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VIEWPOINT

Medicaid Block Grants and Federalism
Lessons From Canada

Benjamin D. Sommers, MD, PhD
Department of Health Policy and Management, Harvard School of Public Health, Boston, Massachusetts; and Division of General Medicine and Primary Care, Brigham and Women's Hospital, Boston, Massachusetts

C. David Naylor, MD, DPhil
Department of Medicine and Institute for Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, Canada.

Medicaid at the Crossroads

Medicaid, the US insurance program for millions of low-income children and adults, has operated for 50 years under a joint state-federal financing system. In exchange for federal funding that covers roughly 50% to 75% of Medicaid program costs depending on the state (the so-called match rate), states agree to administer the program within broad federal guidelines. The Affordable Care Act (ACA) took this combination of federal subsidies and oversight a step further by offering 100% federal funding for those newly eligible under the law's Medicaid expansion through 2016 (with federal funding now at 95% and ultimately declining to 90%). So far, 31 states have opted into the ACA's Medicaid expansion, extending coverage to millions and, through heightened public awareness and a streamlined application process, drawing in millions more who were previously eligible. However, Republican leaders are proposing a fundamental reform in Medicaid financing—a shift to block grants.[1] Instead of a matching subsidy and federal oversight, block grants would give states an annual lump sum with minimal conditions attached.

Block granting for social and health programs has been used with varying levels of success in welfare reform and in a modified version for the Children's Health Insurance Program (CHIP), which provides federal matching funds up to a specified cap. But for such a large state-federal health insurance program, perhaps the most useful precedent is Canada, which made a similar shift to block grants several decades ago.

Canada's Block Grant Experience

Canada's health insurance system has been a joint federal-provincial initiative since the 1950s. Individual provinces enacted single-payer systems for hospital care and medical services between 1947 and 1962. The federal government implemented a 50% subsidy to support provinces' universal coverage policies for hospital care in 1957 and extended this approach to physician services in 1968.[2]

Costs of hospital and physician services escalated steadily across Canada in the 1970s. By that time, most provinces had extended public insurance to prescription drugs for low-income and elderly residents, partial coverage for home care and long-term care, and a mix of other services. Facing low economic growth and rising deficits, the federal government first capped the growth rate in its share of spending and then retreated from a match rate altogether. By 1977, block grants had been implemented. In doing so, the federal government agreed to give provinces an increased share of income tax revenues from their residents. Since then, 2 central issues in the current US debate—restraining the federal cost of Medicaid and giving states more control—have played out in Canada.

The primary long-term effects have been a downsizing of federal spending on health care and increasing strain on provincial budgets. The federal government reduced its spending in 2 ways. First, ending the 50% match uncoupled federal commitments from growth in health care spending; more specifically, the government capped the annual growth rate for the grants starting in 1986, sometimes freezing the growth rate entirely and other times setting it at 2% to 3% *below* per capita GDP growth. Second, one-time cuts to the block grants were made, amounting to 5% in 1982-1983, followed by a 30% reduction in health and social block grants in the mid-1990s. Overall, the proportion of provincial health spending derived from federal transfers declined from approximately 30% in the late 1970s to less than 15% by the mid-1990s.[3,4]

Pushback from the provinces has resulted in some gains in recent decades. Once the economy recovered in the late 1990s, several short-term increases in the block grants were negotiated with earmarks for elements such as primary care reform, improved home care, and reduction of surgical waiting lists. In 2004, the Liberal federal government committed to a sizable increase in the annual growth rate to 6%. A Conservative government took office in 2006 and initially sustained that rate, but later announced that the annual growth rate would decrease in 2017 to either 3% or the per capita GDP growth rate, whichever was higher. When the Liberal party regained power in late 2015, it adopted the same position, albeit softened by modest one-time earmarks for home care and mental health.

Lessons for the United States

Block granting of social programs is not inherently good or bad. Rather, it is a policy associated with specific economic and political trade-offs. Increased local control and predictability for the federal budget come at the risk of increased cost-shifting to states or provinces. That, indeed, is the Canadian experience. Once block funding was initiated in 1977, health care funding became a line item in the federal budget that could be arbitrarily cut or capped for fiscal or political reasons, as opposed to a level of spending pegged to the needs and health care use of the population. Importantly, these cuts occurred under both conservative and liberal federal governments. The federal share of provincial spending today remains substantially lower than in the 1970s.

Given that the primary block grant proposal before Congress already declares its intent to reduce federal Medicaid spending over time fairly substantially,[5]

Corresponding Author: Benjamin D. Sommers, MD, PhD, Harvard School of Public Health, Department of Health Policy and Management, 677 Huntington Ave, Kresge 406, Boston, MA 02115 (bsommers@hsph.harvard.edu).

a similar fate would seem assured if the United States follows suit. Many states, including some led by Republican governors, have voiced their concerns about the potential for a precipitous decrease in federal spending on Medicaid.[6]

In Canada, the retreat from a subsidized match rate system was originally driven in part by concerns that the match rate only applied to physician and inpatient care. Provinces correctly perceived that the effects of federal matching would erode over time as spending increased in other areas of health care. A switch to block grants would allow them to argue for more federal money based on growth in total health care expenditures. But, in reality, the early constraints on block grants were so intense that the provinces never regained the federal subsidy they would have received had the 50% match rate limited to physician and inpatient care simply continued.

For US states, there is no such trade-off: Medicaid already has an extremely generous benefit package, covering inpatient and outpatient services, prescription drugs, physical therapy, home-based services, and long-term care (depending on a person's enrollment category). Because the federal match rate already provides a wide-ranging subsidy, the likely trajectory is clear: reduced funding and fewer federal requirements leading to state-level constraints on coverage.

Another important lesson is that there is little evidence that the alleged advantages of block grants have materialized in Canada. Advocates argue that with greater flexibility and proper incentives, states can reduce costs by improving the efficiency of care.[1] In Canada, however, the provinces' primary means of coping with budget pressures under block grants has been to reduce funding to hospitals and bargain harder with provincial medical associations. Ironically, then, if this scenario plays out in the United States, it would exacerbate one of the chief Republican criticisms of Medicaid—that it pays clinicians such low rates that they have reduced incentives to care for low-income patients.[1] In Canada, the effect of low payment rates to clinicians on care of low-income patients is blunted because federal and provincial legislation has effectively banned private insurance for publicly insured services; hospitals and clinicians accordingly have no choice but to participate. The situation is far more precarious in Medicaid precisely because the US market is segmented with multiple private payers. Facing steep payment cuts, many US physicians and hospitals would likely stop providing care for Medicaid patients entirely. Another likely scenario in the United States is that a block grant system would simply lead many states to restrict eligibility for Medicaid, leaving millions of low-income adults and children newly uninsured.[7]

In conclusion, the Canadian experience suggests that a block grant policy for Medicaid is most likely to succeed in only one aspect—reducing federal spending on the program. It would do so by shifting costs to states and forcing untenable trade-offs that would limit access to care for low-income US residents. Although Canada has often been seen as a panacea for US liberals desiring a single-payer approach to health insurance, perhaps the most useful lesson from north of the border for the current policy debate is a demonstration of how a conservative policy model—block grants—may be a risk not worth taking.

ARTICLE INFORMATION

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