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Prologue: Oregon’s effort to explicitly ration the medical care resources it is prepared to allocate for the poor has triggered widespread interest in the United States. Essays that have dealt with it are rarely free of the opinions and values that authors bring to this controversial subject. For this article, Daniel Fox and Howard Leichter approached the topic with every intention of dealing with it in a balanced fashion. Readers can judge for themselves how well the authors achieved this objective. Fox is president of the Milbank Memorial Fund in New York City. Before his appointment to that post in January 1990, he was professor of social sciences in medicine and director of the Center for Assessing Health Services at the State University of New York, Stony Brook. Fox, who trained in history and public administration at Harvard University, characterizes his calling as that of a “contemporary historian” who works at the intersection of policy analysis, political science, and history. He is the author, coauthor, or editor of fifteen books. Because Fox has examined a wide variety of contemporary health policy issues in many milieux, Health Affairs asked whether anything about Oregon’s proposal and processes surprised him. Fox responded: “What really astonished me and made me, if not a defender of the Oregon plan, respectful of its process, was the wide-open manner in which the rationing debate is being carried out there. If one was searching for a classic exercise of American democracy, in the sunlight, it is Oregon’s debate.” Leichter, who holds a doctorate in political science from the University of Wisconsin, teaches at Linfield College in McMinnville, Oregon. He is also a clinical professor of public health and prevention at Oregon Health Sciences University. Leichter has conducted comparative studies of how health care systems, particularly in Europe, address the issues of containing expenditures.
The Oregon Basic Health Services Act became a projective test for the national media and many health policy experts soon after it became law in July 1989. Proponents praise its boldness: for the first time in the United States, they say, elected officials, community leaders, and health professionals are defining an adequate minimum standard of health care for a substantial number of people. Rationing of health services for some of the poor and for the uninsured has become, in Oregon alone, a public process that is based on expert analysis and opinion and the discussion of community values. Moreover, the priorities recommended by experts in the context of community values are subject to the vote of the legislature. Opponents of the Oregon program complain that it is unfair to poor women and children, who will be the first to experience explicit rationing, and that it oversimplifies the problems of assessing the effectiveness of medical care.

In this article, we describe the politics and policy of the Oregon rationing plan, what the law (actually, package of laws) says, and how this legislation came to be passed in 1989. We neither attack nor defend the Oregon program. Our purpose is to place it in context: to explain why problems that have been politically salient in every state—rising Medicaid costs and lack of access for the uninsured—are being addressed differently in Oregon.

Our thesis is that the events in Oregon occurred mainly because health professionals who believed that these problems could be solved by reason, frankness, and good will occupied positions of authority in both government and the provider community. The people who created and are implementing the Oregon plan assume that the problems of cost and access can be solved by community discussion, by the application to policy of research-based knowledge about assessing opinions and values and weighing the costs and benefits of medical intervention, and by legislative decisions that are accountable to the voters.

These assumptions politicize the ideals of many health professionals. Reason, frankness, and good will are synonyms for competence (and belief in ever-advancing technology), compassion (expressed as concern for patients’ autonomy and comfort), caring, and accountability. Many health professionals in Oregon have expressed unusual public concern about health policy and how it is made. The legislative sponsor of the Oregon plan is a physician. Most of the participants in community meetings across the state to assign value to health services were health professionals, as are seven of the eleven members of the Health Services Commission, which has ranked thousands of medical procedures. The leadership of health professionals is not the whole story in Oregon, but it is the major, and largely unreported, story.
What is new in Oregon is that many health professionals and the legislature seem to have accepted public responsibility to ration services. Health professionals routinely make judgments about the appropriateness of alternative technologies in the context of the needs and resources of their patients. When resources are scarce, as they almost always are, health professionals allocate them on the basis of these judgments. But they rarely (bolder historians would say almost never) make rationing decisions in public, rarely make them about populations rather than about individuals, and rarely do so in coalition with other leading citizens—and especially not with legislators.

Expanding Access And Rationing Care

Oregon’s Basic Health Services Act explicitly confronts two of the most critical challenges facing the nation’s health care system: guaranteeing access to health care for all Americans and containing the growth of health care costs. To accomplish these seemingly contradictory goals, Oregon is trying to ration health care through an accountable political process rather than by the decisions of individual providers or by actions of state government that change eligibility for services or coverage in response to strains on public budgets. The state will define a minimum entitlement to basic health services and apply it initially to certain limited groups, excluding persons covered under Old Age, Blind, and Disabled; Medically Needy; and Children in Foster Care programs. Leaders in the legislature, however, want the entitlement to apply to the entire population. In addition, supporters of the plan reject critics’ accusation that Oregon will finance coverage to the uninsured only by cutting services in current programs. “Nothing could be further from the truth,” say the sponsors. “[T]he state intends to put more state general fund dollars into Medicaid.... No state budget is exempt from the potential of being reduced in order to provide additional funding for the Medicaid program.” Although national attention has focused on only one part of this effort—rationing health care for Medicaid recipients—the Oregon plan involves three related pieces of legislation, each dealing with a different population: those on public assistance, uninsured workers, and the medically uninsurable population.

Expanding eligibility levels. The centerpiece of the plan is Senate Bill 27, or the Oregon Basic Health Services Act. Under the law, everyone who falls below the federal poverty level will be eligible for health care through the Medicaid program; currently, only those with incomes of 58 percent or less of the federal poverty level are eligible for Medicaid in Oregon. Expanding access to an additional 160,000 Oregonians would,
of itself, substantially increase the state’s health care bill. Hence, there would have to be a trade-off between access and benefits to control costs. As explained by State Sen. John Kitzhaber, architect of the Oregon plan, “If we can agree that society cannot afford to buy everything [in health services] for everyone who might conceivably benefit from it, then we have to develop a process to determine what level of care everyone should have access to.” In other words, health care must be rationed.

**Reallocation of resources.** To ensure the “social and political consensus” that Kitzhaber and others believe is vital to the success of the policy, an elaborate mechanism has been designed to allocate health resources. The law creates an eleven-member Health Services Commission to conduct public hearings and encourage public involvement in preparation for recommending a prioritization of health services. The commission is to submit its recommended priorities to the governor and a Joint Legislative Committee on Health Care by July 1 of the year preceding each regular legislative session. Accompanying the list of priorities will be a report by an independent actuary on the rates for each of the services/treatments. The Joint Legislative Committee on Health Care will recommend to the full legislature whether to accept or reject the commission report. Should the legislature accept the report, it must then decide how much it is willing to spend on health care for the next biennium. This money will then be used to buy a package of health services for each recipient from as far down the priority list as the legislative allocation will allow.

Should a revenue shortfall occur, or should the number of persons below the poverty level increase, the state cannot drop people from the program or reduce payments to providers below the cost of providing services “without compromising quality.” Instead, the legislature will retreat back up the list of priorities until it reaches the point at which there is enough money to provide services for all those eligible under Medicaid. This provision helps to explain the support for the plan from many leading providers in the state, including the Oregon Medical Association, Oregon Association of Hospitals, and health maintenance organizations (HMOs) such as Kaiser Permanente.

**Reimbursement.** The legislation establishing the plan guarantees that reimbursement will be negotiated after careful analysis, rather than established arbitrarily and then cut in response to state budget problems. Moreover, the legislation promises to reward the largest and most efficient Medicaid providers (including those called “disproportionate share providers”) and to squeeze those who are inefficient or simply greedy. Finally, by denying reimbursement for specific uncovered services, the plan would discourage anyone from providing them to Medicaid-covered or unin-
sured patients and would, logically, abolish below-cost reimbursement for them. As a result, cost shifting would be eliminated in Oregon for the covered populations. The loss of the ability to shift costs (valued by hospitals, disdained by payers) may account for some of the “serious reservations” that, according to the Senate president and his staff, some providers expressed initially about the plan. (Other reservations involved providers’ fear of losing clinical autonomy and of the erosion of existing mandates for private insurance coverage.)

Once the budget and priorities are agreed upon, the state’s Department of Human Resources will negotiate prepaid, managed health care service contracts with hospitals, HMOs, physician care organizations, and managed care plans. The law provides for exceptions to the prepaid managed care approach in some rural areas.

Increased access to care. In addition, Senate Bills 534 and 935 apply the principle of expanding access to two other groups of Oregonians. The first consists of about 10,000 to 20,000 people who are considered uninsurable due to preexisting medical conditions. S.B. 534 creates an insurance pool from which these people can purchase health insurance. Although the original legislation does not extend the concept of a basic level of services found in S.B. 27 to this group, the plan is to do so in the next legislative session.

The more important of the two bills is S.B. 935. This is aimed at working Oregonians and their dependents who are above the federal poverty level but who have no health benefits and do not qualify for medical assistance. The law affects about two-thirds of the uninsured in Oregon (approximately 260,000 people). Under this legislation, employers are encouraged, through tax credits, to provide health insurance for uninsured employees. To take advantage of the credits, however, they must participate in the program by 30 December 1993. After that date, they must provide insurance but without the tax incentive. Significantly, the law provides that the benefits offered to these employees “must include substantially similar medical services as those recommended by the Health Services Commission [under S.B. 27].” Although S.B. 935 initially applies only to businesses with twenty-five or fewer employees, the legislature is authorized to extend the provision to all employers.

Universal coverage. From the outset of the legislative process, Kitzhaber has portrayed the benefits package created by S.B. 27 as a standard for a minimal level of health insurance coverage for all Oregonians, even for the nation. Kitzhaber believes that no one should be outside the “health care lifeboat”—one of his favorite metaphors. On this point there has been both confusion and disagreement. Although Kitzhaber’s belief in the universality of the legislation has been evident from the outset, it
was not shared by other participants in the legislative hearings on S.B. 27. For example, when one witness in the early stages of consideration of the bill suggested that S.B. 27 “sets up a minimal acceptable level of health benefits and implies that all businesses in Oregon must provide at least that level of benefits,” she was corrected by a committee member who said that he did not interpret the bill to mean that at all. The benefits that employers provide to their employees are the result of contract negotiations, he noted, not state policy.\(^5\) As late as April 1989, after the bill had been approved by the Oregon Senate, another lobbyist argued before the House Committee on Human Resources that “when you develop the list [of health priorities] in Senate Bill 27 that list, as a result of other legislation [Senate 935] also becomes potentially the definition for adequate health care for both your employed, uninsured, and your employed insured. \textit{And this is not something that I think is widely known.}^6\)

Not only was it not widely known, but some of those who were aware of the broader implications of S.B. 27 were troubled by them. The lobbyist for the Oregon Chapter of the National Association of Social Workers, for example, was concerned that extending the minimum standard established in the law to all Oregonians would lead to a leveling down of benefits to an “admittedly inadequate level” for most Oregonians.\(^7\) Only after S.B. 27 became law and critics such as Rep. Henry A. Waxman (D-CA) and Sen. Albert Gore, Jr. (D-TN) began attacking it as “unfair” to the poor did supporters begin emphasizing the not “widely known” point about its relevance to all Oregonians, and not just the poor. On 11 April 1991, Kitzhaber introduced a bill to establish a Health Care Purchasing Authority, which would require insurance carriers to offer the Basic Health Services Plan to companies and individuals, even to companies that self-insure.

However broadly or narrowly one chooses to define or understand the implications of Oregon’s package of health insurance legislation, it is bold in both concept and prospect. How is it that Oregon took on the role of health policy innovator in this instance? The answer to that question lies in both a common malady that afflicts all the states and a particular expression of that problem in the state of Oregon. We begin with the more general affliction.

**Medicaid: ‘The Monster That Ate The States’**

Although no sector of the health care economy has been immune from the escalation of costs, the public sector has been especially hard hit. Government spending accounts for a substantially larger portion of the health care bill today than it did twenty-five years ago: 26.2 percent in
1965 and 41.4 percent in 1987. Private spending over this period increased by 848 percent; public-sector spending by 1,784 percent, mainly as a result of the introduction of Medicaid and Medicare in 1965. Medicare accounts for over 80 percent of federal spending on health. Medicaid has become, in the words of former Oregon Governor Neil Goldschmidt, “the monster that ate the states.”

Medicaid is second only to education in the percentage of state budget it consumes and second only to corrections in rate of growth over the past decade. When it was first introduced, Medicaid consumed about 5 percent of state general fund expenditures; today the figure is about 11 percent and is predicted to go as high as 15 percent by 1995.

The growth in Medicaid costs has a good deal to do with trends in the coverage of the two major groups in the program, persons who receive Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). Eligibility for AFDC has become more restrictive and that for SSI, more expansive. As the number of AFDC recipients—especially children and single (often female) parents—has been reduced, SSI payments for older and disabled persons have kept pace with inflation, since payments are indexed to the cost of living. Between 1975 and 1985, overall benefit levels for AFDC recipients declined 30 percent, while those for SSI and state-provided supplementary income (SSP) recipients increased 10 percent. This has meant that the number of younger people eligible for Medicaid declined, while the number of older people increased. In 1988, about 70 percent of the Medicaid population were children, but they received only 12 percent of money spent on the program, while 73.4 percent went to SSI recipients. In 1972, in contrast, 18.1 percent of Medicaid expenditures went to AFDC-eligible children and 52.8 percent to people on SSI.

State responses to Medicaid growth, In response to the growth in Medicaid spending, the states have adopted one or more of three strategies. All three are, in effect, methods of rationing health services. The first two ration by eliminating coverage or beneficiaries; the third, by creating disincentives for providers to treat. One strategy has been to eliminate certain benefits, as Oregon did in 1987 when it ended state funding of organ transplants. Second, states have redefined eligibility and consequently thrown people off the Medicaid rolls. As a result, the proportion of poor people in general who are covered by Medicaid has declined from a high of about 65 percent to less than 40 percent today.

Third, states have reduced reimbursements to providers—a strategy rendered more difficult by a June 1990 U.S. Supreme Court decision that upheld the right of hospitals and other providers to sue states for higher Medicaid reimbursements. In 1989, for example, Oregon reimbursed...
hospitals for only 78 percent of the actual cost of providing Medicaid services. Oregon was one of the states where a lawsuit by providers seeking increased reimbursements was pending when the court issued its ruling.

**Medicaid trends in Oregon.** Oregon Medicaid trends mirror those at the national level, with one exception. Oregon’s program is unique in a way that helps to explain support for the managed care emphasis of the Basic Health Services plan: an unusually large number of Oregon Medicaid recipients (55 percent) are currently in managed care programs. Between 1979 and 1989, overall federal and state expenditures for Medicaid in Oregon increased by 83 percent, and the cost per recipient increased by 69 percent. However, those eligible for the program increased by only 8 percent during 1979–1989. Between 1979 and 1985, persons in the program actually declined by 17 percent—from 139,918 to 116,614. Only in the 1987–1989 biennium, following an improvement in the state’s economy and nationally mandated expanded eligibility, did the number of Oregon Medicaid recipients exceed the 1979–1981 level.

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**The Transplant Controversy**

The specific personal experiences of Oregon policymakers transformed these statistical trends into innovative policy change. The death of a seven-year-old boy from Portland set the stage for health care rationing in Oregon. Like many other states, Oregon first authorized funding of transplant operations under Medicaid in the 1983–1985 biennium legislative session. In the first two years of the program, requests for transplant funding were approved case by case. The state could reject any transplant request and could stop the program when it had exhausted the allocated funds. In 1985, however, Congress required that states file a plan indicating which procedures they would fund. They were then obligated to fund all transplant requests that fell under the plan.

In 1987, the Oregon Department of Human Resources requested $2.2 million from the legislature to cover thirty-four transplants, an increase of $1 million over the previous biennium. The Human Resources Subcommittee of the House and Senate Ways and Means Committee decided to take transplant funding out of the regular budget and place it on an optional priority list along with other requests for special social programs. The subcommittee had about $20 million at its disposal and requests that totaled about $43 million. The transplant program had to compete with programs dealing with the mentally ill and disturbed, the deaf, head injury victims, juvenile delinquents, and senior citizens. The subcommittee ran out of money before it got to transplants.

Prenatal care was not, however, one of the competing priorities. Much
would be made later on by national media and legislative leaders about how Oregon had eliminated organ transplants for a few patients to spend those dollars on prenatal care for many more women. The state increased funding for prenatal care during the session, but that decision was made by another subcommittee and was unrelated to the transplant decision.

The decision to eliminate transplant funding was hardly noticed by the legislators. State Rep. Mike Kopetski, who introduced the Human Resources budget, called attention to the deletion of the transplant program twice in his speech. Not one legislator questioned the decision. The next transplant decision, however, drew the attention of the nation upon the state. Medicaid officials told the unemployed and uninsured mother of Coby Howard, the seven-year-old with leukemia, that her son could not receive a bone marrow transplant. The boy’s family, friends, and teachers had organized a private fund-raising campaign, which was $30,000 short of its $100,000 goal when the little boy died 7 December 1987.

Coby Howard’s death and the existence of five other uninsured transplant candidates resurrected the transplant issue. In a January 1988 meeting of the Legislative Emergency Board, which acts on behalf of the full legislature during the interim period, Rep. Tom Mason introduced a motion to appropriate $220,000 to the state’s Medicaid program to fund five transplant operations for people whose requests for such procedures had already been denied. The proposal was opposed by Kitzhaber, who presided over a subcommittee meeting on the proposal 28 January 1988. He and House Speaker Vera Katz took the unusual step of attending the subcommittee meeting to vote on the funding request.

Kitzhaber said that the issue before the Emergency Board was not whether the state could find $220,000 to fund these five requests. Clearly it could. He argued, however, that the “basic issue is one of equity.” Thousands of working Oregonians had no private insurance, and still other nonworking Oregonians were ineligible for Medicaid. Neither of these groups were eligible for these transplants. “I think what this [transplant] policy does,” Kitzhaber said, “is it gives to Medicaid recipients certain services that are not, in fact, available to a large number of other Oregonians. ...[T]here’s a basic inequity involved there. What you’re really doing is you’re asking many taxpayers to buy services for people on public assistance that they can [not] even get for their own children.”

Another critical issue was one of priority. Since a state cannot satisfy all demands, it has to make choices on how best to spend its dollars. “What we can do with our limited money is to reduce the number of deaths to the maximum. Save as many people as we can, because we can’t save them all,” Kitzhaber said. Despite an emotional plea by Representative Mason that Oregon not become “known as the state that lets
children die,” his motion failed on a tie vote. Kitzhaber and Katz voted against the motion.17 The next day, however, the full Emergency Board was scheduled to meet, and Mason vowed to bring the issue before it.

That evening, Ted Koppel featured the Oregon transplant decision and Kitzhaber on “Nightline.” He began the program with footage of Coby Howard and said: “When the State of Oregon decided to stop funding organ transplants, it allowed this boy to die.” Koppel later asked: “Is the cost of modern medical technology forcing public officials to play God?”18 It was in the rather heady atmosphere of national media attention, then, that the full Emergency Board met the next day. The arguments about equity, priorities, costs, and compassion were the same; so were the results. The motion was defeated. In the course of the debate, Kitzhaber set the stage for the next act in this drama: “Now I guess I just want to close by saying that we are going to have to ration health care.”

### Why Oregon?

In his closing pronouncement, Kitzhaber meant explicit, systematic rationing, not what had long been occurring in Oregon and elsewhere. In his view, the decision to halt funding of transplants was an exercise in rationing health care one procedure, even one patient, at a time. That the Coby Howard decision became the occasion for a much larger debate can be attributed not only to the highly publicized specific tragedy involved, but to the political and social culture of Oregon and to John Kitzhaber himself. Oregonians, ever mindful of the history of the Oregon Trail and of courageous pioneers, take pride in their innovative social policy. More recently, *The Almanac of American Politics* described Oregon as “a culturally liberal state on many issues, with many young and single voters, and one that is proud of being the first state to ban throwaway bottles and among the first to allow abortions.”19 The popular image that Oregonians have of themselves has been called a “moralistic” political subculture, in which “both the general public and politicians conceive of politics as a public activity centered on some notion of the public good and properly devoted to the advancement of the public interest.”20

Political circumstances also contributed to the ability of the state to tackle the difficult policy issue of rationing. Democrats controlled both houses of the legislature and the governorship, and the leaders of the two houses were close friends and political allies. Kitzhaber, who was first elected to the Oregon House in 1978 and has been in the Senate since 1981, has served three terms as Senate president. His experience as an emergency room physician has added credibility to his role as the premier legislative authority on the state’s health policy system and has aided him
in gaining support within the medical community. Although Kitzhaber had been better known for his interest in environmental than in health issues, once he assumed the position of spokesperson in the transplant controversy, he pursued the issue of resource allocation with enthusiasm. Kitzhaber’s articulateness and personal warmth have helped him achieve national celebrity status since Oregon first made the news with its decision on transplants.

Kitzhaber remained the dominant force in formulating the new health policy partly because Governor Neil Goldschmidt decided that he had other priorities. In February 1988, at the time the Emergency Board was embroiled in the transplant controversy, the governor appointed an eighteen-member Commission on Health Care, which he charged with “identifying Oregonians who find it difficult to gain access to health care.” The commission members came largely from the health field, including the presidents of the Oregon Medical Association, Blue Cross/Blue Shield of Oregon, and the Oregon Health Sciences University. In September 1988, the commission recommended encouraging business to use an existing voluntary tax credit program to cover uninsured employees, creating an insurance risk pool, and extending Medicaid benefits to pregnant women.

Although some commission recommendations found their way into the Basic Health Services law, the report had only a minor impact because the governor did not promote it. Some have suggested that the governor was preoccupied with other policy interests, including prison finance and his “Children’s Agenda;” others have suggested that he was simply uninterested in health care reform. Thus, S.B. 27 was, in every sense of the term, “Kitzhaber’s plan.” He had the power, the allies, and the idea.

### Rationing Health Care

**Senate Bill 27: the legislative route.** Kitzhaber’s dominance was both facilitated and symbolized by one of the first tactical steps he took in preparation for the legislative debate on his bill, namely, the creation of a new Senate Committee on Health Insurance and Bioethics. This move enabled him to bypass the existing Human Resources Committee and its less congenial chairperson and deal with a sympathetic freshman senator, Bob Shoemaker, who, as well as being an attorney and ally of Kitzhaber’s, had served as counsel to the Multnomah County Medical Society.

Although S.B. 27 underwent several revisions, there was little dispute from critics to health providers over its fundamental assumption that the current system was unsustainable and that rationing was unavoidable. Ken Rutledge of the Oregon Association of Hospitals stated, for example,
that “major reform of our current health care delivery system and payment system is needed.” Three committees conducted hearings on the bill between February and June 1989. In February, Kitzhaber said the bill was a “mere skeleton,” really just a “concept.” The skeleton was fleshed out as House and Senate committees heard testimony from providers and insurers, business leaders, social advocacy groups, union leaders, business leaders, and members of public health and welfare bureaucracies.

There was a good deal of disagreement about particulars. The most consequential concern, and the one that would become the rallying point later for opponents both in the state and in Congress, was over the trade-off between access and benefit levels. Central to Kitzhaber’s plan was the notion that not everyone would be able to get all the medical care they might want or need. About 400,000 Oregonians neither qualified for Medicaid nor were covered by private insurance. Any coverage at all would be more than they currently received. But universal access would have to come at the cost of limiting health services both to those on Medicaid and to those with private insurance for whom S.B. 27 might provide a standard of coverage. Since neither the government nor the private sector could afford unlimited health services to everyone, the state would define an adequate or basic level of health services.

But critics wondered if the benefit package that emerged from the process would in fact be adequate. Some who testified indicated that although they supported universal access, if presented with a choice between a “thin” package of benefits for everyone and something short of universal access but with more substantial coverage, they would prefer the latter. In addition, some charged that the plan would create a two-tiered health care system: guaranteed access to limited services for the poor and virtually unlimited services for those who could afford to purchase insurance on their own.

As a result of these concerns, opponents wanted some assurance that the basic benefits package would be rich enough to provide an acceptable level of health care. This view was summarized by Ellen Pinney of the Oregon Health Action Council, a coalition of more than seventy groups representing labor, senior citizens, minority groups, and low-income people. “I think all of us remain somewhat uncomfortable with passing a bill of this magnitude through the legislature without defining, in very clear terms, what the benefits plan will look like,” she said.

Legislators themselves did not know precisely what the package would include. That decision would be made by the legislature after the Health Services Commission completed its “rank-order[ing of] health services according to their benefit to the entire population being served.” However, the legislature did vote to “maintain the status quo in the Medicaid
program until there was a new benefit package for them to review.”

Providers were also concerned about the adequacy of the benefits and reimbursement under the plan. For example, Kaiser Permanente, one of the largest HMOs in the Northwest and a major Medicaid contractor, said that it might not bid on the program at all because it would either lose money or offer inadequate benefits.

It soon became clear that the legislature would have to address the uncertainty about benefits. Under pressure from lobbyists, the House Human Resources Committee amended the Senate version of the bill to include a broad definition of basic health services. This included “so much of each of the following as are approved and funded by the Legislative Assembly: (1) Provider services and supplies; (2) Outpatient services; (3) Inpatient hospital services; and (4) Health promotion and disease prevention services.” The list apparently reduced some of the concerns surrounding the bill.

Many providers began to claim access to the system for their specialties. Dentists, drug and alcohol counselors, mental health specialists, social workers, pharmacists, chiropractors, and osteopaths, among others, pressed to make certain that their services would be included in the package authorized under the law. The earlier versions of the bill had prohibited any reduction in reimbursement without a corresponding reduction in the services they were required to provide. In April 1990, this language was changed to require that the state pay the rates necessary to cover costs of services as determined by an independent actuary. To providers who knew other states’ Medicaid reimbursement policies, the bill would now appear to be almost a model of fairness, even if they risked having all or some of their services excluded from the benefit package.

The membership on the Health Services Commission was also a matter of some debate, as both provider and community groups sought representation on the commission. Ultimately, the bill stated that the commission would consist of eleven members, five of whom would be physicians with clinical expertise in the areas of obstetrics, perinatal care, pediatrics, adult medicine, geriatrics, or public health. One of the physicians would be a doctor of osteopathy; in addition, there would be a public health nurse, a social services worker, and four “consumers of health care.”

The law required the commission to “solicit testimony and information” from groups that did not have direct representation. The groups specified included advocates for seniors; handicapped persons; mental health services consumers; low-income Oregonians; and providers of health care, including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses, and allied health professionals. The legisla-
tors were eager to secure widespread support for the plan. Supporters of the bill frequently used such phrases as wanting Oregonians to “buy into the reform” and to have a “sense of ownership.” Moreover, as Kitzhaber and his staff recall, it was “important to know what consumers wanted out of the system.”

To construct the broadest possible support base for the program, and also mindful of the severe public criticism that followed the death of Coby Howard, the bill included a charge to the Health Services Commission to solicit the views of the general public and thereby help “build a consensus on the values to be used to guide health resource allocation decisions.” This would occur in a statewide series of community meetings.

Finally, the legislative committees adopted several changes to deal with potential problems for providers and consumers in a health system based upon legislated rationing and managed care. Hospitals and physicians were protected from malpractice suits resulting from their inability to provide service; not authorized under the law. Also included was a provision to inform patients about any treatment or services that they might need but that are not covered under the program.

S.B. 27 was approved with overwhelmingly bipartisan support in both houses of the Oregon legislature after extensive debate, especially in the Senate. The law was approved by a margin of 19 to 3 in the Senate and 58 to 2 in the House.

Setting priorities. Two very difficult tasks lay ahead before the state could implement: the Oregon Basic Health Services Act. The first was to obtain Medicaid waivers from the federal government. This part of the story, which as of this writing has not been concluded, is discussed by Lawrence Brown in this volume of Health Affairs. The second task was for the Health Services Commission to construct a list of health service priorities for the legislature. The success of the latter enterprise may well influence the prospects of the former.

To accomplish their task, the Health Services Commission used three formats, two of which were mandated by the law. The first was a series of eleven public hearings held around the state allowing interested parties to express their views. The second was to authorize Oregon Health Decisions (OHD), a highly respected citizens’ advocacy group, to conduct community meetings in every county of the state “to build a consensus on the values to be used to guide health resource allocation decisions.” Ultimately, forty-seven of these community forums were held, during which participants filled out a questionnaire soliciting their opinions on the relative importance of certain health situations and categories, engaged in group discussions, and viewed a slide show. Health care interest groups dominated this stage, as they had in many points of the process.
Although it was the hope and intention of OHD to attract a cross-section of Oregonians, this did not turn out to be the case. Of the slightly more than 1,000 people who attended the meetings, almost 70 percent were mental health and health care workers. Although the term workers is not defined, it should be noted that over one-third of the participants had incomes of $50,000 or more and two-thirds were college graduates. Kitzhaber is convinced that the “discussions were wide-ranging and tended to deal primarily” with broad issues and values rather than with narrow interests. The attendance at the meetings and accounts of the discussions suggest that a substantial number of Oregon providers were comfortable enough with the plan to want to help shape it.

The third mechanism provided the most systematic solicitation and application of citizens’ values in the prioritization process. The commission authorized a statewide, random-digit-dialed telephone survey of 1,000 Oregonians. To conform to the principle of incorporating community values in the ranking process and not simply relying on treatment/outcome data, the commission decided to use a modified version of the Quality of Well-Being (QWB) Scale developed by Robert M. Kaplan of the University of California at San Diego. Respondents were asked to rate thirty-one health situations from 0 (a situation that is “as bad as death”) to 100 (a situation that describes “good health”). Among the situations respondents were asked to rate were: “You cannot drive a car or use public transportation, you have to use a walker or wheelchair under your own control, and are limited in the recreational activities you may perform but have no other health problems,” and “You can go anywhere and have no limitations on physical or other activity, but wear glasses or contact lenses.”

The results of the survey were then formally incorporated into a mathematical cost/utility or “net benefit value” formula that included data on expected outcomes of given treatments for hundreds of health conditions. The “net benefit value” equation was in the form of a word formula where net benefits equal net benefit value divided by net costs. Benefits included the length of time the patient benefits from a treatment, the public values regarding certain health states (for example, death, return to asymptomatic state of health, and so on), and the probability that a state of health will result from a particular treatment. Costs include diagnosis, hospitalization, professional services, nonmedical but prescribed services, and ancillary services.

The formula produced a computer-generated prioritized list of 1,600 condition/treatment pairs. The first version of this list was released 2 May 1990 by the Health Services Commission and received widespread national media attention. Data collection and methodological problems
gave the list some rather surprising priorities: crooked teeth received a higher ranking than early treatment for Hodgkin’s disease, and dealing with thumb sucking was ranked higher than hospitalization of a child for starvation.

Members of the commission insist that the initial prioritization was never intended to be anything more than a test of the methodology. In August 1990, Commission Chair Harvey Klevit told a reporter for the journal Science, “I looked at the first two pages of that list and threw it in the trash can.” The commission created an Alternative Methodology Subcommittee to rework and modify the original formula. On 20 February 1991, the Health Services Commission made public a “Prioritized Health Services List.” The list was considered preliminary and awaits an actuary’s pricing of each of the nearly 800 health services/treatments identified before submission to the legislature in the spring of 1991. The committee chairman noted that there may be “as much as 5 percent variation between” this list and the one reported to the legislature.

The comments accompanying the list made it clear that the commission relied more heavily on negotiations—in their words, on public values and clinical judgment—than it had in the first exercise. As commission member Tina Castanares, a physician, said on behalf of the commission in a statement accompanying the list, “Our own values and judgments... prevailed... where we felt that the other methods fell short.”

An interview in March 1991 with Amy Klare, one of the four consumer representatives on the commission, confirmed the view that the list was the product of intense negotiation among members. One widely debated issue, for example, was the relative priority assigned to various preventive medical and dental services. While some members of the commission, including Klare, felt that the high value assigned to preventive services by Oregonians in the community forums dictated that such services receive a high priority, some of the physician members were less convinced about the relative utility of, say, nutritional supplements and dental check-ups. In the end, however, the force of expressed community values prevailed, and preventive health services received a high priority on the list.

The resulting list contained over 700 rather than the original 1,600 medical conditions and treatments. This scaling down was largely accomplished by grouping related treatments, such as open fractures of the toe, ankle, and lower leg, into broader categories, such as fractures of the lower extremities. In addition, the end result was a far more rational, and presumably medically and politically defensible, product. There are seventeen major categories ranging from “acute fatal, prevents death, full recovery” (for example, various forms of pneumonia) to “fatal or nonfatal
minimal or no improvement in QWB" (for example, “terminal HIV
disease with less than 10 percent survival rate at five years”). From the
perspective of the history of S.B. 27, among the more interesting changes
between the two lists is the relocation of organ transplants from near the
bottom of the original list to various locations throughout the revised list,
depending upon an assessment of potential outcome.

### The Fate Of The Oregon Experiment

The fate of the legislation depends, as it has from the outset, on factors
both within the state and in Washington, D.C. The Health Services
Commission has now created its priority list that must withstand both
medical and political scrutiny. The legislature considered the plan in May
and June 1991, after the actuary provided a cost list for each treatment.
The level of funding will, of course, determine how “basic” the basic
package of health services will be; it will also influence the fate of the
federal waivers. Two new political factors have complicated the entire
process. The first is that Republicans regained control of the Oregon
House in November 1990 (though Kitzhaber remains Senate president–
for one lame-duck session–with a larger Democratic majority). The
second factor is that in the same election, Oregonians approved a property
tax limitation that has strained the state’s budget, especially as it tries to
compensate for shortfalls in local expenditures for education. It is not
clear what effect this new budgetary constraint will have on the health
services plan.

As this article went to press, it remained unclear where the legislature
would draw the line; that is, how much it would appropriate for Medicaid
for 1991–1993. On 1 May 1991, the Health Services Commission sub-
mitted a report to Governor Barbara Roberts estimating the additional
state costs to implement the Basic Health Services plan as ranging
between $700,000 and $40.1 million, depending where the line is drawn.
The chairman of the commission recommended independently that the
line be drawn between items 500 and 600, at a cost of between $19 million
and $30 million. Each of the suggestions for paying these additional
costs—general taxes, an assessment on hospitals and other providers, or
a higher cigarette tax—has powerful opponents.

State officials have followed, often simultaneously, two routes to secur-
ing the waivers. One has been to convince Health Care Financing
Administration (HCFA) officials, and ultimately the secretary of health
and human services, who, state officials are convinced, have the power
to grant the waivers administratively. The second route has been to get
legislative authorization for the waivers. Sen. Bob Packwood (R-OR),
who has supported the state plan throughout the process, renewed his pledge in February to seek congressional approval of the waiver. Packwood warned, however, that his success was dependent, in part, upon two conditions back in Oregon. “The first thing I need to make sure,” Packwood said, “is that there is no dissonant voice coming from Oregon.”

Second, according to Packwood, “it would be immensely helpful if the state could come up with more money.” By some estimates, at least 10 percent more than the current two-year expenditure of $700 million on Medicaid will be needed to fund a credible package. The increase in expenditure, a difficult condition under current state budgetary problems, would go a long way toward quieting some of the opposition to the plan in both Congress and the state. Especially troubling for Waxman and others is the prospect that the benefits of current Medicaid recipients will be cut to provide at least some health benefits to all of the medically needy. If all of the pieces fall into place, Oregon may be able to begin its new approach to rationing Medicaid-funded health services in July 1992—two years later than initially anticipated.

Whether it ultimately does so or not, the state has begun a public policy debate that will be examined closely by other states over the next several years. The subsequent diffusion of the plan, especially if it is successfully implemented, may not require the same constellation of variables that existed in Oregon, namely effective medical and political leadership, a supportive political culture, and fortuitous partisan arrangements. The literature on policy diffusion has taught us that once the legislative ice is broken, innovations quickly spread among the states. If Oregon gets its waivers, and if the program shows even modest success, a number of states are waiting to follow its lead.

**Our assessment of Oregon’s success.** The innovation in Oregon is that leading health professionals, other community influencers, and the legislature have become publicly accountable for explicitly rationing services to the poor and the near-poor. This is a considerable achievement. But Kitzhaber and his staff assert that they have done more: Oregon is “hold[ing] society accountable for the rationing of health services to the poor through the legislature.” We do not find “society’s” participation to be broad to date.

Kitzhaber and his staff also take issue with our finding that the assent and cooperation of providers, and especially of physicians, have been essential to the creation of the Oregon plan. They agree that “health care providers played a central role” in the “prioritization process.” But they insist that the place of providers in decision making “was highly structured.” Time will tell.

In our view, medical professionals played a central role in the Oregon
rationing decision for three reasons. Obviously, they enjoy structural advantages in any health policy debate: status, organization, knowledge, and resources. That they have been willing to use their resources to influence the political process in general is reflected in the fact that in recent years the Oregon Medical PAC has ranked among the top five political action committees in the state in terms of expenditures, and the “Health and Medical” lobby is among the top three in spending on legislative lobbying. Second, they were well represented at critical stages of the process. The third reason is that while readers of The New York Times might well have concluded that rationing was the burning issue of the day in Oregon, readers of The Oregonian would not have reached the same conclusion. Rarely, if ever, during its legislative life was rationing a front-page story in the state’s largest newspaper. Few people outside the social advocacy and health service provider communities either knew of or understood the potentially broader implications that Kitzhaber envisioned for his legislation. For the most part, it was a story about how people on Medicaid and other poor Oregonians would be guaranteed access to health services. It was certainly not an unimportant story, but neither was it apparently central to the concerns of most Oregonians. In the absence of nonmedical popular or elite interest, the playing field was left largely to the medical experts.

Many informed cynics are complaining that the Basic Health Services plan may never be extended beyond poor women, children, and persons currently uninsured. The more idealistic of these cynics charge that the result for the poor and the near-poor will be rationing without representation. This is hardly an innovation. Just as with medical dominance of medical decision making, taxpayers and their elected representatives have a long history of deciding how charitable they want or ought to be.

Other critics of the Oregon plan charge that the technology for assigning priorities to particular treatments is badly flawed. But the technology that is, increasingly, being employed to set priorities in Oregon is one that has been used with considerable public support in this country for two centuries: bargaining among interest groups that makes use of the analysis and opinions of experts and is then ratified by legislative action.

Kitzhaber and his staff are offended by many of their critics. As they told us, “Our detractors consist mainly of uninformed members of threatened interest groups who delight in comparing the Oregon plan to a perfect world.” They are pained that many critics neither visited Oregon nor studied the primary source documents that describe the plan.

The news from Oregon, then, is that the same health policy problems facing other states are being addressed by requiring more public account-
ability for rationing than has happened elsewhere. But the price being paid for the adherence of providers to the Oregon plan—negotiated cost-based reimbursement and provider prominence in deciding priorities—is a familiar price in the history of health policy (and the history of rationing) in this country. Maybe this time, as Kitzhaber and his allies believe, the price will be worth paying because it will limit the “implicit and invisible rationing of the current health system.”

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NOTES

1. Oregon Senate President’s Office, “SB 27 Issues and Responses” (Salem, Oreg.: May 1990), 1–2. Opponents of the program, particularly nationally and those in Washington, D.C., hate criticized state officials for the initial focus on the most vulnerable populations, namely, poor women and children. However, our research provided convincing evidence that the reason for the initial limitation was tactical and administrative; the ambitious nature of the program and the difficulty in providing long-term care under Medicaid led to the exclusion of the other groups from S.B. 27. Persons in the Old Age, Blind, and Disabled and Foster Care programs will continue to receive benefits under existing Medicaid rules.

2. John Kitzhaber; Oregon Senate president, testimony before the Oregon House Committee on Human Resources, 19 April 1989.

3. John Kitzhaber and Mark Gibson, memorandum to the authors, 26 December 1990.

4. Ibid.

5. Senate Committee on Health Insurance and Bioethics, 16 February 1989.


7. Ibid.


10. Ibid., 32–33.


13. Author interview with former Oregon State Legislator Mike Kopetski.

14. Kitzhaber and his staff claim that Kitzhaber presided only because the regular chair, Frank Roberts, was in the hospital. Other sources insist, however, that his attendance at the meeting was quite unusual. Memorandum, 28 November 1990.

15. Transcript of Oregon Legislature Emergency Board, Human Resources Subcommittee,

16. Ibid.
17. Kitzhaber and his staff insist that he had “moved [unsuccessfully] that funding the transplant program be restored and that the funding for prenatal care be increased as well.” The effect of this motion was to persuade “influential members of the committee” that it was necessary to “concentrate on accomplishing the greatest possible good.” Memorandum, 26 December 1990.
26. Ibid. The actuarial report was released 1 May 1991.
29. For a copy of the complete questionnaire, see Health Service Commission, “Preliminary Report” (Salem, Oreg.: 1 March 1990), Exhibit 2.
34. Author interview with Amy Klare, 18 March 1991.
37. Memorandum, 26 December 1990.
38. Ibid.
40. Memorandum, 26 December 1990.