
State Model: Oregon

The Ups And Downs Of Oregon's Rationing Plan

by Daniel M. Fox and Howard M. Leichter

In *Health Affairs*, Summer 1991, we reported on a plan in Oregon (SB 27) to limit, or ration, health care services to the state's Medicaid population in order to extend some basic level of care to all citizens who fell below the federal poverty level. At that time approximately 120,000 Oregonians had incomes below poverty but were ineligible for Medicaid under current state eligibility rules. We concluded our earlier account by noting that two tasks remained before the state could implement this innovative and highly controversial plan. The first was for the state's Health Services Commission (HSC) to establish a comprehensive list of conditions and treatments and for the legislature to fund as many of those as professional judgment, community sentiment, and state resources would allow. The second was to secure federal Medicaid waivers to implement the project.

Two years ago we identified some political factors within the state that "complicated" the implementation of the plan. It seemed to us, however, that securing the federal waiver was the most formidable task. But with the waiver finally secured in March 1993, the political equation has changed, and circumstances within the state have taken on a more significant, negative role.

Oregon's 'Reform Demonstration'

On 19 March 1993 the Clinton administration approved the "Oregon Reform

Demonstration" for a period of five years beginning 1 April 1993, waiving various Medicaid requirements. The state received permission to (1) establish a basic package of health services for all people up to 100 percent of the federal poverty level, based upon a prioritized list of condition/treatment pairs; (2) simplify participation in the program by basing eligibility solely on gross family income, rather than such factors as age, gender, or marital status; (3) restrict freedom-of-choice of providers so that the state may take advantage of the cost savings associated with prepaid managed care delivery; (4) allow reimbursements to managed care providers to exceed standard Medicaid rates—which are deemed too low—to encourage physician participation in the plan; (5) maintain existing Medicaid programs for the aged, blind, and disabled, as well as for people receiving care in mental health and chemical dependency programs, until these populations can be integrated into the new plan (currently proposed for 1 January 1995); (6) deliver health care in the Federally Qualified Community Health Center (FQHC) and Rural Health Clinic (RHC) programs through managed care providers, and at reimbursement rates that are higher than Medicaid's rates; and (7) drop any services normally provided in Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) children's program that have been deemed ineffective by the Oregon HSC.

On 19 August 1991 Oregon requested that the federal government waive certain Medicaid laws so that it could implement a demonstration project built around the principle of universal access to a basic pack-

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age of health care services for the poor. State officials could pursue two routes: convince officials in the Department of Health and Human Services (HHS) to grant the waiver, or get legislative authorization for the waiver. In 1989 the Senate Finance Committee, on which Sen. Bob Packwood (R-OR) is the ranking Republican, voted to grant a waiver.¹ However, it was dropped from the budget bill by the Senate Budget Committee.² State officials then gave priority to securing an administrative waiver. They were encouraged in this effort by what they interpreted as support from Gail Wilensky, then Health Care Financing Administration (HCFA) administrator and soon a White House policy adviser.³

The plan drew more attention in April 1992, when the Congressional Office of Technology Assessment (OTA) reported that for those who were ineligible for Medicaid in Oregon the "implications of the new eligibility and coverage rules [under SB 27] are unambiguously good." The OTA concluded that current Medicaid beneficiaries "would both gain and Lose something under the proposed plan." The OTA also had reservations about the "lack of any minimum level below which benefits may not fall."⁴ By late April state officials, and Wilensky herself, were predicting that a decision from the Bush administration was imminent.

But opponents now became more vocal. Rep. Henry Waxman (D-CA), for example, wrote to HHS Secretary Louis Sullivan that he found "offensive . . . a government rationing proposal that affects only low income families."⁵ Groups in the state that had initially opposed the plan, including the Oregon Catholic Conference, Oregon Fair Share, and the Oregon Human Rights Coalition, renewed their criticism.

The White House, especially Wilensky, now criticized the plan. In June 1992 the Office of Management and Budget (OMB) announced that no decision was imminent. Observers in the state and the national media attributed the delays and Wilensky's backpedaling to Bush administration reluctance to endorse a "rationing" plan during a presidential campaign.

The Americans with Disabilities Act

(ADA) of 1990 presented an unexpected new obstacle. In late July 1992 twenty national organizations representing persons with disabilities publicly urged President Bush to reject the waiver request because the Oregon plan violated the ADA. On 3 August Secretary Sullivan informed Oregon Governor Barbara Roberts that he would not grant the waiver because the state's plan was in conflict with the ADA. In particular, the statewide telephone survey in which Oregonians rated various health situations with regard to their impact on a person's quality of life was "based in substantial part on the premise that the value of life of a person with a disability is less than the value of life of a person without a disability."⁶ According to informed sources, the decision had actually been made in the White House, under the strong influence of C. Boyden Gray, the president's counsel and an ally of interest groups on behalf of disability rights.

The secretary's decision enraged the plan's supporters. Oregon State Senator John Kitzhaber called it a "disgusting performance," and Senator Packwood declared that "we have been betrayed."⁷ Defenders of the plan reminded critics that Oregonians were surveyed about the impact of various health conditions on their own quality of life, not that of others.

Sullivan had, however, "urge[d] Oregon to submit a revised application which addresses these [ADA] concerns."⁸ This message was reinforced by HHS officials; at the end of August they told commission members that if references to "quality of life" were taken from the prioritization process "you have a very high likelihood of approval."⁹

State officials decided to prepare a revised list immediately, rather than awaiting the outcome of the 1992 presidential election. In their new waiver request, submitted ten days after Bill Clinton was elected, the HSC made three major changes to the prioritization process and subsequent list: (1) It eliminated the survey results and judgments about quality of life from the new prioritization; (2) it shortened the list from 709 to 699 condition/treatment pairs; and (3) it placed greater weight on the judgment of the commissioners in assigning ranks.

Clinton Takes Over

The day before Bill Clinton's inauguration, a Bush political appointee in the Justice Department wrote to HHS that the revised plan continued to have "features that violate ADA."¹⁰ This parting shot, soon leaked to disability rights advocates, became a source of new attacks on the Oregon plan.

The HSC accorded highest priority to treatments that would "return the patient to an asymptomatic state of health" after saving his or her life. Justice charged that the designation "asymptomatic" denigrated the quality of life of persons with disabilities.¹¹ Symptom, as defined by Oregon, was apparently another term for *disability*.

The memorandum from the Justice Department amplified the initial HHS rejection that able-bodied citizens tend to devalue the lives of the disabled. Infertility services had low ranking because "they are not highly valued by Oregonians," the HSC wrote. But infertility, Justice said, was a "disability within the meaning of the ADA."

Meanwhile, Oregon officials believed that President Clinton would be more sympathetic to their request. Candidate Clinton had endorsed the plan in May 1992 and again in the second presidential debate in October. When members of the Oregon congressional delegation, including Rep. Ron Wyden (D), Packwood, and Sen. Mark Hatfield (R), met in late January with Donna Shalala, the new secretary of health and human services, she was well informed, generally sympathetic, but noncommittal.

Senator Hatfield forced the administration's hand, after Oregon leaders told him that a waiver decision was needed quickly so that the legislature could fund the plan in the 1993-1995 state budget. Hatfield announced in mid-February that unless the administration made a prompt decision on the waiver, he would attach an amendment to a National Institutes of Health (NIH) authorization bill stipulating that if the waiver decision was not made by 19 March 1993, it would automatically be deemed approved. On 17 February 1993 Shalala told Hatfield that she agreed to the deadline.

In mid-February Hatfield and state offi-

cial learned of the 19 January Justice Department memorandum. The Clinton administration may have wanted to ignore the objections raised by Bush's Justice Department, but disability advocates obtained and leaked to the press a copy of the memorandum. Intense consultations then occurred between HHS and state officials. On 12 March, one week before the decision deadline, a group that included Secretary Shalala's chief of staff, head of intergovernmental relations, and two HHS attorneys made an unpublicized trip to Salem, Oregon. In a day-long session with the governor's staff (and, briefly, Governor Roberts), the Oregon Department of Human Services, and the HSC, these officials tried to reach agreement on changes in the waiver request.

State officials believed that HHS was "looking for a way to make this thing work," despite their concern about political embarrassment from legal challenges to the list and the methodology upon which it was based.¹² State negotiators shared this concern, but they were reluctant to make more pragmatic adjustments on the list of priorities.¹³ In addition, state officials worried that the HSC commissioners would rebel at yet another request for revision.

The HHS negotiators tried to address the 19 January memorandum by urging that the priority accorded to achieving "asymptomatic" status be replaced by the commissioners' judgment of "medical effectiveness." In addition, the HHS officials wanted the state to modify the low ranking of infertility. Two days later the state negotiators reported that the HSC had agreed to change the methodology and revise the list as a condition for obtaining the waiver.

State and federal officials immediately began negotiations on proposed terms and conditions to accompany the waiver. Simultaneously, seventy advocacy groups urged President Clinton to reject the Oregon plan. Newspapers reported that Vice-President Al Gore was going to meet with the president to reiterate his earlier opposition. Rumors circulated in Washington that the strong ties between the Children's Defense Fund and the administration would prevent the waiver's approval.¹⁴ But on 19 March Secre-

tary Shalala approved the waiver for a period of five years. "The President," she wrote to Governor Roberts, "believes that the Federal Government must give States the flexibility to design new approaches to their local problems, provided these proposals meet Federal standards."

Implementation of the Oregon Health Plan was now contingent on state compliance with twenty-nine terms and conditions outlined in a memorandum accompanying Shalala's letter to Roberts. Most important, the state had sixty days to "re-rank the condition/treatment pairs without relying on data which it collected with respect to whether treatment returned an individual to an asymptomatic state."¹⁵ Moreover, although the state was not required to include infertility services at all, the rank of this condition had to be based upon "content neutral factors that do not take disability into account. "Finally, the state had to adopt guidelines for health providers to minimize the likelihood that someone, particularly a disabled person, would be denied care if they had an eligible condition.

Changing Landscape In Oregon

When prospects improved for the Oregon plan in Washington, they became worse in Salem. Oregon government was in crisis as the result of a 1990 property tax limitation initiative estimated to produce a \$1.2 billion state deficit in the biennium beginning 1 July 1993. The state will need an estimated \$83.6 million in state funds to pay for the basic health benefit package (as it stood 19 April 1993) to go into effect 1 January 1994. If the state does not find the revenue, the list of 565 covered treatments must be cut, which would require federal approval. If funding is not forthcoming, state officials say, the plan will not be implemented.

The state's political landscape has changed since the Oregon plan was adopted. In 1989 Democrats controlled both houses of the state legislature, as well as the governorship. Senate President John Kitzhaber and House Speaker Vera Katz were powerful allies. Both have since left the legislature.

Moreover, the Democrats lost control of the House in 1990 and emerged from the 1992 elections with a slim majority in the Senate. No one has yet emerged to fill the leadership void Kitzhaber's departure created.

In addition, bipartisan support for the Oregon plan is eroding. The Republican House Majority Speaker, for example, did not join the governor in the press conference announcing the waiver approval (although he says he supports the plan). One-third of the members of the 1993 Legislative Assembly have no personal investment in or experience with the plan.

The weakening of legislative support is exacerbated by an apparent disarray of allies outside the legislature. At the beginning of the 1993 legislative session, Governor Roberts proposed raising most of the funds to implement the health plan through a health provider tax—1.5 percent on gross hospital revenues and 0.9 percent on physicians and dentists—and from increased cigarette taxes. Both proposals are opposed by such original supporters of the health plan as the Oregon Medical Association (the provider tax) and the Association of Oregon Industries (AOI) (both taxes).¹⁶

The AOI, the state's major business lobby, has become the most serious obstacle to the plan's implementation. The organization accused the state of renegeing on two promises. The plan, it says, was to be financed through general funds, not special taxes that could be passed back to employers as higher insurance premiums. Moreover, the AOI asserts that the waiver conditions prevented the state from reducing the basic benefit package, which is inconsistent with the law's original intent that the state adjust benefits in line with its financial status.

Most important, the AOI may be retreating from the mandate because of its increasing numbers of members from small business.¹⁷ The original law provided that once the waivers were obtained to cover the Medicaid population, employers would be required, by July 1995, either to offer their employees a benefit package substantially similar to that established by the HSC or to pay into a state insurance pool fund, which would be used to subsidize alternative insur-

ance for uninsured workers and their dependents. Small-business leaders and some legislators worry that after the play-or-pay mandate goes into effect, some low-wage employees will be shifted from Medicaid to employer-provided or subsidized insurance, thus putting a new financial burden on small businesses. The state believes that this reflects the original intent of the law and will also help to reduce Medicaid case loads and to lower costs. The shift will, moreover, help meet a precondition of the waivers that “annual expenditures do not exceed pre-defined limits on the number of demonstration eligibles and costs incurred.”¹⁸

Although rescinding the employer mandate would not invalidate the federal waiver, it would make staying within HCFA’s expenditure caps difficult. Roger Auerbach, Governor Roberts’s chief adviser on health care issues, says that maintaining the mandate is “a major policy issue because we need to hold everybody together in support of the plan if we are to achieve our goal of getting this Medicaid expansion financed.”¹⁹

The Oregon Health Plan is seriously threatened, according to legislative leaders. Governor Roberts maintains that the state will find some way to raise the necessary revenue, but she has failed to persuade the legislature on other fiscal issues. A local journalist wrote that “we could be looking at a major anticlimax here.”²⁰ But it is hard to imagine the state walking away from something that so many have struggled with for so long amid such intense national publicity.

Lessons From Oregon

Three lessons emerge from the Oregon experience. The first is that citizen participation is a politically and legally flawed strategy to gain widespread acceptance for innovative reform. The second is that specificity (the infamous “List”) can become a political albatross. No state has emulated the list or seems likely to do so soon.

The final lesson of Oregon is ironic. As a result of debates about rationing, Oregon lawmakers backed into defining a minimum basic package of services. In so doing, they

showed that it is possible to design and implement a plan that puts a floor of coverage under everyone in the state.

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NOTES

1. M.C. Kimball, “Fluid Odds on Oregon’s Medicaid Waiver,” *Health Week* (11 March 1991): 12.
2. A.K. Ota, “Oregon Health Plan May Get Grease,” *The Oregonian*, 9 April 1992, C9.
3. U.S. Congress Office of Technology Assessment, *Evaluation of the Oregon Medicaid Proposal* (Washington: U.S. Government Printing Office, May 1992). 1.23-42.
4. *The Oregonian*, 11 April 1992, A1, A14.
5. Rep. Henry A. Waxman (D-CA), as quoted in M. Abramowitz, “Oregon Blazes a Trail,” *The Washington Post*, 9 June 1992, Health Section.
6. *The Oregonian*, 4 August 1992, A1, A8.
7. *Ibid.*
8. *The New York Times*, 4 August 1992, A5.
9. *The Oregonian*, 27 August 1992, C4.
10. Letter from Timothy Flanigan, assistant attorney general, Office of Legal Counsel, Department of Justice, to Susan Zagame, acting general counsel, Department of Health and Human Services, 19 January 1993.
11. Oregon Health Services Commission, *Prioritization of Health Services*. 1991, Appendix D. D-23.
12. Authors interview with Lynn Read, Oregon Health Plan, 21 April 1993.
13. Authors’ interview with Jean Thome, Oregon Office of Medical Assistance Programs, 6 April 1993.
14. The Children’s Defense Fund (CDF) has been one of the most vocal and active critics of the Oregon plan. During the period under consideration Hillary Rodham Clinton was chair of the CDF board and Donna Shalala, the current HHS secretary, was a member of the board. Shalala replaced Clinton as chair in February 1992.
15. Health Care Financing Administration, “Special Terms and Conditions,” 19 March 1993. The HSC submitted its newest list to the legislature 19 April 1993. The list contains 696 condition/treatment pairs. The proposal is to make the cut-off number 565. Oregon Health Services Commission, *Prioritization of Health Services*, 1993, Appendix F.
16. Observers of the Salem scene also suggest that the tobacco lobby, which provides substantial campaign funds in the state, has become interested in the issue as well.
17. *The Oregonian*, 4 April 1993, B3.
18. Health Care Financing Administration, “Special Terms and Conditions,” 2.
19. *The Oregonian*, 27 March 1993, B2.
20. D. Sarashon, “Oregon Might Just Waive the Waiver,” *The Oregonian*, 21 February 1993, C2.