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## Balancing Regional Government Health Mandates with Federal Economic Imperatives: Perspectives from Nova Scotia and Illinois

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John D. Blum\*

Balancing Regional Government  
Health Mandates with Federal  
Economic Imperatives:  
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*This article focuses on current health policy changes in Canada and the United States at the federal and regional levels. The Canadian discussion centres on the integrity of the Canada Health Act in the era of the Canada Health and Social Transfer, and the strategies that provincial governments have pursued to cope with persistent funding constraints. On the American side, the article examines the role of private sector managed care plans in filling a health policy void resulting from the demise of the Clinton Health Security Act. Two specific regional government health reform initiatives in Nova Scotia and Illinois are discussed as case studies of health care devolution on both sides of the border. The article concludes with a comparative discussion of the two regional reform programs and articulates lessons for health care policy in Canada and the United States from the Nova Scotia and Illinois experiences.*

*Cet article examine les changements récents dans les principes gouvernant le système de santé canadien et américain, au niveau tant régional que fédéral. Du côté canadien, la discussion porte sur l'intégrité de la Loi canadienne sur la santé à la lumière du Transfert canadien en matière de santé et de programmes sociaux, ainsi que de stratégies adoptées par les gouvernements provinciaux pour survivre aux coupures budgétaires. Aux États-Unis, l'auteur étudie le rôle du secteur privé dans le domaine de la santé qui tente de combler les besoins causés par la disparition de la Loi sur l'assurance-santé du président Clinton. Plus précisément, l'article traite des réformes entreprises par les gouvernements de la Nouvelle-Écosse au Canada et de l'Illinois aux États-Unis, deux expériences illustrant la délégation de pouvoirs dans le domaine de la santé. Une étude comparative de ces deux réformes régionales est effectuée. Et, en terminant, les auteurs formulent des solutions à apporter aux systèmes de santé canadiens et américains tirées des expériences de la Nouvelle-Écosse et de l'Illinois.*

### *Introduction*

At the twilight of the twentieth century governments world wide find it increasingly difficult to fulfill the mandates of social service programs that were crafted in more affluent times. More and more governments find themselves in a precarious dance, in which they are forced to balance

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legal obligations and deficit politics. "Doing more with less" has become a popular slogan in government circles, but while this sentiment may be presented with a positive spin, it is a hollow mantra barely disguising the fact that publicly sponsored social programs must undergo drastic and painful changes. Government sponsored health programs, in particular, are under considerable strain as economic realities make it increasingly difficult to meet public demands and to keep pace with science and technology.

Governments in Europe and North America alike are looking for ways to provide comprehensive medical coverage that are cost effective and, at best, do not sacrifice public welfare.<sup>1</sup> In many instances governments are frightened by the economic realities of health care and are seeking to "get out from under" programmatic obligations with little consideration about the impacts of change on health care access or quality. The search for cost savings in health programs has resulted in the exploration of new approaches to funding and managing publicly sponsored health systems, driven almost exclusively by the need to confront the fiscal realities of publicly funded health care. There is also considerable political tension underlying health care reform initiatives. Ongoing changes in Canada and the United States have been viewed by organized medical groups as a direct assault on their continued abilities to control health policy, and in both countries the process of health reform is one that sparks frequent and impassioned debates in the public arena.

This article focuses on how governments in North America are coping with economic pressures in their health care programs and explores changes that are ongoing in the Canadian and American systems. It considers broad changes in health care policy that are occurring in Canada and the United States. It focuses on financing issues and the growth of managed care plans, which are the various systems that combine traditional health insurance with medical care delivery in a single entity. The article continues with an examination of health care changes at the regional government level in Nova Scotia and Illinois, concentrating on jurisdiction-specific reforms in Medicare and Medicaid respectively. It concludes with observations on the respective national and regional reform initiatives, and a consideration of which approaches may have utility across borders.

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1. See generally, M.W. Raffel, ed., *Health Care and Reform in Industrialized Countries* (University Park, Pa.: Pennsylvania State University Press, 1997).

## I. Canadian Health Care

### 1. General Arrangements

Public health insurance remains one of the core pillars of Canadian society and is viewed by many as one of Canada's major national accomplishments.<sup>2</sup> Founded in the late 1960s, the Canadian Medicare program came into being at a time of national growth and prosperity, and within five years of the passage of the *Medical Care Act*<sup>3</sup> all ten provinces were participating in the program.<sup>4</sup> The provinces oversee the administration of health insurance and the delivery of services, so in essence Medicare is really composed of ten provincial and two territorial plans.<sup>5</sup> In theory, the binding elements in the system are the five principles first spelled out in the 1968 *Medical Care Act* (public administration, comprehensiveness, universality, portability, and accountability) and later reiterated in the 1984 *Canada Health Act*.<sup>6</sup>

In practice, the individual plans all have similar components: a hospital plan, a medical services component and a pharmaceutical plan. With the exception of indigents, a wide range of services, such as long term care, are not covered.<sup>7</sup> For health insurance to be provided, the service in question must be demonstrated as one that is "medically necessary" and the provincial plans have the authority to declare services outside the boundaries of medical necessity.<sup>8</sup> Provinces generally reimburse physicians in a fee-for-service manner on the basis of negotiated or mandated fee schedules, although capitated payment is beginning to enter the system, and under the dictates of the *Canada Health Act* physician balance billing is outlawed.<sup>9</sup> Hospital operating expenses are paid annually by means of a global budget and a separate process exists for institutional capital financing.<sup>10</sup>

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2. Conference of Provincial/Territorial Ministers of Health, *A Renewed Vision for Canada's Health System* (Ottawa: Ministerial Council on Social Policy Renewal, 1997) at 1-2; M. Janigan, "A Prescription for Medicare" *Maclean's* (31 July 1995); D. Frum, "Medicare's Critical Condition" *Toronto Sun* (7 December 1996) 11.

3. R.S.C. 1970, c. M-8, repealed by S.C. 1984, c. 6, s. 32.

4. J.M. Fulton, *Canada's Health Care System: Bordering on the Possible* (New York: Health Care Information Centre, 1993) at 49-50; P. Armstrong & H. Armstrong, *Wasting Away: The Undermining of Canadian Health Care* (Toronto: Oxford University Press, 1996) at 158-159; M. Rachlis, *Strong Medicine: How To Save Canada's Health Care System* (Toronto: HarperCollins, 1994) at 32-39.

5. Armstrong & Armstrong, *ibid.* at 158-159.

6. *Canada Health Act*, R.S.C. 1984, c. C-6, ss. 8-12.

7. *A Renewed Vision*, *supra* note 2 at 1.

8. Armstrong & Armstrong, *supra* note 4 at 180-81; S. MacKinlay, "Got Warts? Dig Out Your Wallet" *The [Halifax] Daily News* (31 January 1997) 2.

9. *Supra* note 6.

10. Armstrong & Armstrong, *supra* note 4 at 65-66.

Like any complex system, Canadian health care is one that can be analyzed at several different levels; structural, legal, political, economic, social and cultural. These levels are all intertwined and serve as a backdrop to public need and the current realities of medical science. It is perhaps too easy to succumb to the temptation of trying to understand government programs strictly in economic terms, but in the case of Canadian Medicare, as with U.S. health care, economics has taken centre stage. Many of the recent federal and provincial policy initiatives in health care are in direct response to diminishing resources in the public sector.<sup>11</sup> While quality and access questions are still central to the future of Canadian health care, they are now being addressed primarily in the context of health care finances and, more broadly, of provincial budgets. Beyond the ebb and flow of deficit and revenue politics, the very core of Canada's Medicare program concerns the financial relationship between the federal and provincial governments. Medicare has evolved around a scheme that requires joint federal/provincial funding. Under this scheme, Ottawa has paid the provinces a cash contribution for insured health services and amounts payable for extended health services.<sup>12</sup>

According to the *Canada Health Act*, federal money that is used in provincial health plans is conditioned on a province adhering to the core principles noted in the Act, supplying requisite health care information to Ottawa, and giving the federal government public credit for its contributions.<sup>13</sup> In the event a province fails to meet the dictates of the *Canada Health Act*, and is unwilling to change its noncompliant policies, the federal Minister of Health may refer the matter to the Governor General in Council.<sup>14</sup> The Governor General, in turn, may direct that "cash contributions" or "amounts payable" be reduced or withdrawn until the breach of federal health policy is corrected.<sup>15</sup> Also under the Act, as noted, a province must not allow extra billing or user fees if it is to remain eligible for cash contributions.<sup>16</sup> In the event a province permits extra billing or user fees, the federal government can deduct those amounts from federal contributions. In reality it is unclear how effective the *Canada Health Act* is in binding the provincial health insurance plans to a national system. With the decrease in overall federal funding levels, the threat of financial

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11. A. DePalma, "Canadian Health Care in Crisis: High Costs Hit Hard at System Held Sacred" *The State [Springfield, IL] Journal Register* (15 December 1996) 6.

12. P. Boothe & B. Johnston, *Stealing the Emperor's Clothes: Deficit Off-loading and National Standards in Health Care* (Toronto: C.D. Howe Institute, 1993) at 3.

13. *Canada Health Act*, R.S.C. 1984, c. C-6, ss. 7, 13.

14. *Ibid.*, s. 13.

15. *Ibid.*

16. *Supra* note 6.

penalty may not be enough to hold the provinces in line.<sup>17</sup> As Canada struggles with finding a balance between regional and national identities, the future of large-scale federal legislation such as the *Canada Health Act* will be greatly affected by political and cultural change as well.<sup>18</sup>

## 2. Changing Financial Structure

Historically the Medicare program was funded on the basis of equal shares, but that arrangement was viewed by the federal government as too open-ended, and the provinces saw it as leading to excessive federal involvement in their plans.<sup>19</sup> In 1977 Ottawa enacted the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* which converted health and social service programming into a block grant system.<sup>20</sup> Under Established Program Financing (EPF) the federal government provided a per capita contribution to the provinces which had the effect of placing a financial ceiling on health care and social program contributions, independent of provincial expenditures.<sup>21</sup> In turn, Ottawa agreed to make half of its contributions in the form of cash transfers, and relinquished some tax points (share of income tax power) to the provinces, making it possible for them to obtain the other part of the federal match through tax revenue. Under EPF the federal transfer was to increase yearly according to an escalator clause based on population growth and gross domestic product.<sup>22</sup> As a result of deficit politics, however, the federal government reduced the escalator payment starting in 1986, and eventually froze EDF cash grants for the period 1990 to 1995.<sup>23</sup> This leveling of transfer payments occurred at a time when individual provincial deficits were growing and overall health care expenditures had increased by 42%.<sup>24</sup>

In 1995 the *Federal Budget Implementation Act* abolished EDF and amended the *Canada Health Act* by combining cash contributions and amounts payable into a single payment, as well as by widening the

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17. P.S. Taylor, "Bye, Bye, Bytown: Decentralization of the Canadian Government" *Saturday Night* (December 1996) 19.

18. M. Campbell, "Nationalism Dips at the Dawn of Global Era" *Globe & Mail* (1 July 1997)D1.

19. Rachlis, *supra* note 4 at 36.

20. *Federal-Provincial Fiscal Arrangements and Established Program Financing Act*, 1977, S.C. 1976-77 c. 10, as am. by *Federal-Provincial Arrangements and Federal Post-Secondary Education and Health Contributions Act*, R.S.C., 1985 c. F-8.

21. Boothe & Johnston, *supra* note 12 at 3.

22. *Ibid.*

23. *Ibid.*

24. *Ibid.* at 5.

definition of cash contributions.<sup>25</sup> Under the new law, the federal health, education and social service funds were combined into a single block fund; the Canada Health and Social Transfer (CHST).<sup>26</sup> As a result of this re-arrangement the provinces will have more flexibility to design their own social assistance programs, but they must still adhere to the national standards of the *Canada Health Act*. The practical implications of moving to the CHST are a \$7 billion dollar cut in total entitlements in the 1996-97 fiscal year, followed by an additional \$4.5 billion reduction in 1997-1998.<sup>27</sup> These block grants will result in a decline in federal cash payments to the provinces of \$3.5 billion in 1996-97 and \$6.0 billion the following year, and while the CHST will not phase out cash contributions, they will be restricted for the foreseeable future.<sup>28</sup>

The CHST is composed of three parts, a notional tax transfer (tax points), an equalization factor to offset provincial tax disparities, and a cash transfer.<sup>29</sup> The cash transfer is not a major part of the overall transfer but is designed to act as a residual payment to meet the total entitlement. The 1996 federal budget set out a five year schedule for provincial allocations that was designed to result in an equal per capita transfer.<sup>30</sup> The difficulty that the present CHST scheme raises is the creation of disparities in cash payments to the provinces, resulting in large provinces losing considerable amounts in federal support.<sup>31</sup> While federal cash transfers will eventually increase after 2000, it will take several years for British Columbia, Ontario and Alberta to receive amounts equal to 1995 levels.<sup>32</sup>

It has been suggested that with the growth of tax points the provinces have actually seen an increase in federal transfers, but that position does not reflect the sentiments of provincial governments.<sup>33</sup> While tax points may have increased, the provinces argue that there is still a need for growth in cash transfers, and that the ability to provide health and social programs has been hurt by the shrinkage of federal cash allocations.<sup>34</sup>

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25. *Budget Implementation Act*, S.C. 1995, c. 17.

26. *Ibid.*

27. S. Durkan, "Richest Provinces Benefit: Funding for Social Programs Linked to Population" *Toronto Sun* (7 March 1996) 5. For a detailed discussion of CHST see K. Boessenkool, *The Illusion of Equality: Provincial Distribution of the Canada Health and Social Transfer* (Toronto: C.D. Howe Institute, 1996); Armstrong & Armstrong, *supra* note 4 at 159.

28. Boessenkool, *ibid.*

29. *Ibid.*

30. Ontario, Ministry of Finance, "Federal Transfers to Ontario" (26 July 1996) at 3 [unpublished].

31. *Ibid.* at 5. See also Durkan, *supra* note 27.

32. Durkan, *supra* note 27. See also Boessenkool, *supra* note 7.

33. Boothe & Johnston, *supra* note 12 at 3.

34. Boessenkool, *supra* note 27.

While each province has followed different avenues in grappling with reduced federal support and increased health care demands, certain commonalities in the approaches taken can be identified. As administrators of provincial health plans have considerably more power than their American counterparts, they have taken steps to utilize that authority to make programmatic changes affecting the structure of delivery systems, individual and institutional provider reimbursement, and human resource components.<sup>35</sup>

### 3. *Responses from the Field*

The most typical response of provincial governments to the pressures of rising health care cost was to place a cap on overall expenditures. For implementation, the provinces developed specific spending caps for physician reimbursement and hospital budgets.<sup>36</sup> In the physician area provincial policy makers froze physician fees at various times, developed sliding reimbursement scales to limit increases in volume, and restricted the issuance of new billing numbers in “over-doctored” areas.<sup>37</sup> By and large the physician cost containment strategies have met with limited success because in a fee-for-service system, individual doctors have considerable autonomy to adjust their practices to maximize earning capacity.<sup>38</sup>

In the hospital sector, provincial policies have resulted in dramatic changes. There are many instances nationwide where respective provincial health ministries mandated hospital mergers and closures, and applied a broader, regional view to health care services generally.<sup>39</sup> In addition to hospital closures and mergers, provincial policies have resulted in staff downsizing, use of expanded contract services, shifts toward outpatient services and day surgery, and the implementation of stringent policies on purchasing new equipment or making capital expenditures.<sup>40</sup> Departments of health have refocused their respective health systems into community health models, and while such efforts are laudable for public health purposes, they can also be seen as attempts to shift provincial Medicare programs into lower-cost delivery arenas. In

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35. Armstrong & Armstrong, *supra* note 4 at 64-66.

36. *Ibid.* at 65.

37. *Ibid.*

38. *Ibid.* at 64, 168, 169.

39. D. Eisler, “When A Hospital Dies” *Macleans* (28 April 1997) 28; R. Lewis, “The Toast of New Brunswick” *Macleans* (9 September 1996) 2.

40. Armstrong & Armstrong, *supra* note 4 at 66-88.



the labour area, provinces have had to negotiate contract agreements with health care unions which mitigate the impacts of downsizing by offering early retirement, opportunities for retraining, and promises of new jobs in community health programs.<sup>41</sup> The realities of cost containment have been difficult for labour groups, for, in an era of deficit reduction, unions have had to be conciliatory to prevent massive job cuts.

The politics of Medicare are such that indefinite cost cutting cannot continue unabated, as Alberta discovered when it sought to make \$750 million dollars of cuts. Its plans were thwarted by a wildcat strike of hospital workers, which mirrored public concerns about the viability of that province's Medicare program.<sup>42</sup> Recent provincial Medicare policies have more carefully weighed public tolerance for further cuts to the system, and that posture is, in part, justified by stronger economies and the abatement of deficit crises. On the federal level, health care funding has actually increased, and in the provinces, funding for certain programs, particularly in children's health care, has increased as well.<sup>43</sup> This is not to say, however, that provincial health reforms are over, but if fiscal pressures continue to abate as a result of revenue growth, future changes will be more cautiously made so as not to hamper the public's perception of program integrity, and not to create opportunities for further politicizing health care reform.

#### 4. *The Future*

In ascertaining future directions for provincial health policies, two recent reports, one drafted by the Conference of Ministers of Health and the other by the National Forum on Health, provide insight.<sup>44</sup> The Ministers' report expresses concern about the impacts of rapid change on health care quality, resulting from policies necessitated by shortfalls in federal transfers.<sup>45</sup> The report endorses the continuation of a publicly funded system, but argues for adequate, predictable and sustainable federal funding, and more effective integration of health with economic and social policy.<sup>46</sup> Within the health enterprise, the ministers recommend a system organized around four primary components: personal health

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41. Rachlis, *supra* note 4 at 300-301.

42. Taylor, *supra* note 17 at 41.

43. A. Dawson, "\$400M Boost For Medicare" *Toronto Sun* (19 February 1997) 41.

44. Conference of Provincial/Territorial Ministers of Health, *supra* note 2; National Forum on Health, *Canada Health Action: Building on the Legacy* (Ottawa: National Forum on Health, 1997).

45. Conference of Provincial/Territorial Ministers of Health, *supra* note 2 at 7.

46. *Ibid.* at 8.

services, population-based services, support services and health promotion. The report stresses the need for clarifying the roles of government at the provincial and federal levels, and recommends the development of an administrative mechanism that can act as a national resource on health policy and funding issues, as well as a forum to mediate intergovernmental disputes.<sup>47</sup>

The National Forum report is the result of a two year study of the Canadian health system by a group of 24 individuals appointed by the Prime Minister in 1994.<sup>48</sup> On a broad level, the Forum's final report states that the health prospects of Canadians could be improved by creating more favourable economic and social environments, and to that end it recommends income and social service supports for families and children.<sup>49</sup> More specific recommendations call for restructuring the funding and delivery of primary care, and bringing home care and Pharmacare programs under the umbrella of public health insurance.<sup>50</sup> Like the Ministers' report, the Forum endorses the continuation of public financing of health care and underscores the need for better coordination at the policy level between provincial and federal government. Both reports call for major systematic changes and it is difficult to predict which specific reform recommendations will penetrate fiscal and political barriers. However, there is already some movement towards experimenting with broader home care and pharmacy coverage, and it is likely that other proposals in the two documents will take root.

## II. *Health Care South of the Border*

### 1. *Failure of Government Reform*

With great fanfare, U.S. President Clinton introduced the *Health Security Act* in 1994 which was designed by a committee of 500 to bring order to America's patchwork health care system and, in the process, to provide health insurance to the millions of Americans who lack coverage.<sup>51</sup> The legislation guaranteed universal coverage, choice, and pluralism in the delivery system through publicly sponsored purchasing cooperatives.

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47. *Ibid.* at 9.

48. National Forum on Health, *supra* note 44.

49. *Ibid.*, s. 2.

50. *Ibid.*, ss. 1, 2.2.

51. Julie Rovner, "Congress and Health Care Reform 1993-94" in T.E. Mann & N.J. Ornstein, eds., *Intensive Care: How Congress Shapes Health Policy* (Washington, D.C.: American Enterprise Institute, 1995).

The Clinton bill was noteworthy for its scope and complexity, but its reliance on an expanded role for government regulators engendered opposition from most sectors of the health care industry.<sup>52</sup>

Numerous theories have been posited by political and health policy pundits about why the Clinton health reform effort failed. There seems to be some consensus that the President lacked the necessary popular mandate for such a sweeping change, and that the Congressional Democrats were not well enough organized to meet challenges on health issues from a very unified Republican opposition.<sup>53</sup> While there was a certain level of consensus among the public that health care needed to be reformed, the massive redistributive effort proposed under the Clinton plan lacked support from the American middle class, the majority of whom receive health care coverage through employer plans. The President's health bill was literally picked apart by health care lobby groups and, with the failure of the *Health Security Act* and the Republican capture of the Congress in 1994, the chance for any meaningful, large-scale health reform was lost.

## 2. *Emergence of Managed Care*

With the demise of the Clinton plan, the momentum for reform shifted to the corporate purchaser side where costs have always been the dominant concern. Large employers who provide health benefits to workers and dependents have used their purchasing power to shift U.S. health care away from fee-for-service medicine to managed care systems.<sup>54</sup> Outside of government, corporate America constitutes the major purchaser of health care insurance, and so changes in their policies can result in dramatic alterations of this market. In addition to the support given to managed care plans through corporate benefit departments, the federal government sponsors of U.S. Medicare and Medicaid programs have taken major steps to promote managed care products to enrollees in public programs.<sup>55</sup> The extensive and rapid growth of managed care medicine in both the private and public sectors has brought about *de facto* reform of

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52. *Ibid.*

53. Allen Schick, "How a Bill Did Not Become a Law" in Mann & Ornstein, *ibid.*

54. Eli Ginzberg & Miriam Ostow, "Managed Care - A Look Back and A Look Ahead" (1997) 336 *New Eng. J. Med.* 1018-1020; "The State of Health Care in America 1996" *Business & Health Magazine* (1996).

55. Physician Payment Review Commission, *Annual Report to Congress 1997*, chapters 1, 2, 20; George Anders, "Many States Embrace Managed Care System for Medicaid Patients" *Wall St. J.* (11 June 1993) A1. The Clinton administration has encouraged states to shift Medicaid patients into mandatory managed care by directing the federal Health Care Financing

the American health care system that in many ways is as profound as the reforms which the Clinton plan would have ushered in.

Managed care is a catch-all phrase that covers a wide range of health care programs and entities which have formed in response to those programs.<sup>56</sup> On the programmatic level, managed care refers to a variety of health care plans which combine traditional insurance coverage with medical care delivery. Most typical of the managed care plans are Health Maintenance Organizations (HMOs) which provide enrollees with a comprehensive range of medical services for a set monthly fee, with very limited copayment requirements.<sup>57</sup> HMO plan enrollees are restricted by plan rules that generally require use of plan physicians and prior approvals for specialty care. Failure of the HMO enrollees to follow plan rules can result in denials of payment for treatment, thus forcing the patient to pay for all, or a high portion, of the care received.

There are several types of HMOs ranging from staff models, which directly employ physicians and may own all their medical facilities, to network models, which are composed of medical groups dispersed throughout a particular locale and bound by contract to an HMO corporation.<sup>58</sup> HMOs are licensed state entities, and under state legislation significant capitalization requirements must be complied with, akin to requirements insurance companies must meet.<sup>59</sup> Another popular managed care model is the Preferred Provider Organization (PPO). It is a plan that offers employer purchasers discounted medical services in arrangements with organizations which contract with particular physician groups and institutional health care providers. Unlike HMOs, PPOs are not heavily regulated and structurally are contract entities put together most typically by large health insurers. The newest generation of managed care

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Administration (HCFA) to grant the necessary administrative waivers of requirements in the Medicaid statutes. See Teresa A. Couglin et al., *Medicaid Since 1980: Cost, Coverage and the Shifting Alliance Between the Federal Government and the States* (Washington, DC: Brookings, 1994). By 1994 at least 23% of Medicaid recipients were enrolled in managed care. Colette Frole, "Managed Care May Save Money, But Hard to Say How Much" (1995) 53 Cong. Of Wkly. Rep. 2905. The 1995 comprehensive budget bill urged Medicare beneficiaries to join managed care through a "Medicare Part C" program with the expectation of saving close to \$25 billion over the 7 year budget program. Section 863 of the *Balanced Budget Act of 1995*, 104th Cong. 1st Session, discussed in H.R.Rep. no. 350, 104th Cong., 1st Session, pt. 2, at 1267-71 (1995).

56. Carl H. Hitchner et al., "Integrated Delivery Systems: A Survey of Organizational Models" 29 Wake Forest L. Rev. 273 n.1 (1994); see generally Thomas A. Gilman, *Alternative Delivery Systems* (Frederick, Md.: Aspen Publishers, 1986).

57. George J. Annas, *American Health Law* (Boston: Little, Brown, 1990) at 774-75; see also Stephen B. Boochever, "Health Maintenance Organizations" in Gilman, ed., *supra* note 56.

58. Boochever, *ibid*.

59. Michael F. Anthony, "Preferred Provider Organization" in Gilman, ed., *supra* note 56.

plans are Provider Sponsored Organizations (PSO) which are physician/hospital corporations that assemble and manage a network of medical care services through contract arrangements.<sup>60</sup> Unlike most Health Maintenance Organizations or Preferred Provider Organizations, the PSO directly provides medical care services. The control of these entities is in the hands of medical professionals, which, proponents argue, results in better utilization of services and improvement in clinical outcomes. At this point, however, it is too early to assess the medical care successes of these new organizations.

While a sense of managed care can be developed from a study of the various structures in the field, there are a number of operational elements which are seen in most managed care arrangements, regardless of the specific structure. A capstone of managed care is capitation reimbursement in which physicians, typically primary care doctors, receive a set payment per member, per month, regardless of whether or not the individual patient member receives treatment. A percentage of a doctor's capitation amount is held in a fund to pay for specialty care and often a second withhold fund is created to pay physicians bonuses for reaching specific utilization targets.<sup>61</sup> In a sense, the capitated doctor takes on the dual roles of practitioner and insurer, as the individual clinician acts as a gatekeeper in determining whether there is a need for more intensive clinical and diagnostic services. Inherent in the capitation system is a transfer of risk from the managed care entity to the member doctor, and the issue of how an individual practitioner can best manage risk is one of frequent concern.<sup>62</sup> Capitation is not universal to all managed care arrangements in that some reimburse primary care doctors on a discounted fee-for-service basis, and this type of payment is particularly common for reimbursement of medical specialists.<sup>63</sup> Other hallmarks of managed care include restricted access to medical specialists and costly procedures, as well as the application of stringent clinical treatment

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60. Edward B. Hirshfeld, "Provider Sponsored Organizations and Provider Service Networks Rationale and Regulation" (1996) 22 Am. J. L. & Med. 263.

61. See generally Frances H. Miller, "Foreword: The Promises and Problems of Capitation" (1996) 22 Am. J. L. & Med. 167 at 169; see Health Care Consultants of America, *Physicians Guide to Managed Care: A Comprehensive Guide to Capitation, Discounted Fee-For-Services and Integrated Delivery Systems* (Augusta, Ga.: H.C.C.A., 1996).

62. Miller, *supra* note 61 at 168.

63. PPOs (Preferred Provider Organizations), for example, are networks of fee-for-service providers that have agreed to grant large, third party payers price discounts in return for insurance contracts that steer the insured toward these "preferred" providers through specially tailored forms of cost sharing; Annas, *supra* note 57 at 775.

protocols which often shift medical care from inpatient settings to ambulatory treatment.

### 3. *Market Developments*

In response to the growth of managed care plans there has been a dramatic alteration of many local health care markets as individual and institutional providers are reorganizing to become viable contracting parties.<sup>64</sup> As health care is largely a local enterprise, the nature of reorganization varies around the country, but even in markets where managed care penetration is minimal, hospitals are forming local area acute and ambulatory care networks with other institutions. Many hospitals have created joint venture corporations with members of their own medical staffs, referred to as Physician Hospital Organizations (PHO).<sup>65</sup> These organizations are usually designed to provide a comprehensive range of medical services and to enter into contracts with managed care plans, or to provide services directly to employer groups. In fact, PHOs are a variation of the Provider Sponsored Organizations previously discussed. In areas where managed care is more developed, affiliated networks of hospitals and doctors tend to dominate, and in order to attract business, independent providers are forced into established or newly developed network arrangements.<sup>66</sup> Presumably, health care markets are evolving toward integrated delivery systems that will be characterized by local and regional health care corporations which will provide a full range of medical services from ambulatory care to inpatient services to long term care. The hope is that this market realignment will bring order from chaos. It is too soon to predict whether the forecasts about the likely dominance of integrated delivery systems will be realized, but clearly more market alterations are occurring in American health care in the 1990s than in any prior period.

Commensurate with market restructuring are numerous legal considerations inherent to the development and operation of managed care plans, as well as issues sparked by corporate reorganizations.<sup>67</sup> As might

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64. Anne Stoline & Jonathan P. Weiner, *The New Medical Marketplace: A Physician's Guide to the Health Care Revolution* (Baltimore: Johns Hopkins University Press, 1988).

65. Mike Mitka, "What Makes a PHO Go?" *American Medical News* (20 June 1994) 15. Frederick B. Abbey & K. Michael Treash Jr., "Reasons Providers Form PHOs" (1995) 49 *Healthcare Financial Management* 38-48.

66. Mark A. Hall, "Managed Competition and Integrated Health Care Delivery Systems" (1994) 29 *Wake Forest L. Rev.* 1.

67. See generally, "New Forms of Hospital and Business Structures and Professional Arrangements as Influenced by Taxes, Competition, and Health Care Reform" C 884 ALI-ABA 595 (10 February 1994).

be expected, paramount among the legal issues are matters concerning contract law, but a myriad of other business and insurance law concerns arise as well.<sup>68</sup> For example, with mergers and affiliations of institutional health providers there have been increased concerns about antitrust law violations.<sup>69</sup>

Starting in the mid-1970s, antitrust laws have been applied to health care in a series of public and private actions dealing with questions of professionalism and competition, physician-hospital arrangements and, more recently, provider-payor relationships.<sup>70</sup> Challenges have been raised against market realignments in which federal/state statutory violations such as restraint of trade, price fixing and monopolization were alleged. Government antitrust enforcement has spawned considerable confusion in the private sector, forcing regulators to identify certain transactions that will not result in legal violations, but the so-called "safe harbours" developed by the U.S. Department of Justice and the Federal Trade Commission are not comprehensive or binding.<sup>71</sup> It has been argued that the actual deterrent effect of antitrust laws on health care market reorganization has been minimal.<sup>72</sup> The fact is that few successful antitrust challenges have been mounted. Cases in this area often fail as result of inherent legal complexities and difficulties in defining the relevant product market. Still, it seems short-sighted to overlook the impact of antitrust laws in health care, since virtually every health care transaction must be subjected to an antitrust litmus test, and undoubtedly many health care restructuring arrangements have been abandoned because of concerns over antitrust enforcement.

In addition to antitrust developments, considerable legislative activity has been spawned by managed care. This activity has been promoted by a unique coalition of physicians and consumers who have targeted their

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68. See, Gerald R. Peters, ed., *Healthcare Integration: A Legal Manual for Constructing Integrated Organizations* (Washington, DC: National Health Lawyers, 1995).

69. For an overview, see Jonathan Choslovsky, "Note and Comment: Agency Review of Health Care Industry Mergers: Proper Procedure or Unnecessary Burden?" (1996) 10 Admin. L. J. 291 at 298-309.

70. Mark A. Hall & William S. Brewbaker, eds., *Health Care Corporate Law Facilities and Transactions* (Boston: Little Brown, 1996), ss. 5.19-5.25.

71. U.S. Dept of Justice, U.S. Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, 5 BNA Health L. Rep. 1295, 1307-1310 (29 August 1996), *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust* (1994), *Statements of Antitrust Enforcement Policy for Health Care Areas* (1993).

72. Marc A. Rodwin, "Patient Accountability and Quality of Care: Lessons from Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements" (1994) 20 Am. J. L. & Med. 147 at 154.

efforts against a growing list of perceived abuses.<sup>73</sup> Typifying a growing number of federal and state initiatives (known as patient protection acts) are statutes which prohibit so-called "gag clauses." These clauses are restrictions that some managed care plans have placed on physicians providing enrollees information about non-covered services and incentive payment arrangements.<sup>74</sup> To date it has been state legislatures which have taken the lead in managed care patient legislation, reflecting the fact that the underlying issues have become matters that have political resonance with local politicians. There is also an increasing number of lawsuits being brought against managed care plans by disgruntled consumers, and barriers to such litigation as a result of federal benefit law preemptions to tort actions are beginning to erode.<sup>75</sup> The federal government has joined in the fray with the creation of a presidential panel, the Advisory Commission on Consumer Protection and Quality in the Health Care Industry which primarily has a managed care focus, and a series of Congressional bills which mirror the state patient protection acts. The commission issued a model bill of rights which includes patients' rights to change doctors, to appeal denials of care and to receive payment of emergency room services. All of these rights are in areas where anecdotal evidence of abuses in managed care plans has been presented.<sup>76</sup>

### III. *A Tale of Two Jurisdictions.*

On their face, Nova Scotia and Illinois appear to have little in common other than the fact they are both regional jurisdictions in North America. Nova Scotia is a small, relatively homogeneous province with a single metropolitan area.<sup>77</sup> Illinois, on the other hand, is a large state with a very diverse population dominated by Chicago, a metropolitan region of over six million people.<sup>78</sup> While general comparisons between the two jurisdictions are a stretch, there are commonalities in the area of publicly

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73. For a detailed list of state and federal legislative activity in this area, see Marc A. Rodwin, "Mechanisms of Consumer Protection - The Marketplace and Regulation: Managed Care and Consumer Protection: What are the Issues?" (1996) 26 Seton Hall L. Rev. 1007 at 1029-1032.

74. See, e.g., Mass. Gen. L. ch. 176B, 7 (Supp. 1996); ch. 176G, 6; ch. 176I, 2; Alison Bass, "New Law Bans Gag Rules on Doctors: Health Insurers Contracts at Issue" *Boston Globe* (23 January 1996) 1.

75. Seema R. Shah, "Loosening ERISA's Preemptive Grip on HMO Medical Malpractice Claims: A Response to *PacificCare of Oklahoma v. Burrage*" (1996) 80 Minn. L. Rev. 1545.

76. "Medical Bill of Rights Could Lead to New Laws" *Chicago Tribune* (21 October 1997); Robert Pear, "Panel of Experts Urges Broadening of Patient Rights" *New York Times* (23 October 1997).

77. KCWD, "Nova Scotia: General Information" (ABC-CLIO, 1995).

78. George Ryan, ed., *Illinois Blue Book 1995-96* (Secretary of State, 1995).



sponsored health insurance which make comparative analyses valuable. For this article, the bases of comparison are Nova Scotia Medicare and Illinois Medicaid. Medicaid is the American program for indigent care, and while it is not representative of the entire state health system, it shares many common features with Nova Scotia's province wide Medicare program.<sup>79</sup>

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79. Medicaid is jointly funded by the states and the federal government. The federal share of expenditures is determined by a formula based on state per capita income, under which states with relatively low per capita incomes receive higher federal matching rates. For example, Mississippi, with a per capita income that is less than 70 percent of the national average, had a matching rate of about 79 percent, while Connecticut, with a per capita income that is nearly 135 percent of the national average, received a 50 percent match. Since 1987, this matching rate has been recalculated annually. Overall, federal funds accounted for about 57 percent of total Medicaid spending in 1995.

Federal payments to the states are provided from general revenues to match expenditures submitted by the states. There is no limit on the total amount of federal payments. States may finance their share entirely from state funds or require local governments to finance up to 60 percent of program costs. Only a few states have exercised the latter option, with local sources accounting for a small proportion of state financing in most of these states.

Overall, Medicaid helps to finance health care for one of every eight Americans and about one-half of all Americans living in poverty. There is, however, no uniform national basis for establishing Medicaid eligibility. Within the limits of various federal rules, states may choose different eligibility criteria.

In general, beneficiaries can be grouped in three categories: adults and children in low-income families, blind and disabled individuals, and the elderly. Within each category, people may qualify for coverage because they are either categorically or medically needy.

Under federal law, all persons meeting 1996 standards for Aid to Families with Dependent Children (AFDC) and most on Supplementary Security Income (SSI) are considered categorically needy and covered in all states. Starting in the mid-1980's, the Congress expanded Medicaid eligibility to include some persons who do not receive AFDC or SSI cash payments. For the most part, different income standards apply to each of three newly eligible groups: pregnant women and infants, children below the age of six, and children six and older. States have considerable flexibility in setting age and income thresholds. As a result of these expansions, the proportion of Medicaid beneficiaries who also received cash welfare benefits declined from about two-thirds in 1990 to just over half in 1995.

States also may give Medicaid eligibility to the medically needy, those individuals whose income or resources exceed standards for cash assistance but who meet a separate state-determined income standard and are also aged, disabled, or a member of a family with dependent children. Persons who "spend down" income and assets due to large health expenses may qualify as medically needy. In 1996, 34 states extended eligibility to the medically needy.

In addition to Medicaid, citizens of Illinois who are 65 years and older (as well as individuals with certain disabilities) participate in the federal Medicare program. Medicare is a medical care insurance program covering a wide range of inpatient and ambulatory care, funded through Social Security taxes and general revenue. Unlike Medicaid, there is no direct state government involvement in the administration of Medicare, and even though Medicare primarily covers the elderly, it provides only limited coverage for long term care.

On the private side, most Illinois residents receive health care insurance through employer plans which range from traditional indemnity offerings to various managed care options. Very few individuals in Illinois purchase insurance privately as the costs of doing so are prohibitively high.

Both jurisdictions face serious economic challenges in meeting the legislative mandates underpinning their respective Medicare and Medicaid programs. In both cases, there has been a movement to devolve public health from federal to regional governments, and the intergovernmental relationships are strained by politics, economics and a lack of clarity about appropriate system-wide directions. Nova Scotia and Illinois are both in the throes of implementing major changes in health policies, and while the nature of those changes are a reflection of two very different societies, successful initiatives in public health are likely to have cross-border implications.

## 1. *Nova Scotia*

### a. *Overview of Medicare*

Like other provinces, Nova Scotia's Medicare is composed of three primary components: hospital coverage, medical services insurance and, for the elderly and poor, pharmacy benefits.<sup>80</sup> Core hospital and medical services are provided without charge but an annual premium and copayment is applied to the Pharmacare benefit.<sup>81</sup> There is a charge for other health services, such as long term care and home care, but the Department of Health provides payment in these areas for low income residents. From a structural standpoint, the province's 47 hospitals and 2000 physicians form the core of the delivery system, but in response to severe financial pressures, there is an increasing focus on community health services, particularly home care.<sup>82</sup> While institutional and individual providers are largely private, their funding is predominantly public. The provincial government funds its health system through a complex blend of provincial and federal dollars drawn from sales and income tax revenues and federal transfer payments.<sup>83</sup> Proprietary health care services have made few inroads in the province, although with the delisting of government reimbursed services, the potential for growth of the for-profit sector is a real one. Some private health insurance is offered through employer programs covering services that fall outside the provincial Medicare program.<sup>84</sup>

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80. *Hospitals Act*, R.S.N.S. 1989, c. 208, as am. by S.N.S. 1994-95, c. 7, ss. 11-16, 22-33; *Medical Act*, R.S.N.S. 1989, c. 278, as am. by S.N.S. 1993 c. 28.

81. C. Nicoll, "Pharmacare Costs Down, Exec. says" *The [Halifax] Daily News* (13 February 1997) 4.

82. Nova Scotia Department of Health, Minister's Action Committee on Health System Reform, *Nova Scotia's Blueprint for Health System Reform* (Halifax: Dept. Of Health, 1994).

83. Fulton, *supra* note 4.

84. For example, supplemental health coverage can be provided through programs such as the one offered by Nova Scotia Blue Cross.

Health policy in Nova Scotia, as is the case in other Canadian provinces, is intertwined with financial considerations. In particular, deficit spending and tax policy both have a profound impact on provincial social services.<sup>85</sup> Economic issues affecting Nova Scotia are multifaceted and complex, and beyond the scope of this article, but it does seem reasonable to conclude that the province has been plagued by financial problems that are both national and regional in their etiology, and many recent health care initiatives, in large part, have as much to do with economics as health. In the 1980s, as a result of a serious recession, Nova Scotia imposed tax increases to restore government revenue levels, but the balance between provincial spending and revenue was never equalized and thus deficit spending grew.<sup>86</sup> By 1993 Nova Scotia's annual deficit was \$617 million and by 1996 the total provincial debt was \$8.7 billion.<sup>87</sup> Adding to Nova Scotia's financial woes was the federal policy to cut transfer payments, resulting from Ottawa's adoption of the new Canada Health and Social Transfer payment system.<sup>88</sup> These grim economic realities have resulted in stringent provincial spending controls which have led to a balanced budget in all areas but health care.<sup>89</sup>

In analyzing recent Nova Scotia health policy, two distinct areas can be identified. First, there has been a visible reform process highlighted by several widely publicized reports which lay out broad recommendations for restructuring the provincial health system.<sup>90</sup> The second area concerns the ongoing regulatory initiatives pursued by the Nova Scotia Department of Health to reduce costs and eventually restructure the delivery system. This process has often proceeded outside of general public scrutiny. In an ideal world, the aspirational goals outlined in provincial planning documents should complement the policies of the Department of Health, but it appears that this may not be the case.

#### b. *Recent Alterations: Cost Cutting*

Recent initiatives of the Nova Scotia Department of Health have focused on the creation of a province wide ambulance service and a home health

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85. Nova Scotia Department of Finance, *Government By Design: Building on Solid Ground* (Halifax: Dept. of Finance, 1996) at 81.

86. Nova Scotia Department of Finance, *Shaping the Future Positioning Nova Scotia for a Financially Secure Tomorrow*, vol. 2 (Halifax: Dept. of Finance, 1996) at 81.

87. *Ibid.*

88. Taylor, *supra* note 7.

89. *Government by Design*, *supra* note 85 at 7-8.

90. *Nova Scotia's Blueprint*, *supra* note 82 at 8. Details of other provincial health reports are included here.

care network.<sup>91</sup> However, the bulk of the Department's activity has been directed to a series of cost cutting measures focused on hospitals, labour unions and physicians. A major emphasis of Department policy has been on the control of hospital expenditures which has entailed several facility closures, cuts in acute care beds and reductions in individual facility budgets.<sup>92</sup> By 1995, the Department had cut more than one-quarter of Nova Scotia's hospital beds. This action was motivated by a provincial goal of dropping the acute care bed ratio from 5 per 1000, to 3 per 1000 residents.<sup>93</sup> The Department of Health closed two rural hospitals and converted three facilities two into community health centres and one into a veterans' hospital.<sup>94</sup> The Department also initiated two major hospital mergers. One created the province's largest tertiary-care complex, the Queen Elizabeth II Health Science Centre, by merging four Halifax hospitals.<sup>95</sup> The other merged a maternity hospital and a children's hospital into The IWK Grace Health Centre for Children Women & Families. It is likely that the Department will continue to recommend additional hospital mergers and conversions of smaller acute-care facilities into community health centres. Coupled with hospital downsizing initiatives, there has been a 13 percent drop in hospital admissions, and a 21 percent decrease in inpatient lengths of stay across the province.<sup>96</sup>

Starting in 1993 individual hospital budgets were frozen for three years, then they were decreased by 2 percent for two years, with further decreases likely.<sup>97</sup> The Queen Elizabeth II Health Sciences Centre, the province's largest hospital, had its 1997-98 budget cut by \$24.9 million, and the hospital has been directed to eliminate 500 jobs and 200 beds in the next four years.<sup>98</sup> While hospital waiting lists in the province have not increased as a result of the cuts, patient care services have been affected by the reductions.<sup>99</sup>

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91. *Ibid.* at 35. See also T. Regan, "The Road to Wellville: The Overhaul of Nova Scotia's Health Care. Will it Save the Patient?" *The [Halifax] Daily News* (6 November 1994) 4.

92. C. Nicoll, "No Room at the Hospital? Hefty Bed Cutbacks to Blame for Health Overload - NDP" *The [Halifax] Daily News* (23 September 1995) 6.

93. C. Nicoll, "Stewart Chops \$15 Million From Budget: Three Hospitals Slated to Close" *The [Halifax] Daily News* (13 May 1994).

94. *Ibid.*

95. C. Nicoll, "QEII Will Be World Leader, Stewart Says: Final Debate Begins on Bill to Merge Halifax Hospitals" *The [Halifax] Daily News* (19 December 1995) 4.

96. Nicoll, *supra* note 92.

97. For a general sense of funding priorities that relate directly to funding, see *Government by Design*, *supra* note 85.

98. S. MacKinlay, "Deep Cuts for QEII" *The [Halifax] Daily News* (26 July 1996) 3.

99. C. Nicoll "Surgery Quicker in N.S.," *The [Halifax] Daily News* (19 November 1996) 3; S. Aikenhead, "Heading to the Grace Maternity, Count on Bringing Your Own Kleenex" *The [Halifax] Daily News* (21 March 1995) 21.

The government's hospital cuts may have been more contentious if labour agreements had not been reached with the six unions represented by the Nova Scotia Association of Health Organizations. In 1994, the Department offered an early retirement package to health care workers over 55, estimated to cost the province \$44 million, but allowing for the health care workforce to be downsized by 1000 persons.<sup>100</sup> A larger labour adjustment package was devised the following year which offered early retirement and a voluntary resignation incentive program for Nova Scotia's 14,000 health workers.<sup>101</sup> The provincial goal has been to limit layoffs with no recourse to 10 percent of the workforce, and to shift health workers, particularly nurses, from acute care to home and community care settings.<sup>102</sup> A negotiated agreement was struck between labour unions and the government to provide job transition services for displaced workers through the Nova Scotia Health Service Organization.

Currently it is difficult to determine what overall impact hospital downsizing has had on the provincial health care workforce. It appears that job losses have not yet reached projected levels, and the acute care system has been able to absorb a certain number of displaced workers. The large scale transfer of nurses from acute care settings into home and community care has not occurred. Unquestionably downsizing will alter the health care workforce, but the lack of an immediate and dramatic impact on health providers may be attributed either to successful government and labour strategies, or to the fact that reactions in this sector may be simply delayed.<sup>103</sup>

The third major focus of cost cutting activities in the province has been directed toward physicians. Physician reimbursement was first frozen in 1991, later it was struck by a 3 percent wage cut for two years and a subsequent 12.5 percent budgetary reduction for expenditures in this area.<sup>104</sup> Currently, physician fees are calculated on the basis of a formula (master units) and individual income is controlled by use of a soft cap which allows for a sliding scale of billing over a certain dollar amount.<sup>105</sup> The Department of Health has also placed an overall ceiling on a physician's income which acts as a hard cap that ultimately limits

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100. P. Hays & C. Nicoll, "Health Workers Get Goodbye Deal" *The [Halifax] Daily News* (8 June 1994) 3.

101. C. Nicoll, "We Don't Have any Targets: Health Job-Cut Deal a Milestone" *The [Halifax] Daily News* (21 November 1995) 4.

102. *Ibid.*

103. Nova Scotia Department of Health, *Good Medicine: Securing Doctors' Services for Nova Scotians* (Halifax: Dept. of Health, 1997).

104. "Making Sense of the Budget Numbers" *Newsletter of the Medical Society of Nova Scotia* (May 1994) 4.

105. *Good Medicine*, *supra* note 103 at 4.

individual billing. Besides reimbursement control, the Department has restricted physician practice locations and, until recently, no new physician billing numbers were issued for the Halifax metropolitan area. These government restrictions on fees and billing numbers have resulted in an exodus of doctors from the province, particularly from rural areas.<sup>106</sup> To encourage physicians to remain in Nova Scotia, the Department approved an agreement with the Medical Society to provide rural physicians with guaranteed income and a generous benefit package.<sup>107</sup>

In the report "Good Medicine: Securing Doctors' Services for Nova Scotians," the Department of Health conducted a comprehensive examination of medical practice in the province.<sup>108</sup> The Department recommended that the fee-for-service system be scrapped in favour of a blended capitation system.<sup>109</sup> Under blended capitation, primary care doctors would be paid a set amount per patient with adjustments made for age and sex. Incorporated into a capitation scheme would be payment incentives to encourage physicians to engage in health promotion and preventive care such as Pap tests and immunizations.<sup>110</sup> A cap would be placed on the numbers of patients who could register with a particular physician. Certain services such as obstetrics would remain under a fee-for-service structure, as well as the services of physicians in very rural areas where patient volumes may be too low to make capitation practical.<sup>111</sup> In addition, office-based specialists would continue to be paid on a fee-for-service basis, and hospital specialists would also continue to be reimbursed under the institutional block funding arrangement. The Department proposes that capitation be introduced gradually through several voluntary test sites prior to universal adoption.

In addition to altering the payment structure, the Department is recommending that physicians be provided with supplemental health insurance, relief from escalating medical malpractice premiums and pension plans.<sup>112</sup> To address the shortage of rural physicians, a special fund for after-hours and weekend care is proposed. Other proposals include the development of a temporary pool of physicians to provide relief to rural doctors and the introduction of province-wide telemedicine. In a recently agreed four-year contract, rural physicians will receive

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106. S. MacKinlay, "Province Ends New MD Freeze" *The [Halifax] Daily News* (9 January 1997) 6.

107. S. MacKinlay, "\$8 Million for MDs Gets Cool Response" *The [Halifax] Daily News* (17 April 1997) 4.

108. *Good Medicine*, *supra* note 103 at 4.

109. *Ibid.* at 9.

110. *Ibid.* at 15.

111. *Ibid.* at 10, 14.

112. *Ibid.* at 12-15.

payment for on-call duty and, province-wide, doctors will realize an increase in reimbursement as a result of changes in the master unit reimbursement formula.<sup>113</sup>

In its attempt to effect cost reduction, the Department has been negotiating with the Medical Society to delist a number of elective medical services. In early 1997 the Department released a list of medical services which it indicated would no longer be reimbursed under Nova Scotia Medicare. In prior years the government made certain programmatic adjustments in areas such as pediatric dentistry and eye care, but the current delisting of services represents Nova Scotia's first attempt to constrict the delivery of specific medical care as a matter of explicit public policy.<sup>114</sup> The Medical Society, which was involved in the negotiations over delisting, did not accept the list of 19 services to be removed from Medicare, and took the position that no currently offered service should be delisted if it can be classified as "medically necessary."<sup>115</sup>

Beyond the efforts to contain costs, Nova Scotia health policy has been evolving within the framework of a public reform process started under the Conservative government with the appointment of the Royal Commission on Health Care in 1987.<sup>116</sup> The Conservative reform group published a three volume report which reviewed key aspects of the health system and was followed by a document that outlined a series of reform proposals.<sup>117</sup> The recommendations for reform were driven by a sense that the health system had to be moved away from an acute care model to one rooted in community health. The current Liberal government adopted Conservative ideas on health reform and in 1994 released a document entitled *Nova Scotia's Blueprint for Health System Reform*.<sup>118</sup> The Blueprint affirmed the core federal principles of Canadian healthcare and concurred with the Conservative government's position on the need to move to a community health model. The Blueprint has become the Liberal government's roadmap for health policy; many of the recent policy and regulatory initiatives have been taken in response to its proposals for reform.

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113. *Ibid.* at 14.

114. Nova Scotia Department of Health, "Policy Release, PR #01/97 - Reinsurance of Fee Codes" (14 January 1997).

115. MacKinlay, *supra* note 8.

116. *The Report of the Nova Scotia Royal Commission on Health Care* (Halifax: The Commission, 1989).

117. *Ibid.*

118. *Supra* note 82.

### c. *Devolution*

Perhaps the most noteworthy of the Blueprint reforms that are being put into practice is the current attempt to restructure the health system through a process of devolution. Under the Blueprint, devolution entails shifting the system's management from a centralized Department of Health to regional health authorities.<sup>119</sup> According to the Nova Scotia reform initiatives, both planning and financing of health care as well as the daily management of facilities and programs will become the responsibility of regional entities. The Blueprint calls for the creation of two new entities - Community Health Boards and Regional Health Boards.<sup>120</sup> Presumably these boards will be more sensitive to local health needs and will be more responsive to public concerns than the previous centralized system. Through local planning and management processes sparked by the regional boards, the government hopes to develop a system which is oriented to a public health model and which will de-emphasize costly acute care.<sup>121</sup>

The Community Health Boards (CHB), will focus on health planning at the local level, with a particular focus on primary care services.<sup>122</sup> Regional Health Boards (RHB), on the other hand, will be responsible for planning, policy making, funding and evaluation of regional health needs, all of which activities will be based upon community health plans formulated by CHBs.<sup>123</sup> The Province's four regional health boards will be provided with a total funding envelope which they will use to reimburse institutional and non-fee-for-service individual providers, as well as health programs (such as public health and drug dependency). This power will give them considerable leverage within their regions.<sup>124</sup> Under the new scheme, local health facility boards will be abolished and will be replaced by boards that oversee health institutions across a region, with the exception of the province's four largest tertiary-care centres.<sup>125</sup>

The devolution scheme creating RHBs and CHBs is unique in that the structure being implemented is a system which will allow reform to

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119. *Ibid.* at 26-29.

120. *Ibid.*

121. Nova Scotia Department of Health, Minister's Action Committee on Health Reform, *Background Paper on Regional Health Authorities and Community Health Boards* (Halifax: Dept. of Health, 1994).

122. Nova Scotia Department of Health, *To Our Good Health: an Introduction to Community Health Boards* (Halifax: Dept. of Health, 1996).

123. Nova Scotia Department of Health, *From Blueprint to Building: Renovating Nova Scotia's Health System* (Halifax: Dept. of Health, 1995).

124. *Ibid.* at 4, 6.

125. *Nova Scotia's Blueprint*, *supra* note 82 at 41-45.



emanate from the community level upwards. The scheme is particularly noteworthy because Canadian provincial health systems are characterized by very strong Departments of Health in which most key decisions are made. Devolution has occurred in other provinces, but what distinguishes the Nova Scotia model is its attempt to formulate policy at the local level, by contrast to other provinces where local entities merely carry out directives from central government. Under the Nova Scotia scheme, the Department of Health retains authority for initiating provincial health policy and legislation, planning tertiary services and province-wide programs, overseeing information systems and performing health services research.<sup>126</sup> But the bulk of the daily activity of managing and funding the delivery system is transferred to the RHBs under the Blueprint and the resultant RHB enabling legislation.<sup>127</sup>

Since the Blueprint was released in 1994, significant progress has been made in developing Regional Health Boards, and each of the four regions has one in place. Under the RHB legislation a series of specific duties are delineated but the legislation is quite broad in character, thus posing a challenge to regulators as to how it should be implemented. As a result, each of the four RHBs has followed a different model—a development that was not anticipated by Department of Health. For example, one RHB has focused its efforts on policy and planning. With a lean staff, this RHB is developing a community-based organization focusing on integration of existing services. Two RHBs have adopted a corporate model of organization and function in a manner akin to a health care management firm overseeing the daily operations of area facilities. The fourth RHB has adopted a regional program management model.<sup>128</sup>

At this point it is too early to predict what impact the RHBs will have on system reform as they are still being phased in. The CHBs which were to be created first in the reform process have lagged behind the regional entities in their development, although now more than half of the CHBs are beginning to present community health plans. Within three years, the RHBs will take over the Department's direct funding responsibilities but the population-based formula they will use for reimbursement has yet to be finalized. It seems likely that the RHBs will work toward converting small hospitals into community health centres, particularly in rural areas, but the extent of their involvement in daily operations is uncertain. The four RHBs will also need to better coordinate their activities with the

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126. *Ibid.* at 45-46.

127. *Ibid.* at 41-45; *Regional Health Boards Act*, S.N.S. 1994 c. 12.

128. Interview with R. Criddle, Director, Metro Regional Health Board (July 1996); Interview with A.M. Pellerin, Central Regional Health Board (July 1997).

Department. There has not been a transfer of departmental civil servants to regional operations apart from public health and drug dependency staff, and there is a danger of bureaucratic duplication, and even competition, between the RHBs and the Department.<sup>129</sup>

Nova Scotia health reform is clearly moving forward on several fronts, but like any broad reform it is a difficult process, burdened by politics and financial constraints. The Department of Health, unlike other government departments, has not been able to balance its budget, further magnifying the need for continued cost cutting and adding credibility to those who remain skeptical about the government's abilities to manage the reform process. While it is certainly reasonable to view devolution and its related emphasis on community health as positives steps in revitalizing Nova Scotia health care, these steps can also be characterized as ultimately just different types of cost cutting measures cast in the rhetoric of reform. The government no longer characterizes changes in health care as reform but now speaks of these measures in terms of renewal.<sup>130</sup> However, cynicism is easily overplayed and dismissal of the ongoing changes as a political ploy overlooks a significant series of efforts that have the potential to dramatically alter the future course of Nova Scotia Medicare.

## 2. *Illinois*

### a. *Overview of Medicaid*

Like the rest of America, Illinois is characterized by a diverse health system composed of a patchwork of public and private programs. While Illinois has been slower in the development of managed care than other parts of the United States, there are currently close to twenty plans in the Chicago area and many hospitals in the state have become part of integrated delivery networks.<sup>131</sup> Illinois' Medicaid program has an enrollment of 1.4 million people of which 400,000 are elderly nursing home residents.<sup>132</sup> The majority of Medicaid recipients are low-income individuals, primarily women and children. As is the case with Nova Scotia Medicare, Illinois Medicaid has experienced dramatic growth in the 1990s and is now the state's largest social service program. When Medicaid is combined with the state's health insurance benefit program

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129. "Blueprint Committee," *supra* note 123 at 9.

130. S. MacKinlay, "Selling Health Reform" *The [Halifax] Daily News* (16 July 1996).

131. Illinois Association of HMOs, *Annual Statistics 1997*.

132. Illinois Department of Public Aid, *Research and Analysis: All Programs Caseload Report* File 03.ALLP 797 (July 1997).

for employees and dependents, the Illinois government can be seen to be the jurisdiction's largest purchaser of health care.<sup>133</sup> In the period 1992-94, the state Medicaid program doubled in size, and by 1996 its annual expenditure reached \$6.5 billion.<sup>134</sup> The program's growth has become a threat to the state's abilities to finance other programs and continued unabated growth will result in either major budgetary cuts or a state tax increase.

The financial woes of Illinois Medicaid are not unique to the state, but are shared by every other U.S. Medicaid program. Money problems can be traced to three principal factors: health care cost inflation, demographic and economic changes pushing enrollment, and increased, largely unfunded, federal mandates to expand covered services. Until recently, states had little room to be creative in managing Medicaid programs as they were caught between the expanding federal requirements and court directives that grew out of legal challenges to state attempts to impose cost cutting measures. Medicaid has been largely invisible to the general public because it is a highly complex program serving a poor constituency, and it only becomes politically significant when its costs impact on the state's abilities to provide services in other areas.<sup>135</sup>

Illinois Medicaid offers a comprehensive range of inpatient and outpatient services to program recipients, well beyond the core benefit package mandated by the federal government.<sup>136</sup> Medicaid reimburses hospitals on a predetermined payment scale which is related to the patient's discharge diagnosis; it uses a prospective payment reimbursement model taken from the federal Medicare program. On the outpatient and physician service side, payments are on a fee-for-service basis according to rates contained in a number of reimbursement schedules.<sup>137</sup> The past two decades of Illinois Medicaid have been characterized by state efforts to control expenditures by using waiver provisions in the federal law to adopt approaches to reimbursement and coverage not allowed by the original Medicaid law. The Illinois hospital industry has been plagued by a program with a very slow reimbursement turnaround time and has taken legal action against the state on the grounds that Medicaid failed to meet the federal standards of adequate payment, as

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133. Jay Fitzgerald, "Medicaid Overhaul on the Table" (1994) 20 *Illinois Issues* 18-22.

134. Mark Reuter, "Rocketing Medicaid Costs Pose Major Problems for State Budget" U. of Ideas Business & Economics Series, News Bureau of the University of Illinois (February 1995).

135. "Medicaid Overhaul," *supra* note 132.

136. 89 Ill. Admin. Code 142.400 (1996).

137. 305 ICLS 5/5-19 (1996).

articulated in the Medicaid Boren Amendment.<sup>138</sup> Physician payment rates are among the lowest in the United States. As a result the number of participating doctors is low and those who do participate offset the low rates by increasing their volume of Medicaid patients.<sup>139</sup> The program is also very vulnerable to fraudulent billing problems, particularly in the areas of pharmaceuticals and physician and diagnostic services. Structurally, Medicaid is a maze of complex eligibility and reimbursement rules which are subject to constant change, confusing bureaucrats, providers and recipients alike. The recently enacted federal welfare reform legislation severs the link between Medicaid eligibility and welfare, but the transition to new eligibility rules will only lead to further programmatic confusion.<sup>140</sup>

#### b. *Attempts at Reform*

During the past two decades, Illinois has launched a number of initiatives to restructure its Medicaid program by taking advantage of federal waivers and loopholes in the Medicaid law. The goal is to develop more cost effective approaches to this program. On the hospital side, two initiatives are particularly noteworthy: one is a special service contract bidding system and the other is an institutional provider tax. In 1984 Illinois enacted the *Health Finance Reform Act* which established the Illinois Competitive Access and Reimbursement Equity Program (ICARE).<sup>141</sup> The ICARE program was a contract bidding system in which certain hospitals negotiated a global budget for inpatient Medicaid services, based on an initial blind bidding process. The ICARE global budget is akin to Nova Scotia Medicare, but the Illinois system did not include every hospital, for only low bidders were allowed to participate. The difficulties experienced under ICARE related to the inability to predict accurately inpatient Medicaid utilization. Often participating hospitals were forced to seek supplemental Medicaid funding because they expended their annual allotments prior to the end of their respective

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138. 42 U.S.C.S. 1396a(a)(13)(A) and 42 U.S.C.S. 1983, repealed P.L. 105-33 s.4711, to be codified at 42 U.S.C.S. 1396a(13). With the repeal of the Boren amendment states will have more flexibility in designing payment structures for Medicaid, but whatever is designed must be structurally valid to withstand likely judicial challenges which virtually all state payment schemes are subjected to.

139. Jane Perkins, "Increasing Provider Participation in the Medicaid Program: Is there a doctor in the house?" (1989) 26 Social Security Reporting Service 846.

140. 42 U.S.C. § 615 (1997).

141. P.A. 83-1243 (1984), codified Ill. Rev. Stat. 1984, ch. 111 1/2 s. 6503-1 *et seq.*, repealed 1992; Arsenio Oloroso Jr. "State Eyes Medicaid Fix; Plan to Tax Hospitals Seen" *Crain's Chicago Business* (27 May 1991) 1.

budget years. On the heels of a failed ICARE system, the state adopted the Medicare prospective payment system for hospitals and developed a program to further increase federal funding for hospital and nursing home care by imposing a special tax on these institutional providers.<sup>142</sup> Providers were taxed on the basis of their revenue and those taxes were used to increase the pool of monies the state had available for Medicaid, which in turn increased the federal government's matching payments to the state. In the initial stages of the provider tax arrangement, individual facilities benefitted directly by having their tax payments plus increased federal dollars returned to them directly in their Medicaid reimbursements. Quickly the federal government tightened the loophole, making it more difficult for states to manipulate the federal matching payments through special provider tax schemes.<sup>143</sup>

While ICARE and the provider tax were creative approaches to institutional funding, financial difficulties continued to plague Illinois' Medicaid and a fundamental awareness persisted amongst state regulators that a more basic change to the program was needed. With the growth of managed care in the private sector, both in Illinois and around the country, it was only natural that this seemingly more cost effective way of delivering health care became the primary model for Medicaid reform. The seeds of Illinois Medicaid managed care were sown in the early 1980s with changes in federal law that allowed states to contract with health maintenance organizations (HMO) and other risk-bearing entities for treatment of Medicaid recipients.<sup>144</sup> In 1984 Illinois launched a Medicaid managed care demonstration project in the inner city of Chicago enrolling individuals in HMOs or hybrid managed care plans known as Prepaid Health Plans (PHP). The PHPs were formed by inner city hospitals that had large Medicaid patient populations in their service areas and, while akin to HMOs, they did not have to meet state law capitalization requirements.<sup>145</sup> In the early 1990s, the state launched a special managed care project referred to as Healthy Moms/Healthy Kids which was designed to deliver prenatal care and childhood immunizations to inner city populations.<sup>146</sup> While the state promoted managed care enrollment for Medicaid recipients, it placed limits on the number of Medicaid and Medicare enrollees in licensed managed care entities,

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142. *Ibid.*

143. Lynn Wagner, "Hospitals to Carry On Fight Over Medicaid Restrictions" *Modern Healthcare* (9 December 1991).

144. 47 FR 43087 (30 September 1982), 48 FR 54013 (Nov. 30, 1983), 42 CFR 431 Subpart L.

145. 89 Ill. Admin. Code 142.240 (1996).

146. *Supra* note 137.

fearing that plans with large enrolments of publicly supported patients might not be economically viable.<sup>147</sup> Recognizing the potential for increased utilization from publicly supported patients, HMOs often sponsored separate programs for Medicare and Medicaid patients, typically with fewer participating providers and service options than their commercial counterparts.

By the mid-1990s, growing numbers of the state's 1.1 million Medicaid recipients were enrolled in managed care offerings. This voluntary enrolment was resulting in overall programmatic savings, further encouraging the state to promote this mechanism of delivery, but the effort to move the Medicaid population into managed care was not always a smooth one. A research study of the Chicago Medicaid managed care experience demonstrated that many recipients did not understand the differences between managed care and fee-for-service plans. The educational supports needed to effect a positive transition, as well as meaningful participation in prepaid plans, were not present.<sup>148</sup> The Healthy Moms/Healthy Kids program was plagued by costly administrative difficulties and serious computer problems which reduced the ability of the program to serve large numbers of recipients.<sup>149</sup> With the growth of managed care entities in Illinois, anecdotes abounded about unethical marketing practices in which false and misleading information was given to entice individuals into signing up with various plans. In one reported case, Chicago street gang members were being paid finders fees for every new member they signed up for a particular HMO.<sup>150</sup>

### c. *Mediplan Plus*

In spite of the problems, the financial pressures placed on the state continued. The burden of Medicaid increased to over 35 percent of state expenditures and no other solutions to this cost dilemma, other than managed care, were emerging. In September of 1994, the state of Illinois submitted an application for a federal waiver under Section 1115 of the U.S. *Social Security Act*.<sup>151</sup> The 1115 waivers are designed to test unique

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147. *Ibid.* 5/5-16.3.

148. Janet Reis & Lynn Olson, "The Medicaid Program and Consumer Needs: A Survey Among Residents of a Poor Chicago Neighborhood" (1987) 102 Public Health Service Reports 530-538.

149. "Illinois: Medicaid Reform Plans Under Renewed Scrutiny" *Health Line* (30 January 1995).

150. Porter W. Myrick Jr., "Medicaid Reform in Illinois" (unpublished paper on file with the author).

151. 42 U.S.C. s. 1315(a); Illinois Department of Public Aid, *Illinois Mediplan Plus Protocol* (22 November 1996).

and innovative approaches to health care funding and delivery and allow a state to circumvent many of the standard requirements of the Medicaid law.<sup>152</sup> The 1115 waiver has been the primary means state governments have used to launch broad scale reform measures in their various Medicaid programs. Most recently-obtained state waivers have resulted in large-scale managed care programs.

Illinois' 1115 waiver called for a massive overhaul of the state's Medicaid program, moving the bulk of recipients out of fee-for-service medicine into managed care arrangements.<sup>153</sup> The state had anticipated that the necessary approval from the U.S. Health Care Financing Administration would occur in three to four months and planned to implement the program by the summer of 1995. But approval took considerably longer due to political problems caused by a Republican state administration seeking a waiver from a Democratic-controlled federal agency. Beyond politics, there were serious reservations about the state's abilities to manage a program of such dimensions, in view of its poor experiences with the Healthy Moms/Healthy Kids program, as well as the perception that the timetable for moving so many recipients into existing, and yet to be developed, managed care entities was unrealistic. It was not until July 1996 that the Health Care Financing Administration approved the Illinois waiver application; this was almost two years after the original submission.<sup>154</sup>

The Illinois waiver proposal, referred to as Mediplan Plus, is an attempt to create a statewide integrated health program based on a network of competitive managed care plans.<sup>155</sup> While Medicaid recipients will retain their ability to choose fee-for-service providers, that aspect will likely be phased out over time. Replacing the current system will be a health care environment composed of existing managed care entities and newly created ones known as Managed Care Community Networks (MCCN).<sup>156</sup> To cover rural areas of the state and to allow for

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152. Physician Payment Review Commission, *Annual Report to Congress* (1997) 425.

153. *Supra* note 151.

154. Arsenio Oloroso Jr., "State Medicaid Savings Plan Delayed-Again," *Crain's Chicago Business* (24 February 1997).

155. *Supra* note 151. Currently in Illinois there are two primary types of licensed managed care models, a Health Maintenance Organization (HMO), and a Preferred Provider Organization (PPO) (see prior discussion after n. 56). A third managed care product that is emerging in Illinois is a Provider Sponsored Organization (PSO) which is typically a joint venture arrangement between a medical group and a hospital which in turn contracts to treat patients in a given medical plan and assumes partial or total risk for doing so. Currently the U.S. Medicare program is developing plans to allow its enrollees to participate in PSOs and it is likely that Medicaid programs will do likewise.

156. 89 Ill. Admin. Code 142 *et seq.* (1996).

enrollee choice, individual physicians, rural health clinics, federally qualified health centres, and pediatric ambulatory care centres may be designated as Enrolled Managed Care Providers and may provide services under Mediplan Plus.<sup>157</sup> In addition, for the first year of the program, Prepaid Health Plans created in the 1980s and early 1990s may continue to participate as risk-bearing entities but must convert their organizations into MCCNs.

The state has developed multiple criteria for the participation of managed care entities in Mediplan Plus, such as adherence to state sanctioned formularies and demonstration of adequate numbers of enrolled physicians who are participating providers under contract in Medicaid.<sup>158</sup> The specific services which a managed care entity (MCE) must provide are detailed by state regulations, and it is these services which are eligible for capitated reimbursement. Also, participating MCEs must have the capacity to coordinate their services with community based public health providers. Behavioural health, mental health and rehabilitation services do not fall under Mediplan Plus but will continue to be covered as separate (“carve-out”) services on a fee-for-service basis. This decision raises questions about whether established managed care plans that capitate mental health and rehabilitation services will want to participate since fee-for-service requirements in these areas will add to their costs.

Medicaid managed care plans must provide each enrollee with a care coordinating provider, that is a primary care physician who will direct and monitor an individual’s medical treatment and make the necessary referrals for specialty services. Plans must have agreements with care coordinating providers within thirty miles or thirty minutes of their enrollee populations. The managed care entity cannot restrict a physician from providing information about plan policies in matters such as utilization review and quality assurance, nor information about what competing plans may offer. Recipients are free to join any plan that meets their particular needs, but once enrolled they may not switch to another Medicaid plan for one year.<sup>159</sup>

While the number of MCEs in Illinois is growing, the state lacks sufficient managed care plans to absorb over a million new Medicaid enrollees. Hence, the Mediplan Plus proposal calls for the development of a hybrid managed care entity, the Managed Care Community Network, which will be designed specifically for this population. The MCCN is a

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157. *Ibid.*, 142.260.

158. *Ibid.*, 142.230; 142.260.

159. *Ibid.*, 142.390(d).



type of risk bearing entity, but unlike a licensed HMO, its capitalization requirements are much lower.<sup>160</sup> While county governments may launch MCCNs, the Mediplan Plus scheme envisions that these entities will be created by hospitals that already sponsor Medicaid prepaid health plans or have a significant number of Medicaid patients. State regulations for MCCNs specify net worth requirements which must be met for initial and subsequent years of operation that are dependent on the size of population service areas. MCCNs which fall below required net worth amounts must either meet the state standard or freeze enrollments. Additionally MCCNs will need to establish a trust fund to pay for non-participating providers and, more significantly, to act as a safeguard in the event of bankruptcy or insolvency. A detailed set of regulations has been issued concerning the role of the Department of Public Aid in the event that a participating managed care plan goes bankrupt, including the transferral of management to the state agency. In view of prior financial problems in managed care and the uncertain financial viability of Medicaid-only managed care entities, the attention to bankruptcy protection is not unwarranted.<sup>161</sup>

Even with the creation of a new managed care entity (the MCCN) there is still a need for a more expansive managed care network. Indeed, as noted above, a special category of managed care providers was established for physicians and clinics in rural and inner city areas known as Enrolled Managed Care Providers (EMCP). An EMCP will most typically be a primary care physician who will both provide direct medical care services and also take on the role of managing the overall care of an enrollee across the spectrum of state sponsored health services. The EMCP will act as a system gatekeeper whose authorization will be required for most covered services. Unlike participating managed care entities, EMCPs will be paid on a fee-for-service basis for direct patient care, but they will be capitated for patient management services, with a limitation on their patient lists of 1500 individuals.<sup>162</sup>

A major concern of federal and state regulators alike is the potential marketing abuses which can occur as plans scramble to attract enrollees and increase capitation payment amounts, regardless of service capacities. The state of Illinois requires all participating providers in Mediplan Plus to develop an annual marketing plan which must be approved by state regulators. While the initial regulatory goal is to prevent misleading and fraudulent information about a particular plan, there is also a desire to insure that consumers have access to necessary information. Plans are

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160. *Ibid.*, 142.220(b).

161. *Ibid.*, 142.220(b)(4).

162. *Ibid.*, 142.500(b).

required to have interpreters who can explain plan policies and benefits to non-English speaking recipients. Financial inducements to enroll or disenroll from a plan are prohibited, but in some instances to generate interest in a particular managed care offering, inducements that relate to health care (i.e., health education, screening) may be allowed. Individuals who engage in marketing for participating managed care plans must clearly identify the plan they represent, be registered with the state Medicaid program, and be licensed in a fashion similar to insurance brokers.<sup>163</sup>

The structural changes to be instituted by Mediplan Plus should add order to a rather disjointed health care program and in the process improve individual and public health, but the state's primary motivation behind this scheme is cost control. The core of the cost control effort and the accompanying desire to more efficiently manage Medicaid expenditures rests on capitation. It is thus essential for capitated rates to be set low enough for the state to realize savings, yet sufficient to make the provision of comprehensive managed care to Medicaid recipients economically viable for the plans. There is also a danger that participating plans will maximize their capitation payments by pursuing policies of undertreatment. To insure viability and safeguard against abuses, Illinois regulators will need to develop capitation rates on an individual plan basis. The reimbursement rates will need to be actuarially sound and subject to periodic adjustment based upon individual MCE utilization profiles. If a particular plan has a high rate of justified utilization for more costly services, the state may need to raise its per-plan-per-member monthly rate, but leverage here is limited because state regulations have placed a ceiling on capitation amounts. Rates will also be affected by geography, as the state will calculate capitation on the basis of wage and population variations in five different regions.<sup>164</sup>

Each Mediplan Plus participating program will be required to have a quality assurance plan in place that ensures that the entity meets community quality standards as well as appropriate federal and state mandates. The quality activities are to be overseen by physician plan members, and a senior physician is to be assigned as the executive with primary responsibility for this area. Quality in the Mediplan Plus context entails developing and monitoring access standards, implementing an enrollee orientation program, developing a complaint log, checking the providers' credentials, implementing a state of the art medical record and manage-

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163. *Ibid.*, 142.255(f).

164. *Ibid.*, 142.505

ment information system and conducting peer reviews, quality of care assessments and utilization studies.<sup>165</sup>

A critical component of quality assurance for Mediplan Plus managed care entities will be health education and prevention activities. The managed care movement was founded on the basis of promoting good health, but with commercialization that goal has often been overlooked. It is particularly important for health programs serving the poor that enrollees have access to health education. The state requires that participating plans develop multimedia educational materials on common health matters such as nutrition, chemical dependency, weight control and smoking cessation, and further, that they have education coordinators responsible for these activities. In the area of prevention, managed care plans must follow state guidelines for developing specific services and must have the capacity to track whatever preventive services the state decides to require. In the wide range of mandated quality activities, education and prevention will present managed care plans with the greatest challenges, but these areas, perhaps more than capitation, hold the greatest promise for improving public health, and in turn, containing Medicaid expenditures.<sup>166</sup>

Once the state waiver was approved, the Illinois Department of Public Aid began the detailed process of implementing the Mediplan Plus program. Regulations for the program were issued in October of 1996, and a detailed protocol was submitted to the federal Health Care Financing Administration.<sup>167</sup> Under the waiver process, federal approval of the application is only the first stage of implementation; during both the implementation and operational phases of Mediplan Plus there will be ongoing federal oversight. In early 1997 the state issued a request to organizations and individuals to submit bids to become enrolled managed care providers. Those whose bids are accepted must then negotiate individual participation contracts with the state.<sup>168</sup> The federal regulators have expressed detailed concerns about Illinois Mediplan Plus, focusing on general inconsistencies in state policies and requesting additions and changes in almost every operational area of the program.<sup>169</sup> The U.S.

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165. *Ibid.*, 142.700.

166. *Ibid.*, 142.700(b)(5).

167. *Supra* note 151.

168. Illinois Mediplan Plus, *Request for Proposals for The Mediplan Plus Referral Agent* (1997).

169. Joel S. Truman, Project Officer, Department of Health and Human Services, U.S. Health Care Financing Administration, Letter to George Havanec concerning comments on the Illinois Department of Public Aid Operational Protocol (10 March 1997) (copy on file with author).

Health Care Financing Administration was very concerned with the state's timeline for implementation, and in view of all the changes required by the federal government, it may be well into 1998 before the Mediplan Plus program is operational in any manner.

Like any major reform initiative, Mediplan Plus will likely undergo more changes once it becomes operational. Under the 1997 Balanced Budget Amendments, the section 1115 waiver was altered to allow states greater flexibility in designing and operating managed care programs.<sup>170</sup> Even if federal oversight is relaxed, there are major questions to be answered about the economic viability of managed care plans devoted entirely to indigent patients. The abilities of managed care entities to create effective education and prevention programs for poor populations is very unclear. There are also doubts whether this scheme will attract a sufficient number of participating managed care plans to spark genuine competition in the Medicaid market. While Mediplan Plus introduces a large scale capitated scheme to Illinois Medicaid, forty percent of reimbursement falls into fee-for-service carve-out categories, rendering the managed care portion of the system far from comprehensive.<sup>171</sup> The potential for abuse is also great and the state regulator, the Illinois Department of Public Aid, will be taxed in trying to oversee and manage a program of this scope. There is a danger that if the state does not realize major savings in the early stages of Mediplan Plus, or any scaled-down managed care effort, Illinois will not retain a commitment to making this or any comprehensive managed care scheme work for long, but will begin to look for alternative approaches. The other reality that any state must deal with in Medicaid is the inevitability that both providers and recipients will mount legal challenges which will have the potential to alter specific program initiatives and even overall programmatic operations. On balance, Mediplan Plus is a bold effort but ultimately its success will

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170. With the passage of the Balanced Budget Amendment of 1997, the Director of the Illinois Department of Public Aid, the agency responsible for managing the Mediplan Plus and the federal waiver process, indicated that the state might decide to abandon the program; Judith Graham & Rick Pearson, "Illinois May Drop Plan for Big Medicaid Shift" *Chicago Tribune* (1 October 1997). The announcement triggered predictable political responses from the state Democratic leadership who indicated that they would hold the Republican state administration to its legislated obligations. It seems likely that Illinois will take advantage of the liberalized 1115 Medicaid waiver policies in the Balanced Budget Amendment, and will make changes in Mediplan Plus, but politically it does not seem feasible for the program to be dropped. What is likely to be altered is the notion of a statewide program; it will probably be replaced by managed care programs primarily in inner city areas. See P.L. 105-33, s. 4757, to be codified at 42 U.S.C. s.1315.

171. "Illinois HMOS Say Profits May Suffer Under Mediplan Plus Carve-Out Proposal" (1997) 3 BNA Managed Care Reporter 448-449.

rest on whether it can better serve the health needs of a large and vulnerable population and at the same time attract the support of a skeptical provider community.

### *Conclusion*

There are few nations in the world that have more commonalities than Canada and the United States, but in the area of government-sponsored health care it is hard to imagine that the two countries share the same continent. The differences between the Canadian and American health systems are striking and fundamental, ranging from divergent views about the nature of health itself, to the roles of government in this enterprise, and the nature of effective health care delivery programs.<sup>172</sup> In Canada, economic concerns have spurred a broad reexamination of how provincial health plans can continue to meet their mandates in light of fiscal realities. While change is the order of the day across the spectrum of Canadian health care, there is a continuing commitment, evidenced by the reports of the National Forum on Health and the provincial health ministers, to adaptation within the current structure and to retention of the fundamental principles of a government-sponsored, comprehensive health care system. The United States, by contrast, has moved away from the notion of a universal health program and is relying on the managed care market to bring about access, order and efficiency. Federal budgetary pressures, sparked in part by uncontrolled growth in American Medicare and Medicaid, have led U.S. policy makers to endorse managed care as the best strategy to control and rationalize these programs. While the American public is concerned about health care insurance coverage, the all-important middle class has not expressed a desire for broad-based reform, and public interest in Medicare and Medicaid remains specific to individual needs. There is now a strong backlash against managed care in the United States that is fuelled by a growing consumer movement. But that reaction is not a response to health policy, rather it is the expression of concerns over the disruption that the new managed care schemes cause to traditional relationships within the medical system.<sup>173</sup>

While it is easy to dwell on differences between Canada and the United States, a careful examination of health care systems in the two countries

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172. Nova Scotia, House of Legislative Assembly, *Debates* (4 January 1996) at 571-574.

173. Thomas Bodenheimer, "HMO Backlash—Righteous or Reactionary" (1996) 335 *New Eng. J. Med.* 1601-4.

reveals commonalities in the broad issues that both face. The overriding reality for Canadian and American health care is the need to confront fiscal problems; both governments must find effective ways to contain costs if their respective public health care programs are to survive. Government-sponsored health care has forced the two nations to meet broad and increasingly costly mandates, yet reform efforts of any sort are difficult because they must be developed in highly politicized environments. While the Canadian system is comprehensive, economic pressures have led to considerations of delisting services and questions loom about the future scope of coverage. Similarly in the United States, high cost procedures covered under the Medicare and Medicaid programs are coming under increasing scrutiny and there has been a strong move to mandate lower priced outpatient treatment. In the case of one U.S. jurisdiction, Oregon, cost concerns led state regulators to adopt a highly controversial program of rationing for its Medicaid program.<sup>174</sup>

In both Canada and the United States the economic disparities across jurisdictions have made the goal of national uniformity in government-sponsored health programs challenging to attain. Both countries have experienced strains in intergovernmental relationships between federal and provincial/state governments over health care. In Canada provincial governments clearly have far more control over their respective health plans than has been the case in the American Medicaid program, but in both countries the roles of the different levels of government are not settled and mistrust and politics cloud these relationships. Ottawa clings to the notion that it can enforce the dictates of the *Canada Health Act*, but with the reduction of cash transfers and the tensions in the Canadian federation itself, that may not be easily accomplished.<sup>175</sup> Washington has a federal health bureaucracy in place that has little respect for the abilities of state governments to reform effectively their Medicaid programs without extensive federal oversight, and the newly granted leverage given states under the *Balanced Budget Act* of 1997 may be very short-lived. The notion of converting the federal side of the Medicaid program into a block grant was raised in 1996, as part of the American version of health care devolution, but proved unworkable as a result of Congressional bickering about how particular states' grant funding formulas should be calculated.

In both countries there is uncertainty about the future roles of physicians. In Canada, there is an increased focus on community health

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174. Thomas Bodenheimer, "The Oregon Health Plan Lessons for the Nation" (1997) 337 New Eng. J. Med. 651.

175. Campbell, *supra* note 18.

services, and a concerted effort to move health care outside of physician-dominated tertiary-care centres. Provincial health reform strategies are clearly motivated by a desire to reduce the power of organized medicine over health policy. In the United States, there is a growing reliance on primary care physicians who act as the gatekeepers in managed care plans, but there are shortages of primary care physicians and plans to convert current specialists into general medical practitioners are not well developed. While there is no concerted American effort to break the stronghold of medicine over health policy, the growth of managed care, fuelled by large purchasers, has clearly eroded the power of medical lobbies. They are now engaged in a desperate attempt to recover their authority. In both countries there are increasing consumer demands for the latest innovative medical treatment and a resultant growth of entrepreneurial physicians who for the right fee will satisfy public demands.

For the United States there are lessons in the Canadian experience. First and foremost, there is a need to develop a viable, long-term set of goals concerning the future directions of American health care. While the Canadian system is in a phase of adaptation and reform, even amid change there is a fundamental commitment to a role for government in health and an ongoing attempt to define what the nature of Canadian health care should be. Although the United States runs two giant, publicly controlled health systems, it has never come to terms with what the long range goals of either the Medicare or Medicaid systems should be. Rhetoric about quality, access and efficiency is scattered across the American health policy landscape, but core concepts of health and public health are elusive and tend to be dominated by economic considerations. It may be naive to think that the mere articulation of goals will transform a health system but clearly some sense of direction is needed to avoid the constant and rapid process of reinvention that characterizes U.S. health care. What would be particularly helpful in the American situation would be the development of mechanisms to better link the medical treatment model with the public health needs of the population.

Although the structures being spawned by the U.S. move to managed care may have many potential benefits in terms of economics, access and continuity of health care, the success of this new paradigm depends upon the viability of choice and the strength of competitive health care markets. While the marketplace has been the focal point of American innovation and productivity, it is an untested forum for health care and clearly its orientation to efficiency is not motivated by a sense of equity and access. Even if competitive health markets do produce economic efficiencies and spark competition on the basis of quality for private sector plans, it is not clear that similar results can be produced for Medicaid managed care.

Unquestionably, local markets driven by managed care have already experienced dramatic alterations in local health systems, but the long-term implications of these alterations for the population are not at all clear. In particular, there are uncertainties about whether the realignments of health markets have had any positive benefits for disenfranchised populations. At some point U.S. regulators may need to take a more direct approach to health care markets and use their regulatory power to mandate a more rationalized system, as is being done in Canada, to ensure access to medical care, particularly for low-income individuals and families.

For Canada, as its provinces struggle with reconfiguring their health systems, the American experiences in managed care should be helpful. In particular, the use of risk-adjusted capitation linked to defined health care outcomes could result in more judicious use of physician services, and as such it could become a tool to better manage medical services insurance programs. Capitation, however, is a work in progress and there are now capitated programs in the United States which are focusing on specialists as opposed to primary care doctors.<sup>176</sup> Indeed, there are numerous capitation structures being experimented with in the United States. Those being developed in the American Medicare and Medicaid programs are particularly relevant to Canadian Medicare, if for no other reason than to illustrate the range of possibilities in the area.

While a regulatory approach used by Canadian health plans maybe an effective way to rationalize the health system and bring about cost savings, provincial departments of health should consider giving individual and institutional providers leeway to devise creative treatment models that are not government initiated. In particular, governments may want to allow experiments with direct contract arrangements between government, private insurers and physicians and hospital groups, testing various approaches to risk transference and capitation. Underpinning the American experience in publicly sponsored managed care is a willingness on the part of government to transfer programmatic operations to the private sector, most recently to for-profit managed care programs. While for-profit health care is a difficult proposition in the Canadian context, use of private sector managed care vehicles should not be rejected by provincial governments on philosophical grounds. Their potential to control costs should be carefully considered. As more services fall outside the ambit of provincial plans, policy makers may want to consider allowing various managed care options for these uncovered services, and

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176. "New Physician Payment Schemes Replacing Old HMO Methods" (1997) 8 Physician Manager 4.



if those options are successful, they could be incorporated into provincial Medicare programs and possibly expanded to cover core services.

Moving to the regional government level, there are also several mutual lessons that can be learned from consideration of the Nova Scotia and Illinois experiences. There is an old adage that programs for the poor are poor programs, and while Illinois is locked into a federal/ state Medicaid structure, it should consider that adage in its Medicaid planning. The Mediplan Plus program is an innovative experiment, but if its reimbursement rates are too low, it will not attract the necessary participation of private sector managed care. Without private sector involvement, Mediplan Plus will become a network of hybrid managed care plans that will function outside the context of broader health care markets. In such a scenario, competition and resultant savings among Medicaid managed care plans is unlikely. Illinois needs to take a broader look at its entire health system and devise a service delivery strategy which is more comprehensive than the creation of a program for one segment of the population. While it is unlikely that the state could devise a strategy as sweeping as Nova Scotia's health reform, if Medicaid is ever to develop a more stable future it will need to be better integrated into the state's general health system. Illinois regulators cannot rely exclusively on untested markets, but will need to intervene more directly to ensure equal access to all of the state's medical programs for its low-income residents. The state should craft a detailed strategy for public health services, particularly for the Medicaid population whose health problems frequently stem from social, environmental and educational needs. Finally Illinois needs to have a mechanism to allow for citizen input into the creation of new health programs. Devolution in Illinois along Nova Scotia lines may not work, but large public efforts like Mediplan Plus need to have a better connection to recipients, and not be totally dominated by politicians and bureaucrats whose interests are exclusively driven by cost and political considerations. For a program as detailed and complex as Mediplan Plus, the lack of public input and discourse surrounding its development and implementation is troubling.

In the case of Nova Scotia, considerable progress has been made toward restructuring its health system through downsizing and devolution. If progress is to continue, provincial policy makers will need to allow Regional Health Boards freedom to initiate new and innovative delivery models. In that regard the Nova Scotia Department of Health and Regional Health Boards ought to consider various aspects of U.S. managed care, and attempts to create comprehensive regional health plans should be encouraged. Managed care, viewed as a comprehensive system of health delivery that unites ambulatory and inpatient services

with health education and prevention, is compatible with the goals of Nova Scotia Medicare. In particular, structural details of a public program such as Illinois Mediplan Plus could provide helpful insights to Nova Scotia health policy makers, especially the Managed Care Community Network model. More specifically, Nova Scotia could benefit from considering how Illinois and other American public health insurance programs are dealing with the capitation issue, since the nuances of policy in this area are yet to be formulated by the province and creating appropriate incentives in capitation is a difficult process.

Canada and the United States, and their respective subparts, are studies in contrast and similarities. There are undoubtedly a host of factors that strain efforts at comparison. Still the problems facing health care systems in North America, such as cost containment, access and quality, are universal issues for national and regional governments. Neither Canada nor the United States has a monopoly on creativity or commitment to their respective health systems. It is necessary to look for guidance in different approaches to health care problems and to show a willingness to adapt innovations, recognizing that sound strategies in the face of complex dilemmas deserve to move across borders.