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The Oregon Basic Health Services Act: A Model for State Reform?

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The Oregon Basic Health Services Act: A Model for State Reform?

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I. INTRODUCTION

Americans currently spend \$733 billion, or 12.3 percent of the Gross National Product (GNP), per year on health care.¹ This is nearly twice what Americans spent on health care just seven years ago.² Health care is also one of the fastest growing major items in the federal³ and state budgets.⁴ Not surprisingly, governments, businesses, and individuals all are having difficulty finding resources to meet the increasing costs of health care.⁵ As a result, the health care delivery system has cut costs by denying some people access to adequate health care services.⁶

1. Janice Castro, *Condition: Critical*, Time 34, 34-35 (Nov. 25, 1991).

2. Id. at 34. In 1980, America spent 9.4% of its GNP on health care. Id. at 35.

3. Id. at 34.

4. Daniel M. Fox and Howard M. Leichter, *Rationing Care in Oregon: The New Accountability*, Health Affairs 7, 13 (Summer 1991) (noting that the growth rate of Medicaid expenditures in the past decade has been second only to that of corrections expenditures).

5. See part II.

6. Id.

Currently, an estimated thirty-seven million Americans are uninsured.⁷ In addition, the number of people covered by government-sponsored and employer-sponsored insurance has decreased, and skyrocketing costs are likely to lead to further reductions in coverage.⁸

To cope with the rising number of uninsured residents and to control skyrocketing costs, the State of Oregon recently passed the Oregon Basic Health Services Act (OBHSA).⁹ The most controversial aspect of this legislation package is Senate Bill 27. If the Bill, which still must survive the federal waiver process, becomes effective, it will extend Medicaid benefits to all Oregon residents whose income does not exceed the Federal Poverty Level (FPL).¹⁰ Presently, only about 120,000 of the 320,000 people whose income is below the FPL qualify for Medicaid in Oregon.¹¹ OBHSA is designed to reduce the cost of extending Medicaid by limiting, or rationing, the services Medicaid will cover.¹² Oregon has created a prioritized list of medical services and will fund as many services, in the order of prioritization, as its budget allows.¹³

OBHSA also mandates employer-sponsored health insurance programs by 1994.¹⁴ Employer-sponsored insurance should provide coverage to the 330,000 working Oregon residents who presently do not have health insurance and fail to qualify for Medicaid.¹⁵ The insurance must provide at least the same benefits as those funded by the state.¹⁶ OBHSA also creates a state-risk pool through which individuals who have medical conditions that make them uninsurable through private companies may purchase insurance through the state.¹⁷ If fully implemented, OBHSA will ensure that ninety-seven percent of Oregon residents receive at least basic health care benefits.¹⁸

OBHSA has helped to expand the focus of the national health care debate to include not only who is covered but also what is covered.¹⁹ Eighteen states already have proposed preliminary health care reforms

7. Castro, *Time* at 36 (Nov. 25, 1991) (cited in note 1).

8. See notes 56-62 and accompanying text.

9. Castro, *Time* at 37 (Nov. 25, 1991).

10. See part III.B.

11. David M. Eddy, *Oregon's Plan; Should It Be Approved?*, 266 *JAMA* 2439, 2440 (1991).

12. See part III.B.

13. *Id.*

14. See part III.D.

15. *Id.*

16. Eddy, 266 *JAMA* at 2440 (cited in note 11).

17. See part III.C.

18. Eddy, 266 *JAMA* at 2440 (cited in note 11). John A. Kitzhaber, physician and President of the Oregon Senate, claims that OBHSA will provide basic health care services to all Oregon residents. John A. Kitzhaber, *Oregon Act to Allocate Resources More Efficiently*, *Health Progress* 20, 24 (Nov. 1990). Dr. Kitzhaber played a key role in developing OBHSA.

19. Kitzhaber, *Health Progress* at 24 (Nov. 1990) (cited in note 18).

using the Oregon project as a model.²⁰ Nonetheless, the OBHSA rationing scheme cannot go into effect until Oregon receives federal waivers allowing the state to decrease services and increase coverage.²¹

This Note analyzes OBHSA and compares its proposed rationing system to the current health care delivery system in the United States. Part II outlines the current system of health care delivery and the types of health care rationing that presently are taking place. Part II also discusses the function that federalism serves in balancing state and federal roles in providing health care. Part III reviews the major provisions of OBHSA, focusing on the kinds of benefits the legislation will make available to Oregon residents. Part IV evaluates the strengths and weaknesses of the Oregon plan. This Note concludes that OBHSA is a step toward a more equitable health care system, but it fails to address adequately the problem of waste found in the current system.

II. HEALTH CARE DELIVERY IN THE UNITED STATES

A. *The Structure of the Current System*

Over the past twelve years the cost of health care in the United States has skyrocketed from 9.4 percent of the GNP in 1980 to 12.3 percent of the GNP today.²² This figure could reach fifteen percent of the GNP by the year 2000.²³ At present, the United States spends fifty percent more of its GNP on health care than any other major country.²⁴ This level of spending has contributed to the United States having the best medical centers and doctors in the world.²⁵ Nevertheless, a substantial portion of the United States' population is financially unable to use these superior services. Despite the high quality of its medical technology and personnel, the United States ranks twelfth in the world in life expectancy, twenty-first in the number of deaths of children under age five, twenty-second in infant mortality, and twenty-fourth in the

20. B.D. Colen, *Strong Medicine*, 23 *Health* 32, 34 (May 1991). Canada and Britain also are looking at the Oregon plan as a possible way of keeping their national health care systems solvent. Timothy Egan, *For Oregon's Health Care System, Triage By a Lawmaker With an M.D.*, N.Y. *Times* 1, 18 (June 9, 1991).

21. See notes 102-05 and accompanying text.

22. Castro, *Time* at 34 (Nov. 25, 1991) (cited in note 1).

23. House Committee on Ways and Means, 102d Cong., 1st Sess., *Health Care Resource Book* at III (Comm. Print 1991) ("*Health Care Resource Book*").

24. Health Care for the Uninsured, Hearings Before the Subcommittee on Health for Families and the Uninsured of the Senate Committee on Finance, Pt. 2, 101st Cong., 2d Sess. 238 (1990) ("Hearings: Health Care for the Uninsured, Pt. 2"). In 1987, the United States spent 11.2% of GNP on health care, compared to 8.6% in France, 8.2% in Germany, 6.8% in Japan, and 6.1% in the United Kingdom. Rising Health Care Costs: Are They Really Making It Harder for U.S. Firms to Compete? Hearing Before the Joint Economic Committee, 101st Cong., 2d Sess. 54 (1990) ("Hearing: Rising Health Care Costs").

25. Colen, 23 *Health* at 32 (cited in note 20).

percentage of babies born with adequate birth weight.²⁶ Problems in our health care delivery system well may be responsible for the United States' comparatively poor health statistics.²⁷

Today, the United States and South Africa are the only two industrialized nations that do not provide some form of universal health care to their citizens.²⁸ In the United States a three-tiered system of health care coverage exists. The first tier which covers most Americans, consists of employer-sponsored health insurance and other types of private health coverage. The second tier includes government-funded health care in the form of either Medicaid or Medicare or both. The third tier comprises those who are uninsured because they have no private insurance and they are not eligible for government-sponsored programs.

In 1989, 166 million Americans under the age of sixty-five received health care services under the first tier of coverage.²⁹ Approximately 147 million of the 166 million privately insured received their coverage through employment-based plans. The remaining 19 million either paid for health care coverage themselves or received coverage from some other private source.³⁰ Those that have private health insurance, however, do not necessarily have access to adequate health care. Estimates indicate that over 30 million insured Americans have inadequate health care coverage.³¹

Many business owners now complain that the costs of providing health care have become prohibitive.³² In addition, employers that provide health insurance and compete abroad assert that the rising cost of providing health care to their employees contributes to their inability to compete effectively with foreign businesses.³³ Between 1984 and 1989, the average annual employee premium more than doubled from \$1,453 to \$3,117 per employee.³⁴ During this same period, the number of em-

26. The Health Care Crisis and the American Family, Hearing Before the Senate Committee on Labor and Human Resources, 102d Cong., 1st Sess. 64 (1991) ("Hearing: The Health Care Crisis and the American Family") (reprinting *The Crisis in Health Insurance, Pt. 2*, Consumer Rep. at 1 (Sept. 1990)).

27. See Castro, *Time* at 34 (Nov. 25, 1991) (cited in note 1).

28. Colen, 23 *Health* at 32 (cited in note 20).

29. *Health Care Resource Book* at 77 (cited in note 23).

30. *Id.*

31. E. Richard Brown, *A National Health Program for the United States*, 267 *JAMA* 552, 552 (1992). Overall, an estimated one in four Americans have either inadequate health care coverage or are uninsured. *Id.*

32. See Hearing: The Health Care Crisis and the American Family at 45-47 (cited in note 26) (reprinting *The Crisis in Health Insurance, Pt. 1*, Consumer Rep. at 3-5 (Aug. 1990)).

33. Hearing: Rising Health Care Costs at 82 (cited in note 24) (statement of Walter B. Maher of Chrysler Corporation). In 1988, American car manufacturers paid \$700 in health care costs per vehicle produced compared to \$375 per vehicle in France, \$337 in Germany, \$246 in Japan, and \$223 in Canada. *Id.* at 106.

34. The Changing Face of Health Care: The Movement Toward Universal Access, Hearing

ployers paying the full cost of their employees' premiums dropped from thirty-eight to thirty-two percent.³⁵ For many employees, the cost of health care coverage already has become prohibitive,³⁶ and if health care costs continue to increase, they may be forced to pay an even higher percentage of the cost of employer-sponsored health insurance. As a result, more and more Americans are falling into the second or third tiers of coverage.

The second tier of coverage extends to those receiving government-funded health care benefits in the form of either Medicaid or Medicare or both.³⁷ Medicare is a federally-funded and federally-administered program that provides health care coverage to the elderly.³⁸ Some of the elderly also have private insurance to cover services or costs not paid for by Medicare. The elderly pay about ten percent of the cost of Medicare, but the remaining ninety percent of the funding comes from payroll taxes.³⁹ Consequently, millions of working Americans who cannot afford health insurance for themselves or their families are helping to provide Medicare benefits for the elderly.⁴⁰

Medicaid provides health care services to certain groups of low-in-

Before the House Select Committee on Children, Youth, and Families, 101st Cong., 1st Sess. 6 (1989) ("Hearing: The Changing Face of Health Care").

35. *Id.*

36. See Hearing: The Health Care Crisis and the American Family at 45-47 (cited in note 26) (reprinting *The Crisis in Health Insurance, Pt. 1*, Consumer Rep. at 3-5 (Aug. 1990)). The cost of policies to the individual varies widely depending on what services the policy covers and on the individual's medical history. For a more detailed discussion of individual insurance policies, see *id.* at 49-55 (reprinting *The Crisis in Health Insurance, Pt. 1*, Consumer Rep. at 7-13 (Aug. 1990)).

37. See *Health Care Resource Book* at 77 (cited in note 23). In 1989 this group comprised eighteen million Americans. *Id.*

38. There are two types of Medicare coverage, Parts A and B. Part A provides inpatient hospital services. 42 C.F.R. § 409.5 (1990). Examples of covered inpatient services include semiprivate accommodations, *id.* § 409.11; nursing services, *id.* § 409.12; and the use of hospital facilities, *id.* § 409.10(a)(3). Most elderly Americans receive Part A because one can qualify if he or she is over sixty-five and is eligible for social security. *Id.* § 406.10. United States citizens who do not qualify for coverage may enroll in Part A coverage by paying a premium. *Id.* § 406.20 (a), (b).

Medicare Part B coverage is supplemental health care insurance. People qualify for enrollment in Part B if they qualify for Part A coverage or are at least age 65 and either a United States resident or a lawfully admitted alien who has resided in the United States during the previous five years. *Id.* § 407.10(a)(1) and (2). To receive Part B, however, people must elect coverage and pay a subsidized premium. *Id.* §§ 407.4(a)(2), 407.12. Examples of care provided under Part B coverage are ambulance services, physicians' services, outpatient physical therapy services, and outpatient hospital services. *Id.* § 410.10.

39. Castro, *Time* at 38 (Nov. 25, 1991) (cited in note 1). The burden on taxpayers who pay for Medicare continues to increase. In 1960, the ratio of people under sixty-five compared to people over sixty-five was eleven to one. Today that ratio is seven to one. Of these seven, two are children and one is unemployed; therefore, on average, four working taxpayers provide ninety percent of the Medicaid funds for each elderly person. *Id.*

40. *Id.* It may be some consolation to the uninsured who contribute to the Medicare program through taxes that they will benefit from this program when they themselves are elderly.

come people who meet financial and other categorical standards.⁴¹ To qualify for Medicaid assistance, a person generally must meet the financial requirements of the state's Aid to Families with Dependent Children (AFDC) plan.⁴² Thus, one way a state can control the number of people qualifying for Medicaid is by raising or lowering AFDC financial requirements. The states also have some discretion in setting other categorical standards, but the federal government conditions its funding of state Medicaid programs by requiring coverage for certain groups. Coverage is mandatory for those who meet state-set financial requirements and who are AFDC recipients, pregnant, newborns, children under eight years old, aged, blind, disabled, or fall into another mandatory coverage category.⁴³ For other groups coverage is optional, and some groups cannot receive coverage.⁴⁴ Coverage generally is unavailable to even the most poor who do not meet categorical standards unless a state provides health care services through a state program independent of Medicaid.⁴⁵

The federal and state governments fund the Medicaid program jointly.⁴⁶ The federal government generally matches each state's Medicaid spending on a two-to-one basis.⁴⁷ To receive the matching federal funds, the states must offer the federally defined minimum package of benefits to those that qualify.⁴⁸ The mandatory package of benefits is quite generous,⁴⁹ although the states have discretion in determining whether to offer certain services.⁵⁰ Some states, for example, have cut costs by eliminating expensive optional services, like soft tissue

41. 42 C.F.R. § 435.1(b)(ii) (1991). See also Mary O. Waid, *Addendum: A Brief Summary of the Medicaid Program*, Health Care Financing Review 171 (1990 Ann. Supp.).

42. See 42 C.F.R. § 435.711.

43. See *id.* § 435.100 et seq.

44. *Id.* § 435.1(b)(ii)(2). Examples of optional coverage include services for those who meet financial requirements and are eligible for, but are not receiving, AFDC; those who are under age twenty-one but are not dependent children; and those who would qualify for AFDC if child care costs were paid from earnings. See *id.* § 435.200 et seq.

45. *Id.* §§ 435.1(b)(ii), 435.110(a), 435.116(a), 435.120, 435.222.

46. Hearing: *The Health Care Crisis and the American Family* at 44 (cited in note 26) (reprinting *The Crisis in Health Insurance, Pt. 1*, Consumer Rep. at 2 (Aug. 1990)).

47. *Federal Officials Support Health Plan, But Say Waiver Request Will Face Scrutiny*, 18 BNA Pension Rep. 1515 (1991) ("*Federal Officials Support Plan*") (statement by Tom Scully, associate director of the Office of Management and Budget).

48. See 42 C.F.R. § 435.10 (1991).

49. David M. Eddy, *What's Going on in Oregon?*, 266 JAMA 417, 418 (1991). Mandatory services include inpatient hospital services, outpatient hospital services, laboratory and x-ray services, nursing facility services, physician services, and nurse-midwife services. 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(1)-(5), (17) (1992).

50. Examples of optional services are home health care services, private duty nursing services, clinical services, dental services, and providing prescription drugs. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(7)-(10), (12) (1992).

transplants.⁵¹

Medicaid eligibility varies widely among the states due to the differing levels of state contribution.⁵² In the past decade, most states have reduced the number of people covered by Medicaid because of rising health care costs.⁵³ In 1980 sixty-five percent of the poor qualified for Medicaid, but only forty percent of the poor currently qualify.⁵⁴ As medical costs continue to rise, the number of Medicaid recipients likely will continue to decrease, and an increasing number of people will fall into the third tier of coverage, the uninsured.⁵⁵

The third tier of coverage comprises those who are uninsured. An estimated thirty-seven million Americans, including roughly one out of nine working families, have no health insurance.⁵⁶ Of the thirty-seven million uninsured, eight million are children.⁵⁷ Not surprisingly, studies indicate that people with no health insurance are less healthy than those with coverage.⁵⁸ Perhaps the primary reason the uninsured are less healthy than insured Americans is that they receive little preventative care and generally rely on emergency rooms for acute care.⁵⁹

Most of the people in the third tier of coverage are employees, and the families of employees, who work for small businesses.⁶⁰ Many small

51. States have the option of providing certain soft-tissue transplants. 42 C.F.R. §§ 485.301-.308 (1991).

52. *Oregon's Brave Medical Experiment*, N.Y. Times 22 (May 12, 1990) (editorial).

53. Fox and Leichter, Health Affairs at 12-14 (Summer 1991).

54. Castro, Time at 36 (Nov. 25, 1991) (cited in note 1). See also Fox and Leichter, Health Affairs at 13 (Summer 1991). This Note uses the word "poor" to mean those whose income falls below the FPL.

55. See Fox and Leichter, Health Affairs at 13 (Summer 1991).

56. Castro, Time at 36 (Nov. 25, 1991). The uninsured are generally under age twenty-four and poor.

57. Id.

58. See Hearing: The Changing Face of Health Care at 5-6 (cited in note 34); Health Care for the Uninsured, Hearings before the Subcommittee on Health for Families and the Uninsured of the Senate Committee on Finance, Pt. 1, 101st Cong., 1st Sess. 116 (1989) ("Hearings: Health Care for the Uninsured, Pt. 1").

The results of one California study demonstrate the difference access to basic preventive health care can make. In 1982, California dropped 270,000 people from its Medicaid program so that the state could continue to fund organ transplants. A subsequent study monitored the health of 186 people who lost coverage and compared it to the health of 186 people who did not lose coverage. In the first year, seven of those who had lost coverage died, compared to zero in the group who had coverage. The deaths were caused by people running out of medicine for ailments such as high blood pressure and diabetes. The study estimated that the change in health care policy may have caused between 5,000 and 10,000 deaths yearly. Victor Cohn, *Rationing Medical Care*, Wash. Post Z10 (July 31, 1990). According to Robert Blendon of the Harvard School of Public Health, seventeen percent of all Americans suffering from high blood pressure and diabetes are going without treatment. Castro, Time at 36 (Nov. 25, 1991).

59. Richard Allen, *Caring for the Uninsured: The Oregon Experience*, 115 Arch. Pathol. Lab. Med. 437, 437 (1991).

60. Castro, Time at 36 (Nov. 25, 1991) (cited in note 1).

businesses do not provide health insurance because they cannot afford the high premiums.⁶¹ A second group that falls into the third tier of coverage are the unemployed who do not qualify for benefits under Medicaid.⁶² The growing number of people in the third tier of coverage has generated an increasing debate over the rationing of health care implicit in the current system.

B. Rationing in the Current System

Health care rationing may be defined as the failure to provide all beneficial care to all people.⁶³ Today, any suggestion of rationing health care often is met with expressions of animosity and uneasiness.⁶⁴ Perhaps some opponents of rationing are uncomfortable with such a scheme because they worry about the fair allocation of health care services. Some also may fear that they themselves will be denied potentially beneficial medical services. Yet opponents of explicit rationing plans often fail to acknowledge the many forms of implicit rationing already occurring in the current system.⁶⁵

Although many prefer not to recognize it, the current health care delivery system rations health care. The primary means by which the current system rations is through financial access,⁶⁶ thus rationing people rather than services.⁶⁷ The wealthy and the privately insured gener-

61. Hearing: The Health Care Crisis and the American Family at 45 (cited in note 26) (reprinting *The Crisis in Health Insurance, Pt. 1*, Consumer Rep. at 3 (Aug. 1990)). Firms with fewer than one hundred workers employ about one-third of the U.S. work force, but only one-half of these firms provide health insurance to their employees. *Id.*

62. Medicaid provides services to only 40% of poor Americans. Castro, *Time* at 36 (Nov. 25, 1991).

63. See Michael D. Reagan, *Health Care Rationing—What Does It Mean*, 319 *New Eng. J. Med.* 1149, 1149 (1988).

64. See Marsha F. Goldsmith, *Oregon Pioneers "More Ethical" Medicaid Coverage With Priority-Setting Project*, 262 *JAMA* 176, 176 (1989).

65. In order to differentiate between various forms of rationing, this Note uses the terms explicit rationing and implicit rationing. Explicit rationing occurs whenever medical services themselves are directly and expressly or overtly allocated. Oregon's prioritization process is an example of explicit rationing. Implicit rationing occurs when beneficial medical services are denied through indirect means. For example, the indirect result of a decision to decrease Medicaid funding is that fewer people will qualify for Medicaid.

66. See Larry R. Churchill, *Rationing Health Care in America* 14 (Notre Dame, 1987); Goldsmith, 262 *JAMA* at 176 (cited in note 64). John D. Golenski, medical ethicist and president of the Bioethics Consulting Group in Berkeley, California, has observed that "in the United States now we don't give basic medical treatment to poor people—in huge numbers. That's rationing by non-access. . . . We salve our consciences by giving the full high-tech medical apparatus to fewer and fewer poor people, while we tell ourselves those who are in the [Medicaid] program get everything that everybody else gets. But we throw whole groups of people out of the program and don't think about what happens to them." Goldsmith, 262 *JAMA* at 177 (cited in note 64).

67. See, for example, Eddy, 266 *JAMA* at 418 (cited in note 49).

ally have access to comprehensive medical services.⁶⁸ Those who qualify for Medicaid also receive a rich package of benefits.⁶⁹ Nevertheless, a substantial portion of the population does not fall into either group. Those that do not have any form of health insurance include sixty percent of those living below the FPL and thirty percent of those living within one to two times the FPL.⁷⁰ Those earning close to the FPL often cannot afford to pay for health care, have no health coverage through their employers or Medicaid, and cannot afford insurance.⁷¹ To some degree, the current health care delivery system also rations care by age, in the case of Medicare; by ailment, because federally funded programs pay only for treatment of certain illnesses; by race, in the case of the Indian Health Service; by media appeal, for those who have access to the media; and by provider philanthropy.⁷²

Some argue that health care services should not be rationed at all. This group believes that one's ability to pay for health care services certainly has no place in determining what services one receives. Many others, however, believe that the United States cannot escape some form of health care rationing.⁷³ Because the human body is inherently prone to deterioration and disease, virtually infinite amounts of resources would be required to provide all possible beneficial services to all persons.⁷⁴ No health care system can serve all legitimate needs.⁷⁵

68. Colen, 23 *Health* at 32 (cited in note 20). Even those who are insured privately are not exempt from rationing. Many insurance policies provide very low levels of coverage. One commentator estimates that the health insurance policies of over 30 million Americans provide inadequate coverage. See Brown, 267 *JAMA* at 552 (cited in note 31). Thus, millions of insured Americans are at risk of having no coverage for some essential health care services.

69. See Eddy, 266 *JAMA* at 418.

70. Hearing: *The Changing Face of Health Care* at 7 (cited in note 34). A Massachusetts study found that families earning up to two times above the federal poverty level have little or no disposable income to spend on health insurance. *Id.*

71. *Id.*

72. Churchill, *Rationing Health Care* at 14 (cited in note 66). See George D. Lundberg, *National Health Care Reform; An Aura of Inevitability Is Upon Us*, 265 *JAMA* 2566, 2567 (1991), for additional examples of how the United States health care delivery system presently rations health care.

73. See Daniel Callahan, *Rationing Health Care: Will It Be Necessary? Can It Be Done Without Age or Disability Discrimination?*, 5 *Issues in Law & Med.* 353, 356 (1989). Richard Lamm, director of the University of Denver Public Policy Center and former Governor of Colorado, has observed that "[h]ealth care has become an economic cancer eating into every other public function . . . We shall, inevitably, have to decide what is 'appropriate,' not what merely could be 'beneficial' . . . We shall have to balance quality of life with quantity of life, costs and benefits, preventive medicine versus curative medicine. . . . Any other alternative will be fiscal suicide." Uwe Reinhardt, a Princeton economist, agrees that "[a]t some point we will ration." Former Surgeon General C. Everett Koop has said that "I think you have to face rationing," and David Seitzman, former president of the D.C. Medical Society, has said "I believe [rationing] is the only way to disperse our resources—especially public resources—equitably." Cohn, *Wash. Post* Z10 (July, 31 1990) (cited in note 58).

74. Callahan, 5 *Issues in Law & Med.* at 354 (cited in note 73).

Even countries that provide some form of universal health care ration that care in a variety of ways. These countries, for example, may limit the services funded or impose spending caps. Waiting periods for certain expensive procedures also serve a rationing function.⁷⁶ The question facing the United States, then, is not whether to ration health care services, but how to ration those services and who should decide what to ration.

Under the current system, federal and state officials determine the level of Medicaid funding.⁷⁷ A necessary result of their funding decisions is that some poor people will not have access to services.⁷⁸ Some people prefer this method of implicit rationing to a method of explicit rationing,⁷⁹ perhaps because implicit rationing generates less public awareness than explicit rationing schemes.⁸⁰ Implicit rationing does not actively incorporate public decisionmaking and, therefore, is less likely to gain public attention.⁸¹ In contrast, Oregon's proposed system actively involves the public in the explicit prioritization of health care services, a process that necessarily results in greater public awareness.⁸²

C. *The Role of Federalism in Rationing Health Care*

America's federalist system was designed in part to allow the states, if their citizens so choose, to act as laboratories of innovation.⁸³ In this way, states can implement novel social and economic programs without risk to the entire country.⁸⁴ Denial of the states' right to experi-

75. *Id.* at 356; Churchill, *Rationing Health Care* at 105 (cited in note 66).

76. See Erik Eckholm, *Rescuing Health Care*, N.Y. Times A1 (May 2, 1991) (stating that in Europe, Canada, and Japan, the governments play powerful roles in setting medical prices and limiting overall spending). See also Hearing: The Health Care Crisis and the American Family at 72 (cited in note 26) (reprinting *The Crisis in Health Insurance, Pt. 2*, Consumer Rep. at 9 (Sept. 1990)) (stating that new technology is introduced slowly in Canada, resulting in waiting periods and complaints of people being denied state-of-the-art treatments). The use of funding limits or spending caps rations health care by limiting the number of services that can be offered through government programs. Waiting periods ration care by forcing people to suffer from ailments for longer periods of time. In addition, if state-of-the-art technology is incorporated slowly into the health care system, then those who could benefit immediately from that technology are subject to rationing because they may receive outdated and less effective treatment.

77. Kitzhaber, *Health Progress* at 22 (Nov. 1990) (cited in note 18).

78. See *id.*

79. Representative Waxman, Chairman of the House Subcommittee on Health and Environment and an outspoken opponent of the Oregon plan, has observed that explicit rationing may take necessary benefits from the most vulnerable, the poor. *Oregon's Brave Medical Experiment*, N.Y. Times 22 (May 12, 1990) (cited in note 52).

80. See Charles J. Dougherty, *The Proposal Will Deny Services to the Poor*, *Health Progress* 21, 30 (Nov. 1990). See also Kitzhaber, *Health Progress* at 22-23 (Nov. 1990) (cited in note 18).

81. *Id.*

82. Kitzhaber, *Health Progress* at 23 (Nov. 1990) (cited in note 18).

83. See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis dissenting).

84. *Id.*

ment can bring serious consequences to the nation.⁸⁵ The domination of the health care delivery system by the federal government provides an example of the adverse consequences of limiting state autonomy and experimentation.⁸⁶ The federal government now exercises considerable control over government-funded health care in the United States. Medicare is a federally-funded and federally-administered program.⁸⁷ The federal government also exercises significant control over state Medicaid programs even though the states provide a significant amount of program funding.⁸⁸ Through its taxing and spending powers, the federal government regulates the Medicaid program for the poor. To receive matching federal funding the states are forced to provide Medicaid services according to federal guidelines.⁸⁹ In addition, federal legislation has hampered the ability of states to cap medical reimbursement rates by allowing health care providers to sue states in federal court for "adequate" levels of compensation.⁹⁰ Obtaining waivers of federal health care laws also can be an arduous task and, thus, further complicates state efforts to reform health care.⁹¹ The federal government, then, often hampers the efforts of states seeking to implement what they view as a more democratic, more equitable, and more efficient distribution of health care benefits and resources.

One advantage of the current system is that those who receive Medicaid are guaranteed access to a generous package of benefits because the states must offer certain mandatory services.⁹² Yet providing

85. *Id.* In areas in which the states cannot or do not take steps to cure persistent problems, federal intervention may well be necessary and appropriate. The most obvious example of such an area is that of civil rights. Nevertheless, when states are willing and able to implement solutions to problems in areas such as health care delivery, federal interference seems less appropriate.

86. Charles J. Dougherty, *Setting Health Care Priorities*, Hastings Center Report 1, 7 (May-June 1991). Some argue that there is nothing more lacking in American health care delivery than creativity and innovation.

87. Individuals who wish to purchase optional Medicare benefits or states that wish to provide these optional benefits to their elderly citizens must pay the federal government a fee. For a discussion of Medicare Part B optional coverage, see note 38. See also 42 C.F.R. § 431.625 (1991) (allowing the states to purchase Medicare Part B coverage for their elderly citizens).

88. See note 47 and accompanying text.

89. See notes 41-51 and accompanying text.

90. See *Wilder v. Virginia Hosp. Ass'n*, 110 S. Ct. 2510 (1990) (holding that health care providers receiving Medicaid reimbursements may bring suits challenging state reimbursement rates under 42 U.S.C. § 1983). For an argument that the *Wilder* decision actually contravenes Congressional intent, see Note, *Medicaid, State Cost-Containment Measures, and Section 1983 Provider Actions Under Wilder v. Virginia Hospital Association*, 45 Vand. L. Rev. 487, 500-08 (1992).

91. For example, Hawaii struggled six years to get federal authorization to implement its legislation mandating employer-sponsored health insurance and other aspects of its state universal health care program. Jerome C. Goldstein, *Access to Care—The Problem for the Uninsured and Underinsured*, 117 Arch. Otolaryngol Head Neck Surg. 490, 491 (1991).

92. See 42 C.F.R. § 435.100 (1990).

these required services is so expensive that states generally cannot afford to distribute benefits to all who are in need of them. Thus, many citizens living at or near the poverty level are excluded from Medicaid coverage.⁹³ Believing that its proposed rationing system improves upon the current system, and supported by the majority of its citizenry, Oregon has sought to reassert the role of the states—the role of federalism—in determining the best method of distributing health care to their citizens.⁹⁴

III. OREGON'S RATIONING EXPERIMENT: THE OREGON BASIC HEALTH SERVICES ACT

A. Background

Over the past three decades the amount states have contributed toward Medicaid has skyrocketed. In 1965, when Medicaid was introduced, funding for the program consumed about five percent of state budgets.⁹⁵ This figure is currently about eleven percent and is expected to rise to fifteen percent by 1995.⁹⁶ Medicaid is second only to education as the largest item on most state budgets.⁹⁷ With health care costs rising faster than the growth of the economy,⁹⁸ it is becoming increasingly difficult for the states to meet growing Medicaid expenses.⁹⁹

In 1987, rising health care costs influenced the Oregon legislature to stop Medicaid funding of soft-tissue transplants.¹⁰⁰ State officials justified this action by claiming there were more effective ways to allocate scarce public resources than funding high-cost transplants for relatively few people.¹⁰¹ Instead, the legislature allocated \$1,100,000 that previously would have been used to fund transplants for thirty-four individ-

93. See notes 46-55 and accompanying text.

94. See Kitzhaber, *Health Progress* at 22 (Nov. 1990) (cited in note 18). Support for the plan includes that of the Associated Oregon Industries, a major business lobbying group, the Oregon AFL-CIO, the Oregon Medical Association, and political leaders from both parties. *Oregon, State Seeks Waivers For Universal Health Insurance*, BNA Daily Rep. for Executives C-11 (Dec. 3, 1991).

95. Fox and Leichter, *Health Affairs* at 13 (Summer 1991) (cited in note 4).

96. *Id.*

97. *Id.*

98. See Helen C. Lazanby and Suzanne J. Letsch, *National Health Care Expenditures, 1989*, *Health Care Financing Rev.* 1, 1-2 (Winter 1990).

99. See *id.* Howard B. Dean, the former governor of Vermont, predicts that health care cost containment will be the number one problem the states face over the next five years. Lawrence K. Altman, *The Doctor's World*, N.Y. Times C3 (Sept. 3, 1991).

100. See Norman Daniels, *Is the Oregon Rationing Plan Fair?*, 265 JAMA 2232, 2232 (1991). Oregon is not the only state to reduce costs by eliminating funding for transplants. In 1990, only forty state Medicaid programs included funding for heart transplants and only thirty-eight states funded liver transplants in adults. Spencer Rich, *Organ Transplants: Rationing by Wallet?*, Wash. Post A1 (Sept. 1, 1991).

101. Daniels, 265 JAMA at 2232 (cited in note 100).

uals to fund prenatal care for fifteen hundred women.¹⁰² Officials believed that more lives could be saved per dollar spent by funding prenatal care.¹⁰³ In 1988, however, the plight of a seven-year-old leukemia patient, Coby Howard, drew national attention and sympathy when Oregon refused to fund his bone marrow transplant.¹⁰⁴ Coby died from leukemia after raising \$70,000 of the \$100,000 needed for the operation.¹⁰⁵ In response to this highly publicized incident, Oregon began reexamining its entire health care delivery system.

In 1989, the Oregon legislature passed OBHSA,¹⁰⁶ one of the newest and broadest attempts to improve access to basic health care while, at the same time, attempting to contain costs.¹⁰⁷ OBHSA was borne out of a general consensus that the public and private sectors no longer could afford to pay for everyone to receive all desired health care services.¹⁰⁸ Under the current system, approximately 200,000 Oregon residents qualify for Medicaid,¹⁰⁹ leaving sixteen percent of the population, or 450,000 people, who are poor and near-poor without any private or public health insurance.¹¹⁰ Nearly half of the uninsured are children.¹¹¹ Oregon residents, however, want a system that gives everyone access to basic health care services.¹¹² Under OBHSA, the state has designed a system of prioritized medical services, and if the program is implemented, the state will no longer fund less beneficial procedures through Medicaid.¹¹³ This system of rationing health care services will allow Oregon to expand Medicaid eligibility to cover all persons falling below the FPL.¹¹⁴

102. Jane H. White, *Rationing Healthcare: Is It Time?*, Health Policy 10, 10-11 (Dec. 1990).

103. Daniels, 265 JAMA at 2232 (cited in note 100).

104. Harvey D. Klevit, et al, *Prioritization of Health Care Services; A Progress Report by the Oregon Health Services Commission*, 151 Arch. Intern. Med. 912, 912 (1991). Coby's leukemia was not in remission, so he was not a good candidate for a bone marrow transplant. Id.

105. Id.

106. Id.

107. Castro, Time at 37 (Nov. 25, 1991) (cited in note 1).

108. *Controversy in Oregon: Developing Priorities For Health Care Services*, 18 BNA Pension Rep. 2191, 2191-20 (Dec. 2, 1991).

109. Eddy, 266 JAMA at 418 (cited in note 49).

110. *Oregon, State Seeks Waivers for Universal Health Insurance*, BNA Daily Rep. for Executives C-11 (Dec. 3, 1991) (cited in note 94).

111. Id.

112. *Controversy in Oregon*, 18 BNA Pension Rep. at 2191 (cited in note 108).

113. Kitzhaber, Health Progress at 23 (Nov. 1990) (cited in note 18). See also notes 125-26 and accompanying text.

114. See note 126 and accompanying text. Oregon cannot implement OBHSA without obtaining waivers of federal requirements. The state must obtain one waiver to provide services to people who do not meet the financial and other categorical requirements to Medicaid and a second waiver to redefine the basic package of services that must be provided. Eddy, 266 JAMA at 2439 (cited in note 11). The waivers must be authorized either by the Health Care Financing Administration (HCFA) or by direct congressional action. Lawrence D. Brown, *The National Politics of*

OBHSA actually is a three-part plan designed to provide basic health care services to virtually all Oregon residents.¹¹⁵ Senate Bill 27 establishes the basic rationing scheme with which Oregon hopes to replace the current Medicaid distribution system.¹¹⁶ Senate Bill 534 creates a state health-risk pool to provide persons currently uninsurable under private health policies an alternative to self-funding.¹¹⁷ Finally, Senate Bill 935 mandates employer-sponsored insurance for most Oregon workers and allows those workers whom employers are not required to insure to participate in the state health-risk pool.¹¹⁸ In combination, these measures constitute a bold attempt to increase the equity and effectiveness of current health care delivery by (1) developing a mechanism for policymakers to make explicit health care rationing decisions, (2) allowing the rationing process to weigh the societal costs and benefits of particular treatments for particular medical conditions, and (3) creating clear accountability for allocation decisions and their consequences.¹¹⁹ The following sections review the major provisions of OBHSA.

B. Senate Bill 27

Senate Bill 27¹²⁰ is both the core and the most controversial component of OBHSA.¹²¹ The Bill created the Oregon Health Services Commission and gave it the task of developing the prioritized list of medical treatments and services that forms the basis of Oregon's proposed rationing scheme.¹²² The eleven-member Commission, consisting of five doctors, a health nurse, a social worker, and four health care consumers,¹²³ ranked these services according to the comparative value of the benefits they provide to the population served.¹²⁴ The Bill would expand Medicaid eligibility to all Oregon citizens with incomes below

Oregon's Rationing Plan, Health Affairs 28, 33 (Summer 1991). The federal government never has granted a waiver that permits a state to eliminate mandated Medicaid services. *Id.* For a discussion of the waiver process, see part III.E.

115. See Kitzhaber, Health Progress at 23 (Nov. 1990) (cited in note 18).

116. See part III.B.

117. See part III.C.

118. See part III.D.

119. Kitzhaber, Health Progress at 23 (Nov. 1990).

120. Senate Bill 27 creates new provisions amending Oregon Revised Statutes §§ 113.22, 414.025, 414.036, 414.042, and 414.065 (Supp. 1990).

121. Klevit, et al, 151 Arch. Intern. Med. at 912 (cited in note 104).

122. Or. Rev. Stat. §§ 414.065(1), 414.720(3) (Supp. 1990).

123. *Id.* § 414.715(1). The commission members were appointed by the Governor.

124. Or. Rev. Stat. § 414.720(3) (Supp. 1990). The Commission presented the final list to the Oregon legislature on May 1, 1991. The Legislature approved the list and determined the proposed level of funding on June 30, 1991. Paige R. Sipes-Metzler, *Oregon Update*, Hastings Center Report 13, 13 (Sept.-Oct. 1991).

the FPL, and in any given year, the state would fund as many of the services on the list as it could afford under that year's Medicaid budget allotment.¹²⁵ If the number of qualified recipients increases, the state would not deny access to any, as is the current practice under the Medicaid system, but instead would reduce the number of funded services.¹²⁶

Initially, the Bill applies rationing only to those who qualify for Medicaid based on financial need alone.¹²⁷ The aged, the blind, the disabled, the medically needy, and children in foster care programs would continue to receive currently mandated Medicaid benefits.¹²⁸ Legislators, however, eventually plan to expand the rationing program to all state-funded health care programs.¹²⁹

OBHSA gave the Health Services Commission no particular method for creating the priority list, instead allowing the Commission some flexibility in establishing priorities.¹³⁰ The Commission proceeded by developing a set of seventeen categories, which grouped medical conditions and treatments either by similar types of medical services or by expected outcomes from care.¹³¹ The Commission ranked these categories based on (1) the category's value to the individual, (2) the category's value to society, and (3) the necessity of the services within the category.¹³² The Commission then assigned all medical treatments to the most appropriate categories based on its own judgment.¹³³ Categories one through nine were deemed "essential," most of categories ten

125. Or. Rev. Stat. § 414.720(5) (Supp. 1990) (stating that services on the list will be covered to the extent that funding allows); Id. § 414.036(2) (stating that all below the FPL will qualify for Medicaid benefits). See also Brown, *Health Affairs* at 33 (Summer 1991) (cited in note 114).

126. Or. Rev. Stat. § 414.720(2) (Supp. 1990); Fox and Leichter, *Health Affairs* at 10 (Summer 1991) (cited in note 4).

127. Daniels, *JAMA* at 2232 (cited in note 100). See Or. Rev. Stat. § 414.720(5) (Supp. 1990).

128. Or. Rev. Stat. § 414.720(5) (Supp. 1990); Fox and Leichter, *Health Affairs* at 9 (Summer 1991).

129. Fox and Leichter, *Health Affairs* at 9 (Summer 1991). It is projected that the rationing scheme eventually will include the aged, disabled, and state employees. Id.

130. The statute required the Commission to solicit input from the public and to build consensus on the criteria used in the prioritization process. Or. Rev. Stat. § 414.720(1), (2) (Supp. 1990). The Commission held community meetings in every county in the state. At these meetings participants filled out questionnaires soliciting their opinions on health care values and on the importance of various categories of treatment. Thirteen health care values emerged from these meetings, and the Commission ranked these values based on how frequently each was mentioned. Preventive care and quality of life topped the list. Dougherty, *Hastings Center Report* at 6 (May-June 1991) (cited in note 86).

131. David C. Hadorn, *The Oregon Priority-Setting Exercise: Quality of Life and Public Policy*, *Hastings Center Report* 10, 11 (May-June 1991).

132. David C. Hadorn, *Setting Health Care Priorities in Oregon; Cost-Effectiveness Meets the Rule of Rescue*, 265 *JAMA* 2218, 2220 (1991). These criteria are simply a means of organizing medical services into broad categories. The classification of particular services as "essential" in no way requires that they be funded.

133. Id. at 11.

through thirteen also were deemed "essential," and categories fourteen through seventeen were considered "non-essential."¹³⁴ All of the items in the first category will be funded before any of the items in the second category, and so forth.¹³⁵

134. *Id.* at 10. Category One is acute fatal, prevents death, full recovery. Examples of services in Category One are repair of a deep, open wound of the neck, an appendectomy for appendicitis, and medical therapy for myocarditis. Category Two is maternity care (including care for newborns in the first 28 days of life). Category Two services include obstetrical care for pregnancy, medical therapy for drug reactions and intoxications specific to newborns, medical therapy for low birth weight babies. Category Three is acute fatal, prevents death, without full recovery. Category Three services include surgical treatment for head injury with prolonged loss of consciousness, medical therapy for acute bacterial meningitis, and reduction of an open fracture of a joint. Category Four is preventive care for children. Category Four services include immunizations, medical therapy for streptococcal sore throat and scarlet fever, and screening for specific problems such as vision or hearing problems or anemia. Category Five is chronic fatal, improves life span and quality of well-being (QWB). Category Five services include medical therapy for Type I Diabetes Mellitus, medical and surgical treatment for treatable cancer of the uterus, and medical therapy for asthma. Category Six is reproductive services (excluding maternity and infertility). Category Six services include contraceptive management, vasectomy, and tubal ligation. Category Seven is comfort care. Category Seven services include palliative therapy for conditions in which death is imminent. Category Eight is preventive dental (children and adults). Category Eight services include cleaning and fluoride treatments. Category Nine is preventive care for adults. Category Nine services include mammogram, blood pressure screening, and medical therapy and chemoprophylaxis for primary tuberculosis.

Most of the services in Categories Ten through Thirteen are considered "very important" by the Commission. Category Ten is acute nonfatal, return to previous health. Category Ten services include medical therapy for acute thyroiditis, medical therapy for vaginitis, and restorative dental services for dental caries. Category Eleven is chronic nonfatal, one time treatment improves QWB. Category Eleven services include hip replacement, laser surgery for diabetic retinopathy, and medical therapy for rheumatic fever. Category Twelve is acute nonfatal, without return to previous health. Examples of Category Twelve Services include relocation of dislocation of elbow, orthoscopic repair of internal derangement of knee, and repair of corneal laceration. Category Thirteen is chronic nonfatal, repetitive treatment improves QWB. Category Thirteen treatments include medical therapy for chronic sinusitis, medical therapy for migraine, and medical therapy for psoriasis.

The services in Categories Fourteen through Seventeen are considered "valuable to certain individuals" by the Commission. Category Fourteen is acute nonfatal, expedites recovery. Examples of Category Fourteen services are medical therapy for diaper rash, medical therapy for acute conjunctivitis, and medical therapy for acute pharyngitis. Category Fifteen is infertility services. Examples of Category Fifteen services are medical therapy for anovulation, microsurgery for tubal disease, and in-vitro fertilization. Category Sixteen is preventive care for adults. Examples of services are dipstick urinalysis for gematuria in adults less than 60 years of age, sigmoidoscopy for persons less than 40 years of age, and screening of nonpregnant adults for Type I Diabetes Mellitus. Category Seventeen is fatal or nonfatal, minimal or no improvement in QWB (non-self-limited). Examples of Category Seventeen services include repair fingertip avulsion that does not include fingernail, medical therapy for gallstones without cholecystitis, and medical therapy for viral warts. *Id.*

135. See Hadorn, 265 *JAMA* at 2220 (cited in note 132). Each ranked medical service consists of a treatment for a certain illness or condition. The treatments to be provided, however, are stated only in general terms. For example, the treatment specified for the number one ranked condition, pneumococcal pneumonia, is "medical therapy." The treatment specified for pregnancy, the condition ranked twenty-second on the list, is "obstetrical care." Sipes-Metzler, Hasting Center Report at 13 (Sept.-Oct. 1991) (cited in note 124). This generalization still will allow doc-

The Commission employed several techniques to generate the prioritization of the services within each category. Physicians assessed the possible medical conditions that patients might experience during a five-year period, both with and without treatment.¹³⁶ In addition, the Commission conducted a random telephone survey of a thousand Oregon residents in which survey participants were asked to rate various states of health on a scale between 100 (good health) and 0 (as bad as death).¹³⁷ The Commission used the survey results to create a quality-of-well-being (QWB) scale.¹³⁸ The QWB scale is a numerical concept that estimates the impact of given treatments on a patient's quality of life¹³⁹ and estimates the degree to which treatment of each condition will increase the overall quality of life.¹⁴⁰ Based on the QWB scale, the Commission prioritized all treatments according to their net benefit.¹⁴¹ The net benefit of a condition is the difference between the QWB score caused by the untreated condition and the increase in the QWB score following treatment.¹⁴² Treatments were ranked within each category according to the score received.¹⁴³ To some extent, items were rearranged if the result appeared inequitable based on the Commission's

tors much discretion in selecting the preferred method of treatment.

136. Hadorn, Hastings Center Report at 14 (May-June 1991) (cited in note 131). For example, physicians might determine that treatment of a specified illness would result in a fifty percent chance of full recovery, a twenty-five percent chance of recovery with a moderate mobility limitation, and a twenty-five percent chance of recovery with a major mobility limitation over a five-year period. They also might determine that a failure to treat the condition would result in a fifty percent chance of death and a fifty percent chance of recovery with a major mobility limitation in the same five-year period. Physicians selected a five-year period because they believed this to be a reasonable period against which to measure expected benefits. *Id.*

137. Fox and Leichter, Health Affairs at 21 (Summer 1991) (cited in note 4). Examples of the types of conditions the survey asked the participants to rank include "[y]ou cannot drive a car or use public transportation, you have to use a walker or wheelchair under your own control, and are limited in the recreational activities you may perform but have no other health problems," and "[y]ou can go anywhere and have no limitations on physical or other activity, but wear glasses or contact lenses." *Id.*

138. *Id.* Oregon adopted a modified version of a QWB scale developed by Robert M. Kaplan of the University of California at San Diego. *Id.* The prioritization list Oregon currently is using is the second list generated by the Commission. In May of 1990, the initial prioritization list of 1,600 conditions and treatments was released. The Commission, however, scrapped the list because of its surprising results. *Id.* at 21-22. For example, the list ranked crooked teeth higher than early treatment for Hodgkin's disease and thumb sucking higher than hospitalization for a child suffering from starvation. *Id.* The major changes between the first and second lists were the creation of the seventeen categories, and the reduction in the list from 1,600 services and treatments to 800 more broadly defined service and treatments. *Id.* at 22-23.

139. *Id.*

140. Hadorn, Hastings Center Report at 14 (May-June 1991).

141. *Id.*

142. Klevit, et al, 151 Arch. Intern. Med. at 914 (cited in note 104).

143. *Id.* The QWB score for an individual with a given condition with or without treatment is one less the sum of the weights of all possible conditions multiplied by their probabilities of occurring. The sum of the probabilities of all symptom/limitations must total one hundred percent. *Id.*

judgment.¹⁴⁴

The prioritization process resulted in the creation of seventeen categories containing a total of 709 health services and treatments.¹⁴⁵ Under its current budget, the state would fund procedures 1, pneumococcal pneumonia, through 587, surgery for fracture of the facial bones.¹⁴⁶ Procedures 588 through 709 will not be funded.¹⁴⁷ The Oregon legislature approved Senate Bill 27 by a vote of nineteen to three in the Senate and fifty-eight to two in the House.¹⁴⁸

C. Senate Bill 534

Senate Bill 534,¹⁴⁹ the second part of Oregon's plan to provide universal insurance coverage, creates a state health-risk pool.¹⁵⁰ Risk pools allow people who, because of preexisting medical conditions, are unable to obtain private insurance individually to purchase health insurance through an insurance pool.¹⁵¹ Between 10,000 and 20,000 currently uninsurable Oregon residents will be able to purchase insurance through the state health-risk pool.¹⁵² Typically, high-risk-pool premiums are more expensive than premiums paid under traditional private insurance policies because risk-pool policy holders are more likely to file claims.¹⁵³ The Oregon plan, however, will reduce the cost of the insurance pool to high-risk beneficiaries, by subsidizing the pool through surcharges on

144. Hadorn, 265 JAMA at 2220 (cited in note 132). To determine whether it should reposition an item on the list, the Commission weighed several factors including the number of people that would benefit from the treatment, the value placed on the treatment by society, and the item's cost effectiveness. Between one-third to one-half of the list items were moved by hand, but only five to ten percent of the items were moved more than fifty positions. Hadorn suggests that this rearrangement of the items was reasonable in view of the complexity of the prioritization task. Id.

145. Hadorn, Hastings Center Report at 10, 12 (May-June 1991) (cited in note 131).

146. Sipes-Metzler, Hastings Center Report at 13 (Sept.-Oct. 1991) (cited in note 124).

147. Id.

148. Fox and Leichter, Health Affairs at 20 (Summer 1991) (cited in note 4).

149. Senate Bill 534 creates new provisions amending Oregon Revised Statutes §§ 735.605, 735.610, 735.615, 735.620, 735.625, 735.630, 735.635, 735.640, 735.645, and 735.650 (Supp. 1990).

150. See id.; Dougherty, Hastings Center Report at 3 (May-June 1991) (cited in note 86).

151. Risk pools originated in the 1970s as an alternative to national health insurance and are used in many states. Hearing: The Health Care Crisis and the American Family at 46 (cited in note 26) (reprinting *The Crisis in Health Insurance, Pt. 1*, Consumer Rep. at 4 (Aug. 1990)); Or. Rev. Stat. § 735.615 (Supp. 1990). Examples of conditions that may lead to a high-risk classification, thus rendering the person uninsurable under most private policies, are heart disease, internal cancer, diabetes, strokes, adrenal disorders, epilepsy, and ulcerative colitis. Hearing: The Health Care Crisis and the American Family at 51 (cited in note 26) (reprinting *The Crisis in Health Insurance, Pt. 1*, Consumer Rep. at 9 (Aug. 1990)).

152. Fox and Leichter, Health Affairs at 11 (Summer 1991) (cited in note 4).

153. Hearing: The Health Care Crisis and the American Family at 52 (cited in note 26) (reprinting *The Crisis in Health Insurance, Pt. 1*, Consumer Rep. at 10 (Aug. 1990)). In 1990, twenty-three states had risk pools. Id.

insurance companies who do business in the state. State reserve funds will cover any remaining shortages.¹⁵⁴ Although the state risk-pool presently does not incorporate the Senate Bill 27 rationing scheme,¹⁵⁵ officials plan to incorporate rationing into the risk pool in the future.

D. Senate Bill 935

Senate Bill 935,¹⁵⁶ the third part of OBHSA, is designed to provide coverage for the 330,000 working Oregon residents whose income exceeds the FPL and, thus, prevents them from qualifying for state-funded Medicaid.¹⁵⁷ Under Bill 935, the State currently gives tax credits to employers who provide health insurance if they employ no more than twenty-five employees and have not provided health insurance during the prior two years.¹⁵⁸ To qualify for the credit, an employer must provide its employees with an insurance package at least equal to those funded by the state through Medicaid.¹⁵⁹ Although Senate Bill 935 currently applies only to employers of twenty-five or fewer employees, the legislature is authorized to extend the plan to include all employers.¹⁶⁰ Perhaps the reason that the initial plan did not include all employers is that most larger employers already provide health insurance benefits to their employees.¹⁶¹

The tax credits should be phased out by the end of 1993,¹⁶² and in 1994, insurance coverage may become mandatory for all employers regardless of their size.¹⁶³ If coverage becomes mandatory, the state will

154. Or. Rev. Stat. § 735.614 (Supp. 1990). See also Allen, 115 Arch. Pathol. Lab. Med. at 438 (cited in note 59).

155. Fox and Leichter, Health Affairs at 11 (Summer 1991) (cited in note 4). Incorporating the rationing scheme into the risk-pool would mean that high-risk individuals who suffer from ailments not funded under the Senate Bill 27 rationing scheme would not be able to obtain coverage for these illnesses by enrolling in the state risk-pool. On the other hand, if all illnesses were covered by the risk-pool, the cost might become so prohibitive that many people could not afford to enroll without large government subsidies.

156. Senate Bill 935 creates new provisions amending Oregon Revised Statutes §§ 316.096, 317.113, 653.725, 653.765, and 653.775 (Supp. 1990).

157. Eddy, 266 JAMA at 2440 (cited in note 11).

158. Or. Rev. Stat. § 653.765(1)(a), (b) (Supp. 1990). The amount of tax credits increases as the number of employers qualifying for the credit increases. *Id.* §§ 316.096, 317.113 (1987).

159. *Id.* § 653.775(5). See also Dougherty, Hastings Center Report at 3 (May-June 1991) (cited in note 86).

160. Or. Rev. Stat. § 653.765(4) (Supp. 1990). See also Fox and Leichter, Health Affairs at 11 (Summer 1991) (cited in note 4).

161. See Castro, Time at 36 (Nov. 25, 1991) (cited in note 1) (stating that most of the uninsured work for small businesses). Currently, no effort is being made to expand tax credit eligibility to include large employers.

162. Or. Rev. Stat. §§ 316.096, 317.113 (Supp. 1990).

163. Or. Rev. Stat. 653.745 Sec. 7(1) (Supp. 1990). The legislation, however, provides that if, on October 1, 1993, 150,000 people who did not receive benefits before April 1, 1989 are covered voluntarily by employers, then Section 7 of the Act is repealed effective January 1, 1994. *Id.* §

require employers to pay seventy-five percent of the cost of health insurance for their employees who work an average of at least seventeen-and-one-half hours per week. If employers fail to insure these employees, the state will assess a tax against the business.¹⁶⁴ The tax will be equal to seventy-five percent of the amount it will cost the state to enroll the employee in the state health insurance pool plus fifty percent of the cost of enrolling each employee's dependents in the pool.¹⁶⁵ This Bill should provide health insurance to the 260,000 uninsured, working Oregon residents whose incomes are above the FPL.¹⁶⁶

Employees who earn more than the FPL, but do not work more than seventeen-and-one-half hours per week are not subject to mandatory coverage.¹⁶⁷ These workers and their dependents, however, will be able to purchase health insurance at a "reasonable" price through the state risk pool.¹⁶⁸ Employees who work less than seventeen-and-one-half hours per week and earn less than the FPL will be covered by Medicaid.¹⁶⁹ When combined, Bills 27, 534, and 935 should ensure that ninety-seven percent of Oregon's residents will have access to some form of basic health insurance if and when OBHSA becomes fully effective.¹⁷⁰

E. The Current Status of OBHSA

Oregon cannot fully implement the OBHSA rationing scheme until the State receives waivers of federal law.¹⁷¹ The federal Medicaid statute states that the purpose of granting such waivers is to allow states to experiment with more efficient and effective ways of allocating public assistance funds and to encourage a decreasing dependency on the fed-

653.745 Sec. 16 (Supp. 1990). Thus, if this goal is met by the October 1 deadline, then there will be no mandatory employer-sponsored insurance coverage. Nevertheless, to date only 11,000 employees have received the requisite coverage, and Oregon officials predict that the mandatory coverage provision will become effective. *Oregon, State Seeks Waivers*, BNA Daily Rep. for Executives C-11 (Dec. 3, 1991) (cited in note 94).

164. Or. Rev. Stat. § 653.705(4) (1987) (providing that employees must work an average of 17.5 hours per week to qualify for mandated employer-sponsored insurance); Id. § 653.745 Sec. 7(1) (Supp. 1990) (stating that employers will be taxed if employees are not provided with insurance coverage).

165. Or. Rev. Stat. § 653.745 Sec. 7(1) (Supp. 1990). Legislative programs that require employers either to provide health insurance to their employees or to pay additional taxes that will allow the government to provide the same coverage frequently are referred to as "pay or play" programs.

166. Klevit, et al, 151 Arch. Intern. Med. at 912 (cited in note 104).

167. Eddy, 266 JAMA at 2440 (cited in note 11).

168. Id.

169. Or. Rev. Stat. § 653.705(4) (1987).

170. Eddy, 266 JAMA at 2440.

171. See id.

eral government.¹⁷² If at any time, however, a waiver operates in a manner contrary to Medicaid policy, the waiver can be revoked.¹⁷³ Either the Federal Health Care Finance Administration (HCFA) or Congress can grant the required waivers.¹⁷⁴ Oregon has applied to the HCFA for the waivers and, as yet, still is waiting for a reply.¹⁷⁵ The State has requested a five-year waiver for a demonstration project that would begin in July 1992.¹⁷⁶ HCFA officials have expressed concern about OBHSA's revenue neutrality and about the extent to which services to current Medicaid recipients would be reduced under the proposed rationing scheme.¹⁷⁷ Nevertheless, HCFA has stated that Oregon likely will receive the necessary waivers.¹⁷⁸ If the waivers are obtained, the rationing program will begin in July 1992.¹⁷⁹ If HCFA denies the waivers, Senate Bills 534 and 935, of course, can still go forward, but, in all likelihood, they would not incorporate the rationing scheme.

IV. EVALUATION OF OBHSA

The debate over the proper means of distributing this country's health care resources and benefits has continued for decades. Currently, more groups than ever before are calling for reform of the system in the United States.¹⁸⁰ Yet, there is still no consensus, or even near-consensus, on how to increase access to and the cost-efficiency of health care in the United States.¹⁸¹ At the 1991 summer meeting of the National Governors' Association, however, governors sitting on the Health Care Task Force expressed their skepticism that a federal solution to the health care crisis is likely.¹⁸² The participants released an alternate plan that called for solutions on the state level.¹⁸³ Since the possibility of any

172. 42 U.S.C. § 1315(b)(1) (1988).

173. *Id.* § 1315(b)(3)(B).

174. *Oregon, State Seeks Waivers*, BNA Daily Rep. for Executives C-11 (Dec. 3, 1991) (cited in note 94).

175. *Id.*

176. *Id.*

177. Eddy, 266 JAMA at 2440 (cited in note 11). Revenue neutrality would mean that the overall cost of the program to the federal government would be no more than that of the current program. For a discussion of the anticipated costs of the OBHSA rationing scheme, see note 236.

178. *Id.* *Oregon, State Seeks Waivers*, BNA Daily Rep. for Executives C-11 (Dec. 3, 1991).

179. *Id.* Dr. Kitzhaber, President of the Oregon Senate, predicts that the waiver will be granted because he believes the inequities of the current system are indefensible. Egan, N.Y. Times at 18 (June 9, 1991) (cited in note 20).

180. Eckholm, N.Y. Times A1 (May 2, 1991) (cited in note 76).

181. *Id.*

182. Robert Shogan, *Governors Urge New Approach to Health Care Reform*, L.A. Times A18 (Aug. 18, 1991). Even Arkansas governor and current Democratic presidential candidate Bill Clinton posited that a national solution to the health care crisis was unlikely in the near future.

183. *Id.*

quick federal solutions appears questionable, there is more reason than ever to allow states to go forward with innovative plans that attempt to resolve their own health problems.

Whether or not OBHSA receives the necessary federal waivers, Oregon's rationing proposal has helped to expand the focus of the health-care debate to include not only who is covered but also what is covered.¹⁸⁴ Thus far, eighteen states have developed proposals for health care reform using the Oregon project as a model,¹⁸⁵ and many experts predict that, sooner or later, the United States must ration health care explicitly.¹⁸⁶ OBHSA, which rations health care by differentiating among services instead of differentiating among people,¹⁸⁷ has been both praised and condemned by politicians and health care advocates.¹⁸⁸ Critics argue that the rationing scheme unjustly takes benefits from a politically powerless group who are in need of all health care services they currently receive.¹⁸⁹ Advocates argue that the plan will result in greater equity and efficiency because virtually all residents will have access to at least basic health care coverage.¹⁹⁰ While OBHSA will not solve all of the problems found in the current system, it well may be a more equitable and fair way to dispense limited health care services. The following sections evaluate various aspects of the Oregon proposal, comparing them to those of the current health care delivery system.

A. Governed Through Democratic Principles

As the current debate about whether and how to reform the health care system demonstrates, there may be no single right way to allocate this country's health care resources.¹⁹¹ If services must be rationed in some way, however, Oregon's system of fixed standards, democratically set, has several advantages. OBHSA's standards are open to public debate and subject to change based on experience and results.¹⁹² Because the level of funded services will be known publicly, Oregon officials anticipate that the plan will create a level of accountability not present in the current system.¹⁹³ The Oregon scheme also incorporates factors such as clinical successfulness and community values in the prioritiza-

184. Kitzhaber, *Health Progress* at 23 (Nov. 1990) (cited in note 18).

185. Colen, 23 *Health* at 84 (cited in note 20).

186. See note 71 and accompanying text.

187. Michael Specter, *Providing Health Care for the Poor*, *Wash. Post* A1 (July 1, 1991).

188. Eckholm, *N.Y. Times* A1 (May 2, 1991) (cited in note 76).

189. See Egan, *N.Y. Times* at 18 (June 9, 1991) (cited in note 20).

190. See Kitzhaber, *Health Progress* at 23-24 (Nov. 1990) (cited in note 18).

191. Hadorn, 265 *JAMA* at 2225 (cited in note 132).

192. See Dougherty, *Hastings Center Report* at 1 (May-June 1991) (cited in note 86).

193. Kitzhaber, *Health Progress* at 22 (Nov. 1990) (cited in note 18).

tion process.¹⁹⁴ Thus, the state may be more likely to discontinue funding for services that prove medically ineffective and are no longer valued highly by the community.¹⁹⁵

The adoption of a democratically established prioritization process is not without risks, however. Perhaps the greatest risk of such a process is that socially disfavored conditions and diseases might be assigned lower levels of priority than diseases that are accepted more generally by society.¹⁹⁶ Yet, the Oregon plan does much to minimize the risk that social acceptability will dominate the prioritization process. OBHSA, for example, focuses on the change in a person's QWB—in other words, how much better or worse off a person is with or without treatment—rather than particular diseases.¹⁹⁷ During public surveys, Oregon residents also were asked to rank conditions, not diseases.¹⁹⁸ For example, residents rated the effect of general tiredness, weakness, or weight loss on QWB.¹⁹⁹ A variety of diseases could cause such general conditions, thus the conditions will not reveal necessarily the identity of the underlying diseases being prioritized. Because the Commission uses the possible improvement in a person's condition, not the individual's disease, to determine the QWB, there is less concern that QWB rankings will be discriminatory.²⁰⁰

Another protection against improper discrimination in OBHSA's prioritization process is the structure of the seventeen major categories created by the Commission.²⁰¹ Category One, for example, provides funding if the disease is acutely fatal, death can be prevented, and full recovery is possible.²⁰² All Category One diseases must be funded before any Category Two services receive funding.²⁰³ If a disease meets these requirements, but is not classified as a Category One service, the individual would have a constitutional right to challenge the classification under the due process clause.²⁰⁴

194. *Id.* at 23.

195. Dougherty, Hastings Center Report at 1 (May-June 1991).

196. Hadorn, Hastings Center Report at 12 (May-June 1991) (cited in note 131).

197. *Id.*

198. See notes 138-44 and accompanying text.

199. Hadorn, Hastings Center Report at 13 (May-June 1991). The survey also asked participants to rate the effect of personal experiences on QWB, including loss of consciousness such as seizure, fainting, or coma; burn over large areas of face, body, arms, or legs; sick or upset stomach, vomiting, or loose bowel movement, with or without fever, chills, or aching; and trouble talking, such as lisp, stuttering, hoarseness, or being unable to talk. *Id.*

200. *Id.* at 12.

201. See notes 132-48 and accompanying text.

202. Hadorn, Hastings Center Report at 10 (May-June 1991) (cited in note 131).

203. See notes 132-48 and accompanying text.

204. When the government uses statutory criteria to define which people are entitled to benefits, it creates a property interest in those benefits for those who meet the criteria. See *Perry v.*

Oregon officials also contend that OBHSA would allow Medicaid funding to be balanced better against the value of other social programs without denying basic health coverage to anyone. Assuming that a society provides basic health care, spending on other social programs, such as education and housing, may influence the overall level of the society's health as much or more than further direct spending on medical care.²⁰⁵ At present, health care, housing, and education are all in great need of funds.²⁰⁶ Oregon officials believe that if basic health care can be offered to all Oregon residents, then the benefit of increasing the services included in basic care could more easily be balanced against the benefits of spending on other social programs.²⁰⁷ In the current system, balancing Medicaid spending against other social programs is more difficult because the state must offer such a comprehensive package of benefits that all the poor cannot be covered by Medicaid.²⁰⁸ Therefore, the current system requires officials to balance the harm of not providing any Medicaid coverage to some of the poor against the benefit of spending on other social programs. In contrast, OBHSA provides all the poor with the same level of benefits. By doing so officials can balance the benefit of health care spending to all residents against the value of other social programs to the same residents, thus maximizing the beneficial use of limited funds.²⁰⁹

While OBHSA may allow Oregon to maximize societal benefits, it cannot do so without risk. One risk inherent in allowing state citizens a strong voice in rationing decisions is that underrepresented classes and minorities will not have a strong enough voice in the funding process. Currently, Oregon plans to fund ninety percent of the services on the priority list,²¹⁰ far beyond what many might consider basic health care. Nevertheless, legislators, in conjunction with a majority of the citizenry, could decide in the future that state Medicaid dollars would be spent better elsewhere.²¹¹ In such a case, all the poor might receive only a thin

Sindermann, 408 U.S. 593 (1972). If the classification of a medical condition affects relatively few people, then the individual would have the right to some type of hearing to determine whether that person's disease was classified improperly. See *id.*

205. Kitzhaber, *Health Progress* at 22 (Nov. 1990) (cited in note 18). In the United Kingdom, which has a system of national health care insurance, the most educated people on average live six years longer than the least educated people. Thus, education itself seems to be a factor in good health. *The Future of Health Care in America: Hearings Before the Subcommittee on Education and Health of the Joint Economic Committee*, pt. 2, 100th Cong., 2d Sess. 47 (1988).

206. Callahan, 5 *Issues in Law & Med.* at 362 (cited in note 73).

207. See Kitzhaber, *Health Progress* at 24 (Nov. 1990) (cited in note 18).

208. *Id.*

209. *Id.*

210. Sipes-Metzler, *Hastings Center Report* at 13 (Sept.-Oct. 1991) (cited in note 124).

211. Dougherty, *Health Progress* at 29-30 (Nov. 1990) (cited in note 80). The chance that benefits may be reduced to inadequate levels is a risk in both Oregon's proposed system and the

and inadequate package of benefits.²¹² The current system avoids this problem because all who qualify for Medicaid are guaranteed a minimum level of benefits.²¹³ Absent federal restrictions, however, the poor would receive no such guarantees.²¹⁴

If Oregon implements its rationing scheme in such a way that large numbers of the population are affected by the level of funding, then political pressure should limit the risk of any drastic reduction in the package of OBHSA benefits offered. Under OBHSA's current structure, the legislature's determination of benefits to be funded under Senate Bill 27 also defines the minimum level of health insurance employers must provide employees under Senate Bill 935,²¹⁵ thus creating a potential definition for what constitutes adequate private health insurance.²¹⁶ Because health care costs are expected to continue rising, some employers will provide only required insurance benefits—benefits equal to those funded under Medicaid.²¹⁷ In addition, Oregon officials plan to expand rationing to include state employees and the other currently excluded groups.²¹⁸ Finally, funding also may determine the level of insurance benefits available to state risk-pool participants.²¹⁹ Thus, Medicaid rationing decisions have the potential to affect not only Medicaid recipients, but also substantial numbers of public and private employees and state risk-pool participants. This situation should make drastic funding reductions unlikely because of their potential to harm a large percentage of the population. Nonetheless, until all aspects of OBHSA are in place, the risk remains that the rationing of Medicaid benefits may leave the poor with inadequate health care coverage and little political recourse.

Health care reform on the federal level appears to be coming slowly, if at all. Thus, the states should be allowed to develop more

current system. Under the Oregon plan, a reduction in funding would result in an across-the-board reduction of services to all the poor receiving benefits. Under the current system, funding limitations or reductions result in cutting specified participants out of the system. In Alabama, for example, recipients of Medicaid under the Aid to Families with Dependent Children program lose their benefits if their household income exceeds fourteen percent of the FPL. Eddy, 266 JAMA at 419 (cited in note 49). Additionally, if state Medicaid funding were to decrease, the state also would lose some Federal Medicaid funding, which generally is given to the states on a two to one matching basis. See notes 47-52 and accompanying text.

212. Id.

213. See notes 48-51 and accompanying text.

214. Id.

215. See notes 157-67 and accompanying text.

216. Fox and Leichter, Health Affairs at 12 (Summer 1991) (cited in note 4).

217. See id.

218. Specter, *Providing Health Care for the Poor*, Wash. Post A1 (July 1, 1991) (cited in note 187) (quoting Dr. Kitzhaber, President of the Oregon Senate).

219. Fox and Leichter, Health Affairs at 11 (Summer 1991) (cited in note 4).

immediate solutions to the health care problems faced by their citizens. Oregon officials believe that the OBHSA rationing plan addresses many of the weaknesses in the current delivery system, and that it will allow the state to balance better the needs of the health care system and those of other social programs. Because a majority of Oregon residents support the prioritization plan in its present incarnation,²²⁰ political pressure still should work to protect the interest of minorities who have less of a voice in government funding decisions. A majority of Oregon residents believe the plan will work and will work more equitably than the current system. Therefore, democratic principles weigh in favor of implementing the OBHSA rationing scheme.

B. *The Equities of Health Care Rationing*

Another criticism of OBHSA is that, despite the belief of a majority of Oregon citizens, the legislation is actually inequitable because it rations health care only among the poor, disproportionately discriminates against women and children,²²¹ and currently exempts the blind, elderly, and disabled from rationing.²²² Critics assert that Oregon has followed the path of least resistance by taking benefits from a politically powerless group—those now receiving full Medicaid benefits.²²³ OBHSA advocates counter that the legislation is more equitable than the current system because it treats those living below the FPL equally and will provide almost all Oregon residents with access to at least basic medical services.²²⁴ Whether Oregon's plan is indeed more equitable than the current health care delivery system largely depends on the priority assigned to the rationed services and the value assigned to certain groups of people.²²⁵

Currently about 320,000 Oregon residents live below the FPL.²²⁶ About 120,000 in this group receive no Medicaid benefits²²⁷ because they do not fall into one of the specifically defined categories that qual-

220. Egan, N.Y. Times at 18 (June 9, 1991) (cited in note 20). During its developmental stages, some business groups and advocates for the poor criticized OBHSA. Currently, however, a majority of Oregon residents, business groups, and advocates for the poor support the rationing scheme. This support is attributed to the belief of Oregon residents that OBHSA's distribution of health care benefits and resources is more equitable than the current system. *Id.* Dr. Kitzhaber says that "[i]f we can force the debate to one between the current system and what Oregon is offering, I'm convinced we will win, because the current system is indefensible." *Id.*

221. Dougherty, Hastings Center Report at 1 (May-June 1991) (cited in note 86).

222. Joseph P. Shapiro, *Real Health-Care Fixes*, U.S. News & World Rep. 35, 35 (Aug. 26, 1991).

223. See Egan, N.Y. Times at 18 (June 9, 1991).

224. Kitzhaber, *Health Progress* at 26-27 (Nov. 1990) (cited in note 18).

225. Eddy, 266 JAMA at 2441 (1991) (cited in note 11).

226. *Id.*

227. *Id.*

ify for Medicaid benefits.²²⁸ Thus, qualification for Medicaid benefits depends on factors other than poverty alone.²²⁹ The current Medicaid system, then, rations benefits based on the assumption that some individuals living below the FPL are more deserving of care than others in a similar financial position.²³⁰ Oregon officials assert that the criteria currently used to ration health care among the poor are inequitable and are not based on any consistent social policy or sound clinical criteria.²³¹

Assuming that, as OBHSA supporters assert, it is more equitable to provide all those living below the FPL with equal access to Medicaid benefits, then it may seem inequitable for OBHSA to exclude from rationing the aged, the blind, the disabled, the medically needy, and children in foster care programs.²³² Oregon officials, however, plan to expand the rationing scheme to include these groups in the future.²³³ Nonetheless, even without such an expansion, OBHSA, as it currently stands, is more equitable than the current system insofar as it treats all those living below the FPL as equally needy.

Under OBHSA, the 200,000 Oregon residents who currently receive Medicaid will lose the 122 lowest prioritized services, but 120,000 Oregon residents earning less than the FPL who currently do not receive Medicaid will gain the 587 highest ranked services.²³⁴ Consequently, current recipients living below the FPL will lose the coverage for 24,400,000 (200,000 x 122) low-ranking services, and 70,440,000 (120,000 x 587) additional high ranking services will become available to current non-recipients.²³⁵ Thus, under OBHSA, more services will be available

228. See notes 41-45 and accompanying text.

229. See *id.*

230. Under the current Medicaid system, two people may have identical incomes, but one may qualify for Medicaid and the other may not because the latter does not fit into a qualifying category. See *id.*

231. Jane Gross, *What Medical Care the Poor Can Have: Lists Are Drawn Up*, N.Y. Times A1 (March 27, 1989) (quoting Dr. Kitzhaber, President of the Oregon Senate). Oregon officials claim that the social policy underlying the current system is unsound because budgetary constraints force state governments to exclude some of the poor from Medicaid, while those in a similar financial position receive generous benefits. OBHSA solves this problem by extending equal benefits to all the poor. Oregon officials also assert that the current system is not based on sound clinical criteria because it fails to focus on preventive care and, in addition, fails to focus on providing the most beneficial treatments. For a full discussion of these issues, see Kitzhaber, *Health Progress* at 20 (Nov. 1990).

232. Fox and Leichter, *Health Affairs* at 9 (Summer 1991) (cited in note 4). See Or. Rev. Stat. § 414.720(5) (Supp. 1990). Of course, one might argue that the aged, the blind, the disabled, the medically needy, and children in foster care are in need of more protection than others living below the FPL because these groups have a decreased ability to fend for themselves.

233. Fox and Leichter, *Health Affairs* at 9 (Summer 1991). Dr. Kitzhaber maintains that the rationing scheme eventually will include the aged, disabled, and state employees. See also Specter, *Wash. Post* A1 (July 1, 1991) (cited in note 187).

234. Eddy, 266 *JAMA* at 2440 (cited in note 11).

235. *Id.*

to the poor as a whole than are available to them under the current system.²³⁶

Oregon's decision to treat all people living below the FPL equally seems equitable because all people earning less than the FPL generally cannot afford private health care.²³⁷ Nonetheless, even if all within this group should not be treated as financial equals, Oregon's system still may be more fair to the poor as a group than the current system. Ignoring the prioritization, if those living below the FPL and currently not receiving Medicaid are even thirty-five percent (24,400,000 out of 70,440,000) as worthy of benefits as those currently covered under Medicaid,²³⁸ then OBHSA provides a more equitable distribution of benefits than the current system.²³⁹ The additional coverage extended to the 330,000 Oregon residents whose income exceeds the FPL, but who are currently uninsured due to financial hardship or uninsurability, adds further to the equity of the Oregon plan.²⁴⁰

Some OBHSA critics generally accept that some form of rationing is necessary, but argue that the Oregon rationing plan is inequitable because it creates a two-tiered system of health benefits—a more generous package of benefits for those who can afford private insurance and a

236. See *id.* The cost of OBHSA and the increased number of services that the plan will provide is borne by several groups. At current funding levels, over the first five-year period OBHSA will cost Oregon tax-payers an additional \$95 million and will cost the federal government an additional \$109.6 million in matching funds. Overall, this represents a 3.4% increase in Medicaid spending. The reason the estimated additional cost of Medicaid to the state and federal government is such a small amount is that much of the additional cost will be offset by the anticipated increase in employer-sponsored insurance programs and risk-pool programs. During the initial five years after implementation, the increase in the number of people receiving employer-sponsored coverage rather than Medicaid benefits will save the program \$108.9 million. Redefining the basic package of benefits is expected to save the program \$169.2 million. Implementation of aggressive managed care is expected to save \$224.8 million. Finally, employer mandates, when implemented, are expected to save \$33.7 million. Most of the cost to the state and federal governments will come in the first three years of operation because all uninsured people earning less than the FPL will be receiving Medicaid benefits and the employer mandates will not have kicked in. After the employer mandates kick in, the cost to the state and federal governments will decrease drastically. An actuarial model predicts that after seven years the cost of maintaining OBHSA will be less than the current Medicaid program. The reason for this reduction is that many costs will be borne by Oregon employers, employees, and consumers. *Id.* at 2440-41. A potential drawback of this shifting of health care costs to the private sector is that employers' expenses will increase and make it harder for businesses to survive.

237. One study found that families earning up to two times above the FPL have little or no disposable income to spend on health insurance. Hearing: The Changing Face of Health Care at 7 (cited in note 34).

238. In the Author's opinion, all the poor are equally worthy of Medicaid benefits. The current system, however, differentiates among the poor and prioritizes the treatment of some classes of people over others. See notes 41-45 and accompanying text.

239. Eddy, 266 JAMA at 2441 (cited in note 11).

240. *Id.*

rationed package of benefits for the poor.²⁴¹ These critics believe that OBHSA would be more equitable if it rationed services among all Oregon residents and not just the poor.²⁴² If these critics are consistent in their position that all people should have equal access to health care, however, they also must object to the current system under which sixteen percent of Oregon citizens have no private or public health insurance while eighty-four percent of the population does.²⁴³ In addition, they also must concede that OBHSA would deliver more benefits to a greater number of the poor and, thus, is at least more equitable than the current system.²⁴⁴ Moreover, virtually all health care delivery systems provide more than one tier of health care benefits.²⁴⁵ In countries that have national health insurance, for example, the wealthier citizens continue to buy private insurance and receive more comprehensive medical services than those provided by national insurance programs.²⁴⁶

There are yet other reasons that OBHSA is more equitable than the current system. First, under the current system tax deductions are given to those who pay for their health care.²⁴⁷ These tax deductions effectively subsidize those who purchase health care.²⁴⁸ The uninsured poor and near-poor, however, receive no deductions because they cannot afford to purchase health care.²⁴⁹ The tax laws, then, award health care subsidies to all but those who need them most—the poor.²⁵⁰ In addition, uninsured working Americans pay an estimated \$84 billion in taxes each year to subsidize medical care deductions, primarily for middle and upper class Americans.²⁵¹ Oregon officials believe OBHSA corrects the inequities of current tax laws by providing equal benefits to all the poor and by mandating employer-provided insurance coverage for the majority of working residents.²⁵²

Another reason OBHSA is more equitable than the current system is that access to basic health services often functions as a precondition to obtaining other opportunities.²⁵³ Lack of basic medical services often

241. Shapiro, *U.S. News & World Rep.* at 35 (Aug. 26, 1991) (cited in note 222).

242. See *id.*

243. *Oregon, State Seeks Waivers*, *BNA Daily Rep. for Executives C-11* (Dec. 3, 1991) (cited in note 94).

244. Colen, 23 *Health* at 84 (cited in note 20).

245. *Id.*

246. See *id.*

247. 26 U.S.C. §§ 104-106, 213 (1988).

248. Dougherty, *Hastings Center Report* at 2 (May-June 1991) (cited in note 86).

249. *Id.*

250. *Id.*

251. Castro, *Time* at 42 (Nov. 25, 1991) (cited in note 1).

252. See Kitzhaber, *Health Progress* at 27 (Nov. 1990) (cited in note 18).

253. See Colen, 23 *Health* at 33 (cited in note 20) (quoting Thomas Murray, Ph.D., director of the Center for Biomedical Ethics at Case Western Reserve University). Dr. Murray argues that

results in poor health and, thus, can hamper job placement and job performance.²⁵⁴ In addition, if poor health prevents an individual from working, then that person may be unable to purchase needed medical services and other necessities.²⁵⁵ Without medical services and other necessities of life, the person may not recover fully or return to work.²⁵⁶ Thus, for some, the effects of inadequate health care can produce a cycle of illness, unemployment, and poverty—a difficult cycle to escape.²⁵⁷ For this reason, some have called the current health care system a form of Social Darwinism.²⁵⁸ Providing all persons with access to basic health services may help reduce the differential opportunities that can result from the current system.²⁵⁹

Finally, some OBHSA advocates believe that Oregon's system of universal coverage is more equitable than the current health care delivery system because it will reduce cost-shifting.²⁶⁰ Under the current system, many people who visit emergency rooms have no insurance.²⁶¹ Under federal law, hospitals must at least stabilize the condition of uninsured patients before they are discharged or transferred.²⁶² Because many of the uninsured cannot pay their medical bills, hospitals pass these costs on to paying patients. These inflated costs, in turn, result in higher insurance premiums.²⁶³ Under OBHSA, hospitals should suffer fewer bad debts and should have less need for cost-shifting.²⁶⁴ OBHSA will eliminate some cost-shifting because all Oregon residents who enter the hospital will have some form of health care coverage for most ailments. In addition, those who currently are uninsured will receive basic health care coverage, including preventive care. Presumably, the increase in preventive care will decrease the number of emergency room visits made by those who currently are uninsured and, thus, further reduce cost-shifting. A reduction in cost-shifting should result in patients being charged only for the cost of their own medical expenses.²⁶⁵ Thus,

if all are to have the right to life, liberty, and the pursuit of happiness, then all must have access to basic health care services. *Id.*

254. *Id.*

255. *Id.*

256. *Id.*

257. *Id.*

258. Cohn, *Wash. Post Z10* (July 31, 1990) (cited in note 58) (citing Princeton economist Uwe Reinhardt).

259. Dougherty, *Hastings Center Report* at 4 (May-June 1991) (cited in note 86).

260. See Terry Tang, *Rx For Health Care*, *Seattle Times* A13 (Aug. 18, 1991).

261. *Id.*

262. 42 U.S.C. § 1395dd (1991).

263. Tang, *Seattle Times* A13 (Aug. 18, 1991) (cited in note 260).

264. See *id.* As long as a large number of Americans are uninsured, employers' health care costs will remain artificially high. *Id.*

265. *Id.*

OBHSA could facilitate the elimination of the hidden tax that cost-shifting has introduced into the current system.²⁶⁶ The total net cost of health care also may be less because virtually all people should have access to preventive care.

C. Focus on Preventive Care

One frequent criticism of the current system is its tendency to focus on acute care rather than preventive care.²⁶⁷ In contrast, OBHSA is designed to focus on preventive care. The overwhelming consensus among the Oregon residents who attended the public meetings that preceded OBHSA's adoption was that preventive care should take priority over most costly life-saving treatments.²⁶⁸ Preventive care can reduce net health care costs because possible ailments may be diagnosed before they become serious and more expensive to treat.²⁶⁹ For example, Oregon officials estimate that every dollar spent on prenatal care will save two to eleven dollars in net medical expenses because proper prenatal care expenditures reduce the number of premature babies who require expensive treatments.²⁷⁰ Expenditures on prenatal care also can prevent a lifetime of suffering from the possible side effects of premature birth.²⁷¹ Breast cancer provides another example of how preventive care can reduce costs. One out of nine American women will be diagnosed as having breast cancer.²⁷² Under the current system, government and private health insurers often will not pay the seventy-five dollar charge for a screening mammogram.²⁷³ Almost ironically, however, government and private insurers will pay the high cost of treating the advanced breast cancer that often results from late detection.²⁷⁴ The OBHSA prioritization list classifies mammograms and prenatal care as "essential" services and funds both.²⁷⁵ If OBHSA goes into effect, the legislation also will force employers to provide preventive care coverage because employers must provide at least the same level of services as those funded by the state Medicaid program.²⁷⁶

Oregon officials also argue that the current Medicaid system spends

266. See *id.*

267. See Pamela Warrick, *Is It Worth the Cost?*, L.A. Times E1 (Aug. 5, 1991).

268. Timothy Egan, *New Health Test: The Oregon Plan*, N.Y. Times 31 (May 6, 1990). Oregon residents who attended the cottage meetings also favored quality of life over length of life. *Id.*

269. See Allen, 115 Arch. Pathol. Lab. Med. at 438 (cited in note 59).

270. *Id.*

271. *Id.*

272. Tom Harkin, *Another Pound of Cure*, 266 JAMA 1692, 1692 (1991).

273. *Id.*

274. *Id.*

275. See Dougherty, *Hastings Center Report* at 10 (May-June 1991) (cited in note 87).

276. See notes 157-67 and accompanying text.

too much money on expensive, high-technology treatments in lieu of preventive care.²⁷⁷ Thirty percent of all Medicaid dollars are spent on patients in their last year of life,²⁷⁸ while basic and preventive care is denied to thousands of others.²⁷⁹ Under OBHSA, if death is inevitable and medical care will not improve the patient's QWB, the state will provide only comfort care.²⁸⁰ For example, an AIDS sufferer will receive aggressive treatment for the disease during the early stages of illness, but in the terminal stage will receive only comfort care.²⁸¹ Premature babies, born at less than twenty-three weeks of gestation and weighing less than five hundred grams (1.1 lbs.) will no longer qualify for Medicaid benefits.²⁸² To some, denying such benefits to a person that is close to death may seem cruel; however, Oregon officials believe that redistributing such funding to preventive care will result in the greatest good for the greatest number of people.²⁸³ Thus, they believe OBHSA will lead to a more stable and effective package of medical services.²⁸⁴ Nonetheless, to truly maximize health care benefits Oregon may need to refine its prioritization methods.

D. Specificity

Some OBHSA critics assert that Oregon's prioritization process requires greater specificity.²⁸⁵ These critics suggest that the proposed rankings are too general and fail to distinguish among relevant differences in patients who will receive different degrees of benefit from a given treatment.²⁸⁶ For example, medical and surgical therapy for treatable breast cancer is ranked as one treatment.²⁸⁷ The plan, however, fails to define "treatable breast cancer." Oregon officials contend that, as time passes, ranking methods will become more sophisticated and that OBHSA's present shortcomings are typical of a first generation

277. See Allen, 115 Arch. Pathol. Lab. Med. at 438 (cited in note 59).

278. Cohn, Wash. Post Z10 (July 31, 1990) (cited in note 58). Doctors refer to some terminal cases as \$100,000 funerals because the patient will die with or without the expensive treatments. *Id.*

279. Eddy, 266 JAMA at 418-19 (cited in note 49).

280. If the diagnosis is imminent death, comfort care is classified as service 188 and funded. Sipes-Metzler, Hastings Center Report at 13 (Sept.-Oct. 1991) (cited in note 124). Treatments that will not improve QWB, however, fall to the bottom of the priority list. Hadorn, Hastings Center Report at 10 (May-June 1991) (cited in note 131).

281. Castro, Time at 37 (Nov. 25, 1991) (cited in note 1).

282. *Id.*

283. Hadorn, Hastings Center Report at 11 (May-June 1991) (cited in note 131).

284. Dougherty, Hastings Center Report at 1 (May-June 1991) (cited in note 86).

285. Hadorn, 265 JAMA at 2222, 2224 (cited in note 132).

286. *Id.*

287. *Id.* at 2223.

product.²⁸⁸ Some experts assert that, even as it now stands, Oregon's prioritization system is remarkably farsighted and sophisticated, particularly considering that the Commission had only two years to develop the priority list.²⁸⁹ Even with OBHSA's weaknesses, Oregon officials and the majority of Oregon residents contend that the inadequacies of the current health care system are far too critical to wait for the development of a perfect prioritization process.²⁹⁰ Nevertheless, Oregon should continue its efforts to increase the plan's specificity in order to maximize the equity and efficiency of Oregon's health care delivery system.

E. Waste

Perhaps the biggest drawback of the OBHSA rationing scheme is that it fails to address adequately the problem of waste, a hallmark of the American health care delivery system.²⁹¹ Three of the most significant areas of waste found in the current system are unnecessary treatment, excess administrative costs, and fraud. Elimination of some of this waste would result in enormous savings and, in turn, would reduce significantly the cost of health care to Americans.

The United States currently spends \$733 billion per year on health care.²⁹² Some experts estimate that twenty percent of all medical procedures and treatments are unnecessary.²⁹³ The cost of unnecessary procedures may amount to as much as \$198 billion per year,²⁹⁴ and the United States' Medicaid bill could be cut by up to thirty percent if inefficient and unnecessary procedures were discontinued.²⁹⁵ The savings

288. Id. at 2224.

289. Id.

290. One Oregon doctor observed that, although the Oregon plan has problems, it is certainly better than the system currently in place.

I'd like to see the poor get everything the rich get. But it is time to deal with reality. My patients cannot get lumps biopsied or gallbladders removed. I am tired of trying to convince women to save for three years to get a mammogram. I see kids every day with horrible dental disease that will deform their jaws. This program would give these people a basic chance. It's got plenty of flaws, but . . . isn't it better than what we have now?

Specter, Wash. Post A1 (July 1, 1991) (cited in note 187). One of the OBHSA founders, Dr. Kitzhaber, observed that "[t]he current Medicaid program will give a kid five liver transplants and let his mom die from preventable breast cancer." Id.

291. Dougherty, *Health Progress* at 29 (Nov. 1990) (cited in note 80).

292. Castro, *Time* at 34 (Nov. 25, 1991) (cited in note 1).

293. Id. at 40. Other studies estimate that unnecessary procedures constitute 25% to 33% percent of all medical expenditures. Sherry Jacobson, *Health Care May Be Overbroad*, *The Tennessean* 2A (Oct. 24, 1991).

294. Castro, *Time* at 40 (Nov. 25, 1991) (cited in note 1).

295. Hearings: *Health Care for the Uninsured*, Pt. 2, at 239 (cited in note 24) (citing Eugene Robin of Stanford University). The American Medical Association estimates that \$21 billion is spent each year on unnecessary procedures so that doctors can protect themselves from lawsuits.

generated by the elimination of superfluous care could be great enough to ensure that all Americans receive all necessary, effective medical treatments.²⁹⁶

Numerous factors contribute to the increasing amount of unnecessary care. According to some commentators, one of the contributing factors is an increased need for doctors to practice defensive medicine.²⁹⁷ Another factor contributing to unnecessary care are the kickbacks that many health care providers receive for referring patients to certain suppliers, pharmacies, or laboratories.²⁹⁸ Kickbacks function as an incentive for health care providers to prescribe tests, treatments, or medication that may not be necessary.²⁹⁹ In addition, some doctors have proprietary interests in laboratories and medical equipment, thus giving them an added incentive to prescribe unnecessary procedures. Referring patients to these facilities results in more profit for the doctor.

OBHSA does make some attempt to address the problem of unnecessary procedures. For example, Oregon has passed legislation protecting health care providers who provide services through OBHSA from criminal prosecution, civil liability, or professional disciplinary action for failing to provide services not funded under OBHSA.³⁰⁰ Nevertheless, Oregon could go further in tort reform by capping punitive damage awards, a measure that presumably would reduce malpractice liability premiums and, thus, reduce the costs that doctors must pass on to patients.

Another way in which OBHSA may help to reduce the performance of unnecessary procedures is by assessing the medical effectiveness of treatments, looking at either the outcomes or the public desirability of the service.³⁰¹ Oregon's prioritization process should help reduce the waste in the current system simply because some ineffective, and thus wasteful, procedures receive very low priority and may not be funded.³⁰² Nonetheless, under the current OBHSA proposal, Oregon would fund ninety percent of the services on the priority list, and the legislation seems to provide no mechanisms or disincentives to prevent doctors

Castro, *Time* at 40 (Nov. 25, 1991) (cited in note 1).

296. David C. Hadorn, *The Health Care Resource Allocation Debate; Defining Our Terms*, 266 *JAMA* 3328, 3329-30 (1991).

297. Castro, *Time* at 40-41 (Nov. 25, 1991).

298. Gordon Witkin, Dorian Friedman, and Montika Guttman, *Health Care Fraud*, U.S. News & World Rep. 34, 41 (Feb. 24, 1992).

299. *Id.*

300. Or. Rev. Stat. § 414.735 (1989).

301. Dougherty, *Hastings Center Report* at 1 (May-June 1991) (cited in note 86).

302. Hadorn, 265 *JAMA* at 2224 (cited in note 132). Some experts argue that Medicaid recipients actually may receive an improved quality of care under the rationing scheme because the excessively rich package of often inappropriate, and even harmful, treatments they now receive will not be available. *Id.*

from performing unnecessary government or privately funded services. Furthermore, OBHSA makes no attempt to limit reimbursements for referrals to laboratories in which the referring physician has a proprietary interest.

High administrative costs are another form of waste found in the current system. Lowering administrative costs could save the United States billions of health care dollars each year. One study estimates that administrative costs currently consume 6.7 percent of total health care expenditures in the United States, and consume 34.5 percent of the health insurance premiums paid to private insurers.³⁰³ Oregon ranks fiftieth out of the fifty states in bureaucratic Medicaid spending.³⁰⁴ By contrast, in Canada, which employs a system of universal health care, only 1.4 percent of the funds spent on health care are used to pay administrative costs.³⁰⁵ One of the reasons administrative costs are so high in the United States is that there are more than fifteen hundred private health-insurance programs, each with its own set of complex forms and regulations.³⁰⁶ Canada's administrative costs are much lower because it employs a single-payer insurance system in which the government is the payer.³⁰⁷

A third type of waste found in the current system is fraud. Current estimates suggest that the cost of reimbursement for fraud may be as much as seventy-five billion dollars per year.³⁰⁸ In a survey of Aetna Life & Casualty customers, for example, four out of ten consumers said their doctors had cheated on insurance companies.³⁰⁹ One reason so much money is lost through fraud is that few resources are used effec-

303. *Health Care Resource Book* at 105 (cited in note 23).

304. White, *Health Policy* at 12 (Dec. 1990) (cited in note 102).

305. *Health Care Resource Book* at 105 (cited in note 23). One Harvard study found that twenty-four cents of every dollar spent on health care in the United States went to pay for administrative costs, compared to eleven cents of every dollar in the Canadian system. One commentator suggests that if the United States' health care system could reduce its administrative costs to a level equalling that of Canada, the system would save over \$100 billion, enough to provide health insurance to all the uninsured. Spencer Rich, *Health Care Paperwork Called Waste*, *Wash. Post A1* (May 2, 1991).

306. Castro, *Time* at 42 (Nov. 25, 1991) (cited in note 1).

307. Rich, *Wash. Post A1* (May 2, 1991) (cited in note 305). The increased administrative costs in the United States' plural-payer system, for example, are partially responsible for a broken leg costing sixty-seven percent more to treat in the United States than in Canada. Hearing: *The Changing Face of Health Care* at 8 (cited in note 34). One way administrative costs might be reduced drastically would be through the adoption of a federal, single-payer system in the United States. Oregon officials support a federal solution to the health care problem. Kitzhaber, *Health Progress* at 27 (Nov. 1990) (cited in note 18).

308. Castro, *Time* at 38 (Nov. 25, 1991) (cited in note 1).

309. *Id.* This figure is enormous compared to the estimated five billion in criminal fraud lost in the savings and loan scandal. Witkin, Friedman, and Guttman, *U.S. News & World Rep.* at 34 (Feb. 24, 1992) (cited in note 298).

tively to detect it. Under the current system of health care reimbursement, doctors and hospitals operate primarily on an honor system.³¹⁰ Yet, only about half of insurance companies have organized antifraud programs.³¹¹ Many insurance companies are content to pass along the costs associated with fraud to their customers in the form of higher premiums.³¹² HCFA, which runs the Medicare program, also is criticized often for ineffective detection of fraud.³¹³ In their defense, HCFA officials point out that the cost of Medicare claims rose from \$217 million in 1981 to \$600 million in 1991 and, during the same period, HCFA's staff was cut from 4,972 to 4,027.³¹⁴ One result of these staffing cuts, coupled with the increased workload, is evidenced in a General Accounting Office study which found that over half of the telephone calls of Medicare beneficiaries that complained of possible fraud were not properly referred for investigation.³¹⁵ This figure is particularly startling when one considers that such calls are one of HCFA's primary methods of detecting fraud.³¹⁶ Additionally, there are too few investigators to handle properly the cases that are referred for investigation.³¹⁷

While Oregon cannot change federal practices, it could reduce fraud in state programs by allocating more resources for the detection, investigation, and prosecution of fraudulent claims. The State also could enact legislation that subjects doctors who participate in fraudulent activities to severe penalties. Such a measure would help reduce fraud by forcing doctors, whose authorization often is required before insurance companies and the government will pay for medical testing or the use of certain medical equipment, to scrutinize ordered procedures more carefully.³¹⁸ Currently, many doctors will sign forms authorizing the use of equipment or testing without closely reviewing them. Because doctors do not want to take the time to understand the paperwork, they simply assume that a patient would not have ordered the procedure if it was not needed. Other doctors are pressured into signing authorizations by patients who threaten to find another doctor if they do not.³¹⁹ Increasing the funding to current antifraud programs and enacting stiffer antifraud legislation would help to reduce a signifi-

310. Castro, *Time* at 38 (Nov. 25, 1991) (cited in note 1).

311. Witkin, Friedman, and Guttman, *U.S. News & World Rep.* at 42 (Feb. 24, 1992) (cited in note 298).

312. *Id.*

313. *Id.*

314. *Id.* at 42-43.

315. *Id.* at 42.

316. *Id.*

317. *Id.* at 43.

318. *Id.* at 38.

319. *Id.* at 37.

cant amount of wast presently found in the health care delivery system.

Of the \$733 billion Americans spend each year on health care,³²⁰ estimates indicate that \$198 billion are wasted on unnecessary procedures,³²¹ \$75 billion are lost through fraud,³²² and over \$100 billion could be saved by reducing administrative costs.³²³ If these ill-spent funds were redirected, many more Americans could have access to the high level of care some people now enjoy. Oregon has taken some steps to reduce waste through tort reform and the prioritization of services. Nevertheless, the State could do more to control spiraling health care costs. Possible reforms include capping punitive damages awards, enacting harsher penalties for doctors that participate in Medicaid and insurance fraud, eliminating kickbacks, and increasing funding for the investigation and prosecution of fraudulent practices. Oregon might also consider adopting a single-payer system or another means of lowering administrative costs.

V. CONCLUSION

The health care delivery system in the United States has become far too expensive to maintain equitably. Americans spend more of their GNP on health care than any other industrialized nation, yet America ranks poorly in the level of health of its citizens. One of the reasons that the quality of Americans' health is comparatively lower than other Western countries is that millions of Americans do not have access to health care services while all other industrialized nations, except South Africa, provide some form of universal health care to their citizens. Oregon's attempt to provide some form of universal health care to its residents, while at the same time attempting to control rapidly rising health care costs, is an innovative step and one that should be encouraged.

OBHSA rations health care in a more equitable manner than the rationing in the current system. The equities of OBHSA are most evident in its philosophy that all the poor are entitled to at least basic health care services. This approach seeks to correct the inequities in the current Medicaid system, which effectively bars the access of certain groups of poor people to basic health care services no matter how small their incomes. OBHSA is also superior to the current system in that it incorporates public participation and community values. This provides all Oregon residents with the most effective and desirable medical ser-

320. Castro, *Time* at 34 (Nov. 25, 1991) (cited in note 1).

321. *Id.* at 40.

322. *Id.* at 38.

323. See Rich, *Wash. Post A1* (May 2, 1991) (cited in note 305).

vices because the system takes into account the geographic needs and community values of state citizens. In the current system, little effort is made to differentiate among services based on community values and medical effectiveness.

Despite its many strong points, however, OBHSA still can make improvements that address other deficiencies in the current health care delivery system. The legislation, for example, fails to implement measures that adequately address the waste found in the current system.

While additional improvements in the health care delivery system are needed, the effects of Oregon's pioneering effort are widespread. Eighteen states now have developed preliminary health care reform proposals using the Oregon project as a model.³²⁴ Thus, although it has yet to be implemented, OBHSA already is playing a significant role in the future of health care delivery in this country. Experts predict that, sooner or later, our health care delivery system will have no choice but to ration health care services explicitly.³²⁵ OBHSA provides a model or equitable health care reform worthy of consideration, but to maximize the benefits of the health care delivery system, future legislation must address more comprehensively the problem of waste.

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324. Colen, 23 Health at 84 (cited in note 20).

325. See note 73.

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