

Open Doors to Primary Care Should Add a “Screen” to Reduce Low-Value Care

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Health insurance benefits are an increasingly popular strategy to better engage consumers and control the growth of healthcare expenditures. The most common patient-facing strategy used by public and private payers is consumer cost shifting. The use—and amount—of plan deductibles has increased dramatically in recent years; more than 40% of adults with employer-based coverage are enrolled in a plan with high deductibles.¹ This popular “closed door” cost-sharing model lowers spending through blunt financial barriers, effectively shutting out use of both high- and low-value health services (Figure).²⁻⁵ To mitigate the negative health consequences of this indiscriminate cost-sharing method, value-based insurance design (VBID) uses a clinically nuanced approach by setting out-of-pocket costs based on the clinical value—not price—of healthcare services. In VBID plans, cost sharing is reduced for beneficial services and increased for services identified as not improving health.^{6,7} Potential savings from reduced spending on unnecessary care could be then used to lower premiums or provide more generous coverage of high-value services.

VBID principles are the foundation for section 2713 of the Affordable Care Act, which requires the elimination of consumer cost sharing for recommended preventive services as specified by the US Preventive Services Task Force (USPSTF) and the CDC.⁸ In addition to expanding access to preventive care services for more than 140 million Americans, VBID has been implemented extensively for prescription drugs by public and private payers. A 2018 *Health Affairs* review of 21 studies reported that reduced cost sharing for high-value medications significantly improved adherence and was associated with no effect on total healthcare spending, implying that the incremental drug spending was offset by decreases in spending for other healthcare services.⁹

These examples suggest that there might be additional clinical VBID applications, particularly in the primary care setting. Using more evidence-based primary care services is appealing because counseling in healthy behaviors, prevention, early detection, advanced care planning, and chronic disease management are hallmarks of a well-functioning and efficient delivery system. However, despite the obvious upsides to increased access to high-value primary care,

policy makers must proceed with caution when promoting policies that advocate unrestricted and unlimited primary care access. The problem here is akin to opening the door too wide and enabling easy access to both high- and low-value care (Figure).

Unlike discrete services such as mammography, smoking cessation counseling, a statin prescription, or a complete blood count, a primary care encounter often entails a number of clinical services. Thus, a policy encouraging indiscriminate primary care could lead to the use of services that cause patient harm and wasteful spending (eg, USPSTF D-rated services), diminishing the desirable health benefits and efficiencies that result from the increased use of high-value services. A recent analysis reported that low-cost, high-volume services—many performed in primary care settings—contribute the most to spending on low-value care.¹⁰

In this issue of *The American Journal of Managed Care*[®], Ma et al describe the impacts of a VBID intervention that removed cost sharing for primary care visits.¹¹ The authors found no statistically significant increase in primary care visits, although they reported measures consistent with a better managed patient population—for example, decreased emergency department (ED) visits for primary care–treatable conditions. The study found lower medical spending growth in the VBID cohort compared with the control group (12% vs 17%), driven mainly by lower ED and non–primary care outpatient service use.

Evidence from this study and others demonstrates that lower cost sharing for primary care improves the use of high-value preventive services.^{12,13} However, studies evaluating the impact of programs that reduce financial barriers for primary care visits rarely assess the potential for unintended consequences—specifically, the potential for increased use of no- and low-value care that may result from enhanced primary care access. Any primary care visit can include both high- and low-value services. Our recent *Health Affairs* study found that one program designed to increase the use of high-value primary care services successfully achieved that desired goal but also unintentionally increased low-value care utilization.¹⁴

These unwanted spillover effects warrant the development of targeted payment systems and benefit designs that simultaneously

FIGURE. Use of Doors to Illustrate How Benefit Design Influences Use of High- and Low-Value Services

encourage high-value services and include specific deterrents to low-value care. To improve on nonnuanced “closed door” designs that reduce high-value care and “open door” designs that promote nonspecific services and enable the use of low-value care, the use of “screen door” designs would selectively permit high-value services and filter out low-value care (Figure). The screen door analogy makes plain the need to explicitly decouple high- from low-value care. Without targeted incentives for both kinds of services, their use is likely to continue to move in tandem. A number of provider-facing (eg, alternative payment models) and patient-facing (eg, benefit designs that increase cost sharing for low-value care) levers are currently being implemented and evaluated. Success is more likely if both provider and patient incentives are aligned.¹⁵

Available evidence shows that it is unrealistic to expect that simply improving access to primary care will reduce expenditures on low-value care. If primary care specifically, and our healthcare delivery system in aggregate, are to fulfill their promise of promoting a healthier population and more efficient spending, we must be deliberate in our efforts to curtail spending on low-value services. ■

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