

Lessons from Canada's Equalization Regime:
Examining America's Intergovernmental Efforts to
Achieve Accessible Health Care Coverage Through
Medicaid

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I. INTRODUCTION

The health care industry in the United States is going through a precarious transition. Medicaid,¹ the nation's largest intergovernmental program, provides public insurance to over fifty-five million enrollees,² and a new legislative mandate³ is underway to expand its coverage to an additional thirty-two million individuals by 2014.⁴ While Medicaid plays a crucial role in protecting vulnerable populations of Americans,⁵ the program's growing cost⁶ and media attention⁷ have revealed intergovernmental tensions that threaten the jointly financed and

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1. U.S. DEPT. OF HEALTH & HUMAN SERVICES, MEDICAID, available at <http://www.healthcare.gov/using-insurance/low-cost-care/medicaid/index.html>.

2. John K. Inglehart, *Expanding Eligibility, Cutting Costs- A Medicaid Update*, THE NEW ENGLAND JOURNAL OF MEDICINE, p.105 (Jan.12, 2012) available at <http://www.nejm.org/doi/full/10.1056/NEJMp1113561>.

3. Patient Protection and Affordable Care Act, Pub. Law 111-148, 124 Stat. 119 (2010) (to be codified in scattered sections of the U.S.C.), amended by the Health Care and Education Reconciliation Act of 2010, Pub.Law. 111-152, 124 Stat. 1029 (2010).

4. Benjamin D. Sommers & Arnold M. Epstein, *Medicaid Expansion – The Soft Underbelly of Health Care Reform?* THE NEW ENGLAND JOURNAL OF MEDICINE, p.2085(Nov. 25, 2010), [hereinafter Sommers] available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1010866>.

5. See ROBERT B. HELMS, THE MEDICAID COMMISSION REPORT: A DISSENT, HEALTH POLICY OUTLOOK, p.1(Jan. 12, 2007) available at <http://www.aei.org/article/society-and-culture/poverty/the-medicaid-commission-report/>.

6. Tami Luhby, *Rising Medicaid Costs to Blow Hole in State Budgets*, CNN, (Sept. 30, 2010), http://money.cnn.com/2010/09/30/news/economy/medicaid_state_budget/index.htm

7. Sommers, *supra* note 4, at 2086.

administered program.⁸ Rather than working together to lower costs and equalize quality across states, the contentious relationship between federal and state governments⁹ could be detrimental to the program's efficacy and goals.¹⁰

Canadian citizens enjoy universal health care.¹¹ In Canada, provincial and federal governments work together to drive down health care costs¹² and guarantee its residents "reasonable access" to medically necessary services.¹³ The 1984 Canadian Health Act (CHA)¹⁴ established a publicly funded health care system¹⁵ and a set of principles that require provinces to administer accessible, universal coverage to their citizens.¹⁶ The Canadians also employ an equalization program that is reassessed annually to equalize budgets for health care services in each of Canada's provinces and territories so that citizens get reasonably equal services regardless of their location.¹⁷

In Section I, this article discussed qualities of the Canadian health care system, its intergovernmental relationship, its financing structure of intergovernmental transfers, and its equalization goals, that could benefit the U.S. Medicaid program. Next, Section II will provide more information

8. Inglehart, *supra* note 2, at 105.

9. *Id.*

10. Helms, *supra* note 5, at 2.

11. CANADIAN INSTITUTE FOR HEALTH INFORMATION, EXPLORING THE 70/30 SPLIT: HOW CANADA'S HEALTH CARE SYSTEM IS FINANCED I, 14 (2005), [hereinafter "CIHI"] available at http://secure.cihi.ca/cihiweb/products/FundRep_EN.pdf.

12. See Matthew S. Openshaw, *Prescription Drug Prices, Government Intervention, & Importation: Importing Drugs From Canada*, 23 *NURSING ECONOMICS* 307, 308 (Nov.-Dec. 2005), available at http://findarticles.com/p/articles/mi_m0FSW/is_6_23/ai_n17211609/.

13. See CIHI, *supra* note 11, at 15.

14. *Id.*, citing Canada Health Act, R.S.C., 1985, c. C-6, [hereinafter "CHA"] available at <http://laws-lois.justice.gc.ca/PDF/C-6.pdf>.

15. CIHI, *supra* note 11, at 15.

16. CHA, *supra*, note 14, at c.6, s. 7; see also CIHI, *supra* note 11, at 20. The five CHA principles that guarantee universal health care coverage to Canadian citizens are: public administration, comprehensiveness, universality, portability and accessibility.

17. *Equalization Program*, DEPARTMENT OF FINANCE CANADA, [hereinafter "Canada Equalization"] available at <http://www.fin.gc.ca/fedprov/eqp-eng.asp>.

about Canada's intergovernmental relationship and how its fiscal transfers and equalization program works. Section III will chronicle the historical background of the U.S. Medicaid program and a summary of the U.S. Federal Medical Assistance Percentage (FMAP) calculation. Section IV details why the U.S. must develop a similar effective intergovernmental relationship to cost-effectively negotiate for accessible health care like Canada's provincial-federal team. Additionally, this section explains why the U.S. needs to modify its fiscal measures of states' spending capacity and adopt the principles of Canada's equalization program.

II. THE CANADIANS' PUBLIC HEALTH CARE SYSTEM

The Canadian health care system is comprised of a set of publicly financed, provincially run insurance plans.¹⁸ This single-payer system uses public funds to reimburse private physicians for providing medically necessary services to all citizens.¹⁹ While offering universal coverage,²⁰ Canada's health care spending remains at least five percent less of their gross domestic product (GDP) than that of the U.S.²¹ Both levels of government work together to provide accessible coverage and to ensure that services are relatively equalized across provincial borders.²² Health care is a public good, and the federal equalization policy is designed "to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of

18. Raisa B. Deber, Ph.D., *Health Care Reform: Lessons From Canada*, 93 AM. J. PUB. HEALTH 20, 20 (2003).

19. CIHI, *supra* note 11, at 51-2.

20. *Id.* at 14.

21. KAISER FAMILY FOUNDATION, HEALTH CARE SPENDING IN THE UNITED STATES AND SELECTED OECD COUNTRIES, (2011), available at <http://www.kff.org/insurance/snapshot/oecd042111.cfm>.

22. *Federal Role in Health*, HEALTH CANADA, [hereinafter "Federal Role in Canada"] available at <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fedrole/index-eng.php#a2>.

taxation," which is written directly into the Canadian Constitution.²³

A. Shared Responsibilities and Resources Between Federal and Provincial Governments

The federal government places responsibilities at the provincial level to cost-effectively administer and deliver health care services, but both levels of government work together to contain costs.²⁴ All program enrollees receive the same core services as described by the CHA,²⁵ which allows each province to bargain on prices with providers to maximize access to care.²⁶ Participating providers receive a fee per patient visit and their rates are negotiated between the provincial government and the province's medical associations on an annual basis.²⁷ Furthermore, most of Canada's hospital care is delivered in publicly funded hospitals, which are required by law to operate within their budget.²⁸ This province-based system provides legal mechanisms that encourage strong oversight and cost-containment on the provincial level.

Through shared costs, budgetary committees at both provincial and federal levels can use their market power to negotiate prices and fee schedules with providers to control costs.²⁹ The federal government also takes measures to ensure public health policy goals are met and that affordable.³⁰ For example, pharmaceutical costs are set at a global median

23. See Kirk J. Stark, *Rich States, Poor States: Assessing the Design and Effect of a U.S. Fiscal Equalization Regime*, 63 Tax L. Rev. 957, 957(2010); see also Canada Equalization, *supra* note 17, at 1.

24. Federal Role in Canada, *supra* note 22, at 1.

25. CIHI, *supra* note 11, at 20. The CHA's "comprehensiveness" principle provides a list of health services that must provinces must insure.

26. See Openshaw, *supra* note 12, at 308.

27. CIHI, *supra* note 11, at 51-2, physicians' salaries are largely based on fee schedules that are negotiated between provincial governments and medical associations each year.

28. James Fogarty, *Free for All in Canada*, MEDICAL INDEPENDENT 2 (June 16, 2011), available at http://www.medicalindependent.ie/page.aspx?title=free_for_all_in_canada.

29. See Openshaw, *supra* note 12, at 308.

30. See *id.*

by government price controls and are negotiated on an annual basis between suppliers and the federal government.³¹ The federal government regulates the price of patented drugs on behalf of the public since these costs are often covered by private insurers or employer-based private insurance carriers.³² Overall, both levels of the government work together to provide accessible care.³³

B. Intergovernmental Grants and Canadian's Equalization Formula

Canada's universal health care is equalized across provinces by a federal equalization policy.³⁴ These intergovernmental fiscal transfers for health services have two central features: constitutionally guaranteed equalization transfers (EQT) and Canadian Health and Social Service Transfers (collectively CHST).³⁵ Although government funding for health care services comes primarily from the provinces, EQT and CHST funds from the federal government are provided as a combination of tax transfers and cash contributions to ensure health care services are provided at comparable standards across borders.³⁶ The federal government provides provinces with CHST funding for health care expenditures as long as they each abide by the CHA accessibility guarantees.³⁷ CHST funds are provided in the form of block funds to support health, post-secondary education and social services, and the provinces can flexibly use those funds at their discretion.³⁸ EQT funds are unconditional block grants to the less prosperous provinces that enable them to provide their residents with public services at taxation

31. *Id.*

32. *Id.*

33. *Id.*

34. Canada Equalization, *supra* note 17, at 1.

35. *Federal Transfers to Provinces and Territories*, CANADA FINANCE, [hereinafter *Fiscal Transfers in Canada*] available at <http://www.fin.gc.ca/access/fedprov-eng.asp>.

36. Federal Role in Canada, *supra* note 22, at 1.

37. CIHI, *supra* note 11, at 15.

38. *Id.*

levels that are reasonably comparable to the wealthier provinces.³⁹

These equalization transfers are meant to address fiscal disparities among provinces and are provided unconditionally in order to give each province great flexibility.⁴⁰ The payments are determined by measuring provinces' ability to raise revenues, known as "fiscal capacity."⁴¹ Under a representative tax system (RTS), the amount of equalization aid that a province receives is determined by (1) that province's own per capita revenue capacity, and (2) comparison to the "Ten Province Standard," which is fiscal capacity averaged across all provinces.⁴² The RTS formula measures the amount of money a province could raise from thirty-three different tax bases if each taxed at national average rates.⁴³ This calculates each province's national revenue performance, its fiscal capacity, as compared to the national average.⁴⁴ These fiscal capacities are recalculated annually to ensure provinces receive fair benefits from their EQT grants.⁴⁵

III. MEDICAID IN THE UNITED STATES

In contrast, the costly U.S. Medicaid system suffers from misaligned, intergovernmental incentives that foster constant tension between the federal government and the states.⁴⁶ In the public sector, Medicaid is undeniably important for providing a patient safety net, supplying funds for

39. Canada Equalization, *supra* note 17, at 1.

40. *Id.*; See also EXPERT PANEL ON EQUALIZATION AND TERRITORIAL FORMULA FINANCING, ACHIEVING A NATIONAL PURPOSE: PUTTING EQUALIZATION BACK ON TRACK 18 (2006) [hereinafter Expert Panel] available at http://www.eqtf-pfft.ca/epreports/EQ_Report_e.pdf.

41. Expert Panel, *supra* note 40, at 19 (The basic approach is to assess the financial capacity of provinces to deliver public services).

42. Stark, *supra* note 23 at 974-5.

43. Stark, *supra* note 23, at 976.

44. *Id.* at 977.

45. *Id.* at 975.

46. See Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 442-43 (Dec. 2011).

the states, and generally supporting U.S. healthcare.⁴⁷ However, Medicaid's dual administration and undefined roles of federal and state responsibility have led to intergovernmental inefficiencies and conflict.⁴⁸ This is particularly troubling as the Patient Protection and Affordable Care Act (PPACA) plans to vastly expand enrollment by 2014.⁴⁹

A. Historical Background

Medicaid is a joint federal-state program that Congress passed in 1965 to protect needy populations that would otherwise be uninsured.⁵⁰ The program provides open-ended funding from the federal government to the states as long as the states accept all applicants who meet both categorically "deserving poor" and "financial" eligibility requirements.⁵¹ Misconceptions about these terms have led to varied eligibility requirements and benefits across the states, as well as intergovernmental disputes determining who is entitled to the program's support.⁵² Additionally, states continue to ask for more federal funds but continuously fight for flexibility in carrying out the goals of the program.⁵³ The PPACA only intensifies this adversarial relationship by exacerbating the states' administrative and budgetary weaknesses.⁵⁴

B. Medicaid Financing: Reassessing the FMAP

Medicaid offers matched federal funds in exchange for states' agreement

47. Huberfeld, *supra* note 46, at 433.

48. See Inglehart, *supra* note 2, at 1.

49. Benjamin D. Sommers & Arnold M. Epstein, *Why States are so Miffed about Medicaid- Economics, Politics, and the "Woodwork Effect,"* 365 *NEW ENG. J. MED.* 100, 100 (2011) [hereinafter Sommers & Epstein] available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1104948>.

50. See Helms, *supra* note 5, at 2.

51. See Huberfeld, *supra* note 46, at 445-6.

52. Sommers, *supra* note 4, at 2085.

53. Huberfeld, *supra* note 46, at 472.

54. Sommers & Epstein, *supra* note 49, at 100.

to fulfill certain conditions of using those funds toward medical assistance for mandatory categories of “deserving poor.”⁵⁵ These funds are determined by the Federal Medical Assistance Percentages (FMAP) calculation⁵⁶ and are largely based on the states per capita income and its expenditures on Medicaid.⁵⁷ Unfortunately, the FMAP formula does not adequately reflect the different fiscal capacities of the states and does not take into account the circumstances of states with high concentrations of entitled citizens.⁵⁸ It also creates strong incentives for states to engage in accounting schemes that enhance federal funding, and for the federal bureaucracy to spend money controlling these schemes, in turn creating a “tug of war” of funds.⁵⁹ Simultaneously, flexibility from Medicaid waivers⁶⁰ has resulted in varied quality, many tending to lower quality and the amount of services for Medicaid beneficiaries.⁶¹ Although Medicaid’s ability to deal with welfare issues has varied between states, the federal government traditionally has not intervened in such matters.⁶²

However, the PPACA plans to fundamentally federalize the definition of “deserving poor” by rejecting states’ restrictive categories and developing a super-FMAP that provides federal funding for the newly eligible Medicaid population.⁶³ This supermatch of funds will initially provide funds for 100% of the new enrollees, then phase down to a 90% federal match by

55. Huberfeld, *supra* note 46, at 447.

56. 42 U.S.C. 1396d(b)(2006).

57. CHRISTIE P. PETERS, NATIONAL HEALTH POLICY FORUM, MEDICAID FINANCING: HOW THE FMAP FORMULA WORKS AND WHY IT FALLS SHORT 4 (2008).

58. Helms, *supra* note 5, at 4.

59. *Id.*

60. See 42 U.S.C. §1396n (2006) (recognizing waivers and incorporating them into the Medicaid program if it is cost effective and efficient and not inconsistent with the purposes of the Act).

61. Huberfeld, *supra* note 46, at 448.

62. *Id.* at 450.

63. See Patient Protection and Affordable Care Act, § 2001, 42 U.S.C. §1936a (2010) (expanding Medicaid to include not only “deserving poor” but also everyone else whose income is below 133% of the poverty line).

2020, and remain at that level indefinitely.⁶⁴ Although states only have to pay a small percentage of the costs, they have decried the Medicaid expansion as coercive and unconstitutional,⁶⁵ and will have to pick up the tab for currently eligible individuals that are expected to come out of the woodwork at the start of the PPACA.⁶⁶ Therefore, despite its expansion, the PPACA extenuates Medicaid's intergovernmental tension by continuing the divided governmental responsibility for administering the program.⁶⁷

IV. STATES AND FEDERAL GOVERNMENTS: MIRRORING THE CANADIAN INTERGOVERNMENTAL ADMINISTRATION TO IMPROVE AMERICAN HEALTH CARE

State and federal governments need to unify their efforts to offer comprehensive, basic health services to Medicaid enrollees. The program's history is filled with states' inability to manage and pay for welfare medicine.⁶⁸ State deviation based on budgetary shortfalls is not the kind of experiments or variation that is beneficial for the program and the vulnerable populations it serves.⁶⁹ Modifying the FMAP to include Canada's equalization transfers or resemble Canada's intergovernmental administration would reap benefits for the U.S. Medicaid program.

A. Improving Intergovernmental Relationships to Combat Rising Costs Together

America's strained balancing act between imposing national standards

64. *Id.*; see also Health Care and Education Reconciliation Act of 2010, H.R. 4872, 111th Cong. § 1201 (2010) (the "supermatch" only applies to the newly covered population, which is substantial in terms of raw numbers protected to be at 34 million new enrollees).

65. Huberfeld, *supra* note 46, at 451.

66. Sommers & Epstein, *supra* note 49, at 100.

67. Huberfeld, *supra* note 46, at 453.

68. *Id.* at 472.

69. *Id.* at 472.

and respecting state jurisdiction has imposed difficulties on health policy.⁷⁰ Canada's public health system is ripe with intergovernmental relationships the U.S. can and should learn from.⁷¹ The federal and provincial governments collaborate on various health policy and programming issues by strengthening partnerships through a series of conferences and dialogue.⁷² Similar to the U.S. model, the role of Canada's federal government is limited in decision-making.⁷³ Although it occasionally attempts to influence policy directions through funding or suggesting guidelines, the provinces enjoy a great deal of discretion and flexibility.⁷⁴ One way the federal government exerts major influence is by defining the services that are required by the CHA's "comprehensiveness" principle.⁷⁵ Furthermore, constitutionally supported policies to equalize health services unite Canada's levels of government to maintain a relatively high level of care.⁷⁶ CHST and EQT transfer calculations allow the federal government to effectively measure each province's fiscal capacity and distribute funds to those most in need.⁷⁷ What sets Canada's system apart from the U.S. is that these funding mechanisms remove centralized political judgments in the allocation of funds and allow intergovernmental efforts to focus on cost-containment and quality for the publicly insured.⁷⁸

The U.S. struggles to balance the needs of the states and the federal

70. See generally Sommers & Epstein, *supra* note 49; see also Deber, *supra* note 18, at 23-4.

71. *Federal/ Provincial/ Territorial Collaboration*, HEALTH CANADA, [hereinafter Canada Collaboration"] available at <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/index-eng.php>.

72. *Id.*

73. Deber, *supra* note 18, at 22.

74. *Id.*

75. *Id.*

76. Stark, *supra* note 23, at 957.

77. *Id.* at 977.

78. *Id.*

government regarding health care costs.⁷⁹ The U.S. Medicaid program already has a financial structure of large federal transfers made annually to states administering health care services.⁸⁰ Indeed, the Medicaid Act also requires certain services be provided to enrollees in each state.⁸¹ Therefore, one main change the U.S. needs is improved intergovernmental dialogue toward political compromises for program reform and administration.⁸² Currently, any discussion of reforming Medicaid funding policies is seen as a possible threat to the open-ended flow of federal funds to the states.⁸³ This is not conducive to any serious discussion of reform and will only continue the program's political stalemate. Federal and state governments need aligned federal incentives to focus on cost-containment and improved quality of care.⁸⁴ This can be done by updating the FMAP formula that has not changed since its genesis in 1965.⁸⁵

B. Reassessing the FMAP to Equalize Health Care Services Across State Borders

Numerous nations throughout the world, such as Canada, have in place a complex system of "equalization" grants, whereby the central government makes fiscal transfers to ensure that resources available to state or provincial governments do not vary significantly.⁸⁶ The United States does not have such a system. In fact, since existing grants using the FMAP formula actually exacerbate the states' fiscal disparities, Medicaid enrollees

79. See generally Sommers & Epstein, *supra* note 49.

80. See Peters, *supra* note 57, at 4.

81. See 42 C.F.R. §440 (a list of required or mandatory services for states to provide under Medicaid).

82. See Helms, *supra* note 5, at 4.

83. *Id.*

84. *Id.* at 5. The dissonance between state incentives to expand eligibility and federal attempts to control program expenditures will only intensify as rising costs add pressure to federal and state budgets.

85. Peters, *supra* note 57, at 6.

86. Stark, *supra* note 23, at 957.

are left with health care that wildly varies in quality across states.⁸⁷

Rather than attempting to impose a complex and expensive equalization regime on the U.S. Medicaid program,⁸⁸ modifying the outdated FMAP calculation could align governmental efforts to provide relatively equal health services nationwide.⁸⁹ Currently, the FMAP does not accurately measure fiscal capability, requiring states with fewer economic resources to exert greater fiscal effort to provide public services on par with wealthier states.⁹⁰ By modeling the FMAP closer to a RTS system that determines the CHST and EQT funds in Canada, the remodeled FMAP formula would take better account of the states' relative fiscal capacity in the federal allocation of funds.⁹¹ In fact, public finance experts generally regard the RTS system as an alternative methodology that provides superior measures of states' fiscal capacities because it offers a broader definition of states' available economic resources.⁹² If the U.S. Medicaid program incorporated RTS system measurements to de-politicize and more accurately reflect states' fiscal capacity, state and federal governments could focus their efforts toward improved administration and equalized services across states.

V. CONCLUSION

The U.S. Medicaid program could be more efficient, beneficial, and equalized across states. To improve the program, leaders need to adopt Canada's mechanisms for collaborative intergovernmental dialogues. The program also needs to incorporate Canada's RTS system of fiscal

87. Peters, *supra* note 57, at 5-6.

88. Stark, *supra* note 23, at 959. Beyond budgetary expenses, equalization policies are notoriously complicated and difficult to administer.

89. Peters, *supra* note 57, at 7.

90. Stark, *supra* note 23, at 1005-6.

91. *Id.* at 1006.

92. *Id.*; see also ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS, MEASURING STATE FISCAL CAPACITY: ALTERNATIVE METHODS AND THEIR USES 17-21(1986), available at <http://www.library.unt.edu/gpo/acir/Reports/information/m-150.pdf> (describing alternative methods of measuring states' fiscal capacity).

measurements and bolster its equalization goals.⁹³ It is imperative that the U.S take proactive measures to prepare for Medicaid's upcoming expansion in order to reign in costs and provide consistent, quality care to its beneficiaries.

93. Stark, *supra* note 23, at 1005-6.