- *You may submit your answers on-line at www.gahealthinsurancesurvey.com, return it in the enclosed postage paid envelope, or fax your reply to XXX-XXX-XXXX.*
- *In all your responses, please provide the best information you have available.* ***If you do not know the answer to a particular question, please provide your best estimate.*** *If you need assistance, please contact the GSU researchers at XXX-XXX-XXXX.*

1. **How many permanent employees worked for your firm or organization during the pay period that included 1/1/2011?** __________
   Include all full- and part-time workers at all Georgia establishments or locations for which this office administers benefits. Exclude all contract workers and any seasonal or temporary workers (<120 days per year).

2. **How many of these employees are Permanent full-time?** __________ **Permanent part-time?** ________

3. **On average, how many hours do part time employees work per week?** __________ **hours per week**

4. **How long has your firm/organization existed?** ____________________**Years.**

5. **Of the permanent employees working for your firm / organization on 1/1/2011:**

   How many were eligible under any of your firm / organization's health benefit plans? _________
   How many were enrolled on 1/1/2011 under any of your firm / organization's health benefit plans? __________

6. **Do employees have a choice of more than one health plan?** □ **YES** □ **NO**

7. **Please complete the following table for your 2011 health plan:** (If multiple plans, use the plan elected by the largest % of employees.)

	Employee Monthly Contribution		Employer Monthly Contribution		Total Monthly Cost Per Employee
Individual Employee Coverage		+		=	
Employee plus Spouse Coverage		+		=	
Family Coverage		+		=	

This table refers to a plan that is a: ☐ **HMO** ☐ **PPO** ☐ **Traditional Indemnity** ☐ **High Deductible**

8. **With respect to the plan referenced in question 7:**

What is the copayment for an office visit? $_____________	**Does the Plan Cover Mental Health Care?** □ **YES** □ **NO**
What is the annual per person deductible $_____________	**Does the plan cover an annual Wellness visit?** □ **YES** □ **NO**
Do employees have an option for: **A health savings account?** □ **YES** □ **NO** **A health reimbursement account?** □ **YES** □ **NO** **A flexible spending account?** □ **YES** □ **NO**	**Does this plan or a separately offered plan cover:** **Prescription Drugs?** □ **YES** □ **NO** **Dental benefits?** □ **YES** □ **NO** **Vision benefits?** □ **YES** □ **NO**

9. **Is the employee contribution for health insurance higher if the employee smokes?** □ **YES** □ **NO**
   If yes, what is the monthly surcharge for smokers for individual coverage? $______________

10. **Is the employee contribution for health insurance lower if the employee participates in any wellness related activities (for example weight loss program, health risk assessment)** □ **YES** □ **NO**
    If yes, what is the maximum monthly reduction for wellness related activities for individual coverage? $______________

11. **Does your firm currently pay for or offer at the workplace wellness related activities? (for example, a weight loss program, exercise program, a health club)** □ **YES** □ **NO**

Please Complete Both Sides

12. HOW MANY TIMES HAS YOUR FIRM / ORGANIZATION CHANGED HEALTH INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR DURING THE LAST FIVE YEARS? (IF MULTIPLE PLANS, USE THE PLAN ELECTED BY THE LARGEST % OF EMPLOYEES.) _______________ (0 IF NEVER OR IF FIRST PLAN YEAR)

13. WHAT IS THE FUNDING ARRANGEMENT FOR YOUR 2011 HEALTH PLAN? (IF MULTIPLE PLANS, USE THE PLAN ELECTED BY THE LARGEST % OF EMPLOYEES.)

- □ FULLY INSURED PLAN WITH A LICENSED INSURANCE COMPANY
- □ SELF-INSURED PLAN (INSURANCE COMPANY MAY ADMINISTER)
- □ EMPLOYEES COVERED THROUGH A UNION OR EMPLOYEE ASSOCIATION PLAN

14. IS YOUR 2011 HEALTH PLAN 'GRANDFATHERED' UNDER THE HEALTH REFORM LAW?

- □ YES.
- □ NO
- □ DON'T KNOW OR HAVE NOT DECIDED

15. HAVE YOU SERIOUSLY CONSIDERED DROPPING HEALTH INSURANCE AS A BENEFIT FOR YOUR EMPLOYEES IN RESPONSE TO PREMIUM INCREASES?

- □ YES. WHEN ANNUAL PREMIUMS INCREASE BY ___________% THIS FIRM/ORGANIZATION WILL STOP OFFERING HEALTH INSURANCE.
- □ NO. (ANNUAL INCREASES MAY PROMPT OTHER CHANGES IN CARRIER OR PLAN DESIGN)
- □ DON'T KNOW OR IT DEPENDS UPON MY FUTURE BUSINESS PROFITABILITY.

16. DOES YOUR FIRM/ORGANIZATION OFFER ANY OF THE FOLLOWING BENEFITS TO FULL-TIME PERMANENT EMPLOYEES? (CHECK ALL THAT APPLY)

- □ RETIREMENT OR TAX DEFERRED SAVINGS PLAN
- □ LONG TERM CARE INSURANCE
- □ LIFE INSURANCE
- □ ANY PAID TIME OFF (HOLIDAYS, SICK LEAVE, VACATION)
- □ VOUCHER OR CASH ASSISTANCE FOR PURCHASE OF INDIVIDUAL HEALTH INSURANCE
- □ OTHER

17. DOES YOUR FIRM/ORGANIZATION PURCHASE ANY BUSINESS OR NON-HEALTH BENEFIT RELATED INSURANCE THROUGH A BROKER? □ YES □ NO

18. DOES YOUR FIRM/ORGANIZATION PURCHASE ITS HEALTH INSURANCE BENEFITS THROUGH A BROKER? □ YES □ NO

19. DOES YOUR FIRM/ORGANIZATION USE INFORMATION TECHNOLOGY (IT) SUCH AS INTERNET BROWSERS OR EMAIL? □ YES □ NO

20. DOES YOUR FIRM/ORGANIZATION USE IT TO PURCHASE GOODS AND SERVICES? □ YES □ NO

21. DOES YOUR FIRM/ORGANIZATION HAVE A WEB SITE? □ YES □ NO

22. HOW MANY OF YOUR FULL-TIME PERMANENT EMPLOYEES ARE FEMALE? ______

23. HOW MANY OF YOUR FULL-TIME PERMANENT EMPLOYEES HAVE BEEN EMPLOYED AT YOUR FIRM/ORGANIZATION FOR:

______ LESS THAN 90 DAYS ______ ________FROM 90 DAYS TO 1 YEAR _____ __________ MORE THAN 1 YEAR

24. HOW MANY OF YOUR FULL-TIME PERMANENT EMPLOYEES ARE:

______ AGE 24 OR UNDER ____ 25-54 YEARS OF AGE ____ 55-64 YEARS OF AGE ______ AGE 65 OR OVER

25. HOW MANY OF YOUR FULL-TIME PERMANENT EMPLOYEES EARN:

______ LESS THAN $7.50 PER HOUR (OR ABOUT $15,000 PER YEAR)

______ BETWEEN $7.50 AND $22 PER HOUR (OR BETWEEN $15,000 AND $44,000 PER YEAR)

______ MORE THAN $22 PER HOUR (OR MORE THAN $44,000 PER YEAR)

THANK YOU VERY MUCH FOR COMPLETING THIS IMPORTANT SURVEY. THE INFORMATION YOU HAVE PROVIDED WILL BE KEPT CONFIDENTIAL.

Please Complete Both Sides