REDUCING USE OF LOW-VALUE MEDICAL CARE

PROBLEM OF OVERSPENDING AND UNDERPERFORMING IN THE UNITED STATES

The United States spends more on health care per capita than any other country but does not achieve better outcomes. A substantial share of this spending is devoted to services that buy no additional health, and in some instances, expose patients to serious risk of harm. Experts have estimated that between $158 billion and $226 billion is spent on low-value care every year (2011 dollars).[1] Private payers and the commercially insured bear the cost of between $90 and $140 billion of this amount.[1] Separate research has estimated that between 23% and 37% of Medicare beneficiaries receive at least one low-value service per year, and there is reason to believe even the upper estimates are too conservative.[2]

HARM FROM LOW-VALUE CARE

Beyond the heavy price that public and private purchasers pay, use of low-value care is harmful for patients.
Low-value care can:

- Expose patients to iatrogenic harm. For example, an inappropriate computed tomography (CT) study raises lifetime risk of cancer without commensurate benefit, screening for colorectal cancer often raises the risk of perforation without reducing mortality, and inappropriate use of antibiotics can raise the risk of serious infection.
- Impose high out-of-pocket costs. In an era of high-deductible plans, analyses have found that between 17% and 33% of spending on low-value care is paid by patients, leading to hundreds or thousands in financial exposure.[3,4]
- Lead to lost time, lost productivity, and “botheredness.”

Partnering with more than 70 professional societies, the *Choosing Wisely* campaign has identified about 500 commonly overused services across the spectrum of medical care.[5] Many of these services are expensive, harmful, and/or common.

REDUCING LOW-VALUE CARE

The clinical benefit of a service is never always high-value or low-value; what benefits one person may harm another. This is where clinical nuance comes into play. The tenet of clinical nuance recognizes that 1) medical services differ in the amount of health produced, and 2) the clinical benefit derived from a specific service depends on the consumer using it, as well as when and where the service is provided. In other words, context matters.

While the *Choosing Wisely* campaign has brought greater attention to the issue of low-value care, the broad dissemination of the recommendations has only modestly impacted receipt of targeted services.[6,7] To reduce the use of high-priority, commonly overused services while respecting the need for clinical nuance, several additional approaches merit the attention of payers and purchasers.

Provider-Facing
Coverage Policies- No reimbursement for services that are clearly inappropriate based on administrative data.
Payment Rates- Consider the risk of overuse across services in negotiating or setting allowed amounts.
Provider Profiling Information- Provide reports benchmarking the practice patterns of a clinician or practice against those of peers.
Payment Models- Accelerate adoption of new approaches to reimbursement that reduce financial incentives for overuse.

Patient-Facing
Network Design- Steer patients to providers and plans that minimize use of inappropriate medical services.
Utilization Management- While minimizing administrative burden, selectively consider prior authorization programs.
Value-Based Insurance Designs- Align patients’ out-of-pocket cost-sharing with the value of the underlying service. For commonly overused services, selectively allow cost-sharing to serve as a “speed bump.”

The most effective initiatives in this area will likely couple interventions to change provider behavior with carefully designed incentives for consumers. There are promising examples of each of these strategies in the field today. By learning from existing work and pioneering new approaches, payers and purchasers can better protect patients from the physical, financial, and time-related harms of overuse; support allied efforts in the provider community; and free limited health care resources for more productive uses.

UNIVERSITY OF MICHIGAN CENTER FOR VALUE-BASED INSURANCE DESIGN

University of Michigan faculty first conceptualized and coined the V-BID concept and have guided this approach from early principles to adoption in the private and public sectors, including demonstrations in Medicare Advantage and TRICARE programs. Since its inception in 2005, the University of Michigan Center for Value-Based Insurance Design has led efforts to promote the development, implementation, and evaluation of innovative health benefit designs that improve quality and lower costs -- the primary goals of healthcare reform.

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