading the development of an implantable nerve stimulation system for the treatment of obstructive sleep apnea. Integrity completed a successful IPO exceeding $800 million in value in May of 2018. Mike led the research and development of a therapy focused company during the product commercialization and pivotal trial phases of the company. This company was sold to a medical device company for $406 million in April of 2018. Most recently, Mike was the VP of research and

development at Cardiomia, Inc. Mike has a Master's in electrical engineering from the University of Minnesota (IT), and a Physics degree from Bethel University in St. Paul.

This is an interesting candidate and unique to all others interviewed in that Mike needs to offer the best of everything to his employees and associates because he is essentially developing businesses requiring the highest levels of talent. Access to industry experts make or break an IPO. Mike described the Blue Cross Blue Shield plan he offers as the "Mercedes" plan-the default best plan of the past commonly referred to as a "Cadillac" plan versus others because there are virtually no deductibles and there is essentially no cost to his employees. Rysoa picks up 80% of the premium for all who choose to participate. It is important to remember that an IPO such as Rysoa is acquiring its talent from established companies who have already successfully marketed and sold like products to what is represented by the new IPO. As a result, the employees expect nothing but the best in terms of benefits, pay, and future stakes. Health care is positioned to the employees as a natural extension of their generous salary. In the arena of IPO's distractions and unnecessary considerations related to health care coverage would not be allowed or tolerated.

Strategically, it goes almost without saying that access to the best coverage is a component in a multi-faceted set of requirements and expectations to attracted and maintain the highest levels of talent. The ultimate success of this IPO is dependent upon solid decisions up-front, access to cash, timing, good financial management, and providing a turnkey organization that has been "built to run" versus "built to sell." Mike explained that in today's environment it is not enough to set up a potential business for success and turn it over to a new management team. It is a longer-term investment that involves setting

up the company, assigning resources, and positioning the company as a ready-made investment for the new buyer.

Two notable themes from interviews with these three organizations include:

1. The ACA is not supported or thought of from an employer's perspective. Employers are proud to research and ultimately offer their own coverage.
2. Employees expect coverage and do not necessarily voice their appreciation, but employers are convinced that not offering coverage will be detrimental and put competitive advantages at risk.

Table 5

Parts I and II: Summary of Interviews-Health Insurance Provided

Offering insurance coverage	Org. Strategy	Percent covered	Org. Benefit	Agree w Mandate ?	Primary Goals	Positive Impact ?	Measur-able Impact?	Employee appreciates ?
TCGD	Mandatory	Employee pays $55/mo.	Focus on family values	No, but would offer anyway	Reduce stress, focus on clientele	Yes	No, but confident in correlation	Yes
Trol-Tek	Mandatory	78% for individual 50% for family	Smooth transition through acquisition	No, especially if they cannot afford	Keep long-term employees and no distraction	Yes, but it is an expecta-tion of employ-ees	Yes	No proactive indications from employees
KP Group	Competi-tive edge, specialty business	70% for individ-ual, 60% for family	Also a transition, need to maintain talent	No, unless organiza-tion is closer to 100+ employees	Higher expecta-tions of employees perfor-mance and loyalty	Yes, but there is an expecta-tion from employ-ees	No	No proactive indications from employees
Reynolds	"Giving up" as victim of societal pressures	70% for individual and 50% for families	Purely an expecta-tion of society and empl.	No, vehe-mently disagrees with policy	Maintain compete-tive profile and bury lack of ben	Unsure, but likely "Yes"	No	No
Rysoa	Not mandatory but require-ment for IPO's	80%... expecta-tions for IPO's are 80% to 100%	Attract higher caliber talent throughout launch	No, but an expecta-tion of candidates	Attract talent, maintain talent, keep talent	Yes, but an expecta-tion of IPO talent	No	Yes

PART III: Two Organizations <50 Employees That Do Not Offer Insurance

Interview #6- Eby's Pizzeria. For 32 years Eby has been in the pizza business. Like many small business owners, Eby's story is familiar. Now close to the age of 60, he had a dream dating back to 1987 when he opened a small shop near the Minnesota State Fairgrounds and hired a couple part-time employees, who to this day are still his friends. Eby made his own dough and created a unique sauce that was voted a "Top 10" in the Twin Cities back in the 1990's. He has been on his own through the years, and represented a relatively large local chain as a franchisee. After several years of alignment with this well-known franchisee, Eby discovered that the structure, fees, and politics of franchising was not viable long-term in his mind. Today he is back running his own operation and doing quite well.

Eby employs 16 workers that operate the business. Most are part-time and under the age of 30. The company is poised to grow in the coming years through more effective local advertising, promotion of their secret sauce, highest quality/heaping toppings, and its involvement in the community. Eby's differentiates itself from the competition by supporting local sourcing of ingredients and maintaining a small-town image. Since this organization does not offer insurance, there was no existing discussion relative to the employer sponsored health care coverage. Most employees have sought their own individual coverage through MNSure, are covered through their spouses, or are under the age of 26 and still eligible for family coverage under their parent's plan. At the same time, Eby is in the process of hiring full-time employees and recognizes the competitive angle of offering health care coverage to attract higher levels of talent. Recently an employee left Eby for another local restaurant solely due to the fact that they offer insurance and the

pizzeria does not. This incident coupled with the prospects for more growth has incentivized Eby to open up discussions related to heath care options for employees. Strategically, offering health care coverage aligns well with the pizzeria's quest to maintain a competitive advantage. Eby is now to the point where he is examining the options and costs offered through the ACA. He recognizes the benefits of employer offered coverage and believes that the price/value equation leans toward offering coverage. In his mind he foresees an increase in productivity and efficiencies. Although this is likely not measurable on a direct scale, there would be subtle or refined improvements in employee behaviors and/or levels of job satisfaction. This also leads to additional benefits such as retention and developing an organizational culture that is centered around healthy, happy, productive employees seeking to contribute to a common cause. This is essentially what Eby envisions in the coming years as his company grows and evolves.

Finally, Eby clearly understands costs and its limitations when making decisions in support of growth. Not all companies will be able to afford health care coverage for its employees. At the same time, attracting higher levels of talent and offering benefits may lead to a higher probability of achieving stated goals. This led to a discussion around the employer's obligation (or not) to offer health care coverage. Eby's position is measured. He believes that if a company is under 50 employees, they should definitely offer coverage IF it is financially feasible. In other words, the company should budget for health care coverage. The only way it should not be offered is if organization has no choice, will experience hardship, and/or never plans to grow. In these cases, the company will likely maintain low to modest growth rates and may struggle with long-term prosperity. In the

end, Eby's position is that U.S. companies versus other nations should be in the position to provide health care benefits to its employees.

Interview #7- Sally's Salon. A national franchise with over one thousand locations, Sally is a franchisee who employs eight stylists. She purchased this location from the previous owner six months ago. Sally was a long-time stylist herself at this salon and became close enough to the owner to eventually enter into negotiations to purchase the business due to a desire to retire. Now Sally has realized her dream to become a small business owner and manage a group of professionals who share a vision of enhancing an individual's appearance and confidence. Sally has quickly adopted the leadership role and prioritized new training for her stylists along with establishing solid ground rules under her management. The salon will initiate several organizational changes in the coming months. These include marketing initiatives, sales of product, and emphasis on improving core stylist-client relations to create long-term loyalty and trust to Sally and her organization. A focus on community immersion initiatives is also planned, along with monthly in-house competitive sales "contests" that are friendly in nature.

Since Sally does not currently offer coverage, all of her eight employees must seek and secure their own. Strategically, she is convinced that offering health care coverage to her employees directly would be a benefit worth considering. She has not experienced anything to her knowledge that takes her employees away from their responsibilities, but she can also relate to what it takes to investigate, assess, and secure coverage. She has had to purchase her own over the years and has a young daughter to consider in the process as well. For an individual to shop for health care coverage, the activities required can be overwhelming, especially when it is expensive and complicated. MNSure in Minnesota

has attempted to alleviate this burden for those individuals who must seek coverage. As stated on MNSure's website, (mnsure.org/).

> MNsure is Minnesota's health insurance marketplace where individuals and families can shop, compare and choose health insurance coverage that meets their needs. MNsure is the only place Minnesotans can apply for financial help to lower the cost of your monthly insurance premium and out-of-pocket costs. Most Minnesotans who enroll through MNsure qualify for financial help. Also available to those who qualify are low-cost and free health insurance options provided through government-sponsored health insurance programs Medical Assistance and MinnesotaCare. If you qualify for and enroll in one of these programs, your health coverage is managed through the Department of Human Services.

Three notable findings emerged from interviews with these two organizations:

1. These small employers need to offer health care coverage for their employees in order to attract and maintain good talent.
2. Both companies are interested in growing, and recognize the value in providing benefits. Health care coverage would be the first prioritized benefit offered.
3. The ACA is an option for those who are independent, but organizations would like to offer health care coverage before government options.
4. Cost is a barrier but incentive exists to offset stress and secure employee loyalty.

Table 6

Part III: Summary Table-Interviews- Health Insurance Not Provided

Not offering insurance	Org. Strategy	Fringe Benefits	Where is current coverage obtained ?	Agree w Mandate ?	Why not offer ?	Does ACA affect you in any way ?	Would you offer if feasible ?	Employee responsibility ?
Eby's	Hire young employees or at least under 26, avoid need to hire older FTEs	Limited. Higher pay for marketing efforts, free pizza	Parents due to <26 and MNSure, government derived programs	No, govt. should not be involved in mandating HC due to costs	Cost	No, other than forces those w/out coverage to obtain	Yes, if cost effective, reduce stress and improve focus	Yes, in great part. Most small employers cannot afford to budget for HC coverage
Sally's	Hire young employees or at under 26, avoid hiring of older FTEs	Limited. Marketing incentives	Parents due to <26 and MNSure, government derived programs	No, govt. s/ not be involved in mandating HC due to costs	Cost	No, other than forces those w/out coverage to obtain	Yes, if cost effective, reduce stress, improve focus	Yes, in great part. Most small employers cannot afford to budget for HC coverage

PART IV: Surveys of Seven Participating Organizations

In addition to the employer seven interviews, six organizational surveys (one organization chose not to participate) were distributed and completed to gather specific feedback from their employees. The survey contained 27 questions and a total of 50 were completed and collected. The interviews and surveys overlap in spirit, but the surveys are intended to draw perspectives related to the ACA from an employee's point of view. While the employer interviews were more strategic, exposed, and conversational in nature, the surveys were designed to gather personal, private, and thought-provoking insight into employer/employee perspectives of health care and coverage. The breakout of inputs to the interviews and surveys are summarized below:

Table 7

Summary of interview and survey inputs among all companies in study

Number of Employees	# of orgs.	(Interview) # Employer questions	Total Interview Inputs	# of orgs.	(Survey) # Employee completed	Total Survey Inputs
>50 offering	2 X	27	54	2 X	9	18
< 50 offering	3 X	27	81	2 X	10	20
< 50 not offering	2 X	27	54	2 X	6	12
TOTAL INPUTS	7X		189	6 X		50

Data Analysis

Regarding the ACA and its impact on organizations and society, there are a minimum of 15 notable observations gathered from survey responses from Table 8:

1. Most surveyed believe that health coverage **is** a right of every U.S. citizen. The results are very close; 50% believe it is, 40% believe it is not. This is representative of traditional Democrat versus Republican political dogma as described in Chapter 2.
2. Employees are not comfortable assuming the position that employers are responsible for their health care coverage. There is an indifference among employees in relying upon an employer to provide coverage. This suggests that perhaps the government should be responsible?
3. Those surveyed are very sensitive to small businesses. They respect that not all employers can afford health care coverage for their employees.
4. Access to coverage almost unanimously puts employee's minds at ease.
5. Employees are undecided if employers should budget for health care coverage. This relates back to the sensitivity of small business and their ability to pay,

coupled with a "societal confusion" as to *who* should pay: your employer or the government.

6. Employees clearly believe they are more productive if they know their health care coverage is paid.
7. Employees are generally satisfied with their employer provided coverage.
8. Access to health care coverage is a very important consideration when finalizing employment decisions.
9. Employees appreciate (though perhaps not verbally) employer-sponsored health care coverage.
10. Employees would be ready to contribute more to their health care coverage, especially when working at a small company. This is due to the sensitivity of cost to their employer, coupled with the importance of having coverage.
11. Offering health care coverage differentiates one company from another. Competitive business environments and markets command that employers offer health care coverage to their employees at levels that are enticing to prospective and existing employees.
12. Interestingly, if higher wages/salary were offered, employees would seek their own coverage. This suggests there is a market for self-sought health care plans.
13. Most employees would pay more for coverage given the current structure of plans, especially if there is a threat of discontinuation or a financial burden to the company.
14. Most employees are satisfied with their jobs, their contributions, and their position within the organization.

15. Most employees are satisfied or very satisfied (82%) with their overall benefits and pay packages.

The vast majority of employees surveyed are highly educated. Eighty-nine percent have some college or are college graduates. Most of the comments provided at the end of the survey were largely sympathetic to employers and the cost aspects were prominent. They also stated that the government should be involved in health care to the extent of oversight versus total control. Sixty-eight percent believe that the government should not play an authoritative role in providing and/or mandating health care options through small employers on behalf of their employees. Several participants noted that costs rise through government involvement and that a free market aids in developing and maintaining a competitive landscape where costs are checked, and quality is more of an expectation due to the number of choices available.

Table 8

Results-Summary of Employee Surveys among all companies in study

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1. I believe that health care coverage is a right of every US citizen.	**19**	12	4	13	2
2. As an American, I believe that providing health care coverage for myself and my family is primarily the responsibility of US employers.	0	20	**21**	6	3
3. Access to comprehensive health care coverage (would) put(s) my mind at ease.	22	**23**	5	0	0
4. I am more productive when/if I know that my health care needs are covered/paid.	13	**21**	16	0	0
5. All organizations, large and small, should offer health care benefits to their employees.	10	11	**19**	8	2
6. Access to health care benefits are an important consideration when finalizing employment decisions.	18	**22**	9	1	0
7. I respect that many smaller employers cannot afford to offer health care coverage as part of their overall compensation package.	10	**29**	9	2	0
8. Employee productivity improves when health care costs are (in-part) covered by employers.	9	**33**	5	3	0
9. The availability of employer sponsored health care coverage sets a company apart from those that do not.	14	**30**	6	0	0
10. Employers should budget for health care coverage and provide it for their employees regardless of cost.	7	**14**	**14**	12	3

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
11. I would work for an organization that does not offer health care, provided there is salary enhancements to offset some of the costs.	9	**26**	8	6	1
12. I am willing to stay with my present employer and seek my own health care coverage even though they do not offer, **OR** reduced/modified their health care coverage.	1	20	**21**	5	3
13. Circle as applicable where underlined prior to answering with "X" to the right. I am satisfied with my own *OR* employer sponsored health care benefits/arrangements.	3	**30**	12	5	0
14. I am willing to: begin sharing costs for health care, **OR** pay even more through my employer.	2	**29**	13	8	0
15. My employer recognizes the positive link between productivity and employee satisfaction through strong employee benefit packages.	3	**27**	17	1	2
16. I am satisfied with my health care status or position.	7	**26**	12	4	1
17. My work is highly motivating.	14	**30**	6	0	0
18. The job I do gives me ample opportunities to learn new things.	**25**	21	3	1	0
19. My work has meaning and purpose.	**24**	22	4	0	0
20. I feel the work I do is important for my future.	**30**	14	6	0	0

Additional survey questions

Q1: If you do not currently receive health care benefits from your employer, would you be willing to share costs with your employer? If "yes", what percentage would you be willing to pay? If "no", who is your health care provider?

15□ Yes 12 □ No Percent willing to pay? 5-50%

Q2: Do you have dependents? If "yes", are they covered, what are their ages? Please explain.

23 □ Yes 26 □ No

21 dependents from 1 year to 62 years.

Q3: What is your education level? Circle one.

High School	Some College	College Graduate	Masters Degree	Doctorate
1	15	**31**	3	0

Q4: How would you rate your overall compensation package (salary and benefits)?

- □ **Highly satisfactory** 9
- □ **Satisfactory** **22**
- □ **Neutral** 17
- □ **Unsatisfactory** 2
- □ **Highly Unsatisfactory** 0

Q5: Do you believe that government should have an authoritative role in providing and/or mandating health care options through small employers on behalf of its employees?

20 □ **Yes** **30 □ No** **Please elaborate or explain:**

____

____

Q6: I am… **28 □ Male** 10 □ **Female**

Q7: My age is… 10 □ **18-30** **13 □ 31-45** 11 □ **46-59** 4 □ **60+**

Chapter 5: Discussion

Outline of Themes

The overall dynamics of the ACA are discussed throughout this manuscript. The literature review highlighted provisions, timelines, perspectives, tax credits, legal implications, and psychological considerations among many other topics. The ACA through President Barack Obama reminds politicians and historians of President Franklin D. Roosevelt's signature law introducing Social Security to the American vernacular back in the 1930s. Then in the mid-1960s President Lyndon Johnson signed Medicare and Medicaid into law. Today all three initiatives represent sequential "victories" for workers and/or employees. All three address fundamental employee concerns regarding retirement, financial stability, and health. Further, all three drew criticism and spirited debate primarily among Democrats, Republicans, employees, and employers. Obviously, there are dozens of other related stakeholders involved over the decades that have various aspects of limited or extensive involvement. As a result, markets have emerged, flourished, and disappeared along with this tide of government-backed programs. In any case, the confrontations between the private sector and government influence or control continue. The private sector traditionally takes the position that limited governmental intervention promotes free-market solutions at lower costs, better quality, and higher levels of overall satisfaction. If government is involved, there is a distinct motivation to protect the subject and his/her rights, define parameters that are transparent to public scrutiny if required, and ensure equitable contributions to the cause by those who will ultimately benefit. This may come at unanticipated costs that are not subject to financial scrutiny. Both parties claim to have societal advancement and our children's welfare at its core, but like most complex

issues or encounters, there may be more than one way to solve the matter to the satisfaction of the majority. In any case, my work has produced four themes that most resonated with the problem statement, review of literature, and organizational connections to the ACA.

Theme I: The ACA has helped to stabilize costs and launch an important National Health Care debate

In the seven interviews I conducted, the ACA was well known by all. All employers are fairly well versed with the ACA and how it might/may affect their organizations. Those over 50 employees were not technically affected due to the fact that they must offer health coverage, but those under 50 clearly are paying attention. Those employers with less than 50 employees and not offering insurance meant that employees quickly aligned with their parent's policies if under the age of twenty-six. If they are over this age, they did their best to enroll in a policy through MNSure. As most individuals found through this process, the system was broken and delays in coverage were common. In their respective lives they experienced stress, lack of focus, and a lack of confidence in the system. Many employees in this category choose to not seek health care coverage due to cost and complexity. To be completely honest, these individuals are taking a chance on their personal health. In some cases, they cannot afford the average of $300-$500 per month through MNSure, and if they have a child or two those costs increase by another 10%. This amount includes access to income credits that substantially reduce monthly premiums, but not enough to incentivize many lower income workers to procure coverage. Through the ACA there is a penalty if you do not obtain coverage, but it is far lower than the monthly cost of maintaining coverage; for this reason, the individual's cost can outweigh the benefit of knowing he or she is covered. This becomes more and more of an

issue the older the employee becomes. I spoke with a restaurant employee in her late thirties who did not have coverage. After explaining her financial status to me, her simple reply to not having coverage was "just don't get sick." She recognizes that "getting sick" is relative. There is a difference between coming down with a cold once or twice a year and being involved in an accident of some sort or experiencing a medical emergency. The common cold is self-fulfilling and likely will run its course without the need for clinical or hospital visits. However, when there is an incident where an arm is broken or someone is suffering from a gall bladder attack, the lack of coverage will be devastating and carry long lasting financial and psychological effects. Employers of those without insurance have been difficult to sit down and interview. I had a minimum of two candidates identified and scheduled that ended their participation and declined to re-schedule. They would not answer directly about the reason for exiting the study, but I sense it was due to the sensitivity of the subject and the prospect of information leaking to employees about what I was asking coupled with the financial inability of the employer to participate in offering insurance. Perhaps the employer just did not want to remind himself of this reality.

For those employers offering insurance, educating themselves about provisions and costs included in the ACA became protocol. In the end all three companies with under 50 employees that offer insurance found that there would be no effect on the existing plans they had in place. The overall reaction to the ACA was positive in that now employees who did not have access to coverage may now seek reasonable care options through government supported outlets such as MNSure coupled with access to funding if income levels are low enough to qualify. Based on the data collected, the organizations I met with that offer health care coverage to their employees do so for two primary reasons:

1. They need to offer competitive compensation packages to attract and maintain talent. A good health care coverage plan is a serious qualifier.
2. Many small, family-oriented organizations (<50 employees) consider their employees as "extended family." Offering coverage demonstrates how employers may feel about their employees and their well-being.

Obviously, there are other components involved, but the employers interviewed shared their appreciation for access to coverage for those that previously were unable to afford, or unable to qualify. The ACA represents fulfillment of a large coverage gap. It was estimated (on the high end) that nearly 30 million Americans did not have access to health care coverage. This number was trending upward for several years prior to the signing of the ACA due to annualized increases in health care coverage and was beginning to reach a point where employers could no longer afford to offer coverage. With the new law, many of those who previously did not have health care now found that with the offering of financial incentives and the local support of MNSure customer service, health care coverage was not only affordable, but available.

The often-contentious debate over the last several years has been healthy. We saw both political parties in the Congress and Senate battling bitterly over this monumental initiative. Most influencers and experts agree that the ACA is not perfect or optimized and there will always be serious considerations, complications, and outliers to the integrity of the program. The benefits, however, appear to be slowly taking hold for those who are/were uninsured. Between 7 and 10 million individuals have become enrolled through the ACA (Blumenthal, et. al, 2015) which effectively reduces the number of uninsured from 30 million to 20 million over the past few years. This is not optimal, but the

improvement has helped to reduce overall costs in annual premiums, enhanced organizational overall productivity, and allowed organizations who had cut coverage to reconsider offering once it again.

Theme II: Employers approaching 50 employees will react to mandated health care

Despite the positive reaction to the ACA from an employer's perspective as it relates to providing access to those previously not eligible or able, there is another camp that will reject the mandate as they approach 50 employees. Unlike the specified examples from Theme I above, these employers do not offer insurance primarily due to the fact that partial or majority cost sharing for health care coverage with employees is not feasible. Concurrently the organization may be growing and in need of new and additional talent. In these cases, and supported by the literature submitted, employers will seek to avoid the mandate as they breach 50 employees in one of the following ways:

1. Reduce the number of full-time employees (FTEs) and increase the number of part-time workers logging fewer than thirty hours per week.
2. Split the company into two or more organizations that will employ between 1-40 employees and not breach into the mandate.
3. Strategically plan to not grow and/or not hire additional employees. This may be aligned with #1 above.

For the first point above, Patrick, the general manager from TCGD is a prime example of an organization leader that actively and strategically managed full-time versus part-time employees in order to avoid providing health care coverage. Prior to his role at TCGD, Patrick was the general manager of another country club that did not offer insurance. Over the course of five years the club found itself growing and approaching 50 employees.

Management and ownership of the club recognized it was good that they were growing, but clearly did not want to embark upon the mandate of offering insurance to its employees. As a result, they systematically began to reduce their full-time staff and increased their part-time employees to effectively net forty to forty-five FTEs, thus avoiding the benchmark that would place them into new, unwanted cost structures and unfamiliar administrative responsibilities. According to Patrick, this strategy will work for his former employer well into the foreseeable future. Interestingly, he now also has two management perspectives related to health care coverage; one from an organization that offers coverage and the other that does not. Clearly, there is a noticeable difference in behavior and performance between those who were not offered coverage at his old employer, versus his current position where TCGD does offer coverage. This will be covered more in Theme IV.

For the second point above, business owners need to understand the risk of not complying with what is termed, "commonly-owned companies" and/or "Applicable Large Employer" (ALE) as defined by the ACA. Many business owners that do not offer health care coverage for their employees and are approaching 50 employees have been looking into dividing the organization into two or three parts, each representing well under the defined benchmark for mandated offerings. This may appear as logical, feasible, and even legal, however, ACA regulations linked to IRC § 414(b) and § 414(c) stipulate that when one or more businesses are connected through stock ownership with a common parent corporation, these businesses must combine FTEs and report as one organization when calculating health care coverage regulations. Similarly, those organizations that may believe they are exempt from mandated health care coverage for their employees may need

to investigate their situation further. For example, a 50%/50% set of husband and wife owned businesses that employs 32 FTEs at their real estate firm and 19 FTEs at their restaurant are considered ALE business owners subject to formally offering health care coverage. The choice to not abide by or research these seemingly innocent oversights may cost this couple thousands, or even hundreds of thousands in IRS penalties. This would be in addition to new costs associated with offering coverage through employer contributions, administrative expenses, and other various/unforeseen costs associated with managing a health care program.

Finally, item number three from above suggests that business owners not offering coverage and employing, say between 35 and 45 employees may make a conscious and strategic decision to "mothball" the business and manage sales levels and the relative number of employees required to avoid the health care mandate to provide insurance. Although this is an organizational choice that cannot technically be contested or admonished, it does represent a population of employers that are arguably stunting their own growth at the expense of potential economic contributions to local and/or possibly even global markets. It could be argued that the ACA in this case "disincentivizes" a large number of employers. For example, in Minnesota, approximately 50% of small businesses do not offer health care coverage. Furthermore, there are nearly 132,000 small businesses in Minnesota that employ workers, and approximately 11,000 of those employ between 20-100 employees. It can be deduced then that from all above, a conservative estimate of firms in Minnesota that do not offer health care coverage, and employ between 35 and 45 employees, is 1400. Finally, if Minnesota represents 2% of total U.S. GDP, this number climbs to over 70,000 organizations nationally that could be considered as candidates to

limit their growth plans due to the ACA federal mandate (2018 Small Business Profile, Office of Advocacy, Minnesota).

The point here is that all businesses should (always) be incentivized to grow, yet the federal mandate to provide insurance at 50 employees may inhibit growth from a specific and important population of our organizational profile.

Theme III: It is the "Right thing to do." If financially feasible, most organizations would choose to offer health care coverage to their employees.

Of the seven organizations interviewed, all had varying degrees of input and support for the ACA and the notion of providing health care to employees. On the one extreme, during my interview with Tom from RMG, we spent a great deal of time processing a seemingly societal obligation for employers to provide insurance. Tom is very active and involved in local and national political events and became a bit irritated when reminded of the spirited debates between political parties, and the seemingly unfounded and unreasonable positions that various politicians would take to defend ACA related items in pursuit of favorable ground. RMG is a specialized, value-add organization that can justify its fee structure, so in turn they have little trouble budgeting annually for employer sponsored health care coverage. Regardless, and as outlined earlier, Tom looks for his employees to acknowledge the generosity he does provide to them. Unfortunately, this gratitude does not come his way, which has led him to argue that there is an expectation on the part of the employee and society at large that providing and managing health care resides with the employer.

The other four organizations in this study that offer insurance for their employees have indicated that on an annual basis they critically review renewal packages for overall

cost and benefit changes that may initiate a necessity to change providers, reduce contributions, or offer lower value plans. Over the past ten years, these organizations believe strongly in the ability to afford health care coverage plans for their employees. This means that they will find a way to budget for the costs at the expense of other less prioritized line item costs such as travel or updated computers. For example, if a health care plan renewal package for KP Group is scheduled to increase by $3,500 for the upcoming year, they would audit the increase, approve as justified, and absorb the cost through a reduction in one or two other areas. This decision would not be communicated with the employees and there would be no reduction to their coverage, or disruption to their plan. The reason is simple. The organization can afford this relatively minor increase over twelve months, and believe the benefits in employee coverage to outweigh the cost.

Finally, the two organizations not offering coverage both indicated that in their current financial state they cannot afford to provide coverage, but are planning on budgeting for the possibility in the next two years. This is due to the fact they are growing and their employee average age is increasing. This means that additional FTEs will be coming on board and the likelihood of these new employees seeking health care coverage as part of their pay package is real. Eby has already indicated that in order to attract the type of talent he requires to manage his business, offering health care coverage will be an expectation. This will also be extended to a few other key employees who are now over the age of 26, and posses the experience, knowledge base, and know-how that Eby is ready and willing to pay for in exchange for loyalty and reliability. Eby knows that, unlike before, he will need to budget for this added expense and that including it now in his annual financial plan will require more pizza sales or lower costs elsewhere if necessary.

In exchange, he is convinced that employees will be more productive and dedicated to the organization.

Despite where these organizations are in their journey to maintain and/or provide health care coverage, all agree that costs will always be a serious consideration and adjustments may be necessary along the way. When asked if an organization should or should not offer coverage, the nearly unanimous response was, “it is the right thing to do,” positioning as a moral imperative to offer coverage.

Theme IV: Offering health care coverage reduces stress, improves productivity, and keeps employees more focused on their roles

Referring back to my discussion on *intrinsic and extrinsic motivators*, there appears to be a positive correlation between extrinsic motivators like incentives and employee performance. This is consistent with Hofstede, Hofstede, and Minkov’s (2010) report on motivators linked to education levels. For TCGD, most of their service-based employees would be considered lower on the education scale and are consistently motivated by policies, practices, plans, and incentives. These same employees are less motivated by intrinsic motivators including recognition, achievement, responsibility, advancements, and competence; however, staff employees are clearly more receptive to these attributes. The point here is that between the two country clubs mentioned, employee dynamics are very different and can be linked at least in part to the availability of health care coverage versus not.

It is difficult to quantify objective, absolute proof of the tangible operational benefits to offering health care coverage to employees. One way to attempt to gain some insight here may be to presume that all five participants in this study abruptly decided to

cancel their health care coverage upon the next renewal timeframe. What would happen, how would employees react, and what would the "other side" look like? To answer this series of questions, I spent some extra time with Peter from KP Group. This company employs less than 50 FTE and offers health care coverage. He indicated that health care coverage is a dynamic, sacred component to their employee's pay package and that the prospect of eliminating this item would be devastating. Not only would this disrupt current operations, it would also breach trust. Employees have come to expect health care coverage as part of their pay package. Elimination would send employees scrambling for coverage at the expense of productivity, and send a clear message that KP Group cannot be trusted for long-term employment stability or viability. The reputation of KP Group would be challenged incessantly and its fortitude would be tested well beyond current levels of delineated interpretation.

In the end, all interviewed acknowledged the immeasurable benefits to offering or considering health care benefits. Not offering coverage was a possibility that none of those currently offering were willing to consider. They recognize that intrinsic and extrinsic motivators would be compromised after years of establishing existing pay packages as coveted ingredients for productive, focused attention to organizational objectives. Employers and employees deal with countless inputs related to stress on a daily basis. Eliminating or minimizing the effects of stress-related distractions, especially health, can only contribute positively to organizational fitness.

Limitations

There were two limitations I would highlight here:

1. The number of participants in this study that did not offer coverage and employed fewer than 50 workers was underrepresented in my view. Despite this observation, I did receive comprehensive feedback and surveys that are representative of a larger population. That said, I did have a great deal of difficulty finding/procuring candidates in the 40-employee range, that did not offer coverage. This would have been interesting to tie in with other interviews from this category, and obtain more relative information relating to the "approach" to 50 employees and the mandate.
2. I purchased a business in March of 2016. This was a time when I should have been more aligned with some of my other OD colleagues in actively writing my dissertation. This life-altering event brought my focus away from OD studies and arguably diffused some of the "front page" momentum of ACA and its impact on organizations.

Implications

When I think of implications, I cannot help but reflect upon most of the various courses, topics, classroom discussions, and authors we experienced beginning in 2012 as OD Cohort #7. Implementing a controversial, nationwide health care initiative that has the potential to impact over 50% of small companies will force HR discussions related to strategy, employee benefits, leadership, change, responsibilities, cost, productivity, psychological reactions, culture, competition, competitive advantage, and more. Authors we studied such as Schein, Argyris, Weisbord, Northouse, Galbraith, and many, many others all contributed in one way or another to the subject of organizational change and

its relative impact on employee behavior. Similar to Newton's third law (Cajori, 1934) — "When one body exerts a force on a second body, the second body simultaneously exerts a force equal in magnitude and opposite in direction on the first body"—health care coverage is a benefit when you have it, and a liability against yourself if you do not. An organization's decision to offer or decline coverage for their employees instills a position that can either be improved upon or threatened. If coverage is removed or reduced, the employee is forced to react to the point where equilibrium is achieved. This may mean transferring to a spouse's plan if available, taking on a weekend job to pay for the difference, or leave the company altogether in pursuit of filling in the newfound gap. The last option would have the most profound effect on the organization in that new costs would be incurred to replace the employee, transitional training would be required, and departmental dynamics and/or efficiencies may be compromised. On the other hand, if health care coverage is now offered to employees where it was not previously, the organization will experience additional costs and administrative overhead that must be budgeted. In this case, the organization will react with expectations of higher productivity, loyalty, and allegiances to the "corporate" cause. These two simple, but realistic examples demonstrate the chasm between employee options and organizational expectations in light of reactions and control. Both represent shifts in equilibrium that seek to benefit individual interests and objectives, hopefully with a united eye on organizational improvements through intrinsic and extrinsic motivation.

Future Research

As I began this study, the questions that drove my interest were related to very specific reactions to organizations faced with moving from 49 to 50 employees. We know that they will either adapt to the mandate or make modifications to how they are structured and/or how they operate. It would be interesting for future studies to zero in on exactly how these companies arrive at their ultimate decisions and learn more about the strategic dialog that occurred, and how they ultimately came to their destiny. I rather quickly found it very difficult to locate these types of candidates, and if I had, I knew that aligning with enough critical mass and eventually interviewing them would be out of scope. I believe there is a gap in information and knowledge related to the cost/benefit analysis of financial, psychological, and productivity metrics as the mandate is enabled. It would require a study of financials between existing organizations over 50 employees to those recently breaching 50, considering financials before and after. Additionally, you could design more in-depth studies relative to intrinsic and extrinsic motivators; again, compared to an established firm with over 50 employees. Finally, interviews and surveys focused on productivity prior to and after the mandate would need to extract metric creep information that can be linked back to motivators and financial benefit. All combined this would be tangible, but involved. The results would be interesting to analyze, and I suspect there would be several significant correlations that would in turn help to justify those who are strategically avoiding growth at the expense of providing health care coverage.

Conclusion

Health care coverage, or lack thereof, is an important subject when considering organizational dynamics. The ACA was launched in part to aid small organizations in promoting coverage for their employees. This manifested after years of rising health care costs, declining employer coverage, and an increase in individuals without a health care plan. To address this fundamental concern, our U.S. Congress has gone to battle and essentially divided the country on who should “own” individual health care decisions: the government or the free market. After nearly six years, we can conclude that both politically derived interests have claimed victory. The ACA has successfully insured over 10 million previously uninsured Americans through health care exchanges that did not exist prior to the new law. This has come at a cost of nearly $40 billion in annualized cost to the federal government. On the other hand, organizations over 50 employees retain their independence and are largely unaffected by the ACA, while those under 50 employees are now exposed to new options to offer coverage and/or subject to new regulations or tax credits if participation in the ACA is appropriate for the organization.

The average cost of health care for all organizations has slowed or stabilized as well. From my observations, I did not come across any organizations that were taking advantage of the tax credits. This is probably related to the fact that they are temporary. Individuals, however, appear to be taking advantage of the ACA, although the projections are far below expectations. This could mean that incentives for both employers and individuals that the incentives are just not attractive enough to warrant the activity sought by the ACA.

From a relative perspective, many small organizations adopted a "wait and see" attitude to the ACA for the following reasons:

- It is a government program, and not mandated for us.
- Allow the "kinks" to work out prior to making any decisions.
- Need time to understand cost/benefit analysis of offerings and impact.

The conclusions of this study are fourfold:

1. **All things considered, the ACA is underwhelming and non-binding.**

   The 1296-page ACA document is very comprehensive and considers most every aspect of an employer's and employee's options and expectations. This includes IRS regulations, tax credits, employer mandates, provisions, exceptions, penalties, and rules. The ACA was covered by the media excessively leading up to it becoming law in 2010 all the way through its implementation in 2014. We recall the boisterous, confrontational debates at town hall meetings and between congressional members. Democrats positioned the ACA as providing access to those who do not have it, and more affordable costs for those who do. Republicans argued that the government should let the markets decide and that intervention will increase costs and reduce quality of care. The subject of "rights" versus "privilege" spread across the nation and stimulated fundamental debates about who should really pay for health care. After nearly nine years of formulation, enactment, and practice, it can be argued that not much has changed. From my observations, large companies have maintained much of what they have done prior to the ACA,

but have implemented incremental steps to aid in reducing costs for employees and their annual renewal rates. Small companies offering coverage for the most part have done the same as their larger counterparts: review renewal rates annually and assess fixed cost allocations. Not surprisingly, those organizations approaching 50 employees will either adopt the mandate or enable options to avoid breaching the benchmark. Finally, small employers considering coverage for their employees find the incentives to be temporary or unattractive enough to maintain the status quo.

As aforementioned, the ACA has provided access to 10 million Americans (2016) at an estimated cost of $40 billion. This represents between 25% and 33% of those identified as eligible for coverage. A larger percentage would likely exist by now if stated penalties for non-participation were enforceable. As outlined, incentives for those uninsured to obtain coverage are outweighed by tactics to delay or avoid altogether.

2. **Acceptance of the ACA as a proven, assessable, affordable option will evolve with time.**

Like Social Security and Medicare/Medicaid, the ACA will take time. In reality the law has now been in effect for a total of five years, which arguably is not long enough to gauge as a success or failure. Given the complexity and magnitude of this highly profound law, it will take years of inputs and outputs to refine issues that are not optimized. In general terms the fundamental components of the ACA are worth supporting. Attributes such as pre-existing conditions, lower drug costs, and preventative care are fundamental to

achieving coverage for a broader range of uninsured Americans. It is important to note that the ACA has helped to stabilize the historic rise in annualized premiums and prescription drug costs. Regardless, many states are still not aligned to a national program, which in some cases relates back to political roots. There is a disjointed, inconsistent series of cultures related to health care from state to state. It begs the question, should states be responsible for their own programs given a traditionally "federalist" undertone coupled with well-defined and unique attributes from state to state versus a broad-brush approach to decision making through the federal government? With time, efficiencies among individual states will become best practices for others, and through this process affordability will evolve, quality of care will improve, and the ACA brand will advance to a more respected and trusted status.

3. The "Right thing to do" always comes at a cost. But there is an ROI.

Most organizations that were interviewed and surveyed agree that there is an inherent obligation of employers to provide health care coverage. The ACA has aided in promoting this type of discussion as a society. The number of uninsured identified as 30 million or more suggests there is a societal issue that must be addressed through the government or business organizations. These are the two only sources of income; the government through taxes, and businesses through sales. Between the two, the ACA has refreshed the dialog between these two entities through the support of political will and societal pressure. The government pushes to enact laws, while organizations begin to

weigh and justify the cost/benefit analysis. In the case of companies, an ROI is supposed to be linked to any investment. In the case of health care benefits, the absolute or quantifiable justifications are hard to measure. In fact, most business managers and owners default to bury the 10%-20% fixed costs into presuming that offering an attractive pay package that includes health benefits will directly impact important metrics in a positive manner—thus providing an ROI despite the inability to measure.

Cost will continue to dictate behavior of an employer's ability to provide, and an employee's willingness to participate. Intrinsic and extrinsic motivators are important component to an organization's healthy culture. The ACA has given rise to folding these types of conversations into strategic and performance management. It is the right thing to do.

4. The government and the free market have become more divergent through the ACA process.

It is difficult to read a newspaper story or watch a news broadcast today without noticing a degree of hostility or even animosity with "the other side." This refers to Democrats and Republicans as well as the government and the free market. I contend this began to become accepted as a new normal back in the George Bush era. The public displays of blame, discontent, and dissidence became evident through the Iraq war issues, immigration protests, and the mortgage crisis. Words like "tolerate, inclusion, and feelings" made their way more often into our vernacular. Names like Harry Reid, Nancy Pelosi, Vice-President Cheney, Osama bin Laden, Hillary Clinton, and scores of others

entered what appeared to me as a forceful and transparent approach to implanting agendas. One of course was the ACA. In retrospect, and in writing this dissertation, I could not help but notice the divisive approach to "negotiating." Prior to the ACA becoming law and for the five years or so after, there was a clearly a split in ideologies that defined politics. Congress was now essentially voting among party lines (like never before) versus what is right for respective districts or states. From my observation, this has spilled over into the business arena which in-turn influenced employers and employees. This manifested itself in the employee surveys where there was essentially a split between health care coverage as a "right" or a "privilege." There was also a split in whether employees believe that their coverage is the responsibility of their employer. Finally, there was a split in whether employees believe all employers should budget for and effectively shoulder the costs.

The more frequent theme around "feelings" and "tolerance" aligns back to conclusion #3 where providing health care is the "right thing to do." The reality of costs and responsibilities links back to conclusion #1 where adopting and adapting the ACA depends upon incentives and accountability. In all cases above, more time is required along with a more united approach to upholding and supporting the ACA if it is to survive and eventually thrive.

Personal Reflection

After five years of instruction, classroom time, retreats, extensive time studying, researching, and a two-year hiatus, this OD student is grateful and fulfilled. I am grateful for the many opportunities to debate OD derived topics with family, business associates, fellow cohorts, interested parties, and instructors—all in the spirit of critical thinking. In my humble opinion we dedicate far too little time in today's various environments to taking a step back and assessing what might be happening, prior to formulating opinions or tagging solutions to something that may not even require a fix. OD and the entire process of working through a cohort has instilled in me valuable, lifelong lessons of discernment and critical thinking, and hopefully upon all of us as colleagues in learning. I too am grateful for the gift of listening that has evolved from this program. Assembling and writing this dissertation has honed my listening skills through the interview process, the survey process, and the literature review process. When we read and research, we are essentially listening to a variety of voices that in many cases are representing differentiation and positions we may not agree with, or understand. One important role as researchers and OD doctoral students is to listen, process, respond, and learn so that we in turn may assume a leadership role in disseminating, explaining, and providing value to those who can benefit from what is communicated. This program and writing this dissertation has provided me the opportunity to think more critically and respond more confidently in business settings and social events. Finally, I am grateful for the discipline this dissertation has instilled in me. This is an attribute that many individuals struggle with because it requires self-evaluation, monitoring, and management. When you assemble a dissertation all of these components must be in place and work in concert with one another.

A higher grade of discipline will be part of my DNA as I proceed, and this will certainly be projected (by me) to others in need as well.

Beyond grateful, this OD doctoral candidate is fulfilled. This can only come from literally years of continuous improvements in the ability to answer many of your own questions related to organizational dynamics AND the begin to address inquiries of those who come to you for insight and advice. This is not to suggest that I am in a position to answer every question that may come my way, but I am in a position where I can leverage 22 years of 3M experience, four years of recent small business ownership, and now five to seven years of OD instruction and practice. I welcome the opportunities to apply these three solid components to those who request assistance or are seeking organizational advice. These prospects represent fulfillment during the process of exploration and design along with higher levels of fulfillment when the actions become reality. I have limited experience in this arena at this time, and I look forward to expanding my many talents in the coming years, thanks to many individuals along the way, and the OD program at the University of St. Thomas.

References

Affordable Health California. (2015). Timeline: Affordable Care Act. Retrieved from affordablehealthcareca.com/timeline-obamacare/

Affordable Care Act Implementation: Examining How to Achieve a Successful Rollout of the Small Business Exchanges, Senate, 113th Congress. (2013).

An Update on the Small Business Health Options Program: Is It Working for Small Businesses? House, 113th Congress. (2014).

Bagley, N. (2015). Three words and the future of the Affordable Care Act. *Journal of Health Politics, Policy, and Law*, *40*(3), pp. 589-597.

Baker, J., & Garcia-Yow, E. (2014). Yikes, it's alive! The Affordable Care Act and the next generation of ERISA benefits litigation. *Benefits Law Journal, 27*(2), 88-94.

Beckhard, R. (2006). *What is Organizational Development?* In J. V. Gallos (Ed.), *Organization Development,* (3-12). San Francisco, CA: John Wiley and Sons, Inc.

Blum, J. (2013, December 1). Affordable Care Act impacting small business. *McClatchy-Tribune Business News.*

Blumenthal, D., Abrams, M., & Nuzum, R. (2015). The Affordable Care Act at 5 years. *New England Journal of Medicine*, 18;372(25):2451-8.

Bomey, N. (2016, August 16). Aetna to exit nearly 7 in 10 Obamacare plans. *USA Today-Money*.

Boubacar, I., & Foster, S. (2014). Analysis of small business owners' perception of the patient protection and Affordable Care Act: Evidence from Wisconsin farmers. *Economics Management and Financial Markets, 9*(1), 11.

Cisneros, L. (2014). Paging Dr. Derrida: A deconstructionist approach to understanding The Affordable Care Act. *Santa Clara Law Review, 54*(1), 24-69.

Collins, S., Davis, K., Nicholson, J., & Stremkis, K. (2010). *Realizing health reform's potential: Small businesses and the affordable care act of 2010.* New York Commonwealth Fund.

Congressional Budget Office, (2009). *An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act*, November 30, Washington DC: US Congress, www.cbo.gov/ftpcdocs/107xx/doc10781/11-30 Premiums.pdf.

Congressional Budget Office. (2015). *The Budget and Economic Outlook: 2014-2024,* http://cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014.pdf.

Friedman, J., Bowen, J., Collura, E., & Ryan, N. (2015). Managed care litigation and the Affordable Care Act. *GP Solo—American Bar Association*, March-April.

Gabel, J., Whitmore, H., Sartorius, J., Stromberg, S., & Pickreign, J. (2013). Small employer perspectives on the affordable care act's premiums, SHOP exchanges, and self-insurance. *Health Affairs*, *32*(11), 2032-2039.

Galewitz, P. (2015, October 31). Small businesses snub Obamacare's SHOP exchange. *USA Today: Kaiser Health News*.

Glastris, P. & LeTourneau, N. (2017). Obama's Top 50 accomplishments revisited. *Washington Monthly*, January/February.

Goldstein, A. (2014, March 8). Timeline of major change to the affordable care act. *The Washington Post*.

Hackman, R., & Oldham, G. (1980). *Work Redesign*. Boston, MA: Addison-Wesley Publishing Company, Inc.

Hamby, A. (2014). Understanding the safe harbor rules for determining full-time employee status and the litigation risks associated with workforce restructuring under the Affordable Care Act. *Journal of Pension Benefits*, Spring.

Hardin, R. (2011). The income tax effects of health care reform on small businesses and real estate investors. *Real Estate Issues, 35*, 26-30.

Harter, J. K., Schmidt, F. R., & Hayes, T. L. (2002). Business-Unit-Level relationship between employee satisfaction, employee engagement, and business outcomes: A meta-analysis. *Journal of Applied Psychology, 87*(2), 268-279.

Herzberg, F. (1962). *Work and the Nature of Man.* New York, NY: Thomas Y. Crowell Company.

Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Cultures and organizations: Software of the mind. Intercultural cooperation and its importance for survival.* New York, NY: McGraw-Hill.

Jost, T. (2012). Employers and exchanges under the small business health options program: Examining the potential and pitfalls. *Health Affairs*, *31*(2), 267-274.

Jost, T. (2015). The Affordable Care Act returns to the U.S. Supreme Court. *Health Affairs, 34*(3), 367-370.

Judge T., Bono, J., Thoresen, C., & Patton, G. (2001). The job satisfaction-job performance relationship: A qualitative and quantitative review. *Psychological Bulletin*, *127*(3), 376-407.

Kaiser Family Foundation. (2009). Pulling it together: Implementation. *The Henry J. Kaiser Family Foundation*.

Kates, A., & Galbraith J., (2007). *Designing your organization*. San Francisco, CA: Jossey-Bass.

Klimley, A. (2014). Small businesses wrestle with the Affordable Care Act. *New Jersey Business, 60*(1), 50.

Legal Monitor Worldwide. (2014, April 24). Small businesses find benefits, costs as they navigate Affordable Care Act. *Legal Monitor Worldwide, SyndiGate Media, Inc*.

Levitt, L., & Claxton, G. (2014). *The potential side effects of Halbig*. Henry J. Kaiser Family Foundation. Retrieved from kff.org/health-reform/perspective/the-potential-Side-effects-of-halbig.

Lewis, M. (2014). Six things small business owners need to know about the Affordable Care Act. *Vending Market Watch*. Fort Atkinson, WI: Cygnus Business Media, Inc.

Lowry, S., & Graville, J. (2015). *The Affordable Care Act and small business: Economic issues* (Report No. R43181). Congressional Research Service.

Lucia, K., Corlette, S., Ahn, S., & Clemans-Cope, L. (2015). Post-affordable care act trends in health coverage for small business. *Medical Benefits*. Princeton, NJ: Robert Wood Johnson Foundation and Urban Institute.

Macey, W. H., & Schneider, B. (2008). The meaning of employee engagement. *Industrial and Organizational Psychology*, *3*(30), 22-26.

Magretta, J., (2012). *Understanding Michael Porter – The essential guide to competition and strategy.* Harvard Business Review School Publishing, Boston, MA., pp. 219-220.

Miller, E. (2011). Affordability of health insurance to small business: Implications of the patient protection and affordable care act. *Journal of Health Politics, Policy and Law*, 36(3).

Muller, L., Isely, P., & Levin, A. (2015). Employer reactions to the Affordable Care Act. *Benefits Quarterly*, Q1.

Mullin, J. (2014, March 24). How delays have altered the ACA timeline (in one chart). *The Advisory Board Company: Daily Briefing*.

Mulvey, J. (2012). *What is small? Definition of small business in the patient protection and Affordable Care Act* (Report No. R41159). Congressional Research Service.

Napili, A. (2014). *Patient protection and Affordable Care Act (ACA): Resources for frequently asked questions* (Report No. R43215). Congressional Research Service.

Patient Protection and Affordable Care Act, 29 U.S.C. § 218c (2010).

Newton's Principia, A revision of Motte's translation by F. Cajori. Berkeley University of CA., 1934, p. 13.

Perron, J. (2013). Employer mandate delay does not alter problems with Affordable Care Act: Regulations within the ACA are keeping small-business owners from creating new jobs. *Franchising World*, *45*(9), 10.

Pfeffer, J. (1994). Competitive advantage through people. *California management review*, *36*(2), 9.

Politifact, politifact.com/Obama-like-health-care-keep/. 2009.

Pressman, J. L., & Wildavsky, A. (1984). *Implementation: How great expectations in Washington are dashed in Oakland; Or, why it's amazing that federal programs work at all, this being a saga of the Economic Development Administration as told*

by two sympathetic observers who seek to build morals on a foundation. Oakland, CA: University of California Press.

Rachal, R., & Mobley, T. (2014). *View from Proskauer: Developing issues and litigation arising under the federal mental health parity act and the Affordable Care Act*. Managing Benefit Plans, The Bureau of National Affairs, Inc.

Small Business Profile, Office of Advocacy, Minnesota, (2018). https://sba.gov/sites/default/files/advocacy/2018-Small-Business-Profiles-MN.pdf

Stremkis, K., Schoen, C., & Fryer, A.K. (2011), *A call for change: The 2011 commonwealth fund survey of public views of the US Health System,* The commonwealth fund 6: 1492-1516.

Tanner, M. (2013). The patient protection and Affordable Care Act: A dissenting opinion. *Journal of Family and Economic Issues, 34,* 3-15.

Torres, J. (2013). Affordable care act lets small business focus on what they do. *Journal Publications, Inc., 26*(24), 13.

Tracer, Z., Darie, T., & Doherty, T. (2016, October 14). More than 1 million in Obamacare to lose plans as insurers quit. *Bloomberg Press*.

U.S. Census Bureau. (2001). *Statistics of U.S. Business Annual Data*.

Wickman, G. (2011). *Traction-Get a grip on your business.* BenBella Books, Inc., Dallas, TX., pp. 72-73.

Appendix A

Consent Form

[IRBNet Tracking Number-1069042-1]

Organizational Implications and responses to the ACA of Small Firms Approaching 50 Employees

You are invited to participate in a research study about the Affordable Care Act (ACA) and its implications on small firms that do *not* offer company sponsored health care coverage. You were selected as a possible participant because you represent your company's health care decision-making process to offer coverage or not. You are eligible to participate in this study because your firm is either over or under 50 employees and does or does not offer health care coverage to your employees. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Paul R. Kuhrmeyer, a doctoral student of the School of Education at the University of St. Thomas and advised by Dr. David Jamieson. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

When a company exceeds 50 employees, ACA regulations and requirements open up a whole new set of considerations, one of which would include financial penalties for not offering adequate, affordable coverage. It is unclear how small organizations will react to this new law and the dynamic variables. Organizations will need to annually assess their options to provide insurance, abstain from offering anything, or share in partial costs through salary enhancements or other employee benefit options. All of these options have both positive and negative affects that an organization will need to consider. The purpose of this study is to report on the real-life impact of this legislation on small company organizational behavior, and gather reaction related to the implementation of the ACA.

Procedures

If you agree to participate in this study, I will ask you and/or your designee to do the following things: Answer approximately 35 questions during a short interview at a location of your choice and partake in short explanations and/or dialogue. This time together should take no more than one hour. There will be *no* videotaping or audio recording. I will not be collecting any names of participants, but if you would like follow up on this study, I ask that you provide me with contact information during the interview. **Risks and Benefits of Being in the Study**

There is a risk to this study. If employer interviews are conducted on organization's site, employees may be aware of the participation, so the interview may not be private and others may know you participated. The research involves asking participants for personal views regarding their employer, which may represent a conflict of interest and require

higher levels of privacy and confidentiality for participants. Participants may fear retaliation from their employer should their answers be disclosed.

There are no direct benefits for participating.

Privacy

Your privacy will be protected while you participate in this study. In order to insure privacy, interviews will be conducted in offices or locations (and times) of the interviewee's choice, and surveys will be administered in closed group locations or at the discretion of the employer. All information gathered is isolated to the company participating in this study. The unique results will be assigned a pseudonym and never shared by name with other any other participants, but rather featured for individual content and then combined with all other data in the study.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. I plan to share aggregate results without identifiers with employers. The types of records I will create from the interview include a transcript of our interview and the results of our survey. Digital files will be housed on separate drive unique to this study. The password will be recognized by the investigator only. All hard copies of interviews, collected information, and notes will be maintained in a large three-ring binder and remain at all times with the investigator. When traveling to and from interviews, the office or home, all research materials will be together in a personal backpack unique only to this project.

Furthermore the information will be destroyed within one year of our time together. All signed consent forms will be kept for a minimum of three years upon completion of the

study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with your employer, your employees, Paul R. Kuhrmeyer, or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used. You can withdraw by providing me an e-mail or phone call. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Paul R. Kuhrmeyer. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at 612-845-0935, or at pkuhrmeyer@gmail.com. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age.

You will be given a copy of this form to keep for your records.

____

Signature of Study Participant **Date**

____

Print Name of Study Participant

Paul R. Kuhrmeyer

____

Signature of Researcher **Date**

Appendix B

[IRBNet Tracking Number-1069042-1]

Organizational Implications and responses to the ACA of Small Firms Approaching 50 Employees

Consent for Survey

The purpose of this study is to report on the real-life impact of this legislation (Affordable Care Act-ACA) on small company organizational behavior, and gather reaction related to the implementation of the ACA. You were selected as a participant because you work for a company that does not offer employer-sponsored health care coverage; or you are a participant in your company's health care plan. You are eligible to participate in this study because your firm is over/under 50 employees and does/does not offer health care coverage to your employees.

This study is being conducted by: Paul R. Kuhrmeyer, a doctoral student of the School of Education at the University of St. Thomas. This study was approved by the Institutional Review Board at the University of St. Thomas. If you agree to participate, I will ask you to

answer several survey questions focused on your experiences, insight, and attitudes toward health care coverage. The survey should only take *15-20 minutes* to complete.

The study has no foreseen risk as your participation is confidential.
There are no direct benefits for participating in the study. The records of this survey will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you.

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with your employer or the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until the survey is submitted. You may withdraw by not completing the survey and/or not submitting your completed survey to the assigned recipient who will provide surveys back to me, the researcher. You are also free to skip any questions I ask.

You may ask any questions you have now and any time during or after the survey by contacting the researcher. You may contact me at: *pkuhrmeyer@gmail.com or 612-845-0935.* You may also contact the University of St. Thomas Institutional Review Board at (651) 962-6035 or muen0526@stthomas.edu with any questions or concerns.

By completing the survey, I consent to participate in the study. I am at least 18 years of age.

Appendix C

[*Organizational Letterhead*]

IRB Letter of Permission

Tracking Number 1069042-1

Date xx/xx/xxxx

Paul R. Kuhrmeyer

8 South Long Lake Trail

St. Paul, MN 55127

Dear Paul Kuhrmeyer,

I have reviewed your research summary proposal contained within the consent form you provided to you, entitled *Organizational Implications and Responses to the ACA if less than 50 Employees*. I grant permission for you to survey our employees about their experiences/responses to the ACA and/or their respective health care plan(s). I also grant you permission to interview myself and/or assigned staff to obtain information related to ACA and our organization's experiences and responses to health care decisions. It is

understood that the purpose of your study is to report on real-life impact of legislation on small company organizational behavior and gather reaction related to the implementation of the ACA. It is further understood that:

- Participation is completely voluntary and the participants/organization may withdraw from the study at any time throughout the research process without consequence.
- There are risks for us as participants of the study, including possible employee awareness of employer interviews which will be minimized through closed-door discussions when most employees are not on site.
- Confidentiality of data will be maintained through investigator/interviewee privilege protocol.
- The study will begin on January 8, 2019.

Sincerely,

Official Signature

Name of signer

Title

Appendix D

Interview Questions for Employers and Survey Questions for Employees

Questions for Employers: Intentions of employers offering Health Care Coverage for their employees

Five companies. Interview twelve senior employees (two per company) from HR and/or upper management. Three companies over 50, three under 50.

Organizational/psychological implications and responses to health care coverage at companies with more than 50 employees, and less than 50 employees offering health care coverage.

Introduction

a) Thank the interviewee for meeting and briefly explain the purpose (e.g., you are researching the organizational practices of company's health care benefits as your dissertation research for your dissertation for the doctoral degree in Organization Development from the University of St. Thomas.

b) Explain

- How long the interview will take
- You will be taking notes (or recording the interview)
- The information provided will remain private – only "themes" from the 9 employer interviews will be reported. All information will be summarized and reported as group data. No information or interview comments from individuals will be associated with the interviewer' name or name of their company.

- All information from the interviewer is voluntary. They need not provide any proprietary or confidential information.

c) Ask for questions

d) Ask the interviewee to sign the “Informed Consent” form indicating their understanding and agreement to be interviewed.

Your Company

a) How long has your organization been in existence?

b) In what industries do you specialize?

c) How many FTE (employees) does your company currently employ?

d) Please describe your company’s mission and vision.

e) Tell me about your growth plans (in general terms). What do you hope your company looks like in 5 or so years (compared to the present)?

f) Can you describe your strategy? How does the company try to differentiate itself from its competitors?

g) How do you try to differentiate your company to employees (i.e., what is your “employer brand” or what do you think employees most value about working at your company versus your competitors?)

Your Health Care Plan

a) Who is your Health Care provider?

b) What type of plan do you offer? What are its major features?

c) What are the requirements of the employee to obtain health care coverage from your organization? (i.e., do you offer health care to anyone who is not a .75 FTE employee?)

d) How long have you been managing or approving your organization's Health Care Plan?

e) Have you always offered the type of plan you have today or has there been fundamental modifications over the years?

f) How does your health care plan fit or align with your vision, mission, purpose?

Your Health Care Plan Practices

a) What percentage of typical employee compensation and benefits package is health-care benefits?

b) What percentage of your organizational expenses is health care?

c) What is your responsibility of costs % versus the employee %?

d) Has this mix been modified over the years? In what ways? (e.g., increase in co-pays or deductibles? Shifting costs for dependent coverage to employees? etc.)

e) Is the cost of health insurance reviewed every year? What steps do you typically take to review these costs? If yes, are you concerned about the costs or is it considered a required expenditure?

f) Please describe how you position or communicate the benefit of health insurance to your employees?

g) Do you discuss salary and benefits separately or as a package? How are benefits communicated? How do you ensure that employees understand the value of the Health Care coverage you are providing?

h) If you were not mandated to offer health care coverage, would you continue to do so? Why?

Your Strategic Intent with Your Health Care Plan

a) Do you consider health care coverage as "strategic"? In what sense? Please explain.

b) Please describe your company's basic intention in providing Health Care coverage for your employees. (i.e., Minimize costs? Attract new employees? Retain employees? Other?)

c) Fundamentally speaking, do you consider health care coverage for your employees to be the responsibility of you, the employer? i.e., "the right thing to do".

d) When choosing health care coverage for your employees, are you thinking of minimum coverage, better than adequate coverage, or premium coverage? Please elaborate.

e) What are your overall strategic intentions when discussing or offering health care coverage to your employees?

f) What are your overall strategic intentions when discussing or offering health care coverage with your management team? Is it different from item "d" above?

Your Perceptions of Employer Offered Health Care Plans

a) In your view, how does your health care plan impact your employees? What kinds of comments or reactions from employees have you heard?

b) Do you see any tangible or direct changes in your employees due to heath care coverage availability (e.g., greater productivity, decreased absenteeism, or improved retention relative to competitors or industry averages, etc.?)

c) In your view, do your employees appreciate and value their health care plan or have you heard comments or observed behavior to the contrary? What kinds of comments or reactions have you heard or observed?

Summary- Additional Discussion

a) Do you have any other opinions or comments regarding organizational health care plans that might be of interest to this study?

b) Clarify process for obtaining the results of your study.

c) Thank the interviewer for their time.

Appendix E

Questions for Employers with <50 employees: Intentions of employers for employees

Two companies. Interview six employers (two per company) from HR and/or upper management.

Organizational/psychological implications and responses to health care coverage at companies with less than 50 employees not offering health care coverage.

Introduction

a) Thank the interviewee for meeting and briefly explain the purpose (e.g., you are researching the organizational practices of company's health care benefits as your dissertation research for your dissertation for the doctoral degree in Organization Development from the University of St. Thomas).

b) Explain

- How long the interview will take
- You will be taking notes (or recording the interview)
- The information provided will remain private – only "themes" from the 9 employer interviews will be reported. All information will be summarized and reported as group data. No information or interview comments from individuals will be associated with the interviewer' name or name of their company.
- All information from the interviewer is voluntary. They need not provide any proprietary or confidential information.

c) Ask for questions.

d) Ask the interviewee to sign the "Informed Consent" form indicating their understanding and agreement to be interviewed.

Your Company

a) How long has your organization been in existence?

b) In what industries do you specialize?

c) How many FTE (employees) does your company currently employ?

d) Please describe your company's mission and vision.

e) Tell me about your growth plans (in general terms). What do you hope you company looks like in 5 or so years (compared to the present)?

f) Can you describe your strategy? How does the company try to differentiate itself from its competitors?

g) How do you try to differentiate your company to employees (i.e., what is your "employer brand" or what do you think employees most value about working at your company?)

Health Care Plans

a) To your knowledge do all of your employees have health care?

b) Do you as an employer inform your employees of Health Care options? ie. MNSure, private, etc.

c) Have you ever offered health care coverage through your organization?

d) Have you researched or estimated health care coverage costs through your organization?

e) How does not offering health care plan align with your vision, mission, purpose? What is the greatest or primary benefit to you of not offering health care?

f) Would you consider minimum requirements of an employee to obtain health care coverage through your organization? What might those be?

Your Benefits Practices

a) Please describe the fringe benefits you do provide (if any).

b) Since you do not offer health care coverage, where do you and or your employees obtain coverage? Please explain in detail.

c) Do you discuss salary and benefits separately or as a package? How are benefits communicated? How do you ensure that employees understand the value of the benefits you are providing?

d) Describe what you consider would be the potential benefit to you (as an employer) of offering health care coverage to your employees? Is this something you have considered or discussed with your organization leadership?

e) What would be the maximum % you as an organization would be willing to pay within the employee's overall pay package?

f) What percentage of your organizational expenses would you be willing to spend on health care health care benefits?

g) What is the maximum % of monthly premium costs would your organization be willing to pay versus the employee %? Where did you get this mix?

h) Is the cost of health insurance the primary reason you do not offer? If yes, would, or have you considered options to offset your direct costs?

i) As you grow to approach 50 employees, and you were not mandated to offer health care coverage, would you continue to do so, or would you investigate any other options?

j) Will your organization be affected by the ACA in any way in the coming year or two? If so, what steps have you taken or considered to prepare?

Your Strategic Intent with Your Benefits Plan

a) Please describe your company's basic intention behind your benefits package. (i.e., Minimize costs? Attract new employees? Retain employees? Other?)

b) *Since you do not offer coverage, would you be willing to, and/or what thresholds would be required to consider this as an option?*

c) Because you do not offer health care coverage, do you believe there would be a positive correlation in productivity improvements if offered?

d) As a manager, what are your overall strategic intentions when offering or not offering health care coverage to your employees?

e) Fundamentally speaking, do you consider health care coverage for your employees to be the responsibility of the individual? i.e., "the wage/salary we pay is enough to cover these costs".

f) Would you consider providing health care coverage as "strategic"? In what sense? Please explain.

g) As an organization, do you discuss health care coverage from a strategic point of view with your management team? Is it different from item "c" above?

h) If considering health care coverage for your employees, would you provide minimum coverage, better than adequate coverage, or premium coverage? Please elaborate.

Your Perceptions of Employer Offered Health Care Plans

a) In your view, how would employer sponsored health care coverage impact your employees?

b) Would you anticipate seeing any tangible or direct changes in your employees if health care were provided? (e.g., productivity improvements, decreased absenteeism, or improved retention, etc.)?

c) In your view, would your employees appreciate and value a health care plan through your organization, or have you heard comments or observed behavior to the contrary?

Summary

a) Do you have any other opinions or comments, especially regarding health care plans that might be of interest to this study?

b) Clarify process for obtaining the results of your study.

c) Thank the interviewer for their time.

Appendix F

Employee Attitude Survey Questionnaire

Below are 27 items designed to obtain your opinions about health care coverage. Your responses are confidential. No names or names of the company you work for will be reported. Specific results and responses will not be shared with your employer. Results will be aggregated, and analyzed and reported in group format only. Completing this questionnaire indicates that you understand and consent to participate.

Directions: Please indicate your level of agreement or disagreement with each of the statements provided regarding health care coverage. Place an "X" mark in the box of your answer. Then answer the five short questions below. The entire questionnaire should take less than fifteen minutes of your time.

To assure confidentiality, please do not provide your name or any personal information.

Thank you

Results-Opinions about Health Care

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
1. I believe that health care coverage is a right of every US citizen.					
2. As an American, I believe that providing health care coverage for myself and my family is primarily the responsibility of US employers.					
3. Access to comprehensive health care coverage (would) put(s) my mind at ease.					
4. I am more productive when/if I know that my health care needs are covered/paid.					
5. All organizations, large and small, should offer health care benefits to their employees.					
6. Access to health care benefits are an important consideration when finalizing employment decisions.					

7. I respect that many smaller employers cannot afford to offer health care coverage as part of their overall compensation package.					
8. Employee productivity improves when health care costs are (in-part) covered by employers.					
9. The avail of employer sponsored H/C coverage sets a co. apart from those that do not.					
10. Employers should budget for health care coverage and provide it for their employees regardless of cost.					
11. I would work for an organization that does not offer health care, provided there is salary enhancements to offset some of the cost					

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
12. I am willing to stay with my present employer and seek my own health care coverage even though they do not offer, **OR** reduced/modified their health care coverage.					
13. Circle as applicable where underlined prior to answering with "X" to the right. I am satisfied with my own *OR* employer sponsored health care benefits/arrangements.					
14. I am willing to: begin sharing costs for health care, **OR** pay even more through my employer.					
15. My employer recognizes the positive link between productivity and employee satisfaction through strong employee benefit packages.					
16. I am satisfied w/my health care status/position.					
17. My work is highly motivating.					
18. The job I do gives me opps to learn new things.					
19. My work has meaning and purpose.					
20. I feel the work I do is important for my future.					

Questions

Q1: If you do not currently receive health care benefits from your employer, would you be willing to share costs with your employer? If "yes", what percentage would you be willing to pay? If "no", who is your health care provider?

□ Yes □ No Percent willing to pay? _________________

____

Q2: Do you have dependents? If "yes", are they covered, what are their ages? Please explain.

□ Yes □ No

____

Q3: What is your education level? Circle one.

High School Some College College Graduate Masters Degree Doctorate

Q4: How would you rate your overall compensation package (salary and benefits)?

□ Highly satisfactory

□ Satisfactory

□ Neutral

□ Unsatisfactory

□ Highly Unsatisfactory

Q5: Do you believe that government should have an authoritative role in providing and/or mandating health care options through small employers on behalf of its employees?

□ Yes □ No Please elaborate or explain:

____

Q6: I am… □ Male □ Female

Q7: My age is… □ 18-30 □ 31-45 □ 46-59 □ 60+

Thank you for sharing your insight with us. I appreciate your participation in this study. Paul R. Kuhrmeyer