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LBJ Tropical Medical Center
Pago Pago, American Samoa 96799

Dear Mr. McCuddin:

The attached final report contains our recommendations for a new ASG health care financing plan. The report contains: (1) An executive summary; (2) Information to better understand the health care financing needs; (3) Recommended health care financing objectives; (4) An evaluation of the financing alternatives; (5) The recommended plan; and (6) Suggestions for implementing the plan.

I will be pleased to review and discuss this report with you, your staff, the Council, ASG officials and to receive your comments.

Soifua,


Gerald N. Siegel

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CHAPTER I
EXECUTIVE SUMMARY

I. EXECUTIVE SUMMARY

The American Samoa Health Planning and Development Agency (ASHPDA), with the assistance of Siegel & Associates, has undertaken this special project to determine if there is a better way for ASG to finance its health care. The reason for this undertaking can best be understood by summarizing several key facts and events that have occurred over recent years.

A. THE PROBLEM

- . ASG health care costs for the Department of Health (DOH) have almost doubled over the last eight years -- from \$3.8 million in FY74 to \$7.3 million in FY82.
- . The DOH budget is the second largest departmental budget in ASG and has increased almost twice as fast as the total ASG budget over the last four years -- 28 percent for DOH versus 15 percent for ASG in total.
- . Future increases are likely unless past trends can be reversed and general inflation coupled with the two major cost elements in DOH -- personnel and off-island care -- can be contained.

While the cost side of the ASG health care system is not encouraging, the funding side is even less so because health care funding is heavily linked to the overall ASG funding problems:

- . In FY79, almost two thirds of all government operations were funded from Federal sources and slightly over one third came from local taxes and revenues. Since then, the Federal percentage has slowly declined. The result has been that the local share has had to fund the Federal decrease and the overall increase in the total ASG budget -- for FY82 the Federal share is 50 percent and the local share will be 50 percent.
- . This shift in funding emphasis seems to be clear evidence that DOI intends for ASG to become more financially self-sufficient.
- . Further pressure is likely to come on the Federal half of the funding in FY82 -- which is 28 percent from the DOI grant-in-aid to ASG in general and 22 percent from specific Federal grant programs. Along with decreases in the DOI grant over recent years, many of the specific Federal grant programs are now targeted with 20 percent

- . Do ASG and its citizens need a new health care financing plan?
- . Should all of the financing come from one source of funds or from a combination of financing alternatives?
- . How much of the health care costs should be paid for by residents versus non-residents?
- . Should the participation or enrollment in any new plan be optional or required?
- . Should the funds generated by a new financing plan be placed in the ASG General Fund or should they be specifically designated for the Department of Health and health care programs?

These issues were addressed in a three phased work program designed to:

- . Establish financing objectives
- . Evaluate alternative financing plans
- . Present study findings and recommendations.

D. RECOMMENDED FINANCING OBJECTIVES

Our recommendations call for:

- . A range of different financing objectives over a ten year period --short, mid and long term objectives.
- . Financing objectives that are material in amount and that also appear to be reasonably achievable.
- . Objectives that will finance:
 - The Federal share of the DOH budget, less the specific Federal grants to DOH.
 - Increases in the DOH budget.
 - Other costs at DOH that are not now included in its budget, such as funding depreciation for renewing the plant and equipment, and the DOH share of the general services it receives from other departments.
 - In the long run, financing the DOH share of the local ASG funds.

These requirements translate into the following financial objectives:

- . \$2.8 to \$3.8 million in the short term -- the first and second years.
- . \$6.2 million in the midterm -- the fifth year; and,

- . If the entire DOH budget were financed in the long term, \$12.9 million in the tenth year.

Even the low end of the short term objective, \$2.8 million, is material and significant in relationship to the total FY82 budget -- almost 40 percent. It also appears to be achievable as borne out by the evaluation of the financing alternatives.

E. RESULTS OF EVALUATING THE ALTERNATIVE FINANCING PLANS

Six basic alternatives and several combinations were evaluated:

- . Fee-for-service Plans.
- . Post Payment Plans.
- . HMO (Health Maintenance Organization) Plans.
- . Tax Based Plans.
- . Federal Medicaid Funding for Certain Groups of Citizens.
- . Combinations of the Six Basic Plans.

The pros and cons of each of these was identified and each alternative was evaluated to determine its:

- . Legal Feasibility.
- . Administrative Feasibility.
- . Marketing Feasibility.
- . Financial Feasibility.

In addition, numerous presentations, workshops, and discussions of this work were held with elected and appointed officials in the executive and legislative branches, DOH management, ASHPDA staff, the Advisory Council and its Executive Committee, and other interested groups and individuals. The purpose of this was to solicit a broad range of opinions and suggestions, competing and otherwise, in order that the final results would be the most reasonable from the perspective of the Samoan way and yet be responsive to the current

and future financing needs.

F. RECOMMENDED FINANCING PLAN

Table I, following this page, shows a comparison of the key alternatives evaluated. The fee-for-service and post payment alternatives were rejected because they could not meet the mid and long term financing objectives and the rates would have to be set so high in the short term that they would become excessively burdensome on those receiving and paying for the services. The HMO alternative was rejected because a stable and adequately staffed physician/provider group, an essential requirement for an HMO, is not currently present at DOH/LBJ. The pre-paid, tax based and Medicaid alternatives were all found to be acceptable if used in combination because, separately, each one had some shortcoming.

Therefore, we recommend the implementation of a combination financing plan that has the following conceptual design:

- . A pre-payment plan, with co-payments for inpatient services, that is administered by ASG and has mandatory enrollment for the entire population.
- . A Medicaid component to finance health care for the poor.
- . A tax on soda pop (and possibly on other similar discretionary purchases).
- . A specific earmarking of these funds for the exclusive use by DOH and health care.
- . The question of the sliding fee schedule should be studied when census data are available to evaluate the ability-to-pay issue and be resolved when the recommended conceptual design is detailed in the implementation process. In the meantime, the single rates developed in this study should be adequate for decision-making purposes.

The advantages of the combination plan are:

- . The lowest out-of-pocket costs.
- . The spreading of risk and costs to all those who rely on the availability of services at DOH and LBJ.

TABLE I

COMPARATIVE SUMMARY OF THE KEY ALTERNATIVES

EVALUATION CRITERIA	ALTERNATIVE FINANCING PLANS													
	FEE FOR SERVICE		POST PAYMENT		HMO		PRE-PAID INSURANCE		TAX BASED		MEDICAID PRE-PAID		COMBINATION A	
	RES	NONRES	RES	NONRES	RES	NONRES	RES	NONRES	RES	NONRES	RES	NONRES	RES	NONRES
Average cost per person per year:														
◦ Charge/Premium	\$67	\$133	\$67	\$133	\$40	\$80	\$40	\$80			\$54	\$133	\$22	\$43
◦ Co-Payment					34	34	34	34					21	21
◦ Tax									\$86	\$86			28	28
TOTAL	<u>\$67</u>	<u>\$133</u>	<u>\$67</u>	<u>\$133</u>	<u>\$74</u>	<u>\$114</u>	<u>\$74</u>	<u>\$114</u>	<u>\$86</u>	<u>\$86</u>	<u>\$54</u>	<u>\$133</u>	<u>\$71</u>	<u>\$92</u>
Average cost per family of 7 per Mo.														
◦ Charge/Premium	\$39	\$ 78	\$39	\$ 78	\$23	\$ 47	\$23	\$ 47			\$29	\$ 78	\$13	\$25
◦ Co-Payment					20	20	20	20					13	13
◦ Tax									\$50	\$50			16	16
TOTAL	<u>\$39</u>	<u>\$ 78</u>	<u>\$39</u>	<u>\$ 78</u>	<u>\$43</u>	<u>\$ 67</u>	<u>\$43</u>	<u>\$ 67</u>	<u>\$50</u>	<u>\$50</u>	<u>\$29</u>	<u>\$ 78</u>	<u>\$42</u>	<u>\$54</u>
Can short-term ob- jectives be Met?	YES 2.8million		YES 2.8million		YES 2.8million		YES 2.8million		YES 2.8million		YES 2.8million		YES 2.8million	
Can mid and long- term objectives be met?	?		?		YES		YES		YES		YES		YES	
Are there legal requirements other than compulsory participation?	NO		NO		YES		Yes, for other than std.ins. co. and ASG		YES		YES		YES	
Are there signifi- cant administrative requirements?	NO		NO		YES				Yes, if tax at retail level		YES		YES	
Are there signifi- cant marketing requirements other than compulsory participation?	NO		NO		NO		NO		NO		YES		YES, for Medicaid enrollment	

- . Flexibility to adjust the financial relationships between pre-payments, co-payments and taxes.
- . A more moderate cost differential between residents and nonresidents.
- . A means of financing health care for the poor, if Medicaid funds can be made available to ASG, that relieves the paying public of this burden.
- . By specifically earmarking these funds for DOH rather than becoming available for broad use in the General Fund, some of the public reaction to increased health care costs should be lessened. In addition, it is hoped that through direct pre-payments and co-payments by the consumers, they will become more involved and concerned about how their monies are spent.

The only serious disadvantages to the recommended plan is that time delays are likely where Congressional or Fono action is required for some of the components. However, there may be acceptable approaches to avoiding these delays, and other components of the plan can be implemented without delay. The last chapter of this report suggests a five-phased implementation approach.

CHAPTER II

UNDERSTANDING THE ASG HEALTH CARE FINANCING NEEDS

II. UNDERSTANDING THE ASG HEALTH CARE FINANCING NEEDS

In this chapter, information has been assembled and presented for the purpose of factually understanding the health care financing situation in ASG. By understanding this situation, it is hoped that the financing needs and the amounts to be financed through a new plan can be brought into focus. This, in turn should allow us to make an informed judgment of what the financing objectives should be which will be discussed in the next chapter.

The first section of this chapter contains information on ASG and health care costs and funding for past, present and future years. Because these cost data are drawn from ASG budget documents, the second section of this chapter explores other factors that should be considered in arriving at the total financing needs of ASH health care.

A. COSTS AND FUNDING

The health care financing problem is directly related to the overall ASG financing problem which is graphically shown below.

BASIC FINANCING PROBLEM

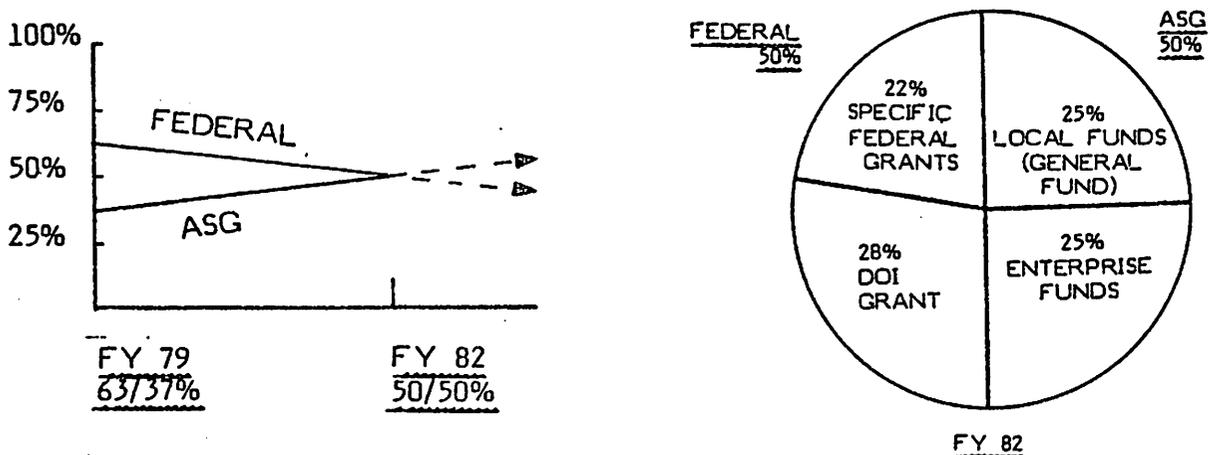


Figure 1

(See Appendix A for detail supporting data.)

It is clear from Figure 1 that:

- The Federal share of the ASG budget has declined from 63 percent to 50 percent over the last four years.
- As the Federal share has declined, ASG has increased its share from 37 percent to 50 percent.
- The Federal Government is causing American Samoa to become financially more self-sufficient.

Figure 1 also shows the four major sources of funds for the FY82 budget:

- The 22 percent that comes from specific Federal grants will undoubtedly be under pressure from the Reagan Administration as part of its across-the-board budget-cutting efforts. Health and education grants have been tentatively targeted for 20 percent cuts by the administration in FY82
- The 28 percent from the DOI grant may also be under pressure as a result of the administration's general budget cuts and also as a possible continuation of the downward trend in DOI funding.
- If either or both of these cuts happen, General Fund departments, such as Health and Education, will be seeking funding help from the ASG side of the budget. These departments, however, do not have access to the enterprise fund. Therefore, there is likely to be considerable competition for the 25 percent of the budget in the General Fund. The competition will not only be those departments that are normally financed out of the General Fund, but some of the enterprises who may need additional funding from the General Fund.

Another dimension to the overall financing problem is shown below:

ASG AND DOH COST INCREASE FROM FY79 to FY82



Figure 2

(See Appendix A for detail supporting data.)

Figure 2 shows that the budgeted expenditures for the government as a whole have increased 15 percent from FYs 79 to 82. This has put a further strain on ASG financial resources because it not only must finance an increasing percent of its budget but an increasing absolute amount as well. Figure 2 also shows that the DOH's budget is increasing almost twice as fast as the overall ASG budget. Moreover, DOH has the second largest budget of all the General Fund departments -- \$7.3 million in ASG for FY82. Thus, DOH represents a major and increasing financing problem for ASG.

Data in Exhibit I, following this page, show that approximately 10 percent of DOH's budget comes from specific Federal grants (item number 13). However, these grants are likely to be only \$400,000 according to the most recent estimates from Department officials who have been anticipating the administration's cuts in specific health grants DOH receives from the Federal Government. In addition to these funds, DOH generates some revenue from the fees it charges for certain acute care services at LBJ. This amounted to approximately one-third of a million dollars in FY80 or about 5 percent of expenditures. With the increased rates going into effect at LBJ, it is estimated that fees will recover approximately 10 percent of the expenditures budgeted for FY82, which will just about make up the cuts in the Federal grants. Because DOH has such a relatively small percent of its budget from Federal grants and from fees (which are deposited in the General Fund and not earmarked for DOH), the Department is heavily dependent on the DOI grant and the ASG General Fund to finance its operations.

Exhibit I and other detailed budget data indicate why costs have been increasing at DOH. Personnel costs are the single largest factor causing the increases and, within that group, doctors and nurses (items 1 and 2) make up

		<u>USE OF BUDGETED EXPENDITURES</u>				
<u>Activity</u>		<u>FISCAL YEAR BUDGET</u>				
		<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>
HOSPITAL - Diagnostic & Treatment						
1. Medical & Surgical		\$704,200	\$906,100	\$934,400	\$1,032,500	\$1,078,000
2. Nursing Services		1,051,200	1,263,500	1,367,200	1,444,000	1,575,500
3. Hospital Administration		237,500	258,500	283,200	331,500	333,000
4. Dietary		159,600	193,500	193,400	239,500	254,500
5. Housekeeping		103,300	123,000	138,800	133,500	141,000
6. Laboratory		161,200	193,900	231,600	217,000	214,000
7. Laundry		57,800	64,500	72,800	73,000	76,500
8. Pharmacy		339,900	366,660	430,100	441,500	444,000
9. Radiology		94,000	112,740	123,500	146,000	159,000
10. Dental Services		131,900	176,500	238,800	245,500	255,500
	Hospital Total	<u>3,040,600</u>	<u>3,658,900</u>	<u>4,013,800</u>	<u>4,304,000</u>	<u>4,531,000</u>
11. Off-island Care		344,000	150,000	683,000	625,000	680,500
	Diagnostic & Treatment Total	<u>3,384,600</u>	<u>3,808,900</u>	<u>4,694,800</u>	<u>4,929,000</u>	<u>5,211,500</u>
<u>OTHER HEALTH</u>						
12. Public Health		506,000	557,000	584,600	649,000	650,000
13. Grant Programs		790,491	761,872	744,321	796,780	728,600
	Other Total	<u>1,296,491</u>	<u>1,318,872</u>	<u>1,328,921</u>	<u>1,445,780</u>	<u>1,378,600</u>
<u>DEPARTMENTAL G & A</u>						
14. Director's Office		88,400	103,100	126,800	138,500	152,000
15. Utilities		218,000	269,500	268,800	348,500	375,500
16. Maintenance		148,000	157,500	201,400	209,500	215,000
	G & A Total	<u>454,400</u>	<u>530,100</u>	<u>597,000</u>	<u>696,500</u>	<u>742,500</u>
17. DOH SUBTOTAL		<u>5,135,491</u>	<u>5,657,872</u>	<u>6,619,721</u>	<u>7,071,280</u>	<u>7,332,600</u>
18. CAPITAL IMPROVEMENTS			405,000			
	DOH TOTAL	<u>\$5,135,491</u>	<u>\$6,062,872</u>	<u>\$6,619,721</u>	<u>\$7,071,280</u>	<u>\$7,332,600</u>

the majority of personnel. The second largest cause of cost increases is due to off-island care. Note, however, that the amount shown in item 11 for Off-Island Care is a budgeted amount and not the actual amount expended, and that the budgeted amount has been consistently much lower than the actual expenditures. In FY80, for example, \$680,000 was budgeted but \$916,175 was actually spent. Such being the case, off-island care is the third largest item, after doctors and nurses, and is the fastest increasing item. It should be noted that while some items substantially exceed the budgeted amounts, others are below budget. The net effect, as shown in the "Annual Financial Report," prepared by the ASG Treasurer/Director of Administrative Services, is that actual expenditures for FY's 79 and 80 were virtually the same as the total amounts budgeted.

Considering the facts and the probable course of future rates of inflation, one of two future situations is likely to happen:

- . DOH costs will continue to increase because of increases in personnel and off-island costs, as well as for supplies and drugs; or
- . Personnel, off-island costs, supply and drug costs, and the health service programs they support, will have to be reduced or contained because there isn't enough in the General Fund or the DOI Grant to meet all departments' demands for funds.

B. ADDITIONAL FACTORS TO CONSIDER IN DETERMINING THE TOTAL DOH COSTS

An understanding of health care costs is not complete until we consider all the relevant costs. Thus far, the budget items have been considered. There are two more cost items that do not typically appear in the department budget detail: (1) Funds to replace or renovate the plant and equipment; and (2) The cost of services received from other departments. In addition to the \$7.3 million budget for FY82, these two items should be added.

1. The Need to Fund Depreciation

In our November 28, 1979 report we noted that the depreciation on the plant and equipment is not funded. Funding such depreciation is a sound management practice to plan for the time when LBJ will need to be renovated or replaced. Where possible, management funds depreciation on what future costs are likely to be, which anticipates the impact of inflation and other changes. At a minimum, however, depreciation should be funded on the basis of historical costs which would generally be what LBJ cost when new (to replace LBJ today would probably cost four to six times what it originally cost to build). Using the more conservative historical cost basis indicates that approximately \$210,000 should be funded and added to the \$7.3 million budgeted total for FY82.

2. The Need to Consider the Cost of Services Received From Other Departments

DOH and other departments receive a range of general services from ASG departments. These include manpower, public works, accounting, budgeting, administrative services, etc. A rate has been established by ASG and DOI which places a value on such services. The current rate is 12.7 percent of the direct salaries and wages of a department. Applying this to the costs developed so far, results in the following (in millions):

. FY82 Budgeted DOH Expenditures	\$7.3
. Fund for Depreciation	.2
	<u>\$7.5</u>
. Indirect Cost (12.7% X \$4.967 for Personnel)	.6
	<u> </u>
Total	<u><u>\$8.1</u></u>

The \$8.1 million represents a conservative and reasonable estimate of the expenditures budgeted for DOH for FY82 plus the other costs that should be considered in the total financing needs of the Department.

One other factor that should also be considered relates to the Federal grants at DOH. The new administration has stated plans to reduce Public Health Services grants in FY82. Our best information at this time indicates that a 20 percent cut will be proposed and that the programs will be combined to form a block grant that would allow, among other things, a reduction of the administrative burden of the present grants program. If such a cut is enacted by Congress, DOH's Federal grants of \$728,600 could be reduced by almost \$150,000 or up to \$330,000 according to recent DOH estimates. If this happens, public health services would either need to be reduced or local ASG funds would need to be applied to make up the cut which would probably mean some other ASG program would need to be cut. While the \$150,000 or \$330,000 is relatively small in the total, this situation serves to illustrate the impact that one department's needs have on other departments in the current financing environment.

C. SUMMARY

The facts show that the cost of health care is substantial and even more so when other cost items outside of the budget are considered. Health care costs are likely to continue to increase at a rate greater than government as a whole unless services are reduced or constrained. In either case, DOH will be competing with other departments for the decreasing DOI share and the ASG General Fund. DOH is more heavily dependent on those sources because it obtains relatively small amounts from specific Federal grants (which appear to be getting smaller because of administration cuts). Moreover, DOH recovers only a relatively small percentage of its costs from the fees collected from services at LBJ. Given these circumstances, the financial future contains many uncertainties for DOH and its financial viability is far from secure.

CHAPTER III

RECOMMENDED FINANCING OBJECTIVES

III. RECOMMENDED FINANCING OBJECTIVES

The purpose of this chapter is to establish financing objectives for the new financing plan. Objectives are needed to insure the financial viability of DOH and to provide a realistic basis for evaluating the various alternatives. Without objectives, the evaluation of the alternatives could lead to mistaken conclusions. For example, one alternative might be able to generate sufficient revenues if the objective were \$500,000 a year, but could not if the objective were more.

A. BASIS FOR ESTABLISHING OBJECTIVES

In order to establish the objectives, a number of factors should be considered. These factors are discussed in the following paragraphs.

1. Material

The objectives should be material in amount -- in other words they should make a difference in insuring financial viability and should not be a token amount without significance.

2. Achievable

The objectives should be achievable -- in other words they should be amounts that could reasonably be expected to be generated. The various alternative financing plans will be evaluated in the next chapter in order to determine what is achievable.

3. Objectives for Different Time Periods

Different objectives should be established for different time periods because the amount desired to be financed ultimately may not be achievable in the short term. For example: If the desired amount were the entire

cost of DOH, a first year plan would be too much of an initial financial shock to those paying, or major legal and administrative actions could not take place, or implementation plans could not be carried out in the short run. Therefore, a three stage time frame is suggested:

- . Short Term: Establishing objectives for the first and second year of the new plan.
- . Mid Term: Establishing objectives for the third through fifth years.
- . Long Term: Establishing objectives for the sixth through tenth years.

4. Range of Objectives for the Short Term

The short term objectives should be stated in a range of amounts. The main reason for this is that until the alternatives have been analyzed, and policy makers select a plan, we will not know how much and to what degree that plan would be able to meet any given objective. In addition, the nature of the factors affecting the entire DOH costs and the available data are such that they do not lend themselves to precision at this time.

5. Items To Be Financed

The decision of what items to finance should include consideration of the following:

- . Federal versus the ASG share of the budget.
- . Costs of DOH in addition to those in the budget.
- . The effect of revenues generated by the existing DOH charges.

Each of these is discussed further below.

(a) Finance the Federal rather than the ASG Share

The previous chapter contained information on the Federal versus the ASG share of the budget. The new financing plan in the short and midterm should be directed at financing the Federal share, less the amount of the specific Federal grants received by DOH, rather than the ASG share. The following are reasons for this:

- From the data shown in Chapter II, it seems evident that the Federal share of the total ASG budget is steadily decreasing. As this happens, there will be increased strains on the existing tax base to supplement any Federal decreases as well as to meet the increasing costs of departments throughout the government. Given this possible course of future events, it would seem to be in the best interests of DOH and ASG to protect the DOH budget against Federal decreases and competition between DOH and the other departments for the discretionary Federal funds.
- Closely related to the above is the urging by DOI for ASG to become financially more self-sufficient in all areas of government. Having the new health financing plan fund the Federal side of the budget, less the specific grants received by DOH, is consistent with DOI's urgings. It should be strongly noted, however, that we are not suggesting that for every dollar of money generated by a new health care financing plan that the Federal share of the budget should be reduced equally. If this were done, the incentive to implement a new plan would be considerably lessened.
- Specific Federal grants received by DOH should be excluded from the Federal share financed by the plan for the following reasons: (1) the DOH grants are reimbursements for specific services provided by DOH to specific recipients entitled to those services by law. Should the law, or grant terms, or the amount of the grant change and decrease, then the health care financing plan should be used as the mechanism for providing for those needs; (2) It appears that the Federal approach is to weigh the total Federal involvement in the ASG budget (as well as the local funds that are available) in determining the DOI grant which is then used as a key balancing amount. Excluding these other Federal grants from the financing plan is consistent with that approach.
- ASG residents are in fact currently financing the ASG share through income taxes, corporate taxes, and other taxes. Therefore, it would seem to be redundant for the new financing plan to finance the ASG portion until the long range when the entire cost of DOH, including the ASG share, might be financed.

(b) Finance Depreciation and Indirect Expenses of DOH

Chapter II discussed two items of costs that are not normally shown in the budget figures -- funding depreciation and DOH's share of the costs of the general governmental services it uses. Of these two, funding depreciation is an extremely important cost to be financed because these resources will be needed to maintain the viability of the Medical Center's plant and equipment. Less vital, but still important, is the need to provide for financing the cost of general services provided outside of DOH.

(c) Finance Annual Increases in Costs

In addition to these two items above, the budget data in Chapter II clearly showed a substantial annual increase in DOH's budget -- 28 percent from FY79 to FY82. It is recommended that all future increases should be financed by the new plan. This would have several advantages: (1) Proposed increases could hopefully be considered with greater flexibility and independence within a health care financing plan rather than in a much larger arena of the Federal and ASG budgetary process; (2) All of the key variables of the health care costs would be the responsibility of the financing plan (except the ASG share in the short and mid term); (3) This would avoid shifting the burden to the other funding sources; and, (4) Health financing would need to be restructured as the increases become the dominant cost factor over time, unless the increases were absorbed by the new financing plan.

(d) Other Considerations: DOH Generated Revenues

The affect of revenues currently generated by DOH should not be considered in determining what amount to finance in the new plan. If the new plan contains a fee-for-service component, which is basically what DOH uses now, then those rates and totals are not likely to be the same as those in effect now, and understanding the impact of the plan would be needlessly confusing. If the new plan does not have a fee-for-service component, then the existing fee based approach would be eliminated and its revenue generating capabilities would not be considered in any event.

(e) Summary of the Items to be Financed

- . The Federal share in the short to long term, less the Federal specific grants received by DOH.

- . The ASG share in the long run.
- . Depreciation in the short term.
- . Indirect costs for general services provided by other departments in the mid to long term.
- . Future budget increases in the short term.

Excluded from the financing plan, as an off-set to the needs, are the revenues generated by the present fee-for-service plan at LBJ.

B. RECOMMENDATIONS FOR FINANCING OBJECTIVES

Exhibit II, following this page, contains recommendations for the range of financing objectives for the short, mid and long terms. The low range for the short term in FYs 82 and 83 is \$2.8 million. This is approximately \$2.2 million more than DOH will possibly generate in revenue in FY82. For a population of approximately 32,400 (in 1980) this represents an additional expenditure of approximately \$68 a year or \$5.65 a month if equally divided among all residents. For an average family of seven, this would represent \$39.60 a month. We understand this is less than the average per capita and family expenditures for alcoholic beverages and tobacco. The average per capita cost for health care at this level would be approximately 6 percent of the average family income. By means of these simple tests, it appears that the objectives for the short range are generally achievable. Moreover, this preliminary objective is material when the following is considered:

- . At the lower end of the short term, \$2.8 represents almost 40 percent of the FY82 DOH budget. When this financing amount is added to the ASG share of \$3.7 million, the total of \$6.5 million represents over 90 percent of the total budget that ASG residents are paying for (the remainder is for specific Federal grants).

RECOMMENDATIONS FOR FINANCING OBJECTIVES (\$ Millions)

FINANCING FACTORS	Year: 1	2	3	4	5	6	7	8	9	10
	FY: 82	83	84	85	86	87	88	89	90	91
1. Total Budget	\$7.3									
2. Federal Share (DOI and Specific Federal (Grants)	X <u>50%</u> 3.7									
3. Less Specific Federal Grants to DOH	.7									
4. Federal Share of DOH Budget to be Financed	\$3.0	\$3.0	\$3.0	\$3.0	\$3.0	\$3.0	\$3.0	\$3.0	\$3.0	\$3.0
5. Depreciation	.2	.2	.2	.2	.2	.2	.2	.2	.2	.2
6. Future Increases: (9% X Total Budget less Specific Federal Grants: \$6.6)	N/A	.6	1.2	1.8	2.4	3.0	3.6	4.2	4.8	5.4
7. Indirect Costs	-	-	.6	.6	.6	.6	.6	.6	.6	.6
8. ASG Share (50% of Total Budget \$7.3)	-	-	-	-	-	3.7	3.7	3.7	3.7	3.7
9. Total To Be Financed by Year	<u>\$3.2</u>	<u>\$3.8</u>	<u>\$5.0</u>	<u>\$5.6</u>	<u>\$6.2</u>	<u>\$7.8</u>	<u>\$11.1</u>	<u>\$11.7</u>	<u>\$12.3</u>	<u>\$12.9</u>
10. Short-Term Range	<u>\$2.8</u> TO	<u>\$3.8</u>								

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CHAPTER IV

EVALUATION OF THE ALTERNATIVE ASG HEALTH CARE FINANCING PLANS
AND THE RECOMMENDED PLAN

IV. EVALUATION OF ALTERNATIVE ASG HEALTH CARE FINANCING PLANS AND THE RECOMMENDED PLAN

This chapter contains an evaluation of the six basic financing alternatives available to ASG:

- . Fee-for-service,
- . Post Payment,
- . HMO Plan (Health Maintenance Organization),
- . Pre-paid/Insurance,
- . Tax Based,
- . Federal Medicaid Funding for Certain Citizens,
- . and, Combinations of the above Six.

Each of these alternatives have been evaluated using several specific criteria:

- . Legal Feasibility.
- . Administrative Feasibility.
- . Marketing Feasibility.
- . Financial Feasibility.*
- . Overall Pros and Cons.

From this evaluation, a set of recommendations has been made of the alternative that in our judgment best meets the evaluation criteria and financing objectives.

A. FEE-FOR-SERVICE PLAN

1. General Description of this Plan

- a. Assumes the fee is paid at the time service is provided.
- b. The fee is determined from the rate schedule established by DOH.

*The financial feasibility analysis is based on assumptions, data and computations detailed in Appendix B.

- c. Variations of this plan may range from the full recovery of the actual cost of the service to a partial recovery of costs.
- d. LBJ presently has a fee-for-service plan that partially recovers actual costs (and a post payment plan for those who cannot pay the total fees at the time the services are provided).

2. Legal Feasibility

- a. No legislation would be needed to implement this plan because ASG Code allows the Director of DOH to revise the rates periodically.
- b. However, legislation would be needed if residents were required to pay charges for medical services and drugs from which the Code presently exempts them.

3. Administrative Feasibility

- a. This plan would only require minimal additional costs to operate over what is now in place.
- b. The additional costs would be incurred for the following functions and activities:

- Periodic rate revisions requiring:

- Collection and calculation of data to determine the new rates.
 - Conducting public meetings to receive comments on proposed rate changes.
 - Modification of the LBJ billing system to institute the new rates.
 - Increased collection efforts at LBJ that could probably be expected from increased rates.

4. Marketing Feasibility

- a. No major marketing effort would be required to sell the new rate program since the Code provides for such changes which

then become mandatory.

- b. However, some consumer education or public relations program should be undertaken to minimize public reaction to increased rates and to acquaint patients with their financial responsibilities.

5. Financial Feasibility

The financial feasibility of this alternative is viewed from two perspectives -- full and partial recovery of costs.

a. Full Recovery of Costs

Exhibit III shows that gross revenue of \$4.3 million could be generated if fee-for-service rates were set to recover full costs. The reason that the full budget of \$7.3 million in FY82 cannot be recovered with these rates is because the cost of off-island care has been excluded, more importantly, the rates for residents exclude medical services and drug costs in order to be consistent with the existing ASG Code. The gross revenue (before bad debt and charity allowances) is more than the high end of the short-term objective of \$3.8 million.

b. Partial Recovery of Costs

A partial recovery of costs, with rates approximately two thirds of full recovery, could generate \$2.8 million in gross revenues which is the low end of the short-term objective. This is shown on Exhibit IV which also shows the estimated charges per year for an average family of seven with average utilization.

Approximately \$468.00 per year for a resident family of seven, and

FULL RECOVERY OF COSTS THROUGH FEE-FOR-SERVICE RATESRESIDENTS

<u>SERVICE</u>	<u>DEMAND X RATE</u>	=	<u>GROSS REVENUE</u> *
IP Day	19,400 x 77.00		\$ 1,493,800
OP Visit	85,750 x 8.40		720,300
Dental Visit	7,100 x 16.30		<u>115,730</u>
			<u>\$ 2,329,830</u>

NON-RESIDENTS

<u>SERVICE</u>	<u>DEMAND X RATE</u>	=	<u>GROSS REVENUE</u> *
IP Day	8,300 x 154.00		\$ 1,278,200
OP Visit	36,750 x 16.80		617,400
Dental Visit	3,100 x 32.60		<u>101,060</u>
			<u>\$ 1,996,660</u>
	TOTAL GROSS REVENUE		<u><u>\$ 4,326,490</u></u>

* Less administrative and marketing costs

PARTIAL RECOVERY OF COSTS THROUGH FEE-FOR-SERVICE RATES
TO MEET LOW END OF SHORT TERM OBJECTIVE - \$2.8 MILLION

<u>RESIDENTS</u>					
<u>SERVICE</u>	<u>DEMAND</u>	<u>X</u>	<u>RATE</u>	=	<u>GROSS REVENUE</u> *
IP Day	19,400	x	\$50.00	=	\$ 970,000
OP Visit	85,750	x	\$ 5.50	=	\$ 471,625
Dental	7,100	x	\$10.60	=	\$ 75,260
					<u>\$1,516,885</u>
<u>NON-RESIDENTS</u>					
IP Day	8,300	x	\$100.00	=	\$ 830,000
OP Visit	36,750	x	\$ 10.90	=	\$ 400,575
Dental	3,100	x	\$ 21.20	=	\$ 65,720
					<u>\$2,813,180</u>
			TOTAL GROSS REVENUE		<u>\$2,813,180</u>

CHARGES PER YEAR FOR

AN AVERAGE FAMILY OF SEVEN WITH AVERAGE UTILIZATION

<u>SERVICE</u>	<u>RESIDENTS</u>	<u>NON-RESIDENTS</u>
IP Day	6.0 x \$50.00 = \$300	6.0 x \$100 = \$600
OP Visits	16.6 x \$ 5.50 = \$146	16.6 x \$10.90 = \$290
Dental Visits	2.1 x \$10.60 = \$22	2.1 x \$21.20 = \$45
	<u>TOTALS</u>	<u>\$935.00</u>
	<u>\$468.00</u>	<u>\$467.00</u>

* Less administrative and marketing costs

- Approximately \$935 per year for a non-resident family of seven.

6. Summary

a. Pros

- Minimal legal, administrative and marketing effort to implement and operate.
- Can easily achieve the short-term financial objectives.

b. Cons

- Meeting the financial objectives for mid and long term is likely to require that residents be charged for medical services and drugs which will then require legal action to change the Code.
- Increasing the rates to a level to recover either full or partial costs (with or without a Code change to charge residents for medical services and drugs) will probably be such a financial burden on non-residents as well as residents that the following reactions are likely to occur:
 - Patients making full payment at the time of service will decrease and they will want to set up a payment plan which will result in increased administrative efforts to collect accounts receivables; and/or,
 - Bad debt experience and accounts receivable write-offs are likely to increase with increased accounts receivable levels because of the financial impact of higher rates, and/or
 - Administrative write-offs of all or part of the bills may increase because of hardship or charity cases.
- This type of plan places all of the financial burden on the specific users of services who pay for the cost of having the medical center available to all residents and non-residents whether or not they use it. This could be particularly burdensome for families or individuals with sporadically high utilization.
- A fee-for-service plan with rates at these higher levels may act as a financial barrier to those seeking needed care -- particularly preventative and outpatient services -- which could ultimately lead to more serious

and costly inpatient services.

The financial feasibility calculations were based on the assumption that all the population would have the means to pay the fees. While this is useful in showing the financial impact on a per capita and per average family size, it is recognized there is some percentage of the population, possibly as high as 20%, who would not have the means to pay the fees and would probably be financed by those able to pay. This means that the fees charged those able to pay would have to be increased by 25% to finance health care for the poor.

B. POST PAYMENT PLAN

1. General Description

This post payment plan is basically the same as the fee-for-service plan except that it is assumed that some patients will not wish or be financially able to pay the full bill at the time the service is provided and will want to set up a payment or installment plan.

2. Legal Feasibility

This is the same as for the fee-for-service plan -- the Code and operating practice at LBJ allow for this plan, unless residents would be required to pay for medical services and drugs, in which case, legal action would be needed to change the Code.

3. Administrative Feasibility

This is also the same as for the fee-for-service plan, which has minimal additional administrative cost, except that there would clearly be the need to increase the credit and collection efforts at LBJ.

4. Marketing Feasibility

This is also the same as for the fee-for-service plan which requires no major marketing effort but which should have a consumer education or public relations program.

5. Financial Feasibility

The full or partial recovery of costs are the same for this plan as

for the fee-for-service plan. However, the net revenue is very likely to be less under a formal post payment plan than under a fee-for-service plan because of:

- . Higher debt write-offs.
- . Higher administrative write-offs for charity and financial hardship cases.
- . The opportunity cost of reduced cash flow because of added accounts receivables.
- . Added administrative costs for credit and collection work at LBJ and possibly at the Department of Administrative Services and the Attorney General's office.

a. Examples of Payment Plans:

- . Payment Plan for Average Hospital Stay with No Down Payment:
 - Resident: $6 \text{ days} \times \$50/\text{day} = \$300 \div 12 = \$25/\text{month}.$
 - Non-resident: $6 \text{ days} \times \$100/\text{day} = \$600 \div 12 = \$50/\text{month}.$
- . Payment Plan for Average Hospital Stay with Down Payment:
 - Resident: $\$300 \text{ Charge} - \$50 \text{ down} = \$250 \div 12 = \$21/\text{month}.$
 - Non-resident: $\$600 \text{ Charge} - \$50 \text{ down} = \$550 \div 12 = \$46/\text{month}.$

6. Summary

The overall pros and cons of this plan are the same as those for the fee-for-service plan. In addition there is the strong likelihood that the net revenue will be less under this plan for the reasons discussed under 5 above.

C. HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN

1. General Description

- a. All HMOs have the following basic characteristics:

- . A comprehensive range of benefits or services provided by the HMO plan.
- . A defined population enrolled in the HMO plan.
- . Risk sharing among the enrollees by pre-paying for services through a capitation amount paid periodically.
- . An organized physician/provider group that is at risk to deliver a comprehensive range of services to the defined enrollees within the total capitation amount.
- . An HMO management component that contracts with the enrollees and providers, and that markets and administers the plan.
- . Preventative and outpatient care is stressed to reduce costly inpatient care.
- . There is consumer participation at the policy making and governance level.

b. Payment Variations

The capitation payments can be arranged on an individual or family basis. They can be structured to recover all or some of the actual costs (assuming that the remainder is financed by some other entity). The capitation amount can be set to cover all of the services provided with no additional costs, or a capitation amount with a co-payment approach can be taken where a charge is made at the time a member receives specific services. The capitation amounts are usually paid monthly or twice monthly. The amounts can be paid by the enrollee or by the employees or shared between them.

c. Organizational Variations

There are many different variations of the HMO approach to delivering health care -- from the Kaiser Foundation Plan where the staff, plant and equipment are totally within the plan (as DOH/LBJ would probably be) to an independent

association of physicians and hospitals offering some of their services under an HMO plan. Regardless which variation is used, HMOs have typically been designed to be a competitive alternative to the traditional fee-for-service delivery system. In addition, the HMO form has the basic characteristics summarized in a. above, particularly:

- . An organized provider/physician group at financial risk.
- . A defined enrollee group.
- . A fixed capitation amount or premium.

2. Legal Feasibility

If DOH/LBJ were to be reshaped into an HMO model (rather than bring in an HMO group to compete with or operate LBJ), legislation would be required to:

- . Permit the contractual relations between the plan, the enrollees and the physician/provider group.
- . Permit and designate the physician/provider group to be at risk and to define the terms of the risk.
- . Determine whether enrollment was to be mandatory or voluntary for residents and non-residents.
- . Determine whether residents will have the cost of medical services and drugs included in the capitated amount.

3. Administrative Feasibility

The key administrative requirement of an HMO at LBJ would be to have a stable and adequate sized physician group willing to go at risk. In addition, the new HMO organization would need to be structured to meet local needs and constraints.

To effectively operate an HMO, the management of the plan will need to have virtual control over the resources and budget to keep

them in constant balance with the changes in demand for services in order to minimize their risk. This means that information and administrative systems would be required for this level of control. There will also be the need for an enrollment system to maintain the membership rolls and to account for the capitation payments and co-payments, if the later is used.

4. Marketing Feasibility

If enrollment in an HMO plan were voluntary rather than compulsory for all residents and non-residents, a significant marketing effort would need to be made to:

- . Develop an overall HMO marketing strategy.
- . Develop and implement a public education program on the HMO concept.
- . Define the target groups to be marketed.
- . Develop and implement a sales program to enroll the target groups.
- . Develop and implement a program to maintain the existing enrollment base and to expand marketing and sales into secondary targets.

5. Financial Feasibility

a. Partial Recovery of Costs, \$2.8 Million, with a Compulsory HMO Plan and No Co-payment

The details of this HMO approach are shown in Exhibit V and are summarized below:

	<u>Residents</u>	<u>Non-residents</u>
. Per Enrollee per Year	\$67	\$133
. Per Family of Seven per Month	39	78

b. Partial Recovery of Costs, \$2.8 Million, with a Compulsory HMO Plan and a Co-payment for Inpatient Services

The details of this HMO approach are also shown in Exhibit V and are summarized below:

PARTIAL RECOVERY OF COSTS, \$2.8 MILLION - WITH
COMPULSORY HMO ENROLLMENT AND NO CO-PAYMENT

<u>ENROLLEES</u>	<u>NUMBER</u>	<u>GROSS PREMIUMS*</u>	<u>ANNUAL PER ENROLLEE</u>	<u>PER FAMILY OF 7 PER MONTH</u>
Residents	22,680	\$ 1,516,885	\$67	\$39
Non-Residents	<u>9,720</u>	<u>1,296,295</u>	\$133	\$78
TOTALS	<u>32,400</u>	<u>\$ 2,813,180</u>		

PARTIAL RECOVERY OF COSTS, \$2.8 MILLION - WITH
COMPULSORY HMO ENROLLMENT AND CO-PAYMENT FOR INPATIENT SERVICES

<u>ENROLLEES</u>	<u>CO-PAYMENT</u>	<u>IP DAYS</u>	<u>CO-PAYMENT GROSS REVENUE</u>	<u>GROSS PREMIUMS*</u>	<u>ANNUAL PREM. PER ENR.</u>	<u>MO. PREM. PER FAMILY OF 7</u>
Residents	\$40/day	19,400	\$776,000	\$911,520	\$40	\$23
Non-Residents	\$40/day	8,300	<u>\$332,000</u>	<u>\$776,480</u>	\$80	\$47
TOTALS			<u>\$1,108,000</u>	<u>\$1,688,000</u>		

* Less administrative and marketing costs

	<u>Residents</u>	<u>Non-residents</u>
. Per Enrollee per Year	\$40	\$ 80
. Per Family of Seven per Month	23	47
. Average Co-payment per Enrollee per Year	34	34
. Average Co-payment per Family of Seven per Month	20	20

6. Summary

a. Pros

The HMO approach places less financial burden on individuals and families than the fee-for-service or post payment plan -- whether a co-payment or non co-payment HMO plan is used. This is because the risk is spread over the entire population rather than the total burden being placed exclusively on the patients using the service.

b. Cons

There are significant legal, administrative and marketing requirements to be met with the HMO approach, particularly if a compulsory enrollment approach is desired in order to spread the risk to the maximum population possible. As with the previous plans, this one also assumes all the population has the ability to pay the premiums. Accordingly, rates would need to be revised to finance health care for the poor.

D. PRE-PAID/INSURANCE PLAN

1. General Description

Pre-paid/insurance plans have the following general characteristics:

- . The insurer is basically the third party that brings together those wishing the insurance (sharing risk) and the providers of service (physicians, nurses, technicians, hospitals, etc.)
- . The insurer accepts premiums from insured parties and reimburses providers for the services provided to the insured.
- . The insurer may be a commercial (a "for profit" such as Mutual of Omaha) or a non-profit (such as Blue Cross), or a government corporation, or a consumer group.
- . The insured parties may be individuals, families or groups, such as associations or employee or employer groups.
- . Providers may be physicians, hospitals, dentists, etc.
- . The services reimbursed have numerous combinations -- from inpatient, to outpatient, to dental, to all services.
- . The amount reimbursed may be 100 percent of the providers' charges (not necessarily the providers' costs) or a fixed amount per service (rate schedule), or a percentage of the charge or the actual costs.
- . The insurer is at risk for the difference between the premiums collected and the reimbursement of services provided.
- . The insurer tries to minimize risk by setting premiums high enough to cover the probable claims for reimbursement.
- . The insurer also adds an amount to the premium to cover the cost of marketing and administering the plan, and an amount for profit, if it is a profit making insurer.
- . The insurer can also defray some of its costs through income gained from investing the premiums that are not yet needed to reimburse providers.

As summarized above, the coverage, premium arrangements, and the organizational variations are numerous.

2. Legal Feasibility

It is likely that the existing laws governing insurance carriers would be sufficient for health insurance carriers. However, if a consumer

controlled insurance plan were planned, specific enabling legislation may be required. But, a government pre-paid plan could be construed to ^{be} permitted under the existing code. Mandatory enrollment is likely to require legislative action.

3. Administrative Feasibility

- a. If a local consumer oriented insurance plan were developed that would have an arm's length relationship with DOH/LBJ then the major administrative requirement would be for an enrollment and a claims processing system.
- b. If an outside insurer were involved, then it would be responsible for its own administrative arrangements. However, DOH/LBJ would need to submit claims (as it would for an arm's length local consumer plan discussed above), and to negotiate reimbursement rates with the provider (DOH/LBJ).
- c. Mandatory enrollment in an ASG pre-paid plan would require an enrollment system but no claims processing system would be required.

4. Marketing Feasibility

- a. If an ASG or local consumer insurance plan were developed as in 3.c or 3.a above, that was also voluntary, then a significant marketing effort would be required similar to that for a voluntary HMO plan. If the plan were compulsory, there would be minimal marketing effort other than a consumer education/public relations effort.
- b. If there were an outside carrier involved, it would be responsible for the marketing requirements.

5. Financial Feasibility

In the most favorable form, the financial aspects of the pre-paid

insurance form would be similar to those for the HMO plan shown in Section C,5. However, the administrative and marketing costs of outside carriers are likely to be significant and would be passed on to the insured through higher premiums. On the other hand, these costs for a compulsory ASG or local consumer plan would probably be minimal and at the same level as an HMO plan.

6. Summary

a. Pros

As with the HMO plan, the pre-paid/health insurance approach places significantly less financial burden on the insured than the fee-for-service or post paid plans. An ASG plan, followed by the local consumer compulsory model, would compare more favorably with the HMO than would the costs of an outside carrier.

b. Cons

An outside carrier would be less financially attractive than an HMO or an ASG or local consumer compulsory insurance model. An outside carrier would also limit Samoan control over the plan and possibly be less responsive to Samoan health care and financial needs. A voluntary ASG or local consumer model would require a significant level of administrative and marketing efforts, probably at the level as for a voluntary HMO plan. As with the other plans, this one does not contain a provision for financing the health care costs of the poor.

E. TAX BASED PLAN

1. General Description

- . A special tax would be levied on existing taxes for the purpose of financing health care.
- . The special tax could be levied on:
 - Individual income tax.
 - Corporate income tax.
 - Excise tax on liquor, tobacco, beer, soft drinks (soda pop), or candy.
- . The special tax could be collected at filing time (as in the case of individual and corporate income taxes), or at the import, wholesale or retail point of sale.
- . The special tax could be a percentage of the import, wholesale or retail price, or a fixed amount per unit (as in the situation with cases, cans or bottles of pop, beer, wine, liquor; or bars or packages of candy).

2. Legal Feasibility

- . Specific legislative action would be required to add to the existing taxes of the various tax generating items.
- . As with the other plans, specific legislation might be required if the additional amounts were to be specifically directed to DOH for health care rather than to the General Fund where the amounts might not directly benefit DOH in total.

3. Administrative Feasibility

- . The least administrative requirements would be incurred if the special tax were levied on the individual or corporate income taxes or at the time of import.
- . The greater requirements would be if the taxes were levied at the wholesale point, and the greatest if levied at the retail point, particularly as a percentage of price. These situations would require ongoing audit functions and probably additional accounting on the part of the wholesalers and retailers.

4. Marketing Feasibility

No marketing program would be required. However, a public education program would probably prove effective.

5. Financial Feasibility

a. Partial Recovery through Multiple Taxes

The following are examples of the taxes that could be levied on various items, some which cause or contribute to health problems:

<u>FY 81 Tax, Profit or Retail Value</u>	<u>Contribution * To Health Care</u>	<u>% Increase</u>
. Individual Income Tax \$ 2.5	\$.336	13.4
. Corporate Income Tax 8.5	1.148	13.5
. Excise Taxes 2.7	.364	13.5
. Liquor Store Profits .4	.056	14.0
. Soda Pop Retail Value 6.5	.896	13.8
TOTAL (\$ Million) <u>\$20.6</u>	<u>\$2.800</u>	<u>13.6</u>

*Less administrative costs.

The increased cost of the above for an individual consumer would be \$86 per year or \$602 for the average family of seven.

b. Partial Recovery through a Single Tax Item

If the entire low end of the short-term objective of \$2.8 million were obtained from a single tax source -- soda pop -- the effect would be as follows (\$000,000)

. Tax: \$6.5 retail x 43% Tax	=	\$ 2.80 Gross Revenue*
. Cost per individual	=	86.00
. Cost per family of seven/year	=	602.00
. Additional cost per can	=	.19 (from .45 to .64)

*Less administrative costs.

6. Summary

a. Pros

A number of taxable items are contributors to health problems, and from an equity standpoint are prime candidates