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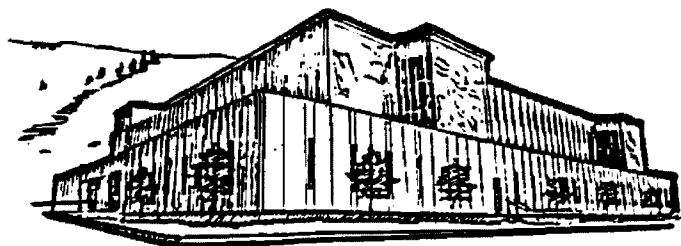
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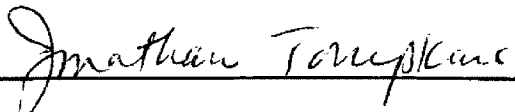
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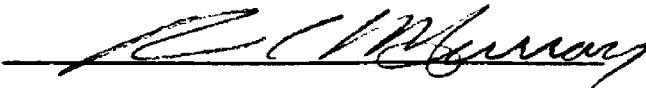
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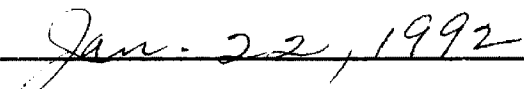
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## CHAPTER 1

### A HEALTH CARE SYSTEM IN CRISIS

America is facing a crisis in its health care system, a system which is plagued by increasing costs and limited ways to respond. Thirty-five million Americans are completely without formal health insurance, despite the fact that the U.S. spends over one and a half billion dollars per day on medical care, more than any other country.<sup>1</sup> These individuals must delay, go without, or depend on charity for care.<sup>2</sup> Even with the highest level of expenditures, the U.S. ranks behind other developed nations on many indicators of health, such as infant mortality rates.<sup>3</sup>

As the percentage of gross national product spent on health care increases from an estimated 12.5 percent in 1991 to over 15 percent by 2000, the nation's health care bill will approach one and a half trillion dollars, two and a half times that of today.<sup>4</sup> The problem of increasing costs is so large and has so many facets that it is difficult to pinpoint a single cause. Among the many contributors are medical malpractice insurance costs, prescription drug costs, overreliance on emergency rooms for primary care, use of technologically sophisticated



equipment, elective surgery, and higher labor costs in a labor-intensive industry.

In the state of Oregon, for example, it is the combination of skyrocketing costs and lack of health insurance coverage that creates a "health care crisis." It is estimated that over 18 percent, or 450,000 of its citizens, lack health insurance, a figure that is increasing by 5 percent annually.<sup>5</sup> An additional 230,000 are underinsured, having forms of insurance that do not adequately cover basic health care needs. In addition, premiums for all policies are rising at the rate of 17 percent per year.

It is the "near poor" who are particularly affected by the health care crisis. The joint federal/state health insurance program for the poor, Medicaid, is available to qualified individuals whose incomes fall below the poverty level. However, faced with rising costs of services and relatively static levels of funds available to secure them, states have been raising their Medicaid eligibility requirements. In Oregon there is a gap consisting of 120,000 residents who do not qualify for Medicaid because their incomes fall between the official Federal Poverty Level and the need standard set by the state to receive it.<sup>6</sup>

In order to expand access to health care, Oregon enacted six new laws in 1989 that will fundamentally change

the Medicaid system currently in place. Through a combination of redefined eligibility rules and a new cost-effective basis for allocating health care funds, the state hopes to cover most of its citizens with basic medical insurance.

Three of the new laws are collectively known as the Oregon Basic Health Services Act. The Act consists of a plan which expands Medicaid to cover those earning up to 100 percent of the federal poverty level (and guarantees them a "Standard Benefit Package" of health services); a mandate that all employers provide at least this package to all permanent employees and their dependents; and the establishment of a high-risk pool to provide coverage for those denied insurance due to pre-existing medical conditions.

Although the first of these plans would greatly increase the number of citizens covered by Medicaid, it may deny funding for some treatments currently covered by Medicaid. The new reimbursement system will use a computer formula that evaluates the importance of the expected benefit combined with the citizen's age, which is then plotted against a "Quality of Well Being Scale" developed for the Oregon Health Services Commission. Several other new commissions will serve to establish, guide, and monitor the implementation, effectiveness, and end results of the reforms. These commissions will operate under careful scrutiny from many interest groups.

In addition, because new laws have the potential for setting standards for states to follow in providing adequate services to needy citizens, Oregon's experience will be closely assessed by other state governments. Although the scope of the problem and Oregon's responses are broad, this paper focuses narrowly on the expected outcomes of those reforms involving the Medicaid program. This examination analyzes the anticipated results of changes in eligibility rules and implementation of the prioritized list of treatments and its expected effects on accessibility of care. The paper concludes with recommendations for other states presently addressing similar problems. While it is too early to study the actual policy outcomes, it is important to identify and analyze anticipated outcomes so that other states can begin assessing the merits of similar policy changes.

## ENDNOTES

<sup>1</sup>Oregon. The Oregon Basic Health Services Act (1990) "The Need for a Clear Public Policy": 3.

<sup>2</sup>Ibid.

<sup>3</sup>Ibid.

<sup>4</sup>American Association of Retired Persons, Building A Better Health Care System: America's Challenge of the 1990s (Washington, D.C.: American Association of Retired Persons, 1990), 4-5.

<sup>5</sup>Oregon. Health Care Facts, Office of Medical Assistance Programs (1991) 1.

<sup>6</sup>Ibid.

CHAPTER 2  
CHANGES IN ACCESSIBILITY OF MEDICAL CARE  
AND ITS ANTICIPATED EFFECTS

The existing health care system in the United States denies needed care to those without health insurance who do not qualify for government assistance and who have too little money to pay for health services. Part of the Oregon reforms is aimed at ensuring that the "near poor" are eligible for Medicaid. This expanded eligibility for Medicaid will greatly increase access to health care for citizens and will help reduce the burden on the health care system to provide care to the uninsured.

The Medicaid program covers only certain segments of the poor. In order to qualify for Medicaid assistance one must fit into a particular category, such as the elderly, the blind, the disabled, or families with dependent children. Current laws dictate that poor people without children are ineligible for Medicaid, regardless of their state of impoverishment. For example, a poor working women is not eligible for aid until she becomes pregnant. This rule may encourage some to strive for this state.

In addition to becoming eligible through participation

in the Aid to Families with Dependent Children program, Medicaid assistance may also be obtained through a needs test for the low-income aged and/or disabled. To be eligible the party must receive cash assistance through the federal Supplemental Security Income (SSI) program. SSI is offered to the elderly, blind, and/or disabled who earn less than a specific amount. In 1988 this was \$532 per month for a couple.<sup>1</sup> In addition to income tests, a couple must also pass a resource test. That is, they must own no more than \$2850 in assets to qualify in 1988.<sup>2</sup>

States have the option to cover specific additional eligibility groups in their Medicaid programs. These optional groups can be divided into three basic categories. The first two are composed of additional groups that the state may cover that are related to the two mandatory categories noted above (AFDC and SSI). For example, eligibility could be extended to include those individuals who are eligible for AFDC but do not apply for it, or to the aged and/or disabled who would be eligible for cash assistance if they were not in an institution. These groups are often referred to as the "optional categorically needy." The third is the "medically needy," those individuals whose incomes/resources are above levels established for the categorically needy but who have incurred large medical expenses.

Finally, there are eighteen other categories of need

that could qualify an individual for Medicaid in a variety of states (these additional categories cover far fewer people than the two primary ones). States that incorporate these categories into their Medicaid eligibility formulas are able to receive federal funding for their inclusion. In addition, states can offer Medicaid eligibility to groups that are not included in the mandatory or optional groups specifically stated, but they do not receive federal matching payments for services rendered to these citizens. Such groups are referred to as "state-only coverage groups."<sup>3</sup>

Although Medicaid does provide access to health care for certain segments of the population, whether an individual is covered depends on in which state the individual resides. States are free to set their own income eligibility standards to qualify for Medicaid, with those earning above a given level excluded. As an example, to qualify for coverage in Alabama one must earn no more than fourteen percent of the federal poverty level, while in California an individual may earn up to seventy-nine percent.<sup>4</sup> Nationwide inconsistencies exist as a result of the patchwork regulatory environment outlining qualification criteria for the program. In addition, because eligibility tests may change, qualifying for Medicaid one year does not guarantee coverage for the next.

## CHANGES IN ELIGIBILITY RULES

The Oregon Health Plan as contained in State Senate Bill (S.B.) 27 guarantees access to basic health services to all citizens earning up to one hundred percent of the federal poverty level, regardless of age, marital or family status, disability or other requirements. Passage of S.B. 27 eliminates the myriad of tests necessary to qualify for care by establishing the federal poverty level as the sole criterion. Upon implementation, an additional 120,000 Oregonians will be covered, solely as a result of this law.<sup>5</sup> Once eligibility is established, benefits will continue for a guaranteed minimum of six months.<sup>6</sup> After this, income levels will be measured again for continued coverage.

Since the eligibility criteria will be based on income, regardless of levels of personal assets, both enrollment and eligibility determinations will be simplified compared with existing Medicaid rules. This process will detach Medicaid from participation in "welfare" programs (AFDC, SSI), and help relieve some of the stigmas that come with them. Because qualification is maintained for a minimum of six months, citizens and their providers will enjoy a continuum of care, a luxury not offered many of the poor. Delivery of services will no longer be haphazard, as the state will offer clients access to help through managed care systems.



Managed care programs utilize self-contained approaches to delivery of care and often result in substantial cost savings in comparison with traditional plans. No matter where an Oregonian resides, she or he will have ready access to services through three principle delivery mechanisms. In the heavily populated Willamette Valley of Oregon, Medicaid services will be delivered by health maintenance organizations.

Health maintenance organizations combine the financing and delivery of health care services into a single system. Participating physicians, hospitals and other health care providers are directly involved in controlling the cost of an individual's health care. They are designed to provide complete levels of personal care in the most appropriate and cost-effective setting. Many emphasize preventative care options, such as the availability of routine physical examinations; often a small co-payment is required for such services. These organizations will be paid a monthly fee for each client, and will be responsible for all services required. Risk can either be accepted by the provider, or shared with the state in a separate plan.<sup>7</sup>

Many clients in areas of Oregon where health maintenance organizations do not exist will utilize physician care organizations. Unlike health maintenance organizations which strive to provide a full range of services to patients, physician care organizations provide a

more limited scope of services. When possible, care will be managed within the organization and will only be contracted out to non-participating providers when necessary.

Physician care organizations will be paid a monthly fee and will be responsible for at least delivery of lab, x-ray, physician services, and well-child exams; they may also opt to cover additional services. Such organizations will then share in the savings due to reduced use of services that are case-managed, including outpatient and inpatient care.

Differing levels of risk can be assumed by the providers, as defined within agreements with the state.<sup>8</sup>

Finally, in mainly rural sections of Oregon where comprehensive managed care organizations may not be feasible, a primary care case manager system will be implemented. Under these arrangements a medical professional will serve both as a primary care physician and as a case manager for the client. The physician will be paid on the traditional fee-for-service basis for care rendered to a client. Additionally, the professional will receive a limited monthly fee for each client for acting as a central referral source and care coordinator. Services delivered by approved referrals will also be reimbursed on a fee-for-service basis.<sup>9</sup>

By utilizing managed health care systems, the Oregon health plan will assure more clients access to medical care and will guarantee greater continuity in care than under the

present Medicaid system. In addition to achieving the above benefits, the plan will give care providers a simpler system to administer, shift the majority of health care decisions to a local, rather than statewide level, and balance the distribution of patients through increased participation of nearby professionals. The State of Oregon should also realize benefits through increased cost-savings due to reliance on managed care, and easier determination of eligibility requirements and payment amounts.

#### CHANGES IN SCOPE OF COVERAGE

By expanding eligibility to all citizens earning less than the federal poverty level, Oregon's plan shifts the debate from who is covered to what is covered. Federal regulations mandate that states cover a basic set of services via Medicaid; implementation of Oregon's reforms will result in additional coverages for enrollees. These categories include dental services, hospice care, adult diagnostic and screening services (such as mammograms and routine physicals), physical/occupational therapy, prescribed drugs, as well as most transplants.<sup>10</sup>

Oregon law also modifies the coverage of some federally mandated benefits. For example, the Early, Periodic, Screening, Diagnosis and Treatment benefits currently mandated for clients under age twenty-one, are

extended under state law to all eligible adults. In addition, 52,100 men who do not currently qualify will become eligible for coverage.<sup>11</sup> All such treatments are to be available according to Oregon's prioritized benefit package. Federal law allows limitations on the number of days per year covered for inpatient hospital services; Oregon's plan provides for unlimited medically necessary hospitalization for any covered treatment. The reforms' emphasis on managed care will help control utilization of laboratory, x-ray, outpatient hospital, and physician services as well.

By October 1993 the program will be widened to include defined coverage of mental health and chemical dependency services, further expanding coverage over the initial system's offerings. Before this future integration of services into the prioritized list of coverages, clients in the plan will be eligible for all such care and services. Projected for inclusion into the prioritized list at roughly the same time is a package which will integrate many senior and/or disabled citizens into the Oregon health plan.<sup>12</sup> Upon implementation, Medicaid will cover what Medicare does not for these individuals.

The delayed participation of seniors and the disabled will allow the state Health Services Commission additional time to address any special needs of these groups. Because of this delay in absorption, as well as concerns that the

plan will have a disproportionate impact on benefits available to children, the state has prepared legal defenses citing federal law and court cases. These defenses assert the delays are unavoidable, and argue that more individuals than ever will qualify for care.<sup>13</sup>

Not only does Oregon's plan extend access to seniors and the disabled, but it also provides health services to all impoverished children. Such expansion of access is consistent with the Bush Administration's position that access to health care should be universal, unnecessary barriers to obtaining health insurance should be removed, and government should concentrate its resources on the neediest citizens.<sup>14</sup> Similarly, Oregon's emphasis on managed-care oversight of service provision stresses the state's shared concern with the federal government regarding cost control.<sup>15</sup>

S.B. 27, the centerpiece of Oregon's reforms, defines the population for whose health care the state is responsible as all those with a family income below the federal poverty level. With this threshold qualification now written into law, the state is prohibited from redefining it to balance the budget. As a result, the vast majority of Oregonians will enjoy guaranteed access to basic health services. The levels of coverage have been determined through a public process, and are based both on social values and on what makes sense clinically in terms of improving health.

## ENDNOTES

<sup>1</sup>Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, Medicare and Medicaid Data Book, 1990 ([Baltimore, MD]: U.S. Department of Health and Human Services, Health Care Financing Administration, 1991), 63.

<sup>2</sup>Ibid.

<sup>3</sup>Ibid., 61.

<sup>4</sup>John Kitzhaber, "A Healthier Approach to Health Care," Issues in Science and Technology 7, (Winter 1990-91): 60.

<sup>5</sup>Oregon. The Oregon Health Plan - Facts, Office of Medical Assistance Programs (1991) 1.

<sup>6</sup>Jean I. Thorne, "Serving the Health Care Needs of the Poor," Speech given at The 1991 National Conference on Health Care: The Oregon Solution in Portland on 9 August 1991 (Salem, OR: Office of Medical Assistance Programs, 1991): 3.

<sup>7</sup>Ibid., 5.

<sup>8</sup>Ibid.

<sup>9</sup>Ibid.

<sup>10</sup>Oregon, Health Care Facts, Office of Medical Assistance Programs (1991) 8.

<sup>11</sup>Ibid., 9.

<sup>12</sup>Diane S. Lund, ed., "Timeline Moved for Aged, Disabled," Oregon Health Forum 1, no. 5 (1991): 3.

<sup>13</sup>Oregon, Response to Issues Raised by Children's Defense Fund Regarding the Oregon Health Plan, Office of Medical Assistance Programs (1991): 4.

<sup>14</sup>Gail R. Wilensky, Ph. D., "Talking Points Before 1991 Conference on Health Care," Speech given at the 1991 Conference on Health Care: The Oregon Solution in Portland on 9 August 1991 (Washington, D.C.: Department of Health and Human Services, 1991): 2-3.

<sup>15</sup>Ibid., 3.

CHAPTER 3  
COST CONTAINMENT AND THE  
PRIORITIZED LIST OF HEALTH SERVICES

The term "cost containment" as used in the health care field refers to the utilization of a variety of cost control strategies to slow the rising costs of care delivery. Like most cost containment strategies in use today, Oregon's reforms use "managed care" systems in pursuit of this goal. "Managed care" refers to an umbrella approach to cost containment; it uses a number of devices aimed at reducing waste and increasing efficiency while maintaining a high quality of care. Patients, for example, must obtain care from a primary care physician rather than a hospital emergency room and they can receive care from a specialist only after being referred by their primary care physician. Patients are in this way "managed," with a resulting reduction in costs. Oregon's use of health maintenance and physician care organizations, as well as the primary care case management system, is an attempt to maximize the impact of health care funding for the uninsured.



Until recently, neither consumers nor providers of health care had any real incentive for making the system more efficient. Most consumers have some type of insurance and those who do not are often still treated. Because there is frequently no direct relationship between the cost of the services received and the cost of insurance (out-of-pocket expenses are low), consumers and providers are often isolated from the real costs of treatment decisions. People feel entitled to all the system has to offer and providers do not usually have to concentrate on the cost or relative effectiveness of the treatments they use. This creates a "cost-shifting" cycle.

"Cost-shifting" occurs when a hospital, faced with large numbers of uninsured clients, increases its fees. As a result, the insurance carrier that has been paying these charges raises its rates. Because of this, employers face higher charges for insurance premiums, and either drop or modify offerings. This company's employees, unable to afford the higher rates, end their coverage, and become uninsured. Once Oregon's plan is under way, hospitals should see a decrease in their burden of uncompensated care and a reduction in the impact of "cost-shifting" as a result of clients' increased access to Medicaid. This projection is determined by the plan's absorption of 120,000 clients who previously depended on charity care and hospital goodwill.

A main goal of changes in the law is to balance the state health budget against medical program costs by refusing to pay for the least cost-effective procedures. By limiting the amounts of expensive, "high tech" care, the state hopes to provide basic coverage to a much wider pool of people. While this goal is attainable, many medical ethicists are troubled by the possibility that Oregon's poor will be denied some treatments.<sup>1</sup> In its zeal to cut costs, the state may face disturbing situations, such as the negative publicity resulting from the 1987 denial of Medicaid funding for a child's liver transplant.

By learning from mistakes of the past, and by minimizing any real or potential adverse impacts of the reforms, Oregon has the opportunity to realize significant cost savings while serving a greater number of clients. According to Jean Thorne, Oregon's Medicaid director, hospitals also have much to gain by participating in the new system. Although a primary goal of the system is to decrease hospital usage, hospitals that participate in the new managed care networks will share in savings resulting from decreased levels of uncompensated services. The plan's hospitals will also share a guaranteed population of paying patients. Facilities not taking part in the plan will most likely be bypassed by the state Medicaid system in favor of those choosing to participate.<sup>2</sup>

There is no doubt that serving 120,000 additional

citizens will be more expensive for the state than if they chose not to do so, even with the heavy emphasis on managed care. Thorne says that the state is aware of this, but is hoping to realize increased levels of health among the poor and more efficient utilization of health services as a result.<sup>3</sup> Even though state Medicaid budgets are rising quickly, there is not necessarily a correlation between the increased funding and better health overall. By ensuring access to routine health services for the poor, Oregon is channeling its rising flow of Medicaid funds toward this goal.

The U.S. General Accounting Office recognizes that Medicaid, nationwide, is the second largest component of state budgets. As a major factor in state finance, the program routinely adds to the fiscal stress placed on government.<sup>4</sup> Despite recent passage of a devastating property tax freeze in Oregon, evidence of grass-roots backing for the reforms is shown by the overwhelming support of the plan in town meetings and the state legislature.<sup>5</sup> The legislature has approved multi-year funding for the program and is searching elsewhere for budget cuts to meet the anticipated shortfalls.

The major method by which 120,000 new enrollees will be added without bankrupting the Treasury is the prioritized list of health services. The list will serve as a guideline as to whether a procedure will be approved for

reimbursement. Under the current Medicaid system, many services are routinely approved for payment that would fall outside of Oregon's defined scope of coverages. While Oregon's list of treatments will include some new procedures (effectively expanding the list), certain currently funded procedures will be eliminated, such as treatments for illnesses which heal on their own.

#### THE "QUALITY OF WELL BEING SCALE"

In order to arrive at the final list of prioritized health services (a main cost containment feature within the reforms), the state of Oregon had to develop a complex process for their proposal, debate, and approval. The agency charged with this task was the newly-created Health Services Commission, an eleven-member body responsible for ranking all health care services according to their importance to the entire population. The commission, composed of five physicians, four consumers, a social services worker, and a public health nurse, reflected a blend of professionals and lay state residents. The Health Services Commission was required to develop a methodology that reflected both social values and clinical effectiveness.<sup>6</sup>

To determine prevailing social values in Oregon, the commission used the "Quality of Well Being Scale" (QWBS)

developed by Robert M. Kaplan and J. P. Anderson at the University of California at San Diego. The QWBS is designed to measure how a person functions independently and how she or he feels normally and during sickness.<sup>7</sup> This is determined through an evaluation of the value society places on the prevention of death and/or on the alleviation of a range of symptomatic conditions such as weakness, fatigue, depression, olfactory dysfunctions, and pain. The QWBS is an indicator of an individual's or population's general state of health, measuring levels of independent functioning and feelings during periods of wellness and illness.

Kaplan and Anderson's scale asks individuals to rate, on a scale from 0 to 100, how they believe health status affects the quality of their lives. Respondents assign their chosen score to each of a series of hypothetical situations, with a score of 100 representing a situation that describes good health, and a score of 0 representing the worst possible situation.<sup>8</sup> The types of situations used to assess the values Oregon residents place on specific aspects of health relate to common dysfunctions such as weakness, diminished mental acuity, paralysis, and chemical dependency, giving the respondent the opportunity to record his or her personal beliefs and values in the survey.<sup>9</sup>

By bridging the gulf that separates scientific fact in terms of symptoms and disabilities from the population's perception of their relative importance, Kaplan and

Anderson's QWBS possesses an advantage over the use of other methods, which generally fail to take subjective feelings into account. The QWBS was slightly modified to integrate values most important to Oregonians through surveys of thousand of individuals who participated in community meetings, members of the medical profession, and many of the nation's foremost health care ethicists. This was done by a random sample telephone survey and by surveys of individuals who were unable to attend the state's town meetings. In addition to interpreting these responses, members of the commission reflected on their own judgements as well as on categories of grouped services (such as maternity care) that reflected their sense of what was most important to state residents.

The QWBS assigns a score of 1.0 to persons in perfect health and a score of 0 for death. The severity of certain limitations in physical or social activity and/or the presence of mental or physical symptoms derived from a list of 24 categories allows the calculation of quality of well-being. Each symptom and disability is weighed on the basis of information supplied by Oregonians using the aforementioned survey methods. The net benefit of a service or treatment for particular conditions or groups of conditions is defined as the difference between the expected quality of well-being score resulting from the condition and that following standard treatment. This method was applied

to a large number of treatments used for the majority of conditions listed in the International Classification of Diseases, ninth edition. Using this system, the quality of well-being was used to derive a cost-benefit ratio, after applying a complex formula.<sup>10</sup> In the case of a liver transplant, for example, the well-being achieved may be high, but so too the costs. The ratio may be so high as not to justify reimbursement for the treatment.

Within this formula "cost" is defined in terms of past charges submitted to Oregon's Adult and Family Services Division as supplied by various providers, payers, and the state Office of Medical Assistance Programs. The costs included all services relating to diagnosis, such as hospitalization, imaging and laboratory services, professional fees, pharmaceuticals, as well as other miscellaneous charges such as social services, rehabilitation, and physical and occupational therapies.<sup>11</sup> These costs were selected to portray as accurately as possible prevailing charges for treatments paid through Oregon's government.

Anticipated outcome results were measured at five-year intervals, a generally accepted norm for treatment success.<sup>12</sup> The duration of benefit of a certain condition-treatment grouping was categorized into one of four lengths: one-year, five-year, five years to less than lifetime in length, and those of lifetime duration. All

data for the 1600 condition/treatment pairings studied were entered into a computer, which then calculated the "cost per benefit year" for each listed item, ranking them from lowest to highest (the precursor to the final prioritized list of health services).<sup>13</sup>

A large portion of the QWBS's validity lies in the acceptance of the reliability of its primary input, health outcomes. The term "health outcome" refers to an analysis of the end results of various medical conditions after the application of medical treatments. Even though health outcome research has received extensive attention over the past twenty years, it is still a methodology in its infancy, in part due to the rapid development of new treatments.<sup>14</sup> During the time it takes to evaluate the health outcome of a certain disease, different, possibly more effective treatments may be available. Also, because of the huge breadth of condition/treatment combinations, there still remains a large portion of outcomes that have not been sufficiently evaluated.

Interpretation of such data was mandatory in order to identify cost-effective combinations for the Oregon plan. Early in the planning it was noted that data such as this was largely unavailable.<sup>15</sup> Optimally, the Health Services Commission could have performed a series of clinical trials (rather than clinically assessing clinical judgements) to buttress their findings, but this enormous undertaking was



both cost- and time-prohibitive. Rather than postpone the project for years, the commission determined that a ranking of services could be legitimately based on the existing research of established professionals.

Oregon's attempt to rank-order condition/treatment pairs is unique in the country. The process of consensus-building through community meetings, surveys of professionals and the lay public reporting to a similarly "mixed," newly-created Health Services Commission infused a variety of different views into a policy making process that formerly was determined solely by government.<sup>16</sup> A high degree of consensus within Oregon emerged from this process regarding the principles by which the relative importance of health services might be identified and where cuts and/or enhancements in delivery could be made. The formation and application of Kaplan and Anderson's Quality of Well Being Scale to develop the state's prioritized list of health services pioneers Oregon's unification of life-extending treatments with life-enhancing treatments, and represents one state's unique solution to a nationwide dilemma.

#### THE PRIORITIZED LIST OF HEALTH SERVICES

Oregon's legislature took the final list of 709 condition/treatment pairings and began the process of determining how many of these the state could afford to

offer to Medicaid clients. The Health Services Commission had assigned the pairs to seventeen categories of care. After ranking the categories, members then ordered the pairs within the categories. Determined to give the legislature detailed and accurate guidance in allocating health care, members defined each individual category as: essential, very important, or as being valuable to certain individuals.

Essential services were defined as those that preserve life, reproductive services, preventative care for all age groups, and comfort care (pain management and hospice care). These services, which are totally covered, are cost-effective and generally improve quality of life, representing Oregonians' highest priorities. Services categorized as being very important will be covered for the most part, and will include treatment of non-fatal conditions where at least some recovery is likely. Treatments that are valuable only to certain individuals generally will not be covered. These include treatments that hasten recovery from non-fatal conditions (sometimes providing slight improvement of quality of life), and infertility services.<sup>17</sup>

Generally, preventative care (especially for children), and comfort care rank high on the list, while treatments that offer little proven efficacy or little chance of improving quality of life (such as treatment of infants with reduction deformities of the brain, or who

weigh under 500 grams and/or are under 23 weeks of age at birth). Topping the list are therapies for pneumonia, tuberculosis, appendicitis, and removal of an airway-obstructing foreign body. Treatments that fall at the end of the list include therapy for superficial, non-infected wounds, therapy (other than comfort care) for end-stage HIV disease, uncomplicated hemorrhoids, and common colds. This listing, while ambitious in creation, development, and implementation, represents compromises. Not all parties are enamored with it, with many disagreeing over the placement of certain services within the list.

Concern over placement of condition/treatment pairings within the list was heightened when a preliminary draft was examined by legislators. They discovered that this list ranked cosmetic breast surgery higher than correction of an open thigh fracture; that dental work for crooked teeth ranked higher than treatment of Hodgkin's disease. The top third of the list contained treatments for artificial insemination, thumb sucking, acupuncture for back pain; and menopause. Conversely, the bottom third included treatment of serious conditions such as a fractured pelvis, ovarian cancer surgery, and chemotherapy for lung cancer.<sup>18</sup>

The final Prioritized Health Services List of May 1, 1991 has reversed many of the placements. It places treatments for fractured pelvises, and lung/ovarian cancers

into the top third of the list. Menopause treatment and many of the others have fallen to the bottom half of the list. Even with the revised list, certain placements are debatable; for example, treatment of botulism ranks above treatment for a traumatic amputation of the leg.<sup>19</sup> In addition, screening exams and diagnostic procedures outrank many types of surgery; prevention and detection of AIDS scores high, but treatment for the disease in its latter stages ranks near the bottom.

By expanding access and completely redefining coverages, it is virtually impossible to accurately predict the plan's total costs due to claims. Because the state cannot afford to cover all 709 condition/treatment pairs on the list, it had a major actuarial firm professionally price various levels of coverage in order to enhance the accuracy of cost projections. In addition, the actuarial firm received input from an advisory committee of Oregon providers and insurers to provide input in the development of these rates. After hearing extensive public testimony, the state legislature decided the benefit package should include all health services through number 587, or roughly 83 percent of the total possible.<sup>20</sup>

Under Oregon's health plan, state residents will not receive certain services which Medicaid currently provides. Examples of coverages lost include treatment for illnesses that heal on their own such as colds and viral sore throats;

conditions which respond to a change of diet (such as food poisoning), or application of an ointment (such as diaper rash); and treatments which are considered not as effective compared to others, such as surgery to correct lower back pain, and various heroic and futile measures such as aggressively treating fatal cancers. To the extent possible, comfort care will be provided to help minimize the effects of conditions that are not covered or are non-treatable.

While some treatments will no longer be covered, eligible Oregonians will qualify for numerous services in the prioritized list that are not required by federal Medicaid mandates, such as dental services, hospice care, prescribed drugs, and diagnostic and screening services for adults (such as mammograms and routine physicals). In addition, the plan pays for physical and occupational therapy, and also provides unlimited medically necessary hospitalization for any covered treatments (Medicaid allows states to impose limits on the number of days of care per year).<sup>21</sup> Coverage of these services illustrates the plan's emphasis on preventative and cost-effective care that has the potential of eliminating or reducing the intensity of future health problems.

Currently, the federal government gives states some options in determining coverage of services. However, these options only affect Medicaid clients aged 21 or older, and

generally do not revolve around offering those types of services which will have a maximum impact on the health of a population. Instead, they emphasize providing coverage for entire ranges of services, including dental care, prescription drugs, and medical equipment. Under the present system, states have little authority to deny treatments, since there is disagreement over which ones are medically necessary.<sup>22</sup>

For example, if a certain treatment has a 5 percent probability of success for a particular client, the burden of proof is on the state Medicaid agency to show that the individual could not possibly benefit in any way from this treatment. Dealing with issues such as these results in agency workers spending official time in hearings, accumulating large attorney's fees as disputes are handled on an individual basis. Oregon's attempt to identify and cover those services which are both beneficial and cost-effective represents the first action taken by a state to control proliferation of dubious medical expenditures, while at the same time expanding eligibility.

However, because Oregon's list places explicit limits on covered treatments in order to keep the total budget under control, individuals who are denied services may need to make a public appeal for funds, or move elsewhere. The issue of whether the state will pay for transplants was highlighted in 1987 when 7-year-old Coby Howard's family

publicly appealed for funds to cover his bone-marrow transplant after Oregon denied payment. The boy died \$10,000 short of the amount needed for the operation, forcing Oregon's denial of treatment into a national spotlight.<sup>23</sup> Oregon's revised Medicaid system does cover organ transplants that are medically beneficial and cost-effective. For example, the new plan will pay for kidney and heart transplants, but it will not cover bone-marrow transplants which are generally less successful and very expensive.

## ENDNOTES

<sup>1</sup>"Cut Health Costs, Not Health Care," Business Week, 21 May 1990: 182.

<sup>2</sup>Marybeth Burke, "Hospitals gain from Oregon plan, says Medicaid director," Hospitals, 5 January 1991, 44.

<sup>3</sup>Burke, 44.

<sup>4</sup>General Accounting Office, Human Resources Division, Medicaid Expands; Fiscal Problems Mount ([Washington, D.C.]: U.S. General Accounting Office, Human Resources Division, 1991), 4.

<sup>5</sup>Ralph Cranshaw, M.D. et al., "Developing Principles for Prudent Health Care Allocation," Western Journal of Medicine 152, (April 1990): 446.

<sup>6</sup>Oregon. The Oregon Basic Health Services Act - Appendix A, Office of Medical Assistance Programs (1990) 1.

<sup>7</sup>Ibid.

<sup>8</sup>Judith P. Rooks, "Let's Admit We Ration Health Care - Then Set Priorities," American Journal of Nursing (June 1990): 42.

<sup>9</sup>Ibid.

<sup>10</sup>Harvey D. Klevit, M.D. et al., "Prioritization of Health Care Services," Archives of Internal Medicine 151, (May 1991): 914.

<sup>11</sup>Ibid.

<sup>12</sup>Ibid.

<sup>13</sup>Ibid.

<sup>14</sup>Patrick G. Marshall, "Setting Limits on Medical Care," Editorial Research Reports, 23 November 1990, 675.

<sup>15</sup>Ibid.

<sup>16</sup>Cranshaw, M.D. et al., 445.



<sup>17</sup>Oregon. The Oregon Health Plan - Standard Benefit Package, Office of Medical Assistance Programs (1991) 2.

<sup>18</sup>Charles J. Dougherty, Ph.D., "The Proposal Will Deny Services To The Poor," Health Progress, (November 1990): 29.

<sup>19</sup>Oregon. Prioritized Health Services List of May 1, 1991, Office of Medical Assistance Programs (1991).

<sup>20</sup>Oregon. Oregon Finalizes Pioneering Health Plan, Office of Medical Assistance Programs (1 July 1991), 1.

<sup>21</sup>Oregon. Medicaid Vs. The Oregon Health Plan, Office of Medical Assistance Programs (1991), 1.

<sup>22</sup>Jean I. Thorne, "Serving the Health Care Needs of the Poor, " Speech given at The 1991 National Conference on Health Care: The Oregon Solution in Portland on 9 August 1991 (Salem, OR: Office of Medical Assistance Programs, 1991): 2.

<sup>23</sup>Melinda Beck et al., "Not Enough for All," Newsweek, (14 May 1990): 53.

CHAPTER 4  
ASSESSMENT AND CONCLUSIONS

The paper's final chapter begins by analyzing the ethical ramifications of Oregon's reforms and broadens to include an assessment of the plan's impacts on eligibility and range of services covered. Within this analysis the plan's potential problem areas are examined and are taken into account in recommendations offered to other states.

ANALYSIS OF THE OREGON REFORMS

If past experience is an accurate predictor of future events, occurrences such as Coby Howard's should be the exception, not the rule. Even so, it is likely that similarly troubling appeals will surface, drawing attention to the system's shortcoming of less-than-total health protection. When this happens, Oregon's prioritized list will not forestall public pleas for donations, appeals to the state, and/or lawsuits to fund denied treatments. It is the assertion of Oregon's reform leaders that major extension of Medicaid eligibility, albeit short of coverage,

will introduce beneficial health coverage to scores of the uninsured, outweighing individual cases of systemic ineligibility or non-coverage.<sup>1</sup>

Another way of examining the Coby Howard case is by refocusing the dilemma: if the state were to increase funding for health care, where should the money go? For example, should the money go to funding transplants as opposed to expanding the availability of pediatric care? Should both be funded? Who decides what is funded? These questions, which have never before been explicitly examined by a state government, reflect a debate over the allocation of health care resources. Often policies such as Oregon's that place specific limits on eligibility and coverage are referred to as "rationing" health care.

If it is acceptable to use the term in this manner, then Oregon surely is the first state in the nation to explicitly ration health care. Prior to Oregon's restructuring of its Medicaid system, concerns such as fiscal limits on health care spending were often dealt with implicitly by agencies nationwide which ration care on a daily basis. Primarily, it is rationed by Medicaid eligibility requirements, when 11 million citizens living below the federal poverty level, without any form of health insurance, cannot qualify for Medicaid. In 32 states, an individual cannot earn more than half of the federal poverty level in order to be eligible for Medicaid coverage. Due to

financial restrictions, states are finding it increasingly difficult to pay for rising Medicaid bills. Often these shortfalls are dealt with by lowering the maximum income ceiling one may earn to qualify for assistance, shutting out those residents who qualified under the old terms, but still earn the same (poverty-level) amount.<sup>2</sup>

Across America, medical care is usually rationed without opportunity for public comment and with no commitment to basic services for citizens. Oregon is unique, not by rationing services for the poor, but for ensuring basic health benefits to the majority of its residents. The prioritized list of health services' recognition of monetary limits has developed into a clearly defined policy of guaranteed coverage, establishing accountability for resource allocation decisions and their effects. By doing so, the state is explicitly responding to the highly individualistic, emotional issues that currently guide health policy.

The limits to medical care may not be as absolute as those imposed by nature (health care is not a resource similar to oil, which is of finite supply, non-renewable). However, the decision to allocate more resources to health care means less are available to serve other pressing needs. As the costs of medical care continue to disproportionately outpace inflation, experts are raising questions about whether the gains are worth the sacrifices, and how long such increases can be sustained.

Despite, or perhaps because of, the plan's new, explicit recognition of "rationing", ample criticism still remains. Arthur Caplan, the director of the Center for Biomedical Ethics at the University of Minnesota, points out that the plan demands sacrifices from those who depend on Medicaid for coverage but explicitly prohibits cuts in what providers can earn.<sup>3</sup> In fact, the reforms do not prohibit cuts in providers' wages; they specify payment at levels necessary to cover costs and ensure access, no more. Additionally, provision of care through statewide managed care plans will greatly help control costs.

Another concern Caplan raises is that it is not fair to require the poorest citizens (including children) to pay for extending coverage to the "near-poor." While it is true that the reforms limit payment for certain services of dubious value, their enactment adds thousands of poor citizens to Medicaid rolls. Also, the appropriation of significant funding disputes the assertion that the poor will pay for expanded eligibility.<sup>4</sup>

Caplan is also concerned that the poor's values are not adequately reflected in the plan. However, the state's dozens of town meetings actively encouraged poor citizens to attend, and transportation was provided. Their feelings were also noted during a statewide telephone survey, and they did not appreciably differ from those of the middle class.<sup>5</sup> Caplan and others also contend that the benefits

provided are inadequate, citing the state legislature's unwillingness to be covered by the plan. He asserts that good reforms may postpone the arrival of perfect reforms, and advocates comprehensive national reform.<sup>6</sup> Oregon's policy makers agree that the issue ultimately must be addressed at the national level, and stress that expanding eligibility using the prioritized list represents a local stopgap plan that awaits national reform.<sup>7</sup>

Another way to approach the issue of "rationing" care solely to Medicaid clients is by examining the treatment of those on Medicare, employer-provided plans, and those currently on Medicaid. All three of these groups are in some way subsidized: Medicare and Medicaid through state and local funding, and employer-provided plans through a sharing of costs between employer/employee, and an employee tax exclusion on the value of these benefits. The current methods of delivery extend subsidies to a huge portion of the population, yet ignore those that are ineligible for insurance. These subsidies do not consider ability to pay, or need. Under the present system many of the millions of citizens who lack insurance subsidize Medicaid, Medicare, and the tax exclusion on benefits, but are not eligible for benefits themselves, because they earn above the threshold to qualify for assistance, because they have too many assets, or because they do not qualify on the basis of gender or age.<sup>8</sup>

However, Oregon's plan solely defines the poor based on levels of income, and offers scores of the uninsured access to a continuum of high-quality, basic levels of health services through cost-effective managed care plans and the prioritized list. The point that the reforms only apply to the uninsured is valid only to the extent that the question of equity will eventually demand federal intervention. States lack the federal authority to distribute resources nationwide; they share funding of Medicaid with the federal government, and do not control Medicare or the tax exclusions on benefits. Until a comprehensive, national solution to the crisis in health care is achieved, states such as Oregon must create homegrown answers to the local problems.

Besides extending coverage, Oregon's program will likely save money in the long run by enabling enrollees to see a doctor as soon as they get sick. At the present time, those who cannot afford medical care often wait until a problem becomes acute and then go to an emergency room in search of free care. This usually forces the hospital to provide the care, and often for a fully-developed illness/injury (rather than one in its initial stages). Practices such as these not only tax the health of citizens, but inevitably lead to initiation of the "cost-shifting" cycle, further driving up the costs of care.<sup>9</sup>

In addition to widespread popular support, the Oregon

plan is supported by a variety of coalitions including groups of doctors, insurance companies, and hospitals. The Oregon Association of Hospitals explains that the plan's authors sought early cooperation and input from a variety of major players in the state's delivery system. Input provided by these groups was frequently integrated into the plan's coverage and structure, providing for a balance of opinions. Many institutional participants view its development as the result of a partnership between the state and businesses.<sup>10</sup>

Although Oregon's reforms represent an important advancement in accessibility, many issues remain unaddressed. Even with the state's implementation of cost containment procedures, success is uncertain because such measures ignore certain contributors to the cost spiral. As American Medical Association (AMA) representative James Todd believes, it is more patients and better technology that are driving costs higher. In addition, the rapidly-growing elderly segment demands more care than others.<sup>11</sup>

Acquisitions of new technologies do not necessarily improve efficiency; conversely, each new machine routinely adds one or two more technicians to the health team. According to a report by Blue Cross and Blue Shield, labor costs have been rising faster than other costs, and they currently account for nearly half of total hospital operating expenses.<sup>12</sup>

Another area of rising costs that is not directly



addressed by the Oregon plan is that of unnecessary medical procedures. The Journal of the AMA suggests that over half of the forty million medical tests performed each day do not really contribute to a patient's therapy or diagnosis.<sup>13</sup> A multitude of treatments and tests are currently available to protect, confirm, or to enrich the practitioner, and many expensive, commonly performed procedures such as coronary bypasses and Cesarean section are of questionable value.<sup>14</sup> The Joint Economic Committee of Congress estimates that \$125 billion in unnecessary tests and treatments can be cut from the system without affecting quality, and that twenty to thirty percent of all medical procedures may be unwarranted.<sup>15</sup> Even though Oregon's plan approves coverage only for treatments that are pre-determined to be cost-effective, if Congress's figures are accurate, then a large portion of these may be unnecessarily administered.

Finally, even if the benefits of Oregon's plan outweigh its liabilities, a major uncertainty remains: the prioritized list initially funds the 587 most important condition/treatment pairs (of 709); nothing prevents the elimination of lifesaving and cost-effective services in the future. Theoretically, this could occur if revenues are insufficient to fund condition/treatment pairs through item 587. Under this scenario, unless additional funding was allocated, the state legislature could reduce the levels of covered services under the plan. For example, if only

enough funds existed to cover the first 400 items, 187 items previously covered would be eliminated. Nothing prevents the line from reaching the most important services in the list. This fear largely exists because the state has not defined a minimally acceptable package of services that must be provided.

In an attempt to assuage this fear, Oregon, in its application for federal waivers inserted a promise that it must receive federal approval before reducing the scope of Medicaid services it provides.<sup>16</sup> Conceivably, when faced with this situation, the federal government could deny the state's request, and mandate that Oregon maintain benefit levels, forcing the state to raise additional funds. The state could shunt money from other programs to the reforms, dip into emergency reserve funds, or raise taxes to make up the differences. Because questions remain as to the actual costs of the reforms, this concern will remain valid until a significant operating track record develops.

Oregon's extensive efforts to obtain a variety of inputs has contributed to the plan's near-universal acclaim within the state. Because a host of different groups were consulted, including hospitals, insurance interests, ethicists, and consumers of all incomes, different points of view, and different levels of priorities converged into a coherent, explicitly-defined proposal. From town hall meetings to telephone surveys to citizen participation on

commissions, the state rigorously polled the population's feelings and needs in the areas of health care accessibility, eligibility, and scope of coverage.

If the reality of fiscal limits is accepted, Oregon's use of a prioritized list of health services represents a carefully planned attempt to define services using a publicly-derived index. While health outcomes research is in its infancy, the state makes use of the latest projections available from a score of different sources. Additionally, the state's use of a variety of managed care plans offers hope for minimizing growth in health expenditures. Inclusion of these measures has extended coverage to the vast majority of the population, and should increase the population's health, while saving money due to reduced cost-shifting among providers.

Given the enormous difficulty facing the country in expanding access to health care, it is likely that, at least in the foreseeable future, states will need to address the issues faced by Oregon on their own. Many have done this to a limited degree already, but none has progressed as far as Oregon. Regardless of the moral and ethical questions surrounding its methods, the state is pioneering a local solution to a truly national problem. Although time will be the ultimate judge of the plan's success, Oregon's reforms contain many innovations that should be considered by interested states.

## RECOMMENDATIONS TO OTHER STATES

1. It is recommended that other states carefully consider Oregon's methods of development, the structure of its laws, and the contents of its reforms. By confronting the problem at the state level, states have the opportunity to modify their systems to best serve their populations.

2. Before adopting any of Oregon's reforms, other states are advised to allow them to develop an operating track record, and to consider those methods that demonstrate proven effectiveness. Similarly, states should examine the wide variety of other existing health reform proposals for additional ideas.

3. Using a public process, states should consider adjusting the scope of the services provided. For example, Oregon's plan does not address the issue of long-term care of the elderly and/or disabled. It also places a higher priority on services such as preventative care, rather than on expensive, sometimes successful operations like liver transplants.

4. Within their reform packages, states should place an emphasis not only on preventative care, but also on health education. Increased awareness of good hygiene, proper health habits, and how to live a healthy lifestyle will undoubtedly reduce the necessity of medical intervention later in life, resulting in healthier residents and lower expenses for the states.

5. Depending on local priorities and fiscal constraints, other states should explicitly define the population that is eligible for coverage. Oregon's plan does not provide universal coverage. Though greatly extending eligibility, certain groups, such as the unemployed that earn above the poverty level (independently wealthy), are excluded. While it is presumed that they should be able to purchase individual policies, this is not always possible for various reasons. States should consider adjusting eligibility rules according to local priorities, which could include scaling back the eligible population, extending coverage to the entire uninsured population, or mandating purchase of basic health policies for those who are not covered.

6. Other states should seriously consider eliminating existing waste in the system, such as the proliferation of duplicate technologies within a market, before introducing a new plan that envelopes it.

7. Oregon's inclusion of unlimited medically necessary hospitalization for covered treatments may lead to longer hospital stays, raising the reforms' total costs. Other states should limit the number of days provided for treating illnesses to the average for that specific condition in order to forestall over-utilization of hospitals and related services.

8. If other states choose to use a prioritization

process similar to Oregon's, its design should reflect differing severities of conditions, which could have the effect of covering condition/treatment pairs that currently fall below Oregon's line of inclusion.

9. Due to possible differences in prevailing values/priorities, other states should alter the derivation of the Quality of Well-Being Scale to reflect the collective concerns of their residents.

10. Curing America's health care illness will require a new, powerful prescription. Oregon's new laws represent a breakthrough ingredient in the formula, and the effects of administering the recommended dosage at the state level will serve as a clinical trial in determining a national cure. It is recommended that whatever composition of ingredients states use to address their symptoms, they should begin planning immediately, before their already sick health care systems take a turn for the worse.

## ENDNOTES

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<sup>2</sup>John D. Golenski, S.J., "Beyond the Hospital's Mission: The People Speak," Healthcare Forum Journal, (January/February 1990): 16.

<sup>3</sup>Arthur Caplan, Ph.D., "Oregon's Plan Would Sacrifice the Poor," Oregon Health Forum 1, (September 1991): 7.

<sup>4</sup>Thorne, 7.

<sup>5</sup>Ibid.

<sup>6</sup>Caplan, 7.

<sup>7</sup>John A. Kitzhaber, M.D., "Oregon Act to Allocate Resources More Efficiently," Health Progress, (November 1990): 27.

<sup>8</sup>Ibid.

<sup>9</sup>Richard Allen, M.D., "Why the Oregon Plan Deserves Your Support," Medical Economics 67, (1 October 1990): 23.

<sup>10</sup>Terese Hudson, "Oregon and Massachusetts: a Tale of Two Reform Plans," Hospitals 65, (5 July 1991): 52.

<sup>11</sup>Patrick G. Marshall, "Setting Limits on Medical Care," Editorial Research Reports, 23 November 1990, 672.

<sup>12</sup>Ibid.

<sup>13</sup>Richard J. Franke, Resolving the Health Care Paradox: A Need for National Debate (Chicago: John Nuveen & Co. Incorporated, 1990), 6.

<sup>14</sup>Ibid.

<sup>15</sup>Citizen Action, Citizen Action Fact Sheet #5 (Washington, D.C.: Citizen Action, 1991), 1.

<sup>16</sup>Lynn Reid (Oregon Office of Medical Assistance Programs), telephone interview by author, Notes, Missoula, Montana, 25 November 1991.



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