# Reducing the Use of Low-Value Medical Care

The US does not achieve health outcomes commensurate with its spending on health care.[1] The overuse of low-value medical care is a major driver of this inefficiency. Low-value care means services and drugs that provide little to no clinical benefit, and in some cases, expose patients to significant harm and unnecessary out-of-pocket costs. The Choosing Wisely initiative identifies over 500 commonly overused, harmful, and/or expensive services, representing the medical spectrum.[13] Reducing the use of low-value care creates "headroom" for high-value care or addressing social determinants of health.

## Low-value care wastes tax-payer money and harms patients in public and private systems.

- Experts estimate that between $158 and $226 billion is spent on low-value clinical care every year.[2]
- Common low-value services (eg, diagnostic testing and imaging before low-risk surgeries) often lead to incidental findings, more tests, and more harm, which are not captured in dollar estimates.

## Low-value care can expose patients to significant harm with little to no clinical benefit.

- PSA Screening for men over 70 is a D-rated service by the USPSTF[16], but Medicare still spent upwards of $79 million on these screenings in 2014.[3]
- Inappropriate CT studies raise the lifetime risk of cancer without commensurate benefit.
- Screening for colorectal cancer too often raises the risk of perforation without reducing mortality.
- Inappropriate use of antibiotics can raise the risk of certain serious infections.


## Low-value care exposes patients to unnecessary out of pocket expenses.

- Analyses have found that between 17 percent and 33 percent of spending on low-value care is paid by patients: hundreds or thousands in financial exposure, especially in HDHPs.[4,12]
- Out of pocket spending on unnecessary care is dangerous; the average American family does not have $400 for an emergency payment.[17]

## Popular reporting continues to draw attention to the drain of low-value care on health care resources.

- Popular and academic articles alike continue to draw attention to significant overuse: New Yorker, PLOS, NPR, NYT The UpShot, Health Affairs, and more.
- Patients worry about paying for health care, especially novel and effective new treatments, while we spend significant sums on care that leads to no benefit or even harm.
- Payers struggle to finance novel approaches to population health (eg, addressing social determinants), while we spend resources on low-value care.

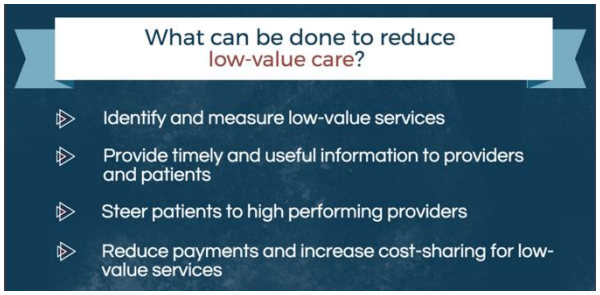
## Reducing low-value care is not health care "rationing".

- Efforts to reduce low-value care are targeted towards services with significant evidence and, in many cases, clinical consensus, yet actual clinical practice patterns lag behind.
- Efforts to reduce low-value care need to be clinically nuanced: no service is always low- or high-value, the value depends on who, what, where, how, and when.
- Reducing low-value care can increase headroom to address social determinants of health.

## How to address low-value care

### We can use claims data to identify and measure likely low-value service provision.[3–10]

- Between 34 and 72 low-value services were provided per 100 FFS beneficiaries in 2014; Medicare spent between $2.4 billion and $6.5 billion on these services.[3]
- Commercially available tools have identified about 2 to 3 percent of all-payer expenditures as low-value, from a small subset of potential low-value services.[11]




### Standard levers to reduce No- and Low-Value Care.

| Provider-Facing | Patient-Facing |
|---|---|
| **Coverage Policies** | **Network Design** |
| Do not reimburse for services that are clearly inappropriate based on administrative data (e.g., claims, enrollment data). | Steer patients to providers and plans that minimize use of inappropriate medical services or use tools like clinical decision support and shared decision-making. |
| **Payment Rates and Payment Models** | **Utilization Management** |
| Consider the risk of overuse across services in negotiating or setting allowed amounts. Accelerate adoption of new payment models that reduce incentives for overuse. | Consider narrowly targeted prior authorization programs while minimizing administrative burden. |
| **Provider Profiling Information** | **Value-Based Insurance Designs** |
| Distribute reports benchmarking the practice patterns of a clinician or practice against those of peers. | Align patients' out-of-pocket cost-sharing with the value of the underlying service. For commonly overused services, allow selectively increased cost-sharing. |
| **Clinical Decision Support Tools** | |
| Alert providers at the point-of-care when a commonly overused service is ordered. | |

### Where to start: high "waste-index" services

The Task Force on Low-Value Care has identified a "Top Five" commonly overused services, based primarily on the fact that these services are almost always low-value (ie, high waste-index), outside of very specific clinical situations, and can be easily identified in administrative data:

1. PSA Screening for Men over 75
2. Population-based Vitamin D screening
3. Diagnostic testing and imaging before low-risk surgery (eg, EKG before cataract surgery)
4. Imaging in the first six weeks of non-specific low-back pain
5. Branded drugs when identical generics are available (eg, Lipitor)

The Affordable Care Act specifically includes language that grants the Secretary authority to not pay for USPSTF D-rated services under Medicare (Sec. 4105). In addition, MedPAC lists 31 low-value services, all of which overlap with the Task Force's Top Five, and many of which are also included in Choosing Wisely lists.

### Payer levers will work best when provider and patient incentives align

The most effective initiatives in this area will likely couple interventions to change provider behavior with carefully designed incentives to affect consumers. There are promising examples of each of these strategies in the field today, such as Cigna's simple medical policy to reduce the number of vitamin D screenings.[18]

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