The Oregon Plan's Impact On the Future of Healthcare Reform

BY JANE H. WHITE

On August 3, 1992, after nearly a year of evaluation, Secretary of Health and Human Services (HHS) Louis W. Sullivan, MD, denied the federal waiver Oregon needed to proceed with the Medicaid portion of its broad-ranging healthcare reform plan:

> I regret . . . that I am unable to give your application final approval until a number of legal issues, which relate primarily to the Americans with Disabilities Act [ADA], are resolved. Particularly given the real possibility that Oregon's general approach will serve as a model for other states, it is critically important that it go forward only with strict adherence to the legal protections that President Bush has worked so hard to enact (Sullivan's August 3, 1992, letter to Oregon Governor Barbara Roberts).

The denial came as a surprise to some policy analysts who believe election year politics may have interfered with the process. Some question whether Oregon's proposal actually violated the ADA; others believe this decision has important ramifications for the future of healthcare reform at both the state and federal levels. This column examines what happened in Oregon and the effect on healthcare reform of the ADA, the waiver process, and politics.

Ms. White is executive editor, Health Affairs.

The Plan in Brief

The Oregon health plan, in brief, is a package of state laws passed in 1989 to guarantee healthcare access while containing costs. The plan aims to cover 450,000 uninsured Oregonians, 120,000 of whom would be covered under Medicaid. (For a detailed description of the Oregon plan, see John A. Kitzhaber, "Oregon Act to Allocate Resources More Efficiently," *Health Progress*, November 1990, pp. 20, 22-27; and Charles J. Dougherty, "The Proposal Will Deny Services to the Poor," *Health Progress*, November 1990, pp. 21-32.)

The plan includes three major parts. First is a high-risk pool for persons denied coverage because of preexisting conditions.

Second, employers are mandated to "play-or-pay," to provide health insurance coverage to employees and dependents or pay a payroll tax to provide such coverage. To make insurance more affordable for small business, the state passed small-group market reforms in 1991. The play-or-pay mandate is currently a voluntary program (with declining tax credits) for small employers.

"Assuming a target enrollment on a voluntary basis is not reached, work-based coverage becomes a mandate on all employers in 1995. However, the mandate on employers is tied by statute to implementation of the expanded Medicaid program," explained Lynn Read, director of Prioritized Health Care System in the Oregon Department of Human Services in her June 15, 1992, testimony before the U.S. Senate Finance Subcommittee on Health for Families and the Uninsured.

The third and most important part of Oregon's proposal involves state plans to reform and expand Medicaid to cover all Oregonians below the federal poverty level. To extend Medicaid coverage to all the poor, Oregon has proposed a complex ranking of healthcare benefits. Thus, rather than ration which poor citizens receive healthcare coverage by restricting eligibility for Medicaid, Oregon plans to ration the scope of healthcare benefits offered, ensuring the most beneficial are covered. Medical procedures deemed less necessary for good outcomes may be denied depending on the level of funding available from the state. Because Medicaid is a joint federal-state program, such significant changes in the type and range of services covered mean Oregon must seek a waiver of Title XIX of the Social Security Act from the federal government.

What Happened in Oregon?

The decision to deny Oregon the waiver hinged on the state's process to rank healthcare benefits. "A number of aspects of the ranking process

reflect discrimination on the basis of disability," said HHS General Counsel Michael J. Astrue in a press statement.

In an analysis of the proposed Oregon reform demonstration, HHS pointed to bias in a telephone survey of Oregonians that influenced the priority list, noting, "There are substantial indications . . . that the quality of life data derived from the Oregon telephone survey quantifies stereotypic assumptions about persons with disabilities" ("Analysis under the Americans with Disabilities Act of the Oregon Reform Demonstration," attachment of Sullivan's August 3, 1992, letter to Oregon Governor Barbara Roberts).

Other specific concerns included the low ranking of liver transplants for alcoholic cirrhosis of the liver and life support for extremely low-birthweight babies under 23 weeks' gestation. Both procedures were below Oregon's cutoff point for funding. HHS questioned whether refusal to cover these procedures violated the ADA.

The most controversial part of Oregon's plan is the process by which the state explicitly prioritized healthcare benefits. An 11-member Oregon Health Services Commission ranked thousands of medical procedures based on input from public hearings, ethicists, healthcare professionals, and a variety of special interest groups. In addition to holding public hearings around the state, the commission authorized Oregon Health Decisions, a citizens' advocacy group, to conduct community meetings to help build consensus around the plan. The Health Services Commission also authorized a telephone survey to gauge Oregonians' values in the prioritization process. The survey results were incorporated into a mathematical cost-utility formula to calculate the net benefit value for the ranked medical procedures. This use of the survey led to part of HHS's discrimination charge.

In reaction to the waiver denial, Oregon health department representatives questioned whether the plan truly violates the ADA. Nevertheless, the Oregon Department of Human Resources has been meeting with federal representatives to sort out the problems. Several HHS and Health Care Financing Administration (HCFA) representatives went to Oregon to meet with the Health Services Commission.

Election Year Politics?

The legal questions surrounding "ADA surfaced late in the [waiver] process," said Oregon's Read in a phone interview. "I don't know that ADA was the [main] issue [regarding denial of the waiver], but we have moved forward as if it is."

Other policy analysts have also questioned whether the ADA was a last-minute attempt to stall the Oregon demonstration rather than a serious concern. Secretary Sullivan responded to such criticisms in a September 1, 1992, letter published in the *New York Times*: "Given the outpouring of comments received by this department and the White House on this issue, I am confident in saying Oregon would have been sued if we had approved the waiver, preventing Oregon from implementing the plan for years."

"The administration's use of the ADA to block the Oregon waiver was a very cynical act," said Ohio Governor Richard Celeste. "It is profoundly wrong to pit individuals with disabilities against healthcare reform in this country."

Read commented, "I do believe we were caught in a political process and don't believe it should have played out this way. If this was election year politics, we were unfortunate in our timing." However, Oregon did submit its waiver application on August 16, 1991, nearly a year earlier and well before the election. Still, Read commended HCFA for being "good to work with" as the state sorts out the waiver problems.

The Oregon Health Services Commission met regularly this fall to alleviate federal concerns about the ADA and review changes to the priority list, said commission research analyst Darren Coffman. Oregon plans to send a letter with attachments back to HHS in early November for reconsideration of the waiver.

The ADA's Effect on Healthcare Reform

The decision to deny Oregon's waiver based on the ADA has roused much debate among the health policy community. "The administration's use of the ADA to block the Oregon waiver was a very cynical act," said Ohio Governor Richard Celeste at an August meeting of the National Academy for State Health Policy (NASHP) in Minneapolis. "It is profoundly wrong to pit individuals with disabilities against healthcare reform in this country." Celeste, in his role as chairperson of the new Center for Vulnerable Populations, is a strong advocate for persons with disabilities and others vulnerable in health matters.

The center, which is codirected by NASHP and Brandeis University and funded by the Kaiser Family Foundation, is currently examining the ADA's implications for healthcare reform. The center has convened a work group to identify research needs and policy barriers with consumer groups, members of Congress, state leaders, the legal community, federal officials, and policy researchers. As we went to press, the center's chart book on the ADA and healthcare reform was slated for publication in mid-November.

In his analysis of the ADA, Lawrence Gostin, executive director of the Boston-based American Society of Law and Medicine, examines how the law will affect the current healthcare system ("Legislative Report: The Americans with Disabilities Act and the U.S. Health System," *Health Affairs*, Fall 1992, pp. 248-257). "The

ADA recasts the fundamental question that society must ask when a clinician refuses to treat a patient; an employer fires a person who has or is predicted to develop a costly disease; or a public health official requires a subject to submit to testing, vaccination, or another compulsory power," writes Gostin. Now healthcare reform must be viewed from the perspective of the person who is subject to discrimination. On future reform, Gostin notes that the ADA "steadfastly refuses to allow a person to be turned away because of the provider's fears and biases toward disability. But it remains uncertain to what extent the act can help ensure access to health care for those who arguably need it most."

The Waiver Process's Effect

"If Oregon is any example, [the federal waiver process] has the potential to have a chilling effect" on state efforts to reform healthcare, said Oregon's Read. To try new methods of healthcare delivery, financing, and eligibility, state policymakers must convince the HHS secretary to grant exemptions from current federal program requirements under Medicaid, Medicare, and the Employment Retirement Income Security Act (ERISA), which regulates employee benefit plans. These exemptions, or "waivers," are the key to testing potential reforms.

The lengthy time required to obtain waivers, the burdensome process, and denials of requests for waivers such as Oregon's have led policymakers and analysts to more closely examine the waiver process and its effect on healthcare reform. Several bills were recently introduced in the Senate to ease the waiver requirements on states. Sen. Patrick Leahy, D-VT, and Sen. David Pryor, D-AR, introduced the State Care Act (S. 3180). Sen. David Durenberger, R-MN, introduced a more moderate version, the State Health Care Financing Act (S. 3223). The general perception among policymakers is that Oregon worked hard to follow the federal waiver requirements. When the waiver was denied, it shook people up. As Celeste described the situation with Oregon in August, "The federal and state governments came together in a stunning clash."

In a major new study funded by Kaiser, a team of health policy researchers from the Fairfax, VA–based Lewin-ICF examined what waiver projects have been funded over the past decade, how the waiver process evolved, and where it might be headed (Allen Dobson, Don Moran, and Gary Young, "The Role of Federal Waivers in the Health Policy Process," *Health Affairs*, Winter 1992, in press). "Whether the waiver process is so onerous that it deters states from investigating potentially valuable programmatic reforms is an important consideration," note the researchers. "This concern is particularly relevant to future waiver requests such as Oregon's that would support extensive health care reform."

To try new methods of healthcare delivery, financing, and eligibility, state policymakers must convince the HHS secretary to grant exemptions from current federal program requirements.

Beyond the need to grant states flexibility to experiment with reform is the question of accountability. Allen Dobson, lead author on the Lewin-ICF report, commented in a conversation, "The Oregon waiver issue is somewhat of a stalking horse. States complain that the feds don't allow enough flexibility. However, to the extent that states aren't accountable, it could be very dangerous." People living in different parts of the country could receive widely varying levels of care without some central accountability of health plans across states.

In discussing the largest barrier to state healthcare reform, Dobson said, "ERISA, when you get down to it, is more pernicious than the ADA in preventing state action." ERISA prevents changes in regulation and taxation of employee benefits. This presents problems for employer-mandated reforms such as play-or-pay—a plan favored by a number of states. In addition, no waiver authority yet exists for ERISA. So far, only Hawaii has been able to circumvent ERISA, since its health plan was enacted before the law's passage.

To get around ERISA, Dobson suggested two options for states. "The first way out of ERISA is don't do employer-based reforms. Instead, do incremental Medicare and Medicaid reform to bring in the uninsured." The second option is to "go for broke . . . and go to a state-run, Canadian-type system, completely bypassing ERISA" and the employer-based system of providing health insurance, he concluded.

A potential third option is for states to push for legislation to ease ERISA restrictions, such as the bills proposed by Leahy, Pryor, and Durenberger. The National Governor's Association has supported such legislation.

Escalating Debate

As states press forward with healthcare reform plans, both the ADA and the federal waiver process will be subject to increased scrutiny and debate. As for Oregon, it will be interesting to see how a second-round amendment to its waiver application will be received by HHS. President-elect Bill Clinton has gone on record in support of Oregon's health plan. Al Gore, on the other hand, has opposed it. Gore's past leadership in organ transplantation legislation has sensitized him to coverage issues for this form of treatment. Some types of transplantation rank low on the prioritization list. Many states will be closely watching Oregon, as the result could directly affect their prospects for action. □