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## PRIORITIZATION OF HEALTH SERVICES

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Speaker: HARVEY KLEVIT\*

MR. PAUL FLEISCHACKER: Dr. Klevit, a pediatrician, has spent 25 years with the Kaiser Plan as a medical director and in several other positions. Currently, he is the medical director for the Oregon Board of Medical Examiners. He is still actively practicing in pediatrics and in endocrinology on a consulting basis. Regarding the Oregon Health Plan, he headed a committee for the development of methodology to produce the prioritization service list. He's also a Commissioner on the Oregon Health Service Commission. He is a Clinical Professor of Pediatrics and Clinical Professor of Public Health and Preventive Medicine at the Oregon Health Sciences University in Portland. He is a member of various professional societies and has written numerous papers.

DR. HARVEY KLEVIT: It's indeed a great privilege for me to be invited to such a prestigious organization as the Society of Actuaries to share some of the details of the inception and I hope implementation of the Oregon Health Plan.

*In 1988, it became necessary for the state of Oregon, like many other states, to address a budgetary shortfall in the funding of health services for Medicaid recipients. The Oregon legislature determined that the government could no longer pay for most organ transplants and excluded such things as bone marrow, pancreas, lung, heart, liver and a few other transplants. Instead, the government would use the money that was recovered to provide maternity care, prenatal and delivery services to about 1,500 women for a total of \$1.1 million. As a result, a seven-year old boy was denied funding for a bone marrow transplant for leukemia, and he died, unfortunately, \$30,000 short of the \$100,000 necessary for private fund raising to obtain the procedure. This boy, whose name was Coulet Howard, became a cause celebrity in spite of the fact that I think most experts in hematology agree that he really didn't have a good indication for bone marrow transplant anyway.*

It was pointed out by a number of bioethicists, predominantly John Golinsky in California, that arbitrary removal of one type of treatment without considering the entire spectrum of health care was inherently unjust. Why pick on transplants? Why not consider surgical treatment of hemorrhoids or tattoo removal? You can go right down the list. Oregon was and still is at this moment rationing health care implicitly through decreasing the number of individuals eligible for Medicaid services; so at the present time only those individuals in the state of Oregon who are under the 67 percentile of the federal poverty line are eligible for services.

In 1990 the federal poverty level guidelines stated that a one-person family must have an annual income of \$6,280 or less to qualify for federal poverty. Let's say for an average family of three then, anything under \$10,560 would be considered the 100 percentile of the federal poverty line. Let me just give you some scenarios of individuals in the state that present problems.

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Approximately, at this point, 450,000 Oregonians, and that's about 18% of the total population, do not have health insurance. Of this 450,000, 65% are actually from families where one or more members are employed; so these are not all the unemployed poor. Fifty-two percent of the total are adults from age 18-65 and, of course, over 65 they get on Medicare. Forty-eight percent are children under the age of 18. Currently, approximately 200,000 poor Oregonians receive Medicaid, the federal/state program to provide health coverage for the poor. Approximately 120,000 other Oregonians living in poverty, over half of them women and children, are not covered by Medicaid.

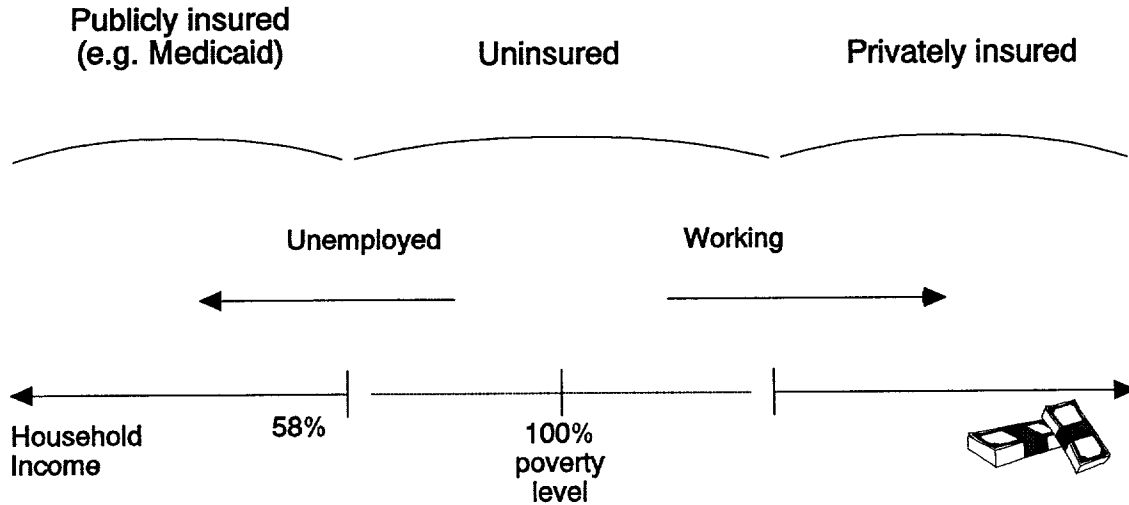
This is sort of a graphic description of the scenario currently (Chart 1). You see that under about the 58% line there is the publicly insured sector, and they're covered by Medicaid. On the right, of course, are the privately insured people, the people whom you so dearly love, and in the middle are the 18% uninsured, of whom many are unemployed. About 60% are unemployed and the rest are the working poor. What happens? Are these poor people who do not have coverage, either private coverage or Medicaid coverage, dying in the streets? What do they do when they need care? Well, you know what they do. They wait until the last minute. They turn into a hospital emergency room and they get care. It's uncompensated care. Uncompensated probably isn't a good term because what really happens is the hospital recaptures that uncompensated care by charging the rest of us more money so that it can balance its books at the end of the year. Private hospitals and clinics recapture through cost shifting, and the public sector does the same thing.

Well, here are some people who have no coverage, and we began to feel very badly about such people. A single mother whose husband died recently and whose 18-year old son just finished high school has no job and no income, but she doesn't fit into any of the right categories the federal government uses to qualify for Medicaid. She's not in a family with dependent children. Currently, the Medicaid mandate is you must be eligible for Aid for Families with Dependent Children. A family of three with an income of \$600 a month are clearly poor. The poverty level is about \$928 a month for a family of three, but they're too rich to qualify for coverage under Medicaid. Finally, consider a 20-year old single woman who works part-time for a fast food chain, earns \$400 a month, receives no health insurance from her employer, and has a chronic medical problem. Although she is poor, she doesn't qualify for Medicaid because she has no children. The only way she can qualify right now for Medicaid is to become pregnant.

This is what Oregon wants to do. We want to have no one in our state uninsured through increasing the level of eligibility for Medicaid and asking for the small employers to contribute. Spearheaded by John Kitzhaber (who himself is an emergency room physician in Roseburg, Oregon, a small logging community, and also the President of the Oregon Senate and an organization known as Oregon Health Decisions, which is a citizens nonprofit organization sponsoring public debate and involvement in health issues), the 1989 legislative session in the state of Oregon adopted sweeping initiatives to reduce considerably the number of individuals without access to health care.

These bills, comprising the so-called Oregon Basic Health Services Act, were designed to complement one another by providing access to basic health care for the 450,000

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uninsured of the state. One bill, Senate Bill 935, was a pay or play arrangement; that is, all employers would be required to provide health insurance for the 260,000 uninsured working Oregonians above the federal poverty level either directly through purchase of insurance or indirectly through contributions to a state-run pool. Another bill established a mechanism for providing coverage for the 20,000 individuals with preexisting conditions, which are often excluded by commercial health insurance – people with cancer, AIDS, diabetes, and so on.

Finally, the third, Senate Bill 27, was the most controversial. It has been widely publicized as Oregon's plan for rationing health care. It was designed to increase the eligibility for Medicaid coverage to the 100 percentile of the federal poverty level from the current 67 percentile. It will bring an additional 120,000 poor Oregonians on the Medicaid rolls. This will be done by limiting the number of health services the state would cover. The benefits covered for Medicaid recipients would also serve as a minimum package for the small employers, which they would be required to provide as well. In summary, there are three bills. One is the employers' pool. The other is the high-risk pool, which has already gotten off the ground, and finally Senate Bill 27, the so-called Medicaid rationing program. In summary, the Senate Bill 27 does several things. It fixes the income level to qualify for Medicaid coverage to the 100 percentile of the federal poverty level. There are very, very few states in the union that cover up to the 100 percentile. Most states reduce the amount of coverage to fit their own budgeting problems by virtue of the fact that the federal government allows you to set your own eligibility line at a certain percentile of the federal poverty level.

Providers, including hospitals, individual physicians, clinics, and so on, will be reimbursed at cost or higher. Currently, physicians might make 40 cents on the dollar and our hospitals are also underreimbursed. It was thought that it's very important to reimburse at cost to provide incentives for the health care providers who are not willing to take care of Medicaid patients because they are not properly reimbursed. It encourages managed health care because of the cost savings that, at least in some managed care systems, one can recover. It established a health services commission that was charged with the "simple" mandate of providing a list of services ranked from the most important to the least important. Finally, it establishes a methodology to adjust benefit packages based on the amount of money available. Because if the legislature decides it has less money for health care, it doesn't tell people you can't have Medicaid any more. The legislature just goes up the list and says that the list only covers the first 500 services rather than the first 570.

Currently, implementation of this plan is for July 1992, but the state still requires a federal waiver for certain Medicaid mandates. Now, it appears that the state has jumped through all the required hoops of Health Care Financing Administration (HCFA), Office of Technology Assessment, Health & Human Services (HHS), and that the waiver decision can be made either by the Secretary of HHS or through congressional action. We survived a hearing that was sponsored by Congressional Representative Henry A. Waxman, who's been an opponent of the system. It now appears that the decision might well be made in the Oval Office, because I don't think Louis W. Sullivan, Secretary of Health & Human Services, is going to give a waiver without the blessing of the Administration.

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The Oregon Health Services Commission then was appointed by the governor in August 1989, and given the simple and straightforward instruction to report a list of health services ranked by priority from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The bill includes additional provisions that are fundamental to the process. That's just the composition of the commission. There are 11 members, five of whom are physicians, and the physicians include a pediatrician, an obstetrician, a geriatrician, a family physician, a public health physician, and then there's a public health nurse, a social worker and four consumers of health care.

In terms of the ethical underpinnings – and there have been great debates – there seem to be two camps of bioethicists in the United States with regard to the Oregon plan. Very many feel that it's a utilitarian approach and that it is not stealing from the poor to pay for the poor. The architects of the plan simply state it is more equitable to assure everyone basic health care rather than to exclude some of the poor from more generous benefits available to most others. Explicit choice is better than hidden rationing. Right now, the rationing is quite hidden. No one really knows how the 67 percentile is arrived upon. All of our meetings have been open to the public, to the press and it is out in the open. Finally, health care priorities should be built on both community values and expert technical judgments about health services.

We had a great deal of public input, including 47 community meetings all over the state, with a great deal of effort to solicit attendance at those meetings by the poor, by the underserved, by minority groups such as migrant labor groups, Hispanic groups, and so on. There were 12 public hearings where the commission listened to various special interest groups who thought they should be included in the priority list, and this included various alternative providers such as chiropractors, naturopaths, massage healers, and so on. There was a telephone survey that was utilized to provide weights to certain symptoms and disabilities that I'll tell you about in a moment for the purpose of calculating the "quality of well-being" (QWB) score, which we used to measure the benefit of a particular service.

The Health Services Commission began with this simple charge that I mentioned, just to draw up a list and give it to the governor. We were given six months to do this. After a couple of hours of being daunted by the enormity of the task, we were given a little more time. It was made clear from the moment of our oath of office that the expectation was for us to take every single diagnosis in the International Classification of Diseases – 9th Revision (ICD-9) manual, which I would assume most of you are familiar with, and every treatment in the current procedural terminology (CPT) manual, and tell the government how good these things were. So how good were the treatments for the diseases? It doesn't take a Ph.D. in mathematics to figure out that's a lot of permutations and combinations, because the government expected each line to be a treatment for a disease. Well, there are thousands and thousands of them, as you well know.

Initially, the health outcomes committee, which I had the good fortune to chair, felt that we needed an objective methodology utilizing numbers, formulas, ratios, and equations because we needed to have some credibility and we needed objectivity. Acceptability and fairness of the final product needed to be based on such an

objective methodology. Besides, the chairman of our commission was a CPA who probably took a couple of actuarial courses and a corporate CEO and he was attracted to such marvels as balance sheets, chi squares, multivariate regression analysis, and so on. We hunted around. How were we going to make this list? We could have torn out all the pages of ICD-9 and CPT and thrown darts. That would have been one way. We decided that we would like to attempt a cost/benefit ratio of some sort.

We attempted to get costs through historical data that had been accumulated by the State Office of Medical Assistance Programs, by Blue Cross/Blue Shield and by other insurance carriers. But how would we measure the benefit part of the ratio?

Well, we stumbled across a method known as the QWB that was devised by a professor at the University of Washington, Donald L. Patrick, and modified by Robert Kaplan at University of California/San Diego. The QWB is simply a report card on health. If you are perfectly healthy, you don't have an ache, you don't have a pain, you're not bald, you don't wear glasses and you don't have any emotional hang-ups, you are a one. If you're dead, you're a zero. Everybody else is some place in between, because a weighted fraction is removed from one for every symptom, every handicap, every disability that you have -- and that would include such things as wearing eyeglasses, taking medications, having difficulty with communication, ambulation, social functioning, and so on.

We decided that's how we're going to get to the benefit side of the cost/benefit analysis. We're going to say that when you develop a certain disease, you have a QWB score. Let's take an easy one. Let's take acute appendicitis. Let's say you are perfect and you start out with a one. Now you have appendicitis and you have symptoms. You have abdominal pain, nausea, vomiting, and fever. The public has given us weights for all of those symptoms, so now you have symptoms of acute appendicitis and you even have a certain disability where, if it's not treated, you may die. Let's say that in a typical case of appendicitis you fall from one to .47, but the friendly surgeon marches in with his knife, he takes out your appendix, and you go almost back up to one again. You might have a scar now and some stitches and maybe you have to take a little medicine or something. The difference between QWB with appendicitis versus QWB without appendicitis after the intervention was defined as the net benefit of that treatment. So now we have a number to represent benefit produced by a treatment, a medical service of some sort, an intervention. But that only gives us the benefit at a point in time. What good is a benefit if it's only going to last a day or even a week? You paid \$10,000 for it. Are you going to be sick again? So, we also added duration of benefit. Get your appendix taken out and you're not going to get appendicitis again, so it's a lifetime benefit. So we subtract the patient's age from life expectancy and multiplied that net benefit by duration. Now what do we have? We have a quality adjusted life year. You divide the quality by cost, and that's cost/benefit ratio, and that gives you the cost to produce a quality adjusted life year in that particular patient. We said, "Eureka, we've found it! This is how we're going to construct this list."

We refined it a little bit more by saying that there is a certain probability that a treatment will work. The appendectomy may only be effective 90% of the time or the cancer treatment may only be effective 20% of the time, so we corrected for

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probability. That's also called health outcome, and there's a big movement going on about that. We were very disappointed in the amount of information in the scientific literature on health outcome, and that's where we called in 200 medical providers of care to tell us how good the various treatments and interventions that they used were. A functioning model of the formula in Oregon is seen below:

$$B_n = \frac{c}{Y * \left[ \sum_{i=1}^5 \left[ (p_{i1} * (1 + \sum_{j=1}^{30} d_{ij} w_j)) - (p_{i2} * (1 + \sum_{j=1}^{30} d_{ij2} w_j)) \right] \right]}$$

[-With Treatment -]      [-Without Treatment -]

Now we stuck all this stuff in the computer and this is the QWB (Chart 2). It just shows you the various categories. This is the list of symptoms, things like abdominal pain, chest pain, coma, rash, itch, that sort of thing. These are the weights that we got by interviewing 1,000 Oregonians so each symptom, each disability had a weight. From all of that and what I've just explained to you, we developed a formula. We provided the computer with the data and put it in a database. I think we used Paradox, and it gave us a list, based upon cost/benefit ratios, from the most cost beneficial to the least cost beneficial.

Initially, the computer gave us a list of some 1,600 lines. It was bulky and we really had some fears and trepidations about this thing, but I'll never forget that day when we knew the first run was coming out of the computer. It made us think a little bit like this. We're rowing along in our lifeboat, and boy, this is one of those days we'll always remember. We're just about ready to go over the waterfall, because that's exactly what happened.

Intuitively, the thing was just wrong. People with life-threatening diseases like heart attacks and bacterial meningitis were on the same position in the list as kids with crooked teeth from thumb sucking. It was just a mess. I still believe the idea is right. We just don't know how to use it yet, and this QWB method needs to be revised so that it can work. We have several people doing research on this methodology, but we were embarrassed. The press had a heyday with us. There was a photograph in the *Portland Oregonian* of a doctor and he's got his catalog of health care rationing. The caption says, "Wow, this is really dumb. Man with bowling ball stuck on thumb is 793, but swallow a tricycle is only 997." We had numerous items like that.

One did not need to be a professor of medicine to see the large number of misplaced items on the initial list. After much discussion, we decided to work on that first methodology to continue to refine it, but define something else, because we only had a few months to give the legislature this list that it would have to approve. Before doing that, we had to take the list to the actuaries to price out each line. Enter actuaries. Isn't that great? Can I mention names? We had a contract with Coopers & Lybrand, which did a wonderful job in pricing out the list after we corrected it and made it workable. So what did we do?

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CHART 2  
HEALTH SERVICES COMMISSION

Condition	Oregon Total Sample		
	QWB Weight	Experienced	
		Yes	No
MH (MOB1) Hospital/nursing home	-0.063	200	257
MT (MOB2) Unable to drive or use transportation	-0.053	93	464
PB (PAC1) In bed or wheelchair controlled by someone else	-0.597	42	491
PW (PAC2) Have used wheelchair/walker under your own control	-0.400	41	519
SN (SAC1) Needed help going to the bathroom or eating	-0.108	18	482
SL (SAC2) Limited in recreational activities	-0.063	178	380
1. Loss of consciousness due to seizures, blackouts, or coma	-0.117	15	288
2. Bad burn over large areas	-0.378	14	540
3. Drainage from sexual organs and discomfort or pain	-0.328	61	489
4. Trouble learning, remembering, or thinking clearly*	-0.395	69	491
5. Difficulty walking because paralyzed or broken leg	-0.270	-	-
6. Pain or weakness in back or joints	-0.273	293	271
7. Pain while urinating or having a bowel movement	-0.311	116	441
8. Stomachaches, vomiting, or diarrhea	-0.382	220	337
9. A lot of tiredness or weakness	-0.291	130	433
10. Coughed, wheezed, or had trouble breathing*	-0.334	163	397
11. Often felt depressed or upset	-0.354	139	418
12. Headaches or dizziness	-0.328	211	353
13. Itchy rash over large area of body	-0.317	93	469
14. Trouble talking	-0.198	20	545
15. Pain or discomfort in the eyes or had vision problems that corrective lens cannot fix	-0.266	49	517
16. Overweight or had acne on the face	-0.228	258	301
17. Pain in ear or trouble hearing	-0.232	177	390
18. Prescribed medication or diet for health reasons*	-0.138	235	329
19. Wear glasses or contact lens*	-0.080	389	179
20. Trouble falling asleep or staying asleep	-0.259	187	376
21. Trouble with sexual performance*	-0.272	38	506
22. Unable to stop worrying	-0.236	93	465
23. Trouble with the use of alcohol or drugs	-0.460	38	486

\* Significant difference in QWB weight relative to experience.



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We decided we're not going to be able to use the cost/benefit ratio, and why don't we try to give priority to generic categories of care rather than trying to tackle this huge textbook of medicine. We decided upon 17 categories of health care. We had 26 first and went down to 17.

These categories had to do with whether the condition and the treatment is a life or death thing, is it something that will kill you if you don't get treatment and, if you do get treatment, will you return to your former state of health and go back to work, or does the treatment save you from death but you might be left with some disability? Is it maternity care? Is it preventive care? Is it comfort care for people who have terminal problems but deserve to have comfort and peace? Is it a chronic disease for which the treatment improves the quality of life? Is it a chronic disease for which the treatment doesn't improve the quality of life?

We then had the chore of taking these 17 categories and deciding what's most important and what's least important. We did that on the basis of what the public told us was most important to them. If anyone comes to us and says it's all wrong, your values are screwy, we can say, "Hey, it's not ours, it's the public's. They told us and that's what we've done." The public gave us some very good data and good values. On the basis of importance to the individual, importance to the populations served and the importance of including a service in a basic health care package, through a delphi process, a consensus forming process, the commissioners arranged these categories on the basis of most important to least important.

As I've already said, we defined the 17 categories. We tucked each condition/treatment pairs, the ones that were so cockeyed on the first list, into a category so it became sort of a subcategory and within the category the condition/treatment pair was ranked on the basis not of cost/benefit ratio, but just net benefit alone. We removed duration of benefit. We removed cost. We had a lot of criticism in cost. The public is really hooked on something called the rule of rescue. It doesn't care how much it costs for you to get the little girl who fell in the well, bring her up and save her life. The public would rather pay for that than pay for 5,000 women who need prenatal care or a family of five who goes out on a picnic on a Sunday afternoon and eats the wrong kind of mushrooms and all need liver transplants. The public would rather pay for one publicized event than other things that would be applicable to many, many more people. We had to take that into account.

The list was then reviewed after we put all of the conditions and treatments into the appropriate prioritized category. We did what we called list jockeying on the basis of such things as public health parameters, and for that reason, say tuberculosis which is coming back, was midway through the list. It was in the 300s and is now on the first page of the list; because if you don't treat tuberculosis, tuberculosis is going to spread to the public. We did some moving on the basis of public health parameters and other things. The nine categories we considered essential – acute, fatal, full recovery with treatment number one.

The public told us that its maternity care was so lousy that was the second most important. Life saving was first. Maternity care was second. Then we get into acute, fatal conditions where treatment prevents death, but the recovery is not complete. Preventive care for children was very high. Then we get into chronic, fatal

things where you can improve the life span with treatment: diabetes, for example. Reproductive services include contraception. They also include, by the way, therapeutic abortion, if the federal government will let us cover it. Reproductive services exclude maternity care, which is higher on the list, and infertility treatment, which is lower on the list. Comfort care for the dying, for those people with incurable diseases comes next. Preventive dental care came out rather high, I thought. Then proven effective, preventive care for adults. Pediatric preventive care was given higher priority than was adult preventive care. That's because we feel that immunizations and picking up children with reading disabilities and that sort of thing early in life probably is more effective than things that adults are subjected to like stress management and antismoking, antiobesity, and so on. Those are the first nine categories.

The next four categories, we told the legislature, were very important but were not essential, and there are some other fatal or chronic conditions where one-time treatment, such as a liver transplant, will improve the quality of well-being. Then the next four are those things that are less valuable to certain individuals, and that's where such things as infertility services, less effective preventive care for adults and fatal or nonfatal treatment is futile and it doesn't do anything for the patient. So those are our categories in the order that they were given priority.

Then we took each specific condition with its treatment and tucked it into the appropriate category, and that gave us a list that was then priced out by Coopers & Lybrand. The legislature looked at the list and said, "Okay, we can afford to fund this thing now that we have the numbers from the actuary down to line 587," which, by the way, was peptic esophagitis, another name for heartburn, and was approved by the legislature. The federal government then was asked for the waiver, and we expect a decision to be made on the waiver any day now. The other thing that I have to mention to you is that if you don't have a diagnosis, then you don't know whether you're entitled to treatment. So everyone with a symptom on this plan is entitled to a diagnostic work-up. We didn't feel we had the time or even the data to try to give priority to diagnostic work-ups or diagnostic treatment.

Each person is entitled to have a diagnosis and every time you have new symptoms you're entitled to a new diagnosis. Now, you might learn, with your diagnosis, that you have a condition that's below the cut point of the list and that the state will not fund it, but at least you know what you have. Necessarily ancillary services are part of each treatment and this includes prescription drugs and durable medical equipment. As I mentioned, preventive care is ranked highly, as is comfort care. Remember, I said we had essential categories, very important categories, and valuable only to certain individuals categories. Ninety-eight percent of everything we called essential has been funded by the legislature, 82% of everything we called very important and only 7% of those things valuable only to certain individuals.

The commission, I think, was disappointed in the first crack at this thing because we didn't have good health outcomes and useful scientific data, but we feel this is a historic document deserving your attention. The commission will continue to work to refine, upgrade and update the list. In fact, in 1992 we are integrating mental health and chemical dependency diagnoses into the master list. We thought the other thing was hard, but this is impossible. It's really a difficult assignment. I think something like this has to be done, and it can be done to forestall the imminent health care crisis

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in the United States. If we fail to obtain this federal waiver and our efforts serve only to stimulate other states to search for more effective approaches to the escalating cost of health care based upon more sound principles, we will not have felt that our labor went unrewarded.

We're covering organ transplants, the ones that have been of proven benefit. We're covering liver transplants for chronic hepatitis, and we're covering bone marrow transplants for childhood leukemia, kidney transplants for chronic renal failure. The only one that might be near and dear to the audience, because there's been so much publicity, is bone marrow transplant for marrow recovery following chemotherapy for breast cancer. The final word hasn't come in on that, even though many health insurance carriers are being forced to cover that.

**FROM THE FLOOR:** Were the decisions all diagnosis-based or was there anything on age? Is there some sort of differentiation for 65 and over?

**DR. KLEVIT:** You won't make it with the federal government if you do that, because that would be age discrimination. The only place where age came in was initially when we used duration of benefit to calculate the cost/benefit ratio. We multiplied by duration, and duration of benefit was obtained in those things with a lifelong benefit by subtracting the age from the life expectancy. So a child is going to have a very long duration of benefit. So things that tend to occur in childhood were very favorably placed on the list because of the long duration of benefit.

**FROM THE FLOOR:** Along those same lines, someone who is older might simply not be able to withstand the treatment because of the physiology of the person, so would that also be taken into account and have a special method of calculation?

**DR. KLEVIT:** I'm really glad you asked that. I think the one thing that I neglected to mention is basic to this whole thing. Just because a treatment for a condition is above the line doesn't mean that the individual or the patient is entitled to that treatment. It depends on whether it's medically necessary. So if you have someone, let's say, with hepatic liver failure and who also has diabetes and is 85 years old, the primary physician is going to say that a liver transplant would not be appropriate, even though if he said it was appropriate it would be paid for. So the bottom line is still up to the clinician who is managing the patient's care.

**FROM THE FLOOR:** Could there be situations where a treatment above the line is encouraged or the doctor might want to use a more appropriate treatment that's below the line?

**DR. KLEVIT:** That's an oft-asked question, and we tried to find examples of that and were hard put. Can you think of something that comes to mind? I think what the questioner asked was are we going to be placed in a position where the more desirable treatment, the one with the more favorable outcome is below the line and we have to substitute some less effective therapy. We were very concerned about that, including the Office of Technology Assessment because that's something it wanted to scrutinize as well. We haven't had any instances of that, but certainly that is a concern.

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FROM THE FLOOR: Because for a provider to be paid that cost or higher, when would you ever pay a provider at higher the cost?

DR. KLEVIT: If I said or higher, I didn't mean to. There would be no reason to pay or higher.

FROM THE FLOOR: On your list, where would treatment for AIDS be, like AZT? How high was that on the list?

DR. KLEVIT: We have AIDS at several locations. First of all, you don't die from AIDS, you die from Kaposi's Sarcoma or pneumocystis pneumonia or cytomegala virus disease. I wasn't kidding, but bacterial pneumonia is first on the list, and it doesn't matter whether you have AIDS or not. Treatment of uncomplicated AIDS, let's say someone who fulfills the official definition of the lowering of T-killer lymphocytes to a certain level, is someplace in the 300s. It's safe. The funding level is not going to attack treatment of AIDS.

Controversy has arisen over a line on the list that addresses terminal patients with AIDS, treatment with chemotherapy; in other words, instituting AZT or some other chemotherapeutic regimen in an AIDS patient who is thought to have less than six months to live. It's the same category as individuals with metastatic cancer who have less than six months to live. That treatment with specific chemotherapeutic intervention is below the line because it was regarded as futile. Maybe at best you're going to increase life another month or so, but at great cost not only to society but also to the individual, and that's why we regarded comfort care so highly on the list. That AIDS patients will be entitled to hospice care, to hospital care for pain control, for nutrition, for whatever they need, but specific chemotherapeutic treatment would not be covered.

FROM THE FLOOR: To what extent does your priority list deal with alternative courses of medication completely separate from any surgical intervention? Does it also deal with medication sequence A versus B and situations where there's a dispute over what's best?

DR. KLEVIT: At this point, it would be doctor driven. We hope that, at the beginning of this program, 80% of all recipients will be under managed care systems. It would be then up to the managed system with the contract with the state to develop its own formulary in an effort to keep its costs down. Again, the bottom line is if the physician says this drug is better than that drug, we'll pay for this drug.

FROM THE FLOOR: How did you deal with public input expressing a desire for something which is a petition, such as where the outcome of not having preventive dentistry isn't really drastic?

DR. KLEVIT: Right. That's why we have several lines for dentistry. As a matter of fact, children's preventive dentistry is very high. Restorative dentistry is much lower. The public gave us a signal that they're tired. In the state of Oregon right now, if you need restorative dentistry, you don't get it. You get a blender. I'm not kidding you. You get a blender to maintain nutrition. That's been subject to a lot of ridicule. Henry Waxman loved that one. It's a very good question. We pretty much stuck

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with what the public told us and I can't think of too many petitions. You ask the average individual who comes to these meetings, because they keep saying I want, I want, I want, We need, We need, We need. Well, what can you get along without? They'd scratch their heads and they'd have a hard time. Then suddenly someone will say, usually a woman, "They do too many hysterectomies in this country." Okay, good. Now, are you talking about hysterectomies for cancer or maybe just for the menopausal blahs?

You work with the public and you help them. This is a hard concept for the public to understand. They seem to understand that they're going to get a better deal, at least those people who have no access to health care are going to get a better deal. The ones who currently do have Medicaid are not going to get quite as good a deal and we're trying to educate them that what they will no longer be entitled to isn't very important anyway.

We had a hard time with intensive care treatment, like maybe we should put an asterisk next to everything that's entitled to intensive care unit (ICU) care. We just couldn't do that and we're going to have to leave it up to the physician. If the physician feels that there is a good reason to pull out all the stops on this particular patient because there is a high probability that you will gain in expected life years or in quality of life, it's going to support it. Again, with managed care, the state has already paid Kaiser or Blue Cross or whoever is managing the care. It's between the physician and the organization that is paying the bills now, because the state is no longer paying the bills. It's the managed care organization. If there are a couple of physicians who put everybody in the ICU at great expense, somehow the chief of that service is going to say, "Hey, Harry, you've been putting a lot of patients in the ICU. Do you really need to?" So it's that kind of peer pressure that we think is going to make the difference.

The answer to that question is going to wait until we have solid outcome data and clinical guidelines for physicians to go by. I'll give that five to ten years.

