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**Bordering Health Care: A Comparison of Coverage  
Costs and Access for U.S. and Canadian Consumers**

*William Farley\**

I. INTRODUCTION

Since the Patient Protection and Affordable Care Act (PPACA) passed March 2010, one of the main criticisms voiced relate to the excessive costs potentially imposed on consumers.<sup>1</sup> Although the functionality of health care under PPACA is untested, nationalized healthcare systems in other countries can provide a basis with which the U.S. can compare. By comparing cost-effectiveness of the newly reformed healthcare system in the U.S. to the national healthcare plan in Canada from a consumer perspective, we can determine whether the U.S. has developed a superior ability to provide healthcare. While it is possible to compare the countries systemically by looking at spending, deficits, and productivity, consumers are ultimately the ones affected by these healthcare plans, and it is thus important to look at the implications for them, both socially and financially.

This article will begin with an overview of the Canadian national healthcare system, briefly explaining the structure of Canadian health care under the Canada Health Act and pointing out the costs of different healthcare services per consumer. Next, it will discuss the rising cost of health insurance in the U.S. and increased amounts of worker's contribution needed for employer-sponsored health plans between 2009 and 2010 in the immediate wake of the passing of PPACA. The article will then explain PPACA itself, highlighting the sections that deal specifically with lowering costs to consumers. Finally, the article will end with a comparison of the expected effectiveness of providing healthcare services to consumers under PPACA (after its full implementation in 2014)

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\* Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2011. Mr. Farley is a staff member of *Annals of Health Law*.

1. Caroline Helwick, *Patient Protection and Affordable Care Act: Dispelling the Myths*, THE ASCO POST (Nov. 2010), <http://www.ascopost.com/articles/november-2010/patient-protection-and-affordable-care-act-dispelling-the-myths>.

with the effectiveness of health care distribution under the Canadian national healthcare system.

## II. THE CANADIAN NATIONAL HEALTHCARE SYSTEM

Our neighbors to the north have famously made it a priority to offer health care to every one of their citizens at almost no cost to individual citizens. While many believe that Canada has a national healthcare plan applicable to all citizens, this is not exactly the case. Instead of having a single national healthcare plan, the health insurance programs of its thirteen provinces and territories make up Canada's national health insurance program.<sup>2</sup> The thirteen different insurance plans have common features and the same basic standards of coverage, but the provinces and territories are allowed to determine a number of factors that distinguish the plans from one another.<sup>3</sup> The Canada Health Act was originally passed in 1984, in the face of tough opposition from provinces and medical associations, but, it enjoyed strong support from voluntary organizations and the public.<sup>4</sup> The goal of the Canada Health Act is to provide reasonable access to health services without financial barriers.<sup>5</sup> Under the Canada Health Act, every insurance plan *must* provide "all medically necessary hospital and physician services on a prepaid basis"; but *may* provide "additional benefits" at their discretion.<sup>6</sup> For example, in Alberta, all medically-necessary physician and specific dental and oral surgical health services are fully covered, while podiatry and optometry are only partially covered.<sup>7</sup> In Quebec, the health insurance plan includes coverage for many prosthetic devices and hearing devices.<sup>8</sup> In addition, provinces are allowed to charge premiums for basic health insurance as long as residents are still provided with medically necessary services, even if

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2. *Canada Health Act—Frequently Asked Questions*, HEALTH CANADA, <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/faq-eng.php> (last updated May 16, 2005).

3. *Id.*

4. *Making Medicare: The History of Health Care in Canada, 1914-2007—Drafting and Passing the Canada Health Act 1978-1988*, CANADIAN MUSEUM OF CIVILIZATION (Mar. 31, 2010), <http://www.civilization.ca/cmcc/exhibitions/hist/medicare/medic-7h09e.shtml>.

5. *Canada Health Act—Frequently Asked Questions*, *supra* note 2.

6. *Id.*

7. *Plan Benefits and Services*, GOV'T OF ALBERTA, <http://www.health.alberta.ca/AHCIP/plan-benefits.html> (last visited Jan. 28, 2011).

8. *Services Covered in Québec*, RÉGIE DE L'ASSURANCE MALADIE QUÉBEC [INSURANCE BOARD OF QUEBEC HEALTH], [http://www.ramq.gouv.qc.ca/en/citoyens/assurancemaladie/serv\\_couv\\_queb/serv\\_couv\\_queb.shtml](http://www.ramq.gouv.qc.ca/en/citoyens/assurancemaladie/serv_couv_queb/serv_couv_queb.shtml) (last updated Apr. 26, 2010).

they are unable to pay.<sup>9</sup>

In order to be eligible for health insurance in Canada, a person must be a resident of a Canadian province or territory.<sup>10</sup> Other than requiring an initial three-month waiting period to establish eligibility, The Canada Health Act allows each province or territory to determine its own residency requirements.<sup>11</sup> When Canadians are traveling outside of their home province, the province they are visiting is required to at least provide medically necessary services.<sup>12</sup> The rates of service for one seeking care outside his or her home province vary depending on interprovincial agreements regarding billing, and are not based on federal regulations.<sup>13</sup> A patient may be billed reciprocally or required to pay up front and then seek reimbursement from his or her home province or territory.<sup>14</sup>

Canada's system theoretically ensures that all Canadian residents have access to medically necessary healthcare regardless of their socioeconomic status or ability to pay.<sup>15</sup> This approach aims to provide services effectively and universally to all Canadian residents, a claim the U.S. is still unable to make. Functioning ideally, the Canada Health Act and provincial health insurance programs would provide access to healthcare that would be almost unrivaled by the U.S. However, certain deficiencies discussed in Section V suggest that the Canadian system's superiority may not be so decisive.

### III. THE RISING COST OF HEALTH INSURANCE IN THE U.S.

Due to the effects of a crippling recession, Americans who are losing their jobs and their homes are also facing rapidly increasing costs of healthcare coverage. A 2010 survey indicates that individual and family premiums are increasing, as are average worker contributions to employer-sponsored plans, and many employers report reductions in the scope of coverage because of the struggling economy.<sup>16</sup> The average premiums of employer-sponsored health insurance increased 5% for single coverage and

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9. *Canada Health Act—Frequently Asked Questions*, *supra* note 2.

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

15. *See generally Canada Health Act—Frequently Asked Questions*, *supra* note 2.

16. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2010 SUMMARY OF FINDINGS 1 (2010) <http://ehbs.kff.org/pdf/2010/8086.pdf>.

3% for family coverage from 2009 to 2010.<sup>17</sup> Furthermore, since 2000, average premiums for family coverage have increased by 114% and average worker contribution amounts have increased 147%.<sup>18</sup> In addition, when seeking health services, most insured workers have to pay upfront out-of-pocket costs until they reach their deductible (the average is \$675 for workers in PPOs under single coverage), before all or most of the services are payable by their plan.<sup>19</sup> The majority of workers also have to pay a portion of the cost of physician office visits either through co-payments (a fixed dollar amount) or co-insurance (a percentage of the charge).<sup>20</sup>

For people who purchase health insurance individually (outside of employer-sponsored programs), costs are often much greater.<sup>21</sup> Many Americans purchase health insurance because they are self-employed or a small business owner, their employer's insurance is too expensive, they work insufficient hours to qualify for an employer plan, they are between jobs, or, their spouse's employer does not offer insurance.<sup>22</sup> In 2009, the average out-of-pocket expenses for costs such as co-pays, deductibles, and other expenses was \$1690, while 26% of individual insurance purchasers reported deductibles of \$5000 or more, and 6% reported deductibles of \$10,000 or more.<sup>23</sup> Six in ten individual purchasers say that it is somewhat difficult to afford the cost of health care, while only 33% of those in employer-sponsored coverage report such a difficulty.<sup>24</sup> Additionally, 77% of people who purchased insurance individually in 2009 reported an increase of their premiums,<sup>25</sup> and the average rate of this increase was 20 percent.<sup>26</sup>

Not surprisingly, most consumers who purchase insurance individually have far less confidence in their coverage than those with employer-sponsored plans.<sup>27</sup> This lack of confidence comes from personal experiences, such as a covered family member not

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17. *Id.*

18. *Id.*

19. *Id.* at 2.

20. *Id.*

21. KAISER FAMILY FOUND., SURVEY OF PEOPLE WHO PURCHASE THEIR OWN INSURANCE 1 (June 2010), <http://www.kff.org/kaiserpolls/upload/8077-R.pdf>.

22. *Id.* at 2.

23. *Id.* at 4–5.

24. *Id.* at 5.

25. *Id.* at 6.

26. *Id.*

27. KAISER FAMILY FOUND., SURVEY OF PEOPLE WHO PURCHASE THEIR OWN INSURANCE 7 (June 2010), <http://www.kff.org/kaiserpolls/upload/8077-R.pdf>.

getting necessary medical care because of the cost, skipping prescription refills because they were too expensive, and problems getting insurance companies to pay bills.<sup>28</sup> Consequently, a vast majority of individual insurance purchasers have significant worries about the future of their health coverage.<sup>29</sup> Amongst individual insurance purchasers, 73% say that they are worried that their insurance will increase so much that they will not be able to afford it.<sup>30</sup> Other worries include not being able to afford insurance due to loss of income, insurers dropping coverage because patients become very sick, and the inability to afford prescription drugs.<sup>31</sup>

The increase in the cost of health insurance seems to be widespread for American consumers. Costs and concerns for people covered by employer-sponsored programs and individually-purchased programs alike show that Americans are struggling as they try to find ways to afford health care for themselves and their families. These are issues that the PPACA should be responsible for remedying. The effectiveness of the PPACA can be determined by analyzing and explaining the various cost-cutting provisions mentioned below.

#### IV. SIGNIFICANT PPACA PROVISIONS FOR CONSUMERS

The PPCAPA is designed to end many of the major abuses of the health insurance industry by holding insurance companies accountable to consumers, lowering healthcare costs, guaranteeing more healthcare choices, and enhancing quality of care for all Americans.<sup>32</sup> Some of the most notable provisions of the Act are concerned with reducing the cost of health care for consumers.<sup>33</sup> Section, including 2718 (“Bringing down the cost of healthcare coverage”), Section 1003 (“Ensuring that consumers get value for their dollars”), and Section 1101 (“Immediate access to insurance for people with a preexisting condition”),<sup>34</sup> will likely have the greatest impact on consumers, both

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28. *Id.*

29. *Id.* at 8

30. *Id.*

31. *Id.*

32. *About the Law*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/about/index.html> (last visited Nov. 11, 2010).

33. *See generally Id.*

34. *See Patient Protection and Affordable Care Act*, Pub. L. No. 111-148, §§ 2718, 1003, 1101, 124 Stat. 119 (2010).

functionally and financially.<sup>35</sup>

Section 2718, known as the medical loss ratio<sup>36</sup> requires plans that offer coverage in the individual or group market to report the amount of premium revenues spent on clinical services.<sup>37</sup> These reports have important implications for the consumer: “Beginning in 2011, large group plans that spend less than 85 percent of premium revenue and small group plans that spend less than 80 percent of revenue on clinical services and quality must provide a rebate to enrollees.”<sup>38</sup> Additionally, the Secretary of the Department of Health and Human Services is allowed to adjust these threshold rates, known as “the applicable minimum standards” in Section 2718, if she determines that it is appropriate to do so.<sup>39</sup> This provision thus incentivizes plan issuers to spend their revenue responsibly and appropriately, or face sanctions forcing them to give money back to consumers. Section 2718 also seeks to ensure that premiums are used for clinical services and quality improvements, by requiring adequate participation by health insurance providers and encouraging competition in the state’s health insurance market.<sup>40</sup> These consumer protections are useful because they force insurers to change their strategy from simply attempting to produce revenue to applying that revenue in compliance with PPACA.

Another important provision in PPACA is Section 1003, entitled “Ensuring that consumers get value for their dollars.” Beginning in 2010, this provision establishes a process of annual review for insurers that increase their premiums for health insurance coverage.<sup>41</sup> This provision comes, in part, in response to health insurance companies

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35. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 2718, 1003, 1101, 124 Stat. 119 (2010).

36. Although this section is titled “Bringing down the cost of health care coverage,” it is often referred to as the “medical loss ratio.” Tim Jost, *Implementing Health Reform: Medical Loss Ratios*, HEALTH AFFAIRS BLOG (Nov. 23, 2010), <http://healthaffairs.org/blog/2010/11/23/implementing-health-reform-medical-loss-ratios/>.

37. Pub. L. No. 111-148, § 2718, 124 Stat. 119 (2010).

38. *Section-by-Section Analysis of the Patient Protection and Affordable Care Act, with Changes Made by Title X and the Health Care and Education Reconciliation Act included within Titles I-IX, where Appropriate*, DEMOCRATIC POLICY COMMITTEE (Sept. 17, 2010), <http://dpc.senate.gov/healthreformbill/healthbill96.pdf>.

39. *Request for Comments Regarding Section 2718 of the Public Health Service Act (Medical Loss Ratios)*, HEALTHREFORM.GOV, <http://www.healthreform.gov/newsroom/section2718.html> (last visited Oct. 11, 2010).

40. *Id.*

41. *Section-by-Section Analysis of the Patient Protection and Affordable Care Act, with Changes Made by Title X and the Health Care and Education Reconciliation Act included within Titles I-IX, where*

realizing an increase in profits of over 250% in the last ten years.<sup>42</sup> The Department of Health and Human Services (HHS) will review the proposed premium increases and will require health insurers to justify any increases that HHS considers unreasonable.<sup>43</sup> If an insurance provider does request unjustified or excessive rate increases, its participation in the state insurance exchanges enabled under PPACA may be jeopardized.<sup>44</sup> These exchanges are designed to lower the overall costs and variance in costs of plan premiums and reduce administrative spending per enrollee for businesses.<sup>45</sup> Although, HHS's new authority to review the proposed premium increases and require health insurers to justify any increases will likely be effective, its power is still somewhat limited.<sup>46</sup> It is able to review proposed insurance rate increases, however there is no federal regulation allowing HHS to deny increases that seem unreasonable, as this is a job typically left to the states.<sup>47</sup> Yet, even with these restrictions, the new HHS authority will be able to provide a rate-review template for state laws to follow, and will attempt to incentivize health insurance providers to comply by threatening non-participation in exchanges which can put providers at an economic disadvantage.<sup>48</sup> Section 1003 will help ensure that if consumers experience premium increases in the future, those increases will be necessary and justified.

Perhaps one of the most interesting provisions in the Act is Section 1101, entitled "Immediate access to insurance for people with a preexisting condition." This Section affords short term and long term remedies to many consumers that have been barred from receiving health insurance coverage based on preexisting conditions.<sup>49</sup> In the short term PPACA establishes high risk insurance pools which offer temporary insurance and premium rate limits for the uninsured with preexisting conditions.<sup>50</sup> In the long term, Section 2704 prohibits any group health plan or insurer to offer coverage that excludes or

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*Appropriate* at 3.

42. Ann Mills et al., *Truth and Consequences Insurance-Premium Rate Regulation and the ACA*, 363 *NEW. ENG. J. MED.* 899 (2010).

43. *Id.*

44. *Id.* at 900.

45. Christine Eibner et al., *The Effects of the Affordable Care Act on Workers' Health Insurance Coverage*, 363 *NEW. ENG. J. MED.* 1393, 1394 (2010).

46. Mills, *supra* note 42, at 900.

47. *Id.*

48. *Id.*

49. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1101 124 Stat. 119 (2010).

50. *Id.* at § 1101(a).

discriminates against people because of preexisting conditions.<sup>51</sup> PPACA also prohibits insurance plans from denying coverage to children under the age of nineteen due to preexisting conditions.<sup>52</sup> This program thus provides coverage to individuals who have been previously unable to obtain health insurance, and will cover them until 2014, when they will ideally have a number of affordable health insurance choices available to them on the state exchanges.<sup>53</sup> The Preexisting Condition Insurance Plan will be available in every state but may vary slightly by state, and will cover a broad range of benefits including primary and specialty care, hospital care, and prescription drugs.<sup>54</sup> This improved access to care is unprecedented in the U.S., and will help millions of Americans gain coverage that was previously unavailable to them. Thus, consumers will no longer be punished by being denied health insurance based on ailments that plagued them before they sought coverage.

#### V. COMPARING THE EFFECTIVENESS OF HEALTH CARE DISTRIBUTION IN CANADA AND THE U.S.

At first glance, the increasing costs of health insurance for consumers in the U.S., and the seemingly ideal model of universal health insurance in Canada, would lead to a conclusion that the Canadian healthcare system is more effective in administering services to consumers; this is not necessarily the case. There are many issues plaguing the healthcare system in Canada that have a drastic impact on Canadian citizens' access to healthcare services.<sup>55</sup> These issues complicate the debate over which healthcare system has superior efficiency and if PPACA will actually improve the effectiveness of the U.S. system.

Although the goal of the Canada Health Act is to provide health care to all its citizens without economic obstacles, in reality, the Canadian system does not function this way.

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51. *Id.* at § 2704.

52. *Text: The Obama Administration's New 'Patient's Bill of Rights'*, KAISER HEALTH NEWS (June 22, 2010), <http://www.kaiserhealthnews.org/stories/2010/june/22/document-patients-bill-of-rights-fact-sheet.aspx?referrer=search>.

53. *Preexisting Condition Insurance Plan*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/provisions/preexisting/about/index.html> (last visited Jan. 29, 2011).

54. *Id.*

55. CANADIAN INST. FOR HEALTH INFO., HEALTH CARE IN CANADA 2009 A DECADE IN REVIEW 62 (2009), [http://secure.cihi.ca/cihiweb/products/HCIC\\_2009\\_Web\\_e.pdf](http://secure.cihi.ca/cihiweb/products/HCIC_2009_Web_e.pdf).

Many Canadians often encounter issues such as reduced hospital bed capacity<sup>56</sup> and excessively long waiting periods for medical services,<sup>57</sup> which is one of the central issues currently burdening the Canadian health care system.<sup>58</sup> Excessive wait times for medical services can cause dire consequences beyond simple irritation or inconvenience. Patients who are forced to wait may experience considerable pain, diminished capacity, increased risk of declining health, or even death.<sup>59</sup> Furthermore, people who live in remote areas may have to travel great distances to see specialists and visit large institutions, which creates an additional obstacle to receiving health care.<sup>60</sup> As of 2007, many Canadians still had significant issues getting access to care: one in six had trouble receiving ongoing care, one in four had trouble getting immediate care for a minor health problem, and one in seven had to wait three months or longer to see a specialist for a new illness or condition.<sup>61</sup> In terms of specialty care, 42 percent of Canadians with chronic conditions waited more than two months to see a specialist in 2008, compared with only 10 percent in the United States.<sup>62</sup> While the Canadian system is designed to offer reasonable care to all its citizens, clearly these issues show that the system is not truly meeting that goal.

According to a government study, the PPACA will only increase the annual health spending growth rate by 0.2% through 2019.<sup>63</sup> Research from the RAND corporation shows that those who become newly insured under PPACA will actually spend more on health care than they did before the Act, but will face lower risks of very high expenditures and will use more services, resulting in an overall net financial benefit.<sup>64</sup> The PPACA is also expected to produce substantial gains in coverage for young adults from ages nineteen to twenty-nine, which was the group that had the highest uninsured rate before the reform.<sup>65</sup> Although some young adults with income above 133% of the

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56. Morris L. Barer et al., *Strangulation or Rationalization? Costs and Access in Canadian Hospitals*, 7 *LONGWOODS REVIEW*, 10, 15 (2003), available at <http://www.longwoods.com/content/17241>.

57. CANADIAN INST. FOR HEALTH INFO., *supra* note 55, at 62.

58. *Id.*

59. *Id.* at 64.

60. *Id.*

61. *Id.* at 65.

62. *Id.* at 66.

63. *Overhaul's Effect On Health Spending Minimal, Government Study Says*, KAISER HEALTH NEWS (Sept. 9, 2010), <http://www.kaiserhealthnews.org/Daily-Reports/2010/September/09/Health-spending.aspx>.

64. ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (H.R. 3590), RAND CORP. (2010), [http://www.rc.rand.org/pubs/research\\_briefs/2010/RAND\\_RB9514.pdf](http://www.rc.rand.org/pubs/research_briefs/2010/RAND_RB9514.pdf).

65. Genevieve M. Kenney et al., *How Will the Patient Protection and Affordable Care Act of 2010 Affect*

Federal Poverty Level will face penalties for opting out of coverage or pay more for coverage than they otherwise would have, they will experience many other benefits, such as the ability to stay on their parents' health insurance plan until the age of twenty-six.<sup>66</sup> If these changes under the Act occur as planned, the significant expansion in coverage for previously uninsured citizens and the long-term decrease in costs could provide an extremely efficient healthcare system that will satisfy many Americans.

## VI. CONCLUSION

In determining which healthcare system—Canadian or post-PPACA American—is more effective for consumers, perhaps the best unit of measurement is consumer satisfaction. By comparing the way that Canadian and American consumers rate their ability to access healthcare services and receive quality care, the superior system can be ascertained. While in the past, Canadian consumers have been more satisfied with their health care than American consumers have been, there is data suggesting that this trend is changing. A study by Harvard professor Robert J. Blendon compared public satisfaction with healthcare systems in Australia, Canada, the United Kingdom, the U.S., and New Zealand beginning in 1988 and 1990, again in 1998, and for a final time in 2001.<sup>67</sup> In 1988, Canada's healthcare system had the highest level of public satisfaction, while the U.S. had the lowest.<sup>68</sup> However, by 2001, dissatisfaction in Canada had increased significantly and in many categories it ranked just above the U.S.<sup>69</sup> In fact, in the category "Access is worse than 2 years ago," Canada ranked higher in dissatisfaction than the U.S.<sup>70</sup>

These statistics suggest that, while at one time Canada clearly had the superior healthcare system, issues such as hospital bed capacity and excessive wait periods have eroded consumers' confidence in this system and have brought the Canadian healthcare system closer in comparison to the U.S.<sup>71</sup> If the healthcare system in Canada continues to

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*Young Adults?*, ROBERT WOOD JOHNSON FOUND., 1 (July 6, 2010), <http://www.rwjf.org/files/research/65648youngadults.pdf>

66. *Id.*

67. Robert J. Blendon et al., *Inequities in Health Care: A Five-Country Survey*, 21 HEALTH AFF. no. 3, 2002 at 182, 183.

68. *Id.*

69. *Id.* at 184 (see Exhibit 2).

70. *Id.*

71. *See generally Id.* at 182-191.

be plagued with these issues and consumer confidence continues to fall, Canada may lose its designation as the superior healthcare system. Likewise, as the U.S. continues to implement the provisions of the PPACA by expanding coverage to the previously uninsured and enacting consumer protections to lower costs, consumer confidence in America can only be expected to grow. As reform in the American healthcare system takes shape, and if the PPACA functions as expected, the healthcare system in the U.S. could prove to be more effective than the healthcare system in Canada.