

Health Policy Report

## THE OREGON HEALTH PLAN — LESSONS FOR THE NATION

First of Two Parts

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**I**N 1989, the state of Oregon embarked on a controversial experiment in the financing of health care. The state planned to add many uninsured people to the Medicaid program and to pay for this expansion by reducing the Medicaid benefit package — more people would be covered, but for fewer services. The Oregon plan provides important lessons to a nation striving to expand health care coverage in an era of shrinking budgets.

At first, the Oregon plan made repeated headlines and provoked strong criticism. “The Oregon plan will target a new group for discrimination — the seriously ill,” wrote an Oregon physician in a letter to the editor of the *Journal*.<sup>1</sup> “It denies care only to the politically powerless poor,” commented health analyst Emily Friedman.<sup>2</sup> “Oregon’s decision to ration health care to its poorest women and children,” charged Al Gore, “is a declaration of unconditional surrender just as the first battles are being fought over the future of our health care system.”<sup>3</sup>

Why all the outrage? After all, Oregon was insuring more people, not fewer. Other states had axed thousands of families from Medicaid and reduced benefits, with little or no fuss. The difference was the method that Oregon chose to create its benefit package — the prioritized list. In 1991, Oregon ranked more than 700 diagnoses and treatments in order of importance. The state legislature then drew a line at item 587; treatments below the line would not be covered. Oregon had openly embraced the “R word”: rationing — worse, rationing for the poor. Liberal Democrats in Congress, the Children’s Defense Fund, the American Academy of Pediatrics, and others condemned the Oregon plan.

On February 1, 1994, the Oregon Health Plan, with its prioritized list, went into operation. How

have Medicaid recipients fared during these first three years? Perhaps surprisingly, the plan has added more than 100,000 people to the Medicaid program, and it is politically popular. Serious complaints about the prioritized list are hard to find. Major problems exist, but they mirror the difficulties of the health care system throughout the nation.

### HISTORY

The Oregon Health Plan began with the poignant story of a seven-year-old boy. In 1987, Coby Howard contracted acute lymphocytic leukemia and needed a bone marrow transplant. Earlier that year, the Oregon legislature had discontinued Medicaid coverage for organ transplantation.<sup>4</sup> Amid much publicity, Coby died.

John Kitzhaber, an emergency room physician in the town of Roseburg, Oregon, was also president of the Oregon senate. In the emergency department, he saw victims of Medicaid cuts with serious illnesses that could have been treated at earlier stages. In the state senate, he lived through the Coby Howard tragedy. Kitzhaber wanted to address the twin problems: lack of insurance among low-income people and denial of life-saving treatment despite coverage of less effective therapies for less serious conditions.

A legislature can reduce Medicaid expenditures by removing people from the program, lowering the rate of reimbursement to providers, or reducing the benefit package. Kitzhaber believed that removing people from the program was the worst of the options. He also believed that many physicians refused to see Medicaid patients because of low reimbursement rates and that the legislature should not reduce payments to providers. The remaining option in the case of a budget crisis was to reduce the benefit package. But how could the benefit package be reduced without letting more Coby Howards die? Perhaps a prioritized list could guarantee that benefit reductions would eliminate only the least effective treatments.

In 1989, Kitzhaber shepherded through the Oregon legislature a plan with several key features: (1) all persons with incomes below the federal poverty level would be eligible for Medicaid, (2) the Medicaid benefit package would consist of a prioritized list of diagnoses and treatments, (3) the legislature would draw a line on the list below which treatments would not be covered, (4) the legislature would not be allowed to reduce reimbursement rates to Medicaid providers, (5) Medicaid services would be provided through managed-care plans, and (6) employers would be required to insure their employees, with the prioritized list as the basic benefit package.

In 1989, the Oregon Health Services Commission was established to create the prioritized list.<sup>5,6</sup> The 11 commissioners were remarkably dedicated, attending many long meetings without pay over a

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three-year period. They sponsored community forums to gain public input into the process; two thirds of the attendees were health care providers, two thirds were college graduates, and only 5 percent were Medicaid recipients.<sup>6</sup> However, consumer organizations representing Medicaid patients were actively involved in the process, and the openness of the Health Services Commission was a breath of fresh air.

The commission established 17 categories of health problems — for example, acute conditions that can be fatal and for which treatment provides full recovery, acute conditions that are treatable and unlikely to be fatal, chronic conditions that are unlikely to be fatal, maternity and newborn services, and preventive care of proven efficacy. All diagnoses and their treatments in the medical and surgical armamentarium were assigned to one of these categories, and the categories were ranked according to 13 criteria, including life expectancy, quality of life, the cost effectiveness of a treatment, and whether it would benefit many people. Treatments that prevent death and lead to full recovery were ranked first, maternity care was ranked second, and treatments that prevent death without full recovery were ranked third. Treatments that result in minimal or no improvement in the quality of life were ranked last. The diagnosis and treatment items were then prioritized within the categories on the basis of outcomes data, a scale for the quality of well-being, and a consideration of the reasonableness of the rankings.<sup>7</sup>

In 1991, the Oregon plan was submitted to the Bush administration for federal approval. The following year, the plan was rejected on the somewhat questionable grounds that the list undervalued the quality of life of people with disabilities. Some Oregonians suspected that the plan was denied because George Bush, about to wage a presidential campaign against Bill Clinton, was afraid to be labeled the “rationing president.”

The Health Services Commission produced another version of the list. Each diagnosis and treatment pair was analyzed with regard to the probability of death or disability with and without treatment.<sup>7</sup> For example, bacterial meningitis has a high probability of causing death without treatment and a lower probability with treatment, whereas metastatic pancreatic cancer is certain to cause death with or without treatment. Each diagnosis and treatment pair was assigned a number based on this analysis, and a new list was formed. Even with this entirely different method, 85 percent of the items on the list were ranked almost the same as they had been in the earlier version.

In March 1993, the plan was approved by the Clinton administration. On February 1, 1994, five years after its initial passage in the state legislature, the Oregon Health Plan went into operation. Later

that year, John Kitzhaber was elected governor of Oregon.

#### THE ACCOMPLISHMENTS OF THE OREGON HEALTH PLAN

The Oregon Health Plan received one of the earliest federal waivers granted under Section 1115 of the Social Security Act. Such waivers suspend many of the federal requirements that normally apply to state Medicaid programs (e.g., regulations governing eligibility and services, safeguarding the freedom to choose a health care provider, and stipulating how providers are reimbursed), thereby allowing states to increase the number of Medicaid beneficiaries and to institute mandatory managed care.<sup>8,9</sup>

All Oregonians with incomes under the federal poverty level (\$13,000 for a family of three) are now eligible for Medicaid. Previously, only 57 percent of people with incomes under the poverty level were eligible. In addition to the 100,000 people newly enrolled in Medicaid through the Oregon Health Plan, 65,000 people are eligible but not enrolled. Some have chosen not to enroll, some are deterred by the complex enrollment process, and some cannot afford the sliding-scale premiums, ranging from \$0 to \$28 per month. However, any of these 65,000 persons who become sick can enroll and receive coverage on the same day — a benefit that no private insurance company provides.

According to the Census Bureau, between 1991 and 1995, the proportion of uninsured Oregonians dropped from 14 percent to 12 percent of the state's 3.2 million population.<sup>10</sup> (State data suggest a greater reduction, from 18 percent to 11 percent.<sup>11</sup>) During the same period, the proportion of uninsured persons in the U.S. population rose from 14 percent to 15 percent.<sup>10</sup>

Several states besides Oregon have provided health insurance to people who were previously uninsured. Minnesota insured an additional 100,000 people through MinnesotaCare. Tennessee added 400,000 people to its Medicaid program, now called TennCare. Massachusetts, New York, and Arizona recently passed legislation to expand coverage, particularly for children. But in most states, because of the decrease in the numbers of Americans with employer-sponsored insurance, the uninsured population is growing.<sup>12</sup> In 1995, 15 percent of the residents of New York, 21 percent of those in California, and 24 percent of those in Texas had no health insurance.<sup>10</sup>

Oregon's success in increasing its Medicaid population by 39 percent has had a price tag, but not a steep one. The state's Medicaid expenditures in 1996 were 36 percent higher than those in 1993.<sup>11</sup> Nationally, Medicaid has undergone an inflation of 30 percent during the same period, whereas coverage has expanded by 11 percent.<sup>13</sup>

### MANAGED CARE UNDER THE OREGON HEALTH PLAN

Eighty-seven percent of persons enrolled in the Oregon Health Plan are in 1 of the 13 capitated Medicaid managed-care plans with which the state contracts. These are all not-for-profit plans; three for-profit plans dropped out (PacifiCare, Qual-Med, and a local health maintenance organization [HMO]). By far the largest Medicaid managed-care plan is HMO Oregon (owned by Blue Cross and Blue Shield of Oregon), with 34 percent of Medicaid managed-care enrollees.<sup>14</sup>

Medicaid managed care has been growing rapidly throughout the United States. In 1996, one third of all Medicaid recipients were enrolled in managed-care plans in 48 states, representing a 33 percent increase in the number for 1995. The federal government is likely to eliminate the waiver process and allow states more flexibility to require that Medicaid beneficiaries enroll in managed-care plans.

Oregon was able to move its Medicaid population into managed care rapidly because managed care has been a major component of Oregon's health system for decades. Kaiser Permanente arrived in the 1940s and started to enroll Medicaid patients in 1976. During the decade before the institution of the Oregon Health Plan, the state enrolled 90,000 Medicaid recipients in HMO-style health plans. Thus, by 1993, when the federal waiver was approved that allowed the state to require that Medicaid recipients enroll in managed-care plans, Medicaid managed care was already well established.

In any Medicaid managed-care plan, one measurement stands out as critically important: the size of the capitation payment from the state to the plan. Kitzhaber recognized the need to make capitation payments reasonably high for two reasons: with adequate payment, physicians, hospitals, and managed-care plans are more likely to support funding for the Medicaid program; and reasonable rates attract physicians to the program, which means greater access to care for beneficiaries. Kitzhaber insisted that capitation payments cover the costs of care, whereas some other states provide payments that are lower than the costs of care.

Although it is difficult to compare capitation payments from state to state (since the mix of services covered by the payments varies), estimates can be made. In 1995, Oregon's capitation rate for nondisabled persons under the age of 65 years was about \$130 per member per month. This payment represented a 30 percent increase over the fee-for-service Medicaid payments physicians received before the Oregon plan was introduced. In Tennessee's TennCare program, in contrast, 1995 capitation rates for a similar population were closer to \$100 per member per month, representing a 40 percent decrease in pre-TennCare payments.<sup>15,16</sup> California's compara-

ble capitation rate is even lower, about \$80 per member per month. New York's rates were considerably higher but have been ratcheted down in the past few years. Studies have shown that the willingness of physicians to provide care for Medicaid patients is related to the level of Medicaid reimbursement.<sup>17</sup>

Are Oregon's doctors, hospitals, and health plans satisfied with the capitation rates? Of course not. Are they extremely dissatisfied? Not really. Physicians still earn one third less for services provided to Medicaid patients than for those provided to patients covered by commercial plans or Medicare. Some physicians are limiting the number of Medicaid patients they see, giving rise to complaints — especially in rural areas — that Oregon Health Plan membership cards are simply hunting licenses that enable the poor to join the hunt for a physician who will give them an appointment. The state counters that in 1996, 88 percent of surveyed Medicaid enrollees were satisfied with their access to health care, as compared with 70 percent in 1994.

### THE PRIORITIZED LIST

In 1990 and 1991, Oregon's prioritized list was a controversial topic of conversation among health care professionals, policy analysts, bioethicists, and politicians. Today, complaints about the list are unusual.

What does the list look like? Table 1 shows three parts of the 1995 list: the top five lines, the bottom five lines, and those near the current line (578) below which services may be denied.<sup>18</sup> A number of diagnoses listed below line 578 — for example, hepatorenal syndrome — can be managed by choosing a treatment listed above the line, such as comfort care (line 260). Pulmonary sarcoidosis, which is near the bottom of the list, can be treated with corticosteroids (line 158, medical treatment for respiratory failure). Expensive therapies that are medically effective, such as renal transplantation for end-stage renal disease and liver transplantation for biliary atresia and other life-threatening hepatic disorders, are ranked high on the list. Contraception is also ranked high, at line 51. Low birth weight (less than 2500 g) is at line 67. Preventive services for children are at line 143, and preventive services with proven effectiveness for adults are at line 181. Medical therapy for human immunodeficiency virus disease and AIDS is at line 168.

Five factors have stilled the argument that the list represents rationing of medical care. First, on balance, the Oregon Health Plan has expanded health care benefits more than it has reduced them. In particular, all enrollees are now covered for dental care and organ transplantation, benefits previously denied to Medicaid recipients.

Second, the line below which services may be de-

**TABLE 1.** THE OREGON HEALTH PLAN'S PRIORITIZED LIST OF HEALTH SERVICES, 1995.\*

The five top items

- Line 1. Diagnosis: severe or moderate head injury, hematoma or edema with loss of consciousness. Treatment: medical and surgical treatment.
- Line 2. Diagnosis: insulin-dependent diabetes mellitus. Treatment: medical therapy.
- Line 3. Diagnosis: peritonitis. Treatment: medical and surgical treatment.
- Line 4. Diagnosis: acute glomerulonephritis, with lesion of rapidly progressive glomerulonephritis. Treatment: medical therapy, including dialysis.
- Line 5. Diagnosis: pneumothorax and hemothorax. Treatment: tube thoracostomy or thoracotomy, medical therapy.

The five bottom items

- Line 741. Diagnosis: mental disorders with no effective treatments. Treatment: evaluation.
- Line 742. Diagnosis: tubal dysfunction and other causes of infertility. Treatment: in vitro fertilization, gamete intrafallopian transfer.
- Line 743. Diagnosis: hepatorenal syndrome. Treatment: medical therapy.
- Line 744. Diagnosis: spastic dysphonia. Treatment: medical therapy.
- Line 745. Diagnosis: disorders of refraction and accommodation. Treatment: radial keratotomy.

Six items near the 1997 cutoff line

- Line 576. Diagnosis: internal derangement of the knee and ligamentous disruptions of the knee, grade III or IV. Treatment: repair, medical therapy.
- Line 577. Diagnosis: keratoconjunctivitis sicca, not specified as Sjögren's syndrome. Treatment: punctal occlusion, tarsorrhaphy.
- Line 578. Diagnosis: noncervical warts, including condyloma acuminatum and venereal warts. Treatment: medical therapy.
- Line 579. Diagnosis: anal fistula. Treatment: fistulectomy.
- Line 580. Diagnosis: relaxed anal sphincter. Treatment: medical and surgical treatment.
- Line 581. Diagnosis: dental conditions (e.g., broken appliances). Treatment: repairs.

\*Data were adapted from Oregon Health Plan Administrative Rules.<sup>18</sup>

nied has been set quite low on the list of diagnoses and treatments and has remained low. Most of the treatments listed below the line have little effectiveness. "Line movement" (movement of the line upward so that fewer treatments are covered) has been minimal, in part because the Health Care Financing Administration (HCFA) must approve any line movement passed by the state legislature. In 1996, the legislature moved the line from 606 to 581. In 1997, the legislature attempted to move the line from 581 to 574, but HCFA approved a move only from 581 to 578. If the line were moved much further up, protests could be expected from health plans, physicians, and patients. That situation is unlikely, however, since HCFA has indicated that it will not favor further movement of the line in the near future.

Third, since the items on the list represent diagnosis and treatment pairs, a diagnosis is required before a treatment can be denied. For simple maladies listed below the line, such as acute bronchitis, treatment is given at the diagnostic visit and is covered. Complex diagnostic workups are also covered.

Fourth, physicians occasionally "game" the system, choosing a diagnosis above the line even though the patient has an illness that falls below the line.

Finally, and most important, the state Medicaid program requires adherence to the list only for the 13 percent of patients whose physicians are paid on a fee-for-service basis by the state. In these cases, *International Classification of Diseases, 9th Revision* (ICD-9) codes and Current Procedural Terminolo-

gy, 4th revision (CPT-4) codes for treatments listed below the line are not reimbursed. But for the 87 percent of Medicaid enrollees in capitated health plans, the state has shifted the financial risk to the plans and provides no additional funds if treatments listed below the line are given. The state has calculated that items below the line account for about 10 percent of all medical expenditures and has therefore subtracted 10 percent from capitation payments to the health plans. In this way, the state saves money as a result of the list. Yet the medical directors of health plans may, and often do, authorize care for diagnoses listed below the line. Recently, the utilization review committee of the CareOregon health plan approved high-dose chemotherapy and bone marrow transplantation for a nine-year-old child with medulloblastoma, a \$75,000 treatment of unproven efficacy that is listed below the line.

Oregon's prioritized list serves as the Medicaid benefit package, indicating which services are covered and which are not. The list parts company with most health insurance and HMO benefit packages, which cover services that are "medically necessary" but leave the interpretation of medical necessity to medical directors within the insurance company or HMO. In contrast, Oregon's program clearly defines services that are deemed medically necessary, and if fiscal constraints require a reduction in benefits, this reduction is accomplished by taking away less appropriate treatments before denying more appropriate ones.

A similar approach to the design of benefit pack-

ages has been proposed by two health policy experts. Robert Brook suggests that substantial resources be devoted — through outcomes research — to the development of detailed guidelines that all health insurance plans can use to determine medical necessity, so that all appropriate care, and no inappropriate care, is covered.<sup>19</sup> David Eddy, arguing that “almost anything would improve on the hopelessly vague terms ‘medically necessary’ and ‘appropriate,’” wants more precise benefit language but rejects the level of detail in Oregon’s list.<sup>20</sup>

Although many particulars of Oregon’s list are open to criticism,<sup>5</sup> it does incorporate a large dose of common sense. As one Oregon physician explained, “Most things at the top are important, and most things at the bottom are not so important.” Oregon’s list represents a new approach to the design of a benefit package, introducing a health policy issue that merits further discussion and debate.

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