

to finance the treatment of the problems they bring about. The revenue yield on some of these, which are purchased with disposable income and are not essential items, could be significant. Since the tax is the sole source of financing, the cost of caring for the poor is covered, which was not provided for in the other plans.

b. Cons

Additional increases on income taxes are surely to be regarded by the tax payers as particularly burdensome. ~~Also,~~ taxes at the retail or wholesale levels are likely to cause significant administrative burdens for tax collectors and for businesses.

F. FEDERAL MEDICAID FUNDING FOR SPECIFIC GROUPS

1. General Description

ASG may be entitled to receive Federal Medicaid funding for eligible citizens who are in need of financial support for medical care. If ASG receives Medicaid funds for the medically needy, these funds can be used to reimburse the cost of on-island as well as off-island care. ASG may request Congress to authorize and appropriate Medicaid funds for American Samoa as the other territories have been receiving. ASG may also request that these funds be available on a block grant basis and that the great majority of the costly and burdensome Medicaid regulations be waived so that the program can be efficiently administered in ASG.

Assuming this takes place, 20 to 33 percent of the citizens may be eligible for Medicaid based on the recent experience of the

Commonwealth of the Northern Mariana Islands in determining the eligibility of their citizens for Medicaid.

While this plan relies on Federal sources, it is a specific grant program that 49 of the 50 mainland states participate in, and all of the territories except for ASG. More importantly, it may help fund the care for those citizens that are most likely to be bad debt or administrative waiver cases under fee-for-service or post payment plans, or who would not be financially able to participate in HMO or insurance plans.

**2. Legal Feasibility**

Congress and possibly the Fono would need to legislate the specifics of an ASG Medicaid program for ASG.

**3. Administrative Feasibility**

The extent of the administrative requirements will depend on the specific block grant or waiver requirements ASG might obtain from Congress or the U.S. Department of Health and Human Services (HHS). At a minimum, an eligibility determination process and up-to-date eligibility file would need to be maintained.

**4. Marketing Feasibility**

At a minimum, some form of a marketing program would need to be taken to enroll eligible citizens into the ASG Medicaid program.

**5. Financial Feasibility**

The partial recovery, \$2.8 million, of the total DOH costs with a Medicaid reimbursement program combined with a pre-paid/insurance plan is summarized below:

<u>Residents</u>	<u>Number</u>	<u>Premium Cost per Year</u>	<u>Gross Revenue</u>
• Medicaid (20%)	4,540	\$ 67	\$ 304,180
• Other Residents in a Pre-paid/Insurance Plan	<u>18,140</u> <u>22,680</u>	67	1,215,380
• Non-residents in a Pre-paid/Insurance Plan	9,720	133	1,291,760
	<u>          </u>		<u>          </u>
TOTAL	<u>32,400</u>		<u>\$2,812,320</u>

\*Less administrative and marketing costs.

Note that Medicaid has reduced the total local outlay in the short run from \$2.8 million to \$2.5 million. This could be further reduced to a \$2.2 outlay if Medicaid would reimburse the medical service and drug costs for the Medicaid eligibles. This in turn would reduce the average annual cost per resident to \$50 or \$29 per month for a family of seven.

#### 6. Summary

##### a. Pros

If ASG can obtain Medicaid funds without the extreme administrative burden of the Medicaid program, significant reductions in on-island and off-island costs could be achieved and health care for the poor could be financed.

##### b. Cons

Under more favorable terms with Congress/HHS on the Medicaid funds, some administrative and marketing cost would be incurred. In addition, legislative action would be required by Congress and may be required by the Fono.

#### G. COMBINATION OF THE ALTERNATIVES

##### 1. General Description

There are almost endless combinations of the previous six basic financing plans. Three specific combinations have been developed which are composed of:

- . A compulsory pre-paid/insurance plan with three different co-payments for inpatient services for residents and non-residents.
- . Medicaid reimbursement for 20 percent of the residents who may be eligible.
- . A tax of 6¢ on each can of soda pop/soft drink beverages.

These combinations have all of the legal, administrative and marketing requirements of the various components listed above. The financial feasibility of combinations A, B and C, displayed in Exhibits VI through VIII, shows that the low end of the short-term objective, \$2.8 million, can be met by spreading the financing burden over a number of payers and sources. A summary comparison of out-of-pocket costs for premiums and co-payment is shown below for the three combinations.

<u>Combination</u>	Monthly Average for Family of 7	
	<u>Residents</u>	<u>Non-residents</u>
A. Pre-payment Premium, and <u>\$25 per Day for Inpatient Services</u>	\$13	\$25
	<u>13</u>	<u>13</u>
	\$26	\$38
B. Pre-payment Premium, and \$15 per Day for Inpatient Services	\$17	\$33
	<u>8</u>	<u>8</u>
	\$25	\$41
C. Pre-payment Premium, and no Co-payment	\$22	\$44
	<u>\$22</u>	<u>\$44</u>

COMBINATION A WITH A \$25 CO-PAYMENT PER INPATIENT DAY

DESIGNED TO ACHIEVE SHORT TERM OBJECTIVE OF \$2.8 MILLION

PLAN	RESIDENTS	NON-RESIDENTS	RESIDENTS & NON-RESIDENTS	FEDERAL	COMBINED	PER FAMILY OF 7 Per Month	
						Res	Non-Res
1. PRE-PAYMENT	\$ 490,000	\$ 417,000			\$ 907,000	\$ 13	\$ 25
2. CO-PAYMENT	485,000	208,000			693,000	\$ 13	\$ 13
3. MEDICAID				\$ 304,000	304,000		N/A
4. Tax on Soda Pop (6¢ per can)			\$ 896,000		896,000	\$ 16	\$ 16
TOTALS	<u>\$ 975,000</u>	<u>\$ 625,000</u>	<u>\$ 896,000</u>	<u>\$ 304,000</u>	<u>\$2,800,000</u>	<u>\$ 42</u>	<u>\$ 54</u>

COMBINATION B WITH A \$15 CO-PAYMENT PER INPATIENT DAY  
DESIGNED TO ACHIEVE SHORT-TERM OBJECTIVE OF \$2.8 MILLION

PLAN	RESIDENTS	NON-RESIDENTS	RESIDENTS & NON- RESIDENTS	FEDERAL	COMBINED	PER FAMILY OF 7 Per Month	
						Res	Non-Res
1. Pre-Payment	\$ 640,000	\$ 545,000			\$1,185,000	\$ 17	\$ 33
2. Co-Payment (\$15 per IP Day)	290,000	125,000			415,000	\$ 8	\$ 8
3. Medicaid				\$ 304,000	304,000	N/A	
4. Tax on Soda Pop (6¢ per Can)			\$ 896,000		896,000	\$ 16	\$ 16
TOTALS	<u>\$ 930,000</u>	<u>\$ 700,000</u>	<u>\$ 896,000</u>	<u>\$ 304,000</u>	<u>\$2,800,000</u>	<u>\$ 41</u>	<u>\$ 57</u>

COMBINATION C WITH NO CO-PAYMENTDESIGNED TO ACHIEVE SHORT TERM OBJECTIVE OF \$ 2.8 MILLION

PLAN	RESIDENTS	NON-RESIDENTS	RESIDENTS & NON- RESIDENTS	FEDERAL	COMBINED	PER FAMILY OF 7 Per Month	
						Res	Non-Res
1. PRE-PAYMENT	\$ 864,000	\$ 736,000			\$ 1,600,000	\$ 22	\$ 44
2. CO-PAYMENT (None)							
3. MEDICAID				\$ 304,000	304,000	N/A	
4. Tax on Soda Pop (6¢ per Can)			\$ 896,000		896,000	\$ 16	\$ 16
TOTALS	<u>\$ 864,000</u>	<u>\$ 736,000</u>	<u>\$ 896,000</u>	<u>\$ 304,000</u>	<u>\$ 2,800,000</u>	<u>\$ 38</u>	<u>\$ 60</u>

## H. RECOMMENDED ALTERNATIVE AND RATIONALE

In this section, a comparison of the various alternatives has been made in order to reject those that fail to meet our evaluation criteria and would be unworkable or unsatisfactory. Those satisfactory alternatives that remain then form the basis for the specific financing plan recommendations.

### 1. Comparison of Alternatives

Table I, following this page, contains a summary comparison of the six basic financing plans and one of the combination alternatives. Each of these is compared and analyzed in the following paragraphs:

#### a. Fee-for-service and Post Payment

These two alternatives should be rejected because of two major flaws: first, even though both of these could meet the short-term financing objectives, it appears highly unlikely that they could meet the mid or long-term objectives unless the Fono changed the ASG Code to require residents to pay for medical services and drugs. Since this is unlikely, these two should be rejected for this reason alone; second, they have another more serious flaw -- the financing falls entirely on those receiving the services at any given point in time, particularly the costly inpatient services. For example, simple averages tell us that once every six years a resident or a non-resident will have an inpatient stay at LBJ of approximately six days (the actual admission rate and length of stay vary by the age and sex of the population). The result of this under a fee-for-service or post payment plan is that the patient, or his or her financial sponsor, is burdened

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
1. 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>
2. 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>
3. Can short-term objectives be Met?	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million	YES 2.8million
4. Can mid and long-term objectives be met?	?	?	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
5. Are there legal requirements other than compulsory participation?	NO	NO	YES	YES	YES	Yes, for other than std.ins. co. and ASG	YES	YES	YES	YES	YES	YES	YES	YES
6. Are there significant administrative requirements?	NO	NO	YES	YES	YES		Yes, if tax at retail level	YES	YES	YES	YES	YES	YES	YES
7. Are there significant marketing requirements other than compulsory participation?	NO	NO	NO	NO	NO	NO	NO	NO	NO	YES	YES	YES	YES, for Medicaid enrollment	YES

with a large bill (\$300 for a resident) at infrequent times. Because of this the bill is less likely to be paid or the high fees may represent a serious barrier to receiving care and people may avoid needed health services because of the high rates.

**b. HMO Plan**

The HMO overcomes the key objections to the fee-for-service and post payment plans because the risk and payment of services can be spread over time among all enrollees, not just those receiving services. In addition, a co-payment concept can be used to generate additional revenues and serves to reduce the monthly pre-payments, and it can also be used to encourage or discourage the use of certain services -- no co-payment for dental and outpatient services, but a copayment for inpatient stays. However, the HMO alternative must be rejected because a key requirement for an HMO is not currently present at DOH and LBJ - an organized and adequately staffed physician/provider group that is willing to be at risk to provide the services for the total premiums that would be paid by the enrollees.

**c. Pre-paid/Insurance**

The pre-paid/insurance plan has most of the advantages but none of the disadvantages of the HMO, fee-for-service or post payment plans. A pre-paid plan sponsored by ASG or a public consumer group appears to be more cost effective than an outside insurance carrier who might not be so flexible

to local needs. Thus, the pre-paid plan is valid for those who have the ability to pay.

d. Tax Based

The tax based plan has major advantages because it appears that significant revenues could be generated from taxes or items which are discretionary rather than essential purchases. However, legislation would be required to implement this plan. In addition, there is a more important disadvantage if the intent were to have the tax based plan support all of the health care financing -- the tax payer is generally not aware that his or her monies are going for health care and continues to be an uninvolved consumer and financer of health services. It is generally accepted in economics that the consumer of goods and services take a greater interest in them and purchase them more intelligently if there is a more direct relationship between the paying and receiving of goods and services. A central theme of the current U.S. efforts to reform health care delivery and contain costs is to bring the consumer into an active decision making role in making health care spending choices. Most believe that the present array of employer-paid health benefits, the tax supported health service, and the U.S. tax code prevent consumers from becoming involved and intelligent decision makers. If we want to avoid this U.S. situation and want more consumer involvement in ASG health care, then a tax based plan shouldn't be used to finance all of the health care costs, but some tax financing should be used along with direct consumer payments.

e. Medicaid

The Medicaid plan would adequately address the issue of financing care for the poor if the funds can be obtained and the regulatory and administrative requirements were not burdensome. However the Medicaid approach would have to be combined with one of the other acceptable alternatives in order to meet the rest of the financing objectives.

f. Summary

The fee-for-service, post payment and HMO alternatives are found to be unacceptable. The pre-paid/insurance plan is acceptable if locally sponsored and a way to finance care for the poor can be found. The tax based plan is acceptable if not used exclusively and consumer involvement is added to this approach. The Medicaid approach is acceptable if ASG and Congress/HHS can agree to reasonable terms for the regulatory and administrative requirements, and Medicaid is combined with one of the other acceptable plans to finance the remaining amounts.

As can be seen, each of the three acceptable plans has some shortcoming that the others could overcome. Thus, some combination of these three seems to be the most reasonable approach.

2. Recommended Financing Plan

A combination financing plan should be implemented that embodies the following concepts:

- A pre-payment plan, with co-payments for inpatient services, that is administered by ASG and that has

mandatory enrollment for the entire population.

- A Medicaid funded component to finance health care for the needy.
- A tax on soda pop (and possibly other similar discretionary purchases).
- A specific earmarking or designation that the funds generated from these sources be set aside exclusively for the use of DOH and health care.
- That the question of a sliding fee schedule based on the ability to pay be studied when 1980 census data are available. Until then the single premium rate proposed below should be adequate for decision making purposes at this time (and may be low enough that it eventually is proven to be equitable).

The specifics of the combination plan are those contained in Combination A, Exhibit VI where:

	<u>Residents</u>	<u>Non-residents</u>
• Premium for Family of 7/month	\$13	\$25
• Co-payment of \$25 per Inpatient Day, Average per Family of 7/month	13	13

In addition, Medicaid and the tax would contribute \$300,000 and \$900,000 respectively in the short-term.

Exhibit IX, following this page, provides a test of this combination plan's ability to meet the mid-term financing objectives, in 1986 or in 5 years, of \$6.2 million. As inflation and costs increase for health care, hopefully salaries and wages will keep pace and the ability to pay will also remain relative. It appears that sufficient flexibility exists within each of the four plan components to proportionately adjust upwards to meet the increased costs. This same

COMBINATION A: WITH A \$25 PER DAY CO-PAYMENT PER INPATIENT DAYDESIGNED TO ACHIEVE MIDTERM 5TH YEAR, OBJECTIVE OF \$6.2 MILLION

PLAN COMPONENTS	RESIDENTS	NON-RESIDENTS	RESIDENTS & NON-RESIDENTS	FEDERAL	COMBINED	PER FAMILY OF 7 Per Month	
						RES	NON-RES
1. PRE-PAYMENT	\$1,634,000	\$1,392,000			\$3,026,000	\$42	\$84
2. CO-PAYMENT (\$25 per IP Day)	679,000	290,000			969,000	\$30	\$30
3. MEDICAID				\$ 413,000	413,000		N/A
4. TAX ON SODA POP (12¢ per Can)			\$ 1,792,000		1,792,000	\$55	\$55
TOTALS	<u>\$ 2,313,000</u>	<u>\$ 1,682,000</u>	<u>\$ 1,792,000</u>	<u>\$ 413,000</u>	<u>\$ 6,200,000</u>	<u>\$127</u>	<u>\$169</u>

flexibility exists when considering their ability to meet the long-term or ten year objectives.

**a. Advantages to the Recommended Plan**

The recommended plan has a number of advantages in addition to its ability to meet the financing objectives:

- . Each component contains sufficient flexibility to be increased or decreased and cause an offsetting affect on the other components if that is desired. For example, increasing the premium so that the co-payment could be reduced.
- . As can be seen in the comparison summary, Table I, at the beginning of this section, the monthly premium outlay, \$13 for a resident family of seven, is the lowest of all alternatives, and the combined premium and average co-payments, \$26, are still the lowest out-of-pocket costs.
- . Table I also shows that the recommended plan has the smallest cost differential between residents and non-residents. In the discussion with ASG officials and other responsible parties, it was generally agreed that there should be some difference but that it should not be as much as 100 percent more for non-residents as in the fee-for-service example. Thus, combination A is an attempt to have a \$26 versus \$38 differential for premium plus the average co-payments, and \$42 and \$54 when the average tax affect is considered.
- . The co-payment feature adds another revenue generating capability and can also be used to encourage the use of preventative and outpatient services, and to discourage but not restrict the use of costly inpatient services.
- . Having the pre-payment plan administered by ASG appears to be the most cost effective approach and provides for the greatest flexibility in adapting to local needs.
- . A mandatory enrollment is necessary to spread the risks over the maximum number. If instead enrollment were voluntary, there would be the need to establish a separate fee schedule for the non-enrollees and have all of the disadvantages associated with that alternative. In addition, we might experience adverse selection -- people enrolling in the plan when they anticipate fee-for-service expenses and then disenrolling when the pre-payment umbrella isn't needed.

- . The Medicaid component provides an excellent answer to the need to finance care for the poor. However, if it can't be made available, then the other components will have to be adjusted to provide that financing.
- . The tax on soda pop (or other discretionary purchases) provides a significant amount and percent of the financing objective, and should not be a financial burden on the consumer or on the seller if administered at the import/wholesale level rather than at the retail level.
- . Earmarking or designating these funds for the exclusive use of DOH and health care should overcome some of the paying public's reaction to increased outlays and give them comfort that monies paid for health care won't go into the general fund for the use of all departments. Hopefully, earmarking these funds coupled with direct consumer payments will raise the level of consumer interest in health care and help bring about the health care improvements desired.

**b. Disadvantages**

The key disadvantages of the recommended plan are that the implementation time could be stretched out if the required legislation is delayed. For example:

- . ASG administration of a pre-payment plan might require Fono action unless it is interpreted to be within the intent of the ASG Code.
- . Mandating enrollment is probably a legislative prerogative, but an executive order could require it until the Fono were able to meet and consider it.
- . Congress must authorize the Medicaid funds. In addition, the Fono may be required to pass enabling legislation for Medicaid unless Congress removes that requirement.
- . The tax on soda pop (or other similar items) is also a legislative prerogative, but a tax could be effected by executive order until the Fono met.

**I. PRELIMINARY SUGGESTIONS ON FINANCING OFF-ISLAND CARE**

All the preceding analyses and recommendations have been focused on financing on-island care. Financing off-island care has been specifically

excluded, because it presents a substantially different problem to control. Relatively more is known about the demand for and the costs of on-island care and they are more predictable. But such isn't the case with off-island care, and until the facts are known and a mechanism for controlling them has been put in place, any plans for enrolling residents and non-residents into a financing plan for off-island care might lead to uncontrolled demand for off-island care and financial disaster. Therefore, until that problem is analyzed and resolved, a final approach and decision on financing off-island care should be delayed. However, the following paragraphs contain a preliminary approach for consideration until the facts are known, and this approach or a better one is developed.

At the beginning of each fiscal year, an estimate of the annual cost of off-island care would be made based on the expected cases that would be authorized for referral and the current costs charged by DOH's approved off-island providers -- assume \$1 million in total. From this subtract the budgeted amount for off-island care -- assume the budget is \$800,000. The difference of \$200,000 would be the annual co-payment that would be shared by the off-island patients. For example:

- . The average off-island patient had a bill of \$6,000 in 1980.
- . Under this preliminary approach, ASG would pay 80 percent, or \$4,800, and the patient enrollee would pay 20 percent, or \$1,200.
- . At the end of the year any over-collections could be reimbursed to these patients or the funds could be used for other purposes. Any overruns could be assessed from the patients or DOH would have to make up the shortfall from other programs.

- . If the patient wanted services at other than the DOH approved providers, then the patient would pay any difference in cost.
- . Patients without the financial means to pay would either be eligible for Medicaid support or other administrative remedies.
- . With a factual understanding of the off-island care problem and an effective control program, insurance carriers would be more likely to offer insurance coverage to the enrollees to help defray all or part of their co-payment.

## V. SUGGESTED IMPLEMENTATION APPROACH

## V. SUGGESTED IMPLEMENTATION APPROACH

The purpose of this chapter is to suggest a framework and an approach to implementing the recommended ASG health care financing plan. The suggested work program will address two underlying requirements:

- Since the recommended financing plan will require action by the Council, the Executive branch, and some legislation by Congress and the Fono, the implementation plan should be flexible and allow for the incorporation of the various components of the recommended combinations as they are authorized.
- Since the recommendations in this report are in the form of a conceptual design of a financing plan (a detail design at this stage would be premature and outside the scope of this project), the implementation plan should concentrate on detailing the financing plan and its components that are ultimately selected by ASG policy makers.

The following implementation approach is based on the assumption that the mandatory pre-payment component and the co-payment component (if supported by the Council and Executive branch) can be implemented first. This means that a favorable legal opinion would first have to be obtained stating that the ASG Code (Title 33, Chapter 3, Medical Treatment by Government), which authorizes ASG to "make a reasonable charge for the use of government facilities at the hospital and dispensaries", also permits the government to require the pre-payment of those charges by all residents and non-residents. If the legal opinion is unfavorable, then legislation will be required and Phase II, on the implementation of the Pre-payment component, would be delayed along with the Medicaid and tax components. However, Phase I on the implementation of the co-payment component could take place when authorized.

### **PHASE I: IMPLEMENT CO-PAYMENT COMPONENT**

**Task I** Prepare guidelines and rules for determining financial hardship cases for those who cannot pay all or part of the co-payment for inpatient days. Data from the office of Development and Planning and from the 1980 Census, when available, should be helpful in establishing

rules for determining the ability to pay co-payments (as well as for use in other tasks).

**Task 2.** Obtain approval on guidelines and rules, developed in Task 1, from DOH and the Executive branch.

**Task 3.** Conduct meeting and obtain public comments on co-payments, guidelines and rules.

**Task 4.** Estimate any additional credit and collection efforts that may be required at LBJ because of the increased co-payments for residents. The experience that LBJ management acquires from the recently planned rate increases should be most helpful in determining any impact that the co-payment component may have. Best judgment would indicate that no additional effort, and possibly less, would be required for non-residents since the new rates will be at \$25 per day plus the itemized ancillary fees for those services, while the co-payment would be a total of \$25 per day. However, some additional effort may be required for residents who would increase from \$5 to \$25 per day. If additional staffing is required, then the position(s) will need to be authorized, recruited and trained.

**Task 5.** Implement new co-payment component.

**PHASE II: IMPLEMENT MANDATORY PRE-PAYMENT COMPONENT**

**Task 6.** Finalize pre-payment amounts to be charged, including the issues of:

- A single amount or a sliding scale based on the ability to pay, exclusive of those who would be enrolled in a Medicaid funded program.
- Amounts per family determined by multiplying the number in a family by a per capita amount, or several amounts based on grouping of family size; for example,
  - Group 1: 1 to 4 in a family
  - Group 2: 5 to 8 in a family.
  - Group 3: 9 or more in a family.
- Develop the control procedures to verify family sizes, income levels, etc. (income tax and census data may prove to be the best source).

**Task 7.** Design the enrollment and payment systems and procedures including:

- Deciding if a payroll deduction and/or another system should be used for payments.
- Determining which employers and how many employees could be covered by a payroll deduction system, and how many others -- self-employed or unemployed -- would need to be covered by some other system.
- Defining the record keeping requirements for enrolling and monitoring payments -- manual or data processing -- and the adaptability of existing ASG systems to accommodate these requirements.
- Developing incentives for employers and enrollees to enroll and make payments on a timely basis.
- Designing an initial enrollment program to contact, motivate and enroll individuals and employer groups.
- Designing the on-going enrollment and maintenance program, such as through contacts with the unenrolled at the hospital or at immigration/emigration times.
- Designing alternative payment plans for those who are not enrolled.

**Task 8.** Estimate the additional staffing and resources necessary to implement and operate the Task 7 activities.

**Task 9.** Obtain budgetary approval for the items estimated in Task 8, and recruit and train personnel.

Task 10. Implement the Task 7 activities.

**PHASE III: IMPLEMENT THE MEDICAID COMPONENT**

Task 11. Finalize the grant terms, conditions and details with Congressional and HHS/HCFA staff, particularly the eligibility, administrative, reporting, billing/cost reporting, and personnel/organization requirements.

Task 12. Coordinate the eligibility determination requirements with the ability to pay guidelines and rules developed for the co-payment and pre-payment components, and resolve any gaps or overlaps.

Task 13. Design systems and procedures for:

- Eligibility determination and enrollment so they are consistent with those for pre-payment enrollment in Task 7.
- Administrative, reporting, billing/cost reporting.

Task 14. Estimate personnel/staffing and other resource requirements for Task 13 activities.

Task 15. Obtain budgetary approval for the items estimated in Task 14, and recruit and train personnel.

Task 16. Implement the Task 13 activities.

**PHASE IV: IMPLEMENT THE TAX COMPONENT**

Task 17. Determine whether the tax will be levied at the import/wholesale level or at retail level and develop collection and credit systems and procedures.

Task 18. Determine the contents of the periodic reports on the amounts collected that DOH and the administrative departments will need.

Task 19. Estimate the resources required to implement the activities in Task 17 and 18.

Task 20. Obtain budgeting approval for the resources estimated in Task 19.

Task 21. Implement activities in Tasks 17 and 18.

## PHASE V: CONDUCT ON-GOING ACTIVITIES.

In addition to those on-going activities identified in the previous tasks, the following will be required:

- . Pre-payment and co-payment rate reviews and revisions.
- . Information system refinements.
- . Public information and public education on residents' and non-residents' responsibilities for enrollment, pre-payments and co-payments.

\* \* \* \* \*

The final major implementation issue that remains to be addressed involves the question of who will be responsible for the implementation efforts. Because there has been increasingly serious discussion about creating a board of health, it is our suggestion that this implementation effort be made one of the duties of the new committee or board. This organization, in cooperation with the DOH Director and the ASHPDA staff could then identify and acquire the necessary resources to initialize and complete the implementation work.

**APPENDIX A  
DETAIL BUDGET AND UTILIZATION DATA**

TABLE 1

SHARE OF TOTAL ASG BUDGET BY REVENUE SOURCE (Millions \$)

	<u>FY 79</u>	<u>FY 80</u>	<u>FY 81</u>	<u>FY 82</u>	<u>Average Change</u>
ASG LOCAL	37%	42%	44%	50%	+ 4.3%
US FEDERAL	<u>63%</u>	<u>58%</u>	<u>56%</u>	<u>50%</u>	<u>- 4.3%</u>
TOTAL	100%	100%	100%	100%	0
ASG LOCAL	\$21.7	\$24.8	\$31.6	\$33.1	\$ + 3.8
US FEDERAL	<u>37.1</u>	<u>34.3</u>	<u>40.2</u>	<u>34.3</u>	<u>- .9</u>
TOTAL	<u>\$58.8</u>	<u>\$59.1</u>	<u>\$71.8</u>	<u>\$67.4</u>	<u>\$ + 2.8</u>

TABLE 2

SUMMARY OF FUNDING SOURCES

	<u>FISCAL YEAR (Millions)</u>							
	<u>79</u>	<u>%</u>	<u>80</u>	<u>%</u>	<u>81</u>	<u>%</u>	<u>82</u>	<u>%</u>
ASG LOCAL FUNDS	\$13.6	24	\$13.8	23	\$17.5	24	\$16.5	25
ASG ENTERPRISE REVENUES	8.1	13	11.0	19	14.1	20	16.6	25
DOI GRANT	22.5	38	17.3	29	25.8	36	19.0	28
FEDERAL GRANTS	<u>14.6</u>	<u>25</u>	<u>17.0</u>	<u>29</u>	<u>14.4</u>	<u>20</u>	<u>15.3</u>	<u>22</u>
TOTAL BUDGET	<u>\$58.8</u>	100%	<u>\$59.1</u>	100%	<u>\$71.8</u>	100%	<u>\$67.4</u>	100%
DEPARTMENT OF HEALTH	<u>\$ 5.7</u>	9%	<u>\$ 6.6</u>	11%	<u>\$ 7.1</u>	9%	<u>\$ 7.3</u>	11%

TABLE 3

## BUDGETED HEALTH CARE EXPENDITURES

DEPARTMENT OF HEALTH FUNDING SOURCE	FISCAL YEAR (1)								
	74	75	76	77	78	79	80	81	82
1. Department of Interior	\$3,100,000	\$3,317,000	\$3,380,000	\$3,306,000	\$3,121,000	\$3,444,000	\$3,651,000	\$4,416,200	\$4,645,500
2. A S G	198,000	667,000	875,000	432,000	1,224,000	1,452,000	2,224,400	1,858,300	1,958,500
3. Federal Grants	<u>573,000</u>	<u>608,000</u>	<u>785,807</u>	<u>656,785</u>	<u>790,491</u>	<u>761,872</u>	<u>744,321</u>	<u>796,780</u>	<u>728,600</u>
Total Budget	<u>\$3,871,000</u>	<u>\$4,592,000</u>	<u>\$5,040,807</u>	<u>\$4,394,785</u>	<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>

(1) Source: ASG Budgets. Note that budget data were used rather than actual expenditures which were not consistently available for all years.

APPENDIX B  
KEY ASSUMPTIONS, DATA AND COMPUTATIONS USED FOR  
EVALUATING THE FINANCIAL FEASIBILITY OF THE  
ALTERNATIVE PLANS

## APPENDIX B

### A. KEY ASSUMPTIONS

1. All DOH costs except for off-island care and medical services and drugs for residents will be recovered in the acute care rates.
2. All inclusive rates for inpatient, outpatient and dental services are used for the purposes of this feasibility evaluation rather than detailed rates.
3. 1980 utilization data used to compute the all inclusive rates for FY82.

	Resident 70%	Non-Resident 30%
.IP Days, 27,700	19,400	8,300
.OP Visits, 122,500	85,750	36,750
.Dental Visits, 10,200	7,100	3,100

4. Resident utilization is estimated at 70 percent and non-resident is estimated at 30 percent.
5. Data on the rates proposed by DOH in 1977 used to calculate the revised all inclusive rates are used in this evaluation (see Pg. 29 of July 30, 1979, Siegel & Associates report).
6. Summary of the rates for non-residents and residents (see Tables 1. and 2 in this appendix for the computation of these rates):

Service	Non-Resident	Resident
IP Day	\$154.00	\$77.00
OP Visit	16.80	8.40
Dental Visit	32.60	16.30

7. 1980 Population of 32,400 for American Samoa is used for per capita calculations.
8. An estimated average family size of seven is used for average family size cost calculations (this was obtained from the Department of Planning and Development).
9. The average number of patient days per person per year is estimated at .85 (27,700 days-32,400 population).

APPENDIX B

TABLE 1  
COMPUTATION OF RATES FOR NON-RESIDENTS

Service	Demand	Rate	Gross Revenue (000)	%	Budget*			
					Share	Demand	Rate	
1977-1978					1980-1982			
IP Days	34,100	\$70.00	\$2,387	64 X	\$6,653	\$4,258	- 27,700	\$154.00
OP Visits	125,260	9.00	1,127	31 X	6,653	2,062	- 122,500	16.80
Dental Visits	11,490	15.00	<u>172</u>	<u>5 X</u>	6,653	<u>333</u>	- 10,200	32.60
Totals			<u>\$3,686</u>	<u>100</u>		<u>\$6,653</u>		

\* \$7,33,000 less off-island care, 680,000 = \$6,653,000

TABLE 2

COMPUTATION OF RATES FOR RESIDENTS

Service	Non Resident Rate	% Medical Services & Drugs*	Resident Rates
IP Day	\$154.00	X	50
OP Visit	16.80	X	50
Dental Visit	32.60	X	50
Medical	\$1,078		
Nursing	1,575		
Pharmacy	444		
Dental	<u>256</u>		
	\$3,353	÷ \$6,653 =	50

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10. The average number of OP visits per person per year is estimated at 3.8 (122,500 - 32,400 population).
11. The average number of dental visits per person is estimated at .3 (10,200 - 32,400).
12. The Federal and ASG share of the DOH budget are based on the data contained in Table 1 in Appendix A. These data described the relationship between the total expenditures and revenues budgeted for all ASG activities including the enterprise funds. That percentage relationship between Federal and ASG funding sources was 50/50 for FY82. Two other choices were available: (1) The budget for DOH in Table 3 in Appendix A shows the Federal share in FY82 to be approximately 65 percent of the total. However, we understand that percentage is based on a previous relationship between Federal and local funds for all departments and that it has changed because of different shifts in the percent and amounts of specific grants one department may receive as compared to the other, and because of the need in the budgetary presentation for the DOI and ASG shares to balance the remainder. Therefore, this approach seems to have become slightly less accurate than the one used here which concentrates on the current aggregate shares of various sources; and, (2) The other choice was to exclude from the total ASG budget the expenses and revenues associated with the enterprise funds. The enterprises are not normally supported by local taxes or Federal grants, and they don't normally compete with the General Fund departments for funding, and they are considered separate in the funding sense. If they had been excluded from the Federal/ASG share computation, the overall Federal share would have been 67 percent and the ASG share from local taxes would have been 33 percent. The reason for rejecting this approach was that by funding the Federal share, less the specific Federal grants to DOH, the overall needs of ASG and DOH are more equitably served rather than subsets of the government. Moreover, the recommended long range approach would result in DOH funding all of its financial needs with the exception of the specific Federal grants, and thereby essentially meeting one of the generally accepted key requirements of a government enterprise fund -- to receive more than 50 percent of its financial support from payors other than its parent governmental entity.

