



# Healthcare When It's Needed

## How To Mitigate High Costs And Deferred Care

Healthcare markets have been extraordinarily dynamic over the past year, with significant public policy changes implemented—or at least contemplated—at both State and Federal levels. Employers, insurers, and providers are trying out new ways to contain costs and improve services. In order to be sustainable and effective, it is essential for public policy and private innovation to be designed with the consumers of healthcare at the focus.

In January 2018, the JPMorgan Chase Institute released [Deferred Care: How Tax Refunds Enable Healthcare Spending](#) highlighting the powerful role that cash flow dynamics play in determining when consumers get healthcare. The report focused on one of the most important cash flow events of the year—tax refunds—and found that consumers delayed care in the months before receiving their refund and immediately increased their out-of-pocket healthcare spending by 60 percent as soon as the tax refund arrived. Moreover, 62 percent of the tax refund-triggered additional healthcare spending was paid for in person and represented deferred care (just 37 percent represented deferred bill payment).

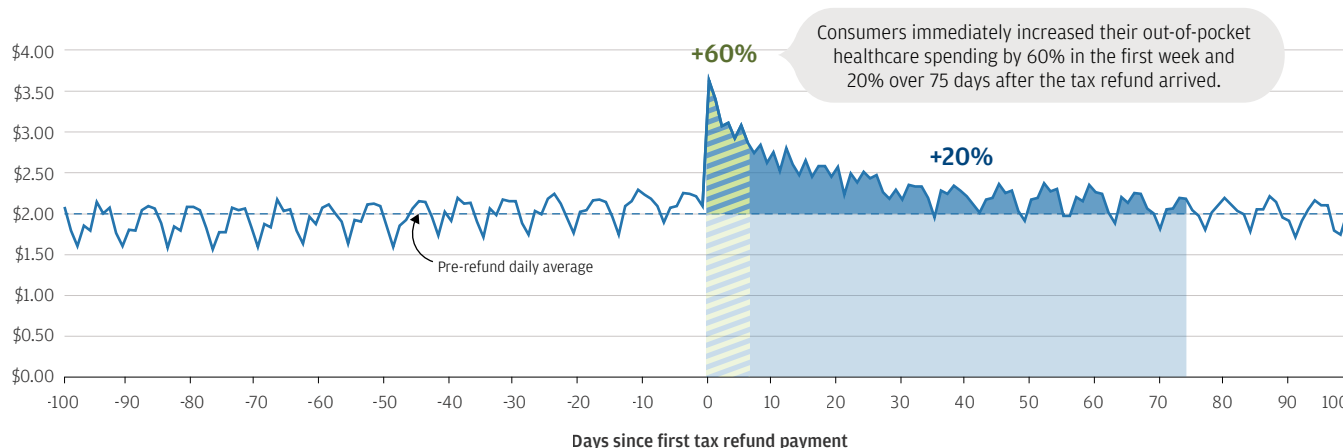
Coinciding with the report release, JPMC Institute President & CEO, Diana Farrell, led a panel discussion on the implications of these findings for insurers, healthcare service providers, market innovators, and employers at the 36th Annual J.P. Morgan Healthcare Conference. Representing these perspectives were Bruce Broussard, CEO of Humana; Toby Cosgrove, the former CEO of the Cleveland Clinic; Bob Kocher, a Partner at Venrock; and Bei Ling, the Global Head of Compensation and Benefits at JPMorgan Chase.

### Key Takeaways

Bringing together the perspectives of an employer, healthcare provider, insurer, and an innovator reinforced three key takeaways for how to reduce total healthcare costs and help consumers receive the care they need when they need it and not just when they have the cash to pay for it.

- **Key Takeaway 1:** We should focus on achieving medical adherence and behavioral change, rather than merely applying price pressures on consumers to drive behavior change.
- **Key Takeaway 2:** Healthcare providers need to be incentivized by paying them more for better health outcomes.
- **Key Takeaway 3:** We need to apply bureaucracy-busting processes, data, and technologies to bring down disproportionately high administrative costs in the healthcare system.

Out-of-pocket healthcare spending per weekday per person



Source: JPMorgan Chase Institute



J.P. Morgan Healthcare Conference Panel from left: Diana Farrell, Bob Kocher, Bei Ling, Bruce Broussard, and Toby Cosgrove. January 8, 2018.

These top-of-the-line practitioners validated the report findings that affordability plays a role in healthcare utilization. When Medicaid expanded in Ohio, Cleveland Clinic saw a 60 percent increase in the number of Medicaid patients and an 86 percent increase in outpatient visit but only a 20 percent increase in inpatient visits.

They also highlighted potential links between the growth of high deductible plans and consumers' healthcare utilization patterns. As an insurer, Humana sees evidence of care being delayed but also care being skipped entirely. In addition to the cash flow problems identified in our study, out-of-pocket costs appear to drive consumers to skip even "high value" care, such as preventive care and medication adherence. Unfortunately, it appears that giving consumers more "skin in the game" causes them to defer "high value" care.

As the degree of coinsurance in standard plans has expanded, the Cleveland Clinic has seen a shift in demand for outpatient and diagnostic services toward the last quarter of the year, when patients are more likely to have reached their deductibles (but no shift in the timing of demand for inpatient care).

But these outpatient services almost always reduce complications and bring down the total cost of care. High levels of coinsurance encouraged consumers to avoid using all healthcare services, not just the high-cost care. This is not an effective way to contain healthcare costs.

Yet, reducing total cost is crucial for ensuring that consumers get the care they need, when they need it. Across government, employers, providers, charities, and patients—someone has to cover these costs. Shifting the burden back and forth among these players will not address the fundamental problem of affordability. Bringing together the perspectives of employers, healthcare providers, insurers, and innovators, the panel reinforced a few key takeaways for how the healthcare system can reduce total healthcare costs in order to help consumers receive the care they need when they need it and not

just when they have the cash to pay for it. We highlight three key takeaways that deserve continued attention and focus at a time when **healthcare costs are on the rise** and too many families do not have enough cash to weather extraordinary medical payments:

**Key Takeaway 1: We should focus on achieving medical adherence and behavioral change. Merely applying price pressures on consumers is unlikely to achieve this goal.**

Understanding and managing healthcare consumer behavior is critical for capping total costs. Mr. Broussard provided a powerful example: a standard package of care for a typical low-severity diabetes patient would typically cost about \$7000 per year; for a high severity patient, about \$49,000. The difference is largely a function of lifestyle behaviors, he noted, adding that, "Medical adherence and preventive care determine your severity level. Everybody wins if you can keep severity under control."



**Bruce Broussard**

*CEO of Humana*



**Bei Ling**

*Global Head of  
Compensation & Benefits  
at JPMorgan Chase*

Financial incentives are often used to encourage consumers to maintain health and prevent costly acute events. Ms. Ling mentioned that at JPMorgan Chase, employees are offered financial incentives to participate in a wellness program that includes preventive healthcare services at no out-of-pocket cost. Yet, only 80 percent of employees participate. Why are the rest leaving money on the table? "It seems like free money, and it's good for you. So why doesn't everyone do it?" she asked. Moreover, even though savvy tools exist for consumers to shop around for healthcare services they will pay for, "people are still more comfortable shopping around for airline tickets or hotel rooms than for healthcare providers."

The Cleveland Clinic tried to encourage their employees to seek care in lower-cost settings than the emergency department by adding significant copays to their insurance plans for emergency room visits, and saw no change in their behavior as result. Subjecting consumers to prices that are difficult to observe, forecast, or avoid is not likely to change their behavior. This can be partially addressed by providing consumers with tools to be more price aware and responsive, like real-time benefits checks and cost comparisons across providers. For the very poorest among us, however, the question is not whether prices will rationalize their utilization but whether they have sufficient cash to receive care at all.

The problem is not really one of misaligned incentives; no one has more interest in reducing costs or avoiding acute illness than patients themselves. Instead, the problem is one of execution. The system has failed to provide effectively designed tools that empower consumers to direct their behavior toward prevention and cost containment. It is time to look beyond price pressures and robo-calls that admonish patients to pay their medical bills and take their medication.

Confronting the reality of consumers' finite budget of time and attention is critical, but this does not mean that every successful behavioral innovation will be a simple "nudge." The most powerful innovations are those that have profound and immediate impact that consumers will recognize as a return on their investment of time, attention, and effort. Despite all the competing demands of modern life, patients are willing to invest time and effort in behavior change if they see a clear return. As an example Bob Kocher pointed to Virta Health, an online clinic that offers its patients an approach to reverse Type 2 Diabetes without medication or surgery. "In a good way, it is intense and difficult, requiring immediate and fundamental changes in a patients' lifestyle and near-daily contact with clinic staff. But because the returns on investment are rapid and dramatic for patients, the program has shown remarkable success. The program also saves money rapidly for payers which aligns incentives." Bob Kocher described.

**Key Takeaway 2: Healthcare providers need to be incentivized by paying them more for better health outcomes.**



**Toby Cosgrove**

*Former CEO of  
Cleveland Clinic*

Ultimately, the two most important players in the system are patients and care providers. Changes in reimbursement can better enable providers to be more effective partners in care. Dr. Cosgrove highlighted clear evidence that, "if you change the model of how physicians are reimbursed, you change how they behave." Driven by that evidence, he reported that the Cleveland Clinic had spun 600 of its physicians off into a primary care group called Cleveland Clinic Community Care, who are paid a baseline salary and then assessed and further compensated according to patient outcomes.

Currently, most healthcare provider cost reimbursement models are based on service volume. Moving to a model that is aligned toward outcomes—value-based or outcome-based care—will require new systems and cultural change. Fortunately, these changes have already begun. By 2020, the care of more than half of the Cleveland Clinic's patients will be paid for in some outcome-based manner. Paying providers for patient outcomes—rather than for services rendered—gives caregivers "skin in the game," and drives them to care differently. So-called "capitated providers" can offer more than immediate treatments, but also the time and attention necessary to thoroughly educate patients on their health options. Thus, the costs of engagement can be offset by savings in the long run and consumers can be better equipped to make more financially sound healthcare choices.

A powerful driver of the speed of change will be the reimbursement approach taken by the Federal government, which is one of the largest payers for care services. Over 60 percent of patients at the Cleveland Clinic are covered by the Centers for Medicare and Medicaid Services (CMS) or have their costs covered indirectly by Federal payers. As CMS adopts a reimbursement approach, it's inevitable that the whole market will quickly follow. As such, moving to value-based care requires continued leadership by the Federal government in that direction.

**Key Takeaway 3: We need to apply bureaucracy-busting processes, data, and technologies to bring down disproportionately high administrative costs in the healthcare system.** More than half the jobs in healthcare are administrative. Rationing care is not necessarily the first place to look to rein in costs; process improvements to control administrative cost may be more effective.

One approach that may be especially effective would be to simplify billing processes and streamline the provider revenue cycle. For example, structuring all billing entirely based on the ICD-10 (the 10th edition of the International Statistical Classification of Diseases and Related Health Problems) makes transactions complicated for consumers and providers, and entrenches a set of administrative costs that may not be necessary in all patient scenarios. "There are other ways to construct a bill and still get it right and save a lot of time," said Dr. Kocher. "It makes a lot more sense to have the health plan play a role in collecting all of the money that will go to the provider and get rid of the revenue cycle intermediation that costs a lot of money and makes things more complicated," he continued. In addition to eliminating some administrative costs for providers, this approach can also improve transparency for the consumer.



**Bob Kocher**

*Partner at Venrock*

Better information sharing can also bring costs down significantly. Improving data interoperability with standardized electronic medical records and record keeping systems that can communicate in real time is both technologically feasible and would eliminate duplicative administrative costs among providers and insurers. Physicians should not be faxing patient histories back and forth in 2018. Similarly, the “provider directory” provided by health plans could go the way of the printed telephone directory. Not every clinician fits well with every patient, but a successful partnership improves outcomes and

brings down costs for all; information tools that help patients find the clinicians best suited to them are technologically feasible and should be in more widespread use.

By reducing administrative costs and delays, insurers and care providers can assess and determine the total cost of care earlier, easier, and faster. As a result, consumers may be better prepared to afford healthcare costs during their visit, instead of delaying payment.

## Related Links

[Click here](#) to listen to the full panel discussion from the 2018 J.P. Morgan Healthcare Conference.

Read the Institute's full research report, [Deferred Care: How Tax Refunds Enable Healthcare Spending](#).

Learn more about the [JPMorgan Chase Institute Healthcare Out-of-Pocket Spending Panel](#).

## Suggested Citation

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