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# MEDICAID RATIONING IN OREGON: POLITICAL WOLF IN A PHILOSOPHER'S SHEEPSKIN

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## SUMMARY

**A**LTHOUGH THE DETAILS of the proposal have shifted since it was first described, the Oregon Medicaid waiver has had one consistent feature: it will reduce benefits to AFDC mothers and children who are currently covered by Medicaid in that state, in the hopes of increasing coverage for other individuals who are now uninsured. Because of the adverse consequences for the AFDC population, there should be strong evidence supporting the purported benefits of the proposal before proceeding with the waiver. One of the most intriguing aspects of the waiver proposal is the claim that the money currently being spent on AFDC beneficiaries could be redistributed to expand coverage to a substantial number of the uninsured. The concept is that far more people could receive the most valuable services if those now being served gave up their coverage of the least valuable services. Other purported benefits of the waiver include enhanced citizen participation in decisionmaking, cost-savings, and improved payment levels and delivery arrangements.

Remarkably, this analysis of the proposal reveals that the waiver is likely to achieve none of its stated objectives, and instead will have adverse consequences not identified by its proponents. What the proposal would do is to insulate politicians from visible responsibility for limiting benefits for AFDC children and adults. Finally, the proposal undermines 25 years of Medicaid as an entitlement program. As such, it would establish as a social ethic the principle that the poor can be relegated to inadequate care. Such an extreme measure is not justified by the fiscal situation in Oregon, which is

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not extraordinarily poor or overtaxed, and does not have a particularly generous or unusually expensive Medicaid program.

## INTRODUCTION

The Oregon waiver and rationing proposal has been described in many ways, and the description has changed since it first appeared. Proponents see what they are doing as developing a rational way to get community-based decisionmaking on the tough questions of health care: large and increasing numbers of uninsured in spite of Medicaid; inadequate personal involvement in scrutinizing the value of medical care; and, uncontrolled health care spending.

The question that needs to be addressed, then, is whether the proposal will solve any of these well-known problems. Answering this is of particular urgency, since the proposal appears certain to hurt a substantial number of people.

AFDC mothers and children will have their benefits cut in accordance with a priority-setting process designed to eliminate health care services that are of little societal value. The intent is to expand coverage to people now uninsured, in effect improving the situation for some low-income Oregonians at the expense of others. As the waiver has been discussed, only the AFDC population will be adversely affected; no one else in Oregon would be worse off. Keeping in mind the perspective of the people likely to be hurt, there should be a high likelihood that the program's intended effects will be accomplished if the experiment is to be warranted. Accordingly, it is necessary to examine closely the evidence for each of the proposal's purported benefits.

Descriptions of the waiver proposal have included a substantial number of potential effects, all of which must be analyzed. One of the most intriguing aspects of the waiver proposal is the claim that the money currently being spent on AFDC beneficiaries could be redistributed to expand coverage to a substantial number of the uninsured. The core of this concept is that far more people could receive the most valuable services if those now being served gave up their coverage of the least valuable services.

Analyzing this concept will be done in three different ways. First, we examine whether the system that would be adopted for determining the value of health care services is sound. Then, we estimate what fraction of medical care would have to be eliminated in order to fund limited coverage for a group larger than the current AFDC population. Finally, we analyze benefits under Oregon's

Medicaid program to see whether one can identify large areas of excessive coverage.

In the subsequent sections, the other purported benefits of the waiver are evaluated: whether it will involve individuals affected by the program in a meaningful way in the decisionmaking process; whether it will curtail health care expenditures, in general or under Medicaid; and, whether it will improve provider payments and facilitate caring for Medicaid beneficiaries. Finally, the waiver is discussed in terms of its political and historical significance.

1. Would the proposal establish a rational basis for deciding what health care services should be provided or covered?

The most recent version of the waiver proposal identifies cost-utility ratios for some 1,600 health services and proposes to restrict coverage from the bottom up, thus eliminating coverage based on societal benefit. Because of criticisms following release of the details of this plan, it may or may not prove to be precisely what is ultimately adopted, but it is representative of the general methodology.

The approach can be summarized as follows: A simple fraction is constructed; into the numerator goes the cost of the service, into the denominator an estimate of the "quality of well-being" that will result and another estimate of the number of years that the benefit will last. For such a formula to be meaningful, accurate data would have to be available for the numerator and for both of the terms in the denominator of this fraction.

One might expect that at least the cost of a service could be easily identified for the numerator. Even there, however, the data problems are enormous. For example, the current draft proposal relies on the historical pattern of charges billed to Medicaid. The difference between charges and costs is well known, and charge data provide no real estimate of costs.<sup>1</sup>

For the denominator, intangibles such as the "quality of well-being" likely to result from a service and the duration of that state of being, are required. Even the qualitative data on such items are grossly inadequate.

First, one must know what the results to be expected from the medical intervention under question are likely to be. The state of

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1. Finkler, *The Distinction Between Cost and Charges*, 96 *ANNALS OF INTERNAL MED.* 102 (1982).

the science of effectiveness, outcomes and appropriateness research, however, is rudimentary, with only a few exceptions. An entire new federal Agency for Health Care Policy and Research was recently created specifically to address the overwhelming needs for good research in this area.<sup>2</sup>

Even if there were a wealth rather than a dearth of effectiveness data, the notion that one can compare the relative value of all services would still be fatally flawed. It is not reasonable to assume that the level of knowledge of the effectiveness of any two services will be comparable at any given point in time, let alone that it would be both comparable and adequate across 1,600 services. There will always be a wide discrepancy among services with respect to outcomes and effectiveness information.

Finally, even assuming that outcomes could be predicted far better than is currently possible, this formula still requires an estimate of the relative value of those outcomes to people who will undergo the medical care. To develop a quality of well being scale, people were surveyed to give their impressions as to the relative value of various states of disability or well-being. But the impressions used were those of the general public, not persons suffering from the disabilities in question. Even more important, the methodology does not permit taking into account the actual attitudes of people who would be afflicted with those conditions once the program is implemented.

These examples only highlight a few of the data problems posed by the waiver proposal. This approach to setting priorities for health care coverage is so flawed that it is difficult to consider it a rational proposal. The use of mathematical ratios lends an aura of scientific certainty that is completely unjustified. To transform grossly inadequate data into mathematical quantities is utterly indefensible pseudo-science.

With respect to implementing a proposal such as the Oregon one in the immediate future, there are not enough good data to support a tiny demonstration project, let alone to justify such a massive social experiment.

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2. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, §§ 6103 and 6911 (42 U.S.C. 299 *et seq.*, and 42 U.S.C. 1320b-12).

2. Can rationing permit expansion of an adequate level of health care coverage to a significant number of the uninsured without massive increases in spending, or would expanding the number of beneficiaries without large spending increases mean that the level of coverage would be useless?

The previous section dealt with the characteristics of the most recent public description of the priority-setting methodology. It is possible to develop quite useful information on the whole idea of redistributing current spending, however, without having to know the details of the actual approach under consideration.

For example, we can start with an estimate of how much it would cost to cover everyone under Oregon's existing Medicaid plan. Then, by varying factors such as payment rates, savings from administrative adjustments, and number of persons to be covered, it is possible to estimate the proportion of medical care that would have to be eliminated to provide various levels of coverage. Ultimately, one can form an educated opinion about the reasonableness of the approach based on how much care it proposes to eliminate or to deliver. That is, a plan that would only eliminate 10-15% of the types of medical care that Medicaid will purchase now as a tradeoff for covering all the currently uninsured might seem to warrant serious consideration, while one that sacrificed one-half or two-thirds of Medicaid benefits would not seem very promising.

Actuarial projections done by Milliman & Robertson, Inc., for the Medical Research Foundation of Oregon help put the financial and coverage aspects of the rationing concept into perspective.<sup>3</sup> They show quite convincingly that any rationing by itself would only free up enough money to provide a grossly insufficient level of coverage for an expanded number of beneficiaries.

Milliman & Robertson estimate that about 86,000 uninsured in Oregon would have to be added to the rolls if the new program were to extend coverage to all persons under age 65 with incomes under the federal poverty level.<sup>4</sup> This would be in addition to the 94,000 currently covered by the Oregon Medicaid program.

Those consulting actuaries project 1991 costs of \$357 million if

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3. Axene, Massingill & Giesa, State of Oregon Actuarial Study of the Under-Age-65 Population Below the Federal Poverty Level (1989) (prepared by Milliman & Robertson, Inc. for the Medical Research Foundation of Oregon).

4. To put these estimates in perspective, the 86,000 or so uninsured below the poverty level who would be covered under the most positive scenario are but a fraction of the 400,000 or so Oregonians that the Oregon Medical Association says may lack health insurance. See *supra* note 33.

all the below-poverty uninsured and current beneficiaries were to be covered for a full slate of Medicaid benefits and providers were to be paid their full charges in a "moderately managed" system. That figure rises to \$393 million when administrative costs are added.

As shown in Table I, spending could be cut substantially — but not by imposing relatively modest rationing.

**TABLE I**  
**TOTAL COST OF PROVIDING BENEFITS TO TARGET**  
**POPULATION WITH AND WITHOUT BELOW-COST**  
**DISCOUNTS AND RATIONING**  
(in millions of dollars)\*

<b>"MODERATELY MANAGED" SYSTEM</b>		
	full provider charges	with discount
benefit package		
full	\$ 393	\$ 230
priority 7-10	354	208
priority 10 only	326	191
 <b>"AGGRESSIVELY MANAGED" SYSTEM</b>		
	full provider charges	with discount
benefit package		
full	\$ 362	\$ 211
priority 7-10	324	190
priority 10 only	296	173

\* based on data in Axene, Massingill, & Giesa, State of Oregon Actuarial Study of the Under-Age-65 Population Below the Federal Poverty Level (1989) (prepared by Milliman & Robertson, Inc.) includes 10% adjustment for administrative costs.

A relatively modest rationing proposal was the preliminary Oregon Medicaid Priority Setting Project, the plan that was in public view when the waiver was first discussed.<sup>5</sup> The first column of Table I shows that cutting back benefits to those rated priority 7-10 under that approach would save only 10%. Even the most draconian of cuts, restricting benefits to just the highest priority, number 10, would only total about 17% in savings.

The rest of Table I demonstrates that big savings would result not from rationing, but from traditional Medicaid expenditure-limiting measures: aggressive management and substantial below-mar-

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5. Golenski & Blum, The Oregon Medicaid Priority-Setting Project (Mar. 30 1989) (unpublished paper).

ket discounts. That combination would save a whopping 46%, with *no* rationing.

The Oregon program, however, promises providers payment at their full costs of providing covered services. This is discussed in detail in section 6, below. For now, it suffices to point out that if the actuarial figures for full costs were actually paid, the costs of covering persons below poverty would be on the order of \$300 million — even with the elimination of 17% of currently covered medical services.<sup>6</sup> To understand what that sum means, consider that Oregon's entire Medicaid budget is currently about \$400 million. Expenditures for the target population are but \$115 million or so.

How much “good” could be achieved for those currently without insurance if the existing Medicaid population were restricted to only those services given the highest priority in the original rationing scheme and the state did not increase spending? Very little. Limiting coverage in that way with *no* new state spending would save about 20%. That would cover about 12% of the currently uninsured people below poverty in Oregon.<sup>7</sup>

If very little good could be done for the uninsured at current spending levels and with only modest rationing, how much “harm” would be done to current AFDC beneficiaries by implementing such an approach? Quite a bit. The dramatic differences between current payment levels and full provider costs would have an immediate effect on benefits early in the implementation of the waiver as currently proposed. The Oregon application to the Health Care Financing Administration (HCFA) projects an increase of 6,000 persons beyond the AFDC population covered in the first year of the waiver.<sup>8</sup> Even though the number of persons would not expand much right away, AFDC beneficiaries would lose substantial benefits if physicians were paid full costs. That is, only 6,000 new persons would come into the program, but, as discussed in section 6 below, physicians would be paid some two to two and one-half times more for their services than under current law. Thus, only 40-50 percent as many services could be provided — with no real gain in coverage.

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6. This was the *maximum* rationing under the “dry-run” priority list developed by the Priority Setting Project.

7. The most drastic rationing was known as priority-10-only rationing under the original methodology. Less drastic rationing, cutting out all services below priority 7, would allow about 6% of the below-poverty uninsured to be covered.

8. CONGRESSIONAL RESEARCH SERVICE, ANALYSIS OF OREGON SENATE BILL 27 (1990) (prepared for the Senate Committee on Finance).



No matter how we look at these figures, the conclusion is clear: any substantial expansion of coverage would require either massive new spending, or a reduction of far more than 17% of currently funded services. Oregon would have to double or even triple spending for the affected part of the Medicaid budget to achieve a reasonable level of coverage of the under-poverty population, or the Health Services Commission would have to create a priority list that would permit cutting about one-half to two-thirds of current health services, depending on whether providers are to be paid at existing Oregon Medicaid rates or are really to be paid full costs.

We have now seen a version of how medical care services could be truncated: the 1,600 health services listed by cost-utility ratios and released on May 2. What is missing is the dollar value of what would be saved by cutting off services at different levels. Once that is available, it will be possible to repeat this analysis to see just how draconian the cuts will have to be.

Inherent in this approach is a serious contradiction for the proponents' strongest argument, that cutting back the schedule of benefits will permit more people to be covered. If the benefit package drops to meaningless levels, the number of inadequately insured people will rise, not fall. Is this program a step forward if two-thirds of health care services are not covered, but more people can get the remaining one-third?

It seems that the answer is the same in Oregon as elsewhere: improved coverage under Medicaid can only be accomplished by increasing spending. The alternative, cutting benefits to a meaningless level, is the most hollow of promises to the currently uninsured.

3. Is the Medicaid program in Oregon sufficiently generous to sustain large-scale reductions in covered benefits so that more persons can have a basic level of coverage?

One of the most frequent justifications of the waiver proposal is that it makes no sense for a limited number of people to have a very rich package of benefits, while so many people have no coverage at all. So, the argument goes, if people currently covered were reduced to a basic benefit package, it would be possible to provide that basic package to a larger number of people.

This argument for the rationing proposal hinges on a characterization of Medicaid as a generous package dictated by the federal government and tying the hands of the states. Since state revenues are limited, then, Medicaid is seen as occupying a particularly oner-

ous proportion of state tax revenues. What the argument ignores is that states have broad authority to limit not only who will receive Medicaid benefits, but also the scope, duration, and payment levels for those benefits.

Oregon's Medicaid program, in particular, is by no means generous, burdensome, or rapidly expanding when compared with those in similarly situated states — especially with respect to the AFDC population, the target of the rationing scheme. Quite the opposite: a variety of studies over a number of years have documented the fact that Oregon actually has a relatively sparse Medicaid program.

For example, a study recently reported that, between January and July, 1989, while fifteen States expanded Medicaid eligibility for pregnant women and infants, only one — Oregon — lowered its eligibility threshold.<sup>9</sup> As of that date, only five states had lower thresholds.<sup>10</sup> Data from another study of Medicaid show that between 1975 and 1986, Oregon had nearly a 4% decrease in the number of Medicaid beneficiaries, while nationwide there was an increase of just over 2%. At the same time, 31 of the 52 Medicaid programs had greater increases in Medicaid payments than experienced in Oregon.<sup>11</sup>

Davidson developed a comprehensive index to compare Medicaid programs that takes into consideration eligibility, benefits, payment levels and administration.<sup>12</sup> Only two states had programs with a lower score than Oregon.

Per capita spending on enrolled beneficiaries is perhaps the best indicator of whether a state's spending is generous for those who are fortunate enough to be covered. Two recent reports show that per capita Medicaid payments on behalf of AFDC children in Oregon are substantially below the national average, and have been declining. In 1986, Oregon's Medicaid payments per child on AFDC ranked 13th lowest among states;<sup>13</sup> by 1988, its ranking had fallen

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9. National Governors' Association, Washington, D.C.

10. HOUSE COMM. ON WAYS AND MEANS, 101ST CONG., 2ND SESS., OVERVIEW OF ENTITLEMENT PROGRAMS 101-29, Table 20 (Comm. Print 1990).

11. CONGRESSIONAL RESEARCH SERVICE, MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS. REPORT FOR THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT 100-AA, Tables I-13, I-14 (Comm. Print 1988).

12. Davidson, Medicaid and Children With Special Healthcare Needs, Table 10 (Jan. 22, 1987) (working paper for National Maternal and Child Health Resource Center, University of Iowa).

13. CONGRESSIONAL RESEARCH SERVICE, MEDICAID SOURCE BOOK: BACKGROUND

to 8th lowest.<sup>14</sup> During the same period, Medicaid spending on AFDC adults declined from 18th lowest among states to 11th.

Total Medicaid spending as a proportion of all state revenues is relatively low in most states, and Oregon is no exception. Yet another report showed that Medicaid expenditures were only 6.9% of Oregon's total spending in 1981, the eleventh-lowest level in the country.<sup>15</sup> Nonfederal Medicaid expenditures as a percentage of the state's budget, at 5.0%, were similarly ranked, with but sixteen states having a lower level.<sup>16</sup>

More recent figures for 1989 and 1990 show an even more dramatic pattern. In fiscal year 1989, total Medicaid spending as a proportion of all state revenues was 6.3% in Oregon, the fifth-lowest level in the country, with a national average of 10.8%.<sup>17</sup> The measure of state dollars put forward to be federally matched, State General Fund expenditures for Medicaid, were 3.7% and 3.5% in Oregon, and 9.0% and 9.2% nationally, in 1989 and 1990, respectively.<sup>18</sup>

Senator Al Gore has put these figures into perspective with a provocative calculation. He estimates that if Oregon would but increase its spending on Medicaid to the national average, it could add nearly 140,000 new beneficiaries — without any rationing.<sup>19</sup>

In short, this rationing wolf is baring its teeth at the wrong grandchild — there is simply no evidence that Oregon's Medicaid budget is the place to begin looking for unnecessary care and exorbitant costs in the current system.

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DATA AND ANALYSIS. REPORT FOR THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT 100-AA, Table IX-3 (Comm. Print 1988).

14. HOUSE COMM. ON WAYS AND MEANS, 101ST CONG., 2ND SESS., OVERVIEW OF ENTITLEMENT PROGRAMS 101-29, Table 18 (Comm. Print 1990).

15. Davidson, Cromwell, & Schurman, *Medicaid Myths: Trends in Medicaid Expenditures and the Prospects for Reform*, 10 J. HEALTH POL. POL'Y & L. 699 (table 2) (1986).

16. *Id.* at 706-07 (table 3).

17. Federal Funds Information Service, National Governors' Association, Washington, D.C., 1990; information provided to the office of Senator Al Gore.

18. Fabricius, Gold & Eckl, *State Budget Actions in 1989 (1989)* (National Conference of State Legislatures, Legislative Finance Paper #69).

19. Analysis prepared by the Office of Senator Al Gore (D-Tenn.), May 22, 1990. Assumes that spending would be at the same per capita level as for current Medicaid beneficiaries, \$1,935 per year; this is a very conservative estimate since spending on current beneficiaries includes high expenditures on the aged and disabled, and new enrollees would more closely resemble the AFDC population.

4. Would the program involve individuals affected by the program in a meaningful way in the decisionmaking process?

The rhetoric about the priority-setting proposal has emphasized the importance of letting people decide for themselves how resources should be allocated. For example, after quite accurately characterizing the insidious way that states have cut Medicaid eligibility by doing nothing — or even by seeming to increase coverage — Senator Kitzhaber then portrays the Oregon bill as establishing “a process to achieve social and political consensus on what should be included in a package of ‘basic benefits.’” He argues that what has been lacking in previous attempts is a “responsible process to determine the level of care to which everyone *should* have access.” The bill, he says, establishes a public process that will “prioritize health care services. . . based on the beneficial effect each service has on the entire population being served. . . .”<sup>20</sup>

In a similar vein, bioethics consultant John Golenski described the “town meetings” and “citizen parliament” convened by Oregon Health Decisions to involve citizens in setting health priorities. One of the principles for setting priorities was that “value judgments should be obtained in such a way that the needs and concerns of minority populations are not undervalued.”<sup>21</sup>

These quotes characterize the way that the program has been portrayed. The reality, however, is quite different: it was politicians who decided to limit the program to AFDC children and adults; a politically-appointed commission is making the recommendations about what the priorities should be; and real decision-making will be done by the legislature and the Governor.

Notwithstanding all of the rhetoric, AFDC adults and children were not the people who decided that only their portion of the Medicaid program should be subjected to rationing. Contrary to the description of the process as something being done by people for themselves, and introducing rational decisionmaking into what was previously *ad hoc* rationing, the rationing proposal looks just like a scheme being imposed on the poor by the nonpoor.

No one asked the AFDC beneficiaries if they wanted to contribute their modest, and already shrinking, share of the Oregon Medicaid budget to this experiment. No one even obtained their informed consent for being experimental subjects.

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20. Kitzhaber, Discussion Paper, Senate Bill 27 (Aug. 1, 1989) (prepared for the Office of the Oregon Senate President).

21. Golenski, A Report on the Oregon Medicaid Priority Setting Project (1990).

The net result looks indistinguishable from other processes for cutting Medicaid spending. AFDC mothers and children have their benefits cut, while having no real voice in the process. Instead, the process that is actually being used would merely insulate politicians from visible responsibility for imposing rationing on AFDC children and adults rather than asking affected people to make such decisions for themselves.

5. Will the proposal curb either medical cost inflation in general or increases in Oregon's Medicaid budget?

In one sense, this question might be answered quite easily. The proposal does not purport to curb Medicaid spending. Rather, its stated purpose is to redistribute public spending so as to expand the number of persons covered. In fact, it would not be unreasonable to infer that a thus-far tacit purpose is actually to increase overall public spending.

There are, nevertheless, two clear reasons for inquiring in more detail as to the likely effects on health care expenditures of the waiver proposal. First, the author of this proposal, John Kitzhaber, specifically highlights the growth in medical care costs in his introduction to the waiver proposal.<sup>22</sup> The implication is that this proposal for Medicaid rationing is an appropriate response to this widely recognized issue. Second, the proposal would establish a mechanism that could easily be used to limit services to be covered. If the approach were to prove workable for the indigent population in Oregon, it might well be seen as a more generally useful way to curb spending.

It appears that any implication that the proposal as it is currently pending could curb health care spending is quite unjustified. Since the only restrictions would be on the Medicaid population, private payers would be able to continue to buy as much health care as the traffic will bear. This means that the principal inflationary factors in health care would be left untouched. Those factors include fraud and abuse, administrative inefficiencies, and unnecessary or ineffective medical care.

Fraud and abuse account for at least \$10 billion per year in the current system, and many place the figure much higher.<sup>23</sup> What does this proposal do to limit fraud and abuse? Nothing in the pro-

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22. Kitzhaber, *supra* note 20.

23. Jenks, *40% of Patients Cite MD Fraud*, 29 MED. WORLD NEWS 56 (1988).

posal is specifically intended to limit fraud or abuse either within or outside of the Medicaid program.

Administrative inefficiencies in our pluralistic system are costly. Administrative expenses range from 5.5 to 40 percent of incurred claims, depending on the size of the group being insured.<sup>24</sup> A major investment firm estimates that "eligibility determinations" eat up \$26 billion per year.<sup>25</sup> What does this proposal do to improve efficiency? The answer, again, is nothing, at least with respect to the vast majority of care. Proponents might claim that the system will increase efficiency within Medicaid by tying all beneficiaries to pre-paid systems. As the discussion in section 6, below, makes clear, however, the piecemeal coverage system being proposed would make matters far more complicated to administer in real medical care situations.

Critics now point to as much as 20-30 percent of medical care as being ineffective, unnecessary or inappropriate. The proposal does promise to address this aspect of cost inflation. The approach that would be used, however, is fatally flawed, as was discussed in section 1, above; it would not assure that the services to be excluded from coverage were the unnecessary or ineffective ones.

In addition to failing with respect to the three major identified causes of medical cost inflation in general, the proposal cannot even be expected to help curb total Medicaid spending because it deals with but a fraction of the Medicaid population. The proposal targets only the AFDC population, which accounts for a relatively small proportion of Oregon's Medicaid expenditures. Moreover, spending on this group is neither the most expensive nor most rapidly growing Medicaid budget component.

In terms of what it pays for, Medicaid is not one program, but three. In general, Medicaid buys medical care for AFDC adults and children, long term care for the impoverished elderly and disabled, and intermediate care for the mentally retarded. AFDC adults and children are the most numerous of the beneficiary groups, but they account for less than thirty percent of expenditures. In addition, their share of the pie has been decreasing dramatically over the last decade.<sup>26</sup>

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24. CONGRESSIONAL RESEARCH SERVICE, *COST AND EFFECTS OF EXTENDING HEALTH INSURANCE COVERAGE* (1989).

25. Paine Weber report.

26. CONGRESSIONAL RESEARCH SERVICE, *MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS. REPORT FOR THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT 100-AA, Figure I-14* (Comm. Print 1988).

With respect to cutting public expenditures, then, the most serious weakness of the rationing proposal is that it targets only the AFDC Medicaid population. Since it affects the smallest part of the Medicaid budget, one that is in fact already constricting, this proposal would do nothing to curb growth in the largest component of Medicaid spending, long term care. Those services unaffected by this proposal will continue to consume an ever-increasing share of Oregon's tax revenues.

The likely consequence is that the new "expanded eligibility" program in Oregon will have less and less money each year. Its resources would be governed by the terms of the waiver, which would provide a tool for controlling expenditures automatically, by simply cutting services to meet the politically acceptable level of appropriations in a given year. As the larger, uncontrolled part of the Medicaid budget continues to grow, the share for "expanded eligibility" would fall. This would be the result unless the proponents of AFDC rationing find the political wherewithal to cut long term care or to increase total state spending drastically.

In sum, although impliedly purporting to address the well-known problem of uncontrolled cost increases in the health care sector, the rationing proposal is not a bold new measure to control medical cost inflation. In fact, the proposal would have no effect whatsoever on overall health care spending. It simply looks to redistribute — and create a passive mechanism for cutting — the smallest part of the Medicaid budget, the AFDC component.

In a very real sense, by narrowing its focus to the AFDC population, this proposal amounts to a political surrender to the increasing costs of health care. Such a rationing approach could perhaps have a positive effect on health care costs — or at least on democratizing societal expenditures for health care — if it were applied to everyone. For example, if Oregon were to say that *no* health care plan could pay for any item that the public program would not cover, then all of those procedures and services would be thrown back into the marketplace. Under a universal application of this proposal, people would have to determine for themselves whether to purchase a low-priority service. In that case, it would be at least arguable that there would be cost-savings. The waiver as proposed, however, offers no such potential for savings.

6. Will the proposal facilitate caring for Medicaid beneficiaries and increase provider payments as promised, or would it merely establish a patchwork quilt of coverage that would vastly complicate caring for covered individuals?

There is an inherent Catch-22 for health care providers in any rationing scheme, and it gets murkier and murkier as the scheme becomes more constraining. That catch is that people will still have medical care needs whether or not the public program will pay to meet those needs — and health care professionals will have to decide whether or not to treat those people. Moreover, health professionals have to care for entire human beings and all the stages and complications of diseases, and cannot circumscribe care to fit a budget-driven pattern of coverage.

One of the promises of the new program is that it will produce a “system that guarantees universal access to adequate care; . . . a system that allows physicians to continue to be patient advocates within the context of the resources society has made available.”<sup>27</sup> Unfortunately, it appears that under any system that provides only certain services and not others, conflicts would immediately arise that would hardly leave physicians as happy advocates for their patients.

As noted above, it is extremely likely that the proposed system would require far more extensive priority-setting and rationing than permitted by the 10 categories on the initial Priority Setting Project list. But even that early list demonstrates the way that conflicts will inevitably make patient care a nightmare. For example, emergency repair of a fractured hip was listed as a priority 10. Physical therapy with predictable return to full or acceptable function, however, had only a priority 9. Subsequent orthopedic procedures for the replacement of a total hip for intractable pain or absence of mobility lagged behind at priority 8, while rehabilitation for improvement of function only rose to level 7.

The pattern is clear, and would be repeated over and over across all of medical care. Acute, emergency treatment covered; subsequent care questionable or not covered. The “physician advocate” would have to tell patients that absolutely necessary care, care that normally would follow earlier care delivered by that physician, is not covered. The more elaborate the priority list, the more complicated the treatment situations and decisions. It is not difficult to

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27. Kitzhaber, *supra* note 20.



imagine how complicated care would become under the more recent 1,600-item approach.

It would be quite a challenge to convince current Medicaid beneficiaries that doctors and hospitals will be much happier to care for them once they have a list of 1,600 procedures to consult to see whether they are covered or not.

The proposed scheme would put more and more people into this situation. Rather than being insured for a reasonable package of appropriate care, individuals under the new program would be partially insured. The result would be chaos for responsible providers. The net effect of this proposal on medical care would trigger more cross-subsidies as providers who met the real needs of their patients were stuck with the bills for excluded (low-priority) services.

When services are not covered, either they are not received, or they are provided and people pay out-of-pocket or don't pay. By definition, the population subject to the rationing scheme is not able to pay out-of-pocket. If cross-subsidies are available, then what care is provided will be covered exactly as it is today. What's more likely is that the care will not be provided at all, or it will be last-minute, last-ditch care.

The legal and ethical consequences of partial-coverage arrangements deserve particular notice. Generally, providers who initiate care must not abandon their patients in mid-course. Inability to pay is not a legally recognized defense against a claim of abandonment.<sup>28</sup>

Under a rationing scheme in which parts of care are covered and other parts are not covered, providers frequently would be in difficult legal and ethical situations. Having delivered care that was covered they would face decisions on patients who need follow-up care that is not covered.

Oregon addressed this problem by obliterating the law of abandonment. Senate Bill 27 immunizes providers from civil, criminal, or professional sanctions if they engage in conduct that would constitute abandonment when dealing with their "expanded-access" patients.<sup>29</sup> Yet another formal distinction would be drawn between public and private patients. Physicians could engage in unethical behavior and the state law would protect them against professional,

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28. A. SOUTHWICK, *THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION* (1988).

29. Oregon Regular Session, Chapter 836, Laws 1989, Senate Bill No. 27, Section 6(1) (codified within Or. Rev. Stat. §§ 414.036 *et seq.*).

civil or criminal sanctions. How far this immunity would extend would have to be tested in court. For example, if the failure to provide uncovered care to an established patient resulted in serious harm or death, would the courts actually sustain immunity for such a physician under the tort system?

Finally, what about the requirement that providers be paid at their full costs of delivering the services? The Oregon legislation requires that providers be "reimbursed at rates which cover the costs of providing the covered services."<sup>30</sup> As Senator Kitzhaber explains, if revenues decline "during the budget period, the state cannot redefine the population nor reduce reimbursement below the actuarially determined cost."<sup>31</sup>

Oregon, however, would be most unlikely to increase provider payments substantially above current Medicaid levels. To do so would require unacceptably large increases in expenditures or an unacceptably low level of benefits. If the state actually were to pay "costs" at a level that providers in Oregon would recognize as such, it could not achieve "discounts" equal to current below-market Medicaid rates. The difference between current Medicaid payment rates and provider charges in Oregon was estimated by the actuarial consultants at some 40-45%.<sup>32</sup> The Oregon Medical Association claims that physicians are paid less than 30% of their full fees by Medicaid, well below their office overhead of 50-60%.<sup>33</sup>

The state cannot have it both ways. Either it must use the non-discounted actuarial estimates, and recognize the vast increases in expenditures required to pay full costs, or it must admit that "costs" in the new system will be defined pretty much as what Oregon's Medicaid program currently pays.

7. Is such an extreme measure justified by an extraordinarily serious fiscal situation in Oregon?

Medicaid was tacked on as a companion to Medicare as a program to provide health care for low-income people. The strength of both programs — and, as it has developed, their political Achilles heel in some ways — is that they are open-ended keys to the Treasury. Both programs are "entitlements." That is, they represent a judgment that physicians and other health professionals should de-

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30. *Id.*

31. Kitzhaber, *supra* note 20.

32. Axene, Massingill, & Giesa, *supra* note 3.

33. OREGON MEDICAL ASSOCIATION, BRIDGING THE GAP: THE ROLE OF OREGON PHYSICIANS IN UNCOMPENSATED CARE.

cide what health care is medically necessary, and public programs should then pay for the care. However much needed care is delivered in a given year, that much should be paid for.

Like Medicare, Medicaid has been plagued with budgetary problems. States have concocted a myriad of ways to keep spending under control. The principal techniques have been to limit payment rates to well below market value; to control eligibility by failing to raise AFDC payment standards with inflation; to place tight constraints on the amount, scope and duration of benefits; and to impose managed, prepaid, and other systems to reduce utilization.

All of these attempts to control spending have meant that the reality of Medicaid has often fallen far short of the promise in some states. Nevertheless, these prior cost-cutting approaches are of a different character than the rationing proposal. As pointed out above, this approach would vastly complicate patient care. More broadly, the long list of waivers being sought would essentially eliminate any assurance that federal funds would be spent on a reasonable package of benefits.

Implementing the rationing scheme would require statewide waivers of freedom of choice, of statewide availability of services, of comparability of benefits across beneficiaries, of protection against exclusions based on specific diagnoses, of provision of mandatory services, and of requirements that contracted providers be federally or state-certified.<sup>34</sup> In short, the state would get federal matching dollars to provide the AFDC population with only such services as its budgetary and political climate at the moment dictated, while continuing to get federal matching funds for long term care for the elderly and disabled.

In this way, the proposal undermines the political compact that linked long term care spending to services for AFDC mothers and children. Nursing homes and intermediate care facilities for the mentally retarded could increase expenditures at the immediate expense of benefits for the AFDC and other expanded-access beneficiaries.

The result under the new proposal is precisely the antithesis of the philosophy of the Medicaid program: an entitlement empowering the low-income population to a reasonable package of medical care. As such, the proposal would reverse direction and set a precedent that less-than-adequate care is sufficient for the poor.

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34. CONGRESSIONAL RESEARCH SERVICE, ANALYSIS OF OREGON SENATE BILL 27 (1990) (prepared for the Senate Committee on Finance).

What proponents of the waiver are calling for would establish a dramatic and quite formal legal distinction between the type and extent of medical care available to poor and nonpoor people. The proponents argue that Medicaid has done this *de facto*, so why not do so more openly. The response is that this approach would constitute a major departure from traditional notions of the moral obligations of the wealthier members of this society toward the less fortunate that were embodied in the Medicaid program some twenty-five years ago. Rather than continue efforts toward a just and equitable societal goal, this proposal says, let's change the goal.

The principal justification for this radical shift away from the Medicaid paradigm is that states have reached the limits of their resources, so they should be allowed to decide for themselves how to spend what they can afford. Perhaps this proposal and its deviation from traditional moral values might be understandable if Oregon were in the midst of extreme economic hardship and simply could not spend more. On the other hand, if Oregon were not particularly worse off than the rest of the states, then the rationing plan could be viewed as no more than an above-average willingness to withhold assistance from the poor.

At least in the case of Oregon, it is not at all clear that the state has actually reached a reasonable limit on public resources. As pointed out in section 2 above, Oregon is actually spending far less than other states on Medicaid. Could the state afford to spend more? Data show that while Oregon is not particularly wealthy, it is certainly not in extraordinary financial straits, nor is it exceptionally overtaxed. Analysts at the Advisory Commission on Intergovernmental Relations have calculated how much a state would raise if it applied national average tax rates to its tax base ("tax capacity"), and how much total revenue it would raise if it added in a number of nontax revenue bases ("revenue capacity").<sup>35</sup> They then compare what a state could have raised to what it actually did raise ("tax effort" and "revenue effort"). In 1986, Oregon's ability to raise taxes and other revenues by these measures were below the national average, but not strikingly so. The state ranked 29th in tax capacity and 31st in revenue capacity. Its tax efforts and revenue effort were just below and just above the respective national averages, ranking 22nd and 14th. Preliminary data for 1988 show that the state is not much better or worse off than it had been earlier.

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35. U.S. ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS, STATE FISCAL CAPACITY AND EFFORT 1986, REPORT M-165.

These numbers do not support any claim that Oregon is vastly overtaxed, compared with its wealth. Several other states could make a much stronger case. For example, Wisconsin and Iowa both were well below Oregon in terms of tax and total revenue capacities, but both were not only ahead of Oregon but actually substantially above the national average in tax and revenue effort.

If Oregon is not particularly poor or overtaxed, are there other reasons why this proposal has some currency in that state? One possibility is that the tax structure, not the relative tax burden, is what stimulates interest in virtually any proposal to constrain public expenditures.

Oregonians have a tax structure that makes tax collection a highly visible activity. Both personal income taxes and property taxes are among the highest in the country, ranking third and eighth, respectively. Personal income taxes are 175% of the national average, and property taxes 138% of the national average.<sup>36</sup> These two taxes are relied on because the state has no sales tax.

With such highly visible taxes, the public watches the income and property tax rates very carefully. Thus, even though Oregonians may not be severely overtaxed, they feel as if they are. Oregon has enacted a Proposition-13 type cap on tax revenues as well. This is a particularly inflammatory combination: the tax cap forces programs to compete directly with each other, fuels notions of a "fixed pot," and all the while the public is watching and policymakers are drawn toward budget cutting devices, such as the proposal to ration Medicaid coverage.

Whenever dramatic new public policy ideas involve tax considerations it is important to examine whether those proposals disproportionately target a politically vulnerable population. With respect to the Oregon waiver, the relevant question is why the proposal deals only with the AFDC component? After all, the original description of the program purported to deal with all aspects of health care.

When asked a question along these lines, an aide to Senator Kitzhaber is reported to have said that the elderly and disabled were exempted "because it was tougher to set priorities and envision benefit cuts because these groups require primarily chronic care rather than acute care."<sup>37</sup> It is not at all clear just what that re-

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36. *Id.*

37. Kosterlitz, *Oregon Wants a Little Medicaid Slack*, 1989 NAT'L J. 2767.

sponse is supposed to mean, since long term care could also be dissected into components and subjected to a priority-setting process.

There is certainly no empirical justification for imposing a rationing scheme on the AFDC population alone. This appears to be a political, not scientific, judgment.

### CONCLUSION

The rationing proposal is an unnecessary, ill-advised human experiment that should not be imposed on the AFDC children and adults of Oregon or any other state. It would fail to achieve its stated objectives while producing substantial confusion and human suffering. Perhaps worst of all, it would raise false hopes while hiding behind a cloak of citizen participation.

