

# Virtual Mentor

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## POLICY FORUM

### Oregon's Experiment with Prioritizing Public Health Care Services

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On May 2, 1990, Oregonians woke up to the headline, “State to Unveil Health Care Priorities for the Poor.” And so began the public phase of the great health care rationing debate [1]. Rationing is a problematic concept in medical ethics; it’s also a reality in the lives of many Americans. And that is why the Oregon Health Plan (OHP) has become a perennial in the world of health care reform controversies. That morning in 1990, many Oregonians got their first look at a priorities list of about 2,000 procedures, also known as the “first list” (or later as “the first list, quickly dumped” [2]). Other lists followed. The state was attempting to decide which procedures its Medicaid program should cover. To most people, that spelled rationing. The most current list is *Prioritization of Health Services, a Report to the Governor and the 75th Oregon Legislative Assembly* [3]. The health services commission refers proudly to it as “the world’s first prioritized list of health services” [4]. A history of the health plan is also on the state’s web site, and is a good introduction to the subject [5].

The importance of the list in the annals of American health policy is that Oregon tried to develop a transparent process for prioritizing medical services through its laws and regulations. That’s the real impact. Rather than relying on undisclosed private decisions by individuals or insurers, Oregon developed a public process. A look back at the impetus for the state’s rationing experiment is helpful.

In 1987, Coby Howard’s case shocked the state. He was a 7-year-old boy on Medicaid who needed a bone marrow transplant, which was no longer covered under the state’s Medicaid plans. The news reports of the boy’s illness and death in December of that year drove home the reality of the legislature’s ongoing debate over what could be done when a needed procedure was denied [6, 7]. As one policy scholar has described it, these debates raised “unanswerable questions of equity” and inequity [8]. Then-governor Neil Goldschmidt initiated a workgroup to reform the state’s Medicaid system. Coby’s illness was also one of the factors that spurred John Kitzhaber—a former ER physician and a state legislator—to act [9].

In the legislature’s deliberations in 1987-1990, rather than championing transplants, then-state senator Kitzhaber argued persuasively that thousands of low-income Oregonians lacked access to even basic health services, much less access to transplants. It was the genesis of an idea to expand basic health care coverage within the state to as many needy people as possible [10]. Kitzhaber later became governor (1995-2003; 2010-present).

The workgroup that was formed came up with several guiding principles that led to the list, among them the following:

- Access to a basic level of care must be universal;
- Society is responsible for financing care for poor people;
- A “basic” level of care must be defined through a public process [11].

As originally envisioned, the health plan (Oregon Medicaid Priority-Setting Project) work group wanted the state’s citizens to have “universal access to a basic level of care” [11]. A panel of experts, the Health Services Commission, was to develop the prioritized list of covered items, and it would be the legislature that would have to “draw the line” at covered and uncovered services [9].

How does it work? The state’s regulations explain how physicians and others should work with the list:

The Prioritized List of Health Services determines which services the OHP may cover. Once a patient’s condition has been diagnosed, providers must use the list to find out whether the condition and treatment fall between Line 1 and the currently funded line number [12].

The Health Services Commission has eleven people on it: five physicians (four MDs and one DO), four consumer members, a public health nurse, and a social worker. Many others worked on the list too. Complex cost-benefit formulae were brought to bear, including an early form of QALYs (quality-adjusted life years), referred to in current documents as Healthy Life Years [13].

The initial list, based on a methodology of cost-benefit analysis yielded some peculiarities, such as possibly covering tooth caps, but not surgery for emergent appendicitis [14]; so techniques that incorporated net-cost components were later used to refine the list, and a set of overarching categories derived from the workgroup’s guiding principles ruled the decision-making process [15]. Analytical approaches to prioritizing health services proved necessary but insufficient for determining covered treatments in the charged political atmosphere, as well as in the judgment of the Health Services Commission, so the commission used its authority to alter or to “move by hand” the procedures or treatments that seemed to be obvious, common-sense priorities based on the commissioners’ judgment, and, in this way, most problems were ironed out. A biennial review of the list was instituted [13].

At the outset, federal waivers were needed to allow a state Medicaid program to operate in such a fashion. The rationing debate shifted to Washington in 1990, and Congress took up the question of whether to allow Oregon to proceed with this kind of extensive Medicaid demonstration project, via congressionally granted waivers. Al Gore contributed an article to *Academic Medicine* titled “Oregon’s Bold Mistake.” Oregon’s Senators, Ron Wyden, a Democrat, and Robert Packer, a

Republican, both favored the plan and helped. In the end, federal waivers were approved and have been periodically altered or renewed.

Throughout its 20 years of use, “the line” between covered and uncovered services moved many times, (as documented in the “Historical Overview” of the list online) when the legislature saw fit, based on recommendations from the Health Services Commission and budget constraints. In 1995, for instance, the line was moved up 27 spaces to line 581 out of 745 total procedures, with the concomitant reduction in coverage.

As an example of the commission’s work to balance competing claims, the highest-priority categories 1 through 6 currently encompass things like the “birth of a child and maternal care” (category 1); “preventive care;” and “life-threatening diseases,” each with many line items in the category, whereas lower-ranked categories include nonfatal, self-limiting, elective, or inconsequential conditions and interventions [15]. This list reinforces the traditional Medicaid priorities of guaranteeing care for mothers and children.

Under Oregon’s model, many people who had been doing without health care could now get basic services. It was hailed by some for this achievement. But others said the real keys to its success were not the list, but a cigarette tax that helped to fund it and the use of managed-care techniques for almost all the recipients, which may have controlled costs [16].

Studying Oregon’s health plan at a Brookings conference in 1992, ethicists split on the consequences of rationing. Some, such as Henry J. Aaron of the Brookings Institution, supported the ideals and encouraged the openness of the experiment. But he cautioned about the likely negative public reaction. Robert Veatch worried that the physician-dominated Health Services Commission would err on the side of strict utilitarianism. Norman Daniels pointed out serious justice issues. Sara Rosenbaum of the Children’s Defense Fund aimed sharp criticism at the plan’s treatment of women and children [17]. A doctor and ethicist, John La Puma (of New York) wrote, “As a practicing internist and clinical ethicist, I would simply like to add some practical medical limitations of the Oregon Plan’s methodology.” He pointed out that the plan would ratify “a new financial ethos in medical care.” and that “the physician should not be placed in the position of defending a public policy that is more interested in saving money than in providing medically necessary services” [18].

What about fairness? Some procedures under the state’s old Medicaid program were covered while others, such as substance abuse programs and, as Coby’s case so emotionally showed, organ transplants, were not. There had never been “universal” coverage of all procedures under Medicaid. The Oregon plan represented a shift from one kind of rationing to another; it shifted responsibility from obscure Medicaid bureaucrats squarely to the shoulders of the state legislators. When the next life-or-death case came around, legislators would be held accountable for not covering specific diseases or treatments.

It was clear that initially (1990), some who already had Medicaid would have to sacrifice some benefits, and, while many low-income citizens would gain coverage, others might lose some coverage [19]. Successive administrations pushed for more health reforms to iron out these disparities and searched for more funding. Governor Barbara K. Roberts (1991-1995) advocated a state sales tax for health care. This proved unpopular with voters [20], who denied her a second term. In 1995, Kitzhaber was elected governor, with health reform as part of his mandate. After his 8-year tenure ended, in 2004, new governor Ted Kulongoski launched a “Future of the OHP” workgroup, to make recommendations on sustainability for the health care budget. In 2007, he signed the Healthy Oregon Act, a roadmap for reform, to cover children and the uninsured—still about 615,000 Oregonians, a frustratingly high number [21].

When an economic downturn hit the Pacific Northwest in the early 2000s, it tested the health system severely. Health policy makers had hoped to include more people. Yet, instead of expanding to cover the “next Coby,” legislators realized they might be making “more Cobys” by covering fewer services. They hoped to reduce coverage but still expand the number of people covered for a minimum or basic level of health care. Ultimately cuts were made, but, in a bow to conservative principles of personal responsibility, co-pays were instituted and, mainly, premiums were charged or raised. This was the price in changing political times for funding from the state legislature and the federal government.

## **OHP 2**

This second phase of the Oregon Health Plan, OHP2 for short, began in 2003. The program divided the plan into two: OHP Plus for those who would have been automatically Medicare eligible, and OHP Standard for those “expansion” populations not generally covered under traditional programs. Uninsured individuals and families who relied on state Medicaid were given a choice of reenrolling, and many chose not to. Enrollments dropped steeply, crashing from 104,000 in 2002 to 49,000 in the “Medicaid expansion program,” which aimed to cover the poorest. Rather than share the cost, people were willing to do without health care at all. Few policymakers were expecting this result. They did not realize how price-sensitive purchasing health care could be for a family living close to the bone. Or how many families would choose to go without and spend their money on other needs or wants. All told, by 2007 the OHP had lost 75 percent of its enrollment [22]. It was time for new reforms.

Oregon’s plan had changed significantly from inception to practice, reducing the scope from covering all low-income Oregonians to only those at or near the federal poverty line and dividing those in the plan into two groups. It is likely that those who conceived of the plan did not anticipate how readily future legislators would cut back on services during a budget crunch.

Prior to his comeback campaign for governor in 2010, Kitzhaber’s health policy group, Archimedes Movement, articulated its ongoing concern about fair resource

allocation: “All medical interventions are not of equal value and effectiveness in producing health, and therefore a prioritization process must be established to decide what will be financed with the public resources” [23]. Now back in the governor’s office, he says “the main goal is not to ration people, but to change the way care is organized and delivered to reduce costs” [24].

That goal of universal coverage at a basic level, though elusive for Oregon, is certainly consistent with the current push for health reform in the Affordable Care Act of 2010 and with the ethically oriented ideals expressed worldwide in aspirational ethics codes such as the UN’s basic human rights statements [25, 26]. Can rationing be a bridge to such an ideal future?

In a free society, news coverage will focus on rationing decisions because of the human drama. In Oregon, media certainly played a role in forming public opinion, perhaps prolonging the superheated rhetoric. For this reason alone, one group of health scholars actually advocated physician-based bedside rationing, rather than public rationing in the U.S., with its acrimonious debate in the news and in state assemblies [27]. Oregon continues to evaluate health reform ideas at a trendsetting pace. The true test of a statewide policy’s success in politics is perhaps more practical: can it be sustained through the economic and political ups and downs of the years?

Though it may not be the purest example of rationing, Oregon with its list is still the bellwether for the U.S. on the problem of prioritization of health care services, and it deserves further attention. As far as we know, no other states have adopted the list. In health care, the state motto applies: “Alis propriis volat.” She flies with her own wings.

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