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Oregon set to ration health care for poor

by Linda Everett

On June 30, Oregon law makers finalized the state's "pioneering" health care plan, which purports to provide basic health care for the state's poor and uninsured. Although legislators funded the benefit package, known as the Oregon Health Plan, the plan must receive federal approval before it goes into effect next year for the 204,000 people currently enrolled in the state's Medicaid program, as well as the 120,000 new enrollees expected to join the program over the next three years. Two separate state programs will also make the basic health care package available to 300,000 working Oregonians whose employers cannot afford insurance or whose preexisting conditions make them currently "uninsurable."

The centerpiece of the Basic Health Services Plan is a list of 709 medical conditions, each paired with a specific therapy. Each pair is then ranked and given a numerical value by using a complex mathematical formula that weighs the cost-effectiveness, "clinical efficiency," necessity, and duration of the therapy, as well as the therapy's "value" to the individual and society. These subjective judgments, using University of California at San Diego Prof. Robert Kaplan's "Quality of Well-being Scale," are one modification of the highly criticized original list which prioritized medical services on the basis of cost-effectiveness alone.

Oregon's leaders are committed to a plan that ratchets the level of health care downward. Under the new plan, a dental filling that costs about $70 and might last 30 years, receives high ranking. But a costly operation that saves the life of an elderly individual would get a lower ranking because its "duration" would last "only" a few years—for the rest of the patient's life. "Terminal" cancer and "end-stage" AIDS rank low and rate only palliative care or death help via hospice care, no cures attempted. Sterilizations and treatment for alcoholism withdrawal are ranked higher than surgery for breast cancer. Incredibly, obesity with "nutritional and lifestyle counseling" is seen as more critical than saving the life of someone with traumatic head injuries or saving premature babies born weighing under 500 grams.

The Oregon Health Services Commission, which drew up the priority list, stresses how much "community input" there was into the plan, referring to public hearings and scores of town meetings. In reality, the issue, from the start, was one of brainwashing Oregonians to accept health care rationing—similar to Nazis' convincing concentration camp victims to take (poison gas) showers "for their own good."

'Managed care'

Every two years, Oregon's leaders will draw up a budget to decide what percentage of the budget will go to health care, thereby placing a cap on the Medicaid program, much like the Canadian health care program does: When the budget shrinks, so does the list of services. Actuarial estimates of each item on the priority list indicate how many items can be covered by the budget. Legislators draw a line through the list where the budget allocation ends; the procedures above the line are covered, those below the line are not. The recently passed budget allocated funds to cover treatments through to line 587 on the list of 709 items.

The concept behind the Oregon plan was created by Senate President John Kitzhaber, M.D., who originally lobbied to cut off transplant funds for Medicaid recipients in order to provide prenatal care to poor pregnant women instead. That policy was responsible for the deaths of seven-year-old Coby Howard and 11 other needy patients in 1988.

The Oregon Health Plan is all based on a "managed care" approach, where doctors literally are gatekeepers, reducing use of specialized or hospital care. The focus of all managed care is "cost containment." The state contracts with physician care organizations (PCOs) and pays a fixed rate per Medicaid recipient to cover all physician, prenatal, and well-baby care, laboratory and radiology services for a specified time period. The PCO is "at risk," and can lose money each time the cost of care exceeds the capitation payment for that patient. Conversely, the PCO and the state split the profits when the cost of care provided is *less* than the capitated rate. The PCO also receives financial inducements to keep patients out of hospitals.

To encourage physicians to take patients on Medicaid, which reimburses physicians at dismally low rates, the state will increase reimbursements to physicians by using a modified Resource-Based Relative Value Scale (RBRVS). The RBRVS rate, which marginally increases primary physicians' rates but cuts specialists' payments, provides an overall increase over current Medicaid reimbursement levels.

Despite the U.S. Government Accounting Office's numerous studies demonstrating how managed care plans have a disastrous impact on the quality of health care, the Bush administration is encourgaing states to *increase* enrollment in managed care programs for Medicaid recipients. The GAO as well as the Office of Technology Assessment are already scrutinizing Oregon's plan, and Secretary of Health and Human Services Dr. Louis Sullivan visited Oregon early in July to review the program himself. These signs indicate that Oregon may receive a favorable reception in Washington when it applies for federal approval of its rationing plan later in July.

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