



# THE POLITICS OF HEALTH CARE TRANSFORMATION

## LESSONS FROM AN INNOVATOR STATE

### Abstract

Instead of undermining the role of states, national health care reform highlights the crucial position of state actors and state capacity. Why were Oregon lawmakers able to come together to pass transformational health care reform that went much beyond the requirements of the federal Patient Protection and Affordable Care Act (PPACA) at a time when counterparts in much of the rest of the country either actively resisted or stalled in their attempts to legislate minimum requirements? Explanations that focus on partisan control of the executive office reveal only part of the story. Policy legacy, interest group configurations, and the capacity for incremental but substantive engagement in building reform structures and laws were key to gaining bipartisan support and muting opposition from entrenched stakeholders.

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Although headlines touted the passage of *national* health care reform in 2010, few policy areas escape a prominent role for the states. The headaches of federalism have been (unsurprisingly) on display in the implementation of the Patient Protection Affordable Care Act (shortened here to ACA). Within hours of its passage, the state of Florida filed suit against the ACA challenging not only the individual mandate but also the Medicaid expansion as “coercive.” Florida was joined by twenty-five other states, even though the reimbursement for Medicaid expansion was quite generous. Originally projected to cover an additional 17 million uninsured, low-income adults, the Medicaid expansion was greatly muted when the Supreme Court ruled in favor of the resisting states that the HHS Secretary could not withdraw all Medicaid funding if they failed to expand.<sup>1</sup> Currently, only 28 states plus the District of Columbia have accepted Medicaid expansion, leaving a large number of people uninsured in states that refused to expand.<sup>2</sup> Twenty-one states continue to have no coverage at all for poor childless adults and thirteen states only cover parents with dependent children up to 50% of the Federal Poverty Line.<sup>3</sup>

States balked not just over the Medicaid expansion but also over the provision to establish insurance exchanges where uninsured people could purchase coverage with federal subsidies. Twenty-seven states have federally run exchanges because those states refused to participate in creating an

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<sup>1</sup>“*National Federation of Independent Business v. Sebelius* 567 U.S. (2012)

<sup>2</sup> “An Overview of Actions Taken by State Lawmakers Regarding the Medicaid Expansion” Kaiser Family Foundation, February 13, 2015, accessed at <http://kff.org/medicaid/fact-sheet/an-overview-of-actions-taken-by-state-lawmakers-regarding-the-medicaid-expansion/#footnote-143468-4> (on March 5, 2015).

<sup>3</sup> “Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children and Pregnant Women as of January 2015” Kaiser Family Foundation, February 2, 2015, accessed at <http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/> (on March 5, 2015).

exchange.<sup>4</sup> Opposition to the ACA has not just been relegated to the courts. Indeed, 17 states passed legislation opposing the ACA.<sup>5</sup> Arkansas enacted a bill in 2013 that prohibits health insurance exchange policies from offering coverage for abortions except through a separate rider;<sup>6</sup> and North Carolina (along with 5 other states) passed a law prohibiting further actions to comply with the ACA without explicit approval of the legislature.<sup>7</sup>

Compared to these reform-resisting states, the story in Oregon seems quite simple. Strong Democratic majorities and executive control led Oregon to embrace health care reform, including both the state exchange and the Medicaid expansion.<sup>8</sup> But what happened in Oregon is actually more complicated. Oregon did not merely accept the ACA; it transformed its Medicaid program through a federal waiver that seeks to tackle cost containment and the actual delivery of health care with global budgeting and the creation of Coordinated Care Organizations (CCOs). While these changes affect the Medicaid population primarily, the state plans to spread this model to health insurance for government employees and teachers, and ultimately to private insurers. While this transformation of the Oregon Medicaid system was championed by a Democratic governor who was long recognized for his work on health care reform, the crucial pieces of enabling legislation were passed in 2011 and 2012 with bipartisan support.<sup>9</sup> Only eight members of the 2011 state legislature opposed the CCO plan despite the

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<sup>4</sup> “Are Premium Subsidies Available in States with a Federally-run Marketplace?” Kaiser Family Foundation, February 25, 2015, accessed at <http://kff.org/health-reform/issue-brief/are-premium-subsidies-available-in-states-with-a-federally-run-marketplace-a-guide-to-the-supreme-court-argument-in-king-v-burwell/> (on March 5, 2015).

<sup>5</sup> Elizabeth Rigby, “State Resistance to ‘ObamaCare’” *The Forum* 10 (2012) 2: 3.

<sup>6</sup> See National Conference of State Legislatures (NCSL) database, “Health Reform: 2011-2013 State Legislative Tracking Database” accessed at <http://www.ncsl.org/research/health/health-reform-database-2011-2013-state-legislation.aspx> (on March 6, 2015)

<sup>7</sup> NCSL, “States Opting-Out or Opposing Certain Provisions of the ACA” (July 2013) accessed at [http://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx#2011\\_bills](http://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx#2011_bills) (on March 6, 2015). See also, Fred Schulte, “War Over Obamacare Heats Up in States” *NPR* (January 21, 2015) accessed at <http://www.npr.org/blogs/health/2015/01/21/378641761/war-over-obamacare-heats-up-in-states?ft=3&f=1001>

<sup>8</sup> Rigby (2012) finds that Republican Party control is a strong predictor of state resistance to the ACA and a much stronger predictor than state capacity or any economic factors.

<sup>9</sup> HB 3650 in 2011 directed the Oregon Health Authority to create a plan for a “Coordinated Care Delivery System for Medicaid” and SB 1580 in 2012 approved the plan for implementing CCOs.

fact that the Oregon House was evenly split with 30 Democrats and 30 Republicans. Although it is true that all the opposition for these measures came from Republicans, transformation of health care in Oregon benefitted from strong Republican support.<sup>10</sup> This accomplishment is all the more surprising because reform in Oregon imposes more cost containment and more regulation than the Affordable Care Act. Given the unknowns of such a reorganization and the stakes involved, one would expect opposition mobilization by key stakeholder groups, especially doctors and hospitals. Opposition, however, was muted.

Why did Oregon pass bipartisan transformative health reform at a time when health care was so polarized at the national level and in so many states? This paper explores three of the most likely explanations that have emerged from 20 interviews with policy participants conducted over the last several months (September 2014 through January 2015) and from the available documents, including: audios of and exhibits from legislative hearings; agency memos, plans and reports; recorded public conferences; speeches and other published communications. The first explanation is that Oregon has long been a leader state in health care reform beginning quite prominently with the development of the Oregon Health Plan (OHP) in 1989 that increased coverage by rationing care, created a culture of innovation around health policy, and developed health policy expertise both in and out of government. Path dependence theory teaches us that even breakthrough political enactments often have policy antecedents that pave the way for new initiatives.<sup>11</sup> Further, experience in a particular policy arena creates policy feedback loops that inform current decision-making.<sup>12</sup> This explanation argues that one cannot understand the enactment of CCOs in 2012 without understanding the legacy of prior health reform in Oregon. The second explanation is that health transformation occurred in Oregon because

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<sup>10</sup> Both HB 3650 and SB 1580 were carried in the Oregon House by the Democratic Speaker and a Republican lawmaker.

<sup>11</sup>Paul Pierson, "The Study of Policy Development" *Journal of Policy History*, 17 (2005) 1

<sup>12</sup>Paul Pierson, *Politics in Time* (Princeton University Press, 2004).

the key stakeholders—doctors and hospitals—did not mobilize in opposition. This argument turns on crucial developments in medicine and medical lobbying that explain why those powerful political forces were either not so powerful or actually went along with the changes. Finally, the third explanation centers on the structure of policymaking in a state with a part-time legislature and an increasingly professionalized bureaucracy. Policy-making under these conditions tends to be more consensual, longer-term focused, and less political in nature. I examine each of these explanations in turn and conclude that all three are crucial components in creating a policy regime capable of transforming health care in Oregon. That policy regime, however, is fragile and the continued success of the reform effort will require attention to potential threats to its stability.

### **Is it really a Transformation?**

Hyperbole in reform efforts abounds; very little in the policy arena is truly new. Furthermore, advocates of reform negotiate a complicated rhetorical space in convincing others that a reform effort is sufficiently transformative to warrant the resulting upheaval but not so revolutionary as to be frightening. As one participant noted: “No one wants to be part of an experiment.” In fact, Senator Bates, overseeing the Joint Subcommittee on Human Services public hearing on the health care transformation, stated that he preferred the term “health care evolution” instead.<sup>13</sup> Despite his efforts, “Health Care Transformation” is the phrase of the Oregon Health Authority to explain the series of changes to the state’s approach to health care. At the core of the transformation was the creation of Coordinated Care Organizations (CCOs), local networks of health care providers, charged with improving health outcomes for Medicaid recipients.

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<sup>13</sup> Oregon State Legislature, Joint Subcommittee on Human Services public hearing on SB 1580, February 7, 2012, available at: <https://olis.leg.state.or.us/liz/2012R1/Committees/JWMHS/2012-02-07-17-30/SB1580/Details>

Coordinated Care Organizations have global budget caps and are subject to quality metrics designed to hold providers and communities accountable for delivering more effective health care, and broader public health initiatives. The fundamental idea is to transform the system away from just delivering services to achieving measurable results. Accomplishing this level of reform required a waiver from the Centers for Medicare and Medicaid Services (CMS). Oregon, in effect, reached a kind of grand bargain with CMS where Oregon promised to reduce health care spending by 2% without cutting beneficiaries or quality of care; in exchange, CMS provided \$1.9 billion dollars to fund the transformation. Oregon reasoned that it could reach significant savings through payment reform to realign incentives for unnecessary services; integration of physical, behavioral and oral health; administrative simplification; increased flexibility in what is considered a legitimate health care cost;<sup>14</sup> and learning through decentralized experimentation and information sharing.<sup>15</sup>

Sixteen CCOs formed across the state, just in time for the broad expansion of Medicaid eligibility through the ACA. Just under a million Oregonians now receive health care through the state's Medicaid program.<sup>16</sup> Given that the population of Oregon is not quite 4 million, Medicaid beneficiaries account for a substantial portion of the insured population in the state. Early reports on the effectiveness of CCOs is very positive. The latest report from the Oregon Health Authority highlighted the following results from 2014:<sup>17</sup>

- Emergency room use decreased 21% compared to baseline year of 2011
- Hospital admissions for diabetes complications fell 9.3%
- Hospital stays for patients with chronic respiratory diseases dropped 48%

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<sup>14</sup> For example, home remediation with use of pillow and mattress covers could reduce emergency use by asthmatic children but that does not normally get to count as a health care expense.

<sup>15</sup> K. John McConnell, et al. "Oregon's Medicaid transformation: An innovative approach to holding a health care system accountable for spending growth" *Healthcare* (7 August 2013).

<sup>16</sup> Oregon Health Authority, "Oregon's Health System Transformation, 2014 Mid-Year Report" (January 14, 2015).

<sup>17</sup> OHA, "2014 Mid-Year Report" (2015): v.

These positive results occurred without increasing per capita costs and despite the influx of a significant number of newly insured patients. The 2014 report details outcomes on 33 state performance metrics and 17 incentive metrics. Policymakers can make comparisons across CCOs, across various demographic groups, and now across time. There is significant variation across the CCOs in terms of outcomes and innovation. Not all CCOs are engaging in the kind of flexible payment, public health initiatives the bill sponsors imagined. However, the state provides a variety of resource and technical assistance to CCOs to enhance learning and outcomes. While a few insist that compromises reached in the political process mean that CCOs are not as transformative as they should be, many outside observers agree that the Oregon reform is significant and a remarkable shift in health care delivery.<sup>18</sup>

### **The Policy Legacy Argument**

Although the field of American political development rarely focuses on state level process (absent federalism) many of its key insights can be applied to state level policy developments.<sup>19</sup> Path dependence theory, feedback loops, and attention to process over time are all useful concepts for thinking about health care transformation in Oregon and provide a reasonable argument for explaining policy outcomes in this case. But the case for policy legacy is not without problems. Given the multitude of variables, it is difficult to identify precisely which ones are most important or even where the story should begin. The past seems most relevant in this case for the enhancement of state capacity in health policy and a consequent culture of innovation and promotion of big ideas.

A single snapshot of policy enactment, as Pierson warns, can blind scholars to key structural factors and the long lag time to see their effects: “What may seem like a relatively rapid process of

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<sup>18</sup> Sarah Kliff, “Can Oregon Save American Health Care?” *Washington Post* (January 18, 2013).

<sup>19</sup> For some notable exceptions, See Amenta, *Bold Relief: Institutional Politics and the Origins of Modern Social Policy* (Princeton University Press, 1998), see chapters on the state New Deals; and Barry Rabe, *Statehouse and Greenhouse: The Stealth Politics of American Climate Change Policy* (Brookings 2004).

reform is in fact only the final stage of a process that has been under way for an extended period.”<sup>20</sup> Enactment of health care reform in Oregon is quite obviously a process over time if for no other reason that even the decision point for creating and implementing Coordinated Care Organizations (CCOs) occurred over two legislative sessions within two different pieces of legislation. So it is most appropriate to study the period of time at least from April 2011 when HB 3650 got its first reading until February 2012 when SB 1580 passed the Oregon legislature. However, SB 1580 (2012) was a referral from the Oregon Health Authority (OHA), which was created by legislation in 2009. The Oregon Health Authority might never have been created if the legislature did not establish the Oregon Health Policy Commission in 2007, which created a “Road Map for Health Care Reform” and designed the OHA as a permanent structure outside of the Department of Human Services (DHS).<sup>21</sup> Given the Democratic Party’s hold on the executive branch in Oregon since 1987, one might be tempted to go into near infinite regress in the search for the “beginning” of a policy that has clearly built on prior legislation, but I focus here on two developments cited often by policy participants: creation of the OHA in 2009 and the OHP in 1989.

Creation of the Oregon Health Authority as a separate entity was cited by both legislators and state agency personnel as an important step for getting to health care transformation. When pressed as to why, the consistent answer was about the unwieldy size; one participant explained that transformation just “wouldn’t have been possible with a 10,000 person agency” like DHS. During an early House Health Care Committee hearing Representative (and Chair) Greenlick explained that he used to teach organizational theory and “I think DHS is simply too big to manage.”<sup>22</sup> However, the authorizing legislation for creation of OHA and its policy board was more than just an administrative

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<sup>20</sup> Pierson (2005): 40.

<sup>21</sup> Oregon Health Policy Commission, “Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System” submitted to Governor Kulongoski, July 2007. [author’s files]

<sup>22</sup> Oregon State Legislature, House Health Care Committee public hearing on HB 2009, January 26, 2009, available: <https://olis.leg.state.or.us/liz/2009R1/Committees/HHC/2009-01-26-15-00/HB2009/Details>.



right-sizing. House Bill 2009 was intended to create a new approach to improving health in the state by joining health care, mental health, insurance and hospital regulation, addiction services, and public health in one agency for better policy coordination. As the director of DHS explained at the time, policy coordination would be matched with a consolidation of state purchasing power for health and health insurance. The broader vision and structural power embodied in HB 2009 excited the more liberal members of the House Health Care Committee and worried the free market advocates. As one Republican representative noted at the time: “This is a shift in power...This is a fundamental structure change in how we do business in the state of Oregon, let alone how we do health care.”<sup>23</sup> This same representative objected to the shift in power to the state government, stating that Oregon was “creating a scenario where the winners are pre-ordained” and there could not be true competition.<sup>24</sup> In addition to creating a separate agency, the legislation directs the organization to develop a variety of plans for: improving health information technology; reducing expensive treatments for chronic conditions; generating new reporting requirements for hospitals; insurers and ambulatory surgical centers; conducting comparative effectiveness research. If the state’s role in health care had previously been “diffuse and unclear” as one participant noted, the creation of the OHA was designed to enhance state power under a unified vision.

It is difficult to ascertain exactly how necessary the structural changes were to creating the Coordinated Care Organizations that followed a few years later. Given the continuity of the personnel who moved over to the OHA from DHS (including its Director) and the continued overlap and need for coordination between the agencies, the importance of OHA might be overstated.<sup>25</sup> Certainly, the OHA would not have been able to carry out many of its plans despite its enhanced structural power if the ACA

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<sup>23</sup> Public hearing on HB 2009, January 26, 2009.

<sup>24</sup> Public hearing on HB 2009, January 26, 2009.

<sup>25</sup> Senior services for long-term care, for example, stayed housed in DHS even though it represented 40% of Medicaid expenditures at the time. Testimony from Dr. Bruce Goldberg, Public hearing on HB 2009, January 26, 2009.

had not passed Congress in March 2010. The expansion of Medicaid in the ACA and the financial support of that from the federal government significantly freed the new state agency to tackle payment alternatives, global budgeting and quality metrics. In fact, one might doubt the broad claim of developing state capacity given that Cover Oregon, the state exchange, which was called for in HB 2009, never came to fruition as a website despite an influx of significant federal dollars.<sup>26</sup> And yet, for a young agency, its personnel seem to have a strong sense of mission and support for the transformation. What is more, they communicate with consistent language and seem to understand the work of the various parts, all of which lends the impression of a cohesive and coordinated organization. In contrast, umbrella organizations like DHS with overlapping but distinct clientele and missions often produces silo programs that operate independently and sometimes at cross purposes.

The vote in the Oregon House in support of OHA and the new vision for health was 38-22, almost exactly along party lines. Only two Republicans joined Democrats in supporting the legislation. With overwhelming Democratic margins in the House, Republicans were not key players.<sup>27</sup> The partisan disagreement here highlights that this was a contentious bill subject to almost 30 public hearings over the course of nearly five months of legislative work. Preceding the passage of the ACA, HB 2009 was buoyed and informed by the national conversation on health reform. Within two years, OHA would propose the broader transformation of health care through the CCOs.

However, if scholars are to take seriously the notion that policy may develop over a significant length of time and contemporary choices are largely framed by prior events, then 2009 may not be early enough to understand the more dramatic changes in Oregon.<sup>28</sup> A handful of policy participants thought the creation of the Oregon Health Plan (OHP) in 1989, was a crucial predecessor to health care

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<sup>26</sup> “Cover Oregon is Dead; Brown signs bill eliminating troubled exchange,” *Associated Press* (March 6, 2015)

<sup>27</sup> The Senate vote attracted a handful of additional Republicans along with the support of every Democratic Senator.

<sup>28</sup> Pierson (2005); Daniel Carpenter, *The Forging of Bureaucratic Autonomy: Reputations, Networks, and Policy Innovation in Executive Agencies, 1862-1928*. (Princeton University Press, 2001).

transformation in 2012. One legislator who was not even a resident of the state in 1989 but subsequently came to Oregon because of OHP explained: “Doing new things in Oregon about health care is not a new thing.” This participant reasoned that the statewide conversations in the late 1980s about health reform prepped a variety of participants—from physicians to insurers—to think more creatively and boldly about health care. Oregon is a small state and the various leaders on health care policy move around to different positions but many of the actors stay the same across time. As Oliver and Paul-Shaheen show “in state-level health policy communities, there is much ‘connective tissue’ in contrast to the ‘hollow core’ and fragmentation at the national level.”<sup>29</sup> The shared experiences, lessons learned, and general familiarity with the personalities and policy preferences of the participants can help to create a cohesive policy community. Most of the policy participants at the agency level had been engaged with health policy for ten years or more but from various positions, giving them an understanding of the broader system issues. A number of the key policy leaders and agency heads, for example, come from the medical field itself and have practiced medicine.

The 1989 reform is also connected to the 2012 reform through Dr. John Kitzhaber—emergency room physician turned politician-- who was the chief legislative leader and visionary for OHP enactment as a State Senator and eventually Senate President in 1989 and then as Governor from 1995 to January 2003. Governor Kitzhaber then returned to the executive office in January 2011, just in time to take up the health reform mantle again. In between his second and third terms in office, Kitzhaber launched the Archimedes Movement in 2006, designed to engage civic leaders in community conversations about reforming health care. Movement participants created a set of principles and a framework for a new way to deliver health care and endorsed the “Triple Aim” goals, a phrase that was repeated often in the

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<sup>29</sup> Thomas R. Oliver and Pamela Paul-Shaheen, “Translating Ideas into Actions: Entrepreneurial Leadership in State Health Care Reforms” 22 *Journal of Health Politics, Policy and Law* 3 (June 1997): 740.

debates around the CCOs.<sup>30</sup> The objectives of the Triple Aim are to improve health, lower costs, and create a better health care experience.<sup>31</sup> In a single year, the Archimedes Movement could boast of 6,500 members across the state, organized into 38 chapters.<sup>32</sup> Looking more like a social activist than a former governor, Kitzhaber and his Archimedes movement sponsored rallies at the Capitol, introduced legislation, lobbied legislators, and spoke around the state at various civic venues.

So dedicated was Governor Kitzhaber to the cause of health reform, both in and out of office, that one must ask if his leadership was the key to health care transformation in Oregon. In their six state study of health policy innovations conducted shortly after the failure of national health reform under President Clinton, Oliver and Paul-Shaheen found that entrepreneurial leadership was the crucial component explaining state-level success and cited Kitzhaber as responsible for bringing about “comprehensive innovation” with the creation of OHP: “Kitzhaber completely changed the image of the issue and thereby invited an entirely new set of actors, including the general public and business groups, into a lengthy debate that normally would have been quickly resolved within the confines of the health policy community.”<sup>33</sup> Policy participants interviewed for this paper cited Kitzhaber’s role as crucial. One participant believed that Kitzhaber embodied “the perfect skill set” for addressing health care as both a political pragmatist and a doctor who understood the system well. Another participant stated that Kitzhaber’s experience and knowledge of health care issues emboldened reformers within government because they knew he was thinking of running again as early as 2009. One Republican legislator even called Kitzhaber “the best politician in the building” to explain why he was able to convince so many Republicans to vote for the transformation.

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<sup>30</sup> The Archimedes Movement changed its name to the more website friendly “We Can Do Better.” See: <http://www.wecandobetter.org/who-we-are/history/framework/> [accessed on March 18, 2015].

<sup>31</sup> The “We Can Do Better” website offers a useful history without authorship attribution or a publication date, <http://www.wecandobetter.org/who-we-are/history/expanded-history/> [accessed on March 18, 2015].

<sup>32</sup> Kitzhaber speech at the Rally for the Oregon Better Health Act, March 26, 2007, found at <https://www.youtube.com/watch?v=noLbqHptOd8> [accessed on December 8, 2014].

<sup>33</sup> Oliver and Paul-Sheheen (1997): 751.

But strong leaders can also produce strong negative reactions. Some policy participants were less willing to give the former Governor so much credit. Even those who felt that Kitzhaber played a vital role produced a number of caveats to his leadership:

- “Physicians think they know everything.”
- “The Governor was languishing and was going to fail.”
- “The Governor was at 100,000 feet. Getting legislation done is another story.”
- “He understands the problems but he doesn’t claim to be the idea guy.”

Still, no one I interviewed—from either party or any position in government—doubted Kitzhaber’s passion for health care policy. His articulate and avid defense of the Oregon Health Plan in the early 1990s, his recruitment of key health policy personnel, his commitment to educating the public about inequities in the health care system, and his sheer power of agenda-setting all indicate that his leadership was a necessary, if insufficient, component of bipartisan transformation.<sup>34</sup> The key is to understand what conditions enabled Kitzhaber’s entrepreneurship on this issue to be so successful.

While there is some compelling evidence that the creation of OHP put Oregon on a path of health care innovation and fostered a policy community with health care expertise, the original Oregon Health Plan vision of universal coverage for a rational system of crucial benefits had been largely undone by the time the current transformation was being formulated. Indeed, the Plan itself had been cut into two plans with different benefits, recession-induced cuts threatened its funding, and enrollment dropped by 75% in 2007, raising the uninsured rate.<sup>35</sup> Writing in 2007, Oberlander found:

OHP is now covering both fewer services and fewer people, and the elimination of entire benefit categories and rollback in enrolled beneficiaries looks more like the arbitrary cuts common in other states than the rational and equitable model of prioritization to which Oregon aspired. The state is trying to hold onto its core principles in health reform, but its grip has weakened considerably. Indeed, the

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<sup>34</sup> For a defense of the OHP’s system of rationing services, see John Kitzhaber and Mark Gibson, “The Crisis in Health Care—The Oregon Health Plan as a Strategy for Change” *Stanford Law and Policy Review* 3 (1991): 64-72.

<sup>35</sup> Philip Perry and Timothy Hotze, “Oregon’s Experiment with Prioritizing Public Health Care Services” *American Medical Association Journal of Ethics* 13 (April 2011) 4: 244.

environment in Oregon today resembles that in the years preceding OHP's enactment, as the state has fallen into the very cycle—rising costs, growing numbers of uninsured people, Medicaid eligibility cuts, increased emergency room use, and cost shifting—that OHP was created to avoid.<sup>36</sup>

Given the unsustainability of OHP, it is difficult to conclude that it created a path that the CCOs followed.

The policy feedbacks in this case were rather negative; fiscal pressures were impossible to curtail and reformers in large measure had to start anew.

### **The Dogs that Didn't Bark: Where Was the Medical Opposition?**

When Kitzhaber first left the Governor's office in January 2003, he was clearly frustrated with the state of Oregon politics and famously stated that Oregon was "ungovernable."<sup>37</sup> About that same time, Kitzhaber complained that "Oregon is a great place to be in politics, but our legislature looks increasingly like the United States Congress, where the objective is the acquisition and maintenance of power, not the exercise of power for any large purpose."<sup>38</sup> When asked about the Archimedes Movement when running for office again in 2010, Kitzhaber explained that he saw a need for "a new space for civic engagement" since "our governance structures in America have not evolved since the Industrial Revolution."<sup>39</sup> Kitzhaber continued: "We've got a set of policies—for health care, transportation, economics—created in the middle of the last century. They haven't changed much in the last 50 or 60 years, while the world around them has changed dramatically. They're all protected by these powerful economic stakeholders who preserve the status quo."<sup>40</sup> Yet, what is remarkable about

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<sup>36</sup> Jonathan Oberlander, "Health Reform Interrupted: The Unraveling of The Oregon Health Plan" *Health Affairs* 26 (2007) 1: w102.

<sup>37</sup>"Kitzhaber Explains His 'Ungovernable' Remark; Grades His Past Performance" *Willamette Week* (August 9, 2010) found at: <http://www.wweek.com/portland/blog-1768-kitzhaber-explains-his-ungovernable-remark-grades-his-past-performance.html> [accessed on March 18, 2015].

<sup>38</sup> Jeff Goldsmith, "The Road to Meaningful Reform: A Conversation with Oregon's John Kitzhaber" *Project HOPE—The People-to-People Health Foundation* (January/February 2003): 118.

<sup>39</sup> "Dr. John Kitzhaber's Unorthodox Ideas on Reforming Health Care" *Kaiser Health News* (no date provided), found at <http://kaiserhealthnews.org/checking-in-with-kitzhaber/> [accessed on February 18, 2015].

<sup>40</sup> "Dr. John Kitzhaber's Unorthodox Ideas on Reforming Health Care" *Kaiser Health News* (no date provided), found at <http://kaiserhealthnews.org/checking-in-with-kitzhaber/> [accessed on February 18, 2015].

the health care transformation in 2011-12 is the extent to which the status quo was not preserved. Traditionally, the most powerful forces for the status quo in health care have been insurance companies, pharmaceutical companies, doctors and hospitals. The first two were not in play with the creation of CCOs. The last two put up surprisingly little resistance given the uncertainties that CCOs generated, especially its global budgeting plan and incentive payment structure using quality metrics. Despite Kitzhaber's stated concerns about entrenched stakeholders threatening health care reform, only long-term care advocates successfully opposed all reform. Doctor and hospital groups engaged in the policy process, working through a complicated bill, compromising and largely supporting the measures.

In the fall of 2010 as various proposals were being considered by the Health Policy Board of the OHA, the Oregon Medical Association (OMA) President Dr. John Evans warned its members that the OHA and its board "have numerous committees producing possible tectonic changes, some quite extensive, changing the landscape for how we practice medicine today and into the future."<sup>41</sup> As Evans goes on to detail the various committees and the reforms proposed, he notes the physicians active in the deliberations; each policy subcommittee has at least one and up to four doctors as members. He concludes: "The ground may feel unstable under our feet, but as physicians and care providers we must stand for *our patients'* best interests."<sup>42</sup> It is clear from the OMA reporting that physicians were intimately involved early in the policy process, that various proposals were openly discussed and debated, and further, that the OMA saw its role as protecting patients, not just physicians. This focus has a rhetorical use, of course, if the primary way physicians want to protect low income access to health care, for example, is to fight any provider payment cuts.<sup>43</sup>

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<sup>41</sup> John Evans, III, MD, "The Map of Health Care is Changing" *Medicine in Oregon* (Fall 2010): 4.

<sup>42</sup> Evans (2010): 5. [Emphasis mine.]

<sup>43</sup> This was the argument put forward by Joanne Bryson, "Deep Budget Deficits Drive Legislative Session" *Medicine in Oregon* (Spring 2011): 6.

However, I would argue that the OMA did embrace CCOs, at least in part, for the perceived benefits they will provide to patients. One policy participant interviewed for this paper who works closely with the OMA and other medical associations argued: “Physicians mostly realized that they needed to change” and that overall, the provider community was open to ideas. The OMA newsletter from Fall 2012 featured a story about how care for a woman with congestive heart failure and diabetes would change under CCOs in ways that would both improve her health and provide more than enough cost coverage for her doctor.<sup>44</sup> The author, a past president of the OMA, concluded: “I understand that Mary is hypothetical and this is a rosy story, but I have seen a real enthusiasm on the part of local doctors to use the CCO model of care to improve care and control costs.”<sup>45</sup>

Other policy participants noted that physicians and hospitals were channeled into reform because the dire budget predictions meant that provider cuts were inevitable, the old system was largely indefensible, and finally that bipartisanship meant there was no place to go if you opposed reform. Although provider groups had lined up in the past and protected their share of the health care dollar, as one participant explained, this time they got involved because we “didn’t really talk about it in a political way;” we just worked “to spend those dollars in a better way.” Others referred to the “burning platform” metaphor with all the players facing significant cuts; policymakers made it clear that the consequences of standing still were severe. Additionally, physicians were involved in the planning process, two physicians-turned-legislators were deeply involved in the legislative process, and many physician groups were involved in lobbying, including the Coalition for a Healthy Oregon (COHO) which is an association of managed care groups that supported health care transformation and the creation of CCOs.<sup>46</sup> The existence of COHO is a reminder both that the OMA does not necessarily dominate medical

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<sup>44</sup> Bob Dannenhoffer, MD, “A Reform Story: How We’ll Care for Mary” *Medicine in Oregon* (Fall 2012): 21-22.

<sup>45</sup> Dannenhoffer (2012): 22.

<sup>46</sup> The role of COHO in supporting reform came up in numerous interviews. See their website for their statement of support, “About COHO” found at <http://www.cohoplans.org/about-coho/> [accessed on March 19, 2015].



groups the way it once did and that changes in the nature of the provider system gets reflected in the political arena.

Two participants interviewed for this paper provided remarkably similar stories about the transformation of the OMA and medical lobbying in Oregon with very different assessments about whether that transformation was positive or negative. From at least the 1970s to the early 2000s, the OMA was dominated by specialists with high incomes who were paid for providing services, not necessarily for improving health outcomes. The OMA during that time was the over-riding force in legislative lobbying and practiced old-style behind-the-scenes and protect-your-money politics. By the early 2000s, primary care physicians began to have an increasing role in the OMA, specialists declined in numbers and influence. In a relatively short period of time, the OMA went from a closed network dominated by male specialists who asserted tremendous political power to one led by female primary care physicians with different priorities for health reform. Meanwhile, the Oregon Academy of Family Physicians (OAFP) began to get more political and in 2006, increased their dues in order to pay for a contract lobbyist. OAFP's tactics were different. They claimed to represent patients, not just doctors and they argued for changes based on better outcomes for patients.

The Managed Care Organizations (MCOs) were in the best position to take advantage of the new CCO structure. So COHO lobbied in support of the transformation. In fact, given the high rates of managed care for Medicaid patients in Oregon, physicians may have been less concerned about the changes than they would have been in another state. The national average for managed care in Medicaid is at 70% but that number masks a large variation across the states.<sup>47</sup> About 98% of Medicaid patients in Oregon were in managed care by 2011, compared to 0% in Alaska and New Hampshire, 64%

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<sup>47</sup> "Managed Care" *Centers for Medicaid and Medicare Services* found at: <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html> [accessed on March 19, 2015].

in Wisconsin, and 88% in Washington.<sup>48</sup> Of course, MCOs were concerned throughout the legislative process about various details embedded in the implementation plans; the hearings are full of technical amendment requests from various groups. But this kind of policy engagement was largely supportive of the overall measures.

Kitzhaber did make a commitment to medical liability reform, an issue quite dear to nearly every doctor group. Senate Bill 1580 included a requirement to develop a liability reform proposal for the next legislative session.<sup>49</sup> But the biggest concessions were probably to hospitals in form of the governing structures for the CCOs. According to multiple participants, hospitals really struggled initially with the CCO proposal since one of the goals of the CCOs is to keep people out of the hospital. One participant noted that not all hospitals came on board because they were “still stuck with heads in the beds” finance mentality. In fact, Salem Hospital filed suit against its CCO for low reimbursement rates and then got legislators to file a bill that would end the dispute in their favor before eventually settling the matter on their own.<sup>50</sup> Since CCOs represent a kind of second order devolution, real decision-making takes place at the local level. The state holds CCOs responsible for meeting various benchmarks and rewards them for good health outcomes but CCOs can still operate as fee-for-service entities with contracts to all the traditional provider groups. Those in the legislature really committed to payment reform felt that CCOs should be mandated to get rid of fee-for-service. Further, more liberal elements argued that the governing boards are largely dominated by stakeholders, especially hospitals, who will resist really innovative reform and operate in their self-interest.

On the whole, while these concessions to provider groups are significant, they are not enough to represent capture of the policy. In fact, CCOs have been remarkably successful so far in meeting the

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<sup>48</sup> “Total Medicaid Managed Care Enrollment” Kaiser Family Foundation State Health Facts Table 2011. <http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/> [accessed on March 1, 2015].

<sup>49</sup> Bob Dannenhoffer and John Moorhead, “Liability Reform: The Oregon Opportunity” *Medicine in Oregon* (a publication of the Oregon Medical Association) (Fall 2012): 20.

<sup>50</sup> Saerom Yoo, “Salem Hospital Drops Suit Against CCO” *Statesman Journal* (July 9, 2013).

quality metrics, keeping costs down, and innovating to create better health outcomes.<sup>51</sup> While not all 16 CCOs have the same level of innovation, cooperation or cohesion, the state is working hard to share best practices across the various units through its Transformation Center, facilitating grants and information flows through learning collaboratives.<sup>52</sup> Given how much easier it is to oppose legislation that seeks to change fundamentals about the health care delivery system, it is remarkable that doctors (and hospitals) did not mobilize against these changes.

### **The Policymaking Structure**

The final argument I examine here is that health care transformation in 2011-2012 was achieved with bipartisan support because the legislature is actually rather weak compared to an increasingly professionalized bureaucracy that has developed the expertise for long range planning as well as a parallel political process that brings stakeholders together to hammer out differences before legislation is ever introduced. This does not mean that the legislative process is irrelevant, but rather, that crucial political work around policy compromises were reached outside the normal legislative process. The work of the state agencies in formulating reform and bringing together stakeholders is vital for the complicated work of transformation given the limitations of what has largely remained a citizen legislature.

Before I progress with this argument, I must note that with only a couple of exceptions, the policy participants I interviewed would not agree with this characterization or at least would be very uncomfortable with it.<sup>53</sup> The policy participants from the agency side do not feel particularly powerful; I was repeatedly told that they serve the legislature in addition to the Governor. They are demonstrably

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<sup>51</sup> Oregon Health Authority, “Oregon’s Health System Transformation, 2014 Mid-Year Report” (January 14, 2015) available at <http://www.oregon.gov/oha/metrics/Pages/index.aspx> [accessed on February 25, 2015].

<sup>52</sup> See OHA, “Learning Collaboratives” on webpage: <http://transformationcenter.org/learning-collaboratives/> [accessed on March 19, 2015].

<sup>53</sup> One long-term participant in Oregon politics repeatedly stated “You are wrong!” when I offered this hypothesis.

deferential to legislative authority and offices. When the legislature is in session, they are often at the beck and call of legislators who ask them to provide information, data, and testimony, sometimes with very little notice.<sup>54</sup> And of course, legislative leaders who are caught in the throes of getting bills heard and passed, often with great difficulty, and who have spent countless hours negotiating various compromises and attending meetings with lobbyists, citizen groups, and various stakeholders do not believe they play a subordinate role. What is more, the legislature contains a number of skilled leaders in the health care field: Representative Mitch Greenlick, who has been a professor of public health at the School of Medicine at Oregon Health Sciences University (OHSU) and involved with Oregon health policy on various committees and task forces for decades; Senator Alan Bates, practicing physician and health policy leader who has served in the state legislature since 2001; and Senator Elizabeth Steiner-Hayward, a practicing physician and associate professor of family medicine at OHSU are three standout leaders with health care expertise and there are others. However, I argue that given the nature of the Oregon legislature, it would have been extremely difficult for health care transformation to pass the Oregon legislature without the extra-legislative work of the Oregon Health Authority.

Despite the various strengths and expertise of many of its members, the Oregon legislature remains an amateur institution, as political scientists understand that term. The legislature meets no more than 160 days in odd numbered years and only 35 days in even numbered years. Salaries are low. Legislators receive \$22,260 per year plus a per diem stipend when they are in session. Most legislative offices can only support a staff of one to two individuals as the budget for staff is \$36,367, and therefore they depend heavily on volunteer intern labor and policy expertise from either lobbyists or state

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<sup>54</sup> I should add that the bureaucracy, like the rest of state government, is also at the mercy of a permissive initiative process that does frequently force its will on policy in the state. See Richard Ellis, "Direct Democracy" in Richard Clucas and Mark Henkels, eds. *Oregon Politics and Government: Progressives versus Conservative Populists* (University of Nebraska Press, 2005).

agencies.<sup>55</sup> As Clucas explains, “the [Oregon] legislature has retained an amateur air” since the “most significant step taken to modernize the legislature occurred in 1975.”<sup>56</sup> Given the modest salaries and the part-time nature of the legislative work, Oregon legislators often must maintain other forms of employment, be retired, or not their family’s main source of income. As the people of Oregon intend, legislators come to Salem, the Capitol, for short stints of legislating and then return home to various occupations or community life. Very little might be accomplished if not for the role of the state agencies in formulating policy and providing a remarkably democratic process for stakeholders and citizens. Examining the role of the bureaucracy in Oregon, Morgan finds that although a bureaucracy is an unlikely place to find democracy governance, “[t]he importance Oregonians place on having a bureaucracy that is directly responsive to the will of its citizens is demonstrated by the numerous independent commissions, the many access points citizens have to the bureaucracy, and the strong open meetings laws.”<sup>57</sup> The Oregon health care bureaucracy follows this pattern of open access and citizen involvement.

In the case of health care transformation, the Oregon Health Authority came up with an Action Plan for Health, fostered an enormous public education campaign, sought feedback from communities and various stakeholder groups and facilitated a crucial set of public meetings in support of the CCO implementation plan prior to the 2012 legislative session. Even the first of these important contributions, creating an 80-page “action plan” was the result of a very public process begun in 2007 and 2008; the Oregon Health Policy Board met with 300 people who served on “20 committees, subcommittees, workgroups, task forces and commissions” and held 6 community meetings across the state attended by more than 850 people.<sup>58</sup> After HB 3650 passed in 2011 and the OHA began to

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<sup>55</sup> Salary and staff budget information from The Oregon Blue Book, <http://bluebook.state.or.us/state/legis/legis01.htm> [accessed on March 2, 2015].

<sup>56</sup> Richard A. Clucas, “The Legislature” in Clucas and Henkels (2005): 121.

<sup>57</sup> Douglas F. Morgan, “Bureaucracy” in Clucas and Henkels (2005): 169.

<sup>58</sup> OHA, “Oregon’s Action Plan for Health” (December 2010): 7.

formulate plans for implementing CCOs, the agency launched “Road Trip 2011” which brought the conversation to medical providers, community leaders and other stakeholders in 8 Oregon cities: Astoria, Bend, Eugene, Florence, Medford, Pendleton, Portland, and Roseburg, reaching about 1,000 Oregonians. These community meetings included a presentation from the director of OHA or a health policy advisor to the Governor, followed by someone from the local health care community, breakdown into small groups for discussion and then reporting back concerns and issues. An additional 133 Oregonians participated in 4 formal workgroups in which at least one participant described as a “robust exchange of ideas.”<sup>59</sup> However, nearly every policy participant cited the importance of the “Wednesday night” meetings for bringing together diverse and discordant stakeholders and legislators around a compromise plan for CCOs.

The Wednesday night meetings were held in the fall of 2011 at Willamette University (just across the street from the statehouse) when the legislature was not in session. Approximately 45 stakeholders and policymakers met once a week for 9-10 weeks. Participants report that it was crucial having these face-to-face exchanges. Often the Governor or his Chief of Staff was in the room, along with key policy personnel from OHA. One Republican lawmaker felt the Wednesday night meetings educated him about health policy; he appreciated hearing candid talk from health experts. The meetings were not recorded and had an informal air with participants sharing best practices, asking questions and formulating ideas. The Wednesday meetings seem to have reassured stakeholder groups that no one would absorb all the costs of transformation, that everyone would have “skin in the game” and work together to produce a better, more rational system. Of course, not everyone was brought along. The long-term care component dropped out of the reform proposal because those interests never bought into the vision and felt that they had too much to lose. Overall, the Wednesday meetings

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<sup>59</sup> OHA, “Transforming the Oregon Health Plan” (September/October 2011) [author’s files]

created a set of shared assumptions and built relationships that would prove vital for keeping a bipartisan coalition together through the legislative process.

### **An (Un)Sustainable Policy Regime?**

While the CCOs represent an important transformation of the health care system in Oregon, it was also the continuation of significant long-range planning. The advent of OHP fostered health policy experts even in the face of policy failure. The Oregon Health Authority and its governing policy board provided the organizational resources for turning the state into a more rational purchaser of health, not just health insurance. Although a dogged defender of health reform was found in Governor Kitzhaber, it is remarkable how much ground work was laid for the current reform in the years that he was out of office. He is out of office again, replaced by a Democrat who is sympathetic to health reform but may not be a champion of it. We may get to test exactly how crucial his leadership has been. Medical providers support the tenets of transformation, but the system has an influx of new resources now; what will happen when global budgets truly do mean more difficult choices for how to rationally spend health care dollars? The fight over health care dollars could merely shift to the local level if efficiencies are inadequate to control medical inflation. Finally, the bureaucracy and its health policy experts have enjoyed an unusual level of continuity—even as Governors changed. That kind of continuity may not be possible in the future. Major policy changes can unravel, as the OHP case demonstrates. The health system has proved remarkably resilient, even in the face of budget crises before. The threats to the new order are clear.

## Legislative Timeline

- 1989 Passage of the Oregon Health Plan (OHP)
- 2007 Creation of the Oregon Health Policy Commission
- 2009 HB 2009 which established the Oregon Health Authority (OHA) is enacted.
- 2010 Patient Protection and Affordable Care Act (ACA) is signed into law by President Obama.
- 2011 HB 3650 establishes a plan for an Integrated and Coordinated Care Delivery System for Medicaid in Oregon
- 2012 SB 1580 approves the OHA proposal for Coordinated Care Organizations (CCOs)