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REVIEW

COST CONTAINMENT



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The key, the secret?

Could DRGs be the keys to international cost containment?
Milan Korcok seeks the answer

The history of healthcare cost containment is replete with sad stories and unaccomplished goals. In the US, Europe and Asia, the litany is familiar: health spending knows no limits, but who is to pay for it? In seeking causes for this relentless inflation, societies have identified many scapegoats: the elderly for staying alive and soaking up expensive medical resources; the avarice of doctors and hospitals for padding their bottom line at the expense of patients; bureaucrats and insurance companies for wasting money that should pay

Healthcare costs have inexorably gone beyond what even the wealthiest nations say they can afford

for patient care; and even patients, for daring to demand the miracles that medical science boasts about.

Healthcare costs have inexorably gone beyond what even the wealthiest nations say they can afford. That's bad enough. But governments, insurance companies, employers, sickness funds, trusts and individual payers complain that they don't know what they're paying for, or how to reasonably price the life and death commodities that are costing them so much. In describing the morass of hospital pricing, for example, Princeton medical economist Uwe Reinhardt has referred to the 'chaos behind a veil of secrecy'.

Seeing clearly

Since the early '80s in the US, and the '90s in Europe, there has been a growing effort to rip away the veil and unravel the chaos by categorising what it costs to treat specific diseases or conditions and then paying hospitals and other providers accordingly. Giving traction to this effort is the growing use of Diagnosis Related Groups (DRGs), developed by Dr Robert Fetter and associates at Yale University in the early 1970s, and put into practice nationally by a US Congress fed up with funding annual double-digit increases for its Medicare programme for the elderly and disabled. Under the prodding of President Ronald Reagan, Congress in 1983 mandated that the Medicare programme put hospitals on strict rations and pay them pre-determined fixed rates according to the specific diagnoses of the patients they treat. Up until then, hospitals had been paid on a cost-plus basis, with no clear definition of what 'cost' entailed. The effect of the mandate was nothing short of revolutionary, an action that Rick Mayes and Robert Berenson, authors of the landmark book *Medicare Prospective Payment and the Shaping of US Healthcare*, described as having 'triggered a shift in the balance of political and economic power between the providers of medical care (hospitals and physicians) and those who paid for it – power that providers had successfully accumulated for more than half a century'. Implementation of the PPS-DRG (PPS – Prospective Payment System) structure was immediate and dramatic. The growth in Medicare hospital payments plunged from 16.2-per-cent annual increases between 1980 and 1983, to 6.5 per cent annually from 1987 through 1990; and between 1982 and 1988 Medicare hospital days dropped 20 per cent. In addition, Medicare spending per capita

dropped from 11.2 per cent for 1975 to 1980 to 1.8 per cent for 1995 to 1999.

For all the disparagement about Medicare and its hazardous funding future, analysts cite it as a marvel of cost containment – albeit containment possible only because a federal government controlled the costs by regulating the prices. This was in stark contrast to the US's overall soaring medical costs (now pushing close to \$8,000 per capita and accounting for 17.6 per cent of the nation's GDP), and for some time the effects of Medicare's PPS and DRGs went relatively unnoticed. But looked at independently, DRGs as building blocks for prospective payment have been extraordinarily successful, even though healthcare spending overall has been on a relentless binge. And it's a message Europeans can't help but assimilate.



For all the disparagement about Medicare and its hazardous funding future, analysts cite it as a marvel of cost containment

The concept of paying healthcare providers fixed, pre-determined prices was clearly attractive to many other societies struggling with rising costs, and by the early '90s the promise of DRGs was transported to Europe, Australia, and in time would be seen making incursions into South America and even Asia.

It seems ironic that a mechanism crafted in the US, the country with the highest healthcare costs in the world, should become a model for pricing transparency and cost control. But the many variations and hybrid evolutions that have taken shape in Ireland, Spain, Portugal, Hungary, Poland, Austria; the G-DRGs in Germany and Switzerland; the GHM in France; AR-DRGs in Australia; HRGs (Health Resource Groups) in the UK; the Diagnose Behandelings Combinaties (DBC's) in the Netherlands; NordDRGs in the Nordic countries, all owe their parentage to the original DRGs used to reconstruct Medicare in the Reagan years.

Though constructing hundreds, or in some cases thousands, of DRGs to reflect the 'average' costs to deliver a bundle of services to a patient in a particular diagnostic grouping is a complicated business (an entire field of science is devoted to it), the intent is relatively simple: a coronary bypass with cardiac catheterisation and major complications (DRG233) should require a similar bundle of hospital resources, therefore cost approximately the same, whether delivered in Hospital A in Utah or Hospital B in Alabama, given some adjustments for severity, patient age, regional wage and cost of living adjustments, and adjustments also for the hospital's population mix, charitable and medical education obligations, and its urban or rural setting.



DRGs give the payers a price they will be expected to pay per a patient's diagnosis – regardless of how long the hospital keeps the patient confined or how much technology or manpower it needs, or wastes, to bring that patient to the point of discharge. If hospitals can do it efficiently and get the patients out in less than the anticipated time and without over-treating or wasting resources or padding their bottom line, the hospital will make a profit. If they overshoot and use more resources than designated or called for by the DRG, they lose. And in the end – those that consistently lose will have to sharpen up their game, make themselves more efficient, and costs will drop all around. At least, that's the plan.

DRG variants

When the DRGs were first activated in Medicare's switch to a system-wide PPS in 1983, there were about 470 individually coded DRGs (all linked to the ICD-9-CM). Now there are close to 800, and several variants of the original DRG system have evolved to cover a broader range of care delivery services.

During their migration to Europe and Australia, DRGs were adapted further for national needs, customs, and medical practice patterns. In some countries they include doctors' services, fixed capital costs, or medical teaching obligations. Others are more sparsely defined. There are also great variances in the scope and specificity of the diagnostic groups and subgroups within. Germany's system, for example, has more than

During their migration to Europe and Australia, DRGs were adapted further for national needs, customs, and medical practice patterns

1,200 diagnostic classifications; the French GHM over 2,300 categories.

Though more than 20 European countries have adopted DRG-type systems, the groupings they use are not yet uniform or comparable, which, if they were, would be a godsend for international health insurers providing cover across multiple borders. Clearly, it would offer stimulus to a body

of commerce that already exists.

In an article published in the *European Journal of Public Health*, Grant Rhodes, formerly at the Department of Health Economics, University of Maastricht, and colleagues, wrote of the developing cross-border traffic in medical services, noting that in border regions throughout the European Union (EU) 'cross-border contacts are developing between insurers-insurers, insurers-providers and providers-providers. Furthermore, in many EU countries price information is becoming more explicit'.



Germany's G-DRG system, in fact, explicitly states: "Contrary to the impression some hospitals like to convey to international patients, these official price regulations (DRGs) apply to all patients, including German and foreign private or self-paying patients. The relevant law (SBG 5) is absolutely unequivocal about that. This makes it possible to evaluate cost estimates and hospital bills on a legal basis."

Don't judge DRGs by price. Not yet

In a recent issue of *Langenbecks Archives of Surgery*, authors Will Quentin, David Scheller-Kreinen, Alexander Geissler, and Reinhard Busse of the Department of HealthCare Management, Berlin University of Technology, wrote on behalf of the EuroDRG Project Group: "The aim of any DRG system is to give a concise measure of what hospitals do." In devising such a measure, the EuroDRG Group analysed patient classification and hospital reimbursements for appendectomy patients from 11 European countries, and they found 'great variations', among them, both in the way DRGs grouped patients and their conditions, complications and co-morbidities, and how they paid the surgeons and hospitals that treated them. The EuroDRG Project is a consortium of partners from 12 countries focusing on analysis, refinement and advancement of DRGs across their spectrum. They include Austria, England, Estonia, Finland, France, Germany, Ireland, Netherlands, Poland, Portugal, Spain and Sweden.

The EuroDRG Group notes, for example, that in Ireland, appendectomy cases are classified into only two DRGs, while in Germany there are 11, accounting for different levels of complexity and age groups. England assigns additional DRGs for certain diagnostic evaluations such as CT scans, and Poland and Austria have additional per diem-based payments for stays in intensive care. And throughout Europe, only the Diagnose >>

in Ireland, appendectomy cases are classified into only two DRGs, while in Germany there are 11, accounting for different levels of complexity and age groups

Behandelings Combinaties (DBC) system in the Netherlands and the AP DRG system in Spain differentiate between laparoscopic and open appendectomy procedures – highly pertinent factors when considering average length of stay and therefore cost.

The Group notes also that while seven countries differentiate between patients with a complicated diagnosis of appendicitis (i.e. with generalised peritonitis or peritoneal abscess) and those without, four countries (Austria, England, Ireland and the Netherlands) do not make this distinction. Thus, if DRG systems don't adequately account for differences between patients, it can only mean that hospitals and surgeons who treat a greater share of more complex cases than others are not paid adequately for their greater efforts, and these cost factors will ultimately have to be addressed. Consequently, says the EuroDRG group, the absolute price levels should not be directly interpreted as reflecting more expensive care in one country compared to another. There are just too many differing components.

The survey published in *Langenbeck's* also notes that in general, costs appear to be lower in countries with a low GDP per capita (Estonia and Poland) and high in countries with a higher GDP, and countries that pay a higher price for one type of patient do not necessarily pay a higher price for all kinds of patients. For example, hospitals in France receive much higher payments for appendectomies performed on young patients, with

peritoneal abscesses, wound infection disruptions and long lengths of stay than hospitals in England. But hospitals in England receive higher payments for performing appendectomies on young patients with secondary diagnoses and short lengths of stay than hospitals in France.

Cost is not always the bottom line

As many analysts, and relatively naïve bystanders, have noticed, controlling cost is but one element in the healthcare equation: its effect on access and quality of services is the flip side. Cutting costs by regulating prices or restricting services by decree, as was done by Medicare in the Reagan years, may yield remarkable results, but can have the effect of restricting access and deteriorating quality of care. Many nations, among them Germany, Japan, Canada, and the UK, have been able to restrain costs through governmental regulation; but not always with happy results. Maintaining a salutary balance between cost and quality has, so far, been a key part of the DRG formulation. Some early analyses are encouraging.

Shortly after Italy implemented its DRG system in 1995, a study of its effect in the northeast region

of 17.3 per cent. At the same time, overall mean length of stay decreased from 9.1 days to 8.8 days. In addition, day hospital (outpatient) use increased seven fold from 16,871 encounters in 1993 to 108,517 encounters in 1996, to which the authors commented: "If appropriate care can be provided in the day hospital (outpatient) or other outpatient setting, this change in severity of illness of hospitalised patients may represent a more efficient use of inpatient resources."

In addition, few significant differences were found in the mortality rates, and though there were some indications of increased severity of illness for some of the study conditions, the authors suggest that what has been known as 'DRG creep' in the US (up-coding conditions to push patients with low severity categories into higher, more acute, more expensive ones) may not have been lost on Italian practitioners.

Clearly, DRGs have downsides that need to be addressed: the incentive to under-treat, to discharge prematurely, to avoid the most severely ill and cherry pick healthier, younger patients. But all alternative payment options have disincentives that mar their values: capitation encourages

controlling cost is but one element in the healthcare equation: its effect on access and quality of services is the flip side

Friuli Venezia Giulia (capital Trieste) showed a quick and unequivocal impact of the PPS-DRG system. The study, authored by a team led by Daniel Z. Louis, of the Center for Research in Medical Education, Jefferson Medical College in Philadelphia, and Americo Cicchetti of the Agenzia per i Servizi Sanitari Regionale, Rome, compared hospital admissions, discharges, lengths of stay and other parameters in 1993 (pre-reform) and 1996 (post-reform). They found that ordinary inpatient hospital admissions (measuring 11 different conditions) dropped from 244,581 in 1993 to 204,054 in 1996; a population-based decrease

under-provision of services or technologies; per diems push providers to keep patients in-house longer than necessary; global budgets often yield low investments in technology and staff; fees-for-service encourage more and more services, whether needed or not; salaries don't do much for motivation and productivity. All offer plenty of disincentives for efficient service.

With healthcare as complex as it is, DRGs will never eliminate all other forms of funding, but as has been proven in the US, and as many European nations are beginning to see, DRGs might provide a practical way to put a rational price tag on goods and services that to date have remained mired in chaos and secrecy for too long.

In his landmark book, Rick Mayes termed the enactment of Medicare's prospective DRG system: "The single most influential post-war innovation in medical financing." In the book *Diagnosis-Related Groups in Europe: Moving Towards Transparency, Efficiency and Quality in Hospitals*, co-author Miriam Wiley, research professor, Economic and Social Research Institute, Dublin, described it as 'this innovation (that) worked its way around the world to the point where, almost 30 years later, the DRG system is the single most important patient classification system in use internationally'. Clearly, the expectations created by DRGs are huge. But there seems to be no shortage of nations willing to meet them. ■



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Setting the record straight

Do Spanish hospitals or private collection agencies have a right to recoup the cost of medical care provided to tourists in possession of a European Health Insurance Card (EHIC) from international insurers? Spanish lawyer [María González](#) says, emphatically: ino!

To put it bluntly, the Spanish national healthcare system is in dire straits. Budgetary cuts for public hospitals are the order of the day. Therefore, it is hardly surprising that cash-strapped hospitals are resorting to any means in order to try and alleviate their financial situation. One such method is to twist the clear intent of European Community (EC) law and force private insurers to pay for medical care provided to foreigners in spite of them having an EHIC.

Deficit tangle

In a bid to resolve their budget deficits, hospitals have outsourced the handling of their bills to private collection agencies. Such agencies derive a hefty 'cut' from cashed invoices. It is no wonder, therefore, that such agencies are extremely aggressive when it comes to the collection of 'alleged' debts. Such vested interest in the successful collection of hospital invoices results in a strongly biased interpretation of EC law and Spanish law. Of course, such interpretation is not in the interest of the private insurers.

In a nutshell, the collection agencies' argument runs as follows:

Article 83 of the 'Ley General de Sanidad' (General Healthcare Act) obliges a hospital to charge health expenses to the third parties obliged to pay. Since a private insurer providing healthcare coverage is obliged

to pay out in accordance with its policy limitations, according to article 83 it appears to be a reasonable third party from which a hospital can claim its expenses back. Furthermore, since this Spanish legal provision does not make a distinction between 'Spanish' and 'foreign' third parties, there is no discrimination contrary to EC law and, particularly, it is in conformity with Article Four (Equality of Treatment) of EC Regulation 883/2004 on the Co-ordination of Social Security Systems. Additionally, it might be considered a free ride for the insurer if it wasn't expected to pay for its policyholders'

the 'third party obliged to pay' exists and it is not the private insurer, but the social security institution of the country of residence of the tourist

treatment once it had collected premiums to cover such contingencies, and it would clearly be unfair for the Spanish public hospitals to bear such a cost.

Well, on initial consideration, this sounds impressive. Spanish law forces public hospitals to 'find' the 'third party' obliged to pay. If the tourist is in possession of a private insurance, then the insurer is supposed to foot the bill. But such reasoning is completely wrong. First of all, the 'third party obliged to pay' is not the private insurer, but the social security

institution of the country of residence of the tourist. Article 19 of EC Regulation 883/2004 states that: "An insured person and the members of his family staying in a Member State other than the competent Member State shall be entitled to the benefits in kind which become necessary on medical grounds during their stay, taking into account the nature of the benefits and the expected length of the stay. These benefits shall be provided on behalf of the competent institution by the institution of the place of stay, in accordance with the provisions of the legislation it applies, as though the persons concerned were insured under the said legislation."

Furthermore, Article 35 of EC Regulation 883/2004 clearly states: "The benefits in kind provided by the institution of a Member State on behalf of the institution of another Member State under this Chapter shall give rise to full reimbursement."

Thus, from the combined reading of Articles 19 and 35 of EC Regulation 883/2004, we can conclude that:

Spanish public hospitals are obliged by EC law (i.e. under EHIC) to provide medical services to tourists. The wording is clear; it is not facultative for Spanish hospitals but mandatory. Such services are provided on behalf of the competent institution (that is on behalf of the British, German, Dutch, etc. social security institution of the patient being treated). Hence, the medical services are not provided on behalf of the tourist or her/his private insurer. The services are provided on behalf of the social security institution where the tourist lives. Thus, the 'debtor' is the 'competent institution'.

The Spanish social security system has the right to be reimbursed from the competent institution and the competent institution is obliged to pay. Thus, the 'third party obliged to pay' >>



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medical services are not provided on behalf of the tourist or her/his private insurer. The services are provided on behalf of the social security institution where the tourist lives

alluded to by Article 83 of the Spanish General Healthcare Act, exists: it is the social security institution of the tourist's country of residence. If s/he is British, it will be the 'Overseas Healthcare Team', if s/he is a German, then it will be the 'Deutsche Verbindungsstelle Krankenversicherung – Ausland' (DVKA) and so forth.

In this vein, it is important to note that providing medical care to tourists in possession of the EHIC is not a burden on the stretched finances of the Spanish social security system. In other words, if the private insurer is removed from the picture, no harm results for the Spanish system. There is a clearly defined 'debtor' (the competent institution of the land of residence) and this debtor, by dint of Articles 19 and 35 of EC Regulation 883/2004, must pay.

Therefore, all the arguments about the unfairness of a situation whereby the private insurer would not be summoned to pay are without merit. Furthermore, forcing a private insurer to pay as a 'first recourse' payer is not neutral since it may increase the premium cost when renewing the insurance.

Since we have proven that the provision of medical services to tourists in possession of an EHIC is not detrimental to the Spanish social security system, why then the current onslaught on private insurers? The answer is clear: the reimbursement procedure laid down by Regulation 883/2004 (and also Regulation 987/2009) takes time, effort and does not directly benefit the hospital concerned.

The money recouped by the Spanish social security (the so called 'INSS' – Instituto Nacional de la Seguridad Social) is allotted between the Spanish regions without directly benefiting the hospitals concerned with the treatment of relatively high numbers of tourists.

The core of the matter is this: the attempt of private collection agencies to force private insurers to reimburse medical costs is a misguided shortcut to circumvent the procedure established by EC law. It is as simple as that. It is a shortcut, albeit illegal, to quickly replenish empty vaults. It is much easier to obtain cash from private insurers by threatening them with litigation than following the straight and narrow path set forth by EC law. In addition to this, and whilst we cannot always generalise, we know of some instances where apparently 'inflated' invoices have been submitted by a collection agency. In other words, the invoices presented to the private insurers did not

correspond with the official published prices for medical services. By marking up the invoice, the collection agency makes sure that its services are also paid for by the insurer. This is, of course, both unethical and illegitimate.

It goes without saying that there are many more grounds (both based on EC and Spanish law) that advocate against the right of Spanish hospitals and private collection agencies to recoup costs from private insurers. We have merely revealed the tip of the iceberg.

Application of the law

It also goes without saying that depending on the specific general clauses and conditions, in some

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instances, the private insurer may be liable to pay. The Spanish healthcare system does not include dental care, specific medicines, etc., and in such instances, the private insurer might be summoned to pay. Furthermore, when Spanish law establishes, in the near future, new co-payment rules, then the private insurer might be obliged to pay the part of the medical service that is no longer provided for free. But such payments will be minor (i.e. €10 per doctor appointment) and many tourists probably wouldn't bother to claim once they have realised that their excess exceeds the value of the claim. Another exception would be a tourist in Spain that is not insured within the framework of the social security system in his/her home country. But such cases are rare.

A final question comes to the fore: What if the tourist has forgotten or lost her/his EHIC? Article 25 of EC Regulation 987/2009 comes to our help and establishes the obligation of the country of stay to directly contact the competent institution (country of residence) to obtain a copy (even a faxed or emailed one) of the EHIC or any document evidencing the right to obtain healthcare in the country of residence. Therefore, Article 25 sets forth a specific obligation of activity of the country of stay. The country of stay, in our case Spain, may not simply dismiss a tourist and bill her/his private insurer because s/he happens not to have the EHIC at hand. An even greater illegality would be if, in spite of showing the EHIC, the card is ignored in order to charge the private insurer.

What to do if the private insurer has already paid in the past to a collection agency? Are such payments recoverable? Or are such payments lost for good? Such payments may be recouped since there was no legal basis for their exaction in the first place and Spanish law establishes that such payments are to be given back to the rightful owner – the insurer. ■



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Incredible Indian costs

ITIJ spoke to experienced industry experts who demonstrate their knowledge and expertise on the Indian healthcare system, and offer advice on the best ways international travel insurers can control expenditure in the country



Pradeep Bery gives examples of common industry practices in the Indian healthcare sector and offers tips on how best to avoid being caught out

When I started providing medical assistance in India, 18 years ago, the cost containment that was necessary was of a different kind. The world of domestic medical insurance, third party administrators and high costs had not caught up with us. Of course, we had simple ‘fraud’ cases. Hospitals (and places purporting to be ‘hospitals’) were paying commissions to touts who used to bring the tourists to the hospitals for a supposedly ‘free’ stay. Places like Agra, Delhi, Manali, Goa and Hampi saw an emergence of thousands of such cases. In the worst-case scenarios, busloads of Japanese tourists were admitted to hospital in Agra for dengue vaccinations, and all cases of gastroenteritis became pre-renal failure – we even heard of kidney transplants being carried out on such patients in Agra. Intervention was clearly needed, so the police and the government were brought in to fix the

situation. As a result, some of the establishments found to have been carrying out fraudulent practices were closed, and a number of doctors headed for the hills. Undoubtedly, this fraud cost insurance companies millions of dollars in those days. Fortunately, it is now under control and we only see a handful of

In the worst-case scenarios, busloads of Japanese tourists were admitted to hospital in Agra for dengue vaccinations, and all cases of gastroenteritis became pre-renal failure

cases such as those detailed above. A few clear indicators should still flag up warnings to international insurers though – beware of the hospital where every case is a dislocated shoulder, which has just been fixed by manipulation and the patient has also left Agra by the last train to Varanasi, or the patient who is in hospital but cannot come to the phone because he has locked his room from inside and cannot be disturbed. When considering today’s healthcare situation, there is no doubt that the cost of healthcare has gone up many times in India. Hospitals are booming, and there is a huge market for patients from Afghanistan, Iraq, Africa and other countries in the surrounding region. All of them come through agents, touts and interpreters, and it is not unknown for these parties to get anything between 10 and 30 per cent of the cost of the hospital stay as a fee. I have heard horror stories about what is happening in hospitals with these medical tourism cases. They come from small remote villages with little knowledge of the world, and are undergoing all sorts of expensive tests and procedures. The other scenario is where all of us are involved.

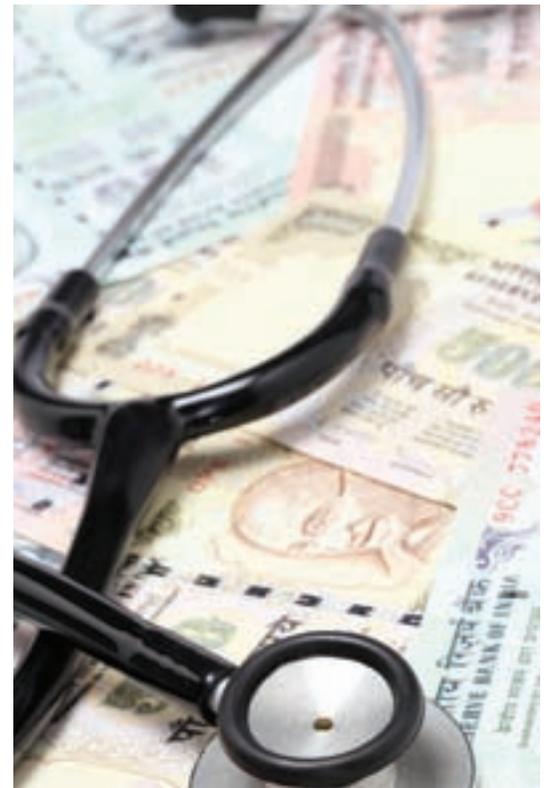
We have two different scenes. The first one is in tourist locations like Goa. The charges that certain hospitals treating international visitors in the state are producing would seem to be 200 to 400 per cent more than the normal fees they would charge. The bills are highly inflated and as a lot of companies now do direct payment agreements, there is no chance for cost containment measures to be enacted, because even before the patient is discharged, the hospital asks for a guarantee of payment for the full amount, or an open ended guarantee, leaving no room for negotiation at a later stage. I spoke with some of these hospital owners, and it seems that they do not even mind waiting a year for the money, as in some cases they have inflated the bills so much that they have factored in non-payment of 20 per cent and interest for one year. So the insurance or assistance company has saved on a correspondent's fee, but instead paid way over the odds for the medical care received by their client. It does not make sense. I have seen medical costs for international patients in places like Goa go up 10 times in the last five years.

The other scenario is in the big cities and places

insurers very soon ... if it isn't already. The only way real and valuable cost containment can happen in India is if insurance and assistance companies stop using such hospitals and doctors. In the majority of cases where the insured is already at a hospital, he or she can usually be moved to a good medical facility nearby. In some cases, especially in the case of non-resident Indians, they think that expensive equals good, and it can be hard to make them understand that they do not have to pay so much over the odds. Insurers need to explain to their client that we couldn't pay five times the going rate because he or she has gone to a hospital that has these practices. The unfortunate part is that these larger non-tourist hospitals in big cities really do not care if we do not give them business. There is a shortage of hospital beds in India, so there is enough business without us in the major cities.

I know I am biased, but you cannot underestimate the role of the local correspondent/agent. By paying a case fee you can save much, much more for the insurance.

The issue is getting more challenging every day and the costs are rising. India is no longer cheap for healthcare as it used to be. We have quality medical care, but it is now coming at a price.



essential, so insurers/cost containers/assistance companies can prepare for a sudden increase in the number of calls it receives from any one area. Figures show that winter, autumn and early spring is when tourists visit India the most – so from October to March, and also July. The most popular tourist destinations, according to 2010 figures, are the states of Maharashtra, Tamil Nadu and Delhi. In 2010, 21.1 per cent of FTAs in India were in the 35 to 44-year-old age group, followed by those aged 45 to 54 years old (19.9 per cent), and those 25 to 34 years old (17.4 per cent). The smallest group were in the 15 to 24-year-old age range (8.3 per cent). Certain tourist hubs are known to house a number of hospitals that indulge in grossly fraudulent practices; for example in Goa, Agra and Varanasi. These hospitals are well known to most people in the assistance and insurance industry and are best avoided whenever possible. Of course, the old problem of getting your client to avoid them remains, but as long as the client calls before going to hospital, most can be steered away from

The charges that certain hospitals treating international visitors in [Goa] are producing would seem to be 200 to 400 per cent more than the normal fees they would charge

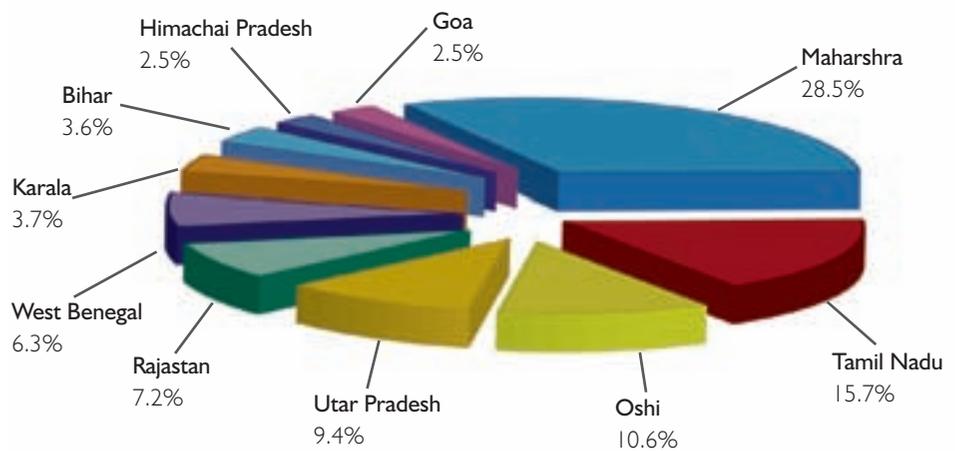
where non-resident Indians come for treatment, including places such as Delhi, Mumbai and Gujarat. Some of the hospitals here have one tariff for domestic insurance, another for medical tourism and yet another for international clients covered by an international insurance plan. In Mumbai, for instance, there is a 75 to 100-per cent surcharge for international patients, and some hospitals allow their doctors to charge what they call a 'negotiable fee', which is just a term for the doctor to charge what he feels like. International insurance companies get hit the most. I have seen medical bills for fees which in some cases are five or 10-times higher than the normal price. There was a recent case in Mumbai where an international patient was charged R425,000 for gall bladder surgery (of which 75 per cent was the doctor's fee). I had my gall bladder removed last year at a top hospital in Delhi for less than R100,000 – this just goes to show that the price variations are not anecdotal. The real problem, though, is that we are letting this happen. Cost containment in India is going to be a significant issue for international travel

Kimberly Chawla explains how increasing numbers of tourists have led to exploding prices

Inbound tourism in India is growing each year, with statistics showing that the number of foreign tourist arrivals (FTA) in 2010 was 5.78 million – an increase of 11.8 per cent from 2009. It has been estimated that by 2015, the number of tourist arrivals could reach eight million, with an average annual growth rate of 8.1 per cent. Thus, the number of illnesses and accidents reported by inbound tourists will, naturally, also increase, so international cost containment departments should become (if they are not so already) well versed in how to reduce and minimise unnecessary costs and fraud relating to traveller client cases in India, while maintaining the quality of care on offer to them.

First of all, the identification of travel trends is

Percentage Share of Top 10 States/UT's of India in Number of Foreign Tourist Visits in 2012



Statistics with permission from the Ministry of Tourism, India



such facilities.

There can be enormous differences in the charges of some hospitals for insured and non-insured patients, Indian and foreign nationals. There can also be a significant differences in the charges if they directly bill an insurance/assistance company compared to a local assistance provider.

Corporate hospitals tend to charge like five-star hotels once they know a patient has foreign insurance. Treatment for common problems in a medium-sized hospital in India is often more reasonable than a corporate 'multi-speciality' hospital.

A comparative analysis of three metropolitan cities in India done by East West Assist concluded that planned procedures such as a hysterectomy or a gall bladder surgery costs almost trebled in Mumbai when compared to Kolkata, and almost doubled in Delhi. Thus if an insured is to have a planned surgical procedure in India instead of 'back home', it may actually be cheaper to fly by commercial airline to Kolkata before the surgery is done!

How to reduce costs

Planned admission

Insurers and assistance companies should ask for a hospital charge schedule and the estimated costs as soon as possible once a patient is admitted, as the hospital could take up to a week to respond, and furthermore it can be worth enquiring if there are any 'packages' of care available. If visiting the patient in hospital, a photo of the charge list should be taken as this has to be exhibited by law (and can be compared to one sent to you by the hospital subsequently).

It is also important that the room category choice must be intimated to the hospital. If the hospital does not have the permissible room category available, they should be asked to shift the patient as soon as the correct room is available. This must be communicated in writing before the patient is

admitted (where possible), so that on discharge there is no misunderstanding or delay. Daily monitoring of the patient should be undertaken, and regular medical reports requested. Another vital point for insurers and assistance companies to note: do not disclose the amount of coverage of the policy!

Emergency admission/you are informed after or during admission

At this point, it is probably best to involve your local provider in order to offer a guarantee of payment (GOP). Involving the local provider in giving a GOP can reduce costs – in some cases, there can be a 50-per-cent reduction in bills. The usual rules apply – there should be direct daily

room, that the patient will need to directly pay for the differences in all related charges. Finally, ensure that you are given a fully itemised bill.

After discharge

The hospital bill must be audited and compared to the hospital price list and other comparable hospitals in the area and then, only then, should full payment be made. This may not always be possible, as some hospitals will not release the patient until full payment is made before or at the time of discharge. Hospitals in certain locations may be cheaper than three-star hotels in India, so there is a possibility you may save money by having the patient stay in the hospital until their flight back instead of arranging for a hotel.

Money for nothing

Some tourists may work in collusion with relatives or hospitals (or the hospital may be non-existent) to indulge in fraud. Insurance providers should therefore be extremely wary of hospitals that have a known history of fraud and keep a tight rein when doling out payments. One of the first rules to keep in mind is to ask to speak to the patient/client, and when doing so, try to call at a time when the treating doctor is not available and speak to the doctor on duty.

Another way insurers can curtail fraudulent activities is to blacklist hospitals that they know are overcharging and instead send their insured to a hospital with similar services but more reasonable pricing. The insurer would soon find that the 'blacklisted' hospital will drop their rates to local charges to woo the insurer's clients back. Insurers should make sure they inform the new white listed hospital why they are using them, as this could stop a similar situation from arising in the future. In cases of reimbursement, the insurer should check the admission records of the hospital, and speak to the treating doctor. Checks for similar >>

The insurer should also inform the hospital about any excess to be paid by the patient and if items such as meals or attendant beds are covered

monitoring by medical professionals, an estimation of costs, duration of hospitalisation and follow-ups. The insurer should also inform the hospital about any excess to be paid by the patient and if items such as meals or attendant beds are covered. The hospital (and the patient) must also be informed that if the patient wishes for a higher category of



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Some of the hospitals here have one tariff for domestic insurance, another for medical tourism and yet another for international clients covered by an international insurance plan

claims, multiple claims by the same client during coverage or other potential fraud indicators should also be carried out.

Billing systems to be aware of

As mentioned by Dr Bery, many large corporate ‘multi-speciality’ hospitals have a dual system of charges, one for the local population, and one for foreigners. We have seen that some smaller hospitals in certain locations have cottoned onto this trend and copied the system. It is worth noting that the charges of doctors and other services that are provided are linked to the category of the room in which the patient is hospitalised – general ward, semi private, deluxe or suite. This difference can be very significant when it comes to costs, especially as the pricing of all investigations, doctors’ visits, and medication follow this sliding scale. There is no difference in care or service at this higher rate. Package rates of hospitals for most of the planned surgical procedures or treatments can reduce costs, although packages offered to foreigners are often higher than for the local population. Ask your local provider to get you a costing via email or fax, so the hospital cannot renege once a package has been offered.



Software used by Indian hospitals allows different rates for different companies to be billed automatically as per company name. Thus, a price list and patient’s bill may correspond when audited, but in reality the charges may be exorbitant.

Cut costs and save money

When seeking to cut costs and save money in the Indian healthcare landscape, it is important to carry out certain procedures. For example, except for in emergencies, the insured should be encouraged to contact their insurance or local service provider in India, so they can be directed to a hospital with more reasonable rates for foreigners, while maintaining the same standards of care.

At times, patients prefer a higher category of room than their insurance allows (or a hospital may not have the required category available at that time). This can be countered by informing the hospital that the patient will need to pay the difference in all the costs and to give priority to the patient when a room is available. At the time of discharge (or well before), the insurance/assistance company

the hospital should not be paid, even if GOP has been given, until an itemised bill is provided

should only pay the room rent, investigations and charges of the permissible category. If unaware of the change in room designation and associated costs, the insurance company will pay for the required room plus all investigations and doctors charges according to the higher category, and the patient just has to pay for the difference in room rent and not the additional charges. A local service provider can offer daily or regular monitoring of the patient’s treatment by medical personnel, and has the ability to prevent unnecessary investigations or an extended stay in the hospital. Lastly, it should be kept in mind that good care for most medical problems can also be obtained in medium-sized or smaller hospitals in most cities, rather than purely in the larger hospitals.

Conclusion

As India is a large country with a population of over 1.2 billion, there is a shortage of beds and hospitals, so most of its hospitals are already filled to their capacity. They do not really need foreign patients, but if there are some present, many will often take advantage of the patient being insured. International insurers should be careful about GOP, as the withdrawal of a GOP before the hospital has accepted a GOP from another agency can be detrimental. For example, if we have given a GOP on behalf of company XYZ, but it turns

out that the patient has more than one insurance – often with better coverage or the employer wishes to directly give the guarantee – we are then advised to withdraw our GOP. The hospital will not allow our guarantee to be withdrawn until they have the guarantee from a company that they accept guarantees from, or have received full payment prior to discharge. Such a situation could spoil a relationship with that hospital where they could refuse to accept a guarantee in future. Of particular concern to international assistance companies should be that Indian hospitals often admit patients to a higher category of room, saying no other bed type is available at that time. The hospital may also wish to directly take full payment from the patient, or they may refuse to admit or treat your patient if there is any pending payment or history or withdrawal of GOP previously. Finally, a note of concern – some hospitals refuse to itemise their charges. In our opinion, the hospital should not be paid, even if GOP has been given, until an itemised bill is provided. ■

Authors



Mr P. Mahajan was a financial consultant and research analyst at KPMG and PWC until he founded East West Assist TPA in 2001. He is the company’s CEO, and has been the secretary general of the Association of TPAs since 2008. He has participated in courses and programmes on health insurance and cost containment conducted by the insurance regulatory body.



Dr Kimberley Chawla has been an internist in clinical practice for 23 years, and joined East West Rescue in 1995. She is also a consultant at East West Medical Center and runs a travel medicine clinic. Penguin published her book Travel Health: A Guide for the Indian Subcontinent in 2001 and the next edition is on its way.



Dr Pradeep Bery is CEO of AXA Assistance India. He has been providing travel assistance and cost containment in India, Nepal, Bangladesh and Sri Lanka for over 18 years. Assistance is his passion and he will retire the day it no longer provides a thrill.



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A man with short, light-colored hair, wearing a white dress shirt and a patterned tie, is shown from the chest up. He is holding a black pen in his right hand and looking off to the side with a thoughtful expression. The background is a bright, out-of-focus window with white frames.

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Wide Variation In Episode Costs Within A Commercially Insured Population Highlights Potential To Improve The Efficiency Of Care

Philip Ellis^{1,2}, Lewis G. Sandy¹, Aaron J. Larson³ and Simon L. Stevens⁴

Author Affiliations

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The man, the myth, the legend

ITIJ spoke to **Steve Jacobson**, chief executive officer of Olympus Managed Health Care (OMHC), about the transition from health insurance attorney to chief executive of his own global company

Where did you grow up and where were you educated? Where do you live now?

I was born and raised in Worcester, Massachusetts. I attended Connecticut College and Tulane University Law School and am currently attending Harvard Business School. Currently, I live in Miami, Florida.

How did you first become involved in the travel health insurance industry, and how did you progress to your current role?

I moved to Miami after law school and worked as an in-house attorney for a large health insurance company. I then moved to Columbia/HCA Healthcare, where I ran its PPO in South Florida. When insurance companies located outside of the US approached me seeking access to the PPO network, I approached the chief executive of the group and asked if we could put a budget together to explore the international niche. Within six months of his declining the opportunity, I started Olympus Managed Health Care out of my apartment on Miami Beach. Fast forward 18 years and Olympus now employs over 80 people, with representation worldwide.

In your opinion, what are the most important tools in OMHC's arsenal when it comes to combating high medical costs or inflated prices?

Infrastructure and expertise from a high level are most important. Ours is a dynamic business, and factors effecting change in our business on the macro and micro levels are a constant. Olympus has invested heavily over that last 18 years in human capital, systems and technology so we are without peer on the infrastructure side. That being said, the best systems and technology are useless if you don't have the expertise to use them. We have the best staff in the industry. Utilising a clearing house to receive claims from providers electronically make our services very effective. Using Medicare allowable and usual and customary charges as benchmarks against the cost of claims is a necessary tool. But our most effective tool to ensure a commercially fair reimbursement is our 'cost up analysis'. This utilises CMS data to analyse the cost of providing the service, rather than looking at the retail price and seeing what discount is available off billed charges. Doing so is like negotiating the price of a car from the sticker on the window, rather than knowing what the dealer paid for the car and offering a reasonable

price above cost.

For managing healthcare costs outside of the US, Olympus relies upon local relationships and historical data (pricing) to identify trends in costs and manage claims from both a clinical and financial perspective. There has been a lot of provider pushback recently, driven mostly, in my opinion, by provider collection agencies and over-zealous attorneys. This has resulted in payers being forced into the untenable position of having to choose between high savings or discount security (sign off from provider). Olympus worked hard to develop a product wherein that trade-off was no longer necessary. To that end, in 2012 we released 'Discount-Secure', a product with industry-leading savings and the security of provider acceptance. To me, it seems like the international payer faces enough challenges without having to trade fair reimbursements with security.

Are costs contained the same way in every country, or do you adapt your strategies to reflect the nature of the local medical industry in certain countries?

Cost containment is like politics, it's all local. Obviously the US is unique in that the billing is codified and therefore consistent. This makes contracting with providers easier. In the case of professional fees, Olympus always seeks to contract on a percentage of RBRVS (Resource-Based Relative Value Scale). For facilities, we seek to contract on a per diem or DRG basis. This is a great way of focusing on reimbursement rather than retail billing. Choicenet International Mexico, our new TPA/cost containment company based in Mexico, focuses on contracting with providers using local fee schedules rather than tourist fee schedules. This results in significant savings and better outcomes, although in many cases is harder to measure.

Do you think President Obama's Affordable Care Act (ACA) will significantly increase pressure on international private insurers with clients in American hospitals, or do you think that such companies are already targeted by US hospitals as a potential source of extra revenue?

This question is the white elephant in the room. The truth is no one really knows what the

outcome of the ACA will be on the international payer. Because of the uncertainty, Olympus is sponsoring research on the issues with law firm Baker McKenzie to discuss the potential effects of the ACA on our clients. That research will be published and made available to our clients and other invited parties in the form of a Whitepaper and follow-up webinar. This will be a great forum for fact gathering and discussion on the issue.

What role do you believe DRGs will play in the future of healthcare delivery and transparency for international insurers?

DRGs and other standardised payment methodologies will continue to play a major role in healthcare cost containment. As facilitators of medical services for international insurers, quality and reasonable costs will always take precedence. The international insurer relies on Olympus to navigate existing and future payment methodologies that deliver meaningful savings. At Olympus, our mission is not only to facilitate US healthcare delivery, but to effectively educate our clients as appropriate.

If you could work in any other industry, what would you do?

I have always worked in the services industry wherein the contributions or products are intangible. I would like to manufacture something you could touch and see.

What do you enjoy doing in your spare time?

I play a lot of golf. I also recently returned from fly fishing the Bitterroot river in Montana. I am not very good, but find it very peaceful. I run a lot and ran my first half marathon last year. I also spend a lot of time coaching my oldest daughter's softball team and youngest daughter's soccer team.

Where is your favourite vacation spot, where are you going on your next vacation, and where would you like to visit that have not yet?

Without a doubt Paris, I really want to live there someday, rather than merely visiting as a tourist. To me it is the cradle of civilisation! Our next trip is a safari in Tanzania, although New Zealand and Australia are also on the to-do list. I hope to get to that part of the world soon. ■

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Breaking the cycle

With its plethora of attractive and affordable holiday resorts, Turkey is considered by many to be a tourist's paradise. However, the cost of international patient care in the country is one of the highest in Europe – and the subject of great controversy. Hans Biekmann reveals the power play behind the high cost of medical care, and proposes a number of potential solutions

Imagine, somewhere in Antalya, in a luxury resort, a German tourist suffers from a stomach ache and visits the hotel doctor complaining about vomiting and cramps. The hotel doctor attempts a basic intervention then recommends the patient goes to a specific hospital for further treatment. The patient is transferred to the hospital, gets treated and then released. The hospital issues the invoice, and charges the travel insurance company via the assistance company. This would appear to be a very simple and smooth process, but there is a catch. Let's take a look at complex dealings that all-too-often go on behind the scenes in tourist resorts across Turkey.

Chain reaction

At the start of the fiscal year, certain arrangements are made by the 'stakeholders' of international patient care operations in the tourist regions of Turkey. These stakeholders include tour operators, hospitals, clinics/doctors and hotels; essentially, any organisation or individual that is directly involved in the guidance, transport or care of patients. The

competition among these entities is so high (due to seasonal fluctuations in patient flow, the variety of available medical providers, and the cost of operating in a highly competitive region), they often choose to establish contract-based relationships with each other to guarantee minimum payments or minimum patient numbers in order to survive. These agreements are even, in some cases, signed documents that allow the entities involved to take advantage of the relatively high number of tourists needing medical treatment during the summer season, and are accounted for, generally, as 'marketing expenses' as they are considered essential for developing new business.

The way these agreements often work is that a tour operator, in co-operation with a hotel, will 'refer' its clients to particular hospitals, or a particular hospital, in exchange for a commission from the hospital/s. For example, if a tourist visiting Capadocia suffers from otitis media – middle ear infection (one of the most widespread tourist diseases in Turkey) – the tour guide or tourist representative will send them to the hospital with

which their firm has an agreement. This may not be the nearest hospital; in fact, the hospital could be an hour's drive from the hotel or site of the incident – but even if there is a hospital across the street, the rep or guide can choose to ignore the comfort of the patient in order





Why do some assistance companies report high incidence rates of medical claims resulting from holidays in Turkey? ANWB in The Netherlands gives its opinion, and provides further insights into its experience of ‘steering’ and how best to achieve cost containment in Turkey

Turkey shows an unbelievably high incidence rate of gastroenteritis relative to claims from other countries – even surpassing the number of claims from countries such as India. We link this with poor food hygiene in many (all inclusive) resorts, due to poorly refrigerated and recycled food: left-over lunches will be served again as dinner or even the next day or days later. Temperatures in summer may rise to over 35 degrees and an occasional power cut may cause a lack of sufficient cooling capacity. Turkey also has a relatively high incidence rate of ear infections, which we relate to poor hygiene in swimming pools. Many of those involved in the tourist industry benefit financially from the referral of patients to local clinics – with hotels receiving a significant share of the healthcare money pie.

Others, including local tour reps, taxi drivers, ambulance drivers, hotel doctors, front-desk staff and even some cost containment companies, make money from referring tourists to clinics. Clinics will pay tens of thousands of Euros upfront to hotels in May to make sure that they refer their guests to them. The clinics themselves will sometimes be paid upfront by cost containment companies to cover the costs of the healthcare that is expected to be delivered in the months ahead. We feel that

this is a very unhealthy interdependency that twists everybody in the chain’s arm.

Turkey is not unique, however. There is a huge cultural gap between North Western (NW) Europe and many other countries in the world, including the US: In NW Europe, healthcare is not considered a means to create profit for shareholders per se. Hospitals and doctors are committed to curing patients for a reasonable salary. In fact, many hospitals are not allowed to make a profit at all. Not so in Turkey, the US, and also Egypt, Spain, Greece, the Dominican Republic, Mexico and so on. When money steers the referral of a patient, don’t be surprised if the patient ends up in a hospital or clinic that is ill prepared to treat their illness.

Healthcare in the tourist areas of Turkey shows prices that are up to five times those in NW Europe. Comparing the general cost of living between these two, there is no logical or decent explanation for that.

ANWB is committed to fighting overtreatment and overcharging in many different ways: by steering patients to the best (not the most expensive) facilities, by relying on our local agents if they prove to adhere to our principles, by making specific arrangements with facilities, and by using the market as a tool.

to meet their financial obligations to the medical facility with which they have an agreement. So, the ground ambulance arrives, takes the patient to the hospital and the patient gets treated. The cost that the hospital invoice reflects includes the actual medical treatment cost plus the commission to the tour operator, commission to the tour guide, the ground ambulance cost, and so forth. A €300 to €500 case can become a €2,000 case.

Cranking up the cost

Many hospitals pay large commission sums to tour operators on a case-by-case basis or provide a

down payment at the beginning of the year. Given that the tourist portfolio of most (European) tour operators in Turkey can easily occupy a small international airport every day for the whole summer, it is not surprising that this down payment is often a significant sum. If debating whether or not to pay the high commission rates demanded by many tour operators, hospitals actually do not have much of a choice: if the hospital does not agree on the rates demanded, the tour operator can choose to strike a deal with a competitor hospital or clinic. Like in any other business, there is a significant ‘power play’ in effect. The tour operators make big bucks and the hospitals have to inflate their treatment prices and/or over-treat patients in order to compensate for this situation they have got themselves into.

Coming back to the initial example of a patient in a resort in Antalya, let’s look at the different ways these behind-the-scenes agreements can affect patient cases. The patient, a hotel customer, visits the hotel doctor complaining of a stomach ache. The hotel doctor is actually in many cases

the hospital’s doctor running a mini-clinic at the hotel. The hospital and the hotel/tour operator have a contract that grants usage rights for the clinic to the hospital in exchange for a ‘rent fee’ paid to the hotel. This inflated rent fee proposed by the hotel is the hospital’s sure-fire way of entering the hotel and collecting patients from whom it can generate revenue. Again, payments such as rent fees are considered ‘marketing expenses’, and such agreements are generally referred to by the hospitals as the ‘taking of a hotel’.

Continuing with our example: the hospital now has access to thousands of tourists that are staying in the hotel. Having already paid the ‘rent’, the hospital now needs to pull patients to its central medical facility to start making money. To do this, the mini-clinic doctor advises patients to go to the hospital he recommends by reasoning that the treatment needed requires more advanced diagnostic or other medical equipment than is available at the mini-clinic. Despite the fact that gastroenteritis patients generally do not need medical attention at a hospital, advising a patient that they need to go to the hospital is a common way of generating revenue. So, instead of a quick solution on



the spot – i.e. the doctor in the mini-clinic providing an oral rehydration solution and/or loperamide – the patient ends up spending a night in the hospital, being subjected to various check-ups, laboratory analyses, diagnostic computed tomography, and so forth.

In summary, some of the hospitals and clinics applying overtreatment and overcharging are doing so as a direct result of the situation whereby some hotels and tour operators receive money by ‘selling their potential patient base’ and thus becoming one of the profiteers in the treatment of foreign tourists. To cover their costs, the hospitals not only have to add the costs of paying commission to tour operators or rent to hotels to their overall invoice, but also (in some cases) increase their revenue by additional means such as turning outpatients into inpatients. This is a continuing trend in Turkey and an increase

in such behaviour is inevitable in the coming years if not replaced by an alternative solution.

This mentality of making the most out of every patient is more comprehensive than most people acknowledge. It seems that everybody is a part of this game. Even some taxi drivers are paid commission to bring patients to certain hospitals. When a tourist gets into a taxi and asks the driver to take them to a hospital, if that driver has an agreement with a particular hospital, he will automatically take the passenger to that facility. It has to be noted that the situation in Turkey is not unique, however. Strong commission chains are in place in many other countries. It may seem like a dark comedy to some, but this is genuinely happening in popular tourist destinations. All the intermediaries involved in such direction, transportation or treatment of patients get a share.



But who pays the price? Whose pocket does this money come out of in the end? The answer, of course, is the foreign travel insurance company. The total cost of the hospital treatment plus the share for the hotel, hotel doctor, taxis, down payment to tour operators, and cost of ambulances all add up to form the total bill – and that’s just for one case. Consequently, travel insurance companies (organisations that run on business models relying solely on consistent risk rates, claims costs and premium gains) are faced with highly fluctuating payments, with their limited budgets for acute medical incidents being taken from them via closed-door agreements and distributed among all benefitting parties.

Who is to blame?

Whose fault is it that international travel insurers end up paying inflated prices for the treatment of clients in Turkey – is it the fault of the hotels, the hospitals, or the tour operators? The answer is: no single party can be blamed. They are all part of a business ‘model’ that has evolved, and they are all accountable for the end result if medical costs become too high. Simply blaming the private hospitals for the increased costs is not fair at all. It is also enlightening to look at the number of bills that are initially guaranteed by international travel insurers to the hospitals each year that are never paid. In addition, the seasonal flow of tourists (therefore,

ITIJ spoke to Dr Murat Akcacioglu of Medicus Clinic in Turkey to ask his opinion on the measures being taken in Turkey to curb excessive healthcare costs. Here’s what he had to say:

First of all, it is true that, overall, healthcare costs are on the rise in Turkey; but there are also very well equipped private and state hospitals, especially in the resort areas of Turkey. The big appetite of private hospitals regarding tourism health is well known, but there are also some very large new state hospitals in the region. Furthermore, taking an active part in the healthcare of tourists, the government has launched a new policy and announced new tourism healthcare prices. State hospitals must charge TL 15 (€6) to Turkish citizens and TL 80 (€35) to foreign patients, and they will each have the same medical examination from the same doctor in a state hospital.

For us, the amount charged is not the problem at the end of the day – the main problem is that tourists are treated differently than Turkey’s own citizens. And this is a money-oriented policy. Once you create a money-oriented policy, the sky is the limit – it seems nobody can stop you. And this is exactly what the private hospitals are doing. They are the main reason for increasing costs. They are competing to find creative ways to feed hoteliers, tour companies and taxi drivers with commissions. And their greedy appetites are killing them: they have to spend a couple of million euros every year to protect their portfolio of hotels. Eventually, they have to get back what they have spent, and this comes from the bill payers’ pocket (from you, the insurance companies). It’s a vicious circle, and it is not sustainable.

How did this begin? This problem is not unique to Turkey, the same thing is happening everywhere around the world. It all started with a handful of doctors or with a handful of hospitals. They realised that they had unique power in their hands: the decision-

making power of a medical doctor over patients’ medical problems. A service provider decides how much service to provide; the service taker (patient) is the weaker party, and will not argue against a very technical, medical diagnosis. The semi-gods are, thus, deciding everything!

This is like writing an open cheque to yourself. You can afford to share some part of the money with third parties, because you can decide on the final bill. Clever, isn’t it? Those that get the largest share of the ‘commissions’ are still the hoteliers, then some (especially British) tour companies, then taxi drivers, and so on. Now, the hospitals cannot avoid paying commissions to these third parties. They have created this situation; they are not the victims. How can a service provider survive without paying commissions? Or, is it possible?

It is very difficult without the support of insurance companies. We, for example (Medicus Clinic) could not survive as the only primary care provider in our region without the active support of Scandinavian and some Dutch insurance companies. But where are the others?

The key is the bill payers: insurance companies. They have to find a way to steer their policyholders to certain, independent primary care providers; otherwise they will keep complaining but keep paying. Essentially, primary care and hospital services must be separated, as primary care is the door keeper for hospital referrals. The only solution is that insurance companies must find the professional, honest and independent (they are not always independent from hospitals) primary care providers and keep supporting them. Or, they have to invest in or set up their own primary care centres in resort areas in various countries.



Europe. Furthermore, an increase in the standard of living in Turkey, together with a steadily growing economy, have formed the basis for higher wages, including those of medical and nursing staff, which, in turn, have also led to higher treatment costs.

Staying ahead of the game

Assistance companies in Turkey are beginning to use a number of methods to keep costs down for travel insurers – sometimes halving the original invoice amount. Marmassistance, for example, applies extensive cost control to the hospitals, negotiating pre-agreed special treatment rates; monitoring the treatment as it takes place; intervening in the treatment, if necessary, to avoid overtreatment and overcharging; going over every detail on the invoice and investigating its accuracy.

Discount agreements on hospital costs are also negotiated and renegotiated with all relevant medical facilities every year. Assistance companies can secure further discounts based on the volume of cases it handles at a particular hospital, and by offering the hospital fast and reliable payment. The current ‘system of profiteers’ that we have looked at in this article has been created as a direct result of insured tourists attempting to seek medical attention by just walking into hospitals. Rather than calling their insurer, or their assistance company via the telephone number on their insurance policy, to ask for advice on local medical facilities, policyholders instead tend to talk to hotel reception staff, their tour representative or even their taxi driver regarding such information. Insurers, thus, often have >>

seasonal flow of patients) plays a major role. In order to accommodate the immense need for medical care in the busier summer seasons and to take advantage of the financial benefit it provides, more and more hospitals have begun operations in and around Turkey’s tourist centres. With the growing number of hospitals has come intense competition. Naturally, the hospitals operate all year round, but they’re finding it very difficult to fill their beds outside of the summer season due to insufficient demand from the indigenous and local expatriate populations. As a result, with vast numbers of empty beds at certain times of the year, a high number of personnel that hospitals are legally not allowed to make redundant in the quieter months, and astronomical operating costs, the hospitals rely heavily on earnings made through the summer season. All these factors turn the hospital business in parts of Turkey into what is essentially similar to the seasonal ice-cream truck business, where the main profit is generated in the summer season, but has to last for the whole year. Additionally, it should be underlined that the quality level of medical treatment available in Turkey has shown a spectacular increase in recent decades, naturally leading to higher treatment costs. Following the healthcare reforms passed by the State and the emergence of many state-of-the-art private hospital groups, medical quality levels today, in many cases, exceed those found in much of Western

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ITIJ also spoke to Ayçe Riley, general manager, Euro-Center, Turkey, to ask for her insights into cost containment measures necessary in Turkey and beyond. This is what she said:

Twenty-seven million tourists visited Turkey in 2011, making the country one of the top seven most popular countries to visit in the world. However, the lack of a regulatory body dedicated to overseeing tourism health issues, and no system to monitor and evaluate the medical performance of hospitals, is confounded by corruption at every level – from hotels to tour operators, and even including taxi drivers – so the health industry as it relates to the treatment of tourists has become very polluted in Turkey. New strategies are needed to keep claims costs, inpatient/outpatient ratios, and claims frequencies at desirable and affordable levels. Otherwise, the travel insurer will carry on financing the corruption indirectly by paying inflated medical bills. In Turkey, the public healthcare system allows people to walk in to hospitals off the street – there is no established referral system or health record management. Also, there is a culture of ‘the more medication, the better’. Managing tourist healthcare within such a culture, within a system that predominantly assures volume by paying commissions to hotels and tour companies, produces magnificent over-treatments, over-investigations and over-diagnosing. What is notable in Turkey, however, is that simple cases are often over-treated, but serious cases are usually managed very skilfully. In order to ensure that your policyholders receive the appropriate level of medical care, there has to be a system in place for referrals. With the relatively high number of tourists in Turkey, and the absence of any coordinated effort to manage their health, there is room for hospitals and other stakeholders to abuse the system and take advantage of travel insurers. Let’s look at inpatient volume in the tourist areas: this has to be analysed in three groups, as each has different issues. The first group concerns unnecessary admissions – simple cases like tourist diarrhoea, sunburn, and

ear infections that would have got better as outpatients. We are noticing an increase in this type of admission, so some of our client companies have taken rapid action by changing their policies and allowing us to steer more effectively. The strategy regarding the avoidance of this type of admission must be to keep them away from hospitals by steering into outpatient clinics. Tourists coming from countries with social security systems usually don’t question a decision of admission, but we see many medical reports where a patient has signed to be discharged prematurely by his or her free will. Free choice has value if it is based on information and we as insurers or assistance companies have to guide the policyholders into right level of medical care for good quality medicine, after which we can practice effective cost containment. The second group is made up of those in real need of hospital care, and here the quality of care is usually good. Still, a good assistance/cost containment company makes a difference. The third group concerns extreme cases – those requiring ICU or long-term care. Even though the private sector has very high quality technology and well equipped ICUs, university hospitals can be a better choice for extreme cases as they have reanimation specialists round the clock on their staff, which cannot be said for most of the private hospitals. Referral to the best quality of care and timely repatriation back home are the most important issues. At Euro-Center, we have implemented a strict referral system for a group of our client companies, whereby policyholders always consult a first line doctor or clinic named by us, and they only get referred to a hospital if needs be. Hospital walk-ins and those referred by hotel doctors or other clinics have to pay cash and get reimbursed later. This has resulted in sizable reductions in average claim costs and inpatient ratios.

no control over which medical facility the patient ends up in, and thus no control over the treatment costs. With the various push-pull forces affecting the steering of patients towards certain facilities, however, it’s easy to see how the patient has become a tool in a money-making system, and a key cause of travel insurers’ claims losses. On initial consideration, the ultimate solution to this dilemma would seem to be for the state to enforce strict regulations regarding the rising cost of international patient care.

We are in regular contact with the Ministry of Health and Ministry of Tourism to try to push for better price regulations. Turkey has a high tourism profile, with this industry bringing in an important source of revenue, and this image should not be damaged but should rather be protected and supported by niche businesses such as those involved in the treatment of foreign tourists and the medical tourism industry. Clinics and hospitals in Turkey should be enormously proud of their excellent facilities and medical expertise, protecting



these achievements as opposed to risking their reputation by gaining a reputation for over-treatment and/or over-charging. Given that there is no particular law in the horizon that would limit treatment costs for international patients in the tourist regions of Turkey, there is only one solution that could bring costs to reasonable levels: patients are referred to the most appropriate facility for their condition/location by their travel insurer or their insurer’s local assistance partner. How to achieve this? Tour operators are, in most cases, based and selling their products in the same country as the insured and the insurer. So why are travel insurers not making a ‘gentlemen’s agreement’ with their national tour operators regarding the steering of patients, and educating their army of tour guides and hostesses about the issues that arise when they become involved in the direction of patients? A tour guide is the person on the front line that can help and advise tourists when it comes to seeking medical treatment the right way. Why not instruct and educate the insured and the tourist, in co-operation with the tour operator, before they leave the country? We as a company are ready to take the bull by the horns and make our own investigations into the dealings of tour operators, hotels and hospitals and advise our clients to level up with their national tour operators to break up such agreements as those that exist in Turkish resorts. Western European insurance companies should do the same. And not just with regards to Turkey, but also the other countries where tourist areas have grown a reputation for systems of overcharging and overtreatment. Marmassistance has a number of other actions in the pipeline, one of which will be launched this month – a strategic partnership with TEMOS, the German hospital certification organisation. Marmassistance will support and advise hospitals and clinics seeking certification, and execute audits in collaboration with TEMOS. We also started an activity this year named ‘scouting doctor’. This involves placing one of our team doctors in resort areas to visit the hospitals and to discuss with and advise hospital management and administration representatives with regards to pending cases. The ‘scouting doctor’ reports directly to his colleagues at



ITIJ spoke to Ata Demirel of the Antolia Hospital Group to find out his thoughts and solutions for tackling cost containment issues in Turkey's tourist regions

In reality, how many patients are actually referred to hospitals by 'stakeholders', or are referred to an inappropriate facility by the referral system explored in this article? How many educated European tourists take advice from taxi drivers when they need a doctor?

You see patients travelling with the same tour operator in every hospital. Do you think that the hundreds of doctors and tens of hospitals in the tourist areas of Turkey depend on such a simple referral system?

Where referrals are made in this way, the patient doesn't lose out, because all parties are working hard to satisfy their needs. In fact, no one loses out: the doctors and hospitals gain patients; and travel insurers are selling more policies every year to tourists visiting Turkey.

Looking at the increased cost of care in Turkey, the reasons for this are manifold. First and foremost, the healthcare sector faces very high costs. Among OECD countries, Turkey has the biggest shortage of doctors and healthcare workers: in Germany, the number of doctors per 1,000 of the population is 3.6; in Turkey, it is 1.6; therefore, the cost of employing doctors and nurses is very high. There is an overall shortage of hospital beds in Turkey, the country has the highest expenditure on energy of all OECD countries, and has one of the highest rates of tax, and the valuable lira has made the euro less valuable in Turkey over the last 15 years. Turkey is also dependent on assistance from abroad for high-tech medical investments, which also increases costs.

In fact, healthcare costs in Turkey are reasonable when you consider the quality and quantity of medical care available. Although the costs behind the provision of medical care in Turkey are much higher than in many other tourist resorts in Europe, our prices are still lower. If there are complaints about high costs in Turkey, and the reason for these high costs are the arguments made in this article, then we have to admit that the roots of these costs

are irrational competition and any kind of support for it. The antidote to such a system can be achieved by wise co-operation between hospitals and insurers. What is needed is not an alternative plan for outpatient cases, not the use of private GPs instead of the use of hospitals already geared up to treat outpatients, not the creation of competition between private GPs and walk-in clinics and hospitals, not putting pressure on other hospitals to match or better the prices you have been guaranteed at another medical facility, and not partnering with hospitals purely because of their cheaper price list. Otherwise, the competition will never end. Today, we have the opportunity to come together to create radical changes and alternative options for cost containment – this involves an honest and open partnership between high-volume insurance companies and well organised institutional healthcare providers that are set up to accommodate international patients. This would involve a long-term partnership agreement between the involved parties, where a budget would be set and paid to the medical provider to cover all healthcare costs for the insurer for the whole year, regardless of the type of illness or injuries treated in that time – whether inpatients, outpatients, ambulance cases, or intensive care. This way, we can start to get rid of almost all of the complicating and undesirable issues in the current referral system. The patient would know which doctor or hospital he should go to, as he will have been advised in advance by his insurer as to which hospital group the insurer has a strong partnership with. This would do away with any other need for cost containment, and do away with the endless discussions about the current 'referral system', over-charging, over-treatment, prices, costs and the like. This may not seem like an easy proposal to accept, but given today's economic realities, we all need major, strong partners – high volume means a better price – and we all need transparency and clear choices.

our headquarters.

Another key factor here is the use of local assistance partners. As many international assistance providers will testify, having a trusted partner on the ground in an area where your own local knowledge might not be so strong, or where the valued reputation of a local assistance partner who has established links with local medical providers can be utilised to the foreign assistance company's benefit, can prove invaluable – not least when it comes to making sure costs are contained. The experience and the bargaining power gained from years of representing the insurer at local hospitals, and dealing with all aspects of international patient cases, ensure and enforce the most reasonable billing, and as a result save the travel insurer a substantial amount of time and money in return. On a wider note, the debate about the referral system not only relates to cutting healthcare costs in Turkey. Lately, the aging of the baby boomers in Western Europe brought heated discussions on how to cut down on healthcare costs in many other countries. The revisions that took place in social security systems and the rise in retirement ages all seemed to have failed in balancing the healthcare budgets. Shaken by the brutal impact the economic conditions have had on the European economies, some countries are now officially considering utilising the referral system to have more control over healthcare costs and bring them down to reasonable levels. So why not do that abroad as well? It is again clear that Turkey does not stand alone in the battle to keep health costs low.

By putting the travel insurance and assistance industries in control of the referral system when aiding tourists in resorts such as those in Turkey, the non-medical profiteers will be kept out of the game, the patient will receive the right service in the right place, and a considerable amount of what would otherwise have amounted to claims costs, remain in the insurer's pocket. The ultimate result: the insurer can, and should, keep premiums low. ■

Author



Hans Biekmann has had a long international career in medical assistance and medical cost control, having worked in the Netherlands, Germany and Austria. Over the last 14 years, he was network director

of ARC Europe in Brussels, responsible for the international service networks of approximately 40 million European members and 11 million vehicles. He launched several products, ran projects and established companies in medical and roadside assistance and medical cost control. Since January 2012, he has been CEO of Marmassistance in Turkey.



Unstoppable

rise?

President Barack Obama's Affordable Care Act is looming on the US healthcare horizon, and Milan Korcok says that with the ACA or without, US health costs will stay high

When President Obama signed the Affordable Care Act (ACA) into law in 2010, Americans were primed to expect a revolutionary change in the way their healthcare was obtained: the uninsured would be insured, the poor would get the same level of care as the more fortunate, no one would be denied care, and costs would be become manageable not only for hardworking families, but for the nation as a whole. The promise was the achievement of a universal healthcare plan that had eluded Americans since President Teddy Roosevelt first advocated one a hundred years ago. But like most political promises, it came with a lot of qualifiers, and though Obama is now in the midst of a torrid election campaign, he and his supporters rarely mention the introduction of health reform in their stump speeches and press releases unless forced to defend it. A *New York Times*/CBS poll taken in July showed 50 per cent of Americans opposing the ACA and only 36 per cent favoring it. A Rasmussen poll

in August showed a 50 against/44 in favour split, and averages of hundreds of polls taken since the Act's enactment in 2010 show virtually no change in those ratios. This is not what this Administration had hoped would be the reaction from a populace that has for generations expressed dissatisfaction with its healthcare accessibility and costs.

If President Obama loses office in the November general election, and the Republican Party maintains its grip on the House of Representatives and makes gains in the Senate, there remains the possibility that the ACA might be repealed. But since parts of it have already been enacted and the repeal process is so cumbersome, it is more than likely that the ACA will leave some residue on America's healthcare landscape – for good or ill. If Obama wins re-election, the die is cast.

The devil is in the detail

The ACA was not designed as a single payer, government monopoly system like Canada's or

insurers can expect a \$778-billion increase in revenue over the next decade by covering the 16 million currently uninsured

And it still leaves the solutions for the US's chronically high healthcare costs unattended. The Act is more about cost shifting than cost reduction. There are no systemic changes to the way healthcare is practised and delivered, and so there appear no incentives for doctors to charge less, hospitals to lower their fees or grant bigger discounts to institutional payers such as insurers or employers (although there are now restraints on the charges they submit to individual, uninsured patients). And in the end, this can have no other result but the US remaining as the nation with the highest healthcare costs in the world, now at over 17 per cent of GDP, and in the foreseeable future devoting one fifth of its economy to healthcare.

If international travel insurers and their cost containment agencies are looking for relief from America's ruinously high healthcare costs, they won't find solutions in the ACA.

For hospitals, some positive signs

When, in July, the US Supreme Court upheld the individual mandate segment of the Act, which dictates that by the year 2014 everybody must buy, or already have, health insurance or face a financial penalty, shares of hospital chains jumped in anticipation that between 16 and 30 million uninsured, and many of the patients they previously had been treating gratis as charity cases, would have their bills paid by an expanded Medicaid, or through private insurance. (The shares of HCA Holdings shot up 10 per cent, Tenet seven per cent, and hospital chains specialising in low-income Medicaid patients also jumped some seven per cent.)

Michael Wiederhorn, an analyst with Oppenheimer & Co., told Reuters: "For hospitals, this (the Supreme Court decision) was a big win," that, "in the short and the long term ... will reduce bad debt."

But Moody's Investors Service also cautioned that upholding the mainstay of the ACA (individual mandate) will generate a credit-negative position for not-for-profit hospitals in that, despite the decrease in uncompensated care, non-profit hospitals will be faced with reimbursement cuts of more than \$150 billion over the next 10 years, much of it via Medicaid cuts specifically for treating patients who now have no insurance. (A trade-off factor in the ACA was that federal government payments for Medicare services would be cut back over the

years, and eligibility for state-funded Medicaid programs would be greatly expanded – a burden dozens of state governments say they will not be able to carry.)

For insurers, more accountability

Shares of health insurers initially dropped on the news from the Supreme Court, but by the end of the day regained their losses and have been moving in relative equilibrium with the rest of the markets. Alan Miller, chief executive of Universal Health Services Inc., was quoted by Reuters as saying: "It's good for us. You've got a lot of people now who are going to be covered and they're going to pay their bills, or the federal government or the state or somebody is going to pay their bills." Miller was referring to the federal and state subsidies

Insurance companies will also be encouraged to join 'exchanges' in which individual low-income buyers might be able to compare the prices of comparable products offered by a variety of insurers

that will kick in to help low income people pay for premiums they might not otherwise be able to afford (mostly through expanded Medicaid). One analyst from Bloomberg expects that insurers can expect a \$778-billion increase in revenue over the next decade by covering the 16 million currently uninsured who will initially join the ranks of the insured. (In all there are more than 30 million uninsured, but it will take more than a decade to get to them all through various programmes). Not all analysts, however, are as confident of the outcome for hospitals or insurers. Said Bob Kirby, a director at Fitch Ratings: "For most industry participants, it is unclear if the incremental revenue generated from increased utilisation and lower levels of uncompensated care will offset the potential >>

Britain's National Health Service, or the systems of several other European countries. It leaves the private sector elements – hospitals, insurers, doctors, clinics, etc. – intact, except that it loads them down with thousands of regulations, expectations and requirements.

this can have no other result but the US remaining as the nation with the highest healthcare costs in the world



compression in margins.” Insurance companies will still be responsible for funding the coverage of their enrollees. But to counterbalance their expected bonanza of new customers, they will also be required to enroll individual applicants with pre-existing conditions, they will be subject to government reviews of premium rate increases, and they will be required to post medical loss ratios (MLRs) of up to 80 cents on every dollar earned in premiums starting in 2014. Insurance companies will also be encouraged to join ‘exchanges’

in which individual low-income buyers might be able to compare the prices of comparable products offered by a variety of insurers. However, the plans offered in these exchanges will be tied to different tiers of coverage – meaning that enrollees will still be subject to substantial co-payments and deductibles – some of them higher than many conventional plans offered currently. And even here, premiums will not be insignificant. One example of a plan now offered to individuals in Texas would cost a 40-year-old single man \$450 a month. Of course that will vary from state to state and may be mitigated by government subsidies and tax credits, but in any event, premiums will not be cheap.

For those not in the individual marketplace, employer-sponsored insurance is still expected to be the main coverage vehicle for the great bulk of Americans, although they will have to shoulder more of the burden of rising premiums by larger deductions, co-payments and out-of-pocket contributions.

For small businesses, costs ‘they can’t afford’

For employers, especially small businesses of more than 50 employees, the requirement that they insure all their employees has major implications for Obama’s re-election hopes as it is seen as a huge impediment to business expansions and start

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If international travel insurers and their cost containment agencies are looking for relief from America's ruinously high healthcare costs, they won't find solutions in the ACA

up, and by extension to America's dismal economic recovery (a 1.5 per cent annual rate of GDP growth in the second quarter of 2012). Many small businesses say that between the prospect of paying for private healthcare insurance for employees and the expectation of tax increases, they're reluctant to commit to business expansions and/or start-ups. Beginning in 2014, the ACA imposes a large new tax on health insurance plans that sell policies to individuals and small businesses enrolled in Medicare and Medicaid, and most of this is expected to be passed on to consumers.

For doctors, an uncertain future

As Medicare and Medicaid are expanded to

encompass more of the uninsured, doctors will be faced with more underpaying patients and will have no option but to charge their privately paying patients more (mostly through their

insurers). Doctors have long complained that Medicare, and especially Medicaid fee rates

(set by federal and state governments), don't cover their costs of operation. They will also, because of the increased regulatory measures and paperwork, either have to hire more office staff or move into salaried positions for hospitals, or quit altogether. The US already has one of the lowest ratios of doctors to population of any country in the OECD (Organisation for Economic Co-operation and Development) and it's only going to get worse. The Association of American Medical Colleges estimates that there will be a shortage of 63,000 doctors by 2015 and 130,600 by 2025.

Clearly, doing business with healthcare providers in the US is going to remain challenging and expensive. This is now, and will be into the future, no place for the timid. ■



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When 'l'hôpital' is the wrong destination

Those seeking medical treatment when abroad all too often head to the nearest emergency room (ER), believing it to be the best place to receive appropriate and timely treatment. Philip Brun explains why an ER is often not the best place to be, however, and looks at the role insurers can play in preventing ER overuse

It's the first night of a family's long-planned vacation to Disney World in Orlando, Florida, when their five-year-old daughter Antoine comes down with serious flu-like symptoms: coughing, dizziness, difficulty swallowing, cold sweats, and high fever. Sophisticated Parisians though they might be, they have no idea how to navigate America's complicated healthcare system. So they gather their family, hail a taxi outside the hotel, and instruct the driver "L'hôpital, s'il vous plaît!" Despite every good intention, they may have just made entirely the wrong call.

Navigating the US healthcare system

The US healthcare system is the world's largest, most costly and complex, and international visitors face special challenges navigating its waters if they need care while travelling. For example, there are more than 600,000 doctors, 60,000 pharmacies and 6,000 hospitals across the US. With so many options in the country's healthcare delivery system, where should a family take a sick child first? What might be Antoine's most appropriate point of entry into our complex healthcare system? Many people in the US and abroad mistakenly believe that a large number of common medical conditions are best treated in an ER. In fact, estimates from the US Centers for Disease Control and Prevention illustrate that almost one-third (32 per cent) of the 124 million annual American ER visits are considered non-urgent or semi-urgent. From blisters to minor burns; sprains, strains, and fractures; to flu symptoms and finger wounds; patients have a habit of flooding US emergency rooms with non-urgent illnesses and injuries that could just as effectively be treated at other medical facilities, such as an urgent care centre, a physician's office, or a retail clinic. The emergency room, however, must remain just that – a special place for the treatment of life-threatening or very serious conditions that require immediate medical attention, such as possible heart attacks and strokes, uncontrollable

bleeding, unconsciousness, or other major traumas. This does not mean that illness or injury should be ignored. Urgent care centres, in particular, can treat many serious health conditions that consumers might commonly rush to the ER to treat – such as stomach viruses and flu symptoms, sprains, strains, fractures and cuts. There are over 8,700 urgent care centres in the US: most accept major health insurance, do not require an appointment, and are considerably less expensive than an emergency room. In a case like Antoine's,

patients have a habit of flooding US emergency rooms with non-urgent illnesses and injuries

patients will be in and out much more quickly than the hours typically spent in a hospital emergency room.

Another appropriate option for visiting non-US residents who need healthcare services might be a retail health clinic – also commonly known as a convenient care clinic – a care facility traditionally located in a shopping mall, pharmacy, or other retail setting. The clinics are staffed by nurse practitioners and physician assistants and offer services for minor, non-urgent health conditions (including minor infections, skin conditions, minor cuts and earaches). Consider the case of a business executive who takes an overnight flight Sunday evening and feels the onset of terrible, flu-like symptoms just prior to his/her important Monday morning meeting. Rather than languishing in the ER for hours, the executive could visit a non-acute

care centre for treatment that could be as simple as a much-needed vitamin booster shot.

These alternatives are not only more appropriate for the treatment of certain medical conditions, but far less expensive than a trip to the ER. UnitedHealthcare data shows that the average total cost of a visit to the ER in 2010 was approximately \$1,300, while the average total cost of a visit to an urgent care facility, physician's office, and convenient care clinic were \$175, \$105, and \$73, respectively. Increased awareness about the appropriate use of ER services also translates into savings for the entire US healthcare system. A study published in the September 2010 issue of *Health Affairs* estimated that redirecting non-emergencies to alternative care centres could lead to annual cost savings of up to \$4.4 billion in national US healthcare spending.

Beyond the prohibitive costs of unnecessary visits to the ER, it is equally important to consider the benefit of avoiding prolonged, stressful waiting times. According to the American College of Emergency Physicians, US ER room patients spent an average of four hours and five minutes in the ER, a figure that has only increased in recent years. Meanwhile, 80 per cent of all urgent care visits in the US are finished in 60 minutes or less, according to the Urgent Care Association of America. And, really, who wants to spend four hours on a Friday night during a holiday or business trip being shuffled between victims of violent crime or traffic accidents knowing you've been delegated to the bottom of a waiting list?

Arming visitors with knowledge

If we know the answers to why we need to change visitor behavior concerning ER overuse (namely, the savings in time and money), the question for insurers is: how to raise awareness among visiting non-US residents about the costs and delays of relying on the ER for medical care? How can we communicate this clearly and effectively to policyholders and help holidaymakers, business people, and students make the right choice rather

Hospital ER vs urgent care centre



Sources:
¹ American College of Emergency Physicians ² Urgent Care Association of America
³ Health Affairs, September 2012

than rushing without a second thought straight to the emergency room?

Insurance companies can offer pre-travel education about appropriate emergency room use with simple explanations about the US healthcare landscape, policies, and procedures on their websites or in printed collateral materials such as travel policy brochures. Once travellers are abroad, the companies can offer emergency room education through multilingual call centres dedicated to international traveller queries and readily accessible mobile apps and online directories that can direct insurance holders to non-urgent care alternatives. The secret to success, in this regard, is to provide travellers with information that is portable and easily accessible. It is unlikely that someone is going to pack a lengthy policy brochure along with their business suits; however, providing a wallet-sized card or membership card with the essential information will enable a just-in-time referral resource. The same is true of websites and mobile apps. The trick is to enable the insured to access them easily when needed, rather than expect people to bookmark or download them prior to travel.

Once accessed, these advances in technology and telemedicine help make it easier and faster for visitors to find the right care wherever they might be. In addition to 24/7 telephone assistance, Antoine’s family could also benefit from online provider directories that enable members to locate the most convenient appropriate provider. Some insurers are testing free mobile apps that can be downloaded to mobile devices to help users locate nearby physicians, urgent care centres, and hospitals (e.g., ‘this retail health clinic is just three minutes from your hotel and has an average wait time of 12 minutes’). Telemedicine and mobile healthcare applications can be especially invaluable when people are visiting rural and remote locations in the US. Several US insurers are now providing these direct to nurses and physician communication channels that offer diagnostic capabilities and co-ordination of care services via the phone or web.

International insurers looking for a US partner that can help alleviate the high costs and

inconvenience of relying on ERs should seek one that offers both web and mobile tools to help members find convenient care centres as well as one that provides live telephonic assistance to customers. Knowing the treatment options available and understanding what distinguishes a true medical emergency can help keep travellers out of US emergency rooms, and keep vacation and business travel plans on track. It’s a win-win situation that helps patients, insurers, and the US healthcare system overall. The savings – in terms of time, cost, and hassle – just might have everyone saying, “*Merci!*” ■

Author



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Costly care

Rising global healthcare costs are a problem for each and every travel insurer. Reid Cawston considers the issue from different perspectives and asks what the industry could do to halt the ever-increasing cost of treating patients when they are far from home

Each and every year since the term 'cost containment' made its way into the international travel insurance marketplace, healthcare cost inflation has averaged between three and nine per cent across most developed countries, well outpacing general inflation rates in most cases. Currently measured key cost drivers of increases to medical costs include capital expenditures such as building and technology, and additionally non-capital spending such as drugs, programming and education. Though present for some time now in the US and other highly developed healthcare marketplaces, emerging cost drivers include personalised medicine and direct-to-consumer marketing, particularly for specialised services, diagnostics and testing services such as MRI scans and genetic testing.

Given the general trend towards socialisation of healthcare reimbursement in jurisdictions such as China and the US, if the government-funded payers (Medicare) are not increasing payments to match this inflation, the cost will be borne by the private sector; the private sector being comprised primarily of private insurance and self-pay (and some charitable organisations). This mechanism is called the Cost-Shift Payment Hydraulic and can be demonstrated by this rather dated but still relevant chart (below), which was a favourite of one of my old colleagues. It shows clearly that as the pressure to reduce or hold the payments by the government-funded entities is exerted on one side, the pressure to recover the cost shifts to the private payer side.

In short, providers will increasingly look to insurance companies to fund the gap created by underfunded social programmes and uncompensated care (patients defaulting on responsibility).

Changing methodology

Cost containment has evolved in the last 20 years, yet for some industry veterans it is now looking much like it did two decades ago. In the beginning, the go-to cost containment solution was to buy a discount on medical charges after the fact, either through a PPO, or later through an HMO or by arbitrating a settlement directly with the provider. With the consolidation of PPOs and HMOs,

and the proliferation of healthcare finance data to support claim negotiators/arbitrators, the same discounts are essentially now available to any payer; the only real differentiator on post episodic discounting is access to unique direct agreements with providers.

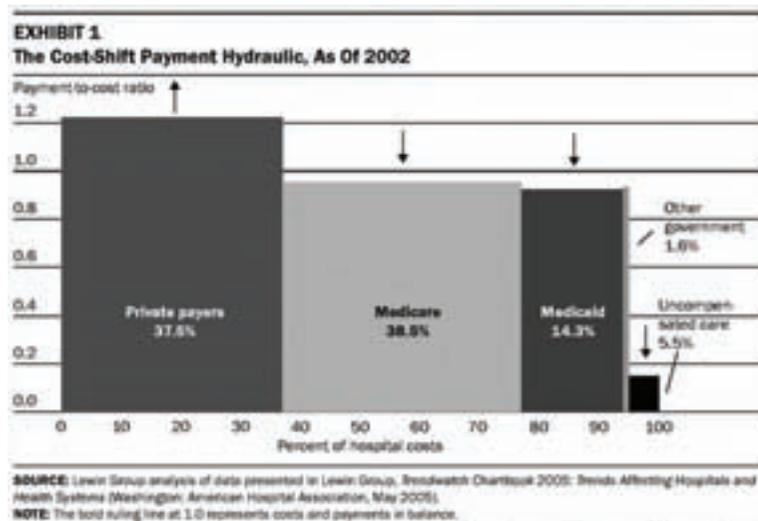
Before the advent and subsequent commoditisation of the PPO discount, assistance companies took the approach that in order to control costs they must control expenditure, but this requires real-time intervention. This mode of cost control is second nature to international assistance companies as they are involved from the point of injury or incident

Managing the care delivery to insured members is something that will always require warm bodies to accomplish successfully

to manage the care of the insured member and therefore, can integrally manage the cost. Many insurers, intermediaries and even some self-styled assistance companies have mislaid those skills though, and have sought to use only contractual means to obtain their best final price for medical care. This method of cost containment has two key business pitfalls: first, over time the seller will find new ways to recoup lost revenues (raising gross fees) and secondly, the insured member does not experience the value-add that is apparent when a professional assistance company is actively managing their care.

The decision to insource or outsource cost containment is cyclical, as it is for any business function. Generally, a vendor presents with a unique value proposition that financially warrants

the buyer to hand over some functions to the vendor as the expertise or capacity is not easily reproducible within the company (outsource). This could be true for cheque cutting, printing, or discounting medical claims. If it makes financial sense over time, the buyer can develop the capacity or skills required to bring the functions back in house (insource). For all service organisations and next only to claims payment



for insurance companies, labour is their chief budget item. Managing the care delivery to insured members is something that will always require warm bodies to accomplish successfully; therefore, actually doing the assistance work is expensive. It will take a significant amount of time for insurers to develop the capacity to insource full assistance services, and in many cases the financial argument will make outsourcing to established assistance companies with capacity and scalability the logical decision.

The key to any successful outsourcing of services for the buyer is their ability to still be able to differentiate themselves in the marketplace. If you and your competitors' phones are being answered by the same call centre, how do you distinguish yourself to your customers and prospects? If both parties are getting the same level of cost containment, how do you compete on price? If I had the answers I'd write a book and get rich, but I think it has to do with defining what type of competitor you want to be. Are you the low-cost option or are you the high-quality option? Arguments can be made that you can be both, but the opportunity to game the system and do both, profitably, is a short-term strategy.

Current trends observed within the ... industry would have to include the disputes being litigated in US courts regarding third parties (or fourth or fifth) to PPO and HMO contracts

Emerging markets

Some of the new travel markets that have emerged along with healthcare provider networks in the travel insurance segment in the last 10 years include Thailand, Egypt and Turkey for the Europeans, and Panama, Europe and Southeast Asia for Americans. With this change in destination patterns, offering travel insurance coverage and service delivery has required market participants to become familiar with the domestic healthcare delivery systems of these destinations and to develop relationships and their networks with the healthcare providers therein.

In many ways being led by the expat insurance experience, the travel insurance segment has seen emerging markets in destinations such as Brazil, China, India, Eastern Europe and Africa.

Previously the travel destinations of an intrepid few, the expats exposed to these exotic lands encourage travel for recreation by returning home with their experiences and stories. Travel insurers can benefit from networks created for the expats and corporate employees. Generally, these networks have been developed to provide primary and emergency medical care locally. With the addition of evacuation capabilities and active medical case management, these networks can easily be leveraged to provide dependable cashless service to the insured traveller.

Trendsetters

Current trends observed within the cost containment industry would have to include the disputes being litigated in US courts regarding third parties (or fourth or fifth) to PPO and HMO contracts. Companies that buy or sell access to contracts that they do not own will always be open to some level of risk. In many cases, the contracts that were executed between healthcare providers and payer organisations were never meant to be assigned or leased to another party. Perhaps the language specifically prohibiting this action may not exist within the contract, but it is just as likely that the scenario was not foreseen. As fiscal belt-tightening increases, there is a strong likelihood that a large US provider group or perhaps an allied association may launch a legal case against these grey-market practices and change the discount landscape entirely. With the incidence of \$1-million plus cases increasing, the incentive to actually pursue a case in the courts becomes viable. (For more about contractual disputes in the US healthcare system, please see **Who's afraid of silent PPOs?** on p38).

Similarly, in the US from about 2004 onwards, the number of legal and accounting firms involved in reviewing hospital revenue management records and attempting to recoup income lost through the application of a contractual discount has grown dramatically. Even with limited success, these firms represent free money to any provider that opens their books on a contingency fee basis. A couple of threatening letters to payers, phone calls to long-ago treated patients, and threats of a collection agency have insurers paying out on policies long considered closed just to stem the possible bad publicity.

What's next? In the US, regardless of what happens to the Affordable Care Act after the next federal election, some aspects will likely still be implemented. A large portion of the population that did not have access to health insurance now do and it will be hard to take that away. Broader coverage, particularly with concurrent lower benefits (high deductibles) will result in busier providers with more administration and more receivables to collect on. Patient responsibility is a major administrative burden on US healthcare providers. Foreign visitors will likely be required



to pay any personal portion in advance of being released, or worse in advance of being treated. Much like the rest of the world, cashless service will be the exception, not the rule. Globally, insurers will need to align themselves with effective assistance partners servicing the destinations their members travel to, or customer satisfaction will decline as the insured traveller is required to pay and claim. In the future, travellers will be further from home, in more remote areas, with more obscure languages, with varying access to quality medical care. ■

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Who's afraid of silent PPO's?



Who is afraid of getting caught taking an improper discount? In this follow-up article for *ITIJ*, contributor **Tom Hudson** tries to answer this question and several others

In my recent article for *ITIJ*, *Contracts Speak when PPOs are Silent* (July 2012; Issue 138), I revisited a topic that I first explored for the ITIC held in Prague in 2006. I participated in a cost containment panel at that conference – paying as little on claims as possible always being a topic dear to the hearts of most ITIC attendees. I remember a number of questions after the presentation; many people in the audience were not familiar with silent or blind PPOs, not to mention aggregator PPOs and rental networks. Today, these terms are generally familiar to the cost containment industry. Some businesses active in paying travel insurance claims may encounter improper discounting from time to time, but for some, improper discounting does not appear to be a problem. One leading cost containment company told me that silent PPOs are much ado about nothing. But another felt that it is still a major problem.

A case in point

In 2006, Shai Gold (today the CEO of International-Triage, LLC) was in the audience in Prague, and he listened intently to my stories about silent PPO abuses. At that time, Shai was the VP of international services at Jackson Memorial Hospital (Miami, FL). Upon returning to his office, he shared the information with the CEO, the hospital attorney, and the director of managed care contracting. The hospital investigated and learned that it had been victimised by improper discounting/silent PPOs. Rather than start an open-ended legal battle to recover unjust discounts, the hospital decided to preserve its relationships in the managed care industry and close the loophole. All cost containment companies, networks and TPAs known to Jackson Memorial were put on notice that any sub-rental of their contract

with the hospital would result in termination of their agreement and litigation to recover illegal discounts. Appropriate clauses were immediately added to all contracts and the practice ended quickly without jeopardising the hospital's industry relationships. "We felt that the best way to address the issue was to send a strong message and at the same time tighten the loose ends. This practice was (and remains) a byproduct of sloppy contracting," said Shai as he related this success story to me when we met in 2009.

Shai Gold's story about Jackson Memorial gives us some insight into the answer to the question posed above: who fears getting caught? The answer may be: not as many as you might think. Certainly, the payers that could have been sued by Jackson Memorial were never in jeopardy. There was a cashless settlement. Payers using silent PPOs frequently can probably breathe easily because they hardly ever get caught. Payers in an untainted payer chain – no discount shenanigans – have no fear, and if they are implicated in an improper discount, they are indemnified. And from the provider viewpoint, there is a trend for large US hospital systems to open doors to international patients and figure out ways to get their bills paid – maybe using an international collection agent as the intermediary and no silent PPO risk. For large

healthcare systems it may be less a concern about silent PPOs and more about lack of co-operation with large, nationwide payer-agents. In other words, is silent PPO litigation a fight between two large interests that do not like each other? That would be large healthcare systems and large payer networks – certainly no love lost there!

Also, it is curious that improper discounting of provider bills is not always characterised as silent PPO abuse. When I contacted one of the attorneys in the Tenet Healthcare case, which was the focus of my July article, he felt that the case was not about improper discounts or silent PPOs. When I mentioned the 27 states that have enacted laws to combat silent PPOs, the lawyer was aware of the Florida statute but did not think it applied to the case. Of course, as I pointed out in the article, the case could be framed as a dispute involving the interpretation of contract language, and if that is how the parties and their counsel proceed – litigating the meaning of contractual provisions rather than improper discounting – then the case could be tried along those lines.

When the *ITIJ* editorial staff thought about the issues I addressed in my July article, they asked some interesting questions and scoped out another article, as follows:

Assess the different silent PPO cases.

Settlements – how much, etc. – what damages have been awarded in silent PPO litigation?

Has silent PPO litigation made PPOs change the way they do business?

The answers to these questions should lead to a better understanding of the effect of improper

Payers using silent PPOs frequently can probably breathe easily because they hardly ever get caught



discounting of hospital bills by payers as well as the implications for the cost containment industry. I will also keep returning to the question of who cares about the consequences of taking an improper discount.

Industry evaluation

Assessing the different cases is not too difficult. There have been a lot of cases, and the volume is not decreasing. Google ‘silentppolitigation’ and spend days looking at the results. The plaintiffs are usually large healthcare systems. Very few silent PPO cases are brought by a single hospital. This litigation is big provider versus big payer. That is why many people reading this article may not care about silent PPOs. Unless they are affiliated with one side or the other, why would they care? It is self-evident that just about any hospital bill can be scrutinised and something wrong can be found. It may be a coding problem or it may be an improper discount. Moreover, the volume of litigation and the claims represented by the cases is a very small percentage of total claims filed. So small, in fact, that it leads some cost containment specialists to debunk silent PPO abuse. “Move on,” they say, “it’s not a big problem.”

Information on settlements is available from law firms and audit services that provide medical bill reviews. While insurance companies have targeted medical providers to reduce costs and increase profits, an audit of hospital accounts receivable payment history can be performed at no cost. Operating out of offices in multiple states, companies like SL Chapman LLC hunt for improper discounting through the use of silent or rental PPOs. Two other audit companies are MedAssets and Triage Consulting Group. These companies specialise in revenue recovery. They attract silent PPO cases by identifying improper discounting and taking the hospital’s case on a contingent fee basis. Audit companies delve into records, find an irregularity, and earn a percentage of what the hospital recovers. Predictably, in the cost containment industry, they are viewed as vultures by some and as useful watchdogs by others. Moving on to address the question of how silent PPO litigation has affected the payer chain, lawyers representing companies in the payer chain know how silent PPO litigation changed business practices. Terms in contracts to pay claims, either directly or indirectly, now protect payers in the chain from anyone in the chain – assistance companies, TPAs, brokers, smaller PPOs – that arranges an improper discount. So contracts have changed, but more than contractual terms, many cost containment experts are savvy enough to avoid doing business with companies that do not stand behind their business practices – that is, the network discounts they pass on. Good companies maintain their good reputation. On the other hand, one frequent ITIC attendee described a less virtuous course of conduct. When a foreign patient is provided a discount to which he is not entitled, there is obviously a saving. The saving, however, is subjected to a

percentage-of-savings fee that generates substantial revenue for the payer chain. Yes, the foreign travel insurer overall pays less (but may be subject to a claim later on) while the payer chain enjoys the savings fee. Of course, the hospital is throwing the party by paying for the abuse.

Any assessment includes class action cases. For example, a class action lawsuit is filed against an insurance company and its adjuster. Medical providers form the class of plaintiffs. They received partial payments on their bills under an alleged PPO agreement. These suits are similar, always pleaded as variations on the silent PPO theme. First, the hospitals do offer discounted rates in exchange for patient volume, and they do have various PPO agreements in place. However, the defendant companies do not steer patients and have no payer agreement with the hospital. They simply take the discount improperly.

Audit companies delve into records, find an irregularity, and earn a percentage of what the hospital recovers

Class action defendant insurers and related co-defendants are too numerous to name, but over the last 10 years, they include Aetna, Cincinnati Insurance, Connecticut Indemnity, CNA, Farmers Group, Mid-Century Insurance, StrataCare, UnitedHealthcare, Universal Underwriters, and Zurich. The Class Action Fairness Act (CAFA) was enacted in 2005 to discourage filing class actions in friendly venues (i.e., forum shopping), and there was a decline in class action suits for a time. Today, the certification of classes by courts (a first step) appears to be increasing.

The damage awards in silent PPO cases (or settlements) depend obviously on the facts of each case, and with class actions, it depends on how many providers opt out of the class. It is not mandatory to remain in the lawsuit. Prudence may dictate a different course, such as the one pursued by Jackson Memorial. In any event, if the case is pursued individually by a single hospital or a larger healthcare system, the damages can be substantial. In one case, the insurer paid \$500,000 in cash and agreed to contractual rates going forward that were favourable to the hospital and would allow the hospital over time to recover what it had lost in past years (and I’ll bet the insurer simply raised its premiums!). A case such as Tenet Healthcare involves four hospitals and a number of patient bills that were allegedly improperly discounted. Based upon my investigation, a typical claim could range from \$10,000 to \$50,000, easily. And one audit specialist advises that millions of dollars have been recovered from various payers during the last decade.

Underhand tactics

There is a darker side to the improper discounting of medical provider bills. Hospitals have alleged that they have been deceived by US insurers and their assistance companies and TPAs when foreign patients receive the benefit of a discount that is only available to domestic patients. The allegations have included violation of state consumer fraud statutes, civil conspiracy, fraudulent concealment and unjust enrichment. Noting the problem, the American Medical Association (AMA) has branded silent PPO activity as fraudulent. The AMA points out that both the seller and the purchaser of the discount rely heavily on the fact that a busy physician practice or the back office of a hospital will have difficulty spotting an improper discount. Of course, the failings of the provider are not an excuse, but it indicts the insurer that takes unfair advantage. Simply put, fraud is conduct undertaken with the intent to deceive, and while the burden of proof is great, it is not insurmountable. Insurance companies that sense any chance of losing a fraud count will settle, and they will not admit any liability. They will simply pay money and probably extract a non-disclosure agreement from the hospital.

In conclusion, there are silent PPO cases filed across the US. Many are class actions, and they pit large providers against large payers. Settlements can be substantial, but like the number of cases compared to total claims, the dollars involved are small when compared to total travel insurance claims paid in any period. The cost containment industry recognises honest payers in the payer chain, and reputable companies work with other reputable companies to pay providers. Finally, who’s afraid of silent PPOs? There are many answers to this question. Each reader will have one. It may be an indifferent answer because your company does not work with a company that does not stand behind its business practices. Or the answer may reflect your concern about improper discounting because your business encounters frequently what the AMA calls fraud. ■

Author



Tom Hudson has practiced law for over 35 years, and during a long career with MEDEX, he developed an understanding of legal matters relating to travel insurance and the assistance business. In addition to practicing law, Tom is a co-founder of American Clinics International, Inc. (FirstMed Centers), MediTRAVEL Insurance LLC, and recently Nurse Call Centers LLC.

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