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Onias Muza Taruwinga

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EXAMINING THE IMPACT OF THE AFFORDABLE CARE ACT ON SMALL BUSINESSES AND INDUSTRIES IN NORTHWEST INDIANA

by

Onias Muza Taruwinga

A Dissertation
Submitted to the Faculty of Purdue University
In Partial Fulfillment of the Requirements for the degree of

Doctor of Philosophy

Department of Technology Leadership and Innovation
West Lafayette, Indiana
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THE PURDUE UNIVERSITY GRADUATE SCHOOL
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I dedicate this dissertation to the women who shaped my life.

My grandmother, Mrs. Jessica Jera Muza, you were the first woman to make me believe in myself. You made me believe that I can kill a lion with my bare hands. Your faith in me was contagious. Your praise of my little achievements made me believe that I can accomplish more and bigger things in life. I would have loved to walk with you on the platform as I receive my degree. Thank you for believing in me! Yes, now I believe I can kill a lion with my bare hands!

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LIST OF ABBREVIATIONS

ACA – Affordable Care Act.
AHRQ – The Agency for Health Research and Quality (to produce a National Quality Report in 2003 with the help of the IOM).
BDDS – Bureau of Developmental Disability Services.
BRS – Bureau of Rehabilitation Services.
CCHSA – Canadian Council for Health Services Accreditation.
CDHC – Consumer Driven Health Care.
CHI – Commission for Health Improvement.
CMA – Canadian Medical Association.
CRC – Covenants on the Rights of the Child.
DDRS – Division of Disabilities and Rehabilitation Services.
DFR – Division of Family Research.
DMHA – Division of Mental Health and Addiction.
FSA – Flexible spending account
FSSA – Family and Social Services Administration.
GDP – Gross domestic product.
HCQI – Health Care Quality Indicators.
HDHP – High-deductible health plan.
HRA – Health reimbursement accounts.
HC – Health Canada.
HMO – Health maintenance organization.
HSA - Health Savings Account.
IDA - Indiana Dental Association.
IOM – Institute of Medicine.
IRB – Institutional Review Board.
MPHAELA – Mental Health and Addiction Parity Equity Act.
NHS – National Health system.
NICE – National institute for Clinical Excellence.
NPF – National Performance Frameworks (of Public Service Agreement between the UK Treasury and Health Departments).
NQI – National Quality Institute.
NSF – National Service Frameworks.
OECD – Organization for Economic Cooperation and Development.
PAF – Performance Assessment Framework.
PECORI – Patient-centered Outcomes Research Institute.
PIs – Performance indicators.
PPO - Preferred Provider Organization.
QCPP – Quality Care Patient Professional.
SCHIP – State Children’s Health Insurance Program.
SBA – Small Business Administration.
UHC – Universal health coverage.
WHO – World Health Organization.
ABSTRACT

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This research examined the lived experiences of small businesses in Northwest Indiana with the implementation of the Affordable Care Act. The interviews were conducted over a period of six months with an attempt to answer the question, “What was the impact of the Affordable Care Act on small businesses and industries in Northwest Indiana?” Additional research questions were, “Did the Affordable Care Act extend coverage to the uninsured, include other medical services that were not covered before, and reduce cost sharing and what lessons can be learned from the implementation of the Affordable Care Act for future policy implementation?” 15 participants from Northwest Indiana were interviewed separately for 30 to 45 minutes each. Based on the analysis of data from interviews and observations, seven major themes emerged. These included the old system needed to be fixed, the Affordable Care Act made things worse was a form of government interference, it increased premiums, resulted in fear, frustration, and confusion, had positive outcomes, and eliminated pre-existing conditions. The outcomes of this study confirmed that while the Affordable Care Act helped some people obtain health insurance by eliminate pre-existing conditions, there is a strong indication that it also resulted in some unwanted consequences. This contribution includes suggestions for future qualitative study on the impact of the Affordable Care Act on small businesses.
CHAPTER 1. INTRODUCTION

This chapter provides an overview to this study. The introduction is designed to provide the background of the study, problem statement, statement of purpose, scope of the study, the significance of the study, purpose of the study, research questions, assumptions, limitations, delimitations, definitions, and acronyms important to understanding this study. Finally, this chapter concludes with an overview of the study.

1.1. Background

Growing up in Zimbabwe, a few big businesses and industries dominated their respective markets. Small businesses and industries were almost insignificant. Even though there were discussions about the contribution of small businesses and industries to the overall economy, little attention was given to them. For that reason, small businesses and industries in Zimbabwe struggled to stay in business. They closed faster than they opened. When I started working in the USA in 2000, I was fascinated by how small businesses and industries played an important role in the American economy. American small businesses and industries are considered a key part of the economy.

When I worked for a small business in Northern Indiana, I noticed that our company struggled to compete with big businesses and industries in offering competitive employee benefits such as health insurance. Health insurance was one of our major costs. I also realized that as an employee of a small business, I paid a higher health insurance
premium than my colleagues who worked for big businesses and I wondered why. I was young and healthy.

The explanation I got was that employees of small businesses and industries pay high health insurance premiums because their health insurance costs are spread among a small pool of employees compared to big businesses and industries. Big businesses and industries spread their insurance costs among a large pool of employees.

This resulted in lower health insurance premiums for their employees. This explanation made sense. I concluded that if small businesses and industries could find ways to create large pools of employees to spread their health insurance costs, they could lower their employees’ health insurance premiums and be able to compete with big businesses and industries.

When the Affordable Care Act was voted into law in 2010, one of its intended benefits was to help create large pools of people for health insurance purposes. Through these large pools, small businesses and industries would spread their health insurance costs and benefit from economies of scale. The Affordable Care Act would put small businesses and industries on the same insurance platform with big businesses and industries.

One year after the implementation of the Affordable Care Act, I was curious to examine its impact on small businesses and industries. My interest in this subject was fueled when I attended business meetings with owners and administrators of small businesses and industries. They seemed to have mixed feelings about the impact of the Affordable Care Act on their small businesses and industries.
I had several unanswered questions concerning the impact of the Affordable Care Act on small businesses and industries; what has been the impact of the Affordable Care Act on small businesses and industries? What has been the experiences of small businesses and industries with the Affordable Care Act? What lessons can be learned from the implementation of the Affordable Care Act for future policy implementation? Did the Affordable Care Act improve the breadth (who is covered), the depth (benefits are covered), and the height (what proportion of the costs is covered) of healthcare?

1.3. **Problem Statement**

There is limited qualitative research examining the impact of the Affordable Care Act from the perspective of small businesses and industries using the qualitative research method. Most of the available research on the subject used quantitative research method. Attempting to answer these questions using the qualitative research method and from the perspective of small businesses and industries is the goal for this study. The purpose is to provide an insight into the background, lived experiences, and perspectives of small businesses and industries with the Affordable Care Act.

1.4. **Statement of Purpose**

The purpose of this study was to examine the impact of the Affordable Care Act on small businesses and industries in Northwest, Indiana. The study elicited, analyzed, and described the experiences of small businesses and industries with the Affordable
Care Act. It also examined implications for future policy implementation. The unit of analysis was the small business/industry.

1.5. Significance of the Study

Small businesses and industries are the engine of the American economy. According to the U.S. Census Bureau (2011), small businesses and industries make up 99.7 percent of U.S. employer firms, 98 percent of firms exporting goods, and 64 percent of net new private sector jobs. The Affordable Care Act was intended to help employees of small businesses and industries improve access to primary healthcare. It was also intended to extend health insurance coverage to 47 million Americans without coverage.

However, upon its roll out, small businesses and industries struggled with increased health insurance premiums, increased direct and indirect costs, challenges with compliance, and technological challenges. Due to increased costs or fear of increased costs, some small businesses and industries closed (Amato, & Schreiber, 2013; Boubacar, & Foster, 2014; Buchmueller, Carey, & Levy, 2013; Lowry, & Gravelle, 2013; Mason, 2014).

Small businesses and industries play an important role in the American economy. According to the U.S. Census Bureau (2011), American small businesses and industries make up:

1. 99.7 percent of employer firms,
2. 64 percent of net new private sector jobs,
3. 49.2 percent of private sector employment,
4. 42.9 percent of private sector payroll,
5. 46 percent of private sector output,
6. 43 percent of high-tech employment,
7. 98 percent of firms exporting goods, and
8. 33 percent of exporting value.

The statistics above show the important role of small businesses and industries in the American economy.

Small businesses and industries are innovative. They invest considerable time and resources in finding more efficient ways to use their resources and more effective ways to use their work force. Small businesses are also nimble. This allows them to be responsive to the changing economic conditions. Based on the information from the U.S. Bureau (2011), it makes sense to conclude that when small businesses and industries succeed, the American economy has a better chance to thrive and compete on the global marketplace. The opposite is also true; when small businesses and industries struggle, the American economy faces great challenges. This is the reason why the small business and industry was the unit of analysis in this study.

In this study, the researcher used the Affordable Care Act definition of small business. In addition to the Affordable Care Act definition of a small business, the researcher also loosely used the Small Business Administration criteria to define the size of small businesses and industries. The Small Business Administration is a federal agency that oversees the affairs of small businesses and industries in America. It defines a small business or industry as a business or industry that is independently owned and operated, and is not dominant in its field. Size is based on the average number of employees for the preceding twelve months and on sales volume averaged over a three-year period.
The Small Business Administration determines industry structure based on five primary factors; average firm size, degree of competition within an industry, startup costs and entry barriers, distribution of firm by size and Gini Coefficient, and small industry share in federal contracts (Small Business Administration Size Standards Methodology, 2009).

1.6. **Research Questions**

The research question central to this study was:

1. What is the impact of the Affordable Care Act on small businesses and industries in Northwest Indiana?

Additional research questions for this study were:

1. Did the Affordable Care Act improve the breadth (did the Affordable Care Act extend coverage to the uninsured), the depth (did the Affordable Care Act include other medical services that were not covered before), and the height (did the Affordable Care Act reduce cost sharing) of healthcare?

2. What lessons can be learned from the implementation of the Affordable Care Act for future policy implementation?

1.7. **Assumptions**

The following assumptions were inherent to the pursuit of this study:

1. Government policies have intended and unintended impact on small businesses and industries.
2. There is a need to examine the impact of the Affordable Care Act on small businesses and industries.

3. Participants are interested in participating in this study.

4. Participants give accurate and honest responses during interview sessions.

5. There is a sufficient number of participants for this study.

6. The chosen data collection methods (interviews and observation) are suitable for the research questions asked.

7. Each participant was available for a 30 to 45-minute interview session.

8. Participants are willing to share their views on how the Affordable Care Act impacted small businesses and industries.

9. Qualitative approach (phenomenological method) is appropriate to elicit the type of response necessary to answer the research questions.

1.8. **Limitations**

The following limitations were inherent to the design of this study:

1. Accessing data from small businesses and industries that reflect the true impact of the Affordable Care Act on small businesses and industries.

2. Identifying informants who committed to face-to-face interviews and share their business records.

3. This study was exploratory and subjective in nature.

4. The data lacks representation since it came from a convenient sample.
5. This study was limited by the accuracy of data collected during interview sessions.

1.9. **Delimitations**

The following delimitations were inherent to the pursuit of this study:

1. This study did not assess the impact of Affordable Care Act on small businesses and industries outside the State of Indiana.
2. The sample in this study did not include small businesses and industries outside Northwest Indiana.
3. The sample in this study did not include only small businesses and industries registered with the SBA.

1.1. **Definition of Key Terms**

- **basket of services** – universal health coverage that ensures that all the basic and necessary drugs and healthcare services are available to everyone.
- **community rating** – an insurance pricing system that prohibits medical underwriting and requires that all of a carrier’s insureds in the same geographical area pay the same premiums, regardless of their health status.
- **cost sharing** – member’s portion of the insurance deductible and co-pays.
- **Gini Coefficient** – a measure of statistical dispersion representing the income distribution of a nation’s residents. It measures income inequality.
health homes - coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders.

life changing event - a major event in life that requires change in insurance benefits such as getting married, moving, changing jobs, or loss of a job.

minimum essential coverage – all health insurance policies are required to have an actuarial value of at least 60 percent to qualify under the ACA guidelines.

Northwest Indiana – in this research, it refers to the following counties: Carroll County, Jasper County, Tippecanoe County, and White County.

offer rate – the percentage of employers offering health insurance benefits to their employees.

PECORI fees – fees imposed by the Affordable Care Act to help fund the Patient-Centered Outcomes Research Institute (PECORI).

purchasing power parity – a theory that states that exchange rates between currencies are in equilibrium when their purchasing power is the same in each of the two countries.

pre-existing condition – any medical condition for which the patient has already received medical advice or treatment prior to enrollment in a new medical insurance plan.
small business/industry - a business/industry that is independently owned and operated, and is not dominant in its field. Size is based on the average number of employees for the preceding twelve months and on sales volume averaged over a three-year period.

social mobilization – collective actions intended to effect social change.

universal health coverage (UHC) - the existence of a legal mandate for universal health services and evidence that the majority of the population has meaningful access to health services.

1.2. Overview of Study

Most of the studies that have been conducted assessing the impact of the Affordable Care Act have used the quantitative method. The majority of these studies focus on areas such as the financial impact, number of jobs lost, or increase in health insurance premiums (Claxton, Rae, Panchal, Whitmore, Damico, & Kenward, 2014; Liberman, Rotarius, Perez, 2012; Mcloughlin, Leatherman, Fletcher, & Owen, 2001). There is limited qualitative research that focus on the lived experiences of small businesses and industries. In light of that, the qualitative research method seemed to be the most suitable approach to answer the research questions presented in this study.

The qualitative research method has the ability to present personal experiences, perspectives, and meanings without aggregating them into mean scores (Groenewald, 2004; Maxwell, 2005; Moustakas, 1994; Patton, 2002). Mean scores lose the individuality of the data. The questions in this study were designed and selected to bring
out the lived experiences of small businesses and industries with the Affordable Care Act and the meanings they attach to those experiences.

This study used interview and observation methods to collect data. Since the goal of this study was to bring out lived experiences, perspectives, and meanings of small businesses and industries, this study was based on the phenomenological approach. Phenomenology seeks to examine participant experiences and the meanings they attach to those experiences (Creswell, Hanson, Plano, Morales, 2007; Groenewald, 2004; Maxwell, 2005; Moustakas, 1994; Patton, 2002). It focuses on the meanings people attach to their experiences and how these meanings help shape individual and shared values (Creswell, Hanson, Plano, Morales, 2007; Moustakas, 1994; Patton, 2002).

1.3. Organization of Study

This dissertation has six chapters and several appendices. Chapter one gives the background, problem statement, statement of purpose, significance of the study, research questions, assumptions, limitations, delimitations, definition of key terms, acronyms, and overview of the study. Chapter 2 provides a literature review on the Affordable Care Act. It begins with literature review on national health systems for Switzerland, the Netherlands, the United Kingdom, and Canada. It provides an overview of the American health system and a synopsis of the health outcomes of the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD). It also provides an overview of the important aspects of universal health coverage. It gives a summary of how healthcare outcomes were met before the implementation of the
Affordable Care Act. Chapter 2 concludes with an overview of the Affordable Care Act and how it was designed to meet the healthcare needs of employees of small businesses and industries.

Chapter 3 provides an overview of the methodology used in this study and its guiding framework. It provides a detailed discussion of the qualitative research method used in this study (hermeneutic phenomenological approach). It gives the rationale why this particular research method was chosen for this study and its strengths and weaknesses. Chapter 4 provides detailed narratives and descriptions of each interview and a detailed explanation of the analysis of data. It also provides demographics of the study participants, detailed participant descriptions, background information, researcher bracketing, interview results, and detailed narratives and descriptions of each interview. Chapter four further presents the results of the data analysis and themes that emerged from data analysis. It also introduced each theme as it emerged from the data and provided the supporting narratives. Chapter 5 contains the summary of the study, conclusions, discussions of the results, recommendations for future policy making, and recommendations for future studies. The appendices include interview transcripts, research questions used, IRB approvals, and other tools used in this study.

1.4. Summary

This chapter described the main motivation of this study. It presented the background, problem statement, the statement of purpose, significance of the study, and
research questions. It also provided a list of assumptions, limitations, delimitations, definition of key terms, and acronyms used in this study.

The next chapter presents a literature review on national healthcare systems for Switzerland, the Netherlands, the United Kingdom, and Canada. It provides an overview of the American healthcare system, a synopsis of health outcomes of the World Health Organization (WHO), and the Organization for Economic Cooperation and Development (OECD). It concludes with an overview of universal health coverage and a summary of how health outcomes were met in America before the implementation of the Affordable Care Act.
CHAPTER 2. LITERATURE REVIEW

The history of national healthcare reform in America goes back to the early 1900s. The discussion included the role of the government in providing health insurance for its citizens. The dialogue about the government’s involvement in providing healthcare insurance picked momentum between 1929 and 1939 during the great depression (Steinmo, & Watts, 1995). The discussion was mainly propelled by the growing income inequality signaled by the disappearing middle class. During this period, medical services became the major cause of bankruptcy and poverty. The government introduced Medicare and Medicaid in 1965. Around 1970s, the economy was growing but inflation and rising healthcare costs became major concerns. Several attempts were made to contain the health insurance costs without success (Brown, 1983; De Lew, 1995; Frank, Goldman, & Hogan, 2003).

This chapter outlines the literature review on national healthcare systems for Switzerland, the Netherlands, United Kingdom, and Canada. It also provides an overview of the American health system, a synopsis of health outcomes of the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD). In addition, it gives an overview of universal health coverage and a summary of how health outcomes were met in America before the implementation of the Affordable Care Act. It concludes with a summary of the Affordable Care Act and how it was designed to meet the health outcomes for the American people.
2.1 An Overview of National Healthcare Systems

Most Americans believe they have the best healthcare system in the world (Davis, & Rowland, 1983; Jost, 2009; Tanner, 2008). Even though major differences exist between the quality of healthcare accessed by high income people and low income people, and among certain minority groups such as African Americans and Latinos, the American healthcare system before the implementation of the Affordable Care Act was fair (Anderson, & Frogner, 2008; Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000). Americans are used to getting what they want, when they want it, and how they want it. Convenience in accessing healthcare services is important to Americans. The challenge is that the cost of attaining healthcare in America is growing faster than people’s income (Amato & Schreiber, 2013; Bradley, 2008; Helms & Guthrie, 1992).

The WHO Healthcare Rankings rank country healthcare systems based on several key indicators; quality, responsiveness to choice of providers, dignity, autonomy, timeliness, and confidentiality (WHO Report, 2007). According to the WHO healthcare rankings, United States is ranked number 37 out of 191 countries on quality. It ranks first in responsiveness to choice of provider, dignity, autonomy, timely care, and confidentiality (Murray, & Frenk, 2010; WHO World Report, 2007). The United States outperforms the rest of the world in outcomes of specific diseases such as cancer, heart disease, AIDS, and pneumonia (Davis, & Rowland, 1983; Jost, 2009; Tanner, 2008). The challenge with the WHO Healthcare Ranking System is that it penalizes healthcare systems for adopting health saving accounts.

As a percentage of its Gross Domestic Product (GDP), America has the highest total expenditure on healthcare. In 2004, American healthcare spending was a little over 15 percent of its GDP while the healthcare expenditure of the United Kingdom was about
eight percent (Anderson & Frogner, 2008; McCoskey, & Selden, 1998; Tanner, 2008).

Healthcare in America is excessively expensive. It is one major reason for driving middle
and low-income families into bankruptcy. Families with more disposable income can
afford to get the best healthcare services whilst families with limited income are not
always able to. A healthcare system that is affordable and convenient (getting what you
need at an affordable price when you need it) is suitable to meet the American people’s
healthcare needs.

Rising healthcare costs and lack of access to healthcare services seem to be the
challenges most national healthcare systems face. Tanner (2008) analyzed trends of
national healthcare systems and drew the following conclusions:

1. Most healthcare systems that promise universal coverage limit care or have long
waiting lists for treatments.

2. As a percentage of the GDP, rising healthcare costs is the main reason for many
national budget deficits, tax increases, and benefit reductions.

3. Waiting lists, rationing of services, and choice restrictions are common in
countries with heavy government control measures.

4. Effective national healthcare systems incorporate competition, cost sharing,
market price, and consumer choice.

5. Lack of satisfaction with national healthcare systems seem to be widespread.

6. In an attempt to provide universal healthcare, most national healthcare systems
are moving away from centralized systems towards a market-oriented system.
There are four basic healthcare models (Exter, Hermans, Dosljak, Busse, Ginneken, Schreyöegg, & Wisbaum, 2004; Shortell, Gillies, Anderson, Erickson, & Mitchell, 1996). The first model is the Beveridge Model named after the reformer who designed the British National Health Service. In this model, healthcare is a service provided by the government. Most hospitals are owned and operated by the government and healthcare workers work for the government. This health model has low cost per capita. It varies from extreme government control to minimum government control. Examples of countries that use this model are Great Britain and Spain (Exter, et al. 2004; Shortell et al. 1996).

The second model is the Bismarck Model named after the Prussian chancellor. It is a welfare system with “sick funds” financed by both the employer and the employee through payroll deductions. Everybody is covered and insurance companies do not make a profit. It is a multi-payer system. There is tight government regulation and the cost-control measures make it look like a single-payer system. Examples of countries that use this model are Switzerland and The Netherlands (Shortell, et al. 1996).

The third model is the national health insurance model. It has elements of both the Beveridge and the Bismarck models. It uses private sector providers with payments coming from government-run health insurance program that all people pay into. Health insurance tend to be cheaper since there are no marketing costs. The single-payer has considerable market power to negotiate lower prices. Canada and Taiwan are examples of countries that use the national health insurance model (Exter, et al. 2004).

The fourth model is the out-of-pocket model. Only a few rich and developed countries use this model. In this model, the rich get all the medical care they need whilst
the poor may go with little or without. Prior to the implementation of the Affordable Care Act, the American healthcare system had elements of each of these four models (Exter, et al. 2004; Shortell, et al. 1996). The next portion of this chapter will explore the healthcare systems of Switzerland, the Netherlands, Canada, and United Kingdom.

2.1.1. The Switzerland Healthcare System

In 1996, Switzerland achieved universal health coverage. This was done by requiring all residents to purchase health insurance. The Switzerland healthcare system is one of the most market-oriented healthcare systems. It is based on the idea of market competition. It is decentralized and operates through 26 divisions which enforce coverage. Only nonprofit health insurance companies are allowed to participate. Risk equalization is allowed only for age and gender. Health insurance premium subsidies are paid through an income tax and a third of the population receive premium assistance (Leu, Rutten, Brouwer, Matter, & Rutschi, 2009; Tanner, 2008; White, 2007). There are no risk-rating restrictions.

There are some challenges with the Switzerland healthcare system. The lack of risk-rating restrictions challenges results in mobility of the insured. The Switzerland healthcare system has the second highest out of pocket expenditure of total national healthcare spending (33 percent). It also has higher deductibles and co-pays than comparable national healthcare systems. The Switzerland government contributes 31.5 percent towards healthcare, compared to 13 percent for the U.S. (Anderson & Frogner, 2008; Leu, et. al. 2009; Tanner, 2008; White, 2007). The quality of the Switzerland
healthcare system is below that of the United States for nearly all comparable services. It does well in the area of transparency and responsiveness to consumer needs.

The Switzerland healthcare system has some notable advantages. It is responsive to patients’ needs for provider choice, dignity, autonomy, timely care, and confidentiality (Daley, Gubb, Clarke, & Bidgood, 2007; Tanner, 2008; White, 2007). The uninsured rate is below one percent of the population. The Switzerland healthcare system offers subsidies to low-income citizens to purchase health insurance. The subsidies are designed to prevent individuals from paying more than 10 percent of their income towards health insurance. According to Leu, et al. (2009), health insurance coverage is required to meet three criteria; effectiveness, appropriateness, and efficiency. Effectiveness is measured through clinical studies. Appropriateness of service refers to producing better outcomes than other options. Efficiency is measured through a cost-benefit ratio which should be better than alternatives. The Switzerland healthcare system partially covers long-term care but does not cover dental care (Daley, Gubb, Clarke, & Bidgood, 2007; Leu, et al. 2009).

The Switzerland healthcare system has had some successes. It achieved universal coverage; consumer choice, universal access, and low differences in services offered. It provides a good example of a regulated competitive model with multiple insurance plans (Daley, Gubb, Clarke, & Bidgood, 2007; Reinhardt, 2004; Tanner, 2008).

The Switzerland healthcare system has also faced some challenges. Between 1996 and 2006, the Switzerland healthcare spending as a percentage of GDP steadily increased. Per capita spending purchasing power parity (in USD) also steadily increased. The Switzerland healthcare system has faced the challenge of how to deal with people who
refuse or fail to comply with the mandate to pay their premiums (Leu, et al. 2009; Murray, & Frenk, 2000; Reinhardt, 2004). This has resulted in healthcare service providers not being paid for some of the services they have provided. In response to refusal or failure to pay for healthcare services rendered, the Switzerland health insurance companies have been allowed to suspend services for up to 24 months to establish the inability to pay (Jost, 2009; Leu, et al. 2009; Tanner, 2008).

In an attempt to maximize their profit margin, Switzerland health insurance companies have improved their risk selection skills by offering multiple policies. They also encourage high cost people to obtain higher cost health insurance policies and low cost people to obtain lower cost health insurance policies (Jost, 2009; Leu, et al. 2009; Tanner, 2008). Health insurance companies also use high deductible policies to attract low risk people. Because the Switzerland health system does not compete on the basis of managing pricing risks and is required to offer identical basic benefits packages, health insurance companies compete on the basis of price and vary the level of deductibles (Jost, 2009; Murray, & Frenk, 2000; Tanner, 2008).

Additional challenges faced by the Switzerland healthcare system include the individual mandate and the regulation, which is part of the managed competition. Consumers are forced to purchase health insurance even if they believe the cost outweighs the value. In addition, public choice dynamics are influenced by lobbyists who influence what conditions should be included in the basic benefits package (Daley, Gubb, Clarke, & Bidgood, 2007; Leu, et al. 2009; Tanner, 2008). The expansion of healthcare services has driven up the price of health insurance premiums. There is no system to deal with individuals who do not comply with the mandate. Because Europe is heavily
regulated, patients are forced to use expensive healthcare providers where they could have used less expensive providers. These challenges undermine the consumer-driven nature of Switzerland’s health system (Jost, 2009; Leu, et al. 2009; Tanner, 2008).

Despite these challenges, the Switzerland healthcare system has been regarded by some as a beginning point for America’s healthcare reform dialogue. It provides universal coverage, preserves the private health insurance system, protects healthcare service providers from government price controls, and defends the central place of markets in the healthcare system (Jost, 2009; Murray, & Frenk, 2000). One of the great lessons from the Switzerland healthcare system is the inadequacy of regulation as a way of stopping health insurance companies from competition based on picking low risk people (Murray, & Frenk, 2000; Leu, et al. 2009; Tanner, 2008).

2.1.2. The Netherlands Healthcare System

The current Netherlands healthcare system was put in place in 2006. Prior to 2006, the Netherlands healthcare system was built on social and private insurance. It had two categories; workers with an annual income below 32,000 Euros and those with an annual income above 32,000 Euros. Workers with annual income below 32,000 Euros enroll in one of the 30 government-controlled ‘sickness funds.’ The second category was for those with an annual income higher than 32,000 Euros (Daley, Gubb, Clarke, & Bidgood, 2007; Jost, 2009; Leu, et al. 2009; Okma, 2008).

The current Netherlands healthcare system is a product of incremental reform. It allows residents to get health insurance through private for-profit or nonprofit companies. Deductibles and co-pays are low and the uninsured rate is below 2 percent of the
population. Health insurance companies are subjected to few risk-rating restrictions. This creates challenges with competition and mobility of the insured (Leu, et al. 2009; Daley, Gubb, Clarke, & Bidgood, 2011; Rosenau & Lako, 2008). The system encourages price competition, community rating, a sliding scale income-based government subsidies, and risk equalization for insurers (Daley, Gubb, Clarke, & Bidgood, 2011; Rosenau, & Lako, 2008).

Even though the current Netherlands healthcare system has been in place for a few years, it has shown some improvements. Price competition has improved. Hospitals are competing by offering an expanded array of services. In addition, waiting lists are disappearing (Leu, et al. 2009; Rosenau, & Lako, 2008; Tanner, 2008). Workers with higher income have the option to enroll in the funds they wish or purchase private insurance.

Netherlands still regard health insurance as a social service program but the system allows for-profit organizations to offer health insurance on the same market with not-for-profit organizations (Jost, 2009; Okma, 2008; Rosenau, & Lako, 2008). Residents pay 6.5 percent of their income for any healthcare plan they choose. It has the lowest (7 percent) of total out of pocket health spending (Tanner, 2008).

Apart from Switzerland, the Netherlands is regarded as a country with the most market-oriented national healthcare system in Europe (Daley, Gubb, Clarke, & Bidgood, 2007; Rosenau, & Lako, 2008; Tanner, 2008). It is an understanding that health insurance companies provide a basic social service, not a profit-making product. The government pays half of the health insurance premiums through social insurance payroll taxes. Employers and workers pay the remaining half. The self-employed and the unemployed
pay their own premiums. Like the Switzerland healthcare model, the Netherlands healthcare model requires that all residents have basic coverage (Daley, Gubb, Clarke, & Bidgood, 2011; Tanner, 2008).

The Netherlands health insurance industry is heavily regulated by the government. Health insurance providers are not allowed to profit off of people’s health needs (Leu, et al. 2009; Okma, 2008; Tanner, 2008). Risk selection does not seem to be an issue. Health insurance companies are required to accept all applicants. Premium variations are based on the health status of the applicant.

The Netherlands healthcare system has had some successes. Premiums and copays are minimum with exemptions for primary care and essential medications. Like the Switzerland healthcare system, the Dutch healthcare system has achieved universal health coverage. It provides consumer choice, universal access, and there are small differences in services offered. It provides a good example of a regulated competitive model with multiple insurance plans (Daley, Gubb, Clarke, & Bidgood, 2011; Okma, 2008; Rosenau, & Lako, 2008).

The Netherlands healthcare system has faced some challenges. There is heavy government regulation. The use of non-contracting services has led to preferred provider organizations-like arrangements possible in loosely integrated systems. Health insurance companies have limited negotiation room on certain services. Premiums and healthcare costs have continued to rise since the national program was started. Like the Switzerland healthcare system, the Netherlands healthcare system has no way of dealing with those who refuse or fail to pay their premiums (Leu, et al. 2009; Okma, 2008; Tanner, 2008).
2.1.3. The United Kingdom Healthcare System

The United Kingdom initiated its publicly funded National Health System (NHS) in 1948. The main goal was to ensure universal access to healthcare (Department of Health, 2002; Ferlie & Shortell, 2001). During the 1980s, the NHS system went through several changes to curb growing healthcare costs. In the 1990s, additional changes were implemented to reflect a managed internal market and new performance indicators. In the 2000s, the focus of the changes was to improve collaboration among healthcare providers (Arah, Klazinga, Delnoij, Ten Asbroek, & Custers, 2003; Department of Health, 2002; Ferlie & Shortell, 2001).

The United Kingdom National Health System is a highly centralized single-payer system. The government pays for all health services through taxes. Most physicians and nurses are employed by the government (Doran, Fullwood, Gravelle, Reeves, Kontopantelis, Hiroeh, & Rolland, 2006; Arah, Klazinga, Delnoij, Ten Asbroek, Cuters, 2003). The United Kingdom government pays the highest percentage of total health expenditure (87 percent) compared to the U.S. which is at 45 percent (Arah, et al. 2003; Doran, et al. 2006; Ferlie, & Shortell, 2001; Tanner, 2009). The United Kingdom government has been successful in controlling healthcare spending as a percentage of GDP, even though this has come at a cost.

The United Kingdom Treasury and the Department of Health created the Performance Assessment Framework (PAF). The goal of the PAF was to improve fund performance, increase autonomy, create a performance information system, and develop performance indicators (Arah, et al. 2003; Department of Health, 2002; Doran et al. 2006). The PAF has six key indicators; health improvement, fair access, effective delivery of appropriate healthcare, efficiency, patient/care experience, and health

The NHS system is based on four performance indicators; clinical effectiveness and outcomes, efficiency, patient/care giver experience, and capacity and capability (Department of Health, 2002; Freeman, 2002). Clinical effectiveness and outcomes refer to how effective the clinical interventions are in meeting the healthcare needs of the patients. On patient/caregiver experience, the system seeks for input from patients and caregivers on how they would rate their experience with healthcare services. Capacity and capability refers to the ability of the system to satisfactorily meet the health needs of its citizens (Department of health, 2002).

Both the PAF and NHS outcomes are primary and community based. The main focus of the PAF is continuous healthcare service improvement and accountability to patients and to the parliament (Department of Health, 2002; Ferlie & Shortell, 2001). The focus of the NHS outcomes is patient care. In addition, the United Kingdom health system has introduced some market-based reform in the last decade. About 10 percent of the population has private insurance through their employers and others through individual purchasing (Arah, et al. 2003; Department of Health, 2002; Freeman, 2002).

The United Kingdom healthcare system has shown some merits. It ensures universal healthcare coverage for all residents. It eliminates market failures and inequality. The NHS has achieved universal coverage and healthcare equity with low administrative costs and low total health expenditure concerns (Gerowitz, Lemieux-Charles, Heginbothan, & Johnson, 1996; Oliver, 2009; Pollitt, Harrison, Dowswell, Jerak-Zuiderent, & Bal, 2010). The British Kingdom believes that the single-payer
system is the best option because it ensures the whole population is subject to the same rules and are treated equitably (Drummond, Brixner, Gold, Kind, McGuire, & Nord, 2009; Oliver, 2009).

The United Kingdom healthcare system has faced some challenges. The system is a highly centralized single-payer system. This causes excessive rationing of services, leading to waiting lists, especially for specialized services (Drummond, et al. 2009; Glied, 2009; Pollitt, et al. 2010). Others have argued that the long waiting lists are a result of insufficient funding (Atun & Menabde, 2008; Gerowitz, Lemieux-Charles, Heginbothan, & Johnson, 1996; Oliver, 2009). Cancer patients wait as long as eight months for treatment. About 40 percent of cancer patients never see a cancer specialist (Doran, et al. 2006; Ferlie & Shortell, 2001; Stevens, 2004; Tanner, 2008). Another perceived disadvantage of the United Kingdom healthcare system is that it offers a limited choice of providers. Due to lack of open market competition, the cost of the United Kingdom healthcare system increased considerably between 2003 and 2008 (Drummond et, al. 2009; Glied, 2009; Stevens, 2004).

2.1.4. The Canadian Health System

The Canadian health system is similar to the American Medicare system. It is complex and mainly public funded. It was started around 1947 in Saskatchewan province. In 1962, it expanded to insure physician services. By 1972, all provinces and territories had joined. More healthcare reforms took place in the 1980s and 1990s, leading to the creation of health regions. Like the Switzerland healthcare system with cantons, the Canadian health regions oversee the daily operation of the healthcare system (Arah, et al.
The system is decentralized and run by provinces and territories. It is financed by the provinces and the federal government through taxes. Canadians’ total out-of-pocket health expenditure is 14.8 percent, almost the same as 14.6 percent for the Americans (Canadian Institute of Health Information, 2000; Lee & Zapert, 2005).

The Canadian healthcare system is part of the Canadian Health Information Roadmap. It is designed to address how healthy Canadians are and how the system is performing (See Figure 2.1). The Canadian healthcare framework has four dimensions; health status, non-medical determinants of health, health system performance, and community and health system characteristics (Canadian Council on Health Services Accreditation, 1996; Canadian Institute on Health Information, 2000).

The first dimension is the health status dimension. It seeks to answer the general but critical question on “how healthy are the Canadians?” It assesses four areas; health conditions, human functions, well-being, and deaths. The second dimension is the non-medical determinants of health dimension explores factors that are known to affect health. These factors are health behaviors, living and working conditions, personal resources, and environmental factors.

The third dimension is the health system performance dimension. It seeks to address the critical systems question, “how healthy is the health system?” It evaluates the health system based on eight domains; accessibility, acceptability, appropriateness, competence, continuity, effectiveness, efficiency, and safety (Canadian Council on Health Services Accreditation, 1996; Canadian Institute on Health Information, 2000).
The last dimension of the Canadian health system framework is the community and health systems characteristics. It seeks to “provide useful contextual information on areas that are not direct measures of the health status or of the quality of care.” It accomplishes this goal by analyzing the community, health system, and the available resources (Canadian Institute on Health Information, 2000). This framework is supported by surveys that seek consumer expectations, priorities, satisfaction, and input (Canadian Institute for Health Information, 2000; National Forum on Health, 1997). Its goal is to place the patient at the center of the healthcare system.

The Canadian healthcare system ranks 30th out of 191 countries in the WHO healthcare system. Universal health advocates have looked at it as a possible model for
the American healthcare reform (Murray, & Frenk, 2010; Tanner, 2008). It has been effective at controlling spending. The Canadian healthcare expenditure is 9 percent of its GDP (Canadian Institute of Health Information, 2000). Recently, there has been a growing number of people insured by their employers. This option offer Canadians more choices.

The Canadian healthcare system has faced some challenges. Waiting lists are a major problem. Waiting lists for services offered by specialists regarded as non-urgent and elective averaged about 18 weeks in 2005 (Esmail, Walker, & Wrona, 2006; Lomas, Woods & Veenstra, 1997). There is also limited access to modern medical technology such as MRIs and CT scans. Physicians and nurses are in short supply. The cost control measures which have been praised as a success have come at the expense of access and quality of care, especially preventive care for chronic health conditions (Lomas, Woods, & Veenstra, 1997; National Forum on Health, 1997; Tanner, 2008). Table 2.1 shows a summary of the four national healthcare system discussed in this chapter.
Table 2.1
Synopsis of National Frameworks for Health System Performance

<table>
<thead>
<tr>
<th></th>
<th>United Kingdom</th>
<th>Canada</th>
<th>Netherlands</th>
<th>Switzerland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Healthcare system</strong></td>
<td>Nationalized and devolved responsibility, publicly funded.</td>
<td>Federal, territorial and provincial with common principles, mixed but mainly public funding.</td>
<td>Regulated publicly and delivered privately in a managed competition.</td>
<td>Combination of public, subsidized private and private systems.</td>
</tr>
<tr>
<td><strong>Performance framework</strong></td>
<td>Coherent national framework with performance indicators, multiple local and firmly established performance indicators.</td>
<td>National framework with indicators for health and health system performance supported by community and health systems.</td>
<td>Coherent national framework system based on patient choice, broad access, quality, and low disparities.</td>
<td>Coherent national framework based on patient choice, broad access, quality, and low disparities.</td>
</tr>
<tr>
<td><strong>Performance improvement</strong></td>
<td>Controls assurance, accountability, and use of benchmarking indicators, financial incentives, and ‘earned autonomy.’</td>
<td>Benchmarking, accountability, planning, and measurement; based on quality health information systems</td>
<td>First to apply to the OECD framework health improvement and outcomes, access and responsiveness, financial contribution.</td>
<td>Improvement of health outcomes, full access and responsiveness.</td>
</tr>
<tr>
<td><strong>Quality of Care</strong></td>
<td>Quality as a main national priority; clinical governance (NSF, NICE, CHI, NPSA, &amp; NPF).</td>
<td>Continuous quality improvement as a priority in health care services (HC, CCHSA, NQI, CMA)</td>
<td>Quality from the patient, professionals, institutions, insurers, and government perspective (QCPP, IOM, OECD).</td>
<td>Quality is consumer driven (CDHC), IOM, and OECD.</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td>Ensures access to effective, timely, and high-quality care.</td>
<td>Improving health promotion, access, system</td>
<td>High quality care, high patient satisfaction and</td>
<td>Achieved universal coverage, offer</td>
</tr>
</tbody>
</table>
The 2000 World Health Organization (WHO) Report assessed the health system performance of 191 member countries. Each member state assessed its health system performance against its own potential. This assessment was based on improving health, enhancing responsiveness to the expectations of its population and fairness of financial contribution (World Health Organization, 2000). Accountability was based on the performance of national health systems, subsystems, institutions, and the overall attainment of health system goals.

The assessment was based on the WHO Healthcare Framework which has six building blocks; an effective and safe health service delivery, a well performing health workforce, a well-functioning health information system that ensures production, analysis, and dissemination of reliable and timely health information, equitable access to medical products, vaccines, and technology, adequate financing to meet people’s health needs, and strategic leadership that provides effective oversight and good governance (World Health Organization, 2007). These building blocks were supposed to ensure
access to healthcare coverage, while guaranteeing quality services and safety. The expected outcomes were improved health, responsiveness, social and financial risk protection, and improved efficiency (World Health Organization, 2007). Figure 2.2 summarizes the WHO Healthcare Framework.

![WHO Healthcare Framework](image)

*Figure 2.2. WHO Healthcare Framework (Source: WHO Report, 2000)*

### 2.3 OECD Health Framework

In 1961, the Organization for Economic Cooperation and Development (OECD) brought together countries sharing the same principles of market economy, pluralist democracy, and respect for human rights. The OECD proposed a conceptual healthcare framework that contains health improvement and outcomes, responsiveness and access, and financial contribution and health expenditure as its key elements (Hurst, 2002; Mosca, 2007).

The OECD Conceptual Framework (See Figure 2.3) is broken down into four subsystems. The first subsystem addresses the health status of citizens of OECD member
countries. This sub system assesses four critical areas; health conditions, human functions and quality of life, life expectancy and well-being, and mortality. (Arah, Westert, Hurst, & Klazinga, 2006; Marshall, Klazinga, Leatherman, Hardy, Bergmann, Pisco, Mattke, & Mainz, 2006; Mattke, Epstein, & Leatherman, 2006; Mosca, 2007; OECD Health Data, 2001).

The second subsystem seeks to assess non-healthcare determinants of health by attempting to answer the important question “are the non-health factors that determine health and healthcare being used across OECD countries?” This question is answered by addressing four factors; health behavior and lifestyle, resources, socioeconomic conditions and environment, and the physical environment.

The third subsystem assesses healthcare system performance by attempting to answer three questions, “How does the healthcare system perform? What is the level of care across the range of patient care needs? What does the performance cost?” It attempts to assess healthcare needs such as staying healthy, and end of life care against quality measures (effectiveness, safety, and responsiveness/patient centeredness), access, and cost (Arah, Westert, Hurst, & Klazinga, 2006; OECD Health Data, 2001; Marshall, et al. 2006).

The fourth subsystem addresses the health system design and context. Its main focus is efficiency at both micro and macro levels. It seeks to address the design and contextual aspects of each health system useful for interpreting the quality of its healthcare. Context is a critical component of this sub system. It addresses country-specific determinants of healthcare system performance such as capacity, social values and preferences, and policy. It assess the health system delivery features specific to

Figure 2.3. OECD HCQI Conceptual Framework (Source OECD, 2001).
OECD identified three types of health systems. The first health system is one with private insurance and private providers. In this system, buyers can influence unit costs and level of health expenditure (Marshall, et al. 2006; Mattke, Epstein, & Leatherman, 2006; Mosca, 2007; OECD Health Data, 2001). Before the implementation of the Affordable Care Act, the American healthcare system was an example of countries in this category. The American healthcare system had private insurance as well as government insurance. The second healthcare system is financed mainly by social health insurance with private or mixed providers. The government determines the level of health expenditure. The Netherlands healthcare system is an example of a country in this category. The third health system is known as the National Health Service. This system is financed by taxes. The United Kingdom health system is an example (Hurst, 2002). Table 2.2 provides a summary of WHO and OECD health frameworks.
Table 2.2

Synopsis of WHO and OECD Health System Performance Frameworks

<table>
<thead>
<tr>
<th>WHO</th>
<th>OECD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Framework</strong></td>
<td>Enhancing quality of life, improving health, responsiveness, and fairness of financial contribution.</td>
</tr>
<tr>
<td><strong>Conceptual Framework</strong></td>
<td>Concept of health system boundaries and health action, goals, health system efficiency, and functions.</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td>Improving health outcomes, overall health system performance and efficiency.</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>Quality is a subset of overall goal attainment, average levels of health and responsiveness.</td>
</tr>
<tr>
<td><strong>Management and Policy</strong></td>
<td>Scope of accountability on three levels; EHSPi, stewardship for all-embracing regulatory oversight.</td>
</tr>
</tbody>
</table>

(Source Arah, et al. 2003 with modifications).

2.4 Institute of Medicine Framework

In 1994, the Institute of Medicine (IOM) created a framework for national health system improvement that went beyond primary (prevention), secondary (intervention), and tertiary (treatment) that was in place (Institute of Medicine, 2001). It became known as the IOM protractor (see Figure 2.4). It shows a system from prevention of health problems to the maintenance of a healthy status (Springer & Phillips, 2007).

The IOM framework has several benefits. It provides a common language for understanding and evaluating the quality of healthcare services. By creating a common language of describing and evaluating healthcare service performance, it creates a consensus on what is important. This framework creates common expectations and
language of evaluating services between providers and service users (Hibbard, & Pawlson, 2004). Whilst the American healthcare system performs well in safety, effectiveness, patient-centeredness, timeliness, and efficiency, arguments have centered on equity and affordability (Ferlie, & Shortell, 2001; Hibbard, & Pawlson, 2004).

Figure 2.4. IOM Health Framework (Source: Institute of Medicine, 2001)

The IOM health framework is divided into three components; prevention, treatment, and maintenance (Institute of Medicine, 2001). These three elements were adapted from Gordon (1987). The prevention interventions are further divided into three categories. The first element is the universal prevention. It addresses general public population with average probability of developing a disorder, risk, or condition. The second element is the selective prevention. It serves a sub-population with a higher risk. The third element is the indicated prevention and it addresses individuals with minimal but detectable symptoms of the risk (Springer & Phillips, 2007).
The second component deals with treatment. It focuses on case identification and standard treatment for the conditions identified. This portion focuses on the actual treatment of the condition. It is not present in most healthcare frameworks. The third component focuses on maintenance of health after the condition or disorder has been treated (Institute of Medicine, 2001; Springer & Phillips, 2007). It focuses on compliance with long-term treatment to reduce changes of relapse and recurrence. It also focuses on the “after care” services and rehabilitation.

2.5 An Overview of Universal Health Coverage

Universal Health Coverage (UHC) is defined as a legal mandate for universal services with evidence showing the majority of a population with meaningful access to these services (Stuckler, Feigl, Basu, & McKee, 2010). Its main criteria is that more than ninety percent of the population has access to skilled birth attendance and insurance coverage. These criteria are broad in application and context. Its framework does not apply to developed countries such as the USA. The Universal Health Coverage framework is applied mainly to low-income and middle-income countries. Its focus is achieving basic coverage since poverty is likely to be an obstacle to accessing healthcare. Countries with low GDPs lack effective control systems, have weak tax-collection capacity, and insufficient human and physical resources to deliver effective care (Eibner, Hussey, & Girosi, 2010; Ferlie & Shortell, 2001; Stuckler, Feigl, Basu, & McKee, 2010).

While Universal Health Coverage is mainly applied to low income and middle class countries, the term “Universal Healthcare” is used to describe healthcare policies in
high-income countries. It involves assessing who the recipients of health services are, range of healthcare services available, and quality of healthcare (Navarro, 1989; Stuckler, Feigl, Basu, & McKee, 2010). It covers five themes; accessibility to healthcare, broad population coverage, a package of point-of-entry healthcare services, healthcare access based on rights and entitlements, and protection from social and economic consequences of illness. Common values of Universal Healthcare are equity, shared responsibility, and quality healthcare delivery which is not based on the ability to pay.

In an attempt to come up with dimensions of a universal healthcare system, Stuckler, Feigl, Basu, and McKee (2010) reviewed 58 articles on universal health coverage. Access to healthcare, insurance coverage, package of services, rights-based approach to universal health coverage, and social and economic risk protection emerged as key dimensions. The aim of universal health coverage is to ensure every citizen has access to insurance and important services such as doctor visits and essential medicines with financial risk protection. An important aspect of universal health coverage includes removal of cultural and social barriers to care (Lagomarsino, Garabrant, Adyas, Muga, & Otoo, 2012; Navarro, 1989; Protection, Patient, & Affordable Care Act, 2010; Stuckler, Feigl, Basu, & McKee, 2010).

According to the WHO World Health Report (2008), universal/comprehensive health coverage refers to ensuring that everyone is fully covered and all necessary services are available to everyone. For a health system to be deemed to have universal coverage, it should have dimensions referred to as breadth (who is covered), depth (which benefits are covered), and height (what proportion of the costs is covered) as depicted in the WHO World Health Report, (2008). The breadth dimension extends
coverage to the uninsured. The depth dimension focuses on including other needed healthcare services. The height dimension focuses on reducing cost sharing (see figure 2.5).

![Diagram of Universal Health Coverage Model](image)

*Figure 2.5. Universal Health Coverage Model (Source: WHO, 2008)*

The three dimensions could be summarized as universal coverage (breadth), comprehensive coverage (depth), and affordable coverage (height). Without one of these three key elements, a healthcare system is not regarded as universal or comprehensive. Using the universal health coverage model, Murray & Frenk, 2000; Lagomarsino, et al. (2012) defined the three dimensions of coverage by asking three questions, “Who is covered, what is covered, and what proportion of the cost is covered?”

In an attempt to define health coverage, WHO coined the phrase ‘basket of services’ to refer to the basic drugs and healthcare services. The goal was to identify a universal package of guaranteed health benefits and essential health services applied to all national healthcare systems. However, the challenge with attempting to create a
‘basket of services’ is that there may be some geographical, cultural, and or social demands on certain health services in one region or group of people more than in the group or region. In addition, the cost of such a ‘basket of services’ may differ from one country to another.

Rights-based approach to universal health coverage starts with the position that health is a human right (Braveman & Gruskin, 2003). Considering health as a human right encompasses services such as medical care, access to safe drinking water, adequate sanitation, education, health-related information, and other underlying determinants of health. These were ratified by all countries through the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and the Covenant on the Rights of the Child (CRC) (WHO, 2008; International Labor Organization, 1944). The right to health also encompasses the right to be free from discrimination and involuntary medical treatment and the right to essential primary healthcare. The challenge is that some of these rights are difficult to enforce in conditions of extreme poverty and civil unrest. There are also cultural factors that may make it difficult to ‘universalize’ these rights.

The basket of services also includes social and economic risk protection. Social and economic risk protection is defined as effective access to affordable healthcare of adequate quality with financial protection in case of sickness (International Labor Organization, 1944). The goal is to protect people from losing their source of livelihood due to a catastrophic health problem such as cancer. The International Labor Organization defined social health protection as “a series of publicly organized and mandated measures against social distress and economic loss caused by the reduction of productivity, loss or reduction of earnings or the cost of necessary treatment that can
result from ill health” (Stuckler, Feigl, Basu, & McKee, 2010, p. 3). Figure 2.6 shows the determinants of health proposed by the American House Committee Ways and Means, Subcommittee on health. There are many different presentations that show the determinants of health. The researcher chose this model because of its simplicity.

![Figure 2.6. Social Determinants of Health (Source: waysandmeans.house.gov).](image)

### 2.5.1. Analysis of Universal Health Coverage

Analysis of universal health coverage can be conducted using disciplines such as economics, sociology, political science, and public health (Jost, 2009; Stuckler, Feigl, Basu, & McKee, 2010). Each discipline has its strengths and limitations. These analyses involve different views about the role of the public versus private sectors, private market versus state, and local versus central government. The discussion also involves duties and responsibilities of individuals in the healthcare system (Jost, 2009; Stuckler, Feigl, Basu, & McKee, 2010).

The public health approach seeks ways to inform and influence policymakers about ways to modify the healthcare system to achieve the desired outcomes. It is
apolitical and conservative. It supports incremental changes to the existing system and relies heavily on the opinions and knowledge of professionals in the public health system (Navarro, 2000). It does this at the expense of opinions of the recipients of the healthcare services.

The public health approach has four challenges. It does not emphasize the importance of the political process that leads to changes in healthcare coverage. It ignores people’s experiences with the healthcare system and only focusses on data related to patient fees, waiting times, access to key medicines, and other broader health concerns such as piped water (Navarro, 2000, Stuckler, Feigl, Basu, & McKee, 2010). The public health approach also tends to evaluate public health outcomes outside the broader systems. In addition, the public health approach overlooks how financing and infrastructure determine the change of health systems. In the health reform process, the public health approach places emphasis on the influence of medical professionals to the exclusion of other key decision makers such as politicians and economists (Stuckler, Feigl, Basu, & McKee, 2010).

The sociological and political approaches focus on power, politics, and institutional forces. It relies on historical case studies and qualitative methods. They focus on class conflict for resources and preferences that leads to a system of social welfare. The main limitation of these approaches is that they are dominated by debate on America, which is the only major industrialized country that has not yet achieved universal healthcare (Stuckler, Feigl, Basu, & McKee, 2010).

The economic approach focuses on economic growth and democracy as key determinants. It states that social welfare (which includes healthcare spending), as a
function of economic growth, is greater as a percentage of GDP at higher levels of economic development. The logic of this argument is that when developing countries grow their economies, they are able to provide higher levels of healthcare coverage (Navarro, 1989; Stuckler, Feigl, Basu, & McKee, 2010). Democracy is seen as responsiveness to public opinions and attitudes. This suggests a correlation between public opinion and policy outcomes.

Connected to the development model are the conditions (social, economic, and political conditions) that support or inhibit the presence of universal healthcare. Lack of effective monitoring systems, limited government resources, and inadequate human resources have the capability to incapacitate a health system (Department of Health, 2002; Ferlie & Shortell, 2001; Stuckler, Feigl, Basu, & McKee, 2010). Hence, poverty is considered a major obstacle to universal healthcare.

2.5.2. Theoretical Paradigms on Universal Health Coverage

Four main theoretical paradigms have been identified to explain universal health coverage and how people access it (Jost, 2009; Stuckler, Feigl, Basu, & McKee, 2010). The first theoretical paradigm is the pluralist model. Multiple players are involved in policy-making. The main players are involved in policy-making and they compete to influence policy. People’s choices are critical. The major limitation of the pluralist paradigm is its misalignment between government-sponsored healthcare and health system outcomes.
The second theoretical paradigm is the institutional model. It focuses on the main stakeholders impacted by policies (medical professionals, hospitals, health insurance companies, and pharmaceutical companies). Its limitation is that it does not evaluate where the main stakeholders attain their power. The third theoretical paradigm is the development model. The underlying assumption of the development model is that developing countries will resemble developed countries due to economic growth and the integration of the global economy. It is based on the correlation between the country’s GDP and its public health spending (Stuckler, Feigl, Basu, & McKee, 2010; McCoskey & Selden, 1998). Its limitation is that it makes an assumption that an increase in economic resources leads to an increase in the allocation of healthcare resources. This has not been the case with all countries with increased resources.

The third paradigm is the class model. Its main assumption is that power relationships between classes determine the nature and extent of how resources are shared in society. It influences the development of social welfare and taxation. Groups compete through unions and political parties. Its main strength is that it can identify the sources of power and its changing distribution in society. Its main limitation is that it is difficult to observe class power, conflict, formation, and consciousness (Blumenthal & Hsiao, 2005; Ferlie, & Shortell, 2001).

The fourth paradigm is the political process model. From a Political Process Model, the discussion about Universal Health Coverage is initiated because the status quo is deemed not sufficient in meeting people’s needs. Two main arguments influence the need for change. First, healthcare costs are too high and there is need to put the cost under control. Second, the healthcare system is ineffective and falling short in delivering
the expected care (Arah, et al. 2003; Ferlie, & Shortell, 2001; Protection, Patient, and Affordable Care Act, 2010; Rosenbaum, 2011; Stuckler, Feigl, Basu, & McKee, 2010). The Affordable Care Act was introduced on this paradigm.

Within these four theoretical paradigms, there are two approaches to changing a healthcare system; gradual reform versus rapid change. The choice of the approach is a political decision and not technical one. Which approach to use depends on current leadership, institutions, existing events, how to create buy-in, how to get the best outcomes, and national context (Fontenot, 2013; Stuckler, Feigl, Basu, & McKee, 2010).

2.6 Before the Implementation of ACA

Before the implementation of the Affordable Care Act, some small businesses and industries across America struggled to meet the healthcare needs of their employees. This struggle has been well documented (Allen, 2001; Bradley, 2008; Formisano, Schwartz, Neale, Galanter, Grossman, & Geis, 1990; Frase, 2009; Helms, & Gauthrie, 1992; Kapur, 2004; Stern, 1992). The challenges small businesses and industries faced with providing health insurance were mainly due to administrative costs, lack of infrastructure, lack of information, and high costs supposedly due to lack of economies of scale (Kapur, 2004; Bradley, 2008; Protection, Patient, & Affordable Care Act, 2010). This led to most small businesses and industries not providing health insurance to their employees.

Providing health insurance has been a challenge for most small businesses in America due to rising healthcare costs. In 2004, the National Federation of Independent Businesses conducted a survey of top ten small business problems in America. The cost of providing health insurance ranked number one with a 65.6 percent “critical” rate. The
1997 Kaiser Family Foundation Report stated that nearly half of the uninsured people are either self-employed or work for small businesses with fewer than 25 employees. In addition to struggling to provide health insurance, most small businesses and industries struggled to recruit and retain talented staff. This was due to tough competition from big businesses on offering benefits such as health insurance (Stern, 1992; Sutton-Bell, & Fields, 1990). Large businesses and industries could afford to offer health insurance because they had more financial resources and a larger pool of employees to spread the risk and benefits from economies of scale.

Mulkey and Yegian, (2001) conducted a study to find out what the small businesses and industries in California could do to increase healthcare coverage among their employees. They hypothesized that small businesses were not providing health insurance due to lack of information on how to create economies of scale, negotiate with insurers, and find the best health insurance carriers. In addition to doing exploratory conversations with local Chambers of Commerce, Mulkey and Yegian, (2001) conducted focus groups with the people responsible for making health insurance purchasing decisions for California businesses with up to 50 employees. The results of their study led them to conclude that lack of information on the part of small businesses cause them not to offer health insurance (Allen, 2001; Mulkey & Yegian, 2001; Stern, 1992). By identifying and addressing information gaps such as tax-deductibility of premiums and market protections, small businesses would be inclined to offer health insurance to their employees (Allen, 2001; Stern, 1992).

Before the implementation of the Affordable Care Act, small businesses and industries had limited ability and influence to negotiate for affordable group health
insurance (Bradley, 2008; Stern, 1992; Sutton-Bell, & Fields, 1990). This resulted in their employees paying higher insurance premiums for limited health insurance coverage. The system that worked for big businesses and industries did not work well for small businesses and small industries due to the fact that each small business had a small pool of staff to spread the health insurance risk. For big businesses and industries, the cost of a few employees with high medical needs was spread among a large pool of healthy employees, making the cost of offering health insurance manageable. For small businesses and industries, the administrative costs of providing health insurance were higher, business profits were marginal, and they struggled to offer a competitive health insurance benefits package. This limited their ability to offer competitive health insurance premiums (Kathawala, Elmuti, & Roszkowski, 1993; Retsinas, 1995).

2.6.1. Ways Small Businesses met Employee Health Needs

Some philanthropic organizations stepped in to help the unemployed people and those employed by small businesses who could not afford health insurance. However, sustainability of such a great investment was a challenge (Frase, 2009; Helms, & Gauthrie, 1992; Schlesinger, Gray, & Bradley, 1996). Other small businesses and industries partnered with or referred their employees to faith-based organizations for healthcare services (DeHaven, Hunter, Wilder, Walton, & Berry, 2004; Kaplan, Calman, Golub, Ruddock, & Billings, 2006). In both cases, sustainability was a challenge.

Due to increased cost of providing health insurance to employees, some small businesses and industries resorted to providing ‘minimalist health coverage.’ This type
of health insurance does not cover expensive procedures such as surgery, a serious health emergency, or long term treatment of an unexpected major illness. At half the cost of a full blown traditional health insurance plan, a minimalist health insurance plan may cover prescriptions, a few doctor visits, a few labs, and a couple days in an in-network hospital (Cardon & Showalter, 2003; Frase, 2009). Minimalist health insurance plans are ideal for younger, hourly, and single employees who are in good health.

Some small businesses and industries resorted to alternative methods to manage their health insurance costs. They used alternative insurance methods such flexible spending accounts (FSAs), high-deductible health plans (HDHPs), health reimbursement accounts (HRAs), health savings accounts (HSAs), health insurance premium stipends, and small business health insurance purchasing alliances or cooperatives (Bradley, 2008; Levinson, & Rahardja, 2006).

A flexible spending account (FSA) is a pretax savings account funded by the employer for qualified medical expenses. It reduces employees’ tax liability (Cardon, & Showalter, 2001; 2003; Jack, Levinson & Rahardja, 2006). HRAs are similar to FSAs except that they are solely funded by the employee on pre-tax basis through payroll deduction (Bradley, 2008; Sheils & Hogan, 1999). The number of employers offering health insurance with HSA was on the increase. HDHPs are a way that employers shift the cost of insurance to their employees through high deductibles. The idea is to turn patients into engaged consumers of healthcare services who put pressure on healthcare providers to improve the efficiency and quality of healthcare (Lee & Zapert, 2005). The underlying assumption is that when healthcare consumers are engaged, they will be
interested in getting value for their money. They will also shop around and compare prices before they access healthcare services.

Other small businesses and industries resorted to providing a health insurance stipend to their employees. This gave their employees the freedom and flexibility to choose their own individual health insurance plan. With health insurance purchasing alliances, small businesses and industries teamed up to benefit from economies of scale (Bradley, 2008; Lee & Zapert, 2005). The challenge with health insurance purchasing alliances was that when one small business or industry pulled out or closed, it altered the whole health insurance pool and cost sharing plan. The impact of adding an employee with high medical needs is greater for a small employer and barely felt by a larger employer.

Other small businesses and industries resorted to not providing health insurance at all. The cost was prohibitive, they lacked technical expertise, they lacked economies of scale, and their businesses had small profit margins. They had a small pull of employees to spread the risk and health insurance costs. Failure to provide health insurance by some small businesses and industries resulted in them losing their ability to attract and retain talented employees. This resulted in some small businesses and industries closing due to tough competition from larger businesses (Allen, 2001; Bradley, 2008; Formisano, et al. 1990; Frase, 2009; Helms, & Gauthrie, 1992; Kapur, 2004; Stern, 1992; Sutton-Bell, & Fields, 1990).
2.6.2. Ways States Provided Healthcare

In an endeavor to help small businesses and the self-employed, some states expanded their existing healthcare plans. Michigan and Massachusetts expanded their State Children’s Health Insurance Programs (SCHIP) to help small employers and the self-employed purchase health insurance (Claxton et al. 2006; Rosenbaum, Borzi, & Smith, 2001). Individual states helped small businesses and industries and the self-employed by organizing small group health insurance markets and subsidize the cost of health insurance coverage for low income employees.

The goal was to make health insurance premiums affordable. This program proved to be helpful to small businesses and industries in Massachusetts and Michigan. Maryland also followed Michigan and Massachusetts when in 2007, the Governor signed into law the Working Families and Small Business Health Coverage Act (Claxton, et al. 2006). This law provided subsidies to small businesses and industries to offset the cost of providing health insurance.

2.7 An Overview of the Affordable Care Act

This section attempts to give an overview of the Affordable Care Act. The Affordable Care Act law document is about 2,700 pages written in legal language. The researcher attempted to highlight the main tenets of the law in common language. This section is not meant to be comprehensive.

In a nutshell, the fundamental goal of the Affordable Care Act was to expand access to health insurance, increase consumer protections, emphasize prevention and
wellness, improve the quality and system performance, expand the health workforce, and curb the rising healthcare costs (Hofer, Abraham & Moscovice, 2011; Huntington, Covington, Center, Covington & Manchikanti, 2011; Protection, Patient, and the Affordable Care Act, 2010).

In an attempt to expand access to healthcare, an important provision in the Affordable Care Act law is that it requires all insurance plans to offer dependent coverage of children until they are 26 years old. This improved access to care for many young and healthy people who did not afford or did not have coverage through their employers. As a result, the percentage of uninsured young adults dropped from 35.6 percent to 26.3 percent in one quarter and a corresponding increase in private health insurance coverage for this age group from 49.3 percent to 56.7 percent in the same quarter (Beronio, Glied, & Frank, 2015). For individuals on Medicare Advantage plans, the Affordable Care Act was supposed to lower overall costs and hospital costs. It was also shorten the length of hospital stays (Custer, 2013; Huntington, Covington, Center, Covington, & Manchikanti, 2011). In the end, the same benefits were expected for individuals on their employers' insurance plans.

The Affordable Care Act was supposed to increase the rewards that employers can offer in their wellness programs. This was an attempt to provide incentives for healthy behaviors (Cawley, 2014; Dixon, & Hertelendy, 2014; McMorrow, Kenney, & Goin, 2014; Molinari, 2014). The Affordable Care Act was supposed to eliminate co-pays, co-insurance, and deductibles for wellness programs. This made preventive services more attractive for employees. In addition, the Affordable Care Act increased the federal
medical assistance for Medicaid for preventive services if a state opted to cover them without cost sharing (Huntington, et al. 2011).

McMorrow, Kenney, and Goin, (2014) examined preventive care use by adults aged 18 to 64 years before the implementation of the Affordable Care Act and the contributions of the Affordable Care Act preventive care services. They concluded that the benefits of preventive care services as stipulated in the Affordable Care Act will have overall long term benefits (McMorrow, Kenney, & Goin, 2014). However, Molinari (2014) argued that increasing patient cost sharing lowers individual utilization and spending. This is because higher co-payments have a tendency to lower the demand for healthcare services.

Using data from 2005 to 2010 from the Medical Expenditure Panel Survey, McMorrow, Kenney, and Goin, (2014) measured the receipt of 8 preventive services. The results of their study showed large income-related disparities (25 percent to 40 percent) in preventive care receipt for non-elderly adults. Education, age, and health status also showed as important drivers. Non-elderly adults with higher income, higher education, and with better health status use more preventive services than their counterparts. They concluded that the use of recommended preventive services is a major public health priority. The expansion of coverage to lower-income adults through the Affordable Care Act was expected to increase the use of preventive care services. They also concluded that the Affordable Care Act would not address all barriers to preventive care, hence the need for additional interventions. In another study, Claxton, et al. (2014) concluded that since the nondiscrimination requirements such as income and gender had
been delayed until 2015, most small businesses had not yet benefited much from these changes.

The Affordable Care Act has a provision to expand coverage of mental health and substance abuse disorders. Before the implementation of the Affordable Care Act, an estimated 12 million of the nearly 50 million uninsured Americans had a mental health or substance use disorder (Beronio, Glied, & Frank, 2014). For those with health insurance coverage for general healthcare, their policies excluded behavioral health entirely or provided partial coverage. High-income people with chronic mental health and substance use disorders struggled to obtain health insurance coverage. This resulted in some people being locked into existing jobs and health insurance plans when a change would have been beneficial.

The healthcare coverage provided by Affordable Care Act in combination with the Mental Health and Additional Parity Equity Act (MPHAEA) enhance the ability of people with mental health and substance use problems to obtain and maintain coverage (Beronio, Glied, & Frank, 2014; Mechanic, 2012). The Affordable Care Act prohibited lifetime and annual limits for people with mental health or substance abuse conditions. It prohibited health plans from dropping healthcare coverage unless the insured was involved in fraud or intentional misrepresentation of material facts (Beronio, Glied, & Frank; 2014).

The Affordable Care Act expanded access to insurance coverage by requiring employers to provide health insurance for their employees or pay a penalty. There are a few exceptions for small employers. It also expanded health insurance coverage by providing tax credits to small businesses to cover specified health insurance costs. It
required that every individual have health insurance except under financial hardship or for religious beliefs. It required states to create insurance exchanges to support individuals and small businesses purchase health insurance with some income-based guidelines. The Affordable Care Act also expanded Medicaid to include people below 133 percent of federal poverty guidelines. It required health insurance plans to cover young adults under 26 years old on their parents’ health insurance policies. In addition to establishing a national voluntary long term care insurance program, the Affordable Care Act also put in place some consumer protections that guaranteed coverage (Huntington, et al. 2011; Protection, Patient, and the Affordable Care Act, 2010; Sommers, Buchmueller, Decker, Carey, & Kronick, 2013).

In an attempt to increase consumer insurance protection, the Affordable Care Act prohibited lifetime monetary caps on insurance coverage and limited the use of annual caps. In addition, it prohibited insurance plans from excluding coverage for pre-existing conditions. Insurance plans were prohibited from cancelling coverage unless there is proof of fraud. It established state-based rate reviews for unreasonable insurance premium increases, the share of premiums for medical services, and an ombudsman office to help health insurance consumers (Baker, 2011; Hofer, Abraham, & Moscovice, 2011; Protection, Patient, and the Affordable Care Act, 2010).

The Affordable Care Act placed special emphasis on prevention and wellness programs by establishing a Prevention and Public Health Fund. This fund provides grants to states for prevention activities such as disease screening and immunization. The Affordable Care Act created the National Prevention, Health Promotion, and Public Health Council to coordinate federal prevention efforts to address tobacco use, obesity
due to inactivity, and poor nutrition. Insurance plans are required to cover preventive care such as immunization, preventive care for children, and adult screenings for high blood pressure, high cholesterol, diabetes, and cancer without cost sharing. It increased the federal share of Medicaid and required Medicaid to cover tobacco cessation services for pregnant women. It increased Medicare payments for preventive services, required federal public education campaign about oral health, and established a federal home-visiting program to support states in fostering health and well-being for children and families who live in at-risk communities. It requires restaurant chains with 20 or more locations to label menus with calorie information and to provide other information such as fat and sodium content upon request (Koh, & Sebelius, 2010; Protection, Patient, and the Affordable Care Act, 2010).

The Affordable Care Act aimed at improving health quality and systems performance through comparative studies on the effectiveness of various medical treatments, development of alternatives to malpractice, and reduction in medical errors. It fostered the development of a payment mechanism that would improve efficiency and results. It invested in health information technology meant to establish a centralized health information system. It focused on improvement of care coordination for patients on both Medicaid and Medicare. It provided options for states to create “health homes” for Medicaid enrollees with multiple chronic conditions to improve care. The establishment of the Affordable Care Act created provisions for data collection and reporting mechanisms to address health disparities based on ethnicity, geographical location, gender, language, and disability status (Protection, Patient, and the Affordable Care Act, 2010).
The Affordable Care Act aimed at promoting health workforce development through several provisions including reforms in graduate medical education, increases in health profession scholarships and loans. It creates support for nursing training programs, support for new primary care models such as medical homes and team management of chronic diseases, increased funding for community health centers and the National Health Service Corps. It provided support for school-based health centers and nurse-managed health clinics (Protection, Patient, and the Affordable Care Act, 2010).

Rising health costs has been a challenge in America. The Affordable Care Act has provisions intended to provide more oversight of health insurance premiums and practices. It placed great emphasis on prevention, primary care, and effective treatments while reducing healthcare fraud and abuse. It aimed at reducing uncompensated care to prevent a shift onto insurance premium costs. It fostered price transparency and educated health insurance purchasing decisions based on comparison-shopping in insurance exchanges. The Affordable Care Act attempted to create a sustainable insurance market and create competition among health insurers based on cost and quality of health services in their plans (Protection, Patient, and the Affordable Care Act, 2010; Rosenbaum, 2011).

An important way the Affordable Care Act would meet these goals was to pool risk by expanding coverage to young and health people (Baker, 2010; Custer, 2013; Eibner, Hussey & Girosi, 2010; Rosenbaum, 2011). Pooling risk refers to spreading the burden of health insurance across a large number of employees. By increasing the number of young and healthy people in the same health insurance pool with the elderly people who have chronic health issues, the Affordable Care Act would lower the cost of health insurance premiums for high-risk people. It made an assumption that many young
and healthy people were going to sign up for health insurance, which would result in lower health insurance premiums for people with chronic health issues. Expanding coverage was a critical first step for the Affordable Care Act in making health insurance affordable to people with chronic conditions.

In the short run, the Affordable Care Act resulted in increased premiums for the young and healthy as it lowered premiums for high-risk people with chronic conditions (Custer, 2013). This is the reason why critiques of the Affordable Care Act refer to it as social medicine. In the end, if more people enroll for health insurance through the exchange, the cost of providing health insurance for every American will even out.

The Affordable Care Act provided for risk adjustment (also referred to as risk equalization) in individual and small group health insurance markets. The Center for Medicare and Medicaid Services wrote a series of three articles describing risk adjustment methodology for individual and small group markets. The risk adjustment methodology consists of a risk adjustment model and risk transfer formula. (Pope, Bachofer, Pearlman, Kautter, Hunter, Miller & Keenan, 2014). Risk transfers are meant to offset the effects of risk selection on health insurance plan costs while preserving premium difference (Hoffman, 2010; Pope, et al. 2014).

The main goal of the Affordable Care Act risk adjustment methodology was to compensate health insurance plans for differences in enrollee health mix. The Affordable Care Act risk adjustment methodology also addressed three specific issues; new population, cost and rating factors, and balanced transfers within the market (Pope, et al. 2014). Without risk adjustment, insurance plans with a higher proportion of high-risk
enrollees would have to charge a higher average premium to remain financially viable (Kautter, Pope, & Keenan, 2014).

The Affordable Care Act was designed to create a platform where healthcare providers are incentivized to share health information. Two of the major barriers to small businesses and industries providing health insurance identified in the American healthcare system were lack of information and lack of incentives. Before the implementation of the Affordable Care Act, there were too many unplanned readmissions, medication errors, and hospital-acquired infections (U.S. Department of Health and Human Services, 2009). In addition, there was no platform for physicians to share information on what treatments work best, whether or not patients are taking their medications as prescribed, and following through with preventive care recommendations and referrals. By incentivizing healthcare providers to share healthcare information, such problems could be avoided.

The concept of a successful healthcare reform is dependent upon the generation, collection, and sharing of information. This is made possible by the improvement in healthcare information technology (Fontenot, 2014). The Affordable Care Act provided incentives for healthcare providers to create electronic health records. It also provided funding for patient-centered outcomes, quality, and coordination of care. (Kocher, Emanuel, & DeParle, 2010). Hillestad, Bigelow, Bower, Girosi, Meili, Scoville, & Taylor, (2005) examined the potential health and financial benefits of electronic medical records. They estimated an annual savings around $81 billion over the next 10 years. Additional benefits would be in healthcare efficiency and safety. When considering
prevention and management of chronic diseases, the benefits could double while also increasing other social benefits (Hillestad, et al. 2005).

Before the implementation of the Affordable Care Act, small businesses and industries failed to provide health insurance due to huge administrative overhead costs. In an attempt to reduce administrative overhead costs, the Affordable Care Act promised to reduce paperwork. Under the administrative simplification provisions, physicians are able to check for coverage electronically before service delivery (Kocher, Emanuel, & DeParle, 2010).

2.8 Summary

This chapter provided an overview of the literature on national health frameworks, universal health coverage, and the Affordable Care Act. The results of this literature provide a basis for the importance of the questions presented in this study.
CHAPTER 3. FRAMEWORK AND METHODOLOGY

The intent of this study was to describe and analyze the lived experiences and perspectives of small businesses and industries with the Affordable Care Act. Based on the nature of the research questions presented, the qualitative method was the most suitable method for this research. Since this study was aimed at understanding the perceptions and lived experiences of small businesses and industries with the Affordable Care Act, the phenomenological inquiry seemed to be the ideal guiding framework in understanding their perspectives.

This chapter describes the method of research and why this particular method was chosen. It gives a brief overview of the importance of theoretical framework. It also describes the theoretical framework that guided this study and provides the universal health coverage model used in this study. It provides the research bias inherent to this study and how to mitigate against it. It provides the research methodology and research environment. It also provides the study location, participant population, and how the participants were sampled. It provides the necessary approvals needed for this research, the data collection methods used, the data analysis methods, credibility, and triangulation.

3.1 Theoretical Framework

several effective health frameworks. The actors’ framework designed by Evans in 1991, the fund flows and payment framework designed by Hurst in 1991, the demand-supply framework designed by Cassels in 1995, the performance framework designed by WHO in 2000, the control knobs framework designed by Hsiao in 2003, the reforms frameworks designed by Roberts, Hsiao, Berman, and Reich in 2004, the public management framework designed by Khaleghian and Das Gupta in 2004, the capacity framework designed by Mills, Rasheed, and Tollman in 2006, the building blocks framework designed by WHO in 2007, the essential public health functions framework designed by PAHO in 2008, and the systems framework by Atun in 2008. The pluralistic model is another framework used to evaluate health systems (Stuckler, Feigl, Basu, & McKee, 2010; Meessen, Bigdeli, Cheng, Decoster, Ir, Men, & Van Damme, 2011).

A framework for evaluating a health system is important for several reasons. It helps healthcare service providers and patrons to have the same expectations. Quality information empowers consumers in healthcare decision-making process. It also empowers health service recipients to be aware of what they should be looking for, evaluate the services they receive, and speak confidently to service providers. (Hibbard, & Pawlson, 2004). When consumers of healthcare services are informed about what to look for and are capable of evaluating the services they receive, it improves the overall quality of healthcare services.

In this study, the researcher used the pluralistic framework to guide this research. The pluralistic framework uses the integrated theory of policy change. The pluralistic framework draws from the economic, socio-political, and public health perspectives (Stuckler, Feigl, Basu, & McKee, 2010; Meessen, et al. 2011). The pluralist approach is
broader than just mass mobilization and collective protest. It involves collective actions
to effect social change through institutional and extra-institutional ways to achieve social
change. Institutions include formal and informal networks that influence and shape the
health service delivery system. The collective actions include social protest, strikes,
awareness and voting campaigns (Meessen, et al. 2011; Stuckler, Feigl, Basu, & McKee,
2010). At its best, the pluralistic framework empowers consumers of healthcare services
to select, evaluate, and advocate for improvement of healthcare systems.

In the pluralist model, multiple players are involved in policy-making. The main
players compete to influence policy. People’s choices are important and taken into
consideration. Its limitation is its misalignment between government-sponsored
healthcare and health system outcomes (Jost, 2009; Stuckler, Feigl, Basu, & McKee,
2010). While it empowers the consumers of healthcare services, it is limited in that the
government is both the sponsor and evaluator of health system outcomes. It minimizes
the role of private sector in the delivery of healthcare services.

The chosen theoretical framework was important in clarifying the concepts that I
considered important in this study. It showed the relationship that exist among the
concepts. These relationships helped clarify the underlying mechanisms, the determinants
of the observed phenomena and their connections or lack thereof (Creswell, Hanson,
Plano, & Morales, 2007). My theoretical framework also referred to the theory that
guided this study. Universal health coverage is part of a broader movement to implement
social welfare systems (Meessen et al. 2011; Stuckler, Feigl, Basu, & McKee, 2010).
3.2 **Conceptual Model**

In conjunction with the pluralistic framework, the researcher used the WHO (2008) Universal Health coverage Model (Figure 2.5). The WHO (2008) Universal Health coverage model addresses three critical areas; who is covered, benefits covered, and what proportion of the costs is covered. Within the context of public health expenditure, the WHO (2008) Universal health Coverage model focuses on universal coverage (extending coverage to the uninsured), affordable coverage (improving cost sharing), and comprehensive coverage, (including other health services in the coverage). This is also summarized as the breadth, height, and depth of universal health coverage (WHO, 2008). The WHO (2008) Universal Health Coverage Model played an important role as the researcher’s conceptual model. It guided the development of this study and helped in making research findings generalizable and meaningful.

A conceptual model is a system of concepts, assumptions, expectations, and beliefs that supports and informs your research (Walker, Harremoës, Rotmans, van der Sluijs, van Asselt, Janssen, & Krayer von Krauss, 2003). These concepts, assumptions, expectations, and beliefs are placed in a logical sequence. A conceptual model guides the development of a study. It is based on the identification of specific concepts and their relationships. The concepts and relationships are derived from observation and an educated guess. A conceptual model is a picture of what is going on with the phenomenon under study (Walker, et al. 2003). It is used mainly for studies in which existing theory is not sufficient. A conceptual model is a schematic presentation that has not been tested which can lead to the development of a theory (Parasuraman, Zeithaml, & Berry, 1985).
Contrasting a conceptual model from a theoretical framework is important. A theoretical framework is broader in its scope whereas a conceptual model is more specific in its application. The chosen conceptual model specified the variables that were needed to be explored in the study. It informed the study design, sample selection, and data collection strategies. It also determined the final interpretation of the results (Brach, & Fraserirector, 2000).

The chosen conceptual model helped make research findings generalizable and meaningful. It was a composition of concepts that helped the researcher know, understand, and simulated a subject. It pulled together and made visible what the implicit theory is. It was also used to clarify an existing theory. A conceptual model helps with theory development. It provides a way of seeing unexpected connections and helps identify holes or contradictions in the researcher’s assumptions. In addition, a conceptual model helps the researcher challenge existing assumptions. In addition to proposing relationships among the concepts under study, it aids in clarifying the concepts (Brach, & Fraserirector, 2000; Pender, Murdaugh, & Parsons, 2002). It helps the researcher see what is missing in the proposed framework. A conceptual model also helps the researcher figure out ways to resolve any contradictions in the research assumptions.

A conceptual model helped with summarizing and integrating knowledge. The arrows indicate causality or the relationship among the concepts (Huberman & Miles, 1994). It answers the important question, “what do you think is going on?” A research problem is considered part of the conceptual model and it answers the question, “What do you want to understand?” A conceptual model clarifies what is known and not known
about a system. It goes beyond simple cause and effect to explore linkages and feedback in systems (Pender, Murdaugh, & Parsons, 2002).

3.3 **Research Methodology**

This study used the qualitative method. There are disadvantages and disadvantages associated with the qualitative method. Because the researcher is an active part of the research process, the qualitative method tends to be biased. In that regard, the researcher is an active part of the research and this makes the data subjective, creating challenges in establishing reliability and validity.

By its nature, the qualitative method uses a small sample size. This does not result in generalizable conclusions. While the qualitative research method provides rich data, it can be difficult to establish validity when using a small sample. Another challenge is that most funders are not willing to fund in-depth studies using a small number of participants. Most funders support research whose results are generalizable in nature. In addition, qualitative data is often too much and difficult to analyze and summarize. Because of that, qualitative research is time consuming (Laverty, 2008; Macys & Pope, 2002; Moustakas, 1994).

Qualitative research requires a qualified and experienced moderator during interview and panel discussions. Finding such a qualified and experienced moderator can be a challenge. Where available, qualified and experienced moderators charge a premium for their service. Another limitation of qualitative research is that the researcher may give too much credit to the results (Moustakas, 1994). Pure bracketing is difficult, making it
difficult to detect or prevent researcher-induced bias (Gadamer, 2008; Laverty, 2008; Moustakas, 1994).

Qualitative research has several strengths. The researcher has direct interaction with participants. This allows the researcher to ask for clarification, provide immediate follow up, and ask probing questions. Member checking improves the qualitative validity of data collected using qualitative method. Qualitative research is important for studying a complex phenomenon. It is good for understanding people’s emic experience of the phenomena being studied. Data is collected in naturalistic settings and the qualitative research method can describe in rich detail the phenomena in its local context. It also helps determine how participants interpret certain constructs. It is also important to note that qualitative research is responsive to local situation, conditions, and stakeholder’s needs. Qualitative research is also strong at determining the causes of a particular event (Laverty, 2008; Moustakas, 1994; Patton, 2002).

This study used the phenomenology method. Phenomenology is defined as the study of lived experiences (Moustakas, 1994; Laverty, 2008; van Manen, 1997). It describes one’s perceptions and senses, acknowledging the immediate awareness and experience (Gadamer, 2008; Heidegger, 1970). Phenomenology is descriptive in nature and focuses on the structure of experience. The phenomenological approach concentrates on the study of consciousness and the objects of direct experience (Heidegger, 1970; Husserl, 1966; Laverty, 2008). Husserl and Heidegger, two Germany philosophers, developed it. The goal of phenomenology is to allow the researcher to identify the essence of human experiences about a phenomenon from the participants’ point of view. Phenomenological study is conducted using inductive methods such as interviews,
discussions, and participant observation. It is based on a paradigm of personal knowledge and subjectivity (Heidegger, 1970; Husserl, 1966). It emphasizes the importance of personal perspective and interpretation.

Phenomenology is a flexible tool that can be used in a wide range of settings and individuals. Results are easy to understand since they are people’s direct opinions and statements (Gadamer, 2008; Heidegger, 1970; Husserl, 1966). In an attempt to capture the participant’s experience, the phenomenological approach provides rich data from the participants' perspective. It allows the participants to paint the picture of their phenomena. It seeks for the meaning of the phenomenon from the participant’s perspective (Gadamer, 2008; Laverty, 2008; Moustakas, 1994).

In general, the qualitative method accepts and appreciates each participant's subjective uniqueness and accounts for individual realities. In particular, the phenomenological approach seeks to shed light on individual experiences and values its uniqueness (Heidegger, 1970, Husserl, 1965).

The phenomenological approach is effective at challenging structural or normative assumptions. The researcher studies a small number of subjects through extensive and prolonged engagement in an attempt to understand their lived experiences and the meanings they attach to those lived experiences (Gadamer, 2008; Laverty, 2008; Moustakas, 1994). When conducting the phenomenological study, the researcher attempts to set aside (bracket) his or her personal experiences to understand those of the participants (Heidegger, 1970; Tufford & Newman, 2012). By cutting through assumptions and accepted wisdom, the phenomenological approach helps the researcher understand subjective experience, exposing people’s motivations and actions (Gadamer,
By adding an interpretive dimension, phenomenology informs, supports, or challenges policy and action (Tufford & Newman, 2012). The phenomenological approach can be applied to single cases or selected samples. Single case studies can be used to draw attention to different situations while multiple participant research increases the strength of inference (Moustakas, 1994; Tufford & Newman, 2012). When conducting qualitative research, it is critical to distinguish qualitative validity from statistical validity (Baker, Wuest, & Stern, 1992; Easton, McComish, & Greenberg, 2000). While statistical validity refers to validity based on statistical strength of the relationship between two variables, qualitative validity refers to the plausibility, credibility, and trustworthiness of qualitative data and how it can be defended if and when challenged (Bashir, Afzal, & Azeem, 2008; Creswell, & Miller, 2000; Maxwell, 1992). Qualitative validity can be drawn from one or a few cases. Phenomenological research does not attempt to show statistical validity. Instead, it is robust in indicating the presence of factors and their effect on individual cases. Phenomenology is tentative in suggesting the relationship to the population from which the participants were drawn (Laverty, 2008; Moustakas, 1994).

There are three main types of phenomenology: transcendental phenomenology (Husserl, 1965; Husserl, 1966; Moustakas, 1994), hermeneutic (constitutive) phenomenology (Gadamer, 2008; Laverty, 2008), and existential phenomenology (Heidegger, 1970). Transcendental phenomenology is rooted in subjective openness (Moustakas, 1994). It requires setting aside every supposition (epoche) and allowing to come to light those issues that are ignored because of status quo. It is “concerned with the
discovery of meanings and essence in knowledge” and is connected to the internal experience of being aware of something (Moustakas, 1994, p. 40). It “emphasizes the subjectivity and discovery of the essences of experience” (Husserl, 1965, P. 5).

Existential phenomenology is associated with the works of Dilthey, Heidegger, Sartre, and Merleau-Ponty. Its methods were derived from Gestalt psychology (Tiryakian, 1965). It requires seeing the world from a new perspective. It provides a way to describe a paradigm’s core assumptions and assumptions that are treated as ‘the truth’ (Thompson, Locander, & Pollio, 1989; Tiryakian, 1965; Valle, 1978). Existential phenomenology is used to study consumer experience. It uses interview data. The interview is a descriptive and in-depth dialogue and participants freely describe their experiences (Thompson, Locander, & Pollio, 1989). Interrogative questions are avoided and the interviewer assumes a non-directive listener position. It seeks an experiential description and the description stays at the level of the respondent’s life-world (Tiryakian, 1965).

Hermeneutic phenomenology was mainly advanced by Heidegger and further developed by Gadamer. Gadamer extended Heidegger’s work into practical application (Gadamer, 2008). Hermeneutic phenomenology seeks out the meaning of the phenomenon from the participants’ perspective. The central question of the hermeneutic phenomenological approach is “what is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?” (Patton, 2002, p. 482).

This study used the hermeneutic phenomenology. The goal was to elicit the personal experiences and meanings of small businesses and industries with the
Affordable Care Act. The hermeneutic phenomenology approach provides a rich and detailed description of human experiences and meaning from their perspective. Hermeneutic phenomenology helped the researcher to capture the unique experiences and meaning of each small business and industry in the study.

Another reason why I chose hermeneutic phenomenology is that the themes emerge from the data. As a researcher, my goal was to bracket my assumptions that tend to color the lenses through which I see the data (Tufford & Newman, 2012). Another reason I used the hermeneutic phenomenology was that it is free from imposed structured statistical analysis. The data speaks for itself. Hermeneutic phenomenology is interpretive in nature (Laverty, 2008). It seeks to delve beneath the subjective experiences and get to the objective nature of things. It helped me to describe accurately a phenomenon from the participant's perspective. The hermeneutic phenomenology approach helped me understand the experiences of small businesses and industries with the Affordable Care Act.

3.4 Research Bias

I had several biases going into this study. These biases came from my personal and professional experience, personal preferences, and assumptions developed over the years. In this section, I attempted to list my biases so that readers are aware of them. Since 2000, I have been involved in working with low income people. Most of them did not have health insurance. From 2000 to 2008, I was the Director of Supported Living for an agency that supports low-income people with developmental and intellectual disabilities in Northern Indiana. This agency provided services in five counties in
Northern Indiana. In this position, I supported low-income people with disabilities and their families to obtain and maintain Medicaid, Medicare, and social security. I was involved in addressing issues that affect low-income people with disabilities at county level.

From 2008 to 2014, I worked with the same population in Western Indiana. In my role as the Executive Director, I was involved in addressing the same issues at state and national level. As a member of two statewide advocacy organizations that focus on addressing the needs of people with disabilities and low income people, I met with Chief Executive Officers, Chief Operations Officers, and Chief Finance Officers of similar agencies in Indiana and nationally. During these meetings, we discussed the health needs of low-income people and people with disabilities across the state of Indiana. These discussions included Medicaid, social security, and health services for low income people and people with disabilities.

At some of these meetings, we were joined and addressed by the Director (or his/her representative) of the state agency that oversees Medicaid for low income with disabilities in the State of Indiana. The state agency that oversees the needs of low income people with disabilities is called the Bureau of Developmental Disability Services (BDDS). BDDS operates under the Division of Disabilities and Rehabilitation Services (DDRS). In addition to BDDS, DDRS also oversees the Bureau of Rehabilitation Services (BRS). The main goal of BRS is to support low-income individuals with disabilities to obtain and retain employment.

Once per quarter (or as needed), we also met with the Director of DDRS (or his/her representative), depending on the needs existing in the state. DDRS operates
under the supervision of Family and Social Services Administration (FSSA). The FSSA Secretary is appointed by and reports to the Governor. Several programs or divisions operate under the FSSA. The Division of Family Resources (DFR) offers food and cash assistance and healthcare eligibility for low-income children and pregnant mothers. The Division of Aging provides community-based supports to low income elderly. The Division of Mental Health and Addiction (DMHA) provides services to people with mental health and addiction challenges. The Office of Medicaid Policy and Planning (OMPP) is responsible for Medicaid, health coverage, and prescription plan. The Office of Early Childhood and Out-of-School Learning (or commonly known as Head Start) is responsible for early childhood education and care.

The organization I worked for between 2008 and 2014 provided rehabilitation services in thirteen states. It also provided services in other countries such as Latvia, Tanzania, Germany, and Great Britain). This gave me a national and international perspective of issues affecting low-income people and people on Medicaid.

In 2014, I was appointed the Chief Executive Officer for a similar organization that supports low-income people and people with disabilities. In addition to supporting low income people obtain and maintain social security and Medicaid, we support them in their efforts to have access to affordable and accessible housing and transportation. In this position, I have access to information at state, national, and international level covering the needs of people with disabilities and low-income people.

Whilst my 16 years of experience working with low income people who struggle to have access to healthcare has given me valuable insights on the need for improving access to healthcare services, it compounds bias. It colors my lenses that I view the
subject under study. My years of working with this population made me a sympathizer of their cause and a self-appointed advocate. Taking a step back from this position and looking at the subject of universal health coverage demanded objectivity on my part.

Since the year 2000, I have seen the great need to provide health insurance to uninsured low-income people. I saw evidence of Medicaid and Medicare abuse. I have seen health service providers order tests or services for people on Medicaid that I deemed not necessary. I witnessed people on Medicaid request for tests that if they were paying for the medical services, they would not otherwise have requested. I observed a disintegrated health service delivery system where the primary doctor did not know what the psychiatrist and the cardiologist prescribed his/her patient.

During this same period, I observed lack of communication between Medicaid and Medicare. When low-income people with disabilities qualified for both Medicaid and Medicare, the two health insurance systems did not communicate well. This resulted in a lot of duplication of services. It also resulted in an uncoordinated service delivery system. As a result, the FSSA implemented a service called Wellness Coordination in 2014. This service was meant to help low-income people with disabilities have a well-coordinated delivery of health services. Agencies that support low-income people with disabilities were required to hire a Registered Nurse whose primary purpose was to proactively coordinate the delivery of medical services between the primary doctor and other healthcare providers.

I entered this study biased that the Affordable Care Act was needed to expand health insurance coverage to include millions of people who did not have health insurance. I also entered this study with a bias that there is need to ensure efficiency in
the Medicaid and Medicare systems. I was also biased for a system that had a combination of private and government funding of the healthcare system. The government works best when it is in the role of monitoring services instead of providing services.

I witnessed low and middle income people go into bankruptcy because of health related costs. A prolonged health condition like diabetes or a sudden major illness such as cancer can drive low and middle income families into bankruptcy; leading to families losing their lifetime savings. I am biased that families should be protected from such unfortunate health calamities.

I have worked with people with intellectual disabilities who receive both Medicaid and Medicare since the year 2000. The two systems do not communicate. This has resulted in duplication of medical procedures, leading to increased government cost on health insurance. There is need for improving the current system by improving health quality and system performance. A creation of a centralized health information system would benefit healthcare recipients and funding sources as well.

The American healthcare system has some good qualities that need to be preserved. It is a multiple player system. Unlike a single-payer system, the American healthcare system is competitive due to having many players on the market. Private and public for-profit and not-for-profit health insurance providers compete on the basis of quality and cost. The multiplicity of such a health insurance system should be protected.

The American healthcare system is competitive in the quality of services offered. There are no waiting lines for critical medical services like one would find in Canada and United Kingdom. Healthcare consumers can get any services they desire in a timely
manner. The American healthcare system has made considerable investment in modern medical technology such as MRIs and CT scans. For every MRI scan done in Canada, 18 are done in America. Such modern medical technology is critical for early detection of health conditions such as cancer and resulting in early and successful treatment.

I have biases against some of the changes introduced by the Affordable Care Act. Instead of expanding health insurance coverage to the uninsured, the Affordable Care Act resulted in increased health insurance costs and loss of health insurance coverage to those who had coverage prior to the implementation of the Affordable Care Act. The main selling point of the Affordable Care Act was that it would extend coverage (breadth) to the uninsured and improve cost sharing. However, whilst there are people who have obtained health insurance coverage through the Affordable Care Act, it has also resulted in other people losing their health insurance coverage due to increased premiums.

I have attempted to put forth my biases so that my readers are fully informed. My goal in putting forth these biases is to attempt to be as objective as possible.

3.5 Research Environment

This section describes the ‘who, where, when, and why’ in regards to participant population, participant sampling, and location of the research.

3.5.1. Study Location

The location of this study was the Northwest region, Indiana, USA. The selection of the location was primarily to give the researcher an experience through seeing, listening, and interacting with the small businesses and industries that operate in
Northwest Indiana. The researcher works for a small business in Northwest Indiana and is a member of service organizations such as the Rotary Club, the Monticello Chamber of Commerce, and the Northwest Economic Development Forum. These relationships provided the researcher a unique opportunity to access key personnel of small businesses and industries responsible for the implementation of the Affordable Care Act.

3.5.2. Participant Population

The sample for this study was selected from small businesses and industries located in Northwest Indiana. Northwest Indiana was chosen due to its variety of small businesses and its dual nature (rural and urban). The researcher also had better access to small businesses and industries in Northwest Indiana. Due to the importance of small businesses and industries to the American economy, it seemed appropriate to make it the focus and the unit of analysis for this study.

3.5.3. Participant Sampling

Purposive sampling was used in this study. Selection was based on availability and willingness to participate in the study. I identified subjects as a source of referral for potential additional subjects from business acquaintances.

3.6 Approvals

I obtained approvals from several authorities in order to successfully conduct this study.
3.6.1. Human Subjects Approval

The researcher obtained Human Subjects Approval from Purdue University. Participants did not receive any monetary compensation for their involvement. This study did not involve any risks to the participants. The Purdue University Human Subjects Committee approved research consent forms in the English language.

3.6.2. IRB Approval

I obtained IRB approval as a necessary part of this research (IRB Protocol #1505016107). This was because I used human participants during interviews. I took all necessary steps to ensure the anonymity of participants and protect their welfare. I informed all participants of their right to withdraw from the study at any point as they wished. I sought the full board review IRB approval.

3.7 Data Collection Methods

This section of the chapter provides an overview of the methods that I used to collect data for this study.

3.7.1. Audio Recording

In order to capture as much information as possible, I did an audio recording of each interview session. The audio recordings were transcribed and coded to ensure anonymity. No names were recorded on the audio recordings. The audio recordings included the date and time of the recording. Audio recordings were used to double check
the accuracy of transcribing. They also helped reduce the researcher's bias on issues brought forward by participants by capturing the exact words used by the participants. Key and common words and expressions from the audio recordings were later analyzed for patterns and themes.

3.7.2. Interviews

The researcher selected fifteen participants to participate in in-depth interviews. The interviews were conducted separately, audiotaped, and later transcribed. The interviews were approximately 30 to 45 minutes long and semi-structured. Participants were allowed to expand on any particular question and the interviewer returned to the predetermined list of questions. This helped ensure that all participants are given an opportunity to express themselves but at the same time asked the same questions in a similar format.

3.8 Data Analysis Methods

The researcher conducted a rigorous review and analysis of the gathered data using the manual method for emerging themes (Basit, 2003; de Carvalho Leite, Drachler, Killett, Kale, Nacul, McArthur, Hong, O'Driscoll, Pheby, Campion, Lacerda, & Poland, 2011; Emmanouilidou & Burke, 2013). The data included interview notes, audio tapes and transcripts, and any other data collected during the study. The researcher made three decisions; selecting the unit of analysis, approach to sampling, and the number of participants needed for this study. The primary question posed in this study was “What is the impact of the Affordable Care Act on small businesses and industries in Northwest
Indiana?" Additional research questions were, “Did the Affordable Care Act improve the breadth (who is covered), the depth (which benefits are covered), and the height (what proportion of the cost is covered) of healthcare? What lessons can be learned from the implementation of the Affordable Care Act for future policy implementation?” Based on these research questions, each small business or industry selected for this study was the unit of analysis.

3.9 Credibility

Collection of valid and credible data and analyzing it in a valid and reliable manner was important in this study. This section addressed credibility of the research tools, data collection, research process, the study (data analysis), and the findings. A rigorous process was used to review the research data. The researcher had no conflict of interest in this study. The researcher was not paid or sponsored to conduct this study.

3.9.1. Triangulation

Triangulation is an important strategy for increasing the validity and authenticity of qualitative research data, evaluation, and research findings (Guion, Diehl, & McDonald, 2011; Mathison, 1988; Morse, Baret, Mayan, Olson, & Spiers, 2008; Nevo, 1985). Triangulation was intended to serve two purposes; confirmation and completeness. For the purpose of confirmation, triangulation was used by “the researcher to select data collection techniques with known strengths and weaknesses and counterbalance threats to validity” (Breitmayer, Ayres, & Knafl, 1993; Patton, 2002; Rubio, Berg-Weger, Tebb,
Lee, & Rauch, 2003). For the purpose of completeness, the researcher combined multiple methods, data sources, and theories to show how each element completed the picture. Triangulation was used to confirm the researcher’s findings.

There are different forms of triangulation; data triangulation, investigator triangulation, theoretical triangulation, and methodological triangulation (Pope, Ziebland, & Mays, 2000; Thurmond, 2001). In this study, the researcher used methodological triangulation (interviews and audio recordings) to provide multiple angles on the subject under study. This gave the researcher more opportunities to verify and authenticate the data collected and its interpretation. Triangulation increased the credibility and validity of the findings of this study. It provided an opportunity for themes and patterns to emerge with limited influence from the researcher's bias (Breitmayer, Ayres, & Knafl, 1993; Mathison, 1988; Ryan, & Bernard, 2003; Taylor & Bogdan, 1984; Thurmond, 2001).

Triangulation provided this researcher with some key advantages. It increased the confidence level in the research data and provided an opportunity for unique thoughts and ideas to surface. The diversity of qualitative data provided “innovative ways of understanding a phenomenon” (Breitmayer, Ayres, & Knafl, 1993; Decrop, 1999; Farmer, Robinson, Elliott, & Eyles, 2006; Thurmond, 2001).

Triangulation had some notable disadvantages. It was time-consuming. The collection, organization, and analysis of data required special planning and organization skills (Halcomb, & Andrew, 2005; Thurmond, 2001). After gathering a lot of data, it was possible to have the researcher's biases taint the selection of what data to consider and the analysis process since the data was not quantitative in nature (Boyatzis, 1998; Bradley,
Curry, & Devers, 2007; Breitmayer, Ayres, & Knafl, 1993; Mathison, 1988; Patton, 1999; Thurmond, 2001).

3.10 Summary

This chapter provided the framework and methodology used for this study. It provided a detailed description of the research framework, research bias, research methodology, research environment, study location, participant population, participant sampling, approvals, data collection methods, data analysis methods, and credibility of the research.
CHAPTER 4. PRESENTATION OF DATA

As explained in the previous three chapters, the purpose of this study was to elicit, describe, and analyze the people’s perspectives and lived experiences with the Affordable Care Act in an attempt to answer the question, “What was the lived experiences of people with the Affordable Care Act?” The central questions were (1) what was the impact of the Affordable Care Act on small businesses; (2) did the Affordable Care Act improve the ‘basket of health services; and (3) what lessons can be learned from the implementation of the Affordable Care Act for future policy implementation? Basket of health services refers to the breadth (who is covered), the depth (which benefits are covered), and the height (what proportions of the costs are covered).

Chapter four provides detailed narratives and descriptions of each interview and a detailed explanation of the analysis of data. It also provides demographics of the study participants, detailed participant descriptions, background information, interview results, detailed narratives, and descriptions of each interview. The chapter then presents each interview question with the given responses.

In an attempt to define the basket of health services, the questions to be answered were; (a) did the Affordable Care Act extend coverage to the uninsured; (b) did the Affordable Care Act include other medical services that were not previously covered; and (c) did the Affordable Care Act improve cost sharing? Interview and observation techniques were used to elicit participants’ lived experiences.
4.1 Participant Descriptions

The following sections give a background summary of each of the fifteen participants (P01 to P15) interviewed for this study. As described in Chapter three, each of the fifteen participants participated in a separate 30 to 45-minute semi-structured interview with audio recording taking place. Participants were chosen based on their involvement in operating small businesses and their knowledge of the impact of the Affordable Care Act on small businesses. Candidates were also chosen based on their knowledge about the health insurance industry and how the Affordable Care Act impacted small businesses.

4.2 Interview Participant Profiles

The information presented in the following sections describe each participant and the rationale for including them in this study. All participants were adults who had been in business for at least ten years. Of the 15 participants interviewed, three were females and twelve were males. Six participants were in the health insurance industry. Of the six participants in the health insurance industry, two were Actuaries, three were Accounts Executives, and one was an Insurance Compliance Director. Two participants were medical doctors and one was a dentist. They operated private practices. Four participants operated personal businesses. Of those four, two were in the construction industry, one was a cleaning supplies distributor, and the other one owned and managed three home improvement stores with lumberyards. The last two participants worked for not-for-profit organizations. One was a Human Resources Specialist and the other was an Executive Director for a not-for-profit human services organization. Out of
the 15 participants, 2 worked for not-for-profit organizations and 13 worked for for-profit organizations.

4.2.1. Participant 01

Participant one was a dentist. He had been a dentist since 1997 and had been in private dental practice since 2006. He was Caucasian and in his mid-forties. He had 15 employees; one dentist, twelve dental hygienists, one front office staff, and one billing specialist. Participant 1 had been researching on how the Affordable Care Act impacted his business since it was voted into law in 2010. He attended several seminars and webinars. He was a member of the National Dental Association (NDA) and the Indiana Dental Association (IDA). Participant 1 did not provide employee health insurance benefits but was planning to do so later in the year. His sources of information were the Family Christian Council, the internet, and the two dental associations; IDA and NDA. Participant one was well informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.

4.2.2. Participant 02

Participant two was a Human Resources Specialist. She worked for a not-for-profit organization for twenty-two years. She was Caucasian and in her late forties. Her current employer had 188 employees. Of the 188 employees, only 58 employees received health insurance benefits (31 percent offer rate). She started as a Receptionist and worked her way up into the Human Resources Specialist position. She was in the Human
Resources Department for thirteen years and was in charge of employee benefits for the same period. She did not have a college degree. She was actively involved in the implementation of company policies in an effort to comply with the Affordable Care Act. She was the company contact person for employee health insurance benefits. She worked with both employees and health insurance representatives. Her sources of information were the internet, her insurance agent, and the Society of Human Resources Management (SHRM). Participant two was well informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.

4.2.3. Participant 03

Participant three was a medical doctor. He had been a medical doctor for twenty-six years. He was a Pediatrician and ran his private practice. He was Caucasian and in his late fifties. Ten years before the implementation of the Affordable Care Act, participant three ran his own practice. In 2000, he joined a large hospital network. He went back to private practice soon after the implementation of the Affordable Care Act. He employed 13 employees. His sources of information on the Affordable Care Act were the Family Christian Council, seminars, webinars, and the Department of Labor. Participant three did not provide employee health insurance benefits. He was informed about the Affordable Care Act because it impacted his clients, business, and employees. Participant three was informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.
4.2.4. Participant 04

Participant four ran a family business. His father started the family business. He was the second generation running the family business. He had been involved in the family business for 47 years. He was Caucasian and in his early sixties. He was knowledgeable about the Affordable Care Act because he provided employee health insurance benefits. He attended a few seminars on the Affordable Care Act but his main source of information was his insurance agent. His family business had 25 employees. He had a two-year college degree. Participant four was informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.

4.2.5. Participant 05

Participant five was a medical doctor. He had been a medical doctor for 20 years. Of those 20 years, he had been a Dermatologist for 16 years. He was Caucasian and in his early fifties. He ran a private practice and employed 14 part-time employees. Participant five did not provide employee health insurance benefits. He was knowledgeable about the Affordable Care Act because it impacted his family, clients, and employees. He attended several seminars on the Affordable Care Act hosted by the Department of Labor and insurance companies. His insurance agent also provided him with information on the Affordable Care Act. He was a member of the Dermatology Association which provided information to its members. Participant five was informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.
4.2.6. Participant 06

Participant six was a family business owner. His grandfather started his business in 1924. He had been running the family business for 18 years. He owned three hardware stores with lumberyards. He was Caucasian and in his mid-fifties. His source of information on the Affordable Care Act was his insurance agent. Other than information from his insurance agent, he did not have any other sources of information. He had 25 employees and provided employee health insurance benefits. He had a four-year college degree in business studies. Before running the family business, participant six was a banker. Participant six had limited information on the impact of the Affordable Care Act on small businesses and was a fair source of information for this research.

4.2.7. Participant 07

Participant seven was a principal owner of an insurance company. He had been in the health insurance business for 37 years. He was licensed to underwrite home, life, health, and renters’ insurance policies in Indiana. He was Caucasian and in his early sixties. Participant seven had a two-year college degree. He obtained his information concerning the Affordable Care Act from seminars presented by the Department of Labor, webinars, and seminars presented by other insurance companies. He employed about 20 employees. His company provided employee health insurance benefits. Participant seven was well informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.
4.2.8. Participant 08

Participant eight was a co-owner of a construction company. His construction company specialized in asphalt, demolition, excavating, dump truck services, concrete and asphalt recycling, and metal and steel buildings. He had been in the construction industry for 28 years. He had been with his present company for seven years and a co-owner for three years. He was Caucasian and in his early-fifties. He had no college education. His main source of information was his insurance agent. His company employed 25 to 35 people, depending with the season. His company did not provide employee health insurance benefits. Participant eight provided information from a personal perspective on how the Affordable Care Act affected him and his family. He was a fair source of information for this research.

4.2.9. Participant 09

Participant nine was a co-owner of a construction company. She had been in the construction business for 28 years. She had been a co-owner of her current construction company for eight years. She was Caucasian and in her late forties. She did not have a college degree. Her sources of information were the internet and the TV. Her company employed 25 to 35 employees, depending with the season. Participant nine’s company did not provide employee health insurance benefits. Participant nine’s knowledge of the Affordable Care Act was somewhat limited.
4.2.10. Participant 10

Participant 10 was a health insurance Accounts Executive. She had been in the health insurance business for 11 years. She was Caucasian and was in her early forties. She had a four-year college degree. Her sources of information were seminars and webinars presented by insurance companies, her company’s Director of Compliance, and seminars and webinars presented by the Department of Labor. Her company employed about 40 employees. Her company provided employee health insurance benefits. Participant 10 was informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.

4.2.11. Participant 11

Participant 11 was an Executive Director of a not-for-profit organization. His organization provided rehabilitation, transportation, and housing services to low income people and people with developmental disabilities. His company also provided home care services to seniors. He had been doing this type of work for 21 years and had been in the Executive Director position for 10 years. He was Caucasian and was in his mid-fifties. His company employed about 190 employees and provided employee health insurance benefits. His sources of information were the internet and his insurance agent. He had a college degree in accounting and was a CPA. Participant 11 was informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.
4.2.12. Participant 12

Participant 12 was a Compliance Director for a health insurance company. He had been in the health insurance business for 30 years and had been in different management positions. He had been in his current role as a Compliance Director with his current employer for four years. He was Caucasian in his early sixties. His sources of information were the internet, seminars, and webinars hosted by insurance companies and the Department of Labor. His company employed above 40 employees and provided employee health insurance benefits. His level of education was not disclosed. Participant 12 was informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.

4.2.13. Participant 13

Participant 13 was an Accounts Executive and a shareholder with an insurance company. He had been in the insurance business for over 30 years. He had been with his current employer for five years. He was Caucasian and in his early sixties. His sources of information were the internet, seminars and webinars hosted by insurance companies, and the Department of Labor. His company conducted business in 38 states and employed over 200 employees. His company offered employee health insurance benefits. His level of education was not disclosed. Participant 13 was informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.
4.2.14. Participant 14

Participant 14 was a Principal Actuary Consultant of a company that consulted with health insurance companies. He had been in the health insurance consulting business and with the same company for 14 years. He was Caucasian and in his mid-forties. He had a four-year college in actuary science. His sources of information were fellow health insurance actuaries, his company, seminars hosted by health insurance and actuary companies, and seminars by the Department of Labor. His company employed over 300 employees and provided employee health insurance benefits. Participant 14 was well informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.

4.2.15. Participant 15

Participant 15 was a Senior Vice President and Chief Actuary of a major health insurance company. He had been with his current employer for 15 years. He was Caucasian and in his late fifties. He had a four-year college degree in actuary science. His sources of information were fellow health insurance actuaries, his company, and seminars hosted by health insurance companies, actuarial companies, and seminars by the Department of Labor. His company employed over 500 employees and provided employee health insurance benefits. Participant 15 was well informed about the impact of the Affordable Care Act on small businesses and was a good source of information for this research.
4.3 Coding and Thematic Analysis

Discovering themes is a fundamental and critical part of conducting qualitative research (Ryan & Bernard, 2003). It has a great impact on the quality of the research. The process of discovering subthemes and themes is referred to as coding and theme analysis. It is the process of sorting and organizing data into related groups called codes and themes. It is the first step in analyzing qualitative data.

There are over 32 coding approaches. For this research, the researcher used the hybrid approach. The researcher’s main approaches were the grounded theory approach and the a priori theory approach. Grounded theory is an approach for developing themes that is grounded in data (Strauss & Corbin, 1994). It is an explorative approach. With the a priori approach, the researcher develops codes and themes before exploring the data. A priori codes and themes may come from the researcher’s prior knowledge and or literature review.

The hybrid approach was chosen for two reasons. The first reason was it allows data to speak for itself. The second reason was to take advantage of the a priori knowledge of the researcher and themes that emerged from literature review. A priori codes were from literature review, interview questions, and the researcher’s prior knowledge on the subject. Grounded codes and themes emerged from the data. The researcher attempted to lay aside his prior knowledge, presuppositions, assumptions, and knowledge on the subject and allowed themes to emerge from participants’ data. In the data analysis process, the researcher asked three key questions by Charmaz (2006), 1) what is going on, 2) what are people saying, 3) what are people doing?
The researcher started the coding process with open coding. Open coding is the process of analyzing qualitative data. In this process, the researcher looked and listened for unique and distinct concepts, ideas, relationships, and categories. The researcher started this process by listening to the audio recordings and writing down phrases that were unique, repeated, or the participant put extra emphasis. During the transcription process, the researcher also looked for unique and distinct concepts, ideas, and categories. The researcher created an outline using unique ideas and concepts as headings and subheadings. The headings and subheadings formed the basis for the initial analysis. The researcher read the transcribed data several times to ensure all important concepts were identified. Some of the subheadings were collapsed into new headings as new relationships and meaning emerged. In this process, the researcher followed the strategies outlined by Strauss and Corbin (1990), Charmaz (2006), and Gibbs (2008).

There are different techniques used to identify themes. The researcher used the manual method to identify themes. It is an in-depth line-by-line scrutiny of the transcribed data. The manual technique had its advantages and disadvantages. It was labor intensive and time consuming. The manual technique helped the researcher to get familiar with the data. The second reason was that the researcher was knowledgeable with the manual data analysis technique.

In creating themes, the researcher followed Opler’s (1945) three principles of analyzing themes. The three principles are; common expressions found in data, agreed upon in a culture and sets of inter-related themes, and the appearance of themes, their pervasiveness across cultures and practices, people’s reactions when violated, and how specific contexts control their frequency, force, and variety (Opler, 1945).
According to Ryan and Bernard (2003), “themes come in different shapes and sizes (p. 87).” Some are specific while others are broad. This researcher started with broad themes and worked to narrow them down to specific. This was done through collapsing headings and subheadings into subthemes and themes. The first method used to identify themes was the inductive approach. It involved examining emerging patterns within the data. The second method was the a priori approach. Themes came from the researcher’s prior understanding of the phenomenon under study, interview protocol, and literature review (Ryan & Bernard, 2003). A priori themes were derived from the phenomenon being studied; definitions found in literature review, researchers’ values, theoretical orientations, and personal experiences (Maxwell, 1996). The researcher’s main approach was the inductive approach. A priori themes were used to validate the themes developed using the inductive approach.

In attempting to identify themes, the researcher’s first step was listening to all the audio interview recordings at least two times. Any words or phrases repeated more than once were written down as headings and subheadings. Common words and phrases were further organized based on emerging relationships. The second step was transcribing all interview audio recordings word for word into handwritten notes. While transcribing each audio recording interview, the researcher created headings and subheadings. During this process, the researcher identified common words, phrases, and expressions.

The third step was typing all the transcribed data. During this process, the researcher identified and typed headings and subheadings. After typing the responses, the fourth step was proofreading all the typed materials and underlining common words and phrases. In this process, the researcher was looking for concepts that were repeated,
typologies, and categories (terms that sounded familiar or were used in unfamiliar ways), and metaphors and analogies. The researcher also looked for transitions (speech pauses or change in tone) and similarities and differences or constant comparisons. In addition, connectors (words that signaled causal relationships or conditional relations), missing data, and theory-related materials were also identified (Ryan & Bernard, 2003).

4.4 Textual Analysis

Each participant was asked the same 15 questions with minor wording variations. In certain situations, follow up questions were asked, depending with the responses provided. The following section provides a textual analysis of the responses for each of the 15 questions. Since questions one and two were designed to get background information about each participant, the responses were combined and analyzed together. The responses for questions three through 15 were analyzed separately. The first manual textual analysis was done within questions. The second manual textual analysis was done across questions.

4.4.1. Questions 1 and 2 Textual Analysis

Question 1 was, “What is your position in this organization?” Question 2 was, “How long have you been with this organization?” Participant one (P01) was a dentist who ran his private practice. He had been a dentist for 19 years but had been running his private practice for nine years. Participant 2 (P02) was a Human Resources Specialist. She had been with the same company for 22 years but had been in the Human Resources
Specialist position dealing with employee benefits for 13 years. Participant 3 (P03) was a Pediatrician with a private practice. He had been a medical doctor for 26 years; moving back and forth between operating a private practice and being part of a large hospital network.

Participant 4 (P04) was a small business owner who distributed industrial cleaning supplies. He had been part of the family business for 47 years. Participant 5 (P05) was a Dermatologist who ran his private practice. He had been a Physician for 20 years and a Dermatologist for 16 years. He worked for a hospital network before going back to operate his private practice for nine years. Participant 6 (P06) managed three Hardware stores with lumberyards. His grandfather started this business in 1924. He had been running the family business for 18 years.

Participant 7 (P07) was a principal owner of an insurance company. He had been in the insurance business for 37 years. He had been a principal owner for 27 years. Participant 8 (P08) was a co-owner of a construction company. He had been in the construction business for 28 years. He had been with the company for seven years and had been a co-owner for three years. Participant 9 (P09) was a co-owner of a construction company and had been in the construction business for 28 years. She had been with the company for 28 years and had been a co-owner for eight years.

Participant 10 (P10) was an Accounts Executive for an insurance company. She had been in the insurance business for 11 years and had been with her present company for five years. Participant 11 (P11) was an Executive Director for a not-for-profit human services organization. He had been with his organization for 21 years and had been an Executive Director for 10 years. Participant 12 (P12) was a Director of Compliance for
an insurance company. He had been in the insurance business for 30 years and had been with his current employer for four years.

Participant 13 (P13) was a principal owner of an insurance company. He had been in the insurance business for 31 years and had been with his present company for five years. Participant 14 (P14) was a Principal Actuary Consultant for an actuary company that consulted for health insurance companies. His title was Principal and Consulting Actuary. He had been with his employer for 14 years. Participant 15 (P15) was a Senior Vice President and Chief Actuary for a national health insurance company. He was the senior ranking Actuary and was responsible for the company’s nationwide financial planning. He had been with his company for 15 years.

Table 4.1 summarizes the 15 research participants’ profiles. It shows their professional backgrounds, whether their companies offered health insurance, number of years they had been working, gender, and their sources of information concerning the Affordable Care Act.
Table 4.1
Profile Summary of the 15 Research Participants.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Profession</th>
<th>Offer Insurance</th>
<th>Years</th>
<th>Gender</th>
<th>Source of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>P01</td>
<td>Dentist</td>
<td>No</td>
<td>19</td>
<td>M</td>
<td>Professional association</td>
</tr>
<tr>
<td>P02</td>
<td>Human Resources</td>
<td>Yes</td>
<td>22</td>
<td>F</td>
<td>Seminars, insurance agent, Internet</td>
</tr>
<tr>
<td>P03</td>
<td>Medical Doctor</td>
<td>Yes</td>
<td>26</td>
<td>M</td>
<td>DOL, Seminars, Family Christian Council</td>
</tr>
<tr>
<td>P04</td>
<td>Cleaning Supplies</td>
<td>Yes</td>
<td>47</td>
<td>M</td>
<td>Insurance agent</td>
</tr>
<tr>
<td>P05</td>
<td>Medical Doctor</td>
<td>No</td>
<td>20</td>
<td>M</td>
<td>DOL, insurance agent</td>
</tr>
<tr>
<td>P06</td>
<td>Hardware store</td>
<td>Yes</td>
<td>18</td>
<td>M</td>
<td>Insurance agent</td>
</tr>
<tr>
<td>P07</td>
<td>Insurance agent</td>
<td>Yes</td>
<td>37</td>
<td>M</td>
<td>DOL, Seminars</td>
</tr>
<tr>
<td>P08</td>
<td>Construction</td>
<td>No</td>
<td>28</td>
<td>M</td>
<td>Insurance agent</td>
</tr>
<tr>
<td>P09</td>
<td>Construction</td>
<td>No</td>
<td>28</td>
<td>F</td>
<td>Internet, TV</td>
</tr>
<tr>
<td>P10</td>
<td>Insurance agent</td>
<td>Yes</td>
<td>11</td>
<td>F</td>
<td>DOL, seminars</td>
</tr>
<tr>
<td>P11</td>
<td>Executive Director</td>
<td>Yes</td>
<td>21</td>
<td>M</td>
<td>Insurance agent, Internet</td>
</tr>
<tr>
<td>P12</td>
<td>Insurance Director Compliance</td>
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<td>30</td>
<td>M</td>
<td>DOL, Seminars</td>
</tr>
<tr>
<td>P13</td>
<td>Insurance Agent</td>
<td>Yes</td>
<td>30</td>
<td>M</td>
<td>DOL, Seminars</td>
</tr>
<tr>
<td>P14</td>
<td>Actuary</td>
<td>Yes</td>
<td>14</td>
<td>M</td>
<td>DOL, Seminars</td>
</tr>
<tr>
<td>P15</td>
<td>Actuary</td>
<td>Yes</td>
<td>15</td>
<td>M</td>
<td>DOL, Seminars</td>
</tr>
</tbody>
</table>

4.4.2. Question 3 Textual Analysis

Interview question three was, “How would you characterize your medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?” This interview question sought to establish the situation before the implementation of the Affordable Care Act. Participant 1 said things were better before the implementation of the Affordable Care Act:

Things were better before the Affordable Care Act was introduced. Premiums and co-pays were affordable and people were not forced to pay for services or provide services that were against their value system. There were things that needed to be fixed with our health insurance system, but everyone had access to healthcare.
Participant 2 concurred with participant one that prior to the implementation of the Affordable Care Act, employee co-pays, premiums, and annual deductibles were low.

To the contrary, participant three talked about the advantages brought about by the Affordable Care Act:

The advantages of the Affordable Care Act I can think of include a drive to a centralized record keeping system. The idea is to have a nationwide integrated healthcare record keeping whereby you can be vacationing in California and in an emergency, you go to an Emergency Room and they can pull up your medical history. The other advantage includes the fact that people who previously did not have access to healthcare now do.

Participant 3 however added that the idea of computerization of medical records was “a little bit scary” because “the government cannot even secure their own computers.” Participant 3 also had the following to say concerning the Affordable Care Act:

Most people’s health insurance premiums have gone up… So the Affordable Care Act is a form of taking from those who have and giving to those who do not have. Social medicine. Nothing could be morally wrong than forcing people to provide abortion, contraceptives, and morning-after pill.

Participant 4 gave a more generalized response. He went back several years before the implementation of the Affordable Care Act. This made it difficult to separate changes that took place before the Affordable Care Act and those caused by the implementation of the Affordable Care Act:

Our agent announced that they no longer underwrite us early this year. They said they are pulling out of the State of Indiana which is a shame because it was a good insurance company. Before the Affordable Care Act, we had people with Leukemia and some other long-term ailments. Once those came on our plan, our insurance premiums and deductibles went up because we have a small pool of employees.
When asked how he would characterize his medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act, participant five had the following to say:

Prior to 2015, my family (my wife and three daughters) paid a monthly premium of $4,200 plus a $6,000 deductible for my wife and I and $3,000 deductible for my three daughters. It is strange to think of the United States as being such a wealthy nation yet having some of the highest medical costs, not having the best healthcare system, and not having broad coverage.

When asked the same question, participant 6 said, “They actually haven’t changed.”

Participant 7 talked about how the old system affected people with pre-existing conditions and healthy people who were in the same pool:

Coverage was guaranteed but the challenge is that it was too expensive and a lot of people could not afford it. Group plans were guaranteed but they could put pre-existing condition waiting periods on people that had medical conditions who were not previously insured. In addition, they could basically charge double the rate to the whole group not just to that one person with a pre-existing medical condition. For healthy groups, it was not an issue. For groups that had people with diabetes, cancer patients, and that sought of a thing, it cost them a lot of money. The Affordable Care Act did away with that.

In response to the same question, participant 14 added more information about how insurance companies determined premiums before the implementation of the Affordable Care Act:

Insurance companies could basically charge you more if you were sicker and less if you were healthier. They could charge different premiums by gender. Young females with maternal claims were definitely more expensive than generally young males. You could also deny someone coverage if you felt that their pre-existing condition could be too expensive to insure.

Participant 14 added that the lack of subsidies and paying for health insurance with after tax dollars made it difficult for some people:
The health insurance market was kind of like the Wild West and there were no subsidies to help people with paying premiums. You pretty much had to pay those premiums with after-tax money. All employees were essentially paying the same.

Participant 15 talked about the ever-increasing rates for small employers. He said premiums were increasing by between 7 percent and 15 percent each year prior to the Affordable Care Act. In addition to increasing premiums, the offer rate was also decreasing:

Increasingly, it was unaffordable to them and they could not compete in their market places. The offer rate (percentage of small employers offering health insurance to their employees) had declined down to 30 percent to 40 percent. So you had two thirds of smaller employers who could not just afford to offer health insurance. Those who offered it, they offered it with a pretty high employee payroll deduction. So the percentage of employees not taking coverage among small employers was relatively big. It was around 60 percent to 70 percent. HSAs were becoming popular.

When asked how he would characterize his medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act, participant 8 had positive things to say about the Affordable Care Act:

I kind of like it. It has saved me a lot of money. I used to pay $800 per month for health insurance for my whole family but now I pay only $200 per month. Another benefit I get from Obamacare is that my son who is 22 years old can stay on my health insurance until he is 26 years old. That is a good deal.

In response to the same question, participant nine said, “As a company, we decided we did not afford to offer employee health insurance benefits. The premiums were too expensive and beyond our reach.” Participant 10 responded from an insurance policy underwriting perspective:

It changed the way health insurance plans were underwritten from a risk perspective. The 51 to 200 employee sized companies were affected by PECORI fees, transitional fees, and an additional $5.75 per employee per month strictly for the Affordable Care Act.
Participant 11 said their medical benefits prior to the implementation of the Affordable Care Act were decent. Their old health insurance plan was grandfathered in and their premiums remained low. Participant 12 said the biggest impact was in the fully insured small markets. He added that he had not seen employers reduce medical benefits because of costs related to the implementation of the Affordable Care Act.

To the contrary, participant 13 focused on how health insurance costs prior to the implementation of the Affordable Care Act were increasing faster than people’s salaries:

I think everyone agrees that the old healthcare system was becoming too expensive for most people. Health insurance costs were increasing faster than people’s salaries could cope up. Healthcare was the leading cause of bankruptcy in this country. It was a system of ‘have’s and have nots.’

Participant 15 pointed out that the Affordable Care Act had not done a great deal to change the circumstances that existed prior to its implementation:

The required benefits were actually richer than what is commonly offered on the marketplace. That put upward pressure on premium rate increases going into the effectiveness of the Affordable Care Act because small employers were purchasing coverage but it was a slimmer plan design required by the Affordable Care Act. They had to increase that benefit, so that increased the premiums.

Participant 15 also responded by giving information on the transition from the old health insurance system to the Affordable Care Act and how rates increased:

From a public policy perspective, some would debate very well that the plan designs required by the Affordable Care Act were in the best interest of the public. The truth based on evidence is clear that in many cases, that was more expensive coverage because the benefits are richer and the members’ cost share went down. Those employers that delayed in joining the Affordable Care Act continued to experience 7 percent to 20 percent rate increases.
4.4.3. Question 4 Textual Analysis

With some minor word variations, the researcher asked each participant, “What went through your mind when you learned that you needed to comply with the Affordable Care Act?” This interview question was meant to elicit for responses that addressed the research question, “What lessons can be learned from the implementation of the Affordable Care Act for future policy implementation?” People’s perceptions about a new policy have an impact on the success or failure of that policy. Six participants (P01, P02, P03, P09, P11, & P13) viewed the Affordable Care Act as an unnecessary government interference with people’s lives. They also viewed it as a way to introduce more government controls and fines. This represented 40 percent of all participants. Participant 1 said:

Well, government bureaucracy again. The government reaching out its hand into our pockets, taking our money, and telling us what to do. More government controls and infringing on people’s rights. I also knew that there was going to be a lot of rules and regulations to follow, failure of which would result in hefty fines.

Participant 9 shared similar sentiments as participant one:

I know it is the government trying to reach their hands into our pockets. Whenever you see the government coming up with something, all they are trying to do is to reach into your pocket and controlling you and telling you what to do and what not to do. The federal government has no place in running people’s lives and telling them what to have and what not to have. I do not like it and I am not happy about it.

Three participants (P02, P11, & P13) viewed the Affordable Care Act as, “more rules and regulations, more paperwork, and possibly fines if that paperwork is not in place.” Participant 11 added:
Well, more government regulations, more infringement on our rights, and the government telling people what to do with their money and health. The government telling people who your doctor should be, when to see your doctor, why you should see your doctor, and how much you should pay your doctor. Our history has consistently shown that anything introduced by the government is flawed, not well thought through, and intended to take advantage of people.

Participant 3 also gave a similar response but focused more on the government introducing more paperwork and compliance. He said, “I knew there was going to be a lot of paperwork to satisfy their need for compliance.”

When asked the same question, participant 4 had the following to share about the Affordable Care Act:

We thought the government had come up with some neat idea of lowering people’s insurance premiums. I was excited because I thought this would be a great opportunity for some of us with some health needs to get some relief.

Participant 5 focused on the challenges people faced with implementing government programs and the associated cost:

The challenge with government programs is that there is a lot of red tape, which ends up costing ordinary people a lot of money to implement. Another challenge with government initiatives is that they are too massive and not well thought through. At the end of the day, it ends up not being as effective as it was planned to be.

Participants 7 and 14 shared the same sentiment echoed by participant five that “federal government programs are not well thought through.” Participant 7 added that the government would end up focusing “on compliance which would mean a lot of paperwork to be completed and audits with steep fines.” Participant 6 said the implementation of the Affordable Care Act had not changed things. It did not cost them or save them money.
Participant 7 suggested that the federal government should have consulted with insurance companies on how to do it. Because the federal government did not consult insurance companies, he knew “there was going to be chaos, confusion, and problems.” Three participants (P07, P13, & P14) used the words “frustration and confusion” to describe what went through their minds when they learned that they had to comply with the Affordable Care Act. Participant 14 said, “Any programs introduced by the government are not always well laid out and there is always confusion followed by frustration.” Participant 13 said in addition to confusion and frustration, there was going to “be a lot of political wrangle and finger pointing. You cannot have a government program without tons of paperwork and compliance.”

Six participants (P01, P02, P09, P10, P11, & P15) concurred that the Affordable Care Act was a form of “government interference.” This represented 40 percent of all participants. Participant 10 said, “We knew that a lot of paperwork to stay compliant was coming.” He added, “the federal government was going to start doing audits and we had to stay on top of our game.” Two other participants (P14 & P15) also shared this sentiment. Participant 14 said “the federal government will be doing audits and hitting companies with non-compliance fines and penalties.” Participant 15 expected more paperwork, more compliance, and more government audits.

Participants 6 and 12 focused on the unclear expectations and uncertainty of the Affordable Care Act. Participant 6 said, “There was apprehension and uncertainty in the minds of many of us.” Participant 12 added:

Government programs come with a lot of unexplained expectations. A law that is 2,700 pages long and still under revision has a lot of do’s and don’ts that someone
needs to look through and define for everyone. That is what came to my mind and that is what I have been doing daily for the past four years.

Participant 8 was skeptical about the Affordable Care Act at first but realized that it was the law and had to comply with it. He believed in some good government sponsored programs such as Medicaid and Social Security and hoped the Affordable Care Act would be like them. He felt that “it was not fair to have people go without health insurance because they cannot afford.”

4.4.4. Question 5 Textual Analysis

Interview question five was more general and open-ended. It was designed to allow the participants to respond in more general and broad terms. It asked participants, “Please describe your experience with the Affordable Care Act.” This interview question was meant to provide responses to the research question, “Did the Affordable Care Act extend coverage to those who were previously not covered, include other medical services not previously included, and improve cost sharing?” Participant 1 did not speak to the change in breadth, width, and height of healthcare services as a result of the implementation of the Affordable Care Act. Instead, he talked about compliance. He said, “A lot of work to stay compliant.” He said the law was complicated and no one knew what was supposed to be done and what the standards of audit were. Participant 1 said:

They took something that was working and needed to be tweaked. They overhauled it and made it worse. We are incurring lots of costs related to compliance. We are spending a lot of time focusing on compliance instead of improving the quality of patient care.
In describing her experience with the Affordable Care Act, participant 2 also talked about compliance as the major focus. She said, “There are several emails from our insurance agent that I need to read and make sure we are in compliance.” In describing her experience with the Affordable Care Act, she used three words; fear, confusion, and frustration:

I would use three words; fear, confusion, and frustration. Fear of being found out of compliance, confusion about what needs to be done, and frustration about lack of communication from the government and ever-changing expectations, rules, and regulations. In addition to all this, there is a lot of added time and cost. We have to spend several hours per week to ensure we do all the paperwork correctly.

Participant 3 said she spent an average of five to eight hours per week reading and processing emails from her insurance agent. These emails are meant to help employers stay compliant. Participant 11 also used the word “fear” to describe his experience with the Affordable Care Act. He said, “We do not know if we are in compliance or we will find out when we are audited.”

Participant 3 also used three words to describe his experience with the Affordable Care Act, “frustration, anger, and confusion.” He explained that his frustration was a result of too much expected of them:

Healthcare providers are frustrated because there is so much expected of us without much incentive for it. The system is not simple for people like us to be able to understand it and implement whatever it is they want. I have been forced by these changes to either join huge hospital systems to survive or just shut down.

Participant 10 also used the word “fear” to describe her experience with the Affordable Care Act. Her fear was a result of not knowing what was coming and fear of failure to maintain the current premiums since they were grandfathered. Employers did not know if they were going to be able to continue to offer employee health benefits.
Participant 10 talked about fear before the implementation of the Affordable Care Act:

I think there was a lot of fear especially around 2009 and 2010 when things started rolling out. There was also fear from the employer side whether they were even going to be able to maintain health benefits for their employees. So I think there was a little surprise for me because of the amount of fear that I saw as the transition took place.

When asked to describe his experience with the Affordable Care Act, participant 5 used the words “frustration and fear” to describe his challenge with getting reliable information. He said, “My challenge has been to obtain reliable information. Lack of reliable information caused a lot of frustration and confusion.” In response to question 5, the majority of the participants seemed to suggested that the expectations were not clear. The general feeling from participants was ‘just tell us in simple terms what you are looking for and we will do it.’

In response to the same question, participant 7 talked about how the Affordable Care Act open enrollment window was affecting people. He talked about a family whose son had some health needs and needed health insurance but had to wait until the enrollment window opened. He explained that many people thought they could just buy health insurance any time of the year but that was not the case. The Affordable Care Act enrollment window is November through January unless someone has a qualifying event (such as the birth of a child, adoption, marriage, changing jobs, or lost insurance).

Participant 9 focused on the challenges with obtaining insurance through the federal exchange due to computer problems:
When they introduced the Affordable Care Act, there were serious problems with their computers. People could not register. Others thought they were registered when in fact it never went through. No one, not even Obama seemed to know what was going on and what the problem was. It took them forever to figure out what the problem was and how to fix it. Even if you called the customer service numbers, they were jammed. It was just a total mess.

Participants 6 and 11 had a different perspective. His response was that there was not much change. They put everything in the hands of his insurance agent and paid the bill.

Participant 11 said his company was still on their old plan. They managed to increase the employee portion of premiums by not more than 5 percent as required by law to stay compliant. The challenge was that the employer had to cover the additional cost.

Participant 11 had this to say concerning the Affordable Care Act:

According to what our agent told us, we cannot increase employee contributions by more than 5 percent. If we do and we get audited, we will get into serious trouble… If we join the exchange, we were told that our rates would go up by double digits. Indirectly, the Affordable Care Act has affected us in that we are losing good employees to companies that pay better.

Participant 12 gave a lengthy response in an attempt to describe his experience with the Affordable Care Act. He used the words “confusion, frustration, and anger” in describing the state of the markets as a whole. He mentioned that there were some employers who had buried their heads in the sand and were not in compliance. He said:

It has mostly been confusion, frustration, and anger, and a lot of administration time spend by employers that they had not counted on. There are also a lot of hidden costs. The 9 percent increase is really an easy target to spot. There are health taxes and PECORI fees. The larger employers have to track employee hours on a weekly basis… They also have to do IRS reporting, get help from vendors which cost money or spend a lot of time doing it themselves. I mean, it’s a mess.

In addition to using the words “confusion and fear” to describe his experience with the Affordable Care Act, participant 13 also used the words “mistrust and
misunderstanding.” He said, “The law has changed several times and that is a challenge. These changes are the cause of confusion, fear, mistrust, and misunderstanding.”

Participant 15 added that the Affordable Care Act encouraged and accelerated the movement of small employers out of offering health insurance. It gave small employers (with less than 25 employees) reasons not to offer employee health insurance benefits since they were not mandated to. Participant 7 summed up his experience with the Affordable Care Act by saying, “overall, the Affordable Care Act has not worked.”

Participant 8 had positive things to say about his experience with the Affordable Care Act:

For me and my family, it has been a wonderful experience. Our premiums have gone down and we are receiving the healthcare services we need. I also have my son on my insurance until he is 26 years old. This is a big bonus for me. I do not have to worry about health insurance when he is in college.

In reference to his experience with the Affordable Care Act, participant 14 quoted someone who said, “The only healthcare system worse than the Affordable Care Act is our current system.” By saying this, he suggested that the Affordable Care Act was better than the old system:

Prior to the Affordable Care Act, there were a lot of issues with people getting sick and not getting insurance. I think that has definitely helped in that area. I do not think it has done anything to reduce the cost of health insurance. It has definitely insured more people but it did not make it more efficient. It hasn’t reduced the unit cost of healthcare.

The common key words used to describe the participants’ experience in response to question 5 were fear, confusion, frustration, and anger.
4.4.5. Question 6 Textual Analysis

Interview question 6 was designed to elicit response whether on the overall, the Affordable Care Act made things better or worse. The interview question was, “Overall, did the Affordable Care Act make things better or worse? Please explain.” Three participants (P01, P02, & P03) concurred that the Affordable Care Act made things worse. Participant 1 said:

Definitely worse. How can things get better when I am paying more to provide the same services? How can things be better when I am expected to do more paperwork to stay compliant? How can things be better when I am expected to do more and still get paid the same amount of money?

While Participant 1 appreciated the idea of a centralized electronic record keeping system introduced by the Affordable Care Act, he was skeptical about the goal of the government in implementing it:

The idea of the centralized electronic record keeping sounds good, but when it comes from the federal government, it makes one wonder what their actual goal is. If used properly, that is the only good thing that will come out of this whole mess.

Participant 2 said, “People’s insurance premiums have gone up and in some cases doubled. Small clinics have closed and county hospitals are all either owned by IU Health or the Franciscan Alliance.” She also added that people are driving long distances to receive specialized care. Participant 2 said the Affordable Care Act made things “more complicated.” Many people do not know who qualifies to get the federal subsidies. Participant 3 added:
The Affordable Care Act made things worse for me. I feel I am being squeezed from both sides. I used to provide pro bono services to people without health insurance. Now I cannot afford to do that anymore. I have to make sure my staff are spending more time completing forms to stay in compliance. My margin of error is so slim such that if I made some mistakes, I will be treated as a criminal by the federal government and pay a lot of fines. It has made it difficult to focus on patient care. I have to worry about making sure that all my records are straight in case they walk in. This has resulted in increased cost of providing services.

When asked whether the Affordable Care Act made things better or worse, participant 9 was quick to give a rundown of things that were not working well with the Affordable Care Act:

Are you kidding me? How can it make things better when people lost coverage, premiums went up through the roof, and people cannot visit their regular doctors anymore? It made things a hell lot worse, at least so far. How can they call it affordable when premiums are going up and healthcare is no longer affordable? When your insurance premium goes up, prescription drugs go up, and you have to drive more than one hour to receive specialized services, that is not good.

Participant 9 talked about how the implementation of the Affordable Care Act had affected people in small and rural communities.

I have heard of people having to drive to Lafayette and beyond to receive specialized care because those services are no longer available in their small towns. Specialists have moved to bigger cities where they can benefit from large numbers because their rates have been reduced, making it impossible for them to survive in small towns. My husband has to see a prostate specialist and a lung specialist. He has to go to Indianapolis because the specialists in Lafayette are either not in our network or are not taking new patients. So that creates a challenge for many people. I think for those on fixed income, that creates an even bigger challenge.

While the Affordable Care Act did not reduce the rates doctors are reimbursed, the effect of additional costs introduced by the Affordable Care Act may have led some participants to suggest that their rates were reduced. Participant 11 used the phrase, “irreparable damage” to describe the effect of the Affordable Care Act on the healthcare system. He pointed out that before the Affordable Care Act, our healthcare system was
broken and needed to be fixed. He also admitted that the insurance rates were out of control and healthcare costs were the leading cause of people filing for bankruptcy.

Participant 13 used the phrase “biggest confusion” to describe the process of people switching back and forth between employer insurance and the federal exchange:

In most cases, the exchange product has gone up in price considerably each year; 14 percent to 20 percent in some cases… It is confusion because your employees can be on the exchange and pick one of the several policies that are available. At one point, you had a group plan and everyone had the same benefits and the price was the same for everything. Now you can have employees with 5 to 6 different plans. Who is going to keep record of it because they all have questions on their different plans? And who on your staff is going to be competent on all these plans so that they can answer these questions? Also, the fact that they took something good or not as good but was working rather well and made it worse is concerning.

Participant 11 talked about how the Affordable Care Act did not fix the healthcare problems that existed before it was introduced:

I am not sure the Affordable Care Act fixed or will fix any of these problems. Premiums have gone up, networks are getting narrower and narrower, doctors have been forced to join bigger hospital networks, and one has to drive to Indianapolis to be seen by specialists. People who live in small communities are suffering.

Participant 11 added that the Affordable Care Act actually made things worse:

I am sure the intent was good but the outcome has been disastrous. Obama took a broken healthcare system and made it even more broken. I believe things are now worse and are even going to get even worse. The Affordable Care Act attempted to solve three problems but instead created seven problems in the process.

Participant 5 also agreed that “some people’s health insurance premiums have considerably gone up.”

Participant 4 had a different experience with the Affordable Care Act. Participant 4 said, “With my heart and prostate health issues, my insurance premiums were just too high. It has provided more choices of health insurance plans.” Participant 8 said the
Affordable Care Act definitely made things better. He also appreciated that his premiums had gone down and he can keep his 22-year old son covered under his insurance.

While participant 4 celebrated the elimination of pre-existing conditions, he complained about the lack of choice when a patient needs to visit specialist doctors out of network. He agreed with participants 1 and 2 when he said:

“Overall, things have been rough for many of us. I had my choice of doctors. I went off of my family doctor’s recommendations. But now he is in one network, my heart doctor is in another network, and my cancer doctor is in another network. I need all the three of them, but I can only have one. They are all critical to my life and my survival.”

In addition to talking about most people’s premiums having gone up, participant 5 praised the Affordable Care Act for increasing the number of patients that came into his practice with health insurance, the elimination of pre-existing conditions, and allowing kids under 26 years to remain on their parents’ health insurance plans:

“We now have a lot of clients that come to our practice with health insurance. That is a good thing. The idea of no pre-existing conditions is awesome. I really like it. Everyone can now get care regardless of your financial standing. I like the fact that children can stay on their parents’ health insurance until they turn 26 years old. That is a neat idea.”

Participants 6 and 15 said they had not experienced any changes and things were still fairly the same as they were before the implementation of the affordable Care Act.

However, participant 15 added that the Affordable Care was another form of taxation and added regulatory burden:

“There is a health insurance fee for the industry. The fee has raised most for-profit health insurers’ tax rates mostly by 10 percent. That is just a vast increase on taxation. The Co-ops that were launched when the Affordable Care Act started, there are only five left out of 23. You see large carriers like United Healthcare scaling down and pulling out of certain states like Indiana. I would say the most burdensome part, past the financials, is regulatory burden.”
Participant 12 responded from a comprehensive healthcare reform perspective. He said the Affordable Care Act was not true healthcare reform because it did not reduce cost and it did not improve the quality of care:

Well, it is not healthcare reform. Healthcare reform really gets to the nuts and bolts of increasing quality of care. I think lots of economists would agree that you really do not bend the cost curve to a meaningful degree until you can get at the true quality of care. The irony is that when the quality of care goes up, the cost curve does bend down. It’s like we dropped an atomic bomb on an ant hill. The problem was uninsured Americans and the low income bracket.

4.4.6. Question 7 Textual Analysis

Interview question 7 was designed to elicit participants’ response by asking their preference between the previous healthcare system and the Affordable Care Act. The question was, “If you had been given the choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?” Six participants (P01, P02, P03, P04, P12, & P14) pointed out that the old healthcare system needed to be fixed. They felt it worked and it was better than “the mess they created.” This represented 40 percent of all participants in this research. Participant one said:

Given a choice, I would have opted to stay with the old system and make some calculated changes to make it more transparent and increase accountability. May be the Affordable Care Act will improve with time but as of right now, I would definitely opt for the old system.

Participant 14 concurred with participant 1 that the old system needed some attention due to increasing costs and lack of a centralized health information system:
There is no doubt about the fact that the old healthcare system needed some attention. Cost of health insurance was always rising and it was becoming apparent that many people were soon not going to afford it. There was no centralized health information system where doctors and hospital systems could check if a patient visited their emergency room. While the Affordable Care Act is attempting to create a centralized health information system, it has not helped with reducing the cost of healthcare. If the old system had been tweaked a little bit, it would have helped a lot.

Four participants (P02, P06, P07, & P11) concurred with participant 14 that the old healthcare system needed to be fixed because it was becoming too expensive.

Participants 1 and 2 focused on people with pre-existing conditions. They concurred that some people with pre-existing conditions could not afford to buy health insurance in the old system. Participant 7 went back and forth between the old system and the Affordable Care Act. He believed that the old system was too expensive but the Affordable Care Act did not fix that problem:

Well, the problem with the old healthcare system is that costs were increasing faster than people could afford. Looking at the Affordable Care Act, it did attempt to create a common database which can tell the healthcare provider what services were provided and when. However, the challenge with the Affordable Care Act is that premiums for most people have gone up. So I am torn in between the old system and the Affordable Care Act. I would say the old system needed some changes to make it better and the Affordable Care Act did not do that. They took a broken system and made it more broken. At this point, employers are saying the Affordable Care Act has made health insurance more expensive. Another advantage in the old system is that employers could offer employees a financial assistance to go and buy insurance elsewhere.

Three participants (P10, P11, & P12) also concurred with participant 7 that the previous system needed help but was not sure the Affordable Care Act was the correct answer to the situation. Participant 11 added:
The previous system was broken and needed to be fixed. Healthcare costs were ever increasing by around 9 percent each year and people’s income was increasing by between zero percent and 3 percent. That is not sustainable. The American healthcare system is the number one cause of people filing for bankruptcy. Definitely, the old system needed to be fixed, however, the solution has not been good either. The solution, in this case, the Affordable Care Act has been equally bad if not worse.

Participant 11 also talked about the impact of the Affordable Care Act on the middle class. He added that the current tax system helped those who own businesses to benefit from the Affordable Care Act:

To a certain extent, the Affordable Care Act is good for people who are poor but already covered by Medicaid. The Affordable Care Act is not good for the middle class who may not qualify for government benefits because their income is just above the approval line. In the same token, the rich, those with companies, know how to hide their wealth when they file their taxes. So at the end of the day, the Affordable Care Act benefits the poor and the rich who own companies but it is a burden to the working class.

Participant 12 said the old system needed to be fixed due the cost of insurance increasing by an average of 15 percent. The Affordable Care Act failed to correct the problems in the old system. Participant 12 added:

The challenge is that the Affordable Care Act did not do anything to correct the situation. Instead, it made things worse. My short answer would be that I would opt for the old healthcare system with some serious tweaking and focus on quality improvement.

Participant 2 added that the Affordable Care Act did not solve any of those problems except for people with pre-existing conditions. She said, “I would opt for the old system with some thoughtful and intentional changes.”

In response to the same question, participant 13 gave the old healthcare system a “C−” grade and the Affordable Care Act a “D” grade. He echoed the sentiments that the old system needed some work due to cost of healthcare always increasing. He concurred
with participant 12 that the Affordable Care Act did not do anything to address the problems of the old system. Participant 3 concurred that the old healthcare system was better:

It was predictable and we knew what we were getting. It was not perfect and needed some changes but Obamacare made it worse. Cost of healthcare has gone up and quality of healthcare has not changed. In the old system, we did not live under the fear of pending audits and huge paybacks.

Participant 4 added that even though the old plan was more expensive, he would definitely opt for it because of its ability to allow patients to see doctors and specialists across networks as long as there was a referral.

Participant 5 was undecided. He talked about the good and the bad in both systems. He did not like the fact that in the old system, healthcare costs were going up faster than people’s income but liked the fact that people had choices of where to get their healthcare services. Concerning the Affordable Care Act, he liked the elimination of pre-existing conditions and kids staying on their parents’ health insurance until they turn 26. He concluded by saying, “If they can polish the Affordable Care Act, things may turn out to be better.”

Participant 9 viewed the two healthcare systems as a choice between two bad options. She said she “liked the old healthcare system but it was becoming too expensive.” She was quick to add that the Affordable Care Act did not help either. “Things changed from bad to worse.” She concluded, “with some tweaking, I would have opted for the old way of doing things.” Participant 15 said while the Affordable Care Act solved the problem of people with pre-existing conditions, it created bigger issues.
To the contrary, when asked whether he would opt to stay with the Affordable Care Act or stay with the old system, participant 8 said:

I would go with Obamacare for several reasons. Our company did not provide health insurance. We had to go out and buy health insurance for ourselves. The other reason I would go with Obamacare is that our monthly payments went from $800 per month to $200 per month. That is a huge savings. Another good reason is that my son who is 22 years old can stay on our health insurance for the next four years.

It is important to note that participant 8 was the only one of the 15 participants who mentioned that the Affordable Care Act reduced his premiums by 75 percent. Participant 8 mentioned that he did not have a pre-existing condition.

4.4.7. Question 8 Textual Analysis

Interview question 8 was meant to elicit responses that answer the main research question, “What was the impact of the Affordable Care Act on your work/business?” The interview question was the same as the main research question. Participants 1 and 11 used the words “fear and uncertainty” to describe their experience with the Affordable Care Act. Participant 1 talked about the fear of audits and increased costs:

As a business owner, I am afraid when an audit comes, I may be found non-compliant. The fines could be so high that I may be forced out of business. The other negative impact is increased costs associated with the compliance of the Affordable Care Act.

Participant 1 added that there has been an increase in costs related to obtaining durable medical equipment for his dental practice:

In order to buy durable medical equipment, I have to pay at least 10 percent to 15 percent more. The manufacturers are passing on those costs to us. Unfortunately, I cannot pass those costs to my patients because service rates are set and I cannot increase them.
While participant 1 talked about the increased number of patients with health insurance, he also added that the Affordable Care Act negatively impacted the middle class:

While it is true I have more patients come in with health insurance compared to before the Affordable Care Act, there is also a large group of middle income people whose premiums have increased considerably.

Participants in response to interview question 8 expressed the feeling of fear and uncertainty several times. Fear and uncertainty bring instability to business. Participant 11 explained why he felt that the Affordable Care Act created fear and uncertainty:

It is difficult to plan when you do not know what is coming and its impact on your business. There is so much fear coming from lack of information, government regulation, and infringement on people’s rights. Fear and uncertainty are not good words in business. In my view, the greatest impact of the Affordable Care Act is fear and uncertainty among businesses.

Three participants (P02, P03 & P04) also cited fear of being audited and being found out of compliance. Participant 4 said, “We are not sure if audited, will we be found in compliance. We are supposed to work on being compliant with a law that we do not fully understand.” Participant three added:

It has increased the amount of paperwork that we all have to do to stay compliant. We have to track part-time employee hours to make sure they remain part-time. We have to read a lot of weekly emails from our insurance broker to stay compliant. I spend an average of 5 to 8 hours per week doing work related to compliance with the Affordable Care Act. This is additional work we are not reimbursed for.

Participant 4 shared similar experience with doing a lot of paperwork. He said, “There is a lot of paperwork that my Office Manager has to complete regularly. We have to ensure part-time employees are working part-time hours.” In response to the same question, participant 3 said:
I have to make sure all the paperwork is in order. I am focusing more on compliance than taking care of my patients. I went into the medical field to take care of people, not to spend hours focusing on compliance and audits.

Participant 3 added that healthcare costs have increased across the board as a result of the Affordable Care Act. He pointed out that while the cost of healthcare has increased, quality of care has not improved. Instead, he pointed out that quality of care has been compromised:

There has been an increase in healthcare costs across the board… Other than the fact that we see more people come in with health insurance and people with pre-existing conditions do not have to pay as much as they used to, the rest is a mess. The price of durable medical equipment has gone up by at least 10 percent. Costs have increased and quality of care has been compromised. I fear that at some point, it is going to deteriorate to some cost saving endeavor and people’s lives are affected in the process.

Participant 11 explained that in order to successfully address the cost of healthcare in America, there has to be a comprehensive approach. That comprehensive approach should include addressing costs related to pharmaceutical companies and hospital systems:

The Affordable Care Act was put in place to control healthcare costs and make healthcare affordable to all Americans. So, far, it has not accomplished that. For anyone to control healthcare costs, you have to focus on three things; insurance companies, the pharmaceutical companies, and health institutions such as hospitals and rehabilitation centers.

Participant 5 cited the challenges of additional fees and taxes associated with the Affordable Care Act. Participant 5 was quick to add that the full impact of the Affordable Care Act “is yet to be seen since it has only been fully functional for a few years and there are more aspects that have not yet being implemented.” Two of the three participants (P01 & P05) who were in the medical profession concurred that they have seen more patients come into their practices with health insurance.
Participants 7 and 13 said the Affordable Care Act definitely made things worse due to the fact that premiums for the young and healthy increased. As a result, some young and healthy people chose not to obtain health insurance. Participant 9 the Affordable Care Act was not affordable at all. She said, “They call it ‘Affordable Care Act’ yet most people’s premiums have gone up.” Participant 7 pointed out that for people with pre-existing conditions, “The Affordable Care Act has been a lifeline.”

Participant 8 had positive things to say about the Affordable Care Act:

At least I can compete with bigger companies when it comes to offering health insurance. Technically, I can give my employees $2 to $3 raise per hour since I am not required to provide insurance. This makes me be able to compete with big companies when it comes to employee salaries. Also, health insurance ceases to be a competition factor when it comes to hiring employees because people can get health insurance through the exchange. As a small employer, I do not have to worry about providing health insurance because I do not have the capacity and expertise to do it. I can concentrate on doing what I know best.

Participant 6 was not sure what the full impact of the Affordable Care Act was on small businesses. However, he pointed out that one good outcome was that if he failed to offer employee health insurance benefits, they could go to the exchange and obtain it cheaper. In response to the same question, participant 12 felt that the Affordable Care Act did not improve the quality of healthcare and did not reduce the cost of healthcare.

Five participants (P09, P12, P13, P14, & P15) concurred that the Affordable Care Act had given them more business. This is because they were all in the insurance industry. This represented 33 percent of all participants. Participant 9 said:

…from a business perspective, it gave us a challenge to solve our clients’ health insurance problems. It gave us more business. We no longer do any underwriting on medical policies. It made things a lot easier for insurance companies.
Participant 13 said, “We definitely got more problems to solve and that is good for us. That means we have work to do.” Participants 14 and 15 agreed that they had more business than they ever did and participant 14 said, “That is good for our business.”

In response to how the Affordable Care Act affected small businesses, participant 14 had the following to say:

Probably the biggest things are that there is a wide disparity in terms of what small businesses are paying for health insurance. The change from the medical underwriting to the community rating, some small businesses had their premiums drop significantly but others have had their premiums increase significantly. The third trend we are seeing is that most small businesses have gone to a level funding product. It is kind of a self-funded insurance for small businesses that have a low stop loss attachment point.

4.4.8. Question 9 Textual Analysis

Interview question 9 elicited responses on each participant’s personal preferences of the aspects of the affordable Care Act they liked or they did not like. This interview question attempted to answer the research question, “What lessons can be learned from the implementation of the Affordable Care Act for future policy making?” It was also meant to solicit responses to answer the research question, “Did the Affordable Care Act extend coverage to the uninsured, include other medical services that were not previously covered, and did it improve cost sharing?” In some responses, participants switched back and forth between what they liked and what they did not like. This question was divided into two parts, “What aspects did you like” and “What aspects did you not like?”
4.4.8.1. Aspects Participants Liked.

The first part of question 9 asked participants what they liked about the Affordable Care Act. Participant 10 liked the aspect that people who used to be denied coverage could no longer be denied. She also liked the intent of the Affordable Care Act, but felt that it did not address everything that was broken with the old healthcare system.

Four participants (P01, P02, P06, & P07) shared similar responses about the elimination of pre-existing conditions and children staying on their parents’ insurance until they turn 26 years old as aspects they liked about the Affordable Care Act.

Participant 6 gave an example of his friend’s wife who had a serious health condition and said the Affordable Care Act “has been a blessing to him and his wife.”

Participant 5 said:

Well, I think it is good that people with pre-existing conditions are now covered and their premiums are reasonable. America has the best healthcare system, yet very expensive and the number one reason for making people file for bankruptcy. I do not think that was fair. The question is ‘at whose expense?’ Someone should be paying the bill. I also like the fact that children can stay on their parents’ health insurance until they turn 26 years. That is a huge bonus.

Participants 11 and 12 also liked that pre-existing conditions were eliminated.

Participant 7 pointed out that from an insurance agent point of view, “It is much easier to deal with the Affordable Care Act and it is fair to the American public.” He added that the Affordable Care Act had been a blessing to many people who could not obtain health insurance due to pre-existing conditions:

There have been many times over the years I wished I could help someone but I could not. They could not afford the premiums in the comprehensive pool and they couldn’t get insurance through regular carriers. The ‘no waiting period’ for people with pre-existing conditions is a good thing for the consumer. I am not sure it is a good thing for the insurance industry as a whole.
Participant 12 mentioned that other than the elimination of pre-existing conditions, there was not much to like about the Affordable Care Act. He added that since the Affordable Care Act was the new law and someone had to deal with it, he enjoyed helping employers find solutions. Participant 13 said the Affordable Care Act had given them more business. The same sentiment was shared with participant 14. Participant 14 said, “This is the best thing that ever happened to us.” It is important to mentioned that the three participants (P12, P13, & P14) who shared this response worked for health insurance companies. That may be the reason why they felt the Affordable Care Act created more business for them.

In response to what he liked about the Affordable Care Act, participant 14 had the following to say:

I do think it is important that we have protection for people that are sick. It does seem kind of unfair that due to no fault of your own, you have to pay significantly more for health insurance than someone who is healthy.

Participant 3 shared the same sentiments with six other participants (P01, P02, P05, P08, P13, & P15) about the elimination of pre-existing conditions and children staying on their parents’ health insurance until they turn 26 years old. This represented 47 percent of all research participants. Participant 13 said, “For parents whose kids are still living in their basements and struggling to develop wings, they can relax because their kids can stay on their insurance.” Participant 3 also liked that the Affordable Care Act resulted in more people being insured. Participant 3 was concerned about the people who lost their health insurance coverage due to the implementation of the Affordable Care Act. He felt that the
people who lost health insurance coverage due to the Affordable Care Act group were not getting attention.

Three participants (P04, P05, & P15) shared the same sentiments that it was not fair for people with pre-existing conditions to pay higher premiums. Participant 4 said:

With my heart and prostate issues, I no longer pay as high a premium as I used to. I am sure someone is paying the difference. At least no one can be denied coverage anymore due to pre-existing conditions. I did not develop prostate cancer due to a bad lifestyle. I did not develop heart problems due to a bad lifestyle. Well, with my heart issue, it might be that I overworked. Why would someone be punished for a condition they did not contribute to its development? That is not right.

Participant 8 was the only participant who indicated that his premium went down because of the Affordable Care Act. He also said the Affordable Care Act coverage was good and deductibles were low. Participant nine did not have anything she liked about the Affordable Care Act.

4.4.8.2. Aspects Participants did not Like

The second part of question 9 elicited responses from participants about what they did not like about the Affordable Care Act. Participant 14 talked about the lack of personal responsibility built into the Affordable Care Act. He was also concerned about the country’s ability to pay for the Affordable Care Act:

I feel that there is not a lot of personal responsibility requirements in it. I do worry about the country as a whole being able to afford all this. It is easier to say we have insured all these additional people but are we spending money that we could have spent on something else such as better education?

Participant 14 added that while it is important to celebrate the people who got health insurance because of the Affordable Care Act, there may be an equally significant
number of people who lost coverage because of the implementation of the Affordable
Care Act. Participant 14 also expressed concerns about the increasing premiums:

It is easier to quantify people that were not insured and now have health insurance
but difficult to quantify those that lost coverage because their premiums went up
and they could not afford it anymore. I do worry about the new pricing. It seems
like the new premiums for 2017 in a lot of states are increasing significantly.

Participant 1 did not like the involvement of the federal government in people’s
affairs. He added that “instead of worrying about providing quality care for my
patients…., I am now more concerned about the business aspect and staying in
compliance.” He also added that this created a situation where small private practices in
small towns and rural communities had been forced to join major hospital networks.
Participant 9 concurred that doctors had moved out of small towns and rural communities
to big towns in search of economies of scale. This left people in small towns and rural
communities with limited options, forcing them to travel long distances for specialized
care. Participant 3 added:

Most small private practices in small and rural communities like me have been
forced by the prevailing circumstances to close and join major hospital systems.
This has left a huge void in small communities that cannot be filled. Now you
have the elderly and people with special needs having to drive long distances for
specialized care. That is really sad.

Eight participants (P02, P03, P05, P06, P07, P09, P11, & P15) did not like the fact
that other people’s premiums went up to pay for those with pre-existing conditions. This
represented 53 percent of all participants. Participant 11 said the Affordable Care Act had
narrowed the network systems. He further said the Affordable Care Act made it difficult
for people who require specialized medical services outside their networks. He
questioned whether the Affordable Care Act was really affordable, “I thought it was supposed to be affordable?”

Two participants (P08 & P15) mentioned that there was a limited number of networks as a result of the Affordable Care Act. Participant 3 added that premiums had gone up without any improvement in the quality of healthcare. Participant 2 did not like the fact that there was a lot of paperwork and there were too many moving pieces with the Affordable Care Act. She felt that the Affordable Care Act forced people to provide or pay for services against their conscience:

I do not like the fact that we are being forced to provide certain services or pay for certain health insurance coverage against our conscience. That is not right.

Participants 12 and 13 had a lot to say about aspects they did not like about the Affordable Care Act. They talked about how the Affordable Care Act reduced the number of insurance carriers on the market. Participant 12 talked about the lack of transparency with the cost structure set up:

The way the cost structure is set up with the carriers is not good. Transitional reinsurance tax and other taxes that are collected all go into one pool of dollars that is supposed to feedback to carriers to offset their losses the first couple of years. I am not quite sure when United Healthcare say they are losing money what they mean by that. Aren’t the payments flowing from the bank account set up for the Affordable Care Act taxes to go to the carriers?

Participant 12 mentioned the regional monopoly being created as a result of the implementation of the Affordable Care Act:

What is also happening is that the carriers are now controlling certain regions and monopolizing those markets. In my view, this kills competition when it comes to prices. Another challenge is that the markets have shrunk and very soon we may end up with only two major carriers.
Participant 12 suggested that carriers should have been required to join the exchange and stay for at least three years:

You also have carriers pulling out of the exchange. I think they should have said if you join the exchange, you are in for at least three years.

Participant 13 mentioned that the Affordable Care Act did not do anything to address people’s bad lifestyle choices that resulted in costly diseases:

It feels like the Affordable Care Act has done all these things but is not focusing on health maintenance. People in America still have the mindset that fix me and do not worry about my lifestyle. That is a wrong mindset.

Participant 13 also added that the Affordable Care Act did not address the main cause of increasing healthcare costs which included costs related to hospitals and the pharmaceutical industry:

The hospitals are still charging what they were charging and doing what they were doing before the Affordable Care Act. The pharmaceuticals are still charging what they were charging before the Affordable Care Act. So, there is no real healthcare reform.

In addition to addressing the costs of hospitals and pharmaceutical companies as part of the healthcare reform, participant 13 talked about the lack of accountability for poor performance in hospitals and lack of transparency on how much hospitals and doctors charge for different medical procedures:

Another interesting thing is that if you ask your doctor how much the procedure will cost, they have no idea. I think hospitals need to be required to post the price list for all their procedures. Another problem is that hospitals are rewarded for fixing their own problems. They create a problem and they get paid even more to fix it. That is not right.

Participant 4 did not like being forced to provide certain services against his conscience.

Participant 3 also shared this sentiment.
4.4.9. Question 10 Textual Analysis

With minor variations, every participant was asked “what were some unexpected consequences of the Affordable Care Act?” The goal of this interview question was to elicit responses that would address the research question, “What lessons can be learned from the implementation of the Affordable Care Act for future policy implementation?” It was also meant to provide responses that answer the main research question, “What was the impact of the Affordable Care Act on small businesses?” Seven participants (P01, P02, P03, P05, P06, P09, & P11) were concerned that most people’s premiums increased. This represented 47 percent of all participants. Participant 9 said:

I do not think that Washington knew that our premiums would go up. If they did, it would not have passed. I think they were equally surprised to see people’s insurance rates going up.

Five participants (P01, P02, P06, P09, & P10) mentioned that small private medical practices had been forced to close and join large hospital networks. As a result, people from small and rural communities were driving long distances to receive specialized medical care.

When asked “what were some unexpected consequences of the Affordable Care Act,” three participants (P01, P09, & P12) summarized their responses by using the word “everything.” Participant 1 highlighted private practices in small and rural communities closing, people having to travel long distances for specialized care, and premiums going up:

Private practices in small communities have been forced to close and join bigger hospital systems… people are having to travel to Lafayette or Indianapolis to receive care. I do not think they realized that most people’s premiums would go up.
Participant 1 also talked about how the middle class had been negatively affected by the implementation of the Affordable Care Act:

I believe there are many middle class people that are without health insurance right now because they are right at the income level where they make a little too much to qualify for health insurance subsidies but at the same time, they do not make enough to be able to afford health insurance.

In defining “everything” that was unexpected consequence of the Affordable Care Act, participant 9 talked about people not being able to keep their doctors, premiums going up, lack of choices, and fewer networks:

Everything that was promised did not materialize. They said you can keep your doctor. That did not happen… They said it is going to be affordable. That is not true. People’s premiums increased. They said people will have choices of doctors and hospital networks. That is not the case. We now have fewer networks. They said it will make our healthcare system better. It actually made our healthcare system worse. They took a not-so-good system and turned it into a nightmare… Empty promises.

In defining “everything,” participant 12 cited increased premiums, small practices in small and rural communities closing, and networks narrowing as unexpected consequences of the Affordable Care Act:

Honestly, I would say everything we are seeing was unexpected. People’s premiums went up, small private practices in small and rural communities have been closing down, networks have significantly narrowed, and people are forced to choose doctors within chosen networks.

Participant 12 also talked about a lot of people with pre-existing conditions joining the federal exchange and fewer young and healthy people joining. This resulted in increased premiums for the young and healthy:
It appears that most people who signed up for health insurance through the federal exchange were people with pre-existing conditions. Also, not as many young and healthy people signed up for health insurance through the exchange as they expected. So this skewed the premiums for the few young and healthy people who signed up for health insurance through the exchange because their premiums went up.

Participants 2 and 9 talked about how the Affordable Care Act resulted in the narrowing of networks. They felt that the narrowing of networks due to some insurance companies pulling out of certain markets and or from the exchange was unexpected.

Participant 2 added:

…most health insurance companies are pulling out of Indiana. I heard United Healthcare announced that they are considering pulling out of the State of Indiana and from the federal exchange. I think they promised insurance companies certain promises or conditions but the federal government is now failing to meet those conditions or promises.

In addition to pointing out that most people’s premiums went up, participant 4 talked about the contradictory expectation of the Affordable Care Act that children could stay on their parents’ insurance until they turn 26 and expecting them to join the federal exchange to help lower overall exchange premiums. In his perspective, this provision “resulted in less young and healthy people joining the exchange.” The result was most of the people who joined the federal exchange had pre-existing conditions which caused the premiums of the few young and healthy people who joined the exchange to go up. In an attempt to explain the unexpected consequences of the Affordable Care Act, Participant 10 said:
Well, I do not think they saw it coming that by lowering the premiums for people with pre-existing conditions, they automatically increased the premiums for the young and healthy. The narrowing of networks is another major setback and an unexpected outcome. This has also led to small and private medical practices in small communities to close. I think someone needs to do a study on how many people lost their insurance coverage as a result of the implementation of the Affordable Care Act.

When asked the same question, participant 7 focused on the loopholes created by the Affordable Care Act. These loopholes are being taken advantage of by people who own companies. The people who do not need subsidies are qualifying for subsidies while those who need them are not. He focused on the current tax system as the reason why people who are well to do are getting subsidies:

There are people who are reasonably well off that are getting considerable subsidies. Our tax system is so corrupt that you can make your income look so small if you have some type of business. So you have this person on the street who is just over the threshold to qualify for subsidy and they do not get it. They don’t buy insurance because they cannot afford it, whilst this guy over here who drives a Cadillac is getting $1,000 in monthly subsidies. I think they should have kept it away from our tax system. The subsidies are based on your gross income. Well, if you have a business, above that line of gross income is your Schedule C for your business. You can make your business look like it is losing money.

In addition to most people’s premiums increasing, participant 11 pointed out that it appears most of the people who jumped onto the federal exchange were people who were previously uninsured or had pre-existing conditions. The Affordable Care Act provided relief for them. However, for those who were young and healthy, there was no incentive to join the federal exchange. Participant 11 pointed out that “the result was a “pre-existing condition-loaded system” without enough young and healthy people to balance it out.”
Participants 11 and 13 pointed out that since the fines and penalties for not providing or obtaining health insurance in most cases are lower than the total premiums, some individuals are tempted not to obtain health insurance. Participant 13 explained:

Because the fine of not getting health insurance is lower than the total yearly premiums, some young and healthy people are choosing to pay the fine. I think the fine for not obtaining health insurance should be doubled to discourage young people from choosing not to obtain health insurance.

Participant 13 added that some employers are also tempted not to provide health insurance and opting to pay the fine:

The same thing is true with company fines. If my company’s portion of the health insurance for 50 people is $300,000 and my fines for not providing health insurance are $100,000, I may be tempted to pay the fine. After all, that is a savings of $200,000. I do not think they saw this thing.

Participant 13 talked about how employers could avoid paying penalties by providing Minimum Essential Coverage plans. A Minimum Essential Coverage plan is defined in the Affordable Care Act as a health insurance plan that provides Minimum Essential Services. Examples of Minimum Essential Services are a few doctor’s office visits and a limited prescription coverage. Minimum Essential Coverage plans cost about $50 per employee per month. By providing a Minimum Essential Coverage plan, an employer is protected from the $2,000 fine per employee per year. However, since this plan does not meet the coverage test put in place by the Affordable Care Act, employees can go to the federal exchange and obtain health insurance. If an employee goes to the federal exchange and gets a subsidy, the employer has to pay a yearly fine of $3,000 per employee.

In order to comply with the individual mandate, all Americans are expected to maintain health insurance that meets the minimum essential coverage. Minimum essential
coverage plans are supposed to have an “Actuarial value” of 60 percent or more and should cover the ten essential health benefits:

1. Laboratory services.
2. Emergency services.
3. Prescription drugs.
4. Mental health and substance abuse disorder.
5. Maternity and newborn care.
6. Pediatric services including oral and vision care.
7. Rehabilitative and habilitative services and devices.
8. Ambulatory patient services.
9. Preventative and wellness services.
10. Chronic disease management and hospitalization (Source: Protection, Patient, and Affordable Care Act, 2010).

4.4.10. Question 11 Textual Analysis

Interview question 11 focused on eliciting responses concerning benefits which participants realized with the implementation of the Affordable Care Act. The interview question was, “What benefits have you realized with the implementation of the Affordable Care Act?” This interview question was designed to determine whether the breadth, width, and height of healthcare coverage improved because of the implementation of the Affordable Care Act. It also provided responses to the main research question, “What was the impact of the Affordable Care Act on small businesses?” Two participants (P01 & P05) said they benefited from more patients walking into their practices with health insurance. It is important to point out that participants 1 and 1 were in the medical field. Participant 1 said:

At least we have more insured patients walking through the door, but that is offset by compliance costs. I also liked the fact that my employees can also go to the federal exchange and obtain health insurance…if I decide not to offer health insurance, they are covered if their spouses do not have it through their employers.
Participant 6 also appreciated the fact that if he failed to provide employee health insurance benefits, his employees could obtain it at the federal exchange cheaper than he could offer. Participant 9 also shared the same sentiments. Three participants (P10, P12, & P14) added that hospitals and doctor’s offices were seeing more patients with health insurance.

Participant 7 explained how the Affordable Care Act had made the job of insurance agents much easier:

From an insurance business point of view, our job has become much easier. We do not have to underwrite people anymore. The process is much simplified and way easier than it used to be. We have also seen an increase in business as people look for answers and we work to provide those solutions.

Participant 14 shared the same sentiments with participant 7 that they had seen an increase in business as they attempted to solve people’s problems pertaining to the implementation of the Affordable Care Act.

Participant 2 added that people with pre-existing conditions were no longer paying too much to receive quality healthcare. Participant four added that people with pre-existing conditions can no longer be denied coverage and that government subsidies for those who could not afford to pay premiums was a good thing. Two additional participants (P07 & P10) mentioned the elimination of pre-existing conditions as a great benefit. Participant 7 said allowing kids to stay on their parents’ health insurance until they turn 26 was a great benefit.
4.4.11. Question 12 Textual Analysis

Interview question 12 elicited participants’ responses pertaining to the challenges they faced with the implementation of the Affordable Care Act. The goal of this interview question was to elicit responses that answer the research question, “What lessons can be learned from the implementation of the Affordable Care Act for future policy implementation?” The interview question was, “What challenges have you faced with the implementation of the Affordable Care Act?” Participant 1 was concerned about the morality of forcing companies to provide coverage and services that contradicted their values and were against their conscience.

Participant 1 also talked about the challenge of compliance with a law that is complicated and had moving parts:

Well, I think my greatest challenge has been how to stay compliant with such a complicated law. There are a lot of moving parts such that it is very difficult to be sure that you are doing the right thing.

Three participants (P02, P03, & P07) shared the same sentiments concerning challenges with computer problems during the rollout of the Affordable Care Act. Participant 2 added that with pending audits, no one seemed to know what the audits would entail. Participants 3 and 7 added that at the beginning, no one at the federal government level seemed to know what was going on. Participant 3 said the, “Affordable Care Act is so huge and affects many areas such that everyone seemed to be clueless.” He also added that the ever changing nature of the law and failure to find reliable and unbiased sources of information on the Affordable Care Act were additional challenges.

Participant 7 talked about poor communication from the federal government. Poor communication was evident during the Affordable Care Act rollout. There was no
communication on how to resolve the issues with the federal exchange. Participant 5 and 11 concurred with participant 3 on the lack of reliable sources on the Affordable Care Act. The issue of poor communication seemed to be a major challenge during the roll out phase when people had questions and were looking for answers.

Three participants (P04, P06, & P10) indicated that they had no challenges with implementation of the Affordable Care Act. They mentioned that they went through insurance agents who handled everything for them. Four additional participants (P10, P12, P14, & P15) who indicated that they did not experience much challenges with the implementation of the Affordable Care Act worked for insurance companies. Participant 11 did not experience much challenges with the Affordable Care Act since their plan was grandfathered in. He however, added that the lack of good and reliable information, free from political persuasion or pressure from an insurance agent trying to sell you a product, was a challenge. Ten participants (67 percent) concurred that they had no challenges with implementing the Affordable Care Act. This was because they either used an insurance agent to obtain information or worked for an insurance company.

4.4.12. Question 13 Textual Analysis

Interview question 13 elicited for response concerning participants’ sources of information. The interview question was, “What has been your sources of information concerning the Affordable Care Act?” The goal of this question was to check how reliable participants’ services were. Six participants (P02, P04, P06, P08, P09, & P11) got their information from insurance agents. This represented 40 percent of all research
participants. In addition to getting information from insurance agents, four participants (P02, P08, P09, & P11) also used TV, newspapers, and the internet.

In addition to using insurance agents, participants 3 and 5 got their information from professional medical publications and professional associations. Five participants (P07, P10, P11, P12, & P13) got their information concerning the Affordable Care Act from the internet, seminars, and webinars presented by insurance companies and by the Department of Labor.

Five participants (P08, P11, P13, P14, & P15) worked for insurance companies. Most insurance companies put together an internal team to research and stay up-to-date with the Affordable Care Act. Participants 14 and 15 were senior actuaries for their respective companies. They were heavily involved in interpreting the Affordable Care Act Law to their insurance field agents. In addition to attending seminars and webinars hosted by the insurance industry and the Department of Labor, participant 14 co-authored articles on the Affordable Care Act. As the Senior Ranking Actuary for his company, participant 15 contributed to several panel discussions on the subject. He also co-authored articles on the Affordable Care Act. Most of their articles were related but not specific to the impact of the Affordable Care Act on small businesses.

4.4.13. Question 14 Textual Analysis

Interview question 14 elicited participants’ responses pertaining to the aspects of the Affordable Care Act they would want to see maintained. The interview question was, “If the Affordable Care Act was to be revised, what aspects would you want to see
maintained?” The focus of this interview question was to provide responses to the research question, “What lessons can be learned from the implementation of the Affordable Care Act for future policy implementation?” Participant 1 gave two items; kids staying on their parents’ health insurance until they turn 26 years old and the elimination of pre-existing conditions. Nine participants (P01, P02, P04, P05, P06, P07, P10, P11, & P13) concurred that if the Affordable Care Act was to be revised, the elimination of pre-existing conditions should be maintained. This represented 60 percent of all participants. Four participants (P01, P02, P05, & P10) mentioned that kids staying on their parents’ health insurance until they turn 26 was a good thing. This represented 27 percent of all participants. Participant 2 said:

Well, it is good that everyone is covered. I like the idea of kids staying on their parents’ health insurance until they turn 26. I also like the fact that people with pre-existing conditions can no longer be denied coverage.

In answering the same interview question, participant 6 shared his friend’s wife’s experience with the Affordable Care Act:

He cannot see anything wrong with the Affordable Care Act. For him and his wife, it has been a life saver. His wife has some significant pre-existing health conditions and is now covered. That is a good thing. I told him that I understand where he is coming from because it is benefiting him and his wife…

Participant 7 talked about the importance of maintaining guaranteed coverage (elimination of pre-existing conditions) because before the implementation of the Affordable Care Act, there were too many people with pre-existing conditions who could not afford to pay their premiums.

Participant 8 talked about the importance of maintaining kids’ coverage under their parents’ health insurance plans until they turn 26. He added that this is a huge
saving for families since most young people do not have stable jobs at that stage in their lives. Participant 8 talked about choice on coverage and deductibles:

I like the fact that you can choose what you want. You can choose your coverage and your deductible. This is very important to me. I can choose my coverage and my deductible based on my needs.

4.4.14. Question 15 Textual Analysis

Interview question 15 elicited participants’ response pertaining to aspects of the Affordable Care Act they would wanted to see revised. The interview question was, “If the Affordable Care Act was to be revised, what aspects would you want to see revised?” This interview question was directed at answering the research question, “What lessons can be learned from the implementation of the Affordable Care Act for future policy implementation?” The issue of personal choice and people’s value system came up in several responses. Five participants said the Affordable Care Act “went against people’s value systems” (P01, P02, P04, P09, & P11). This response accounted for 33 percent of all participants. The same five participants also shared the theme that the Affordable Care Act “took away people’s choice.” Participant 1 said, “People need to have choice on what procedure they can be covered for based on their value system.” Participant 11 added:

Another sticky issue they need to reconsider is forcing companies to provide services that are against their values and conscience. That is not right. They need to find a way to fix it.

Participant 11 also addressed the issue of allowing people to access medical services across networks as something that needed to be revised:
They need to figure out how to allow people to receive services across networks without breaking their banks. People need to be able to receive necessary and needed medical services out of network without having to pay too much. There are certain services that are a must that are offered outside the network that need to be covered.

In response to the same question, five participants (P02, P07, P08, P09, & P11) said the Affordable Care Act resulted in “high premiums” and this needed to be revised. This represented 33 percent of the responses to this question. Two participants said if the Affordable Care Act was to be revised, the government needed to “make it simpler” (P01 & P04). Two participants pointed out that “the employer mandate” needed to be revised (P10 & P12).

4.5. Notable Responses

There were some notable responses from three participants. These responses were either from participants in specialized professions that shed light on certain areas or the responses provided unique and insightful information or suggestions. The first notable response was from participant 12. He focused on the possibility that the Affordable Care Act, like other entitlement programs (Medicare and Social Security) may be here to stay:

This is the biggest legislation since Medicare. In the history of the USA, an entitlement has been repealed zero times. Now that we have the health exchange set up and you have carriers completely retooled and hospital systems have recalibrated their systems, I do not think Americans understand that they are stuck with the Affordable Care Act.

This response was unique in the sense that it presented a potential reality that people may need to deal with. It also provided a unique perspective in policymaking concerning entitlements.
The second notable response came from participant 11. In order to successfully bring the cost of healthcare under control, there has to be a system in place that addresses healthcare costs related to pharmaceutical companies and hospitals systems. Without putting cost control measures on the pharmaceutical industry and hospital systems, there will not be a successful healthcare reform. Participant 11 had the following to say:

They also need to find a way to put a check on pharmaceutical companies and hospitals. The Affordable Care Act did not do anything to bring their excessive costs under control. I think this is very critical. There has to be a system in place to check and control pharmaceutical companies and big hospitals.

This response was unique in the sense that it attempted to address the root cause of the increasing healthcare costs. Without controlling the pharmaceutical and hospital costs, participant 11 suggested that healthcare costs will continue to rise.

The third notable response came from participant 15. It gave some insights into why healthcare costs have continued to increase even after the implementation of the Affordable Care Act. It also addressed the declining offer rate before and after the implementation of the Affordable Care Act:

We had a circumstance that small employers were facing rate increases of 7 percent to 15 percent per year prior to the Affordable Care Act. It was unaffordable to them and they could not compete in their market places. An offer rate is the percentage of smaller employers offering health insurance to their employees. The offer rate has declined to, and in some jurisdictions down to 30 percent to 40 percent. So you had two thirds of the smaller employers saying we cannot just afford to offer health insurance. There was a growing advent of Health Savings Accounts. The Affordable Care Act has not done a great deal to change all those circumstances.

This response was unique because it painted a picture of what was happening prior to the implementation of the Affordable Care Act in light of increasing rates and declining offer
rates. These two factors need to be considered in an attempt to answer why most people’s premiums continued to go up after the implementation of the Affordable Care Act.
CHAPTER 5. THEMES AND FINDINGS

The previous chapter presented data on each research participant, each research question. It presented the techniques used by the researcher to identify themes. It presented the emerging sub themes within each question. It also presented the emerging sub themes and themes across questions. It also highlighted sub themes and themes that were not common in the responses from participants but were prevalent in literature review.

5.1. Emerging Sub Themes

This section addresses sub themes that emerged from each question. It presents sub themes from the interview data across questions and across participants. It also presents sub themes and themes from literature review and the researcher’s past knowledge. It introduces each emerging theme, how each theme speaks to the research questions, and provides supporting narratives. It also addresses how each theme answers the research questions presented in this study.

5.1.1. Emerging Sub Themes from Question Three

Three common sub themes emerged in response to interview question three. The first sub theme was most people’s “premiums and co-pays increased” because of the implementation of the Affordable Care Act. Five participants (P01, P03, P04, P05, & P09) mentioned this sub theme in response to question 3. This represented 33 percent of all participants. This sub theme suggests that the Affordable Care Act did not improve
cost sharing in the healthcare industry. Instead, most people ended up paying higher premiums than they used to before the implementation of the Affordable Care Act. The word “premium” was mentioned 172 times and the phrase “premiums increased” was mentioned 40 times during this research.

The second sub theme was the “old system was too expensive.” Four participants (P07, P13, P14, & P15) mentioned this sub theme in response to question 3. This represented 27 percent of all participants. The third sub theme that emerged was the Affordable Care Act “eliminated pre-existing conditions.” Three participants (P06, P07, & P14) mentioned this sub theme in response to question 3. This represented 20 percent of all participants. By eliminating pre-existing conditions, one can argue that the Affordable Care Act improved the basket of health services for people with pre-existing conditions. It extended their coverage, expanded their medical coverage, and improved their cost sharing.

Other sub themes were mentioned once in participants’ responses but were also common in literature review. The first sub theme was the Affordable Care Act “forced people to get insurance” and the Affordable Care Act “saved some people money.” The sub theme “saved some people money” is be linked to the elimination of pre-existing conditions. The people who had pre-existing conditions prior to the implementation of the Affordable Care Act saw a reduction in their premiums, hence saving them money. Table 5.1 summarizes the emerging sub themes from interview question three and the number of participants who mentioned each theme.
Table 5.1

*Emerging Sub Themes from Interview Question Three.*

<table>
<thead>
<tr>
<th>Question 3 Emerging Sub Themes</th>
<th># Of Participants Who Mentioned It</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA resulted in increased premiums</td>
<td>5</td>
</tr>
<tr>
<td>Old system was too expensive</td>
<td>4</td>
</tr>
<tr>
<td>ACA eliminated pre-existing conditions</td>
<td>3</td>
</tr>
<tr>
<td>ACA forced people to get insurance</td>
<td>1</td>
</tr>
<tr>
<td>ACA saved people money</td>
<td>1</td>
</tr>
</tbody>
</table>

5.1.2. Emerging Sub Themes from Question Four

Five common sub themes emerged in response to interview question four. The first sub theme was the Affordable Care Act resulted in “more paperwork.” There were eight participants (P03, P04, P05, P06, P07, P10, P14, & P15) who shared this sub theme. This represented 53 percent of all participants. The second sub theme was the Affordable Care Act resulted in “more rules and regulations.” There were six participants (P01, P02, P09, P10, P11, & P13) who shared this sub theme. This represented 40 percent of all participants.

The third sub theme was the Affordable Care Act was “government interference.” This sub theme was mentioned by four participants (P01, P02, P03, & P09). This represented 27 percent of all participants. The fourth sub theme was the Affordable Care Act resulted in potential “government fines.” Four participants (P03, P13, P14, & P15) mentioned this sub theme. This also represented 27 percent of all participants. The fifth sub theme was the Affordable Care Act caused “frustration and confusion.” Two participants (P07 & P14) mentioned this theme. Table 5.2 summarizes the emerging
themes from interview question four and the number of participants who mentioned each theme.

Table 5.2

<table>
<thead>
<tr>
<th>Question 4 Emerging Sub Themes</th>
<th># Of Participants Who Mentioned It</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA resulted in more paperwork</td>
<td>8</td>
</tr>
<tr>
<td>ACA resulted in more rules and regulations</td>
<td>6</td>
</tr>
<tr>
<td>ACA resulted in government interference</td>
<td>4</td>
</tr>
<tr>
<td>ACA resulted in more government fines</td>
<td>4</td>
</tr>
<tr>
<td>ACA resulted in frustration and confusion</td>
<td>2</td>
</tr>
</tbody>
</table>

5.1.3. Emerging Sub Themes from Question Five

Six common sub themes emerged in response to interview question five. The first sub theme was the Affordable Care Act resulted in “confusion.” Five participants (P01, P02, P03, P12, & P13) mentioned this sub theme. This represented 33 percent of all participants. Participants shared that there was confusion due to people not knowing what to do since the Affordable Care Act expectations were not clear.

Confusion lead to the second sub theme of “fear.” Five Participants (P02, P05, P10, P11, & P13). This represented 33 percent of all participants. The third sub theme was the Affordable Care Act caused “frustration.” Four participants (P02, P05, P05, & P12) mentioned this sub theme. This represented 27 percent of all participants. The fourth sub theme was the Affordable Care Act created “additional costs.” Two participants (P01, & P12) mentioned it. The fifth sub theme was the Affordable Care Act focused on “compliance” rather than improving the healthcare system. Two participants (P01 & P11) mentioned this sub theme. The sixth sub theme was the Affordable Care Act created “anger.” Two participants (P03 & P12) mentioned it.
There were two sub themes mentioned once in participants’ responses that were prevalent in literature review. The first sub theme was the Affordable Care Act launching had “computer problems” during the rollout phase. The second sub theme was the Affordable Care Act resulted in “mistrust and misunderstanding. Table 5.3 summarizes the sub themes from interview question five and the number of participants who mentioned each sub theme.

Table 5.3

<table>
<thead>
<tr>
<th>Question 5 Emerging Sub Themes</th>
<th># Of Participants who Mentioned It</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA resulted in confusion</td>
<td>5</td>
</tr>
<tr>
<td>ACA resulted in fear</td>
<td>5</td>
</tr>
<tr>
<td>ACA resulted in frustration</td>
<td>4</td>
</tr>
<tr>
<td>ACA resulted in additional costs</td>
<td>2</td>
</tr>
<tr>
<td>ACA focused on compliance</td>
<td>2</td>
</tr>
<tr>
<td>ACA resulted in anger</td>
<td>2</td>
</tr>
<tr>
<td>ACA launching had computer problems</td>
<td>1</td>
</tr>
<tr>
<td>ACA resulted in mistrust and misunderstanding</td>
<td>1</td>
</tr>
</tbody>
</table>

5.1.4. Emerging Sub Themes from Question Six

Several sub themes emerged in participants’ responses to interview question six. The first sub theme was the Affordable Care Act “made things worse.” Seven participants (P01, P02, P03, P04, P09, P11, & P15) mentioned this sub theme. This represented 47 percent of all participants. It was made by collapsing several sub headings. The first sub heading was the Affordable Care Act “made things worse.” The second sub heading was the Affordable Care Act resulted in “private practices closing.” Two participants (P02 & P11) mentioned it. The third sub heading was the Affordable Care Act caused “more
paperwork.” Two participants mentioned it (P02 & P11). The fourth sub heading was the Affordable Care Act was “complicated.” Two participants (P01 & P04) mentioned it. The second sub theme was “premiums went up” as a result of the Affordable Care Act. Five participants (P02, P09, P11, P13, & P15) mentioned this sub theme. This represented 33 percent of all participants. This sub theme is related to the first sub theme “made things worse.”

The third sub theme was the Affordable Care Act “affected rural and small communities.” It was created by collapsing three sub headings. The first sub heading was the Affordable Care Act resulted in “people driving long distances for care.” Four participants (P01, P02, P09, & P11) mentioned this sub heading. This represented 27 percent of all participants. The second sub heading was the Affordable Care Act “affected rural and small communities.” Three participants (P02, P09, & P11) mentioned this sub theme. This represented 20 percent of all participants. The third sub heading was the Affordable Care Act resulted in “narrowed networks.” Two participants shared this sub heading (P08 & P11).

Four additional sub themes were mentioned once but also appeared in literature review. The first sub theme was the Affordable Care Act “reduced choices of doctors.” One participant mentioned this sub theme (P04). The second sub theme was the Affordable Care Act “made it harder for the middle class.” One participant mentioned this sub the (P15). The third sub theme was the Affordable Care Act “did not improve quality.” One participant mentioned this theme (P15). The fourth sub theme the Affordable Care Act “lacked choice.” One participant mentioned this theme (P02).
While the first sub themes showed the negative impact of the Affordable Care Act, the next sub themes showed the positive impact of the Affordable Care Act. The first positive sub theme was “kids under 26 years can stay on their parent’s health insurance.” Two participants shared this theme (P05 & P08). The second positive sub theme was the Affordable Care Act “provided more insurance choices.” It was mentioned by one participant (P04) but was also common in literature review. The third positive sub theme was the Affordable Care Act caused premiums to decrease. One participant (P08) also mentioned it. The fourth positive sub theme was the Affordable Care Act increased our business (P05). Table 5.4 summarizes the sub themes that emerged from interview question 6.

Table 5.4

_Emerging Sub Themes from Interview Question Six._

<table>
<thead>
<tr>
<th>Question 6 Emerging Sub Themes</th>
<th># Of Participants Who Mentioned it</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA affected rural and small communities</td>
<td>9</td>
</tr>
<tr>
<td>ACA made things worse</td>
<td>7</td>
</tr>
<tr>
<td>ACA resulted in increased premiums</td>
<td>5</td>
</tr>
<tr>
<td>ACA resulted in more paperwork</td>
<td>2</td>
</tr>
<tr>
<td>ACA resulted in narrowed networks</td>
<td>2</td>
</tr>
<tr>
<td>ACA allowed Kids &lt;26 to stay on parents’ insurance</td>
<td>2</td>
</tr>
<tr>
<td>ACA was complicated</td>
<td>2</td>
</tr>
<tr>
<td>ACA provided more insurance choices</td>
<td>1</td>
</tr>
<tr>
<td>ACA caused premiums to decrease</td>
<td>1</td>
</tr>
<tr>
<td>ACA resulted in less choices of doctors</td>
<td>1</td>
</tr>
<tr>
<td>ACA negatively affected the middle class</td>
<td>1</td>
</tr>
</tbody>
</table>
5.1.5. Emerging Sub Themes from Question Seven

Nine sub themes emerged from the responses given by participants to interview question seven. The first sub theme was “the old system was too expensive.” Ten participants (P01, P02, P04, P06, P07, P09, P10, P11, P12, & P14) shared this sub theme. This represented 67 percent of all participants. The second sub theme was the Affordable Care Act “made things worse.” Five participants (P03, P07, P11, P12, & P15) shared this sub theme. This represented 33 percent of all participants. The third sub theme had four participants (P01, P02, P13, & P14) who concurred that they would “stay with the old system.” This represented 27 percent of all participants.

The fourth sub theme had four participants who agreed that the Affordable Care Act “helped people with pre-existing conditions” (P01, P02, P05, & P07). This represented 27 percent of all participants. The fifth sub theme was the Affordable Care Act helped families due to “kids staying on their parents’ health insurance until they turned 26.” Three participants (P02, P05, & P08) shared this sub theme. This represented 20 percent of all participants.

The sixth sub theme focused on what the old system failed to accomplish in light of creating a centralized health information system. The sub theme was the old healthcare system “lacked a centralized health information system.” Two participants shared this theme (P07 & P14). The seventh sub theme pertained to the negative impact of the Affordable Care Act. It was the Affordable Care Act “caused premiums to go increase.” Two participants (P03 & P07) mentioned this theme. The eighth sub theme was the Affordable Care Act “was not good for the middle class.” Two participants mentioned it. The ninth sub theme was the Affordable Care Act “benefited the poor.” Two participants
mentioned this theme (P11 & P14). Table 5.5 summarizes the emerging sub themes from interview question seven and the number of participants who mentioned them.

Table 5.5  
Emerging Sub Themes from Interview Question Seven.

<table>
<thead>
<tr>
<th>Question 7 Emerging Sub Themes</th>
<th># Of Participants Who Mentioned it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old system was too expensive</td>
<td>10</td>
</tr>
<tr>
<td>ACA made things worse</td>
<td>5</td>
</tr>
<tr>
<td>I would stay with the old plan</td>
<td>4</td>
</tr>
<tr>
<td>ACA eliminated pre-existing conditions</td>
<td>4</td>
</tr>
<tr>
<td>ACA allowed kids &lt;26 to stay on Parents’ insurance</td>
<td>3</td>
</tr>
<tr>
<td>Old system lacked centralized health information system</td>
<td>2</td>
</tr>
<tr>
<td>ACA caused premiums to increase</td>
<td>2</td>
</tr>
<tr>
<td>ACA is not good for middle class</td>
<td>2</td>
</tr>
<tr>
<td>ACA benefited the poor</td>
<td>2</td>
</tr>
</tbody>
</table>

5.1.6. Emerging Sub Themes from Question Eight

Nine sub themes emerged from responses to interview question eight. The first sub theme was the Affordable Care Act resulted in people being “afraid of audits.” Five participants shared this sub theme (P01, P02, P03, P04, & P11). This represented 33 percent of all participants. The second sub theme was the Affordable Care Act resulted in “increased costs.” Five participants (P01, P03, P05, P07, & P13) shared this sub theme. This represented 33 percent of all participants. The third sub theme was the Affordable Care Act resulted in “increased paperwork.” Four participants (P02, P03, P04, & P05) shared this sub theme. This represented 27 percent of all participants.
The fourth sub theme was the Affordable Care Act “gave us more business.” This sub theme came from four participants who worked for health insurance companies (P09, P13, P14, & P15). Related to this sub theme was the fifth sub theme. Three participants who were in the medical field indicated that the Affordable Care Act resulted in “more people with health insurance” (P01, P03, & P05). When combined, these two sub themes accounted for 40 percent of all participants. The sixth sub theme that emerged was the Affordable Care Act resulted in “created uncertainty.” Two participants (P01 & P11) mentioned this sub theme. The seventh sub theme was the Affordable Care Act “focused on compliance” instead of improving the quality of healthcare and reducing cost (P03 & P04).

The eighth sub theme was the Affordable Care Act “made things worse.” Two participants (P07 & P13) mentioned this sub theme. The ninth sub theme was “not sure” of what the impact of the Affordable Care Act was (P06 & P09). There was one sub theme mentioned once but was also prevalent in literature review. It was the Affordable Care Act had “no impact” on my business. Table 5.6 summarizes the emerging sub themes from interview question eight.
### Table 5.6

*Emerging Sub Themes from Interview Question Eight.*

<table>
<thead>
<tr>
<th>Question 8 Emerging Sub Themes</th>
<th># Of Participants Who mentioned It</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA resulted in fear of audit</td>
<td>5</td>
</tr>
<tr>
<td>ACA increased costs</td>
<td>5</td>
</tr>
<tr>
<td>ACA increased paperwork</td>
<td>4</td>
</tr>
<tr>
<td>ACA gave us more business</td>
<td>4</td>
</tr>
<tr>
<td>ACA insured more people</td>
<td>3</td>
</tr>
<tr>
<td>ACA created uncertainty</td>
<td>2</td>
</tr>
<tr>
<td>ACA focused on compliance</td>
<td>2</td>
</tr>
<tr>
<td>ACA made things worse</td>
<td>2</td>
</tr>
<tr>
<td>Not sure of the impact of ACA</td>
<td>2</td>
</tr>
<tr>
<td>ACA had no impact</td>
<td>1</td>
</tr>
</tbody>
</table>

5.1.7. Emerging Sub Themes from Question Nine

Eight sub themes emerged from the responses given to interview question nine. The sub themes were grouped into two categories; themes in favor of the Affordable Care Act and themes against the Affordable Care Act. There were three sub themes in favor of the Affordable Care Act. The first sub theme in favor of the Affordable Care Act was the Affordable Care Act “eliminated pre-existing conditions.” Twelve participants indicated that the elimination of pre-existing conditions was a good outcome of the Affordable Care Act. This represented 80 percent of all participants. The second sub theme was “children staying on their parents’ insurance until they turn 26” was a good thing. Eight participants shared this theme. This represented 53 percent of all participants. The third sub theme that emerged was that the Affordable Care Act brought us “more business.” Three participants (P13, P14, & P15) shared this theme. Table 5.7 summarizes sub themes that emerged from question 9 in favor of the Affordable Care Act.
Five sub themes emerged against the Affordable Care Act in response to interview question nine. The first sub theme was “premiums went up.” Fourteen out of 15 participants said premiums went up (all participants except P08). This represented 93 percent of all participants. The second sub theme was that the Affordable Care Act “narrowed networks.” Five participants (P08, P11, P12, P13, & P15) agreed that the Affordable Care Act had resulted in narrowed networks. This represented 33 percent of all participants. The third sub theme was the Affordable Care Act “took away people’s choices.” Two participants (P03 & P04) shared this sub theme. The fourth sub theme was the implementation of the Affordable Care Act resulted in “small medical practices joining bigger hospitals.” Two participants (P03 & P09) shared this sub theme. The fifth sub theme was that the Affordable Care Act did “not improve healthcare.” Two Participants (P03 & P13) shared this sub theme.

There were three additional sub themes mentioned by once but were prevalent in literature review. The first sub theme was “some people lost coverage.” The second sub theme was the Affordable Care Act was “government interference.” The third sub theme was the Affordable Care Act “killed price competition.” Table 5.8 summarizes the emerging sub themes from interview question nine against the Affordable Care Act.

<table>
<thead>
<tr>
<th>Sub Theme</th>
<th># Of Participants who Mentioned It.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliminated pre-existing conditions</td>
<td>12</td>
</tr>
<tr>
<td>Kids &lt;26 stay on parents’ insurance</td>
<td>8</td>
</tr>
<tr>
<td>ACA brought more business</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 5.7

Emerging Sub Themes for the Affordable Care Act
Table 5.8

Emerging Sub Themes against the Affordable Care Act.

<table>
<thead>
<tr>
<th>Question 9 Emerging Sub Themes</th>
<th># Of Participants Who Mentioned It</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA caused premiums to increase</td>
<td>14</td>
</tr>
<tr>
<td>ACA resulted in narrowed networks</td>
<td>5</td>
</tr>
<tr>
<td>ACA took away people’s choices</td>
<td>2</td>
</tr>
<tr>
<td>ACA resulted in small practices joining big networks</td>
<td>2</td>
</tr>
<tr>
<td>ACA did not improve healthcare</td>
<td>2</td>
</tr>
<tr>
<td>ACA resulted in some people loosing coverage</td>
<td>1</td>
</tr>
<tr>
<td>ACA is government interference</td>
<td>1</td>
</tr>
<tr>
<td>ACA killed price competition</td>
<td>1</td>
</tr>
</tbody>
</table>

5.1.8. Emerging Sub Themes from Question Ten

Five sub themes emerged from participants’ responses to question ten. The first sub theme was “premiums increased” because of the Affordable Care Act. Eight participants (P01, P02, P03, P05, P06, P09, P10, & P11) shared this sub theme. This represented 53 percent of all participants. The second sub theme was the Affordable Care Act resulted in “fewer networks.” Three participants (P02, P09, & P10) shared this sub theme.

The third sub theme was the current outcomes of the Affordable Care Act “were unexpected.” Three participants (P01, P09, & P12) shared this sub theme. The fourth sub theme was the Affordable Care Act resulted in “small practices in small communities closing.” Two participants (P01 & P10) shared this sub theme. The only sub theme that emerged that had a different focus was the Affordable Care Act “fines were not high enough.” Two participants mentioned this sub theme (P11 & P13). Table 5.9 summarizes the emerging sub themes from interview question ten.
Table 5.9

*Emerging Sub Themes from Interview Question Ten.*

<table>
<thead>
<tr>
<th>Question 10 Emerging Sub Themes</th>
<th># Of Participants Who Mentioned It</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA caused premiums to increase</td>
<td>8</td>
</tr>
<tr>
<td>ACA resulted in fewer networks</td>
<td>3</td>
</tr>
<tr>
<td>ACA outcomes were unexpected</td>
<td>3</td>
</tr>
<tr>
<td>ACA resulted in small practices closing</td>
<td>2</td>
</tr>
<tr>
<td>ACA fines are not high enough</td>
<td>2</td>
</tr>
</tbody>
</table>

5.1.9. Emerging Sub Themes from Question Eleven

Two sub themes emerged from participants’ responses to question eleven. The first theme was the Affordable Care Act resulted in “more patients with health insurance.” Four participants (P01, P05, P12, & P14) shared this sub theme. It is important to point out that the four participants who gave this response were in the medical field and health insurance industry. The second sub theme that emerged from the responses to question eleven was that the Affordable Care Act eliminated “pre-existing conditions.” Three participants shared this response (P04, P07, & P10). Table 5.10 summarizes the emerging sub themes from interview question eleven.

Table 5.10

*Emerging Sub Themes from Interview Question Eleven.*

<table>
<thead>
<tr>
<th>Question 11 Emerging Sub Themes</th>
<th># Of Participants Who Mentioned it</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA resulted in more people with insurance</td>
<td>4</td>
</tr>
<tr>
<td>ACA eliminated pre-existing conditions</td>
<td>3</td>
</tr>
</tbody>
</table>
5.1.10. Emerging Sub Themes from Question Twelve

Six sub themes emerged from responses to question 12. The first sub theme was the implementation of the Affordable Care Act resulted in “no changes.” Seven Participants (P04, P06, P10, P11, P12, P14, & P15) shared this sub theme. Five of the seven participants who shared this sub theme used insurance agents to obtain information on health insurance. The other two participants who shared this sub theme worked for insurance companies. The second sub theme was the implementation of the Affordable Care Act had serious “computer glitches.” Three participants (P02, P03, & P07) shared this sub theme.

The third sub theme was there was “lack of reliable sources of information” during the implementation of the Affordable Care Act. Three participants shared this sub theme (P03, P05, & P11). Because of computer glitches and lack of reliable information, the implementation of the Affordable Care Act resulted in a lot of “confusion.” This was the fourth sub theme that emerged from the data. Three participants concurred on this sub theme (P03, P07, & P11). The fifth sub theme was the Affordable Care Act focused more on “compliance.” Two participants shared this theme (P01 & P07).

There were two additional sub themes mentioned once by participants but were prevalent in literature review. The first sub theme was the Affordable Care Act “forced people to obtain health insurance.” The second sub theme was there was “poor communication” during the Affordable Care Act rollout. Table 5.11 summarizes the emerging sub themes from interview question twelve.
Table 5.11

*Emerging Sub Themes from Interview Question Twelve.*

<table>
<thead>
<tr>
<th>Question 12 Emerging Sub Themes</th>
<th># Of Participants Who Mentioned It</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA resulted in no challenges</td>
<td>7</td>
</tr>
<tr>
<td>ACA resulted in computer glitches</td>
<td>3</td>
</tr>
<tr>
<td>ACA resulted in confusion</td>
<td>3</td>
</tr>
<tr>
<td>We lacked reliable sources on the ACA</td>
<td>3</td>
</tr>
<tr>
<td>ACA focused on compliance</td>
<td>2</td>
</tr>
<tr>
<td>ACA forces people to obtain health insurance</td>
<td>1</td>
</tr>
<tr>
<td>Poor communication in launching ACA</td>
<td>1</td>
</tr>
</tbody>
</table>

5.1.11. Responses to Question 14: Sources of Information

Six sub themes emerged from the data provided by participants in response to interview question 13. Question 13 elicited participants’ response about their sources of information concerning the Affordable Care Act. The interview question was, “what has been your sources of information concerning the Affordable Care Act?” Nine participants (P07, P10, P11, P12, P13, P14, & P15) got their information from “Department of Labor seminars.” This represented 60 percent of participants. Six participants (P02, P04, P06, P08, P09, & P11) got their information from their “insurance agents.” This represented 40 percent of all participants. Four participants (P02, P08, P09, & P11) got their information from newspapers. The same participants said they also got their information from the internet (P02, P08, P09, & P11). Three participants said they got their information from professional associations (P01, P02, & P05). Table 5.12 summarizes participants’ sources of information.
Table 5.12

Participants’ Sources of Information.

<table>
<thead>
<tr>
<th>Question 13 Sources of Information</th>
<th># of Participants Who Mentioned It.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depart of Labor</td>
<td>9</td>
</tr>
<tr>
<td>Insurance Agent</td>
<td>6</td>
</tr>
<tr>
<td>Newspapers</td>
<td>4</td>
</tr>
<tr>
<td>Internet</td>
<td>4</td>
</tr>
<tr>
<td>Professional Associations</td>
<td>3</td>
</tr>
</tbody>
</table>

5.1.12. Emerging Sub Themes from Question Fourteen

Two sub themes emerged from the responses provided by participants in answering interview question 14. Interview question 14 was, “What should be maintained if the Affordable Care Act was to be revised?” The first sub theme was “maintain the elimination of pre-existing conditions.” Eight participants (P01, P02, P03, P04, P05, P06, P07, & P10) shared this sub theme. This represented 60 percent of all participants. The second sub theme was “maintain kids under 26 years covered by their parents’ insurance.” Five participants (P01, P02, P05, P08, & P10) shared this sub theme. This represented 33 percent of all participants. Table 5.13 summarizes the emerging sub themes from interview question fourteen.

Table 5.13

Emerging Sub Themes from Interview Question Fourteen.

<table>
<thead>
<tr>
<th>Question 14 Emerging Sub Themes</th>
<th># Of Participants Who Mentioned It.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pre-existing conditions</td>
<td>8</td>
</tr>
<tr>
<td>Kids &lt;26 staying on their parents’ insurance</td>
<td>5</td>
</tr>
</tbody>
</table>
5.1.13. Emerging Sub Themes from Question Fifteen

Four common sub themes emerged from the responses provided to interview question fifteen. The first sub theme was the Affordable Care Act “took away people’s choice.” Five participants (P01, P02, P04, P09, & P11) shared this sub theme. The second sub theme was the Affordable Care Act “went against people’s values.” The same five participants (P01, P02, P04, P09, & P11) also shared this sub theme. The third sub theme was the Affordable Care Act “resulted in increased premiums.” Five participants (P02, P07, P08, P09, & P11) shared this sub theme. The fourth sub theme was “make the Affordable Care Act simpler.” Two participants shared this sub theme (P01 & P04)

There were six additional sub themes mentioned once in participant responses but were prevalent in literature review. The first sub theme was the Affordable Care Act “caused delays in payments to doctors and hospitals.” The second sub theme was more radical in its approach. It was “scrap off the whole Affordable Care Act.” The third sub theme was the Affordable Care Act should “provide incentives for doctors to do their work.” The fourth sub theme was “people need to pay higher premiums for lifestyle diseases.” The fifth sub theme was “revise the subsidy system.” The sixth sub theme was the Affordable Care Act needs to help “people driving long distances for specialized care,” especially those from small and rural communities. Table 5.14 summarizes the emerging sub themes from interview question fifteen.
Table 5.14

Emerging Sub Themes from Interview Question Fifteen.

<table>
<thead>
<tr>
<th>Question 15 Emerging Sub Themes</th>
<th># Of Participants Who Mentioned It.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA took away people’s choice</td>
<td>5</td>
</tr>
<tr>
<td>ACA goes against people’s value systems</td>
<td>5</td>
</tr>
<tr>
<td>ACA resulted in increased premiums</td>
<td>5</td>
</tr>
<tr>
<td>ACA needs to be simpler</td>
<td>2</td>
</tr>
<tr>
<td>ACA resulted in payment delays to doctors</td>
<td>1</td>
</tr>
<tr>
<td>Scrap off the Affordable Care Act</td>
<td>1</td>
</tr>
<tr>
<td>Give doctors incentives to do their work</td>
<td>1</td>
</tr>
<tr>
<td>Pay higher premiums for lifestyle diseases</td>
<td>1</td>
</tr>
<tr>
<td>Revise the subsidy system</td>
<td>1</td>
</tr>
<tr>
<td>ACA resulted in people driving long distances for services</td>
<td>1</td>
</tr>
</tbody>
</table>

5.2. Major Themes

In this section, the researcher presents a summary of the major themes from 15 participants and across all 15 questions. The researcher analyzed the sub themes and collapsed them into major themes. Sixty-six initial headings, sub headings, and sub themes emerged from interview data. The initial headings and sub headings were analyzed and grouped into seven major themes. The seven major themes were further grouped into three sections; themes in favor of the Affordable Care Act (positive), themes against the Affordable Care Act (negative themes), and neutral themes. There were two positive themes, four negative themes, and one neutral theme. There were no mixed themes. It is important to note that in this research, the Affordable Care Act was referred to 132 times in a positive way (21 percent) and 508 times in a negative way (79 percent).
5.2.1. Old System need to be fixed

The first major theme that emerged was "the old system needed to be fixed." This theme was considered to be neutral since it was not for or against the Affordable Care Act. It was mentioned 28 times by participants. Participants felt that the “old system was too expensive” and needed to be fixed. The phrase “old system was too expensive” was mentioned by 11 participants in response to question seven. This represented 73 percent of all participants. It was also mentioned by four participants in response to question three, and by one participant in response to question six. The need to fix the old system referred to high premiums and the system insurance companies used to establish premiums.

Participant 5 talked about how healthcare costs were constantly increasing yearly whilst income was following behind:

"I believe the old system was good but was in serious need of tweaking. The challenge with the previous system is that healthcare costs were increasing by around 10 percent each year and people’s income could not match that. There was a large group of people who were uninsured and that was not right."

Similarly, Participant 7 also said the old healthcare system was broken and needed to be fixed:

"Our previous healthcare system was becoming very expensive. At some point, the system was going to burst at its seams. Cost of health insurance was going up faster than people’s income… Now, I am the first one to tell you that health insurance prior to the Affordable Care Act was broken and needed to be fixed."

Participant 8 said, "I used to pay more money on a monthly basis before Obamacare."

Participants 7 and 8 concurred that increasing costs was a major problem with the old healthcare system. Participant 9 said, "I liked the old healthcare system but it was
becoming too expensive." Participant 12 also stated that the old healthcare system was becoming too expensive:

The old system definitely needed to be fixed. The cost of providing health insurance was going up by an average of 15 percent each year. Most employers were passing on about 10 percent of that cost to the employees. At some point, this was going to cause a train wreck. The system definitely needed to be fixed.

Participant 13 concurred that the old healthcare system had become too expensive:

I think everyone agrees that the old healthcare system was becoming too expensive for most people. Health insurance costs were increasing faster than people’s salaries could cope with. Healthcare was the leading cause of bankruptcy in this country. It was a system of ‘have’s and have nots.’ At some point, we were going to hit a tipping point where the uninsured number of people was going to be considerably high such that leaders would not ignore it.

Participant 8 added that lack of communication between different health insurance companies and healthcare providers was prevalent in the old healthcare system:

There was no coordination between healthcare providers. For example, if there was a patient on both Medicaid and Medicare, Medicare did not know what medical services were provided through Medicaid and what charges were paid by Medicaid. A healthcare provider could provide a service and bill Medicare then turn around and provide a similar service and bill Medicaid. That was not right.

Participant 8 also talked about the challenges with increasing costs in the old healthcare system:

Well, the problem with the old healthcare system is that costs were increasing faster than people could afford. At some point, there was going to be a national crisis where a majority of the people would either be on Medicaid or go without health insurance.

Participant 14 talked about how unfair the old system was in establishing insurance premiums:

Insurance companies could basically charge you more if you were sicker and less if you were healthier. They could charge different premiums by gender. Young females with maternal claims were definitely more expensive than generally young males. You could also deny someone coverage if you felt that their pre-
existing condition could be too expensive to insure. The health insurance market was kind of like the Wild West and there was no subsidies to help people with paying premiums. You pretty much had to pay all those premiums with after-tax money.

Participant 14 also talked about how insurance costs were rising steadily before the implementation of the Affordable Care Act and continued to rise after the implementation:

Health insurance in this country has been on the rise for a while now. This created a national concern on the affordability and accessibility of healthcare services. Healthcare costs were increasing by between 9 percent and 20 percent yearly. Most of these costs were passed on to the employee and it was becoming a burden on employees out there.

Participant 14 added that while the healthcare costs were rising steadily yearly, the quality of healthcare was not improving. There was a situation whereby costs were increasing but quality of healthcare was not improving:

The quality and cost of healthcare in American was in bad shape and needed some attention. So that part of the deal to me needed to be fixed. There is no doubt about the fact that the old healthcare system seriously needed some attention. Cost of health insurance was always rising and it was becoming apparent that many people were soon going to not afford it.

Participant 14 explained how the old system lacked a centralized health information system. This lack of a centralized health information system resulted in duplication of services by providers and unnecessary additional cost to the patient:

There was no central system where doctors and hospitals could check the medical services a person who walked into their doors had received a few weeks ago. That was a challenge because it resulted in duplicate tests and examinations. There was no centralized health information system where doctors and hospital systems could check if a patient visited their emergency room.
Participant 7 added, "I would say that the old system needed some changes to make it better." Participant 15 talked about how premiums in the old healthcare system kept increasing:

We had a circumstance that small employers were facing rate increases of 7 percent to 15 percent per year prior to the Affordable Care Act. Increasingly, it was unaffordable to them and they could not compete in their marketplace. We sell what is referred to as an offer rate.

In addition to the ever-increasing premiums, participant 15 also talked about the declining offer rate. The offer rate is the percentage of employers offering employee health insurance benefits. Participant 15 had the following to say about the declining offer rate:

The offer rate had declined considerably, and in some jurisdictions down to 30 percent to 40 percent. So you had two thirds of the smaller employers saying we cannot just afford to offer health insurance. Those that offered it, offered it with a pretty high employee out of the pocket contribution through payroll deduction. Employee share could easily be a third of the premium.

The low offer rate problem was compounded by the inability of employees of small businesses failing to take the offered coverage due to high premiums. Participant 15 explained:

So the percentage of the employees actually taking the coverage among those small employers offering it was relatively small. I am going to guess and say it was around 60 percent to 70 percent. So if you think about all the employees working for small companies, way over half were not purchasing small group health insurance. Given a situation where 30 percent to 40 percent of small businesses were offering health insurance and 60 percent to 70 percent of their employees were actually affording the premiums and deductibles, the actual number of employees of small businesses accessing health insurance through small employers was very small.
For illustration purposes, if one takes 100 small businesses with 50 employees each, that is a total of 5,000 employees. If these small businesses have an offer rate of 30 percent, it means that only 30 out of 100 small businesses offer health insurance to their employees. That amounts to 1,500 employees who work for small businesses who have access to health insurance. If 60 percent of the 1,500 employees afford the premiums and take health insurance coverage, that brings the actual number of insured employees to 900 employees. The rest (4,100 employees) either do not have access to health insurance coverage because their employers do not offer it or they cannot afford the premiums. So the combination of lower offer rates and high premiums resulted in few small businesses employees having health insurance. Based on the responses provided, 73 percent of the participants believed that the old healthcare system needed to be fixed.

Participant 15 further talked about how cost sharing was changing and how Health Savings Accounts (HSAs) were on the increase:

The coverage itself was growing in terms of what we call the cost share. Cost share refers to the member’s deductible and co-pay, that sought of thing that you pay out of pocket related to a particular service. So that was also growing in the advent of high deductible plans and HSAs. HSAs were becoming popular and they remain popular even today.

5.2.2. Premiums Increased

The second major theme was the Affordable Care Act resulted in "increased Premiums." The theme "the old system needed to be fixed" provided a background to people’s views and perceptions about the old system before the implementation of the Affordable Care Act. With 73 percent of participants concurring that the old system
needed to be fixed, it is logical to conclude that the majority of people wanted the old healthcare system to be improved.

When the Affordable Care Act was introduced, people assumed that premiums were going to go down. However, based on 93 percent of the participants (14 out of 15), premiums for most people went up. The word “premium” was mentioned 172 times and the phrase “premiums increased” was mentioned 45 times. In response to question nine, it was mentioned by 14 participants (93 percent of all participants), by eight participants in response to question ten (53 percent of all participants), by six participants in response to question six (40 percent of all participants), by six participants in response to question three (33 percent of all participants), by five participants in response to question fifteen (33 percent of all participants), by two participants in response to question three, by two participants in response to question seven, and by two participants in response to question five. In response to the question, "What were some unexpected consequences of the Affordable Care Act," eight out of 15 participants said premiums increased. This represented 53 percent of all participants.

5.2.3. ACA Had Positive Outcomes

The third major theme that emerged was the Affordable Care Act had “positive outcomes.” It was mentioned 43 times. This theme was created by collapsing several subthemes together. The first subtheme under this major theme was the Affordable Care Act “allowed kids under 26 years to stay covered by their parents’ insurance.” Participants mentioned this subtheme 18 times. It was mentioned by eight participants in response to
question nine. This represented 53 percent of all participants. It was also mentioned by five participants in response to question 14, by three participants in response to question seven, and by two participants in response to question six.

It is important to note that by allowing kids under 26-year old to be covered by their parents’ insurance, it reduced the number of young and healthy people who should have obtained health insurance through the exchange. This provision contradicted the assumption that many young and healthy people would join the exchange, thereby helping to lower the exchange premiums.

The second sub theme under this major theme was the Affordable Care Act “provided more health insurance choices.” This sub theme was mentioned ten times. Participants who shared this sub theme appreciated the fact that people who bought health insurance through the exchange had the ability to choose their coverage, premium, and deductible to a certain extent. In the old healthcare system, every employee paid the same premium. The insurance agent and the employer agreed on what premiums they were going to offer and employees elected either to take it or leave it.

The third sub theme was the Affordable Care Act “resulted in more people with health insurance.” This sub theme was mentioned seven times. It is important to point out that this response came mainly from participants who worked in the medical profession. The fourth sub theme was the Affordable Care Act “increased our business.” Five participants mentioned this sub theme. It is important to point out that all the five participants who shared this sub theme worked for health insurance companies. The fifth sub theme was the Affordable Care Act “saved us money.” Three participants mentioned
this sub theme. Table 5.15 summarizes the sub themes that were collapsed to form the
major theme the Affordable Care Act “had positive outcomes.”

Table 5.15

<table>
<thead>
<tr>
<th>Sub Theme</th>
<th># of Times Theme Was Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kids under 26 covered by parents</td>
<td>18</td>
</tr>
<tr>
<td>ACA provided more insurance choices</td>
<td>10</td>
</tr>
<tr>
<td>ACA resulted in more people with insurance</td>
<td>7</td>
</tr>
<tr>
<td>ACA increased our business</td>
<td>5</td>
</tr>
<tr>
<td>ACA saved us money</td>
<td>3</td>
</tr>
</tbody>
</table>

5.2.4. ACA Caused Frustration, Fear, and Confusion

The fourth major theme that emerged was the Affordable Care Act caused
“frustration fear, and confusion.” This theme was created by collapsing six sub themes.
The first sub theme was the Affordable Care Act caused “frustration.” This sub theme
was mentioned 11 times. It was mentioned by six participants (repeated by participants
P02, P03, & P12), by two participants in response to question four, by two participants in
response to question 12, and by one participant in response to question 15. It referred to
the feeling people had as they tried to obtain health insurance through the exchange but
failed due to computer challenges during the rollout. It also referred to the feeling people
had due to lack of reliable sources of information.

The second sub theme was the Affordable Care Act resulted in “fear.” This sub
theme was mentioned 44 times. It referred to people’s fear of government audits by the
Department of Labor. The third sub theme was the Affordable Care Act created
“confusion.” This sub theme was mentioned 22 times. It was a result of people not
knowing whether they were insured after signing up for insurance at the exchange. It also referred to confusion about who qualified for federal subsidies. The Affordable Care act law document is so huge such that people were not confident they knew everything in it.

The fourth sub theme was the Affordable Care Act resulted in “uncertainty.” This sub theme was mentioned 8 times. It emanated from lack of information on the audit requirements and whether employers would be audited, found owing, and have to pay the federal government large sums of money. Uncertainty was also a result of whether the Affordable Care Act was going to be permanent or the next president would come in and eliminate it or make major changes.

The fifth sub theme was the Affordable Care Act caused “anger” among people. This sub theme was mentioned three times. This sub theme was a result of the preceding sub themes. Fear, Confusion, frustration, and uncertainty resulted in anger as people attempted to find answers to their questions. The sixth sub theme was the Affordable Care Act resulted in “mistrust and misunderstanding.” This sub theme was mentioned once but was also common in literature review. Table 5.16 summarizes the sub themes collapsed to build the main theme “fear, frustration, and confusion.”

Table 5.16

<table>
<thead>
<tr>
<th>Main Theme: Fear, Frustration, and Confusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub Themes</td>
</tr>
<tr>
<td>Fear</td>
</tr>
<tr>
<td>Confusion</td>
</tr>
<tr>
<td>Frustration</td>
</tr>
<tr>
<td>Uncertainty</td>
</tr>
<tr>
<td>Anger</td>
</tr>
<tr>
<td>Mistrust and misunderstanding</td>
</tr>
</tbody>
</table>
5.2.5. Unnecessary Government Interference

The fifth major theme that emerged was the Affordable Care Act was unnecessary “government interference.” This major theme was built by collapsing five sub themes. The first sub theme was the Affordable Care Act was “unnecessary government interference.” It was mentioned six times; four times in response to question four, once in response to question three, and once in response to question nine. Participants felt that the government had no business in telling people where to get their medical treatment, when to get it, and how much they should pay.

The second sub theme was the Affordable Care Act introduced “more rules and regulations.” This sub theme was mentioned ten times. The third sub theme was the Affordable Care Act resulted in “more government paperwork.” It was mentioned 14 times; eight times in response to question four, two times in response to question six, and four times in response to question eight. This sub theme referred to the paperwork employers had to complete to stay compliant with the Department of Labor.

The fourth sub theme was the Affordable Care Act resulted in more “government fines.” This sub theme was mentioned twenty-six times. The sixth sub theme was the Affordable Care Act focused on “compliance” and not reducing the cost of healthcare and improving the quality of healthcare. This sub theme was mentioned 54 times. When people focus on compliance and not the intent of the proposed program, it results in people checking boxes and doing the minimum to get by. This reduces the effectiveness of the initiative. Table 5.17 summarizes the sub themes that were collapsed to form the main theme “government interference.”
Table 5.17

*Major Theme: Government Interference.*

<table>
<thead>
<tr>
<th>Sub Themes</th>
<th># of Times Theme was Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>54</td>
</tr>
<tr>
<td>Government fines</td>
<td>26</td>
</tr>
<tr>
<td>More government paperwork</td>
<td>14</td>
</tr>
<tr>
<td>More government rules and regulations</td>
<td>10</td>
</tr>
<tr>
<td>Government interference</td>
<td>6</td>
</tr>
</tbody>
</table>

5.2.6. ACA Made Things Worse

The sixth major theme that emerged was the Affordable Care Act “made things worse.” This theme was mentioned 135 times. It was built by collapsing several sub themes. The first sub theme was the Affordable Care Act “made things worse.” This sub theme was mentioned 46 times. The second sub theme was the Affordable Care Act “narrowed networks.” This sub theme was created by collapsing other sub themes that were mentioned 20 times: narrowed networks mentioned five times, and affected rural communities mentioned 15 times.

The third sub theme was the Affordable Care Act “made it difficult for the middle class.” This sub theme was mentioned 19 times. Most participants felt that the Affordable Care Act met the needs of low income people who were already covered by Medicaid but did little to meet the healthcare needs of the middle class who barely qualified for subsidies but do not make enough money to afford insurance. The fourth sub theme was the Affordable Care Act “lacked choice and forced people to get insurance.” This sub theme was mentioned 15 times. Participants felt that the Affordable Care Act affected people’s choice of medical services. The fifth sub theme was the Affordable Care Act
“had computer problems” during its rollout. This sub theme was mentioned five times.

The sixth sub theme was there was “poor communication” and this sub theme was
mentioned once. Table 5.18 summarizes the sub themes of the main theme the Affordable
Care Act “made things worse.”

Table 5.18

*Major Theme: ACA Made Things Worse.*

<table>
<thead>
<tr>
<th>Sub Themes</th>
<th># Of Times Theme Was Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA made things worse</td>
<td>46</td>
</tr>
<tr>
<td>ACA narrowed networks</td>
<td>20</td>
</tr>
<tr>
<td>ACA made it difficult for the middle class</td>
<td>19</td>
</tr>
<tr>
<td>ACA lacked choice</td>
<td>15</td>
</tr>
<tr>
<td>ACA launching had computer problems</td>
<td>5</td>
</tr>
<tr>
<td>Poor communication</td>
<td>1</td>
</tr>
</tbody>
</table>

5.2.7. ACA Eliminated Pre-existing Conditions

The seventh major theme was the Affordable Care Act “eliminated pre-existing
conditions.” Participants mentioned this theme 86 times. It is important to note that this
theme was mentioned by 14 out of 15 participants as a positive outcome of the
Affordable Care Act (93 percent of all participants). It was mentioned by 12 participants
in response to question nine. This represented 80 percent of all participants. Eight
participants (53 percent of all participants) mentioned it in response to question 14. Four
participants mentioned it in response to question seven, three participants in response to
question three, three participants in response to question 12, and one participant in
response to question eight.
Based on the responses by participants, this theme was viewed as the most important benefit of the Affordable Care Act. There were no sub themes collapsed to make this main theme. It is important to point out that by eliminating pre-existing conditions and lowering their premiums, the extra cost was passed on to the young and healthy who obtained health insurance through the exchange. From the responses provided by participants, it appears that participants appreciated the elimination of pre-existing conditions but were not happy that the premiums for the young and healthy who obtained health insurance through the exchange increased as a result.

Table 5.19

<table>
<thead>
<tr>
<th>Summary of Major Theme</th>
<th># of Times Theme Was Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA made things worse</td>
<td>106</td>
</tr>
<tr>
<td>ACA had positive outcomes</td>
<td>43</td>
</tr>
<tr>
<td>ACA was government interference</td>
<td>110</td>
</tr>
<tr>
<td>ACA caused fear, frustration, and confusion</td>
<td>89</td>
</tr>
<tr>
<td>ACA resulted in increased premiums</td>
<td>45</td>
</tr>
<tr>
<td>Eliminated pre-existing conditions</td>
<td>86</td>
</tr>
<tr>
<td>Old system needed to be fixed</td>
<td>24</td>
</tr>
</tbody>
</table>

5.3. Recommendations to improve ACA

The last category under this section is recommendations. There were six recommendations to improve the Affordable Care Act. The first recommendation was the government needs to “expand networks.” This recommendation was mentioned 32 times. The second recommendation was the government needs to find a way to “protect faith-based organizations.” This recommendation was made three times. The third recommendation was the government needs to “revise the subsidy system,” especially the
employer mandate. This recommendation was mentioned three times. The word “revise” was mentioned 53 times in this research.

The fourth recommendation was people need to be held accountable for lifestyle diseases by making them pay higher premiums. This recommendation was made two times. It is important to note the word “lifestyle” was mentioned 17 times. The fifth recommendation was that the government should increase individual fines for people who choose not to obtain insurance and corporate fines for corporations which choose not to offer employee health benefits. This recommendation was mentioned three times. By raising individual and corporate fines, some participants felt it would deter individuals from not obtaining health insurance and also employers from not offering employee health benefits. It is important to point out that fines have never been a good motivator to make people do something.

The sixth recommendation was the government needs to “scrap off the whole Affordable Care Act.” This recommendation was mentioned two times. Table 5.20 summarizes recommendations given by participants to improve the Affordable Care Act.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th># Of Times</th>
<th>Recommendation Was Made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand networks</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Protect faith-based providers</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Revise the subsidy system</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Increase individual and corporate fines</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Higher premiums for lifestyle diseases</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Scrap off the whole Affordable Care Act</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
5.4. **Major Theme Categories**

The following section puts the seven major themes into three categories; themes in favor of the Affordable Care Act, themes against the Affordable Care Act, and neutral themes.

5.4.1. **Themes in Favor of the Affordable Care Act**

Two themes in favor of the Affordable Care Act emerged from data analysis. The first positive theme was the Affordable Care Act “had positive outcomes.” It had a total of 43 responses. This theme was created by collapsing several sub themes. The first sub theme was “kids under 26 years remained covered by their parents’ insurance.” This sub theme was mentioned 18 times. The second sub theme was the Affordable Care Act “provided more insurance choices.” This sub theme was mentioned ten times.

The third sub theme was the Affordable Care Act resulted in “more people with health insurance.” This sub theme was mentioned seven times. The fourth sub theme was the Affordable Care Act “increased our business.” This sub theme was mentioned five times. The fifth sub theme was “more people have health insurance” as a result of the Affordable Care Act. This sub theme was mentioned five times. The sixth sub theme was the Affordable Care Act “saved us money.” This sub theme was mentioned three times (see table 5.15 for more details).

The second theme in favor of the Affordable Care Act was the Affordable Care Act “eliminated pre-existing conditions.” This theme was mentioned 86 times. It was mentioned by 14 out of 15 participants as a positive outcome of the Affordable Care Act.
This represented 93 percent of all participants. Based on the responses given by participants, the elimination of pre-existing conditions was viewed as the most valuable benefit of the Affordable Care Act. There were no sub themes collapsed to develop this main theme.

It is important to note that the elimination of pre-existing conditions resulted in lowering of premiums for those who had pre-existing conditions. However, it may have contributed to the increase of premiums for those who did not have pre-existing conditions. One of the major assumptions of the Affordable Care Act was that a large number of young and healthy people would join the exchange and help maintain low premiums. Since that assumption did not materialize, it resulted in an increase in premiums for the few young and healthy who purchased health insurance through the exchange. While the total increase in premiums after the implementation of the Affordable Care act cannot be attributed to the elimination of pre-existing conditions (PECORI fees, $5.75 per employee per month, and transitional fees to name a few), the elimination of pre-existing conditions played a part in increasing premiums for the young and healthy.

5.4.2. Themes Against the Affordable Care Act

Four major themes emerged against the Affordable Care Act from the participants’ responses. The first negative theme was the Affordable Care Act “made things worse.” This theme was developed by collapsing six related sub themes. It was mentioned 106 times. Some of the sub themes were the Affordable Care Act; made things
worse (mentioned 46 times), narrowed networks (mentioned 20 times), affected rural and small communities (mentioned 19 times), lacked choice (mentioned 15 times), and had computer problems (mentioned five times), and poor communication (mentioned once).

Refer to table 5.18 for more information on the sub themes.

The second negative theme was the Affordable Care Act was “government interference.” This theme was developed by collapsing the following sub themes; government interference (mentioned 6 times), more government regulations (mentioned 10 times), more government paperwork (mentioned 14 times), government fines (mentioned 26 times), compliance (mentioned 54 times). This theme was mentioned 110 times. Refer to table 5.17 for more information on the sub themes.

The third negative theme was the Affordable Care Act resulted in “fear, frustration, and confusion” among people. This theme was mentioned 89 times. It was created by collapsing six sub themes together. The six sub themes were the Affordable Care Act resulted in; fear (mentioned 44 times), confusion (mentioned 22 times), frustration (mentioned 11 times), uncertainty (mentioned eight times), anger (mentioned three times), and mistrust and misunderstanding (mentioned once). Refer to table 5.16 for more information on the sub themes.

The fourth negative theme was that the Affordable Care Act resulted in “increased premiums.” Participants mentioned this theme 45 times. The word “premium” was mentioned 172 times. Based on the responses by most participants, increasing premiums was one major cause of the negative outcome of the Affordable Care Act. There were two responses that called for the total scrapping off of the Affordable Care Act.
5.4.3. Neutral Theme

There was one neutral theme and it was the “old healthcare system needed to be fixed.” Of the 15 participants, 11 of them concurred that the old healthcare system needed to be fixed. This represented a 73 percent of all research participants. There was a general consensus that the old healthcare system was getting out of control and needed serious attention. Several factors contributed to this situation. Some of the factors were increase in medical malpractice leading to increase in malpractice insurance, increasing cost of living, increasing pharmaceutical costs and hospital costs.

The old healthcare system also needed to be fixed due to what some participants called “unfair rate structure.” Women at child-bearing age were charged higher premiums than their male counterparts. People who attempted to shop around for health insurance faced numerous challenges on the open market. For those who were part of an insurance pool through an employer, premiums were averaged based on the pool one was part of. If one was healthy but was in a pool with people who have lifestyle habits such as smoking that adversely affect their health, they ended up paying similar premiums as smokers. If one person in the pool developed a chronic condition, it would cause premiums for the whole pool to increase.

5.5. Recommendations

This section addresses important issues that were raised by participants. These issues were not necessarily in favor of or against the Affordable Care Act but provided critical information.
5.5.1. Lack of Reliable Sources of Information

There was one major recommendation. It was there was “lack of reliable sources of information” concerning the Affordable Care Act. This recommendation was based on the responses to question 13 which asked for participants’ sources of information. The following were cited as sources of information on the Affordable Care Act by participants; insurance agents (mentioned 20 times), Department of Labor (mentioned 10 times), internet (mentioned 6 times), newspapers (mentioned 4 times), and professional associations (mentioned 3 times).

The above responses from participants show that 77 percent of the sources participants used were something other than the official source, the Department of Labor. The federal government could have done a better job in creating a single reliable source of reliable information on the Affordable Care Act. Having a single reliable source of information could have had a positive impact during the role out and early stages of the Affordable Care Act.

Based on the responses from participants, it appears that insurance agents played a major role in disseminating information to people. While insurance agents were deemed a reliable source of information on the Affordable Care Act, some participants were cautious. They felt that insurance agents may have been motivated by trying to sell a product. It is important to point out that insurance agents interviewed for this research obtained their information from the Department of Labor.

Participants mentioned lack of a reliable source of information during the roll out of the Affordable Care Act 46 times as a challenge. Instead of presenting this challenge as a theme, this researcher chose to present it as a recommendation.
CHAPTER 6. SUMMARY, OUTCOMES, AND IMPLICATIONS

This study elicited, described, and analyzed the lived experiences and perspectives of small businesses with the Affordable Care Act. The central questions were (1) what was the impact of the Affordable Care Act on small businesses; (2) did the Affordable Care Act extend coverage to the uninsured, include other medical services that were not covered before, and reduce cost sharing; and (3) what lessons can be learned from the implementation of the Affordable Care Act for future policy implementation? This study presented the results of the data analysis and themes that emerged from data analysis. This study also introduced each theme as it emerged from the data and provided the supporting narratives. This study concludes with a summary of the study, significance, conclusions, discussions of results, recommendations for future studies, and recommendations for future policy implementation.

6.1 Summary of this Research

Over the course of a twelve-month period, this researcher engaged 15 participants from Northwest Indiana in semi-structured audio-recorded interviews. The purpose was to elicit, describe, and analyze the lived experiences and perspectives of small businesses with the implementation of the Affordable Care Act by answering the research question, “What was the impact of the Affordable Care Act on small businesses in Northwest Indiana?” The researcher believed that understanding the perspectives and experiences of small businesses with the Affordable Care Act would shed light on understanding the impact of the Affordable Care Act on small businesses and make recommendations for future policy implementation.
6.1.1. Research Questions

The questions central to this research were:

1. What was the impact of the Affordable Care Act on small businesses and industries in Northwest Indiana?

2. Did the Affordable Care Act improve the breadth (extend coverage to the uninsured), the depth (include other medical services that were not covered before), and the height (reduce cost sharing) of healthcare?

3. What lessons can be learned from the implementation of the Affordable Care Act for future policy implementation?

6.1.2. Significance of this Research

Small businesses are the engine that drives the American economy. They create more jobs than major employers and export a considerable portion of their goods. Small businesses are key in fueling the American innovation. Given the critical role small businesses play in the American economy, it was important that more research be conducted on the impact of the Affordable Care Act on small businesses.

There has been a lot of research done on the impact of the Affordable Care Act. Much of the research was quantitative in nature. It used quantitative tools to analyze the financial impact of the Affordable Care Act and its impact on businesses. More research has been done on the impact of the Affordable Care Act on the quality of healthcare services. Limited research has been done to assess whether the Affordable Care Act improved the breadth, width, and height of healthcare services using qualitative methods.
Not everything in life can be quantified. Fear, anger, frustration, and confusion cannot be put in numbers. While it is true that it can be stated that 10 out of 15 people (67 percent) were afraid, the state (breadth and depth) of that feeling cannot be fully captured by statistical tools. It cannot be averaged. One cannot establish the mean, median, and mode of fear, frustration, and confusion. Such feelings and perceptions can only be narrated and presented in its qualitative state. That is one of the reasons why the researcher used the qualitative method.

Based on the above argument and the research questions the researcher intended to find answers to, the phenomenological approach was the most ideal method for this research. The researcher believed that people’s perceptions and feelings are important because they shape or become their reality. It is the hope of this researcher that this study posed more questions and created more curiosity and dialogue on this subject. The ultimate goal of the questions and curiosity raised by this study will lead to more qualitative research and dialogue on this subject and will bring about more answers on this subject.

6.1.3. Methodology of this Research

The researcher used qualitative research method in the form of interviews and observations. The goal was to elicit, describe, and analyze the lived experiences and perspectives of small businesses with the implementation of the Affordable Care Act. The method of inquiry was phenomenology. The researcher used a hybrid approach which included the grounded approach and the a priori approach (Charmaz, 2006 &
Strauss and Corbin, 1998) in an attempt to gain an understanding of the lived experiences and perspectives of the phenomenon.

6.1.4. Data Analysis

The researcher’s data analysis was guided by Opler’s (1945) three principles of analyzing themes. The researcher listened to the audio recordings, transcribed them, examined them, and distilled the data for emerging sub headings and headings that expressed participants’ perspectives and experiences with the Affordable Care Act. The emerging sub headings and headings were further collapsed into related headings which were formulated into sub themes and themes. The sub themes and themes were further collapsed into major themes. The major themes were divided into themes in favor (positive) of the Affordable Care Act, themes against (negative) the Affordable Care Act, and neutral themes.

6.2. Major Themes

Seven consistent themes emerged from the data. There were two positive themes, four negative themes, and one neutral theme. The two positive themes were the Affordable Care Act “eliminated pre-existing conditions and it had positive results.” The four negative themes were “government interference, premiums increased for most people, frustration, fear, and confusion, and the Affordable Care Act made things worse.” One neutral theme was the old healthcare system needed to be fixed. Participants also provided recommendations to improve to improve the Affordable Care Act.
6.3. **Impact of the Affordable Care Act on Small Businesses**

Seven major themes emerged from the data analysis. These themes were put into three categories; themes in favor of (positive), themes against (negative) the Affordable Care Act, neutral themes. There were no mixed themes. There were two positive themes, four negative themes, and one neutral theme. The first positive theme was the Affordable Care Act had some positive outcomes. The second positive theme was the Affordable Care Act eliminated of pre-existing conditions. The neutral theme was “the old healthcare system needed to be fixed.” However, nearly every participant felt that the Affordable Care Act did not fixe those problems.

The first negative theme was that the Affordable Care Act “made things worse.” Participants mentioned this theme 106 times. This was a prevalent feeling among most participants. The second negative theme was the Affordable Care Act was viewed by participants as “government interference.” This theme was mentioned 110 times. The third negative theme was the Affordable Care Act resulted in “fear, frustration, and confusion.” Participants mentioned this theme 89 times. The fourth negative theme was the Affordable Care Act resulted in “increased premiums.” Participants mentioned this theme 45 times.

Based on the majority of the responses from the 15 participants interviewed during this research, the Affordable Care Act was viewed in a negative light. Four of the seven themes that emerged from the data showed that people viewed the Affordable Care Act unfavorably. The Affordable Care Act was mentioned 132 times (26 percent) in a positive way and 508 times (73 percent) in a negative way. The impact of the Affordable Care Act on small businesses was deemed negative. While the Affordable Care Act was hailed for insuring about eighteen million people who were previously uninsured, the
general perception was there may be a considerable number of people who lost coverage because their premiums increased as a result of the implementation of the Affordable Care Act.

6.4. Recommendations for Future Policy Implementation

The following recommendations are for future government policy implementation.

*Explore the creation of a single source of up-to-date and reliable information on government initiatives.* Based on the responses from the participants, most participants got their information from a third source. Investing in a single reliable source of information for important government initiatives alleviates people’s fears. It will also reduce stress, fear, confusion, and uncertainty caused by misinformation or lack of information. If the federal government had a single reliable source of information on the Affordable Care Act, it appears about 74 percent of the research participants were not aware of it.

*Incentivize health insurance companies for competing across state boarders.* Due to several insurance companies pulling out of certain markets, there is lack of choice and competition. Lack of competition may result in price increases since insurance companies will be monopolizing certain regions. By incentivizing insurance companies to compete across states, it will provide more insurance choices and result in competition on price and quality.
Pilot test government initiatives in a few states or regions before implementing them nationally. Instead of implementing a massive federal government program across the whole country, it would be a good idea to pilot test the program or initiative in one state or region. This way, the federal government can fine-tune the program before rolling it nationwide. If the Affordable Care Act had been pilot tested in a few states before the national rollout, most of the challenges faced during the implementation phase (such as computer problems) would have been proactively resolved before the national rollout.

6.5. Recommendations for Future Studies

The following are recommendations for future study. As with any study, it is impossible to thoroughly explore and exhaust all relevant and potential topics under this study.

Investigation into the inverse relationship between improving the quality of healthcare and decreasing the cost of healthcare. The two actuaries interviewed for this study suggested that there is an inverse relationship between increasing the quality of healthcare and decreasing the cost of healthcare. Exploring and investigating this relationship promises practical solutions for the ever increasing cost of healthcare. This research may require more specialized skills in areas such as Actuary Science, Statistics, and Economics.

Investigation into the impact of the Affordable Care Act on the middle class. Some of the feedback from this study indicated that the Affordable Care Act negatively impacted the middle class. There seem to be limited research on the impact of the Affordable Care Act
on the middle class. These are families that are slightly above the cutoff point to qualify for subsidies but cannot afford health insurance premiums.

*Investigate ways to decrease premiums and increase offer rates.* Based on literature review and the responses provided by some participants, offer rates have been on the decline for the past 10 years. They are now at their lowest (30 percent to 40 percent). There is so much to explore on how to decrease premiums and increase offer rates.

*Investigate into ways to incentivize small businesses which are not mandated to offer employee health insurance to do so.* Based on some of the responses provided by participants, since the Affordable Care Act was implemented, there seem to be less motivation among small businesses to offer employee health insurance benefits because they are not “mandated” to do so. Small businesses used to provide health insurance before the implementation of the Affordable Care Act. When people stop doing good for the sake of doing good, society ultimately loses.

It is beyond the scope of this research to answer every question on the impact of the Affordable Care Act on small businesses. As I explored this study, I had more questions than my time and resources could allow to explore. Of greater significance to me was how the Affordable Care Act can reduce healthcare costs and improve the quality of healthcare at the same time. This to me, seems to be a promising research in terms of its usefulness and relevance to the current health market situation.
6.6. **Summary**

This chapter concluded this study by attempting to summarize its goals, findings, and recommendations. This chapter also presented answers to the research questions presented at the beginning and throughout this study. Evidence seem to indicate that the Affordable Care Act improved the breadth of healthcare services by extending coverage to the uninsured. However, there is no evidence to indicate that it improved the depth (benefits covered) and the height (proportion of the costs covered) of healthcare.

The researcher hopes that an inquisitive seed has been planted in the minds of many to curiously do more research on this topic. While this study sought to find answers to the research questions presented, the researcher will feel a sense of accomplishment if it created a kin interest in further research on this topic. The researcher hopes that this research, more than providing answers to the research questions presented, created more questions that will lead to more research. When a research results in more curiosity and questions, it eventually leads to more research. More research leads to more questions and more questions eventually lead to more answers. It is the hope of this researcher that this research has resulted in more questions and increased curiosity on this subject.
LIST OF REFERENCES


Navarro, V. (1989). Why some countries have national health insurance, others have national health services, and the US has neither. *Social Science & Medicine, 28*(9), 887-898.


The Kaiser Family Foundation and Health Research and Education Trust, 1997 Report.


APPENDIX A. IRB APPROVAL

To: LINDA NAIMI
   YONG 435
From: JEANNIE DICLEMENTI, Chair
      Social Science IRB
Date: 06/05/2015
Committee Action: Exemption Granted
IRB Action Date: 08/05/2015
IRB Protocol #: 1505016107
Study Title: Examining the impact of the Affordable Care Act on small businesses and industries in Northwest Indiana

The Institutional Review Board (IRB) has reviewed the above-referenced study application and has determined that it meets the criteria for exemption under 45 CFR 46.101(b)(2).

If you wish to make changes to this study, please refer to our guidance "Minor Changes Not Requiring Review" located on our website at http://www.irb.purdue.edu/policies.php. For changes requiring IRB review, please submit an Amendment to Approved Study form or Personnel Amendment to Study form, whichever is applicable, located on the forms page of our website www.irb.purdue.edu/forms.php. Please contact our office if you have any questions.

Below is a list of best practices that we request you use when conducting your research. The list contains both general items as well as those specific to the different exemption categories.

General
• To recruit from Purdue University classrooms, the instructor and all others associated with conduct of the course (e.g., teaching assistants) must not be present during announcement of the research opportunity or any recruitment activity. This may be accomplished by announcing, in advance, that class will either start later than usual or end earlier than usual so this activity may occur. It should be emphasized that attendance at the announcement and recruitment are voluntary and the student’s attendance and enrollment decision will not be shared with those administering the course.
• If students earn extra credit towards their course grade through participation in a research project conducted by someone other than the course instructor(s), such as in the examples above, the students participation should only be shared with the course instructor(s) at the end of the semester. Additionally, instructors who allow extra credit to be earned through participation in research must also provide an opportunity for students to earn comparable extra credit through a non-research activity requiring an amount of time and effort comparable to the research option.
• When conducting human subjects research at a non-Purdue college/university, investigators are urged to contact that institution’s IRB to determine requirements for conducting research at that institution.
• When human subjects research will be conducted in schools or places of business, investigators must obtain written permission from an appropriate authority within the organization. If the written permission was not
submitted with the study application at the time of IRB review (e.g., the school would not issue the letter without proof of IRB approval, etc.), the investigator must submit the written permission to the IRB prior to engaging in the research activities (e.g., recruitment, study procedures, etc.). This is an institutional requirement.

Category 1
- When human subjects research will be conducted in schools or places of business, investigators must obtain written permission from an appropriate authority within the organization. If the written permission was not submitted with the study application at the time of IRB review (e.g., the school would not issue the letter without proof of IRB approval, etc.), the investigator must submit the written permission to the IRB prior to engaging in the research activities (e.g., recruitment, study procedures, etc.). This is an institutional requirement.

Categories 2 and 3
- Surveys and questionnaires should indicate:
  - only participants 18 years of age and over are eligible to participate in the research; and
  - that participation is voluntary; and
  - that any questions may be skipped, and
  - include the investigator’s name and contact information.
- Investigators should explain to participants the amount of time required to participate. Additionally, they should explain to participants how confidentiality will be maintained or if it will not be maintained.
- When conducting focus group research, investigators cannot guarantee that all participants in the focus group will maintain the confidentiality of other group participants. The investigator should make participants aware of this potential for breach of confidentiality.
- When human subjects research will be conducted in schools or places of business, investigators must obtain written permission from an appropriate authority within the organization. If the written permission was not submitted with the study application at the time of IRB review (e.g., the school would not issue the letter without proof of IRB approval, etc.), the investigator must submit the written permission to the IRB prior to engaging in the research activities (e.g., recruitment, study procedures, etc.). This is an institutional requirement.

Category 6
- Surveys and data collection instruments should note that participation is voluntary.
- Surveys and data collection instruments should note that participants may skip any questions.
- When taste testing foods which are highly allergic (e.g., peanuts, milk, etc.) investigators should disclose the possibility of a reaction to potential subjects.
APPENDIX B. IRB PROTOCOL CHANGE LETTER

----- Forwarded Message ----- 
From: "Christa J Blevins" <cjblevin@purdue.edu>
To: "Linda L Naimi" <lnaimi@purdue.edu>
Cc: "Onias Muza Taruwinga" <otaruwin@purdue.edu>
Sent: Friday, June 5, 2015 2:39:36 PM
Subject: IRB Protocol 1505016107, "Examining the impact of the ..."

Hello Professor Naimi,

The above named protocol has been received and is currently in the review process.

Please be aware that this protocol qualifies for exemption and consent forms (signed consent) are not required for exempt research. As participants must still consent to participate in the voluntary research one option is to change the consent form so it reads “Information Sheet”. You can simply remove the signature lines and give each subject a copy of the information sheet prior to participating.

You should hear from our office soon regarding the status of the protocol. Please feel free to contact me with any questions.

Thank you,

Christa Blevins
Senior Protocol Analyst
Purdue University
Human Research Protection Program
Young Hall, Room 1036
765-496-6702
cjblevin@purdue.edu

CONFIDENTIALITY NOTICE: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information or otherwise protected by law. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.
APPENDIX C. INTERVIEW PROTOCOL

Introduction to the participant/Welcome Message:

Dear Participant,
Greetings from the Research Team consisting of Dr. Linda Naimi and Onias Taruwinga. We are a team of Technology, Leadership, and Innovation from the College of Technology, Purdue University. Our aim is to examine the impact of the Affordable Care Act on Small businesses and industries in Northwest Indiana with the goal of influencing future public policy implementation. To reach this aim, we have to understand your experience, perspectives, and meanings with the implementation of the Affordable Care Act. Your valuable participation will give us direction towards gaining a better understanding of the impact of the Affordable Care Act on small businesses and industries in Northwest Indiana.

I will be conducting the interview. The experiences and the information you will share with me today will be kept confidential and will be accessed only by Dr. Naimi and myself. Also, as noted in your information sheet, specific measures will be taken to protect your identity and all identifiers will be removed from your responses.

I appreciate your willingness to participate in an interview and a demographic questionnaire that will take 40-60 minutes. Please note that your participation in the interview process is voluntary. If you agree to participate, you have the option to withdraw at any point of time without any penalty. Do you have any questions before we begin?

Thank you for your time and participation.
APPENDIX D. CONSENT FORM

RESEARCH PARTICIPANT INFORMATION SHEET
Examining the impact of the Affordable Care Act on small Businesses and industries in Northwest Indiana, USA.
Linda Naimi, Associate Professor
Technology, Leadership, and Innovation
Purdue University

What is the purpose of this study?

- This research aims to examine the impact of the Affordable Care Act on small businesses and industries in Northwest Indiana, USA.
- Funding for this research will come from the student researcher and the Technology, Innovation, and Leadership department at Purdue University, West Lafayette, Indiana, USA.
- The individuals are being asked to participate in this study because the researcher is making an assumption that government policies impact (negatively and positively) on small businesses and industries in Northwest Indiana, USA.
- I plan to enroll 40 people in this study.

What will I do if I choose to be in this study?

After signing this Consent Form, you will be interviewed by the researcher, and then fill a demographic questionnaire. These questions in the interview include your perceptions of the Affordable Care Act, how the use of technology facilitated or failed to facilitate the implementation of the Affordable Care Act, and how it has impacted your and the way you do business. The researcher will describe the project and seek your consent for participation and also recording the interview. The interviews will be conducted in a comfortable place of your choice. The interview session will take approximately 40 minutes.

How long will I be in the study?

The interview session will take approximately 40 minutes and the demographic questionnaire will take 10 minutes. With your permission, the researcher will contact you later for follow up questions.

What are the possible risks or discomforts?

This research possess minimum risk to you which is no greater than everyday activities. There is risk of breach of confidentiality. Safeguards are in place to minimize the risk of breach of confidentiality, as outlined in the confidentiality section.
Are there any potential benefits?
There are no direct benefits to you for participating in this research project.

What alternatives are available?
Not applicable.

Will I receive payment or other incentive?
There is no incentive or payment for participating in this research project.

Are there costs to me for participation?
There are no costs associated with participating in this research project.

What happens if I become injured or ill because I took part in this study?
Not applicable.

Conflict of Interest Disclosure
Not applicable.

Will information about me and my participation be kept confidential?

Please note that the research activity is not anonymous, but we will take steps to keep your interviews confidential. Your interview recordings will be transcribed and deleted after the study results have been analyzed. The transcriptions will be saved as word documents on a password protected standalone personal computer and a password protected memory stick belonging to the researchers and accessed by them only. All data will be kept in a locked room on Purdue campus. All the transcripts shall remain confidential and all identifiers will be removed from the data so that no information/response can be traced back to you. Your responses might be used for other research in the future. The transcriptions will be stored for at least ten years from the date of research after which the data will be destroyed. Also, the project’s research records may be reviewed by departments at Purdue University responsible for regulatory and research oversight.

Certificate of Confidentiality
Not applicable.

What are my rights if I take part in this study?
Your participation in this study is voluntary. You may choose not to participate or, if you agree to participate, you can withdraw your participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Who can I contact if I have questions about the study?
If you have questions, comments or concerns about this research project, you can talk to one of the researchers. Please contact Dr. Linda Naimi at her office number (765) 496 6939, Fax (765) 496 2519, Email, naimi@purdue.edu, or Onias Tanuwings at his phone number (574) 870 4744, email otanuwins@purdue.edu

If you have questions about your rights while taking part in the study or have concerns about the treatment of research participants, please call the Human Research Protection Program at (765) 494-5942, email (hrp@purdue.edu) or write to:
Human Research Protection Program - Purdue University
Ernest C. Young Hall, Room 1032
155 S. Grant St,
West Lafayette, IN 47907-2114

I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research study, and my questions have been answered. I am prepared to participate in the research study described above. I have been offered a copy of this information sheet.
APPENDIX E. INTERVIEW QUESTIONS

1. What is your position in this organization?
2. How long have you worked here?
3. How would you characterize your medical benefits and health care coverage prior to the implementation of the Affordable Care Act?
4. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?
5. Please describe your experience with the Affordable Care Act.
6. Overall, did the Affordable Care Act make things better or worse for you? Please explain.
7. If you had been given the choice, would you have opted to go with the Affordable Care Act or stay with your previous health care system?
8. From your perspective, what has been the impact of the Affordable Care Act on your work/business?
9. What aspects of the Affordable Care Act do you like/don't you like?
10. What were some unexpected consequences of the Affordable Care Act?
11. What benefits have you realized with the implementation of the Affordable Care Act?
12. What challenges have you faced with the implementation of the Affordable Care Act?
13. What has been your sources of information concerning the Affordable Care Act?
14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?
15. If the Affordable Care Act was to be revised, what aspects would you want to be revised?

Closing

Thank you for allowing me to interview you today. It has been a pleasure speaking with you. Thank you for sharing your thoughts and experiences regarding the Affordable Care Act and how it has impacted your life and work. Your responses will be very helpful in this research. If I have any additional questions, would it be okay if I contact you for follow up or clarification?

Thank you again for your time and participation.
APPENDIX F. INTERVIEW DATA

Participant 01

Q01. First of all, I just want to thank you for taking time out of your busy schedule to meet with me. I know you have a busy schedule and I really appreciate your willingness to meet with me. Like I stated in our phone conversation, I am a PhD student at Purdue University in the College of Technology. My research focus is examining the impact of the Affordable Care Act on small businesses.

P01. Interesting topic. Why did you choose this particular topic?

Q01. Well, there are several reasons why I chose this topic. I have worked in the healthcare industry for 16 years. Currently, there is a lot of debate going on concerning the Affordable Care Act, also commonly referred to as Obamacare. I am interested in finding out what is really going on the ground.

P01. Interesting. So, what have you found out so far?

Q01. Well, you are my first participant in this research. I am also curious to find out about your experience. What is your position in this business and how long have you worked here?

P01. Well, I own this dental practice. I have owned it since 2007. I started practicing in 1997 and bought this business in 2007. So, I am going into my tenth year of owning the practice. We have been in this location since 2011. This is our fourth year in this location. My wife went to high school here. She went to nursing school and that is where we met. I am a native of Merryville Indiana. Before I came to this town, I did some work in Southern Indiana for one year. We moved up here when we got married.

Q01. Does your dental practice offer medical insurance benefits to your employees?

P01. Uh, medical insurance is an interesting subject. What happened is when the Affordable Care Act came out, uh, this is a great subject. I am a member of the Indiana Dental Association (IDA). I am also a member of the American Dental Association (ADA). This is a national organization across the whole country. The ADA is located in Chicago and the IDA is located in Indianapolis.

Q03. OK. How would you characterize your medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?

P01. Well, things were better before the Affordable Care Act was introduced. Premiums and co-pays were affordable and people were not forced to pay for services or provide services that were against their value system. There were things that needed to be fixed with our health insurance system, but everyone had access to healthcare. You could walk into the emergency room and receive care. The IDA had a plan through Blue Cross Blue Shield and it was a good plan. When the Affordable Care Act came out, the Indiana Dental Association jumped on board and said we are going to be self-funded. They knew the challenges that were coming with the exchanges. They knew that the financial power of the group was such that when they looked at things, we were better off going to a
self-funded plan. That has been in place for a year and we have done well. They have made some changes. There has been less coverage on simple things. I have been blessed. My family has been healthy. We have had no children with major issues and have been healthy. What happened is the IDA decided that if we can pay into this fund, it can pay for itself through interest earned. What happened is that the private sector, in this case Blue Cross Blue Shield, did not want to lose our business.

Q03. Interesting. So what did they do?
P01. You see the insurance companies don’t like this because they know that people would be jumping around and shopping around. With this craziness, they would lose business. If we were going onto the exchange, it was not going to be underwritten by them. So what they did is they worked with the IDA group. The dentists who lead the IDA have a lot of knowledge because we dentists work with insurance a lot.

Q03. OK.
P01. What they did is they worked out a relationship with each other; the insurance company and the IDA. They said we will do business with you. You are still going to be profitable. However, IDA would be funding the full amount in the insurance. They did not go into a catastrophic type coverage with Blue Cross Blue Shield.

Q03. I see.
P01. They get some administrative income with many people in the plan. The nice thing about it is that it was a great arrangement. Uh, my coverage about stayed the same.

Q03. So how much were you paying in premiums prior to the Affordable Care Act?
P01. Well, yes it was a similar premium. My plan has not changed that much. I am solid. If you look at people covered under this plan from an insurance point of view, hospital or physician’s office point of view, or someone who wants to send a medical claim, they like it because we are regarded as a PPO. I can choose any hospital I want to go to. It is not like some of these plans that are coming out where I have to go to certain hospitals. Their choices are limited. I got something in the mail and IU Health is developing their own plan. They will know what the coverage is, they understand the cost, and there is no administration fees. They have similar relationships with other insurance companies, I assume. But they know that when you need medical services, you will have to go to an IU hospital.

Q03. So this is guaranteed business for them.
P01. Yah. So I would say one impact of the Affordable Care Act I have seen outside the dental field is that there has been a lot of time, money, and energy wasted because businesses are trying to flex their muscles. I do know that with pharmacy changes, there has been some challenges. For example, you can get a Z-Pack of three pills but not a pack of five pills. Insurance companies will not cover a pack of five pills even though your doctor says you need 5 pills. The pharmacies cannot refill it right away. You have to go back to your doctor for
another script and you will have to pay out of pocket. This is just one of those
changes that are crazy. No logic to it whatsoever.

Q03. OK. Interesting.
P01. That is one little change in one area that I can think of. There has been some
changes on the insurance side and benefit plans because they knew they were
going to receive less money. So you get unto a plan but you are not familiar with
what it covers. The nice thing with our plan is that we still have great coverage
because we are paying into the IDA. In that situation, it has been a good
situation for us.

Q03. I see.
P01. We know that as claims are paid out of the interest from this fund, we are going
to be powerful as we shop around. Or we may be able take care of ourselves
through self-funding.

Q03. Interesting
P01. So IDA has done a great job with responding to the Affordable Care Act. I think
when you first do this, you are holding your breath as a group and you pray that
you do not have a major claim until you build a good cash reserve. It is like
investing. When I went to the IDA West Central meeting, I learned that people
who had major claims and major health issues prior to the exchange were a good
match for the Obamacare. This is because they were going to get coverage
outside the network without many major limitations. There are some legal
measures that have been put in place. For instance, I have a staff member who
needs a different coverage. So to answer your question, I do not provide health
insurance to my staff. I could not match it because other staff did not want to
pay for certain coverage, yet people that needed that particular coverage could
not have it. In other words, I could not come up with a plan with coverage that
would meet everyone’s needs and preferences. Now someone has started it
again. The IDA has changed. For whatever reason, the requirements are that
everyone has to apply for health insurance.

Q03. So your staff have to apply to the IDA for health insurance coverage?
P01. Yes, they have to apply to the IDA for health insurance. They are in the process
of applying since you and I talked two weeks ago. They are in the process of
doing it to come up with some plans for some few key individuals who may not
have health insurance through their spouses or have medical challenges. The
problem with this is that when you have insurance in general, when you get a
single female or male, or someone working here who does not have health
benefits through a spouse and have a pre-existing condition, it gets really hard to
find coverage for yourself.

Q03. Is it because you have a small pool and the risk is not spread among many
people?
P01. Yes. Yes, you are right. That is what we are trying to do right now. They came
back to me and said, you know I would consider helping an individual with their
pay and other things. May be help them with their medical bills. It has always
been a challenge as an employer. Most of the people that work for me have
health insurance with their spouses or someone else. I know Obamacare has the 26-year mark for children when they are not married. That has helped to some extent. They can stay on their parents’ health insurance until they are 26 years old. I do not know the exact details of the plan but I know they can stay on their parents’ health insurance plan until they are 26 years old or get married. I know that has helped a lot of young people who are not yet married and whose employers do not offer health insurance benefits. I am not sure what the cost has been to the parents and to the health insurance system as a whole.

Q03. OK.

P01. And to the insurance and others, I do not know what all their plans are. I know in my head, common sense tells me that there is nowhere you can pass the law to provide health insurance to the people without someone paying for it, having an increase in premiums, reduction in benefits, or have providers suffer. So what has happened is that those with pre-existing conditions are no longer denied health insurance coverage but those who are healthy have seen their premiums go up to cover for others. It appears like the goal was to have hundred healthy people take care of the five unhealthy people but that has not been the result. The money to cover those with pre-existing conditions has to come from somewhere.

Q04. When you first learned that you had to comply with the Affordable Care Act, what went through your mind?

P01. Well, government bureaucracy again. The government reaching out its hand into our pockets, taking our money, and telling us what to do. More government controls and infringing on people’s rights. I also knew that there was going to be a lot of rules and regulations to follow, failure of which would result in hefty fines.

Q05. Please describe your experience with the Affordable Care Act.

P01. Well, a lot of work to stay compliant and the cost associated with that. The law is complicated and it seems as if no one knows what we are supposed to do. No one knows how we will be audited. In my view, they took a system that was working and needed to be tweaked and overhauled and made it worse. We are incurring a lot of costs related with compliance. We are spending a lot of time focusing on compliance instead of improving the quality of patient care.

Q06. Overall, did the Affordable Care Act make things better or worse for you? Please explain.

P01. Definitely worse. How can things be better when I am paying more to provide the same services? How can things be better when I am expected to do more paperwork to stay compliant? How can things be better when I am expected to do more and still get paid the same amount of money? The idea of centralized electronic record keeping sounds good, but when it comes from the federal government, it makes one wonder what their actual goal is. If used properly, that is the only good thing that will come out of this whole mess.

Q07. If you had been given a choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?
P01. Definitely, the old system needed some help, but I believe it was much better than the mess they created. Given a choice, I would have opted to stay in the old system and suggest some calculated changes to make it more transparent and increase accountability. May be the Affordable Care Act will improve with time but as of right now, I would definitely opt for the old system.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?

P01. Several issues that I can run off the top of my head. The first one is fear and uncertainty. As a business owner, I am afraid that when an audit comes, I may be found non-compliant. The fines could be so high that I may be forced out of business. The other negative impact is increased cost associated with compliance and Affordable Care Act and additional taxes. In order to buy durable medical equipment, I have to pay at least 10 percent to 15 percent more. The manufacturers are passing on those taxes to us. Unfortunately, I cannot pass those costs to my patients because service rates are set and I cannot increase them. While it is true that I have more patients come in with health insurance compared to before the Affordable Care Act, I want to believe that there is also a larger group of middle income people whose premiums have increased considerably. I wonder if there is anyone who is keeping numbers of people losing their health insurance because they cannot afford the Obamacare premiums. I am wondering when I will have to go against the federal government over something I do not agree with. I am wondering if I will be able to get staff that I can invest in and that are good to my patients. I am wondering if my good staff will leave me and go work somewhere. Will patients be at risk of something such that if they get sick, they will not receive care? I am wondering if hospitals will remain open in this small town. It has to affect them somehow. They have already centralized all specialties and it could be the reason why. Premiums have increased, limited services in small towns, and it has also lead to people's choice of providers being limited if not taken away. A lot was promised but people are disappointed because most of those promises were never fulfilled. I know of a good doctor who is leaving town because of changes introduced by the Affordable Care Act. This is going to affect a lot of patients. He was fluent in Spanish and so there is going to be a void in care when it comes to the Hispanic population.

Q08. If you were not a member of the IDA and you were a stand-alone dental practice, how would you get information concerning the Affordable Care Act and how would the Affordable Care Act impact you?

P01. I would be giving less benefits, increase premiums, and see less Medicare and Medicaid patients.

Q09. What aspects of the Affordable Care Act do you like?

P01. Well, I think it is a good thing that people with pre-existing conditions are now covered and their premiums are reasonable. America arguably has the best healthcare system, yet very expensive. It is the number one reason why people file for bankruptcy. I do not think that was right. The question is at whose
expense did the premiums of people with pre-existing conditions go down? Someone should be paying the bill. I also like the fact that children can stay on their parent’s health insurance until they turn 26 years old. That is a huge bonus for families.

Q09. What aspects of the Affordable Care Act don’t you like?
P01. I do not like the fact that the federal government is coming in and telling us what to do. Anything that is proposed by the government does not always end well. I am afraid that the government has ulterior motives behind all the data they are collecting. I do not like the fact that instead of worrying about providing quality care for my patients and let business take care of itself, I am now more concerned about the business aspect and staying in compliance. This has created a situation where most private medical practices in small communities have shut down to join major hospital systems. That is sad.

Q10. What were some unexpected consequences of the Affordable Care Act?
P01. Well, I want to believe everything. What I just said. Small private practices in small and rural communities have been forced to close and join bigger hospital systems. I know of a family medical practice that was doing very well here in town that ended up closing. Because of that, people are having to travel to Lafayette or Indianapolis to receive care. That is not right. I do not think they saw that coming. I do not think they realized that most people’s premiums would go up. Yes, for those that had pre-existing conditions, their premiums went down. But for the majority of people, their premiums went up considerably. Health insurance networks have also narrowed down. I do not like the fact that there may be a hospital system near you but it may not be covered in your network. I cannot verify this but I believe there are a lot of middle class people that are without health insurance right now. They are right at the income level where they make a little too much to qualify for health insurance subsidies. At the same time, they do not make enough to be able to afford health insurance.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?
P01. As a business, I cannot come up with any tangible benefits we realized with the implementation of the Affordable Care Act. At least we have more insured patients walking through the door but that is offset by compliance costs. I also like the fact that my employees can also go to the federal exchange and obtain health insurance. In that case, if I decide not to offer health insurance, they are covered if their spouses do not have it through their employers.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?
P01. Well, I think my greatest challenge has been how to stay compliant with such a complicated law. There are a lot of moving parts such that it is very difficult to be sure that you are doing the right thing. I am sure after the first audit we will know what to expect. It may make things better if they do not keep changing the rules. Being forced to provide certain coverage that contradicts with my values is
a challenge for many of us who are Christians. Another challenge is being forced to provide certain procedures against my conscience. I think Obamacare is going to result in poor care, a lot of errors, and providers leaving certain markets and practices. I also believe that the private insurance companies are against Obamacare.

Q13. What has been your sources of information concerning the Affordable Care Act?
P01. Uh, it has been a little bit from different organizations. The IDA, ADA, and the Family Research Council have been my main sources. And of course anyone can go on the internet and it is flooded with information on Obamacare. The IDA is a good source. Here are some IDA notes that I prepared for you. I do not know if they are helpful at all. Once in a while, private insurances throw stuff out and I also read it. One latest source was a dental source. The challenge is that if you are a medical provider, the Affordable Care Act requires that you sign up so that you can write prescriptions. That is the only way your prescriptions will be accepted.

Q13. Do you regard that as barriers for medical providers?
P01. Yes, they are and they are from Medicare. I cannot just be a provider. There are a lot of processes that I have to do. And of course the compensation is very low. There are also some durable medical equipment issues. I work with labs that produce equipment I use in my practice. They had a small increase in their fees which they passed on to us because of taxes related to the Affordable Care Act. There are a lot of medical equipment taxes that have caused price increases just to cover the cost. The uncertainty of the Affordable Care Act caused practices to create an “uncertainty tax” just to cover the cost. This has resulted in dentists delaying or reducing their investment in dental equipment. These taxes are squeezing the life blood out of us small practices and killing innovation. Another area of concern is abortion coverage. Practices like ours are forced against our Christian values to cover services such as abortion that we do not agree with. This is not right. It is not fair.

Q13. Why do you think the private insurance companies are against it?
P01. Because they have great systems already working well and they do not want to have to invest in redesigning systems for which they are not being paid for. They are spending money and time meeting with attorneys on how to respond, not spending time on how best to provide better care for patients. Doctors, insurance companies, and hospitals are spending more time on compliance instead of finding better ways to improve patient care. In my view, the Affordable Care Act was more of a “let us pass it and we will understand it later.” I have one staff that has a pre-existing condition and she has been searching on the exchange but she has not had luck because it is too expensive. In addition, there is a lot of paperwork we have to do.

Q14. If the Affordable Care Act was to be revised, what aspects would you like to see maintained?
P01. Keep kids covered under their parents' insurance until they are 26 years old. They should also maintain providing coverage to all people with pre-existing
conditions. In addition, I think they should also give doctors a certain amount of money per month for a certain number of visits, like a contract.

Q14. You mean a fee for service kind of deal?
P01. Yes. The simplest plan is to pay doctors so much money per month and let the patient receive so much services per month for any procedure they do. When that money runs out, it is on me as the doctor.

Q14. How will you measure quality and outcomes in that situation?
P01. Well, doctors are out there to do the best for their patients. They need to be trusted to provide the best care to their patients.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see revised?
P01. Choice. People need to have a choice on what procedures they can be covered for based on their value system. Honestly, I think 50 percent of the Affordable Care Act should be done away with. It is important that they keep it simple so that people are not confused. The system is too huge and people do not fully understand it. There is a lot of coverage that people are not aware of. I also would want them to revise it so that it creates less chaos. They need to do more communication. There is need for a serious and honest dialogue concerning what is working and what is not. The launching of the Affordable Care Act was a total mess. There were IT glitches, the toll free numbers were jammed, and it was just a mess. They could have planned it better and ensure they protect faith-based providers. There are already delays when you try to get a bill paid from hospitals because their systems are now centralized. Hospitals are trying to cut costs. I would like to see a simplified system. This is just way too complicated for me and most of us. I would also want to see a protection and incentive for private practices in small communities. These private practices in small communities are important and I hate to see them disappear just like that. I would like to see premiums go down to where they were before the implementation of the Affordable Care Act, if not even lower.

P01. And there is more confusion and more delays in being paid for our services from insurance companies.

Q14. I really appreciate your time. I know you have a busy schedule and this is valuable time from your schedule. Is there any additional information you would like to share with me concerning the Affordable Care Act that I did not ask?
P01. Nothing that I can think of right now.

Q14. Thank you so much. May I contact you if I have follow up questions?
P01. Absolutely. I will send you an email so you have my email address. If you want a really good source on your topic, I suggest the previous owner of the Medical Center here in town. He is a great source on this subject.

Q14. I would really appreciate if you can email me his contact information or call him and introduce me to him.
P01. Once again, thank you so much for your time. I look forward to talking to your friend who once owned the Medical Center.
Participant 02

Q01. Thank you for taking time from your busy schedule to meet with me. I will take no more than 40 minutes of your time.
P02. Not a problem.
Q01. What is your position in this organization?
P02. I am the Human Resources Specialist. I am the one who is in charge of employee benefits.
Q02. How long have you been with this company?
P02. Twenty-two years.
Q02. Of the twenty-two years, how many years have you been in the Human Resources department?
P02. Uh gush, I would say around twelve to thirteen years.
Q02. Are you the one who is in charge of the company health insurance benefits?
P02. Yes, not the whole time but I was part of the picture.
Q03. How would you characterize your company health insurance benefits before the Affordable Care Act?
P02. Uh, well, we were lucky in that before the local clinic sold out to IU Health, they had their own health plan and so we purchased health insurance through them. It was very affordable because we could use their doctors. Out of pocket co-pay was low, employee portion was $30 per pay period, and there was a $250 deductible per year. Then they sold to IU Health just a few years prior to the Affordable Care Act coming in. So we had to look elsewhere for health insurance and the rates were astronomical. That started the changes and that was a big ouch for us.
Q03. $30 per month premium was excellent!
P02. Oh Yeah. Our former Executive Director had a knee jack reaction and bumped employee portion to where it is now, $100 per pay period. And we had to get a very high deductible, which is $3,000. I think we could have gone up to that deductible gradually, but to jump to such a high deductible was too much. Employee morale just sunk and the complaints were too many and terrible.
Q03. So how much do you know about the Affordable Care Act and how it impacted your rates?
P02. I just see that when the Indiana Governor created HIP2, we had a lot of young women and their families join HIP2. Uh, I do not think that is a good thing because we will have generations on government assistance. I can give you an examples of people affected. Before the Affordable Care Act, my co-worker used to purchase health insurance around $300 per month. After the Affordable Care Act, her monthly premiums jumped to $700 to $750 per month.
Q03. Wow! That was a huge jump!
P02. Yep. That is why she went onto our plan. Uh, so that was negative. Somebody has to pay for all these people who were uninsured and are now insured by the Affordable Care Act.
Q03. OK, I see.
P02. I can see the rates keep going up in the next couple of years.
Q03. Why do you think the rates will keep going up in the next couple years?
P02. Because the more people you get insured that were uninsured due to pre-existing conditions, someone is going to have to pay for that cost. It is going to be us who did not have pre-existing conditions. Somebody has to cover that gap. We have another employee who was on our plan and has a family. He could not afford to insure his whole family. When the market place opened in October 2014, he was eligible for a tax credit. He got his family insured. He enrolled through the exchange and dropped our insurance. At the end of the year when he had his taxes done, because he had a refund, he had to pay back that tax credit.

Q03. Interesting. How about the issue of choice? Do you think the Affordable Care Act is having an effect on people’s choices of doctors and hospitals?
P02. Are you referring to choice for people who go through the market place or who go through the HIP2 Plan?
Q03. Market place.
P02. You have to go further from your place of residence to bigger cities to get doctors, dentists, and other specialists covered under your plan. Our current health insurance plan is through CIGNA. They have a very broad network of doctors that accept it throughout Indiana. But if you go on the market place, that is where you will run into trouble.

Q03. Tell me more about it.
P02. There are smaller insurance companies and so they are going through the bigger cities. That is where they are getting their physicians.
Q03. How is that affecting people who live in small and rural communities?
P02. Small and rural communities do not have economies of scale which help insurance companies. I do not think I will ever see it in my lifetime. What would have benefited the people is if they had made hospitals and doctors to be an open market place just like when you need an oil change for your car. You shop around to give you the opportunity to know the price before you go in. That would have driven the prices down because there would be competition on the market.

Q03. That is a very interesting concept. This is the first time I have heard that suggestion.
P02. You will never see that. Doctors play hand in hand with insurance companies, so you will never see that. That would have benefited people and healthcare costs would have gone down or at least be under check.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?
P02. More rules and regulations. More paperwork to do for the government and possibly fines if that paperwork is not in place.

Q05. Please describe your experience with the Affordable Care Act.

P02. I would use three words; fear, confusion, and frustration. Fear of being found out of compliance, confusion about what needs to be done, and frustration about lack of communication from the government and ever changing expectations, rules, and regulations. In addition to all this, there is a lot of added time and cost. We have to spend several hours per week to ensure we do all the paperwork correctly. There are several emails from our insurance agent that I need to read and make sure we are in compliance. There is also an additional cost associated with the Affordable Care Act.

Q06. Overall, did the Affordable Care Act make things better or worse? Please explain.

P02. I do not think the Affordable Care Act made things better for people. It actually made things worse. You have poor people who will still get on the plan, Medicaid, and State health insurance plans. People’s insurance premiums have gone up and in some cases doubled. People have to drive to Lafayette or even Indianapolis to receive specialized care. Some small clinics have closed and county hospitals are all either owned by IU Health or the Franciscan Alliance.

Q06. Since low income people were already covered by Medicaid, did the Affordable Care Act help the middle class people?

P02. Those that qualified for Medicaid are still on Medicaid. The Affordable Care Act just made things harder for the middle class which is a small growing number. You know that poor people are covered. The rich people can take care of themselves. The middle class was left our hanging to dry. The Affordable Care Act has increased the amount of paperwork we do. We have to track everything and everybody’s hours. We have to track how many hours part-time employees are working. We have to send out a lot of forms. Companies are having to pay a lot of taxes.

Q06. Is this cost associated with the Affordable Care Act?

P02. Yes, it is. I have a lot of fear because I have to make sure that everything is done right.

Q06. Tell me more about it.

P02. We have to make sure that someone who is eligible to be covered is covered. We have to make sure that employees that have a part-time status are working part-time hours all the time. We do not want to pay fines when we are audited. As an employer, we have to keep track of who is doing what. The audit is random. For example, if they audit you during the month of March and they find out that a part-time employee worked more than 29 hours, the employer could be fined for not providing that employee with health insurance.

Q06. That is a lot of work.

P02. Oh yeah. We have to stay on supervisors to make sure they are watching part-time staff hours. We also have to educate the supervisors why we are asking them to do all this work.

Q06. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?

P02. I like the concept of everyone being able to have health insurance, but I do not think it is happening because people are being forced to do something. When
you take away people’s right to choose, they are bound to resist, even if it is a good program.

Q06. So you are talking about choice.
P02. Yes. They took away people’s choice. People like choices. The other thing is that the Affordable Care Act is very confusing. If you are not educated or do not have access to a computer, you will have a very hard time finding out what is on the market.

Q06. That is interesting. So you are saying one’s level of education can actually have an impact on how much you pay in insurance premiums when you go through the federal exchange?
P02. Yes. Of course there are some local insurance companies that are starting to get into that. They schedule meetings at local libraries and ask people who need to know more about the Affordable Care Act to attend. That has been helpful. There are also insurance sales reps that have come to libraries and hospitals doing seminars but getting that information out to people so they know the venue where the meetings will take place and how it will benefit the people has been a challenge. There are other people who have computers at home but it requires more than basic education and knowledge to be able to navigate the exchange and come up with the best insurance plan that meets your needs. I know our insurance broker set a dash board on their website where you can find information. It helps us on what companies need to do. They also send us emails reminding us on what we need to do. We also have to let them know that we read the emails and we have followed through with their recommendations. It is really a nice reminder to us. It is very good thing.

Q06. Do they track who read their email?
P02. Yes they do. That have made it a lot easier for us.

Q06. That sounds like a lot of work.
P02. Yes, it is a lot of work on their part and on our part, but it helps us understand things and changes.

Q07. If you had been given a choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?
P02. That is a tough one. I know that the healthcare system before the Affordable Care Act was becoming too expensive every day. I also know that there were people with pre-existing conditions who could not afford to buy health insurance. That needed to be addressed. However, the Affordable Care Act does not seem to have solved any of those problems except people with pre-existing conditions. It appears that those costs were shifted to other people who did not have pre-existing conditions. So to answer your question, I would opt for the old system with some thoughtful and intentional changes.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?
P02. It has increased the amount of paperwork that we all have to do to stay compliant. We have to track part-time employee hours to make sure they remain part-time. We have to read a lot of weekly emails from our insurance
broker to stay compliant. I spend an average of 5 to 8 hours per week doing work related to compliance with the Affordable Care Act. This is all additional work we are not reimbursed for. The fear of being audited and found out of compliance is one huge fear of the unknown. If only we knew what is expected in a simplified way, it would make things a lot easier for us.

Q09. What aspects of the Affordable Care Act do you like?

P02. I like the fact that people with pre-existing conditions are no longer paying high premiums due to no fault of theirs. That was not right. Now they can pay normal premiums like anyone in their age range. I also like the fact that children can stay on their parents’ insurance until they turn 26 years old. This is great for parents.

Q09. What aspects of the Affordable Care Act don’t you like?

P02. I do not like the fact that everyone else’s insurance premiums had to go up considerably to accommodate those few people with pre-existing conditions. There is so much paperwork and nearly every piece of the Affordable Care Act is moving or being changed. That is not right. When you know the answers, they change the questions. I also do not like the fact that people are being forced to get insurance. People need to be allowed to make choices.

Q10. What were some unexpected consequences of the Affordable Care Act?

P02. I do not think they knew that nearly everyone’s premiums would go up. Also, it looks like most insurance companies are pulling out of Indiana. I heard that United Healthcare announced that they are considering pulling out of the State of Indiana and from the federal exchange. I think Obama made certain promises or conditions to insurance companies but the federal government is now failing to meet those conditions or promises.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?

P02. I cannot think of any benefits other than the fact that people with pre-existing conditions are no longer paying an arm and a leg to receive quality healthcare. Also, the fact that children can stay on their parents’ health insurance is a plus.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?

P02. At first when it was rolled out, there were a lot of computer problems. With all the resources that the federal government has, one would think they had this figured out but it was a complete mess. There is a lot of fear of the unknown. No-one really seem to know what the audit will entail. Our insurance broker keeps us informed and takes good care of us. Just a lot of paperwork.

Q12. May you please explain the emails you get from your insurance agent. How much time does it take for you to process the emails?

P02. It is a lot of work but that is how we can stay compliant. We send the information from those emails to all our employees in their pay checks. That way, we do not have to remember whether or not we communicated with our employees.
Q12. How much time would you say you are spending processing the emails to stay compliant with the Affordable Care Act?
P02. I do not know if I can quantify the time we spend processing Affordable Care Act related information but I know that we definitely spend more time to make sure everything is signed and dotted.

Q12. Am I hearing you correctly that you spend more time making sure that you are compliant?
P02. Yes, we spend considerable amount of time on compliance.

Q12. If I were to ask you to throw out a number of hours per week you spend processing Affordable Care Act related information, how many hours would you say you spend per week?
P02. Uh, I would say we spend a good eight hours a week reading emails from our broker, processing them, and answering employee questions.

Q12. So eight hours per week times 52 weeks, that is 416 hours per year you are spending on compliance.
P02. Yes. I am being paid a fifth of my time each week to make sure we are compliant.

Q13. What has been your main source of information concerning the Affordable Care Act?
P02. Our insurance agent. I also educate myself.

Q13. Where do you get the additional information?
P02. I keep on with the local news, I get the SHRM (Society of Human Resources Management) site. If I have spare time at home, I just get on the internet and find out what is happening.

Q13. Do you pay your insurance agent for providing those weekly updates?
P02. I do not know. That information is kept in the business office but I am sure there is a cost associated with all the work they do.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?
P02. What do I like? Uh... (Long pause). I do not like anything about it. I am not sure that can be answered right now because we have a presidential election coming this November. We do not know what the next president will do. I don’t like either Trump or Hillary, so we will see what will happen. It is like a circus. Some of it is hard to answer because they keep pushing back some of the changes like the Cadillac tax. So I think we will have to wait to see who gets in and what he or she will do. Well, it is good that everyone is covered. I like the idea of kids staying on their parents' health insurance until they turn 26. I also like the fact that people with pre-existing conditions can no longer be denied coverage. I think that is neat.

Q15. If the Affordable Care Act was to be revised, what aspects would you want to see revised?
P02. Number one, I do not think full-time status should be at least 30 hours per week. I think it needs to be at least 35 hours per week. People need to work 40 hours per week to receive full-time benefits. I do not know where to begin but I know
that health insurance costs are just unrealistic. They are too high. I also do not like the fact that people are being forced to provide insurance coverage for services that is against their value systems. That is not right. Another problem is that what the federal government did with the Affordable Care Act was to rob Peter to pay Paul. They are forcing the young healthy to pay higher insurance premiums to cover those with pre-existing conditions. That is not fair. Most services at major hospital networks are now centralized. For example, if you use either IU Health or Franciscan Network, everything is now centralized to reduce cost. You can no longer call your doctor’s office and speak to your nurse. There is a centralized scheduling system in place. There is anxiety and fear even though it has leveled out right now. I think anxiety was high when employers thought that they were going to all employees at 29 hours per week. This meant that every employer would have to double their employees. Since right now the labor poor has shrunk, this would have caused a lot of challenges.

Q15. Earlier on, you suggested that you would want doctors and hospitals to be like an open market. Is that something that you would also want to see added if the Affordable Care Act was revised?

P02. Definitely. That would help people to shop around and it would drive the healthcare costs down.

Q15. How will that drive the healthcare costs down?

P02. Making doctors and hospitals become an open market will accomplish two things. It will help patients see how much they charge for their services and compare around. It will also make their pricing system competitive as they will know what the other doctor or hospital charges. Right now, no one knows how much a procedure costs until after the procedure is done and you receive your bill. At that point, it is too late to do anything.

Q15. How has the Affordable Care Act improved or reduced the quality of healthcare services?

P02. Last time I had a regular doctor’s visit, the nurse called me and bumped my appointment by ten minutes. I wondered why, then I realized that they are trying to see as many patients as they can in one hour.

Q15. Was that an issue before the Affordable Care Act?

P02. No, it was not. Your doctor spend time with you before the Affordable Care Act. Now doctors want to see you in as a short time as possible and send you out. I would also suggest a rating system for doctors and hospitals. It is interesting to note that the healthcare system is the only industry which is paid to do a procedure, they make a mistake, and to correct that mistake, you will have to pay them more money.

Q15. Is there anything more you would like to share with me concerning the Affordable Care Act that I have not asked?

P02. Nothing that I can think of right now.

Q15. Well, thank you so much for taking your time to share this information with me. Is it OK for me to contact you with follow up questions.

P02. Oh, sure!
Q15. Thank you so much. You have been very helpful and answered all my questions.

Participant 03

Q01. Thank you so much for creating time to meet with me. I know you have a very busy schedule. As I stated in our phone conversation, I am a PhD S at Purdue University in the College of Technology. The focus of my research is examining the impact of the Affordable Care Act on small businesses. Thank you so much for taking time from your busy schedule to meet with me.

P03. Oh, no problem.

Q02. How long have you had your medical practice?

P03. Well, I came to this town in 1990. This town is my hometown and I opened my practice in 1990. After six years, I built a building for a clinic that was large enough to accommodate several physicians. With some of these changes in healthcare, it forced and enticed smaller practices to join larger healthcare entities. It was at that time that the county was looking at selling or getting rid of the county hospital.

Q02. I see.

P03. There was a choice between Franciscan Alliance and IU Health. Our previous alliance had been with the Franciscan network for five years. And you know that is a whole different ball game. I am now actually going back on my own. I am mature enough. I can retire if I want to but I do not want to.

Q02. That is good for the community to have experienced physicians like you.

P03. It is not my desire to continue working. I wasn't really happy with the alliance (without going into details). I didn't not feel that I could take care of my patients and provide the best care under a large system like that. So rather than retire, I decided to go back on my own. It is not all about money. There are a lot of changes in healthcare. The Affordable Care Act is one of the major pressures and probably the most prominent pressure that is causing changes in the healthcare industry.

Q03. How would you characterize your medical benefits and healthcare coverage prior to the Affordable Care Act?

P03. Of course I am not an expert on the Affordable Care Act. I am going to try to answer to the best of my knowledge. I probably have not kept up with the specific regulations about the Affordable Care Act. But being part of a larger entity for the past five years, I really did not need to keep up with the changes associated with the Affordable Care Act until I decided to go on my own. Where do I start? That is a very wide open question. It is easy to look at it from a negative side. There are definite advantages. The advantages I can think of include a drive to a centralized record keeping system. I had never touched a computer until the year 2000. That was the first year I started using computers. But I have always been compulsive about keeping my records even when I was on paper. So there are many advantages of computerization and centralized record keeping. Every healthcare practice uses the same system and can access...
records from anywhere. The idea is to have a nationwide integrated healthcare
record keeping whereby you can be vacationing in California and in an
emergency, you go to an Emergency Room and they can pull up your medical
history.
Q03. That sounds like a neat idea.
P03. That sounds like a good idea but it is a little bit scary. Being pushed by the
government, the question is who will have access to your medical records? The
government cannot even secure their own computer systems (long laughter).
You know what I mean. The government is pushing at one level but they are
behind with computerization. Even as computers have evolved, the integration
of computers into the healthcare industry has been lagging behind. There are
still a lot of facets that have to interact well. One entity wants to blame it on the
other and vice versa and the system is not integrated. It sounds good in theory
but where the rubber meets the road, it is not. Other advantages of the
Affordable Care Act include the fact that people who previously did not have
access to healthcare now do have access to healthcare.
Q03. The question is on whose expense are those people having access to healthcare?
P03. Exactly. This is being done on the expense of businesses and other people. Most
people’s health insurance premiums have gone up anyway for $300 per month
to $1,200, even higher. So, the Affordable Care act is a form of taking from those
who have and giving to those who do not have. Socialism. Others call it social
medicine. And for me this is why I look at this whole Affordable Care thing as
more of a negative than positive thing. I am not saying there are no potential
positives that will come out of the Affordable Care Act. It is multi-faceted. Some
of the problems related to the Affordable Care Act you cannot blame it all on the
Affordable Care Act. But I think it is a huge part of it.
Q03. May you please talk about choice in light of the Affordable Care Act.
P03. Nothing could be morally wrong than forcing people to provide abortion,
contraceptives, and morning-after pill. We are not talking about organizations
that are prejudiced. We are talking about standing up for the sanctity of life. So
we keep demented people alive till the last breath by artificial means but we do
not protect the unborn. I think the change in morality from the Christian
perspective to the humanistic perspective is not solid morality. I think the basic
question about the Affordable Care Act should be, “is healthcare a right or a
privilege?” Because it kind of boils down to that. The liberal view sounds like
healthcare should be a right. To what extent? I would venture to say that in my
28 years of practice, a large portion of people hospitalized is due to lifestyle
choices. It is their right to smoke, yet also they expect that it is their right to be
treated from lung cancer. It is all about your worldview. For the Affordable Care
Act to work in its real form, they really need, and I am not a scholar, but they
really need a lot of well-trained primary care physicians for the system to work.
Because if you think about it, to save money and socialize medicine, which is
what it is all about, not quality of care, you need a lot of primary care physicians
and a fewer specialists. It may take one surgeon for 15 primary care physicians,
one nephrologist for 50 to 100 primary care physicians. So, there should be a lot of primary care physicians and few specialists. Our system right is upside down. We have more specialists than primary care physicians.

Q03. May I have a copy of your handouts?
P03. Yeah, I do not know how helpful it is. These are my notes I prepared for the meeting.

Q03. How has the Affordable Care Act helped to correct the shortage of primary care physicians?
P03. I think it is part of the intent but it is having somewhat of an opposite effect. The Affordable Care Act was supposed to be an entity that takes care of a defined population and focus on cost and quantity. They always threw the term quality but I know quality is actually secondary to saving money. Not to go on a tangent here, but we need to be teaching our children in schools how to live quality lifestyles. Instead, we are teaching them that it is OK to have two moms and two dads and it is normal. We are not teaching them healthy habits; exercise, how to each right, how to avoid smoking, and how to avoid drugs.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?
P03. You know how the federal government is. Whenever it gets involved in your personal business, the result is taking away of people’s rights, putting in place programs that do not work the majority of people, and the federal government telling us what to do. I knew there was going to be a lot of paperwork to satisfy their need for compliance.

Q05. Please describe your experience with the Affordable Care Act.
P03. It has been mainly frustration, anger, and confusion. There is also another added layer of fear of federal government audits. Healthcare providers are frustrated because there is so much expected of us without much incentive for it. The system is not simple for people like us to be able to understand it and implement whatever it is they want. I have been forced by these changes to either join huge hospital systems to survive or just shut down. I cannot work in huge hospital systems because I cannot guarantee my patients the best care. I could shut down and go home if I wanted to. I am 57 years old and have enough to retire. But I want to make a difference. This is my community. They need me and I need them. I cannot just walk away from my people.

Q06. Overall, did the Affordable Care Act make things better or worse for you? Please explain.
P03. The Affordable Care Act made things worse for me. I feel I am being squeezed from both sides. I have been taking good care of my patients for three decades. What has changed now? I used to provide some pro bono services to people without health insurance. Now I cannot afford to do that anymore. I have to make sure that I have my staff spend more time completing forms to stay in compliance. My margin of error is so slim such that if I make some mistakes, I will be treated as a criminal by the federal government and pay a lot of fines. That is not American. It has made it difficult for me to focus on patient care.
have to worry about making sure that all my records are straight in case they walk in. This has resulted in increased cost of providing services.

Q07. If you had been given the choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?
P03. I would have chosen the old system. It was predictable and we knew what we were getting. I know that it was not perfect and needed some changes, but Obamacare made it worse. Cost of healthcare has gone up and quality of healthcare has not changed. In the old system, we did not live under the fear of pending audits and huge paybacks.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?
P03. Well, I have to make sure all paperwork is in order. Like I said earlier, I am focusing more on compliance than taking care of my patients. I went into the medical field to take care of people, not to spend hours focusing on compliance and audits. There has been an increase in healthcare costs across the board and it makes one wonder whether or not the federal government did not just do this to pad their employment numbers. Other than the fact that we see more people come in with health insurance and people with pre-existing conditions do not have to pay as much as they used to, the rest is a mess. The price of any durable medical equipment we need to buy has gone up by at least 10 percent. Costs have increased and quality patient care has been compromised. I fear that at some point, this is all going to deteriorate to a cost savings endeavor and people’s lives are going to be affected in the process.

Q09. What aspects of the Affordable Care Act do you like?
P03. Well, I like the fact that we have more insured people. However, the other side of it is how many people have lost their health insurance because of this change? I do not think anyone is paying attention to those statistics. I like the fact that people with pre-existing conditions do not have to pay as much as they used to. However, the question again is at whose expense? I like the fact that children can be covered under their parents’ insurance until they are 26 years old. This gives them time to stabilize and obtain stable jobs.

Q09. What aspects of the Affordable Care Act don’t you like?
P03. I do not like the fact that most people’s premiums have gone up considerably. That is not fair. While people’s premiums are going up, the quality of healthcare is not improving. There is something fundamentally wrong with that. I do not like the fact that we are being forced to provide certain services or pay for certain health insurance coverage against our conscience. That is not right. Most small private practices in small and rural communities like me have been forced by the prevailing circumstances to close and join major hospital systems. This has left a huge void in small communities that cannot be filled. Now you have the elderly and people with special needs having to drive long distances for specialized care. That is really sad. What is the end result we are trying to achieve with all these changes?

Q10. What were the unexpected consequences of the Affordable Care Act?
P03. Well, they told us that you can keep your doctor but that has not been the case. Due to shrinking in networks, patients have been forced to move around. Another challenge is that most people who obtained insurance through the exchange had increases in premiums. And in addition to increased taxes, there is increased paperwork to stay in compliance.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?

P03. I do not know about the word benefits. At least we have seen an uptick in the number of people who come into our practice with health insurance.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?

P03. A lot. At the beginning, no one seemed to know what was going on at the federal government. There was a lot of blaming and finger pointing. Their computer systems were always done and they could not seem to figure out how to resolve it. Now it has been resolved and I hope the system will not experience such problems again. The Affordable Care Act is so huge and affects so many facts of care such that no one really seems to know what is going on. They also keep changing the goal posts and expectations. Another challenge has been finding a reliable and unbiased source of information.

Q13. What has been your source of information concerning the Affordable Care Act?

P03. A lot of it has been through the American Academy of Family Physicians and other family physician organizations. They provide a lot of journals and articles and support for practices. They are also still trying to support smaller private practices as much as they can. This increase in regulation and red tape is too much.

Q13. Please explain more about the regulation and compliance as they pertain to the Affordable Care Act.

P03. Compliance and regulation has increased the physician’s workload and decreased our face to face time with patients. I still examine my patients. Physicians no longer have time to take a thorough patient history. Patient history, physical exams, labs, and X-rays are now secondary. They help confirm or rule out your initial impression. If you go to the Emergency Room, you will be lucky the physician talks to you. They will send a person to take your medical history, that person goes back and talks to the physician about your medical history, and the physician will order treatment (labs, medication, X-rays, etc.) and makes a determination of what is going on without even examining the patient. This is a sad outcome. Having the physician examine the patient is very important.

Q14. If the Affordable Care Act was to be revised, what are some things you would want to see revised?

P03. That is a difficult question. There again, I just think healthcare is generally heading down the wrong path. I still feel that the capitalistic system works well and works best. My opinion is that there is no incentives for physicians to stay after 5PM to see patients who are ill. They end up sending them to the
Emergency Room who will err on the safe side and admit the patient for an overnight observation. So at the Emergency Room, the patient is seen by a Hospitalist who is not a Specialist. Hospitalists spend the majority of their time on the computer and not doing face to face consultation with the patient. I guess coming back to your question, I guess what I would want to see is to go back to capitalism. This means taking away the whole Affordable Care Act. In a capitalistic system, healthcare providers receive an incentive to take care of people. But again, life is about choices. There are a lot of people who are under or uninsured because of choice. All it appears is that America is becoming a socialist country and socialist countries are becoming capitalists.

Q14. Interesting. Tell me more about it.
P03. So where I see things going is that there will be two healthcare systems; one for the rich and another one for the poor. Life is all about choices. We have really done our young folks in this country a disservice. We have not taught them proper values.

P03. And no offense (laughing) but the healthcare industry is now being run by business people, not doctors.

Q14. If the Affordable Care Act was revised, what aspects would you would want to see maintained?
P03. Let me answer one more question on something that needs to be drastically changed.

Q14. Please go ahead.
P03. Tort reform has not been part of the Affordable Care Act or healthcare reform. It has to be. The only way you can bring cost under control is through Tort reform.

Q14. You were part of the Franciscan Alliance. How much of you decision to leave and go solo was caused by the Affordable Care Act?
P03. Like I said earlier, it was a unique situation designed for a hospital entity but we could all see what was coming down the road. One other thought, back to that Tort reform, it has to be discussed as part of the Affordable Care Act. Well, I kind of took a tangent there. What was your initial question? If the Affordable Care Act was revised, I believe there should be some ability to our country for everyone to have healthcare coverage. However, no one wants to judge someone else. So, should someone who smoke have a higher premium? People who develop lung cancer due to smoking should pay more for treatment. The other thing is rationing of healthcare. It is called practice standards. They should come up with practice standards that they expect every physician to follow.

Q14. Who should come up with those standards?
P03. There is a national organization that does it. They are a blanket decisions. For example, no one over 75 years should get a PSA to check for cancer, no more colonoscopy, no more mammograms. I have healthy people that live well into their 90’s. What may be OK for one may not be OK for the other.

Q15. If the Affordable Car Act was revised, what aspects would you want to see revised?
P03. I would want to see the whole law scrapped and they go back to capitalism. I am not sure that will take place in my lifetime. I would suggest giving people choices and lowering people’s premiums. I would also suggest incentivizing small private practices in small and rural communities so that they have a reason to continue practicing out there.

Q15. Thank you so much for taking your time to meet with me and answer my questions. Is it OK of me to call you if I have follow up questions?

P03. Sure, please feel free to contact me. You also have my email.

Q15. Thank you so much for your time. I really appreciate your willingness to meet with me.

Participant 04.

Q01. Thank you for taking your time to meet with me today. I know you have a busy schedule and I appreciate your sacrifice.

P04. Oh not a problem. I can spare an hour or so.

Q01. As I stated in our phone conversation, I am studying towards a PhD degree with Purdue University. My focus is examining the impact of the Affordable Care Act on small businesses.

P04. OK. Well, I hope I can help you towards your goal.

Q01. I understand it is your dad who started this business, correct?

P04. Correct.

Q01. What is your position and how long have you been in this business?

P04. I have been in this business for 47 years old. This is family business and my brother and I own it.

Q03. How would you characterize your medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?

P04. We, uh, we started out, uh, this was way back before insurance wasn’t so expensive yet. We paid 100 percent of our employees’ healthcare. And then later on, we could no longer do that because the government required that if it was free to someone, it should be free to everybody. So anybody that had coverage through their spouse’s employment, we had to raise their wages equivalent to whatever everybody was getting in health insurance premiums. So we made it a participant plan so that they could take it or choose not to.

Q03. OK.

P04. So, at that point, we started paying a percentage of employees’ health insurance. At the last point, we were paying, uh, before the Affordable Care Act, we were paying $45 per pay period.

Q03. And how much were the employee deductibles?

P04. That was our most recent plan and it has just expired and the deductible was $5,000.

Q03. OK.
P04. Co-pay was around $20. The health insurance agent we were with no longer underwrites businesses in Indiana. So that is the second health insurance company that has dropped out of Indiana.

Q03. And has that happened since the implementation of the Affordable Care Act?

P04. Yes. Our current agent announced that they would no longer underwrite us early this year. Technically, it goes until March this year.

Q03. Did they give reasons why they are pulling out of the State of Indiana?

P04. They said they are pulling out of the State of Indiana which is a shame because it was a good insurance company. They paid doctors on time. We had some issues before when we were with United Healthcare. We had some doctors who would not accept it. United Healthcare was slow in paying claims. Late 1990s to around 2000, we had some significant health issues and we are a small group. As you can imagine, we had people with Leukemia and some other long term ailments.

Q03. Did your previous health insurance cover pre-existing conditions?

P04. No, no. So once those came on our plan, our insurance premiums went up since we are a small group.

Q03. And $5,000 deductible sounds quite high.

P04. Yes, because we had a small pool of employees. $3,000 would have been ideal. $2,000 would have been even better. So it just got to a point where we could not afford it. When those cases went away, even then, they didn’t reduce our rates because we had a bad loss history. We were expecting a drop in premiums but it did not happen. So that is pretty much where we are. Right now, we pay anywhere from $253 to $644 per employee per month.

Q03. You indicated that your current plan is expiring in a month. Have you started working on another plan?

P04. Yes, we have and it is effective February 1st.

Q03. And what insurance company are you going with?

P04. We went to the exchange, www.healthcare.gov.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?

P04. Well, we thought the government had come up with some neat idea of lowering people’s insurance premiums. I was excited because I thought this would be a great opportunity for some of us with some health needs to get some relief.

Q05. Please describe your experience with the Affordable Care Act.

P04. We went through an agency.

Q05. Do you feel you have been getting the information you need in a timely manner?

P04. Well, like I said, we just started February 1st. We have not had an issues come up. And the other thing is that with our current plan we got through the federal exchange, everyone is on a different plan. Some people chose Blue Cross Blue Shield and others chose different plans. There are some plans with HSA (Health Savings Accounts) and others you can’t. It depends with co-pays and that kind of a thing. I think we have two employees that do not have HSA anymore (he hands a copy showing their current health insurance rates).

Q05. Are these rates for the old insurance plan expiring in March or for the new ones?
P04. These are the rates for the new ones.
Q05. So from your perspective, did your premiums and co-pays increase or decrease when you went with the federal exchange?
P04. Well, our deductible went down. We had been paying $50.41 per week. Everybody paid the same. But now everybody pays different rates because it depends on your household income. It also varies by county of residence.
Q05. Interesting. Tell me more about it.
P04. When our agent came, he ran all employees under White County and we have people who live in Cass County and Carroll County and their rates were changed.
Q05. Did their rates go up or down?
P04. Residence of Cass and Carroll counties had their rates go up. I am not sure why. Depending on what plans they chose, people’s deductibles went up or down. There were so many options to choose from. There is Bronze level, there is Silver level, and there is a gold level.
Q06. Overall, did the Affordable Care act make things better or worse for you? Please explain.
P04. From my experience, the Affordable Care Act has made things worse. There are some good things that have come out of it, please do not get me wrong. But overall, things have been rough for many of us. I had my choice of doctors. I went off of my family doctor’s recommendations. But now he is in one network, my heart doctor is in another network, and my cancer doctor is in another network. I need all the three of them, but I can only have one, not all of them. They are all critical to my life and my survival.
Q06. That is not a good situation.
P04. My wife decided that I need to see a heart doctor and get checked out. I went to my family doctor who is a great doctor and he sent me to a Heart Specialist in Lafayette who is on the Franciscan Alliance network. So now that I am on the IU Health network so that my cancer specialist is in network, my family doctor whom I have seen for over thirty years is now out of network. My heart doctor who is with the Franciscan Health Alliance is now also out of health. So I have choices to make; either to stay with my family doctor whom I have had for over thirty years and pay out of network or choose another family doctor. I also have to choose to stay with my Heart Specialist who is with the Franciscan Alliance who is now out of network or choose another heart doctor who is in the IU Health network. It is just too much change at a critical point in my life and also given the condition of my health right now.
Q06. So would I be correct to say the issue of choice is not there?
P04. From my experience, it depends on your needs. When our agent quote us, he wanted a list of all our providers. That list determined which network you would be on. We have some employees whose doctors were not in the network, so they changed everything; doctors, pharmacies etc. Some people had to change their doctors to get the rates they wanted. So, it has been very much involving.
Q06. So, if I am hearing you correctly, there is choice when it comes to health insurance plans, but there is limited choice when it comes to doctors who may
be in your network. Some people have had to change their doctors they have had for decades as in your case. Did I hear that correctly?

P04. Oh gosh, I hate to think about it. My family doctor has been there for me for a long time, about forty plus years.

Q06. So now you are going to lose a doctor you have had for forty years, knows you very well, and has your complete medical history which is important for continuity of care?

P04. I have to pay more for the same services I have received for forty plus years now that he is outside the network. Our insurance agent also mentioned that part of the Affordable Care Act is to narrow networks. So in my case, I can only choose one of the three; my primary doctor, or my heart doctor, or my prostate cancer doctor.

Q06. So, when they talk about narrowing the network, what do they mean?

P04. Well, for me the previous health insurance network, we had Anthem, IU Health, and Franciscan Alliance. All these networks were covered. But now with the Affordable Care Act, they will only work with one network and my choice is IU Health because that is where my Cancer doctor is. So that is what their thinking is with narrowing networks.

Q06. Is that affecting people’s choices?

P04. Yeah, yeah, it does.

Q07. If you were given a choice, would you opt to go with the Affordable Care Act or would you stay with your old healthcare system?

P04. We would definitely go back and get a traditional plan like we had before. Our agency quoted us with another insurance network and it was $1,700 higher. So, even though I want to go back to my old traditional plan, they have made them more expensive. Our agent said it would definitely be more expensive.

Q07. Did he explain why it would be more expensive?

P04. I am assuming it is because of the healthcare costs that are increasing. But at least it would have given us a choice of networks. When we had Assurant health plan, everyone was being charged $50.41 per week. My premium went up from $50.41 per week to $150 per week on the Affordable Care plan.

Q07. How many employees do you have?

P04. Seventeen. Technically, the cost of my health insurance under the old scenario was way better than what I am paying now.

Q07. So, let me ask this question again. Do you think the Affordable Care Act made things better or worse?

P04. Well, it made things worse in my view. My spouse qualifies for Medicare this March. Currently, I pay $287 for the two of us per week. When she comes off my plan, I will be paying $349 per month.

Q07. Please help me understand how you will pay more when your spouse comes off your plan and goes on Medicare.

P04. (Laugh). That is what I said. Well, our agent said you cannot think about this logically. It has to do with income, number of people in your household, and age. He explained that currently, we are getting a subsidy because of my spouse’s
age. When she drops off our health insurance plan to receive Medicare, that subsidy will no longer be there.

Q07. So, your insurance premiums should go down because you qualify for Medicare, but because of your business income, your premiums are increasing?
P04. Yes, that is correct.

Q07. What is your take about that?
P04. I think the Affordable Care Act is punishing me because I am choosing to stay in the workforce and work. If I choose to close my business, I can be on Medicare and my health needs will be taken care of by the government. So I am receiving a disincentive for working hard and running a business. Also, you cannot be on the Affordable Care Act insurance when you are over 65 years old. You will have to be on Medicare. Now there are caps. If you go over a certain amount, you do not qualify for subsidy.

Q07. So if you decide to stay at home, you qualify for subsidies but if you decide to go to work, you get charged more in insurance premiums?
P04. Correct. (Laughter). Welcome to the new America!

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?
P04. Well, I am not sure how to answer that one. I know that people’s premiums have been all over the board. Some have seen increases and others have seen decreases. For my business, we made a conscious decision to allow our insurance agent to do that part for us. There is a lot of paperwork that my Office Manager has to complete regularly. We also have to ensure that part-time employees are working part-time hours. There is also fear about federal government audits. We are not sure if audited, will we be found in compliance. We are supposed to work on being compliant with a law that we do not fully understand.

Q09. What aspects of the Affordable Care do you like?
P04. Well, there are a few things that have benefited people but most of it has not been good. Like I said earlier, with my heart and prostate issues, I no longer pay as high a premium as I used to. I am sure someone may be paying the difference. At least no one can be denied coverage anymore due to pre-existing conditions. I did not develop prostate cancer due to a bad lifestyle. I did not develop heart problems due to a bad lifestyle. Well, with the heart issue, it might be that I overworked. Why would someone be punished for a condition they did not contribute to its development? That is not right.

Q09. What aspects of the Affordable Care Act don’t you like?
P04. I do not understand why most people’s premiums went up. I thought since we are all sharing the health insurance costs in a large national pool, this will drastically reduce the premiums. I do not like the fact that the government is forcing employers to provide certain health coverage they do not agree with. That is not right. I think that needs to be changed.

Q10. What were some unexpected consequences of the Affordable Care Act?
P04. I do not think they knew that most people’s insurance premiums were going to do up. Another interesting outcome is that they expected young and healthy people to join the federal exchange but also allowed them to stay on their parents’ health insurance until they are 26 years old. You cannot have both. It has to be one of the two. I think the provision that children can stay on their parents’ health insurance until they are 26 years old resulted in less young and healthy people joining the exchange. I do not think they knew that most of the people who would join the exchange would be those with severe health conditions like me.

Q11. What benefits have you realized from the implementation of the Affordable Care Act?

P04. Well, no one can deny me health insurance coverage anymore because of my pre-existing condition. I also like the fact that the government provided subsidies for those that cannot afford premiums. That is a good thing.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?

P04. Well, we went with an agent, so he handled everything for us. We did not experience any challenges.

Q13. What has been your sources of information concerning the Affordable Care Act?

P04. For us, it has been our insurance agent. We did not venture out there to look for any information. We trusted that he would give us the right information we need. If he makes mistakes, then we are screwed.

Q14. Interesting. If the Affordable Care Act was to be revised, what aspects do you want to see revised?

P04. I don’t know. There is a lot of it. I think simplification of the whole Affordable Care Act would help. I would still want to have a choice on networks. It would be nice if they could find a way to lower people’s premiums and also expand the networks.

Q15. What are some of the aspects of the Affordable Care Act you would want to see maintained?

P04. Certainly the no pre-existing conditions. It is a good thing.

Q15. Is there any other information pertaining to the Affordable Care Act that you would want to share with me that I did not ask?

P04. Not that I can think of right now.

Q15. Thank you so much for sharing this information with me. This is very helpful for my research. May I contact you if I have follow up questions?

P04. Sure. I am available. Gina who works in our office is also very helpful.

Q15. Thank you so much for your time.

Participant 05.

Q01. Thank you so much for taking the time to meet with me. I know you have a very busy schedule and I really appreciate you sparing some time for me. As I stated in my phone call, I am studying towards my PhD at Purdue University.
P05. Oh, good for you. What is your area of study?
Q01. My research focus is examining the impact of the Affordable Care Act on small businesses. How long have you been practicing?
P05. I have been a physician for 20 years and I have been a dermatologist for 16 years. I have had my own practice since 2007. That is about nine years.
Q01. How many employees do you have?
P05. I have lots of part timers. I have five office staff. I have, as far as RNs and medical staff are concerned, I have eight. Because we have lots of days when it sounds chaotic but it works well. There are at least two people who are there every day; one from the office staff and one from the medical staff.
Q01. So five office staff and eight nursing staff?
P05. Yes.
Q01. Do you have other doctors that work in your practice?
P05. No, it’s a solo practice.
Q03. How would you characterize your medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?
P05. I believe the old system was good but was in serious need of tweaking. I do not know if the Affordable Care Act accomplished what they intended it to do. The challenge with the previous system is that healthcare costs were increasing by around 10 percent each year and people’s income could not match that. There was a large group of people who were uninsured and that was not right. Having said that, I cannot afford to give health insurance coverage to any of my employees. I cannot possibly do it. The reason being that my wife currently works at the practice. She and I do have health insurance through United Healthcare. We used to have it through Anthem prior to 2015. Anthem’s monthly premium for us was going to be $4,200 per month to cover my wife, our three daughters, and I. That came with a $6,000 deductible for my wife and I and $3,000 for our daughters. So we switched to United Healthcare and our combined premiums are about $2,700 per month and a $7,500 combined deductible for the whole family. So it is a little more deductible but still very expensive. And that is why I cannot afford to offer anyone health insurance coverage. The problem, whether it has to do with the Affordable Care Act or not, in general, the goal is to get more people more coverage. That I definitely agree with. It is strange to think of the United States as being such a wealthy nation yet having some of the highest medical costs, not having the best healthcare system, and not having the broad coverage. It does not make sense. I am sure there are brighter minds than mine that need to look at this but having more coverage is great. Much of the problem has to do with how things have evolved in the United States. It is like you are getting your car insurance through the church. Uh, we get life insurance through a group. It does not matter where you are, it is about your driving record.
Q03. OK
P05. So with health insurance, even the Affordable Care Act made a lot of difference. I cannot just join Tippecanoe Medical Group and get health insurance through them.

Q03. Help me understand why it is so.

P05. Well, I do not know but that is how the rules are written. That is how it is set up. I can join the State Medical Association but I cannot obtain health insurance through them as a group. If that were possible, that would be a huge group. Insurance companies would make money, premiums would come down, and people would save money. Another option would be to join the American Dermatologist Association with ten thousand members. Or even better, join the American Physician Association with even more members. If every physician joined a group like that, it would be a win/win outcome. But the legislation is written such that you cannot do that.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?

P05. Well, there are two theories here. The first one is that whenever the government introduces a program, there is a hidden agenda. The second one is that the government has good intentions and was trying to help people. I can see it from both angles. I think the challenge is that with any government programs, there is a lot of paperwork and compliance that come with it. There is also government red tape which ends up costing the ordinary people a lot of time and money to implement. Another challenge with government initiatives is that they are too massive and not well thought through. At the end of the day, it ends up not being as effective as it was planned to be.

Q05. Please describe your experience with the Affordable Care Act.

P05. For me it has been all over the map. It has both good and bad aspects. My challenge has been to obtain reliable information. Lack of reliable information caused a lot of frustration and confusion. I mean we are smart people and if we cannot figure it out, how about the ordinary people on the streets?

Q06. Overall, did the Affordable Care Act make things better or worse? Please explain.

P05. I think it did both. There are things that were made better and things that were made worse. For example, we now have a lot of clients that come into our practice with health insurance. That is a good thing. The idea of no pre-existing conditions is awesome. I really like it. Everyone can now get care regardless of your financial standing. I like the fact that children can stay on their parents’ health insurance until they turn 26 years old. That is a neat idea. There are also bad things that have happened as a result of the Affordable Care Act. Some people’s health insurance premiums have considerably gone up. As a Christian, I do not like the thought of the federal government being in my backyard and telling me what services I should provide and how I should provide them. That is not their place to do that.

Q07. If you were given a choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?
P05. Not very sure. I am torn in between the two systems. There are aspects I like in both and there are also items I do not like in both. I do not like the fact that in the old system, the cost of health insurance was going up faster than people’s income. People with pre-existing conditions were being made to pay high premiums. That was not fair. However, I like the fact that in the old system, people had choices of where to get their healthcare services. On the other hand, the Affordable Care Act has some neat things. Everyone is covered and there are no pre-existing conditions anymore. Kids can stay on their parents’ health insurance until they turn 26 years old. I don’t know, I think neither system is perfect. If they can polish the Affordable Care Act, things may turn out to be better.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?

P05. Well, we definitely have more patients come in with health insurance. So from that perspective that has been a plus for our business. The challenge has been that there are fees and taxes associated with the Affordable Care Act. I think the main impact of the Affordable Care Act is yet to be seen since it has been in place a few years and there are still aspects that have not yet been implemented.

Q09. What aspects of the Affordable Care Act do you like?

P05. I like the fact that people with pre-existing conditions are no longer being made to pay higher premiums through no fault of their own. I also like the fact that our children can stay on our insurance policies until they turn 26 years. That is a huge benefit. From a business perspective, we have more patients with health insurance and that is a good thing.

Q09. What aspects of the Affordable Care Act don’t you like?

P05. They need to figure out a way to ensure that premiums are affordable. I am sure rates will go down after a couple more years of implementing the Affordable Care Act. I do not like the fact that the government is telling providers what services to provide and how much to charge for it. That is not right.

Q10. What were some unexpected consequences of the Affordable Care Act?

P05. Well, I think premiums going up was definitely one surprise. Another unexpected consequence is that some small private medical practices have been forced to close and join large hospital systems. This may not be a problem for big towns but it should be a challenge for small and rural communities. People are having to drive long distances to access specialized medical care and that is not right.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?

P05. Like I said, on the business side, we have had a great improvement in terms of patients coming in with health insurance. That is a really good thing for our practice. It’s just the paperwork and compliance that has made it very difficult.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?
P05. I think getting reliable sources on the Affordable Care Act has been a challenge. The federal government should have scheduled more seminars to educate businesses and people about the Affordable Care Act. If I am struggling with understanding it, I wonder how the ordinary people on the streets are doing.

Q13. What has been your sources of information concerning the Affordable Care Act?

P05. Some of it came from a publication called Dermworld which is put out by the Academy of Dermatology. I also attended a health fair at Ivy Tech Community College where we met with a lady who was hired by the state to try to help people go through the market place. So we tapped into her but it was still difficult. What we found is that the Affordable Care Act is not affordable. We ended up going through United Healthcare. We also got information through our bank. They have a person who specializes in health insurance.

Q13. Have you looked at the market place to compare premiums?

P05. Ah, we looked at having employees getting individual plans. As far as providing it through the market place, it was substantially more expensive. We expected that it would be affordable but it was not.

Q13. So if I heard you correctly, going through the exchange did not benefit your employees, correct?

P05. It really did not. The advantage we have seen is that there are more patients coming into our practice with coverage than before. But at the same time, there are more patients with HSA accounts and high deductible plans. We have a lot more people we are chasing to pay their bills before their insurance kicks in. So, based on the number of patients that we see, there are more people having to pay high deductibles out of pocket than they used to. We are getting new patients because of being covered, but they pay more money out of pocket due to high deductibles.

Q13. Did the number of patients with high deductibles increase before or after the Affordable Care Act?

P05. It increased after the Affordable Care Act.

Q13. Why do you think it is so?

P05. What happened is that more of the people we saw were getting their insurance through their employers. As the insurance rates went up, employers tried to cut costs by providing high deductible HSA accounts. Because of that, more and more people are having HSA accounts than before. If you are healthy and you do not have a lot of expenditures, HSA accounts are ideal for you. You pay lower fees but you also have high deductibles.

Q13. Would you say your practice is spending more money trying to collect money from your patients?

P05. Yes. Part of why I have all that staff is that there is always something new.

Q13. Are you referring to compliance?

P05. Yes. We are spending more time and money trying to collect. We do in-house billing. My Billing Coordinator is very good at getting people to pay. We have to send out a number of certified letters every month and removing patients from our practice. If they do not comply with the certified letter within three days, we
turn them over to debt collectors. I am amazed at how often that happens. People will come in and have procedures done but they do not pay. That is why we end of terminating a lot of patients. Typically, we receive 70-73 percent of what we bill. That is what is allowed. This is what we are supposed to get. Everything in medicine has a name and all that.

Q13. Are you referring to billing codes?
P05. Yes. For any procedure, there is a code and a fee associated with it. Insurance companies will say we will give you a discounted Medicaid rate which is 70-73 percent plus a small percentage. You can charge whatever you want to charge but they will tell you what they are willing to pay. That system was already in place. What happened before the Affordable Care Act is that the federal government was desperately trying to bring down medical costs. The way they have been trying to do it is fee-for-service. The thought is to entice the physician to do more exams, more procedures, and code more so you can get paid more. There is a system that has been in place since 1995 that shows how you can get more points in your billing; diagnosis, evaluation, treatment, etc. You get points for each level from 1 to 5. If you do a procedure above that, you put a modifier code and you have a procedure code and you get paid more money.

Q13. Interesting.
P05. Yeah. In the past, if the government wanted to audit, they would back up a van, load all those records, and go through them. So what they have done is to incentivize the use of an electronic recording keeping system which would earn you the meaningful user status. If you became a meaningful user in 2011, you got more financial incentive, if you became a meaningful user in 2012, you got a little less, and in 2013, you got even less through 2015. If you were not a meaningful user by 2015, you would receive 5 percent less revenue, no matter what you did. If you were not a meaningful user by 2016, you would pay a penalty.

Q13. Interesting.
P05. Yeah, interesting. In most cases, most practices have had to hire extra people to do electronic medical record keeping and install and maintain Physician Quality Review Systems (PQRS). We have had to do all that work so we can comply. The government hired Regional Audit Contractors (RAC). They go out and get all this data from all physicians. If they find any physician who overcharged by waste or abuse, the government allows the RACs to retain 30 percent of whatever they collect. So these RACs are medical reimbursement hunters. Their livelihood depends on every mistake doctors make in billing. If you go on Propublica treatment plan website, you can see all the billing records any doctor has billed. So what the RAC does is go for outliers. Just recently, I got a letter from an insurance company saying there are certain things I did that was outside the norm. Now that was new to me. The last time I checked on Propublica, I was way done in line as far as total number of patients, total dollars billed, and everything. I try to keep my expenses as low as possible. Because of the fact that the government is trying to reduce medical costs by trying to find any waste or
abuse, trying to comply with all this slows us down. We end up seeing less patients and it takes longer to see a patient. What the government is trying to do is to move away from a fee-for-service to be paid for quality.

Q13. How do they measure quality?
P05. That is a good question. It is all evolving. There is a thing called relative value unit. If you are a General Surgeon and you do appendectomy and I am a Dermatologist and I do a skin cancer surgery, there is a formula that they put in place that says, “what is the relative value you do versus I do in terms of reimbursement?” This system has been around for decades. But there is a new system which is about quality. The new system says, “What was the outcome of all your services? How many post op complications did you have? How many referrals did you make? How many readmissions did you have?”

Q13. It sounds like it is outcome and quality driven. However, the question is, “doesn't that provide a disincentive to the physician not to do those complicated procedures to avoid post-surgery complications and readmissions?”
P05. Yes I think it can get that unintended outcome. I don't fully understand the new system. The Health and Human Services Secretary’s goal is to have a fee-for-service system gone by 2018. That is what they want.

Q13. So do you think this may create a disincentive for people to go into the medical profession?
P05. It is very much possible. In the future, most people will receive their services from Nurse Practitioners and Physician Assistants. There is a natural transition taking place right now. And these Nurse Practitioners and Physician Assistants will be hired by large institutions, pharmaceutical companies, and the federal government.

Q13. What has been your experience with the Affordable Care Act compliance?
P05. That is the big thing about the Affordable Care Act. We are spending a lot of hours to stay compliant instead of providing medical services. We are also investing a lot of money in software and equipment to be compliant; computer software for electronic medical records which costs about $600 per month, $300 per month for practice management, $200 per month for people who help us complete meaningful user stuff, just to name a few. Every year, we have to attest to follow the meaningful user system and there is HIPAA compliance in addition to all this.

Q13. Are all these additional costs you mentioned associated with the Affordable Care Act?
P05. Yes. In addition, there are also a lot of hidden costs and extra staff to stay compliant. I am glad we have an electronic record system. I wouldn't have had any incentive to do it. The government knew that, that is the reason they gave an incentive. In the past, I could flip through a patient’s medical records to see all the procedures I have done. But now with the electronic recording keeping, I cannot do that. We have the best medical record keeping system, but there are certain things you just cannot do as fast as flipping charts.
Q14. If the Affordable Care Act was to be revised, what are the aspects you like about the Affordable Care Act do you like to see maintained?

P05. The biggest thing from a personal point is our kids being on our insurance until they turn 26 years old. That is wonderful. Right now, they cannot get decent jobs to get decent health insurance. Also, from a patients’ perspective, I cannot be denied health insurance coverage because of pre-existing conditions. That is great because I have some medication costs that are astronomically high. So that is really good because I can be covered. In addition, the fact that many people have coverage is good for both themselves and also of the doctors they visit. People can no longer be denied because of pre-existing conditions, and young and healthy people can be on their parents’ health insurance until you turn 26 years old. And we see that in our patients too. Our patients are very happy about it, especially when they are at the age that they can be covered until they are 26 years old. I know for sure that there are patients who come to see us who would never have come before because they didn't have coverage and they could not afford. It is interesting because when they started talking about it, they talked about a single payer provider and to give people the ability to pay into Medicaid. I think it would be nice to allow people to buy into Medicaid. What I would like to see maintained is not being denied because of pre-existing conditions, uh, the 26-year olds staying on their parents’ insurance, and allowing low income people to supplement their income. The thought is that if people have enough coverage, they will use the Emergency Room less. The other thing I would like to see changed is one should be able to join yourself to any size of a group and be considered part of that group for the purpose of obtaining health insurance. If I can join the American Medical Association with four hundred thousand plus members, it would be an awesome thing because we can spread the risk. Allow people to buy into the Medicaid system.

Q15. If the Affordable Care Act was to be revised, what aspects would you want to see revised?

P05. The expense is the biggest. Personally, my insurance rates have skyrocketed. I mean astronomically. That is the single largest expense that I have other than employee salaries. For my wife, three daughters, and myself, you are looking at about $50,000 per year in health insurance premiums. So the expense is the biggest thing. Probably the extra layer of things that we have to think about instead of focusing on quality patient care is another thing that needs to be revised. Compliance issues cause additional layers and the fact that we are now subject to tremendous amounts of scrutiny whether you are fraudulently billing or you are wasteful. My question is, “How do they make the determination that you are wasteful?” The mandate infringes on people’s rights. I do not like forcing people to pay a penalty if they do not want to have health insurance. The best way to do it is to make it the same as auto insurance. People pay into it and spread the risk. I also do not like the fact that people that have insurance through their spouses are fined for not taking their employer’s insurance.
Q15. Is there anything you would like to share with me concerning the Affordable Care Act?
P05. From a patient and a citizen’s perspective, I support the Affordable Care Act. I thought it was a good thing to do. But as it plays out, I didn't realize its impact on me professionally. The product they ended up with is not what both sides wanted. Could it be improved? Sure!

Q15. Well, thank you so much for your time. I am sure I will have some follow up questions. Is it OK if I can contact you?
P05. Sure! Anytime!
Q15. Thank you so much for your time!

Participant 06.

Q01. Thank you for taking time from your busy schedule to meet with me. I know you have a very busy schedule and I really appreciate your willingness to create time for me.
P06. Oh, not a problem. Before we start, may you please give me a rundown of what we are talking about today?
Q01. As I stated in our last phone conversation, I am studying towards my PhD degree with Purdue University.
P06. Oh, congratulations on your studies. You are working full time and studying too? That must be a crazy schedule.
Q01. Thank you. Yes, it is crazy but it is manageable. My research focus is the impact of the Affordable Care Act on small businesses. Do you own this business?
P06. Yes, I do.
Q02. How long have you owned this business?
P06. I have been running this business for eighteen years. Ah, the company has been here since 1924.
Q02. Has the business been in the family since it was founded?
P06. Yes, my grandfather started the business. So it has been around for a while.
Q02. How many employees do you have?
P06. I have 25 employees. I have three stores; one here in this town, one in another town east of here, and another one in another town north of here.
Q03. How would you characterize your medical benefits and health insurance coverage prior to the implementation of the Affordable Care Act?
P06. They actually haven't changed since the Affordable Care Act. When I started eighteen years ago, we paid 100 percent of both the employee and family health insurance coverage. As the cost kept increasing, you know, it became prohibitive. Ah, we currently provide employee insurance and the employees pay about $5 per week. It is very affordable for the employees. Families are on their own.
Q03. How much is the deductible?
P06. Deductible is $2,500.
Q03. That is very reasonable.
P06. Yes it is. It cannot get any better than that.
Q03. How have you managed to maintain such low premiums? That is about $21.50 per month.
P06. We have had low claims. We also have had to shop around for health insurance each year. Ah, you can't go with the same insurance company year in and year out. The challenge now with the Affordable Care Act is that the players have become so few. So, ah, its Anthem one year and United Healthcare another year. This year, it is United Healthcare and next year it is Anthem and we keep doing it that way. I found out that with business insurance, you are penalized for your loyalty. So you have to shop around every year.
Q03. When did the pool of health insurance companies start becoming small?
P06. Ah, about five years ago. I do not think that has anything to do with the Affordable Care Act. It may be, I do not know.
Q03. It is amazing that your health insurance premiums and deductible are so low.
P06. Well, the company pays $500 per employee per month.
Q03. And the employee pays about $21.50 per month?
P06. Yes, right around $20 per month. The last time I figured out, the company contribution is about $3 per hour per employee if we were to decide not to offer health insurance. But we realize that health insurance is very important for our employees. We have not gotten into a situation where if an employee has insurance through a spouse, we say to them, we will pay you an extra $3 per hour.
Q03. Interesting.
P06. The $2,500 deductible is expensive. We have a good prescription drug coverage. The Prescription portion is very expensive. So we could probably lower premiums or may be offer a lower deductible. But the way we made our decision based on the age of our employees. I kind of have an older pool of employees. I have people with medical conditions such as blood pressure, arthritis, etc. So we decided that the prescription benefit was better for us.
Q03. May you please explain how the prescription cards works.
P06. OK, I will use myself as an example. I will go to a pharmacy and a drug that may cost $120, I will pay $10. I have a son who is on a few expensive medicine. At the end of the year, his drug expense are about $400 per year. That is what we paid out of pocket. The portion that the insurance paid through the prescription card was about $13,000. So, uh, you know, uh, the prescription drug plan we are on, don't get hurt, and don't get sick. Otherwise it will cost you a lot of money. The other option is you don't take medication and you can get hurt as many times as you want.
Q03. You mentioned that each employee pays $5 per week which is about $21.50 per month. How much does a plan that covers the employee and his whole family cost?
P06. The family plan is over $1,200 per month now. The way ours is broken down is we have employee, employee plus spouse and then the full family option. Employee plus spouse is around $800 to $900 per month. So that is the killer for me. If you look at the employee plus family plan, it is about $300 per week for a guy who is not making that much money to begin with.

Q03. That is high premium.

P06. Yeah, it is high.

Q03. Did the premiums change with the introduction of Affordable Care Act or before?

P06. It has always been around that range. Now you may have to help me with the Affordable Care Act. With our size, I do not know how that affects us. But one of the things I was told by my insurance agent is that if we had gone to the community renewing in 2014, our rates would have gone up by 15 percent. That is an additional $10 per hour per employee I would have had to pay in additional expenses. That would mean I would start cutting people or making my employees part-time workers. I cannot afford to lose my good staff. I spend one day per year with a bunch of eighteen lumber dealers. It is the best use of my time throughout the year. We talk about payroll and other issues that impact our industry. I am one of the smallest guys in the group in terms of business size. This group allows me to compare profit margins, payroll, vacation time, health insurance, and other business related expenses. Another company in our group just decided to give every employee $2 per hour raise and not offer health insurance.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?

P06. As always, when you hear our government propose a program that is meant to help people, you always wonder what the real motive it. And the challenge with most government initiatives is that they are loaded with a lot of forms that need to be completed for compliance. I think there was apprehension and uncertainty in the minds of many of us. And of course, fear of the unknown always accompanies such initiatives.

Q05. Please describe your experience with the Affordable Care Act.

P06. For me, there was not much change. I made a business decision to work with my insurance agent and that has worked out well. We are still on our old plan that was grandfathered in.

Q06. Overall, did the Affordable Care Act make things better or worse for you? Please explain.

P06. For us, we have not experienced any changes. Things are still fairly the same as they were before the Affordable Care Act.

Q07. If you had been given the choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?

P06. I am not sure. That is a tough pick. Our previous healthcare system was becoming very expensive. At some point, the system was going to burst at its seams. Cost of health insurance was going up faster than people’s income. At the same time, I
have not seen enough of the Affordable Care Act to recommend it. I am sure there are good things that it brings to the table. For example, if I cannot manage to offer health insurance, my employees can go to the exchange and obtain health insurance. What that means to me is that failure to offer health insurance is no longer a factor in running my business. I don’t know. I have heard a lot of complaints about the Affordable Care Act. May be I would opt for the old system with serious changes to lower the premiums for everyone, including those with pre-existing conditions. May be that is what the Affordable Care Act us going to eventually accomplish.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?

P06. Not very sure. At least one positive one. If I fail to offer health insurance, my employees can go to the exchange and obtain it there cheaper. In fact, I can even give them a raise so that they stay with me while they go to buy health insurance elsewhere. Of course my health insurance agent told me that if I decide to give them a raise and not offer health insurance, I cannot tell them that I am doing it so that they can go and buy insurance at the federal exchange. I am told it is illegal. However, I know there are a lot of loopholes in the system and if push comes to shove, we will play around with the system and remain in compliance with the law.

Q09. What aspects of the Affordable Care Act do you like?

P06. I like the fact that everyone now has access to health insurance. People with pre-existing conditions are no longer paying through the nose to obtain health insurance. My friend was telling me that the Affordable Care Act has been a blessing to him and his wife. Apparently, his wife has a serious health condition that has been costing them a lot of money in monthly premiums. Since they joined the exchange, their premiums have gone down. That is a good thing I guess.

Q09. What aspects of the Affordable Care Act don’t you like?

P06. I hear that some people who obtained their health insurance through the federal exchange have seen their premiums increase by as much as 15 percent. That is not good. If your health condition has not worsened, why would one’s premiums go up? That does not make sense to me and I don’t like it.

Q10. What were some unexpected consequences of the Affordable Care Act?

P06. Well, I think what we were just talking about. Other than people who had pre-existing conditions, most people’s premiums have gone up by around 15 percent. I do not think they expected that to happen. I think they expected that people’s premiums would go down. Another surprise of the Affordable Care Act is that most of the small and private practices in small and rural communities have closed. I do not know if there is a correlation, but I know most of them started closing around the time the Affordable Care Act was introduced. This community used to have enough medical services but most of them have closed and moved to big cities.
Q11. What benefits have you realized with the implementation of the Affordable Care Act?
P06. I have not seen any so far. At least I like the fact that if I fail to provide health insurance for my employees, I can send them to the federal exchange and they can obtain it there. For the most part, they can obtain it cheaper than I offer here. So that is a great benefit.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?
P06. Since we have used our insurance agent, we have not faced any challenges. That has helped to keep things stable. I do not know what is coming after that.

Q13. What has been your sources of information concerning the Affordable Care Act?
P06. I do not get much information. I rely on my insurance agent. For me, it is not just about price but its service and also knowing that my agent will help me to stay compliant.

Q13. So, when it comes to compliance with the Affordable Care Act, you rely on your agent to do the work for you?
P06. Yeah, yeah. I pay him to do that because that is his expertise.

Q13. Has that increased your costs to have your agent do all the work for you so you stay in compliance with the Affordable Care Act?
P06. I am sure there is a cost associated with that but I am willing to pay that. It saves me time and money later down the line. I am sure I can buy cheaper health insurance elsewhere but I trust my agent. I trust that he has me covered and is leading me down the right path.

Q13. What has the Affordable Care Act done to your choice of providers?
P06. It decreased our choice of providers. Now I am only limited to United Healthcare and Anthem. Nobody else is interested. We used to belong to a healthcare trust. This was way back when I started. We had a gentlemen in our group who fought cancer for a long time. With 100 companies in the trust, good ones started jumping out until we were the ones stuck in that trust with bad claims for a long time. We ended up getting out of that trust.

Q13. How about your choice of doctors? Has that changed with the implementation of the Affordable Care Act?
P06. We have decent coverage here. That hasn't been a factor yet. I don't feel that the Affordable Care Act hurt us or helped us there. It is still the same as it was.

Q13. If you decide to go on the market exchange for health insurance, what would you want to see for your employees?
P06. Accessibility is the biggest thing. One thing we struggle with in this town is work-related injuries. There is no workplace injury clinic. We either send the injured employee to the Emergency Room or the hospital. The Emergency Room is three times expensive.

Q13. You mentioned accessibility. What else?
P06. We have given up because I don't find it now. I need stability. I need to be able to budget in terms of how many employees I need. How can I get commitment
from these three to four guys that have each put in an average of 35 years of service for me?

Q13. Did I understand you correctly that you are relying on your insurance agent to provide you with information concerning the Affordable Care Act?
P06. Yes, I do.

Q13. You mentioned accessibility as one of the challenges with the Affordable Care Act, what else?
P06. Accessibility, stability, and pricing. The only thing I have had to do with our health insurance so far is shopping around insurance companies for the best rates. Now that most insurance companies have pulled out of the federal exchange or are planning to, it is going to make things a little harder.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?
P06. I was talking to a friend during lunch and we happened to talk about the Affordable Care Act. What a coincident. He said to me he does not know why people are complaining. He cannot see anything wrong with the Affordable Care Act. For him and his wife, it has been a life saver. Apparently, his wife has some significant pre-existing health conditions and now is covered. That is a good thing. I told him that I understand where he is coming from because it is benefiting him and his wife, but it is not right for someone else to pay for their portion of their health insurance bills. Now, I am the first one to tell you that health insurance prior to the Affordable Care Act was broken and needed to be fixed. I do not think the Affordable Care Act did a good job fixing those problems. I think it created more problems in addition to the ones it was attempting to fix. Having said that, getting rid of Obamacare and going back to the old system is not going to happen.

Q15. If the Affordable Care Act was revised, what aspects would you want to see revised?
P06. I think it is fair that people should be responsible for known lifestyle-related health conditions. How this will be carried out, I do not know. But I think there is need for a high price tag to be placed on smokers. Smoking is known to cause around 85 percent of lung cancer cases. Those people who develop lung cancer due to smoking needs to be made responsible for their choices. Now I know there are people who are overweight due to genetics. That is a different story. Having said that, I know it is difficult to differentiate who is overweight due to lifestyle choices and who is overweight due to hereditary issues.

Q15. Thank you so much for your time. You have been very helpful and answered all my questions. Do you have any other information about the Affordable Care Act you would want to share with me?
P06. I cannot think of anything right now.

Q13. Thank you. May I contact you if I have follow up questions?
P06. Sure. You have my phone number and email. I may not be able to respond to you right away but I will do my best to be timely.

Q15. Thank you so much.
Participant 07

Q01. Thank you for taking time from your busy schedule to meet with me. I talked to several business owners and most of them mentioned your name as a reliable source on health insurance information.

P07. Well, I will tell you that I will share only what I know.

Q01. Sure. Like I said in our phone conversation, I am doing my PhD with Purdue University. For my research, I am examining the impact of the Affordable Care Act on small businesses.

P07. Sure.

Q01. And what is your position in this organization?

P07. I am a principal owner and I also work as an insurance agent. I have actually been in the insurance business since 1979. My focus is life and health insurance policies.

Q02. How long have you been with this insurance company?

P07. Since 1990.

Q03. How would you characterize medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?

P07. Well, one of the biggest problems that has always existed in individual and group medical insurance for employers is underwriting. People with pre-existing health conditions that cause high expenses would cause the premium rates to be substantially higher for that group. So, on one hand, looking at it strictly from an insurance business perspective, charging higher premiums for a group with members with pre-existing conditions was the way to do it. You cannot pay collect half a million dollars in premiums and pay out 1 million dollars in claims and stay in business too long. You will be out of business in no time. The health insurance system we had back then was called Indiana Health Insurance. It was a comprehensive health insurance plan. This is where uninsured people in Indiana would go for insurance. Coverage was guaranteed. But the challenge is that it was expensive and a lot of people could not afford it. The group plans were guaranteed but they could put pre-existing condition waiting periods on people that had medical conditions who were not previously insured. In addition, they could basically charge double the rate to the whole group not just to that one person with a pre-existing medical condition. So, for healthy groups, it was not an issue. For groups that had people with diabetes, cancer, and that sought of a thing, it cost them a lot of money. The Affordable Care Act did away with that.

Q03. OK.

P07. Now with the Affordable Care Act, your health condition does not matter. It is not even gender specific. When we underwrite a new group, it is just basically based on your age. We do not ask height and weight. We do not ask any medical questions. It is about your age and that is basically it.
Q03. So the element of pre-existing conditions is no longer existent?
P07. That is gone. It is gone and what that did is that it raised the premiums for everyone. Because you still have the same scenario, you cannot collect half a million dollars in premiums and pay out 1 million dollars in claims. So there is a lot of people who have gone to Indiana Comprehensive plan instead of being on the group plan which helped pull the premiums down. They did away with that after a certain period. The government decided that you cannot do that anymore. So now the Indiana Comprehensive plan is completely gone. It does not exist anymore. Uh, so people have the groups that they can go to. There is no waiting period for people with pre-existing conditions, there is no medical underwriting, and the rates are the rates. It does not matter how healthy you are or how sick you are. You are going to pay the same rate as the guy next to you if you have the same demographics in your group.

Q03. OK.
P07. So from a business perspective, there should be some underlying assumptions that is driving this business. In the old system, I was having to pay more because of a pre-existing condition. Now in the new system, the rates for people with pre-existing conditions have gone down but the rates of the young and healthy have gone up.

Q03. Did you say the rates for the young and healthy have gone up?
P07. Yes. Basically, the real sick people are not paying much as before. So we have robbed Peter to pay Paul and we leveled it out.

Q03. What has been people’s reaction to that?
P07. Well, there is a variable that people charge. They can charge 15 percent extra for tobacco users. That is the maximum the Affordable Care Act can allow. It is one of the major complaints about the Affordable Care Act. Those that are healthy are complaining that I made healthy choices in life, that is why I am healthy and others chose unhealthy lifestyles that is why they are unhealthy. In this situation, the cost of their bad lifestyle choices is being pushed onto me.

Q03. Does the Affordable Care Act allow extra charges only for tobacco users or there are other lifestyle related diseases?
P07. The extra charge allowed is only for tobacco users. Because you know, one can get into questions like alcohol, drug use that sought of thing, you are going into health protected information that you cannot deal with because of HIPAA. I am sure you are aware of HIPAA. Yes they can charge a little bit for tobacco users but most companies do not do that on group insurance. On individual plans, they do.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?
P07. You see the federal government has not been in the insurance business and the insurance companies have been doing this for centuries. The federal government should have consulted the insurance companies on how to do it. When I realized that they did not, I knew there was going to be chaos, confusion, and problems. Another thing with government programs is that they are not
well thought through. At the end of the day, I knew the government would focus on compliance which would mean a lot of paperwork to be completed and audits with steep fines. I knew that lack of information would create fear and frustration among people who were trying to do their best to comply with what they did not know.

Q05. Please describe your experience with the Affordable Care Act.

P07. Overall, individual, or group insurance?

Q05. All the three categories.

P07. Well, my experience with it is that there has been a terrible misconception of how it works. You will be surprised at how people do not realize that they cannot just buy health insurance any time of the year when they want to. Uh, for group insurance, you can. But for individuals, they can only buy health insurance during the open enrollment period or when there is a life changing event. In fact, I was speaking with someone on the phone. The reason you had to wait is that this person wanted to get health insurance for their son because he has problems with his shoulder. I asked this parent if their son had a life changing event; getting married, moving, lost coverage or something like that. She said no. I told the parent that her son is not eligible for health insurance until the open enrollment.

Q05. Are you suggesting that the Affordable Care Act has an enrolling window and once that window is closed, you have to wait?

P07. Yes. From November 1st to January 31st is the open enrollment period. Anyone can enroll into a plan during that time. If you enroll on November 1st, your insurance coverage will be effective January 1st. If you enroll between January 1st and January 31st, your coverage will be effective February 1st. So that is the annual open enrollment window when you can buy health insurance. That is called the individual mandate. Unless you are in a group that qualifies for an exemption, uh, which there are some religious groups that are exempt. If you are not a U.S. citizen, you do not have to get it. But if you do not qualify for an exemption, that is when you have to get your insurance under the individual mandate. Once the 31st of January is past, you are done for the rest of the year. Let’s say if you were to change jobs and you went to an employer that does not offer health insurance benefits, that would give you a 60-day window to buy health insurance on the Affordable Care exchange. But once that 60-day window is over with, you cannot buy until that open enrollment window which is November 1st to January 31st. If you get a job and your employer offers benefits, then you qualify under the rules. Typically, most employers have a 30-day or 60-day waiting period before you can get health insurance benefits. And if it is a policy that hasn’t been grandfathered in, then the pre-existing condition would be an issue. If it is an older plan and I have several of those still out there that I wrote seven to nine years ago, their rates are so much lower than the Affordable Care Act rates. They are staying on those policies as long as they can. December 2017 is the end of those plans. After that, it is either the Affordable
Care Act health insurance plan or you have to go to a self-insured program. Overall, the Affordable Care Act has not worked.

Q05. OK, please tell me more about it.
P07. That is my observation simply because they wanted to get the young healthy people into the insurance pool and they did not accomplish that. And the reason is that we used to use a ratio of 7:1. I am what you call an old guy. I am getting close to qualifying for Medicare. So they look at me who is an old man and a twenty-year old. They will charge me seven times what they charge the twenty-year old. The Affordable Care Act says that cannot be done anymore. The Affordable Care Act ratio is 3:1 instead of the old ratio of 7:1. The Affordable Care Act raised the premium on the twenty-year old. So the premiums for the twenty-year olds at least doubled. For example, it went from something like $100 to $200 per month. In some cases, the twenty-year olds looked at it and realized that the premiums were higher than the penalty, so they decided to pay the penalty.

Q05. So are you suggesting that many young people may actually have opted for the penalty?
P07. Yes because the penalty is less than the total annual premiums. If the Affordable Care Act had left the ratios where the insurance industry had them, there would have been a lot of people insured. If you are young and healthy and it is cheaper to pay the penalty than it is to buy insurance, then a lot of people will not buy insurance. They tell themselves that I am young and healthy. I can invest my monthly premiums and pay the penalty instead of buying health insurance. I think some of them reasoned out that if I get sick and incur a huge medical bill, I will make a payment plan or just file for bankruptcy and just walk away from the bill. So if they are not going to take the responsibility to do the right thing, you cannot force them to do it. The Affordable Care Act was trying to do that but it just didn’t work. And now we are starting to see the effects of these unhealthy people who were in a pool by themselves and now they joined the federal exchange and they are driving the rates up. I think you are going to see a huge increase in premium rates in January 2017. I really think you are going to see a double digit rate increase for all the commercial insurance carriers.

Q05. Why do you think so?
P07. Just because when you take United Healthcare and Anthem Blue Cross Blue Shield across the country and you put them together, they are the largest health insurance providers in the country. United Healthcare is the single largest insurance company in United States. They announced that they are pulling out of the individual market.

Q05. Tell me more about it.
P07. I just got the email last week. They (United Healthcare) are pulling out of 22 states and they just announced that they are also pulling out of Indiana. They are pulling out of the federal exchange. So, all the people who were on a subsidized plan and those single plans that were buying from them will no longer be covered as of January 1, 2017.
Q05. So what is United Healthcare’s business strategy?
P07. They are just going to stick with group benefits for large groups. Plus they still have their own company that sells dental insurance plans and short-term health insurance plans and all sought of things. They are saying we cannot survive under the current situation. Part of their reason for pulling out has to do with risk insurance. This is risk insurance for health insurance companies. As part of the Affordable Care Act, the government was supposed to reimburse insurance companies for their losses. This was put in place because no one had a grip on what it was going to cost to insure all these people with pre-existing conditions joining the pool. Well, they missed it and so the insurance companies lost a lot of money. Then the government said we are not going to pay you as much as we said we were going to. I think they figured out that United Healthcare lost about $650 million in one year. So that is why United Healthcare decided that we are not going to continue to lose this much money for too long. So, United Healthcare decided that they would take their ball and go home. You see the government cannot force them to do anything. This is why when the Affordable Care Act came out, they said if you like your current insurance policy, you keep it. You know that all these things that the government said, they forgot that insurance companies are private entities. So the insurance companies decided that we are no longer going to offer this policy anymore. Well, the government could not mandate that the insurance companies sell something they do not want to sell. I believe the Affordable Care Act was too hastily put together. I don’t think they let the insurance companies have enough say in its design. After all, the insurance companies have quite a lot of experience in insurance; a lot more than the government.

Q05. OK.
P07. And I think, at the back of their minds, all the people in Washington could see is all these insurance companies making large profits. Well, they were making huge profits because they are such large entities. Their profit margin as a percentage was not that high. I think when the Affordable Care Act was signed into law in 2010, Anthem made 3 percent profit. 3 percent is not exorbitant. Now, the dollar amount that the 3 percent amounts to is based on volume and size and is in billions of dollars.

Q05. I see. So they benefit from economies of scale.
P07. Yes exactly. If they go below that 3 percent profit margin, they start losing money and have to start cutting somewhere.

Q05. So what you just explained is sought of a national picture. How about when you look at those groups that you have been underwriting health insurance plans before the implementation of the Affordable Care Act? What differences have you observed?
P07. Well, most of the groups that I had were grandfathered in, then grandmothered once they extended the enrollment period. The ones I still have on books are pretty healthy. They were pretty healthy when we initially issues the group health insurance plans. All we do every year is look at the premiums of insurance
policies offered through the federal exchange versus the renewal. Until the rates of the old policy catches the federal exchange rates, they are staying where they are. But for a lot of these groups, if they were to switch to the Affordable Care Act insurance policies, it would cost them 30 percent to 35 percent more on their premiums. That is how much higher the federal exchange policies are.

Q05. Same demographics but they would end up paying more if they switch to the federal exchange?

P07. Yes. The exact same demographics. It is because of eliminating the pre-existing conditions, no waiting periods, no underwriting, no extra charges, and all the guarantees that come with it. There is no underwriting, so you cannot charge extra on the premium. From a mechanical point of view, the Affordable Care Act made my work very easy as an insurance agent. Because the application process is much easier, there are no medical questions to be asked. All you do is get people’s age and you give them the rate. Whereas before, there were these medical questionnaires. We had to get all the medical questionnaires filled out correctly, get additional information, submit it to the underwriter, and have the underwriter review it. That is not part of the equation anymore. So it is much easier in that respect. That is why when all these grandfathered policies expire, there is going to be a big effect on the whole plan. If an employer has under 50 employees which is the threshold to be considered as a large employer, you are not required by law to offer health benefits to your employees. It is totally optional. Above 50 employees, you either have to offer benefits that are affordable and meet the minimal essential requirements or you pay a fine of $2,000 per employee per year. But they have a deductible. The first 30 employees are exempted from the fine.

Q05. So, if you have 50 employees and you do not provide health insurance benefits, you only pay a fine on 20 employees? If my math is correct, you would only pay $40,000 in fines.

P07. Yes. If you look at it from a perspective of paying $40,000 to the government versus paying high premiums, an employer may be tempted to take that route. If your total annual premiums to provide health insurance to your employees is $250,000 and your fines add up to $40,000 and you opt to pay the fine, it amounts to $210,000 net savings to the employer as a result of not offering health insurance. Now, under the individual mandate, it is your responsibility to go and get insurance on your own. It is important to point out that there has to be a substantial difference for an employer to take this route because there is still value in offering benefits to your employees.

Q05. Definitely.

P07. Employees want employers to take care of them by providing a health insurance plan that is reasonable and they are willing to pay their fair share. If they drop their plan, there is nothing that says they have to pay their premium. So, if they choose not to, now they are under the risk of their employees going to another employer because that other employer offers health insurance benefits. So, to
me, December 31st of 2017 is the next big day in the Affordable Care Act implementation process.

Q06. Overall, did the Affordable Care Act make things better or worse? Please explain.
P07. From what I gather, I think it depends with one’s perspective. I see it as an advantage in case I fail to provide health insurance. My employees can go to the exchange and obtain it cheaper. But I also hear that the exchange rates are higher for employers. So that sounds like a mixed bag.

Q07. If you had been given the choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?
P07. Well, the problem with the old healthcare system is that costs were increasing faster than people could afford. At some point, there was going to be a national crisis where a majority of the people would either be on Medicaid or go without health insurance. There was no coordination between healthcare providers. For example, if there was a patient on both Medicaid and Medicare, Medicare did not know what medical services were provided through Medicaid and what charges were paid by Medicaid. A healthcare provider could provide a service and bill Medicare then turn around and provide a similar service and bill Medicaid. That was not right. Looking at the Affordable Care Act, it did attempt to create a common database which can tell the healthcare provider what services were provided and when. However, the challenge with the Affordable Care Act is that premiums for most people have gone up. So I am torn in between the old system and the Affordable Care Act. I would say that the old system needed some changes to make it better and the Affordable Care Act did not do that. It took a broken system and made it more broken. The Affordable Care Act is all cost driven. I think most people would have stayed with the old system as long as it was less expensive. At this point, people and employers are saying the Affordable Care Act has made health insurance more expensive. Another advantage people had in the old system is that employers could offer employees a financial incentive to go and buy insurance elsewhere. But now with the Affordable Care Act, it is illegal to do that.

Q07. Do you think even though it is not allowed under the Affordable Care Act, there could be some businesses that may be doing that?
P07. I have not yet seen that. That is why December 31st 2017 is when you are going to see that. And the reason the rates are still reasonable on the plans they have compared to what is available on the exchange is because the rates haven’t gone up as much as I thought they would. I really thought the rates would go up faster but they haven’t. Most of the renewals I did in the last 3 years have had single digit increases; anywhere from 3 percent to 7 percent. I think you are going to see 15 percent increases on the Affordable Care Act rates this year.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?
P07. I believe it made things worse. It definitely made things worse. For people with pre-existing conditions, the Affordable Care Act has been a lifeline. For the young and healthy, it caused their premiums to go up. I believe this has caused a lot of
young and healthy people not to obtain health insurance. There is also a lot of chaos on the insurance market. People are afraid that they may be audited but they do not know how to meet the regulations.

Q09. What aspects of the Affordable Care Act do you like?
P07. Guaranteed coverage. I like it from the standpoint that it is much easier to deal with and it is fairer to the American public. Uh, there has been many times over the years I wished I could help someone but I could not. They could not afford the premiums in the comprehensive pool and they couldn't get insurance through regular carriers. So that is a good thing. Uh, eliminating the pre-existing condition waiting period is a good thing for the consumer. I am not sure it is a good thing for the insurance industry as a whole. Uh, but those two things are probably the best things I can see about the Affordable Care Act.

Q09. What aspects of the Affordable Care Act don’t you like?
P07. I do not like the rating structure. I do not like uh, (long pause).

Q09. Please explain the rate structure.
P07. Well, I do not like the fact that the premiums are so high because of not letting the insurance companies do any underwriting. They are basically saying we are all clones. We are all the same so we charge the same for everyone. You cannot do that. What if they came out and said people that have 10 to 12 traffic accidents per year will pay the same rates as those who have never had an accident? Who is going to pay more money?

Q09. The person with a good driving record.
P07. There you go. So I do not like that aspect whereby everyone pays the same. I also do not like the narrow networks of only being able to get insurance during that 3-month window from November 1st through January 31st. Another thing I do not like is they didn't make the penalties high enough to cause people to conform to the law. Uh, this year, the penalty for an adult is $600 and $300 for each child in the household. So if you have a family of four, you are talking about less than $2,000. To obtain insurance for the same family, it is going to cost you $800 to $1,200 per month. The penalty needs to be $5,000 to $7,500 per family. It has to have enough teeth in it to discourage people from not getting insurance. If you do that, it is going to put more healthy people in the pool. That will help reduce all the costs, but they just did not do that.

Q09. Interesting.
P07. The same thing with the employer plan. The penalty of $2,000 per employee is too low. Most employers are paying around $400 to $500 per employee per month towards health insurance. If an employer has 20 employees and chooses not to provide health insurance, they will not pay a penalty. If you get into the 50 plus employees, let us say 50, and the employer pays $400 per month, that is $20,000 in total premium payments per month and $240,000 per year. If that employer chooses not to provide health insurance, that employer only pay fines on 20 employees since the first 30 employees are exempted. Fines for the remaining 20 employees at $2,000 per employee amounts to $40,000 per year. If the employer chooses not to offer health insurance benefits and pay the fine,
that amounts to a $200,000 net savings per year. I believe the penalty should have been around $5,000 per employee. If you want to force people into something, you have to get into their pocket book. You cannot just tell them to do it. No one likes to be told to do something.

Q10. What were some of the unexpected consequences of the Affordable Care Act?
P07. Cheating on tax returns (laugh). So, this is all driven by your tax returns. There are people who are reasonably well off that are getting considerable subsidies because our tax system is so corrupt. If you own a business, you can make your income look so small if you want to. So you have the person on the street who is just over the threshold to qualify for subsidy and they do not get it. They don't buy insurance because they cannot afford it, whilst this guy over here who drives a Cadillac is getting $1,000 in monthly subsidies. I think they should have kept it away from our tax system. Uh, there are a lot of loopholes that people can hide their income. The subsidies are based on your adjusted gross income. Well, if you have a business, above that line of gross income is your Schedule C for your business. Well, you can make your business look like it is losing money in our current tax system. So, those people who do not need subsidies are getting them while those who need them are not. That was a bad idea tying it to tax returns. Why would the IRS want to get involved in health insurance? So I did not like that aspect of the plan. What else? Uh, really those two things are the main ones; the cost and subsidy system.

Q10. How about choice of doctors and hospitals?
P07. Here is what drove that issue. Uh, the way insurance companies try to control costs over the last few years was through HMO and PPO networks. So providers have a contract with the insurance companies that they would not charge anything above what contractually they are allowed to by the insurance companies. Well, when those plans came out, the insurance companies knew that the premiums would go up. So they narrowed the networks. So that is a negative. With United Healthcare pulling out, it was the only insurance company with a broad network. They had every hospital in Indiana in their plan. You could be in Texas on vacation and you would put in a zip code of where you are and you would find a provider in your vicinity. Well, next year, I will have only 2 plans available; IU Health and Anthem. If you are on the IU Health plan and you are in Texas and you have a non-life threatening event, then you are not covered. No one is going to have a national network next year. So that is going to cause problems. You have all these people who vacation in Florida. Unless it is a life threatening emergency, they are not going to have coverage.

Q10. Does that suggest higher exposure when you travel out of state?
P07. Typically, it’s going to be an emergency that is only covered. The good part is that IU Health premiums are a lot less than Anthem. If you are in Florida and you have a heart attack, the ambulance takes you to the hospital, are you covered? Yes you are covered. However, after you get stabilized and they need to do further tests, are you covered? The answer is no. From that point, it is no longer regarded as an emergency. Now you have this heart problem but you have to
drive back to Indiana for what is regarded as non-emergency care. You can be airlifted but it is not covered by your insurance. You are supposed to drive 18 hours from Florida back to Indiana to receive non-emergency care. So there is a storm coming (laughing) and I am not sure I am willing to suffer through it. It is going to be a major issue. It won’t be something that will happen with great regularity but when it happens, it is going to be bad.

Q10. Interesting observation.

P07. I have done something for travel policies. You can buy travel insurance policies for out of the country but it is not available in the country. The travel insurance will pay directly to the foreign provider.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?

P07. I think no pre-existing conditions and allowing kids to stay on their parents’ health insurance until they turn 26 years old are good benefits. The only challenge with the second one is that those same young and healthy were also expected to join the federal exchange pool so that they can help lower the premiums. From an insurance business point of view, our job has become much easier. We do not have to underwrite people anymore. The process is much simplified and way easier than it should to. We have also seen an increase in business as people look for answers and we work to provide those solutions.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?

P07. Overall, I think the challenge with the Affordable Care Act has been implementing a huge system change without good communication from the federal government and a non-working computer system for people to obtain information. They could have done a lot better at the launching. I felt like it was done in a hurry and the initial results were total disaster.

Q13. What has been your sources of information concerning the Affordable Care Act?

P07. I attended several seminars and webinars presented by national insurance companies. I also attended seminars presented by the Department of Labor. The internet was a good source of information but as we all know, one has to be careful to ensure that the source is legitimate and not fueled by political interest.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?

P07. The guaranteed issue has to be maintained because there are just too many people with health conditions that you can’t go back to the old system. Uh, under the pre-existing condition waiting period, I would see a problem with imposing a pre-existing condition period because I call it the fire department mentality. If people cannot go and get health insurance today and get a procedure down tomorrow, may be they need to wait for 90 days. I would like to see that maintained with the guaranteed issue. That is what I would keep.

Q15. If the Affordable Care Act was to be revised, what aspects would you want to see revised?
P07. I would suggest that they completely revise the subsidy system. It is not fair. Uh, I would raise the penalties. I would actually make it a penalty to make people get with a plan to help the pool. After all, the whole idea behind this thing is to get all the healthy people into the pool to lessen the strain on the pool. So they have to figure out a way to do that. I would change the rating structure back to 7:1 to make it less expensive for young people and to incentivize them to join the pool. I would charge a higher penalty if they do not join a pool. I would love to legislate something about networks but I know you cannot. Another thing, the first time I heard the name of this act, ‘The Affordable Care Act,’ what has Affordable Care Act to do with insurance? To me, it does not have anything to do with insurance. Insurance is a vehicle to pay the bill. If they want to have ‘affordable care’, there is need to be some constraints on the medical community to not charge some of the fees they charge.

Q15. Tell me more about it.

P07. To me, that is affordable care. I see a cardiologist because I had an open heart surgery 20 years ago. When I go to see him, we sit down and talk about Purdue Basketball or something like that and it’s a $300 charge for 10 minutes. The medical community has saved so many lives but they are charging too much. If they want to call it ‘The Affordable Insurance Act,’ that is something totally different. If it is going to be the Affordable Care Act, there should be a little pressure put on the other side on what they charge. It is important for people to ask how much a procedure costs when a doctor recommends it. In most cases, the doctor does not know.

Q15. Well, thank you so much for your time. Is there any information about the Affordable Care Act that you would like to share with me I did not ask?

P07. No.

Q15. Thank you so much. May I contact you if I have follow up questions?

P07. Sure! You have my card. You can contact me.

Q15. Thank you.

Participant 08

Q01. Thank you for taking time from your busy schedule to meet with me.

P08. Oh, no problem.

Q01. Like I stated in our phone conversation, I am a student at Purdue University. My research focus is examining the impact of the Affordable Care Act on small businesses.

P08. It must be interesting to talk to people about that subject.

Q01. Yes, it is. What is your position in this organization?

P08. I am a co-owner. I have been in this industry for 28 years. I started working for this company 7 years ago and I have been a co-owner for the past 3 years.

Q03. How would you characterize your medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?
I kind of like Obamacare it. In fact, it has saved me a lot of money. Prior to Obamacare, I used to pay $800 per month for health insurance for my whole family. Obamacare lowered my monthly premiums.

When you first learned that you would need to comply with the Affordable Care act, what went through your mind?

I wanted to see what it would look like and for me it has been good. I was really not sure what was coming. At first, I was skeptical but I understood it was the law of the land and we all had to do what we needed to do to be in line. I know there are a lot of good sponsored government programs such as Medicare and Social Security and I hoped that this would be one of those. It is not fair to have people go without health insurance because they cannot afford.

Please describe your experience with the Affordable Care Act.

I used to pay more money on a monthly basis before Obamacare. We had a different insurance plan before they introduced Obamacare and it was through Blue Cross Blue Shield. Our insurance agent brought us all the information we needed and the process was very easy. For me and my family, it has been a wonderful experience. Our premiums have gone down and we are receiving the healthcare services we need. I also have my son on my insurance until he is 26 years old. That is a big bonus for me. I do not have to worry about his health insurance when he is in college.

How many are you in your family?

We are three; my wife, my son, and I. Before Obamacare, I used to pay around $800 for my whole family but now I pay only $200 per month for my whole family. Another benefit I get from Obamacare is that my son is 22 years old and is in college. He can stay on our health insurance plan until he turns 26 years old. That is a very good thing. That means I can keep him covered for another four years. He does not have to worry about finding his own insurance. I love it. That is a good deal. He does not have a stable job. For the most part, we are a healthy bunch of people plus we are also saving money. As a company, we do not provide health insurance. I was told that the number of our employees is below the threshold.

How many employees do you have?

Well, our work is seasonal. During winter, we are down to bare bones but during summer and fall, we have between 25 and 35 employees. Most of our employees are part-time. I have a great bunch of guys I work with.

Did you say you pay $200 per month for health insurance for your whole family?

Yes. I am told how much one pays depends on one’s income. With Obamacare, we do not have to worry about our employees going without health insurance. If they are not covered by their spouses’ health insurance, they can always go to Obamacare and get coverage. This is huge for us as a company. We do not have to loose good employees to other employers because we do not offer health insurance. This is a great benefit for us as a small business. We can compete with big companies. When your employees have access to health insurance, you can
be guaranteed that they will stay with your company. For us, Obamacare makes that possible.

Q06. Overall, did the Affordable Care Act make things better or worse for you? Please explain

P08. Definitely better. Our premiums went down from $800 per month to $200 per month. In addition, we can also keep our 22-year old son on our insurance plan for the next 4 years. Now that is a winner for me.

Q07. If you had been given the choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?

P08. I would go with Obamacare for several reasons. Our company did not provide health insurance. We had to go out and buy health insurance for ourselves. So that is a big change, a good change brought by Obamacare. The other reason I would go with Obamacare is that our monthly payments went from $800 per month to $200 per month. That is a huge savings. I see it as a raise I got from Obamacare. Another good reason is that my son who is 22 years old can stay on our health insurance for the next 4 years. That is another savings again. If my son was supposed to pay $200 per month on his own insurance, that is a total of $4,800 savings for him. I hope by the time he turns 26 years, he would have finished college and found a decent and stable job. Another benefit is that there are agents that are paid to come, meet with people, and explain how Obamacare works. So, a savings of $500 to $600 per month is a huge raise for me and my family.

Q07. May you please describe the process you went through to obtain health insurance through the exchange.

P08. It was very simple. The agent did a lot of work for us. There were no medical questions asked. The agent only asked out age, gender, and whether or not we smoked. And that is it! It was very simple and straightforward.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?

P08. Well, let me see. At least I can compete with bigger companies when it comes to offering health insurance. Technically, I am giving my employees an Extra $2 to $3 per hour since I am not required to provide health insurance. This makes me be able to compete with big companies when it comes to salaries I can offer my employees. Also, health insurance ceases to be a competition factor when it comes to hiring employees because people can get health insurance through the exchange. Like I said earlier on, as a small employer, I do not have to worry about providing health insurance because I do not have the capacity and expertise to do it. I can concentrate on doing what I know best.

Q08. Did you experience any computer glitches when you attempted to sign up for health insurance on the exchange?

P08. No I did not. I actually just used an agent. I hear there were a lot of problems with computer registration. I did not experience any of that. But I am told it was bad.

Q09. What aspects of the Affordable Care Act do you like?
P08. Well, that is a good question. I like the fact that my monthly premiums are down. That is a big plus. That is a bonus for me. I also like the fact that I can keep my son on my insurance until he turns 26. This gives me peace of mind knowing that he is covered whilst at college. Coverage is good and the deductibles are low. Depending on your gross income, it is a huge reduction in premiums. If you make good money (say $200,000 per year), you pay the same for Obamacare as Blue Cross Blue Shield.

Q09. What aspects of the Affordable Care Act don't you like?

P08. Not sure. I would have to think about that. Well, some people say there are limited network doctors. My family is healthy, so that has not been a problem for us. We have not yet run into that problem.

Q10. From your experience, what were some of the unexpected consequences of the Affordable Care Act?

P08. I have not yet experienced any. I have heard some people talk about having to go to Lafayette or Indianapolis to see specialists. For us, that has not been the situation. To be honest, I have not experienced anything negative.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?

P08. So far, I would say none. I wait to see what the future holds.

Q12. What challenges have you realized with the implementation of the Affordable Care Act?

P08. Again the same answer. We have not experienced any challenges since we have not implemented it. We went through our agent.

Q13. What has been your source of information concerning the Affordable Care Act?

P08. Like I said earlier, we used an independent agent. She went through different programs with us. I am sure if some people did not have access to a computer or use an agent, it created some challenges.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?

P08. In my view, I like the fact that you can choose what you want. You can choose your coverage and your deductible. This is very important for me. I can choose my coverage and my deductible based on my needs. I also like the fact that kids can stay on their parents’ insurance plan until they turn 26. That is a huge hidden savings for families. Most kids do not have stable jobs until they hit their late twenties. I also like the fact that the premiums are affordable; the poor and the rich pay the same premiums.

Q15. If the Affordable Care Act was to be revised, what aspects would you want to see revised?

P08. I cannot think of any. I think as long as they can figure out a way to keep premiums down for everyone, then it will be a win/win outcome.

Q15. Thank you so much for your time. Is there any additional information you would like to share with me about the Affordable Care Act that you did not?

P08. If I remember anything, I will contact you.

Q15. Thank you. May I please contact you if I have follow up questions?
P08. Sure! I am always on the road but if you call my cell, I will be glad to answer any questions you may have.

Q15. Thank you so much!

Participant 09

Q01. Thank you for taking your time to meet with me this early. I know you have a busy schedule and I just want to thank you so much for creating time for me.

P09. Oh, no problem. What questions do you have for me?

Q01. What is your position in this organization?

P09. I am a co-owner. I have been in this industry for all my life. Let’s see, I am 47 years, so about 28 years. I have been a co-owner of this business for 8 years.

Q03. How do you characterize your medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?

P09. As a company, we decided we could not afford to offer health insurance to our employees. The premiums were too expensive and beyond our reach. So we decided not to offer health insurance. Most of our employees were covered by their spouse’s insurance. Others bought insurance for themselves or they went without.

Q03. How many employees do you have?

P09. Well, it varies, depending on the season and contract work that we have going on. But generally, the number is around 25 during low volume seasons and 35 during high volume seasons. Some of them are part-time.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?

P09. Well, I know it is the government trying to reach their hands into our pockets. Whenever you see the government come up with something, all they are trying to do is to reach into your pocket and control you by telling you what to do and what not to do with your money. I don’t like it when the government tells us what to do. We worked hard to start our business without the government’s help. Now, when we are up and running successfully, they come and start putting controls and telling us how to run our business. The federal government has no place in running people’s lives and telling us what to have and what not to have. I do not like it and I am not happy about it.

Q05. Please describe your experience with the Affordable Care Act.

P09. Well, I do not know. First of all, I don’t like it when the government comes in and tells me what to do with my money that I worked for. When they introduced the Affordable Care, there were serious problems with their computers. People could not register. Others thought they were registered when in fact it never went through. No one, not even Obama seemed to know what was going on and what the problem was. It was a total mess. It took them forever to figure out what the problem was and how to fix it. You would think with all the money and expertise the federal government has, they would have figured out how to make things work from the beginning or at least figure out how to resolve the
computer problems. It makes one wonder if they had even put in some thought and time to plan the role out. Even if you tried to call the customer service numbers, they were jammed. It was just a total mess.

Q06. Overall, did the Affordable Care Act make things better or worse for you? Please explain.

P09. Are you kidding me? How could it make things better when people lost coverage, premiums went up through the roof, and people cannot visit their regular doctors anymore? It made things a hell lot worse, at least so far. May be they will have plans to fix it and make things better. This November we will have presidential elections and have a new president. So, we do not know what will happen to it. I hope they will just scrap it off, put in place a new system, or just go back to our old system. From my perspective, the Affordable Care Act has made things worse. How can they call it ‘affordable’ when premiums are going up and healthcare is no longer affordable? I have heard stories of people having to drive to Lafayette and even beyond to receive specialized care because those services are no longer available in their small and rural communities. Specialists have moved to bigger cities where they can benefit from large numbers because their rates have been reduced, making it impossible for them to survive in small communities. My husband has to see a prostate cancer specialist and a lung specialist. He has to go to Indianapolis because the specialists in Lafayette are either not in our network or are not taking new patients. So that creates a challenge for many people. I think for those on fixed income, that creates an even bigger challenge. When your insurance premium goes up, prescription drugs go up, and you have to drive more than one hour to receive specialized services, that is not good. There are four of us on our health insurance; my two kids, my husband, and I. Prior to the Affordable Care Act, the four of us were paying $760 per month. My husband and I are smokers, so that does not make things better. With the Affordable Care Act, our monthly premium rose to $874. I think the increase had to do with us being heavy smokers and my husband’s age. He is getting up there in age and getting more expensive to provide health insurance.

Q07. If you had been given the choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?

P09. You see I do not like that question.

Q07. You do not have to answer it. We can go to the next question.

P09. No that is OK. I can answer it. I guess what it means is you are asking me to choose between two bad options. I liked the old healthcare system but it was becoming too expensive. The Affordable Care Act did not help either. Things changed from bad to worse. With some tweaking, I would have opted for our old way of doing things.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?

P09. Not much so far, but I am sure there is a lot coming. I think they said there are certain portions of the Affordable Care Act that are yet to be rolled out. Who
knows what is coming with those portions that are yet to be rolled out. Most likely, it is bad, that is why they delayed it. Since we only have less than 50 employees, we have not experienced much impact like other businesses with 50+ employees. As a company, we are in the process of looking for health insurance for our employees. I mean it is expensive to provide health insurance but it helps you to attract and retain good employees. Since I am told that the premiums are based on income, I hope the premiums for our employees will be affordable. This is funny. They call it ‘affordable care act,’ yet most people’s premiums have gone up. What is affordable about it? So, as a company, we hope to provide health insurance to our employees starting around July 2016 if we find reasonable rates. If the rates are not reasonable, we will not just provide health insurance and just wait to see how things will shape up.

Q09. What aspects of the Affordable Care Act do you like?
P09. I am not sure there is anything I like. I think it is just another way the federal government is reaching into our pockets, taking our money, and telling us what to do. I believe it is another way the federal government is taking money from hard working Americans to give to the poor because they are lazy and do not want to work. I mean, as a community, we should take care of our sick, elderly, and disabled. That is the reason why Medicaid and Medicare are in place. I also do not like the fact that people’s premiums have gone up and there is no solution in sight to bring them down. That worries me a lot. OK, I like the fact that those who were uninsured can now get coverage. But those of us who had insurance and like it, should have been allowed to keep it. We were told by Obama that if you like your current doctor, you can keep him. That has not been the case. That has not been the case. Instead, people have had to change doctors for one reason or the other beyond your control. Many doctors have moved out of small communities to big towns. This has left people with no options but to travel long distances for healthcare. I want to believe that this has adversely affected those people who are on limited income, those with unreliable means of transportation, the elderly, and the poor. It took away people’s choices and dictated to people what they should do with their healthcare.

Q10. What were some unexpected consequences of the Affordable Care Act?
P09. Everything there is was unexpected. Everything that was promised did not materialize. They said you can keep your doctor. That did not happen. People have had to change doctors they had for many years. They said it is going to be affordable. That is not true. People’s premiums have increased. They said people will have choices of doctors and hospital networks. That is not the case. We now have fewer networks. They said it will make healthcare better. It has actually made healthcare worse. They took a no-so-good system and turned it into a nightmare. So I would be correct to say that everything they promised concerning the Affordable Care Act did not materialize. What we have is a direct opposite of all their promises. Empty promises. Once you choose a network, you are only limited to doctors in that network. If you have to receive specialized
services, you may have to travel long distances to find doctors in your network, otherwise you will pay high fees to see a specialist who is not in your network. I do not think that Washington knew that our premiums would go up. If they did, it would not have passed. I think they were equally surprised to see people’s insurance rates go up. I think they expected a lot of people to sign up but that has not been the case. I can also bet you that there are many people who have lost their health insurance because they cannot afford the premiums but we never hear about them. It also appears that most of the small doctor’s offices in our small communities are closing. And these big hospital systems are taking over every county and community hospital. That is not right.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?
P09. Probably none. At least everyone can buy health insurance. But the question is at what price and what would the quality of coverage be? My employees can also go on the exchange and buy health insurance if I cannot afford to provide it.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?
P09. Technically, we have not implemented it so I cannot think of any challenges. But I am sure there are a lot when we get to that point when we enroll.

Q13. What has been your sources of information concerning the Affordable Care Act?
P09. Well, it has mainly been the media; TV, Newspapers, radio, and also the internet. I spend a great of time reading about the Affordable Care Act.

Q13. Which websites do you visit?
P09. Nothing in particular. I just surf the internet and see what pops up. There is so much written out there on the subject. At some point, I believe that all sources get their information from the same source.

Q14. If the Affordable Care was to be revised, what aspects would you want to see maintained?
P09. I would suggest that they scrap the whole thing off and start all over.

Q14. How are about the 17 million people that already got their insurance through the exchange? How about the millions if not billions of dollars that have been invested into creating the exchange?
P09. Well, I doubt that it will go away. I guess they can salvage some elements. I think the idea of the government providing health insurance of some sought to people who need it is a good idea. However, the government should not rob Paul to pay Peter. Also, the element of no pre-existing conditions is a good one. For my husband, this is a big plus since he is getting up there in years and also he is a heavy smoker. I guess that sounds very selfish. I also like the idea of kids being able to stay on their parents’ insurance until they are 26. Most kids at that stage in their lives are still trying to settle and do not have stable jobs. That to me is a definite plus.

Q15. If the Affordable Care Act was to be revised, what aspects do you want to see revised?
P09. Well, it appears everyone’s premiums went up. That is not fair. How can people’s premiums go up when there are so many people in the pool? It does not make sense. Unless the majority of the 17 million people who joined the exchange had health issues like my husband. People should also be allowed to see any doctor they want. It is very difficult for people who live in small communities to have to drive an hour away to a major city to receive specialized care that they used to receive in their backyard. There also seemed to be no incentive for doctors to run small practices in small communities. I am afraid that with all this centralization of health records, the government will do crazy stuff with our information.

Q15. Is there any other pertinent information about the Affordable Care Act I did not ask you want to share?

P09. I think I shared all the information I know about the Affordable Care Act. I am just afraid that the federal government messed up something that was working for many of us and put in place something that is crazy and not good. Obama told us that if you like your doctor, you can keep him. What happened to that promise? We are now being forced to change doctors because of these crazy networks. Several health insurance networks have pulled out of Indiana and more are threatening to pull out. This is just going to be a big mess. There is so much uncertainty and people are worried. There are changes coming and companies are struggling to stay compliant with all these rules. Companies are afraid that when audited, they will be found not compliant and be heavily fined. We will see how everything will unfold when it is fully implemented. After all, we will have a new president and so something might be changing anyway.

Q15. Thank you so much for your time. May I call you with follow up questions?

P09. Sure, as long as you can find me here at the office. You have my number and so you know how to find me.

Q15. Thank you so much!

Participant 10.

Q01. Thank you so much for taking time from your busy schedule to meet with me. Like I stated in my email, I am studying towards my PhD with Purdue University. For my research, I am examining the impact of the Affordable Care Act on small businesses. I know you have been in the health insurance business for years.

P10. OK.

Q01. What is your official title?

P10. Accounts Executive.

Q02. How long have you been in the health insurance business?

P10. I have been with my present company since 2011.

Q02. OK. And how long have you been in the health insurance business?

P10. I worked for a claims processor from 2005 to 2011, so that is 6 years. I have been in the health insurance business for a little over 11 years. I also worked with a self-funded accounts and national accounts prior to that.
Q03. How would you characterize the medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?

P10. It changed the way health insurance plans were underwritten from a risk perspective. It also changed much for companies in the small company category. What are you qualifying as small business? It is revenue or the number of employees?

Q03. Both revenue and the number of employees.

P10. The 51 to 200 employee sized companies were affected by the PECORI fees. There are also the transitional fees that you pay. When as an agent we do the renewal, we charge $5.75 per employee per month strictly for the Affordable Care Act. These are cost fees for people who participate on the plan. That also does not include indirect costs of employer reporting and compliance.

Q03. How much do you think that has impacted businesses? Have businesses created extra positions to take care of compliance and reporting?

P10. I have not seen businesses create extra positions. What they have done instead is to squeeze more out of their current employees. Others have resorted to paying outside venders to take care of their reporting and compliance needs.

Q03. Have you seen a lot of businesses that pay an outside vendor to take care of these extra demands for them?

P10. Yes. An outside vendor or if they have an online system, they can purchase the module that is specifically designed for ACA reporting. The online software will take care of that. But then, the employer is the one who has to ensure that the data is put into the system.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?

P10. We knew that a lot of paperwork to stay compliant was coming. We knew that we had to communicate more and frequently with our business customers to make sure they stay on top of things. We also knew that the federal government at some point was going to start doing audits and we had to stay on top of our game.

Q04. Was the Director of Compliance position created in preparation for the Affordable Care Act?

P10. Yes, it was.

Q04. So as a company, is that an additional expense that you have incurred to stay compliant?

P10. Yes. We knew that it was coming and we knew that there was so much involved with it that it took the burden off of each of us Account Executives to know every single regulation line by line. We have him as a resource that can help with that.

Q05. Please describe your experience with the Affordable Care Act.

P10. (Long pause). I think employers have adjusted overall more favorable than I thought they would in the beginning. I think there was a lot of fear especially around 2009 and 2010 when things started rolling out. All the grandfathered plans, we were looking at them and wondering if they were going to obtain and maintain their grandfather status. They were not allowed to make many changes
higher than 5 percent or else they would lose their grandfather status. I think there was a lot of fear from the employer side whether they were even going to be able to maintain health benefits for their employees. So I think there was a little surprise for me because of the amount of fear that I saw as the transition took place.

Q05. What do you think caused that fear?
P10. Fear of government regulation in some cases, fear that someone was going to absorb the cost of the federal exchange. Like the transitional fees were being put in place to help offset the cost of members who were previously denied coverage and went on the federal exchange. As an employer, seeing the government shift the cost back to you was frightening.

Q06. Overall, did the Affordable Care Act make things better or worse for you? Please explain.
P10. I think it depends with who you are in the health industry. I think it made it more complicated. There are a lot of individuals that have an exchange plan who do not understand what they have, what the plan covers, and what the plan does not cover. I think there is a lot of confusion on the subsidies and how they work, who qualifies, and who does not qualify. I met a family of five and the children are all under 26 years. They are still able to be covered. Both parents worked and have a combined income of about $90,000. They did not know that they qualify for subsidy. The wife wanted to take a job and she had just graduated from college with a social work degree. She wanted to take a job with a domestic violence shelter that did not offer benefits. She carried benefits because she worked at a school. Her husband worked for a construction company. Her benefits were better. She could not get the job in the area she went to school. She was in tears over having to stay where she was and not take the new job. From an underwriting perspective, it made things a lot better. In the old system, we had to ask a lot of medically related questions and sometimes the underwriter would kick back the file with more questions. With the Affordable Care Act, we do not have to ask all those questions. Also, from an insurance business perspective, it has given us more customers to work with.

Q06. So she had to pass on the good job she went to school for because she could not get health insurance?
P10. Yes, she ended up taking a little while and transitioning to a different job from there.

Q06. You talked about these old plans that were grandfathered in. May you please explain.

Q06. What do you think is going to happen when they expire?
P10. There are not very many left grandfathered. To remain grandfathered, you are tied to that plan offering percentile of employer contribution and employee contribution. If the employer contributed 80 percent and the employee contributed 20 percent, you cannot change that more than 5 percent from March 2010 forward. So we are six years in now and there are not many companies that
have been able to maintain that without passing on the cost to their employees through benefit changes or through changing that percentage by more than 5 percent.

Q06. Do you think when these grandfathered plans expire, people will see an increase or decrease in premiums?

P10. I think most plans have already gone up. Those grandfathered plans which will expire in December 2017 will see an increase in premiums.

Q06. With some of the Affordable Care Act stages still being introduced in the next 12 to 18 months, do you think people also see an increase in their premiums?

P10. I think the Cadillac tax affects the employer more than the employee. It affects the employer because it will be a tax directly to the employer. It depends with how the employer reacts to that. I think if the employer cannot absorb that, then that will have a huge impact on the employee contribution structure.

Q06. So, going back to my question, do you think the Affordable Care Act made things better or worse?

P10. I think it allowed people to... (Long pause), I do not know how to answer your question. I think people who were previously denied coverage or worked for an employer who did not provide health insurance coverage, and they couldn't get coverage through individual markets because they had pre-existing conditions, or something like that, the Affordable Care Act was good for them. Now they can have coverage when they never had it before. I think for a lot of employers, it made it more complicated to figure out who they were going to offer the same amount of benefits they have always offered without passing on that cost on to employees.

Q06. So who is paying the difference in premiums for the people who had pre-existing conditions but are now allowed to join the exchange?

P10. The employers are paying.

Q06. How about employees?

P10. Yes of course. Every time employers incur costs, they pass them on to their employees. There is nowhere the employer can absorb that whole cost. That is very rare. For people who had no access to care with pre-existing conditions, it definitely made things better. But to those who had access to care and had health insurance, it made things worse. One thing the Affordable Care Act does not address is the cost of healthcare. I think you can look at the State of Massachusetts. They instituted a similar program long ago. I do not remember when it started. They reached a point where major insurance companies could not work with the state anymore. They felt like the state had tied their hands, but providers could still charge whatever they wanted to. And so it became not profitable for them. At that point, the State of Massachusetts stepped in and started regulating some facility costs as well. That hasn't happened with the Affordable Care Act. So you look at the healthcare industry with 9-13 percent cost increase year after year. Who can keep up with that?

Q06. Interesting.
P10. If you look at hospitals in Indiana, they are charging 200 percent to 500 percent of cost of their services. They are building new facility after new facility. What is going to change?

Q06. So, am I hearing you correctly that the Affordable Care Act did not address the cost of healthcare? Are you suggesting that it focused on health insurance but that is just one piece of it? The pharmaceutical companies and hospitals continue to charge whatever they charge and yet on the other hand, the health insurance sector is being squeezed.

P10. Yes, that is what is exactly happening.

Q06. I would like to go back to what President Obama said, “If you like your plan, you can keep it.” Do you see that happening out there or the situation on the ground is different?

P10. I think it is different. I think a lot of the exchange plans, like what I was referring to, people have plans on the change they do not understand. A lot of people have very narrow networks. For example, you could have an Anthem plan that does not include a hospital or many hospitals that are in close proximity to you. Same carrier but different networks.

Q06. So the notion that you can keep your doctor if you like him is out through the window?

P10. Unfortunately in most cases, yes. You have to be very careful.

Q07. If you had been given a choice, would you have opted to go with the Affordable Care Act or stay with the previous healthcare system?

P10. That is an interesting question (long pause). I think the previous system needed help. There is nothing that regulates what hospitals can charge for their services. No one regulates what the total bill will be for a procedure. We have PPO networks in place. But a PPO is a discount off of some total bill charge. And so you could have a 70 percent discount off of $2,600 MRI or you could have a 20 percent discount off of a $500 MRI. The first discount sounds better than the second but who is paying less? An MRI in Indianapolis can cost anything from $500 to $2,600, depending with where you go for care. I don’t know. That is a tough question. The old system was working but insurance costs were always increasing faster than people’s salaries could afford. I was afraid that at some point, the system would burst. But what I liked about the old system is that it was predictable. Going in, we knew what to expect. The Affordable Care Act is good in the sense that everyone now has access to health insurance. There are no pre-existing conditions anymore and that is a good thing. I think the old system needed to be fixed but I am not sure the Affordable Care Act did that or made things worse.

Q07. OK.

P10. Uh, I’m just not sure the Affordable Care Act was the correct answer of the situation. It might have been part of it. I understand the desire for everyone to have access to care. Uh, but even if I was uninsured, I could walk into a hospital and receive care prior to the Affordable Care Act. Indirectly, those with insurance paid for those who utilized healthcare services without insurance. So, either way,
those who could afford to pay for their health insurance are still paying for those that could not afford through increase in premiums. The Affordable Care Act is just using a different avenue but the same people are still paying.

Q07. Did you say the old system needed some help but you do not think that the Affordable Care Act solved that problem?
P10. Yes you are right. The Affordable Care Act did not address the real reason why health insurance is always increasing. It did not address cost drivers caused by the pharmaceutical companies and hospitals. The Affordable Care Act only focuses on one part of the equation which is the cost of health insurance. Let me give you an example. One of our clients had an employee who went for a procedure at a hospital in Indiana. This client was told upon registration that you can pay $10,000 for the procedure within seven days, or we will bill your health insurance company $109,000. We have a copy of the letter. And if that employee was on Medicare, the cost of that same procedure was $2,000.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?
P10. Well, as an insurance agent, I do not have to ask as many questions as I used to be required to. Basically, there is no longer any medical underwriting. The process is so simplified that it made my work a lot easier. On the business side, the Affordable Care Act has been good for our industry. We have seen an increase in business as employers come to us for solutions.

Q09. What aspects of the Affordable Care Act do you like?
P10. I like the, uh, I like the fact that people have access because I have friends who were denied coverage. Now they have coverage. I like the intent, I, uh, (long pause) I just don't like the way the, uh, it doesn't address everything that is broken within the healthcare system in this country.

Q09. What don't you like about the Affordable Care Act?
P10. Well, if you look into that deeper, these hospital systems are building in every small town in Indiana. They are also buying or providing help to physician practices that used to be independently run. They are all being engulfed by these hospital systems too.

Q09. Let me go back to the coverage of the Affordable Care Act. If I go to Florida and I have a heart attack, am I covered?
P10. It depends with your plan. I would think that for emergency care, yes you are covered because medical facilities by federal law have to treat you for emergency conditions.

Q09. What if they treat me for the heart attack and I am alert, but they need to run further tests such as MRIs, X-rays, etc., am I still covered?
P10. No. At that point, you have to go back to your network because it is now regarded as non-emergency. Typically, in the past 2-3 years, if you compared a United Healthcare quote and an Anthem quote, United Healthcare always came higher. It is because Anthem still has out of network benefits and United Healthcare does not. So once you are out of that emergency situation, any further tests and treatments are out of pocket. Now, there are some policies that have national
coverage but you are going to pay more for those policies. These are also offered on the federal exchange.

Q10. What were some of the unexpected consequences of the Affordable Care Act?

P10. Most small medical practices have had to join major hospital networks. I do not remember much of the top of my head, what have you heard?

Q10. Some people have been seeing the same Cardiologist, Cancer Specialist, and family doctors for as long as 20 to 30 years. Now, suddenly each of the three are now on a different network. The patient is forced to drop the other two so as to look for doctors in the chosen network. In this situation, this patient has lost the medical history and relationships built with that doctor over many years and has also lost continuity of care.

P10. The other fear is that you have more people with pre-existing conditions join the network than the young and healthy. You are also covering people under their parents’ health plans until they turn 26 as part of the same regulation. Why would you do both? Young people have no incentive to join the network because they are covered under their parents’ insurance. The individual mandate fines are not high enough to encourage people to get health insurance. What is happening is that if a young and healthy person gets insurance, the total annual premiums are higher than the fine. The fines are not high enough to encourage people to buy health insurance. Fines for businesses are also not high enough to encourage businesses to offer health insurance to their employees. If you have 50 employees and you do not provide health insurance, you are only fined on 20 employees because the first 30 employees are exempt. 20 employees multiplied by $2,000 per employee equals $40,000. If you provide health insurance to those 50 employees, you are looking at paying about $450,000 in total annual premiums. So, some employers choose to pay a fine of $40,000 instead of $450,000 in health insurance benefits.

Q10. So in this case, can an employer choose to give employees a raise or bonus and not provide health insurance?

P10. Well, no. That is illegal. You cannot do that.

Q10. Well, I will not tell them that it is for health insurance.

P10. In that case, yes. That is what I suggested to this other client. They were going to get a grant and pay for health insurance through that grant. I told them not to do that. I told them to bump her salary and she can get her own insurance. Do not allow them to pay directly for your insurance. That would get them in bigger trouble down the road if they were audited. The other challenge is that the fines are the same whether you are for-profit or not-for-profit business.

Q10. Any other additional unexpected consequences of the Affordable Care Act?

P10. Well, I do not think they saw it coming that by lowering the premiums for people with pre-existing conditions, they automatically increased the premiums of the young and healthy. They did not see that one coming. The narrowing of the networks is another major setback and an unexpected outcome. This has also lead to small and private medical practices in small communities close. I think
someone needs to do a study on how many people lost their insurance coverage as a result of the implementation of the Affordable Care Act.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?
P10. Well, it goes back to those people who had pre-existing conditions with high premiums and now their premiums are low. That is a definite benefit. Allowing young people to stay on their parent’s health insurance until they turn 26 years old was another benefit. Hospitals are and doctor’s offices are seeing more and more patients come in with health insurance. That is good for their business.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?
P10. Not much on my part. It’s more on the customer side where they have experienced some challenges.

Q13. What has been your sources of information concerning the Affordable Care Act?
P10. Lots of different sources. The different guidelines that come out regularly from the government, especially from Department of Labor. We also have a Director of Compliance on staff. He is full time and his job is to read the legislation. He has read everything line by line. We also partnered with Ice Miller and other law firms in Indianapolis to interpret and share some of the information at employer level through webinars and seminars. When the Affordable Care Act was signed into law, our company hired a Compliance Director.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?
P10. (Laugh). I would like to see cost addressed. I would also like to see everyone have access to healthcare. I think doing away with pre-existing conditions and allowing kids under 26 years to be covered by their parent’s health insurance are good elements. However, allowing kids under 26 to stay on their parents’ health insurance contradicts their aim of trying to get younger and healthy people sign up with the exchange.

Q14. How do you think the cost of healthcare should be addressed?
P10. Uh, I would have to start at the facility level at some point.
Q14. And you mean hospitals?
P10. Yes.
Q14. What if hospitals say we are passing on the cost from pharmaceutical companies and other auxiliary healthcare providers such as therapists?
P10. Yes, the pharmaceutical industry costs have to be put under control too.
Q14. What else in addition to addressing the issue of healthcare costs?
P10. Well, the pharmaceutical industry has a lot of hidden costs. Even if you look at pharmacy benefit managers; Caremark, Express script, or OptimaX, they all have different prices that may or may not match up on an apple to apple comparison. Trying to figure the best arrangement and what costs are hidden, who is getting rebates behind the scenes from the manufacturers for brand name drugs, and how those rebates are passed on or not pass on to the employer and what that looks like is a nightmare. There is a lot that goes into that.
Q15. If the Affordable Care Act was to be revised, what aspects would you want to see revised?
P10. I think the Cadillac tax needs to be revised. It is just another way they are forcing healthcare into this tunnel and including many different things employers are trying to do to help their employees. Employers are going to be penalized if their plans are valued at a higher level than another plan.

Q15. Is there anything else that I have not asked you about the Affordable Care Act you would like to share with me?
P10. (Laughter). I think it would be good if you are interested, to talk to our Director of Compliance. He will be a joy to talk to. He knows a lot more about the Affordable Care Act and the compliance component than I do.

Q15. Yes, I would love to talk to him.
P10. I will introduce you to him in an email and the two of you can plan to meet.

Q15. I would really love to talk to him.
P10. OK, I will set it up for you.

Q15. Thank you so much for your time. May I contact you if I have follow up questions?
P10. Sure, anytime.

Participant 11

Q01. Thank you for taking your time to meet with me. I know you have a busy schedule and I really appreciate the fact that you created time to meet with me. As I stated in our phone conversation, I am doing a research towards my PhD degree with Purdue University.
P11. Interesting. Where you do get the time to do all that in addition to working full time? You are a busy man!

Q01. Oh, thank you. Well, I am almost at the finish line and I cannot wait to get done with school.
P11. I was looking forward to meeting with you. So what is your focus?

Q01. I am examining the impact the impact of the Affordable Care Act on small businesses.
P11. That sounds like an interesting and sensitive research topic. I would love to read a summary of your findings. I would love to hear what other people are saying about the Affordable Care Act.

Q0101. Sure, I will be glad to share my findings with you. What is your position in this organization?
P11. I am the Executive Director. I have been in this position for 10 years.

Q02. How long have you worked of this organization?
P11. I have been with this organization for 21 years.

Q03. How would you characterize your medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?
P11. Well our medical benefits have been decent. I wish we could improve them but I am happy with where we are now. Since we switched to United Healthcare before the implementation of the Affordable Care Act, things have been going well for us. Our advantage is that United Healthcare has several networks in our area that is included in their coverage. So our employees are well taken care of. We have always kept an eye on our premiums in the last five or so years to make sure they remain low so our low wage employees can afford them. It does not make sense to provide the best healthcare plans that our employees cannot afford. Coming back to your question, prior to the implementation of the Affordable Care Act, our coverage was good. Premiums were low and are still fairly low. Our prescription drug program was good and is still good. We are not sure where things will go since things are still changing. We have a lot of fears about what is coming which we do not know.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?

P11. Well, more government regulations, more infringement on our rights, and the government telling people what to do with their money and health. I knew it was the government trying to come in and tell us when I can see my doctor, why I should see my doctor, how much I should pay my doctor, and who my doctor should be. Our history has consistently shown that anything introduced by the government is flawed, not well, thought through, and intended to take advantage of people.

Q05. Please describe your experience with the Affordable Care Act.

P11. We have not experienced much of the Affordable Care Act since we are still on our old plan. We were first grandfathered in. One challenge we have been facing as a company is that for us to maintain our ‘grandmothered’ status, we have to maintain the current proportions as they are. In other words, we cannot increase the percentage share of employee contribution by more than 5 percent per year. We have been eating this cost for a while and I do not know how long we can continue to do it. This has put so much financial burden on our organization. Health insurance costs are going up every year by an average of 9 percent. According to what our agent from the United Healthcare told us, we cannot increase employee contributions by more than 5 percent or something like that. If we do and get audited, we will get into serious trouble and may be heavily fined. The company has to bear the financial burden of increases in healthcare costs. If we join the exchange, we were told that our rates would go up by double digits. So, as a company, we felt squeezed from both sides. Because of the increased costs related to healthcare insurance, we cannot afford to give our employees any raises. We have not been able to give employee raises for the past 7 or so years. Indirectly, the Affordable Care Act has affected us in that we are losing good employee to companies that can pay better. As a small not-for-profit organization, we cannot compete with big companies in terms of salaries and we are losing good employees. In addition, there has been a lot of fear concerning the Affordable Care Act. We do not know if we are compliant or
we will find out when we are audited. At that point, it may be five or seven years into the implementation and we will be expected to pay heavy penalties and fines for all these years. We hope our agent is giving us the right information and keeping us out of trouble.

**Q06.** Overall, did the Affordable Care Act make things better or worse for you? Please explain.

**P11.** I am sure there are a lot of good things that the Affordable Care Act has done. However, overall, there has been lot of irreparable damage done. I totally agree that our healthcare system was broken and needed to be fixed. I know that our health insurance rates in this country are out of control. They increase each year by around 9percent, general cost of living by about 2percent, and people’s income by about 2percent. So that is an annual increase in costs to the employee of about 9percent. This is a runaway cost. There is no way people can afford life at such a pace. We have the best healthcare system in the world, but most Americans cannot afford it. In fact, the number one reason why people file for bankruptcy is healthcare costs. That is not fair. Increasing healthcare costs are sending people into poverty. Things cannot continue the way they are. But at the same time, I am not sure the Affordable Care Act fixed or will fix any of these problems. Premiums have gone up, networks are getting fewer and fewer by the day, doctors have been forced to join bigger hospital networks, and one has to drive to Indianapolis to be seen by specialists. People who live in small communities are suffering. May be this animal should be renamed “unavailable and unaffordable no care act.” I am sure the intent was good but the outcome has been disastrous. Face it, our healthcare system was broken and needed to be fixed even though many people will not agree with me because they do not like change. Obama took a broken healthcare system and make it even more broken. I believe things are now worse and are going to get even worse. The Affordable Care Act attempted to solve three problems but instead created seven additional problems in the process. The initial three were not solved. My greatest fear is that we are renewing our plan in the fall and I do not know what is going to happen. We work on our budget around April/May and it runs from July 1st to June 30th. If the rates increase in October after we have already done our budget, we are screwed. I do not know what I will do. I cannot pass on those costs to my staff who make $8 per hour.

**Q07.** If you had been given a choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?

**P11.** Like I said earlier, the previous healthcare system was broken. It needed to be fixed. Healthcare costs were increasing by 9percent each year and people’s earnings were increasing between 0percent and 3percent. This was not sustainable. That was not acceptable. Something needed to be done. America has the best healthcare system but the most expensive and most unaffordable. Having the best healthcare system that the general population cannot afford is as bad as not having one. The American healthcare system is the number one cause of people filing for bankruptcy. You only need to go into the hospital
without insurance, have a procedure done for $100,000 and your next trip is to the court house to file for bankruptcy. In that process, you can lose your house, car, savings, and everything. That is not acceptable. So, coming back to your question, definitely the old system need to be fixed. However, the solution has not been good either. The solution in this case, the Affordable Care Act, has been equally bad if not worse. So you are asking me to choose between two evils. Both are detriment to our economy and to the common American. To a certain extent, the Affordable Care Act is good for people who are already poor but those are already covered by Medicaid. The Affordable Care Act is not good for the middle class who may not qualify for government benefits because their income is just above the approval line. In the same token, the people who own companies, know how to hide their wealth when they file their taxes. So at the end of the day, the Affordable Care Act benefits the poor and the rich who own companies but is a burden of the working middle class. By the way, I am an Accountant by profession and I have run my own companies in the past. I know how Accountants and business owners hide profits and create losses on schedule C on your tax return. So, at the end of the day, the Affordable Care Act benefits the poor and the rich but a burden to the working class.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?

P11. I think the greatest impact the Affordable Care Act has created is fear and uncertainty. It is difficult to plan when you do not know what is coming and its impact on your business. There is so much fear coming from lack of information, government regulation, and infringement on people’s rights. Fear and uncertainty are not good words in business. The Affordable Care Act was put in place to control healthcare costs and make healthcare affordable to all Americans. So far, it has not accomplished that. For anyone to control healthcare costs, you have to focus on three things; insurance companies, the pharmaceutical companies, and health institutions such as hospitals and rehabilitation centers. As long as pharmaceutical companies are still charging an arm and a leg on life saving drugs, healthcare costs will continue to rise. As long as hospitals are still charging whatever they want for life saving procedures, healthcare costs will continue to rise. How can it be that three local hospitals charge different prices for the same procedure? A C-section cost will vary by as much as $10,000. Same procedure, same time. How does one explain and later alone justify the price disparity among these hospitals located in the same zip code? It is totally insane. So there is no success in controlling healthcare costs as long as hospitals can charge whatever amount they wish. A difference of up to 20 percent can be explained but not 100 percent to 150 percent in price difference. Pharmaceuticals run the show because they have deeper pockets. They can afford to take everyone for lunch without feeling a pinch in their pockets. They have smart and well paid lobbyists on their side. When they cough, the House of Representatives and the Congress catch a cold. They fund these politicians’ campaigns and no one dare challenge what they charge to the
public. I know this does not answer your question but it needs to be said. In my view, the greatest impact of the Affordable Care Act is fear and uncertainty among businesses.

Q09. What aspects of the Affordable Care Act do you like?
P11. I am not sure there is anything I like about it. At least people with pre-existing conditions are covered. They do not have to give up all they have worked for their whole life to receive healthcare. They cannot be denied coverage because of their pre-existing conditions. Their premiums are low and affordable, but I also know that someone else is paying for that portion of their medical bills. For the most part, most pre-existing conditions were not as a result of lifestyle choices as some people put it. African Americans are predisposed to having high blood pressure. Denying them coverage or making them pay more because of such pre-existing conditions they have no control over is unfair. Let me see, what else do I like about the Affordable Care Act? I like the fact that children can stay on their parents’ health insurance until they turn 26 years old. That provision helps them to get established and get decent jobs. That is a definite positive aspect of the Affordable Care Act.

Q09. What aspects of the Affordable Care Act don’t you like?
P11. Well, most people complain that their health insurance premiums went up. I thought it was supposed to be affordable? They promised that premiums would go down, we are all covered, and we are all happy. But that is not the case. The Affordable Care Act has also narrowed the network systems that are available. You cannot be seen by a doctor on the IU Health network and a Specialist on the Franciscan Alliance network under the same insurance. You have to choose one network. If your family doctor is with IU Health network and your Gynecology is with the Franciscan Alliance, you are forced to choose one.

Q10. What were some of the unexpected consequences of the Affordable Care Act?
P11. Well, I think the narrowing of the networks is definitely one. I do not think they knew that was going to happen. It appears that most of the people who jumped onto the federal exchange are people with pre-existing conditions. Those who are healthy did not join in the numbers they expected. So it resulted in a pre-existing condition-loaded healthcare system without enough healthy people balance it out. Oh, another mistake which I think is also an advantage is that a lot of young and healthy people who were expected to join the exchange were covered under their parents’ insurance. What that means is that they will stay on their parents’ insurance until they turn 26. If this provision of staying on your parents’ insurance until they turn 26 was not available, more young and healthy people would have joined the exchange and generally lower people’s premiums. What is happening right now is that some young people are covered by their parents’ insurance, others have opted not to buy health insurance and pay a fine, and a few have joined the exchange. This leads me to another unexpected consequence of the Affordable Care Act. Because the fine for not getting health insurance is lower than totally yearly premiums, some young and healthy people are choosing to pay the fine. I think the fine for not obtaining health insurance
should be doubled to discourage young people from choosing not to obtain health insurance. The same thing is true with company’s fines. If my company’s portion of the insurance for 50 people is $300,000 and my fines for not providing health insurance add up to $100,000, I may be tempted to opt for the fine. After all, that is a savings of $200,000. I do not think they anticipated this. Also, I do not think they anticipated that people’s premiums would go up. I think they were all surprised as we are. The increase in the premiums was a real surprise.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?

P11. Benefits? I am not sure we have realized any benefits as a company. I am sure we will have to look into the Affordable Care Act options come October but I do not think they can be classified as benefits. I have been repeatedly told that by switching to the Affordable Care Act, our premiums will go up by around 15 percent. That is not fair. They forced us to maintain our premiums at 5 percent or below, yet when we switch to their plan, they can charge us up to 15 percent more.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?

P11. Not many challenges since we were grandfathered in. I think one of the challenges has been where to get good and reliable information that is free from political persuasion or pressure from an insurance agent who is trying to sell you a product.

Q13. What has been your sources of information concerning the Affordable Care Act?

P11. Many different sources. And I think that has been our challenge; trying to find reliable sources. The TV, Internet, and insurance agents are the top three. Our HR person has also attended numerous webinars and conferences hosted by different groups in Indianapolis and locally. There were also some informational meetings that were held at the local library to educate people about the Affordable Care Act.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?

P11. The aspect of no pre-existing conditions is a big one. I cannot think of anything else that should be maintained.

Q15. If the Affordable Care Act was revised, what aspects would you want to see revised?

P11. They need to figure out how to allow people to receive services across networks without breaking their banks. People need to be able to receive necessary and needed medical services out of network without having to pay too much. There are certain services that are a must but are offered outside the network that need to be covered. Or better still, they need to ensure that whether you are in network or not, the fees are the same. For example, when you are out of state and you need non-emergency medical care, you should be able to get it at the same cost as network services. I will again recommend that the fines to individuals who choose not to obtain health insurance should be increased. For
companies, fines for not providing health insurance should also be doubled to ensure every company out there provide health insurance. I am not big on this one but I want every company to provide health insurance, irrespective of the number of its employees. If they do not want, they should pay some fee to the government to help support their employees who get insurance on the federal exchange. Just a small fee will go a long way. Another sticky issue they need to reconsider is forcing companies to provide certain medical services that are against their values and conscience. That is not right. They need to find a way to fix it. They also need to find a way to put a check on what pharmaceutical companies and hospitals charge. The Affordable Care Act did not do anything to bring their excessive costs under control. I think this is very critical. There has to be a system put in place to check and control pharmaceutical companies and big hospitals.

Q15. Is there any more information you would like to share about the Affordable Care Act that I did not ask?

P11. Nothing I can think of.

Q15. Thank you so much for your time. May I contact you if I have follow up questions?

P11. Sure. You have my contact information.

Q15. Thank you so much for your time.

Participant 12.

Q01. Thank you so much for taking time from your busy schedule to meet with me today. I know this may be too early for many people and I apologize if this is too early for you.

P12. Oh, not a problem. At least meeting early in the morning helps because my mind is still fresh and my schedule is still open. I am glad to meet with you.

Q01. Like I said in my email, I am studying towards my PhD with Purdue University.

P12. Congratulations! How do you juggle between full time work and school? Where do you even get the time to do all that stuff?

Q01. Thank you. Well, I have always wanted to complete my PhD and so I have had to create time in my busy schedule to make it happen.

P12. Well, congratulations. What is your area of study?

Q01. I am in the College of Technology, Leadership, and Innovation. For my research, I am examining the impact of the Affordable Care Act on small businesses.

P12. That must be an interesting topic.

Q01. Yes, it is. What is your position in this organization?

P12. I am the Director of Compliance Services. So, basically, I help our clients to stay in compliance with the Affordable Care Act and other regulatory bodies that
apply to employee benefits. The bulk of my work in the last two years has been dealing with compliance with the Affordable Care Act.

Q01. What is your professional background? Are you an attorney by training?
P12. No, I am not a lawyer. My background is in group medical benefits. My whole career has been in that area in different positions from sales, sales management, to quality management. I have worked with clients such as the federal government, OPM, State of Indiana, Ford Motors, General Motors, and Chrysler. So I have a long track record in group medical benefits. I have been in the health insurance business for a long time. Some of the innovations they are talking about, I have been familiar with them for years. Its old stuff that is being recycled, actually poorly recycled.

Q01. How long have you been in the health insurance business?
P12. 30 years.
Q02. How long have you been with your present employer?
P12. Uh, about 4 years.
Q02. Where you brought on board to help with the Affordable Care Act?
P12. Yes. It was, sought of. I knew the owner of this company through my career. We kept in touch quite often. The organization that I worked for withdrew from the market. Basically, they shifted their focus. The Affordable Care Act was taking shape and the owner of this company called me to join him. He said knowing me and my background, he wanted me to help his company with the Affordable Care Act compliance. I suggested to him that he gets an attorney but he said he does not want an attorney because of their narrow focus. He said he had a J.D. on staff and he also used outside attorneys but he wanted someone who understands what employers are going through and understands how the Affordable Care Act fits into the equation of the financing of the health insurance at the employer level.

Q02. Was your position created as a result of the Affordable Care Act?
P12. Yes and no. Normally, it would be the case because of my background with large employers. Technically, yes. It was created as a result of the Affordable Care Act. On the other hand, because of my background in marketing and sales, we could also use the fact that we have business acumen around the Affordable Care Act way before most of our competitors. We felt we can use it to generator new business. So, uh, the fact is a lot of employers needed a lot of hands-on help with implementing and staying compliant with the Affordable Care Act but they were not getting it. So, initially, yes it was a cost because we have more than just me working on this. Uh, yes, it was a cost outlay but it was an investment because we were able to reach out to the market and tell them we have solutions to help them. The Affordable Care Act is complicated.

Q03. How would you characterize medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?
P12. Uh, I would say the biggest impact frankly, is in the fully insured small market. The Affordable Care Act mandated benefits called Essential Health Benefits. This requires only a limited amounts of ‘out of pocket’ and you have to cover the
term coverages with care. On the fully insured plan, frankly in terms strictly of
benefits, they had to make some accommodations but they were on track to
have high deductible plans such a HSAs or something like that for better or for
worse. That is the track they were all on across the country. I don't think that
was changed or even disturbed by the Affordable Care Act that much. Uh, you
will have employers say they had to cut benefits because of the cost related to
the implementation of the Affordable Care Act. I have not seen it.

Q03. You mentioned that the HSA contributions were rising. Did I hear that correctly?
P12. No. The number of employers offering the high deductible health plans with a
savings account (HSA) was escalating.

Q03. OK.
P12. And I do not think it stopped because of the Affordable Care Act. It stayed on the
same trajectory.

Q04. When you first learned that you would need to comply with the Affordable Care
Act, what went through your mind?
P12. Uh, well, at first what I did was to read the regulations that apply specifically to
employers. Well, as always, government programs come with a lot of
unexplained expectations. You know very well that a law that is 2,700 pages
long and still under revision has a lot of do’s and don’ts that someone need to
look through and define for everyone. Government laws are written in legal and
technical language and they need someone to put it in the common day to day
language. That is what came to my mind and that is what I have been doing daily
for the past 4 years.

Q04. Did you read the whole 2,700 paged Affordable Care Act document?
P12. Eventually, but what I really studied was around the shared responsibility pieces.
It struck me and it took a while for me to figure it out. It took me a few times to
understand it. But as I cycled through it, frankly what struck me is how porous it
was. Uh, maybe it’s just how my mind works. I saw loopholes which some of the
national press picked up on. And I have never understood whether they were
purposely put in there or if it was just sheer ignorance.

Q04. What were some of the loopholes?
P12. Well, there is a lot of the employers running below 25 employees. What that
means is that these can opt not to offer health insurance and they are off the
hook. The penalty set is $2,000 per employee and there was a lot of fear that the
government was going to make employers pay a lot of fines. Everyone was just in
panic mode. And then eventually, people started to read and see where the
mandate said an employer had to offer Minimum Essential Health Coverage.
That is one thing on one hand. Health insurance carriers have to offer Essential
Health Benefits with out of pocket maximums. These are two different things. Do
you remember the Essential Health Benefits that were talked about in the press
that everyone was going to get? Well when you look over here, what applies to
large self-funded employers which is Essential Minimum Coverage is not defined
in the Affordable Care Act. The only place, by default, that there is any relative
definition is that Minimum Essential Coverage must have the preventative
services described by the Health and Human Services department. That is it! The entire act only tells you what Minimum Essential Coverage is not. It does not tell you what it is. So, it did not take very long before legal minds figured it out. They realized that all they have to do is to develop a product that just offers the preventative services as outlined in the Affordable Care Act. Now that is nothing. Because of that ambiguity, a cottage industry was born overnight to go to these large employers to help them. And in defense of the employers, these might have been employers that did not have the money in the first place. These businesses could be fast food restaurants, temporary employment agencies etc. Some of them did not have the cash, so this was a way to avoid the large penalty. Now, they are still subject to per individual penalty if their employees go to the healthcare exchange and obtain health insurance. That is just a one off situation. So all of this hype that was out there for two years about heavy fines such as $75 million was all out through the window.

Q04. So have they reconciled the Essential Health Coverage and the Minimum Essential Coverage?

P12. No. That is why when you look at it over time, you realize that probably it was not an accident. It was just written that way to allow people to figure it out on their own. So, these giant employers who thought they would be mandated to offer employee benefits, no. The Affordable Care Act is a toothless tiger.

Q04. Interesting.

P12. Uh, so what you see at times may be large staffing companies that have high turnover of employees who thought they would be legally put out of business and that is not the case. There may be staffing companies that work in low margin businesses such as religious groups that come to do cleanup operations and work for that employer for a few months on and off. This is not the ones that place high tech IT people.

Q04. What are the items included in the preventative service required by the employer mandate?

P12. None of that is major medical. These are things such as basic visit to the doctor, to the dentist for annual dental checkup etc. They are self-funded and there is no risk to them at all. They have very little benefit. Employers thought that they have two choices; pay $2,000 fine or they were going to put on a full blown medical plan which could run on an average of $11,000 per employee. So they thought they were going to be out of business overnight. I believe it was attorneys from Atlanta who discovered that it was not defined. You can put together anything you want and it goes. There is a little bit of a mine field there but essentially there is no large employer out there that is going to pay this mandate, unless they are just stupid. And to avoid discrimination, the Affordable Care Act would look at premiums to ensure everyone pays the same premium. Audits will ensure management are not paying low premiums than employees yet on the same plan. The Affordable Care said they would take those anti-discriminatory rules and apply them to the fully insured. There has never been those rules for the fully insured. So, if you go out to a client who is fully insured,
they cannot do what I just described. If you offer the Essential Minimum Coverage, you offer that on a self-funded basis for all those hourly employees that cannot afford, then you let the management people stay on the fully insured.

Q05. Please describe your experience with the Affordable Care Act?
P12. My experience and my clients’ experiences are different. But on the whole, the markets seem to have a massive confusion and frustration. Employers with around 100+ employees saw anywhere from 7 percent to 9 percent cost increase the first two years and then it settled down to around 3 percent to 4 percent. Now that is for employers with 100+ employees. They will smoothen out as taxes go down. But there has been lots of confusion, frustration, and anger. Frankly, this is all I did for the past 2 years and it is all I could do to keep up. There are employers out there as we speak who are in a mess. They are not in compliance at all. But to answer your question, it has mostly been confusion, frustration, anger, and a lot of administrative time spend by employers that they had not counted on. There are also a lot of hidden costs. The 9 percent increase is a really easy target to spot. Then there are health taxes and fees. The larger employers have to track employee hours on a weekly basis which they did not used to do. They also have to do the IRS reporting, get help from vendors which costs money, or spend a lot of time doing it themselves. I mean, it’s a mess. When the Department of Labor does an audit, they are going to ask for everything to verify employee status and whether or not they were offered benefits. For any employees who were not offered benefits, they will want proof that they were part-time. If you fail to prove that they were part-time, then you get fined. This is where the employers need to get their act together. If you hired an employee as a part-time and she worked more than the part-time hours, you should have a legal document that says you have a schedule of variable hours. Variable hours mean that as an employer, you do not know how this part-time employee’s hours are going to be. In that situation, you as an employer are allowed to track that employee’s hours. If she averaged full time, then the employer owes her full time benefits for the entire following year. So when they come for an audit, they want to see that document that shows employee definition plan.

Q05. From your experience, do you think employers are afraid that if audited, they might be in a payback situation?
P12. I do not think there is enough fear. When I go around and meet with employers, I tell them that even if you do not hire my company, hire someone else to help you with this stuff. Every employer out there needs to pay attention to this. Whether you know it or you do not, the Department of Labor staff who addressed us a few months ago said we are coming. She was pleasant but very firm. She said the Department of Labor may take a little longer but they are coming. Now, I do not think employers fully grasp that. Whether or not they ever come, what I think everyone needs to do is to be conscious about it. If they
come, they will levy a fine of $100 per day per affected employee. This could be massive.

Q05. Do you think that may shut down some businesses?
P12. I think to get into compliance is not that difficult. You will need to get help and it will take time. Once they hit the audit trail, you need to demonstrate your best effort. They have been punitive and they are not easy to deal with. But if you have your records in place, you should be OK. I imagine there are these employers who have done nothing about it and are out there and have blown it off. They are going to be hammered. If the Department of Labor has hired and trained all these auditors, they have to do something and they have to be paid. That revenue has to come from those audits they do. The IRS is buried and has no time and manpower. Frankly, I think they are just too far behind. But the Department of Labor auditors are coming. If you get audited several years later and records are not in place, it can be very costly and difficult for your business.

Q05. Do you think this may lead some employers to just give up and close their businesses?
P12. Politically, I do not think they will be allowed to go that far. But over time, enforcement will become tight just like the corporate laws on COBRA. They may write a bunch of infractions that add up to $500,000 and then just ask you to pay $100,000 or something like that. That is still a lot of money. If your only job is to go out and find mistakes, you will find them.

Q05. Do you think this may result in older business owners just close the shop and go home?
P12. It is very much possible. It hasn't happened to the degree we anticipated because attorneys have hammered it with webinars. Yes it is an expense for those employers but most of them have shielded themselves. But I get you. If you are ready to retire and you do not have a child to take over the business, you can be tempted to close the shop.

Q05. May you please explain the reason for the 8percent to 9percent increase in health insurance costs.
P12. Yes, that is mainly incurred by large self-funded employers.

Q05. How do you define large employers?
P12. Well, employers with 100+ employees. And the increase in costs is a result of transitional fees and PECORI fees. The average increase was 9percent for a group of about 25 employees. Now when you get into the smaller employers that are fully insured, the carriers that sell them health insurance are subject to regulatory measures. Now, this whole thing is nothing about healthcare delivery, it is all about insurance companies. The health insurance rates of employers with about 25 employees will go up significantly. I suggest that you check the Milliman website for actuarial reports on this subject.

Q05. May you please explain how the plans that were grandfathered in and will expire in December 2017 will be affected.
P12. Well, you might have two things going on there. There was the Anthem or any of the fully funded insurance plans. Those were grandfathered. They are mostly
Affordable Care Act compliant. They have a few challenges but the main attraction with that is it kept them from going into the community rating. Community rating is for the most part not necessarily to the employer’s advantage in every case. Ironically, some of the younger and healthier groups that may be cheaper to insure under the old methodology might see more of an increase to offset the other side of the equation. When they changed how you get rating, everything shrunk. Age banding can vary a little bit by state but we used to have up to five or six age bands. Now, they were all compressed into three. So what that does is it pushes up the premium of the 20-year old because he is now banded together with people in their thirties. The 40-year old also experiences an increase in premium because he is now banded together with the 50-year old people and so on. The interesting thing about banding is that it does compress the older ones down a little bit. But on the whole, it made rates go up a bit. So the Affordable Care Act administration through the Health and Human Services seems like every year they allow the carriers to go another year on the grandfathered plan if they want to. They just keep pushing the rates up. So employers compare their grandmothered rates to exchange rates. If your grandmothered plan has low rates, you stay with it until the exchange rates are lower. At that point, you switch.

Q06. Overall, did the Affordable Care Act make things better or worse? Please explain.
P12. Worse.

Q06. May you please explain why you say it made things worse.
P12. Well, it is not healthcare reform. Healthcare reform really gets to the nuts and bolts of increasing quality of care. I worked in that arena for a long time. A good source for articles is Health Affairs. They have great articles on this subject. I think a lot of Economists would agree that you really do not bend the cost curve to a meaningful degree until you can get at the true quality of care. The irony is that when quality of care goes up, the cost does bend down. We saw that work in managed care. The public did not want it but the government let those large carriers merge, rate went up, and it just did not work. Now we are back to trying the same thing. But to answer your question, this is insurance fears. To me, it’s like we dropped an atomic bomb on an ant hill. The problem was uninsured Americans and the low income bracket. It is good that we expanded Medicaid, as long as the states can pay into it. The money has to come from somewhere. It is good that if people have pre-existing conditions, they are now covered and do not have to pay high premiums. But that is a very narrow band of people that were helped. The press does not cover it enough. If you are in the next tier up, what we have found is that every American who was buying individual health insurance from Anthem for example, their rates may have gone from up $6,000 to $12,000 per year and even more in some cases due to the change in age banding. The overall pricing of the block went up because of the increased risk in that band. So, my question is, “What was the real end game here?” Larger insurance companies got huge influxes of business overnight. Hospitals arguably, benefit in the long term by people coming in with insurance. But I think in the
process we created some pervasive incentives. We created a situation where lower income folks who may already have been covered by programs such as HIP2 are now covered by the federal exchange. May be we could have expanded Medicaid instead of starting another whole new and expensive program.

Q06. Did the Affordable Care Act make any difference on the cost of healthcare in America?

P12. Not at all. It aggravated the situation by raising premiums. United Healthcare pulled out of the exchange. You look at the 4 largest health insurance carriers and you see that two are merging and the other two are also merging. What is really going on here? We are increasingly moving to two major insurance companies thereby reducing competition on the market. I think this is kind of disingenuous. Sometimes I think the people who put this together did not know what they were doing but on other days I feel like they knew what they were doing. They perfectly understood what this was going to do to insurance markets. The main focus of the Affordable Care Act is the financing of healthcare and the honest truth is that it has not worked. How can something that rise large employers’ premiums by 9 percent and small employers by 25 percent to 50 percent be regarded as controlling the cost of healthcare? The premiums for the middle class families sky rocketed. All this was done to help a small portion of low income people who in most instances have no interest in getting coverage anyway? This is squeezing out the middle class.

Q06. Are you suggesting that the Affordable Care Act benefited the low income and high income business owners but is affecting the middle class?

P12. That is correct. The Affordable Care Act is another burden on the middle class which is already being squeezed by the current tax code. In addition, it pushes the rates up across the market.

Q06. In what other ways has the Affordable Care Act affected or benefited people?

P12. There is so much attention given to the 14 million plus people who have been insured as a result of the Affordable Care, but I believe there are also another large number of people, may be 10 million from another income bracket who lost coverage in the process. These statistics are like on the job market where they measure unemployment. It is always inaccurate because there are always people who are on the float; they have come off of unemployment and they are between jobs. This is kind of what is happening here. They may say we enrolled 14 million but there may be another 10 million who lost coverage.

Q07. If you had been given the choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?

P12. The old system definitely needed to be fixed. The cost of providing health insurance was going up by an average of 15 percent each year. Most employers were passing on about 10 percent of that cost to the employees. At some point, this was going to cause a train wreck. The system definitely needed to be fixed. The challenge is that the Affordable Care Act did not do anything to correct that situation. Instead, it made things worse on the general. My short answer would be that I would opt for the old healthcare system with some serious tweaking
and focus on quality improvement. The Affordable Care Act did not do anything to control either the cost of healthcare or the quality of healthcare.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?
P12. Like I just said, the Affordable Care Act did not improve the quality of healthcare or reduce the cost of healthcare. At least from my business perspective, it gave us a challenge to solve our clients’ health insurance problems. It gave us more business. We no longer do any underwriting on medical policies. It has made things a lot easier for insurance companies.

Q09. What aspects of the Affordable Care Act do you like?
P12. The only thing I can come up with has nothing to do with the Affordable Care Act. Since the Affordable Care Act is here, I have enjoyed helping employers find solutions. In terms of the Affordable Care Act itself, I just like that there are no pre-existing conditions but of course it comes at the expense of having to overhaul the whole system so quickly that the carriers have had to change so much. I like the transparency of the exchange and also that it is fairly easy now that it is working. But it’s like saying I like a candy but I wish it did not cost a thousand dollars. It is not worth the cost. The complexity of the rules are punitive and forbidding. I wonder at what cost.

Q09. Why aspects of the Affordable Care Act don't you like?
P12. Well, the way the cost structure is set up with the carriers is not good. Transitional reinsurance tax and other taxes that are collected all go into one pool of dollars that is supposed to feedback to carriers to offset their losses the first couple of years. I am not quite sure what United Healthcare mean when they say they are losing money. Aren't the payments flowing from the bank account set up for the Affordable Care Act taxes to go into to the carriers? I do not know what is happening there. Which by the way is another pet peeve of mine. If they set this thing together, what is going on? What is also happening is that carriers are now controlling certain regions and monopolizing those markets. This, in my view killed competition when it comes to prices. You also have carriers pulling out of the exchange. I think they should have said if you join the exchange, you are in for at least 3 years. Not this in and out business. Another challenge is that the networks shrunk and now very soon we may end up with only 2 major carriers.

Q10. What were some unexpected consequences of the Affordable Care Act?
P12. Honestly, I would say everything we are seeing was unexpected. People’s premiums went up, small private practices in small and rural communities have been closing down, networks have significantly narrowed, and people are forced to choose doctors within the chosen networks. It appears that most of the people who signed up for health insurance through the federal exchange were people with pre-existing conditions. That should not surprise anyone. Also, not as many young and healthy people signed up for health insurance as they expected. So this skewed the premiums for the few young and healthy people who signed up through the exchange because their premiums went up.
Q11. What benefits have you realized with the implementation of the Affordable Care Act?
P12. Well, we have more business as insurance companies, so that is good for us. Hospitals and doctor’s offices are seeing more people come in with health insurance. That is good for their business.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?
P12. I cannot think of any on my side of business. Just working hard to get current information to our clients and staying on top of all these changes.

Q13. What has been your sources of information concerning the Affordable Care Act?
P12. Well, I have been the source of information for all our Accounts Executives out there in the field. I have attended several seminars and webinars hosted by the Department of Labor and other national insurance companies. I will get you some research papers published by Milliman and other companies out there that focus on the Affordable Care Act. I have also attended seminars hosted by Ice Miller and several other groups.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?
P12. It’s a hard question because it is not a fair question. It does not have an answer because this is the biggest legislation since Medicare. In the history of the USA, an entitlement has been repealed zero times. Now that we have the health exchange set up and you have carriers completely retooled and hospitals have recalibrated their systems, I do not think Americans understand that they are stuck with the Affordable Care Act. Now, hold that thought, maybe we can do some tweaks. The healthcare exchange and the mandates are not going anyway because now we are stuck with it. All these years, the Republicans have been talking about repealing the Affordable Care Act, yet not even one has said what he is going to replace it with. I do not know how it will be tweaked but something has to be done about it. Middle class Americans are being squeezed and the middle class is being killed. I think the employer mandate is ridiculous. It needs to be done away with.

Q15. If the Affordable Care Act was to be revised, what aspects would you want to be revised?
P12. I think we covered most of it but I think they need to find ways to encourage the young and healthy to join the exchange. This will ultimately improve the premiums. I think they need to reconcile Essential Health coverage and Minimum Essential benefits. There is a lot of ambiguity there. We have discussed most of the things that need improvement.

Q15. Thank you so much for your time. I really appreciate you taking time from your busy schedule to meet with me. Is there anything concerning the Affordable Care I did not ask you would like to share?
P12. Nothing that I can think of.

Q15. Thank you so much. May I contact you if I have follow up questions?
P12. Sure! Here is my business card. I will send you the Milliman article I mentioned.
Q15. Thank you so much. I looked forward to reading it. I will also visit their website and check some articles there.

Participant 13

Q01. Thank you for taking time from your busy schedule to meet with me today. I really appreciate your time.

P13. Just remember I am not a lawyer. Let me bring a few article for you that I came across as I was preparing for our meeting.

Q01. Sure.

P13. Here is an Affordable Care Act tool kit that our company developed for our clients. It is a step by step tool and it addresses topics such as cost sharing, annual limits, and then the waiting period which is 30 days. It also provides education on the elimination of pre-existing conditions and also talks about how we write claims.

Q01. Thank you so much.

P13. You are welcome.

Q01. What your position in this company?

P13. I am a principal co-owner.

Q02. How long have you been with this organization?

P13. For about 5 years now. I was involved with a company and we sold out to another company. Let me go way back. I had an ownership in an agency that was pretty large and the majority owner decided to sell the company to Anthem for some reason.

Q02. How long have you been in the insurance business?

P13. Probably about 10 years. We sold that company to Anthem and I started my own office and operated it for about 6 months. Another company Rep asked me to join his friends to do a benefits company which I agreed to and we joined forces. We ran that benefits company for another 10 years and built good reputation. We were providing wellness plans. Another company approached us and wanted to buy us out and so we sold it. We picked up another agency that provided casualty, workers compensation and we sold it again. At that point, I decided to go out on my own doing employee benefits. After about 10 years, I was bought out by this present company which was trying to put out a large agency.

Q02. Does this company operate in other states?

P13. We operate in 38 states. The last time I checked, we were ranked the 13th largest in the country.

Q03. How would you characterize medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?

P13. (The participant’s business partner walks in and he introduces him to me). This is my business partner and he handles the property and casualty for us. He also has knowledge about the Affordable Care Act from his property casualty side. He can provide us with more answers from his perspective.
Q03. Please meet you sir.
P13. (Partner). Thank you. My colleague told me that you are doing your doctorate?
Q03. Yes, I am. I am studying with Purdue University in West Lafayette.
P13. (Partner). That is amazing. What is the focus of your study?
Q03. For my research, I am examining the impact of the Affordable Care Act on small businesses.
P13. (Partner). That is amazing that you are working full time and doing your doctorate. And that should be an interesting research topic. We also have someone at our corporate office who specializes in the Affordable Care Act in case you ask us questions we cannot answer. My background is property casualty and workers' comp. I deal specifically with not-for-profit agencies in Indiana. There is a connection between workers' comp and the Affordable Care Act in the sense that when an employee has high workers' comp claims, it impacts their health insurance. From the Affordable Care Act standpoint, those two touch points. We also sell Affordable Care Act compliance insurance policies. In case an employer forgets to insure an employee, the fines can be very steep.
Q03. What have you experience out there in terms of companies buying the additional Affordable Care Act compliance insurance?
P13. Not much but they are coming. They need to make sure that COBRA notices are being send out and there is evidence to that effect. If you terminate an employee, they want to make sure that COBRA letters were sent out on time. If you gave an employee an enrollment form and they decided not to take coverage, you need to have the employee sign a waiver form. By signing the waiver form, the employee is saying I was offered insurance but declined. As an employer, you want to make sure you document on each employee, especially the COBRA stuff.
Q03. How would you characterize your medical benefits and healthcare prior to the implementation of the Affordable Care Act?
P13. I think everyone agrees that the old healthcare system was becoming too expensive for most people. Health insurance costs were increasing faster than people's salaries could cope with. Healthcare was the leading cause of bankruptcy in this country. It was a system of 'have's and have nots.' At some point, we were going to hit a tipping point where the uninsured number of people was going to be considerably high such that leaders would not ignore it.
Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?
P13. Well, confusion and frustration at the beginning as people tried to figure out how to navigate the system. I also expected that there will be a lot of political wrangle and finger pointing. After that, I knew dust would settle and people would start seeing clearly. I also knew, just like any other government program, there was going to be a lot of paperwork and compliance. You cannot have a government program without tons of paperwork.
Q05. Please describe your experience with the Affordable Care Act.
P13. The biggest thing we have seen is confusion on the part of the employer. And fear of course. The law has changed several times and that is a challenge. There is a lot of misunderstanding out there. The biggest challenge for employers is understanding what they have to file and what the actual penalties could be if they don't file. Some of these penalties are multiplied by the number of days you are out of compliance times the number of employees and this can be sneaky. So we provide our clients with checklists that show what they are supposed to be doing. The checklist shows what is supposed to be done, by what date, how the form is supposed to be filled, and how it should look like when filled properly. We check it for you if you have already filed. We developed an in-house tool that will track it for you.

Q05. You mentioned that there is confusion among employers. May you please explain what was causing the confusion.

P13. (Partner). There is a lot of confusion because of the different laws that are going into effect at different stages. There are changes that are happening on the healthcare side and the property and casualty side is slow to react. Because of that, we are getting a lot of endorsements. Exclusions are being put on our policies for HIPAA and all sought of different items we have to make sure everybody is aware of. This is also affecting the directors and officers policies and increasing their exposure. We always encourage our customers to ensure that all their policies are under one umbrella; directors and officers, workers’ comp, liability, and health insurance. These impact each other and if they are offered by different companies, there is no one who ensures that they are speaking to each other. As an employer, you need to make sure these policies are talking to each other, or else it increases your liability. That is where the misunderstanding and mistrust come from. We are not quite sure what healthcare is doing and how that is going to impact everyone else.

Q06. Overall, did the Affordable Care Act make things better or worse for you? Please explain.

P13. Well, I do not think people took it seriously. It seems that the biggest confusion on the employer is on the regulation changes. In most cases, the exchange product has gone up in price considerably each year; 14percent to 20percent in some cases. That is new, especially if you agreed to pay your employees’ premiums. It is confusion because your employees can be on the exchange and pick one of the several policies that are available. So you can have a situation whereby at some point, you had a group plan and everyone had the same benefits and the price was the same for everything. Now you can have employees with 5 to 6 different plans. Who is going to keep record of it because they all have questions on their different plans they chose? And who on your staff is going to be competent on all these plans so that they can answer their questions? Also, the fact that they took something good or not as good but that was working rather well and make it worse is concerning. There are several things they failed to take into consideration when they set the Affordable Care Act rates. The fact that they offer people policies that cover all pre-existing
conditions but have no idea what the pre-existing conditions are and what they are getting into. I will give you an example. If someone needs dialysis 2 times per week and it is going to cost $2,000 per visit, that is $17,200 per month and that equals to $206,400 per year just for dialysis, unless they get a kidney transplant or they die. I am sure with kidney problems comes other health-related issues. This person's total medical bills could be around $500,000 per year. Not that I wish anyone die but if this person lives for 10 years, that is a total of at least $5 million dollars on one person. I do not think they calculated all this. The fact that they were forcing employees to buy health insurance or pay a fine if their employers did not provide is not right. The employer was paying something towards the cost of health insurance. That should have been maintained, then ensure that it meets the affordability test requirements by augmenting it. Now with the Affordable Care Act, if the employer has less than 50 employees, he is not required to provide health insurance.

Q06. What about the issue of children staying on their parents' health insurance until they are 26 years old?

P13. Well, the Affordable Care Act sought of contradicted itself on that. Because of that provision, some young people joined their parents' health insurance. They were also supposed to join the exchange pool so that it balances out with those who have pre-existing conditions. In my view, this actually caused exchange premiums to go up because there were a few young and healthy people who joined the exchange compared to a lot of people with pre-existing conditions. Other young and healthy people decided not to buy coverage. And if their income is below a certain level, they would receive subsidies from the government.

Q07. If you had been given a choice, would you have opted to go with the Affordable Care Act or stay with your previous healthcare system?

P13. Everyone agrees that the old system was working but needed some work. The cost of healthcare was always increasing and people needed help. I am not sure I can safely say the Affordable Care Act addressed that either. At least the old system was predictable and people knew what to expect. It may be too early to judge the Affordable Care Act but right now, if I were to rate it, I would give it a D and the old system a C-.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?

P13. We definitely got more problems to solve and that is good for us. That means we have work to do. It destabilized the healthcare industry in a big way. It created confusion and fear in the market. It is going to take time to get things back on track. In addition to all this confusion, the Affordable Care act did not make any dent to the quality of healthcare. Quality is still low and instead, costs have gone up.

Q09. What aspects of the Affordable Care Act do you like?

P13. Like I said earlier, definitely it means more business for us. I like the fact that people with pre-existing conditions are now covered at reasonable premiums. They can no longer be denied coverage based on pre-existing conditions. That is
a good thing. For parents whose kids are still in their basements struggling how to develop their wings, they can relax because they can stay on their insurance without any extra charge. I think that is a good thing. Some of them are already living in our basements anyway, why not just cover them?

Q9. What aspects of the Affordable Care Act don’t you like?
P13. It has reduced the number of health insurance carriers out there. It feels like the Affordable Care Act has done all these things but is not focusing much on health maintenance. People in America still have the mindset that fix me and do not worry about my lifestyle. What I do is up to me. That is a wrong mindset. The hospitals are still charging what they were charging and doing what they were doing before the Affordable Care Act. The pharmaceuticals are still charging what they were charging before the Affordable Care Act. So, there is no real healthcare reform. Another interesting thing is that if you ask your doctor how much the procedure will cost, they have no idea. I think hospitals need to be required to post the price list for all their procedures. They have to. There is a reason why those buildings are so big and they are still building. United Healthcare does the best job I know. They have a website where you can actually go and check the procedure you want done in your zip code. They will send you a list of doctors with the best outcomes. But because not all doctors are on your health insurance plan, you may be limited. You cannot just go to a doctor because he/she has the lowest fee structure or best outcome. Another problem is that hospitals are rewarded for fixing their own problems. They create a problem and they get paid even more to fix it. That is not right.

Q10. What were some of the unexpected consequences of the Affordable Care Act?
P13. That is an interesting question. If I have less than 50 employees, I do not have to provide health insurance for my employees. But if I have 100+ employees, I have to provide coverage. I have to provide it to 95 percent of eligible employees. I cannot force my employees to pay more than 9.6 percent of their pay towards health insurance. If my plan does not qualify, or my plan is not deemed to provide the essential coverage, which means it has to pay 60 percent of every claim, then as an employer I have to pay $2,000 for every eligible employee, less 30 employees. If it costs the employer $200,000 per year in premiums to cover 50 employees, you can choose not to provide health insurance and pay the fine and you will come out better financially. Out of your 50 eligible employees, the first 30 are exempt from the fines. So you are only left to pay fines for 20 employees. 20 employees at $2,000 per person equals $40,000. $40,000 in fines compared to $200,000 in insurance premiums is like day and night to a business that is struggling financially. In this situation, some employees have opted to provide the Minimum Health Coverage plan which costs them $50 per employee per month. This way, you are protected from the $2,000 fine per employee. But since this plan does not meet the coverage test, the employee who does not take coverage can go to the federal exchange and apply for a subsidy. If he gets the subsidy, then the employer has to pay $3,000 per year of that employee.

Q10. Are there any other unexpected consequences of the Affordable Care Act?
Q13. Positive or negative (laughter)

Q10. Both.

Q13. Uh, probably the single positive is that everyone has coverage. They got rid of the pre-existing condition thing. Life time limit used to be a $1 million dollars. With some of the health conditions like kidney diseases that require dialysis, that could cost $10,000 to $15,000 per week. If they receive dialysis for 5 to 10 years, you can have someone use $10 million in health insurance coverage. So, it is a positive thing for those kinds of people that coverage is available and they can go for as long as they can live. Another good thing is that the Affordable Care Act has put healthcare in front of people. We are talking about it every day. Whereas in the past, we did not talk about it.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?

P13. I think we talked a lot about that. People with pre-existing conditions are covered and their premiums are now reasonable. As an insurance company, we have seen a huge increase in business as employers scramble around for solutions. This has kept us busy.

Q12. What challenges have you faced with the implementation of the Affordable Care act?

P13. Not much challenges on our side that I can think of.

Q13. What has been your sources of information concerning the Affordable Care Act?

P13. Our company provides health insurance services on a national scale. We are in about 38 states, so we have a lot of company resources to support Accounts Executives in the field. I have also attended seminars and webinars hosted by other health insurance companies and the Department of Labor.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?

P13. The idea of no pre-existing conditions should be maintained at all cost. That was a brilliant idea. Also the idea of trying to ensure that everyone is covered is a good thing.

Q15. If the Affordable Care Act was to be revised, what aspects would you want to see revised?

P13. More transparency. Let everyone know what is in this Affordable Care Act. If you are going to reinvent the healthcare, why create a whole new system when there is a system that is working and you know what the cost is? Why not expand Medicare? It would appear cheaper. They should have involved all the stakeholders in the design and development of the Affordable Care Act. The fact that they are asking you to report your withholding tells me that at some point they are going to tax that as income.

Q15. Thank you so much for your time. I know you have a busy schedule and I really appreciate your willingness to meet with me. Is there any information about the Affordable Care Act I did not ask you want to share with me?

P13. If I do, I will email you.

Q15. Thank you so much. May I contact you if I have follow up questions?
Sure! You have both my cell phone number and my email address. If I do not know the answer, I will find it for you.

Thank you so much!

Participant 14

Thank you so much for taking time from your busy schedule to meet with me. I am student at Purdue University. For my research, I am examining the impact of the Affordable Care Act on small businesses.

Oh, not a problem. I am glad I could help. So how far are you with your studies?

I am expecting to complete my research in December this year and graduate in May 2017.

Good luck in your studies.

Thank you. What is your position in this organization?

I am a Principal Actuarial Consultant with this organization. My full title is Senior Vice President and Chief Actuary. We do a wide variety of work. I work with risk insurance across the world. We have four disciplines. The first one is the healthcare discipline which I am part of. We consult with health insurance companies, providers, employers, federal government, and state entities. We also have a life insurance discipline line which deals with property and casualty and employee benefits with mainly deals with retirement planning, defined benefit plans, and administering 401(k) for companies.

How long have you been doing this?

Fourteen years. How are you defining a small business?

I am using the Small Business Administration guidelines and the definition of the Affordable Care Act. How do you characterize medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?

Uh, this is not really specific to small employers but before the Affordable Care Act, the individual health insurance market, at least in Indiana and many states, medical underwriting was allowed. Insurance companies could basically charge you more if you were sicker and less if you were healthier. They could charge different premiums by gender. Young females with maternal claims were definitely more expensive than generally young males. You could also deny someone coverage if you felt that their pre-existing condition could be too expensive to insure. The health insurance market was kind of like the Wild West and there was no subsidies to help people with paying premiums. You pretty much had to pay all those premiums with after-tax money. Now on another hand, on the employer sponsored insurance you would get a tax benefit because it was not considered a taxable income to you. Employees could pay their share
of their contribution prior to taxes being taken out of their pay check. Basically, employers were making employees pay the same premiums and as a whole, the employer insurance was not community rated. So their insurance premiums reflected the health status of that group. All the employees were essentially paying the same. Looking at your question from a national perspective, health insurance in this country has been on the rise for a while now. This created a national concern on the affordability and accessibility of healthcare services. Healthcare costs were increasing by between 9 percent and 20 percent yearly. Most of these costs were passed on to the employee and it was becoming a burden on employees out there. There was no central system where doctors and hospitals could check the medical services a person who walked into their doors had received a few weeks ago. That was a challenge because it resulted in duplicate tests and examinations. The quality and cost of healthcare in American was in bad shape and needed some attention. So that part of the deal to me needed to be fixed. I am not sure if the Affordable Care Act solved that part.

Q03. May you please explain community rating?

P14. So, uh, medical underwriting is when you can rate by age, gender, and health status. This is kind of the opposite of community rating where you are getting anyone who wants insurance the same premiums. So in the Affordable Care Act, there is what they called the Adjusted Community Rating in the individual and small group market where premiums are only allowed to vary by age by a 3:1 ratio.

Q03. Are you suggesting that age is the only factor used in providing rates on the federal exchange?

P14. Well, age and tobacco usage. With tobacco usage, premiums can increase up to 50 percent. Prior to the Affordable Care Act, employers had a very strong rationale to offer health insurance to their employees because it was a good benefit to have and it was also a source of protection for the employee. The individual market was kind of like the Wild West whereby if you get sick and you have huge claims, you were done. Your premiums would go up and you would be on your own. Now it was desirable to work for a company that offered health insurance because the employer subsidized the health insurance. In terms of how the insurers charged employers prior to the Affordable Care Act, for employers with employees over 50, really nothing has changed. Prior to the Affordable Care Act, those employees were paying a premium based on their pool including past claim experience for the group. However, before the Affordable Care Act, the employees with 50 and under employees, there was no one rating system across the country. Some states already had adjusted community rating for those small group markets. Whereas other states did not. Indiana allowed medical underwriting. There were some limitations on how you can rate a small business prior to the Affordable Care Act. For example, there was a +35 percent corridor based on health status. You could also rate on gender which I think was important. So, in terms of what the rating changes did, if you were a small employer that had all young and healthy males, you got a pretty
significant increase with the Affordable Care Act because you are now subsidizing the sicker and older population. If you had a small group of employees who were females, older, and sicker, your premiums have gone down with the Affordable Care Act.

Q03. What have you heard from the market concerning the fact that the healthy are paying for the sicker?

P14. Well, that is the purpose of health insurance. It is to spread the risk of insurance across. It is accurate that the new Affordable Care Act rating created three subsidies; the young subsidizing the old, male subsidizing females, and the healthy subsiding the sick.

Q03. You described your experience with the Affordable Care Act. What do you see out there in the market? How is the market responding to the Affordable Care Act?

P14. In terms of the small businesses?

Q03. Yes, small business market.

P14. I would say there is no play or pay requirement for small businesses. There is no penalty for terminating health insurance for your employees.

Q03. How does that play out if a small business chooses not to offer health insurance and your employees go to the federal exchange and buy health insurance?

P14. That does not affect small employers. Now, it gets a little complicated when you, let’s say own 5 McDonald Restaurants and each has 20 employees. Each of those sites or restaurants may be below the 50 but the Affordable Care Act looks at the control group. If you own all those stores, your employee count is based on the sum of the 5 restaurants.

Q03. If I have 5 companies in different industries and each company has less than 20 employees; landscaping, a restaurant, a body shop, a dealership, and a gas station, how do they establish the total number of my employees?

P14. It is based on the control group, I guess I am not an expert on that.

Q03. How much did the Affordable Care Act affect small businesses?

P14. There is no penalty for them but looking at health insurance, we have seen a fairly significant 10-15 percent decline in the number of people who are insured in the small group markets from the year 2012 to 2015. I am sure the number of insured people in the small business markets was on the decline prior to the Affordable Care Act.

Q03. What do you think is causing that decline?

P14. Like I was talking before, in the individual health market before the Affordable Care Act, there was no protection for employees. But now with the exchanges, we have subsidies that make it affordable for a lot of low income people. We also have the same adjusted community rating in the individual market as well. It has to be done on the guaranteed issued basis. The employer markets are now part of the individual markets. So, if all your employees were low income and you were previously offering them insurance, that may not make sense anymore now because there is this alternative source of insurance that is basically in most cases going to cost them less than they were paying when you covered them.
While it is a benefit, they are not going to value it as much as they did prior to the implementation of the Affordable Care Act. Do you understand how the premium subsidy on the exchange works?

Q03. Please go ahead and explain.
P14. The subsidies are available to households with income between 100 percent and 400 percent of the poverty level. For a single person, it is roughly $11,000 to $48,000. But the subsidies start off very high if you are at 100 percent of the federal poverty line (FPL). They drop down pretty significant, even to 200 percent to 250 percent of FPL. So what we found is that generally around 200 percent to 250 percent of FPL that is where it becomes more advantageous to qualify for the premium subsidy and get your coverage through the exchange versus going through the employer coverage. But every employer offers different plans.

Q03. How has this benefited the middle class?
P14. Do you understand the affordability test?
Q03. Yes, a little bit.
P14. If you look at who is buying insurance through the exchange, it’s kind of like 75 percent of people on the exchange are below 200 percent FPL. I would agree that if you define the middle class as people above the 250 percent, the Affordable Care Act has not really benefited the middle class. Especially the Medicaid expansion up to 138 percent and then the premium subsidies were predominantly for people below the 250 percent FPL. Those below the 250 percent is the population that is newly insured under the Affordable Care Act.

Q03. How about people above the middle class that own businesses? What have you seen in that particular market?
P14. I do not have experience on the ground. However, I would agree that the qualification for subsidies is based on the income you are reporting. You could have a million dollars in the bank but if you’re only getting $35,000 interest out of that, which is your only income.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?
P14. Any programs introduced by the government are not always well laid out and there is always confusion followed with frustration. When the federal government introduces any initiative, it takes time for it to be tweaked and start working as per plan. In the meantime, they will be hitting companies with non-compliance fines and penalties.

Q05. Please describe your experience with the Affordable Care Act.
P14. I would say for us as a company, the Affordable Care Act created more opportunities as we tried to solve the puzzle. We have been busy in the last 4 years and I can see us busy in the next 5 or so years solving this puzzle. It created more business for us.

Q06. Overall, did the Affordable Care Act make things better or worse for you? Please explain.
P14. Well, right after the Affordable Care Act was passed, someone said the only healthcare system worse than the Affordable Care Act is our current one. Prior to the affordable Care Act, there were a lot of issues with people getting sick and not getting insurance. I think that has definitely helped in that area. Now, I do not think it has done anything to reduce the cost of health insurance. It has definitely insured more people but it did not make it more efficient. It hasn’t reduced the unit cost of healthcare. But on the business side, it has created plenty of work for us. That is good for our business.

Q06. From your perspective, what should the ACA have done to reduce the cost of health insurance?

P14. There is kind of the 80/20 rule in healthcare where 20percent of the population is responsible for 80percent of the cost. I think there is certainly some benefits on the Affordable Care Act like if you get involved in a car accident or something like that. There is also a situation whereby you go to a doctor and that doctor has no idea of what the previous doctor did. I think better communication between medical providers. That is really important. It is being done through the electronic record keeping which the Affordable Care Act incentivized medical providers to acquire. I am seeing a lot of development with that. I think part of it is that Americans utilize more healthcare than other countries. We take more prescription drugs than other countries. I have no way of knowing how much I am going to pay for the services I receive. There is no way of judging who is doing better than the other.

Q06. The price range of an MRI procedure can range from $500 to 2,600 within the same zip code.

P14. That is part of the problem. Everyone charges whatever they want. I broke my wrist about 4 years ago. All they did was to put a cast on it but they had to order a CT scan. The whole episode ended up costing $1,700 to end up getting a cast put on my wrist.

Q06. Did I hear you correctly that the Affordable Care Act did not do much to reduce the cost of healthcare costs?

P14. Healthcare trends have been moderating but the hard question is what is causing that? Is it because the economy is not doing very well, so people have no disposable income to spend on healthcare, or something else? I am not totally convinced that you can say that is truly the case. There is evidence that may be portions of the Affordable Care Act have introduced what they call Accountable Care Organizations on the Medicaid side but now we are seeing them also on the commercial side. I think the jury is still out whether that actually is going to save money. In my mind, I have a hard time deciphering the difference between the Affordable Care Act and a provider service organization that services health insurance companies. The Provider sponsored health insurance is kind of like the next step up.

Q06. Did the Affordable Care Act attempt to reduce costs at the hospital and pharmaceutical levels?
P14. I would agree that the Affordable Care Act lacks price transparency. There is lack of competitive pressure between two hospital systems. But at the same time, it is back to the basic question that if my insurance company is paying the bill, why should I care about it? I am not sure there is an easy answer to that but I think high deductible Health Savings Accounts (HSAs) are meant to make you put your skin in the game. Other than that, there are no tools available to allow healthcare consumers to make smart decisions about cost. Unless you are doing some elective procedure, when you go into the hospital, it is an emergency.

Q07. If you had been given a choice, would you have opted to go with the Affordable Care Act or stay with your previous Healthcare system?

P14. There is no doubt about the fact that the old healthcare system seriously needed some attention. Cost of health insurance was always rising and it was becoming apparent that many people were soon going to not afford it. There was no centralized health information system where doctors and hospital systems could check if a patient visited their emergency room. At the same time, while the Affordable Care Act is attempting to create a centralized health information system, and that is good by the way, it has not helped with controlling the cost of healthcare and reduce healthcare costs. If the old system had been tweaked a little bit, it would have helped a lot.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?

P14. As an insurance business and health insurance consultants, we have more business than we ever did. That is good for us. Probably the biggest thing is that there is a wide disparity in terms of what small businesses are paying for health insurance. The change from the medical underwriting to the community rating, some small businesses had their premiums drop significantly but others have had their premiums increase significantly. The third trend we are seeing is that traditionally, most small businesses have purchased health insurance plans where they pay a premium to the insurance company. That is their cost for the year for providing health insurance benefits. It is a kind of an upfront payment. Are you familiar with self-funding at all?

Q08. Yes. That is what my employer is on.

P14. A lot of insurance companies have introduced what they called a level funding product. It is a kind of a self-funded insurance for small businesses that have a low stop loss attachment point. Most medium businesses have $250,000 to $500,000 as a stop loss. But most of these small businesses have like $20,000 in stop loss. It’s a way to get around the adjusted community rating rules. So I think some of the decline in the fully insured market is probably small businesses going to this level funding product. I think compliance is a bit of a headache for a lot of businesses and there is a lot of reporting requirements.

Q09. What aspects of the Affordable Care Act do you like?

P14. From a business perspective, this is the best thing that ever happened to us. It created a lot of business for us. Employers’ headaches is our opportunity to figure out solutions for them. From a personal perspective, I do think it is
important that we have protection for people that are sick. It does seem kind of unfair that due to no fault of your own, you have to pay significantly more for health insurance than someone that is healthy. At the same time, I feel that there is not a lot of personal responsibility requirements in it. It’s good in that it provides more protection for people in individual market. We do a lot of work for Medicaid and we have seen a huge expansion of Medicaid population. States have expanded their Medicaid programs. I do worry about the country as a whole being able to afford all this. It is easier to say we have insured all these additional people but are we spending money that we could have spent on something else such as better education. It is easier to quantify people that were not insured and now have health insurance but difficult to quantify those that lost coverage because their premiums went up and they could not afford it anymore. I do worry about the new pricing. It seems like the new premiums for 2017 in a lot of states are increasing significantly.

Q09. Are you predicting that premiums will go up and if so, by what percentage?

P14. In the employer market, we have seen 6percent to 7percent every year. Now the individual market, it is more difficult to estimate because it is still an immature market. When it started around 2012, it was too aggressive and 2014 was more of a self-correcting period. Now it is sought of stabilizing. That is one of the reasons for driving up premium increases.

Q09. Do you think a 6percent to 7percent annual increase in health insurance costs while income is growing by 2percent to 3percent will cause the system to collapse at some point?

P14. I think that is going to put a downward pressure on long term trend rates. Economists have predicted that. Basically, the percentage of GDP spent on healthcare will hit a ceiling and start coming down.

Q09. What aspects don’t you like about the Affordable Care Act?

P14. I guess from an employer’s perspective, it does seem like the reporting and compliance requirements are very burdensome. There is also a lot of fear among employers concerning the audits and classification of employers and keeping accurate records. For insurance purposes, we just focus on the health insurance costs.

Q10. What were some of the unexpected consequences of the Affordable Care Act?

P14. It is surprising how many times it has been tweaked a little bit. I think for a lot of insurers in the individual market, there was an assumption that everyone was going to get rid of their older plans after 2013. For political reasons, there was a lot of uproar because the federal government changed their rules after the insurance companies had already set their premiums for 2014. That was one big change. The other thing is the risk corridor situation. In the individual and small group market, the Affordable Care Act has provision which limits insurers’ profits and losses from 2014 through 2016. This interpreted that the insurers were going to get what was prescribed in the risk corridor formula. Even if all the insurers lost money, they were going to get basically their risk corridor losses paid by the federal government. CMS kept saying that it is going to be budget
neutral because half of the insurers are going to make a loss and the other half will make a profit. I felt it was kind of odd because insurers had a strong incentive to price as low as possible to grab a market share and get their losses covered by the federal government. So Senator Rubio described it as ‘we do not want to bail out the insurers. So they changed the risk corridors and made it budget neutral on a national level. So, in 2014 insurers received 12 cents per dollar of what they were expecting to get. They asked for $3 billion but only get $300 million. That put a lot of the co-op plans out of business. They had to leave the market. That was a pretty interesting twist. Also, the Supreme Court decision to make the Medicaid expansion an optional thing for the states back in 2012 created an interesting situation whereby 30 states expanded Medicaid and 20 have not. It creates this weird thing with states that have not expanded Medicaid, many people are now eligible for health insurance. There is now an insurance gap in those states that have not expanded Medicaid. The states that have not expanded Medicaid are also artificially inflating the exchange enrollment. Otherwise, most of those people would be on Medicaid. In my opinion, the exchange enrollment is actually worse than reported. If you adjust for states that have not expanded Medicaid, you would take out about 2 million people from the number that has enrolled.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?

P14. There is definitely more business for us as we attempt to solve people’s problems pertaining to the implementation of the Affordable Care Act. I think hospitals are also seeing more and more patients walk in with health insurance. From a business perspective, that is a good thing.

Q12. What challenges have you faced with the implementation of the Affordable Care Act?

P14. None that I can think of. I think it is just about staying in top of all the changes that are made to the rule itself as they implement upcoming pieces of the Affordable Care Act.

Q13. What has been your sources of information concerning the Affordable Care Act?

P14. As a senior Actuary, I have been part of several discussions with other Actuaries in the country. I have also co-published some articles on the topic. There are several seminars and webinars hosted by the insurance industry and the federal government.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?

P14. I think the Affordable Care Act focused more on insurance reform and it is not doing anything to address the cost of healthcare. I would want to get more price transparency into the system. I am sure hospitals are going to be against that. It does not seem like there is any provider accountability. Why does it cost X dollars for a treatment in one hospital and 50 percent of that in another hospital in the same zip code? It seems like there is need for more accountability in the whole system. We are seeing a lot of competition with the Affordable Care Act
and that is a good thing. The small group market has been stable compared to the individual market.

Q15. If the Affordable Care Act was to be revised, what aspects would you want to see revised?
P14. I think we need to do away with the Medicaid fee-for-service. I think that will bring the price down a little bit. From a consumer’s perspective, the Affordable Care Act is challenging because the way the subsidies are structured. The subsidies are tied to the silver plan on the market. But the relative price on the market changes every year. If I paid $50 per month in 2015, I may have to pay $150 in 2016 because my insurance increased my premium. That structure is good for competition but I think it also creates a challenge between market insurers and health plans. How can an insurer manage a person when they are flipping between their employer’s insurance and the exchange? I think there should be a plan that allows you to keep your insurance plan for several years instead of disrupting the insurers. I think in 2014, some insurance companies put out insurance premiums that were too low and they had huge losses. That is one of the reasons United Healthcare pulled out of the exchange. The insurance commissioner should have been on the lookout for rate review. I think insurance companies like United Healthcare were trying to buy the market with super low premiums in 2014. Everyone had to change plans from one year to the next. I think it is going to level out. California has more price stability because they manage their plans better.

Q15. From your perspective, what should be done to the Affordable Care Act?
P14. Looking at the subsidy structures and the exchange, I think we need a subsidy structure that allows for more consumer flexibility from one year to the next. I think that could address some issues where people have to change plans each year. I do worry about health insurance premiums for some people who are paying around $15,000 per year. That is a lot of money. How do we create more affordable insurance options for people that are not qualifying for subsidies or the middle class? That is the key question. And again, trying to drive the cost of healthcare cost down is the only thing that is going to create a long term solution. The insurance rate reform was important but it really did not address the actual cost of healthcare.

Q15. Thank you so much for your time. I really appreciate your willingness to meet with me on a short notice. Is there any additional information concerning the Affordable Care Act you would like to share with me?
P14. Well, there is a lot of information. It just depends with what you are looking for.
Q15. May I contact you if I have follow up questions?
P14. Sure! You have my business card.

Participant 15

Q01. Thank you so much for taking you time from your busy schedule to meet with me. This will help me tremendously towards my research.
P15. Not a problem. So I heard you are doing your PhD at Purdue University. Is that correct?
Q01. Yes, sir. I am doing a PhD and for my research, I am examining the impact of the Affordable Care Act on small businesses.
P15. Do you live here in Indianapolis and commute to West Lafayette?
Q01. No, I live in West Lafayette and work 35 minutes north of West Lafayette. What is your position?
P15. Senior Vice President and Chief Actuary. I work in the finance group here. I am responsible for the company's financial planning process nationwide. I am also the senior ranking Actuary.
Q02. How long have you been with this organization?
P15. Fifteen years.
Q03. How would you characterize medical benefits and healthcare coverage prior to the implementation of the Affordable Care Act?
P15. We had a circumstance that small employers were facing rate increases of 7 percent to 15 percent per year prior to the Affordable Care Act. Increasingly, it was unaffordable to them and they could not compete in their market places. We sell what is referred to as an offer rate. An offer rate is the percentage of a smaller employers offering health insurance to their employees. The offer rate had declined considerably, and in some jurisdictions down to 30 percent to 40 percent. So you had two thirds of the smaller employers saying we cannot just afford to offer health insurance. Those that offered it, offered it with a pretty high employee out of the pocket contribution through payroll deduction. Employee share could easily be a third of the premium. So the percentage of the employees actually taking the coverage among those small employers offering it was relatively small. I am going to guess and say it was around 60 percent to 70 percent. So if you think about all the employees working for small companies, way over half were not purchasing small group health insurance. The coverage itself was growing in terms of what we call the cost share. Cost share refers to the member's deductible and co-pay, that sough't of thing that you pay out of pocket related to a particular service. So that was also growing in the advent of high deductible plans and Healthcare Savings accounts (HSAs). HSAs were becoming popular and they remain popular even today. The Affordable Care Act has not actually done a great deal as it was intended to. It has not done a great deal to change all those circumstances. The required benefits were actually richer than what was commonly offered in the marketplace. That put upward pressure on premium rate increases going into the effectiveness of the Affordable Care Act because small employers who were purchasing coverage but it was a slimmer plan design required by the Affordable Care Act. They had to increase that benefit, so that increased premiums. From a public policy perspective, some would debate very well that the plan designs required by the Affordable Care Act were in the best interest of the public. The truth based on the evidence is clear that in many cases, that was more expensive coverage because the benefits are richer and the members' cost share went down. There
was an increase in the cost of coverage and so in that year of effectiveness, it varied by markets. The Affordable Care Act took effective in 2010, the exchanges came up in 2014, but then small employers who had insurance were allowed to stay on their coverage for a while. So there was a delay in that area and in the meantime, those employers that delayed continued to experience this 7 percent to 20 percent rate increases.

Q03. Interesting.
P15. Yeah. So that pressure on small businesses trying to manage their overhead expenses. For those that went to the market to look for coverage, as a baseline, they would see a more expensive coverage because of the benefits. In many markets though, as a counter to that, insurers were allowed to differentiate premiums based on relative health status; sickness and wellness of the employees. So a small employer that had employees that were very sick would see a much higher premium rate before the Affordable Care Act. So, under the Affordable Care Act benefits, that is no longer permissible. You can no longer charge premiums based on pre-existing conditions. Before the Affordable Care Act, we always had to cover it under HIPAA. You could differentiate the premiums within some bands but you could still get a rate that is 2 to 3 times higher.

Q03. How many bands existed before the Affordable Care Act?
P15. Before the Affordable Care Act, there were about 5 or so bands and after the implementation of the Affordable Care Act, they were compressed to about 3 bands. That is commonly referred to the demographics. In most markets, they were not strict bands as we refer them but they were a continuous rank in mathematical terms. One was allowed to have a 5:1 range from the lowest or cheapest demographic adjusted rate to the highest. So that has been compressed for adults to a 3:1 and the child age factor is much lower. It creates some issues too because new bone babies cost a lot more than 2 year olds.

Q04. When you first learned that you would need to comply with the Affordable Care Act, what went through your mind?
P15. More paperwork, more compliance, and more government audits. It just meant that we had to ensure we understand the law and do whatever it takes to be on the right side. And of course during that time, we knew there would be confusion, fear, and frustration as companies tried to figure out the expectations. Their fear became our business.

Q05. Please describe your overall experience with the Affordable Care Act.
P15. The movement of small employers out of offering coverage has accelerated somewhat but not dramatically.

Q05. Was that expected?
P15. Yes, and I thought it was going to be more dramatic because the small employer could say to his employees, ‘look, how about if I just raise everyone’s wage, you can go to the exchange, get subsidies, and get better coverage?’ I actually thought there would be fewer small employers offering health insurance. It has gone down but not at the rate I thought it would. It accelerated somewhat but
not as profound as I thought it might. But I do think that pressure is still there. We will reach a tipping point where a new small business is just going to say it does not make sense from day one to offer health insurance. I will just pay a better hourly rate that is attractive to perspective employees and encourage them to go get health insurance at the federal exchange. There is a social movement out there to increase minimum employee wages to $10.15 per hour. If I can pay $15 per hour and encourage employees to go to the exchange and if their family income is below $80,000 per year, they can get a subsidy and get health insurance.

Q05. Interesting. So this is actually encouraging small employers to not offer health insurance.

P15. To a certain extent. The other thing that people are catching on to is that the special enrollment period on the individual enrollment period allows you to join frequently during the year. It is not that difficult to qualify to join the exchange other than outside January 1. I would like to think this is not possible but people are personally and economically wise. If you think about it from the business owner’s perspective saying ‘I will pay you more and you go to the federal exchange and get your own health insurance.’ The downside of that is if you have more than a certain number of employees, there is a penalty. At the end of the day, most employers care for their employees and they want to provide them with good benefits. In many situations, small employers employ family members and close friends. In that case, the employer might continue to offer health insurance. There is still a place for offering health insurance as a small employer, despite the business economics.

Q05. Earlier on, you stated that the number of businesses offering health insurance has been going down.

P15. Yes, it has been going down for the past 20 years.

Q05. At what point will this cause a national outcry and effect a meaningful change to stop this downward spiral of small businesses not offering health insurance?

P15. There is anecdotal evidence that employers that are on the minimum number of employees threshold are making some of their employees part-time so that they are below the threshold. So we are already seeing a lot of that happening. At some point, if you imagine a new president who is sensitive to this issue, the argument for an employer with 58 employees would be that if I can reduce the number of my full time employees to 49, I do not have to worry about providing health insurance. I can escape all this $3,000 penalty per employee. You can see that happen which will totally accelerate the issue of moving all these employees to the individual exchange. So that is one direction. The other direction is to say this is fundamentally wrong. The employer should be required to offer health insurance. Therefore, take that penalty all the way down to one or two employees. I think the direction of the economy will drive all that. If the economy stays where it is or improves, maybe there is less sympathy for small businesses. If the economy was to start to contract again, then you would see unemployment start to rise and they would say let’s really understand what is
causing this pressure. There are hundred things causing unemployment. This is not the only one. It will be more plausible to say the Affordable Care Act implications are stopping small businesses from getting to a certain threshold and that will be a reason to lessen that pressure.

Q06. Overall, did the Affordable Care Act made things better or worse? Please explain.
P15. I do not think it made things any different for me. I think for the whole health insurance industry, it presented both opportunities and challenges. For people with pre-existing conditions, it made things way better for them. Their premiums went down and they can no longer be denied coverage due to their pre-existing condition. Also, for low income people and those with adult children under 26 years old, it made things better for them. However, the middle class is being squeezed from both ends. There are those who are just above the point to qualify for federal subsidies but at the same time do not make enough money to afford health insurance, those are in a tricky position. It made things worse for them. There is no doubt about it. One example is that there is a health insurance fee on the industry. This fee has raised health insurers’ tax rates mostly by 10 percent all but itself. It has been dramatic. It amounts to $16 billion dollars per year. The theory was that because it’s now mandated employees have to buy on the exchange, that would be the equivalence of the profits. But profitability has been negative on this. That is just a vast increase on taxation. It had to be applied to subsidies, so I get it. From the federal government’s perspective, it is a zero sum. But to the industry, it is taking the burden of all those health subsidies and saying the health insurers should pay all that now. So the co-ops that were launched when the Affordable Care Act started, there are only 5 left out of 23. You take them as a subset of the microcosm, it has been devastating. Now I know they were created through the Affordable Care Act but they are also trying to live under it and it is another very difficult situation. You see very large carriers like United Healthcare scaling down and pulling out of certain states like Indiana. They are licensed countrywide but are going to be in 5 markets. We just recently published this week that we will be evaluating by rating area. Each state has a rating area and we will be evaluating by rating area whether the economics are there. It is tied into a number of issues such as regulatory and financial in terms of rate increases that are approved through the public exchange markets. So, it has been difficult. I would say the most burdensome part, past the financials is the regulatory burden.

Q06. Are you referring to compliance?
P15. Yes. It is very heavy. I see and understand why they are in place and necessary under the construct of the Affordable Care Act, but it has added a lot of internal costs and delay in operating the business. You know insurance is not going through this alone. There are lots of other industries that are subjected to significant regulations for well-intended purposes. At some point, you ask yourself how much is too much? That is an open debate in our country today. Our investors ask us directly, “Are you making a really wise decision investing in Affordable Care Act compatible plans? They are seeing that the earning streams
are very volatile. It takes a significant amount of capital to stay it in and so as an investor and steward of the trust funds, pension funds, and public investments in many cases, are you being good stewards in investing in that kind of business which has volatile earning streams? The way the Affordable Care Act is structured, it limits profitability on the upside but on the downside you are on your own. The gains are limited but the losses are limitless. It has made things, as the co-ops proved this, very difficult for businesses to thrive.

Q06. How about from the smaller employer perspective? What have you observed in terms of the impact?

P15. I think it improved the options for the small employer who is looking to get out of offering coverage.

Q06. Is that good or bad?

P15. I won’t put a value to that. That is for researchers to do (laugh). I think the other angle you can think of is for an employer who has an employee or a dependent with a very serious health condition. Then it has been helpful in that regard because they have, from that perspective, affordable premiums. If you have an employee with a child with hemophilia, a very expensive condition, that premium would be on the very top end of what was permitted before. Because of the Affordable Care Act, that premium has been cut in half, if not by more. It has really dramatically improved that employee’s outcomes. The other side of it is that the other employees with relatively good health are paying probably 20 percent to 30 percent high premiums.

Q06. Is that fair?

P15. If you are talking about an unforeseen event that neither of us saw coming, yes that is the point of insurance. That is completely fair and equitable. We both wanted to cover a risk, we did, and one of us emerged with a thing we were concerned about. The issue you are raising is what about a condition that was created by my own lifestyle? Because I eat too much, smoke too much, and drink too much, now is it fair that they pay the same premium? In that context, no it is not fair. The question is what do you do? Statistics show that the U.S. population is getting heavier and heavier. More and more people are smoking and making poor health decisions. What do you do about that? I think the counter argument is that this is where our citizens find themselves for better or worse.

Q07. If you were given the choice, would you have opted to go with the Affordable Care Act or stay with the previous healthcare system?

P15. I think the Affordable Care Act created bigger issues. There were people who had serious existing conditions and while they could get group insurance as required by the law, their premiums would be higher; may be 2 to 3 times for a group with a member like that. But on the individual side, they could not get health insurance. States had enacted things like high risk pools and that is the reality of how we need to handle things. We need to finance those through more broad financial structures. No one wants to see a child born with hemophilia or spinal bifida not get the healthcare they need. So what do you do about that? You can say you have to pay for it for yourself or say that is a general public health issue
that has to be funded more generally. So if we went back to the old system, the high risk pools need to get a new look. They were very weak, narrow, and poorly funded. I think we would need to differentiate between lifestyle choices people make and truly unfortunate situations.

Q07. How do you differentiate that because some lifestyle decisions one made 20 years ago will have its effects show up today when you changed your lifestyle?

P15. It is difficult and I would say we would have to create some regulations around it but we already have regulations. There has to be some decisions made about what constitutes having done it to myself or it is unexpected but it happened. I think we need to create a safety net even for those who made poor lifestyle decisions and changed but are now living with the consequences. For example, if we have a young, healthy male who rides a motorcycle without a helmet and gets involved in an accident, we have to take care of that person. It has to be funded somehow.

Q07. Did the Affordable Care Act address what it intended to address in the first place?

P15. It did somewhat, but not very much.

Q07. What did it address and what did it not address?

P15. It established some research funding for clinical outcomes analysis and it is like a $1 per employee. It took a while to get off the ground but that is long development. I was not expecting some immediate discoveries. That I think makes sense and it will in time yield better economics in treating conditions. There was some support for better integrated delivery but it is pretty limited. Potentially, health insurers will have to accomplish that on their own. There are two pieces we talked about. The first one is lifestyle. This refers to creating more healthcare demand. The second is the fragmentation of our healthcare system. It creates a lot of excessive care, a lot of retesting of things as people move from one side of care to another side of care and from one professional to another professional. There is a lot of double checking and that originates in liability. So another part of the response should be liability reform and tort reform. If I have an unfavorable health outcome, it is very difficult for the healthcare professional to escape notion that they are not liable for that. It’s a huge issue. If you were to add up all the lawsuits won by people, it would be a significant dollar amount of money. It is small in comparison to all the care that is being delivered. It is really difficult for the healthcare system to fund all that and protect itself.

Q07. That makes good sense. However, do you think it is fair for hospitals to be paid to correct their own mistakes?

P15. No, it does not make sense. It is a challenge. It is only in the recent years that health insurers have stopped paying for a “never event.” A never event is when you go into the hospital to get your left leg amputated and they amputate the right leg. The reason is that hospital systems own the hospitals and bring in doctors to do procedures on patients. If something goes wrong, who is responsible for that? The current system is so fragmented that no one is directly responsible. If you have a situation where there is ownership among those
physicians of the hospital system, there would be greater cohesion, better coordination of care, and probably better quality of care.

Q08. From your perspective, what has been the impact of the Affordable Care Act on your business?
P15. Well, definitely it has given us more work to do and that is good for our business.

Q08. Are there any other unexpected consequences of the Affordable Care Act you have experienced out there?
P15. None major that come to my mind.

Q09. What aspects of the Affordable Care Act do you like?
P15. I like the fact that people with pre-existing conditions are no longer having to pay higher premiums because of no fault of their own. That is a definite plus. No one can ever be denied health insurance coverage because of pre-existing conditions. I think it also benefits families with children under 26 years old. They can stay on their parents’ health insurance without paying higher premiums. That is a good thing.

Q09. What aspects of the Affordable Care Act don’t you like?
P15. I do not like the fact that most people’s premiums have gone up considerably. The Affordable Care Act has also resulted in the narrowing of networks. We may end up with a few huge insurance companies and at that point, the market will lose competition and they will just end up charging whatever they want. It appears like the whole thing was poorly planned and poorly executed.

Q10. What were some unexpected consequences of the Affordable Care Act?
P15. I think we covered most of them but I think the major ones are increase in premiums, low enrollment among the young and healthy, narrowing of networks, and confusion on the market.

Q11. What benefits have you realized with the implementation of the Affordable Care Act?
P15. Of course, more business for us (laughter).

Q12. What challenges have you faced with the implementation of the Affordable Care Act?
P15. Well, the federal government promising insurance companies and not following through with their promises. Other than that, nothing on our end.

Q13. What has been your sources of information concerning the Affordable Care Act?
P15. Our Company has several Actuaries and we have had several discussions and research at that level. Also, as a senior ranking member, I have been part of several panels and discussions. The Department of Labor has also done seminars and webinars.

Q14. If the Affordable Care Act was to be revised, what aspects would you want to see maintained?
P15. The subsidies are the most important thing. Increasingly, the effectiveness of this system rests on the quality of premiums and cost sharing subsidies. You can not force everyone to buy individual health insurance. If we are going to keep the system, we have to ensure that those subsidies keep pace with what the real cost of insurance is which is the ultimate cost of healthcare. I do think that we
have to take a look at rules around ownership of healthcare facilities and prices. I think more common ownership would actually help to bring more cohesion in the delivery of care and a great economic interest. Let’s do the smart and most economic thing because the other side of all this excess spending is generated from activities of people accessing healthcare. We are not necessarily improving the quality of life when we are rendering healthcare. We provide healthcare we agree we do not need but just because of liability concerns. There is a lot of double checking to avoid liability. We need to permit a situation where common ownership of healthcare is created.

Q15. If the Affordable Care Act was to see revised, what aspects would you want to see revised?

P15. The biggest thing on my mind from where we sit right now in terms of incremental change is the special enrollment periods on the individual exchange needs to be tightened up. And they need to be validated. There should be very few reasons why someone can enter the individual exchange. This will force citizens to make a healthcare decision in January, which is when they should make the decision. You are either in or you are out for the year. There is a mandate that everyone who does not have coverage should have coverage. I understand people’s reaction to that. That is the law and there is a reason why that law was put into place, but I definitely think it is detrimental to let people join for very mild reasons without any verification or validation. It completely undermines the idea of people getting in and staying in for the balance of the year and paying their fair share.

Q15. Has the Affordable Care Act done anything to improve the quality of care?

P15. No. It was really focused on health insurance reform, not healthcare reform. True healthcare reform should focus on the total healthcare system, not just one aspect which is health insurance. Hospital systems are still charging what they were charging prior to the implementation of the Affordable Care Act. For healthcare reform to be effective, it has to focus on the insurance systems, hospital systems, and pharmaceutical systems. It has to have an influence on all those three. And it has become an urgent matter because of the percentage of the GDP being consumed by healthcare. There are two avenues; either you nationalize the whole thing or create better visibility between the purchaser and the delivery of services, creating more transparency. Nationalization of healthcare is how most western nations are structured. I am not a fan of that system. The second option presents some work but it is actually difficult to create enough transparency so that the individual consuming the care or the employer who is paying the premium see what it really costs to receive services.

Q15. Thank you so much for taking time from your busy schedule to meet with me.

P15. Onias, it has been a pleasure talking to you. I hope this has been helpful.

Q15. Yes, it was. May I contact you if I have follow up questions?

P15. Sure. Here is my business card.

Q15. Thank you so much.
VITA

Onias Muza Taruwinga

PROFILE
Professional with extensive management experience in systems development and implementation. Possess a record of effective customer service and creative problem solving. Exceptional organizational skills, a demonstrated client focus, and an ability to accomplish desired outcomes with limited resources. Friendly and a quick learner. Able to handle multiple tasks while being sensitive to deadlines. Excellent instructor.

EXPERIENCE

CDC Resources Inc., Monticello, Indiana, CEO 2014 to Present

- Oversees $6 million operational budget.
- Recruits and trains key leadership staff.
- Reports agency operations to the Board of Directors.
- Networking with other not-for-profit CEOs.
- Advocates for the organization at local and state level.
- Planning and executing friend and fund raising programs.
- Responsible for 189 employees.

Mosaic Inc. Terre Haute, Indiana, Executive Director 2008 to 2014

- Responsible for creating and operating a $4 million budget.
- Responsible for recruitment and retention of key leadership staff.
- Reports agency operations to the Board of Directors.
- Revises existing and develops new policies and procedures for the company.
- Networking with other CEOs through professional associations.
- Advocates for the organization at local and state level.
- Planning and executing friend and fund raising programs.
- Forecasts, alters, and creates marketing strategies to meet market demands.
- Responsible for 120 employees.

Ivy Tech State College, Indiana

Adjunct faculty of Management and Business Leadership. 2012 to 2014
ADEC Inc., Bristol, Indiana, Director of Operations 2001 to 2008

- Developed and monitored outcome measures and departmental goals.
- Trained managers and supervisors on company policies and procedures.
- Responsible for creating and running a $3.5 million budget.
- Revised and developed policies and procedures for the department.
- Networked with other agencies regarding trends, new services, and supports.
- Supervised 10 managers, a nurse, and a behavior clinician.
- Oversaw 60 clients with developmental disabilities.

ADEC, Inc., Bristol, Indiana, Program Manager 2000 to 2001

- Responsible for tracking financial disbursements for 30 Medicaid clients.
- Supervised 6 managers and 45 staff.
- Developed a new scheduling system to manage overtime.
- Developed training procedures for new staff.
- Trained supervisors and staff on Medicaid regulations.

EDUCATION
Purdue University, West Lafayette, IN
PhD, Technology, Leadership, and Supervision
Major: Leadership and Innovation.
GPA: 4.0/4.0 December 2016

Bethel College, Mishawaka, IN, USA
MBA, Master of Business Administration 2002
Major: Business Administration
GPA: 3.42/4.0

Andrews University, Berrien Springs, MI, USA
BA, Bachelor of Arts 1995
GPA: 3.36/4.0

PROFESSIONAL CERTIFICATES
Negotiation Strategies and Techniques, George Washington University 2003

COMPUTER SKILLS
Excellent skills in Windows, Excel, Microsoft Word, Microsoft Outlook, Open Office, and Ready Access. Strong Internet skills.