

Defining Basic Health Benefits: Lessons Learned From the Oregon Health Plan

John W. Saultz, MD

The Oregon Health Plan was instituted in 1994 with the goal of assuring basic health care for everyone in the state. The plan used an innovative public process to rank health services as its method of defining basic health care benefits. Due to its inability to constrain health care costs and an economic recession in the state, many of the plan's core elements are no longer operational. This essay outlines lessons learned from the Oregon Health plan's successes and failures and describes a new process of health reform that began in Oregon in 2007.

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As the quality, safety, and affordability of American health care remain suboptimal, it seems that everyone is talking about health care reform. For many people, this is largely a political debate that focuses on economic incentives and the growing cost of employer-funded health insurance. For others, it is a matter of public health and social justice. Talking about health reform can be a confusing proposition for many family physicians and for most people outside of health care. It is with this in mind that this essay begins with a discussion of history. If we are to avoid repeating the mistakes of the past, it is critical that we learn the lessons of how and why previous attempts at health reform have failed. Some authors are now examining the failed Clinton Health Plan of 1992 for such historical lessons.¹ I would like to focus on another health reform experiment that took place in my state that has come to be known as the Oregon Health Plan (OHP).

Oregon in 1988

The OHP began in the late 1980s after an agonizing public debate about the state's decision to stop providing organ transplant coverage to Medicaid patients. At that time, about 18% of Oregonians lacked health insurance, including 10% of children.^{2,3} Oregonians over age 65 were largely covered by the Medicare program. The income eligibility cut-off for Medicaid coverage was at 53% of the federal poverty level. Policy leaders were debating how we could justify paying for expensive transplants when so many people were not receiving basic health services, such as prenatal care. This directly led to the question of how to define "basic" health care.

As a result of this debate, a series of three laws were enacted in 1988 that were intended to fundamentally restructure how access to health care coverage in the state would work. The first of these laws would expand Medicaid eligibility to 100% of the federal poverty level. The second would require employers to provide coverage to all employees, and the third created a high-risk pool for Oregonians with uninsurable preexisting condi-

tions. The state then specified that this expanded coverage was only for a package of basic benefits that would be created and maintained by an explicit public process carried out by a new state agency called the Oregon Health Services Commission (HSC).

The HSC was to consist of 11 members, each appointed by the governor and approved by the state senate. Its task was to hold public hearings with the intent of creating an explicit ranking of all health care services from the most important to the least important. This ranking process was to be independent of the legislature. The state legislature would then determine how much money to spend on the Medicaid program, and an actuarial analysis would determine how far down on the prioritized list the funding process could go given the amount to be spent. The legislature could not change the rank order. So to fund a particular procedure or service, they would have to spend enough money to fund everything above it on the list. Employers would be required to provide their employees with at least as many services as the state provided to the Medicaid population, thereby covering

everyone in the state. Table 1 lists the explicit policy objectives and principles that were followed in creating the OHP.⁴

Implementation in 1994

Implementing the OHP required a waiver from the federal government because the scope of services to the traditional Medicaid population might be reduced by the new process. There were large political stakes in this request, because 1992 was a presidential election year, and one of the candidates was making health reform a major campaign issue. After numerous delays, the waiver was received, and the plan began on February 1, 1994. While awaiting the federal waiver, the HSC struggled to find a method by which to rank the services. The first attempt involved a complicated formula analyzing the cost-effectiveness of each service.⁵ This resulted in a ranked list that defied common sense when some simple office procedures ranked higher than procedures, like appendectomy, that were often life-saving. Eventually, the commission arrived at a process of sorting all services into 17 categories ranging from treatment of acute fatal conditions where treatment should result in full recovery (number 1) to treatments offering little or no improvement in the quality of life (category 17). Public debates were

conducted around the state during this process, and there was extensive national and international press coverage.

An important part of the OHP process involved the state contracting with managed care plans to actually implement the model once it was approved. At Oregon Health and Science University (OHSU), we were concerned about large numbers of patients being diverted from our clinical practices and teaching hospital. So we decided to partner with the local health department's nine safety net clinics to form a not-for-profit Medicaid HMO called Careoregon. At that time, I was the family medicine residency director at OHSU. I knew little about managed care but a fair amount about the safety net system. I agreed to become Careoregon's founding medical director to get the process started. I cannot overemphasize how idealistic and committed all of us were as we worked on this process. We all believed that meaningful health reform had taken place in our state and that we were conducting a nationally important health policy experiment.

Accomplishments of the OHP

The OHP was broadly successful in prioritizing health care services, and it immediately provided health coverage to more than 100,000 Oregonians who had not been in-

sured previously.⁴ I can personally recall having patients in my office cry from happiness because they were finally able to see a physician without worrying about the cost. The percentage of uninsured Oregonians dropped from 18% to 11%,² and emergency department use decreased by nearly 10%.⁶ The process received national recognition and was widely viewed as a model for statewide health care reform. Functioning as a medical director as well as practicing as a family physician allowed me to witness this process from both the macro and micro levels. It was an exciting and rewarding time.

Problems With the OHP

Even before the OHP was implemented, however, it had already broken faith with the most idealistic of us. The state never seriously attempted to get the necessary federal waiver to create the employer mandate portion of the program. Thus, from the start, the OHP became a Medicaid experiment rather than a serious attempt to achieve universal health care coverage. During the mid-1990s as the state's economy boomed, things moved along pretty well, but warning signs were occurring as early as 1996. The state resisted increasing the capitation rate to the managed care plans, even as the cost of care increased. We all assumed that managed care would bring cost controls to bear of the system, but cost containment failed and commercial reimbursement grew rapidly. This resulted in downward pressure on provider reimbursement from Medicaid while payment rates grew quickly for commercially insured patients. Thus, the payment difference between Medicaid and commercial reimbursement widened, and health systems and physician practices began restricting access to Medicaid patients. Reflecting a more conservative legislature, the state then instituted a process of income-adjusted premium charges to OHP

Table 1

Explicit Policy Objectives and Principles Followed in Creating the Oregon Health Plan (OHP)

OHP Policy Objectives

- The goal is health not health care
- Public process
- Meet budget constraints by cutting everyone's benefits, not by cutting people
- Fund clinically effective care
- Develop explicit health service priorities
- Maintain integrity of prioritization process

OHP Principles

- Explicitly ration service rather than implicitly ration people
- Utilize capitated managed care
- Rank services (diagnosis-treatment pairs) according to effectiveness by a politically independent process—the Oregon Health Services Commission

patients. This resulted in many of the healthiest of them dropping out of the plan so they could use the premium dollars for other things. This, of course, undermined the actuarial assumptions about per capita costs, and the Medicaid health plans began to lose money.

Among the most serious problems from my point of view was the passage of legislative term limits in the state. By 2000, few were left in state government who actually remembered the basic principles of the plan. Although our democratic governor, John Kitzhaber, was widely viewed as the champion of the plan, a Republican majority in both houses of the legislature focused increasingly on how to control the growing costs of the program.

The OHP Dies

The final blow to the OHP occurred when the state’s economy entered a recession in 2001. As one of only a few states without a sales tax, our income tax-based state revenue fell dramatically during the recession. A recent paper in *Health Affairs* explains the ultimate demise of the plan, so I will not belabor the point here.⁷ Suffice to say that the state Medicaid program now

consists of a two-tiered system with different benefits for standard and OHP-plus patients. This was done to keep as many people under coverage as possible, but it completely violates the uniform benefit standard that so many of us embraced at the plan’s creation. We are now back to 18% of Oregonians without health insurance and many more are underinsured. In fact, state government is now talking about starting over with a new plan for universal coverage that was passed by the 2007 state legislative session.

Lessons Learned

Table 2 lists seven important questions that must be addressed before successful health reform can take place. Everyone usually wants to talk about question number seven. Our experience in Oregon convinces me that we must start with questions number one and two. There is no way to seriously debate who should pay until we know a lot more than we currently do about what we plan to buy. So, in no particular order, here are some of the lessons I’ve learned from the entire lifecycle of health reform in Oregon.

First, the initial steps to take are to define health system goals and to tackle the question of defining basic benefits. The method of doing this must be a public process and cannot be created purely by policy wonks or government bureaucrats. Oregon discovered that a public process can work, at least in a small state like Oregon. It remains to be seen how this might work in a state with a much larger and more diverse population or a less progressive public policy community.

Second, it is important to keep in mind that health care reform is hard work and takes time. If you try to go too fast, you will make too many mistakes and public support will falter.

Third, do not underestimate the opposition. Health care spending

now constitutes more than 16% of the American economy.⁸ Lots of money is involved, and lots of people and organizations do not want change to happen.

Fourth, always remember that the devil is in the details. The best ideas in the world won’t help you if you cannot deliver a plan that ordinary people can understand.

I also think there are some important personal lessons in this experience. When I think back on those years, it now seems to me that we were quite naïve. We thought that getting the changes passed into law meant that we had won. It was such an exhilarating feeling, but all we had won was an initial battle. Health reform is a war of many battles, and we are still a long way from winning anything important and enduring. Now we are poised in Oregon for a second attempt. The mood is more reserved and cautious; we have been burned and our optimism is now flame tempered by experience. It remains to be seen whether we can create and sustain positive changes this time.

From Evolution to Revolution

I am a very different person than I was in 1994. I have a different kind of passion for the work of health reform, and I think I am fairly representative of my colleagues in this regard. In preparing this essay, I tried to think how best to explain this difference. I think the best way to do so is to differentiate between evolutionary and revolutionary thinking. For most of our professional lives, we have tried to improve things by evolution. This involves incremental change characterized by forming coalitions requiring compromise. We try to get a little better each day and we are trying to improve the systems in which we work gradually. Contrast this with revolutionary change that seeks not simply to improve the system but to replace it. I have reached a point of frustration and

Table 2

Questions to Address in a Health Care Reform Process

1. What are the primary goals of our health care system?
2. What basic level of benefits should we provide to everyone?
3. What mechanisms will we use to ensure quality and value?
4. What outcomes matter to us?
5. How will the system manage cost?
6. What is the proper balance between social insurance and free-market consumerism?
7. What portion of cost should be borne by government, business, and individuals?

pessimism that no longer allows me the luxury of any remaining faith in the current health care system.

Revolutionary change is much more risky. It is contentious and chaotic. There are winners and losers. The sides in this coming revolution will pit those trying to lower health care costs and improve access against those trying to increase profits without regard for affordability and accessibility. If I am right about this, then family medicine's tactics now must change dramatically. This sort of change has to start with undermining faith in the current system while working to create a clearly different, new way of delivering care.

Basic Health Care in Oregon: 2007

Within the past year, the HSC has worked on a new model to prioritize health care services based on the principle of spending our health dollars on things that improve population health. Table 3 lists the new categories that will be used in creating a new prioritized list of services. Each and every health care service will be placed into one of these nine categories.⁵ Notice that the first four categories on the new list address services that improve community health as well as benefiting the individual. Basic health benefits must give highest priority to those services central to population health, such as access to primary care and mental health services. Regardless of how the care is paid for, we must create incentives for people to use these services, not barriers to restrict them.

The 2007 legislative session in Oregon resulted in passage of a major health reform bill, known in Oregon as Senate Bill 329.⁹ This new law creates the Oregon Health Fund Board, which has been tasked to recommend a universal coverage plan for every Oregonian under age 65 to the next legislature. The law requires that everyone receive the OHC's new basic benefit pack-

age and that this care be delivered in primary care medical homes. Among the biggest controversies in this process was the decision to exclude Medicare patients. Many of us think that this is a major mistake. But we are moving forward with substantial support from the business and public health communities. If successful, the Oregon Health Fund should provide basic coverage to everyone in Oregon except those who remain in Medicare. The process has until January 2009 to recommend legislation that will establish such a universal coverage system. I am proud that family physicians are playing a major role in this process, as we did in the creation of the OHP. We are doing so with a renewed sense of urgency as more and more of the people in our state are being hurt by the system as it now is.

Conclusions

We have learned a lot from the OHP. There is now strong public support across the country for major change in American health care. We have to get it right this time, and we aren't likely to do this if we repeat the mistakes of the past. The public process of defining basic health benefits worked in Oregon and can be a roadmap for others to follow.

Table 3

2007 OHP Service Categories

1. Maternity and newborn care
 2. Primary and secondary prevention
 3. Chronic disease management
 4. Reproductive services (excludes maternity and infertility)
 5. Comfort care
 6. Fatal conditions
 7. Nonfatal conditions
 8. Self-limited conditions
 9. Inconsequential care
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But the OHP can also be a cautionary tale. Health reform will not succeed if it doesn't ensure the long-term affordability that is essential for care to be accessible for everyone. Table 4 lists some core elements of strategy for family physicians in an American health care revolution. It might help the process of change if we were to talk about these strategies in each of our state academies and residency programs. I suggest you argue about the list and add to it if you'd like. Disagree about it. Use it to clarify your own ideas, because I do not think the

Table 4

Strategies for Family Physicians in a Health Care Revolution

- Stop being in denial—this is not someone else's problem to solve.
 - Stop whining—we are really not the ones suffering in this crisis.
 - Health care is becoming unaffordable to too many people—we must reduce its cost.
 - Truly cost-effective care will require a fundamental change in our clinical method—we must partner with our patients to create this new clinical method.
 - Decreasing total health care costs will require increased spending on primary care—we need to insist on this.
 - A lot of money is being taken out of the health care system by people and organizations that add little value to it—we must speak out about this.
 - The financial crisis in health care is a symptom of underlying moral uncertainty about the mission of our health care system and the values of our society—we must incite public debate.
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health system will change if we simply stay in our offices and hope for the best.

I hope that our experiences in Oregon will help each of you in your own environments. Fixing health care access to improve the health of our population is worth devoting the rest of our careers to accomplishing. I wish I could tell you that it won't take that long, but I think it will.

Correspondence: Address correspondence to Dr Saultz, Oregon Health and Science University, Department of Family Medicine, 3181 S.W. Sam Jackson Park Road, Portland, OR 97239. 503-494-6602. Fax: 503-494-4496. saultz@ohsu.edu.

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