RATIONING REVISITED

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In 1993, the Department of Health and Human Services granted Oregon a Medicaid waiver that allowed Oregon to implement a health plan prioritizing payment for certain types of treatments. The federal government granted this waiver at about the same time the managed care revolution transformed the provision of healthcare in the United States. The health plan, implemented in 1994, has expanded healthcare coverage for uninsured individuals in Oregon.

In recent years, healthcare spending has increased at an astronomical rate, and more and more Americans have become unable to afford health insurance. In an effort to curtail this disturbing trend, managed care plans have implemented certain cost containment measures, such as requiring approval by a primary care provider or preauthorization from the plan's administrator before the insured can undergo certain procedures. Many Americans have reacted negatively to managed care because it limits their choices—otherwise known as rationing their healthcare. In this article, Dr. Rice examines the Oregon Health Plan and asks whether that plan represents the rationing of healthcare.

I. INCREASING HEALTHCARE EXPENDITURES

Fix Health Care Now[1]; *Healthcare 'Crisis' Grows for Middle Class*[2]: these headlines are examples of those that have appeared as healthcare spending rose at its fastest rate of increase in ten years, to 8.7% in 2001. Healthcare spending reached $1.4 trillion, accounting for 14.1% of Gross

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1. David Broader, *Fix Health Care Now*, WASH. POST, Jan. 6, 2002, at B7, *available at* 2002 WL 2519257. The Society of Actuaries created a task force to "develop a descriptive model that articulates the dynamics of the healthcare system." Soc'y of Actuaries, *Healthcare System in Crisis Task Force* 2002–2003, *at* http://www.soa.org/committees/hsctf.html (last visited Oct. 27, 2003). The National Coalition on Health Care issued a white paper describing the confluence of rising health insurance costs, the impact of growing unemployment, the effects of the economic downturn, and changes in coverage. *See* Joel E. Miller, *A Perfect Storm: The Confluence of Forces Affecting Health Care Coverage* 3–10 (2001), *at* http://www.nchc.org/materials/studies/A%20Perfect%20Storm.pdf (last visited Oct. 27, 2003).

2. Alexandra Marks, *Healthcare 'Crisis' Grows for Middle Class; Rising Jobless Rate Leads to More Uninsured, Prompting Congress and White House to Seek Ways to Widen Coverage*, CHRISTIAN SCI. MONITOR, Apr. 3, 2002, at 3, *available at* 2002 WL 6425087.

Domestic Product (GDP), which is the largest share ever recorded.[3] This amounts to more than $5,000 per person in the United States.[4]

The major reason for the increase in health spending was an increase in the use of medical goods and services purchased for an aging population.[5] The economic recession, which has been exacerbated by the terrorist attacks of September 11, 2001, also created a sharp increase in health spending. Although there was some increase in the price of healthcare, it was not nearly as large as the increase in quantity of services used. For example, doctors ordered more diagnostic tests; patients spent more days in hospitals; hospitals provided more outpatient services; and healthcare providers used a greater amount of technology.[6]

Spending on prescription drugs rose more rapidly than spending on any other healthcare category in 2001, up 15.7% from the prior year to $140.6 billion.[7] Expenditures on pharmaceuticals now exceed spending on nursing home care and home healthcare combined.[8] Greater use of services and higher prices have combined to drive spending on hospital care to more than $451 billion.[9] Medicare spending increased 7.8% to approximately $242 billion, whereas Medicaid expenditures grew 10.8% to $224.3 billion.[10] Payments for physician and other clinical services increased 8.6% to $313.6 billion.[11]

The consumption of resources for healthcare means that there are fewer resources available for other areas, such as education, infrastructure, or creating new manufacturing capacity. If the result of such spending reliably produced a healthier population, then one could make the argument that the spending was justified.[12] Unfortunately, the United States continues to rank well below other industrialized nations in the health status of its population, in spite of spending far more per capita than other countries.[13] While there are a number of explanations for this disparity, it does indicate that the United States is not receiving the expected return on its investment.

What can be done? Both the states and the federal government have attempted a number of approaches to reduce health expenditures. For example, the enactment of the Prospective Payment System for

3. Katharine Levit et al., *TRENDS: Trends in U.S. Health Care Spending, 2001,* HEALTH AFF., Jan.–Feb. 2003, at 154, 154.

4. *Id.* at 155.

5. *Id.* at 159–61.

6. *Id.* at 158–59.

7. *Id.* at 155–57.

8. *Id.* at 155.

9. *Id.* at 155, 158–59.

10. *Id.* at 161–62.

11. *Id.* at 155–56, 159.

12. *See* David E. Bloom & David Canning, *The Health and Wealth of Nations*, SCI., Feb. 18, 2000, at 1207, 1207–09.

13. Gerard Anderson & Peter Sotir Hussey, *Comparing Health System Performance in OECD Countries*, HEALTH AFF., May–June 2001, at 219, 227.

Medicare in 1983 was seen as a way of fairly allocating payment for services among providers—reducing the disparity between the cognitive specialties (*e.g.*, family medicine, internal medicine) and the procedural specialties (*e.g.*, surgery, orthopedics, cardiology).[14] It also grouped all diagnoses into 473 categories and established uniform payments for each.[15] If a hospital exceeded the reimbursement rate for a particular category, then that institution bore the cost overrun. More recently, Congress, alarmed at the rate of increase in Medicare spending, simply reduced the payments to hospitals, as well as to physicians, and forbade providers from recovering the difference from patients.[16]

States have also been hit hard by the growth in spending for Medicaid. States have attempted to limit such growth, either by reducing the array of covered benefits or by changing eligibility requirements so that fewer people qualify for coverage.[17]

In the private sector, the 1990s saw widespread use of managed care plans in an attempt to control healthcare spending. Two of the strategies employed by the private sector to control spending are the insistence on the use of a "gatekeeper" to approve referrals to specialty services and getting prior authorization from the insurer before elective hospitalization.[18] As we have seen, however, the public is displeased by this prior restraint.[19] The major reason for this failure is that managed care lacks political legitimacy.

> Managed care plans are private, often for-profit, entities trying to tell sick patients who want care and physicians who think the care is necessary and who profit from providing it that it is better for the cost of that care to flow to the managed care company's bottom line than to finance medical services.[20]

II. RATIONING

An economist would define rationing as the process of allocating goods when faced with scarcity.[21] In the context of healthcare, however, the term is frequently used—especially in a pejorative sense—to describe

14. James R. Bean, *The Historical Development and Interrelationships of Current Procedural Terminology and the Medicare Fee Schedule*, NEUROSURGERY FOCUS, Apr. 2000, at 1, 2; *see also* 42 U.S.C. § 1395ww(d), (g)–(h) (2000).

15. *See* 42 U.S.C. § 1395ww(d), (g)–(h).

16. Theodore R. Marmor & Gary J. McKissick, *Medicare's Future: Fact, Fiction and Folly*, 26 AM. J.L. & MED. 225, 239 (2000).

17. Jeffrey A. Buck & Mark S. Kamlet, *Problems with Expanding Medicaid for the Uninsured*, 18 J. HEALTH POL., POL'Y & L. 1, 12 (1993).

18. Matthew J. Binette, *Patients' Bill of Rights: Legislative Cure-All or Prescription for Disaster*, 81 N.C. L. REV. 653, 674–75 (2003).

19. *See id.* at 669.

20. Henry J. Aaron, *The Unsurprising Surprise of Renewed Health Care Cost Inflation*, HEALTH AFF.: WEB EXCLUSIVES, Jan. 23, 2002, *at* http://www.healthaffairs.org/WebExclusives/2101Aaron.pdf (last visited Oct. 28, 2003).

21. J. L. HANSON, A DICTIONARY OF ECONOMICS AND COMMERCE 402 (4th ed. 1974).

the distribution of services or goods based on cost.[22] It is also used to describe the limitation of services that are thought to be too expensive for society as a whole.[23] Still, others limit its use to decisions that are explicitly made to restrict access to a particular category of recipient.[24]

The public—and its political leaders, as well—appears to believe that rationing of healthcare does not currently exist and to propose it is anathema. Rationing *does*, in fact, occur, although it is virtually always implicit rather than explicit. Implicit rationing occurs by budget, price, queue, administrative barriers, insurance coverage, and subtle social factors. To deny that healthcare services are being rationed in the United States today is to ignore reality.

In *Pegram v. Herdrich*, Justice Souter, writing for a unanimous Court, said that "inducement to ration care goes to the very point of any HMO scheme."[25] The Court noted that for more than a quarter of a century, Congress had encouraged the formation of HMOs and hence endorsed "the profit incentive to ration care."[26]

Most clinicians do make choices about the allocation of services and often factor in the cost of a treatment, particularly when it is known that the patient is going to bear some of the cost. For example, a physician might prescribe a drug with a higher incidence of side effects rather than a drug with fewer side effects but a higher cost.[27] Likewise, health plans make decisions about the timing of imaging studies in order to reduce their costs.[28]

The difficulty with these ad hoc decisions is that they are not guided by any overarching policy, which means that they are applied unevenly and implicitly. This can and does result in litigation against providers and insurance companies, which is what happened in *Pegram*.[29]

22. Lawrence D. Brown, *The National Politics of Oregon's Rationing Plan*, HEALTH AFF., Summer 1991, at 28, 30.

23. *Id.*

24. *Id.*

25. 530 U.S. 211, 221 (2000).

26. *Id.* at 233.

27. Elizabeth L. Mitchell, *The Potential for Self-Interested Behavior by Pharmaceutical Manufacturers Through Vertical Integration with Pharmacy Benefit Managers: The Need for a New Regulatory Approach*, 54 FOOD & DRUG L.J. 151, 157 (1999).

28. *See Pegram*, 530 U.S. at 215; *cf.* Brian P. Battaglia, *The Shift Toward Managed Care and Emerging Liability Claims Arising from Utilization Management and Financial Incentive Arrangements Between Health Care Providers and Payers*, 19 U. ARK. LITTLE ROCK L. REV. 180–81 (1997); Bryce A. Jensen, Note, *From Tobacco to Health Care and Beyond—A Critique of Lawsuits Targeting Unpopular Industries*, 86 CORNELL L. REV. 1334, 1350 (2001).

29. 530 U.S. at 211.

III. EXPLICIT RATIONING: THE OREGON HEALTH PLAN

In 1993, the Federal Department of Health and Human Services granted Oregon a waiver for its Medicaid program.[30] This demonstration project was intended to accomplish four major goals: expand eligibility, prioritize healthcare benefits, eliminate cost shifting to the private sector, and enhance enrollment in managed care.[31]

The impetus for this plan was the case of a seven-year-old child who, in 1987, developed acute lymphocytic leukemia, for which the appropriate treatment was a bone marrow transplant.[32] Unfortunately for the child, the Oregon legislature had discontinued Medicaid coverage for organ transplantation.[33] In spite of public pleas by the child's family and other advocates, the state held fast to its position, and the child succumbed to his disease.[34]

Two years later, Dr. John Kitzhaber, an emergency room physician from Roseburg, Oregon and then-President of the Oregon State Senate, led the effort that resulted in the Oregon Health Plan (OHP).[35] One of OHP's key features was the creation of a standard benefit package that consisted of a prioritized list of diagnoses and treatments.[36] The legislature, moreover, was supposed to establish a funding level below which treatments would not be covered.[37] The legislature also created the Oregon Health Services Commission, whose principle charge was the creation of the prioritized list.[38]

During the three years that the Commission met, it sponsored community forums to solicit public input, and it worked tirelessly to educate the public about its deliberations and the choices the state and the taxpayers faced.[39] The Commission was composed of six healthcare providers, four consumer representatives, and one social worker.[40] It received broad input from organizations, such as the Oregon Medical Association, the Oregon Dental Association, the Mental Health Coalition

30. Scott D. Litman, Note, *Health Care Reform for the Twenty-First Century: The Need for a Federal and State Partnership*, 7 CORNELL J.L. & PUB. POL'Y 871, 887 (1998).

31. OFFICE FOR OR. HEALTH PLAN POLICY & RESEARCH, OR. DEP'T OF ADMIN. SERVS., ASSESSMENT OF THE OREGON HEALTH PLAN MEDICAID DEMONSTRATION 1 (1999), *available at* http://www.ohppr.state.or.us/docs/pdf/Medicaid%20Assessmentdemonstration.pdf (last visited Oct. 28, 2003).

32. Catherine Grace Vanchiere, Comment, *Stalled on the Road to Health Care Reform: An Analysis of the Initial Impediments to the Oregon Demonstration Project*, 10 J. CONTEMP. HEALTH L. & POL'Y 405, 408–09 (1993).

33. Brown, *supra* note 22, at 32.

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

of Oregon, and the Oregon Association of Hospitals and Health Systems.[41]

The Commission's efforts led to a categorization of health problems.[42] The Commission then ranked the categories according to twelve criteria, such as the patient's life expectancy, the likelihood that treatment would improve the quality of life, the number of people expected to benefit, and the cost effectiveness of the treatment.[43] The Commission ranked those treatments that could be expected to prevent death and were likely to lead to full recovery first; maternity care second; and treatments expected to prevent death but unlikely to lead to full recovery third.[44] The lowest ranked treatments were those that could be expected to result in minimal or no improvement in the patient's quality of life.[45] Within the categories, the Commission prioritized diagnosis and treatment pairs on the basis of the quality of well-being and known outcomes data.[46] The Commission also gave consideration to the perceived reasonableness of the rankings.[47]

After a prolonged negotiation with both the first Bush and Clinton Administrations, Oregon ultimately received its requested waiver in March 1993.[48] The state's system went into operation in February 1994.[49]

Does the Oregon Health Plan represent rationing? If one examines the list of prioritized services and concludes that Medicaid will not pay for conditions that fall below the approved line, then the answer could be yes. On the other hand, the plan has expanded the number of uninsured Oregonians now eligible for care under Medicaid. Seen in that light, the answer might be no.

A major criticism of the Oregon plan was that it was limited to the uninsured, those least likely to have political influence.[50] That was not the intention of its creator. Rather, Dr. Kitzhaber, who became Governor in 1995, intended to extend the plan to state employees, the other major recipient of state-sponsored healthcare coverage.[51] Existing labor contracts, however, thwarted Governor Kitzhaber's intentions.

41. *Cf.* OFFICE FOR OR. HEALTH PLAN POLICY & RESEARCH, OR. DEP'T OF ADMIN. SERVS., PRIORITIZATION OF HEALTH SERVICES: A REPORT TO THE GOVERNOR AND THE 70TH OREGON LEGISLATIVE ASSEMBLY vii (1999), *available at* http://www.ohppr.state.or.us/hsc/index_hsc.htm (last visited Oct. 28, 2003).

42. *See id.* at 17–19.

43. *See id.* at 19–20.

44. *See id*. at app. G-83 (Treatment Index).

45. *See id.*

46. *See id*. at 17–19.

47. *Cf. id.* at 19.

48. *Id.* at 5.

49. *Id.*

50. Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL., POL'Y & L. 161, 164 (1999).

51. Governor Kitzhaber explained to me his intentions in a personal communication some ten years ago.

Oregon's plan is distinguished from other approaches to limiting benefits by three major characteristics: it is explicit; it was developed in the full light of day; and there is political accountability for its funding level. None of those three characterize implicate rationing decisions. In fact, there has been widespread public support for the plan since it was passed in 1989.[52] This support came largely from the "rhetoric and process of rationing."[53] And shifting the debate from "which populations should be covered" to "which benefits should be covered" promotes justice and equity in the health care system.

52. Jacobs et al., *supra* note 50, at 169–71.
53. *Id*. at 171.