# IT'S HEALTH CARE, NOT WELFARE

## Attitudes and Opinions of Small Business Owners in Oklahoma Toward Reforms to the Medicaid Health Care Program

Submitted to

The Oklahoma Health Care Authority

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Health Care Not Welfare Project

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# EXECUTIVE SUMMARY

The Oklahoma Health Care Authority (OHCA), on behalf of the State of Oklahoma, is requesting a five-year Medicaid Research and Demonstration Waiver to redesign the current Medicaid program in Oklahoma. The program, It's Health Care Not Welfare, has the overall goal of healthier Oklahomans. The key objectives are:

- Patient Responsibility
- Effective Purchasing
- Acceptable Provider Reimbursement
- Flexible Benefits
- Expanded Eligibility
- Budget Predictability

The Department of Family & Preventive Medicine at the University of Oklahoma Health Sciences Center, has undertaken a series of studies on the impact of reform options on stakeholders – physicians and other health care providers, beneficiaries (uninsured workers and their families), and small business employers. This report describes the level of interest of small business employers (50 employees or less) in participating in the reform options either through a voucher or a buy-in to the current program, in order to provide health coverage to currently uninsured workers.

To determine the level of interest of small business employers in participating in the proposed program, a study was designed and conducted to answer three major questions:

1. *What types of small businesses in Oklahoma currently offer health insurance, and is there any significant demographic difference when compared with businesses that do not offer insurance?*
2. *How many small business employees participate in employer-sponsored insurance (ESI), and are there any significant differences between employees who choose to participate and those who do not?*
3. *What is the likelihood that small businesses will participate in some type of government-sponsored employee benefit program, which could include vouchers, buy-in, or a combination?*

Fifty small business employers statewide participated in this study. After controlling for all demographic variables, including type of business, firm size, years in business, corporate status, education and income level of employees and location, all businesses indicated a willingness to participate in any or all of the reform options (voucher, buy-in). Businesses that currently DO NOT offer coverage were interested at participating regardless of the level of financial support, although most were interested in a jointly funded program to maintain control over program design and implementation. This was true even for employers who expressed a negative opinion of the current Medicaid program or general distrust of government programs.

## METHODS

A 21-item survey was designed and analyzed to answer the three major questions listed above.

Subjects for this study were drawn from the yellow pages, chambers of commerce, trade organizations, community business groups (such

as the Rotary Club), and individual contacts or word of mouth. Only businesses with greater than 50 full-time employees were excluded.* One hundred and fifty surveys were distributed. Fifty (50) completed surveys (33%) were received; 1 was excluded because the company employed over 50 full-time workers. The remaining 49 were entered into a database and analyzed using a standard statistical database program (SPSS).

Comments and opinions of employers were collected during individual and focus-type group discussions. A set of codes for theme and nonverbal communication were developed and entered in a database, and the data were used to enrich the results of the survey.

The discussion process also provided a forum for project staff to educate employers about possible reforms to the Medicaid program that might impact their businesses and their employees. This education endeavor was an important component of this project. Reform options were discussed either individually or in small groups with approximately 175 small business employers in Oklahoma.

## RESULTS

One-half of the small businesses surveyed (25 out of 49) offered health care benefits for their employees. Years in Business is the only variable that impacted whether or not employer-sponsored insurance (ESI) was available. Nationally validated variables predicting ESI, such as corporate status, type of business, urban vs. rural location, had no impact on whether ESI was offered, although in our study, rural businesses were slightly more likely to provide health care benefits than urban businesses.

When asked their opinions on the current Medicaid system to determine their receptiveness to a state-managed health care program, business employers expressed mixed feelings about the current Medicaid program, ranging from slightly positive to very negative with the majority having a slightly negative opinion.

Despite the negative opinions of Medicaid and distrust of government, participants were receptive to a health care benefits package for employees, operated by the state that would include ANY of the reform options discussed – voucher, subsidy or buy-in.

## DISCUSSION

In this study, Years in Business was the only predictor of the offer of employer-sponsored insurance. Companies in business longer (18 years or more) were more likely to offer ESI than newer companies, which indicates a reluctance of employers starting businesses in an age of double-digit increases in health care costs to become involved in the volatile health care marketplace. A program that targets new or start-up companies could have a significant impact on reducing the number of uninsured workers in Oklahoma.

During the 2002-2003 fiscal year, small business employers saw their premium costs increase at a rate of 15.9%, as compared to 13.8% for large companies (those with more than 500 employees). The smallest companies, those with fewer than 50 employees with which this survey is concerned, continue to be the hardest hit. Many smaller companies fear that if they add health care coverage, they would have to drastically increase employee contributions or rescind the benefit altogether in the future.

Of the 49 small business employers who participated in our study, 25 currently offer health care benefits; all 25 stated they would continue to do so over the next year. All study participants were interested in a government subsidy program of some type, especially those who were not currently offering ESI. Though all

* A business with greater than 50 total employees could participate provided the number of full-time workers did not exceed 50. This allowed the inclusion of businesses employing part-time or seasonal workers, who frequently are not offered ESI.

were interested in a government-assisted health care coverage program, the tendency was toward slightly less than 100% premium subsidy indicating that the employers wished to maintain some control over how the benefits program for their businesses was designed and managed.

In addition to cost, trust is a key issue. In small businesses where the bottom line tends to be narrow and dynamic, employers fear 3rd party payers and do not trust the government to administer employee benefits programs.

Despite the negative opinions of Medicaid and distrust of government expressed by participants, statistical analysis of survey responses indicates that Opinion of Medicaid is NOT a factor for likelihood to participate in ANY of the reform options. Among employers not currently offering ESI, a state/federal subsidy was second only to employee retention as a motivation to offer employee health benefits; among employers currently providing health coverage, state or federal was ranked last. This indicates that small businesses without health insurance would be more willing to participate in the reform options than companies that already have a benefits program in place.

## CONCLUSIONS & RECOMMENDATIONS

### *Study Conclusions*

- Companies in business longer than 18 years were significantly more likely to offer ESI than younger companies perhaps due to the volatility of the health care marketplace.
- No other demographic variable (firm size, location, income and education level, etc.) was significantly associated with ESI.
- All businesses surveyed expressed interest in some type subsidy program provided they could maintain some financial control over the program than businesses not offering ESI. Any program likely to be well received despite the overall distrust of government in general and Medicaid in particular.

### *Recommendations*

A public relations and educational effort aimed at informing small business employers about health care costs and benefits would be helpful in achieving buy-in to any reform program. Incentives to make offering benefits reasonable, attractive and practical from a business perspective would be critical for the success of any reform program.

Major issues for employers are:

- profit margin
- cash reserves
- administrative burden
- impact of having to rescind benefits or increase employee contribution in the future
- A mistrust of government and government-sponsored programs.

Incentives could take the form of:

- tax deductions
- vouchers and buy-in were equally acceptable
- administrative assistance
- stop-gap measures to protect and stabilize employee benefit programs
- employer participation in the design and implementation of the program.

### *Limitations of this Study*

Accessing this group proved difficult owing partly to a distrust of government intervention and perhaps, partly to business employers not wanting to discuss the fact that they do not offer health care benefits, an opinion expressed by one owner who was willing to talk with us. Although the demographics of this study are roughly representative of small businesses in Oklahoma and the US, the small sample size limits the generalizability of the results. Larger scale studies with this population would be necessary to insure the validity of these findings.

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# IT'S HEALTH CARE NOT WELFARE

## Attitudes and Opinions of Small Business Employers in Oklahoma Toward Reforms to the Medicaid Health Care Program

## ABSTRACT


The Oklahoma Health Care Authority (OHCA), on behalf of the State of Oklahoma, under the authority of Sec. 1115 of the Social Security Act, is requesting a five-year Medicaid Research and Demonstration Waiver to redesign the current Medicaid program in Oklahoma. The reform options would extend Medicaid coverage to working adults and families with incomes up to 200% of the federal poverty level (FPL) (Figure 1). (The federal poverty for a family of four is $18,300; 200% of FPL would be approximately $37,000 for a family of four, see Figure 2.) Figure 1 shows the eligibility criteria for current beneficiaries and for the expansion group (Uninsured). Required co-payments, co-insurance, deductibles and one-time enrollment fees, collected on a sliding scale, based on income, are being considered for this group to extend financial viability of the program and create greater beneficiary responsibility for their health care. Small businesses (50 employees or less), less than half of which offer health coverage to employees in Oklahoma, [1, 2] would be offered incentives, such as vouchers (cash payments to businesses or individuals) or buy-in (the opportunity for an employer, employee or individual to participate in the current Medicaid program), to participate in providing health coverage to currently uninsured workers.

The study reported here was conducted by faculty and staff at the University of Oklahoma Health Sciences Center Department of Family & Preventive Medicine to discover the attitudes and opinions of small business employers in Oklahoma toward reforms to the current Medicaid program that might affect their employees. Three major questions were posed:


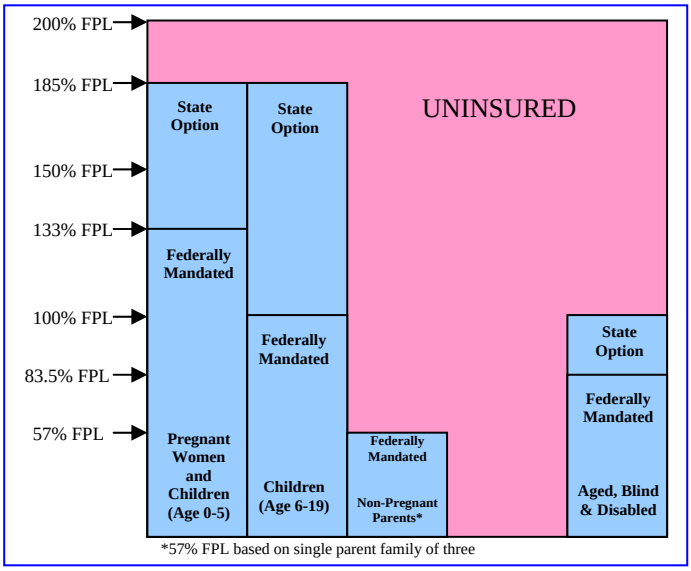


Figure 1. Current and Expansion Medicaid Eligibility

1. What types of small businesses in Oklahoma currently offer health insurance, and is there any significant demographic difference when compared to those businesses that do not offer insurance?
2. How many small business employees participate in current employer-sponsored insurance (ESI) programs and are there any significant differences between employees who choose to participate and those who do not?
3. What is the likelihood that small businesses will participate in some type of state-sponsored employee benefit program, which could include vouchers, buy-in, or some combination?

Surveys were distributed to 150 small business employers statewide; 50 completed surveys were returned. One was excluded because the company employed greater than 50 full-time employees. Focus- type small group or one-on-one discussions were held with approximately 175 employers across the state to enrich the qualitative survey data.

Years in business was the only significant predictor of an employer-sponsored insurance program. Older businesses (18 years or more) were significantly more likely to have an ESI in force than younger companies, which indicates hesitancy on the part of individuals starting companies to become involved in the volatile healthcare marketplace. A program that targets newer or start-up companies could have a significant impact on the number of uninsured workers in Oklahoma.

Among employers not currently offering ESI, a state/federal subsidy was second only to employee retention as a motivation to offer employee health benefits; among employers currently providing health coverage, state or federal was ranked last. This indicates that small businesses without health insurance would be more willing to participate in the reform options than companies that already have a benefits program in place.

| Family Size | Annual (Monthly) Income | | | |
|---|---|---|---|---|
| | 100% | 133% | 185% | 200% |
| 1 | $8,980 | $11,943 | $16,613 | $17,960 |
| | ($748) | ($995) | ($1,384) | ($1,497) |
| 2 | $12,120 | $16,120 | $22,422 | $24,240 |
| | ($1,010) | ($1,343) | ($1,869) | ($2,020) |
| 3 | $15,260 | $20,296 | $28,231 | $30,520 |
| | ($1,272) | ($1,691) | ($2,353) | ($2,543) |
| 4 | $18,400 | $24,472 | $34,040 | $36,800 |
| | ($1,533) | ($2,039) | ($2,837) | ($3,067) |
| 5 | $21,540 | $28,648 | $39,849 | $43,080 |
| | ($1,795) | ($2,387) | ($3,321) | ($3,590) |
| 6 | $24,680 | $32,824 | $45,658 | $49,360 |
| | ($2,057) | ($2,735) | ($3,805) | ($4,113) |

**Figure 2**. Current Federal Poverty Levels Based on Family Size and Income*

*Source: Oklahoma Health Care Authority.

# INTRODUCTION

The United States loses from $65 billion to $130 billion annually when people who are uninsured get sick and/or die early, according to an Institute of Medicine report released in 2003. The report found that it would cost less to "simply insure" the approximately 41 million Americans who now lack health insurance. [3]

Most Americans with coverage receive health insurance benefits through their employer or through a spouse or family members' employer, but an estimated 18.5 percent of healthy adults between the ages of 18 and 65 have no coverage at all. Many of these individuals are working or able and looking for work, and the number of uninsured working adults is increasing. [2, 4] Many, too, are family members of workers who have coverage through their employer but cannot afford the premiums for family coverage.* Premium costs for small business employers rose at an alarming 15.5% during 2002 (compared to 13.8% for large companies). [5]

When the economy slumps, the number of employers offering affordable health insurance decreases as does the number of workers who are willing or able to purchase insurance either through their employer or through a government or private source. However, according to a study released recently by State University of New York-Stony Brook's Center for Survey Research, during a poor economy the number of workers who would take a lesser paying job for one that offers benefits increases [6] That study found that 71 percent of non-retired, working adults would choose a lower salary with health benefits, a 180-degree change from a study by the National Center for Health Statistics, which reported data for 1992. [2]

Oklahoma, and other Midwestern states, saw health care premiums rise at a rate of 13.8 percent, second only to western states, according to the Kaiser Family Foundation. [5] Most employers blame increased prescription drug costs and rising hospital costs for the increases, although profit-taking by insurers is a major contributor as well.

According to the Physicians' Working Group on Single-Payer National Health Insurance and other national studies, the U.S. spends $41 billion to provide coverage for the uninsured. [7] In addition, the uninsured are four times more likely to require costly emergency room or hospital care, a significant portion of the $41 billion. A recent Associated Press article noted, however, that emergency room use was on the rise for insured individuals as well as the uninsured, which drives the costs of health care even higher. Lack of access to physicians on a timely basis was speculated as one reason for the increase in ER use by the insured. [8]

Another recent Associated Press article reported that more Americans are losing their jobs, and thus any benefits that may have been associated with their employment. [9] And the rate may be even worse than the headlines suggest. Six point one (6.1) percent of (8.9 million) Americans looking for work are unable to find employment, according to August 2003 Department of Labor statistics.[10] Last year, the economy sent an additional 1.4 million people

* The average annual premium cost for a family of four in 2002 was about $9,100. (Source: Oklahoma Health Care Authority)

into poverty; half of these are children. In 2002, 12.4 percent of the population or 34.8 million people lived in poverty, up from 12.1 percent for the preceding year. Equally disturbing is that income is rising at a barely perceptible rate, below 4 percent. [11] The average American saw their paycheck increase by only $51 last year. A record number of those who are employed (48.9 percent) say they are dissatisfied with their jobs. Oklahomans are among the most dissatisfied, with a 55 percent dissatisfaction rate. [12] This precarious economic situation has an equally precarious and dangerous side-effect: fewer and fewer Americans have access to or can afford health care coverage.

In Oklahoma, the economy has remained relatively stable over the past year. The Oklahoma Employment Security Commission reported a slight variation among job sectors but overall, the number of new jobs created between May 2002 and May 2003 was equivalent to the number of jobs lost over that period of time. [13] Yet the number of uninsured Oklahomans has increased to 650,000, 200,000 of whom are children.

Only 38 percent of small businesses offer health insurance to their employees.[1, 2, 14] The most commonly cited reason for not providing employer-sponsored insurance (ESI) is cost. Employers worry that the expense of premiums will adversely impact their profitability, especially during economic downturns. Premiums costs are too variable, and employers fear having to take coverage away coverage in the future or raise the employee-share of premiums.*

National studies report that low-wage workers, those in temporary or part-time positions, and those in seasonal occupations such as construction and agriculture, tend not to subscribe to ESI (even if some or all of the premium is paid by the employer) unless they have a specific need (familial illness, married with no insurance through their spouse's work, children not eligible for government sponsored health care).[2, 4] (In fact, only 19 percent of companies with fewer than 50 employees that offered ESI, offered coverage to part-time employees.)[14] Low subscription rates by employees mean a smaller risk pool and increased premium costs for employers.

With the current cost of health insurance averaging approximately $9,100 per year for a family, employers and employees alike find it difficult to afford coverage. The average monthly cost, as reported by the Kaiser Family Foundation in a report issued in September, 2003, is $42 for an individual and $201 for a family, an annualized out-of-pocket expense of $504 for single coverage, and $2,412 for family coverage, up approximately 16 percent from the previous year. [5] Small business employers experienced a 15.5 percent across the board increase in insurance premiums (compared to 13.8 percent for large firms). These increases have a significant impact on the profitability and viability of the company.

The NEHIS study reported in 1997 that in smaller firms, especially among lower-wage workers, 54 percent of workers preferred higher wages to employer-sponsored health insurance.[2] A recent study conducted by the University of New York at Stony Brook's Center for Survey Research, however, indicated that employee attitudes are changing. Seventy-one percent (615) of the 865 adults surveyed said they would choose a lower-paying job to get health benefits while only 24 percent (206) said they would prefer no coverage and higher wages. Workers surveyed also stated that more paid leave would make them feel healthier and more were concerned about losing coverage in coming year. [15]

Large national studies have reported that company size is the number one predictor of whether or not a business offers ESI. The National Employer-Sponsored Health Insurance Survey (NEHIS), conducted in 1993, found that

* Nationally, the most commonly offered employee benefit was paid time off.[12]

employer-sponsored insurance rates increased dramatically with firm size. Only 33 percent of firms with 10 employees or fewer offered health benefits compared to 67 percent of firms with from 10-24 employees, 83 percent of firms with 25-99 employees and 96 percent of firms with 100 employees or more.[2]

Oklahoma was among ten states studied in a 1993 employer-based health insurance survey conducted by the Robert Wood Johnson Foundation. [1, 2] In that study, the characteristics of businesses in Oklahoma were similar to those of the other nine states with regard to businesses offering health benefits. Larger businesses tended to offer coverage more than smaller businesses; the longer a business has been operative predicts whether or not health care benefits are offered, and so forth.

To gather current information about the characteristics of small businesses in Oklahoma and to determine the receptiveness of small business employers to reforms to Medicaid that would expand health care coverage to low income workers, three specific study questions were developed:

1. What types of small businesses in Oklahoma currently offer health insurance, and is there any significant demographic difference when these businesses are compared to those that do not offer insurance?
2. How many small business employees participate in employer-sponsored insurance programs, and are there any significant differences between employees who choose to participate and those who do not?
3. What is the likelihood that small businesses in Oklahoma will participate in some type of state-sponsored employee benefit program, which could include vouchers, buy-in, or some combination?

Survey instruments were distributed to 150 small business employers statewide from July 2003 to October 2003. Program staff made presentations to or held discussions or focus groups with approximately 175-200 employers to describe the reform options and to delve more deeply into their attitudes and opinions about the possibility of a state-sponsored health care program for low income workers.

Educating employers about issues affecting health care in Oklahoma as it impacts the state, the business climate and the workers, and the goals of a state government-sponsored insurance program for low-income workers was a secondary goal of this project. Gathering employer attitudes and opinions of a possible state program for coverage required that employers be informed about the current status of health care in Oklahoma, and the consequences of not providing accessible and reasonable health care for the working poor.

This report presents the results of a 21-item survey instrument and the qualitative data from discussions with small business employers in Oklahoma. The current status of employer-sponsored insurance (ESI) among these businesses is described as are the characteristics of the study sample. We report here on employers' receptiveness to a government-supported health coverage program, and attitudes and opinions about the types of programs they feel would be most beneficial for their business and for their employees.

# METHODS

## *Subjects*

**Table 1.** Number of Businesses in Our Sample by Type of Business*

| Industry | Our Sample |
|---|---|
| Agri, forestry, fishing, hunting | |
| Mining | |
| Utilities | 1 |
| Construction | |
| Manufacturing | 2 |
| Wholesale trade | 2 |
| Retail trade | 7 |
| Transportation, warehousing | |
| Information | |
| Finance, insurance | 6 |
| Real estate | |
| Professional, scientific, technical | 2 |
| Mgmt of companies, enterprises | 1 |
| Admin., support, waste mgmt, remedial services | |
| Educational services | 1 |
| Health care, social assistance | 12 |
| Arts, entertainment and recreation | |
| Accommodation and food services | 6 |
| Other services | 7 |
| Unknown | 2 |
| Total | 49 |

*Business types are from the U.S. Department of Commerce

Subjects in this study were owners (or owner representatives, e.g., managers, operating officers, etc., who could speak for owners) of small businesses (50 employees or less) throughout Oklahoma. The types of businesses participating in this study are shown in Table 1. Subjects for this study were drawn from the yellow pages, chambers of commerce, trade organizations (such as Pharmacy Providers of Oklahoma), community business groups (such as the Rotary Club), and individual recommendations and contacts.

A 21-item survey was designed to solicit demographic data about small businesses, and employers' attitudes and opinions concerning a statewide health insurance benefits package for low-income workers and their families. A copy of the survey is included in Appendix A. A letter to different employer groups was included with mailed surveys (Appendix B).

In addition, a brief document describing the current status of health care coverage for individuals who are neither eligible for state or federal programs nor can afford to purchase coverage either on their own or through their employer was developed (Appendix C). These materials were mailed or hand-delivered to approximately 150 businesses in across the state. Figure 3 shows the location of businesses in this study. A total of 50 small business employers responded to this survey; 49 valid surveys were analyzed; one survey was excluded because the company employed over 50 people.

The types of businesses represented in our sample are roughly similar to the fix of business types in Oklahoma and in the U.S., according to data from the U.S. Department of Commerce (see Figures 4a, 4b, and 4c below), although there are a disproportionate number of health care employers represented. This bias is due to the number of small business contacts associated with the health care industry with which we were familiar. This study is about health care and small businesses associated with this sector were more likely to respond. We acknowledge that this is a limitation of the study. However, no single demographic characteristic had a significant impact upon the answers to the major questions of this study.

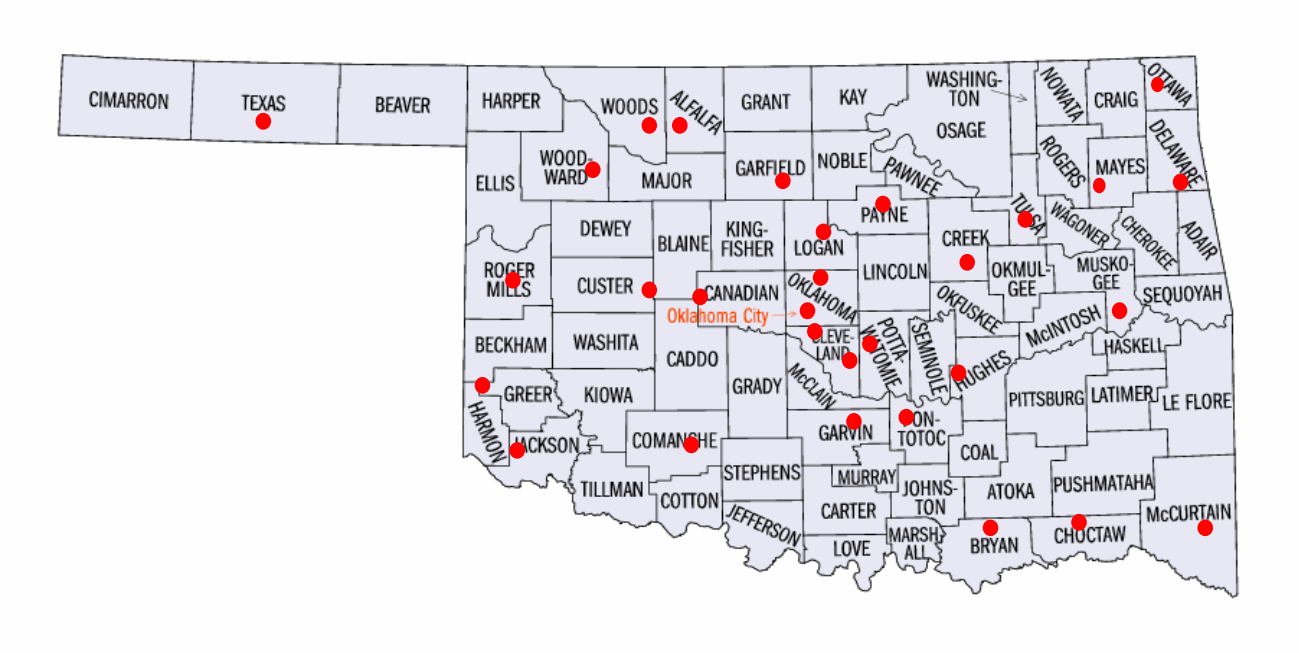


**Figure 3.** Locations of Small Business Owner Participants in Oklahoma

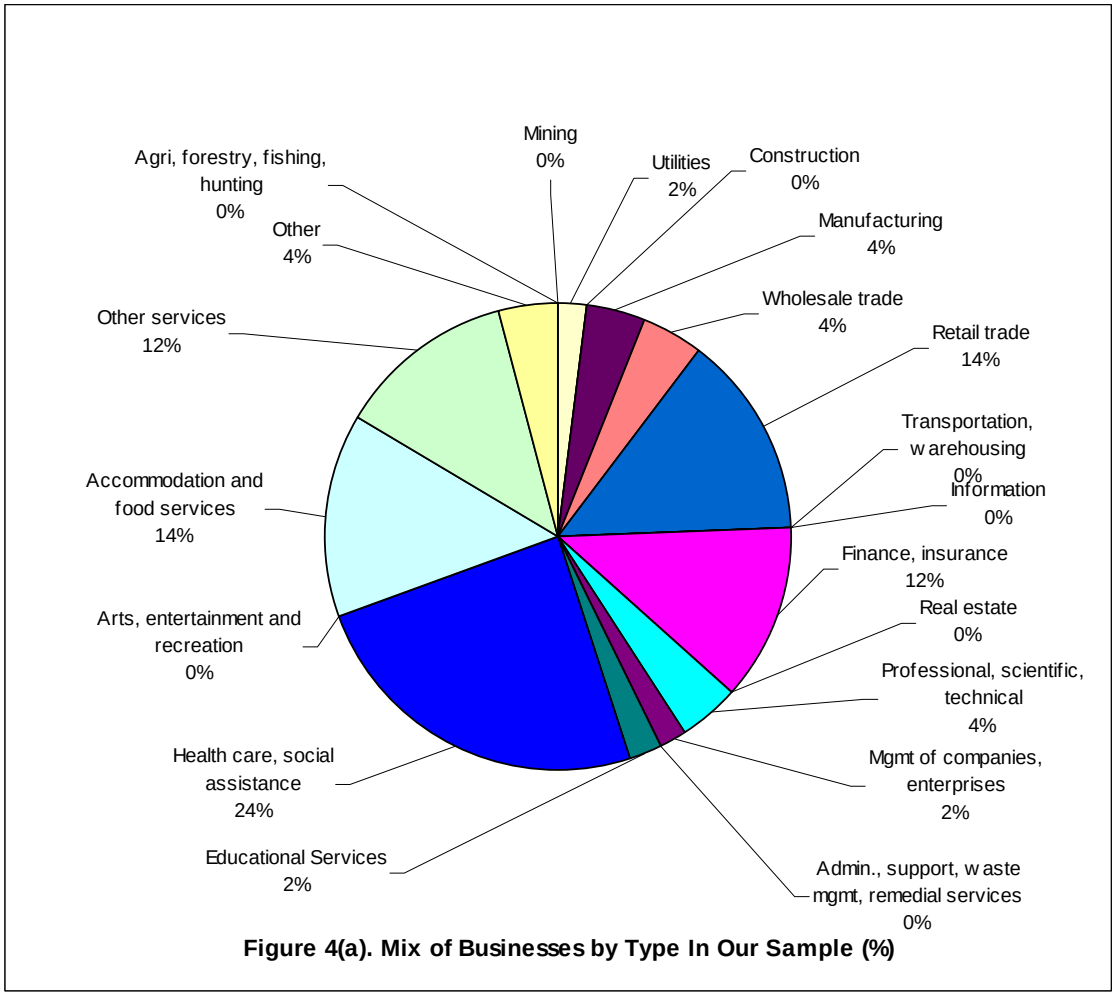


**Figure 4(a). Mix of Businesses by Type In Our Sample (%)**

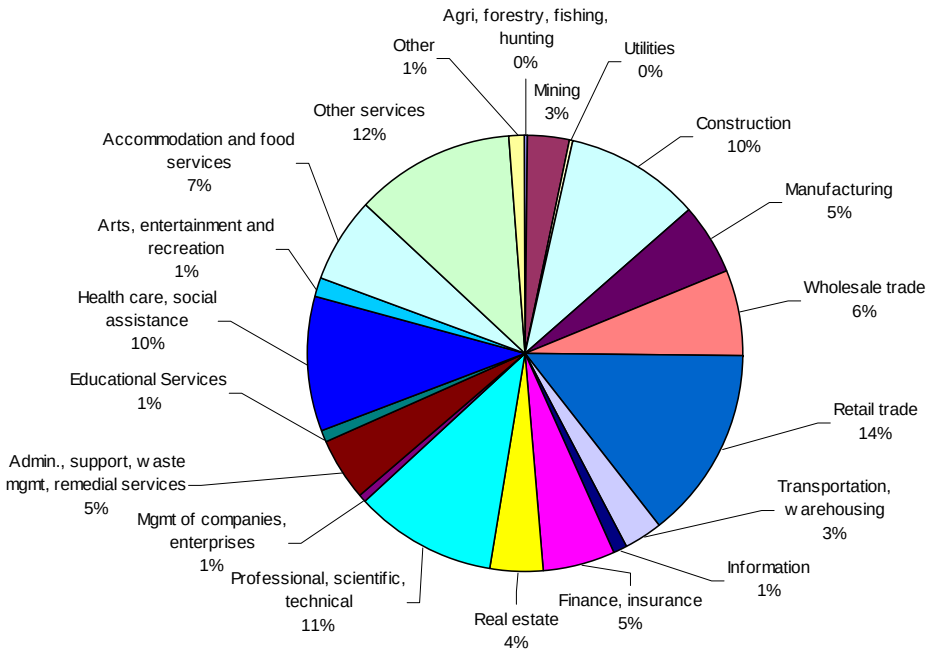


**Figure 4(b). Mix of Business Types in Oklahoma (%)**

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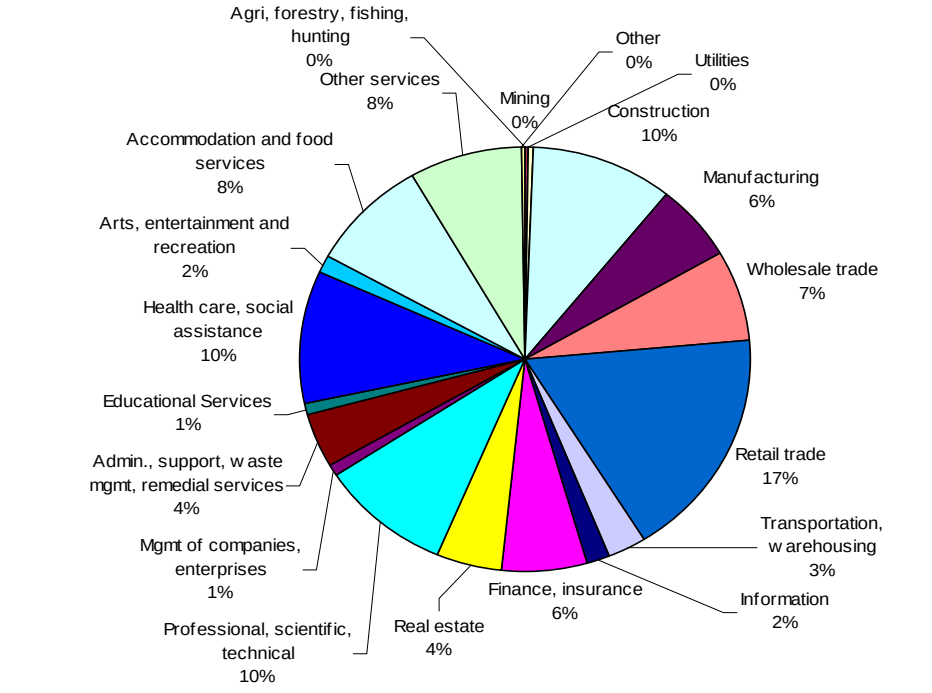



**4(c). Mix of Business Types in the U.S. (%)**

Source: U.S. Department of Commerce.

In all, project staff spoke to over 175 small business employers in a variety of forums – individually, small group focus type discussions and larger meetings such as Rotary Clubs. One-hundred fifty (150) surveys were distributed and 50 (33%) were completed, of which 49 were useable.

### *Instruments*

A 21-item survey instrument (Appendix A) was designed to gather demographic data about each business and to explore each employer's attitudes and opinions about a Medicaid reform program.

In addition to collecting quantitative data from surveys, program staff made presentations and held one-on-one or small focus-type group discussions with employers to educate them about the health care issues and reform options, and to gather qualitative data regard employer-sponsored health care. A Facilitator's Guide for Small Business Employer Groups (Appendix D), which includes how the groups should be conducted, introductory remarks and additional questions, ice breakers, etc. was developed and utilized at group sessions. A Small Group Checklist (Appendix E) was developed to assist in the planning and organization of group sessions.

Consent forms were developed in accordance with University of Oklahoma Health Science Center (OUHSC) human subjects protection policies. All instruments and overall project methodology were submitted to the OUHSC's Institutional Review Board (IRB) for approval. The project received exempt status from the OUHSC IRB in July 2003. Because of the exemption, consent forms to participate in this study were not required.

## *Individual Interviews and Small Groups*

As described above, small business employers were given the opportunity to discuss health care issues, including government-sponsored health insurance and Medicaid reforms with program staff one-on-one or in small focus-type group sessions. Small groups were conducted according to a Facilitator's Guide (Appendix D) and using traditionally and well-publicized methods.[4] Preplanning was accomplished using a Small Group Checklist (Appendix E) developed by project staff.

Discussions were conducted with approximately 175 employers across Oklahoma (see Figure 3). All group discussions were led by a facilitator and often by an assistant facilitator. The facilitator was responsible for guiding the session, asking questions, and probing for clarification. Both the facilitator and the assistant facilitator took notes to assure that pertinent comments, attitudes and opinions were recorded accurately. Notes from the facilitator(s) were transcribed, coded for theme and nonverbal communication, and entered into an Excel spreadsheet for interpretation.

It was determined, based on pilot sessions, that audio- and/or video-recording of sessions would adversely impact the honesty of the participants' responses. Participants were much less inhibited by an individual taking notes. Although this reduced somewhat the ability of the staff to gather information, the comfort of the participants and their willingness to be honest about the topic were deemed more important. Because the purpose of the report is to provide honest attitudes and opinions rather than actual verbal and nonverbal data, note-taking was adopted for information gathering. We acknowledge that this is a limitation of this study and discuss this further under the Limitations of This Study section in the Results below.

## *Data Analysis*

Data from the survey was entered into an Access database to be organized and refined. Clean data was then analyzed using a standard statistical software program (SPSS). Pearson correlations, significance, and case summaries were run and the findings are reported in the Results section. Raw data can be found in Appendix G.

Qualitative data, collected by observers and coded by theme and nonverbal communication, were entered into an Excel spreadsheet and analyzed by project staff. Data from that analysis is described in the Results section. Appendix F is a copy of the Excel spreadsheet of small business employer comments.

# EDUCATIONAL ENDEAVORS

A significant education endeavor was included in this study. A document (Appendix C) describing the current crisis in health care in Oklahoma was developed and goals of a possible Medicaid reform program were elucidated. Businesses were informed of the epidemic of uninsured and underinsured Oklahomans – 650,000 Oklahomans have no coverage, 450,000 are able-bodied adults who are either employed, looking for work, or employable, and 200,000 are children – and of the impact the uninsured and underinsured have on the economy as a whole and on rising costs of health care in particular. Oklahoma, and other Midwestern states, saw health care premiums rise at a rate of 13.8%, second only to western states, according to the Kaiser Family Foundation. [5] Most employers blame increased prescription drug costs and rising hospital costs for the increases, although profit-taking by insurers is a major contributor as well.

According to the Physicians' Working Group on Single-Payer National Health Insurance and other national studies, the U.S. spends $41 billion to provide coverage for the uninsured. [7] In addition, the uninsured are four times more likely to require costly emergency room or hospital care, a significant portion of the $41 billion. Uninsured women are more likely to die from breast cancer than insured women, and the uninsured in general tend to get sicker and die earlier than those with health coverage.

Educating employers about these cost shifting issues, and with the goals of the Medicaid reform options covering low-income workers and their families was an important part of the methodology of this project. Small business employers need to make informed choices about health care for their workers and their businesses, and make a meaningful contribution to the design and implementation of any health care program that could impact their business and their employees.

The small focus-type group discussion process provided a forum for project staff to educate employers about the Medicaid reform options. Project staff made formal and informal presentations to business and trade groups such at the Rotary Clubs, Oklahoma Hospital Association and Health Care Coordinators of Oklahoma. Over 200 small business owners from a variety of business types (see Table 1) attended these presentations.

Comments and feelings from these meetings were noted by facilitators and entered into an Excel spreadsheet to enrich the quantitative data collected (see Appendix F).

# RESULTS

A total of 50 small business owners completed the 21-item survey; 49 surveys were validated and analyzed as described below. One survey was eliminated, as mentioned above, because the company employed more than 50 full-time individuals. Data about the current status of employer-sponsored insurance (ESI) and employers' attitudes and opinions of a potential state-sponsored program for low income workers and their families was analyzed as follows:

(1) **Raw quantitative data** from the 21-item survey was organized and entered into a Microsoft Access database. The resulting data was then analyzed using a standard statistical software program (SPSS). The raw data are included with this report in Appendix G. Comparisons were made among business characteristics to discover whether any variable (e.g., firm size, years in business, corporate status) had a statistically significant impact on whether a business was likely to offer ESI or participate in a state-sponsored program.

(2) **Qualitative data** (comments, opinions, and nonverbal communication) collected by the facilitator(s) as notes and observations from individual and group meetings were entered into an Excel spreadsheet. A code representing general themes of the discussions was developed (see Appendix F) and responses were coded by program staff.

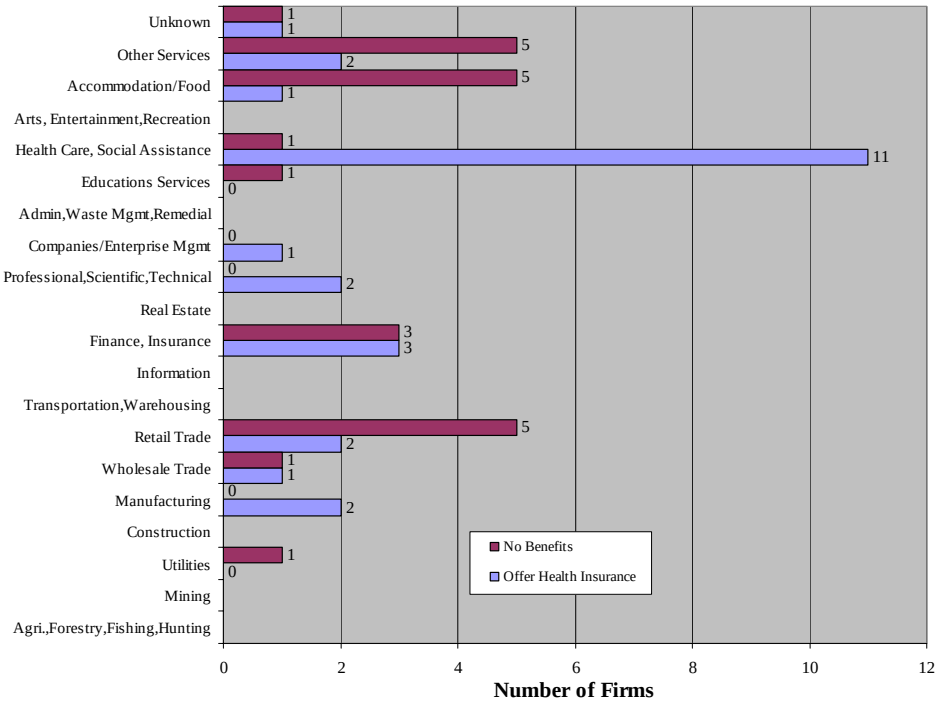



**Figure 5. Businesses Offering Health Benefits by Type of Firm**

## *Demographic Variables*

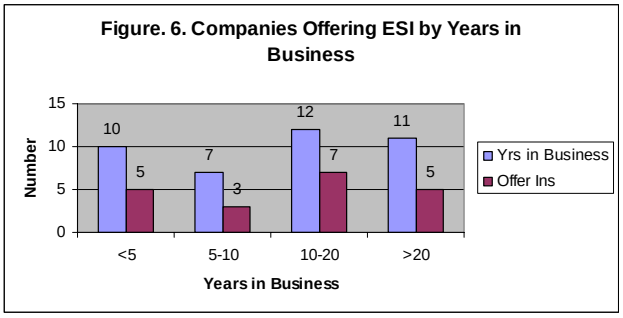
### *1. Type of Business and Whether Health Insurance is Offered*

As described under Methods (above) and depicted in Figures 4a, b, and c, the types of businesses included here are roughly representative of the mix of business types in Oklahoma. Figure 5 shows the number of responses for each of the small business types and the number and percent of small businesses that offer health insurance by business type. Of the 49 respondents to our survey, 25 (51%) of respondents offer health insurance.

The health care industry is slightly more heavily represented here, and provided ESI at the highest rate. The high representation is due to two factors: (1) Our project staff are associated with the health care industry and have many contacts in health care, and (2) the health care industry has a two-fold stake in the outcome of this project; first, as the employer of 700,000 Oklahomans, many of whom are without coverage, and second, as providers of health care. In this study, businesses associated with health care provided ESI at a very high rate (11 of 12 or 92%).

In general, however, business type was not significantly associated with likelihood to participate in the reform option program.

### *2. Years in Business*




The number of years a firm has been in business was significantly associated with the likelihood to offer ESI (p=.036). The mean number of years in business for firms in our study offering coverage is 27.8 years; the median is 18.0 years. The mean years in business for firms not offering some type of health care coverage is 13.4 years; the median is 7.5 years.

### *3. Corporate Status*

Most businesses in our study (32 of 49 or 65%) (Figure 7) were incorporated, which differs from national study data. [2]

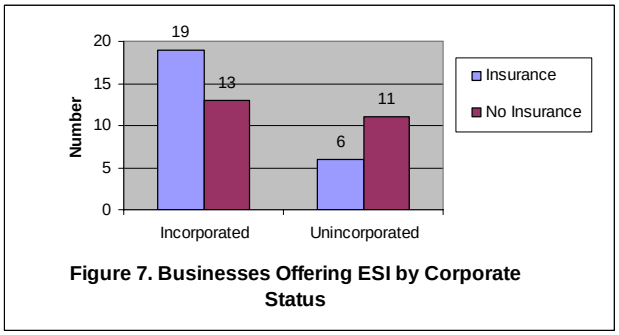



**Figure 7. Businesses Offering ESI by Corporate Status**

Incorporated businesses were more likely than unincorporated businesses to offer ESI but the difference was not statistically different. Corporate status had no impact on whether a business would be likely to participate in a state health care program.

### *4. Number and Location (Urban, Rural or Both) of Establishments**

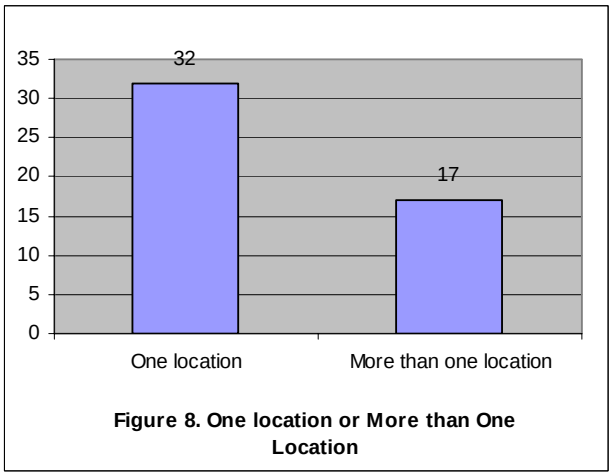



**Figure 8. One location or More than One Location**

* An establishment is defined as a single business location; a firm is defined as the entire company. A firm many have more than on establishment.

Most national studies report that the number of business locations (or establishments) predicts ESI. Figure 8 shows the number of businesses in our study with one location compared to those with more than one location.

Thirty-seven employers responded to this question; 10 (27%) had businesses in urban areas; 24 (65%) had businesses in rural areas; and 3 (8%) had establishments in urban and rural areas. Twelve (12) respondents did not answer this question, which may due to the wording of the question (see Appendix A).

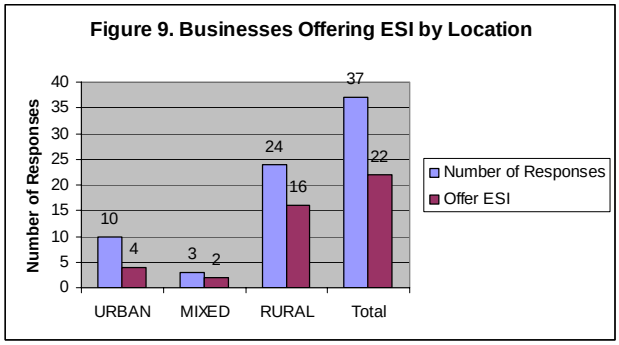



Figure 9 shows the total number of businesses with urban locations, rural locations or both compared to those offering ESI. Although not statistically significant, the businesses with rural locations tended to offer ESI at a slightly higher rate than businesses with only urban locations. This reflects the individuals who responded to our survey and may not be representative of all businesses in Oklahoma. Larger studies would be needed to determine if urban, rural or a combination of urban/rural location has a true impact on the likelihood to offer employer-sponsored insurance, especially given national studies demonstrating that urban establishments tend to offer ESI at a higher rather than rural establishments. [2, 4, 5]

### *5. Firm Size (Number of Employees)*

Most of the firms in this study had fewer than 10 employees (both full- and/or part-time) as shown in Figure 10. Of the 49 respondents, 39 had fewer than 10 employees; 8 employed from 10-25 employees, and 2 employed more than 25.

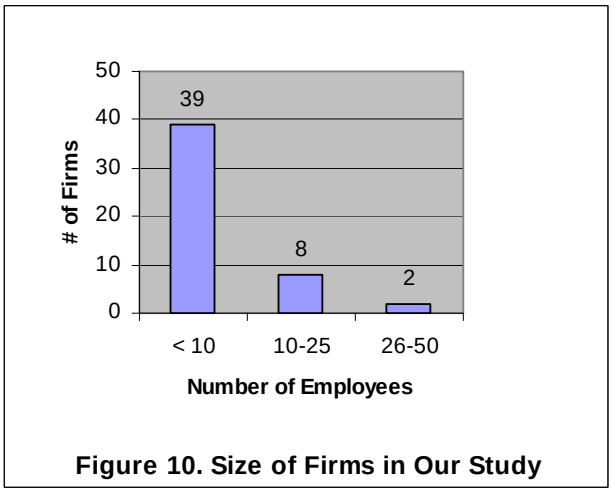



**Figure 10. Size of Firms in Our Study**

In most national studies, firm size is a standard predictor of ESI. [2, 4, 5] National definitions, however, usually group all firms with fewer then 50 employees into one category. In this study, the difference in the availability between small firms (10 employees or less) and the larger firms studies was not statistically significant (Figure 11). Firm size did not predict the likelihood that the employer would participate in the reform option program.

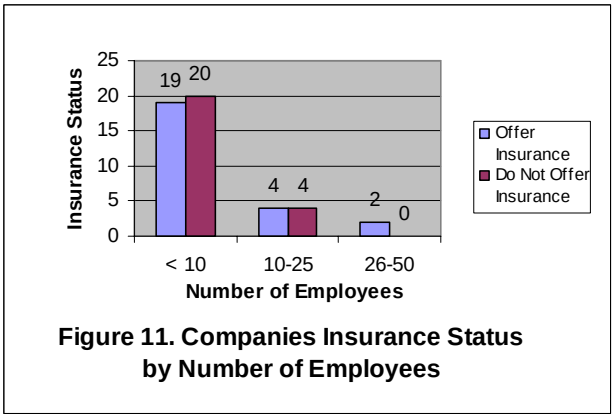
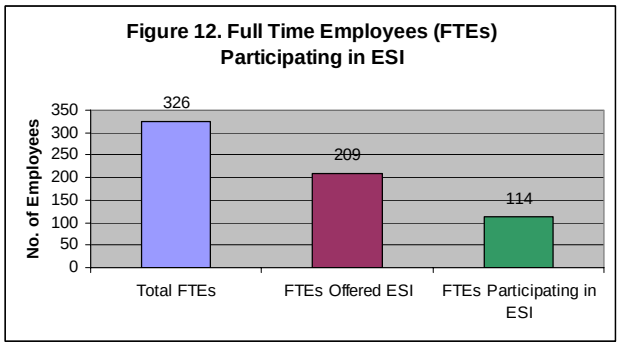



**Figure 11. Companies Insurance Status by Number of Employees**

Twenty-five of 49 businesses reported in this study offer some type health insurance benefit to their employees; 12 out of 13 (92.3%) pay for some or all of the employee portion of the premium. These businesses employ a total of

326 individuals, 209 of whom are full time and the remainder are part-time or seasonal. Even though all employers but one paid all or a major portion of the premium for full time employees, only 114 of 209 employees (54.5%) participated in health insurance through their employer. This study did not investigate the degree to which employees who participated in ESI covered their families through their employer as well. Future studies are planned to look at this issue.




Though businesses offering ESI often made the benefit package available to part-time employees, our study was not able to differentiate between employees who participated in ESI and those who did not by FTE. This study did not investigate the participation of part-time employees in ESI. Therefore, we have not included data for part-time employees in this study. Nationally, most small businesses that pay all or a portion of the employee premium tended not to provide that benefit for part-time employees. [2, 4, 5] Since a large number of the uninsured workers in the U.S. are probably part-time or seasonal workers, a study of the economic and financial impacts of insuring part-time workers would provide useful data for policymakers and stakeholders.

### *6. Education Level*

Education level of employees is a standard predictor of ESI. As the amount of education necessary to work in a business increases, the likelihood that the employer will offer a richer employee benefits package to attract high quality workers tends to increase as well. [2, 16]

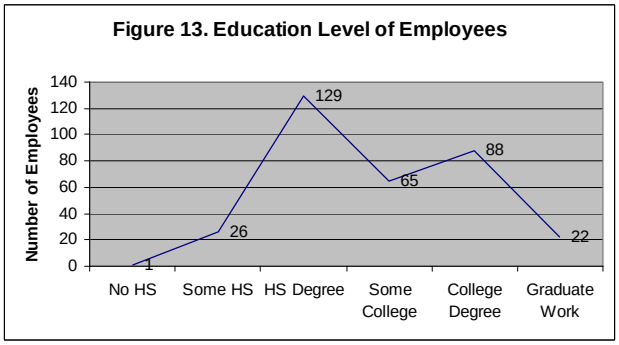



**Table 2**. Tendency to Offer ESI by Education Level of Employees

| | Education Level | |
|---|---|---|
| Offer ESI | Mean | Median |
| No | 3.75 | 3.4 |
| Yes | 4.09 | 4.0 |

Thirty-six (73.5%) employers responded to the question concerning the level of education required of employees in their business. A weighted education level index was generated using the number of employees for each education level: No High School = 1, Some High School = 2, High School Degree or GED = 3, Some College = 4, College Graduate = 5 and Graduate Work = 6) (Table 2). Businesses with a higher level of education (mean = 4.09 or some college) among their employees were somewhat more likely to offer ESI but the results were not statistically significant. This coincides with results from national studies.[2, 4, 5] Education level was not a significant predictor of whether an employer was likely to participate in the reform option program.

### *7. Income Level*

Income level of employees is another predictor of employer-sponsored health insurance. As the income of employees in a business increases, the likelihood that the employer will offer a

more robust employee benefits package for workers tends to increase as well.[2,15] During times of economic affluence, workers tend to prefer pay increases to richer benefits packages. However, during economic downturns, workers state they would accept lower pay to have a job with health insurance coverage. [4]

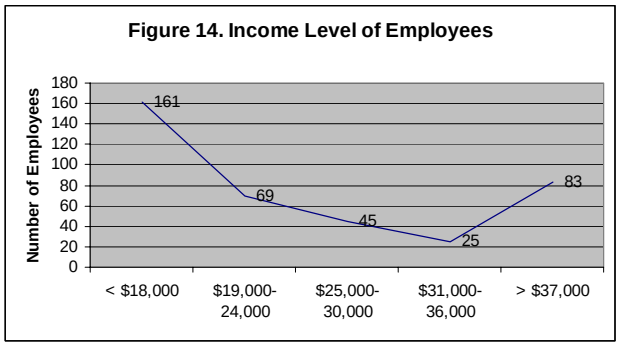



**Table 3.** Tendency to Offer ESI by Income Level of Employees

| | Income Level | |
|---|---|---|
| Offer ESI | Mean | Median |
| No | $22,000 | $22,900 |
| Yes | $26,000 | $26,000 |

Forty-three (87.8%) employers responded to the question concerning income level of employees in their business. A weighted income level index was generated using the number of employees for each education level (Table 3). Businesses with a higher income level (mean = $26,000) among their employees were somewhat more likely to offer ESI but the results were not statistically significant. This coincides with results from national studies.[2,4,6] However, income level was not a predictor of whether an employer was likely to participate in the reform option program.

## *ESI Offer and Participation Levels*

Twenty-five of the 49 responders to our survey reported offering an employee health care benefit package; 20 employers responded to the question about the portion of employee health insurance paid by the employer. Ninety-five percent of employers (19 of 20) offering ESI paid a portion of that coverage, ranging from 25% to 100% where answers were reported in percentage of employee premium. One employer paid each employee a $220/month stipend that was intended to be used to purchase health insurance: 2 of 4 full-time employees in that company used the stipend to purchase ESI. Table 4 below shows the employer contribution to ESI and the number of full-time employees choosing to participate in the ESI program.

**Table 4.** Employee Participation in ESI by Employer Premium Contribution

| % Premium Paid by Employer | Number of Employee Participants | FT Employees |
|---|---|---|
| 0% | 12 | 42 |
| 25% | 8 | 8 |
| 70% | 5 | 8 |
| 80% | 5 | 8 |
| 100% | 2 | 4 |
| 100% | 2 | 4 |
| 100% | 4 | 5 |
| 100% | 4 | 5 |
| 100% | 7 | 8 |
| 100% | 10 | 11 |
| 100% | 1 | 1 |
| 100% | 1 | 1 |
| 100% | 1 | 1 |
| 100% | 1 | 1 |
| 100% | 3 | 3 |
| 100% | 4 | 4 |
| 100% | 18 | 18 |
| 100% | 7 | 6 |
| 100% | | 4 |
| $220/mo. | 2 | 4 |
| No response | 6 | 12 |
| No response | 8 | 14 |
| No response | 3 | 4 |
| No response | | 30 |
| No response | | 3 |

Survey data for this study was not rich enough to allow analysis of the reasons employees chose not to participate in fully-

funded ESI programs. Given data from similar national studies, however, lower income workers tend to not enroll in ESI for one of two reasons: [4]

1. They have coverage available that provides better benefits or is more affordable through a spouse's employer.
2. Co-pays and deductibles are too high and thus workers prefer to take the premium dollars as a cash supplement when the option is available.

**Table 5.** Full-time Employee Participation in ESI

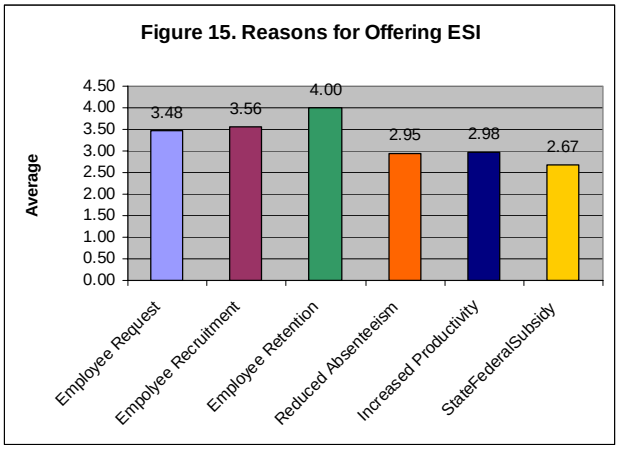
| Employer Pays Portion | Mean | Median |
|---|---|---|
| No | .2857 | .2857 |
| Yes | .7134 | .8000 |

Table 5 above indicates that employees are almost 3 times more likely to participate in ESI if all or some of the premium is paid. If a voucher or buy-in program were in place for low income workers who currently do not enroll in employer-sponsored coverage, these data indicate employees would most likely participate in such a program.

As noted below in the Limitations of this Study, not enough data was collected in this study to establish a meaningful correlation test for employee participation levels based upon paid portion of health insurance and other demographic information. Additional, larger scale studies of employers and employees would be necessary to provide more valid, generalizable data. Inferences can be drawn, however, from similar studies conducted nationwide, which conclude that during economic robustness, workers prefer pay increases to health insurance benefits and during economic downturns, workers will take lower paying jobs with the offer of employer-sponsored insurance. [2, 4, 5, 16]

## *Reasons to Offer ESI*

For small business employers who do not currently offer employer-sponsored insurance, there are a number of business reasons that make considering ESI, either through a human resources or primary group plan or through a state program such as the reform options under discussion here. [2, 4, 5] To discover which of these reasons were most important to the employers who participated in our study; we asked respondents to rate how important these nationally-validated reasons are to them and to their businesses. On a Likert scale of 1 to 5, with 1 being not at all important and 5 being very important, employers currently offering ESI and those who were not currently offering ESI ranked "employee retention" at the most important reason for providing employee health insurance benefits. Figure 15 shows the reasons (average importance) for offering ESI among all respondents.




Among employers who do not currently offer ESI, a state or federal subsidy was the second most important motivating factor for offering ESI, which suggests that small businesses not currently offering an employee health benefits package would be receptive to either a voucher or a buy-in option. Table 6 shows the breakdown of responses for employers NOT currently offering ESI.

**Table 6.** Reasons for Offering ESI Among Employers NOT Currently Offering Coverage

| | Reason | Average* |
|---|---|---|
| 1. | Employee retention | 3.9 |
| 2. | State/federal subsidy | 3.4 |
| 3. | Employee recruitment | 3.4 |
| 4. | Employee request | 3.2 |
| 5. | Increased productivity | 3.0 |
| 6. | Reduced absenteeism | 2.7 |

*On a scale of 1-5, with 1 being not at all important.

Employers who currently offer ESI said that employee request was the second most important reason, following employee retention (Table 7), and that a subsidized program was the least important reason. This suggests that employers currently providing an employee benefit package would be less likely to participate in a state voucher or buy-in program.

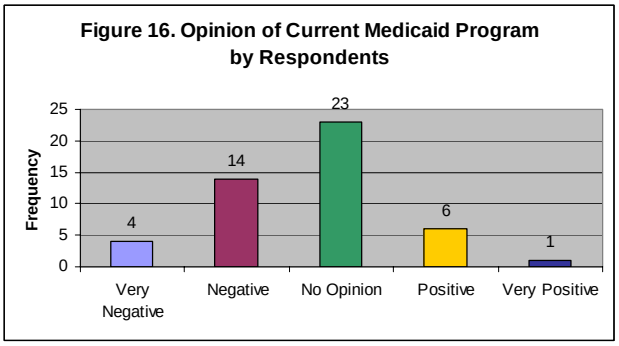
**Table 7.** Reasons for Offering ESI Among Employers Currently Offering Coverage

| | Reason | Average* |
|---|---|---|
| 1 | Employee retention | 4.0 |
| 2. | Employee request | 3.8 |
| 3. | Employee recruitment | 3.7 |
| 4. | Reduced absenteeism | 3.1 |
| 5. | Increased productivity | 2.8 |
| 6. | State/federal subsidy | 1.9 |

*On a scale of 1-5, with 1 being not at all important.

## *Opinion of Current Medicaid Program*

Small business employers were asked to rank their opinion of the current Medicaid program on a scale of 1-5, with 1 being very negative and 5 being very positive. Figure 16 shows the frequency of the responses from employers who answered the question (48 of 49).

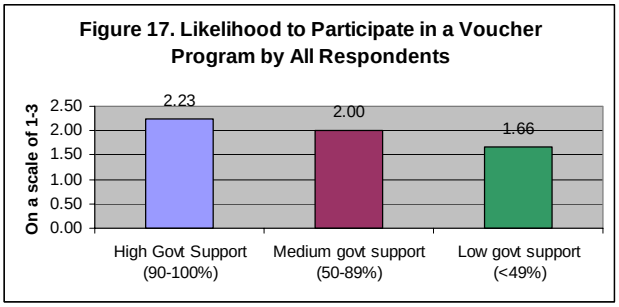



The majority (30%) had no opinion of the current program. Of those with an opinion (25 of 48), most had negative to very negative feelings about the current program. However, a negative opinion of the current Medicaid program was not an indicator for which businesses would participate in the reform programs.

## *Program Preferences*

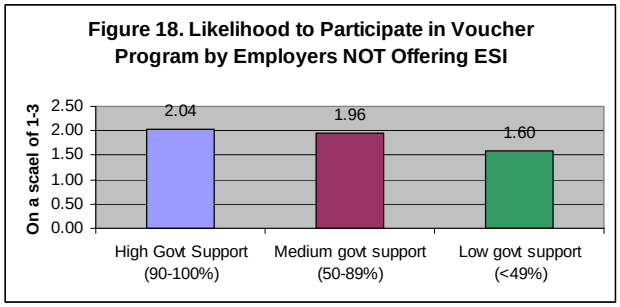
### Voucher Program

Employers were asked to rank their level of interest at participating in a government-sponsored voucher program on a scale of 1-3, with 1 being Not Likely and 3 being Very Likely. A voucher is an out-right payment to either employers or individuals and their families to be used only to purchase health care coverage. Figure 17 shows the results for all respondents. Results were calculated for high government support (90-100% of premium), medium government support (50-89% of premium), and low government support (less than 49% of premium).



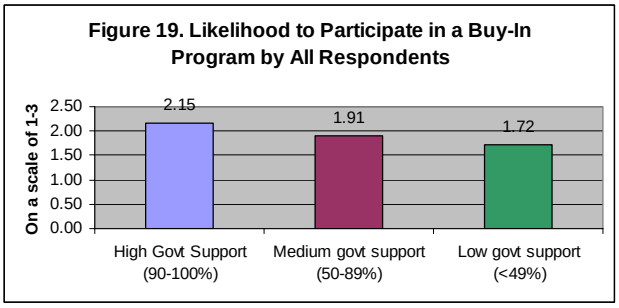

Businesses NOT currently offering any kind of ESI were likely to participate in a voucher

program at any level of government support but a surprising number indicated that a moderate or medium level of government subsidy would be preferable implying their desire to maintain some control of the program (Figure 18).

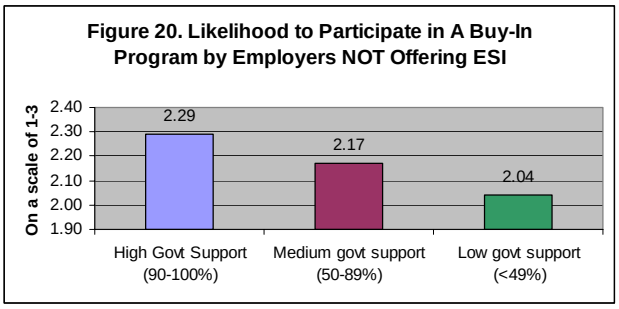



## Buy-In Program

Employers were asked to rank their level of interest at participating in a buy-in program on a scale of 1-3, with 1 being Not Likely and 3 being Very Likely. A buy-in program would allow employers and eligible uninsured individuals and their families to buy health coverage under the current Medicaid program. Figure 19 shows the results for all respondents. Results were calculated for high government support (90-100% of premium), medium government support (50-89% of premium), and low government support (less than 49% of premium).




Businesses NOT currently offering any kind of ESI were likely to participate in a buy-in program at any level of government support but again, many indicated that a moderate or medium level of government subsidy would be preferable implying their desire to maintain some control of the program (Figure 20).



## *Summary of Data*

**Table 8. Demographic Trends and the Likelihood of Offering Employer-Sponsored Insurance**

| Item | Type | Degree | Significance | Interpretation |
|---|---|---|---|---|
| Years in Business | Positive | .301 (Med) | .036 (Med) | Older businesses seem to offer health insurance **more frequently** than businesses with fewer years in business. |
| Corporate Status | Positive | .229 (Low) | .113 (Low) | Incorporated businesses seem to offer health insurance **somewhat more frequently** than unincorporated businesses, although the significance is low. |
| Education Level | Positive | .257 (Low) | .131 (Slight) | More educated companies seem to offer health insurance **somewhat more frequently** than less educated companies, although the significance is slight. |
| Income Level | Positive | .211 (Low) | .174 (Slight) | Businesses with higher income levels seem to offer health insurance **somewhat more frequently** than lower income companies, although the significance is slight. |
| Firm Size | Positive | .235 (Low) | .105 (Low) | Larger companies (FT Employees) seem to offer health insurance **somewhat more frequently** than smaller companies, although the significance is low. |
| Urban vs. Rural | Negative | .253 (Low) | .131 (Slight) | Rural businesses seem to offer health insurance **somewhat more frequently** than Urban businesses, although the difference is not statistically significant. |

**Table 9. Likelihood That Small Business Employers Will Participate in the Reform Program**

| Item | Type | Degree | Significance | Interpretation |
|---|---|---|---|---|
| Buy-In vs. ESI Offer Status | Negative | .3 (Med) | .03 (Med) | Those businesses current offering health insurance seem to be less likely to participate in a buy-in program than businesses that do not currently offer ESI. |
| Voucher vs. ESI Offer Status | Positive | .36 (Med) | .01 (High) | Those businesses offering health insurance seem to be **more** likely to participate in a voucher program than businesses that do not currently offer ESI |
| Importance vs. ESI Offer Status | N/A | Very Low | Little to None | ESI status **does not seem to affect** how important whether any of the businesses in this study considered |

## *Comments, Themes, and Nonverbal Communication*

Facilitators made note of comments and nonverbal cues from small business employers during individual and focus-type group discussions. A coding system was developed and codes were applied to the comments recorded by facilitators during one-on-one meetings or small group focus-type meetings and/or to the answers from program staff in response to questions. Codes were also developed to capture nonverbal responses. Comments were transcribed then coded and entered into an Excel Spreadsheet (Appendix F).

Comments included:

1. ***questions from employers about how the reform program would work***

   "Will eligibility be determined by total assets as well as gross income?"

   "Who would qualify?"

   "How will insurance be provided to beneficiaries?"

2. ***suggestions for policymakers***

   "One of the ways this program could work in Oklahoma is for the small business employer and the employee to co-contribute to the program and their dollars be matched and doubled by the general government."

3. ***comments about problems employers face trying to provide employee health coverage***

   "We have, in the past, given employees money to purchase their own insurance. They would never purchase their own insurance but use it for something else. We quit giving the money to them. Most of them are younger workers who don't see the need to insure their families or themselves."

4. ***statements about current Medicaid or government programs***

   "If you have the uninsured buy in to Medicaid that will make the program worse. We already have trouble getting access to … specialists. Unless there is some way to improve access to care, forget it."

Comments were used by program staff to develop a flavor for the attitudes and opinions expressed on the survey forms. In general, despite negative or pessimistic attitudes expressed during discussions, small business employers were receptive to a government health care program and agreed at somewhat high to high rates to participate in either a voucher or buy-in program.

Given the small number of respondents in this study, very few comments and/or nonverbal responses were recorded. This method, however, will be of value in reporting on attitudes and opinions of beneficiaries and physicians and other health care providers.

## *Limitations of the Study*

There are two major limitations to this study: lack of random sampling and small sample size.

Random sampling was not possible in this study because of the short study duration (June 2003-October 2003). The lack of randomization limits the generalizability of these results to the population of all small business owners in Oklahoma. Participants in this study were volunteers, recruited from the yellow pages, Chambers of Commerce, Rotary Club and professional and trade organizations, one-on-one staff contact and word of mouth. All employers whose businesses met inclusion criteria (i.e., businesses employing 50 people or fewer) and who wished to participate were included. Study results are similar to those of a broad scale national study[2] and can, therefore, be utilized by policymakers, in addition to other relevant information, when making decisions impacting small businesses in Oklahoma.

Small sample size and small number of responses (49 of ~150 or 33%) is a second major limitation. A number of factors impinged on our ability to collect a larger sample of small business employers. Time constraints created by OUHSC IRB requirements limited the time available to contact and assemble small groups. Local and state chambers of commerce,

anticipated to be our primary source for access to businesses in various communities proved to be less forthcoming than hoped. This could be due to the fact that several local chambers of commerce offer group-type health insurance to local small businesses and they were, therefore, hesitant to support a state subsidized program. However, given that our findings mirror the findings of large scale national studies, we believe that these results can be used by policymakers with a reasonable degree of confidence.

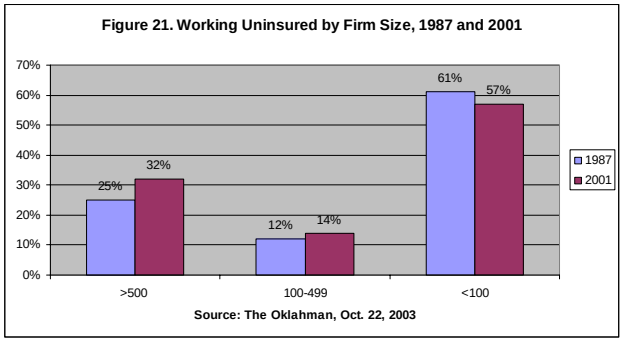
A third, less important limitation of this study is that electronic recording devices were not used to collected data nor were standard procedures for measuring verbal and nonverbal responses used for analyzing results of the group and individual sessions. Nonverbal data and comments and opinions collected during the focus-type group discussions and the individual interviews were collected using paper and pen by the facilitator and/or assistant facilitator based on pilot studies demonstrating a degree of discomfort, particularly with physicians and other health care providers, with electronic recording of the sessions. Participants stated they would be much more forthcoming and honest if no electronic recordings of the discussion were made and thus their anonymity could be assured. Because honesty in the attitudes, opinions, and suggestions of participants was paramount for the success of this project, a less invasive system of note taking was employed. The spreadsheet of comments and nonverbal communication along with the theme codes are attached in Appendix G.

Although the types of businesses represented in our sample as shown in Figures 4a, 4b, and 4c above are roughly similar to the fix of business types in Oklahoma and in the U.S., according to data from the U.S. Department of Commerce (see below), there are a disproportionate number of health care employers represented in our sample. This bias is due to the number of small business contacts associated with the health care industry with which we were familiar. It is also because this study is about the health care industry and small businesses associated with this sector were more likely to respond to our invitations. We acknowledge that this is a limitation of the study. However, no single demographic characteristic had a significant impact upon the answers to the major questions of this study.

# DISCUSSION

Years in Business was the only demographic variable associated with the offer of employer-insurance by smaller companies (50 employees or less) in Oklahoma. Companies in business longer (18 years or more) were significantly more likely (p=.036) to offer ESI than younger companies, which implies a reluctance on the part of individuals starting businesses in an age of double-digit increases in health care costs to become involved in the volatile health care marketplace.

During the 2002-2003 fiscal year, small business employers saw their premium costs increase at a rate of 15.9%, as compared to 13.8% for large companies (those with more than 500 employees). The smallest companies, those with fewer than 50 employees with which this survey is concerned, continue to be the hardest hit. These rising costs will prohibit small companies that do not currently offer employee health coverage from offering it to their employees in the near future. In addition, nationally, many smaller companies fear that if they add health care coverage, they would have to drastically increase employee contributions or rescind the benefit altogether in the future if costs should rise to a prohibitive degree. Recent reports, however, suggests that the problem of the working uninsured is spreading to larger businesses. [17, 18] Trends since 1987 show that the rates of uninsured in large companies (those with over 500 employees) have risen 7%, from 25% in 1987 to 32% in 2001. Still, the vast majority of uninsured workers are in small companies (fewer than 100 employees) (57%). [17]




Of the 49 small business employers who participated in our study, 25 currently offer health care benefits; all 25 stated they would continue to do so over the next year. All study participants were interested in a government subsidy program of some type, especially those who were not currently offering ESI. Though all were interested in a government-assisted health care coverage program, the tendency among both groups of employers (those currently offering ESI and those who do not) was toward slightly less than 100% premium subsidy indicating that the employers wished to maintain some control over how the benefits program for their businesses was designed and managed. Companies offering no ESI were interested in a slightly higher level of government involvement than businesses with an ESI program in place.

Among employees with access to health coverage through their employers, only 114 of 209 employees (54.5%) participated in health insurance through their employer. Reasons for lack of employee participation, even among workers in companies where the full employee premium was paid by the employer, were not investigated in this study. However, for the expansion of Medicaid to be successful in achieving the goal of providing health coverage

to low-income workers, the reason for non-participation will need to be elucidated.

This study did not investigate the degree to which employees who participated in ESI covered their families through their employer as well. As this is a component of the reform options, future studies are planned to look at this issue.

Of the demographic variables investigated in this study, only Years in Business was a statistically significant predictor of ESI (see Table 8). Variables that impacted ESI to a mild or moderate degree were, in order of importance:

- Years in Business
- Corporate Status
- Education Level
- Income Level
- Firm Size
- Urban vs. Rural

Older companies, incorporated companies, companies with a more educated workforce, those with a higher income level, and those with a larger number of employees were more likely to offer ESI. In this study, companies with rural locations were more likely to offer ESI than companies with urban locations but the difference was not significant. Because this statistic is at odds with data from national studies, [2, 4, 5] we feel this may be due to the small size of our sample.

A program that targets companies within these demographics, especially new or start-up companies, could have a significant impact on reducing the number of uninsured workers in Oklahoma.

Of the reasons expressed by employers for providing ESI, employee retention was ranked first with both those employers who currently offer ESI and those that do not. Interestingly, state or federal subsidy was ranked last in importance by businesses with ESI, and second by businesses without ESI. This is an important finding of this study especially for policymakers attempting to initiate discussions with employers over a state option health care program. An approach that emphasizes employee retention and state support will be well-received among employers not currently offering ESI. Businesses with ESI in force will require a different emphasis to achieve buy-in to the reform program for their uninsured workers and families.

In general, the results of our study indicate that, regardless of business type, size, years of operation, location, and other demographic indicators, business employers felt health care benefits were important and were equally interested in participating in the reform program. However, the small size of our sample limits the ability to generalize these results.

### *Comments, Themes, and Nonverbal Communication*

Comments were transcribed then coded and entered into an Excel Spreadsheet (Appendix F). Comments included:

1. ***questions from employers about how the reform program would work***

"Will eligibility be determined by total assets as well as gross income?"

"Who would qualify?"

"How will insurance be provided to beneficiaries?"

2. ***suggestions for policymakers***

"One of the ways this program could work in Oklahoma is for the small business employer and the employee to co-contribute to the program and their dollars be matched and doubled by the general government."

3. ***comments about problems employers face trying to provide employee health coverage***

"We have, in the past, given employees money to purchase their own insurance. They would never purchase their own insurance but use it for something else. We quit giving the money to them. Most of

them are younger workers who don't see the need to insure their families or themselves."

***4. statements about current Medicaid or government programs***

"If you have the uninsured buy in to Medicaid that will make the program worse. We already have trouble getting access to … specialists. Unless there is some way to improve access to care, forget it."

Comments were used by program staff to develop a flavor for the attitudes and opinions expressed on the survey forms. In general, despite negative or pessimistic attitudes expressed during discussions, small business employers were receptive to a government health care program and agreed at somewhat high to high rates to participate in either a voucher or buy-in program.

Codes were also developed to capture nonverbal responses. Given the small number of respondents to this study, very few nonverbal responses were recorded. This method, however, will be of value in reported on attitudes and opinions of beneficiaries and the providers.

# CONCLUSIONS AND RECOMMENDATIONS

## *Study Conclusions*

- Companies in business longer than 18 years were significantly more likely to offer ESI than younger companies perhaps due to the volatility of the health care marketplace. A program that targets this demographic could have a significant impact on the number of uninsured workers in Oklahoma.
- No other demographic variable (firm size, location, income and education level, etc.) was significantly associated with ESI.
- All businesses surveyed expressed interest in some type of subsidy program, provided they could maintain some financial control over the program. Any program is likely to be well received despite the overall distrust of government in general and Medicaid in particular.
- The majority of small business employers surveyed favored a program to which the government contributed less than 100% premium subsidy indicating that the employers wished to maintain some control over how the benefits program for their businesses was designed and managed.

## *Recommendations*

A public relations and educational effort aimed at enlightening small business employers about health care costs and benefits would be helpful in achieving buy-in to any reform program. Incentives could be instituted to make offering benefits reasonable, attractive and practical from a business perspective.

Major issues for employers are:

- Profit margin
- Cash reserves
- Administrative burden
- Potential impact of having to rescind benefits or increase employee contribution in the future
- A mistrust of government and government-sponsored programs.

In order for small businesses in Oklahoma that do not currently offer coverage to participate in a state health benefits program, those businesses would need:

1. Assurance that the state could effectively manage such a program
2. Input into the development of the coverage package
3. Financial and other incentives, such as the voucher or buy-in option, and assurance that the state will continue to provide coverage and not rescind benefits during times of economic crisis. Other incentives that might be investigated include:
   - tax deductions
   - stop-gap measures to protect and stabilize employee benefit programs
   - employer participation in the design and implementation of the program.
4. Relief from the administrative burdens such a program could carry
5. Flexibility, of benefits, of cost options, of employee contributions, etc.

Educational efforts could target such positive benefits of ESI as:

- Employee retention and recruitment
- Reduced absenteeism due to healthier employees and their families
- Reduced worker's comp due to employee use of primary and preventive health care
- Decreased health care costs over time by eliminating cost shifting that occur when uninsured use the emergency room

Including employers from businesses of all types during the design, development and implementation of any government sponsored health care program would help insure buy-in and success of such a program.

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# APPENDICES

A. Small Business Employer Survey

B. Invitation Letter

C. Education Piece

D. Small group facilitator's guide

E. Small group checklist

F. Notes from Small Business Encounters

G. Glossary of Statistical Terms

H. Summary Data

I. Biographical Sketches of Program Staff

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