Reducing Use of Low-Value Medical Care

Problem of Overspending and Underperforming in the United States

The US spends more on health care per capita than any other country but does not achieve outcomes commensurate with that spending.[1] A substantial share of this spending is devoted to services that buy no additional health, and in some instances, expose patients to serious harm. Extrapolating from studies of variation in patterns of practice, experts estimate that between $158 and $226 billion is spent on low-value care every year (2011 dollars).[2] Private payers bear the cost of between $90 and $140 billion of this amount.[2] And there is reason to believe even the upper estimates of low-value care are too conservative.

Patient-specific estimates of low-value care drawn are most actionable, and great progress has been made in using claims data to identify and measure instances of likely low-value service provision.[3–10] Commercially available tools can identify about 2 to 3 percent of all-payer expenditures as low-value.[11] Separate research has estimated that between 23% and 37% of Medicare beneficiaries receive at least one low-value service per year.[3]

Harm from Low-Value Care

Beyond the heavy price that public and private purchasers pay, low-value services harm patients. Low-value care can:

- Expose patients to iatrogenic harm. For example, an inappropriate computed tomography (CT) study raises the lifetime risk of cancer without commensurate benefit. Screening for colorectal cancer too often raises the risk of perforation without reducing mortality. And inappropriate use of antibiotics can raise the risk of certain serious infections.
- Impose high out-of-pocket costs. In an era of high-deductible plans, analyses have found that between 17 percent and 33 percent of spending on low-value care is paid by patients.[4,12] This can mean hundreds or thousands in financial exposure.
- Lead to lost time, lost productivity, and "botheredness."

Partnering with more than 70 professional societies, the *Choosing Wisely* initiative has identified about 500 commonly overused services across the spectrum of medical care.[13] 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 counts.

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.[14,15] To reduce the use of high-priority, commonly overused services while respecting the need for clinical nuance, several additional approaches merit the attention of purchasers.

Provider-Facing
Coverage Policies Do not reimburse for services that are clearly inappropriate based on administrative data (e.g., claims, enrollment data).
Payment Rates and Payment Models Consider the risk of overuse across services in negotiating or setting allowed amounts. Accelerate adoption of new payment models that reduce incentives for overuse.
Provider Profiling Information Distribute reports benchmarking the practice patterns of a clinician or practice against those of peers.
Clinical Decision Support Tools Alert providers at the point-of-care when a commonly overused service is ordered.

Patient-Facing
Network Design Steer patients to providers and plans that minimize use of inappropriate medical services, including through tools such as clinical decision support and shared decision-making.
Utilization Management Consider narrowly targeted prior authorization programs while minimizing administrative burden..
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 to affect 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 purposes.

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