# Choosing Wisely
## Low-Value Services, Utilization, and Patient Cost Sharing

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THE JUNE 2012 ISSUE OF *CONSUMER REPORTS* includes a cover story entitled "5 Medical Tests You Don't Need." The story reflects a joint Choosing Wisely[1] initiative by *Consumer Reports* and the American Board of Internal Medicine aimed at "encouraging physicians, patients and other health care stakeholders to think and talk about medical tests and procedures that may be unnecessary, and in some instances can cause harm."[2]

The framing of this initiative as a way to improve quality and patient safety is important. For too long, efforts to reduce the use of low-value services have been decried by critics as rationing or as schemes to enhance insurance company profits. The rationing frame has often been motivated by political posturing or stakeholder financial interests and has helped perpetuate the consequences of unchecked health spending on individuals, families, and federal and state budgets. The *Consumer Reports* story reveals to the general public something many in the medical profession already know: While much health care spending does provide substantial individual and social value, some of it supports care of little or no value.

Efforts to tie patient cost sharing to the benefit of the treatment in question and not just the cost through value-based insurance design (VBID) have recently proliferated within employee benefits circles. If co-payments are increased for low-value services and reduced for high-value services, standard economics predicts that patients will migrate from the former to the latter, making better use of health spending dollars. Several studies have found that patients who faced increases in medication co-payments decreased their use; of these, some also found that savings in pharmacy costs were offset by higher rates of emergency department utilization and hospitalization, so no money was saved overall—while rates of adverse events increased.[3]

These findings seemed to imply that reducing co-payments could have the reverse effect: increasing adherence and reducing emergency department utilization and hospitalization—better outcomes without higher costs.[4] The logic behind this promoted efforts to reduce co-payments for high-value medications in high-risk populations.[5] However, subsequent studies have found that increasing and decreasing co-payments do not have mirror-image effects. Lowering co-payments does not improve utilization nearly as much—typically only 1 to 4 percentage points on baseline medication possession ratios (MPR) of 60% to 80%[6]—an asymmetry that was not predictable from standard economic theory. This means that there would be 20 to 25 people whose adherence did not change for every completely nonadherent patient (MPR=0%) who became highly adherent (MPR >80%). A study in which patients who had acute myocardial infarction (AMI) were randomly assigned to standard co-payments or zero co-payments for statins, β-blockers, and angiotensin-converting enzyme inhibitors found disturbingly low MPRs of 39% in the year following AMI in the control group with improvement to only 45% in the zero co-payment group, a difference that resulted in no significant reduction in the rate of total major vascular events or health care spending.[7]

There are several reasons for the asymmetry between the large effect of increasing co-payments and the small effect of lowering them. First, people tend to be loss averse, and as a result, co-payment increases are far more potent than co-payment decreases. Second, co-payment reductions every 30 or 90 days may be too infrequent to motivate daily medication adherence. Third, co-payment increases and decreases target different populations. Increases target adherent patients but decreases are meant to attract patients who are not taking medications. Those who do not take medication will not notice changes in prices they are not paying.

These results imply that even though VBID may not be highly effective in increasing utilization of desired services, it could be effective in decreasing utilization of low-value services. Higher patient cost sharing would deter patient demand for certain types of low-value services: patients

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would be less likely to demand that their physician order magnetic resonance imaging (MRI) for new-onset back pain or antibiotics for upper respiratory tract infections. If health plans went so far as to not cover prostate-specific antigen screening (now rated "D" by the US Preventive Services Task Force) so patients had to cover the full costs, such decisions, coupled with communications describing that such services either harm patients on average or provide extremely small benefits relative to the costs, would send a powerful signal to patients, who may generally assume that all health care services provided are of high value.

However, there are at least 2 reasons why increased patient cost sharing is an imperfect solution to this problem. First, while patient-centered care is important, many patients need guidance in deciding whether services are or are not worth it. Many items in the list of 45 low-value services identified in the Choosing Wisely campaign have clinical qualifications such as "Don't order sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis." However, few patients are able to judge whether their specific case of acute rhinosinusitis is complicated or uncomplicated. Such judgments must be made by physicians. To increase prices for low-value services across the board may deter both low-value usage and usage by some patients for whom a given service may be of higher value. Moreover, patients tend to respect the advice of their physician. If a physician recommends an MRI for a patient who has new-onset lower back pain but no motor deficits (another example on the Choosing Wisely list), many patients will assume they should undergo the test regardless of the price.

Second, even physicians often have little understanding of what procedures are of low value (a situation the Choosing Wisely campaign aims to correct) and some may have conflicts of interest that contribute to higher rates of utilization. All 45 services on the Choosing Wisely list are tests ordered by physicians, some frequently, and the difficulty of changing these practice patterns is large. Social welfare is enhanced by the use of high-value services, but individual physician income is enhanced by the use of high-margin services, and value and margin are not always aligned. To connect them, the underlying financial incentives for clinicians to provide services need to be connected to their value.

The Choosing Wisely campaign derives its great promise by reflecting the growing consensus among medical professional societies and consumer groups that many commonly used clinical services provide little or no benefit for most patients. But if it is difficult in many situations for patients to choose wisely, and if there are significant challenges in getting physicians to choose wisely, then who should be doing the choosing?

The difficulties of achieving reductions in overutilization by affecting decisions by individual patients or physicians points to the pressing need to revisit the bogeyman of health care rationing. The development of guidelines that include the assessment of cost and value are urgently needed but the Centers for Medicare & Medicaid Services, Agency for Healthcare Research and Quality, and Patient-Centered Outcomes Research Institute are all prohibited from the development of such recommendations.[8] The United Kingdom's National Institute for Health and Clinical Excellence is charged with weighing costs and benefits in coverage decisions in recognition of the fact that not all services are worth their cost. The Choosing Wisely initiative represents an important first step toward the identification of low-value services, more meaningful because it was a step taken jointly by consumer groups and professional specialties. The next step is to move beyond a list of low-value services toward the testing of approaches to reduce their use, ideally through a combination of benefit design, physician payment policies, and social and professional guidance informed by clinical evidence. Given fiscal realities, reducing low-value services is what will allow continued support for the coverage of high-value services.

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