

Report from the Field

**The Oregon Health Plan and the Political Paradox of Rationing:
What Advocates and Critics Have Claimed and What Oregon Did**

Lawrence Jacobs
University of Minnesota

Theodore Marmor
Yale University

Jonathan Oberlander
University of North Carolina---Chapel Hill

Journal of Health Politics, Policy and Law

Vol 24, No. 1

February, 1999*

Our analysis is based predominantly on field research in Oregon, including interviews with government officials and other participants in Oregon's health policy community. Unless otherwise indicated, all uncited quotes are from interviews with OHP administrators, consumer advocates, and elected officials; the interviews were conducted in June 1996 and May 1997 in Salem, Oregon. We want to thank all our interviewees for their cooperation, especially Bob DiPrete of the Oregon Health Plan staff. We gratefully acknowledge the financial support of the Harvard Innovations in Government Project, the research assistance of Eric Ostermeier and Laura Sutton, the helpful suggestions of one reviewer, and the splendid cooperation of Mark Peterson, the journal's editor. Kieke Okma and Victoria Bilski were especially helpful and skillful in the final editing of this article and have our warmest thanks.

Abstract The article proceeds in three sections. First, we very briefly review the original proposals and ensuing (and misleading) debate over rationing in Oregon. Next, we explore how the politics of rationing unfolded in Oregon from the enactment of OHP to its implementation. Finally, we consider the character of Oregon's innovation and the broader lessons that it holds for reform efforts elsewhere.

The Oregon Health Plan (OHP) has been widely heralded as an important innovation in medical care policy. Oregon's pioneering model of prioritizing funding for health care through systematically ranking services has drawn an extraordinary amount of national and international attention. Indeed, the Oregon story has seemed so compelling and by now is so familiar that it has attained what Rudolf Klein termed "nearly mythical status" in the health policy community (Klein, Day, and Redmayne 1996: 108).

Oregon's claim to policy fame is its apparent willingness to confront head-on the hard choices and unavoidable trade-offs raised by the inflationary and technological pressures of modern medicine. From the late 1980s on, the state sought through unusual means to expand access to health insurance for uninsured Oregonians. The price for expanded coverage was to be paid by rationing medical care services provided to Oregon's low-income Medicaid population. The rationing of services ostensibly rested on an elaborate technical analysis, one that merged cost-benefit analysis and medical outcomes research with public participation in policy making decisions. A Health Services Commission was organized to compile clinical information from physicians, treatment cost and benefit data, and community values from the public. This commission reduced over 10,000 services to a prioritized list that initially ranked 709 condition

and treatment pairs. The legislature's decision on how much to fund Medicaid was presented as "drawing a line" in this list, financing only those services above the line. All of this part of the story is set out accurately in Howard Leichter's companion essay in this issue.

The Oregon approach---budget control through explicit rationing of services---was indisputably innovative. It represented a striking contrast both to the well-established practice of implicitly rationing medical care in the United States by income and insurance coverage, and to the somewhat less visible resource allocation decisions made by health policy makers and professionals in other countries.

From the beginning, as Leichter observes, OHP ignited substantial controversy. What appeared as brave innovation to some analysts was viewed by others as a dangerous and morally dubious experiment. Positions on the Oregon plan---whether favorable or critical---were formed early on, during the heated debate over its enactment in the late 1980s. And those positions still largely define contemporary understandings of rationing in Oregon.

That is quite unfortunate because the operation and results of OHP have in crucial respects very little to do with the original proposals, or with the debate over its enactment. The worst fears of Oregon's critics and the tough choices promised by its advocates both failed to materialize. In this article, we contrast the expectations and perceptions with the realities of medical care policy making in Oregon. Our purpose is not to elaborate on the technical features of OHP, but to reevaluate its status as a health policy innovation and to analyze its overlooked political dynamics.

The Oregon plan does indeed represent a significant innovation in American health

policy, but the nature of its innovation, we contend, has been widely misinterpreted.¹ In particular we emphasize three critical developments: the failure of OHP's rationing promise to produce substantial cost savings, Oregon's considerable expansion of health insurance, and the growing political support within the state. Ironically, the Oregon plan, which began under a cloud of controversy and predictions of its imminent demise, proved far more politically durable than health reform efforts by other states that were heralded as promising alternative routes to change.

The article proceeds in three sections. First, we very briefly review the original proposals and ensuing (and misleading) debate over rationing in Oregon. Next, we explore how the politics of rationing unfolded in Oregon from the enactment of OHP to its implementation. Finally, we consider the character of Oregon's innovation and the broader lessons it holds for reform efforts elsewhere.

The Oregon Surprise

During the 1980s, Medicaid spending increased dramatically and the program consumed a growing share of state budgets. In response, many states lowered eligibility standards for Medicaid to an income level well below the federal poverty line (FPL) and cut coverage for optional enrollee categories such as the medically needy. By the end of the decade, the health insurance program for poor Americans covered only 42 percent of the poor; in order to qualify for Medicaid, AFDC recipients typically needed to live on incomes that were only 50 percent of

¹ On this point and several others we are in full agreement with Leichter's characterization of OHP ---the original proposals, the way institutional and cultural factors supported efforts to expand coverage to uninsured Oregonians, and the very limited degree of explicit rationing of health care. But we diverge in our assessment of the final results of the rationing process, and on the analysis of the political strategy policy making processes that shaped

the FPL (OTA 1992: 76--77). In addition, those who were not “categorically eligible,” such as low-income adults without children, were excluded from Medicaid in most states.

Oregon's reformers promised an alternative to the practice of denying coverage to the insufficiently poor. At a time when most states were ratcheting down income eligibility for medical assistance, Oregon proposed to extend Medicaid coverage to all persons living below the poverty line, regardless of traditional eligibility categories. Indeed, Oregon's longer-term goal was universal coverage; the expansion of Medicaid was to be followed by an employer mandate to cover all of Oregon's workers and their families.

However, it was the state's proposed financing mechanism for Medicaid expansion that drew the most attention. Put simply, Oregon said it intended to pay for enlarged Medicaid enrollment by covering fewer services: "A basic set of health benefits more limited than those currently offered by Medicaid" (OMAP 1991: ES3). Services would be explicitly prioritized according to their medical benefit and contribution to the population's overall health status. The state legislature could not respond to funding shortfalls, as it had done in the past---and as was common practice in other states---by cutting eligibility for Medicaid. Instead, they would have to reduce program coverage of services according to guidelines established in the prioritization process. In other words, expanded access to health insurance for the poor was to be purchased by rationing their medical care. Advocates understandably preferred the less incendiary language of “prioritization” and “resource allocation.”

The aim of the "prioritization" process was to allocate Medicaid-covered funds in a more sensible, systematic, and utilitarian manner – benefiting the greatest number of recipients possible within limited resources – In the eyes of the plan's advocates, rationing meant not

simply limiting services, but rationalizing medical care priorities.

OHP's case for denying coverage to low-ranked services for Medicaid recipients touched off a firestorm of protest. Critics assailed the plan as unfair for singling out the poor and especially women and children for rationing. Fears that the state was unjustly singling out the poor for rationing were fueled by reports that low-income Oregonians were underrepresented among attendees at community meetings to discuss the priorities of the OHP (OTA 1992: 76-77).

Critics maintained that the OHP's promise to ration care was not only unfair, but unnecessary. Eliminating administrative waste, squeezing drug companies and providers, and spending more represented, they claimed, proven alternatives. Brookings Institution economist Joshua Wiener argued, for instance, that it was "troubling to ration medically effective procedures before we have truly exhausted other routes to cost containment" (Wiener 1992: 110). Finally, the methodology of Oregon's rationing plan drew fire. The attempt to conflate thousands of complex diagnoses and treatment scenarios into 709 homogenous categories appeared to defy human and organizational ability---and common sense. Even proponents of the inevitability of rationing, such as Henry Aaron, contended that the OHP was problematic (Aaron 1992: 110). Oregon's approach of covering all services above and no services below the line regardless of an individual patient's medical condition or treatment prognosis meant that "patients who stood to benefit greatly were denied care, while others, who benefited slightly, received it" (Wiener 1992:

110).² In the eyes of outside critics, OHP confirmed the worst dangers of policy analysis. Moral and professional judgment would be replaced by the detached logic of cost-benefit analysis and a flawed methodology (Brown 1991a; Garland, Levit, and DiPrete 1991; Fox and Leichter 1993; Rosenbaum 1992).

Depending on one's perspective, this initial debate still defines either the serious limitations or the courageous virtue of the OHP. Largely missed in the decade since controversy first enveloped the Oregon plan is how the plan has actually operated. The reality is that developments during the implementation of OHP were nearly opposite of those feared by critics and yet were less than what was hoped for by advocates.

The Myths and Reality of the Oregon Health Plan

Critics and defenders of the OHP from outside Oregon would both be surprised---as we were---by four developments during its implementation. These developments reveal a persistent gap between understandings of OHP by critics and the realities of OHP's operation.

The Rationing That Never Was

OHP did not generate substantial savings---as its initial rhetoric promised---by rationing Medicaid services. Setting priorities and drawing a "line" were never implemented as a formulaic mechanism, as Leichter also notes. Some savings were realized by limiting services

2 Here as elsewhere we do not deal with the validity of specific criticisms of OHP's conception of rationing or its methodology for doing so. But one should note that its moral posture did in fact seem undermined by the restriction of rationing to the poor. And one should note as well that its method was indeed flawed in quite obvious ways. For example, if a procedure was hugely helpful in just 5 percent of cases and had *on average* a lower ratio of benefits to costs than the procedure one line higher on the list, that gave no reasonable grounds for funding the latter but not the former. Critics rightly ridiculed the proposal on such grounds, but we cannot separate our own recognition of this problem from those cited by others.

and using managed care. But the legislature financed the expansion of Medicaid enrollment and subsidies to those above the poverty line largely through general revenues and the imposition of a tobacco tax. In 1993, the initial expansion of Medicaid coverage was funded primarily through a 17 percent increase in state general funds, and a ten-cent cigarette tax (OMAP 1997). OHP saved additional funds by pushing more Medicaid recipients into managed care plans. By 1997, 87 percent of all Medicaid recipients were in managed care plans as compared with 33 percent before enactment of the OHP (OMAP 1997). Administrators estimate that the increased reliance on managed care accounts for 6 percent of savings off the total costs of the program (OMAP 1997).

In striking contrast to their initial claim that prioritization would finance Medicaid expansion, OHP administrators estimate that the list saved the state only 2 percent on total costs for the program over its first five years of operation (OMAP 1997: ES3). This failure to cut costs through prioritization resulted from the rules imposed by the federal government and HCFA, as well as the political dynamics within the state, which we discuss later in the article. During the budget crisis in 1996, for instance, HCFA pared back the state's attempt to reduce the number of covered benefits, though it did fully approve Oregon's reduction the previous year.

Far from representing a radical new step toward systematic rationing of medical care, the OHP has been funded the old-fashioned and familiar way: by raising revenues and contracting with managed care plans. Oregon, no doubt, was well positioned to use these familiar approaches because of its growing economy and its comparatively low level of expenditures on Medicaid. For example, prior to OHP's enactment, Oregon ranked forty-sixth among all states in spending on Medicaid as a proportion of the state budget.

Not only did rationing fail to produce significant reductions in services, but the process of drawing up the "list" actually generated a more generous package of benefits than what Medicaid or even the private sector had offered prior to OHP's implementation. Mental health services, for instance, which government and private insurers have resisted covering, are not only included but are subject to no limitations on the duration of care. HIV carriers---an especially expensive, vulnerable, and stigmatized set of patients---have found that legislators are unwilling to cut off their coverage, which extends far beyond basic services (Conviser, Retondo, and Loveless 1994, 1995). Despite the fears of national critics, then, the rationing did not prove to be a significant cost containment device. Indeed, the list has functioned much more as a mechanism for defining a benefits package than as a strict rationing instrument.

In a further departure from the paradigm of strict rationing, doctors, hospitals, and private insurance companies delivering health services to OHP beneficiaries have not consistently "rationed" care, as anticipated in the original presentation of the Oregon reform. Doctors and hospitals regularly provide (and insurers pay for) services "below the line" that they consider appropriate or medically necessary. One major health plan contracting with the state found that 5 percent of its total costs for OHP were actually "below the line." Below-the-line treatment is in fact inevitable. Many OHP patients are diagnosed not with one condition on the list, but with co-morbidities that are difficult to treat separately. In addition, all diagnostic services are above the line and are often required to diagnose conditions not covered by the list. The point is that OHP's "list" has not been strictly enforced by medical providers---nor is it possible to do so.

OHP's limited rationing and external misunderstandings of that are vividly illustrated by the case of organ transplantation. OHP caught national attention when the media focused in 1987

on the death of a seven-year-old boy with leukemia who had been denied a bone marrow transplant, the case of Coby Howard. The Howard case seemed to confirm fears that rationing in Oregon would literally kill patients who were denied high-cost, low-benefit services. Indeed, some transplants are understandable targets for rationing because they may require high costs for a few patients and deliver uncertain benefits. In fact, the main proponent of OHP---John Kitzhaber---targeted cuts in transplant coverage during the initial debate as a means to generate the savings to expand access. Oregon, he argued, should "save as many people as we can, because we can't save them all" (Fox and Leichter 1991: 15).

The rhetoric about rationing transplants during the debate over the enactment of the Oregon plan, however, stands in stark contrast to the program's reality. Coverage of transplants actually became more generous under OHP than under the previous Oregon Medicaid system or under many commercial plans. In part, the expanded coverage resulted from new federal guidelines in the 1988 catastrophic health insurance legislation that required states to cover transplants for children. Yet OHP exceeds the new federal requirements. The state voluntarily expanded coverage of transplants for a number of conditions, including bone marrow, heart, and lung transplants, from children (as mandated by the federal government) to include adults. Moreover, in contrast to the initial rhetoric, the state's internal process for ranking health services consistently ranked transplants high on the list.

Expanding Access

OHP's architects promised from the outset to expand access to Medicaid to all the poor as the payoff from rationing. On that count, OHP has more than delivered. Oregon's Medicaid program now covers all residents below the poverty line. The number of beneficiaries has increased by almost 50 percent, with a total of 320,000 new beneficiaries covered over the plan's first four years. At any given time, over 100,000 newly eligible Oregonians enroll in the expanded Medicaid program.

National and international attention has focused mostly on the techniques of OHP's Medicaid reform. Oregon's reformers, on the other hand, actually saw Medicaid expansion as but one step toward their broader goal of universal access. They proposed to reduce the number of uninsured by pursuing a "pincer movement" that combined expansion of Medicaid with a range of policies to help those above the poverty line. These policies included requiring an employer mandate, establishing insurance pools for high-risk groups, reforming insurance practices to allow portability and to prohibit exclusions based on preexisting conditions, and offering subsidies to individuals above the poverty line to purchase commercial health insurance. Reforms for those above the poverty line have produced significant but mixed results. The effort to implement an employer mandate and to move toward universal coverage were blocked by opposition from segments of the business community and by federal reluctance to grant exemption from the Employee Retirement Income Security Act (ERISA). On the other hand, Oregon did establish insurance pools for small businesses and high risk groups in addition to other expansionist measures that Leichter's article describes. By 1998, there was also no evidence that the expansion of Medicaid had reduced employer-based coverage, a concern raised

by critics early on. Work-related health insurance has remained essentially constant since 1994.

In 1996, 340,000 Oregon residents remained uninsured as a result of the failure of the employer mandate and other reform proposals (OHP 1997). Nonetheless, the number of uninsured Oregonians fell dramatically after OHP's implementation in 1994. In 1993, for instance, 17 percent lacked health insurance; the proportion dropped to 11 percent in 1996 (OHP 1997). In the same year, 1996, the national rate of noncoverage for health insurance was 15 percent. The percentage of Oregonian children without health insurance fell from 21 percent in 1990 to 8 percent in 1996. Nationally it rose from 14 percent to 15 percent during that period (OHP 1997).

From Technocratic Analysis to Administrative Reality

Oregon did not implement the purely scientific model of rationing health care it seemed to have promised, as Leichter's essay also recognizes. Resource allocation decisions remained largely adaptations to political and administrative realities. This is nicely illustrated by how the prioritization list was revised. Originally, planners envisioned that medical treatments would be moved up or down (or in the case of new procedures, onto) the list on the basis of a cost-benefit formula that yielded precise quantitative values for specific medical procedures. Scientific and objective methodologies, not political pressures or other considerations, were to determine the state's health spending priorities.

In practice this technocratic vision failed. Adjustments to the list have been determined not by scientific formula, but "by hand" on the basis of the judgments by the Health Services Commission. Federal requirements and opposition within Oregon over the rankings in the initial

list also compromised the original rationing methodology. In fact, an analysis by the Office of Technology Assessment (OTA) found that quantitative cost-benefit data, when compared to the considerable influence of subjective judgments by the Health Service Commissioners, had "surprisingly little effect" on the ordering of health services in the list (OTA 1992: 76--77). Once the list of medical treatments was altered to reflect political pressures and administrative judgments, it became much harder if not impossible to base future ranking of services on a formulaic basis.

Growing Political Support

Critics predicted that OHP would be swept away (or at least stalled) by a tidal wave of opposition within the state (Fox and Leichter 1993). After all, health reform efforts in Massachusetts, Vermont, Kentucky, Washington State, and elsewhere had collapsed. In the 1990s, the added burden of an untested rationing plan only seemed to increase the odds against the program's survival. Denying services, it was reasoned, could only spark anger and counter-mobilization by advocates of the poor and other vulnerable populations, as well as by providers resenting interference in their clinical judgments. Commentators warned that adopting OHP would touch off explosive media stories of patients going without care and predicted an unraveling of support by legislators.

However, the predictions of imminent doom turned out to be unfounded. OHP became what some observers inside the state term the "third rail" of state politics. By the time its founding legislation passed in 1989, OHP had ample support from the general public, the Oregon Medical Association, large business organizations, and the AFL-CIO. Members of the Oregon

house and senate gave the legislation nearly unanimously approval. Despite intense tobacco industry opposition, there was a 54-46 percent vote in favor of a 1994 referendum to impose a thirty-cent cigarette tax to finance OHP. Nor did the national Republican electoral tidal wave of 1994 undermine this popular support within Oregon.

Advocacy groups for the aged and disabled converted from skeptics to supporters. Their initial fears that OHP would systematically deny necessary medical care to vulnerable populations were calmed. They came to appreciate that OHP offered better benefits (especially for mental illness and disability) than many private insurers. The same advocates who once denounced OHP later supported expanding the program to encompass an even larger share of the state's population.

Years after authorizing the program, the legislature continued to reward OHP with new infusions of funds. For example, attempts to divert funds from the cigarette tax earmarked for the program in 1994 were defeated and the expansion of coverage has consistently won popular support and broad, bipartisan majorities in the legislature. Politicians from both parties frequently claim credit for the success of OHP. The program emerged relatively unscathed from a 1995 state budget crisis, which did result in the imposition of an assets test, a slight reduction in benefits, and a sliding-scale premium for those eligible for OHP as a result of the Medicaid demonstration project.

The Political Sources of Oregon's Surprise

National and international observers of OHP seem to have missed the story of its increased political support, its generous benefits, and the absence of systematic rationing

(Bodenheimer 1997).³ In part, they misjudged the Oregon case because of the initial rationing rhetoric used by OHP advocates and critics alike. Reformers now concede that they overemphasized the scientific grounding of rationing, repeatedly compromised what was presented as a scientific process, and oversold the extent to which services would be cut. These facts about OHP are only reluctantly (and quietly) acknowledged by program architects and have not reached outside observers whose impressions of the Oregon plan were seared by the original rationing rhetoric.

Yet the main reason the Oregon story has been misread, we believe, is that most analysts have overlooked or misunderstood the political dynamics of rationing in Oregon. As we have argued, rationing did not function as a key technical instrument for reallocating resources. The focus on the technical dimension of rationing has obscured its political value: namely, the extent to which the *rhetoric and process* of rationing (as opposed to its programmatic application) were crucial in mobilizing support for OHP.

Mobilizing Support in an Inhospitable Environment

The policy entrepreneurs who formulated and promoted OHP shared an unwavering devotion to expanding health insurance, a commitment that would sustain them through a decade or more of setbacks and harsh external criticism. Their motto was, "we keep coming back." Priority setting was never the ultimate objective of Oregon's reformers; it was celebrated as the pragmatic means to widen access to health insurance.

3. Like Leichter's current essay, Thomas Bodenheimer's is a notable exception. Neither, however, emphasized the difference between the rhetoric of rationing and the reality of expansion through other means. Leichter suggests that rationing was never meant to be strictly enforced (only a guideline). We disagree. Bodenheimer concentrated on what Oregon did, not on what it claimed or why that was important as a strategy for gaining political support.

Oregon's policy entrepreneurs possessed a talent for interacting with a multiplicity of players and for adjusting to changes in the political environment. John Kitzhaber, who led the reform effort and is currently governor, combined the political sensitivity of a veteran state legislator with both considerable rhetorical skills and a strong commitment to fighting for health reform. Others committed to reform (within and outside government) possessed similar blends of policy expertise and broad political experience in working with legislators and the executive branch in the health policy arena.

From the beginning, reformers drew on these political skills in tailoring policy proposals to what they saw as significant political challenges, though they did not appreciate just how daunting these would be. The political situation during the second half of the 1980s was hardly propitious for health reforms. Republicans hostile to government activism had controlled the White House for three consecutive terms. They had significant influence in Oregon's government ---controlling the governor's seat during 1981--1985 and cutting Democratic majorities in the state house to razor-thin margins.

Reformers designed their proposal on the premise that OHP needed bipartisan support to carry it through the natural vagaries of electoral politics. They also worried about state business interests. In the end, they were successful in winning the backing of Oregon's larger firms, or at least neutralizing them, while tempering the damage from the expected opposition of small business.

In short, the process of implementing OHP arose less from a technocratic vision than from a realistic assessment of the obvious political barriers to reform.

The Political Strategy of Oregon's Policy Entrepreneurs

Oregon's health leaders designed their strategy to mitigate the anticipated resistance of interest groups and to mobilize the state's potentially fractious political community behind a broad vision of health reform. They latched onto the language and procedures of policy science and rationing as the centerpiece of a strategy to build and "manage political momentum." Their strategy had four central components.

The first was to capitalize on Oregon's participatory culture. As noted earlier, the prioritized list was to be shaped by cost-benefit analysis and by public judgments about basic values solicited through professionally conducted town hall meetings and public opinion surveys. These meetings, and the activities of the Health Services Commission, attracted sustained media coverage and public attention.

While external critics mostly focused on the final priority list produced by the commission and its alleged shortcomings, Oregonians championed the process that produced it. Within the state, the process of discussing and prioritizing health services was viewed as a welcomed continuation of Oregon's participatory political culture. Land use planning and other policy issues in Oregon have long generated community involvement and corporatist bargaining through commissions, Oregon's traditional way of bringing to bring together government, interest groups, and citizens (Morone 1990).

The state's political culture thus offered reformers a political opportunity. Instead of experts designing OHP in a closed room, policy entrepreneurs chose a process that methodically sought out the attention of everyday Oregonians and sparked a very public debate across the state. Reformers solicited public participation as a part of a genuine effort to incorporate the

public's "substantive input on the relative importance of health care services." But they also recognized the political benefits of public participation.

Oregon's reformers and their external critics (Brown 1991b) appreciated the technical limitations of obtaining a representative measure of public preferences (Daniels 1992: 70). They hoped that soliciting some public discussion would induce what was termed a "public buy-in" into OHP and a sense that it was "their" process.

Reformers welcomed public debate partly to avert two damaging reactions to Oregon's efforts to help the uninsured. First, they worried about a welfare backlash. Proposals to expand benefits to poor residents ran the real risk of alienating Oregonians.⁴ The second fear of reformers was that apathy, disinterest, and rampant public distrust of government would undermine OHP. Pursuing reform without considerable public support, OHP advocates believed, would set the process up to fail.

Inviting debate in public forums was a carefully designed tactic, its advocates explained, to "break out of the alienation from government" and to avert a welfare backlash. Indeed, OHP administrators look back and credit public participation and the prioritization discussion for restoring some confidence in Oregon government and for creating a higher level of "trust" and a "reservoir of good will." As one administrator explained to us, "the public input process was effective at building . . . consensus . . . precisely because [policy makers] said that [the public's views were] being taken seriously and reflected in policy decisions."

Critics of the design of the public forums and their admittedly skewed representation

⁴ After all, it was precisely this fear of the politically damaging consequences of targeting the uninsured that prompted President Clinton to frame his health reform plan as offering "security for all."

miss their political significance.⁵ The primary value of public discussions was not in accurately representing or measuring citizen attitudes, but in building support for controversial reform by opening up the consultative process to them. By contrast, the Clinton administration's closed health reform process in 1993 invited mistrust and fueled damaging speculation about secret deals.

The second strategy was to transform the legislative politics that had previously dominated health policy. In particular, reformers organized the process of prioritization to change the "political paradigm" and make legislators politically accountable for explicit decisions to cut benefits. Although the stated purpose of rationing was to cut unnecessary services, the architects of OHP viewed it as largely a mechanism to "put legislators on the hook and force them to make the commitment to expanding access." They astutely calculated that explicit discussion of rationing particular services would be politically difficult. In fact, they believed it would pressure legislators to expand access without significantly reducing covered services.

Following the script of reformers, independent actuaries are first to estimate the cost of each treatment ranked by the Health Services Commission and to present the legislature with the list carrying a price tag assigned to each of the ranked services. Legislators then decide how much of the list Oregon can afford. "The idea," a longtime administrator explained, was to replace "quiet decisions" over cutting the number of people eligible for Medicaid with "very

5 Misunderstanding the political significance of these public meetings does not mean that critics were mistaken about their representatives. There is no question that civic participation in Oregon's great rationing debate was dominated numerically by those working in medical care. On the other hand, the views of Oregonians were solicited in a variety of ways, which meant within the state that the external critics seemed like nitpickers.

public decisions to change the benefit package according to very explicit guidelines.” John Kitzhaber put it bluntly: "Let legislators make explicit decisions so that they can be held accountable for them" (Mahar 1993: 24).

The result was to put legislators in the position of reaching decisions on funding that have direct and visible cause-and-effect consequences for reducing (or expanding) the number of services offered. Under OHP, withholding treatment for specific services would be easily traceable to a specific legislative decision not to provide funding. Legislators are therefore in the politically uncomfortable position of facing voters' scrutiny over very public, explicit decisions to deny payment for specific health services to program beneficiaries. Legislators in both political parties face the clear prospect that constituents may recoil at such cuts in actual coverage and punish them in the next election.

Paradoxically, then, the use of rationing rhetoric made the actual rationing of medical care for poor Oregonians *less* not more likely---just as reformers hoped.

The third strategy was to define their target population expansively to encompass a broad rather than restricted set of beneficiaries. National observers riveted their attention on Oregon's changes in Medicaid, but the state's reformers persistently presented their proposals within Oregon as encompassing a population much broader than Medicaid recipients. Their specific proposals for an employer mandate, insurance pools, and private insurance reforms were all aimed at dispelling the perception that health reform was a poor people's program providing "handouts" to a stigmatized target population.

In addition to supporting programs reaching beyond the poor, Oregon's reformers explicitly presented rationing as an effort to define the care of the entire population. Participants

in its design were warned against singling out the Medicaid population. "The concept of OHP," one longtime OHP administrator emphasized, rested on "making the prioritized benefit package the floor for all Oregonians' coverage, not just Medicaid."

Reformers also used the process of prioritization to transcend formal boundaries between government and private individuals and groups in order to organize continuous negotiations among doctors, hospitals, insurance companies, employers, and labor. This was the fourth strategic element. As one administrator explained, "[Rationing] provided a nexus for the discussions about how limited resources would be allocated" and kept the different stakeholders "directly engaged" for a protracted period.

Hospitals supported reform from the start as a means to reduce the financial drain of handling uncompensated care and inappropriate visits to the emergency room. More telling, though, was the conversion of physicians from initial skeptics to loyal supporters. According to administrators, doctors "didn't particularly take to the idea of public input about what is important in health and health care." They were persuaded of its political importance as a tactic to induce Oregonians' support in a period when the public was in no mood to defer to experts. Physicians had a second concern: the "absence of sound, scientific, longitudinal studies" on the costs and benefits of health services prevented the Health Services Commission from devising a list based on objective as opposed to subjective evaluations. But physicians working on the commission and reformers led by fellow physician Kitzhaber persuaded doctors that they would in fact continue to make "medical decisions every day based on their best clinical judgment." After the implementation of OHP, physicians indeed continued to exercise their judgment, providing services that were at times not covered by the list. Physician support for OHP was also

cultivated with the promise that Oregon would provide generous payments for covered services. That promise has held; Oregon's capitation payments for OHP enrollees are comparatively high (Bodenheimer 1997). After physicians' reservations were addressed, they rallied behind OHP's goal of expanding access to the uninsured and funding more of the cost of treating Medicaid patients.

Organizing ongoing bargaining over OHP's priorities was especially important in managing political relations with business representatives. Large and small business concerns, for example, were sharply divided over OHP reforms and the employer mandate. Small businesses were steadfast opponents; larger firms favored the mandate because it would compel small firms to contribute to their employees' health costs and thereby reduce the costs shifted to large employers. While large business initially backed an employer mandate, the election of a Republican state legislature in 1994, vociferous small business opposition, and the near certainty that the Gingrich-controlled Congress would not grant an exemption from ERISA weakened their support for the employer mandate. The result---as some reformers anticipated---was the excision of the employer mandate from OHP reforms in 1995. The prioritization process, though, kept big business "engaged" in the coalition that supported OHP as a whole even as some of OHP's components---like the employer mandate---became targets of vocal opposition and were dropped.

Conclusion

Intended and Unanticipated Consequences

The operational Oregon Health Plan bears little resemblance to the program envisioned

either by promoters or by critics during the national debate over its adoption. The political strategies of reformers were crucial in shaping the Oregon surprises. Reformers used the rhetoric and public discussion of rationing to mobilize citizen support, involve medical providers and other interest groups in the process, and establish a new mechanism for political accountability. Ultimately, this helped maintain a broad political coalition that has paradoxically made it harder for politicians to ration medical care and easier to raise funds for the state's poor.

Much of what has happened in Oregon, then, was intended but not well understood outside the state. Still, political strategy alone cannot explain the surprises in Oregon. Unanticipated developments and fortuitous conditions also played a critical role in the development of OHP.

Clearly, Oregon's reformers never fully controlled or anticipated their destiny. They were blindsided by unexpected political troubles---especially the protracted battle for a Medicaid waiver and the chorus of national criticism. Ironically, the same political strategies and processes crafted to produce consensus within the state produced controversy outside it. These largely unanticipated developments had important feedback effects on the formulation of OHP. For instance, the national outcry over the Howard case and the initial list intensified HCFA's scrutiny and constrained the state's ability to place services such as transplants lower on the list and to cut funding for other services. Similarly, federal opposition to the plan helped erode the scientific foundation of the prioritization process and guarantee that subsequent reordering of the list could not be done on a formulaic basis.

Oregon's health reformers also benefited from several favorable contingencies that raised the probability of success but could not have been predicted. The program was implemented

during a period when the state economy prospered, medical inflation moderated, and its most prominent sponsor was elected governor. Absent these favorable conditions, Oregon might have been forced to make harder choices about spending priorities and OHP might have confronted stronger pressures for strict rationing and even more hostile criticism.

Oregon's Innovation

The formal appeal of the Oregon plan was largely technocratic. The state promised to develop a rational, scientific instrument---the list---to define medical care priorities. The reputed technical power of this administrative instrument has drawn many visitors to Oregon eager to learn its precise formulas and possibly acquire an innovative rationing tool to negotiate the technological, political, and financial dilemmas of modern medicine. Yet, the technical power of this innovation has proven largely to be an illusion.

Systematic rationing simply has not arrived in Oregon. Based on the rather small and relatively insignificant set of medical services now excluded from OHP (as well as its generous benefit package), observers will be hard pressed to discover evidence in Oregon for the “tough decisions” reformers promised. Nor has OHP operated as an objective, scientific vessel of resource prioritization, as the process of updating the list “by hand” has vividly demonstrated. Reformers have, in fact, repeatedly compromised the much heralded scientific rigor of their rationing decisions in order to gain political support.

In short, the actual implementation of rationing in Oregon has failed to demonstrate the successful application of quantitative cost-benefit analysis to resource allocation in medicine. Instead, OHP's operation confirms the prediction of the OTA that Oregon's "outcome and cost-

effectiveness data . . . are inadequate for use as the building blocks of a ranking system for all services” (OTA 1992: 76--77).

The innovation in Oregon, then, is more political than technical. State reformers used the rhetoric of priorities to build a durable political coalition in favor of expanded access for the uninsured. Remarkably, Oregon used a method---rationing---thought to be dangerous to the uninsured in a successful effort to help them. The real innovation in Oregon, then, was developing a coherent political strategy to accomplish reform in an national environment hostile to social reform.

Oregon's experience offers some basis for reconsidering the traditional reticence of reformers to publicly discuss rationing. In Oregon, the rhetoric of rationing pulled into the open the decisions that privately occur every day and that deny services to uninsured or underinsured Americans. OHP's experience points to an unanticipated but possible political benefit of rationing rhetoric: it reconfigured debate toward openly acknowledging, as a society, what medical services Americans---even the politically eviscerated poor---should receive or go without. And it put politicians in the vulnerable position of pulling the plug on particular medical services. Paradoxically, a process ostensibly aimed at saying no might force the voters and politicians---as it did in Oregon---to recoil in horror and say yes.

Whether Oregon's innovation can or should be borrowed by others, however, remains in serious doubt. Explicit discussion of rationing has been avoided by others because it elicits substantial controversy and opposition, as it did with OHP. Public forums and deliberative democracy also present vexing ethical problems regarding how to protect the needs of patients who are small in number and politically and economically vulnerable.

In the end, what was widely regarded outside of Oregon as innovative---a scientific approach to confronting the hard choices raised by medical care's costliness---was not the significant innovation. Far from representing a radical new step toward systematic rationing of medical care, OHP was in fact funded the old-fashioned and familiar way: by raising revenues directly and negotiating sensible contracts with providers. Oregon no doubt was well positioned to use familiar approaches because of its growing economy, moderate medical inflation, and its comparatively low level of prior expenditures on Medicaid. But Oregon's political culture also provided a welcome environment for innovative rationing talk. There was widespread support for expanding access to health insurance, a tradition of citizen participation in policy making, and a somewhat less hostile posture towards the poor. Most dramatically, OHP had the sustained commitment of a political sponsor (Governor Kitzhaber) and a remarkably stable set of state officials who shared that commitment. Absent these conditions, OHP might well never have emerged in Oregon, let alone anywhere else.

This raises the question of what broader lessons are to be learned from the Oregon experience, especially from the gap between claim and reality. The most obvious lesson is that innovation is fundamentally a local matter, one of adapting ambitious hopes to local constraints and opportunities. OHP is not like a MRI machine, something transportable across borders. In that sense, the realities of Oregon's innovation are a reminder of the limits of interstate as well as international borrowing of reform instruments. The less obvious lesson is that strategic skill is as important as clever ideas in the actual reform of public policy. The Oregon reformers fashioned a broad strategy for expanding health insurance coverage. The fact that no other state (or nation) has followed its technical model is irrelevant to what its innovative experience suggests: namely,

that to innovate requires a combination of policy idea, political support, and administrative feasibility. That, not transplantation, is the lesson for and of comparative policy studies.

References

- Aaron, Henry J. 1992. The Oregon Experiment. In *Rationing America's Medical Care: The Oregon Plan and Beyond*, ed. Martin Strosberg, Joshua Wiener, and Robert Baker, with I. Alan Fein. Washington, DC: Brookings Institution.
- Bodenheimer, Thomas. 1997. The Oregon Health Plan---Lessons for the Nation. *New England Journal of Medicine* 337(9):651--655.
- Brown, Lawrence. 1991a. The National Politics of Oregon's Rationing Plan. *Health Affairs* 10(2):28--51.
- , 1991b. Letter: Settling the Score on Oregon. *Health Affairs* 10(4):310--312.
- Conviser, Richard, Margaret J. Retondo, and Mark O. Loveless. 1994. Predicting the Effect of the Oregon Health Plan on Medicaid Coverage for Outpatients with HIV. *American Journal of Public Health* 84(2):1994--1996.
- 1995. Universal Health Coverage, Rationing, and HIV Care: Lessons from the Oregon Health Plan Medicaid Reform. *AIDS and Public Policy Journal* 10(2):75--82.
- Daniels, Norman. 1992. Justice and Health Care Rationing: Lessons from Oregon. In *Rationing America's Medical Care: The Oregon Plan and Beyond*, ed. Martin Strosberg, Joshua Wiener, and Robert Baker, with I. Alan Fein. Washington, DC: Brookings Institution.
- Fox, Daniel, and Howard Leichter. 1991. Rationing Care in Oregon: The New Accountability. *Health Affairs* 10(2):7--27.
- , 1993. The Ups and Downs of Oregon's Rationing Plan. *Health Affairs* 12(2):66--70.

Garland, Michael, Harvey Levit, and Bob DiPrete. 1991. Letter: Policy Analysis or Polemic on Oregon's Rationing Plan? *Health Affairs* 10(4):307--311.

Klein, Rudolf, Patricia Day, and Sharon Redmayne. 1996. *Managing Scarcity*. Philadelphia: Open University Press.

Mahar, Maggie. 1993. Memo to Hillary: Here's How to Cure What Ails Our Health Care System. *Barron's*, 1 March, 8--11, 22--26.

Morone, James. 1990. *The Democratic Wish*. New York: Basic Books.

Office of Medical Assistance Programs (OMAP). 1991. The Oregon Medicaid Demonstration: Waiver Cost Estimate. Prepared for HCFA and submitted by the Office of Medical Assistance Programs. Salem: Oregon Department of Human Resources (15 April).

----- . 1997. Unpublished data provided to authors, July. Salem: Oregon Department of Human Resources, 15 April.

Office of Technology Assessment (OTA). 1992. Evaluation of the Oregon Medicaid Proposal. Washington, DC: GPO.

Oregon Health Plan. *The Uninsured in Oregon, 1997*. Salem: Office for Oregon Health Plan Research.

Rosenbaum, Sara. 1992. Poor Women, Poor Children, Poor Policy: The Oregon Medicaid Experiment. In *Rationing America's Medical Care: The Oregon Plan and Beyond*, ed. Martin Strosberg, Joshua Wiener, Robert Baker, with I. Alan Fein. Washington, DC: Brookings Institution.

Wiener, Joshua. 1992. Rationing in America: Overt and Covert. In *Rationing America's Medical Care: The Oregon Plan and Beyond*, ed. Martin Strosberg, Joshua Wiener, and Robert Baker,

with I. Alan Fein. Washington, DC: Brookings Institution