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Greg Phyllip Roggin

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# THE "OREGON PLAN" AND THE ADA: TOWARD RECONCILIATION

## INTRODUCTION

Americans spend over \$733 billion on health care each year.<sup>1</sup> As a result, the United States has the finest physicians and medical centers in the world.<sup>2</sup> Unfortunately, an increasing number of Americans are effectively denied access to these superior medical services because they cannot afford to pay the high costs.<sup>3</sup> The results are devastating. The United States ranks twelfth in the world in life expectancy<sup>4</sup> and has one of the highest infant mortality rates among industrialized nations.<sup>5</sup>

In spite of these problems, the United States is one of the only industrialized nations that fails to offer its citizens a universal health care program.<sup>6</sup> Medicaid is the closest alternative, but rising health care costs have forced many states to drastically reduce the number of eligible recipients.<sup>7</sup> As a result, over thirty-seven million Americans are presently uninsured.<sup>8</sup> These individuals can only hope that they will never require medical treatment.

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1. Janice Castro, *Condition: Critical*, TIME, Nov. 25, 1991, at 34, 34-35.

2. B.D. Colen, *Strong Medicine*, HEALTH, May 1991, at 32.

3. Eric L. Robinson, Note, *The Oregon Basic Health Services Act: A Model for State Reform?*, 45 VAND. L. REV. 977, 979 (1992).

4. *The Health Care Crisis and the American Family: Hearing Before the Senate Comm. on Labor and Human Resources*, 102d Cong., 1st Sess. 64 (1991).

5. *Id.*

6. Colen, *supra* note 2, at 32. South Africa is the only other industrialized country which does not offer its citizens universal health care coverage. *Id.*

7. Daniel M. Fox & Howard M. Leichter, *Rationing Care in Oregon: The New Accountability*, HEALTH AFF., Summer 1991, at 7, 12-14.

8. Castro, *supra* note 1, at 36.

In an effort to reverse this unjust trend, several states have taken the initiative in developing programs that increase accessibility to health care services.<sup>9</sup> Oregon has assumed a leading role in this effort.<sup>10</sup> Oregon's innovative plan extends insurance coverage to ninety-seven percent of its population by rationing health care.<sup>11</sup> If effective, the "Oregon Plan" would serve as a model for other states as well as a viable solution to the national health care crisis.<sup>12</sup>

To implement its bold plan, Oregon needs to obtain federal waivers under the Social Security Act.<sup>13</sup> The Bush Administration denied Oregon's waiver application, claiming that the plan would violate the Americans with Disabilities Act (ADA).<sup>14</sup> In response, Oregon revised its plan to comport with the ADA.<sup>15</sup> The Clinton Administration granted Oregon's waiver application, provided Oregon makes certain changes to the prioritization process.<sup>16</sup>

This Note examines the current relationship between the Oregon Basic Health Services Act (OBHSA) and the ADA. Part I of this Note outlines the OBHSA and its controversial original prioritization methodology. Part II examines the key components of the ADA. Part III sets forth the rationale behind the Bush Administra-

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9. OREGON HEALTH SERVICES COMM'N, PRIORITIZATION OF HEALTH SERVICES: A REPORT TO THE GOVERNOR AND LEGISLATURE 5 (1991) [hereinafter 1991 COMM'N REPORT].

Alaska has adopted an "elimination" list designating categories of health care that can be eliminated should the financial need arise. *Id.* Alaska is the only state other than Oregon to rank health care services. *Id.* Other states which have attempted to contain health care costs include California, Hawaii, Massachusetts, New York, and Washington. *Id.*

10. See, e.g., David M. Eddy, *What's Going on in Oregon?*, 266 JAMA 417, 417 (1991) [hereinafter *What's Going On?*].

11. David M. Eddy, *Oregon's Plan: Should it be Approved?*, 266 JAMA 2349, 2441 (1991) [hereinafter *Oregon's Plan*].

12. Colen, *supra* note 2, at 84. Eighteen states are currently using the "Oregon Plan" as a model. *Id.* Furthermore, Britain and Canada are also considering the plan as a possible solution to their health care problems. Timothy Egan, *For Oregon's Health Care System, Triage By a Lawmaker with an M.D.*, N.Y. TIMES, June 9, 1991, at A18.

13. 42 U.S.C. § 1315(a) (1988).

14. 42 U.S.C. §§ 12101-12213 (Supp IV 1992); U.S. DEP'T HEALTH & HUMAN SERVICES, ANALYSIS UNDER THE AMERICANS WITH DISABILITIES ACT (ADA) OF THE OREGON REFORM DEMONSTRATION (1992) [hereinafter DHHS REPORT].

15. OREGON HEALTH SERVICES COMM'N, THE OREGON HEALTH PLAN REVISED PRIORITY PROCESS (1992) [hereinafter OHSC REVISION].

16. See *infra* notes 279-87 and accompanying text.

tion's rejection of Oregon's waiver application. Part IV analyzes Oregon's revised prioritization process in light of the ADA. Part V explores the Oregon waiver and the required changes in the prioritization process. Finally, Part VI proposes a balancing test for courts to use when confronted with a conflict between the OBHSA and the ADA.

## I. THE OREGON BASIC HEALTH SERVICES ACT

### A. Medicaid: A Brief Overview

Medicaid is a federal health care program that covers the medical expenses of qualified low income and medically needy persons.<sup>17</sup> Individuals must meet their state's pre-set financial requirements to qualify for Medicaid's basic benefits package.<sup>18</sup> This package includes: inpatient hospital services, outpatient hospital services, laboratory and X-ray services, and mid-wife services.<sup>19</sup>

The federal and state governments jointly finance this program under the Social Security Act.<sup>20</sup> A state is eligible to receive federal funds<sup>21</sup> provided it follows federal statutory and regulatory guidelines.<sup>22</sup> The amount of federal assistance ranges from fifty to eighty cents for each state Medicaid dollar spent.<sup>23</sup> This is known as the federal medical assistance percentage (FMAP).<sup>24</sup>

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17. 42 U.S.C. §§ 1396-1396u (1988 & Supp. III 1991). See Mary O. Waid, *Addendum: A Brief Summary of the Medicaid Program*, in HEALTH CARE FINANCING REV. 171-72 (Ann. Supp. 1990) (discussing the complete history of Medicaid).

18. 42 C.F.R. §§ 435.1 to -.1009 (1992) (providing a regulatory scheme under which states may vary coverage). In Oregon, the Medicaid eligibility amount is \$420 per month for a family of four. Colen, *supra* note 2, at 33.

19. 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(1)-(5), (17), (21).

20. 42 U.S.C. §§ 1301-1397e (1988 & Supp. III 1991).

21. Robinson, *supra* note 3, at 982.

22. Sara Rosenbaum, *Mothers and Children Last: The Oregon Medicaid Experiment*, 18 AM. J.L. & MED. 97, 99 (1992). These guidelines prevent alteration to either the basic benefit package or the distribution system without federal government approval. For a detailed description of these guidelines, see 42 U.S.C. § 1396a(a). Sometimes the federal government will grant waivers to state governments trying an experimental project. See 42 U.S.C. § 1315 (setting forth conditions for the waiver).

23. Rosenbaum, *supra* note 22, at 100.

24. *Id.* Oregon's 1991 FMAP was 63.5%. *Id.*

Since Congress introduced Medicaid in 1965, the cost of health care has skyrocketed.<sup>25</sup> As a result, state Medicaid expenditures have increased dramatically.<sup>26</sup> Medicaid consumes an average of eleven percent of most state budgets,<sup>27</sup> and is expected to pass fifteen percent within the next two years.<sup>28</sup> To combat this growing financial burden, many states have decided to revamp their Medicaid distribution systems.<sup>29</sup>

Under the current Medicaid plan, a state may implement its own distribution system provided it obtains the necessary waivers under the Social Security Act.<sup>30</sup> Although the Act requires waivers for a state to alter funding of mandatory Medicaid services,<sup>31</sup> waivers are unnecessary to eliminate optional services.<sup>32</sup> For example, a state wishing to redefine its basic benefits package must obtain waivers,<sup>33</sup> but does not need waivers to eliminate soft-tissue transplants.<sup>34</sup> Waivers are granted either administratively by the Health Care Financing Administration (HCFA) or statutorily by Congress.<sup>35</sup> If the

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25. Robinson, *supra* note 3, at 979. In 1991, the United States spent 12.3% of its GNP on health care, compared to 9.4% in 1980. *Id.* While the United States spends 50% more of its GNP on health care than any other major country, a substantial number of its citizens cannot afford access to health care services. *Id.*

26. *Id.* at 988.

27. *Id.* In 1965, this figure was only 5%. *Id.*

28. *Id.*

29. Robinson, *supra* note 3, at 983. To cope with the rising costs of health care, most states have lowered the maximum allowable income to levels far below the federal poverty line (FPL), reducing the number of individuals Medicaid covers. *Id.* As a result, over 60% of the poor (*i.e.*, those whose incomes fall below the FPL) qualified for Medicaid in 1980, while less than 40% qualify today. *Id.*

30. 42 U.S.C. § 1315(a). However, the federal government has never granted a waiver allowing a state to abolish services within the Medicaid basic benefits package. Lawrence D. Brown, *The National Politics of Oregon's Rationing Plan*, HEALTH AFF., Summer 1991, at 28, 33.

31. 1991 COMM'N REPORT, *supra* note 9, at 40.

32. See 42 U.S.C. § 1315(a); *cf.* 42 U.S.C. § 1396a(9)-(10). Optional services include clinical services, dental services, home health care services, private nursing services, and soft-tissue transplants. § 1396d(a)(7)-(10), (12).

33. § 1315(a); *cf.* 1991 COMM'N REPORT, *supra* note 9, at 40.

34. 42 C.F.R. §§ 485.301-308 (1992) (providing that states may use Medicaid funds to support "organ procurement organizations" provided the organizations meet regulatory guidelines).

35. *What's Going On?*, *supra* note 10, at 417.

federal government denies the waiver, the state cannot implement its program without risking the loss of its FMAP.<sup>36</sup>

### B. *History of the OBHSA*

By 1987, the rising costs of health care prompted the Oregon Legislature to reallocate its scarce Medicaid funds.<sup>37</sup> With only \$21 million to pay for \$48 million in critical social programs,<sup>38</sup> Oregon decided to eliminate optional Medicaid services such as soft-tissue transplants.<sup>39</sup> Rather than spend \$1.1 million on soft-tissue transplants for an average of 11 people per year,<sup>40</sup> the legislature redirected the funds toward prenatal care for over 1500 women.<sup>41</sup> To justify this decision, Oregon claimed that funding prenatal care would save more lives.<sup>42</sup>

The legislature's "adjustment" of fund allocation soon came under severe scrutiny. In December of 1987, a seven-year-old boy named Coby Howard was refused funding for a potentially life-sav-

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36. 42 U.S.C. § 1396(c); *see also* 42 C.F.R. § 430.35 (1992). Without federal financial assistance, states would be unable to fund their Medicaid programs.

37. *See* Norman Daniels, *Is the Oregon Rationing Plan Fair?*, 265 JAMA 2232, 2232 (1991). An Oregon citizens' group called Oregon Health Decisions (OHD) strongly influenced this decision. *Id.* at 2234. OHD conducted meetings for the general public about the status of state health care. *Id.* The survey found that most people in Oregon wanted Medicaid expanded to guarantee universal access to basic care, rather than provide expensive procedures for a few. *Id.* The results of this survey influenced the Legislature's decision to reallocate its Medicaid funds. *Id.* at 2235.

38. *What's Going On?*, *supra* note 10, at 417.

39. *Id.* Only 38 states funded liver transplants, and only 40 states funded heart transplants in 1990. Spencer Rich, *Organ Transplants: Rationing by Wallet?*, WASH. POST, Sept. 1, 1991, at A1.

40. Colen, *supra* note 2, at 33.

41. *Id.*

42. Robinson, *supra* note 3, at 989. *See also* Daniels, *supra* note 37, at 2232 (claiming that the consequences of ignoring the need for prenatal care are much worse than the consequences of refusing to fund transplants for a few children).

Prenatal care is a form of preventative health care. One California study illustrates the importance of access to preventive health care. Victor Cohn, *Rationing Medical Care*, WASH. POST, July 31, 1990, at Z10. In 1982, California dropped 270,000 people from its Medicaid program to fund organ transplants. *Id.* After monitoring two groups of 186 people, the study concluded that California's change in policy may have caused between 5,000 and 10,000 deaths. *Id.* Most of these deaths may have been prevented, as they resulted from lack of medicine for diabetes and high blood pressure. *Id.*

ing bone marrow transplant.<sup>43</sup> After raising \$80,000 of the \$100,000 needed for the operation, Coby died of leukemia.<sup>44</sup> This highly publicized incident forced the Oregon Legislature to re-examine its entire Medicaid distribution system.<sup>45</sup>

In 1988, Medicaid was only available to Oregon residents who did not have a pre-existing medical condition<sup>46</sup> and who earned less than fifty-two percent of the federal poverty level.<sup>47</sup> These stringent standards left over 400,000 Oregonians without insurance.<sup>48</sup> Thus, a family of four struggling to survive on \$541 per month was considered "too rich" to qualify for Medicaid, even though private insurance would drain over \$200 per month from the family's meager funds.<sup>49</sup>

Realizing that "the public and private sectors no longer could afford to pay for everyone to receive all desired health care services,"<sup>50</sup> the Oregon Legislature passed the Oregon Basic Health Services Act (OBHSA).<sup>51</sup> The OBHSA attempts to solve the problem of uninsured Oregonians by offering coverage to all Oregon residents who fall below the federal poverty level. The OBHSA also creates an insurance fund for up to 20,000 residents who were previously ineligible for health insurance because of pre-existing medical conditions.<sup>52</sup>

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43. Colen, *supra* note 2, at 33. See Harvey D. Klevit et al., *Prioritization of Health Care Services: A Progress Report by the Oregon Health Services Commission*, 151 ARCHIVES INTERNAL MED. 912, 912 (1991) (clarifying that Coby was not a good candidate for a bone marrow transplant because his leukemia was not in remission).

44. *What's Going On?*, *supra* note 10, at 417.

45. Colen, *supra* note 2, at 33. Oregon's refusal to fund Coby's operation prompted public criticism that Oregon was trying to save money at the expense of a young boy's life. See Cohn, *supra* note 42.

46. Colen, *supra* note 2, at 33.

47. *Id.*

48. *Id.* The federal poverty line for a family of four is \$5,040. *Id.* Only 162,000 of these people had any chance of qualifying for Medicaid. *Id.* "To continue to withhold Medicaid eligibility from some 238,000 people, in order to offer extensive benefits to a small portion of those in need, seemed morally questionable." *Id.* (quoting John D. Golenski, Ph.D.).

49. *What's Going On?*, *supra* note 10, at 418.

50. Robinson, *supra* note 3, at 989.

51. OR. REV. STAT. §§ 414.705-.750 (Supp. 1992).

52. Robinson, *supra* note 3, at 994.

### C. Overview of the OBHSA

The OBHSA is a three part plan which would provide access to basic health care for ninety-seven percent of Oregon's citizens.<sup>53</sup> Senate Bill 935 offers coverage to over 330,000 employed Oregonians with incomes above the federal poverty level.<sup>54</sup> To accomplish this goal, the Bill offers tax incentives for employer-sponsored insurance.<sup>55</sup> Senate Bill 534 guarantees insurance to all employees with incomes above the federal poverty level who do not qualify for employee-sponsored coverage. The Bill creates a state health-risk pool to accomplish this goal.<sup>56</sup>

The crux of the OBHSA is Senate Bill 27,<sup>57</sup> which extends Medicaid coverage to almost all citizens below the federal poverty line. This controversial bill established the Oregon Health Services Commission (OHSC), an eleven-member group consisting of five doctors, four health care consumers, one nurse, and one social worker.<sup>58</sup> Every two years this group will create a list of various medical conditions and corresponding treatments.<sup>59</sup>

Initially, OHSC compiled a list of 709 condition/treatment pairs.<sup>60</sup> OHSC ranked these pairs according to the treatment's importance

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53. See *Oregon's Plan*, *supra* note 11, at 2441.

54. Robinson, *supra* note 3, at 995. Senate Bill 27 covers those who are below the federal poverty level. See *infra* notes 57-67 and accompanying text for a description of Senate Bill 27.

55. Robinson, *supra* note 3, at 995. Under Senate Bill 27, all employers with fewer than twenty-five employees are eligible for tax credits if they have not provided health insurance during the past two years. This bill authorizes the Legislature to eventually extend the plan to all employers, regardless of the number of employees. *Id.* All employers who qualify must provide "an insurance package at least equal to those funded by the state through Medicaid." *Id.*

56. *Id.* at 994. Risk pools offer coverage to people who are otherwise uninsurable because of a pre-existing medical condition. Up to 20,000 otherwise uninsurable Oregonians will receive coverage under this risk pool program. *Id.* For a discussion of risk pools, see *id.* at 994 n.151.

57. OR. REV. STAT. §§ 414.705-.750 (Supp. 1992).

58. § 414.715. The composition of OHSC is statutorily mandated. *Id.* Senate Bill 27 also expressly provides for a Subcommittee on the Elderly, Blind, and Disabled for the purpose of assisting OHSC in "identifying special health needs of these populations." Act of Aug. 5, 1991, ch. 753, § 7, 1991 Or. Laws 753. Members of OHSC are limited to four year terms, and receive no compensation except necessary travel expenses. § 414.715(2)-(3).

59. § 414.720.

60. Rosenbaum, *supra* note 22, at 104. The HSC defined services as pairs of medical conditions and the corresponding treatments. *What's Going On?*, *supra*



in contributing to the patient's quality of life.<sup>61</sup> OHSC then placed each pair in one of seventeen service categories<sup>62</sup> based on the expected benefit of the treatment.<sup>63</sup> For example, "treatable brain cancer" (line 371) received higher priority than "traumatic brain injury" (line 684) because of its greater benefit and contribution to the quality of life.<sup>64</sup> Funding is on a priority basis until all cash resources are depleted.<sup>65</sup> Any item below the cut off line will not be funded.<sup>66</sup> Although the OHSC recommended coverage through line 640, the Oregon Legislature decided to provide funding for only the first 587 condition/treatment pairs.<sup>67</sup>

The most controversial aspect of the OBHSA is the method of prioritization.<sup>68</sup> The following section examines the methods OHSC employed in prioritizing the original list of condition/treatment pairs.

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note 10, at 417. The HSC defined conditions under the International Classification of Diseases (ICD-9) codes. *Id.* Current Procedural Terminology (CPT-4) codes were used to define treatments. *Id.* The HSC analyzed over 1,600 conditions before creating the list of 709 condition/treatment pairs. *Id.* For a complete listing of prioritized condition/treatment pairs, see 1991 COMM'N REPORT, *supra* note 9, at app. J.

61. Charles J. Dougherty, *Setting Health Care Priorities; Oregon's Next Steps*, HASTINGS CENTER REP., May-June 1991, at 1, 3. See also Rosenbaum, *supra* note 22, at 104. The pairs were prioritized "using a formula that considers the cost of the treatment, the benefits to be obtained from the treatment, and the quality of life that can be expected for an individual receiving the treatment for the particular condition in question." *Id.*

62. Rosenbaum, *supra* note 22, at 104-05. See *infra* note 101 and accompanying text for a detailed list of service categories.

63. Rosenbaum, *supra* note 22, at 105.

64. Joseph P. Shapiro, *To Ration or Not to Ration*, U.S. NEWS & WORLD REP., Aug. 10, 1992, at 24.

65. *Id.* To contain costs, the bill requires the state to contract with pre-paid managed care plans and simultaneously determine the level of reimbursement to physicians. Dougherty, *supra* note 61, at 3.

66. Shapiro, *supra* note 64, at 24. Examples of condition/treatment pairs which fall below the funding line include: post-mastectomy breast reconstruction (line 600), end-stage AIDS (line 702), and life support for a baby born with an incomplete brain (line 709). Senate Bill 27 also protects health care providers from legal action for refusing to provide non-funded services. Dougherty, *supra* note 61, at 3.

67. Rosenbaum, *supra* note 22, at 105.

68. See, e.g., Alexander M. Capron, *Oregon's Disability: Principles or Politics?*, HASTINGS CENTER REP., Nov.-Dec. 1992, at 18 (arguing that Oregon's prioritization process is widely criticized for failing to cover many medically effective treatments).

#### D. Priority-Setting Methodology

After OHSC compiled a complete list of medical conditions and corresponding treatments,<sup>69</sup> the group prioritized the various condition/treatment pairs<sup>70</sup> to reflect public values on health care in Oregon.<sup>71</sup> OHSC actively solicited both individual and community values.<sup>72</sup>

OHSC obtained individual values through a random-sample telephone survey of 1000 Oregonians.<sup>73</sup> The participants evaluated various conditions on a scale of 0 (death) to 100 (good health),<sup>74</sup> representing an estimate of the degree to which a given medical condition would reduce the overall quality of life.<sup>75</sup> Many questions required the respondent to evaluate the quality of a life with

69. See 1991 COMM'N REPORT, *supra* note 9, at app. J.

70. OR. REV. STAT. § 414.720(3) (Supp. 1992) (stating that "the Commissioner shall report to the governor a list of health services, including health care services of the aged, blind and disabled . . . ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population served").

71. See § 414.720(2).

72. Robinson, *supra* note 3, at 991. OHSC is statutorily required to "actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions." § 414.720(2).

73. Michael J. Garland, *Rationing in Public: Oregon's Priority-Setting Methodology*, in *RATIONING AMERICA'S HEALTH CARE: THE OREGON PLAN AND BEYOND* 37, 44 (Martin A. Strosberg et al. eds., 1992).

74. David C. Hadorn, *The Oregon Priority-Setting Exercise: Quality of Life and Public Policy*, HASTINGS CENTER REP., May-June 1991, at 16. The participants were only subjected to one hypothetical problem at a time. *Id.* See also Garland, *supra* note 73, at 44 (observing that individual responses were purely hypothetical).

The following are examples of some of the questions asked in the telephone survey:

You can be taken anywhere, but have to be in a bed or wheelchair controlled by someone else, need help to eat or go to the bathroom, but have no other health problems.

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 participation of recreational activities. You have no other health problems.

You can go anywhere and have no limitation on physical or other activity, but have drainage from your sexual organs and discomfort or pain.

You can go anywhere and have no limitations on physical or other activity, but have trouble with sexual interest or performance.

1991 COMM'N REPORT, *supra* note 9, at C-14, C-15. See also *id.* at C-13 to C-17.

75. Hadorn, *supra* note 74, at 11, 14.

debilitating conditions such as paralysis.<sup>76</sup> OHSC aggregated the results to establish a standard individual value for each condition.<sup>77</sup> Debilitating conditions received very low values.<sup>78</sup> For example, the three conditions with the lowest quality of life ratings were: confinement to a bed or wheelchair controlled by someone else, alcoholism and drug addiction, and use of a wheelchair or walker under one's own control.<sup>79</sup> OHSC used these results to create a quality-of-well-being (QWB) scale,<sup>80</sup> which estimates the impact of certain treatments on a patient's quality of life.<sup>81</sup> According to this scale, mod-

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76. One of the scenarios provided: "You can go anywhere. You have difficulty in walking because of a paralyzed or broken leg, but you have no other limitations on activity." 1991 COMM'N REPORT, *supra* note 9, at C-16.

77. Garland, *supra* note 73, at 44. *But see* Hadorn, *supra* note 74, at 16. Hadorn argued that the telephone survey was inherently problematic because it only stipulated one problem per hypothetical situation. *Id.* "Obviously, this assumption is problematic, since illness and disability tend to occur together." *Id.* For example, it is unrealistic to assume that a patient with third degree burns is unlimited in physical mobility or social activity. *Id.*

78. *See, e.g.*, 1991 COMM'N REPORT, *supra* note 9, at C-9, C-10.

79. *Id.*

80. Robinson, *supra* note 3, at 993. Oregon's QWB scale is a modified version of the QWB scale developed by Robert M. Kaplan. *See, e.g.*, Robert M. Kaplan, *A Quality-of-Life Approach to Health Resource Allocation*, in RATIONING AMERICA'S HEALTH CARE: THE OREGON PLAN AND BEYOND 60 (Martin A. Strosberg et al. eds., 1992) (applying the QWB scale to the Oregon Plan); Robert M. Kaplan & James Bush, *Health-Related Quality of Life Measurement for Evaluation Research and Policy Analysis*, 1 HEALTH PSYCHOL. 61-80 (1982) (outlining Kaplan's original QWB test).

81. Robinson, *supra* note 3, at 993. Some health care specialists have quantified the QWB scale with a priority-setting process called the "quality-adjusted life year" (QALY) approach. Hadorn, *supra* note 74, at 13. The QALY approach integrates quality of well being considerations with estimates of life expectancy. Results are quantified on a "percentage of normal quality of life" basis (*i.e.*, two years of "one-half normal" life are equivalent to one year of normal life). *Id.*

There are three main criticisms of the QALY approach. First, it assumes that a short, good life is equivalent to a long, unhealthy life. *Id.* at 14. Second, the approach favors treating one person who stands to gain ten QALYs, rather than treating nine people who will each gain one QALY. *Id.* Third, quantification of an "amorphous and ill-defined" factor, such as quality of life, is inherently difficult and subject to inaccuracies. *Id.*

For more information about QALYs, see generally John Harris, *Qualifying the Value of Life*, 13 J. MED. ETHICS 117 (1987); Graham Loomes & Lynda McKenzie, *The Use of QALYs in Health Care Decision Making*, 28 SOC. SCI. & MED. 299 (1989); Jacob Najman & Sol Levine, *Evaluating the Impact of Medical Care and Technologies on the Quality of Life: a Review and Critique*, 15 SOC. SCI. & MED. 107 (1981); Warren Reich, *Life: Quality of Life*, in ENCYCLOPEDIA OF BIOETHICS, 829, 837 (1978).

erate physical limitations were estimated to reduce the overall quality of life by thirty-seven percent.<sup>82</sup>

A non-profit community group called Oregon Health Decisions (OHD) helped OHSC obtain information on community values.<sup>83</sup> Between January and March 1990, OHSC and OHD conducted 47 community meetings involving over 1000 Oregonians.<sup>84</sup> Unlike the telephone survey, these meetings ascertained health care values important to the community as a whole.<sup>85</sup> In addition to these meetings, OHSC held public hearings on health care.<sup>86</sup> The telephone survey, community meetings, and public hearings produced a general consensus of thirteen health care related values.<sup>87</sup>

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82. Hadorn, *supra* note 74, at 14. Seizures, fainting, and comas were estimated to reduce the overall quality of life by 11%. *Id.*

83. Michael J. Garland & Romana Hasnain, *Health Care in Common: Setting Priorities in Oregon*, HASTINGS CENTER REP., Sept.-Oct. 1990, at 16, 17. See *supra* note 37 for a discussion of the OHD.

84. Garland & Hasnain, *supra* note 83, at 17. These meetings were largely homogenous: 93% of the participants were Caucasian; 70% were college educated; over 50% were between 21 and 50 years old; and 33% had household incomes of over \$50,000. *Id.* See also Daniels, *supra* note 37, at 2234 (arguing that the community meeting procedure did not "involve a representative cross section of Oregonians").

85. Garland & Hasnain, *supra* note 83, at 17. To this end, each community meeting consisted of several small group discussions in which the participants identified the "values that guided their priorities." *Id.* The small groups subsequently joined to determine which values would accurately depict the consensus of the community as a whole. *Id.*

86. See OR. REV. STAT. § 414.720 (Supp. 1992) (requiring OHSC to use public hearings as a basis for prioritizing the list of condition/treatment pairs).

87. 1991 COMM'N REPORT, *supra* note 9, at 21. The values were:

prevention (avoiding harm and suffering, improving quality of life, and exercising wisdom and personal choice);

quality of life (attending to emotional well-being, pain and suffering, independence, and functional capacity);

cost-effectiveness (wise investment in health);

ability to function (restoration of emotional well-being, productivity, independence, and general quality of life);

equity (contributing to fairness of community life);

effectiveness of treatment (preference for treatments that are known to work);

benefits many (seeking to treat problems affecting a large proportion of the community);

mental health and chemical dependency (connection between mental and physical health in support of functional ability and productivity);

personal choice (preservation of autonomy and personal dignity);

OHSC used these values to construct seventeen general categories of health care,<sup>88</sup> and devised prioritization criteria by which to rank these categories.<sup>89</sup> It consolidated the thirteen value themes<sup>90</sup> into three broad criteria:<sup>91</sup> value to society,<sup>92</sup> value to the individual at risk,<sup>93</sup> and essential to basic care.<sup>94</sup> The OHSC commissioners assigned a weight to each criteria,<sup>95</sup> and then individually judged all 17 categories under the three criteria.<sup>96</sup> After a group discussion<sup>97</sup> concerning the accuracy of the scores in light of the community

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community compassion (seeking to ensure humane response to the terminally ill and other vulnerable persons);  
 impact on society (attending to effects of treatment on others);  
 length of life (acknowledging that life is necessary to realize any values);  
 personal responsibility (encouraging individual autonomy and control over one's own health).

*Id.* at app. F, 9-24.

88. See *infra* note 101 for prioritized listing of the 17 categories.

89. Garland, *supra* note 73, at 47. See also *infra* notes 91-111 and accompanying text.

90. See *supra* note 87 for a listing of the 13 value themes.

91. Garland, *supra* note 73, at 47. See also Paul T. Menzel, *Oregon's Denial: Disabilities and Quality of Life*, HASTINGS CENTER REP., Nov.-Dec. 1992, at 21, 22 (enumerating the three criteria).

92. "Value to society" is defined as "comprising the values of prevention, benefit to many, impact on society, quality-of-life impact, personal responsibility, cost-effectiveness, community compassion, and response to mental health and chemical dependency problems." Garland, *supra* note 73, at 47.

93. "Value to the individual at risk" is defined as "comprising the values of prevention, quality of life, ability to function, length of life, personal responsibility, equity, effectiveness of treatment, personal choice, community compassion, and response to mental health and chemical dependency problems." *Id.*

94. "Essential to basic care" is defined as "comprising the values of prevention, benefit to many, quality-of-life impact, cost-effectiveness, and impact on society." *Id.*

95. Menzel, *supra* note 91, at 22. "Value to society" was assigned a weight of 40. *Id.* "Value to the individual at risk" was assigned a weight of 20. *Id.* "Essential to basic care" was assigned a weight of 40. *Id.*

96. Garland, *supra* note 73, at 47. The commissioners individually scored each of the service categories using a 1 (lowest) to 10 (highest) scale. *Id.*

97. After the group discussion, the commissioners were allowed to change their scores. *Id.* However, during the course of the discussion, the commissioners stressed their role as representatives of the people. *Id.*

meetings,<sup>98</sup> telephone survey,<sup>99</sup> and public hearings,<sup>100</sup> the commissioners ranked the seventeen categories by number.<sup>101</sup>

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98. See *supra* notes 84-87 and accompanying text.

99. See *supra* notes 73-82 and accompanying text.

100. See *supra* note 86 and accompanying text.

101. The 17 categories were ranked as follows:

1. Acute fatal, prevents death, full recovery. Examples: Repair of deep, open wounds of neck, appendectomy for appendicitis, medical therapy for myocardis;
2. Maternity care (including care for newborn in first 28 days of life). Examples: Obstetrical care for pregnancy, medical therapy for drug reactions and intoxications specific to newborns, medical therapy for low birth weight babies;
3. Acute fatal, prevents death without full recovery. Examples: Surgical treatment for head injury with prolonged loss of consciousness, medical therapy for acute bacterial meningitis, reduction of open joint fractures;
4. Preventive care for children. Examples: Immunizations, medical therapy for streptococcal sore throat and scarlet fever (reduces disabilities, prevents spread), screening for specific problems such as vision or hearing problems, or anemia;
5. Chronic fatal, improves life span and QWB (Quality of Well-Being). Examples: Medical therapy for Type I Diabetes Mellitus and asthma, medical and surgical treatment for treatable cancer of the uterus, medical therapy for asthma;
6. Reproductive services (excluding maternity and infertility). Examples: contraceptive management, vasectomy, tubal ligation;
7. Comfort care. Examples: Palliative therapy for conditions in which death is eminent;
8. Preventive dental (children and adults); Example: Cleaning and fluoride;
9. Preventive care for adults (A-B-C). Examples: Mammograms, blood pressure screening, medical therapy and chemoprophylaxis for primary tuberculosis;
10. Acute nonfatal, return to previous health. Examples: Medical therapy for acute thyroiditis, medical therapy for vaginitis, restorative dental service for dental cares;
11. Chronic nonfatal, one time treatment improves QWB. Examples: Hip replacement, laser surgery for diabetic retinopathy, medical therapy for rheumatic fever;
12. Acute nonfatal, without return to previous health. Examples: Relocation of dislocated elbow, arthroscopic repair of internal derangement of knee, repair of corneal laceration;
13. Chronic nonfatal, repetitive treatment improves QWB. Examples: Medical therapy for chronic sinusitis, medical therapy for migraine, medical therapy for psoriasis;
14. Acute nonfatal, expedites recovery. Examples: Medical therapy for diaper rash, acute conjunctivitis, medical therapy for acute pharynges;
15. Infertility services. Examples: Medical therapy for anovulation, microsurgery for tubal disease, in-vitro fertilization;
16. Preventive care for adults (D-E). Examples: Dipstick urinalysis for hematuria in adults less than 60 years of age, sigmoidoscopy for persons less than 40 years of age, screening of nonpregnant adults for Type I Diabetes Mellitus;

OHSC subdivided the seventeen ranked categories into three groups.<sup>102</sup> The first group (categories 1-9) was classified as “essential.”<sup>103</sup> The categories of the second group (10-13) were “very important.”<sup>104</sup> The third group (categories 14-17) consisted of treatments deemed “valuable to certain individuals.”<sup>105</sup>

OHSC subsequently placed each of the 709 condition/treatment pairs<sup>106</sup> into one of the 17 health care categories.<sup>107</sup> The Commission used both outcome data from medical experts and the QWB scale<sup>108</sup> to calculate a “net benefit” for each treatment pair.<sup>109</sup> The Commission prioritized each of the 709 treatment pairs within its category using the “net benefit” information.<sup>110</sup> “Hand Adjustment” of the final list compensated for any unreasonable results.<sup>111</sup>

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17. Fatal or nonfatal, minimal or no improvement in QWB (non-self-limited).  
Examples: Repair fingertip avulsion that does not include fingernail, medical therapy for gallstones without cholecystitis, medical therapy for viral warts.

Dougherty, *supra* note 61, at 10.

102. Menzel, *supra* note 91, at 22. The categories were ranked according to the mean score for each category. Garland, *supra* note 73, at 48. The mean score was determined by dividing the sum of the weighted scores by the number of commissioners. *Id.*

103. Menzel, *supra* note 91, at 22. See *supra* note 101 for a list of categories 1-9.

104. Menzel, *supra* note 91, at 22. See *supra* note 101 for a list of categories 10-13.

105. Menzel, *supra* note 91, at 22. See *supra* note 101 for a list of categories 14-17.

106. See 1991 COMM’N REPORT, *supra* note 9, at app. J (enumerating complete prioritized list of the 709 condition/treatment pairs).

107. Dougherty, *supra* note 61, at 10. See *supra* note 101 for a list of the 17 health care categories.

108. See *supra* note 80 and accompanying text for a discussion of the QWB scale; see also Hadorn, *supra* note 74, at 11 (claiming that “[e]stimates of how treatments affect quality of life were by far the single most important factor in determining the priority order on that list.”). *Id.*

109. Garland, *supra* note 73, at 49. “The net-benefit ratio is obtained by subtracting the probable outcome if a condition was not treated from the probable outcome of treating a given condition.” *Id.*

110. *Id.* OHSC obtained probability estimates from 54 expert panels. *Id.* at 48-49. Each panel member based his or her findings on five factors: 1) the median age at the onset of the diagnosis; 2) the probability of use of designated treatment; 3) expected duration of benefits; 4) expected outcomes both with and without treatment; and 5) cost to payer both with and without treatment. *Id.* at 48.

111. See *infra* notes 112-21 and accompanying text.

### E. *Hand Adjustments*

After prioritizing the list of 709 condition/treatment pairs, OHSC noticed that some of the items were "out of place."<sup>112</sup> OHSC commissioners "hand adjusted"<sup>113</sup> anomalous rankings using a reasonableness test.<sup>114</sup> The test focused on six considerations: the impact on public health, the cost of medical treatment, the frequency of the condition, the effectiveness of treatment, the cost of nontreatment, and the social costs involved.<sup>115</sup> As a general rule, the commissioners favored preventive over rehabilitative treatment for a given condition.<sup>116</sup>

OHSC adjusted forty percent of the condition/treatment pairs by at least fifty places.<sup>117</sup> According to a congressional Office of Technology Assessment (OTA) Report, however, the personal judgments of the commissioners "overshadowed the initial net-benefit-based rankings."<sup>118</sup> In other words, the personal values of the OHSC commissioners ultimately determined the final priorities.<sup>119</sup> After completing the adjustments, OHSC submitted the revised list of 709 prioritized treatment pairs to the Oregon Legislature for

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112. Garland, *supra* note 73, at 49. For example, treatments for thumb-sucking and acute headaches were ranked ahead of treatments for cystic fibrosis and AIDS. Jack H. Nagel, *Combining Deliberation and Fair Representation in Community Health Decisions*, 140 U. PA. L. REV. 1965, 1977 n.41 (1992). See also Norman Daniels, *Justice and Health Care Rationing: Lessons from Oregon*, in RATIONING AMERICA'S HEALTH CARE: THE OREGON PLAN AND BEYOND 185, 192 (1992) (acknowledging that "reproductive services (excluding infertility), preventive medical services, and dental services were given priority over some medical or surgical treatments for various serious, but not fatal, conditions").

For more information on the ranking problems of the initial list, see generally Timothy Egan, *Oregon Shakes Up Pioneering Health Plan for the Poor*, N.Y. TIMES, Feb. 22, 1991, at A12; Virginia Morell, *Oregon Puts Bold Health Plan on Ice*, 249 SCIENCE 468, 468 (1990); Bruce C. Vladeck, *Unhealthy Rations*, AM. PROSPECT, Summer 1991, at 101, 102.

113. *E.g.*, Garland, *supra* note 73, at 49.

114. *Id.* at 49.

115. *Id.* at 49-50. See also Menzel, *supra* note 91, at 22 (enumerating the factors of the reasonableness test).

116. Garland, *supra* note 73, at 50.

117. Nagel, *supra* note 112, at 1979.

118. *Oregon Medicaid Rationing Experiment: Hearing Before the Subcomm. on Health and the Env't of the House Comm. on Energy and Commerce*, 102d Cong., 1st Sess. 175-76 (1991) (testimony of Clyde J. Behney, Health Program Manager, OTA).

119. *Id.*



funding.<sup>120</sup> On June 30, 1991, the legislature approved funding for the first 587 treatment pairs.<sup>121</sup>

### F. Waiver Application

Before Oregon can implement the OBHSA, it must obtain federal waivers under the Social Security Act<sup>122</sup> from either Congress or HCFA.<sup>123</sup> Although Oregon needs a total of eleven waivers, two are of paramount importance.<sup>124</sup> The first would allow Oregon to expand coverage to all Oregonians below the federal poverty level who would not otherwise qualify for Medicaid.<sup>125</sup> The second would allow Oregon to replace the implicit federal rationing scheme with its explicit prioritized list of services.<sup>126</sup> On August 19, 1991, the Oregon Department of Human Resources submitted the OBHSA Waiver Application to HCFA.<sup>127</sup>

Although the original prognosis was positive,<sup>128</sup> the Department of Justice notified HCFA<sup>129</sup> in early 1992 of a possible conflict between the OBHSA and a new, powerful piece of legislation, the Americans with Disabilities Act (ADA).<sup>130</sup> Because of this conflict,

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120. *E.g., Oregon's Plan, supra* note 11, at 2349.

121. *Id.* The legislature compared the benefits to the costs of service, which actuaries estimated. *Id.* Many previously covered services were dropped, such as treatments for bursitis, diaper rash, and the common cold. *Id.* According to David M. Eddy, when the legislature drew the line for funding, "[it] was saying that services above the line were deemed to be worth their costs to publicly mandated programs, even within the context of competing social needs, whereas services below the line were not." *Id.*

122. 42 U.S.C. § 1315(a) (1988).

123. *What's Going On?, supra* note 10, at 417.

124. *Oregon's Plan, supra* note 11, at 2439.

125. *Id.* See *supra* notes 46-49 and accompanying text for a discussion of why some Oregonians who fall below the FPL do not qualify for Medicaid.

126. *Oregon's Plan, supra* note 11, at 2439. See *supra* notes 69-111 and accompanying text for a description of Oregon's prioritization methodology.

127. *Oregon's Plan, supra* note 11, at 2439.

128. Telephone Interview with Gail Wilensky, Former HCFA Administrator (Feb. 7, 1993). See also Timothy Egan, *Oregon Seeks to Revive Health Care Rationing Plan*, N.Y. TIMES, Aug. 14, 1992, at A17 [hereinafter *Revive Health Care*] (quoting Gail Wilensky: "The plan would have been approved had it not been for the legal opinion that it violated the Americans with Disabilities Act.").

129. *Revive Health Care, supra* note 128, at A17.

130. 42 U.S.C. §§ 12101-12213 (Supp. IV 1992). See *infra* notes 133-204 and accompanying text for a complete discussion of the ADA.

Secretary of Health and Human Services Louis Sullivan formally rejected Oregon's waiver application on August 3, 1992,<sup>131</sup> claiming that the OBHSA violated the ADA.<sup>132</sup>

## II. THE AMERICANS WITH DISABILITIES ACT

### A. History

During the development of the OBHSA, the National Council on Disability began to devise the ADA,<sup>133</sup> an Act which seeks to eliminate discrimination against disabled individuals.<sup>134</sup> The ADA is essentially an expanded version of section 504 of the Rehabilitation Act of 1973 (Rehabilitation Act).<sup>135</sup> Therefore, a brief examination of section 504 and its subsequent history is necessary to understand the ADA.

Section 504 prohibits discrimination on the basis of handicap in any program or activity that receives federal funding.<sup>136</sup> Section 504

131. DHHS REPORT, *supra* note 14, at 1.

132. *Id.* See *infra* notes 205-42 and accompanying text for a discussion of waiver rejection.

133. Nancy Lee Jones, *Essential Requirements of the Act: A Short Historical Overview*, 69 MILBANK Q. 25, 27 (Supp. & 1991).

134. 42 U.S.C. § 12101(b) (Supp. II 1990).

It is the purpose of this Act:

- (1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;
- (2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;
- (3) to ensure that the Federal Government plays a central role in enforcing the standards established in this Act on behalf of individuals with disabilities; and
- (4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.

*Id.*

135. 29 U.S.C. § 794 (Supp. III 1973).

136. Jones, *supra* note 133, at 30. Section 504 also applies to executive agencies and the U.S. Postal Service. *Id.*

Section 504 provides:

[N]o otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . .

29 U.S.C. § 794.

This Note generally uses the word "disabled" rather than "handicapped" to reflect the current accepted terminology. S. REP. NO. 116, 101st Cong., 1st Sess. 21 (1989), reprinted in BERNARD D. REAMS ET AL., *DISABILITY LAW IN THE UNITED STATES* at

defines a handicapped person as an individual with a mental or physical impairment which substantially limits a major life activity.<sup>137</sup> The definition also covers individuals who either have, or are perceived as having, a medical history of such a condition.<sup>138</sup> Although section 504 protects the interests of handicapped individuals, the scope of its application remains unclear.<sup>139</sup>

In 1985, the Supreme Court defined the scope of section 504 in *Alexander v. Choate*.<sup>140</sup> In that case, Tennessee proposed to reduce the number of hospital days Medicaid covered from twenty to fourteen.<sup>141</sup> Respondents argued that such a limitation violated section 504 because it would have a disproportionate effect on the handicapped.<sup>142</sup> The Court held that the fourteen-day limitation did not violate section 504 because it was "neutral on its face" and did not deny handicapped individuals access to Medicaid services.<sup>143</sup> The Court reasoned that anti-discrimination statutes do not prevent the government from limiting the scope of Medicaid programs because the statutes "do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular

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doc. 2 (no pagination) (1992). However, the word "handicapped" is used when referring to the Rehabilitation Act in order to be consistent with the language of that Act.

137. 29 U.S.C. § 706(7)(B) (1988). Section 504 defines a handicapped individual as "any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment." 29 U.S.C. § 706(7)(B).

For a discussion of "major life activities," see *infra* note 189.

138. 29 U.S.C. § 706(8) (1988).

139. Jones, *supra* note 133, at 32 (stating that "[s]ection 504 does not provide bright lines or absolute rules . . .").

140. 469 U.S. 287 (1985).

141. *Id.* at 289. In 1980, Tennessee's projected Medicaid costs exceeded the state's Medicaid budget by \$42 million. The directors of the Tennessee Medicaid program decided to implement a variety of cost-saving measures. *Id.*

142. *Id.* at 289-90. During the 1979-80 fiscal year, 27.4% of all handicapped patients required more than 14 hospital days, while this figure was only 7.8% for non-handicapped patients. *Id.* at 290. The respondents argued that any limitation of the number of hospital days Medicaid covered would disproportionately disadvantage handicapped patients. *Id.*

143. *Id.* at 309. The Court further argued that Tennessee has made health care "equally accessible to both handicapped and nonhandicapped persons, and the state is not required to assure the handicapped 'adequate health care' by providing them with more coverage than the nonhandicapped." *Id.*

needs."<sup>144</sup> The Court concluded that the "reasonable accommodation"<sup>145</sup> element of section 504 requires balancing the rights of the disabled with the continued integrity of federally-funded programs.<sup>146</sup>

After the *Choate* decision, several important reports concerning discrimination against the disabled established the foundation for the ADA.<sup>147</sup> In 1986, Congress directed the National Council on Disability (Council)<sup>148</sup> to submit a report on the status of all federal policies and programs affecting the disabled.<sup>149</sup> This report, entitled *Toward Independence*, documented pervasive discrimination against the disabled.<sup>150</sup> In calling for a comprehensive law which provides equal opportunity for disabled individuals,<sup>151</sup> the report recommended the creation of an omnibus Americans with Disabilities Act.<sup>152</sup>

In 1986, a series of polls supported the findings of the Council's report<sup>153</sup> concerning the educational and socio-economic disadvantages that most disabled Americans face.<sup>154</sup> The results indicated

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144. 469 U.S. 287, 303 (1985).

145. See *infra* note 169 for the definition of "reasonable accommodation" under the ADA.

146. 469 U.S. at 300. *But see* Southeastern Community College v. Davis, 442 U.S. 397, 405 (1979) (stating that an otherwise qualified handicapped individual must be afforded meaningful access to the benefits of any federally-funded program or activity).

147. Arlene Mayerson, *The Americans with Disabilities Act: An Historic Overview*, 7 LAB. LAW. 1, 3 (1991).

148. *Id.* The National Council on Disability is an independent federal agency. *Id.*

149. *Id.* Congress directed the Council to make legislative recommendations which would enhance the quality of life for disabled individuals. *Id.* To this end, the Council held forums in every state. *Id.*

150. NAT'L COUNCIL ON THE HANDICAPPED, *TOWARD INDEPENDENCE: AN ASSESSMENT OF FEDERAL LAWS AND PROGRAMS AFFECTING PERSONS WITH DISABILITIES* app. at A-3 (1986).

151. *Id.* at 18.

152. Mayerson, *supra* note 147, at 4.

153. *Id.* The polls were conducted by Louis Harris and Associates. *Id.* The polls included: *The ICD Survey of Disabled Americans: Bringing Disabled Americans into the Mainstream* (Mar. 1986); *The ICD Survey II: Employing Disabled Americans* (1987), noted in Mayerson, *supra* note 147, at 4 n.11.

154. Mayerson, *supra* note 147, at 4. The polls found that disabled Americans "are uniquely underprivileged and disadvantaged . . . [t]hey are much poorer, much less well educated, and have less social life, have fewer amenities, and have a lower

that disabled individuals do not have meaningful access to public buildings, transportation, insurance, and education.<sup>155</sup>

The National Council on Disability issued a follow-up report entitled *On the Threshold of Independence*, which proposed a bill addressing the above concerns.<sup>156</sup> After some minor changes,<sup>157</sup> this bill was introduced to Congress in 1988 as the Americans with Disabilities Act.<sup>158</sup> Following numerous committee hearings<sup>159</sup> and bipartisan conferences,<sup>160</sup> the ADA passed the House on July 12, 1990,<sup>161</sup> and the Senate the next day.<sup>162</sup> President Bush signed the ADA on July 26, 1990.<sup>163</sup> Most sections went into effect on July 26, 1992.<sup>164</sup>

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level of satisfaction than other Americans." *Id.* (citing S. REP. NO. 116, 101st Cong., 1st Sess. 8 (1989)).

155. Mayerson, *supra* note 147, at 4. The report found that approximately 8.2 million disabled Americans wanted to work, but could not find employment. *Id.*

156. *Id.*

157. The original bill was revised to address big business concerns that the 1988 bill was too ambiguous and too strict. *Id.* at n.12.

158. *Id.* at 4.

159. In the House, the ADA was referred to four committees: Education and Labor, Energy and Commerce, Transportation and Public Works, and Judiciary. Jones, *supra* note 133, at 27-28. In the Senate, the ADA was referred to only one committee, Labor and Human Resources. *Id.* at 28.

The congressional hearings produced several important findings. Over 43 million Americans have one or more mental or physical disabilities. 42 U.S.C. § 12101(a)(1) (Supp. II 1990). This increasing number of Americans face discrimination on a daily basis in such essential areas as health care, education, housing, employment, and access to public services. § 12101(a)(3).

Although the nation's goals are to ensure equal opportunities for all Americans, disabled individuals have not been afforded the same social, vocational, educational, and economic opportunities as other Americans. § 12101(6),(8). Unlike victims of race or sex discrimination, disabled individuals have heretofore been without legal recourse. § 12101(4). Congress enacted the ADA to combat this "unfair and unnecessary" discrimination. § 12101(9).

160. Jones, *supra* note 133, at 28.

161. 136 CONG. REC. H4582 (daily ed. July 12, 1990).

162. 136 CONG. REC. S9695 (daily ed. July 13, 1990).

163. Jones, *supra* note 133, at 29.

164. *Id.* at 34-43. The effective date varies from section to section. *Id.*

### B. Overview of the ADA

The ADA extends the scope of the Civil Rights Act of 1964 to disabled individuals.<sup>165</sup> While the ADA embodies the principles of Section 504 of the Rehabilitation Act of 1973,<sup>166</sup> it encompasses the private sector as well as previously covered federally-funded programs.<sup>167</sup>

Congress divided the ADA into five titles. Title I prohibits employment discrimination against a "qualified individual with a disability."<sup>168</sup> The ADA entitles the disabled individual to "reasonable accommodation"<sup>169</sup> without creating "undue hardship"<sup>170</sup> on the employer.<sup>171</sup>

165. Mayerson, *supra* note 147, at 7.

166. *Id.* For a discussion of section 504, see *supra* notes 136-39 and accompanying text.

167. Jones, *supra* note 133, at 26-27.

168. 42 U.S.C. § 12112(a) (Supp. IV 1992). For a complete definition of "disability" under the ADA, see *infra* notes 186-204 and accompanying text.

The general rule is that "no covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." 42 U.S.C. § 12112(a).

"The term 'qualified individual with a disability' means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices . . . meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." § 12131(2).

169. § 12111(9). "Reasonable accommodation" means making the employment facilities accessible and usable to disabled individuals, and "job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment . . . devices . . . examinations . . . training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities." *Id.*

For a complete discussion of the ADA's "reasonable accommodation" requirement, see C. Geoffrey Weirich, *Reasonable Accommodation Under the Americans with Disabilities Act*, 7 LAB. LAW. 27 (1991).

170. 42 U.S.C. § 12111(10). "The term 'undue hardship' means an action requiring significant difficulty or expense, when considered in light of the factors set forth in subparagraph (B)." § 12111(10)(A). These factors include the nature and cost of the accommodation and the financial resources of the business. § 12111(10)(B).

For a complete discussion of "undue hardship," see Russell H. Gardner & Carolyn J. Campanella, *The Undue Hardship Defense to the Reasonable Accommodation Requirement of the Americans with Disabilities Act of 1990*, 7 LAB. LAW. 37 (1991).

171. 42 U.S.C. § 12112(b)(5)(A). For further discussion of Title I, see Jones, *supra* note 133, at 34-37.

Title II prohibits discrimination against disabled individuals in the administration of any services, programs, or activities of a public entity.<sup>172</sup> All state and local government agencies qualify as public entities.<sup>173</sup> Medicaid is a public service for the purposes of Title II.<sup>174</sup> Consequently, Title II covers the administration of state Medicaid funds.<sup>175</sup>

Title III prohibits private entities from discriminating in the operation of public accommodations.<sup>176</sup> Public accommodations include hotels, transportation, restaurants, bars, movie theaters, museums, and schools, among others.<sup>177</sup>

Title IV directs the Federal Communications Commission to provide telecommunication relay services for speech-impaired and hearing-impaired individuals.<sup>178</sup> Furthermore, all federally-funded public service announcements must include closed captioning.<sup>179</sup>

Title V contains several miscellaneous provisions<sup>180</sup> and explicitly preserves the minimum standards established by the Rehabilitation Act.<sup>181</sup> Another provision bars Titles I through IV from restricting

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172. 42 U.S.C. § 12132 (Supp. IV 1992). Title II provides that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” *Id.*

173. § 12131(1)(A), (B). The National Railroad Passenger Corporation also qualifies as a public entity. *Id.* § 12131(1)(C). For provisions concerning public transportation, see 42 U.S.C. §§ 12141-12165.

174. See *supra* note 172 and accompanying text for text of relevant Title II language.

175. This coverage was the basis of the DHHS rejection of the OBHSA waiver application. See *infra* notes 205-42 and accompanying text for a discussion of the waiver rejection.

176. 42 U.S.C. §§ 12181-12189. (Supp. IV 1992) The general rule is: “[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.” § 12182(a).

177. § 12181(7). This is a partial listing. Note that the list does not include religious institutions. For a complete definition of “public accommodation,” see 42 U.S.C. § 12181(7)(A)-(L).

178. Jones, *supra* note 133, at 39.

179. *Id.*

180. 42 U.S.C. §§ 12201-12213 (Supp. IV 1992).

181. See 42 U.S.C. § 12201(a) (stating that “[e]xcept as otherwise provided in this Act, nothing in this Act shall be construed to apply a lesser standard than the standards applied under Title V of the Rehabilitation Act of 1973 . . . or the regulations issued by Federal agencies pursuant to such title”) (citation omitted).

or prohibiting insurers and administrators of health benefit plans from traditional underwriting and risk assessment practices.<sup>182</sup> However, this provision is not to be used to evade the purposes of Titles I and III.<sup>183</sup> Furthermore, Title V provides that states do not have immunity under the Eleventh Amendment for violations of the ADA.<sup>184</sup>

Each of the preceding titles establishes different guidelines to prevent discrimination against disabled individuals.<sup>185</sup> Together they significantly expand section 504 to adequately protect the rights of today's disabled citizens.

### C. ADA Definition of Disability

The ADA bases its definition of disability on the standards set forth by the Rehabilitation Act.<sup>186</sup> Under the ADA, three different criteria classify an individual as a "person with a disability."<sup>187</sup> (1) a mental or physical impairment<sup>188</sup> which substantially limits that person in major life activities;<sup>189</sup> (2) a record of such mental or physical

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182. § 12201(c).

183. *Id.*

184. § 12202. This section provides that states are to be treated the same as any other public or private entity, and as such, are subject to legal and equitable remedies. *Id.*

185. See *supra* notes 168-84 and accompanying text for a discussion of the ADA guidelines. For a more in depth examination of the various ADA provisions, see Jones, *supra* note 133, at 34-42.

186. Chai R. Feldblum, *The Americans with Disabilities Act Definition of Disability*, 7 LAB. LAW. 11, 11 (1991). See *supra* notes 135-39 and accompanying text for a discussion of the Rehabilitation Act of 1973.

187. 42 U.S.C. § 12102(2) (Supp. IV 1992).

188. The Equal Employment Opportunity Commission (EEOC) defines a "physical or mental impairment" as "a physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting [any] neurological, musculoskeletal, respiratory, cardiovascular, or reproductive system," to name a few. 29 C.F.R. § 1630.2(h)(1) (1992). The Department of Health and Human Services (DHHS) regulations provide examples of diseases and conditions which would be covered. These include muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, cerebral palsy, epilepsy, drug addiction, and alcoholism. 45 C.F.R. app. A(3) § 84 (1992).

Thus, an impairment must be some type of mental or physiological disorder. A simple physical characteristic such as blue eyes or blonde hair will not suffice. Feldblum, *supra* note 186, at 13.

189. 42 U.S.C. § 12102(2)(A). According to the EEOC, "major life activities" include "caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 29 C.F.R. § 1630.2(i) (1992).



impairment;<sup>190</sup> or (3) a reputation as having such impairment.<sup>191</sup> The ADA covers all individuals meeting any one of the above criteria.<sup>192</sup>

Most conditions that qualified as "handicaps" under the Rehabilitation Act also qualify as "disabilities" under the ADA.<sup>193</sup> Three controversial conditions are AIDS, alcoholism, and drug use.<sup>194</sup> The ADA extends coverage to any person with AIDS, or an asymptomatic HIV infection, under the first prong of its definition.<sup>195</sup> Similarly, alcoholics qualify for ADA coverage provided that their

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190. 42 U.S.C. § 12102(2)(B). This prong applies to individuals who either (1) have a history of an impairment, but are no longer affected by such impairment, or (2) have been misclassified as having such impairment. 45 C.F.R. § 84.3(j)(2)(iii) (1992).

Examples of the former include heart disease, cancer, and emotional illness. 45 C.F.R. app. A(3) § 84. A leading example of the latter is the misclassification of mental retardation.

191. 42 U.S.C. § 12102(2)(C). According to the EEOC, an individual has the reputation of having such an impairment if: (1) said individual has a mental or physical impairment which either does not substantially limit a major life activity, or only limits a major life activity as a result of the attitudes of others; or (2) said individual is treated as though a major life activity is substantially limited by a mental or physical impairment, even though such impairment does not exist. 29 C.F.R. § 1630.2 (1992). For a more detailed discussion of this topic, see generally Feldblum, *supra* note 186, at 17-18.

192. 42 U.S.C. § 12102(2) (Supp. IV 1992).

193. Examples include hearing, speech, and vision impairments, mental retardation, emotional disturbances, epilepsy, learning disabilities, diabetes, cancer, cystic fibrosis, and heart disease. Robert L. Burgdorf, Jr., *Legal Analysis in THE AMERICANS WITH DISABILITIES ACT: A PRACTICAL AND LEGAL GUIDE TO IMPACT, ENFORCEMENT, AND COMPLIANCE* 77, 82-83 (BNA Special Report 1990)(analyzing whether these conditions constitute disabilities).

194. See Feldblum, *supra* note 186, at 20-24 (analyzing whether AIDS, alcoholism and drug use constitute disabilities).

It may be argued that alcoholism and drug use are not "true" disabilities, but rather curable habits. Inclusion of "habits" within the definition of disability undermines a major premise that disabled people do not have the power to rid themselves of their disability.

Classifying AIDS as a disability is controversial for two reasons. First, it is the only terminal illness to be expressly included. Second, legislation that forces HIV-negative individuals to come into contact with HIV-positive individuals will naturally provoke controversy because of the contagious nature of AIDS.

195. See *id.* at 20. The ADA uses the term "HIV disease," which accurately covers the entire spectrum of HIV-related illnesses, including those who are mistakenly perceived to be HIV-positive. *Id.*

alcohol dependency either substantially limits, or is perceived as limiting, one or more major life activities.<sup>196</sup>

While the ADA expressly excludes illegal drug use from its definition of disability,<sup>197</sup> there are several exceptions. Any individual who is participating in a drug rehabilitation program,<sup>198</sup> who has successfully completed a drug rehabilitation program,<sup>199</sup> or who is wrongfully regarded as engaging in drug use,<sup>200</sup> may qualify as a disabled individual notwithstanding the above rule.<sup>201</sup> Furthermore, no individual may be denied health services solely on the basis of current illegal drug use.<sup>202</sup>

The ADA's broad definition of "person with a disability" extends protection to all Americans who meet its criteria.<sup>203</sup> Any privately or federally-funded program which appears to discriminate against the disabled is in direct violation of the ADA.<sup>204</sup>

### III. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES REJECTION OF THE OBHSA WAIVER APPLICATION

On August 3, 1992, Secretary of Health and Human Services Louis W. Sullivan denied Oregon's federal waiver request.<sup>205</sup> In a

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196. *Id.* at 23. Individuals who only drink alcohol on a casual basis are not covered because there is no impairment of a major life function due to alcohol dependency. *Id.*

197. 42 U.S.C. § 12210(A) (Supp. IV 1992). "Illegal use of drugs" means the use of drugs which have been deemed unlawful under the Controlled Substances Act (21 U.S.C. § 812), but does not include controlled substances taken under the supervision of a physician, or any other legal drug. § 12210(d)(1). However, individuals who abuse legal prescription drugs, such as Valium, are excluded from coverage. See Feldblum, *supra* note 186, at 22.

198. 42 U.S.C. § 12210(b)(2).

199. § 12210(b)(1).

200. § 12210(b)(3).

201. § 12210(b).

202. 42 U.S.C. § 12210(c) (providing that "notwithstanding subsection (a) . . . an individual shall not be denied health services, or services provided in connection with drug rehabilitation, on the basis of current illegal use of drugs if the individual is otherwise entitled to such services.").

203. Feldblum, *supra* note 186, at 26. Unlike the Rehabilitation Act of 1973, the ADA extends coverage to people who associate with disabled individuals. *Id.* at 25-26. While the ADA does not limit the type of relationship, claimants must prove that they were discriminated against because of their association with a disabled individual. *Id.* at 26.

204. See *supra* notes 168-84 and accompanying text for ADA provisions.

205. DHHS REPORT, *supra* note 14, at 1.

letter to Oregon Governor Barbara Roberts, Sullivan cited inconsistencies with the ADA as the primary reason for the waiver denial.<sup>206</sup> An accompanying Department of Health and Human Services Report (DHHS Report) concluded that OBHSA's prioritization process caused the inconsistencies.<sup>207</sup> More specifically, the report disagreed with a basic premise of the prioritization process, that the value of a life without a disability is greater than the value of a life with a disability.<sup>208</sup>

The DHHS Report cited two aspects of the OBHSA prioritization process which reflected this premise: the telephone survey<sup>209</sup> and the hand adjustments.<sup>210</sup> The DHHS Report criticized the quality of life data acquired from the telephone survey as reflecting stereotypes about disabled individuals.<sup>211</sup> The survey asked a random sample of Oregonians how they would rate the quality of a life with certain debilitating conditions.<sup>212</sup> Numerous scholars have criticized this approach as inherently flawed.<sup>213</sup> They argue that individuals without disabilities generally undervalue the quality of a life with some degree of disability.<sup>214</sup> OHSC acknowledged the existence of

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206. Letter from Louis W. Sullivan, Secretary, Dep't of Health and Human Services, to Barbara Roberts, Governor, State of Oregon (Aug. 3, 1992) (on file with the *Washington University Journal of Urban and Contemporary Law*) [hereinafter Waiver Rejection Letter]. While Sullivan rejected Oregon's waiver application, he encouraged Oregon to submit a revised proposal. *Id.*

207. See *supra* notes 69-111 and accompanying text for a description of the prioritization process.

208. DHHS REPORT, *supra* note 14, at 1.

209. *Id.* at 1; see *supra* notes 73-82 and accompanying text for a description of the telephone survey.

210. DHHS REPORT, *supra* note 14, at 2; see *supra* notes 112-19 and accompanying text for a description of the hand adjustment process.

211. DHHS REPORT, *supra* note 14, at 1.

212. The debilitating conditions included paralysis and alcoholism. See *supra* note 74 for examples of telephone survey questions.

213. See *infra* note 214 for some of the scholars' views.

214. See Hadorn, *supra* note 74, at 12. Hadorn argued that the use of a purely objective quality of life measurement does not necessarily correspond to the "perceived" quality of life. *Id.* Furthermore, quality of life judgments are often shaped by the "social acceptability" of the conditions in question. *Id.* (citing Warren Reich, *Life: Quality of Life*, in *ENCYCLOPEDIA OF BIOETHICS* 829, 837 (1978)).

See also Menzel, *supra* note 91, at 22 (arguing that quality of life evaluations of other peoples' lives are inherently dangerous because of a lack of first hand knowledge).

this bias in the OBHSA telephone survey.<sup>215</sup> However, it argued that the telephone survey had a limited impact on the final ranking of condition/treatment pairs.<sup>216</sup>

Contrary to OHSC's claims, the DHHS Report found that the impact of the biased telephone survey was quite significant.<sup>217</sup> In reaching this conclusion, the DHHS substituted a constant value in place of the survey-generated values.<sup>218</sup> The results were astounding. More than 120 condition/treatment pairs moved 30 places on the prioritized list.<sup>219</sup> Over 50 pairs moved at least 50 places, with one such pair shifting 161 places.<sup>220</sup> These findings indicate that the biased results of the telephone survey precluded funding for many condition/treatment pairs that would have otherwise received funding.<sup>221</sup> The DHHS determined that this result unjustly discriminated against the disabled in violation of the ADA.<sup>222</sup>

The DHHS Report also found the process of hand adjustments discriminatory.<sup>223</sup> OHSC based these adjustments on community values,<sup>224</sup> including "quality of life"<sup>225</sup> and "ability to function."<sup>226</sup> According to the DHHS Report, these two values are biased against

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215. 1991 COMM'N REPORT, *supra* note 9, at C-11 (admitting that ". . . those who had experienced the problem did not feel it was as severe as those who had not experienced the problem.").

216. DHHS REPORT, *supra* note 14, at 1. See U.S. CONG., OFFICE OF TECHNOLOGY ASSESSMENT, EVALUATION OF THE OREGON MEDICAID PROPOSAL 186 (1992) [hereinafter OTA ASSESSMENT] (stating that "OTA analysis of the list showed that the weights from the public survey had relatively little effect on the final rankings").

217. DHHS REPORT, *supra* note 14, at 1-2.

218. The DHHS substituted a constant value equivalent to a mean score of 50 on a scale of 0 to 100. *Id.* at 2. This effectively canceled out the bias of the telephone survey.

219. *Id.* at 1-2.

220. *Id.*

221. The DHHS concluded that "[u]nless Oregon funds all of the health services on its prioritized list every year, it is unlikely . . . that the telephone survey data will have no effect on which medical conditions are treated." *Id.*

*But see* Capron, *supra* note 68, at 20 (arguing that the process of replacing community values with a constant would "falsely suggest that anyone, disabled or otherwise, would regard all possible outcomes as equally beneficial").

222. DHHS REPORT, *supra* note 14, at 2. Specifically, the biased effect of the telephone survey violates Title II of the ADA, which prohibits discrimination in the administration of public services; see *supra* notes 172-75 and accompanying text for a discussion of Title II.

223. DHHS REPORT, *supra* note 14, at 2.

224. See *supra* note 87 and accompanying text for a list of all the values used.

the disabled because they emphasize restoring health and functional independence.<sup>227</sup>

OHSC also moved treatments for “severe or exacerbated conditions” to comparatively unfavorable positions.<sup>228</sup> The DHHS rejected this methodology as expressly discriminating against the disabled, claiming that “severe or exacerbated conditions” are virtually synonymous with the ADA’s definition of disability.<sup>229</sup>

The biased telephone survey and hand adjustments resulted in a prioritized list of condition/treatment pairs<sup>230</sup> that blatantly discriminated against the disabled in violation of the ADA.<sup>231</sup> The DHHS Report cited two specific examples: liver transplants and treatment for low birth weight babies.<sup>232</sup>

Although liver transplants for non-alcoholic cirrhosis of the liver received funding,<sup>233</sup> the same treatment for alcoholic patients fell below the cut off line.<sup>234</sup> Similarly, life support for low birth weight babies of less than 500 grams and under 23 weeks gestation was not

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225. The “quality of life” value derived at the community meetings is defined as attending to emotional well-being, pain and suffering, independence, and functional capacity. Garland & Hasnain, *supra* note 83, at 17.

226. The community value of “ability to function” is defined as restoration of emotional well-being, productivity, independence, and general quality of life. *Id.*

227. DHHS REPORT, *supra* note 14, at 2.

228. 1991 COMM’N REPORT, *supra* note 9, at 28 (stating that “where severe or exacerbated conditions were ranked in a relatively favorable condition compared to prevention of disease, disability or exacerbation, these occurrences were reversed.”).

229. DHHS REPORT, *supra* note 14, at 2; *see, e.g.*, Menzel, *supra* note 91, at 23 (equating “severe or exacerbated conditions” with disability).

230. *See* 1991 COMM’N REPORT, *supra* note 9, at app. J (enumerating prioritized list of condition/treatment pairs).

231. DHHS REPORT, *supra* note 14, at 2 (stating that the ranking should be redone without consideration of the aforementioned community and individual values).

*But see* Capron, *supra* note 68, at 20. Capron argued that the DHHS Report misrepresents the role of quality of life data in Oregon’s prioritization process. *Id.* Furthermore, although it may be reasonable to interpret the ADA as prohibiting any rule which expressly denies health care to a group of people based on disability, it would be absurd to interpret it as prohibiting the use of “limited health care resources” to treat other conditions first. *Id.*

232. DHHS REPORT, *supra* note 14, at 2 (stating that these blatantly discriminatory rankings must be remedied before the OBHSA may be approved).

233. 1991 COMM’N REPORT, *supra* note 9, at app. J l. 366.

234. *Id.* at l. 690.

funded,<sup>235</sup> while life support for low birth weight infants of at least 500 grams was funded.<sup>236</sup> The DHHS found these results violated Title II of the ADA<sup>237</sup> because the distinctions were based on the existence of disabling conditions—alcoholism and low birth weight.<sup>238</sup>

The DHHS Report concluded with several suggestions for revision of the OBHSA. First, Oregon should reprioritize the list of condition/treatment pairs without the influence of the biased telephone survey.<sup>239</sup> Second, Oregon must revise the hand adjustment process to eliminate methodology that assigns lower quality of life ratings based on disability.<sup>240</sup> However, Oregon may consider neutral factors such as the cost of medical procedures, prevention of death, and the length of hospital stays when allocating medical resources.<sup>241</sup> Third, the new plan must remedy blatant examples of discrimination before the necessary waivers would be granted.<sup>242</sup>

#### IV. OREGON'S RESPONSE

The DHHS rejection of Oregon's waiver application shocked most health care experts, including Oregon state officials.<sup>243</sup> Although Governor Roberts maintained that the original methodol-

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235. *Id.* at l. 708. Oregon defended this decision with statistics showing that only one in ten such babies survive, and there is a good chance that the few surviving babies will be disabled. Shapiro, *supra* note 64, at 24.

236. 1991 COMM'N REPORT, *supra* note 9, app. J l. 22.

237. See *supra* notes 172-75 for a discussion of Title II of the ADA. Title II prohibits discrimination in the administration of public services. *Id.*

238. DHHS REPORT, *supra* note 14, at 3; see *supra* notes 185-203 and accompanying text for the ADA definition of disability.

239. DHHS REPORT, *supra* note 14, at 2.

240. *Id.*

241. *Id.* The DHHS Report states that Oregon may consider "any constant neutral factor that does not take disability into account or that does not have a particular exclusionary effect on persons with disabilities." *Id.* at 3. (citing *Alexander v. Choate*, 469 U.S. 287, 302 (1985)).

242. DHHS REPORT, *supra* note 14, at 2-3; see also *Federal Government Refuses to Approve Oregon Medicaid Reform*, UPI, Aug. 3, 1992, available in LEXIS, Nexis Library, UPI File (stating the DHHS conclusion that "a decision not to cover a treatment based entirely on the existence of a disabling condition, where similarly situated individuals without that condition would receive treatment, would violate . . . the ADA").

243. Menzel, *supra* note 91, at 21.

ogy did not violate the ADA,<sup>244</sup> OHSC agreed to examine the OBHSA for any appearance of discrimination.<sup>245</sup> The result was a new prioritization process which addressed DHHS concerns.<sup>246</sup>

OHSC reordered the list of condition/treatment pairs using an ADA-compatible analysis. First, OHSC eliminated the telephone survey data.<sup>247</sup> The Commission subsequently ranked the list of condition/treatment pairs according to the effectiveness of treatment.<sup>248</sup> To determine the effectiveness of treatment, OHSC relied on outcome data supplied by medical experts.<sup>249</sup> This data concerned the probability of death, the probability of an asymptomatic recovery, and the medical cost of treatment.<sup>250</sup> OHSC first ranked condition/treatment pairs on the ability of the treatment to prevent death.<sup>251</sup> Tied pairs were then ranked based on the treatment's ability to return the patient to an asymptomatic<sup>252</sup> state of health.<sup>253</sup> The Commission ranked remaining tied pairs according to the aver-

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244. Barbara Roberts, *Bush Blows It on Health Care*, N.Y. TIMES, Aug. 11, 1992, at A19 (opinion/editorial). Roberts cited several reasons why the DHHS analysis of the OBHSA was wrong. First, the OBSHA does not apply to the disabled until 1993. *Id.* Second, various disability groups within the state of Oregon assisted in the prioritization process. *Id.* Finally, the OTA Report found that the OBHSA showed a preference for prevention and treatment of disabilities. *Id.*

245. Governor Barbara Roberts, Governor Sends Revised Health Plan to Bush Administration, News Release (Nov. 13, 1992) (on file with the *Washington University Journal of Urban and Contemporary Law*) [hereinafter News Release].

246. OHSC REVISION, *supra* note 15, at preface.

247. *Id.* at 2.

248. *Id.* Effectiveness of treatment was judged under two principles: 1) the maintenance of life is of primary importance, and 2) an asymptomatic condition is the most desirable state. *Id.*

249. *Id.* at 1.

250. *Id.* at 1-2. Medical experts were asked to estimate the probability of each of these factors, both with and without treatment. *Id.*

251. OHSC REVISION, *supra* note 15, at 3.

252. An "asymptomatic state" means a return to the patient's pre-condition health state, if medically possible. *Id.* at n.2. It does not necessarily mean perfect health. *Id.*

253. *Id.* at 4. This procedure entailed two steps. First, tied pairs were ranked according to the ability of the treatment to save a life and subsequently return the patient to an asymptomatic state of health. *Id.* If pairs were still tied, they were ranked on "the treatment's ability to take the patient from a symptomatic to an asymptomatic state of health." *Id.*

age cost of treatment, with the more expensive treatment receiving lower priority.<sup>254</sup>

OHSC examined the new prioritized list and subsequently hand adjusted items which seemed out of place.<sup>255</sup> Movement of pairs was rounded to pre-determined groups of twenty-five lines.<sup>256</sup> The Commission based its decisions on various considerations,<sup>257</sup> including the principle that preventative treatment should be ranked higher than curative treatment for a given condition.<sup>258</sup> Neutral community values were also used to determine the degree of adjustment for non-life-threatening conditions.<sup>259</sup> These included: maternity care,<sup>260</sup> general prevention services,<sup>261</sup> comfort care,<sup>262</sup> and family planning services.<sup>263</sup> OHSC eliminated all values pertaining

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254. *Id.* Remaining pairs with the same ranking were assigned the same line number, and ordered alphabetically by diagnosis. *Id.*

255. *Id.* For example, cerebral palsy, ALS (Lou Gehrig's disease), and anencephalous (babies born without a brain) were combined and moved to line 152. *Id.* at preface.

Line numbers refer to the ranking of the condition/treatment pair. For example, Hodgkin's Disease has a rank of 68 out of a total 688 pairs. *Id.* at app. l. 68.

256. OHSC REVISION, *supra* note 15, at 4. For example, maternity care was moved to the group of lines 50-74. *Id.*

257. *Id.* at 4. These considerations included:

- 1) Prevention before curative treatment;
  - 2) Degree of incongruency with adjacent conditions;
  - 3) Community values in determining placement of non-life-threatening conditions;
  - 4) Severity of contagious diseases and public health risks;
  - 5) Ranking of cancer treatments according to survival rate after treatment;
- and
- 6) Symptomatic relief for self-limiting conditions.

*Id.* at 4-5.

258. *Id.* at 4. For example, dysplasia of the cervix was ranked higher than cancer of the cervix. *Id.*

259. *Id.* at 5. These values were only used to determine the general group placements. *Id.*

260. *Id.* at app. ll. 50-74.

261. OHSC REVISION, *supra* note 15, at app. ll. 125-74.

262. *Id.* at app. ll. 150-74.

263. *Id.* at app. ll. 250-74. These groupings were based on community values including preference for: healthy mothers and babies, comfort care (*i.e.*, pain medication for terminally ill patients), family planning services, general preventative care, and high prioritization for contagious diseases. *Id.* at preface.



to “quality of life” and “ability to function.”<sup>264</sup> After completing the hand adjustments, the Commission reorganized each group of twenty-five lines using the above prioritization process.<sup>265</sup> The final list contained 688 condition/treatment pairs.<sup>266</sup> The Oregon Legislature approved funding for the first 568 pairs.<sup>267</sup>

Unlike the original list,<sup>268</sup> the results of the revised prioritization process do not violate the ADA.<sup>269</sup> Specifically, the revised list addresses DHHS concerns regarding liver transplants and low birth weight babies.<sup>270</sup> OHSC combined all liver transplants for cirrhosis of the liver because the effectiveness of treatment does not depend on the cause.<sup>271</sup> Individuals continuing to engage in the same habits which damaged the original liver, however, are not eligible for transplants because such activity dramatically decreases the effectiveness of treatment.<sup>272</sup> OHSC also combined treatment for all babies weighing less than 2,500 grams.<sup>273</sup>

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264. *Id.* at 1, 6. See *supra* notes 208-38 and accompanying text for DHHS criticisms.

265. See *supra* notes 247-64 and accompanying text for a discussion of Oregon's revised prioritization process.

266. OHSC REVISION, *supra* note 15, at preface. The reduction from 709 condition/treatment pairs to 688 pairs was the result of two OHSC decisions. *Id.* at 5-6. First, OHSC merged neuromuscular dysfunction conditions (for which there is no effective treatment) into a new symptomatic treatment line. *Id.* at 5. Second, the OHSC merged lines where the treatment was a continuum of care. *Id.* at 6.

Before finalizing the list, OHSC held a public hearing where various advocacy groups testified. *Id.* at 6. This process resulted in the deletion of two condition/treatment pairs: End Stage HIV Disease, and Anencephalous and Similar Anomalies and Reduction Deformities of the Brain. *Id.*

267. Telephone Interview with Gail Wilensky, *supra* note 128.

268. See 1991 COMM'N REPORT, *supra* note 9, at app. J. See also *supra* notes 69-111 and accompanying text for a discussion of the original prioritization process.

269. Letter from Barbara Roberts, Governor, State of Oregon, to Louis W. Sullivan, Secretary, Dep't of Health and Human Services (Nov. 13, 1992) (on file with the *Washington University Journal of Urban and Contemporary Law*) (stating the belief of Governor Roberts that the revised prioritization process does not violate the ADA).

270. See *infra* notes 274-75 and accompanying text.

271. OHSC REVISION, *supra* note 15, at preface, app. I. 132.

272. *Id.* at preface; see also Capron, *supra* note 68, at 20 (proposing a distinction between potential liver transplant recipients who are alcoholics, and those who have their alcoholism under control).

273. OHSC REVISION, *supra* note 15, at preface, app. I. 40.

On November 13, 1992, Governor Roberts submitted the Revised Oregon Health Plan to the DHHS for waiver approval.<sup>274</sup> Although Roberts was confident that the new prioritization process was entirely consistent with the ADA,<sup>275</sup> the Bush Administration refused to make a decision on the resubmitted waiver application.<sup>276</sup> Consequently, the fate of the OBHSA passed to the hands of the Clinton Administration.<sup>277</sup>

## V. THE DHHS CONDITIONAL WAIVER APPROVAL

On March 19, 1993, the DHHS approved Oregon's waiver application, entitled "Oregon Reform Demonstration."<sup>278</sup> The five-year waivers<sup>279</sup> are contingent upon Oregon's compliance with twenty-nine special terms and conditions,<sup>280</sup> several of which require further revision of the prioritization process.<sup>281</sup> First, Oregon must reorder condition/treatment pairs without considering the treatment's ability to return the patient to an asymptomatic state.<sup>282</sup> Considera-

274. Letter from Barbara Roberts to Louis W. Sullivan, *supra* note 269.

275. Governor Roberts said the new rankings reflect "only the degree to which a particular treatment saved life or returned a person to his or her original health status without placing a value on that status." Spencer Rich, *Oregon Resubmits Health Plan; Program Revised to Eliminate Bias*, HOUSE CHRON., Nov. 14, 1992, at A8 [hereinafter *Oregon Resubmits*].

276. Telephone Interview with Gail Wilensky, *supra* note 128.

277. Clinton faces a tough decision. As both Governor of Arkansas and a presidential candidate, he vehemently supported the OBHSA. Edwin Chen, *Clinton May Inherit Controversial Oregon Health Plan*, L.A. TIMES, Dec. 2, 1992, at A22. However, Vice President Gore testified against the plan last year, calling it "a horrible mistake." *Id.* The Children's Defense Fund, formerly chaired by Hillary Clinton, also strongly opposed the OBHSA. *Id.*

278. Letter from Donna Shalala, Secretary, Dep't of Health and Human Services, to Barbara Roberts, Governor, State of Oregon (Mar. 19, 1993) (on file with the *Washington University Journal of Urban and Contemporary Law*); see also Letter from William Toby, Jr., Acting Administrator, HCFA, to Kevin W. Concannon, Director, Oregon Dep't of Hum. Resources (Mar. 19, 1993) (on file with the *Washington University Journal of Urban and Contemporary Law*) [hereinafter *Formal Waiver Acceptance Letter*].

279. Although effective from April 1, 1993 to December 31, 1998, the waivers are subject to annual renewal by the DHHS. *Formal Waiver Acceptance Letter*, *supra* note 278, at 1.

280. *Id.*; see also *id.* at enclosure (listing all 29 special terms and conditions).

281. *Id.* at enclosure.

282. *Id.* at enclosure, condition 1. Such a requirement would arguably discriminate against disabled individuals, who are incapable of returning to asymptomatic states. *Id.*

tion of medical effectiveness, however, is permissible when making hand adjustments.<sup>283</sup> Second, all infertility services<sup>284</sup> must be ranked using neutral factors that do not consider disability.<sup>285</sup> Third, before denying treatment to any individual, especially individuals with disabilities, health care providers must determine if the individual has a condition that qualifies for treatment.<sup>286</sup> If so, treatment for all conditions must be provided.<sup>287</sup> If not, treatment must only be provided where the expected outcome is comparable to that of a funded condition/treatment pair.<sup>288</sup> All revisions to the prioritized list are subject to HCFA approval.<sup>289</sup>

In response to the DHHS conditional waiver approval, OHSC revised its prioritization process.<sup>290</sup> Using existing data, OHSC ranked condition/treatment pairs on the ability of the treatment to prevent death.<sup>291</sup> Tied pairs were ranked according to cost, with more expensive treatments receiving lower priority.<sup>292</sup> Any remaining tied pairs were ordered alphabetically by diagnosis.<sup>293</sup> OHSC considered community values<sup>294</sup> when making hand adjustments,<sup>295</sup> which were rounded to groups of twenty-five lines.<sup>296</sup> The final pri-

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283. *Id.* at enclosure, condition 1.

284. Formal Waiver Acceptance Letter, *supra* note 278, at enclosure, condition 2. Coverage of infertility services under the demonstration is optional. *Id.*

285. *Id.*

286. *Id.* at enclosure, condition 3.

287. *Id.*

288. *Id.* at enclosure, condition 3.

289. Formal Waiver Acceptance Letter, *supra* note 278, at enclosure, condition 5.

290. OREGON HEALTH SERVICES COMM'N, PRIORITIZATION OF HEALTH SERVICES: A REPORT TO THE GOVERNOR AND LEGISLATURE 15-16 (1993) [hereinafter 1993 COMM'N REPORT].

291. *Id.* at 16.

292. *Id.*

293. *Id.*

294. *Id.* at 17-18. The community values included: general preventative services; comfort care; maternity care; family planning services; prevention of a condition before treatment; medical ineffectiveness; prevention of additional complications; prevention of future costs; cosmetic services (should not be covered); self-limiting conditions (should not be covered because treatment is ineffective); congruent conditions (should receive similar priority); and public health risk (prevention of communicable diseases is a high priority for the state and federal government). *Id.*

295. 1993 COMM'N REPORT, *supra* note 290, at 16, 18.

296. *Id.*

oritized list containing 688 condition/treatment pairs<sup>297</sup> was completed on April 19, 1993.<sup>298</sup>

## VI. PROPOSAL

The OBHSA presents a viable solution to Oregon's health care problems, and possibly to those of the nation as well.<sup>299</sup> Implementation of the OBHSA at the state level will provide a testing ground for determining the plan's effectiveness, without jeopardizing the stability of the entire country. If successful in Oregon, the OBHSA should be implemented at the national level as a realistic solution to the health care crisis. Although the OBHSA has received the necessary federal waivers, lawsuits over alleged ADA violations may obstruct its implementation.

Courts facing this issue should balance the rights of the disabled with the continued integrity of the OBHSA.<sup>300</sup> On one side of the scale is the disabled individual's right to meaningful access to health care, which is measured by the effectiveness and necessity of treatment. On the other side is the degree to which accommodation would impair the efficacy of the program. Courts should infer a rebuttable presumption in favor of the latter because the existence of a federal waiver implies that the OBHSA is consistent with the ADA. By adopting the above balancing test, courts could protect the rights of the disabled quickly and efficiently without severely impairing the integrity of the OBHSA.

## VII. CONCLUSION

Oregon has reconciled potential problems between the OBHSA and the ADA. The revised prioritization process will provide health care coverage to ninety-seven percent of Oregon's citizens, without discriminating against the disabled. If effective, the OBHSA would present a viable solution to the national health care crisis. Thus, the fate of millions of uninsured Americans could depend on the OBHSA.

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297. *Oregon Resubmits*, *supra* note 275.

298. 1993 COMM'N REPORT, *supra* note 290, at 16. At the time of publication, the Oregon Legislature had not determined the funding cut-off line.

299. Colen, *supra* note 2, at 34.

300. *See Alexander v. Choate*, 469 U.S. 287, 300 (1985).

Unfortunately, lawsuits may hamper the implementation of this program. Adoption of a balancing test would address inconsistencies between the OBHSA and the ADA without denying the remaining population meaningful access to health care.

*Greg Phyllip Roggin\**

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\* J.D./M.A., 1994 Washington University.