and operation. But millions of poor Americans do not qualify because each state sets its own eligibility standards, adjusting them annually to match their budgets. Alabama currently has the most stringent standards: a family of two qualifies only if it earns less than $88 a month, or 13% of the federal poverty level of $700 a month for one parent and one child. In Oregon, a family is eligible if it earns less than 58% of the federal poverty level, or approximately $400 a month. Because eligibility requirements can be raised, a family can be supported by Medicaid one year and dropped the next—subjecting citizens to a devastating medical roller coaster.

Under the new system, this practice of "forcing more and more people under the table," as Kitzhaber calls it, would come to an end. Instead, Oregon would enroll everyone eligible for Medicaid but restrict access to treatments at the bottom of the list: those that are, according to some measure, most expensive and least effective. State officials estimate that this will add 77,000 people to the current 130,000 now receiving Medicaid benefits. Another 300,000 people would be covered by the private sector. The Health Services Commission list—in its final form—will serve as the guideline for deciding which treatments are funded and which are not, for both Medicaid and private insurance recipients.

But as the commission, along with Kitzhaber and his allies, discovered, deciding how to rank health care treatments is no simple task. The procedure Oregon hit on combined community values—as described by Oregonians themselves—with a mathematical technique for estimating costs and benefits (see box, page 470). "We attempted to assess what value a community places on health, what types of care it deems important," said Michael Garland, a bioethicist at the Oregon Health Sciences University and president of Oregon Health Decisions. OHD held 47 public meetings throughout the state, and conducted a telephone survey, asking participants to rank a variety of health situations in terms of "quality of well-being."

These findings—which indicated that Oregonians generally favor preventive health care—were then mathematically correlated with cost-benefit data for various medical procedures to produce the controversial list. The ranking method clearly needs revision. How much revision is needed is a matter of debate, however. Some commissioners favor keeping the mathematical formula, while others believe the list needs a human touch and should be done by hand. Nevertheless, says Harvey Klevit, "We can make it work. It's just going to require some more time."

Yet complex as they are, the problems with the list are only part of the political, ethical, and financial quagmire in which the state of Oregon now finds itself. None of Oregon's Medicaid reforms can be implemented until the state receives a federal government waiver that would allow the state to cut some types of care for the "categorically needy" in order to add more people to the program. The state has sought the approval of the U.S. Department of Health and Human Services and Congress.

In so doing, it has run headlong into Washington's lobbying process and found itself outflanked and outgunned. Several groups, notably the Children's Defense Fund, the American Academy of Pediatrics, and the National Association of Community

Oregon's Plan Comes to the Capital

In Washington, just mentioning the idea of rationing health care charges the political atmosphere. Oregon's proposal to ration its Medicaid services—by means of a list of medical procedures ranked according to the "net benefit" they provide—is no exception. From the time that Oregon issued its preliminary list in May, there has been a sharply partisan, political reaction in Washington.

With the exception of Oregon's bipartisan congressional delegation, members of Congress have reacted to the rationing plan along party lines. Democrats worry that the plan unfairly targets the state's most politically vulnerable citizens—children and poor women. Republicans, on the other hand, like it for its innovative qualities and presumed fiscal austerity.

But why should anyone care what Washington officials think? The answer is that Medicaid is a federal program with strict eligibility and care requirements. Oregon needs waivers of some of those rules to put its plan into effect—and other states that are thinking of following suit may be influenced by whether Oregon is successful in obtaining waivers.

Under Medicaid law states are barred from refusing medical services to eligible individuals, but, through the use of a ranking system, Oregon proposes to restrict the treatments it will cover. And by expanding coverage for poor families while restricting their benefits, Oregon would violate a requirement that families receiving federal aid through the Aid to Families with Dependent Children program automatically receive full Medicaid coverage as well. Altogether, the state is seeking waivers of nine separate Medicaid regulations, which can be granted either administratively through the federal agency that manages Medicaid or legislatively through Congress. The state is pursuing both avenues, although the legislative route is running into political trouble. Last year, for instance, Senator Bob Packwood (R–OR) attempted to attach a waiver provision to the legislation reconciling the entire federal budget. A Packwood aide calls that move "entirely non-controversial."

But the waiver was dropped in a House-Senate conference when congressional leaders agreed to strike non-germane provisions from the bill. And Packwood's maneuver still rankles among the plan's opponents. "This was not appropriate in a procedural sense," says an aide to Representative Henry Waxman (D–CA). "You don't make a major change like this without hearings and investigation, and there just wasn't time for any of that."

But far more than procedural issues are at stake. "If you're going to ration health care, you do it across the population, not just for poor women and children," says Waxman. "The state says it's making the tough choices, but politically it's not making a tough choice at all." At the heart of Waxman's argument is the fact that poor women and children—the only ones whose treatments would be restricted under the plan—make up 70% of Oregon's Medicaid population but receive only 30% of the state's Medicaid budget. The rest of the Medicaid population is composed of the blind, elderly, and disabled. Those groups are a much tougher target because they have potent political lobbies, according to Children's Defense Fund analyst Sara Rosenbaum.

But the plan's congressional supporters aren't discouraged. Oregon's reform "might provide a lifeline to those who now fall between the cracks in our health care system," Packwood and Representative Ron Wyden (D–OR) wrote in the *Washington Post*.

For now, both the legislative and administrative waivers are stalled until Oregon revises its priority list. And, says an aide to the Senate Finance Committee, Congress is in a wait-and-see mode: "Most members are keeping their mouths shut until they see what the final list looks like. Then they'll say whether they're opposed or not."

■ DAVID P. HAMILTON