



Health Care 101

The California Association of Health Plans (CAHP) is proud to play a role in statewide efforts to improve our health care system so that all Californians can benefit. The 40 public and private health care plans represented by CAHP serve 21 million Californians. The association is committed to improving the health of California's communities by promoting the growth of health plans dedicated to providing high-quality, affordable and accessible health care to their members.

Californians and Health Insurance

In California, 25.2 million people have health care coverage and another 6.6 million are uninsured. Most Californians get health insurance through their employers or organizations to which they belong. This is called **employer-based** or **group insurance**. The employers purchase insurance through plans such as those members of CAHP and offer the coverage to their employees. Employees usually pay a portion of the costs.

Nearly 20 percent of Californians get health insurance through **government programs** that operate at the national, state and local levels. Examples include Healthy Families, Medicare, Medi-Cal and programs run by the Department of Veterans Affairs and Department of Defense.

For Californians who don't have access to either group insurance or government programs, there is **individual health insurance**. They can purchase this insurance directly from an insurance company

Those who do have coverage Californians have health care coverage. The table below shows the numerical breakdown for the types of coverage Californians have. (Note: Details may not add to totals because individuals may receive coverage from more than one source.)

Employer or Group-Based	54.7%
Individual	8.7%
Medicaid or Medicare	17.7%
Military Program	2.1%

Source: California HealthCare Foundation

Health Insurance Protects Families

The purpose of health insurance is to help pay for medical care. People cannot predict what their medical bills will be in the future. In some years, the consumer may have low medical expenses. In other years, medical bills can be very large. With health insurance, consumers and their families are protected financially in the event of an unexpected serious illness or injury.

Consumers with health insurance also are more likely to have a regular doctor and more likely to get preventative medical care. As a result, they are likely to be healthier, which means they can enjoy a better quality of life and avoid major medical costs that can occur by waiting until they become seriously ill to seek care.

The Benefits of Managed Care

Managed care enables health plans to provide the public with better and more cost-effective health care services by coordinating care among providers and focusing on tools that help prevent or manage debilitating conditions. These plans strive to keep costs down for all their members by spreading the coverage risk among a broader pool of consumers. Managed care plans employ various tools to provide better health care, including encouraging the use of evidence-based medicine, coordinating care through a primary physician and offering consumer support. Managed care plans use other mechanisms to reduce unnecessary health care costs, including cost controls, economic incentives and management of high-cost health care cases.

The concept of “managed care” health coverage programs began in the 1980’s. Today, nearly 90 percent of insured Americans are enrolled in some form of managed care program, according to the America’s Health Insurance Plans. Managed care is sometimes used as a general term for the activity of organizing doctors, hospitals and other providers into groups, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Health Care Costs Impact Premiums

While CAHP plans strive to keep costs down for all their members, the cost of coverage is ultimately determined by the cost of health care. The Centers for Medicare and Medicaid Services found that \$2 trillion was spent on health care in 2005. The money was spent in the following manner:

Hospital Care	32%
Physician & Clinical Services	21%
Prescription Drugs & Nursing Home Care	16%
Dental & Other Professional Services	10%
Administrative & Investments	13%
Home Health Care & Other Medical Products	5%
Government Public Health Activities	3%

The impact of health care costs on premiums is evident in the breakdown of how premiums are spent. Out of every \$1 paid in premiums to health plans, 86 cents go to health care providers and services. A PriceWaterhouseCoopers study conducted in 2006 for America’s Health Insurance Plans found the health care premium is spent in the following manner:

Physician Services	24%
Outpatient Care	22%
Inpatient Hospital Care	18%
Prescription Drugs	16%
Home Health Care & Other Medical Products	6%
Government Payments & Administration	6%
Consumer Services	5%
Health Plan Profits	3%

Types of Health Insurance

Today, there are many more kinds of health insurance to choose from than were available just a few years ago. Most Californians who have health insurance are enrolled in a managed care plan, including HMOs and PPOs.

But there are other types of coverage as well, including Health Savings Accounts, Fee-for-Service plans, government programs, disability insurance, long-term care insurance and other coverage that can offer additional financial protection for consumers.

Models of Health Plans

- **Health Maintenance Organizations (HMOs)** - These are organizations that provide a wide range of comprehensive health care services for a specified group or individual for a fixed premium. Consumers generally pay a fee, known as a co-payment, for physician services, prescriptions and other health care services. With an HMO, consumers can choose from a large selection of primary care physicians within their network. Once selected, most HMOs require that consumers' medical visits begin with the selected physician and that the consumers stay in the HMO network. These plans are licensed by the Knox-Keene Act and the Department of Managed Care.
- **Preferred Provider Organizations (PPOs)** - These are health plans that negotiate discounted fees with their "preferred providers:" hospitals, doctors and other health care providers. These plans then encourage enrolled members to use the preferred network of providers by offering lower co-payments and other incentives. Enrolled members also have the option of visiting physicians, hospitals and other health care providers outside the network of preferred providers but usually will pay more for out-of-network providers. These plans are licensed by the Knox-Keene Act and governed by the California Department of Insurance.
- **POS (Point-of-Service)** - This is an HMO option that allows the consumer to receive a service from a non-HMO provider at a higher cost to the enrollee. The higher cost can take the form of a deductible and/or a higher point-of-service charge.
- **Indemnity Insurance (Fee-for-Service or Traditional Health Insurance)** - This type of coverage generally assumes that the medical provider (usually a doctor or hospital) will be paid a fee for each service provided to the patient that is covered under the policy. With fee-for-service insurance, patients choose their doctors and submit a claim to their insurance companies for reimbursement. Patients will only be reimbursed for "covered" medical expenses; that is, the covered services listed in the plan's benefits summary.
- **Self-Insured Health Plans (Single Employer Self-Insured Plans)** - This type of plan is used by large employers, labor unions, school districts and municipalities. These groups provide a pool of money and then pay for health care for their employees. Third-party administrators usually handle the administrative tasks and often health insurance companies are contracted to act as the third-party administrator. Most of these plans fall under the Employer Retirement Income Security Act (ERISA), a federal law enforced by the Department of Labor.
- **Health Savings Accounts (HSAs)** - These are federal accounts that were created by the Medicare bill signed into law on December 8, 2003. They are designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis.

Government Health Care Programs

- **Medicare** – This is a federal health insurance program for people age 65 and older, some disabled people younger than age 65 and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant).
- **Medicaid** - A federally funded, state-run program that provides health insurance coverage to individuals and families with limited incomes and resources.
- **Medi-Cal** - This is California’s Medicaid health care program. This program pays for a variety of medical services for children and adults with limited income and resources. Medi-Cal is supported by federal and state taxes. It serves 7 million low-income Californians.
- **Medi-Cal Managed Care** - These are Medi-Cal programs that have networks of providers, including doctors, pharmacies, clinics, labs and hospitals. Consumers must use the providers in the network when they need health care.
- **Healthy Families** - This is California’s low-cost insurance program that provides health, dental and vision coverage to nearly 750,000 children who do not have insurance today and do not qualify for no-cost Medi-Cal. Healthy families is jointly financed by the federal and state governments through SCHIP (the State Children’s Health Insurance Program.).

For more information, please visit www.calhealthplans.org or call (916) 552-2910.