

CONSUMER

Health Insurance Handbook



GUAM HEALTH PLANNING AND DEVELOPMENT AGENCY

CONSUMER HEALTH INSURANCE HANDBOOK

JANUARY 1987

**Guam Health Planning and Development Agency
and
Guam Health Coordinating Council**



**Room 155, Administration Building
212 West Aspinall Avenue
Agana, Guam 96910**

ACKNOWLEDGEMENTS

The Guam Health Planning and Development Agency and the Guam Health Coordinating Council would like to express their sincere appreciation to the Western Oregon Health Systems Agency for granting permission to excerpt material from its consumer health insurance handbook (1984).

The Agency and Council would also like to thank the following for their participating in the development of Guam's consumer health insurance handbook:

- FHP, Inc.
- Staywell
- Guam Memorial Health Plan
- Mark's Insurance Underwriters

TABLE OF CONTENTS

	Page
Introduction	1
What Is Health Insurance?	2
Who Needs Health Insurance?	3
What Kind Of Coverage Is Available?	4
What's The Difference Between Insurance Providers?	4
How Much Does It All Cost?	10
What To Look For In Health Insurance	12
The Best Health Insurance Of All	14
Glossary Of Insurance Terms	16

INTRODUCTION

Health insurance, like automobile or life insurance, can be complex and difficult for consumers to understand. Health insurance policies are often lengthy and filled with technical language that creates confusion for consumers trying to decide on the type of health plan that may best suit their health care needs. In some cases, the expression "just as long as I am covered" reflects the consumer's only concern. Vital details such as the cost of health care, the medical benefits offered and the limit of the insurance coverage are ignored. As a result, many end up paying for a health plan that leaves them underinsured or overinsured.

The Guam Health Planning and Development Agency has prepared this Consumer Health Insurance Handbook for you the consumer. The handbook is intended to provide information about health insurance so that you can make sound decisions when shopping for a health insurance policy.

Because many of us are unfamiliar with the various health plans, this handbook includes information about health insurance in general, as well as the types of insurance programs available on Guam, what they cover and do not cover, and the costs of health care with and without insurance.

INDEMNITY PLAN?

HMO?

PUBLIC INSURANCE?



WHAT IS HEALTH INSURANCE?

The general purpose of health insurance is to ease the financial burden that may arise from unexpected health care.

A simple, non-surgical stay at Guam Memorial Hospital, for example, may cost anywhere from \$2,700 to \$3,300. This doesn't include the doctor's fees or any Emergency Room charges that may have been necessary. An individual or family who is uninsured may be in debt for quite some time because of an incident such as this. Even an insured person may have to pay the medical bill out-of-pocket if services used were not included in the health benefits offered in his particular plan. Before purchasing health insurance it is very important that you thoroughly read and understand what the policy has to offer in terms of benefits, what it requires in co-payments and deductibles, and what health services it excludes from coverage.

You must also consider the cost of health care when

shopping for health insurance. Modern medicine, with its sophisticated equipment and advanced medical procedures is quite costly. So too is the health insurance that covers such care. Insurance coverage for an individual may cost \$500 or more a year, and for a family the cost may be as high as \$2,000 or \$3,000. For that kind of money, it's important for you to know what you're paying for.



WHO NEEDS HEALTH INSURANCE?

People of all ages should be adequately covered by some type of health insurance in the event of illness or injury. A sound health plan can ensure access to proper health care and safeguard against medical costs that can put an uninsured person in debt for many years.

The type of health plan one looks for should reflect the individual subscriber's needs. A young, single person may not use or need the same services that a family person does. If that's the case, a young, single subscriber would be wise to avoid enrollment in a family-type plan.

Employers and health insurers generally distinguish between the different types of subscribers either through the premiums charged, the benefits offered, or both. The Government of Guam, for example, offers each of its employees the same benefits regardless of subscriber classification. However, the premiums charged to GovGuam employees, varies from one class to another.



Within the private sector, the benefits and premiums offered to the different classes of subscribers may vary from one employer's health plan to another.

The question then, is "what type of subscriber are you?"

If you're a government employee who is single and has **no dependents**, you belong to the Class I category of subscribers. If you're employed in the private sector, single, and have no dependents, you're classified as a **Single Plan** subscriber. Single parents generally fall into the same category as married employees with dependents.

If you're a government employee and married, you may be classified as a **Class II** subscriber if one spouse works for the government, or a **Class III** subscriber if both spouses are government employees. If, on the other hand, you're married and work in the private sector, your health insurance classification is based on whether or not you have any dependents. **Couple and Two Party Plan** subscribers refer to those without dependents; **Family Plan** subscribers include those with dependents. Young couples may insure themselves for maternity care and get coverage for children from date of birth. If you have children you may need coverage for both medical and dental care in case of accidents, routine childhood illnesses, and dental needs.



If you're uninsured or underinsured and are unable to provide for your own medical care costs, you can apply at one of two public health programs, Medicaid or the Medically Indigent Program (MIP). Both programs contract private clinics to administer medical services to eligible enrollees. The programs are intended for those who do not have medical insurance coverage because of a financial inability to pay, as well as for those who have medical coverage in the event that such coverage is inadequate to cover the entire cost of medical treatment.

Persons who are 65 and older, or have been prematurely disabled, and who have contributed to the Social Security or Railroad Retirement Fund are eligible for Medicare through the Social Security Administration.

WHAT KIND OF COVERAGE IS AVAILABLE?

There are two types of health insurance coverage, one for groups and another for individuals.

A Group coverage is obtained through an employer's contract with either an HMO or indemnity insurance to provide health care for its employees. This type of coverage is offered by employers who provide fringe benefits for their employees. In a group coverage plan, the employer may pay

anywhere from half to all of the total premium costs for health care. The employee is required to pay the difference.

Individual coverage is usually more expensive than group coverage. An individual plan is generally provided to those persons without fringe benefits offered by their employers. This means that the individual and family have to shop for their own health insurance and pay the entire premium cost for health care themselves.

WHAT'S THE DIFFERENCE BETWEEN INSURANCE PROVIDERS?

The various indemnity or traditional insurance plans as well as the island's two Health Maintenance Organizations provide group coverage. Individual coverage is provided by most indemnity plans and one HMO as well. Guam Memorial Health Plan (GMHP).

Health Maintenance Organizations:

Coverage through a Health

Maintenance Organization is a prepaid insurance program. There are two HMO service plans on Guam. FHP has one, GMHP has another.

Almost half of Guam's population (43 percent) is covered by either FHP or GMHP, with GovGuam and federal government employees as leading subscribers. Both HMO's assume the responsibility of providing a broad range of

health services at a fixed prepaid fee. Having a fixed prepayment fee means enrolled members pay biweekly premiums in advance for health services.

FHP, Inc.

FHP is a federally qualified California-based HMO. It has a medical group practice of 20 physicians in various medical specialties. Most of FHP's services are provided at the FHP medical center in Tamuning. The facility is equipped with its own dental department, pharmacy, physical therapy unit, home care services, x-ray and diagnostic laboratories.

As part of FHP's effort to provide a wide selection of physicians and services, it has a contract with the Seventh Day Adventist (SDA) clinic to serve its enrolled members. Persons enrolled with FHP have the option of using either the SDA clinic or the FHP center for their total patient care needs. A total of 16 physicians are employed at the SDA clinic and provide a wide range of health services. Over 25,000 persons are enrolled with FHP, most of whom

are GovGuam and federal government employees.

Guam Memorial Health Plan (GMHP)

The Guam Memorial Health Plan began as a part of the Guam Memorial Hospital Authority and was sponsored by the Government of Guam to provide low-cost health care coverage to the citizens of Guam. GMHP has since become a non-profit and federally approved HMO that is no longer part of the Government. Health services are provided to employees in both the public and private sectors, as well as to other interested individuals in the community. The health services of the Guam Memorial Hospital, ITC clinic, and several private physicians are contracted by GMHP to serve its more than 19,000 enrolled members.

The two HMO plans provide excellent coverage and are the most popular mode of health insurance among GovGuam and federal employees. A fixed fee for health care has attracted these two major employers and several commercial or business organizations to insure their employees with the FHP or GMHP health

programs.

There are three big advantages to enrolling with an HMO.

- (1) HMO enrollees pay a fixed premium for comprehensive health care. That is, the premiums remain unchanged throughout the term of coverage regardless of increases in health services.
- (2) HMOs stress staying healthy rather than focusing entirely on treating sickness. Preventive care such as immunizations, periodic eye and ear exams, and dental exams twice a year are standard benefits.
- (3) HMO enrollees do not have to fill out medical claim forms whenever health services are used. HMO health plans receive the bill directly from the attending physician, relieving subscribers from any paperwork.

The major disadvantage of enrolling with an HMO is the limited choice of physicians. A physician not belonging to an HMO is not covered by the plan. So if your personal physician is not in an HMO, you will have

to switch to a physician who is or choose another mode of insurance.

Indemnity Insurance Plans

Indemnity plans or traditional fee-for-service insurance is the second most popular mode of insurance favored by health consumers. Staywell, UIU, and Nanbo are examples of the many indemnity insurance companies on Guam. This type of program covers doctor, hospital, clinic, and other health services for a monthly premium. They are called fee-for-service plans because they pay the doctor a fee for every health service carried out to their enrolled members. The traditional insurance programs are popular among the small commercial organizations.

The two major advantages of membership in an indemnity plan are the lower premiums, flexibility in coverage and a choice of doctors.

- (1) The premiums for traditional insurance are much lower than those of an HMO because a deductible is required for each health service provided. The higher the deductible, the lower the premium.

(2) A good comprehensive health plan enables consumers to tailor the extent of coverage and the cost of the plan to fit their needs and to cover most of their medical bills.

(3) Traditional insurance allows you significant freedom in choosing a physician to take care of your health care needs.

The disadvantages of membership in an indemnity plan include the often lengthy processing of the medical claim forms and the possibility of high health care costs.

(1) Enrolled members are given the task of filling out medical claim forms whenever services are used. This can be especially burdensome if a large amount of paperwork is involved. All health plans have deadlines for members to submit medical claim forms, and some insurance plans will not provide coverage if claims are not filed before the deadline. This may mean that members have to pay the charges themselves.

(2) Attempts by traditional insurance plans to control health care costs have not been successful because they pay an amount based solely on the physician's fee for services. This means that the insurance companies pay the physician's charges regardless of whether the amount of services provided was adequate or more than necessary. As a result, traditional insurance plans usually increase their rates to meet the physician's fee for services rendered.

Public Insurance Programs

If you cannot afford health insurance, you may be eligible for one of two medical assistance programs administered by the Department of Public Health and Social Services. These programs have rigid eligibility requirements to ensure that the limited resources are available to those in need.

Medicaid

Medicaid is one of the major public health insurance plans available for those persons with little or no financial ability to provide for their own health care. It is financed

by both federal and local funds, and covers a specific list of services. Medicaid contracts physicians, clinics, and the hospital to provide care for program participants. Each time a service is provided, the health care provider submits a claims form to the Medicaid office for payment.

Medically Indigent Program (MIP)

If you cannot afford health insurance or health care, but do not qualify for Medicaid, you may be eligible for assistance from the Medically Indigent Program. The eligibility requirements are a little less stringent than Medicaid's and the coverage is considered somewhat more flexible. However, you must still demonstrate a need for such assistance.

Medicare

This program is a federal health insurance plan intended to protect the elderly from the high cost of health care. Anyone 65 or older who is receiving Social Security is eligible, as are certain disabled people of any age.

The program contains two

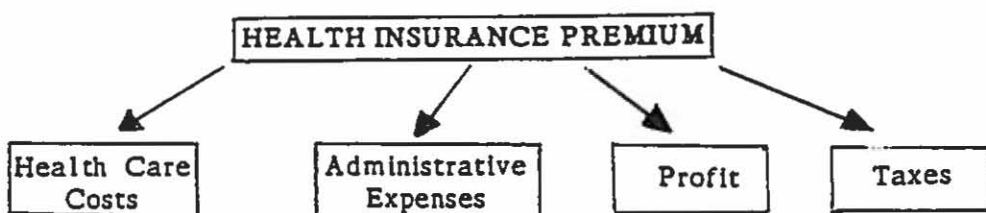
parts. Part A provides for hospital and home health care. Part B is an optional supplementary program that only covers physicians' fees and certain medical costs; it does not cover hospital care. Under part B both the enrolled member and the federal government share in the monthly premium payments. Full information on Medicare is available at the Social Security Administration Office, located on the first floor of the Pacific Daily News Building in Agana. Just ask for the booklet entitled "Your Medicare Handbook."



HOW MUCH DOES IT ALL COST?

With the costs of health care rising, it is important that you understand how the payment system works in order to know how your health care dollar is spent. Occasionally you may wonder why you have to pay for certain medical services when you are already paying premiums for coverage. You must understand that in most health plans, premiums alone do not cover the costs of health care. Premiums are often coupled with a deductible or co-payment feature.

Premiums refer to the amount of money that you, the subscriber, must pay to keep the coverage in effect. Premiums are paid periodically, usually bi-weekly for HMOs and monthly for traditional insurance plans. Premiums vary from one kind of health insurance to another. Each plan sets its rates according to the administrative and operational costs of providing health services to its enrolled members.



Although premiums differ in any given health plan, an average may give you a general picture of the costs of health care. In 1986, for instance, the average monthly premium of Guam's two HMOs for medical and dental coverage among Government of Guam employees was \$82.72 for class I; \$245.38 for class II; and \$252.81 for class III. In traditional insurance plans the premium costs are much lower with an average monthly premium of \$46.86 for single plan and \$163.55 for family plan members.

Given these average premiums for the two types of health plans, you can see that HMOs charge more than the traditional insurance companies do. Be careful, however, to avoid shopping for health insurance solely on the basis of premium costs. Be sure that you fully understand the coverage you are buying. Remember that while HMO coverage is more expensive, it includes a broad range of health services with modest co-payment features.

In traditional insurance plans, the lower premium is often the primary attraction. The premium costs are lower because a deductible is part

of the insurance plan. You generally must pay a portion of the medical costs for each health service received. The inclusion of a deductible helps keep monthly premiums at a lower cost than on HMOs.

Deductibles and co-payments, commonly known as "out-of-pocket" expenses, refer to the specific amount of money that a health plan subscriber must pay to the provider before receiving a service. While both terms mean essentially the same thing, the term deductible is usually associated with indemnity insurance and co-payment with HMOs. Once you pay your portion--usually between 15 and 20 percent--the plan will pay the rest.

In most cases, there's a limit on the amount of money one pays in deductibles or co-payments during any term of coverage. Once this "out-of-pocket limit" is reached, the health plan will pay 100 percent of the charges. For example, Staywell has a \$1,000 out-of-pocket limit for its members. It pays 80 percent of medical charges up to \$5,000. If the medical expenses are over \$5,000, the plan will then pay 100 percent of up to \$95,000 in medical charges.

Some health insurance plans require that enrolled members file a medical claim form with the company before it pays its share of the medical bill. Some insurance plans will not pay for services if medical claims are not

filed on time. Be sure you read your insurance policy carefully to see if any sort of deadline applies to you. A medical claim form usually includes the following:



- Physician's name
- Nature of problem
- Treatment
- Itemized charges

WHAT TO LOOK FOR IN HEALTH INSURANCE

Before purchasing any kind of insurance, the consumer should thoroughly examine the composition of the health plan. If your usual method of shopping for health insurance is by comparing the financial costs such as premiums, deductibles, and co-payments, stop and look at the **health benefits** being offered as well.

Health benefits refer to the types of services covered by a health plan to serve the needs of enrolled members. In shopping for any kind of health plan, it is your responsibility to review the health benefits being offered

to ensure that the services you need are covered by the plan. If for example, you purchase a health plan and receive treatment that is not covered under the plan, you may have to pay the total medical bill yourself. So before purchasing any kind of insurance, examine the benefits being offered.

" ..only
ONE
eye
exam
per
year? "



Medical Benefits should include:

Outpatient Care (clinics, private doctor):

- Doctor's visit
- Consulting specialist
- Routine physical exams
- Laboratory/x-ray services
- Sterilization
- Immunization
- Maternity/well baby care
- Eye and ear examination
- Prescription drugs
- Physical therapy
- Inhalation therapy

Inpatient Care (hospital):

- Emergency care
- Semi-private room
- Surgical procedures, equipment, and supplies
- Intensive care
- Hospitalization for maternity
- Prescription drugs
- Physician/nurses' services
- Diagnostic and laboratory/x-ray services
- Ambulance
- Off-island emergency care and referrals

Dental Benefits should include:

- Clinical exams
- Routine extraction
- Dentures
- Routine x-rays
- Treatment of gum disorders
- Crowns
- Fillings
- Drug prescription
- Bridges

Routine cleaning;
Root canal;
Oral surgery.

In addition to the benefits offered, it would be wise to look over the **exclusions** of each health plan as well. You may not wish to enroll in a plan that excludes health services that you consider vital. If you have any questions about exclusions, don't hesitate to call on your insurance representative or personnel officer.

Most health insurance companies and both of the island's HMOs offer a brochure or handbook that describes the types of benefits being offered in their respective plan. Read these and review brochures carefully; study their benefits and financial features.

When looking at an HMO's health plan, you may want to ask:

How much is the premium and how often must it be paid?

What services are fully covered?

What services require a co-payment and how much is the co-payment?

What services are not covered by the health plan?

Who are the HMO providers and where are they located?

What are the working hours of the HMO operations?

When reviewing an indemnity plan, you may want to consider:

How much is the premium and how often must it be paid?

THE BEST HEALTH INSURANCE OF ALL

Health insurance has become one of today's wisest investments. But while insurance may protect us from expensive, unexpected health care costs, the best way to contain health costs is **not to get sick or injured in the first place**. Most of us are born healthy, and we become sick or injured through a combination of environmental factors and an unhealthy or unsafe life style.

Here are some basic habits that can turn the odds for good health and a long life in your favor:

What services are covered and what are the deductibles for the inpatient and outpatient services?

What services are not covered by the health plan?

What, if any, is the deadline for filing medical claims?

Is the insurance plan a comprehensive one?

*Make time on a regular basis for exercise, such as brisk walks, swimming, jumping rope, bicycling, running, or calisthenics.

*Eat a sensible, balanced diet. Snack only on fresh fruits and vegetables. Cut down on fatty foods, sugar, and salt. Eat a hearty breakfast. Drink lots of water.

*Get the right amount of sleep--usually between six and eight hours every night. Also learn to relax, and do it regularly.

*Keep a well-stocked first-aid kit in your home and your car. You may be able to keep a minor problem from becoming serious.

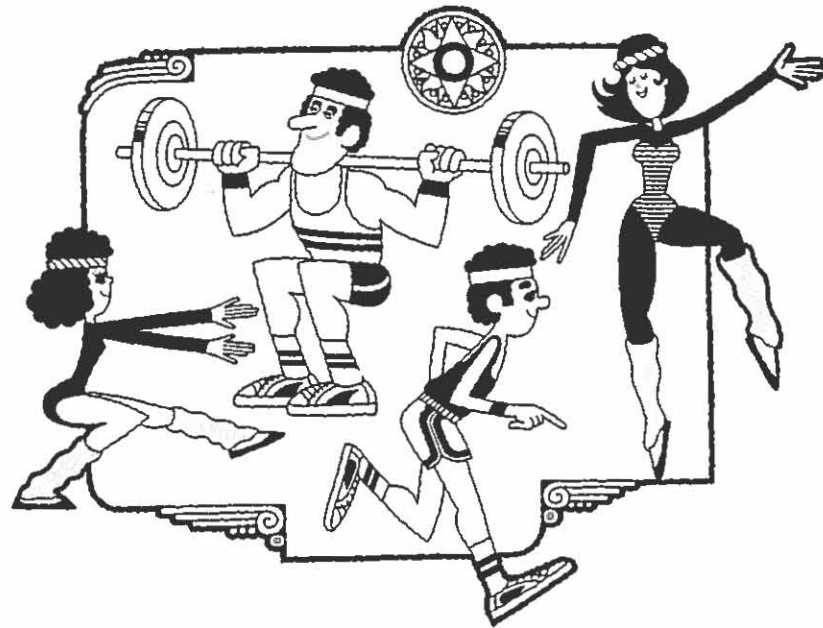
*Be especially careful to protect infants and children by keeping toxic substances out of reach and by using approved restraints in your car.

*Don't poison yourself with tobacco, and moderate your use of liquor. Smoking and alcoholism are both major killers!

*Be alert to lumps, and to sudden changes in weight. Learn to handle stress, and have your blood pressure checked regularly.

*Maintain yourself in a safe environment, do what you do with care and awareness, and use protective devices like seat belts and helmets.

*Not surprisingly, your general attitudes and your mental health status can affect your physical health. If you're constantly depressed, anxious, complaining, or nervous, get some help.



GLOSSARY OF INSURANCE TERMS

Benefits - The health services that are covered by a plan.

Claim - The indemnity plan's payment to providers who carried out services to enrolled members.

Co-payment - The portion of costs which the subscriber must pay; often the subscriber pays 20 percent, the plan pays 80 percent. Co-payment is a term usually associated with HMO's.

Deductible - The portion of health care costs subscribers must pay before the plan begins coverage. Deductible is usually associated with traditional insurance plans.

Dependents - The spouse and children of the insurance subscriber. Under some plans, parents and other family members may be eligible as dependents of the subscriber.

Exclusion - The types of health services that are not covered by the plan.

Fee-for-service - The traditional system of payment to providers. The payment is based on a charge made by the provider for services carried out to enrolled members.

Group coverage - An employer's contract with the plan to cover its employees and their dependents.

Health Maintenance Organization - A health plan that provides a wide range of comprehensive health services for a fixed, prepaid periodic payment.

Indemnity - The traditional plan's specific cash reimbursement made to the provider for services rendered to the plan's enrollees.

Individual coverage - An individual's contract with a health plan to provide coverage to the individual and his family.

Premium - The periodic payment required of the members to keep their plan's coverage in effect.

Provider - A physician, health professional, or organization who administers health care service to subscribers.

Subscriber - The individual who purchases insurance coverage, whether solely for himself or for his dependents as well. Coincides with member and enrollee.