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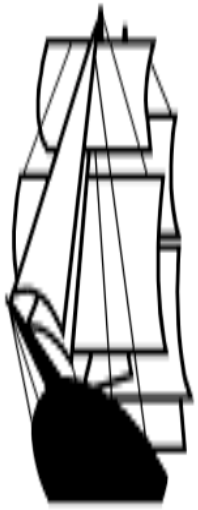

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Insuring Our Health

Financing Health Care in the FSM

By Marcus H. Samo

Introduction

Years ago, when we were still a trust territory, a visit to a dispensary in the village or even to the hospital cost only ten cents. When essential medicines, such as antibiotics, medical supplies and personnel were needed, they were provided free of charge. If a patient needed off-island care, he or she was flown to Guam or Hawaii on a naval or commercial flight at no cost to the patient. The Trust Territory Administration paid the bill for all of this. Health care was perceived by Micronesians as a social right, and people were by and large content with the services they received.

Today, we are an independent nation. US subsidies to the FSM have dropped and are bound to decline still more in years ahead. Meanwhile, the cost of health care has multiplied many times over and people no longer seem content with the services they receive.

While we may still perceive health care as a social right--a service that the government owes us--the fact is that someone has to pay the cost. Until recently, the practice had been that the government bears most, if not all of the cost, while charging the public only nominal fees. This practice has made it impossible for hospitals to recover any substantial part of their expenses. As health care becomes more expensive and budget problems continue to grow, a more viable means of financing health care must be explored further with local hospitals, government policy and decision makers, private clinics and insurance plan managers.

Hospitals Not Able to Recover Cost

But first, what are the hospitals doing to recover some of their costs? Our hospitals continue to provide basic care and certain tertiary services while expecting the public to share a portion of the total cost. On entering a hospital anywhere in the FSM, one notices the *"Pay Here"* sign prominently displayed as a reminder to pay for the services received. This does not mean that the hospitals charge the public like supermarkets charge customers. It simply means that the

To be fair to all enrollees, the health insurance plan needs to be judicious and prudent in allocating health care dollars so that the vast majority, not just a few, benefit. As a staff member of the NGHIP stated, "There are 17,000 people enrolled in the plan, but it only takes twenty of them to deplete the funds, although the average revenue collected each year is $2 million and the maximum coverage for each enrollee is $50,000."

Moreover, it should be understood that as provisions and financing of health care continue to be intricately related, health insurance will continue to be even more important. Hospital and insurance managers, and government policy and decision makers will need to work together to provide a funding scheme in which health insurance can be a conduit for offsetting some of the health care costs. In doing so, it needs to ensure (1) a scheme where one's benefits are commensurate with one's contribution to the plan, (2) the amount of one's premiums matches one's lifestyle or behavior, and (3) a sense of autonomy exists in order to effectively and efficiently advance its operation as an insurance plan.

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medical referral should be based exclusively on medical decisions rather than political considerations.

Have A Single Insurance Plan Manager for Off-Island Care

Because the total population in the FSM is very small, extra caution should be taken when considering forming another plan. If that happens, all of the parties should work together to utilize their collective bargaining power when seeking off-island health care providers to accept referred patients. Assuming that health care providers are secured and payment is in order, most companies are likely to give group discounts.

Share Visiting Medical Specialists

There have been many medical specialists visiting the FSM recently. In order to minimize the cost of further follow up at outside health care facilities, there should be coordination of visiting medical specialists with the insurance program to follow up on those who have been referred abroad.

Conclusion

It is no secret that the cost of health care throughout the world has risen dramatically. The FSM is not immune to this, particularly when the expectation of having a health care system based on a medical or curative model that provides immediate remedies to medical woes seems desirable at all levels. But the equity and quality of health care should be rationed and should always be the cornerstone of providing adequate care and maintaining solid public health.

The relatively new NGHIP has just begun to address that demand. Being the only available health insurance plan in the FSM and operated entirely by membership dues, it can still be positioned to provide adequate health care while meeting its obligation in providing entitlements to its members when they need them, either locally or abroad.

hospitals are trying to recover some small part of their expenses, something that they never had to worry about before.

Another way that the hospitals attempt to control the escalating cost of health care is by putting a limit on the number of referrals to off-island hospitals, something that used to be provided at no cost to patients. In spite of these changes, the financial burden of health care is still difficult for the government to bear. One further way of reducing the burden on the national government still must be explored: a strategy to finance much of health care costs through health insurance.

What is Health Insurance?

Health insurance implies that an individual or groups of individuals are entitled, usually through some form of regular payment, to access basic health care when it is needed. The concept basically means that individuals who are covered in the plan are assured of receiving the health care to which they are entitled.

To what exactly is an individual entitled? In general, people get prescribed packages of care that the health insurance plan sets as fair compensation for the total payment received from the subscribers and their employers. Some employers pay a certain percentage of the total payment or premium, while employees must pay the rest. Sometimes employers do not pay any portion of the premium and if the employees wish to have health insurance, they are responsible for paying the total premium costs themselves.

In some plans, the cost of hospitalization and referrals to specialists may be covered, while in others they may not be. Similarly, some plans may cover only the basic preventive health care, while foregoing the more expensive care such as organ transplants, hemodialysis, and other experimental services.

How Does Health Insurance Work?

In any health insurance plan, there are always risks involved. For the plan managers, the risks have to be managed carefully to avoid any adverse impact on the overall financial well being and sustainability of the plan. There are two factors that have direct impact on a plan: (1) the number of people enrolled and (2) their prevailing health condition. The more people who are enrolled in a plan, the bigger the net collection is and the more "paying power" it has to negotiate or provide better services for its members. Likewise, the greater the number of enrollees, the more people there are to share the collective health risk. Therefore, if the net health status is poor and only a few people are enrolled, its burden will be greater on an individual than if there were more people enrolled. This means that if the prevailing health status of those enrolled is poor, it is expected that more medical care will be required and more expenses will be paid out. From a financial point of view, the proportion of the risks should not exceed the expected total premiums in the plan.

Generally, there are two types of health insurance. The one that sounds popular to many people is commercial health insurance, which is normally for-profit. Unfortunately, commercial health insurance companies are often labeled greedy organizations that collect money from people and end up denying care when people really need it. The other type of health insurance is social health insurance, where the premiums collected are used to pay for needed medical care for everyone in a country, insured or not. By virtue of its technical operation and allocation of resources, the FSM National Government Health Insurance Program (NGHIP) is an example of a plan that tries to meet the social need of the entire population at the expense of the few who contribute to the plan. For example, as of October 1, 2000, there were 16,434 members registered under the plan. Less than half (7,132) of these registered members were paying members, the rest were either dependents or relatives of those members.

ernment-related plans, while the state-government health plans concentrate on improving the local health care infrastructure and building the capacities of the local medical providers.

One area that has pressing concerns in this respect is health care for those residing in the outer islands. It is known that those who do not regularly receive preventive services are five times more likely to have serious conditions that will require off-island referrals. Therefore, if more people receive basic preventive care, chances are they will cost the government or the health insurance plan less money over time.

Focus on Affordable and Cost-Effective Health Care

The aim of the insurance program should be to improve the health of those enrolled in the plan through both curative and preventive services. It should not spend too much of its revenue on the administration of the plan, but rather should spend most of its resources on providing affordable and cost-effective health care to its beneficiaries.

Increase Premium for Unhealthy Lifestyles

Perhaps it is time to base one's premium payment on his/her actual relative risk. Those who are at greater risk for developing certain diseases due to smoking, drinking, and lack of exercise--acquired unhealthy lifestyles or behaviors--should pay higher premiums than those who do not engage in these unhealthy lifestyles.

Have An Autonomous Plan

To the greatest extent possible, it will be in the best interest of the organization to operate independent of the government bureaucracy. The government can act as an overseer, but the day-to-day administration, which includes management, strategic planning, adjustment of premium rates and packages of benefits, may be best handled independent of the government's direct control. Likewise,

Set a Waiting Period

Should a person who has been contributing to the health insurance plan for ten years have the same entitlement as someone who has just been enrolled for a few weeks? Time, in this case, is a variable that determines the amount of revenue the plan actually receives from an insured person. One way this can be arranged is through a waiting period of six months in order for the plan to collect an equitable contribution perceived as equivalent to the average cost of a medical referral. Conversely, the absence of a waiting period not only means that the plan may not receive a fair contribution from an individual, but also increases its risk of misuse and bankruptcy. It has happened that enrollees who signed up during an open enrollment period were referred off-island for medical treatment just a few weeks later. Others find ways to enroll some of their sick relatives who would not otherwise have been eligible to be referred abroad. The issue is not whether or not their health conditions warrant referral--after all, every FSM citizen at some point in his life could need a medical procedure that is not available locally--rather, the issue is whether or not the collected contribution is equitable to what others would normally pay over a given time period.

Allow Competition as an Incentive for Leaner and Meaner Services

It could be assumed that competition could lead to a wider variety of services with better results. In a country where health status is relatively poor and dominated by diabetes, heart disease, cancer and infectious diseases, the presence of multiple health insurance plans will mean only one thing: fewer healthy people to share the inherent collective risk.

It is only a matter of time before other health insurance plans are introduced to our islands. When that happens, it could be suggested the NGHIP is not necessary. However, I believe the opposite is true because at some point the plans will refer patients abroad. Unless many more medical specialists come to practice in the FSM, an agency will be needed to coordinate these referrals. In this situation, the NGHIP could be utilized to handle outside referrals for all gov-

A Look at Health Insurance in the FSM

The FSM National Government Health Insurance Program (NGHIP) is mandated to give a certain percentage of its collected revenue to local hospitals with the understanding that services will be provided to insured members of the program on an as-needed basis. This percentage is based on the number of enrollees residing in each respective State. As of October 1, 2000, NGHIP should have paid a total of $31,500 every month to all of the hospitals in the FSM. Assuming that this amount was not consumed by the costs associated with patient care, the hospitals could use this amount at their discretion. By contrast, most commercial insurance companies deal with private health care providers on a fee-for-service basis; this means that a payment is made only after services are provided to insured members of their program. If no medical care is provided, no funds are given.

The procedure for enrolling in the NGHIP plan is less stringent than other insurance plans. In fact, most commercial companies define dependents as parents and their children up to 18 years old, and they set payment options based on actual health risk. For example, a person who smokes two or three packs of cigarettes a day, drinks excessively and does not exercise regularly will pay a higher premium than someone who does not smoke, drinks red wine moderately and exercises regularly. For commercial insurance, this information is absolutely necessary in assessing one's relative health risk in order to estimate the true cost of indemnifying against certain diseases.

The FSM Government is responsible for overseeing NGHIP. This can be problematic because the program must adhere to bureaucratic policies and procedures. At times, certain aspects of the program must be evaluated and changed. Passing through several echelons of governmental authority can be cumbersome and time consuming. For example, recently it became necessary to increase the premium rate by 10% to accommodate the increase in health care costs. Unfortunately, passing a regulation through the normal channels would have been untimely and slow, so an emergency regulation was

deemed the only solution.

Another, and perhaps more appalling example is when an insured patient needs to be referred to an outside medical institution. There have been instances where an FSM State Hospital refused to initiate the referral of an insured person from another State, despite his tenured residency, due to the fear that they would be responsible for costs that exceed the maximum coverage of $50,000. Thus, these individuals had to go back to their state of origin and have their case referred from there to the health insurance program for final approval.

Ideally, those covered by the NGHIP would receive needed medical care outside the FSM through medical referral, as long as they are members in good standing. When a subscriber to the NGHIP needs medical care, it is unfortunate if their employer has not paid and they are denied care, despite having paid their part of the premium. Such a situation would be a grave injustice.

Essentially, the kind of health care provided under the NGHIP can be divided into two levels. The first and most basic level entitles enrollees to all services that the FSM hospitals can provide. Many people believe this is the same as having no insurance at all, since the hospitals are "socially obligated" to provide care anyway. From this perspective, medical care is provided to everyone, regardless of his ability to pay.

The second level of care is off-island health care. This is when an insured person cannot be treated at any of the local hospitals and is being sent out for further examination or treatment. It should be noted, however, that this arrangement is not new. The Government has always acted as the insurer when it sends out uninsured persons and guarantees payment. Financing health care in the FSM this way has caused many of the FSM State Governments to spend a substantial amount of its state health budget on a small number of people.

Recently, in one of the FSM states, medical referrals to Honolulu alone created a deficit of $5.2 million in that State. This practice not only robs the local hospitals of their meager resources, but also hampers their ability to negotiate essential health care services with health care providers abroad.

Many people have been fortunate enough to undergo expensive medical procedures in Honolulu, Guam or the Philippines. These FSM citizens return and are referred to the local hospitals and doctors for regular follow-ups and medication refills. When patients are continuously sent off-island for needed medical care and little is done to increase the capacities of local doctors and facilities, the inequity of health services will continue to grow and the modest resources allocated for health care will continue to be spent outside the FSM.

What Can Be Done To Improve the NGHIP?

While health insurance cannot be all things to all people, the annual $378,000 capitation payment to the hospitals in the FSM is substantial enough to offset the costs associated with adequate health care. In order to develop a health insurance infrastructure system that is resilient and conducive to the circumstances in the FSM, perhaps the following should be considered.

Set a Minimum Package of Care

Allocating meager resources in a socially equitable manner is a challenging task in an area where health care has previously been regarded as a social right. Therefore, policy and government leaders, in tandem with hospital and health insurance managers, should work to design an affordable basic package of health care that a person can expect to receive from the hospitals. Anything not within the minimum package will be financed through the insurance scheme, either in full or in part, and the local hospitals and the insurance company will work together to finance it.