1. (Reviewer 2) The author indicates that she will discuss health risk, economic risk, and the effect of patient-physician relationship on choice of health plans (page 3) but then introduces additional variables “delivery system characteristics” on page 5 without explanation.

*In response to this comment, I added the following lines on page 3 of the revised manuscript and made reference to it again on page 6 of the manuscript.*

(See pg. 3 of revised draft) The role of delivery system characteristics has been tested less often. Therefore, this study examines the effects of health risk, economic risk, patient-physician relationship, as well as delivery system characteristics on choice of plans.

(See pg. 6 of revised draft) *As noted earlier, in the enrollment choice literature the role of the delivery system characteristics has not been pursued with the same rigor… Berki and Ashcraft (1980) attribute this difficulty to the lack of a conceptual framework that guides investigators during analyses.*

*However, due to their importance, delivery system characteristics will be examined in this study.*

2. (Reviewer 2) The discussion on page 3 is somewhat unclear in that the author under “health risk” states that families with certain characteristics were more likely to be “offered” HMOs and then concludes that these families therefore are more likely to ‘choose’ HMOs because they are at greater risk or are more vulnerable.

*As the reviewers correctly noted, the use of the word “choose” is incorrect. I have clarified it with the highlighted additions and changed the word “choose” to “recall being offered.”*

(See pg. 3 of revised draft) Investigators who first proposed the risk vulnerability hypothesis found that when offered a dual choice option of HMOs and FFS plans, persons with attributes that suggested risk vulnerability, such as those over the age of 40, those who are married, and those families with children between the ages of 6 and 18 years, were most likely to recall being offered an
HMO option. Arguing that selective memory was a reflection of vulnerability, the investigators concluded that individuals who are at greater risk or feel more vulnerable, both financially and medically, are more likely to recall being offered HMOs because HMOs provide comprehensive benefits at low out-of-pocket costs (Bashshur & Metzner, 1970).

3. (Reviewer 2) The relationship between age and risk on the bottom of page 3 is unclear as well.

To clarify it, I included the following highlighted additions to the section on “health risk.”

(See pg. 4 of revised draft) The type of chronic conditions had no effect on the choice of HMOs versus FFS plans; however, age as another measure of health risk was a significant predictor of choice, although its effect contradicted the risk vulnerability hypothesis: younger, not older, employees were more likely to enroll in HMOs than in FFS plans (Taylor et al., 1995). Similar effect of age on enrollment choice was also found by Davis, Scott, Schoen, & Morris (1995) and Feldman et al.

4. (Reviewer 2) On page 7 under the sub-heading “development of the multidimensional scale” the author states, “Next studies on enrollment choice were reviewed…” without providing any citations.

Over 20 studies on enrollment choice were reviewed to develop the scale. As in the interest of space, all studies cannot be cited in the manuscript, I cited a sample of the studies.

(see pg. 8 of revised draft)

Development of the multidimensional scale

Next, studies on enrollment choice, including several discussed in the literature review section of this paper (e.g., Berki and Ashcraft, 1980; Feldman, et al., 1989; Mechanic et al., 1990), were analyzed.
5. (Reviewer 2) What proportion of the 12 plans were of different types (FFS, PPOs, IPAs)? (page 7)

(See pg. 8 of revised draft) A total of fourteen plans offered by three employers in a mid-sized city were analyzed for scale development. These 14 plans consisted of three FFS plans, four PPOs, six IPAs, and one staff-model HMO. The same staff-model HMO was offered by all three employers. The three FFS plans were very similar in several characteristics. Therefore, during scale development, they were considered as one plan. The resulting 12 plans were compared for similarities and differences.

6. (Reviewer 2) How were the sample participants contacted? What were they told about the study? (see page 8).

7. Why were respondents in two companies studied three weeks after the open enrollment period and those on a third company seven months after open enrollment (see page 8).

I split the section entitled “sampling and data collection” in the original draft into two sections “sample” and “data collection,” and I responded to all three questions of the reviewer in the two sections.

(See pg. 9-11 of revised draft)

Sample

Initially, three companies in the mid-sized city that offered their employees a choice of multiple health insurance plans were selected to participate in the study. To increase the accuracy of subjects’ responses, Berki and his colleagues recommended that data on enrollment choice decisions be collected after the end of the enrollment period and before the beginning of coverage under the new plan (Berki, Ashcraft, Penchansky, & Fortus (1977). However, due to the difficulty of surveying enrollees during this narrow window of opportunity, investigators have rarely heeded this
advice (Davis et al. 1995; Feldman et al. 1989; Taylor et al. 1995). In some studies, data collection occurred 11 to 24 months after enrollment (Grazier et al. 1986; Garfinkel et al. 1986).

In this study, in an attempt to increase the accuracy of the responses, arrangements were made with the three companies to conduct the survey shortly after the enrollment period ended. However, a few months before the survey was to begin, one company, consisting of predominantly service employees, withdrew from the study. The company decided to change the array of health insurance plans offered to its employees, a move that required several employees to change their physicians. The management feared that the change would anger the employees and withdrew from the study. Consequently, another company consisting of largely service employees that offered its employees a choice of multiple health insurance plans was selected in its place. For this company, at the time of the survey, seven months had elapsed since the enrollment period ended. Therefore, for two companies, data were collected within three weeks after the open enrollment period ended, and for the third company, seven months after the open enrollment period ended.

From the three companies’ lists of employees, those who were not offered health benefits by their employers and those who terminated their services at the time of the survey were excluded from the study. Employees who lived outside the state in which the company was located, such as sales department personnel, were also excluded from the study. This was
because staff-model HMOs, which require enrollees to obtain services from only their facilities, cannot be a viable option for out-of-state employees. The resulting 2,027 manufacturing and service employees constituted the non-random sample of this study.

**Data collection**

Data were collected through self-administered surveys. To increase the response rate, the management of the three companies distributed a memo to the employees informing them that a study on enrollment choice of health insurance plans was being conducted by independent investigators from a university and encouraged employees’ full participation. To reduce the cost of the survey, the three companies agreed to distribute the survey material internally through their mail rooms. The survey material consisted of a self-administered questionnaire, a cover letter, and a stamped envelope addressed to the investigators at the university.

In the cover letter, the employees were informed that the purpose of the study was to determine the factors affecting employees’ choice of health insurance plans. Employees were also advised that their participation was voluntary and were informed of the steps that would be taken to protect their confidentiality. They were instructed to seal their completed questionnaires in the stamped self-addressed envelopes and mail them directly to the investigators at the university. They were assured that neither the employer nor fellow employees would have access to their individual answers and the results would be shared with the management
only in summary form. In addition, employees were advised to contact the investigators or the university’s Institutional Review Board in case of questions or concerns about the study. Follow-up letters encouraging participation in the study were sent to the employees. The total response rate was 53.72% for the three companies.

8. (Reviewer 1) My only reservation is the low response rate; this limitation and its implications should be addressed in the discussion. (Reviewer 2) The author does not discuss any limitations of the study and this should be inserted before the discussion of the conclusions.

On page 16 of the revised manuscript, I changed the subheading “Conclusion” to “Discussion.” Then, as per the reviewers’ suggestions, I inserted a section called, “Limitations of the study” before the discussion section. I addressed the low response rate and other limitations of the study in the “Limitations of the Study” section.

(See pg. 15 of revised draft)

Limitations of the study

The response rate of 53.72% indicates that less than half of the employees did not respond to the survey. Although the low response rate is comparable to that of similar studies on enrollment choice involving several companies and the same method of data collection (47.8% in Feldman et al., 1989), the findings of this study may not be representative of all the employees surveyed and must be generalized with some prudence. Further, the study is based on a non-random sample of manufacturing and service employees from three corporations who were offered a choice of multiple health insurance plans. Due to the non-random nature of the sample, the results should be generalized with caution to employees from similar corporations. For greater generalizability, the scale needs to be tested on a random sample of manufacturing and service employees with multiple plan
options. Finally, employees who chose not to be covered by their employer’s plan and opted, instead, to be covered by their spouses’ plan were excluded from this study. As such, the results and implications of this study do not apply to them.

9. (Reviewer 2) The primary defect of the manuscript is that it is difficult to know how to apply these findings to practice without a description of the demographic characteristics of the respondent and how these characteristics influenced choices of health care plans. It is unlikely that all consumers will behave similarly in making these choices.

_The reviewers have correctly noted the effect of demographic characteristics on choice of plans. However, their influence will be discussed in another paper; therefore, they are not included here. Nevertheless, in response to the reviewer’s comment, I have given a description of the demographic characteristic and added a section called “Implications for practices.”_

(See pg. 17-19 of the revised draft. All added words and sentences are bolded.)

**Implications for practice**

The study has implications for social work practice. There is growing empirical evidence that choice is essential for employees’ satisfaction with health insurance plans (Davis et al., 1995; Gawande, Blendon, Brodie, Benson, Levitt, & Hugick, 1998; Ullman, Hill, Scheye, & Spoeri, 1997). Accordingly, researchers have recommended that employers offer their employees at least a dual choice of HMOs and FFS plans (Davis et al., 1995; Gawande et al., 1998). However, this study suggests that an offer of any HMO and FFS plans is insufficient. HMOs differ along several characteristics and employers must recognize the multidimensional nature of enrollment choice when selecting plans for their employees. Due to high health care costs, employer decisions are likely to be guided more by the cost dimension of a plan than by its freedom, psycho-social access, and
perceived clinical quality dimensions which respond to employee needs.

Social workers using a systems perspective can facilitate dialogue between the payers (employers), the providers (plans), and the consumers (employees). Social workers can advocate for stronger employee representation in employers’ health benefits decision-making process. The strength of personal experiences that employees bring to the decision-making process can make the plans more responsive to employee needs.

Employees in any company differ along several demographic characteristics. In this study, employees varied in age (range 21-68 years), sex (76% males and 24% females), family size (1-10), annual family income ($3000-$87,000), and number of chronic conditions per family (0-30). The effect of these characteristics on choice will be discussed in another paper. However, literature reviewed in this paper suggests that demographic characteristics influence employees’ choice of plans in a variety of ways. Therefore, employers should conduct annual surveys of their employees to determine the responsiveness of plans to employee needs. Social workers can facilitate empowerment of employees by advocating for data banks that will record the experiences of employees with their health insurance plans. Information on the elements of psychosocial access, such as the doctor's warmth or the friendliness of staff, can only be obtained from the personal experiences of enrollees. Prior to enrollment, employees should be encouraged to research the data bank for information on plan characteristics that are important to them.
Social workers who conduct group sessions with employees who have particular needs, such as cancer or mental health problems, can encourage participants to share information on the responsiveness of the plans to their special needs. Several health insurance plans do not disclose information regarding management practices that affect the perceived quality of care or details on restrictive plan characteristics that affect the use of their services. Social workers can advocate for greater disclosure and transparency by managed care plans. Unless information about plans that individuals need for enrollment decisions is generated and disseminated in an easily discernable manner, there will be poor choice of managed care plans or reluctance to enroll in unfamiliar managed care plans. This can lead to inefficiency, high cost, and dissatisfaction with the plans.