Behind the Jargon

Overutilization, Overutilized

Deborah Levine
Jessica Mulligan
Providence College

Abstract Overutilization is commonly blamed for escalating costs, compromising quality, and limiting access to the US health care system. Recent estimates suggest that nearly one-third of health care spending in the United States is a result of unnecessary care. Despite the surge of exposés that purport to uncover this "new" problem, narratives about overutilization have been circulating in health policy debates since the beginnings of the health insurance industry. This article traces how the term *overutilization* has spread in popularity from a relatively small community of mid-twentieth-century insurance experts to economists, physicians, epidemiologists, and eventually the news media of the early twenty-first century. A quick glimpse at the history of the term reveals that there has been constant disagreement and debate over the meaning and impact of overutilization. Moreover, the term has been put to very different uses, from keeping socialism at bay to preserving the fiscal integrity of Medicare to protecting the health of patients. The overutilization narrative, seductive in its promise of cutting costs without sacrificing access to quality care, too often drowns out other difficult conversations about social welfare, health equity, prices, and universal coverage.

Keywords overutilization, health insurance, managed care, health policy research

Introduction

Physicians, the insurance industry, policy makers, payers, and patients agree: the American health care system wastes money. A frequently cited

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statistic claims that roughly $700 billion per year of US health care costs—a third of overall expenditures—are spent on unnecessary care (Health Affairs 2012). Rooting out and eliminating this costly overutilization motivated the team behind the Affordable Care Act (ACA), as well as the myriad Republican responses to the ACA. If only Americans could cut this excess care, the United States would be able to craft a health system that reins in costs, provides high-quality care, and ensures access for many, all while maintaining its historical commitment to competition and profit.

It seems easy enough to agree with—just get rid of that unnecessary care and we will be a healthier, wealthier country, without needing to impose unpopular price restrictions or rationing systems. A key problem in all of this, however, is in how different actors define the problem of "overutilization" and who should determine what constitutes necessary, appropriate care.

Despite recent headlines "exposing" overutilization of health services, these debates are not at all new. In fact, they stretch back at least as far as the early days of American health insurance, when industry executives openly worried that unreasonable patient demands and greedy physicians would bankrupt their firms and possibly push the nation toward socialized medicine. This article traces the history and use of the term *overutilization* and how the term has spread in popularity from the relatively small community of mid-twentieth-century insurance experts to economists, physicians, epidemiologists, and eventually the popular media of the early twenty-first century.

Our current policy debates use *overutilization* as a catch-all term, assuming that there is widespread agreement about what it means, when in fact the definition of appropriate use varies with good reason depending on whether the issue is considered from the perspective of the patient, the payer, or the provider of care. Competing claims of authority are common. A pediatrician and a parent may hold different views about the appropriateness of antibiotics or ear tubes to treat recurrent ear infections. One person's unnecessary prescription is another person's cure for a sick child. For high-cost treatments like knee replacements, surgeons and insurance companies often come to very different conclusions about whether a procedure is being appropriately utilized. For example, the American Board of Internal Medicine recently embarked on its "Choosing Wisely" campaign in which medical specialty societies generated lists of procedures with questionable medical efficacy. Almost immediately, this campaign to control overutilization came under criticism for focusing on low-margin services and failing to take on major money makers like "stents for heart patients and spinal surgery" (Rau 2014; see also Morden et al. 2014). Here, one person's unnecessary surgery is another person's income.

It is only when these definitional differences are papered over that it is possible to imagine that fixing the system is as easy as eliminating waste. This overutilization narrative presumes that providers and patients use health care inappropriately; patients, in particular, are often portrayed as gluttons who gorge themselves on surgeries, pharmaceuticals, and frivolous trips to the doctor when they have access to generous insurance plans that shield them, the story continues, from the true cost of services. Since insurance premiums are partially based on the volume of services consumed, overuse makes the system more expensive for everyone. Concern with efficiency, runaway costs, and overuse came to dominate health policy in the 1970s in what has been dubbed "economism," largely because of the influence of economists like Mark Pauly and new empirical data about cost sharing and plan designs stemming from the Rand studies (Fox 1990; Frankford 1994; Melhado 1998; Nyman 2007). Proponents of economism concluded that more competitive health care markets, increased cost sharing, and utilization controls were not only necessary but socially beneficial in the fight to curb overuse. A major effect of this focus on overutilization is that it crowds out other conversations about social welfare, health equity, prices, and universal coverage. In fact, if overutilization is the key problem of the health system, then expanding insurance coverage to more people would enlarge, rather than solve the problem (Stone 2011). It should be no surprise that in this moment of expanding coverage through the ACA, we are also witnessing heightened anxiety about waste and overuse (Dow et al. 2013). Perhaps the ultimate triumph of the overutilization narrative is that for many health policy experts, less care is now equated with better care.

In this piece, we do not weigh in on the merits of one procedure versus another or argue over who is most to blame for overuse. Rather, we trace some of the uses to which the discourse on overutilization has been put. We start from the premise that solving our multiple health care crises cannot really be as simple as eliminating waste, and so we ask: what has the focus on overutilization accomplished, and what has it obscured?

Overutilization's Origins: A Threat to a New Industry

The conversation about overutilization began in insurance literature in the mid-twentieth century. Patients and physicians were charged with threatening the new and profitable industry growing up around voluntary health insurance. In one early example, O. D. Dickerson interrogated "The Problem of Overutilization in Health Insurance" in the *Journal of Insurance* in

1959. Dickerson worried that too often, "little attempt is made in health insurance contracts to define what is reasonable, what is necessary, and what good or bad health means." He linked the problem of overutilization to hypochondriac patients who seek too much care, developing a " 'crush' on the physicians . . . and find[ing] in continued medical treatment the attention and affection lacking in daily life" (Dickerson 1959: 65). Dickerson also placed blame on physicians for overindulging their patients and collecting high fees from those with health insurance coverage, pointing out that it had become common to "increase the complexity of treatment, and the fees charged, when the patient has insurance" (66). Hospital administrators, whom Dickerson argued frequently "look upon health insurance primarily as a device to keep their hospitals filled to capacity with paying patients," also contributed to the problem (67). Dickerson blamed physicians, patients, and hospital administrators as the major sources of health care overutilization.

For Dickerson, the answer to overutilization was more careful industry structuring of insurance policies designed to curb the practice, mainly an early version of cost sharing using both co-payments and deductibles, and also in developing more precise methods to measure and define reasonable and necessary care, particularly for inpatient hospital services. Without these, he argued, "overutilization could bring about the destruction of the voluntary health insurance industry," both paving the way for the end of the newly popular and lucrative industry and forcing government to become more involved in the industry, thus pushing doctors into the "socialized medicine which they purport to fear so much" (72, 70). Argued in a period where Blue Cross and Blue Shield were attempting to block the entry of commercial insurers to the marketplace, Dickerson may have been concerned with the competition between insurance models, but his primary purpose was to preserve and grow the health insurance industry.

Dickerson also discussed the relationship between overutilization and moral hazard, another perennial worry of the insurance industry in this period. Moral hazard is a concept that was discussed in the insurance literature at least as early as the 1930s (Jost 2007) and has taken several different, though related, meanings in the twentieth century. For Dickerson (1959: 65), individuals with insurance are more likely to take health risks because they are not responsible for paying the actual costs of their care and are more likely to understand ambiguous complaints as disease and thereby seek unnecessary medical treatment. In its later, more economistic guise, moral hazard came to mean the inefficiencies generated by health insurance because rational insured actors respond to the price incentives of

insurance by consuming more health care than they otherwise would (Pauly 1974; see also Nyman 2007; Stone 2011). While moral hazard is a concept that exists in other insurance models, particularly life insurance and fire insurance (Murphy 2010; Knowles 2011), overutilization seems to be a concept unique to health insurance schemes. The overutilization narrative does include the irresponsible behavior of insured individuals but also draws on other explanations for overuse, including physician prescribing practices and the cultural imperative among health care professionals to "do more" (Brownlee 2007). Moreover, rhetorically, moral hazard has remained an insider term within health policy; you are not likely to turn on cable news today and find pundits discussing it. *Overutilization*, however, and its more colloquial synonym, *overuse*, has long since entered into popular discourse.

Overutilization Experts

Between 1960 and 1980 overutilization went from an insider insurance company term to one of the most important areas of concern for health researchers and policy makers alike, especially with the major coverage expansions that came with the passage of Medicare and Medicaid in 1965. With distinct methodologies and often quite different policy recommendations, a host of prominent economists, physicians, and public health researchers grappled with the specter of overutilization; physicians reflected on how the threat of overuse might impinge on their autonomy and bank accounts; public health researchers marveled at the vast variation in usage patterns that did not seem to correlate with better health outcomes; and economists abandoned their long-standing focus on the social benefits of health care and instead turned their attention to stamping out the inefficiencies created by overuse. Evan Melhado (1998: 215) termed this latter strand the "economizing model" of health research because it "focuses on improving efficiency, minimizing risks borne by third-party payers, constraining cost increases, and improving the functioning of markets" (see also Frankford 1994). Here, we sample some of the uses to which *overutilization* was put as it gained in importance among experts.

The burgeoning academic interest in overutilization was made possible by the availability of new, huge data sets documenting utilization patterns of health care services across the United States. Blue Cross and Blue Shield each published extensive studies of their utilization patterns that questioned physician and patient motivations and called on hospital administrators to exercise restraint in delivering care (Fitzpatrick 1965; Maybee

1966). The passage of Medicare and Medicaid legislation in 1965 led to amplified concerns about overutilization, as well as a newly available national data set, allowing health policy researchers unprecedented access to data demonstrating geographic variations in care and cost differentials in providing care to those populations (Donabedian 1976; Rabin et al. 1974). Wide differences were consistently documented in the care and cost of health services throughout the country, but the meaning of these utilization patterns were up for debate. As Thomas Fitzpatrick, a vice president at Blue Cross of Western Pennsylvania, wrote in 1965,

> These variations can be studied and have been studied. They do fail to tell us one important thing, however. If we have one group experiencing 135 hospital admissions per 1000 members per year and another experiencing 78 admissions per 1000 per year, which one is appropriate? Does the first group have too many, or the second group have too few? (16)

It is significant that determining appropriate levels of utilization was still very much an open question—even for insurance executives—in this period. Absent was the current absolute certitude that characterizes the overutilization narrative and evidence-based medicine about what constitutes appropriate and necessary care. In other words, the overutilization narrative we know today had not yet become cultural common sense.

By the late 1970s physicians had taken up the problem of overutilization, echoing worries about rising demand and the runaway costs of health care services. Unsurprisingly, physicians argued for the supreme importance of professional autonomy in the face of encroaching third-party oversight. For example, in his article "Overutilization of Health Care" (1977), the physician and Kansas congressman William Roy was convinced by the data that much care is ultimately unnecessary but wrote that, nevertheless, reducing utilization rates is exceedingly difficult. "We as a society—and especially as physicians—are comfortable when we talk about eliminating the overutilization of health services . . . but there is no local enthusiasm for telling another physician that a procedure or test should not be done because likely benefits are marginal or too small compared to costs" (Roy 1977: 132). Roy rejected proposals of both governmental and insurance industry bodies, arguing that more regulation of physician activities (including widespread adoption of utilization review) will simply create more costs to the system, and advocated for "market regulation of the utilization of medical services," through modes of physician self-regulation and competition (138).

As Roy hinted in his work, during the 1970s utilization review began to be touted as yet another tool ideally suited to address overutilization. Paul Ellwood, a physician and one of the key supporters behind the HMO Act of 1973, was explicit about this promise in his many writings about competitive health maintenance organizations. In his important 1972 piece in the *Milbank Quarterly,* for example, Ellwood promised insurers, physicians, and policy makers that promoting competitive health maintenance organizations would lead to sophisticated and mutually beneficial strategies for controlling utilization, which in turn would "encourage low cost, high volume ambulatory and preventative services, and . . . discourage overutilization of high-cost inpatient hospital care" (22). Ellwood's model of competitive health maintenance in the 1970s differed substantially from the version that took hold in the 1980s and 1990s; insurer-dominated, for-profit managed care organizations, for example, were not part of Ellwood's plan. A key innovation that did carry forward was the appeal to careful data monitoring and financial incentives aimed at achieving population health as well as limits on health service utilization.

Health maintenance organizations were not the only ones interested in these new data; a number of physicians and epidemiologists during the period began analyzing variations in cost and use of services and leveraged their findings to advocate for evidence-based medicine and cost-saving measures system-wide. One of the most famous of these studies was conducted by the physician John Wennberg (1973) and his group of researchers at Dartmouth College. By documenting the vast differences in utilization and practice patterns across even very small geographic areas, the Dartmouth studies made a direct appeal for changing physician diagnostic and decision-making practices to limit overutilization. Wennberg and his collaborators were working outside the insurance industry with very different goals, yet the discrepancies in utilization of key services across small areas that they uncovered played an important role in pushing the idea of overutilization of expensive health care services into a much more influential role in policy debates.[1]

In the years since, the Dartmouth studies gained tremendous popularity and became a driving force toward evidence-based medicine across both academic and popular literature. At the same time, insurance companies continued to refine their data collection and analysis techniques, explicitly

1. In this article we sampled some of the leading voices on overutilization in the American health system. An additional area for future research, which falls beyond the scope of this brief article, would be to connect the emergence of fraud, waste, and abuse regulations in the 1970s with concerns about overutilization as a driver of health care costs.

arguing that utilization review was the key way to improve health care costs in the United States.

Utilization Must Be Controlled: Managed Care and the New Common Sense

During the 1980s and 1990s, under pressure from payers and in response to rising health care costs, insurance companies began experimenting with new organizational models, utilization review techniques, and forms of paying providers (such as capitation). In discussing these kindred practices, we use the umbrella term *managed care*, which acknowledges that this model of care comprises a diverse set of practices employed to different effects by various heterogeneous organizations—from staff model HMOs to independent practice associations (IPAs) to preferred provider organizations PPOs (Glied 1999). The proliferation of methods for controlling cost through controlling utilization signals that in this period overutilization was no longer just a theoretical term. Managed care propelled "overutilization" from being a feature of debates among experts to one of the most important rationales for restructuring the provision of care, to controversial effects.

An Institute of Medicine (IOM) report on utilization review from 1989 sums up the mood of the time well. The report called utilization review a "growth industry" given escalating health care costs and the substantial losses seen by "many commercial insurers"; "Blue Cross and Blue Shield plans, and HMOs . . . [have] a growing perception that a significant amount of medical care is unnecessary" (IOM 1989: 2). This report was optimistic about the potential of "third party" utilization review to rein in costs but cautious about its impact on quality and threat to physician autonomy. A central recommendation from the report was to make decision-making criteria more transparent and strengthen the appeal process.

Like the insurance industry of Dickerson's day, managed care organizations intensely scrutinized inpatient hospital stays:

> Inpatient hospital care consumes more than 30% of health insurance dollars . . . [so] it is understandable that reducing these costs has become the highest priority of health care purchasers, and that utilization review and management, the process of evaluating and attempting to reduce the cost of medical practice, has become a major growth industry with providers and purchasers of health care. (Credé and Hierholzer 1989: 33)

Payer organizations used retrospective, then concurrent, then finally prospective review methods to limit hospital stays, with each new form of

review infringing a bit more on the traditional locus of medical authority: clinical decision making. These changes were so widely accepted that shorter hospital stays, influenced also by the shift to prospective payment, soon became the norm, and these review methods were applied to other costly services (Flynn, Smith, and Davis 2002: 461–63).

During this period, managed care organizations pushed utilization control measures into new domains. They implemented primary care gatekeeping to control access to specialists, narrowed access still further by curtailing their networks, required preapprovals and prescription drug formularies, and demanded preauthorizations in the areas of durable medical equipment, diagnostic tests, mental health care, and elective surgeries (463). By the 1990s reducing the use of care became a legitimate health policy goal through the promotion of standardized treatment guidelines by insurance plans and the use of these diverse utilization review mechanisms (Gabel 1997: 141–42; Wickizer 1990: 329–30).

Despite the well-documented backlash by both patients and providers against these stringent measures, the true mark of the success of managed care was that overutilization came to be seen as the driver of runaway health costs, and some form of utilization review is now used in almost all forms of health insurance in the United States (Gray 2006; Coombs 2005). In response to the backlash, provider networks expanded, PPO plans became dominant, and the need for preauthorizations decreased, but the idea that overutilization was a problem had already become widespread and institutionalized. This process was helped by enlisting physicians in the battle to reduce use by making them more financially liable through risk-based payment methodologies. Employers, in turn, had more financial skin in the game as a result of the adoption of experience-based, as opposed to community-based, rating (Gabel 1997). Consumers, too, were enlisted in the project of trying to control utilization through increases in patient cost sharing like premiums, co-payments, and deductibles (139). This was the beginning of an important shift toward patient responsibility and the era of "consumer-driven" health care that persists to this day (Jost 2007). By the end of the 1990s overutilization had become everyone's financial problem. In the decade that would follow, it became everyone's health problem as well.

Too Much Care Is Bad for You: A New Focus on the Danger of Waste

By the turn of the twenty-first century, overutilization came to mean more than just a barrier to economic efficiency; it was increasingly seen as a

threat to health. This perspective was best exemplified in the influential IOM reports that sought to remake the health system at the turn of the twenty-first century. The IOM reports *To Err Is Human* (1999) and *Crossing the Quality Chasm* (2001) advocated reshaping the health system by realigning incentives. Throughout *Crossing the Quality Chasm,* the IOM argues that the health care system should be more efficient by "avoiding waste, including waste of equipment, supplies, ideas, and energy" (6). Shortcomings in each of these domains were understood as symptoms of an uncoordinated health system with serious design flaws: "There is substantial evidence documenting overuse of many services—services for which the potential risk of harm outweighs the potential benefits" (6).

In the years since the IOM report, rhetoric about overutilization of care has become even more popular and aimed toward ever wider audiences. The warning against iatrogenesis (physician- or hospital-induced illness) takes center stage, recalling feminist critiques of medicine from decades before but now with a new consumerist spin. Smart health care consumers must now understand that there are problematic cost incentives built into the health care system and guard against overtreatment and unnecessary care in order to protect their health. Not only did these ideas captivate the experts at the IOM, but the popular media took up this narrative with gusto.

There are two major strands of the contemporary popular overutilization literature that deal with the patient role. The first concerns poor, uninsured, or Medicaid patients who are cast as inappropriate overutilizers and described by terms such as *free riders*, *frequent flyers*, or *hot spotters*. Some of this literature is sympathetic to the plight of Medicaid beneficiaries and the uninsured and tries to explain the logic behind their utilization patterns (Abraham 1993; Billings and Raven 2013; Gawande 2011; Malone 1998; Paradise and Garfield 2013). Others, especially in the news media, fall into a familiar rhetoric of blaming poor people for using emergency departments, lacking coverage, and depending on government aid.

The second strand of the patient-focused overutilization literature is directed at better-off, well-educated, insured patients. This literature is not just *about* them; it is *for* them. Often written in the second person, this literature urges patients to beware of overtreatment and waste because ultimately, it is bad for *your* health. The well-educated patient is urged to protect herself from too much care. The popular writing about overutilization uses some of the same language and relies on the same studies discussed in the academic literature. Wennberg, for example, is almost

always discussed and is sometimes portrayed as a great hero struggling against an illogical and harmful system, more like Sisyphus than Atlas (Brownlee 2007: 13–42). The tone, however, is noticeably different in these popular texts; it is alarmist and fear inducing.[2]

As an example, consider *The Treatment Trap: How the Overuse of Medical Care Is Wrecking Your Health and What You Can Do to Prevent It* by Rosemary Gibson and Janardan Prasad Singh (2010). The authors set out to "introduce you to people who have had unnecessary treatment" and "the stories of highly empowered individuals who avoided its pitfalls" (18). This book is not concerned with the cost to the system of unnecessary trips to the ER; instead, the care they find unnecessary includes procedures that only the well-insured could even consider: heart bypass surgeries, full-body CT scans, hysterectomies, ear tubes, back surgery, stroke surgeries, and Pap smears on women who have had hysterectomies (19–20). The warnings are presented in dramatic fashion, with greed and a cultural predilection to always "do something" blamed for the overtreatment "epidemic": "As with any epidemic, this one isn't good for you. The pathogen that causes it is a mixture of money and human nature. One doctor calls it the 'green monster' . . . its appetite is voracious, and it is obese" (22).

In the contemporary moment the academic literature continues apace with ever more studies demonstrating that overutilization occurs, more calls for better measures of it, and the oft-mentioned claimed that this is an unexamined or understudied issue (see, e.g., dartmouthatlas.org; Emanuel and Fuchs 2008; Health Affairs 2012; Korenstein et al. 2012). However, there has also been an interesting shift in some of the pieces written by and about physicians; these books and articles are written for a popular audience and in the mode of self-disclosure.

Take Atul Gawande's influential *New Yorker* article "The Cost Conundrum" as an example. In it Gawande argues that overuse explains why care is so expensive in the United States. He cites the Dartmouth studies as evidence that costlier care is often worse care and contends that the physician actors are aware of the problem.

In Gawande's article the term *overutilization* is introduced by doctors themselves to discuss why McAllen, Texas, spends more per Medicare beneficiary than anywhere else in the country even though their patients are no sicker and the care has not been shown to be of higher quality: " 'Come on,' the general surgeon finally said. 'We all know these arguments

2. Similar examples of books that aim to educate patients about the hazards of overutilization include Welch and Schwartz 2011 and Hadler 2008. Articles in news magazines also abound; see, e.g., Santa Cruz 2013 and Pines and Meisel 2011.

are bullshit. There is overutilization here, pure and simple.' Doctors, he said, were racking up charges with extra tests, services, and procedures" (Gawande 2009).

Perhaps to counter Gawande's image of the overprescribing doctor and certainly to promote "medical professionalism," the American Board of Internal Medicine Foundation has launched the "Choosing Wisely" initiative, mentioned earlier, that

> is focused on 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. To spark these conversations, leading specialty societies have created lists of "Things Physicians and Patients Should Question"—evidence-based recommendations that should be discussed to help make wise decisions about the most appropriate care based on a patient's individual situation. (ABIM Foundation 2014)

These lists are bypassing third-party payers and are instead being disseminated directly to patients through various partnerships, including with *Consumer Reports*. Here, physicians are once again striving to reassert their authority to determine what care is appropriate and necessary in conversation with patients now so accustomed to thinking of themselves as health care consumers.

Conclusion: *Overutilization* Has Overreached

For sixty years, *overutilization* has been a key term in health policy debates. The term emerged in literature about the potential demise of voluntary insurance and then spread to new domains: first with inpatient hospital stays and then eventually with almost every other form of care. The audience for this narrative expanded as well: from industry insiders to economists, physicians, public health researchers, the media, and finally, patients.

Utilization review and other techniques for curbing overutilization like requiring prior authorization, capitated payments, and increasing patient cost sharing have now been employed by insurers and providers for decades. Yet the overall impact on health care costs appears negligible (Kale et al. 2013); costs continue to rise. Moreover, some analysts point out that the United States may be underutilizing a host of important services relative to other countries, especially primary care (Anderson et al. 2003; OECD 2011).

Overutilization of certain services probably is one of the many problems in our health care system. But there are grave consequences to considering

overutilization *the central* problem. For one, the increased patient cost sharing that is supposed to rein in overutilization has contributed to a situation in which 31.7 million people with insurance are considered underinsured because they dedicate such a high proportion of their household income to medical bills (Schoen et al. 2014). And as to the sizable uninsured population, the prospect of expanding coverage has too often been cast as a menace to the system rather than a laudable and socially responsible achievement.

There is a need for a more critical conversation about who wins and loses thanks to the present system setup. Some work is already happening in this regard, but it has yet to reach the wide popular audiences and become "common sense" in the way that overuse has. Academic researchers have called attention to how much we pay for services and pointed out that our high prices are largely to blame for runaway health care costs (Anderson et al. 2003; Oberlander and White 2009).[3] Others have argued that risk-pooling techniques need to be resocialized by turning away from the highly segmented, experience-rated pools that currently dominate insurance marketplaces (Ericson, Barry, and Doyle 2000). But it is too difficult for these counternarratives to be heard above the seductive din about overutilization and the attendant need for individual consumer restraint that continues to dominate discussions of health care costs in the United States.

Overutilization is a management neologism that has become an economistic health policy fairy tale where costs can be cut, services denied, and hospital days reduced with no harm—financial, physical, or otherwise—to patients, providers, or payers. Curbing overutilization alone will not redeem our health care system. And real people stand to lose when reducing utilization and increasing efficiency is seen as the primary goal of health policies.

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Deborah Levine is assistant professor of health policy and management at Providence College. Her research focuses on the history of medicine in the United States. She is currently at work on a book about the history of diet, nutrition, and obesity in the United States. Other research interests include the history of health policy in North America, the history of medical education, and the history of disease.

3. Some recent journalistic pieces in the *New York Times* and *Time* magazine have focused on price, perhaps indicating that this narrative has made some inroads into popular consciousness. See, e.g., Rosenthal 2014 and Brill 2013.

Jessica Mulligan is assistant professor of health policy and management at Providence College, where she teaches courses in public health, health policy, and cultural studies of medicine. Trained as a medical anthropologist, she is currently researching insurance, financial security, and health reform from the perspective of the newly insured and uninsured. She is the author of *Unmanageable Care: An Ethnography of Health Care Privatization in Puerto Rico* (2014).

References

ABIM Foundation (American Board of Internal Medicine). 2014. "Choosing Wisely." www.choosingwisely.org (accessed January 10, 2014).

Abraham, Laurie Kaye. 1993. *Mama Might Be Better Off Dead: The Failure of Health Care in Urban America*. Chicago: University of Chicago Press.

Anderson, Gerard F., Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan. 2003. "It's the Prices, Stupid: Why the United States Is So Different from Other Countries." *Health Affairs* 22, no. 3: 89–105.

Billings, John, and Maria C. Raven. 2013. "Dispelling an Urban Legend: Frequent Emergency Department Users Have Substantial Burden of Disease." *Health Affairs* 32, no. 12: 2099–108.

Brill, Steven. 2013. "Why Medical Bills Are Killing Us." *Time Magazine,* March 4.

Brownlee, Shannon. 2007. *Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer*. New York: Bloomsbury.

Coombs, Jan Gregoire. 2005. *The Rise and Fall of HMOs: An American Health Care Revolution*. Madison: University of Wisconsin Press.

Credé, William B., and Walter J. Hierholzer. 1989. "Utilization Review and Management: A Brief Analysis of a Growth Industry." *Infection Control and Hospital Epidemiology* 10, no. 1: 33–36.

Dickerson, O. D. 1959. "The Problem of Overutilization in Health Insurance." *Journal of Insurance* 26, no. 1: 65–72.

Donabedian, Avedis. 1976. "Effects of Medicare and Medicaid on Access to and Quality of Health Care." *Public Health Reports* 91, no. 4: 322–31.

Dow, Alan W., Arline Bohannon, Sheryl Garland, Paul E. Mazmanian, and Sheldon M. Retchin. 2013. "The Effects of Expanding Primary Care Access for the Uninsured: Implications for the Health Care Workforce under Health Reform." *Academic Medicine* 88, no. 12: 1855–61.

Ellwood, Paul. 1972. "Models for Organizing Health Services and Implications of Legislative Proposals." *Milbank Memorial Fund Quarterly* 50, no. 4: 73–101.

Emanuel, Ezekiel, and Victor Fuchs. 2008. "The Perfect Storm of Overutilization." *JAMA* 299, no. 23: 2789–91.

Ericson, Richard, Dean Barry, and Aaron Doyle. 2000. "The Moral Hazards of Neoliberalism: Lessons from the Private Insurance Industry." *Economy and Society* 29, no. 4: 532–58.

Fitzpatrick, Thomas. 1965. "Utilization Review and Control Mechanisms: From the Blue Cross Perspective." *Inquiry* 2, no. 2: 16–29.

Flynn, Kathryn E., Maureen A. Smith, and Margaret K. Davis. 2002. "From Physician to Consumer: The Effectiveness of Strategies to Manage Health Care Utilization." *Medical Care Research and Review* 59, no. 4: 455–81.

Frankford, David M. 1994. "Scientism and Economism in the Regulation of Health Care." *Journal of Health Politics, Policy and Law* 19, no. 4: 773–99.

Fox, Daniel 1990. "Health Policy and the Politics of Research in the United States." *Journal of Health Politics, Policy and Law* 15, no. 3: 481–99.

Gabel, Jon. 1997. "Ten Ways HMOs Have Changed during the 1990s." *Health Affairs* 16, no. 3: 134–45.

Gawande, Atul. 2009. "The Cost Conundrum." *New Yorker*, June 1.

Gawande, Atul. 2011. "The Hot Spotters." *New Yorker*, January 24.

Gibson, Rosemary, and Janardan Singh. *The Treatment Trap: How the Overuse of Medical Care Is Wrecking Your Health and What You Can Do to Prevent It.* New York: Ivan Dee.

Glied, Sherry. 1999. "Managed Care." NBER Working Paper No. 7205. Cambridge, MA: National Bureau of Economic Research. www.nber.org/papers/w7205.

Gray, Bradford H. 2006. "The Rise and Decline of the HMO: A Chapter in U.S. Health-Policy History." In *History and Health Policy in the United* States, edited by Rosemary A. Stevens, Charles E. Rosenberg, and Lawton R. Burns, 309–39. New Brunswick, NJ: Rutgers University Press.

Hadler, Nortin M. 2008. *Worried Sick: A Prescription for Health in an Overtreated America.* Chapel Hill: University of North Carolina Press.

Health Affairs. 2012. "Reducing Waste in Health Care." *Health Affairs*, December 13.

IOM (Institute of Medicine). 1989. *Controlling Costs and Changing Patient Care? The Role of Utilization Management.* Washington, DC: National Academy Press.

IOM (Institute of Medicine). 1999. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press.

IOM (Institute of Medicine). 2001. *Crossing the Quality Chasm: A New Health System for the Twenty-First Century*. Washington, DC: National Academy Press.

Jost, Timothy. 2007. *Health Care at Risk: A Critique of the Consumer-Driven Movement.* Durham, NC: Duke University Press.

Kale, Minal S., Tara F. Bishop, Alex D. Federman, and Salomeh Keyhani. 2013. "Trends in the Overuse of Ambulatory Health Care Services in the United States." *JAMA Internal Medicine* 173, no. 2: 142–48.

Knowles, Scott. 2011. *The Disaster Experts: Mastering Risk in Modern America.* Philadelphia: University of Pennsylvania Press.

Korenstein, Deborah, Raphael Falk, Elizabeth A. Howell, Tara Bishop, and Salomeh Keyhani. 2012. "Less Is More: Overuse of Health Care Services in the United States. An Understudied Problem." *Archives of Internal Medicine* 172, no. 2: 171–78.

Malone, Ruth E. 1998. "Whither the Almshouse? Overutilization and the Role of the Emergency Department." *Journal of Health Politics, Policy and Law* 23, no. 5: 795–832.

Maybee, H. V. 1966. "Blue Cross and Blue Shield Objectives within the Utilization Review System." *Inquiry* 3, no. 2: 13–17.

Melhado, Evan. 1998. "Economists, Public Provision, and the Market: Changing Values in Policy Debate." *Journal of Health Politics, Policy and Law* 23, no. 2: 215–63.

Morden, Nancy E., Carrie H. Colla, Thomas D. Sequist, and Meredith B. Rosenthal. 2014. "Choosing Wisely—the Politics and Economics of Labeling Low-Value Services." *New England Journal of Medicine* 370, no. 7: 589–92.

Murphy, Sharon. 2010. *Investing In Life: Insurance in Antebellum America*. Baltimore, MD: Johns Hopkins University Press.

Nyman, John. 2007. "American Health Policy: Cracks in the Foundation." *Journal of Health Politics, Policy and Law* 32, no. 5: 759–83.

Oberlander, Jonathan, and Joseph White. 2009. "Public Attitudes toward Health Care Spending Aren't the Problem, Prices Are." *Health Affairs* 28, no. 5: 1285–93.

OECD (Organisation for Economic Co-operation and Development). 2011. "Why Is Health Spending in the United States So High?" www.oecd.org/unitedstates/49084355.pdf.

Paradise, Julia, and Rachel Garfield. "What Is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence." Kaiser Family Foundation (KFF), August 2. kff.org/medicaid/issue-brief/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence/.

Pauly, Mark. 1974. "Overinsurance and Public Provision of Insurance: The Roles of Moral Hazard and Adverse Selection." *Quarterly Journal of Economics* 88, no. 1: 44–62.

Pines, Jesse M., and Zachary F. Meisel. 2011. "Why Doctors Order Too Many Tests (It's Not Just to Avoid Lawsuits)." *Time*, February 25.

Rabin, David, Thomas W. Bice, and Barbara Starfield. 1974. "Use of Health Services by Baltimore Medicaid Recipients." *Medical Care* 12, no. 7: 561–70.

Rabin, David, and Elisabeth Schach. 1975. "Medicaid, Morbidity, and Physician Use." *Medical Care* 13, no. 1: 68–78.

Rau, Jordan. 2014. "Doctors Overlook Lucrative Procedures When Naming Unwise Treatments." *Kaiser Health News*, April 14. www.kaiserhealthnews.org/Stories/2014/April/14/doctors-overlook-own-lucrative-procedures-when-naming-others-unwise.aspx.

Rosenthal, Elisabeth. 2014. "Why We Should Know the Price of Medical Tests." *New York Times*, August 5. well.blogs.nytimes.com/2014/08/05/why-we-should-know-the-price-of-medical-tests/.

Roy, William. 1977. "Overutilization of Health Care." *Bulletin of New York Academy of Medicine* 54, no. 1: 1978.

Santa Cruz, Jamie. 2013. "You're Getting Too Much Healthcare." *Atlantic*, December 9. www.theatlantic.com/health/archive/2013/12/youre-getting-too-much-healthcare/281896/.

Schoen, Cathy, Susan L. Hayes, Sara R. Collins, Jacob A. Lippa, and David C. Radley. 2014. "America's Underinsured: A State-by-State Look at Health Insurance

Affordability Prior to the New Coverage Expansions." *Commonwealth Fund*, March 25. www.commonwealthfund.org/publications/fund-reports/2014/mar/americas-underinsured.

Stone, Deborah. 2011. "Moral Hazard." *Journal of Health Policy, Politics and Law* 35, no. 5: 887–96.

Welch, Gilbert, and Lisa Schwartz. 2011. *Overdiagnosed: Making People Sick in the Pursuit of Health*. Boston: Beacon.

Wennberg, John. 1973. "Small Area Variations in Health Care Delivery." *Science* 182, no. 4117: 1102–8.

Wennberg, John E., ed. 1996. *The Dartmouth Atlas of Health Care*. Dartmouth, NH: Center for the Evaluative Clinical Sciences. www.dartmouthatlas.org/downloads/atlases/96Atlas.pdf.

Wickizer, Thomas M. 1990. "The Effect of Utilization Review on Hospital Use and Expenditures: A Review of the Literature and an Update on Recent Findings." *Medical Care Research and Review* 47, no. 3: 327–63.