



Frequently Asked Questions

What is CAHP?

The California Association of Health Plans (CAHP) is a statewide trade association representing more than 40 full-service health care plans licensed under the Knox-Keene Act.

What is CAHP's purpose?

CAHP works to sustain a strong environment in which our member plans can provide access to products that offer choice and flexibility to the more than 21 million Californians they serve through legislative advocacy, education and collaboration with other member organizations.

How does CAHP accomplish its goals?

CAHP works to educate policy makers, opinion leaders and regulators on the implications of health care policy concepts and proposals. The association also promotes collaborative efforts among health plans, providers, purchasers, brokers, other health care associations and other stakeholders as we advocate the provision of high quality, affordable and accessible health care.

What is the Knox-Keene Act, and what are Knox-Keene plans?

The Knox-Keene Act is the California law that regulates and licenses managed care plans. It is designed to promote the delivery and quality of health and medical care to the people of California. It is the first and most extensive state law regulating HMOs and other health plans in the United States. All CAHP member plans have achieved Knox-Keene licensure. The California Department of Managed Health Care has the responsibility to oversee licensure and plans' compliance with state regulations.

What are managed care plans, and how do they benefit consumers?

Managed care plans 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. 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).

What factors affect the cost of health coverage?

While CAHP plans strive to keep costs down for their members, the cost of hospital care, physician services, prescription drugs and other services impact the premiums plans charge. In 2005, Americans spent \$2 trillion on health care, according to the Centers for Medicare and Medicaid Services. More than half of that went to hospitals and physician and clinical services. Sixteen percent was spent on prescription drugs and nursing home care, while 10 percent went to dental and other professional services. The rest of the \$2 trillion was spent on administration, investments, government public health activities, home health care and medical products.

The impact of health care costs on premiums is evident in the breakdown of how premiums are spent. A 2006 PriceWaterhouseCoopers study for America's Health Insurance Plans found 86 cents out of every \$1 paid in premiums go to health care providers and services. Another 16 cents are used to pay for prescription drugs, 6 cents are spent on home health care and other medical products, 6 cents go to government payments and 5 cents are expended on consumer services. Just 3 cents out of every \$1 paid in premiums go to health plan profits.

How do CAHP plans provide health insurance to Californians?

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. Many 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

What is the purpose of health insurance?

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.

How many Californians have health insurance?

The California HealthCare Foundation reports that 25.2 million Californians have health care coverage. Of those, 54.7 percent receive their health insurance via employers or group-based coverage, 8.7 percent purchase health coverage individually, 17.7 percent are on Medicaid or Medicare and 2.1 percent receive health care coverage through military programs.

How many Californians are uninsured?

The California HealthCare Foundation reports that 6.6 million individuals in California are uninsured.

What types of health insurance are available in California?

Nearly nine out every 10 Californians who have health insurance are in managed care plans. Managed care is sometimes used as a general term for the activity of organizing doctors, hospitals and other providers into groups, such as HMOs, PPOs, and POS plans.

What is an HMO?

HMOs (Health Maintenance Organizations) 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 deductible or 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 California Department of Managed Health Care.

What is a PPO?

PPO is a Preferred Provider Organization. These are plans that negotiate discounted fees with their "preferred providers:" hospitals, doctors and other health care providers. PPOs then encourage enrolled members to use this network of preferred 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. Consumers also can refer themselves to a specialist without having to first see a primary care physician. These programs are licensed by the Knox-Keene Act and the California Department of Insurance.

What is a POS plan?

POS, or Point-of-Service, 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. In a POS, consumers can select their own physician, if that physician has previously agreed to provide services at a discounted fee. As in an HMO, in POS, the consumer would have to use the chosen physician, once selected, as a gateway first before moving on to a specialist.

What is indemnity insurance or fee-for-service coverage?

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 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.

What are self-insured health plans?

These plans are often 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.

What are Health Savings Accounts (HSAs)?

These are accounts offered by the federal government 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.

What is Medicare?

It is a government program that provides health insurance coverage for people age 65 and older. Certain people younger than age 65 can qualify for Medicare, too, including those who have disabilities and those who have permanent kidney failure or amyotrophic lateral sclerosis (Lou Gehrig's disease). Program eligibility does not consider income.

What is Medicaid?

It is a federally funded, state-run program that provides health insurance coverage to individuals and families with limited incomes and resources.

What is Medi-Cal?

This is California's Medicaid health care program. This program pays for a variety of medical services for children, seniors and persons with disabilities with limited income and resources. Medi-Cal is supported by federal and state taxes. It serves 7 million low-income Californians.

What is the Healthy Families program?

The Healthy Families Program is California's low-cost insurance that provides health, dental and vision coverage to children who do not have insurance today and do not qualify for the no-cost Medi-Cal program. The Healthy Families program 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.