Small Business Acceptance of a Health Insurance Premium Assistance Program for Low-Income Workers

The Primary Care Health Policy Division

Department of Family and Preventive Medicine

University of Oklahoma Health Sciences Center

Oklahoma City, Oklahoma

June 30, 2005

Submitted to

The Oklahoma Health Care Authority

This report completes Part B of Article IV, Section 4.1, Premium Assistance Implementation Design - DFPM shall assist the OHCA in the design of the needed systems to handle dissemination of information, eligibility determination, enrollment of business and employees, and the flow of money. The design work shall include the following specific items, and performed work shall be reported to OHCA in a report not later than June 30, 2005. Part A) Develop a marketing plan including recommendations on target audiences, channels of information, and specific modalities of information - submitted to OHCA on May 18, 2005. Part B) Assist OHCA with instrument design and data analysis for small business employers. This report is due to OHCA no later than June 30, 2005.

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Small Business Acceptance of a Health Insurance Premium Assistance Program for Low-Income Workers

Executive Summary

"Most Oklahoma small business owners want to provide medical coverage to their employees, but because health insurance costs are so high, they just can't afford it. By offering premium assistance through this program, we can get health coverage to uninsured Oklahomans and help businesses at the same time."

Oklahoma Governor Brad Henry
May 2005

Purpose: This study was conducted primarily to evaluate whether a health insurance premium assistance program that provided premium subsidies for small businesses to purchase private insurance could (a) allow employers who currently offer health coverage to continue coverage at present levels, and (b) influence employers who currently do not have a health insurance program to consider offering benefits for their employees.

Nationally, employers currently offering health benefits, especially small business employers, are finding it difficult to maintain present levels of coverage because of rising premium costs. Similarly, high premium costs are preventing many small and start-up businesses from considering health coverage for their employees. This study found that many employers in Oklahoma who currently offer coverage for their employees may have to reduce or drop benefits because of rising premium costs.

An additional benefit of the study was to educate small business employers about a newly created health insurance premium assistance program for low-income workers in small businesses, and encourage business owners to consider participating. The premium assistance program is to be funded by a fifty-cent-per-product tobacco tax, which was passed by a vote of the people in November 2004 and enacted in January 2005. Revenues from this tax, which are currently accruing and being held in reserve, will provide health insurance premium assistance to qualifying employers and their low-income employees in the form of a voucher for a percentage of the health insurance premiums for each qualifying employee and their qualifying dependents. The program will also provide premium assistance for qualifying sole proprietors and self-employed persons.

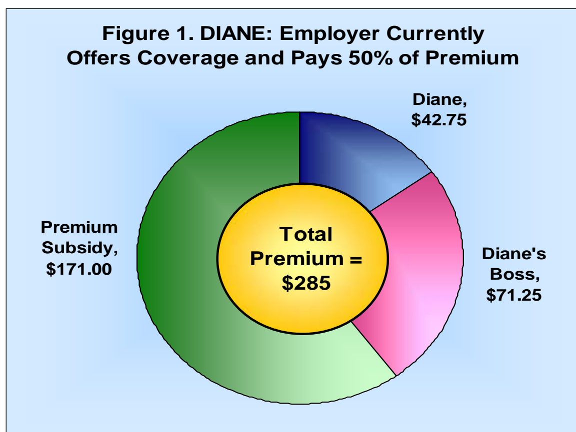
Background: At 23.6%, Oklahoma has the 5th highest per capita percentage of uninsured adults between the ages of 18 and 64. Only Nevada (23.9%), New Mexico (26.0%), Louisiana (26.4%) and Texas (30.7%) have a larger percentage of uninsured citizens. Among the 50 states and the District of Columbia, Oklahoma has the 6th highest number of uninsured workers with 20.6% of the workforce lacking health insurance. To address this issue, Oklahoma Governor Brad Henry proposed to expand state-sponsored insurance for low-income workers through the establishment of a new premium subsidy program. The program, part of Governor Henry's Oklahoma Health Care Recovery Act, will be funded through new revenues from an increase in the state tax on tobacco products which went into effect in January 2005. Revenues are accruing and being held in reserve to fund the premium assistance program.

Initially, the program will target employees of Oklahoma small businesses (25 employees or

fewer) with incomes at or below 185% of the federal poverty level (FPL) ($35,798 annually for a family of 4). Employees will be responsible for 15% of the monthly premium or 3% of their annual gross family income, whichever is less; employers will contribute 25% of the premium for qualifying employees. The following hypothetical examples describe how this program could work.

Example 1. Employer Currently Offers Coverage and Pays 50% of Employee Premium[*]

Diane is a single mother with three children who works as a secretary/receptionist for a small automobile repair company that currently offers employee health benefits. She earns $27,000/year. Her children (twin girls, 6, and a boy, 10) have health coverage through the State Children's Health Insurance Program (SCHIP).[†] Diane is currently without coverage because she cannot afford her portion of the health insurance premium (half of $285 = $142.50) even though her employer would pay the other half ($142.50).

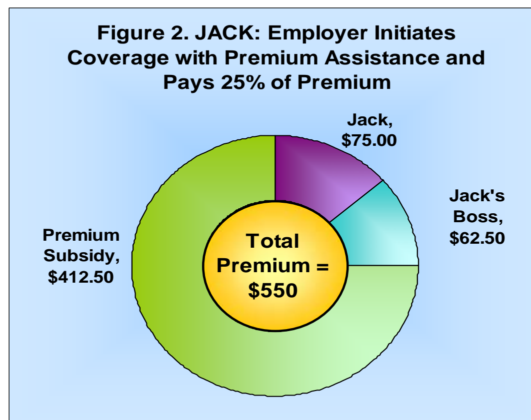


With the new premium assistance program, Diane's out of pocket maximum contribution for health insurance premiums for herself might be 15% of the monthly premium ($42.75/month) (Figure 1). Diane's employer would pay 25% of Diane's premium ($71.25) instead of the 50% he previously paid. The premium assistance program would pay the difference ($171.00).

Example 2. Employer Begins Offering Coverage and Pays 25% of Employee Premium[‡]

Jack is a husband and father of two who works for a small moving company that does not currently offer employer-sponsored insurance. He earns $30,000/year and his wife stays home with the two children (ages 2 and 4). Jack's two small children have health coverage with SCHIP. Jack and his wife are currently without coverage because they cannot afford individual health insurance.

If Jack's employer participates in the new premium assistance program, the total premium for Jack and his wife would be approximately $550/month ($250 for Jack and $300 for his wife). If Jack was responsible for 15% of the premium, the amount would be $82.50 but because the premium amount cannot exceed 3% of his gross family income, Jack's out of pocket monthly contribution for premiums for himself and his wife would be $75.00. (Figure 2). Jack's employer would pay 25% of Jack's premium ($62.50). The premium assistance program would pay the remaining $412.50.



If funding becomes available, the program may be expanded to include small businesses with up to 50 employees, and incomes up to 200% FPL.

[*] NOTE:Example reflects premium payments only and do not include co-pays, deductibles, etc.

[†] SCHIP is the state health care program through Medicaid for children in families with annual incomes below 185% Federal Poverty Level (see Table 1, page 1)

[‡] NOTE: Example reflects premium payments only and do not include co-pays, deductibles, etc.

Buy-in by Oklahoma small businesses is essential to the success of the program. Therefore, OHCA requested a study to measure the acceptance of the program by business owners across the state to determine how likely small businesses were to participate. The study also examined whether businesses with health coverage were considering dropping or reducing benefits, and how likely businesses that do not offer health coverage are to consider offering coverage with and without some type of assistance. This report describes the results of that study.

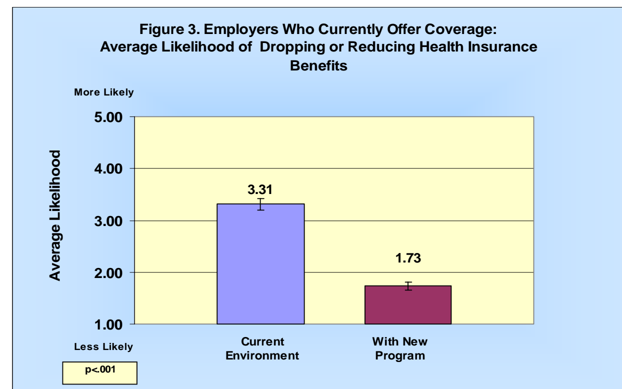
Methods: A 3-part survey was designed. Part 1 asked demographic information about the businesses. Part 2a was completed by small business employers currently offering health insurance coverage. Part 2b was completed by business employers who currently do not offer coverage, and Part 3 allowed respondents to make comments or suggestions about the Oklahoma premium assistance program (see Survey in Appendix A). The survey included a brief overview of the premium assistance program to educate small businesses.

More than 4,000 surveys were distributed statewide by regular mail, e-mail, fax, by hand, and through professional associations and organizations, such as the Oklahoma Chambers of Commerce; 298 surveys were returned. Statistical analysis indicated that 271 surveys were needed in order to have 90% confidence that the survey was representative of businesses throughout Oklahoma.*

Results: **Employers Currently Offering Health Insurance**

Employers currently offering coverage were asked how likely they would be to reduce or drop coverage in the current environment and how likely they would be to reduce or drop coverage with a premium assistance program. Responses to those questions were on a scale of 1 to 5 (1= likely to reduce or drop, 5= unlikely to reduce or drop).

Figure 3 shows that in the current environment, employers are somewhat likely to drop or reduce coverage (average response = 3.31). With premium assistance, however, employers are less likely to drop or reduce coverage (average response = 1.73). This improvement is statistically significant ($p<.001$). This indicates that a premium assistance program is highly likely to allow employers to continue providing health benefits at the current level.



Employers NOT Currently Offering Health Insurance

Employers who currently do not offer coverage were asked how likely they would be to consider offering coverage in the current environment, and how likely they would be to consider adding coverage with a premium assistance program. Responses to those questions were on a scale of 1 to 5.

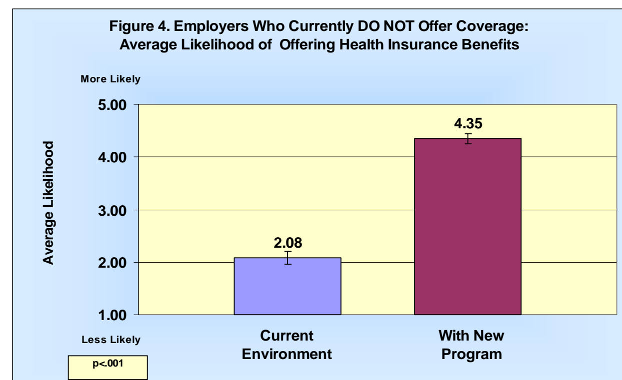
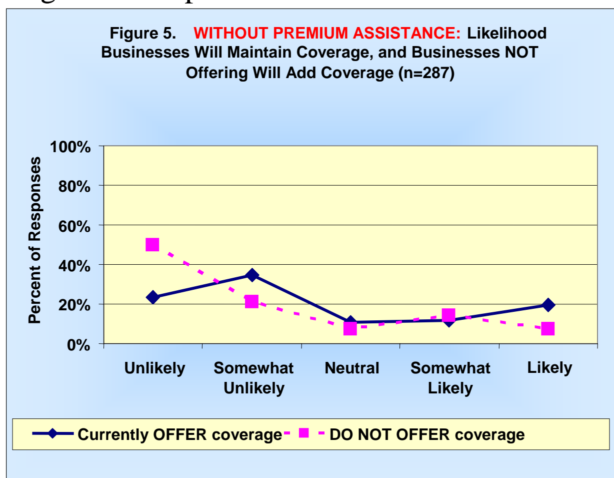


Figure 4 shows that in the current environment, employers who currently do not offer coverage are not likely to consider doing

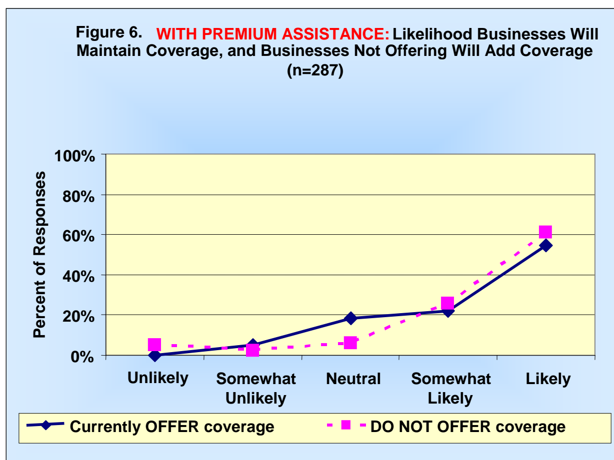
*Tompson, Stephen K., *Sampling*, New York: Wiley, 1992, Ch. 4, http://calculators.stat.ucla.edu/

so (average response = 2.08). With premium assistance, however, these employers are much more likely to consider offering health benefits for their employees (average response = 4.35). This improvement is statistically significant ($p<.001$).

Figures 5 and 6 show the comparison another way. Without the premium assistance program, is it likely that employers who currently offer insurance will reduce or drop coverage. Similarly, employers who currently do not offer insurance are unlikely to consider offering coverage without premium assistance.



However, if a premium assistance program is offered, employers currently offering insurance are highly likely to maintain current coverage and employers who currently do not offer coverage are highly likely to consider offering coverage (Figure 6).



Conclusions:

- ☑ **With premium assistance**, employers who were considering dropping or reducing coverage are less likely to do so.
- ☑ **With premium assistance**, more low-income workers will be able to enroll in or retain health coverage through employers currently offering coverage.
- ☑ **With premium assistance**, small businesses in Oklahoma that currently do not offer coverage are more likely to consider adding insurance benefits.
- ☑ **Without premium assistance**, more small businesses that currently offer coverage may be forced to reduce or drop coverage resulting in more uninsured workers.
- ☑ **Without premium assistance**, Oklahoma small businesses that currently do not offer health coverage are unlikely to consider adding health insurance benefits.
- ☑ Of employers currently offering coverage, the average percent of the premium paid by the employer is approximately 80%. This figure applies only to employers in our sample with 25 employees or less.
- ☑ Of the top three reasons for dropping or reducing coverage or not offering coverage at all, cost was the reason given by nearly 99% of respondents.
- ☑ Although both payment methods are acceptable, there was a statistically significant preference ($p<.001$) for a mailed check over Electronic Funds Transfer (EFT).
- ☑ The Oklahoma premium assistance program has the potential to reduce the number of uninsured low-income workers and extend coverage to the dependents of low-income workers, thus reducing the total number of uninsured Oklahomans.
- ☑ Comments received with the survey indicate that small businesses in Oklahoma are very receptive to a premium assistance program.

> ***"Please make it possible for us to continue to have health insurance."***
> **Oklahoma Small Business Owner**

Table of Contents

Page No.
Executive Summary i
Introduction 1
Methods 6
Results 8
  Analytical Statistics 14
  Results at a Glance 18
Discussion 19
Key Findings at a Glance 23
References 24
Appendices 29
  A. Small Business Employer Survey with Premium Assistance Program Education Piece
  B. Raw Data and Comments
  C. Biographical Sketches of Project Faculty and Staff

Tables
1. 2005 Federal Poverty Levels 1
2. Likelihood of dropping or reducing benefits in the next 2 years in current environment 14
3. Likelihood of dropping or reducing benefits in the next 2 years with new program 14
4. Likelihood of offering health benefits in next 2 years in current environment 15
5. Likelihood of offering health benefits in the next 2 years with new program 15
6. Acceptability of EFT for subsidy payment 16
7. Acceptability of check in the mail for subsidy payment 16
8. Percent of premium costs paid by employer by geographic region 17
9. Results at a Glance 18

Figures
1. DIANE: Employer Currently Offers Coverage and Pays 50% of Premium ii
2. JACK: Employer Initiates Coverage with Premium Assistance and Pays 25% of Premium ii
3. Employers Who Currently Offer Coverage: Average Likelihood of Dropping or Reducing Health Insurance Benefits iii
4. Employers Who Currently DO NOT Offer Coverage: Average Likelihood of Offering Health Insurance Benefits iii
5. WITHOUT PREMIUM ASSISTANCE: Likelihood Businesses Will Maintain Coverage, and Businesses Not Offering Will Add Coverage iv
6. WITH PREMIUM ASSISTANCE: Likelihood Businesses Will Maintain Coverage, and Businesses Not Offering Will Add Coverage iv
7. Percentage of Uninsured Adults in America (Age 18-64) by State 2
8. Percentage of Uninsured American Workers by State 2
9. DIANE: Employer Currently Offers Coverage and Pays 50% of Premium 4
10. JACK: Employer Initiates Coverage with Premium Assistance and Pays 25% of Premium 5

11. Number of Full Time employees (n=287) 8
12. Number of Part-Time and/or Seasonal Employees (n=281) 8
13. Mix of Businesses by Type (%) in Sample 9
14. Mix of Businesses by Type (%) in Oklahoma 9
15. Location of Businesses in the Sample 9
16. Does Your Business Currently Offer Health Insurance Benefits 9
17. Average Number of Employees in Each Income Category 10
18. Acceptability of Electronic Funds Transfer (EFT) and Mailed Check as Premium Subsidy Payment Methods 10
19. Percent of Premium Costs Paid by Employer (n=156) 11
20. Small Businesses OFFERING Health Insurance: Comparison of the percentage of small businesses considering dropping or reducing coverage with current and new program (n=155) 11
21. Currently Offering Coverage: If you have considered reducing or dropping benefits, why? (n=139) 12
22. Small Businesses NOT OFFERING Health Insurance: Comparison of the percentage of small businesses considering adding health insurance benefits with current and new program(n=133) 12
23. Currently Not Offering Coverage: Reasons for Not Offering Health Insurance (n=127) 13
24. Employers Who Currently Offer Coverage: Average Likelihood of Dropping or Reducing Health Insurance Benefits 20
25. Employers Who Currently DO NOT Offer Coverage: Average Likelihood of Offering Health Insurance Benefits 20
26. WITHOUT PREMIUM ASSISTANCE: Likelihood Businesses Will Maintain Coverage, and Businesses NOT Offering Will Add Coverage 21
27. WITH PREMIUM ASSISTANCE: Likelihood Businesses Will Maintain Coverage, and Businesses Not Offering Will Add Coverage 21
28. Preference for Reimbursement Method: Electronic Funds Transfer (EFT) Compared with Mailed Check 21

Introduction

"Most Oklahoma small business owners want to provide medical coverage to their employees, but because health insurance costs are so high, they just can't afford it. By offering premium assistance through this program, we can get health coverage to uninsured Oklahomans and help businesses at the same time."

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A second goal was to educate small businesses employers about a newly created health insurance premium assistance program for low-income workers, and encourage them to consider participating.

The new program is part of the Oklahoma Health Care Recovery Act and is to be funded by a fifty cent per product tobacco tax, which was passed by a vote of the people in November 2004 and enacted in January 2005. A portion of the revenues from this tax, which are accruing and being held in reserve, will provide health insurance premium assistance to qualifying employers and their low-income employees in the form of a voucher for a percentage of the premiums for each qualifying employee and their qualifying dependents. The program will also provide premium assistance for qualifying sole proprietors and those who are self-employed.

Qualifying employers are those (1) with 25 or fewer full and/or part-time employees, (2) currently offering or willing to offer health insurance benefits, and (3) willing and able to pay a minimum of 25% of the premium cost. Qualifying employees (and spouses) are those with annual family incomes at or below 185% of the current federal poverty level (Table 1).

Table 1. 2005 Federal Poverty Levels

	100% FPL		185% FPL		200% FPL	
Family Size	Annual Income	Monthly Income	Annual Income	Monthly Income	Annual Income	Monthly Income
1	$9,570	$798	$17,705	$1,475	$19,140	$1,595
2	$12,830	$1,069	$23,736	$1,978	$25,660	$2,138
3	$16,090	$1,341	$29,767	$2,481	$32,180	$2,682
4	$19,350	$1,613	$35,798	$2,983	$38,700	$3,225
5	$22,610	$1,884	$41,829	$3,486	$45,220	$3,768
6	$25,870	$2,156	$47,860	$3,988	$51,740	$4,312
7	$29,130	$2,428	$53,891	$4,491	$58,260	$4,855
8	$32,390	$2,699	$59,922	$4,993	$64,780	$5,398

SOURCE: Federal Register, V 70, N 33, Feb. 18, 2005, pp. 8373-5. http://aspe.hhs.gov/poverty/05poverty.shtml

If funding is available, the state hopes to eventually expand the program to businesses with up to 50 employees and to employees with annual family incomes up to 200% FPL.

To accomplish the goals of this study, faculty and staff with the University of Oklahoma Health Sciences Center (OUHSC) Department of Family & Preventive Medicine (DFPM) Division of Primary Care Health Policy designed a survey and an accompanying educational piece describing the premium assistance program. The survey was disseminated to small businesses statewide (see Appendix A for a copy of the survey and the educational piece). This report describes the results of that study.

Background

At 23.6%, Oklahoma has the 5th highest per capita percentage of uninsured adults between the ages of 18 and 64. Only Nevada (23.9%), New Mexico (26.0%), Louisiana (26.4%) and Texas (30.7%) have a larger number of uninsured citizens (Figure 7). At last count, more than 20 million working Americans are uninsured.[1] Among the 50 states and the District of Columbia, Oklahoma has the 6th highest number of uninsured workers with 20.6% of the workforce lacking health insurance coverage (Figure 8). Only Montana (21.4%), Florida (21.9%), New Mexico (22.6%), Louisiana (22.6%) and Texas (26.6%) have a greater per capita percentage of their workforce without health benefits.[2] People who lack health coverage are less likely to have a personal doctor and more likely to report poor or fair health when compared to people with health coverage.[2]

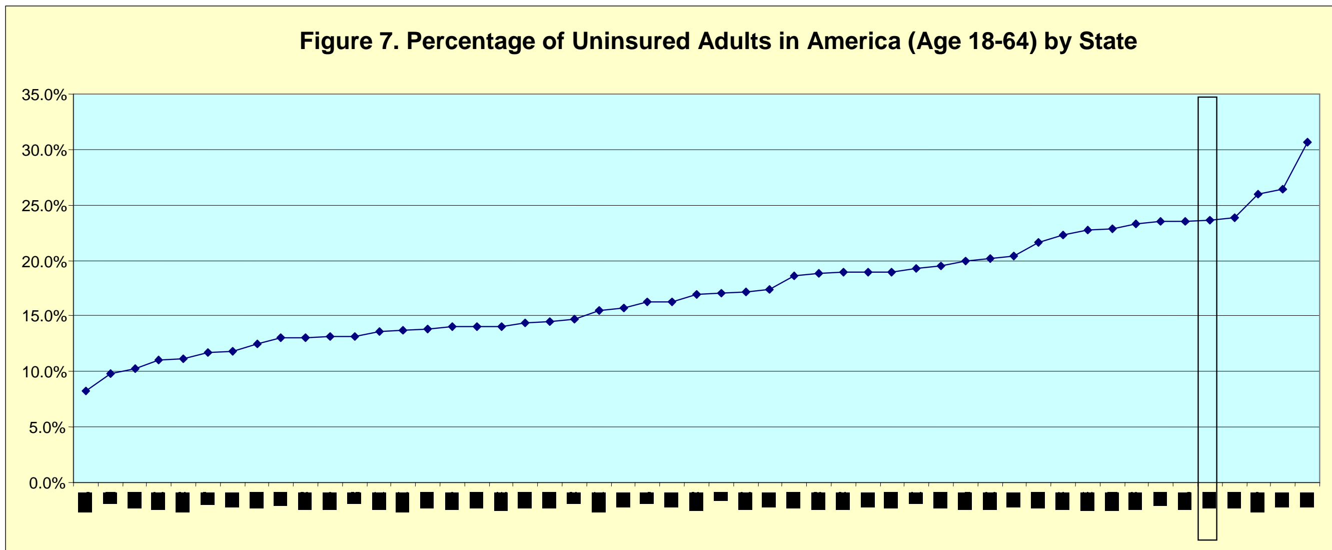


Figure 7. Percentage of Uninsured Adults in America (Age 18-64) by State

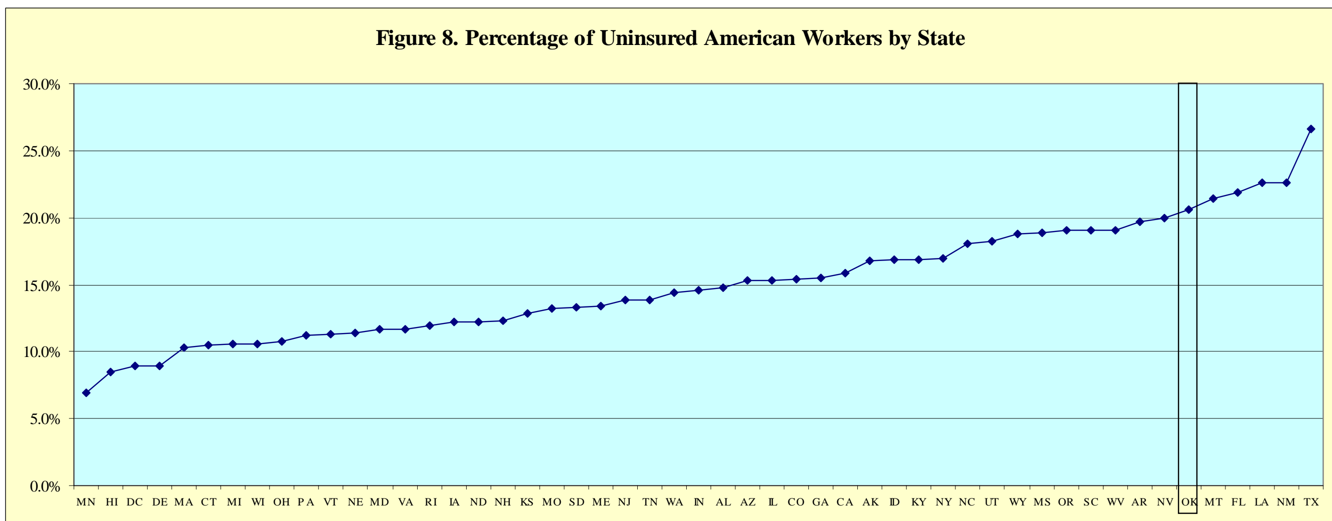


Figure 8. Percentage of Uninsured American Workers by State

Historically, Americans have relied on employer-sponsored health insurance but 5 years of soaring premium costs are changing the landscape for businesses of all sizes. The average cost of health benefits in 2004 was $6,679 per person, and businesses can expect their share of health care costs to increase 8%, or $603 per employee, this year.[3] These costs have forced more and more employers to reduce or drop benefits, or increase the employee share of health care costs (premiums, deductibles, co-pays, co-insurance).[4-8] Small businesses are most likely to bear the greatest burden for increasing premium costs.[9-12] The news is equally bad for families. The Washington Times reported recently that medical costs are expected to rise to $12,214 for a family of four in 2005, of which families can expect to pay approximately 17% or $2,035. This figure does not include premium costs.[13] Recent reports indicate that a growing number of uninsured are having to choose between food, heat and health care.[14]

Medicaid, the federal/state joint program that provides health care for the poorest Americans, is struggling.[15-21] With health care premium costs soaring and employers dropping coverage or increasing employee cost-shares, many states are finding their Medicaid rolls growing while the funds available for the program are diminishing.[22] As the federal government faces historic deficits and struggles to reduce its share of the expanding Medicaid budget, more of the costs for the program are likely to be shifted to the states, most of which are struggling to balance their own budgets while still providing health care for their most at-risk citizens. Some states, such as Tennessee and Missouri, are reducing eligibility requirements to eliminate some higher income citizens from the Medicaid rolls,[23-29] although their plans meet with strong resistance.[30] The Missouri plan, which was recently signed into law, reduces eligibility from 75% of the federal poverty level to 30% (see Table 1 for federal poverty level categories).[24,27]

Other states are investigating mandates that would require employers to provide health insurance coverage for their employees. California, Connecticut, and Maine are among the states currently investigating employer mandates.[31-39] The Maryland Assembly passed an employer mandate but the measure was vetoed by the governor.[40,41] (These approaches, however, will have to address ERISA[*] limitations on state regulation of self-insured businesses.[42,43]) Minnesota is considering an individual insurance mandate that would be similar to requiring car insurance.[44]

Other states are considering ways to expand coverage under Medicaid as a way to control the costs of providing health services to the uninsured, especially uninsured workers. The uninsured are more likely to access care through expensive emergency services, to wait longer to see a doctor, and to be sicker, requiring hospitalization.[2,45-51] By expanding coverage, these states hope to reduce expensive acute care by replacing it with routine physician visits and preventive care. Currently, New Jersey, New York, Utah, Kansas, Iowa, Maine, and Oklahoma are developing programs to increase state coverage for low-income uninsured individuals and families.[28,52-64]

The Oklahoma Premium Assistance Program

Like most states, Oklahoma is struggling to balance its state budget and still provide an adequate level of health care for its most at-risk citizens. In an historic effort to cover Oklahoma's uninsured workers, Governor Brad Henry proposed the Oklahoma Health Care Recovery Act, which was passed by both houses of the legislature. The Act included a request for funding, in the form of an additional fifty-cent-per-product tax on cigarettes. This tax was approved by a vote of the people in November 2004, and went into effect in January 2005. A portion of the revenues are accruing and being held in reserve to pay for a health insurance premium assistance program for small businesses and their low-income workers.[65-67] The

[*] Employee Retirement Income Security Act of 1974.

Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, will manage the premium assistance program.[52] Since Oklahoma's success in developing and funding this program, other states, e.g., Montana and Kansas, are investigating similar programs.[57,58,63,68,69]

> ***"Offering insurance makes us a better Oklahoma based company, what a leading edge concept--GO OK GO!"***
> Oklahoma Small Business Owner

To launch the premium assistance program as a Medicaid demonstration program, Oklahoma must receive approval from the Centers for Medicare/Medicaid Services (CMS) in the form of a Medicaid 1115/HIFA Waiver Amendment. OHCA submitted the waiver in January 2005.[70] The approval of the waiver, which is expected soon, would allow Oklahoma to establish the following elements as part of the Oklahoma Health Care Recovery Act:

1. A premium assistance program for small employers to benefit their qualifying employees and the employees' families. Initially, premium assistance will be available only to families with incomes at or below 185% of the federal poverty level (as shown on Table 1 above). If funding is available, another goal of the program is to include families up to 200% FPL.

2. The program will initially be open to small business employers with up to 25 full or part-time employees including businesses that currently offer health insurance. Ultimately, the program may be expanded to larger businesses starting with those having up to 50 employees.

3. To be eligible, employers must contribute at least 25% of the employee premiums. Employees will be responsible for up to 15% of the premium subject to the following limits:

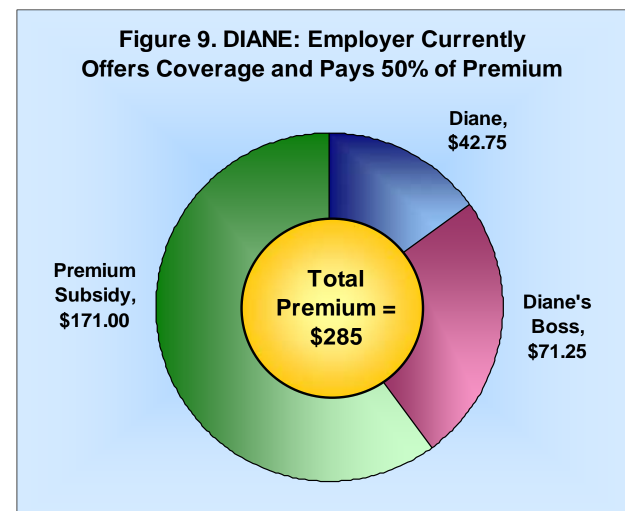
- Workers will contribute no more than 3% of their annual gross household income toward premiums.
- Workers will pay no more than 5% of their annual gross income for all health care expenses (premiums, deductibles, co-pays, etc.).
- The program may subsidize expenses over and above those described above, based on income levels and eligibility.

The hypothetical examples below describe how the program might work.

Example 1. Employer Currently Offers Coverage and Pays 50% of Employee Premium[*]

Diane is a single mother with three children who works as a secretary/receptionist for a small automobile repair company that currently offers employee health benefits. She earns $27,000/year. Her children (twin girls, 6, and a boy, 10) have health coverage through the State Children's Health Insurance Program (SCHIP).[†] Diane is currently without coverage because she cannot afford her portion of the health insurance premium (half of $285 = $142.50) even though her employer will pay the other half ($142.50).

With the new premium assistance program, Diane's out of pocket maximum contribution for health insurance premiums for herself would be 15% of the monthly premium ($42.75/month) (Figure 9). Diane's employer would pay 25% of Diane's premium ($71.25) instead of the 50% he was previously paying. The premium program would pick up the remaining $171.00.



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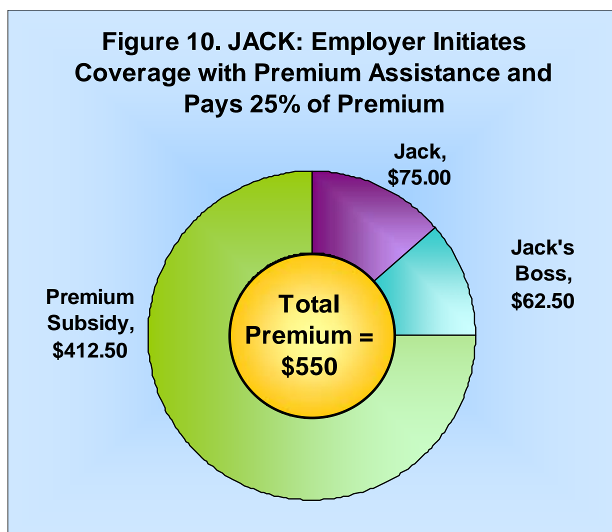
Jack is a husband and father of two who works for a small moving company that does not currently offer employer-sponsored insurance. He earns $30,000/year and his wife stays home with the two children (ages 2 and 4). Jack's two small children have health coverage with SCHIP. Jack and his wife are currently without coverage because they cannot afford individual health insurance.

If Jack's employer participates in the new premium assistance program, the total premium for Jack and his wife would be approximately $550/month ($250 for Jack and $300 for his wife). If Jack was responsible for 15% of the premium, the amount would be $82.50 but because the premium amount cannot exceed 3% of his gross family income, Jack's out of pocket monthly contribution for premiums for himself and his wife would be $75.00. (Figure 10). Jack's employer would pay 25% of Jack's premium ($62.50). The premium assistance program would pay the remaining $412.50.



This type of program has been initiated by other states, most recently in New York (HealthyNY).[71,72] Although considered a model program, one of the greatest problems HealthyNY faced was sufficient enrollment by small businesses.[53] To ensure adequate enrollment, OHCA asked OUHSC's Division of Primary Care Health Policy to conduct a study measuring the active interest in participating in the premium assistance program among members of the target business community. A second goal of the study was to educate the Oklahoma business community about the premium assistance program with the hopes of increasing interest and enrollment. This report describes the results of the study and includes recommendations, comments and suggestions from the target community.

[*] NOTE: Example reflects premium payments only and do not include co-pays, deductibles, etc.

Methods

In order to determine small business employers' interest in, and eligibility for the premium assistance program, faculty and staff of the DFPM distributed a survey (Appendix A), statewide via e-mail, postal mail, and fax. The surveys were distributed through individuals, organizations, and associations, including professional organizations and chambers of commerce, in a manner similar to previous studies.[73-80] The survey included a short educational piece describing the premium assistance program. The exact number of surveys distributed is unknown since packets of surveys were delivered to organizations for distribution. However, we estimate that 3,500-4,000 surveys were disseminated statewide.[*]

Subjects

Target subjects for this study were all small businesses employing up to 50 full or part time workers. However, it should be noted that because surveys were distributed widely by a number of associations and organizations to their entire membership, several larger businesses were contacted and completed the survey as well. Surveys were completed by employers from all types of businesses from agriculture to service industry businesses.

A total of 298 completed surveys were received, exceeding the goal of 271 which was calculated to be the number necessary to achieve a 90% confidence that our sample was representative of the population of Oklahoma (see Raw Data and Comments, Appendix B). The UCLA statistics website was used to arrive at this figure.[†]

"We need assistance. No one on our staff has insurance yet everyone works 40 hours per week. We cannot afford the premiums when take home pay is already so low."

Oklahoma Small Business Owner

Survey Instrument and Materials

A 3-part survey instrument was developed to develop a portrait of the health insurance status of small businesses in Oklahoma.

- Part 1 of the survey requested descriptive data about the business.
- Part 2a was to be completed by businesses currently offering health benefits for employees;
- Part 2b was to be completed by businesses that currently do not offer health benefits.
- Part 3 provided survey respondents with the opportunity make comments and suggestions regarding the premium assistance program. Space was also provided for optional contact information. All answers are reported anonymously. The survey is attached as Appendix A.

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[*]We would like to thank the Oklahoma Chambers of Commerce, especially the Oklahoma State Chamber, for their enthusiastic support of this project, and for distributing surveys to their members.

[†]Thompson, Stephen K., *Sampling*, New York: Wiley, 1992, Ch. 4, http://calculators.stat.ucla.edu/

The survey questions were made up of 3 types of questions:

1. Check boxes for demographic data,
2. Likert scale (1-5) responses, and
3. Fill in the blank.

This complex mix of question types required three different methods of analysis, as described below.

Data Analysis

For data analysis and comparison purposes, the total group of survey respondents (n=298) is labeled All Respondents. All Respondents answered the descriptive questions in Part 1 of the survey (questions 1-5). Those respondents currently offering health insurance benefits were asked to complete Part 2a. Those respondents not currently offering health insurance were asked to complete Part 2b. A copy of the survey instrument is attached in Appendix A.

Survey questions were designed to facilitate statistical analysis. Part 1 responses (questions 1-5) describe each business according to number of employees, income ranges, type of business and business location were entered into an Excel spreadsheet and charts graphically depicting the material were generated. Responses to Part 2 questions (both Part 2a and Part 2b) were assigned a value from 1 to 5, with 1 being least, 5 being most, and 3 being neutral. These values were entered into an Excel database and analyzed to determine mean, median, mode, standard deviation, and standard error of the mean. Data entry was subjected to random testing to ensure accuracy. Every 4th entry was checked against the original survey by a member of the staff not involved in the data entry process to ensure there were no errors. The raw data is attached in Appendix B.

Answers requiring a written response were entered exactly as they appeared on the completed survey. The Excel database was imported into SPSS V.11 for statistical analysis. Frequency and mean statistics were calculated and some graphical representations were created in SPSS V.11. Other graphical representations were generated in Excel for ease of representation. All statistical measures of association or analytical testing tools were calculated using SPSS V.11 software. Outcomes from these analyses are reported in the Results section of this report.

Resources and References

Since its inception in March 2003, the Primary Care Health Policy Division has been building a library of relevant policy materials. These materials include newspaper accounts, research reports and articles, and internet resources. Citations to these materials have been entered into an EndNote Reference Management Library database. To date, the library includes over 400 documents and citations. Materials relevant to Medicaid program innovation, uninsured and underinsured working adults and families, and current national discussions about health care are included in this library. The database and the library are available for use by OHCA staff, and by others upon special request. The numerous references cited in this report are part of this library and database.

Biographical sketches for all program faculty and staff is attached in Appendix D.

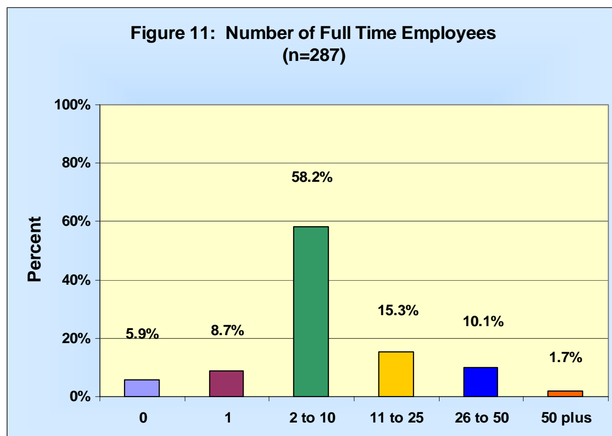
Results

NOTES: Although a total of 298 surveys were received and analyzed, some respondents did not complete all of the questions. These incomplete surveys were included in the analysis. This accounts for the discrepancy in the number of responses for each question shown in the results and figures below. For example, 287 out of 298 survey respondents completed Question 1; 11 respondents did not.

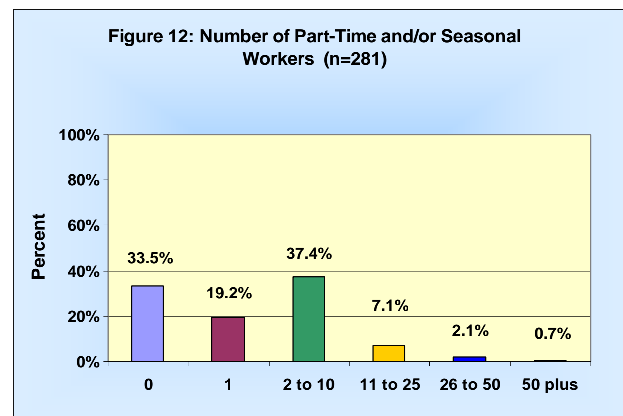
Each of the following numbered results sections includes a brief discussion of the statistical analyses and the significance of those analyses. A detailed discussion of the statistically significant results is on page 14, ***Analytical Statistics***.

Part 1. All Respondents (questions 1-5)

1. Number of full time employees. The target sample for this study was small businesses with 50 or fewer employees. All but 6 of the respondents who completed the questions (n=286) fell into this range (Figure 11). The average number of employees per business in this study is 2.2 (standard deviation, 1.02).



2. Number of part-time/seasonal employees. As the premium assistance program will provide premium assistance for both full- and part-time as well as seasonal employees, we asked respondents how many of their employees fell into these categories. Again, most of the workforce represented by the respondents fell within our target small business group. All but 2 respondents reported fewer than 50 part-time or seasonal employees. The mean number of part-time and/or seasonal employees is 1.7 (standard deviation, 1.02) indicating there are between 1 and 2 part-time and/or seasonal employees in each business. Despite the "shotgun" method used to disseminate the survey, most of the respondents fell within the target population, making the survey results appear representative of small business owners in Oklahoma (Figure 12).



3. Types of businesses. Surveys were received from a broad range of businesses. Businesses were organized and coded according to the U.S.

Department of Commerce business type listing. Figures 13 and 14 show the distribution of business types in our sample compared with business types for all of Oklahoma. Although agriculture is over represented in our sample (an agricultural insurance representative distributed the surveys to his clients, who were eager to complete the survey), our sample appears to be representative of the mix of businesses in Oklahoma.

Figure 13. Mix of Businesses by Type (%) in the Sample

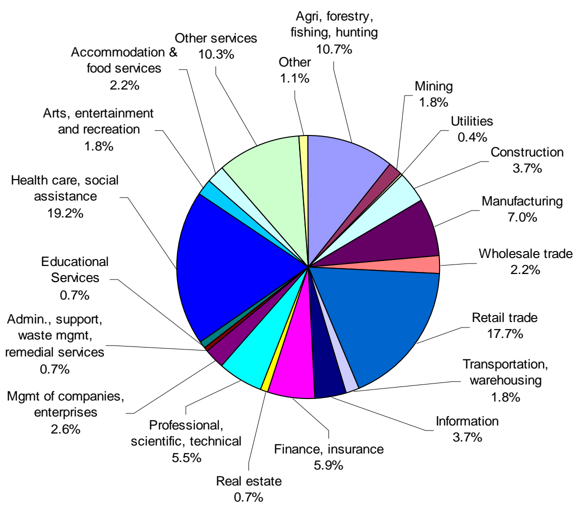
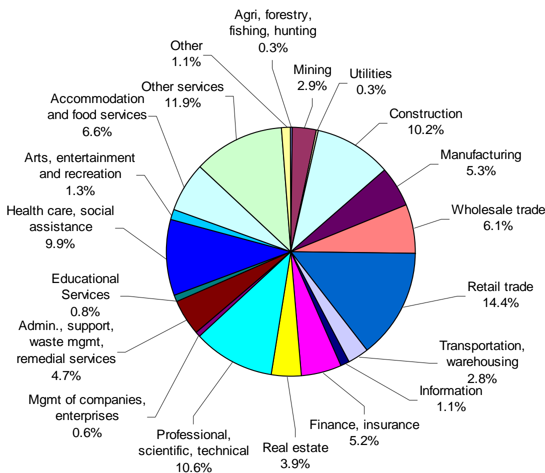


Figure 14. Mix of Businesses by Type (%) in Oklahoma*



* Source: U.S. Department of Commerce

4. Location of businesses. One hundred forty six (146, 51.0%) of the businesses that responded to the survey were located in "urban" areas; 104 (36.4%) reported being located in "rural" areas, and 36 (12.6%) reported establishments in "both" rural and urban areas (Figure 15). The picture of the sample that emerges from these questions is that it represents mostly small businesses (fewer than 50 employees) located in both urban and rural areas of the state and representing a broad range of business types.

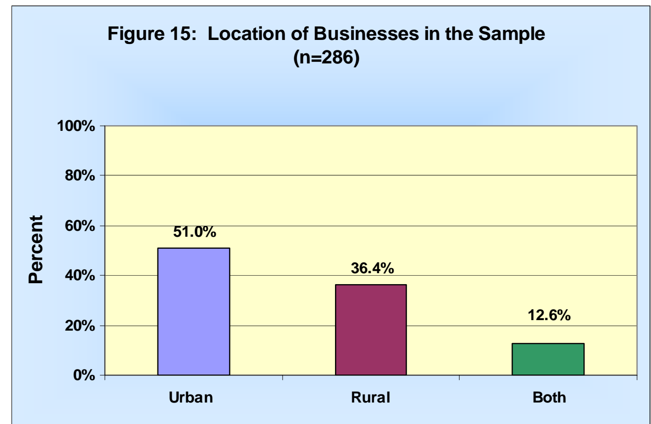


Figure 15: Location of Businesses in the Sample (n=286)

5. Does your business currently offer employee health insurance? Slightly more than half of those surveyed (53.9%) indicated that they currently offer health insurance benefits for employees; 46.1% indicated they do not offer health benefits. Nine respondents did not complete the question (Figure 16).

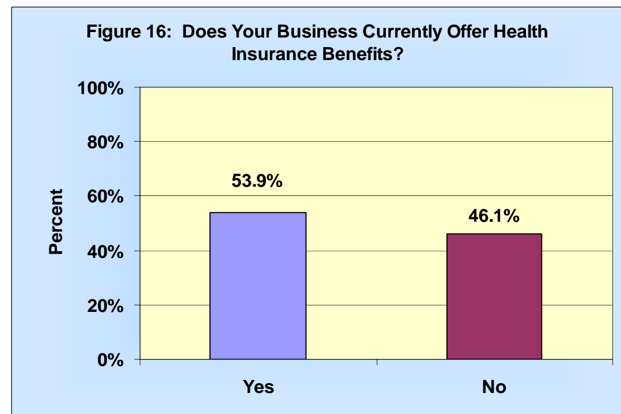
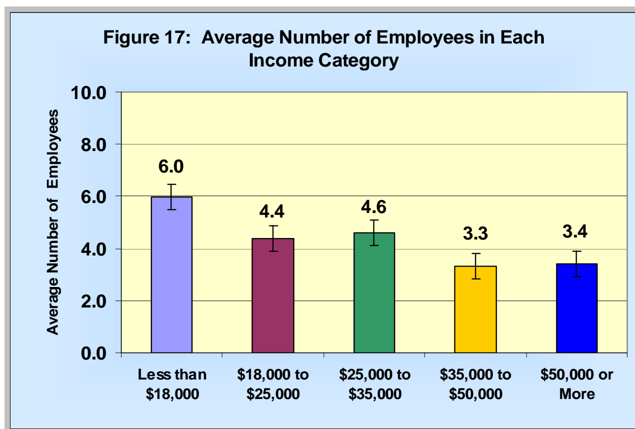


Figure 16: Does Your Business Currently Offer Health Insurance Benefits?

Respondents who answered "Yes" to question 6 were asked to complete question 7 and

the questions in Part 2a (questions 8-12). Respondents who answered "No" to question 6 were asked to complete question 7 and skip to questions 13-15. All respondents were invited to offer comments or suggestions (question 16) and to provide optional contact information if they were interested in additional information.

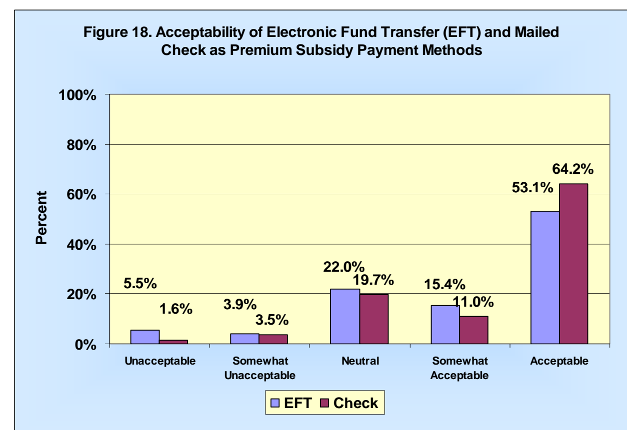
6. Annual income brackets. According to our survey results, small business owners reported that the largest income bracket for their employees was less than $18,000 and that most of their employees earned between $18,000 and $35,000 (Figure 17).



In Figure 17 above, each bar represents the average number of employees in each income category as reported by each small business employer who responded to this question. This is not the frequency of responses in each category, but the average of the total number of responses for this question. Error bars represent the Standard Error of the Mean for each group. The results indicate that a large number of employees in this sample fall within the income range for the premium assistance program.

7. How acceptable is Electronic Funds Transfer (EFT) as a method of premium payment? Respondents were asked to indicate on a scale for 1-5, with 1 being "least acceptable" and 5 being "most acceptable", how acceptable Electronic Funds Transfer (EFT) would be to them as a method of payment for premiums as part of the premium assistance program. The mean response for EFT was 4.05 (standard deviation, 1.19) indicating that this method of reimbursement was "somewhat acceptable" to "acceptable" (Figure 18, column 1).

8. How acceptable is a mailed check as a method of premium payment? Respondents were also asked how acceptable, on a scale of 1-5 with 1 being "least acceptable" and 5 being "most acceptable", a mailed check would be as a method of reimbursement for premiums. The mean response for mailed check was 4.3 (standard deviation, 1.00), indicating that this method was "somewhat acceptable" to "acceptable" (Figure 18, column 2).



Employers indicated that both methods of reimbursement were "somewhat acceptable" to "acceptable." However, there was a statistically significant difference in preference for a mailed check over EFT ($p<.001$).

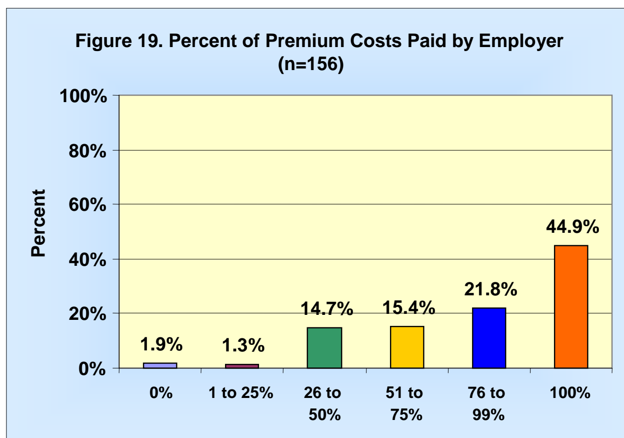
Part 2. Insurance Status

Part 2 of the survey was divided into 2 sections. Part 2a was to be completed by businesses that currently offer health insurance benefits (n=156, 54.5%). Part 2b was to be completed by businesses that currently do not offer health insurance benefits (n=131, 45.6%). Total number of respondents for Part 2a and 2b was 287; 11 respondents completed only Part 1.

2a. Small Businesses That Currently Offer Health Insurance

9. Please list the number of employees participating in health plan. This was a self-report question and subject to wide variation. The mean number of employees participating in employer-sponsored insurance program was 10.3 (standard deviation, 15.03). The median response was 5 verifying that there was wide variation in the responses. The range of responses was 1 to 130 employees participating in employer-sponsored insurance.

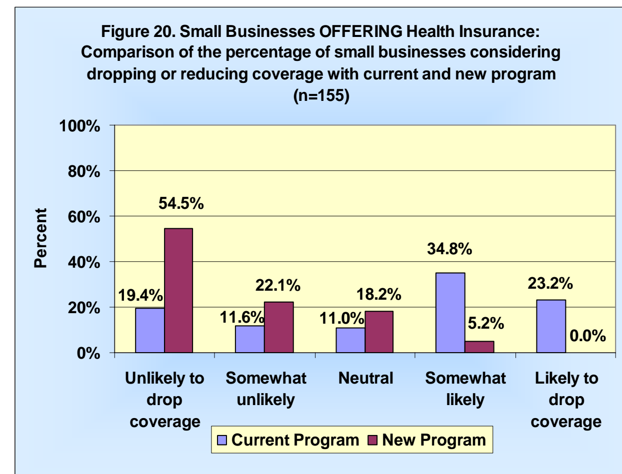
10. What percent of the premium costs do you pay for your employees? Of the 156 respondents currently offering health insurance benefits, 70 (44.9%) pay 100% of the employee cost and 34 (21.8%) pay from 76% to 99% of the employee cost (Figure 19). Only 5 (3.2%) pay 0 to 25%.



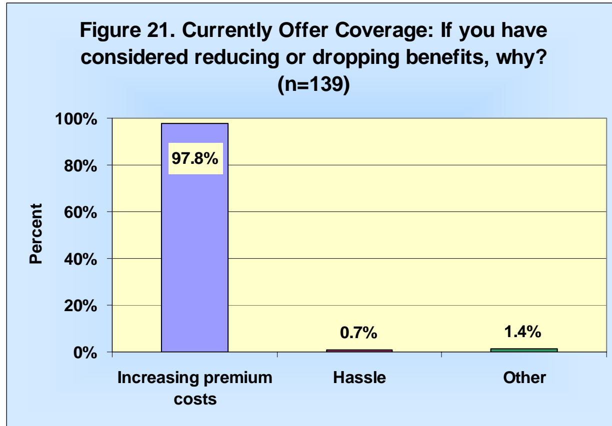
11. <u>In the current environment</u>, how likely would you be to drop or reduce health benefits in the next 2 years? Of the 155 respondents answering this question, 36 (23.2%) stated they were "likely" to reduce or drop coverage in the next 2 years; 54 (34.8%) said they were "somewhat likely" to reduce or drop coverage. Based on these results, nearly 60% of those surveyed were "likely" to "somewhat likely" to drop or reduce coverage in the current environment. Figure 20 compares the responses to Question 11 and 12. On Figure 20, column 1 represents the responses for Question 10 and column 2 shows the responses for Question 11.

> ***"We have reduced benefits each year due to the increased premiums."***
> Oklahoma Small Business Owner

12. <u>With this new program</u>, how likely would you be to drop or reduce health benefits in the next 2 years? Compared with the responses to Question 11, 84 out of 154 (54.5%) indicated they would not reduce or drop coverage if premium assistance for low-income workers was available (column 2, Figure 20). The mean response for this question was 1.7 (standard deviation, 0.93) indicating that most respondents were "unlikely" to "somewhat unlikely" to change to their employee benefit plan in the next 2 years if a premium assistance program was available.



13. If you have considered reducing or dropping benefits, why? We asked employers to select the main reason they might consider making changes to their employee benefits program: increasing costs, administrative hassle, or other. Most (136 out of 139, 97.8%) said increasing premium costs were forcing them to consider reducing or dropping their employer-sponsored insurance package; one employer selected administrative hassle (Figure 21).



Two employers selected other, although one would actually fall in the increased cost category.

- "I probably won't be able to continue to pay 100% of the cost."
- "Only have 1 employee not covered on spouse's insurance-we were almost dropped by the insurance company."

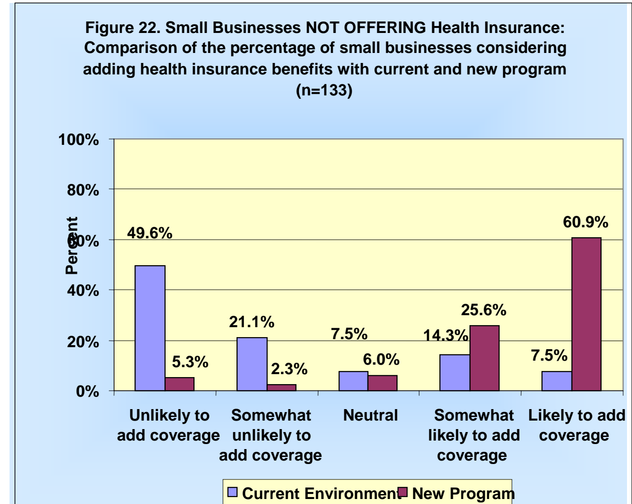
"With skyrocketing premiums, how long can small businesses keep this up?"
Oklahoma Small Business Owner

Part 2b. Small Businesses That Currently DO NOT OFFER Benefits

Questions 14-16 were answered only by employers that currently do not offer employee health insurance benefit packages.

14. In the current environment, how likely would you be to offer health benefits in the next 2 years? With no changes in the current employer-sponsored insurance market, 66 of the 134 (49.6%) respondents said they were "unlikely" to offer employee health insurance. Figure 22 compares the responses to Question 14 (column 1, Figure 22) and Question 15 (column 2, Figure 22).

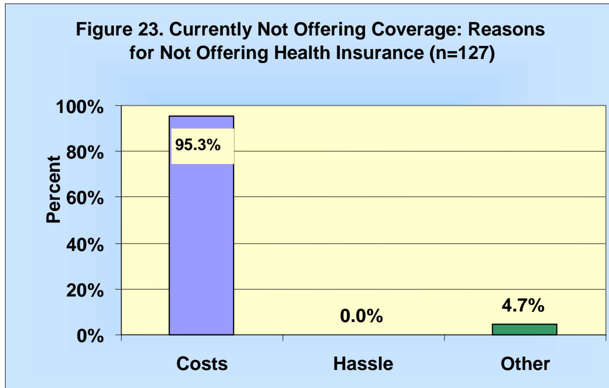
The mean response to this question was 2.1 (standard deviation, 1.349) indicating that most respondents were "somewhat unlikely" to "neutral" about the prospect of offering employee health insurance benefits in the current environment.



15. With this new program, how likely would you be to offer health benefits in the next 2 years? Eighty-one respondents (61%) indicated that they would be "likely" to offer health benefits within the next two years with the new program; 34 (25.6%) indicated they were "somewhat likely" to offer health insurance in the next 2 years with this program (column 2, Figure 22).

The mean response for this question was 4.3 (standard deviation, 1.06), indicating that overall, the group of small business employers who currently do not offer health coverage were "somewhat likely" to "likely" to offer health coverage with a premium subsidy program.

16. Please indicate your reasons for not offering health insurance. The majority of employers (121, 95%) responding to this question said that cost was the main reason they did not currently offer insurance (Figure 23). The six who said it was not strictly cost, indicated that "employees have coverage through spouse," "I'm the only employee," and "Have an employee with diabetes. Cost too high with this employee included." Other studies, too, have shown that employees with chronic illnesses create special problems for employers and employer-sponsored insurance coverage.[74]



Part 3. Comments

Part 3 (question 17) was open to all respondents.

17. Please write comments/suggestions below. Attach additional pages as necessary. Respondents were requested to provide comments or suggestions about the premium assistance program. Although not all comments are shown, the comments included are representative of all received. For a complete list of responses see Appendix B. Raw Data and Comments.

"If the premiums are reasonable, I would love to give my people health insurance."

"This may help recruit new employees when needed. Thanks!"

"This may be the most significant program for small business owners in years--great job!"

"We need assistance. No one on our staff has insurance yet everyone works 40 hours per week. We cannot afford the premiums when take home pay is already so low."

"Cost has always been the only hold up in offering health insurance. As a small business, I can offer a 401K program much cheaper than I can health insurance. I've always thought that is wrong."

"I wish new small companies could have this insurance without any income brackets."

"We desperately need this program to continue our health benefits--Please help!"

"I think this is a great idea. The only insurance I currently have is with a $3,000 deductible and doesn't cover anything unless it is catastrophic. It is the only premium rate I can afford."

"Please make it possible for us to continue to have health insurance."

"We have reduced benefits each year due to the increased premiums."

"If the premium for insurance was lower with our current carrier, our employees would all join us. Due to the high cost, they are unable to. Also due to the increase of the premiums every year, we will have to drop coverage at the end of July, 2005

"Health insurance is too costly, cannot maintain this benefit unless the costs are brought down."

"If this doesn't start soon, we are going to drop the insurance benefits because it is too expensive. And if the employees have to share half of the cost, they can't afford to have insurance. Start ASAP please!"

"This program will help small business and our employees."

"I think this is an excellent program. I'm trying to do the right thing by giving my employees insurance. Many businesses that pay more than I do, do not have insurance."

"This program is needed to help recruit employees for our industry."

"We're excited about the opportunity to decrease our health care costs. Health premium increases have been out of control for the last several years."

"Small businesses and non-profits desperately need sufficient coverage so turnover of staff can be reduced."

Analytical Statistics

In order to determine whether a change in opinion occurred regarding insurance after learning about a premium subsidy program, questions and their responses had to be paired and statistically tested. In some comparisons, pairs of questions were stratified by geographical location or other demographic indicators to determine statistical significance.

- Likelihood of dropping or reducing benefits in current environment and with new program.
- Likelihood of offering insurance in current environment and with new assistance program.
- Acceptability of checks in the mail compared with Electronic Funds Transfer (EFT) as a mechanism for premium re-payment.
- Premium costs paid by employers by geographic region (urban, rural, both).

Small Businesses Currently Offering Coverage: Likelihood of Dropping or Reducing Coverage in Current Environment and With New Premium Program

Question 11 on the survey asked "In the current environment, how likely would you be to drop or reduce health benefits in the next 2 years?" The mean for this question was 3.31 (standard deviation, 1.44). This indicates a response between "neutral" and "somewhat likely" to drop or reduce health benefits in the next two years. **Question 12** on the survey asked "With this new program, how likely would you be to drop or reduce health benefits in the next 2 years?" The mean response for this question was 1.74 (standard deviation, 0.93).

A t-test was calculated for the difference between means and found that they were statistically different between these two groups. This indicates that with the current health insurance environment, respondents were "neutral" to "somewhat likely" to drop or reduce benefits in the next 2 years, and with a new program participants are "unlikely" to "somewhat unlikely" to drop or reduce benefits within the next 2 years.

To further investigate the responses to this pair of questions, the answers were stratified by geographical location: "urban", "rural", and "both" (indicating a business owner has business locations in both rural and urban areas). Shown in the tables below are the means and variances for the different geographical areas (Tables 2 and 3).

Table 2. Likelihood of <u>dropping or reducing</u> benefits in the next 2 years in <u>current environment</u>

	Overall	Urban	Rural	Both
Mean	3.30	3.18	3.56	3.52
Std. Dev.	1.44	1.48	1.35	1.33
n	155	79	52	21

Table 3. Likelihood of <u>dropping or reducing</u> benefits in the next 2 years with <u>new program</u>

	Overall	Urban	Rural	Both
Mean	1.70	1.53	2.02	1.90
Std. Dev.	0.93	0.89	0.98	0.83
n	154	79	52	21

For **Question 11** regarding dropping or reducing benefits in the current environment, the means range from 3.18 to 3.52. An Analysis of Variance (ANOVA) demonstrated statistically significant differences between the geographical groups. Those in "urban" areas feel less strongly toward dropping or reducing benefits. Respondents in "rural" or "both" areas feel more strongly towards dropping or reducing benefits. The result indicates respondents are "neutral" to "somewhat likely" to drop or reduce benefits in the current environment in the next 2 years.

When the results were stratified by geographical location for the next survey question "with this new plan, how likely would you be to drop or reduce benefits in the next 2 years?", some statistically significant differences were found. The overall mean of 1.70 (standard

deviation, 0.93) indicates a response between "unlikely" and "somewhat unlikely" to drop or reduce benefits.

Further analysis revealed that respondents in urban areas felt "unlikely" to "somewhat unlikely" to drop or reduce benefits with the new plan (mean=1.53, standard deviation, 0.89). Respondents in rural areas however did not feel as strongly, with a mean response of 2.02 (standard deviation, 0.98), indicating a response of "somewhat likely" to drop or reduce health benefits in the next two years in the current environment. Respondents with businesses in "both" rural and urban areas answered with a mean value of 1.90 (standard deviation, 0.83). There was no statistically significant difference between "rural" and "both" respondents. ANOVA indicated that there were statistically significant differences between these two groups. The "urban" group felt more "neutral" than the "rural" or "both" groups with regard to dropping or reducing benefits in the next two years under the current plan.

Small Businesses NOT Offering Coverage: Likelihood of Offering Coverage in Current Environment and With New Premium Program

Question 14 and **Question 15** on the survey were answered by respondents who do not currently offer health benefits as part of their employees benefit packages. The number of responses in this sample was 132.

Question 14 on the survey asked "In the current environment, how likely would you be to offer health benefits in the next 2 years?" The mean response for this question was 2.10 (standard deviation, 1.35). This indicates a response between "somewhat unlikely" and "neutral". These responses were further stratified into geographic regions and it was found that the responses were very close together (urban=2.08; rural=2.08; both=2.33) (Table 4).

Table 4. Likelihood of offering health benefits in the next 2 years in current environment

	Overall	Urban	Rural	Both
Mean	2.10	2.08	2.08	2.33
Std. Dev.	1.35	1.22	1.47	1.59
n	132	64	51	15

An ANOVA showed there were statistically significant differences between the means of the "both" respondents and all other geographic regions. The overall response indicates a feeling close to "somewhat unlikely" to offer health benefits in the next two years in the current environment.

Question 15 on the survey asked "With this new program, how likely would you be to offer health benefits in the next 2 years?" The mean response to this question was 4.36 (standard deviation, 1.42). This indicates a response between "somewhat likely" and "likely".

These responses were also stratified by geographical region. "Urban" respondents had a mean response of 4.33 (standard deviation, 0.99). The "rural" respondents had a mean response of 4.28 (standard deviation, 1.12) and employers with businesses in "both" urban and rural areas had a mean response of 4.67 (standard deviation, 1.05). There were statistically significant differences between the means for "both" respondents and the other geographical groups. This indicates that employers with businesses in "both" rural and urban areas felt more strongly toward offering benefits with the new program than respondents in the rural or urban areas (Table 5).

Table 5. Likelihood of offering health benefits in the next 2 years with new program

	Overall	Urban	Rural	Both
Mean	4.36	4.33	4.28	4.67
Std. Dev.	1.04	0.99	1.12	1.05
n	132	64	51	15

An ANOVA was calculated to compare the differences between means for questions regarding the current insurance environment versus this new program, and showed a statistically significant difference between the responses in the current insurance environment and the new program. This indicates that employers are more likely to drop or reduce benefits in the current environment, if they are already offering them. If they are not currently offering them, they are less likely to begin offering health benefits to their employees. If they are currently offering health insurance benefits to their employees, they are less likely to drop or reduce benefits in the next two years with a new program and more likely to offer health benefits if they are not already doing so.

Acceptability of Electronic Funds Transfer (EFT) Versus Check in the Mail Payment

Question 7 on the survey asked respondents to indicate "how acceptable" payment by Electronic Funds Transfer (EFT) would be. The overall mean response for EFT was 4.05 (standard deviation, 1.19). This indicates a response close to "somewhat acceptable". Responses for this question were stratified by geographical region. Urban respondents had a mean of 4.01 (standard deviation, 1.23). Rural respondents had a mean of 4.06 (standard deviation, 1.18). Business owners with businesses in "both" urban and rural areas had a mean response of 4.31 (standard deviation, 1.03). All of these groups had responses between "somewhat acceptable" and "acceptable" (Table 6).

Table 6. Acceptability of EFT for subsidy payment

	Overall	Urban	Rural	Both
Mean	4.05	4.01	4.06	4.31
Std. Dev.	1.19	1.23	1.18	1.03
n	254	124	95	32

An ANOVA showed there to be a statistical significance between the "both" respondents and the urban and rural respondents. Respondents in the "both" category felt more strongly in favor of EFT as a subsidy payment method than the other two groups.

Question 8 asked how acceptable a check in the mail would be for the subsidy payment. The overall mean was 4.33 (standard deviation, 1.01). No statistically significant differences were found for any geographical region, thus the overall mean of 4.33 is generalizable to the entire sample. A mean of 4.33 indicates a response between "somewhat acceptable" and "acceptable" (Table 7).

Table 7. Acceptability of check in the mail for subsidy payment

	Overall	Urban	Rural	Both
Mean	4.33	4.31	4.35	4.38
Std. Dev.	1.01	1.09	0.94	0.83
n	254	124	95	32

A t-test was calculated for the difference between the mean of EFT and the mean of a check in the mail and there was determined to be a statistically significance preference for a mailed check over EFT ($p<.001$). However, as both mailed check (mean, 4.33) and EFT (mean, 4.05) scored in the "somewhat acceptable" to "acceptable" range, either payment method would be satisfactory

Premium Costs Currently Paid by Employers Offering Health Benefits by Geographic Region

Question 10 asked "What percent of the premium costs do you pay for your employees?" The mean response for this question was 3.89 (standard deviation, 1.26). This indicates a response between "51-75%" and "76-99%" of premium costs are paid by employers. Responses were stratified by location. "Urban" respondents had a mean of 3.96 (standard deviation, 1.28), indicating a response close to "76-99%" of premium costs. "Rural" respondents had a mean of 3.87 (standard deviation, 1.33) indicating a response between "51-75%" and "76-99%". Respondents with small business "both" urban and rural had a mean of 3.69 (standard deviation, 1.03) indicating a response of "76-99%" (Table 8).

Table 8. Percent of premium costs paid by employer by geographic region

	Overall	Urban	Rural	Both
Mean	3.89	3.96	3.87	3.69
Std. Dev.	1.26	1.28	1.33	1.03
Range	51% to 99%	76% to 99%	51% to 99%	76% to 99%
n	254	124	95	32

An ANOVA showed there to be a difference statistically between those employers with businesses in "both" urban and rural areas from those employers that had businesses in either "urban" or "rural" areas.*

*The Primary Care Health Policy Division wishes to acknowledge and thank Robert M. Hamm, Ph.D., for his assistance and expertise in designing, analyzing, and understanding the statistical elements of this study.

Table 9. Results at a Glance

Part 1. Business Demographics. Survey Questions 1-5 (All Responders)	Response	Interpretation
Q1. How many full time employees do you have? (n=286)	Mean* = 2.2	Most employers had between 1 and 10 full-time employees
Q2. How many part-time employees do you have? (n=281)	Mean* = 1.7	Most employers had between 1 and 10 part-time employees
Q3. What type of business do you own?	See Figures 9 and 10	Businesses in our sample appear representative of businesses in OK
Q4. Where is your business located? (n=286)	146 urban 104 rural 36 both	51% urban 36% rural 13% both
Q5. What income brackets are represented by employees in your firm?	Largest % in income bracket of <$18,000	Majority earned less than $35,000
Q6. Does your business currently offer employee health insurance?	153 (53.7%) yes 131 (46%) no	
Q7. How acceptable is Electronic Funds Transfer (EFT) as payment?	Mean* = 4.05	EFT is somewhat acceptable to acceptable
Q8. How acceptable is mailed check as payment?	Mean* = 4.33	Check is somewhat acceptable to acceptable and is statistically more acceptable than EFT ($p<.001$)
Part 2a. Employers Currently Offering Employee Health Insurance. Survey Questions 9-13		
Q9. How many employees participate in your plan? (self-report)	Range = 1-131	Median = 5
Q10. What percent of the premium costs do you pay for your employees?	Mean* = 3.9	Indicates most employers pays on average between 51% and 99%
Q11. In the current environment, how likely are you to drop or reduce health benefits in the next 2 years?	Mean* = 3.3	Neutral to somewhat likely
Q12. With the new program, how likely would you be to drop or reduce health benefits in the next 2 years?	Mean* = 1.7	Unlikely to somewhat unlikely
Q13. If you have considered reducing or dropping benefits, why?	97.8% indicated cost	
Part 2b. Employers Not Currently Offering Employee Health Insurance. Survey Questions 14-16		
Q14. In the current environment, how likely would you be to offer health insurance benefits in the next 2 years?	Mean* = 2.1	Somewhat likely to neutral
Q15. With the new program, how likely would you be to offer health benefits in the next 2 years?	Mean* = 4.3	Somewhat likely to likely
Q16. If you have considered reducing or dropping benefits, why?	95.3% indicated cost	

* Means are based on a Likert scale from 1 to 5 with 1 being least and 5 being most.

Discussion

"Rising health insurance rates and workman's comp rates are going to soon wipe out small business in Oklahoma."

Oklahoma Small Business Owner

With 23.6% of Oklahoma's citizens uninsured, including 20.6% of the workforce, the state government and the state's Medicaid agency, the Oklahoma Health Care Authority, were ready to act. With the passage of the Oklahoma Health Care Recovery Act and the enactment of a $.50 additional tax on tobacco products, the state demonstrated both the will and the means to address the issue of the uninsured in Oklahoma. The Oklahoma premium assistance program, a Medicaid demonstration project conducted under an 1115a/HIFA Medicaid Waiver Amendment, is intended to extend health benefits to 50,000 of Oklahoma's low-income workers. If the program is successful – both fiscally and for health outcomes – the program may be expanded to include more low-income workers and small businesses.

This study was undertaken to determine the extent to which eligible Oklahoma small businesses (initially up to 25 employees) with qualifying employees (those earning less than 185% of the federal poverty level or about $35,798 for a family of 4) would be interested in participating in a premium assistance program. The study was also aimed at determining whether the availability of the premium program would (1) effect decisions about reducing or dropping employee health benefits by employers who currently offer employer-sponsored insurance, and (2) whether the program would induce employers who currently do not have health insurance benefits for their employees to consider offering coverage.

After soliciting sufficient demographic information to ensure that our sample would be representative of businesses statewide, we asked specific questions aimed at determining the extent to which a premium subsidy program would be accepted and subscribed to by Oklahoma businesses. To provide a basis for comparison, we also asked how likely employers who currently offer coverage were to either drop or reduce benefits for their employees over the next two years and what impact a premium subsidy program could have on that decision.

We asked similar questions of employers who do not currently offer coverage. We asked how likely they were to consider offering health benefits over the two years, and what impact a premium subsidy program for low-income workers might have on their decision.

For both groups, the availability of a premium subsidy program made a large impact on their decisions concerning employee health insurance benefits.

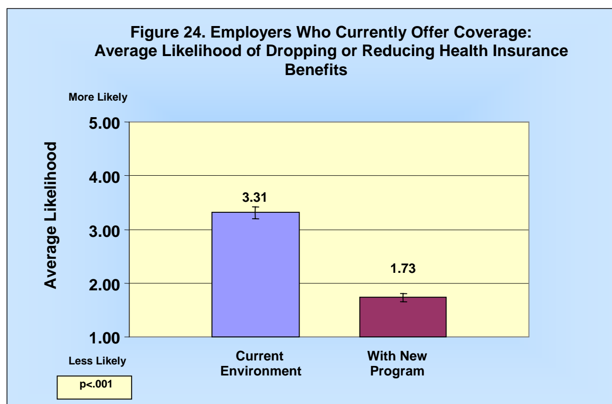
Employers Currently Offering Health Benefits

"We have reduced benefits each year due to the increased premiums."
Oklahoma Small Business Owner

Employers currently offering coverage were asked how likely they would be to reduce or drop coverage in the current environment and how likely they would be to reduce or drop coverage with a premium assistance program. Responses to those questions were on a scale of 1 to 5 (1= "likely to reduce or drop", 5= "unlikely to reduce or drop").

Figure 24 shows that in the current environment, employers are "somewhat likely to drop or reduce coverage" (average response = 3.31). With premium assistance, however, employers are less likely to drop or reduce coverage (average response = 1.73). This improvement is statistically significant ($p<.001$). This indicates that a premium assistance program is highly likely to allow employers to continue providing health benefits at the current level.

With the addition of a premium subsidy program hundreds of employees may be able to keep their insurance, knowing the burden of cost will not be shifted entirely to them.

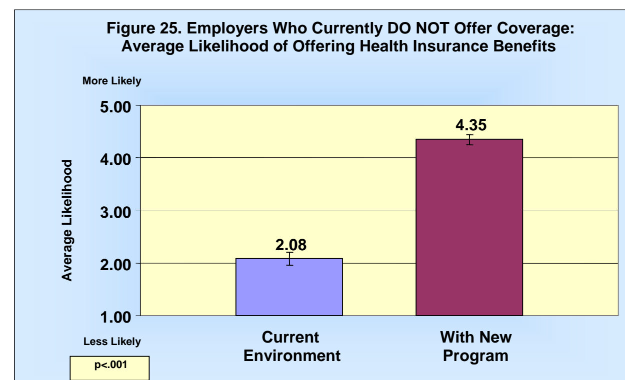


Employers NOT Currently Offering Health Benefits

"If the premiums are reasonable, I would love to give my people health insurance."
Oklahoma Small Business Owner

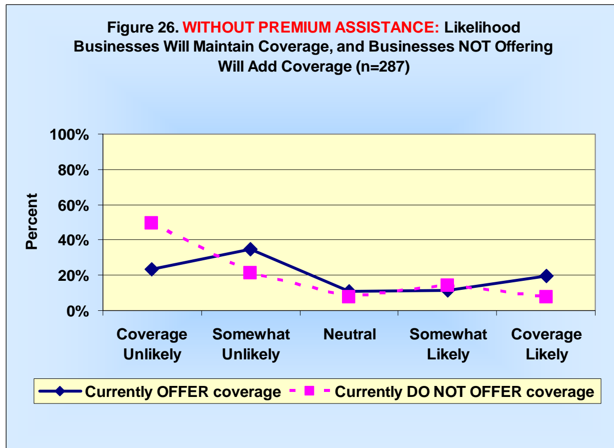
Employers who currently do not currently offer coverage were asked how likely they would be to consider offering coverage in the current environment, and how likely they would be to consider adding coverage with a premium assistance program. Responses to those questions were on a scale of 1 to 5.

Figure 25 shows that in the current environment, employers who currently do not offer coverage are not likely to consider doing so (average response = 2.08). With premium assistance, however, these employers are much more likely to consider offering health benefits for their employees (average response = 4.35). This improvement is statistically significant ($p<.001$).

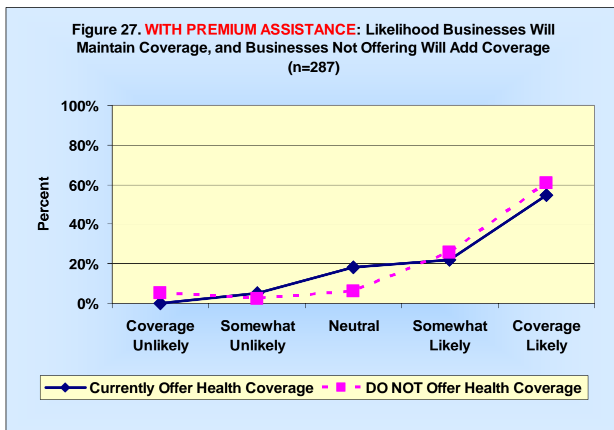


Without a premium subsidy or other financial assistance, employers who currently do not offer health insurance are highly unlikely to even consider an employee health insurance package in the current economic climate.

Figures 26 and 27 show the comparison another way. Without the premium assistance program, is it likely that employers who currently offer insurance will reduce or drop coverage (dashed line). Similarly, employers who currently do not offer insurance are unlikely to consider offering coverage without the premium assistance program (solid line) (Figure 26).

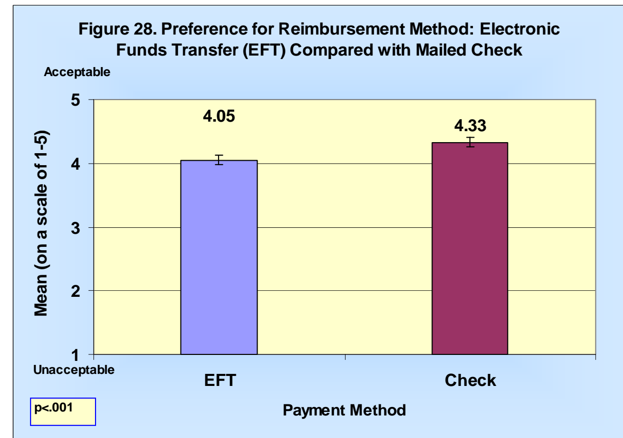


However, if a premium assistance program is offered, employers currently sponsoring insurance are highly likely to maintain current coverage (dashed line) and employers who currently do not offer coverage are highly likely to consider offering coverage (solid line) (Figure 27).



Preference for Payment Using Mailed Check and Electronic Funds Transfer (EFT)

All employers who completed the survey were asked to rate (on a scale of 1-5, with 1=unacceptable and 5=acceptable) their preference for a mailed check and for Electronic Funds Transfer (EFT) as a mechanism for premium payment. Data analysis showed a small but statistically significant difference in preference for a mailed check (mean=4.33) over EFT (mean=4.05) ($p<.001$) (Figure 28). Either method would be acceptable, but it should be recognized that a significant number of respondents preferred to receive a check by mail. If possible, businesses could be offered a choice. However, if the decision is made to use EFT for payment, then a public relations and educational effort that addresses these concerns and explains the decision might be undertaken.



Summary Statements and Comments

Employers who participated in this study supported a premium assistance program for low-income workers in Oklahoma. Nearly all of the participants who made comments (Question 16) showed their willingness to participate even though they would be sharing part of the financial burden.

> ***"Small businesses and non-profits desperately need sufficient coverage so turnover of staff can be reduced."***
> **Oklahoma Small Business Owner**

Employers who participated in this study expressed awareness of the rapid increases in health care costs and the impact those costs have on their businesses and on their employees.

> ***"We're excited about the opportunity to decrease our health care costs. Health premium increases have been out of control for the last several years."***
> **Oklahoma Small Business Owner**

"I think this is an excellent program. I'm trying to do the right thing by giving my employees insurance. Many businesses that pay more than I do, do not have insurance."

Oklahoma Small Business Owner

The results of this study indicate that the Oklahoma business community is highly aware of the issues surrounding employer-sponsored health insurance coverage and that they are ready and willing to participate in efforts to expand health benefits for their workers. Our study also demonstrates that without premium assistance, employers who currently offer coverage will be forced to drop or reduce coverage (which includes transferring more of the costs to their employees). Similarly, employers who do not currently offer coverage will be unable to consider doing so unless some financial assistance is available.

Policymakers can conclude from this study that a premium assistance program has the potential to prevent the number of uninsured from growing, by enabling small employers to continue to offer health insurance coverage. This program will most likely reduce the number of low-income workers and their dependents, who may be currently uninsured, by increasing the number of small businesses that are able to offer health insurance coverage.

"Please make it possible for us to continue to have health insurance."

Oklahoma Small Business Owner

Key Findings at a Glance

- ☑ **With premium assistance**, employers who were considering dropping or reducing coverage are less likely to do so.
- ☑ **With premium assistance**, more low-income workers will be able to enroll in or retain health coverage through employers currently offering coverage.
- ☑ **With premium assistance**, small businesses in Oklahoma that currently do not offer coverage are more likely to consider adding insurance benefits.
- ☑ **Without premium assistance**, more small businesses that currently offer coverage may be forced to reduce or drop coverage resulting in more uninsured workers.
- ☑ **Without premium assistance**, Oklahoma small businesses that currently do not offer health coverage are unlikely to consider adding health insurance benefits.
- ☑ Of employers currently offering coverage, the average percent of the premium paid by the employer is approximately 80%. This figure applies only to employers in our sample with 25 employees or less.
- ☑ Of the top three reasons for dropping or reducing coverage or not offering coverage at all, cost was the reason given by nearly 99% of respondents.
- ☑ Although both payment methods are acceptable, there was a statistically significant preference ($p<.001$) for a mailed check over Electronic Funds Transfer (EFT).
- ☑ The Oklahoma premium assistance program has the potential to reduce the number of uninsured low-income workers and extend coverage to the dependents of low-income workers, thus reducing the total number of uninsured Oklahomans.
- ☑ Comments received with the survey indicate that small businesses in Oklahoma are very receptive to a premium assistance program.

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Appendices

A. Small Business Employer Survey with Premium Assistance Program Education Piece

B. Raw Data and Comments

C. Biographical Sketches of Project Faculty and Staff

Appendix A
OKLAHOMA PREMIUM ASSISTANCE PROGRAM DESCRIPTION

What is the Oklahoma Premium Assistance Program?
A *voluntary* health insurance subsidy for small employers and low-income workers.

How is it funded?
By the newly enacted Tobacco Tax. Funds are currently being deposited in a reserve account for this program.

Who can participate?
Workers earning up to 185% of the Federal Poverty Level (FPL) and small businesses employing 25 employees or fewer. This program may be expanded to cover those earning up to 200% FPL and businesses employing up to 50 workers.

2004 Federal Poverty Level (FPL) Schedule		
Family Size	**185%**	**200%**
1	$17,224	$18,620
2	$23,107	$24,980
3	$28,990	$31,340
4	$34,873	$37,700

How much will the program pay?
- Employer portion of the premium will be 25%.
- Workers will pay a portion of the premium, with deductibles and other co-pays based on their family size and income.
- The remaining portion of the health insurance premium will be paid by the Oklahoma Premium Assistance Program.

Who is conducting this survey and why?
The Oklahoma Health Care Authority is conducting this survey. Data analysis will be done by independent researchers at the University of Oklahoma Health Sciences Center. The purpose of this survey is to gather feedback as policymakers move forward with the fine-tuning and implementation of the Oklahoma Premium Assistance Program. Your answers will be confidential and anonymous. If you wish to discuss this program with us or provide additional information, please complete the contact information at the end of the survey.

For more information, please visit http://www.ohca.state.ok.us/general/premium_assistance.htm.

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Suite 124
Oklahoma City, OK 73105

DFPM
900 NE 10th Street
Oklahoma City, Oklahoma 73104
Attention: Sarah Hyden

Appendix A
OKLAHOMA PREMIUM ASSISTANCE EMPLOYER SURVEY

Please print and return your completed survey by fax (405-271-8800 or 405-271-4125) or by mail (please fold and seal).
Thank you for completing this survey.

Part 1. All Participants. Please check the box that applies or fill in the blank.

1. How many full time employees do you have?
   ☐ 0 ☐ 1 ☐ 2-10
   ☐ 11-25 ☐ 26-50 ☐ more than 50
2. How many part-time/seasonal employees?
   ☐0 ☐ 1 ☐ 2-10
   ☐ 11-25 ☐ 26-50 ☐ more than 50
3. Type of business you own/operate:
   ____
4. Where is your business located?
   ☐ Urban ☐ Rural ☐ Both
5. Does your business currently offer an employee benefit package that includes health insurance?
   ☐ Yes ☐ No

Part 2a. If you CURRENTLY OFFER health insurance, please answer questions 9 - 13, and 17.

9. How many employees participate in your plan?
   ____
10. What percent of the premium costs do you pay for your employees?
    ☐ 0% ☐ 1-25% ☐ 25-50%
    ☐ 51-75% ☐ 76-99% ☐ 100%
11. In the current environment, how likely would you be to drop or reduce health benefits in the next 2 years?

Unlikely	Somewhat Unlikely	Neutral	Somewhat Likely	Likely
☐	☐	☐	☐	☐

12. With this new program, how likely would you be to drop or reduce health benefits in the next 2 years?

Unlikely	Somewhat Unlikely	Neutral	Somewhat Likely	Likely
☐	☐	☐	☐	☐

13. If you have considered reducing or dropping benefits, why?
    ☐ Increasing premium costs
    ☐ Hassle
    ☐ Other, please explain:
    ____
    ____

6. How many of your employees fall into the following annual income brackets.
   ___less than $18,000 ___$18-$25,000
   ___$25-$35,000 ___$35-$50,000
   ___$50,000 or more
7. As the payment method for the premium subsidy, how acceptable is Electronic Funds Transfer (EFT)?

Unacceptable	Somewhat Unacceptable	Neutral	Somewhat Acceptable	Acceptable
☐	☐	☐	☐	☐

8. As the payment method for the premium subsidy, how acceptable is receiving a mailed check?

Unacceptable	Somewhat Unacceptable	Neutral	Somewhat Acceptable	Acceptable
☐	☐	☐	☐	☐

Part 2b. If you DO NOT CURRENTLY OFFER health insurance, please answer questions 14 - 17.

14. In the current environment, how likely would you be to offer health benefits in the next 2 years?

Unlikely	Somewhat Unlikely	Neutral	Somewhat Likely	Likely
☐	☐	☐	☐	☐

15. With this new program, how likely would you be to offer health benefits in the next 2 years?

Unlikely	Somewhat Unlikely	Neutral	Somewhat Likely	Likely
☐	☐	☐	☐	☐

16. Please indicate your reasons for not offering health insurance below:
    ☐ Cost
    ☐ Hassle
    ☐ Other, please explain: ____________________

Part 3. All Participants.

17. Please write comments/suggestions below. Attach additional pages as necessary.
    ____

Contact Information (optional)

Name ____
Address ______________________________________
City____________________State ________Zip ______
Phone _______________________________________
Email____

APPENDIX B. RAW DATA AND COMMENTS

Survey #	Q1. # Full Time Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	Q2. PT/Temp Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	biz code	Q3.Type of Business	Q4. Location (1=Urban; 2=Rural; 3=Both)	Q5. Currently Offering Ins? (1=yes; 2=no)
1	0	0	G	Gift Boutique	1	2
2	2	1	K	Commercial Real Estate	1	2
3	0	0	G	Mary Kay Cosmetics	2	2
4	2	0	P	non-profit	2	2
5	2	0	S	chamber of commerce	2	2
6	2	0	M	Office	2	2
7	2	0	F	Wholesale Retail Tire	1	2
8	1	0	P	non-profit	1	1
9	2	1	M	Personnel Agency	1	1
10	2	1	S	Cable TV Company	3	1
11	2	0	J	CPA firm	2	1
12	0	2	D	Construction	2	2
13	0	2	J	Investment company	2	2
14	1	0	M	Business consulting	2	1
15	3	2	G	RV Sales, service, campgrounds	3	1
16	2	1	G	Retail office equip	2	2
17	3	1			1	2
18	2	0	I	computer consulting	1	1
19	2	0	S	Trade Association	1	1
20	2	2	P	Pharmacy	2	2
21	4	2	J	Public Accounting	1	1
22	0	1	A	Farm/Ranch supply	2	2
23	2	0			2	2
24	1	1	J	investments	1	1
25	2	2	G	medical equipment	2	2
26	3	1	G	John Deere/car dealership	2	1
27	1	0	P	non-profit	2	2
28	2	0	J	insurance agency	1	1
29	2	2	G	dry cleaner	2	1
30	2	0	I	computer consulting and repair	1	2
31	3	0	B	stone quarry	3	2
32	2	2	G	Retail screen printing and monogramming	1	1
33	2	1	S	service business	2	2
34	5	5	O	Education	3	1
35	4	2	J	Bank	2	1
36	4	2	J	Bank	2	1
37	4	2	E	metal fabrication	1	2
38	2	2	L	engineering/consulting	1	1
39	2	1	P	Optometrist	2	1
40	2	2	D	general contractor	1	1
41	2	3	P	heartland hospice	2	1
42	2	2	G	retail gifts and luggage	1	2
43	4	4	G	Supermarket	2	1
44	1	0	P	chiropractic office	3	2
45	3	2	J	Bank	2	1
46	1	0	L	law office	1	2
47	3	2	D	post frame construction	2	1
48	2	0	G	printing brokerage	1	2
49	3	2	P	medical office	1	1
50	4	1	P	medical services	2	1
51	5	2	P	long term care	2	1
52	3	0	B	oil and gas exploration and production	2	1
53	2	1	G	office equipment	2	2

APPENDIX B. RAW DATA AND COMMENTS

Survey #	Q1. # Full Time Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	Q2. PT/Temp Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	biz code	Q3.Type of Business	Q4. Location (1=Urban; 2=Rural; 3=Both)	Q5. Currently Offering Ins? (1=yes; 2=no)
54	2	1	S	mailing service	1	1
55	2	0	D	electrical contractor	1	0
56	4	2	T	Municipality	1	1
57	2	1			1	2
58	2	0	J	insurance agency	2	1
59	2	0	Q	graphic arts	2	2
60	2	2			2	1
61	2	3	P	Older Americans Nutrition program	2	2
62					2	1
63	3	3	P	non-profit	2	1
64	2	1	P	501c(3)	2	2
65	2	0	G	internet/mail order sales	1	2
66	3	2	D	Construction	1	2
67	2		P	residential assisted living	1	2
68	2	3	M	staffing agency	2	2
69	2	0	L	law firm	1	1
70	2	2	I	Newspaper	1	2
71	2	0	G	municipal equipment sales and service	2	2
72	2	2	G	commercial coffee service	1	2
73	2	1	G	Propane	3	1
74	2	2	G	Propane	3	1
75	2	1	G	Propane	3	1
76	1	2	H	transportation of propane & gas products	3	1
77	1	2	H	Propane	3	1
78	4	2			1	1
79	5	2	S	commercial laundry	3	2
80	0	0	S	window cleaning	1	2
81	2	2	P	Childcare	2	2
82	2	0	L	planning/consulting	1	2
83	2	1	L	veterinary hospital	1	2
84	4	0	E	manufacturing/sales	1	1
85	4	0	E	Mfg	1	2
86	2	2			1	2
87	3	2	G	retail grocery	1	1
88		2	G	retail gift shop	1	2
89	4	2	J	insurance agency	3	1
90	4	0	S	plumbing/HVAC	3	1
91	2	0	L	law office	1	1
92	0	0	G	car audio	1	2
93	4	0	E	aircraft manufacturing	2	1
94	2	2	L	land surveying	3	2
95	4	3	P	home healthcare	2	2
96	2	0	L	Attorneys	1	2
97	2		R	food processing	2	2
98	2	0	P	dental office	1	1
99	2	2	P	Childcare	1	1
100	1	1	S	plumbing	3	2
101	2	1	G	Print shop	1	1
102	2	2	G	hardware, auto parts, feed retail	2	2
103	2	1	G	truck repair and tire shop	2	2
104	4	2	E	Machine shop	2	2

APPENDIX B. RAW DATA AND COMMENTS

Survey #	Q1. # Full Time Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	Q2. PT/Temp Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	biz code	Q3.Type of Business	Q4. Location (1=Urban; 2=Rural; 3=Both)	Q5. Currently Offering Ins? (1=yes; 2=no)
105	1		P	chiropractic office	1	2
106	2	0	Q	therapeutic massage	1	2
107	2	0	C	HVAC/utility hook-ups on mobile homes	1	1
108	0	2	E	welding and fabrication	2	2
109	2	0	P	family practice physician	2	2
110	2	1	I	computer software	1	1
112	2	0	L	law firm	1	2
113	2	1	S	dog and cat boarding/grooming	1	2
114	3	2	N	manufacturing waste heat recovery units	3	1
115	3	3	E	manufacturing	1	2
116	2				3	1
117	2	2	G	retail fabric store	1	2
118	1		E	Machine and welding	1	1
119	0	0	B	independent oil producer	2	2
120	2	2	G	retail donut shop	1	2
121	2	2	S	veterinary clinic	2	1
122	2	0	G	sales and service	2	1
123	3	0	I	communication	1	1
125	4	2	G	screen painting	1	1
126	2	2	S	veterinary hospital	1	1
127	2	0	G	auto service		1
128	2	1	E	window manufacturing & sales	2	2
129	1	0	G	car lot	1	2
130	2	1	G	grocery market	2	2
131	2	0	E	mfg and retail fence products	1	2
132	2	1	S	self storage	1	1
133	2	1	D	Irrigation contractor	2	2
134	3	0	E	Foundry	2	2
135	2	0	P	healthcare	1	1
136	2	1	F	wholesale distributor	1	1
137	4	2	Q	country club	1	1
138	2	3	R	restaurant	1	2
139	1	0	D	hvac	1	1
140	2	0	S	offset printing	1	1
141	2	0	P	non-profit	2	1
142	2	0	S	service business	1	2
143	3	1	M	payroll processing service	1	1
144	2	0	L	law firm	1	2
145	2	2			2	1
146	3	2	A	Livestock feed mfg	2	1
147	2	2	G	hardware	2	1
148	2	1	G	garage door company	1	1
149	2	1	L	law firm	1	1
150	1	0	D	construction	2	2
151	3	1	G	new & used auto sales	1	1
152	2	1	L	architecture/graphics	1	1
153	1	1	T	tag agency		2
154	3	2	P	day care	1	2
155	2	3	P	outpatient physical therapy	1	1
156	2	2	P	childcare	2	2
157	2	0	G	hardware	2	1

APPENDIX B. RAW DATA AND COMMENTS

Survey #	Q1. # Full Time Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	Q2. PT/Temp Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	biz code	Q3.Type of Business	Q4. Location (1=Urban; 2=Rural; 3=Both)	Q5. Currently Offering Ins? (1=yes; 2=no)
158	3	2	E	manufacturer	2	1
159	2	1	P	medical practice	2	2
160	2	3	Q	bowling center	1	1
161	2	2	O	Christian school	1	2
162	3	0			1	1
163	3	2	E	manufacturing	1	1
164	1		S	newspaper	3	2
165	2				1	2
166	2	0	G	service stations	1	1
167	0	0	N	sanitation and trash hauling	3	2
168	0	0	D	painting and remodeling	3	
169	2	2	A	cattle, preconditioning, feeding	2	2
170	2	0	D	HVAC	2	1
171	2	0	F	distributor	1	1
172	2	1	B	oil company	2	2
173	1	1	G	clothing/tailoring	1	2
174	3	0	I	telecommunications	3	1
175	2	2	G	Retail	1	2
176	0	0	S	auto repair	1	2
177	2	0	P	medical practice	2	2
178	2	0	S	packaging and supplies	2	2
179	2	1	S	plumbing	1	2
180	2	2	P	Pharmacy-dme	1	1
181	2	2	P	eyecare practice	1	2
182	1	1	G	retail jewelry	1	2
183	2	2	P	Faith 7 Activity Center sheltered Workshop	1	2
184	1	1	S	copying	2	2
185	0	0	P	medical records copy service	1	2
186	2	3	R	retail restaurant	1	1
187	2	2	S	tanning salon	1	2
188	3	2			1	2
189	2	0	S	contract service	1	1
190	0	2	G	jewelry repair	2	2
191	2	2	P	ambulance service	2	1
192	2	2	P	optometrist	1	1
193	3	2	E	steel service center	2	1
194	3	2	F	tire retail and wholesale	1	1
195	3	1	J	insurance agency	1	2
196	2	2	P	day care	2	2
197	2	2			2	
198	2	2			2	2
199	2	2	F	commercial printing	1	1
200	2	0	M	property management	1	1
201	3	2	P	childcare	1	1
202	2	1	S	chamber of commerce	1	1
203	2	0	G	transmission repair	1	2
204	2	0	I	wireless-retail cell phones	1	2
205	4	2	K	Commercial Real Estate	1	1
206	4	1	L	law firm	1	1
207	4	0	P	non-profit	1	1
208	2	2			3	2
209	1	1	S	landscaping services	2	2
210	2	0	P	chiropractic physician office	1	1

APPENDIX B. RAW DATA AND COMMENTS

Survey #	Q1. # Full Time Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	Q2. PT/Temp Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	biz code	Q3.Type of Business	Q4. Location (1=Urban; 2=Rural; 3=Both)	Q5. Currently Offering Ins? (1=yes; 2=no)
211	4	2	P	Private Drug and Alcohol Rehab Center	3	1
212	4	2	G	Retail Building Materials	1	1
213	1	2	P	Non-profit 501c3 Resale store	1	2
214	2	0	P	Physicians clinic	1	1
215	2	2	G	Retail liquor store	1	2
216	2	2	L	Consulting Engineer	1	1
217	2	1	G	Auto Accessories	1	2
218	2	0	G	Automotive & Transmission	1	2
219	2	2	G	Grocery store & Deli	2	2
220	2	0	I	wireless-retail cell phones	1	2
221	4	3	P	Acute Care Hospital	2	1
222	2	2	Q	Non Profit Arts	1	1
223	2	0	M	Property management/Real Estate	1	1
224	0	2			2	2
225	0	2			2	2
226	3	1	S	Publishing	1	1
227	3	3	P	Childcare	1	2
228	2	2	B	oil and gas management	1	
229	2	1		2	2	
230	4	2	P	non profit alcohol & drug counseling	1	1
231	2	0	J	Insurance agency, owner/operator	1	2
232	0		S	self proprietorship	2	2
233	2	1	T	tag agency	1	2
234	1	3	R	Catering	1	2
235	6	4	S	Church	1	2
236	1	0	J	independent insurance agent	3	2
237	1	0	H	trucking company	2	2
237	4	4	R	food service	2	1
239	2	2	E	manufacturing/sales	1	1
240	2	0	P	non profit veterans org.	3	2
241	4	2	P	non profit credit counseling	3	1
242	3	0	G	motorsports dealership	1	1
243	3	3	P	non-profit child development center	1	1
244	3	2	H	moving company & safety surface flooring	3	2
245	2	0	J	insurance agency	1	1
246	2	0			1	1
247	2	0	E	Manufacturer/distribution	3	1
248	2	0	E	electrical sign company	1	1
249	2	0			1	2
250	1	0			1	2
251	2	0	H	trucking company	3	2
252	3	0	L	Research	1	1
253	2	1	F	drapery workroom	1	2
254	2	2	P	home health hospice	1	1
255	2	0	R	restaurant supply	1	2
256	2	0	E	machine shop		2
257	2	2	S	advertising specialties	1	2
258	2	1	P	Non profit adoption agency	1	1
259	2	1	P	dental laboratory	1	1
260	2	0	J	insurance agency	1	1

APPENDIX B. RAW DATA AND COMMENTS

Survey #	Q1. # Full Time Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	Q2. PT/Temp Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	biz code	Q3.Type of Business	Q4. Location (1=Urban; 2=Rural; 3=Both)	Q5. Currently Offering Ins? (1=yes; 2=no)
261	2	2	P	medical clinic	1	1
262	2	1	J	insurance office	3	2
263	2	0	P	Physicians clinic	1	1
264	2		G	jewelry store	1	2
265	5	0	E	manufacturing	2	1
266	2	2			2	1
267	2	2	A	local coop grain elevator	2	1
268	3	2	A	Cooperative	2	1
269	2	2	A	grain elevator, feed, service station	2	1
270	4	4	A	Agricultural retail	2	1
271	2	2	A	grain, fertilizer, farm retail	1	1
272	2	2	A	Farm Services	2	1
273	2	3	A	cotton gin	2	1
274	3	2	A	agricultural grain storage	2	1
275	3	3	A	grain elevator, feed, fertilizer	2	1
276	3	3	A	grain elevator, service station, c-store	2	1
277	2	2	A	grain elevator, farm supply	2	1
278	4	1	P	mental health	2	1
279	3	2	A	agriculture	2	1
280	2	1	A	grain and farm supply	2	1
281	2	4	A	Cooperative, cotton gin	1	1
282	3	3	A	Farm coop grain and supply	2	1
283	5	5	A	agricultural cooperative	3	1
284	2	2	I	technology consulting	3	2
285	4	4	A	agribusiness	2	1
286	2	3	I	agricultural and internet service provider	2	1
287	4	0	A	grain elevator	3	1
288	2	2	A	coop	2	1
289	3	2	A	grain elevator	2	1
290	3	2	A	agri supply	3	1
291	3	2	A	Coop	3	1
292	2	2	A	Ag cooperative	2	1
293	2	2	A	Farm Cooperative	2	1
294	2	3	A	coop	2	1
295	3	2	A	Ag services & retail--grain	3	1

	Q1	Q2			Q4	
mean	2.219931271	1.272084806			1.613793103	
Std dev	1.023726119	1.107757094			0.697858384	
se						

Symbol Legend
U=Unlikely
SU=Somewhat Unlikely
N=Neutral
SL-Somewhat Likely
L=Likely

APPENDIX B. RAW DATA AND COMMENTS

Survey #	Q1. # Full Time Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	Q2. PT/Temp Employees (0=0; 1=1; 2=2-10; 3=11-25; 4=26-50; 5=50+)	biz code	Q3.Type of Business	Q4. Location (1=Urban; 2=Rural; 3=Both)	Q5. Currently Offering Ins? (1=yes; 2=no)

APPENDIX B. RAW DATA AND COMMENTS

Income Less than $18,000	Income $18-25,000	Income $25-35,000	Income $35-50,000	Income $50,000+	Q7. EFT? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q8. Check? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q9. How many in plan?
	1				4	4	
		2		3			
	2				5	3	
1	1				5	5	
1	2				5	3	
					1	2	
		1			3	5	1
1	6				5	5	7
1		1			5	5	3
	1	2		1	4	5	1
1					5	5	
2					5	5	
	1				4	3	
6	1	7	5	3	5	3	14
1	1	5	1	1	5	5	
8		3			5	4	
	1	1		1	5	5	3
	2	1	4	1	4	4	8
6	4		3		5	5	
	2	3	25	18	5	5	44
1					3	3	
	1	1			5	5	
2					2	5	1
4					5	5	
3	4	7	1	3	5	4	13
	1				3	5	
		1		2	5	5	3
7	3				5	5	5
2					4	5	
20	10				5	5	
8					5	4	1
1	5	1			3	3	
		25	35	25	5	5	82
9	5	9		7	5	5	
9	5	9		7	5	5	
6	10	4	3		4	5	
		1	3	4	5	5	3
6	1	2			5	5	4
		4	4		5	5	4
	11	9	2		3	3	12
6	6				3	3	
50	10		2	3	5	5	
	1				5	5	
6	6	2	2	5	5	5	17
	1				4	4	
6	5	4	2		5	5	8
		5		3	5	5	
3	8	4		6	5	3	21
14	16	4	1	9	5	5	44
45	10			10	5	3	10
			6	7	5	5	11
2		7			4	4	
1	3	2			3	3	3

APPENDIX B. RAW DATA AND COMMENTS

Income Less than $18,000	Income $18-25,000	Income $25-35,000	Income $35-50,000	Income $50,000+	Q7. EFT? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q8. Check? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q9. How many in plan?
		3	2	2		5	4
12	13	3	1		3	3	30
2	3				5	5	
		3			5	5	3
	2				5	5	
1	2	4	1	2	4	4	8
26		1			1	5	2
		3					
28	10	3	3	1	5	5	16
5	5						
2					4	5	
4	1	7	2	2	5	5	
6					5	3	
1					3	3	
1			1		4	3	2
4		2			5	2	
2	2				4	5	
	1				3	3	
1	2				4	4	4
2	3	1	1		4	4	4
1	3		1	4	4		3
2		1			4	4	1
2	5	7		2	4	4	12
3	18	8	3	7	5	5	30
50	10	10		5	3	3	
					3	3	
6					5	3	
			3	5	5		
1	1				3	3	
6	4	3	1	1	5	5	10
1	9	2	1	1	5	5	
1	5	4	5	3	2	2	
12	3	5		2	5	5	9
	1		1		5	5	
0	2	3	4	3	5	5	11
	7	6			4	5	4
		4		2	3	3	6
					5	5	
		7	2	7	5	5	16
1	2				4	5	
6				1	5	1	
2					2	5	
8	1	1			5	5	
1		1		1	4	5	3
6		1			5	3	4
1					5	5	
1	1				3	5	2
3	2	2			5	5	
	1	2			2	5	
2	14	1	2		2	5	
	1				5	5	
2					3	5	
3	2	2			3	5	4
2	1						3

APPENDIX B. RAW DATA AND COMMENTS

Income Less than $18,000	Income $18-25,000	Income $25-35,000	Income $35-50,000	Income $50,000+	Q7. EFT? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q8. Check? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q9. How many in plan?
1	2	1			3	3	
1	1	2	2	1	4	5	6
	1				3	3	
1		6			4	4	
2		12			5	5	22
7	10		1	2	5	5	
3	3				3	3	5
4	4	1					
		1			5	5	1
					5	5	
2		2			2	5	2
6					5	5	3
							2
3	4	5	2		5	5	11
17	8	2	4	3	5	5	22
4	2				3	5	3
	1	2			3	5	2
3		3			5	5	
	1				1	5	
3	1	1			3	3	
	3	1			5	5	
	2	2			5	5	4
	2	1	1		5	5	
	22	2			3	3	0
			1	1	4	4	2
	2		1		5	5	3
23	2	3	4	1	4	5	12
all					5	2	1
1					5	5	1
	1		1		5	5	0
	1		2		4	5	2
4	3			2	2	2	
	3	10		5	5	2	10
	1		1	1	3	4	
	40%	40%	10%	10%	5	5	
2	4				3	3	3
1		3			3	3	2
1	2	2	3		3	3	4
1					3	3	
4	1	9	7	4	1	5	15
1		1		2	3	3	2
		1			4	2	
10	3				5	5	
10		1	6		1	1	6
10	10	3			3	4	
3	1		2		5	5	2
15	6	2	1		1	5	11
1	2		1		5	5	
12	5	1			5	5	5
10		1	4	5			
	1	6	2		5	4	9
1	2	2	3	3	3	3	
1					1	5	

APPENDIX B. RAW DATA AND COMMENTS

Income Less than $18,000	Income $18-25,000	Income $25-35,000	Income $35-50,000	Income $50,000+	Q7. EFT? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q8. Check? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q9. How many in plan?
2	1	1			5	5	
	2				5	5	2
					5	5	
		1		2	5	5	
2		2			4	4	2
2					5	5	2
3					5	5	
1					3	3	
	5	5	3	3	5	5	10
1					5	5	
	3						
	2	2			2	3	
3	1	3			3	3	
4	1	1		1	4	5	3
3	1	2		1	5	5	
	1				3	3	
11					5	5	
1					3	3	
					5	5	
16		4		2	1	5	5
3					5	2	
all					4	5	
		2			4	5	2
1		1			3	3	
3	8		3		1	5	6
4		1		1	3	5	2
3	5	5	1		1	5	6
3	5		4	2	5	5	3
6	4	4			1	5	
5					4	4	
	6				3	4	6
4	2				3	4	
2	3				1	5	4
2					5	5	2
2					5		2
	1				1	5	2
		1	2		5	5	
1	1				5	1	
2	3	12	10	7	5	5	32
1		16		22	5	5	32
	2	15	16	12	5	5	31
	3			1	5	5	
1		1			5		
4	1				5		3
23	6	18		3	5	5	15
2	12	21	5	2	4	5	24
2	1	1			5		
4	1				5		3
14	2				5		
2	1	1		2		5	4
1			2	1	5		
	1					5	

APPENDIX B. RAW DATA AND COMMENTS

Income Less than $18,000	Income $18-25,000	Income $25-35,000	Income $35-50,000	Income $50,000+	Q7. EFT? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q8. Check? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q9. How many in plan?
11	1				4	5	
1	1				5	1	
23	12	6	4	5	5	5	7
3	1				5		2
9					5		6
2		1			5	5	
2		1			5	5	
1	2	5	2	2		5	
26					5		
							3
	1				3	3	
1	6	23	5	1	5		31
	1	1					
					0	5	
3					5	5	
1					5		
5	3	2			5	5	
				1	5	4	
		1			4	2	
86	7	1	3	2	5		23
6			1	5	5	5	5
1	5				5	5	
2	20	9	4	1	5		32
0	2	6	6	3	5	3	17
34	5	1			5		11
	10				2	5	
2				1	5	5	2
1		1	2		4	5	3
		8		1	3	3	3
		all			3	5	3
2					4	5	
		1			5	5	
2					5	5	
		8	2	6	3	3	15
1	3				4	4	
3	6		4		5	5	7
2	4		2		3	5	
5	2				5	5	
2	1			2	2	5	
	3				3	5	4
			2		5	5	2
				2	5	4	1
2	1			4	5	5	3
	3	1	2		5		
		6	1	2	3	5	8
2	1	1			5	5	
5	62	30	6	11	5	3	130
2	8		3		3	3	8
	1	1		1	3	3	3
		8	1		4	5	9
3	2	2	1		3	5	5
15	5	25	3	1	3	5	38
	2	6		1	5	5	7
2	7		1		3	5	4

APPENDIX B. RAW DATA AND COMMENTS

Income Less than $18,000	Income $18-25,000	Income $25-35,000	Income $35-50,000	Income $50,000+	Q7. EFT? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q8. Check? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q9. How many in plan?
		2	1		5	5	3
	10	1	2	1	5	5	14
1	3	10	1	1	5	5	17
4	10	2	2	1	5	5	19
5	1	4	4	1	4	4	12
		35			3	5	9
	1	11	2		5	4	15
1	3	4	2		5	5	9
		4	3	3	5	5	9
9	6	5	1		5	4	9
5	25	2	10	2	5	5	56
	3	2	2		5	3	
27	15	15	8	4	5	5	42
16	3		1		5	5	4
3	11	7	4	1	5	5	20
	6	2		1	3	3	9
4	6	8	2	1	5	5	17
	3		6	2	5	3	10
	2	8		1	3	3	11
	3	1			3	5	4
2	1	3	1	1	5	5	8
	3		1		1	5	3
10	4	5	1		4	4	12

5.9893617	4.38342541	4.60127389	3.30490196	3.40918367	4.116363636	4.34482759	10.2839
9.93615413	5.99414079	5.59315043	4.49744432	4.06265585	1.190406242	1.00185504	15.0323 5

APPENDIX B. RAW DATA AND COMMENTS

Q10. % of Premium costs (0=0%; 1=1-25%; 2=25-50%; 3=51-75%; 4=76-99%; 5=100%)	Q11. Currently Drop or Reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q12. With new program drop or reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q13. Why dropping or reducing? (1=costs; 2=hassle; 3=other	Other, Explain:
5	1	1	1	
5	5	1	1	
4	4	3	1	
1	3	3	3	Only have 1 employee not covered on spouse's insurance-we were almost dropped by insurance company
5	4	3	1	
4	5	1	1	
4	4	3	1	
5	4	4	1	
2	2	2		
5	1	1		
2			1	
5	2	3	3	I probably won't be able to continue to pay 100% of the cost
3	5	3	1	
5	1	1	1	
5	1	1	1	
5	2	1	1	
5	2	1	1	
5	3	1	1	
5	4	1		
4	3	1		
2	4	4	1	
3	1	3	1	
4	5	3	1	
5	4	3	1	
5	5	1	1	
0	3	3	1	
3	4	2	1	

APPENDIX B. RAW DATA AND COMMENTS

Q10. % of Premium costs (0=0%; 1=1-25%; 2=25-50%; 3=51-75%; 4=76-99%; 5=100%)	Q11. Currently Drop or Reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q12. With new program drop or reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q13. Why dropping or reducing? (1=costs; 2=hassle; 3=other	Other, Explain:
3	4	1	1	we plan to hire more full time workers
1			1	
5	3	3	1	
5	4	1	1	
3	4	1	1	
4	4	3	1	
3	2	1	1	
0	1	1	1	
4	4	2	1	
4	2	2	1	Our insurance premium for all companies went to over 200,000/yr--we can not keep this up!
4	4	2	1	1
4	4	2	1	
4	4	2		
4	4	1	1	
3	4	1	1	
	3	1	1	
5	1	1	1	
2	4	1	1	
5	1	1		
5	5	2	1	
3	1	1	1	
3	5	1	1	
5	5	1	1	

APPENDIX B. RAW DATA AND COMMENTS

Q10. % of Premium costs (0=0%; 1=1-25%; 2=25-50%; 3=51-75%; 4=76-99%; 5=100%)	Q11. Currently Drop or Reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q12. With new program drop or reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q13. Why dropping or reducing? (1=costs; 2=hassle; 3=other	Other, Explain:
4	5	1	1	
5	1			
4	5	1	1	
4	5	2	1	
2	4	1	1	
5	1	1	1	
5	5	2	1	
5	5	1	1	
2	5	1	1	our other employees cannot afford insurance, If it was lower they would join us.
2	1	1		
4	5	2	1	I have dropped benefits each year over the last 3 years
2	5	2	1	
2	1	1	1	
4	4	1	1	
0	3	3	1	
5	3	3	1	
5	4	1	1	
3	4	1	1	
5	1			
5	3	3		
2	1	1	1	
5	1	1		
5	5	1	1	
4	5	2	1	
5	5	1	1	
5	5	1	1	
3	4	1	1	
3	3	1	1	
4	5	1	1	
5	1	1	1	
2	5	2	1	
3	4	2	1	

APPENDIX B. RAW DATA AND COMMENTS

Q10. % of Premium costs (0=0%; 1=1-25%; 2=25-50%; 3=51-75%; 4=76-99%; 5=100%)	Q11. Currently Drop or Reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q12. With new program drop or reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q13. Why dropping or reducing? (1=costs; 2=hassle; 3=other	Other, Explain:
2	2	1	1	
4	5	2	1	
5	5	1	1	
4	4	1	1	
5	3	1	1	
3	4	2	1	
2	4	1	1	
2	1	1	1	
5	4	1	1	
5	5	1	1	
5	1	2	1	
3	1	2		
2	1	1	1	
4	3	1	1	
5	4	1	1	
5	5	1	1	
4	5	1	1	
4	2	2	1	
5	4	2	1	
4	2	2		
2	2	1	1	
5	4	1	1	At this time of the 5 employees, I pay for 3 of them to have insurance, 2 have it from spouse. Average monthly cost is $250, if it goes higher, they pay the difference or drop it.

APPENDIX B. RAW DATA AND COMMENTS

Q10. % of Premium costs (0=0%; 1=1-25%; 2=25-50%; 3=51-75%; 4=76-99%; 5=100%)	Q11. Currently Drop or Reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q12. With new program drop or reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q13. Why dropping or reducing? (1=costs; 2=hassle; 3=other	Other, Explain:
				This program will keep them insured.
2	4	1	1	
	4	1	1	
5	4	1	1	
5	4	1	1	
3	5	2	1	
5	4	1	1	
5	3	4	1	
4	3	3	1	
2	5	4	1	
5	4	2	1	
3	5	1	1	Difficult to get coverage each ear at renewal time
3	4	3	1	
5	5	2	1	We pay 100% and will most likely have to begin charging the employee for part of the premium. We have already raised the deductible in a cost saving measure.
5	4	1	1	
5	4	1	1	Coverage is so minimal; no hospitalization or emergency coverage for example. I have an employee who has been here 8 years and is considering bankruptcy after an appendectomy
4	1	1	1	
5	4	2	1	
2	1	1		
5	4	2	2	
3	1	1		
2	4	3		

APPENDIX B. RAW DATA AND COMMENTS

Q10. % of Premium costs (0=0%; 1=1-25%; 2=25-50%; 3=51-75%; 4=76-99%; 5=100%)	Q11. Currently Drop or Reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q12. With new program drop or reduce? (1=U; 2=SU; 3=N; 4=SA; 5=A)	Q13. Why dropping or reducing? (1=costs; 2=hassle; 3=other	Other, Explain:
2	1	1		
5	1	1	1	
2	1	1	1	
5	1	1		
5	2	1	1	
			1	
5	5	4	1	
2	1	1		
5	4	3	1	
5	4	1	1	
5	3	3		
3	3	3	1	
3	4	4	1	
4	2	2	1	
5	2	1	1	
5	5	1	1	
5	2	3	1	
5	4	3	1	
5	4	2	1	
4	4	2	1	
4	2	2	1	
3	2	1	1	
5	4	1	1	
5	1	1		
3.5	4	2	1	
4	5	3	1	
5	5	3	1	
4	3	3	1	
5	4	2	1	
4	2	3	1	
3	4	4	1	
5	5	3	1	
5	4	1	1	
5	2	4	1	
4		1		
3	2	2	1	
			136	
			1	
			2	

3.889240506	3.305732484	1.730769231	1.035971223
1.265192286	1.439651046	0.932192378	0.252812354

APPENDIX B. RAW DATA AND COMMENTS

Q14. Currently to offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q15. New program offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q16. Reason for not offering? (1=cost; 2=hassle; 3=other)	Other:
3	5	1	
4	2	1	Non-availability
1			
3	5	1	
4	5	1	Size of group
2	4	1	
1	3	1	
1	4	1	
2	5	1	
2	4	1	
1	5	1	
1	1	1	
1	4	1	
2	4	1	
2	4		
5	4	1	
1	3	3	
2	1	1	
1	5		
1	1	1	
3	4		
5	5	1	
4	5	1	
1	5	1	
2	5	1	
1	4	1	
1	5	1	

APPENDIX B. RAW DATA AND COMMENTS

Q14. Currently to offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q15. New program offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q16. Reason for not offering? (1=cost; 2=hassle; 3=other)	Other:
3	3	3	budget will determine
1	4	1	
2	4	1	
1	5	1	unable to find an insurance program which offers insurance to individuals working 10-30 hours per week
1	5	1	
2	5	1	
2	5	1	
2	5	1	
3	4	1	
1	5	1	
2	5	1	administration and benefits
4	5	1	
1	4	1	
1	3	1	
1	4	1	
1	5	1	
2	5	1	
3	4	1	
2	5	1	lack of reasonable options for small biz owners--too costly with too many rules
1	5	1	
5	5	1	
4	5	1	Trying to wade through paperwork
1	5	1	
1	5	1	
2	5	1	
1	5	1	
1	5	1	
2	5	1	
2	4	1	
1	5	1	

APPENDIX B. RAW DATA AND COMMENTS

Q14. Currently to offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q15. New program offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q16. Reason for not offering? (1=cost; 2=hassle; 3=other)	Other:
4	5	1	
4	5		
4	5	1	
1	4	1	only one employee needs coverage
1	5	1	
1	1	1	
1	3	1	
3	5	1	
1	5	1	
2	4	1	
1	5	1	
1	5	1	
2	5	1	
4	4	1	
5	5	1	Previously most employees had coverage thru spouse/retirement, etc.
1	4	1	
1	5	3	employee has diabetes and can not find affordable health care coverage
2	4	1	
4	5	1	
1	4	1	
2	5	1	
1	4	1	

APPENDIX B. RAW DATA AND COMMENTS

Q14. Currently to offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q15. New program offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q16. Reason for not offering? (1=cost; 2=hassle; 3=other)	Other:
1	5	1	
1	5	1	
1	5	1	
1	5	1	
3	3		
1	5	1	
1	4	1	
1	4	1	
1	5	1	
5	5	1	
1	4	1	
3	5	1	
1	5	1	
1	5	1	
5	5	1	
1	5	1	
2	5	1	
2	4	1	
1	4.5	1	
2	5	1	
1	3	1	
5	5	1	
1	5	1	
4	5	1	
1	4	1	
2	2	1	
1	5	1	

APPENDIX B. RAW DATA AND COMMENTS

Q14. Currently to offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q15. New program offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q16. Reason for not offering? (1=cost; 2=hassle; 3=other)	Other:
1	3	1	
2	5	1	
1	4	1	
1	1	1	
1	1	1	
5	5	1	In the childcare industry -it is very difficult
1	4	1	
4	5	3	Employees have health insurance through spouses work. Owner has individual policy
4	1	3	I am the only employee in my business
1	5	1	
4	4	1	
4	5	1	
1	5	1	
1	5	1	
2	5	1	
1	5	1	
1	5	1	
3	5	1	
1	5	1	
4	4	1	
1	4	1	
2	5	1	
2	5	1	
		3	Rapidly growing, haven't had the need until recently
1	5	1	
5	5		

APPENDIX B. RAW DATA AND COMMENTS

Q14. Currently to offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q15. New program offer? (1=U; 2=SU; 3=N; 4=SL; 5=L)	Q16. Reason for not offering? (1=cost; 2=hassle; 3=other)	Other:
4	4		
5	5	1	
4	5	1	
4	5		
		121	
		0	
		6	

2.081481481	4.369402985	1.094488189
1.344151799	1.036784185	0.426001544

Comments?

Rising health insurance rates and workmens comp rates are going to soon wipe out small business in Oklahoma--and this statement comes from a Democrat!!

If the premiums are reasonable, I would love to give my people health insurance. Option

I do not believe this program will impact what we do

This may help recruit new employees when needed. Thanks!

Please do not increase the amount of record keeping required by the employer. We are a cafeteria plan now. Will we still get a tax benefit for the 25% we as employers will have to pay? How does this plan compare to a Health Care Savings Account?

Please explain: it is much saner to put the money one would spend on insurance in one's own savings account (it doesn't have to be a "medical" account) than to pay lying cheating insurance company a penny. Except for trauma, preventive and alternative therapies such as herbs, excellent nutrition and acupuncture are far superior to allopathic medicine (symptom treatment with drugs) and most insurance will not cover these healing modalities

employee turnover is high, perhaps insurance would reduce the rate

Cost to great for employer and employee

Must offer more than just catastrophic plan with large deductibles

This may be the most significant program to SBO's in years--great job!

Do small business have to be below the 185% future to participate?

Our program is a government funded program; however, we are not classified as government employees. Our program contracts with the state to provide title III Older Americans Act services (including home delivered meals and congregate meals) so individuals age 60 and older in Cotton, Jefferson, and Tillman counties. Even though our program has 27 employees (too many for the 25 employee limit but much less than 50 here is the breakdown in the # of hours and employees. 4 employees, 10 hours/wk, 20 employees, 15-25 hours/wk; 3 employees 30-40 hrs/wk.

thank you for attempting this program

we need assistance. No one on our staff has insurance yet everyone works 40 hrs/ week. We cannot afford the premiums when take home pay is already so low.

we could be more responsible with a significant subsidy

with skyrocketing premiums, how long can small businesses keep this up?

See attached letter for comments from this business (lengthy comments)

self-employed---how can this work?? What if you work for a large company that wants to cut your benefits or do away with them all together and you make less than 20,000. Is that person eligible to get these benefits?

Offering insurance makes us a better Oklahoma based company, what a leading edge concept--GO OK GO!

raise minimum qualifications

cost has always been the only hold up in offering health insurance. As a small business, I can offer a 401K program much cheaper than I can health insurance. I've always thought that is wrong. I would also be interested in help with a medical savings plan if that is the state's only option.

See attached letter

I wish new small companies could have this insurance without any income brackets.

we desperately need this program to continue our health beneifts--Please help!--see attached letter

APPENDIX B. RAW DATA AND COMMENTS

Comments?

I think this is a great idea. The only insurance I currently have is with a $3,000 deductible and doesn't cover anything unless it is catastrophic. It is the only premium rate I can afford.

we need this badly!

please make it possible for us to continue to have health insurance

we have reduced benefits each year due to the increased premiums

if the premium for insurance was lower with our current carrier, our employees would all join us. Due to the high cost, they are unable to. Also due to the increase of the premiums every year, we will have to drop coverage at the end of july, 2005

health insurance is too costly, cannot maintain this benefit unless the costs are brought down

See attached letter

This sounds like a great program

we are very interested in this new health insurance assistance program

Private insurance is too high to afford

If this doesn't start soon, we are going to drop the insurance benefit because it is too expensive. And if the employees have to share 1/2 of the cost, they can't afford to have insurance. Start ASAP please!

We have considered on several occasions about doing away with health insurance completely. The cost is outrageous and the deductible is over $5,000. In my case I've paid these high premiums for a year and the insurance company has never paid out one penny due to the high deductible. Without insurance, I could take the premiums payment and apply them to any medical bills i might incur.

we plan to expand and have at least 1 or 2 employees by 2006

Insurance for 2 employees over 60 is $15,000/yr with a $1500 deductible

This program will help small business and our employees

EE Base often covered under spouses plan

Awesome--make it easy to understand!

medical needs are too high without insurance

This program will be great

can't afford health insurance

I think this is an excellent program. I'm trying to do the right thing by giving my employees insurance. Many businesses that pay more than myself, do not have insurance.

I think this is an excellent program. I'm trying to do the right thing by giving my employees insurance. Many businesses that pay more than myself, do not have insurance.

Hope it works out

this program is needed to help recruit employees for our industry

business is owned and operated by husband and wife (part-time)

I have independent contractors. Would like to offer to them as well. They are self-employed.

Comments?
I think this would be a great program. My husband works on a federally funded job that offers no benefits or insurance. We have carried COBRA insurance for 18 months which has caused us great financial difficulties. Now we are searching for alternatives.
See attached letter, comments too extensive
We're excited about the opportunity to decrease our health care costs. Health premium increases have been out of control for the last several years.
Small businesses and non-profits desperately need sufficient coverage so turnover of staff can be reduced
some have preexisting conditions
I think it is an excellent idea
I would enjoy participating in planning and looking at benefit options
I think this product should be offered to all small businesses, not just low income families of small businesses. **Also see cover of fax sheet for more extensive comments.

APPENDIX C
BIOSKETCHES OF PROJECT STAFF

Garth L. Splinter, M.D., MBA
Division Head, Primary Care Health Policy Division

Dr. Garth Splinter began his post-secondary education at the University of Oklahoma where he majored in industrial engineering, receiving his Bachelor of Science degree in 1974. He then enrolled at Harvard University's business school where he earned his MBA in 1976. He graduated from the Oklahoma University College of Medicine in 1984, with a Doctor of Medicine degree. He completed residency training in family medicine in 1987 and joined the faculty at the Oklahoma University Health Sciences Center (OUHSC) as the Director of the Health Sciences Center for Health Affairs and Rural Health Programs and part-time Medical Director for the Employees Group Insurance Board. Dr. Splinter served as Special Assistant on Health Care Issues to Governor David Walters from 1991–1994. He was also the Chair of the Commission on Oklahoma Health Care and served as Principal Investigator for the Robert Wood Johnson Grant of State Initiatives on Health Care granted to the Governor's office.

In 1994, Dr. Splinter was appointed by the Governor and approved by the Oklahoma Senate as Chief Executive Officer of the newly created Oklahoma Health Care Authority, the agency that oversees Medicaid. During Dr. Splinter's five years as CEO, the Oklahoma Medicaid program was successfully converted to statewide managed care. In 1999, Dr Splinter joined the Department of Family Medicine, University of Oklahoma College of Medicine, as an Associate Professor. From 1999 to 2003, he also served as the Chief Medical Officer of the University Hospitals Trust under a contract with the University. From 2001, to the present he has served as a board member for Ribomed Biotechnologies, Inc., a Phoenix-based startup company. From 2003, to the present he has been the Director of the Primary Care Policy Division in the Department of Family Medicine. In that position, he negotiates and manages health policy studies addressing such issues as Medicaid reform, employee sponsored health care, and issues related to the uninsured and underinsured in Oklahoma. He served as director for previous successfully completed projects for the Oklahoma Health Care Authority including "Its Health Care Not Welfare," the "Oklahoma Voucher System," and the study reported herein. He is currently overseeing studies on the implementation of a premium assistance program for small businesses in Oklahoma.

Laine McCarthy, MLIS
Associate Professor and Writer/Analyst, Primary Care Health Policy Division

Laine McCarthy, MLIS, joined the Department of Family & Preventive Medicine on January 1, 1984 as a Research Assistant. She served as a Senior Administrative Manager and as a Technical Writer before her promotion to the rank of Instructor on January 1, 1995. In June, 1998, Ms. McCarthy was promoted to Clinical Assistant Professor, then in June 2001, she received promotion to Clinical Associate Professor. She has a BA degree in English Education from the University of Arizona-Tucson, and a Masters in Library and Information Studies from the University of Oklahoma-Norman.

During her tenure with the University, Ms. McCarthy has been the recipient of several education and training grants including two grants from the Bureau of Health Professions, Health Research and Services Administration (HRSA), US Department of Health and Human Services. The first grant was awarded in 1992 ($320,000) to establish a library in the Department of Family & Preventive Medicine, and develop and implement a residency curriculum in evidence-based medicine. The second grant, awarded in 1998 ($500,000), established a faculty information technology training program for in-house and community physicians. She has presented the results of these grant programs in several national forums including the Society of Teachers of Family Medicine and the American Academy of Family Physicians. Ms. McCarthy is also the author of numerous manuscripts and books on a variety of topics including primary prevention of microalbuminuria (published in the Journal of Family Practice), writing case reports, medical terminology and evidence-based medicine. She has participated in the design and conduct of numerous successful research projects including the "Its Health Care Not Welfare"

project and the "Oklahoma Voucher System" project for the Oklahoma Health Care Authority in addition to the study reported here. Laine currently serves as writer/analyst for the Division of Primary Care Health Policy and is part of the research team investigating the issues surrounding the implementation of a premium assistance program in Oklahoma.

Sarah D. Hyden
Projects Coordinator, Primary Care Health Policy Division

Sarah Hyden joined the University of Oklahoma Health Sciences Center (OUHSC), Department of Family and Preventive Medicine, Primary Care Health Policy Division as Project Coordinator in May of 2003. She holds a Bachelor of Science degree from Southern Nazarene University. Prior to joining OUHSC, she spent six years in healthcare sales and marketing field, with a focus on outreach and contact management, specifically with physicians and other health practitioners. Sarah Hyden is responsible for supervision of projects within the Primary Care Health Policy Division. Additionally, she ensures all work requirements and time deadlines are met; establishes protocol for completion of grants, contracts and/or Division research and analysis projects. Sarah conducts research projects including presentations, survey administration and data collection to targeted populations throughout Oklahoma and serves as liaison between the Department, the Division and various government and university agencies. She has participated in the design and conduct of numerous successful research projects including "Its Health Care Not Welfare," the "Oklahoma Voucher System," and the performance reporting study reported here for the Oklahoma Health Care Authority. She is currently projects coordinator of the research team investigating the issues surrounding the implementation of a premium assistance program in Oklahoma.

Andrea L. Barker, MPH
Health Policy Analyst, Primary Care Health Policy Division

Andrea Barker is the health policy analyst for the division. Andrea joined the department in August of 2003 after working as a research associate in health policy research at the Oklahoma State Health Sciences Center in Tulsa for two years. She has also served as an independent statistical consultant for various non-profit agencies in Oklahoma. Andrea earned her bachelor's degree from the University of Nebraska in Lincoln in 2000 and completed her Masters of Public Health degree at the University of Oklahoma Health Sciences Center in 2002. Her primary responsibilities for the division are data analysis and statistical reporting. She has experience using statistical tools such as SPSS and MS-Excel and has published several articles on health policy research prior to joining the division.

Denise M. Brown, PHR
Associate Project Coordinator, Primary Care Health Policy Division

Denise Brown has been in the healthcare field since 1974. Denise has been with the University of Oklahoma Health Sciences Center (OUHSC) since 1984 and joined the Department of Family and Preventive Medicine in 1989. Ms. Brown holds a Bachelor of Science degree in Social Work and is a certified Professional in Human Resources. She has an extensive background in human resource, administrative and hospital based management; including patient and employee relations. As Associate Project Coordinator she works closely with the Projects Coordinator to develop mailing lists to strategically cover the state of Oklahoma; schedules and assists with the coordination of discussion groups; attends and provides information for discussion groups; contacts providers and participants to attend discussion groups and reviews project reports. Andrea will be in charge of research and analysis as part of the research team investigating the issues surrounding the implementation of a premium assistance program in Oklahoma.

APPENDIX C
BIOSKETCHES OF PROJECT STAFF

Steven A. Crawford, M.D.
The Christian N. Ramsey, Jr., M.D., Endowed Chair in Family Medicine
Department of Family and Preventive Medicine

Steven A. Crawford, M.D., is the University of Oklahoma, College of Medicine's Christian N. Ramsey, Jr., M.D., Chair in Family Medicine. Dr. Crawford graduated Magna cum laude from Claremont McKenna College in 1975 and from the University of Illinois, College of Medicine in 1979. He completed his residency training at the Waco Family Practice Residency Program in 1982 and a family medicine teaching fellowship, also in Waco, in 1983. Dr. Crawford served as chair of the family medicine department at the Oklahoma City Clinic, a private for-profit, physician-owned, multi-specialty group practice, from 1989 until 1998. He has served as Professor and Chair of the Department of Family and Preventive Medicine since 1999. His prior appointments include Interim Chair, Vice-Chair, Residency Program Director, and Associate Residency Program Director at OU. He has also served as Chief of the Family Medicine Service at the OU Medical Center since 1990 and Chairman of the OU Medical Center Board of Trustees since 2000.

Dr. Crawford has served as the elected president of the Oklahoma County Medical Society in 2002 and served as the president of the Oklahoma Academy of Family Physicians in 1994. He has also served as Chair of the Oklahoma Health Care Authority's Medical Advisory Committee and in many other professional positions over his career.