Oregon's brave plan to explicitly ration health care in order to cover more people soon ran into problems. Vidhya Alakeson looks at the reasons and asks whether history will repeat itself.

High ambitions
The Oregon Health Plan was created in 1989 to expand coverage to some of the 400,000 citizens who at the time had no health insurance. Spearheaded by state senator turned governor John Kitzhaber, the plan was intended to extend coverage to people with incomes less than 100% of the federal poverty level ($12,100 (£7000; €9000) for a family of four). To free up money to cover additional people, Kitzhaber needed to find a way to spend less on existing Medicaid recipients. States tend to favour two approaches to control costs in Medicaid: they either pay providers less or reduce the number of people eligible. Oregon rejected both methods and instead opted for a new, bold approach: it would ration the benefits covered under Medicaid.

Instead of cutting benefits haphazardly, the state decided to approach the task of rationing in a transparent and logical manner by introducing a prioritised list of treatments. The Oregon Health Services Commission was created to develop the list. By law, its 11 members must include five doctors, a public health nurse, and a social worker. Its four remaining members can be either consumers or purchasers. The starting point for the list is a set of broad treatment categories arranged in priority order. Within each category, pairs of medical conditions and treatments are ranked based on effectiveness and cost.

The theory of how the list would function to control costs and extend coverage was simple: a line would be drawn on the list based on the amount of money the Oregon legislature set aside for its health plan every two years. Everything above the line would be covered but nothing below it. When the first list was created in 1993, it contained 696 condition-treatment pairs and the cut-off point was drawn at 565. Over time, the line would be moved further up the list and the benefit package squeezed in order to find the money to cover more and more people.

Putting theory into practice
The plan was initially a big success. Between 1990 and 1996, the numbers of uninsured people fell in Oregon from 19.9% of the working age population to 7.6%, while the uninsured in the US as a whole was on the rise. But the theory that more people could be insured by continually raising the line up was difficult to take in full public view. Furthermore, what remained covered by the plan after dropping so many conditions would have made sense from a healthcare perspective. According to Jonathan Oberlander, a political scientist from the University of North Carolina at Chapel Hill who has followed the Oregon experiment closely, the intentions behind the plan were good and noble but the notion that healthcare costs can be controlled line by line was foolish.

Demise of Oregon Health Plan
In 2002, Governor Kitzhaber’s tenure was coming to an end, and he wanted to make greater progress on health reform before
leaving office. Having failed to secure federal approval to use the prioritised list to reduce benefits, Kitzhaber pursued a different strategy. He split the Oregon Health Plan in two: OHP Plus, the original plan based on the prioritised list, was maintained for the groups eligible for Medicaid by law—low-income mothers and children and disabled and elderly people; OHP Standard was added for anyone earning below 185% of the federal poverty level. To meet the state’s healthcare budget, OHP Standard could only provide 78% of the benefits included in OHP Plus. To get to that figure, the state was forced to do what it had wanted to avoid all along: it arbitrarily dropped treatments from coverage, including at one point all mental health and substance use services, and reduced eligibility by imposing a cap on enrolment. The final cost saving strategy was the introduction of premiums, deductibles, and copayments.

Enrolment in OHP Standard began in 2003. By the end of 2004, 80,000 people who had been covered had lost their insurance. The problem was timing. The introduction of OHP Standard coincided with a serious economic downturn. Between 2001 and 2003, Oregon had the highest level of unemployment in the country. Struggling to make ends meet, most people enrolled in OHP Standard simply could not afford to pay their premiums and copayments, and were consequently dropped from coverage.

The state was unable to step in and rescue the plan. Unlike most US states, Oregon has no sales tax and is heavily dependent on corporate and personal income taxes to finance health care. Revenue from income tax falls in a downturn, but the demand for public programmes such as OHP Plus rises as people lose their jobs and employer provided health insurance. Without sales tax revenues to act as a buffer, the state was forced to close enrolment to OHP Standard in July 2004. Only 24,000 people remained in the programme, compared with the 130,000 who had been covered by the original plan in 1996.

Despite the turmoil, the prioritised list has survived and is still used to decide which services will be covered under OHP Plus. In 2006, the Oregon Health Services Commission revised the list’s methods in order to give greater weight to preventive services and management of chronic disease. At the height of the plan’s success, Oregon often hosted international visitors and delegations from other US states curious to learn about the prioritised list. But no states have followed Oregon’s lead, preferring to stick with more familiar and aggressive approaches to cost control in Medicaid. Internationally, only South Africa has adopted a prioritised list based on Oregon’s methods as a foundation for its prescribed minimum benefit. Introduced in 2001, South Africa’s list includes 271 diagnosis and treatment pairs covering mainly secondary care and 25 common chronic conditions.

Oregon’s new health reform effort
Rates of uninsured are now creeping close to where they were before the creation of the Oregon Health Plan. Around 600,000 people, or 18.6% of Oregon’s population, are currently uninsured. This prompted a new health reform effort in 2007 and the creation of the Oregon Health Fund Board to develop a reform blueprint. The blueprint, now out for consultation, bears the imprint of lessons learnt from past experience. Its ambition is measured. The aim is to start with universal coverage for children in 2009 and then focus on rebuilding the number of people on low income covered back to the levels achieved in 1996. There is no cost sharing for low income groups, and the reform does not rely entirely on Medicaid. Importantly, the blueprint also addresses cost control, proposing a range of primary care innovations to rein in the costs of chronic disease.

But one thing the blueprint cannot overcome is the economy. Once again, Oregon is embarking on health reform in an economic downturn, the magnitude of which was unforeseen when the reform initiative began in 2007. Stuck with its narrow tax base, the outcome for Oregon this time is unlikely to be any different from the last, unless a new president can find federal funds to support this and other state health reform efforts. But with federal deficit of around $10 trillion, health reform at national and state levels may become yet another victim of the current economic crisis.

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