Profiling California's Health Plan Enrollees:

Findings from the 2007 California Health Interview Survey

October 2010

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This UCLA Center for Health Policy Research report was funded by the California Office of the Patient Advocate.

The views expressed in this report are those of the authors and do not necessarily represent the UCLA Center for Health Policy Research or the California Office of the Patient Advocate.

Suggested Citation:
DH Roby, GL Nicholson, GF Kominski. *Profiling California's Health Plan Enrollees: Findings from the 2007 California Health Interview Survey.*
A Report for the California Office of the Patient Advocate.
Los Angeles: UCLA Center for Health Policy Research, 2010.

CHIS california health interview survey

This report is based on data from the 2003 to 2007 California Health Interview Survey (CHIS). The largest statewide health survey conducted in the U.S., CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Public Health, the California Department of Health Care Services, and the Public Health Institute. For more information on CHIS and for access to CHIS data and results, visit *www.chis.ucla.edu.*

THE PATIENT ADVOCATE

The State of California Office of the Patient Advocate
The Office of the Patient Advocate (OPA) is an independent state office that represents the interests of health plan members. Established in July 2000, the OPA has three primary functions: consumer education, public reporting, and collaboration with government and nongovernment patient assistance programs. For more information, visit *www.opa.ca.gov*.

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Acknowledgments

The authors are grateful to the staff of the Office of the Patient Advocate (OPA), including Sandra Perez, Barbara Marquez, Barbara Mendenhall, Ed Mendoza, and Cori Reifman, for their guidance, leadership, and support of this report and of the California Health Interview Survey. We would also like to thank the California Department of Mental Health for its support of CHIS survey design and data collection, which allowed us to analyze variables related to mental health for this report. Thanks also go to Nadereh Pourat, Daphna Gans, and Shana Alex Lavarreda for their thoughtful and thorough review of this report. In addition, Peggy Kan and Jenny Chia provided statistical assistance and data analyses. Gwendolyn Driscoll, Porsche Johnson, Celeste Maglan, and Mary Nadler provided valuable editorial, publication, and communication services, while the Ikkanda Design Group deserves our thanks for designing the report. Lastly, the authors thank David Grant, CHIS director, and Royce Park, CHIS assistant director for survey planning and operations, for their dedication to collecting information on HMO enrollees in California.

Executive Summary

Health maintenance organizations (HMOs) serve as insurers and providers of health care to 21% of the U.S. population, according to the Kaiser Family Foundation.[i] HMOs have higher rates of penetration in California than in any other state. Although the majority of HMO enrollees have either employer-based or individually purchased coverage, HMOs also provide care through California's Medicaid program (Medi-Cal) for low-income families, as well as through the federal Medicare program for individuals ages 65 and over.

California's Medicare beneficiaries are more likely to join Medicare Advantage (MA) plans than are Medicare beneficiaries in other states. MA plans can be HMOs, preferred provider organizations (PPOs), or private, fee-for-service (FFS) plans.[ii] However, the majority are HMOs. Changes are currently on the horizon in California due to a pending §1115 Medicaid demonstration waiver[iii] and the enactment of the recently passed Patient Protection and Affordable Care Act (PPACA). An understanding of the current state of affairs for health plan enrollees and of the differences among multiple insurance products and sources will be vital for effective implementation of both health care reform and the waiver.

With the recent passage of health care reform legislation (the PPACA and the Health Care and Education Affordability Reconciliation Act in early 2010), an increase is expected over the next ten years in the number of Californians who will be able to obtain health insurance. It is expected that by 2019, 93% of Californians will be insured,[iv] a large proportion of them through HMO plans and similar products offered by the large insurers that already represent a substantial portion of the individual and employer-based market in the state. Health care reform will expand Medicaid eligibility, increase commercial enrollment in managed care plans, and potentially impact Medicare Advantage plans.

Using the most recently available data from the 2007 California Health Interview Survey (CHIS), this report provides a detailed profile of demographic characteristics, disease conditions, health status, health care use, and barriers to care among California residents. The report provides a pre-reform snapshot of health status and utilization characteristics of Californians who were either enrolled in commercial or public managed care plans or who were uninsured in 2007.

Commercial insurance lines are comprised of employer-based coverage and individually purchased insurance. Because of the significant presence of Kaiser Permanente in California – 40% of the commercial HMO market – and its unique integrated staff model system for providing care (as compared to the delegated model used by other health insurers), this report

i Kaiser Family Foundation State Health Facts. State HMO Penetration Rate, July 2008 based on HealthLeaders, Inc. Special Data Request, March 2009. Accessed from *www.statehealthfacts.kff.org* on April 25, 2010.

ii Kaiser Family Foundation, Medicare Advantage Plan Penetration: 2009. Accessed from *http://healthplantracker.kff.org/topicresults.jsp?i=8&rt=2* on April 25, 2010.

iii The California Medicaid Section 1115 Waiver renewal aims to increase coordination of care for beneficiaries currently enrolled in fee-for-service Medi-Cal, with emphasis on vulnerable and high-cost populations (seniors and persons with disabilities, children with special health care needs, dually eligible Medicare/Medicaid enrollees, and persons with significant mental illness). The aim is to move these groups into integrated Medi-Cal managed care systems. For more information, see *http://www.dhcs.ca.gov/provgovpart/Documents/A%20Bridge%20to%20Reform %206-10-2010.pdf*.

iv Lavarreda SA, Brown ER, Cabezas L, and Roby DH. *Number of Uninsured Jumped to More Than Eight Million from 2007 to 2009*. Los Angeles: UCLA Center for Health Policy Research. Accessed from *http://www.healthpolicy.ucla.edu/pubs/files/Uninsured_8-Million_PB_%200310.pdf* on April 25, 2010.

analyzes commercial Kaiser Permanente plans separately from all other commercial HMO products. Public insurance lines include Medicare, Medi-Cal, and other forms of public insurance, such as the Children's Health Insurance Program (known in California as Healthy Families). Through these comparisons, this report will serve as a useful tool for guiding policy and decision making in Medicaid, employer-based insurance, and the individual insurance market as each undergoes significant change over the next decade.

Enrollment In Managed Care Plans Has Increased

In 2007, 50.1% of all Californians (an estimated 18.4 million) reported being currently enrolled in an HMO, a significant increase from 48.8% (an estimated 16.8 million) in 2003 (Exhibit 1).[v] However, the majority of growth in HMO enrollment occurred in the public sector (Medi-Cal and Medicare) rather than the commercial sector. In recent years, those insured through their employers have increasingly chosen PPO over HMO coverage.

An estimated 13.4 million Californians (37% of the population) reported being currently enrolled in non-HMO plans (PPO or FFS) in 2007. The proportion of Californians enrolled in PPO or FFS plans remained stable between 2003 and 2007, as the number of California residents who reported that they were currently uninsured dropped only slightly (from 4.9 million, or 14.3% of the population, to 4.8 million, or 13.2% of the population). It is likely that this slight decline in the percentage of uninsured was a short-lived trend. New research reveals that the high unemployment rate in California since 2007, increases in premium costs in both the individual and employer-based insurance markets, and an increased number of employers choosing not to offer health insurance coverage has resulted in a decline in the number of commercially insured and a significant rise in the number and percentage of Californians who were uninsured during all or part of the year.[iv]

Enrollment in Medi-Cal and Medicare HMOs Is on the Rise

Total Medi-Cal enrollment stayed mostly stable, with an estimated 4.6 million in 2007, down from 4.7 million in 2003. Medi-Cal HMO enrollment increased by 245,000, to 2.4 million Californians, in 2007. Medicare HMO enrollment increased from 1.8 million in 2003 to 2.2 million in 2007. The increase in Medicare HMO plan enrollment coincided with passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[ii] While the commercial insurance plans have shown movement out of the HMO market, the publicly insured plans have focused on increasing HMO penetration. The movement of Medicare and Medi-Cal enrollees into managed care has driven the increase in statewide HMO enrollment (Exhibit 3; Appendix A).

Increase in Commercial PPO Enrollment

In 2007, 68% of insured Californians had some form of commercial insurance, either HMO or PPO. An estimated 12.8 million Californians were enrolled in commercial HMO plans and an estimated 8.8 million in commercial PPO plans. Enrollment in commercial PPO plans increased from 26% of the total insured in 2003 to nearly 28% in 2007 (Exhibit 3).

v This estimate of insurance coverage from the 2007 California Health Interview Survey is the current point-in-time estimate, based on respondent report of current health insurance status and enrollment at time of interview. This data contrasts with the all-year or part-year insurance status information that is also reported in other CHIS-based policy briefs and reports. For example, CHIS releases two estimates to capture the uninsured: In 2007, 4.8 million people were uninsured at the time of interview, while 6.4 million had been uninsured for all or part of the year.

HMO Enrollees: Health Status and Medical Conditions

CHIS 2007 data show slightly poorer overall health status ratings and slightly higher chronic disease rates among commercial HMO enrollees than commercial PPO enrollees. Among the publicly insured, reported overall health status was greater for HMO enrollees, and some rates of reported chronic disease were lower for enrollees in HMOs than for those in FFS plans (Exhibit 9).

Behavioral Risk Factors Are Prevalent Across Plans

Overweight and obesity remained prevalent among all insurers and plans. Reported rates of being overweight were comparable for enrollees across all insurers and among the uninsured, with between 34% and 36% of Californians reported as being overweight. Among commercial plans, reported obesity rates were highest for Kaiser HMO enrollees (26%) and lowest for those in PPOs (18%). Reported obesity rates were similar in public plans and the uninsured (each at 24%). Smoking rates were lower among commercial plan enrollees (between 11% and 13%) and higher among those in public insurance plans, with public FFS plan members having the highest rate (27%) (Exhibit 10).

Mental Health Needs Are High Across Plans

Regardless of insurer or health plan type, only a quarter of adults reported having had a discussion about emotions with their primary care physician at last checkup. Between 15% and 18% of adults reported having needed help for a mental health issue in the past year, and between 6% and 8% reported having had serious psychological distress. Cost as a barrier to mental health treatment was cited most often among those who were uninsured (71%) or who were enrolled in commercial PPO (41%) and public FFS (47%) plans (Exhibits 13 and 14).

Health Care Use by HMO Enrollees in California

Preventive Screening

More than 80% of women in commercial insurance plans reported having had breast or cervical cancer screenings in the recommended time frame according to national clinical guidelines. Commercial PPO plans reported the highest rate of cervical cancer screening within the past three years (89%), and commercial Kaiser HMO plans reported the highest rate of mammography within the past two years (87%). Colorectal cancer screening rates were lower across all payers than either breast or cervical cancer screening. Among the commercial lines, Kaiser HMO had the highest rate (64%) of members having had a screening within the past five years. Screening rates were similar for public plans. Though generally low, Kaiser HMO led the commercial insurers in STD testing within the last year, at 22% (Exhibit 12).

Doctor Visits and Emergency Room Use

Between 11% and 15% of adults across all insurance lines reported not having seen a doctor in the past year. Forty-one percent of the uninsured reported they had not seen a doctor in the past year. Emergency room visits within the past year were similar across the commercial plans (16-19%) and higher in the public insurance plans, with 27% of public FFS enrollees reporting an ER visit within the past year (Exhibit 11).

Delays in Care

Commercial PPO enrollees reported slightly more delays in getting needed care (18%) than enrollees in commercial HMOs or Kaiser HMOs. Members of public HMOs reported fewer delays in obtaining needed medical care within the last year (11%). Delays in filling prescriptions were not significantly different across commercial plans (25-29%) compared to public plans (24% HMO and 19% FFS) (Exhibit 11).

Cost Sharing Among Commercial HMO Plans

Enrollment in HDHPs Is High

Twenty-eight percent of adult commercial PPO enrollees reported having an annual deductible over $1,000. Fourteen percent of adult commercial HMO enrollees and 12% of Kaiser HMO enrollees reported having deductibles over $1,000. Among commercially insured enrollees with a high deductible, only 31% in PPOs, 23% in HMOs, and 20% in Kaiser HMOs reported having a health savings account for medical expenses (Exhibit 4).

Policy Implications

Despite being insured, Californians in HMO, PPO, and FFS plans still face barriers to accessing primary care and obtaining prescriptions, with differences among commercial enrollees as well as among Medi-Cal and Medicare enrollees. Efforts should be made to ensure that those with insurance through HMOs, either public or commercial, are able to see a doctor when they need to, obtain prescription drugs, and receive appropriate preventive services.

There appears to be a trend toward high-deductible health plans (HDHPs) in the commercial market. CHIS data show that a significant proportion of Californians with commercial HMO or PPO insurance were enrolled in plans with high deductibles, which may present barriers to accessing both primary and specialty care. Special attention should be paid to individuals who purchase HDHPs for affordability reasons but who do not understand the implications of the high deductible on their ability to use and pay for health care. It will be necessary to develop educational materials and guidance on health insurance purchasing for low-income enrollees so that they can make the most informed decisions possible when purchasing HDHPs. This need for information will become increasingly important under the PPACA when the individual mandate goes into effect in 2014.

Socioeconomic differences in use, access, and outcomes appear to remain a concern regardless of insurance status and HMO enrollment. Specific populations may be particularly sensitive to changes in network providers, cost sharing and premium amounts, and new policies related to benefits and provision of services. Therefore, HMOs should continue to work toward limiting or eliminating disparities by providing enabling services, materials in multiple languages, trained health care interpreter staff and physicians, cultural competence training, and targeted outreach. In addition, with the enactment of health care reform and changes to Medi-Cal due to the proposed waiver renewal, the diverse patient population of the newly insured will need to be educated and informed about their rights under the new law and also prepared to navigate the health system and to appropriately use their health insurance coverage.

Recommendations

Educate Californians – Make consumers aware of the impact of insurance purchasing decisions and health plan type on their ability to afford and use health care.

Empower Californians – Guide consumers to compare health plans (both HMOs and PPOs) based on standard quality and access measures. This will allow individuals to more easily evaluate their choices and to purchase the health insurance products that will best meet their needs.

Ensure Equity –Allow all individuals and their families to access needed care regardless of income or race/ethnicity.

Introduction

Health Maintenance Organizations (HMOs) serve as insurers and providers of health care to a large proportion of Californians. Californians opt into HMO plans at a higher rate than residents of any other state, in both the commercial and public insurance markets.[1] With the passage of the Patient Protection and Affordable Care Act (PPACA) in March of 2010, individuals and families will be required to purchase health insurance through their employers or through new state health insurance exchanges; alternatively, they may qualify for insurance under expanded Medi-Cal (Medicaid) eligibility criteria. California's health insurance market is very different from that of the rest of the nation, and the mandate to purchase insurance is likely to result in enrollment increases in managed care products, both commercial and public. In addition, the current §1115 Medicaid demonstration waiver[2] process in California is expected to result in a significant proportion of current fee-for-service (FFS) beneficiaries enrolling in private managed care plans or approved county alternatives.[3]

These policy changes and the resultant increases in the population enrolled in managed care will require vigilance on the part of state regulators, insurers, consumers, and advocates alike to ensure adequate access to high-quality care for the insured. Insurance companies in California will need to compete with one another for the previously uninsured and for consumers shopping for coverage in the new health insurance exchanges. Consumers will likely be making coverage decisions based on premium prices, benefit packages, out-of-pocket spending requirements, network structure, and quality. This report identifies areas in which HMOs, preferred provider organizations (PPOs), and FFS products in the commercial and public insurance markets differ, and it identifies potential opportunities for improvement in preparation for the full enactment of PPACA and the individual mandate requirement.

According to the Kaiser Family Foundation, the overall state HMO penetration rate in the U.S. was 21% in 2008. In California, HMOs have higher rates of penetration than they do in any other state. One-quarter of all HMO enrollees in the United States live in California.[4] Although the majority of HMO enrollees have employer-based or individually purchased coverage, HMOs also provide care through California's Medi-Cal program for low-income families and through the federal Medicare program for individuals 65 and over. California's Medicare beneficiaries are more likely to join Medicare Advantage (MA) plans than are Medicare beneficiaries in other states: 34% of Californians are enrolled in MA plans, compared to 23% of Medicare beneficiaries

1 Kaiser Family Foundation State Health Facts. State HMO Penetration Rate, July 2008 based on HealthLeaders, Inc. Special Data Request, March 2009. Accessed from *www.statehealthfacts.kff.org* on April 25, 2010.

2 The California Medicaid Section 1115 Waiver renewal aims to increase coordination of care for beneficiaries currently enrolled in fee-for-service Medi-Cal, with emphasis on vulnerable and high-cost populations (seniors and persons with disabilities, children with special health care needs, dually eligible Medicare/Medicaid enrollees, and persons with significant mental illness). The aim is to move these groups into integrated Medi-Cal managed care systems. For more information, see *http://www.dhcs.ca.gov/provgovpart/Documents/A%20Bridge%20to%20Reform%206-10-2010.pdf.*

3 California Department of Health Care Services. *California Section 1115 Comprehensive Demonstration Project Waiver: A Bridge to Reform Section 1115 Waiver Proposal,* June 2010. Accessed from *http://www.dhcs.ca.gov/Pages/SACMeetings.aspx* on September 19, 2010.

4 Kaiser Family Foundation State Health Facts. State HMO Penetration Rate, July 2008 based on HealthLeaders, Inc. Special Data Request, March 2009. Accessed from *www.statehealthfacts.kff.org* on April 25, 2010.

plans can be HMO, PPO, or private FFS plans.[5] However, the majority are HMO products. Changes are on the horizon in California due to a pending §1115 Medicaid demonstration waiver and the enactment of the recently passed Protection and Affordable Care Act (PPACA).

An understanding of the current state of affairs for health plan enrollees and of the differences among multiple insurance products and sources will be vital for effective implementation of both health care reform and the waiver.

Comparing the health status and characteristics of California's insured population has historically been difficult due to data limitations. While insurers have administrative data on their beneficiaries (for example, age, gender, location, and marital status), they often lack information on health status, health behaviors, chronic illness, income, educational level, English language proficiency, race/ethnicity, and other characteristics. Reliance on clinical data from charts, physician order entry systems, electronic medical records, and practice management systems has limitations when collecting data on the insured. Moreover, a significant share of insured individuals do not visit a physician or use health care services in a given year, and so there is no data for these "non-users" of care. Instead, insurers rely on limited clinical information for those who do use services in order to develop and operate quality improvement programs, conduct needs assessments for their enrolled populations, and assess access to health care for their own beneficiaries.

The California Health Interview Survey (CHIS) is a population-based survey that assesses the health status, behaviors, chronic illness rates, income, education, race/ethnicity, mental health status, and other factors for different insurance products. CHIS collected data on HMO enrollment and health plan names in 2003, 2005, and 2007. The findings presented in this report are based primarily upon CHIS 2007 data. However, when possible, trends using multiple years of data related to HMO enrollment, characteristics, and health status of HMO members are explored.

This report focuses on analyzing health status and use of health care services among enrollees in commercial HMO, commercial PPO, public HMO, and FFS plans, as well as among individuals without insurance. Commercial insurance products are comprised of employer-based coverage and individually purchased insurance. Public insurance lines include Medicare, Medi-Cal, and other forms of public insurance, such as the Children's Health Insurance Program (known as Healthy Families in California). Due to Kaiser Permanente's size in California and its unique non-delegated model for providing care, commercial Kaiser Permanente plans are analyzed separately from all other commercial HMO products. Although Kaiser Permanente operates in the public insurance sector, with a sizable proportion of Medicare and Medi-Cal patients, separate analyses for public Kaiser health plans are not presented in this report.

Importance of the Study

Much of the attention in health services research and policymaking has focused on access to care for the uninsured and underinsured. With the recent passage of health reform legislation (the PPACA and the Health Care and Education Affordability Reconciliation Act in early 2010), more Californians will be able to obtain insurance over the next five years. By 2016, the full penalties for not complying with the

5 Kaiser Family Foundation, Medicare Advantage Plan Penetration: 2009. Accessed from *http://healthplantracker.kff.org/topicresults.jsp?i=8&rt=2* on April 25, 2010.

individual insurance mandate will be implemented; by 2019, it is expected that 93% of Californians will be insured,[6] with a large proportion of this group obtaining health insurance through new, state-based American Health Benefit Gateways. These new health insurance exchanges will provide a marketplace for health insurers to compete for policyholders. In California, it is especially likely that more residents will opt into HMOs and other similar products offered by the large insurers in the state who already represent a sizable portion of the individual and employer-based market. By providing comparisons by payer source of those enrolled in HMOs, PPOs, and FFS plans, this report will be useful in guiding policy and decision making as our health care system undergoes significant change over the next decade.

Health care reform will expand the provision of care to new Medicaid enrollees, increase commercial enrollment in managed care plans, and potentially impact Medicare Advantage plans. By improving access to health insurance products for people with preexisting conditions (such as chronic illnesses) who were previously uninsured, health insurance companies could potentially experience higher rates of chronically ill members in the short term. However, once the individual mandate is fully implemented in 2016, it is likely that healthier individuals will join insurance companies. Lower-risk groups more often opt into lower-cost, more tightly managed plans.[7] An influx of low-risk enrollees could lead to a rise in commercial HMO enrollment and competition based on quality, cost, and accessibility of providers within managed care networks. There is already limited evidence of health plans creating more affordable products by lowering premiums but limiting provider networks in response to the enactment of PPACA.[8]

About the Office of the Patient Advocate

The Office of the Patient Advocate (OPA) was formed by the California State Legislature in 2000 to represent the interests of health plan enrollees. The government-appointed Patient Advocate reports directly to the Secretary of the Business, Transportation and Housing Agency. OPA is responsible for directing the outreach and education programs targeted to commercial health plan members. Working closely with the Department of Managed Health Care (DMHC) to inform and educate consumers about their rights and responsibilities as HMO enrollees, OPA helps consumers make informed choices and become their own best health care advocates. As implementation of health care reform moves forward in California and the rest of the nation, OPA may be able to play a significant role in monitoring the experiences of Californians with health insurers, access to health care, and quality of care. The information in this report will allow OPA to continue data-driven planning that will be vital in implementing health care reform and adapting to changes in our system of health care. We expect that health insurers doing business in California will also find this information useful for gaining a better understanding of their beneficiaries' needs, characteristics, health behaviors, and health care utilization.

6 Lavarreda SA, Brown ER, Cabezas L, and Roby DH. *Number of Uninsured Jumped to More Than Eight Million from 2007 to 2009*. Los Angeles: UCLA Center for Health Policy Research. Accessed from *http://www.healthpolicy.ucla.edu/pubs/files/Uninsured_8-Million_PB_%200310.pdf* on April 25, 2010.

7 Naessens JM, Khan M, Shah N, Wagie A, Pautz R, Campbell CR. Effect of Premium, Copayments, and Health Status on the Choice of Health Plans. *Medical Care* 46, no. 10 (2008): 1033-1040; Nicholson S, Bundorf K, Stein RM, Polsky D. The Magnitude and Nature of Risk Selection in Employer-Sponsored Health Plans. *Health Services Research* 39, no. 16 (2004): 1817-1838.

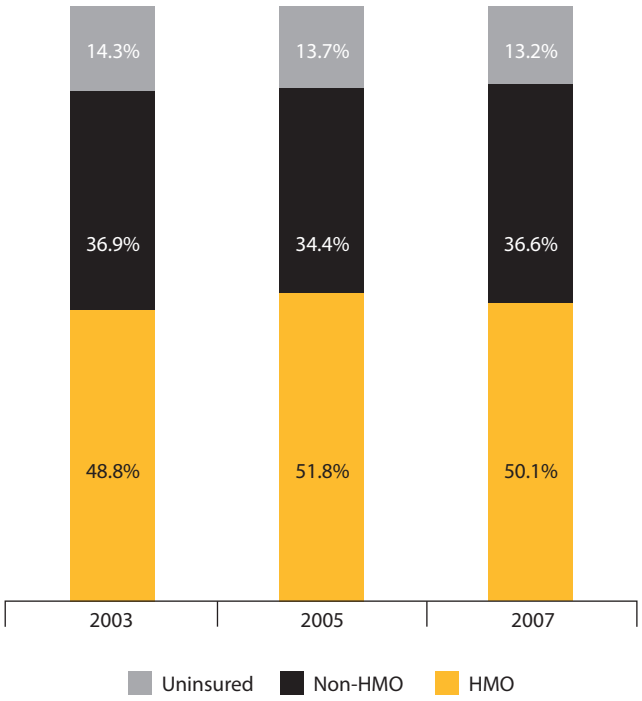
8 Abelson R. Insurers Push Plans That Limit Choice of Doctor. *New York Times*, July 17, 2010. Accessed from *http://www.nytimes.com/2010/07/18/business/18choice.html* on July 19, 2010.

Current Enrollment

According to data from CHIS 2007, an estimated 18.4 million Californians (50.1% of the total California population) were enrolled in HMOs. Non-HMO plans accounted for 13.5 million Californians, or 36.6% of the total state population. An estimated 4.8 million Californians, or 13.2% of the population, were uninsured in 2007 (Exhibit 1).[9] The current estimate of the number of uninsured Californians is closer to 8.2 million, due to a decrease in both employer-based coverage and individually purchased policies. (With the recent economic downturn, higher numbers of adults qualifying for Medi-Cal have led to increased Medi-Cal HMO enrollment.[10]) CHIS data show that the overall HMO enrollment rate between 2003 and 2007 increased slightly but significantly.

The majority of insured Californians were enrolled in either commercial PPO or commercial HMO plans, with the largest proportion of insured belonging to commercial HMOs. Though the estimated number of Californians enrolled in commercial HMOs increased from 12.1 million in 2003 to 12.8 million in 2007, the proportion of insured Californians who reported enrollment in commercial HMO plans decreased

Exhibit 1.
Percentage of the Population Enrolled in HMO or Non-HMO Insurance Plans, California, 2003-2007



Note: Overall HMO enrollment includes both commercial and public insurance. HMO enrollment between years is statistically significant at $p < .05$.

9 Enrollment figures from the California Health Care Foundation's *California Health Plans and Insurers* state that 22 million individuals were enrolled in DHMC-regulated health plans (primarily HMOs), with a total insured population of 25 million. (Wilson K., California Health Care Almanac, California Plans and Insurers. California Health Care Foundation. Oakland, CA: January 2009.)

10 Lavarreda SA et al., 2010

slightly, dropping from 42% to 40% (Exhibit 2; Exhibit 3; Appendix, Figure A-2). Several reports have suggested that Californians insured through the commercial sector are less likely to choose HMO insurance options today than they were in past years.[11]

Rising commercial PPO enrollment in particular has lessened the dominance of commercial HMOs in California among the overall population. The proportion of individuals who reported enrollment in commercial PPO plans increased from 26% in 2003 to nearly 28% in 2007, an increase of an estimated 1.2 million Californians (from 7.6 to 8.8 million) during that period (Exhibit 3; Appendix, Figure A-2). Additionally, though 91% (19 million) of commercially insured Californians received commercial insurance through their employers, about 2 million (9%) of the commercially insured purchased insurance in the individual market. This group includes those who are self-employed, who do not have employer-provided health insurance, or who are otherwise uninsured or do not qualify for public health coverage. In 2007, only 40% of the individually purchased insurance market, or 797,000 Californians, were enrolled in HMOs, compared with 60% of the employer-based market. Consumers purchasing insurance on the individual market are faced with high premium prices, significant deductibles, and other out-of-pocket spending requirements. This cost burden often results in individual purchasers choosing high-deductible health plans (HDHP), which tend to be PPO products instead of HMO products.[12]

Total Medi-Cal enrollment stayed mostly stable, with an estimated enrollment of 4.6 million in 2007 compared to 4.7 million in 2003 (Exhibit 3; Appendix Figure A-2). In 2007, 2.4 million Californians were enrolled in Medi-Cal HMOs, an increase of 245,000 over 2003 enrollment (2.1 million). Medi-Cal FFS enrollment during that same period dropped from 2.5 million to 2.2 million (Appendix A).[13]

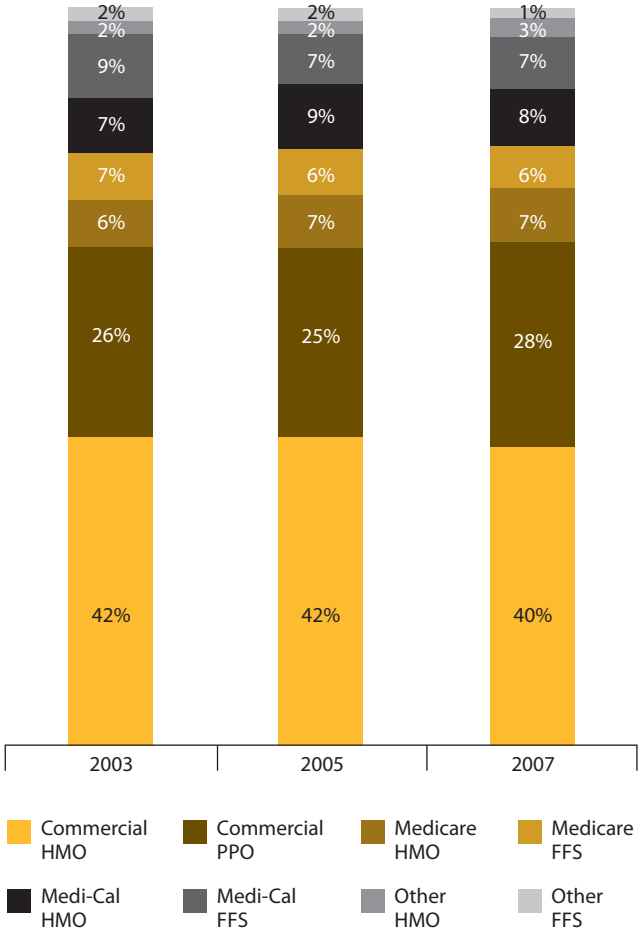
Exhibits 2 to 4 present the HMO and non-HMO enrollment among different insurance payer types – commercial, Medicare, Medi-Cal, and other public health plans.

11 California Health Care Foundation. California Health Care Market Report 2006. *http://www.chcf.org/~/media/Files/PDF/C/CHCMarketReport 2006.pdf*. Accessed on April 25, 2010.

12 November EA et al. Individual Insurance: Health Insurers Try to Tap Potential Market Growth. Center for Studying Health System Change Research Brief, No. 14. (2009). Accessed from *http://www.rwjf.org/files/research/51093.pdf* on June 15, 2010; Robinson JC et al. Consumer-Driven Health Care: Promise and Performance. *Health Affairs* 28, no. 2(2009): w272-w281.

13 Data on 2003 and 2005 Health Plan enrollment available in Appendix A.

Exhibit 2.
Percentage of the Population Enrolled in HMO or Non-HMO Insurance Plans, California, 2003-2007



Note: Difference between 2003 and 2007 is statistically significant for Commercial PPO, Medi-Cal HMO, Medi-Cal FFS at $p < .05$.

There are seven major health plans operating in California: Kaiser Permanente, PacifiCare (United Health), Blue Cross, Blue Shield, Health Net, Aetna, and Cigna. The 2007 figures for HMO plan enrollment show that in the commercial HMO setting, Kaiser Permanente insured the greatest proportion of members, at 40% of the total commercial HMO market (about 5.2 million Californians). In the commercial PPO market, the largest insurer in 2007 was Blue Cross, which comprised about 36% of the commercial PPO market (approximately 3.1 million Californians) (Figure 3). These percentages have remained stable since 2003, based on CHIS data and historical enrollment data from multiple sources.[14] The individual-purchase market continues to be dominated by Kaiser Permanente and Anthem Blue Cross;[15] for employer-sponsored insurance, there are a larger number and variety of health plans providing insurance products for employees.

14 Cattaneo & Stroud, Inc. 2006 Statewide HMO & Special Programs Enrollment Study. Accessed from *http://www.cattaneostroud.com/2006HMO.htm* on June 15, 2010; California Health Care Foundation. California Health Care Market Report 2006. *http://www.chcf.org/~/media/Files/PDF/C/CHCMarketReport2006.pdf.* Accessed on April 25, 2010.

15 November EA et al., 2009.

Exhibit 3.
Health Plan Enrollment by Insurer Type, 2007

	Kaiser	Blue Cross	Pacificare	Blue Shield	Heath Net	Aetna	Cigna	Other	Total
Commercial HMO	5,211,000	1,877,000	1,046,000	1,177,000	1,140,000	487,000	228,000	546,000	12,839,000
	84.6%	29.5%	60.5%	48.3%	54.6%	37.4%	46.1%	12.8%	40.4%
Commercial PPO	–	3,188,000	276,000	1,051,000	326,000	726,000	249,000	1,936,000	8,873,000
	–	50.0%	16.0%	43.2%	15.6%	55.7%	50.4%	45.5%	27.9%
Medicare HMO	715,000	123,000	356,000	99,000	173,000	35,000	1,000	286,000	2,262,000
	11.6%	1.9%	20.6%	4.1%	8.3%	2.7%	0.2%	6.7%	7.1%
Medicare FFS	–	399,000	30,000	73,000	43,000	44,000	13,000	219,000	1,901,000
	–	6.3%	1.7%	3.0%	2.0%	3.4%	2.7%	5.2%	6.0%
Medi-Cal HMO	159,000	419,000	13,000	9,000	256,000	6,000	3,000	609,000	2,422,000
	2.6%	6.6%	0.8%	0.4%	12.3%	0.5%	0.6%	14.3%	7.6%
Medi-Cal FFS	–	213,000	5,000	9,000	94,000	4,000	0	262,000	2,201,000
	–	3.3%	0.3%	0.4%	4.5%	0.3%	0.1%	6.2%	6.9%
Other HMO	75,000	139,000	3,000	14,000	54,000	0	0	101,000	847,000
	1.2%	2.2%	0.2%	0.6%	2.6%	0%	0%	2.4%	2.7%
Other FFS	–	14,000	0	4,000	1,000	0	0	296,000	451,000
	–	0.2%	0.0%	0.2%	0.0%	0%	0%	6.9%	1.4%
TOTAL	6,159,000	6,373,000	1,731,000	2,437,000	2,087,000	1,302,000	495,000	4,255,000	31,796,000

Note: Percentages sum in columns. Individuals with 'Unknown' health plan are included in total, but data are not shown.

Insurance Barriers

Insurance Status in Past Year

Between 3% and 5% of commercially insured enrollees reported having been uninsured for part of the last year (Exhibit 4). Among the publicly insured, the rate was nearly 10%. (This CHIS question was asked of adults younger than 65 years of age, so the publicly insured group represents primarily Medi-Cal enrollees.) Interestingly, of the currently uninsured, only 23% spent part of the year uninsured, a figure that has remained stable since 2003. Given the economic recession that began in 2007, it is likely that this figure will be higher for 2009. As we move toward enacting health care reform and focus on increasing access to coverage as well as improving quality of care, care coordination, and patient-centered care, it will be important to understand the reasons behind significant lapses in coverage and attempt to increase the percentage of people who have uninterrupted insurance coverage all year long.

High-Deductible Health Plans

High-deductible health plans (HDHP) have been gaining market share in the health care market as one way to encourage more rational use of health care services.[16] HDHPs are insurance plans with lower monthly premiums than typical health insurance coverage, but with much higher deductibles for health care services. For these plans, the average annual deductible for individuals with employer-based insurance is more than $1,800.[17] Studies have shown that significant cost sharing may create disincentives for both necessary and unnecessary care.[18] While individuals with high-deductible plans may be less likely to utilize the emergency room for care, they may also delay necessary treatment or doctor visits.[19]

Another mechanism for improving the affordability of health insurance is the Health Savings Account (HSA). The HSA allows individuals with high-deductible health plans to set aside tax-deductible funds for medical expenses.[20] High-deductible plans coupled with HSAs are typically marketed toward those with higher incomes, but more employers and health plans are providing high-deductible plans for lower-income individuals. Furthermore, high-deductible plans may be offered to employees without the accompanying tax incentive of the HSA; where an HSA may mitigate the reduction in use of needed care, plans without an accompanying HSA may have more deleterious effects on use of needed care.[21]

16 Reed et al. High-Deductible Health Insurance Plans: Efforts To Sharpen a Blunt Instrument. *Health Affairs* 28, no. 4 (2009): 1145-1154.

17 Kaiser Family Foundation/HRET. Employer Health Benefits Survey 2009: Summary of Findings. *http://ehbs.kff.org/pdf/2009/7937.pdf*. Accessed May 17, 2010.

18 Buntin MB et al. Consumer-Directed Health Care: Early Evidence About Effects on Cost And Quality. *Health Affairs*, 25, no. 6(2006):w516-w530.

19 Wharam JF et al. Emergency Department Use and Subsequent Hospitalizations Among Members of a High-Deductible Health Plan. *Journal of the American Medical Association* 297, no.10 (2007): 1093-1102; Newhouse JP. Consumer-Directed Health Plans and the RAND Health Insurance Experiment. *Health Affairs* 23, no.6 (2004): 107-113.

20 A.P. Mahajan and R.H. Brook. High-Deductible Health Plans and Better Benefit Design. *Annals of Internal Medicine* 148, no. 9 (2008): 704–706.

21 Cohen RA. Impact of Type of Insurance Plan on Access and Utilization of Health Care Services for Adults Aged 18-64 Years with Private Health Insurance: United States, 2007-2008. NCHS Data Brief, no. 28 (2010). Accessed from *www.cdc.gov/nchs/data/databriefs/db28.pdf* on June 15, 2010.

We define high-deductible health plans in CHIS data as individual health plans having a deductible over $1,000.[22] Three million commercially insured Californians reported having a high-deductible health plan in 2007. Adult commercial PPO enrollees had the highest proportion (28%) of high-deductible plans (Exhibit 4). Generally, HMO products have much lower cost-sharing requirements than comparable PPOs. However, 14% percent of commercial HMO members and 12% of commercial Kaiser HMO members reported having a high-deductible plan.

Among the commercially insured, 38% of those with individually purchased HMO plans had high deductibles, compared with 12% of those with employer-based plans. Of those individuals with a deductible higher than $1000, 23% of commercial HMO enrollees had a Health Savings Account. Among low-income enrollees (i.e., with incomes less than 200% of the Federal Poverty Level), 25% in commercial HMOs, 32% in commercial PPOs, and 24% in commercial Kaiser HMOs had high deductibles. Of all HMO enrollees with deductibles higher than $1,000, more than half (54%) had deductibles of at least $2,000 (Figure 4).

22 Adults with commercial insurance (employer-based or individually purchased health plans) are asked whether their health plan deductible is higher than $1,000.

Exhibit 4.
Insurance Cost and Status, 2007

	Commercial HMO	Commercial PPO	Commercial Kaiser HMO	Public HMO	Public FFS	Uninsured	Total HMO	Total Non-HMO
Insurance Cost								
Deductible Higher than $1,000	14%	28%**	12%	–	–	–	13%	27%**
Has a Health Savings Account or Similar Fund for Medical Expenses*	23%	31%	20%	–	–	–	21%	30%**
Low-income (Less than 200% FPL)*	25%	32%**	24%	–	–	–		
Deductible Higher than $2000*	–	–	–	–	–	–	54%	60%**
Insurance Status								
Uninsured Part of Year (<65 yo)	5%	4%	3%**	9%	9%	23%**	5%	6%

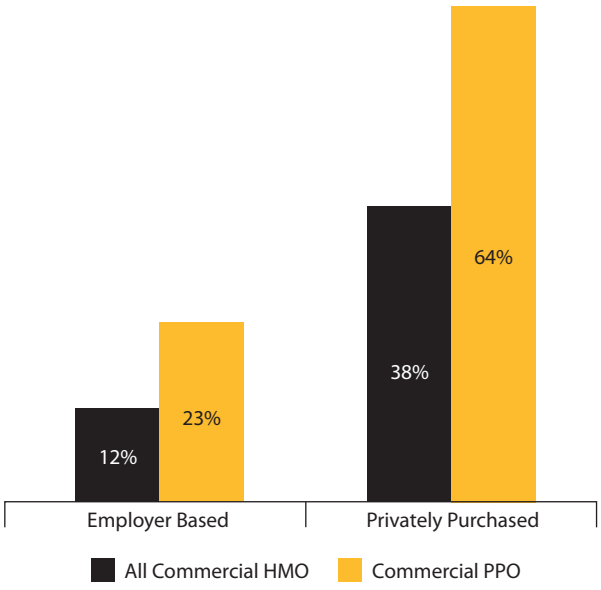
Note: Insurance Cost questions are asked only of the commercially insured (employer-based or individually purchased health plans).

* Among individuals with deductible higher than $1,000

** Denotes significant percentages at the p < .05 level. Reference group for statistical testing for commercial insurance lines is Commercial HMO. Reference group for public insurance lines is Public HMO. Uninsured is compared to Public HMO where applicable. Total Non-HMO is compared with Total HMO.

Thirty-eight percent (212,000) of Californians in all privately purchased HMO plans and 12% (1 million) in all employer-based HMO plans reported having high deductibles. Sixty-four percent (1.2 million) of Californians in privately purchased PPOs and 23% (536,000) in employer-based PPO plans reported having high deductibles (Exhibit 5).

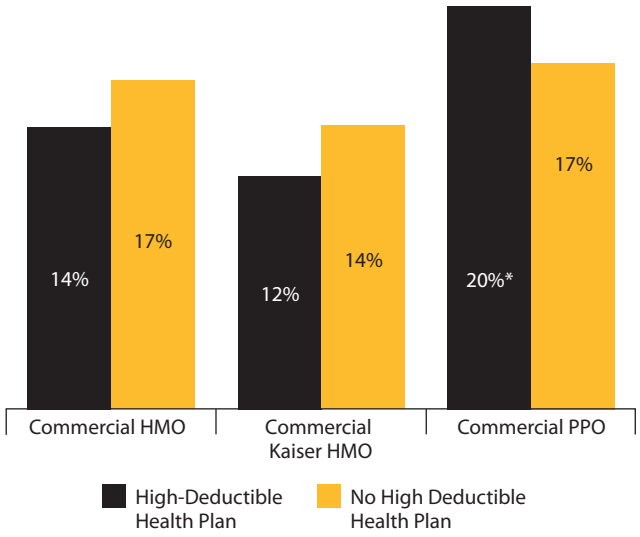
Exhibit 5.
Proportion of High-Deductible Health Plans Among Commercially Insured by Plan Type, 2007



Note: All Commercial HMO includes Kaiser HMO and other Commercial HMO.

Given the increasing reliance of many Californians on high-deductible health plans, we examined the relationship of high deductibles and delays in care. Exhibit 6 examines delays in care by insurance type among individuals with a deductible of $1,000 or more. Individuals with high-deductible plans in commercial HMOs, either Kaiser or non-Kaiser, were slightly less likely to delay needed care than their counterparts whose plans had lower deductibles, though the difference was not significant. However, 20% percent of those enrolled in commercial PPOs with high deductibles reported delays in care, significantly more commercial HMO or commercial Kaiser HMO enrollees.

Exhibit 6.
Delays in Needed Medical Care Among Commercially Insured with High Deductible Plans, 2007



*Difference is statistically significant at $p < .05$.

Personal Characteristics

California is a diverse state culturally, ethnically, and linguistically, and the HMO market in California therefore reaches a diverse population. Figure 7 provides a comparison of the sociodemographic characteristics of HMO enrollees and PPO/FFS enrollees in commercial and public sources of insurance. It is important to have an understanding of this high level of diversity by source of insurance coverage. Both insurance companies and the state government will be heavily involved in marketing, enrollment, and outreach to Californians in order to ensure that every resident has access to health insurance coverage.

Age

Approximately half of Californians in all commercial insurance lines in 2007 were in the 35–64 age group. Public HMO and public FFS health plans had large proportions of children and the elderly due to the enrollment of these populations in Medi-Cal and Medicare, respectively. The majority of the uninsured were working-age adults, 18-34 (43%) or 35-64 (45%) years of age.

Gender

Among commercial lines, Kaiser HMO had the largest proportion of women (52%). Public insurance plans had the highest proportion of female enrollees compared to all other insurance lines, with 54% in HMOs and 53% in FFS plans. Women comprised a smaller proportion of the uninsured (45%) than they did of the insured.

Urban/Rural

Among all of the commercial lines, PPOs had the largest proportion of rural enrollees (13%), while Kaiser HMO had the lowest proportion of rural enrollees (7%). Public FFS had a significantly larger proportion (16%) of rural enrollees compared with public HMOs. This is not unexpected, given the network structures used in HMOs and PPOs throughout the state, regardless of payer. However, as we move toward implementation of the Medicaid 1115 waiver to expand managed care in Medi-Cal, rural counties will likely need to develop county alternatives to managed care plans due to the lower availability of physicians and the lack of managed care network infrastructure in their areas.

Income

Thirty-six percent of enrollees in public FFS plans reported having incomes lower than 100% of the federal poverty level (FPL), a figure that is significantly higher than that for both public HMOs and the uninsured (both 31%). Commercial PPOs had a higher proportion of enrollees at the top income level (300% FPL and higher) and lower proportions of enrollees at every other income category, compared with commercial HMOs.

Education

Commercial PPOs had the highest proportion of college-educated enrollees (74%) and the lowest proportion of enrollees with less than a high school education (6%). Among the public insurance sources, FFS had a greater proportion of enrollees with some postsecondary education (44%) than HMOs (40%). A greater proportion of Californians without insurance had less than a high school education (34%) compared with those enrolled in public HMOs, and the highest proportion of all insurance status categories.

Exhibit 7.

Selected Demographic Characteristics by Insurer Type and HMO Status, 2007

	Commercial HMO	Commercial PPO	Commercial Kaiser HMO	Public HMO	Public FFS	Uninsured	Total HMO	Total Non-HMO
Citizenship								
U.S.-Born Citizen	76%	82%*	78%	75%	78%*	49%*	76%	81%*
Naturalized Citizen	14%	11%*	15%	14%	10%*	13%	14%	11%*
Non-Citizen	10%	7%*	7%*	12%	12%	38%*	10%	9%*
Years in U.S. (among non-U.S.-born)								
Less than 5 years	9%	12%*	4%*	13%	11%*	18%*	9%	12%*
15 years or more	64%	64%	74%*	62%	62%	49%*	66%	63%
English Proficiency[a]								
Speaks English Only[c]	62%	71%*	64%	59%	64%*	34%*	62%	68%*
Speaks English Well/Very Well	29%	25%*	29%	24%	19%*	29%*	28%	23%*
Speaks English Not Well/ Not at All	9%	5%*	8%	17%	17%	37%*	11%	9%*
Education[a]								
Less than High School Degree	10%	6%*	9%	27%	25%	34%*	14%	12%*
High School Grad	25%	23%*	25%	34%	31%*	32%	27%	24%*
Some College or Higher	65%	74%*	66%	40%	44%*	34%*	59%	64%*
Gender								
Female	49%	50%	52%*	54%	53%	45%*	51%	51%
Age								
0-17 years	28%	28%	27%	37%	29%*	12%*	30%	28%
18-34 years	24%	24%	21%*	12%	14%	43%*	20%	20%
35-64 years	47%	48%	51%*	15%	21%*	45%*	39%	39%
65+	1%	1%	1%	37%	37%	1%	12%	13%
Urban/Rural								
Rural	11%	13%*	7%*	10%	16%*	12%*	10%	14%*
Marital Status[a]								
Married	63%	65%	63%	47%	47%	38%*	58%	59%
Income (as a percentage of the Federal Poverty Level)[a]								
Less than 100%	5%	3%*	4%*	31%	36%*	31%	13%	14%*
100%-199%	11%	9%*	11%	31%	25%*	31%	17%	14%*
200%-299%	14%	11%*	17%*	14%	12%*	15%	15%	11%
300% and higher	70%	78%*	69%	24%	28%*	23%	55%	61%*
Employment Status[b]								
Currently Employed (Part or Full-time)	84%	83%	83%	47%	43%	71%*	79%	75%*

a Adults (18+) only

b Adults 18-64 only

c "English only" refers to all English-only speakers. Only adults who speak a language other than English in the home or who were interviewed in a language other than English were asked about English proficiency. Percentages sum to the total adult population.

* Denotes significant percentages at the $p<.05$ level. Reference group for commercial insurance lines is Commercial HMO. Reference group for public insurance lines is Public HMO. Uninsured compared to Public HMO where applicable. Total Non-HMO is compared with Total HMO.

Note: Percentages sum in columns.

Citizenship Status

Among the commercially insured, PPO enrollees had the highest proportion of U.S.-born citizens and the lowest proportion of permanent residents and non-citizens. Public FFS beneficiaries had a higher proportion of U.S.-born and naturalized citizens compared with public HMO enrollees, which might be partially due to the larger numbers of seniors and persons with disabilities who are often enrolled in Medi-Cal FFS products. Nearly half of all of the uninsured (48.9%) were U.S.-born citizens, with another 13% naturalized citizens. Thirty-eight percent of the uninsured were either permanent residents with a Green Card or non-citizens. The percentage of U.S.-born citizenship among the uninsured increased slightly from 2003, when 46% of the uninsured were U.S.-born citizens (Exhibit 7).

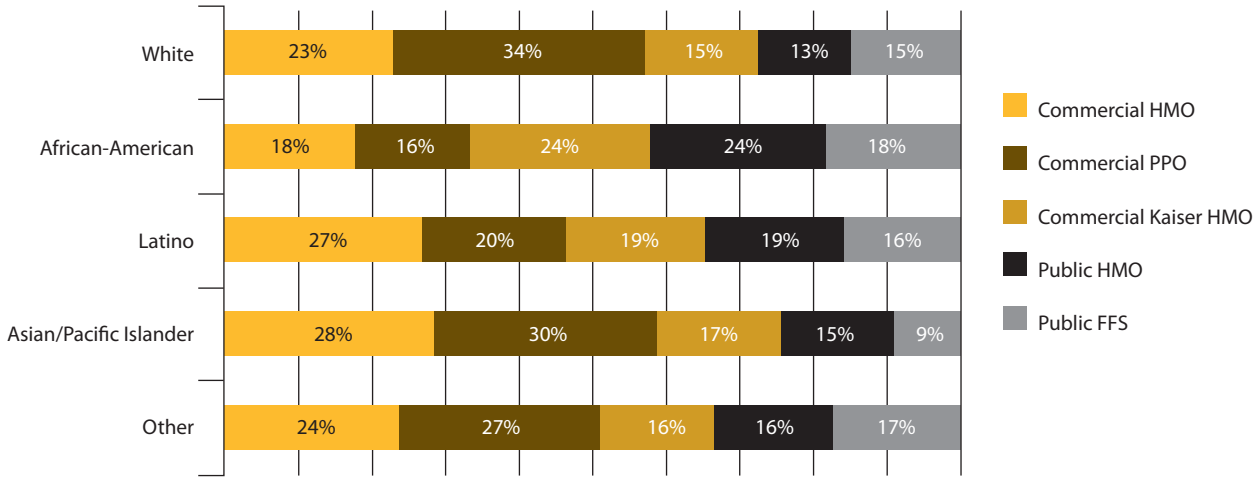
Language

English fluency is connected to an individual's ability to comprehend and interact with his or her health care provider if the provider is an English-only speaker. CHIS 2007 data show that individuals speaking English not well or not at all (i.e., having limited English language proficiency) represented 9% of commercial HMO enrollees, with the figure as low as 5% among those enrolled in commercial PPOs. The uninsured had a 37% rate of limited English proficiency, and the rate of limited proficiency in both public HMO and FFS was 17% (Exhibit 7).

Race/Ethnicity

Figure 8 graphs insurance sources by race/ethnicity for 2007. Approximately one-third of insured white Californians were enrolled in commercial PPO lines, with whites significantly more likely than those of other races to have enrolled in commercial PPOs. Commercial HMO enrollment was highest among Asian-Americans/Pacific Islanders (28%) and Latinos (27%). African-Americans had the highest enrollment in commercial Kaiser HMOs, at nearly 25%, with all other races less likely to have enrolled in commercial Kaiser Permanente products. African-Americans were also significantly underrepresented in commercial PPO insurance lines (16%) compared to all other races. A larger proportion of African-Americans were enrolled in public insurance plans (HMOs and FFS plans) than those of all other races. Among the publicly insured, only whites and other races had significantly more individuals enrolled in FFS plans than in HMOs. African-Americans, Latinos, and Asian-Americans/Pacific Islanders all had significantly more individuals enrolled in public HMOs than in public FFS plans.

Exhibit 8.
Payer Source Among Insured by Race/Ethnicity, 2007



Note: Percentages within Race/Ethnicity group refer to percent of total insured within that group. Denominator is all insured Californians.

Health-Related Characteristics

Health Status

Health status and health conditions among insurer types are shown in Exhibit 9. Studies have shown that HMOs tend to enroll healthier populations,[23] but data from CHIS 2007 indicate a better health profile for the commercial PPO segment. The vast majority of enrollees in all commercial product lines reported an overall health status of very good or better. Among Californians under age 65, commercial PPO members reported the highest percentage of good health (93%). Public HMO enrollees under age 65 reported good health status at higher rates (80%) than those who were enrolled in public FFS plans (74%) or who were uninsured (76%). Among individuals 65 years and older, a higher proportion of non-HMO enrollees (72%) reported very good or better health than was the case among their HMO-enrolled counterparts (68%).

23 Xiao Q and Savage G. HMO's Consumer Friendliness and Preventive Health Care Utilization: Exploratory Findings from the 2002 MEPS. *Journal of Health and Human Services Administration* 31, no. 2 (2008); 259–89.

Exhibit 9.
Health Status and Chronic Conditions by Insurer Type and HMO Status, 2007

	Commercial HMO	Commercial PPO	Commercial Kaiser HMO	Public HMO	Public FFS	Uninsured	Total HMO	Total Non-HMO
Self-Reported Overall Health Status								
Excellent/Very Good/Good (Less than 65 years of age)	90%	93%*	90%	80%	74%*	76%*	88%	88%
Excellent/Very Good/Good (65 years of age or higher)[a]	–	–	–	–	–	–	68%	72%*
Chronic Conditions								
Asthma								
Less than 18 years of age	15%	14%	18%	15%	15%	11%	15%	14%
18+ years	13%	13%	15%	13%	15%	10%*	14%	14%
Diabetes								
18-64	5%	4%*	6%	13%	13%	5%*	6%	6%
65+[a]	–	–	–	–	–	–	21%	16%*
High Blood Pressure								
18-64	20%	18%	23%*	29%	32%	15%*	22%	21%
65+[a]	–	–	–	–	–	–	63%	58%*
Heart Disease								
18-64	3%	3%	3%	7%	7%	3%	4%	4%
65+	–	–	–	–	–	–	22%	24%
Condition Limits Basic Physical Activity								
18-64	10%	9%	11%	29%	33%	13%*	13%	14%
65+	–	–	–	–	–	–	13%	14%*

a Breakdowns by Insurer Type not given for 65+ as nearly all respondents (96%) are enrolled in Medicare. Sample sizes were too small for analysis of the uninsured among 65+.

* Denotes significant percentages at the $p < .05$ level. Reference group for commercial insurance lines is Commercial HMO. Reference group for public insurance lines is Public HMO. Uninsured is compared to Public HMO where applicable. Total Non-HMO is compared with Total HMO.

Chronic Conditions

The rate of asthma diagnosis among children was similar across all insurance types. Among adults, asthma diagnosis was lowest for the uninsured (10%). Diabetes diagnosis among the non-elderly was slightly lower for commercial PPO enrollees than for HMO enrollees. Among the elderly, non-HMO enrollees had lower rates of diabetes diagnosis (16%) than HMO enrollees (21%). Non-elderly Kaiser HMO enrollees had the highest rates of high blood pressure diagnosis among the commercial insurance lines. Again, elderly non-HMO enrollees had lower rates of high blood pressure diagnosis (58%) than HMO enrollees (63%). Between 9% and 11% of adults in the commercial lines reported having a condition that limited basic physical activity, while 29-33% of the publicly insured reported having such a condition (Exhibit 9).

Risk Factors

Exhibit 10 presents behavioral risk factors by insurer type. Among the commercial enrollees, obesity rates were lowest for those in PPOs (18%) and highest for those in Kaiser HMOs (26%). Public insurance enrollees and the uninsured have similar rates of obesity. Commercial PPO enrollees make up a slightly lower proportion of current smokers (11%) than commercial HMO and commercial Kaiser HMO enrollees (both 13%). On the public insurance side, FFS plans had a greater proportion of current smokers (27%) than HMOs. The rate of heart disease was similar among commercial and public insurance lines. Reported binge drinking within the past year among non-elderly enrollees was quite high (between 34% and 36%) among all the commercial lines and the uninsured. Binge drinking rates in the public insurance lines were lower, at 22–23%.

Exhibit 10.
Behavioral Risk Factors, by Insurer Type and HMO Status, 2007

	Commercial HMO	Commercial PPO	Commercial Kaiser HMO	Public HMO	Public FFS	Uninsured	Total HMO	Total Non-HMO
Obesity (18+)								
Overweight (BMI 25-29.9)	36%	34%	35%	36%	36%	36%	35%	35%
Obese (BMI 30+)	21%	18%*	26%*	24%	24%	24%	24%*	20%
Smoking Status								
18-64								
Current Smoker	13%	11%*	13%	22%	27%*	23%	14%	14%
Quit Smoking	21%	22%	22%	19%	19%	17%*	21%	22%
Never Smoked	66%	67%	65%	59%	54%*	60%	65%	64%
65+[a]								
Current Smoker	–	–	–	–	–	–	6%	7%
Quit Smoking	–	–	–	–	–	–	42%	42%
Never Smoked	–	–	–	–	–	–	52%	52%
Alcohol Use[b]								
Binge Drinking in Past Year (18-64 years)	35%	36%	34%	22%	23%	35%*	33%	33%
Binge Drinking in Past Year (65 years or older)	–	–	–	–	–	–	9%	8%

a Breakdowns by Insurer Type not given for 65+ as nearly all respondents (96%) are enrolled in Medicare. Sample sizes were too small for analysis of the uninsured among 65+.

b Binge drinking is defined as 5+ drinks for males or 4+ drinks for females in a single day.

* Denotes significant percentages at the $p < .05$ level. Reference group for commercial insurance lines is Commercial HMO. Reference group for public insurance lines is Public HMO. Uninsured is compared to Public HMO where applicable. Total Non-HMO is compared with Total HMO.

Access to Services

Doctor Visit in Past Year

Among the commercial lines, the proportion of enrollees who had not seen a doctor in the past year was similar (14%). Enrollees with public HMO and FFS insurance reported not having seen a doctor at similar rates (12% and 11%). Not surprisingly, 41% of the uninsured reported not having seen a doctor within the past year. Several provisions of the PPACA may allow uninsured individuals with pre-existing conditions to become insured prior to 2014, when the individual mandate is phased in. Once insured, they are likely to experience better access to care, and the level of delayed care due to cost or lack of insurance should decrease (Exhibit 11).

Emergency Room Visit in Past Year

Public FFS insurance had the highest proportion of enrollees who reported having visited the ER in the past year (27%), a figure significantly higher than that for enrollees with public HMOs (24%). The uninsured reported the lowest rate of ER usage, at 13% (Exhibit 11). This finding, corroborated in previous studies, highlights the need for insured Californians to learn about appropriate ER use and the importance of preventive primary care.[24]

24 Newton MF, Keirns CC, Cunningham R, Hayward RA, and Stanley R. Uninsured Adults Presenting to U.S. Emergency Departments. *JAMA* 300, no. 16 (2008): 1914-1924.

Exhibit 11.
Utilization Measures by Insurer Type and HMO, 2007

	Commercial HMO	Commercial PPO	Commercial Kaiser HMO	Public HMO	Public FFS	Uninsured	Total HMO	Total Non-HMO
Doctor Visits in Past Year								
No Visits	14%	14%	14%	12%	11%	41%*	13%	13%
Emergency Room Use								
ER Visit in Past Year	17%	16%	19%	24%	27%*	13%	20%	20%
Usual Source of Care								
Doctor's Office, HMO, Kaiser	79%	81%	72%*	64%	64%	24%*	70%	71%
Community or Government Clinic/Hospital	15%	12%*	22%*	25%	25%	22%*	21%	20%
Other Place/No One Place	0%	1%	0%	0%	1%	2%	0%	1%
ER or No Usual Source of Care	6%	7%	5%	10%	10%	53%*	8%	9%
Delays in Care								
Delays in Medical Care in Past Year	16%	18%*	14%	11%	14%*	22%*	17%	14%*
Delay in Medical Care Due to Cost[a]	32%	41%*	32%	39%	52%*	87%*	33%	44%*
Delays in Filling Prescriptions in Past Year	29%	25%	29%	24%	19%	29%*	28%	23%*
Delay in Prescriptions Due to Cost[b]	39%	34%	27%*	46%	51%	70%*	38%	39%

a Among those with delays in care
b Among those with delays in prescriptions

* Denotes significant percentages at the $p < .05$ level. Reference group for commercial insurance lines is Commercial HMO. Reference group for public insurance lines is Public HMO. Uninsured is compared to Public HMO where applicable. Total Non-HMO is compared with Total HMO.

Usual Source of Care

Ten percent of both public HMO and public FFS enrollees reported having no usual source of care or use of the ER as a usual source of care. Over half (53%) of the uninsured reported having no usual source of care. Commercial product lines all reported similar rates of having no usual source of care, between 5% and 7%. Interestingly, only 72% of commercial Kaiser HMO enrollees reported having used a doctor's office as a usual source of care, compared to 79% of those commercial HMOs and 81% in commercial PPOs. Instead, more Kaiser HMO enrollees reported their usual source of care as a community clinic (22%) than did those in other commercial HMOs (15%) or commercial PPOs (12%). It is likely that these Kaiser HMO enrollees viewed their local medical group or hospital-based practices as a clinic rather than as a private office (Exhibit 11).

Delays in Medical Care and Prescriptions

Commercial PPO enrollees reported slightly more delays in medical care within the past year (18%) than commercial HMO or Kaiser HMO enrollees. In the public insurance segment, enrollees with FFS reported slightly higher rates of delays in care (14%) than those in public HMOs (11%). The uninsured reported the highest rate of delays in medical care (22%). Eighty-seven percent of the uninsured who delayed care in the past year had done so due to cost. More than half of public FFS enrollees (52%) reported delaying care due to cost, a figure significantly higher than that for public HMO enrollees (39%). Commercial PPO enrollees reported having delayed care due to cost at higher rates (41%) than did those in commercial HMOs and Kaiser HMOs (32%). Delaying filling prescriptions was fairly common among enrollees in all insurance lines and the uninsured, with between 19% and 29% of enrollees reporting a delay in the past year (Exhibit 11).

11 Connecticut, the District of Columbia, Hawaii, Massachusetts, Maryland, Minnesota, Missouri, New Hampshire, New Jersey, Pennsylvania, Vermont, and Wisconsin have all adopted and implemented income eligibility for their Medicaid and/or SCHIP programs that exceed California's level of 250% of the federal poverty level. See Kaiser Family Foundation's *statehealthfacts.org* website.

Preventive Health Care and Screenings

Cancer Screening

Exhibit 12 presents the rates of recommended mammogram, cervical, and colorectal cancer screenings. Recommended screening intervals are: every 1-2 years for mammograms (for women ages 40 and older), every 2-3 years for cervical cancer screens (for women 18 and older), and every five years for colorectal cancer screening (for men and women 50 and older).

Enrollees among all commercial lines reported having recommended mammograms at rates over 80%. Commercial Kaiser HMOs reported the highest rates of mammogram screenings within the past two years (87%) of all women in the commercial lines. Enrollees with public insurance coverage reported two-year mammogram rates approaching 80%. Only 57% of the uninsured reported having had a mammogram within the past two years.

There were similarly high rates (all more than 80%) of cervical cancer screening within the past three years among enrollees in all commercial lines. Among the commercial insurance lines, PPOs had the highest rate of cervical cancer screening (89%). The rate of screening among public FFS enrollees (85%) was not significantly higher than the rate among public HMO enrollees (82%). Nearly three-fourths of the

Exhibit 12.
Preventive Screening by Insurer Type and HMO Status, 2007

	Commercial HMO	Commercial PPO	Commercial Kaiser HMO	Public HMO	Public FFS	Uninsured	Total HMO	Total Non-HMO
Breast Cancer Screening (Women Ages 40 and Older)								
Mammogram Within Past 2 Years	83%	81%	87%*	78%	77%	57%*	82%	79%*
Mammogram Longer Than 2 Years Ago	9%	12%*	8%	17%	18%	24%*	11%	14%*
Never Had a Mammogram	8%	7%	5%	6%	5%	19%*	7%	6%
Cervical Cancer Screening (Women Ages 18-64)								
Pap Screen Within Past 3 Years	87%	89%*	86%	82%	85%	73%*	86%	88%*
Pap Screen Longer Than 3 Years Ago	5%	5%	7%*	6%	8%*	11%*	6%	6%
Never Had a Pap Screen	8%	6%*	6%*	12%	6%*	16%	8%	6%*
Colorectal Cancer Screening (Adults Ages 50 and Older)								
Colonoscopy/Sigmoidoscopy/ FOBT Within Past 5 Years	60%	58%	64%*	66%	64%	26%*	64%	61%*
Colonoscopy/Sigmoidoscopy/ FOBT Longer Than 5 Years Ago	13%	15%	14%	17%	16%	14%*	15%	16%
Never Had a Colonoscopy/ Sigmoidoscopy/FOBT	27%	17%	23%*	17%	20%	60%*	22%	23%*
STD Testing (All Adults Ages 18-64)								
STD Test Within Past Year	19%	18%	22%*	38%	35%	26%*	22%	21%

Notes: Percentages sum in columns.

FOBT is Fecal Occult Blood Test, an example of a colorectal cancer screening method.

*Denotes significant percentages at the p =.05 level. Reference for commercial insurance lines is Commercial HMO. Reference for public insurance lines is Public HMO. Uninsured is compared to Public HMO where applicable. Total Non-HMO is compared with Total HMO.

uninsured reported having had a cervical cancer screening within the past three years.

Kaiser HMO enrollees reported the highest rates of colorectal cancer screening within the past five years among commercial lines (64%). Public HMO enrollees reported a similar rate of colorectal cancer screening (66%), but it was not significantly higher than the rate for those with public FFS plans (64%). Only 26% of the uninsured over the age of 50 reported having had colorectal cancer screening within the past five years.

Kaiser HMO enrollees reported the highest rates of STD testing among those enrolled in commercial lines (22%). Rates of STD screening among those in public insurance lines were higher, at between 35% and 38%.

In general, it appears that the uninsured are at highest risk of not receiving appropriate cancer screening. With the introduction of the individual mandate and a health insurance requirement, plans will have the opportunity to encourage new enrollees to receive appropriate cancer screening if there is capacity to treat all of the new patients likely to seek out health care.

Mental Health

Mental health service access and utilization is an often overlooked but highly important topic. More than 2 million Californians are estimated to be affected by mental illness each year.[25] Most individuals who need mental health services do not access care, for a number of reasons, including stigma, cost, underinsurance or lack of insurance, or lack of provider availability. The cost of untreated mental illness is high: mental illness is the leading cause of disability among people ages 15 to 44,[26] and the associated costs in reduced work productivity stand at more than $60 billion annually in the United States. Even among the insured, cost sharing for mental health treatment tends to be higher, and limits on care are usually more restrictive than they are for medical health insurance. In 2009, regulations related to mental health parity designed to decrease benefit restrictions for those insured through large employers went into effect.[27] Exhibits 13 and 14 present data on mental health need, access, and treatment among California's population based on insurance status and health plan type.

25 Lee, D. Mental Health and Universal Coverage. January 2008, California Endowment. *http://www.calendow.org/uploadedFiles/Publications/By_Topic/Access/Mental_Health/Mental%20Health%20and%20Universal%20Coverage.pdf*

26 The numbers count—Mental disorders in America. National Institute of Health, 2006. Accessed from *www.nimh.nih.gov/publicat/numbers.cfm* on October 8, 2010

27 Information on the Federal Mental Health Parity Act: *http://www2.cms.gov/HealthInsReformforConsume/04_TheMentalHealthParityAct.asp.*

Exhibit 13.
Mental Health Assessment and Treatment

	Commercial HMO	Commercial PPO	Commercial Kaiser HMO	Public HMO	Public FFS	Uninsured	Total HMO	Total Non-HMO
Mental Health Assessment in Primary Care								
Doctor Discussed Emotions at Last Checkup	27%	24%	25%*	27%	28%	25%	26%	28%*
Doctor Discussed Emotions Understandably[a]	98%	98%	96%	98%	96%	96%	97%	98%
Doctor Arranged Treatment for Emotional Problem[b]	53%	45%*	52%	62%	62%	52%*	56%	51%*
Treatment Made Emotions Better[c]	75%	77%	71%	69%	57%*	58%*	72%	69%

a Among those who discussed emotions at checkup

b Among those who experienced severe psychological distress and talked about emotions at checkup

c Among those who had treatment arranged

*Denotes significant percentages at the $p < .05$ level. Reference for commercial insurance lines is Commercial HMO. Reference for public insurance lines is Public HMO. Uninsured is compared to Public HMO where applicable. Total Non-HMO is compared with Total HMO.

Exhibit 14.

Mental Health Needs and Treatment, California, 2007

	Commercial HMO	Commercial PPO	Commercial Kaiser HMO	Public HMO	Public FFS	Uninsured	Total HMO	Total Non-HMO
Mental Health Need								
Needed Help for Mental or Alcohol/Drug Problem in Past Year	8%	6%	8%	10%	11%	10%	8%	8%
Experienced Serious Psychological Distress in Past Year	15%	18%	17%	15%	16%	17%	16%	17%
Days Could Not Work Due to Mental Issue – Past Year[a]								
1-29 Days	28%	28%	27%	24%	23%	31%*	26%	26%
30 Days or Greater	13%	9%*	12%	30%	33%	18%*	18%	18%
Mental Health or Alcohol/Drug Treatment								
Seen by a Primary Care Provider for Mental or Alcohol/Drug Problems in Past Year	7%	7%	7%	9%	10%	5%*	8%	8%
Seen by a Psychiatrist for Mental or Alcohol/Drug Problems in Past Year	8%	10%	9%	9%	10%	6%*	9%	10%
Still Receiving Treatment from Professional for Mental or Alcohol/Drug Problem[b]	54%	52%	47%*	65%	74%*	42%*	55%	60%*
Did Not Complete Treatment for Recommended Mental Health Problem[b]	32%	38%*	45%*	44%	40%*	33%*	39%	38%
Take Daily Prescription Medicine for Mental Health Problem	9%	10%	8%	13%	15%	6%*	10%	12%
Mental Health Treatment Barriers								
Did Not Seek Help for Needed Mental Health Problem Due to Cost of Treatment[c]	32%	41%*	24%*	36%	47%*	71%*	30%	43%*
Did Not Seek Help for Needed Mental Health Problem Due to Difficulty Getting Appointment[c]	9%	10%	8%	20%	17%	20%	11%	12%

a Among adults with psychological distress in past year

b Among adults who have seen a professional for a mental health or alcohol/drug problem

c Among adults who felt they needed emotional treatment but did not receive it

* Denotes significant percentages at the $p < .05$ level. Reference group for commercial insurance lines is Commercial HMO. Reference group for public insurance lines is Public HMO. Uninsured is compared to Public HMO where applicable. Total Non-HMO is compared with Total HMO.

Mental Health Need

Enrollees in all insurance lines showed similar rates of needed help for mental health or alcohol/drug problems based on the CHIS questionnaire. Serious psychological distress was reported among 6% to 8% of enrollees with commercial insurance. Rates among public insurance enrollees were slightly higher, at between 10% and 11%. However, these differences were not statistically significant.

Between 37% and 39% of enrollees in commercial lines reported missing at least one day of work in the past month due to a mental health issue. In public insurance lines, more than half of all enrollees (54% in HMOs, 56% in FFS plans) reported missing at least one day of work in the past month for a mental health issue, and 49% of the uninsured reported missing work due to a mental health issue.

Mental Health Assessment

Between 24% and 28% of all adults stated that a doctor had discussed emotions with them at their last visit. Nearly all who reported discussing emotions with a doctor felt that they were able to understand the discussion. Treatment decisions were made for about half of those who were in distress and had talked about it with their physician. Among the commercial lines, PPO enrollees reported significantly lower rates of arranged treatment (45%) than did those in public HMOs (62%). For those who received treatment, around 70% of the commercial insurance enrollees reported feeling better as a result. Only 57% of public FFS enrollees reported feeling better, a significantly lower figure than that for public HMO enrollees (69%), but comparable to the figure for the uninsured (58%).

Mental Health Treatment

Between 5% and 10% of all adults reported having been seen by either a primary care provider or a psychiatrist for a mental health or alcohol/drug problem. Between 8% and 15% of all adults reported taking daily prescriptions for a mental health problem.

Of those who received treatment, around half were still in treatment at the time of interview. In the public insurance programs, nearly 75% of FFS enrollees reported still being in treatment, compared with 65% in public HMOs. Continued treatment rates in the commercial lines were lower, with Kaiser HMOs having the lowest rate (47%) of enrollees still being in treatment. Between 33% to 50% of Californians did not complete recommended treatment. Among the commercially insured, Kaiser HMO enrollees reported the highest rates of non-completion (45%). In the public lines, 44% of HMO enrollees reported non-completion, compared to 40% of FFS enrollees.

Interestingly, the uninsured reported one of the lowest rates of non-completion (33%) of mental health treatment regimens. It is important to note that for many uninsured individuals, county mental health departments are often responsible for managing and maintaining the mental health of the population with perceived need.

Adults who reported needing mental health help but not receiving it cited cost as a barrier somewhat often. Among the commercial lines, 41% of PPO enrollees who needed but did not receive help cited cost as the reason, compared with 32% of those in HMOs and 24% of Kaiser HMO enrollees. Forty-seven percent of FFS enrollees cited cost as a treatment barrier, compared with 36% among HMO enrollees. Almost three-quarters of the uninsured cited cost as a treatment barrier.

Difficulty in getting an appointment for a mental health issue was cited by approximately 10% of commercial insurance enrollees and between 17% and 20% of the publicly insured. Twenty percent of the uninsured reported difficulty in obtaining a mental health appointment.

Policy Discussion

Health Care Access

Californians insured through HMO, PPO, and FFS products still face barriers to accessing primary care and obtaining prescriptions. Differences exist among enrollees in commercial as well as public insurance plans. Efforts should be made to ensure that those with insurance through HMOs are able to see a doctor when needed, obtain prescription drugs, and receive appropriate preventive services.

High-Deductible Health Plans

There appears to be a trend toward HDHPs in the commercial market, with 2007 CHIS data showing a significant proportion of Californians in commercial HMO or PPO insurance plans reporting having a high deductible. High-deductible plans may present access barriers to primary and specialty care for their enrollees. Though such plans are more likely to be purchased in the individual market, one million Californians with employer-based HMO coverage reported having high-deductible plans. Further, lower-income individuals reported higher than average rates of having high-deductible plans than, even in the employer-based segment. Special attention should be paid to individuals who purchase HDHPs for affordability reasons but who do not fully understand the implications of the high deductible on their ability to use and pay for health care. Because HDHP enrollees are disproportionately low-income, it will be necessary to develop educational materials and guidance on health insurance purchasing to assist people in making informed decisions when purchasing HDHPs.

Reaching health care consumers with up-to-date information will grow increasingly important under the PPACA when the individual mandate goes into effect. Employer-based insurers could continue to offer HDHPs, and these plans will also be available through the new health insurance exchanges. To comply with the mandate and attempt to save out-of-pocket costs, consumers may purchase plans with lower premiums; however, they could still face high deductibles and cost-sharing requirements based on the actuarial value of the plan they purchase. Although preventive care will be included free of charge, other needed primary care (including pharmaceuticals) may still be delayed due to cost and benefit limitations.

Disparities in Health Care

Socioeconomic differences in use, access, and outcomes appear to remain a concern, despite insurance status and HMO enrollment. HMOs should continue to work toward limiting or eliminating disparities through the provision of enabling services, materials in multiple languages, trained health care interpreter staff and physicians, cultural competence training, and targeted outreach to specific populations whose members may be sensitive to changes in network providers, cost sharing and premium amounts, and new policies related to benefits and provision of services. In addition, with enactment of health care reform and changes to Medi-Cal due to the proposed waiver renewal, members of the diverse patient population need to be educated and informed about their rights under the new law and also prepared to navigate the health system and to appropriately use their health insurance coverage.

Public HMO and FFS Plans

Public HMO plans (Medi-Cal, Healthy Families, and Medicare) provide services to a wide range of Californians, including the elderly, low-income families, children, and the disabled. Among the non-elderly, those enrolled in HMO plans appeared to have better overall health status, as well as comparable access to primary care and screening services. Among the elderly population, FFS enrollment seemed to be associated with slightly better health status and similar rates of health service use. Although selection of HMO or FFS coverage depends on county of residence and the presence of managed care plans in the area, the characteristics of Medi-Cal enrollees in HMO plans differ from those with FFS coverage.

The complex needs of HMO enrollees throughout the state, in multiple payer sources, need to be carefully monitored by state regulators now and in the future during implementation of health care reform and the pending §1115 Medicaid Demonstration Project waiver. While PPACA strives to make insurance available to a much larger portion of the population, the burden falls on states to develop systems for monitoring and enforcing patient protections, regulating insurance premiums, maintaining competitive health insurance markets, and fostering collaboration among consumers, regulators, and insurers.

In the case of the Medicaid waiver, known as "the Bridge to Health Reform," many Medi-Cal beneficiaries who are currently enrolled in fee-for-service would be enrolled in privately run Medi-Cal HMOs, while others would be enrolled in "county alternative" plans designed to coordinate care for those with chronic illness and other ongoing medical needs. The results presented in this report provide additional information on the characteristics of the Medi-Cal FFS population and the prevalence of characteristics such as chronic illness, lower health status, and others that are important from a planning perspective.

Recommendations

While this report found differences between HMO and PPO products and payer sources in terms of enrollee characteristics, access, and quality, the causes of these differences are not clear. It is important to keep in mind the role of the consumer in purchasing and utilizing health care, and also in obtaining appropriate and necessary services as part of their health insurance enrollment. In order to improve consumer use of health care in California, we recommend the following steps be taken to arm consumers with the necessary information and the ability to navigate our complex health care system.

Educate Californians – Make consumers aware of the impact of insurance purchasing decisions and health plan type on their ability to afford and use health care. Although PPO plans may provide a greater choice of physicians compared to closed HMO networks, consumers need to be aware of the impacts of higher out-of-pocket cost sharing through deductibles and coinsurance.

Empower Californians – Guiding consumers to compare health plans (both HMOs and PPOs) based on standard quality and access measures will allow individuals to more easily assess health insurance products and purchase products that best meet their needs. In addition, Medi-Cal FFS and HMO enrollees will be able to make more informed decisions when choosing among multiple health plan choices on the HMO market, the traditional FFS system, or a commercially run Medi-Cal HMO plan. Transparent, understandable quality measures by health plan and primary care provider or medical group, already partially available through the Office of the Patient Advocate,[viii] will be helpful to California residents selecting health insurance products through the new health insurance exchanges in 2014 and beyond.

11 State of California. Health Care Quality Report Card, available from *http://www.opa.ca.gov/report_card/*. Accessed on July 19, 2010.

Ensure Equity– The disparities that exist in health-care use, quality outcomes, affordability, and access to care are often linked to specific ethnic communities and groups with lower incomes. Insurance coverage should allow low-income individuals and families to have the same access to needed care as people with higher incomes and of different races. In the face of health care reform that will greatly increase insurance coverage, it is necessary to make sure that all consumers have equal access to high-quality care, whether they are enrolled in HMOs or PPOs through their employers, HMO or FFS systems through Medi-Cal or Medicare, or individually purchased insurance products.

Changes to the health care system both in California and the nation are likely to continue. The complexities inherent in our system of health care have harmed the low-income, vulnerable, and uninsured populations for years. Now that health care reform is on the horizon, it will be necessary to educate, empower, and guarantee equity for users of our health care system in order to ensure high-quality health care and quality of life as well as affordable, appropriate care.

Appendix A.
2003 & 2005 CHIS Health Plan Enrollment

Figure A-1.
2005 Health Plan Enrollment by Payer Type

	Kaiser	Blue Cross	Pacificare	Blue Shield	Heath Net	Aetna	Cigna	Other	Total
Commercial HMO	5,092,000	1,954,000	1,162,000	1,071,000	1,070,000	419,000	326,000	1,253,000	12,899,000
	83.9%	33.2%	72.2%	50.4%	58.2%	36.8%	43.6%	21.6%	42.0%
Commercial PPO	0	3,046,000	219,000	832,000	257,000	629,000	260,000	2,159,000	7,789,000
	0.0%	51.8%	13.6%	39.2%	14.0%	55.2%	34.7%	37.2%	25.4%
Medicare HMO	751,000	119,000	195,000	100,000	141,000	44,000	135,000	445,000	2,195,000
	12.4%	2.0%	12.1%	4.7%	7.6%	3.8%	18.1%	7.7%	7.1%
Medicare FFS/PPO	0	220,000	9,000	46,000	21,000	25,000	7,000	292,000	1,934,000
	0.0%	3.7%	0.6%	2.2%	1.2%	2.2%	0.9%	5.0%	6.3%
Medi-Cal HMO	171,000	293,000	14,000	30,000	228,000	16,000	17,000	532,000	2,688,000
	2.8%	5.0%	0.8%	1.4%	12.4%	1.4%	2.2%	9.2%	8.8%
Medi-Cal FFS	0	137,000	8,000	11,000	77,000	6,000	1,000	325,000	2,009,000
	0.0%	2.3%	0.5%	0.5%	4.2%	0.5%	0.2%	5.6%	6.5%
Other HMO	52,000	75,000	3,000	29,000	37,000	0	2,000	405,000	663,000
	0.9%	1.3%	0.2%	1.3%	2.0%	0.0%	0.2%	7.0%	2.2%
Other FFS	0	36,000	0	5,000	8,000	0	0	395,000	527,000
	0.0%	0.6%	0.0%	0.2%	0.4%	0.0%	0.0%	6.8%	1.7%
TOTAL	6,066,000	5,880,000	1,610,000	2,125,000	1,840,000	1,138,000	747,000	5,807,000	30,704,000
	100%	100%	100%	100%	100%	100%	100%	100%	100%

Note: Percentages add in columns. Unknown health plan is included in total but data are not shown.

Figure A-2.
2003 Health Plan Enrollment by Payer Type

	Kaiser	Blue Cross	Pacificare	Blue Shield	Heath Net	Aetna	Cigna	Other	Total
Commercial HMO	4,764,000	1,663,000	1,069,000	1,037,000	1,168,000	408,000	407,000	1,216,000	12,199,000
	84.0%	32.4%	78.6%	51.5%	62.8%	42.3%	50.3%	21.8%	41.5%
Commercial PPO	0	2,690,000	186,000	778,000	314,000	465,000	354,000	2,392,000	7,663,000
	0.0%	52.3%	13.7%	38.7%	16.9%	48.2%	43.8%	42.9%	26.1%
Medicare HMO	652,000	85,000	56,000	84,000	118,000	28,000	11,000	345,000	1,808,000
	11.5%	1.7%	4.1%	4.1%	6.4%	2.9%	1.4%	6.2%	6.1%
Medicare FFS/PPO	0	240,000	5,000	54,000	18,000	40,000	13,000	321,000	1,936,000
	0.0%	4.7%	0.3%	2.7%	1.0%	4.2%	1.6%	5.8%	6.6%
Medi-Cal HMO	209,000	218,000	40,000	28,000	153,000	8,000	18,000	352,000	2,177,000
	3.7%	4.2%	2.9%	1.4%	8.2%	0.8%	2.2%	6.3%	7.4%
Medi-Cal FFS	0	136,000	3,000	6,000	35,000	12,000	4,000	264,000	2,546,000
	0.0%	2.6%	0.2%	0.3%	1.9%	1.2%	0.5%	4.7%	8.7%
Other HMO	48,000	76,000	1,000	19,000	45,000	1,000	1,000	320,000	571,000
	0.9%	1.5%	0.1%	1.0%	2.4%	0.1%	0.1%	5.7%	1.9%
Other FFS	0	33,000	0	8,000	10,000	3,000	0	368,000	510,000
	0.0%	0.6%	0.0%	0.4%	0.5%	0.3%	0.0%	6.6%	1.7%
TOTAL	5,672,000	5,140,000	1,360,000	2,014,000	1,861,000	965,000	808,000	5,579,000	29,409,000
	100%	100%	100%	100%	100%	100%	100%	100%	100%

Note: Percentages sum in columns. "Unknown" health plan figures are included in total but data are not shown.

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This report was done at the request of and sponsored by the California Office of the Patient Advocate, www.opa.ca.gov

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