



Major Risk Medical Insurance Program

Open Enrollment 2006

8,850 Open Enrollment (OE) Packets Mailed

- **119 (1.34%) OE Requests Processed**
- **110 (1.24%) OE Transfers Completed**
- **9 (< 1%) OE Requests Not Approved**
(Premium payment not received by deadline date.)

Health Plan:	Requests to Transfer IN:	Requests to Transfer OUT:	Change:
Blue Cross (PPO)	27	62	-35
Blue Shield (HMO)	2	23	-21
Contra Costa	0	7	-7
Kaiser North	33	1	+32
Kaiser South	48	17	+31
Total	110	110	0

2006 MRMIP Open Enrollment Results

Transfer requests from **Blue Cross of California** to:

• Blue Shield of California (HMO)	1
• Contra Costa Health Plan	0
• Kaiser Permanente Northern California	24
• Kaiser Permanente Southern California	37
Total for Plan	62

Transfer requests from **Blue Shield of California (HMO)** to:

• Blue Cross of California	8
• Contra Costa Health Plan	0
• Kaiser Permanente Northern California	4
• Kaiser Permanente Southern California	11
Total for Plan	23

Transfer requests from **Contra Costa Health Plan** to:

• Blue Cross of California	2
• Blue Shield of California (HMO)	0
• Kaiser Permanente Northern California	5
• Kaiser Permanente Southern California	0
Total for Plan	7

Transfer requests from **Kaiser Permanente Northern California** to:

• Blue Cross of California	1
• Blue Shield of California (HMO)	0
• Contra Costa Health Plan	0
• Kaiser Permanente Southern California	0
Total for Plan	1

Transfer requests from **Kaiser Permanente Southern California** to:

• Blue Cross of California	16
• Blue Shield of California (HMO)	1
• Contra Costa Health Plan	0
• Kaiser Permanente Northern California	0
Total for Plan	17

Summary:

Total OE packets mailed:	8,850
Total OE requests received and processed:	119
Total OE transfers completed:	110
Total OE not approved due to premium not paid by the deadline date (not included in the total OE transfer completed):	09

2006 MRMIP Open Enrollment Customer Satisfaction Survey Results

This survey was mailed to 8,850 subscribers with a 10% response rate. A total of 880 subscribers responded to the survey and commented on the following:

1. How satisfied are you with the level of service you have received from your health plan? (Choice of doctors, written materials, customer service).

Subscribers' Responses:	Total Responses:	Approximate Percentage:
Extremely satisfied	244	28.44%
Very satisfied	318	37.06%
Satisfied	239	27.86%
Not very satisfied	46	5.36%
Not at all	11	1.28%
Total Responses:	858	100%

2. How satisfied are you with the level of service you have received from your doctor's office, medical group or clinic, and the staff who work there?

Subscribers' Responses:	Total Responses:	Approximate Percentage:
Extremely satisfied	295	35%
Very satisfied	314	37%
Satisfied	198	23%
Not very satisfied	35	4%
Not at all	9	1%
Total Responses:	851	100%

3. General Comments. Responses solicited from subscribers who changed their health plan or who are not satisfied with their current plan. Multiple responses were encouraged. Therefore, the total does not reflect the number of responses to the survey.

- Cost of subscriber contributions: 103
 - I cannot afford my current plan: 66
- Other: 12
- Appointments to see the doctor have to be made too long in advance: 37
 - 4 weeks or more 33
 - 3 weeks 9
 - 2 weeks 3
- Not being able to see a doctor when the need is urgent: 23
- Problem getting prescriptions. Prescription needed is not on formulary: 26
- Problem getting help or advice from my doctor's office during regular office hours: 18
- Problem getting care that I or my doctor believed to be necessary: 21

Agenda Item 10c
05/16/2007 Meeting

• Problem getting a specialist when I need one:	19
• Problem getting a doctor I'm happy with:	21
• Not satisfied with medical care received:	20
• Doctor's office is too far away:	12
➤ 25-45 miles	9
➤ 15-25 miles	5
➤ 10-15 miles	1
• Not satisfied with the hours or days a primary care doctor's office is open:	8
• Primary care doctor left the plan:	5

Total survey responses received = 880

Customer Satisfaction Survey

The following survey is designed to help us improve the quality of service provided by the Major Risk Medical Insurance Program (MRMIP) and to make suggestions for changes to our participating plans' service. On a scale of 1 to 5 (1 is the worst; 5 is the best), please circle your response.

	Not at all	Not very satisfied	Satisfied	Very satisfied	Extremely satisfied
1. How satisfied are you with the level of service you have received from your health plan? (Choice of doctors, written materials, customer service)	1	2	3	4	5
2. How satisfied are you with the level of service you have received from your doctor's office, medical group or clinic, and the staff who work there?	1	2	3	4	5

Please fill out the following section if you are changing your health plan or if you are not satisfied with your current plan. Please check one or more of the reasons below. This information will be kept confidential.

<input type="checkbox"/>	(a) Not satisfied with medical care received
<input type="checkbox"/>	(b) Primary care doctor left the plan
<input type="checkbox"/>	(c) Problem getting a doctor I'm happy with
<input type="checkbox"/>	(d) Problem getting care that I or my doctor believed to be necessary
<input type="checkbox"/>	(e) Problem getting a specialist when I need one
<input type="checkbox"/>	(f) Not being able to see a doctor when the need is urgent
<input type="checkbox"/>	(g) Not satisfied with the hours or days a primary care doctor's office is open
<input type="checkbox"/>	(h) Problem getting help or advice from my Doctor's office during regular office hours
<input type="checkbox"/>	(i) Appointments to see the doctor have to be made too long in advance. Check one: <input type="checkbox"/> 2 weeks <input type="checkbox"/> 3 weeks <input type="checkbox"/> 4 weeks or more
<input type="checkbox"/>	(j) Doctor's office is too far away. Check one: <input type="checkbox"/> 10-15 miles <input type="checkbox"/> 15-25 miles <input type="checkbox"/> 25-45 miles
<input type="checkbox"/>	(k) Problem getting prescriptions. Prescription needed is not on formulary
<input type="checkbox"/>	(l) Cost of subscriber contributions <input type="checkbox"/> I cannot afford my current plan
<input type="checkbox"/>	(m) Other: (use reverse side if necessary)

If you are changing plans and selected more than one reason above, please provide the primary reason you are changing your plan: _____

Please mail your completed survey and the Transfer Enrollment Form (if you are changing plans), in the enclosed envelope to:

**California Major Risk Medical Insurance Program
P.O. Box 9044
Oxnard, CA 93031-9044**