

Issue Brief: How the Oregon Health Plan Discriminates

The Oregon Health Plan (OHP) delivers Medicaid and EPSDT under a Section 1115 demonstration waiver ranking health care services in a prioritized list from most to least important. Only services over a certain line are funded regardless of individual determinations of medical necessity.

In 1992, Oregon submitted a waiver application relying on the quality-adjusted life year (QALY) to prioritize services for coverage that was denied by the U.S. Department of Health and Human Services as violating the Americans with Disabilities Act (ADA):

“Our principal concern is that Oregon’s plan in substantial part values the life of a person with a disability less than the life of a person without a disability. This premise is discriminatory and inconsistent with the Americans with Disabilities Act.” [New York Times, HHS Secretary Louis W. Sullivan, M.D.](#)

The waiver was later approved in 1993, after committing to changes for ADA compliance. Despite ADA concerns, Oregon has reverted to an approach for prioritizing health services for coverage that factors cost effectiveness and the quality-adjusted life year (QALY). Officially, Oregon excluded the survey-based QALY data that triggered denial of its initial waiver application in 1992. Yet, the voting members of Oregon’s Health Policy Commission have authority to override the results of non-QALY considerations, which they did in over 70% of the cases. The outcome for how care is valued and prioritized is the same:

“Because most objective measures representing health outcomes were not allowed, the subjective collective judgment of the Commissioners became more of a factor. As a result, many of the public values on health that had been expressed through the community meetings, the telephone survey, and in public testimony were reflected through the application of Commissioner judgment in the final prioritization process.” [Bob DiPrete and Darren Coffman, A Brief History Of Health Services Prioritization In Oregon.](#)

Today, the Health Evidence Review Commission (HERC) website explicitly describes the use of QALYs in its cost effectiveness framework, and it is embedded in the prioritization formula.

As reconstructed in 2008, Oregon’s [revised prioritization framework](#) emphasizes preventive services and chronic disease management in order to keep the “population healthy rather than waiting until an individual gets sick before higher cost services are offered to try to restore good health.” This focus on preventative care for the healthy population has deprioritized – and in some cases defunded – coverage of health services for individuals living with disabilities, including mental health services for children. The process uses QALYs both explicitly – as a direct part of the formula – and implicitly, through QALY-based analyses of factors within the formula:

$$Score = \left(\begin{matrix} \text{Category} \\ \text{Weight} \end{matrix} \right) \times \left[\begin{matrix} \text{Impact on Healthy Life} \\ + \text{Impact on Suffering} \\ + \text{Population Effects} \\ + \text{Vulnerability of Population} \\ + \text{Tertiary Prevention} \end{matrix} \right] \times Effectiveness \times \left(\begin{matrix} \% \text{ Need for} \\ \text{Medical} \\ \text{Services} \end{matrix} \right)$$

Under this category weighting scheme, preventative services start with a category weighting multiplier of 95 – more than double that of care to cure a fatal illness, with a weight of just 40, and nearly 5 times the weight of services for nonfatal conditions. As an example, a routine dental exam is considered preventative, so it has a weight of 95 – while an appendectomy to treat appendicitis, or surgery to remove a treatable cancer would have a weight of just 40.

After the category weight, five population and individual impact measures are summed together - Impact on Healthy Life (sometimes referred to as Impact on Health Life Years and reflecting QALY inputs); Impact on Suffering Population Effects; Vulnerability of Population Affected; and Tertiary Prevention. The scores for these five factors are proposed by the HERC Medical Director and confirmed or amended by a vote of HERC's Value-based Benefits Subcommittee. HERC does not routinely seek input from patients or individuals impacted by the health conditions in evaluating impact on healthy life or suffering. Instead, commissioners are frequently presented with QALY metrics calculated by the Institute for Clinical and Economic Review (ICER) as they vote.

The final two factors in the formula – effectiveness and need for medical services – are multiplied together into an “effectiveness” score. The “effectiveness” score is proposed by the HERC Medical Director based on a review of medical evidence and factoring in QALY-based cost effectiveness analyses and confirmed or amended by the HERC Evidence-based Guidelines Subcommittee with this QALY-based framework:

“The cost of a technology will be considered according to the grading scale below, with “A” representing compelling evidence for adoption, “B” representing strong evidence for adoption, “C” representing moderate evidence for adoption, “D” representing weak evidence for adoption and “E” being compelling evidence for rejection:

- *A = more effective and cheaper than existing technology*
- *B = more effective and costs < \$25,000/LYS or QALY > existing technology*
- *C = more effective and costs \$25,000 to \$125,000/LYS or QALY > existing technology*
- *D = more effective and costs > \$125,000/LYS or QALY > existing technology*
- *E = less or equally as effective and more costly than existing technology”*

[Prioritization of Health Services: A Report to the Governor, 2013](#), p. 24. (**Emphasis** added)

After a category is determined and weighting factors established, a total score is calculated and reviewed by the HERC, which reserves the right to manually override the scores to move services up or down the prioritized list.

Oregon also chooses to provide coverage for some services that aren't on the list at all. For instance, it is the policy of the state of Oregon to provide Medicaid coverage of physician assisted suicide, including counseling and lethal prescriptions. OHP patients who have been denied coverage of potentially life-extending health services that were “below the line” have been advised by OHP that physician assisted suicide is a covered alternative. (See for instance [“Death Drugs Cause Uproar in Oregon. Oregon woman denied drugs for lung cancer, but offered assisted-death drugs,”](#) ABC News, 2008)

Below the line – examples of excluded services for disabilities:

- Selective Mutism (psychotherapy recommended)
- Otosclerosis (hearing aid, cochlear implant or surgery options)
- Bell's Palsy (facial palsy, medication and physical therapy often recommended)
- Spastic Diplegia (form of cerebral palsy, physical therapy recommended)
- Personality Disorders Excluding Borderline and Schizotypal (psychotherapy recommended)

[Prioritized List of Health Services](#), Oregon Health Authority website.

Oregonians deserve better. It is time to end this failed, discriminatory experiment.

Disability Rights Oregon (DRO)

For more than 40 years, DRO has served as Oregon's federally authorized and funded Protection & Advocacy System. DRO is committed to ensuring the civil rights of all people are protected and enforced, including youth in correctional settings.