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Introduction

This year’s Cost Containment Review is ITIJ’s ninth such publication, and it’s incredible to look back and see the development of the industry over the past almost-decade. From just a few companies offering cost containment services in specific regions, there are now firms all over the globe that offer some kind of cost control, whether that is through audits of medical bills, negotiating discounts and rebates, or setting up hospital networks. The methodology of cost containment has evolved over the years too – from purely offering discounts to detailed analysis of medical treatment given to expats and travellers in even remote parts of the world. No longer just in the US, the global travel health insurance industry has embraced new and innovative cost containment concepts and applied them to their own areas, demonstrating expertise and professionalism at every turn.

ITIJ’s 2014 Cost Containment Review provides analysis of the most important issues surrounding cost containment today. It looks at how clear wording can control a policyholder’s behaviour in such a way that cost containment happens automatically; analyses how the bundling of hospital bills can help rein in spending; and assesses the value that wellness programmes have when it comes to claims ratios for healthy employees. Keeping control of medical costs in Russia is another industry challenge that we explore this issue, while elsewhere advice on how to measure the value of your cost containment partner makes for very interesting reading.

We hope you enjoy this year’s Review!
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As an industry, our ability to apply the medical terms and conditions stipulated within a policy is only as good as the wording used to write the policy. While the most fulfilling part of my job is to apply my medical knowledge to benefit ill or injured travellers covered by our products, I accept my responsibility to be fiscally attentive to our clients in the application of the medical Ts and Cs of their policies. Some are liberal and others are strict, and we learn to apply benefits within these respective boundaries.

To this end, it is essential that policy wording be carefully thought out and easily interpretable on a medical as well as a layperson level. In the 18 years I have been dealing with travel and travel-health related policies, I have worked with our commercial teams to help them and our clients write their Ts and Cs in ways that our medical personnel can apply them practically. As a result, there are clear and articulately written policies that define their terms precisely, but others remain vague, and these policies inevitably lead us into muddy waters.

Whether it is a ‘Cadillac’ policy that is liberal with benefits, or one that is narrowly defined, the wording must be clearly understandable by the medical evaluators, the administrative staff, the customer and, ultimately, the regulatory body or court that will review an appealed decision. There are two key areas of customer management and decision-making that will be affected by the clarity and strength of the Ts and Cs:

- the ability to direct the customer to the preferred network provider, and
- the medical factors that will determine coverage, such as pre-existing or related conditions and the onset of symptoms.

Getting patients into your network

This subject is a controversial area, and suffice to say that the more directive and specific the wording of a policy regarding early notification of the assistance/insurance centre, and the stricter the requirement to respect network preferences, the greater the likelihood that you will be able to direct

If policy wording isn’t strong enough, insurers can find themselves shelling out for more than they’d bargained for. Dr Cai Glushak issues a plea for clarity from underwriters
the member into your network. ITIJ has previously discussed ‘in-network’ coverage possibilities, but what language is more likely to get the patient to phone first?

There is nothing more frustrating for medical staff who are asked to get involved in a case of, say, biliary colic (gallstone pain) than to find out that the patient has already been admitted and is on their way to the operating suite. Most of these operations can be deferred until the patient is back in their home country if the pain has been controlled and there are no signs of complication. Of course, we do not wish to discourage patients from seeking immediate medical care for truly urgent or life-threatening conditions. However, pointed language that requires, or at least strongly encourages members to call their assistance centre prior to seeking care or within a short timeframe after presenting for care in any but the most urgent situations is more likely to give you the opportunity to direct them into your network, and may even assist them in identifying the best qualified provider, even for a truly urgent problem. Depending on the strictness of your coverage terms related to network choice, such language will also give you strength on the back end when deciding if the patient behaved reasonably. If your team determines a procedure or admission was unnecessary in retrospect or that the patient could have checked with you to select a network provider, clear policy wording could support a denial of coverage if the patient could reasonably have been expected to contact your assistance centre.

An example of poor language is: “You must call your assistance provider within 48 hours of seeking medical attention or being admitted to hospital.”

This is generally unhelpful. Most acute interventions happen within the first 24 to 72 hours of seeking medical care. If contacted at the 24-hour point, we have lost the chance to discuss the need for admission with the initial treating physician (TP). Furthermore, it is much more effective to agree on a plan of care with the TP from the outset (even if the patient requires admission) that corresponds to the travel circumstances, than to try to change the management plan of a physician who has already made promises to the patient about the treatment they can expect (and many well-intentioned practitioners will simply offer the same approach as that of a permanent resident).

The following language from an Argentinian policy (paraphrased) is very compelling and more likely to ensure a call before seeking care, or will support an insurance denial if it is determined that unreasonable or avoidable costs were incurred.

An example of acceptable language is: “In order to obtain benefits, the beneficiary or companion must call and obtain authorisation from the assistance centre before making a decision to seek care or incur costs related to a medical condition. In cases in which prior authorisation was not obtained, no claim for reimbursement will be processed. Only in the case of a real and demonstrable emergency that prevents immediate notification of the assistance centre, will a claim be considered for later review for authorisation or denial.”

Such language sets out the expectation on the policyholder very clearly and, although no strict timeframe for notification related to an emergency condition is indicated (of course this is dependent on circumstances), the principle is clear. A retrospective review could then clearly indicate whether a policyholder resorted to reasonable and timely means to contact the assistance provider. Of course, once the patient calls in, it is incumbent on the assistance centre to have a well-organised approach when steering the caller to the most appropriate provider. If a caller fails to respect clear and practical policy requirements and seeks care from a non-networked provider, the ultimate arbiter of a coverage decision will be guided by the reasonableness of a layperson to distinguish a life-threatening or urgent condition from a more routine complaint that would afford adequate time to consult their assistance service before choosing a provider. Typical language that often applies to the decision-making burden on the policyholder may refer to a ‘prudent layperson’...
and ‘reasonable judgment’. It is particularly important to include language that encourages members to notify you before they are admitted to hospital. We are all painfully aware of overtreatment and admission for conditions such as gastroenteritis, otitis media and sunburn in tourist locations, but unnecessary admissions even occur in more conventional settings. For example, one does not always need to undergo an immediate operative repair of a broken bone, even if this would be the usual course of care for a local resident. Being aware of an offered admission before it occurs allows the assistance medical team to influence the case before a course of care has been initiated. In some cases, we have even had success transferring a patient to a preferred facility if admission is necessary and the patient is stable. It all depends on the handling of the member and treating facility once the assistance team have been contacted. But you don’t even get to square one if you cannot compel the member to phone first.

All about language
In order for medical staff to accurately and expeditiously interpret medical information in the context of the Ts and Cs, it is essential the language make sense on a medical as well as layperson level. It has to be understandable and interpretable at both ends. Not surprisingly, the ultimate verdict by any arbiter will depend on how clearly the language supports the coverage decision made by the insurance entity. Furthermore, vague language will often lead to prolonged discussion and serious delays in determining coverage, weighed down by requests for clarification, additional research and other exchanges. This not only consumes inordinate administrative time (adding to service costs), but negatively impacts the customer journey, frustrates providers and may actually impede the rendering of assistance, even in life-threatening situations. The following areas seem to generate the most confusion in applying the medical aspects of Ts and Cs:
- pre-existing medical conditions;
- duration of the pre-existing condition;
- related medical conditions and risk factors;
- stability of the medical condition; and
- duration and onset of symptoms.

Obviously, it is necessary to spell out clearly the conditions upon which a coverage decision will be made related to the above concepts. While I am an advocate of articulating the Ts and Cs in as much detail as possible to apply these concepts, the intent is not to turn the policy brochure into a legal treatise. Consumer protection regulations such as the Treating Customers Fairly approach promulgated in the UK increasingly require that product brochures explain key terms simply, prominently and clearly, and not rely too much on fine print. However, I see nothing wrong with making the key factors clearly visible and understandable in simple statements, accompanied by references to detailed descriptions further into the brochure. Either way, definitions are essential and will vary depending on the strictness of the policy. What follows is an investigation of the areas that generate the most confusion in travel health insurance policies.

Pre-existing conditions
The brochure language should define this term including the following aspect: must this be a definitive diagnosis, or can it include symptoms or other clinical problems for which the patient has consulted a healthcare worker, even if no diagnosis has been made? For example, a patient has seen her home doctor for recurrent left lower quadrant abdominal discomfort on three occasions, been given pain medications and has no clear diagnosis. During her travel, she has a recurrence of pain that is now severe and is diagnosed with acute diverticulitis and admitted for antibiotics, CT scan and possible surgery. Acceptable wording to define a pre-existing condition could be:

“…any complaint for which a member has sought treatment prior to travel (or the policy effective date).”

Vague wording, on the other hand, could read:

“…any medical condition that was present prior to the policy effective date.” Does ‘medical condition’ require a diagnosis or a specific description in the medical record? A patient is likely to argue that no diagnosis had been made and there was no reason to suspect the condition was serious; yet it was clear this was an ongoing problem under regular surveillance.

Clearly specify whether a pre-existing condition must have previously been clinically evident in some form. While most policies consider a pre-existing condition to be one that has presented some form of clinical manifestation in the past, some strict ones exclude all diagnoses that result from an underlying evolving pathology of longer
duration, even if producing no symptoms prior to travel. We know that cancers, atherosclerosis, hypertensive cardiac and cerebrovascular conditions and chronic arthritis, as examples, generally take months to years to evolve prior to causing any clinical symptoms. Therefore, such strict policies would exclude tumors, myocardial infarctions, strokes and virtually all conditions other than acute infections and traumas that are the end result of an underlying physiological condition.

For example, a 35-year-old previously healthy male is admitted for acute onset headache and confusion. He is found to have a ruptured cerebral aneurysm and is admitted to intensive care after neurosurgical intervention. Because a ruptured aneurysm is clearly the result of a longstanding underlying pathology, there are policies that will not cover this presentation. However, less restrictive policies will only exclude this from cover if there were never any clinical symptoms prior to travel and no clearly related pre-existing conditions (such as hypertension).

Acceptable wording: “A pre-existing condition is any condition that results from an underlying, evolving or chronic process, such as atherosclerosis or hypertension, that began prior to the policy period, even if it has never caused any symptoms or been identified by a medical practitioner.”

Although this represents an unusually narrow scope of coverage, such language would support a very strict policy. Alternatively, less restrictive polices generally aim to exclude only those conditions that have already been raised to clinical awareness prior to travel. If the policy is intended to exclude any clinical condition that has been brought to the attention of a healthcare worker, whether or not the patient was aware of or understood the nature of it, this should be stated. Patients may not be aware of what their physician has documented or done for them. However, the medical record may clearly indicate that the problem in some way has been identified — if it is not meant to be covered, language should state this.

Acceptable wording: “…whether or not the member has been made aware of the medical condition that has been documented by his/her healthcare provider.”

For example, a 25-year-old patient presents with wheezing. He states he has no known medical problems and takes no medications. He has been referred for pulmonary function tests, which have not yet been completed. As this was of recent onset, his GP had not yet decided on a diagnosis. The assistance medical team have no doubt that he has been seen by his GP twice in the last year for wheezing and been given antibiotics. He has been referred for pulmonary function tests, which have not yet been completed. As this was of recent onset, his GP had not yet decided on a diagnosis. The assistance medical team have no doubt that he has been seen by his GP twice in the last year.

Duration of the pre-existing condition
This is usually fairly well defined in many policies, but it helps the medical team to know exactly how far back they are expected to look when researching the duration of the pre-existing condition. Unless otherwise stated, a pre-existing condition (such as seizures) could go back to infancy, if that is when it was diagnosed. If the look-back period is six months or two years prior to the policy period or travel date, this must be explicitly stated. The medical team can then seek the exact date of the first diagnosis of the condition.

Related conditions
One of the thorniest areas for adjudication is ‘related conditions’ and the risk factors associated with an acute diagnosis. If the policy is intended to exclude a diagnosis only if that very diagnosis was previously made, then the language should refer only to pre-existence of the condition itself. More and more, however, insurers wish to exclude conditions resulting from or related to associated conditions, sometimes defined as ‘risk factors’ for a given disease. Some typical associations include:

- diabetes, hypertension and hyperlipidaemia for a heart attack;
- acute bronchitis or pneumonia for emphysema;
- hip fractures for osteoporosis; and
- acute infections for conditions that suppress immune responses (such as diabetes or steroid treatment).

The difficulty for medical evaluators is that it is not often possible to say that one of these associated conditions has been directly or definitively causal of the acute diagnosis. Unless someone’s blood pressure or glucose was actively spiralling out of control and one...
Acceptable wording: clearly state this. Developing such complications, it is important to intended to cover patients who are at high risk of bronchitis or pneumonia, so if the policy is not could show a direct progression to the resulting stroke or heart attack, most associations only place the patient at increased risk for the acute problem. Of course, even a healthy patient can get acute bronchitis or pneumonia, so if the policy is not intended to cover patients who are at high risk of developing such complications, it is important to clearly state this.

Acceptable wording: ‘A related condition is defined as any pre-existing condition that is known to be a risk factor for; places you at increased risk of, or is associated with, the development of your current medical problem.’ Unacceptable wording: ‘...conditions that are a direct result of an associated condition.’

Is a hip fracture a direct result of osteoporosis? Depending on the mechanism, any person can fracture a hip, so denial based on this logic may be subject to challenge in all but the most obvious situations.

Stability of the medical condition
This is another term fraught with uncertainty when referring to a pre-existing condition. How does one determine whether longstanding pre-existing hypertension or coronary artery disease has been stable or well-controlled? These are subjective terms that will likely require intense scrutiny of a patients’ past medical records (if you can get your hands on them!) to make a determination.

Language to be avoided: “You will be covered for conditions that have been well-controlled (or stable) in the six months prior to the policy period.”

Better language: “A condition is considered pre-existing if within the six months (or whatever timeframe) prior to the policy period you have had any changes to your medications for that condition, had any exacerbation of symptoms or required any new tests.”

At least based on the medical records available, the latter criteria can be objectively evaluated.

Duration and onset of symptoms
Many policies are not intended to cover serious conditions if the symptoms appeared before the patient travelled. This makes sense if the expectation is that patients not place themselves at risk of falling ill during their voyage if there are signs they might develop problems after they depart. However, most insurers would cover conditions if their symptoms prior to travel were minor. While it is difficult to craft language that tightly defines the boundaries around ‘minor’ or ‘serious’ in so far as pre-travel symptoms go, most adjudicators would be comfortable with terms such as ‘reasonable judgment’ and ‘prudent layperson’.

Reasonable language: “The policy will not cover conditions related to symptoms that begin prior to travel that would cause a prudent layperson using reasonable judgment to seek medical attention.”

While most of us would not expect a healthy person with a tickle in his/her throat or a mild headache to defer getting on a plane (even if the end result was pneumonia or an aneurysm), we would likely agree that a 60-year-old man with a history of heart problems who has been experiencing new shortness of breath for one week prior to travel to have consulted a physician before leaving (and subsequently lapsing into full blown heart failure). On the other hand, if the policy would strictly exclude any condition in which the first symptoms arose before travelling, then state this very clearly:

Good language: “…condition associated with any symptoms that began at any time prior to travelling.” Usually, the onset will be clearly documented in the medical record.

Vague disclaimers are nobody’s friend
There are a number of areas in which the articulation of policy wording directly affects the ability of the medical evaluator to give clear direction to the underwriter to support an expedient coverage decision that will stand up to the test of appeal and strict regulators. Understandably, some insurers have purposely allowed the policy language around pre-existing and related conditions to be general or vague because it affords them greater flexibility in determining cover. The downside is that vague terms are more subject to challenge and may lead to a prolonged and rocky road of exchanges, information finding and continuous discussion. I would argue that the tighter the consumer regulation around your product and the more restrictive you wish the policy to be, the better more specific and detailed terms will serve your needs.

The involvement of medical staff for review of, and input into, new and updated policy language better ensures they will be able to efficiently apply them in order to support prompt coverage and assistance for eligible insureds, and helps to create a firm position for the client in case of a denial consistent with the intentions of the policy. While excellent medical assistance runs in the veins of those of us who are dedicated to serving ill and injured travellers, if we are to be relied upon to interpret the medical data to properly support travel policies, we really need clear wording. We are only as good as the language you give us. All we ask is that you keep it objective, simple and clear. This makes for a smoother assistance process, a better customer journey, and – ultimately – better protects the insurer’s bottom line.
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20 YEARS
A crack in the foundation: the case for reasonable value

Jason C. Davis analyses the fallout for travel insurers following the recent ruling by a California court that hospital charges have to be reasonable, even where a patient receives medical treatment out-of-network.

In a recent NBC story, a man was billed US$9,000 for a band-aid and a tetanus shot. You likely already know this sad old song; his insurer was out-of-network and so the full ‘chargemaster’ billed charges were due. Despite the fact that hospital charges are set unilaterally and at an irrationally high level, and virtually no one pays them, ‘charges’ have been deemed the liability for insurers and their members when no contract for payment exists. To date, the US courts have offered little protection from this dynamic. For a travel insurer, the only way to avoid these charges is to negotiate a fair rate or have a good contract with the provider, and both can be difficult propositions.

However, in the matter of Children’s Hospital Central California vs. Blue Cross of California, a recent ruling stated that a hospital’s full billed charges were not enough to determine the reasonable and customary value of out-of-network services, and that other ‘reasonable’ sources, such as the rates paid by commercial payers and Medicare, should also be considered. Could this be a crack in the foundation of the US hospital payment model? Does this case have favourable implications for travel insurers?

**Round one: the foundation stands**

This case involves a dispute between Anthem Blue Cross (Blue Cross) and Children’s Hospital (Children’s) for $10.8 million of post-stabilisation care for Medi-Cal members (i.e. California Medicaid) while the two parties were negotiating a new contract. Despite not having a contract in place for 10 months, Blue Cross paid the hospital a Medi-Cal contracted rate of $4.2 million, leaving $6.6 million unpaid. Children’s Hospital sued for the balance.

In the original ruling, the ‘test’ for determining reasonable and customary value was limited to six criteria outlined by the California Department of Managed Care, which are: provider training, qualifications, and length of time in practice; nature of services; the rates usually charged by the provider; geographic prevailing provider rates; other relevant economic aspects of the medical provider’s practice; and any unusual circumstances. Of note, there is no mention of average commercial reimbursements or rates paid by Medicare.

And so what happened? There was a judgment for $10.7 million in principal and interest, following a jury verdict finding that the hospital’s fully-billed charges were the reasonable and customary value for post-stabilisation services rendered to the plan’s Medi-Cal managed care beneficiaries.

It is important to note that there was no news coverage for this ruling. Why? It was not news. As mentioned above, this is what we had come to expect from the courts on cases like this. But then something different happened.
Round two: Cracks appear in the foundation

Breaking news! Blue Cross appealed, and California’s Fifth District Court of Appeals ruled that the reasonable and customary value of the services should be determined not only by looking at the aforementioned six criteria (apparently these were never meant to be exclusive), but also by considering reasonable fair market value (Quantum Meruit logic) including, but not limited to, rates paid by the commercial payers and Medicare. The unexpected ruling sent shock waves through the industry: “This ruling will absolutely change the landscape between hospitals and health plans in litigation going forward,” commented Dan Baxter, of Wilke, Fleury, Hoffelt, Gould & Birney LLP (Attorney for Anthem Blue Cross). And while this shift might potentially be good news for insurers, it might not be welcomed by medical providers. “The decision will be bad for all patients in California and the healthcare system in general,” said Glenn Solomon of Hooper, Lundy, and Bookman, PC. It is important to note that this case centres on a California public programme (not a private payer), governed by California statutes (not a federal law), in a specific district court in California, for a specific type of care (post-stabilisation). As such, the potential applicability of the case could be viewed as narrow. Somewhat surprisingly, however, people are reacting like this ruling could have profound effects reaching far past the singular context of this case. Glenn Solomon succinctly captures the potential ‘suggestive’ consequences of this ruling: “If a health plan can get the benefit of contracted rates without actually engaging in a contract themselves, there’s less incentive for them to enter into a contract in the first place. That’s not just bad for hospitals. It’s bad for all of California.”

If left ‘as is’, a new trial would determine the reasonable value of the services as per the broader definition of the appellate court. Nevertheless, there is little doubt that the reasonable value will be much less than the billed charges. Furthermore, this trial should be relatively quick, since most of the other matters have been addressed in the original trial.

What’s next? A review from a higher court

The hospital has asked the California Supreme Court to review the recent decision. If the Supreme Court agrees to review the case, it could rule with the information at its disposal or elect to review it all ‘from scratch’. The outcome of a review of the available facts (which would take a month or so) would be either agreement with the original ruling (which would stand) or agreement with the appellate court (and the new trial would proceed). However, if the court wants a full review, it could also (believe it or not) make some other ruling drawn from considerations deemed missed from the first two courts. I may be wrong, but given the perceived and stated importance of the matter, I think we can expect the court will want to perform an exhaustive review of the case ‘from scratch’, and that it will likely be a year or longer before we know how this saga ends. As for predictions to the final outcome of the case, good money is on the status quo (that the original ruling stands). To date, the courts have been reticent to interfere with how the market generally operates, regardless of how dysfunctional it can appear. No matter the outcome, will this be the case that unravels the hospital payment model and end member balance billing for high charges? I highly doubt it. Candidly, it will take more than one case to do that; it would likely require sweeping regulatory reform on the scale of Patient Protection & Affordable Care Act.

So now what?

Travel insurers need not stare into the maze of US law to find ways to improve their bargaining position with hospitals; they need to look at their policy language. If the policy language agrees to pay whatever a hospital is offering (which ends. As for predictions to the final outcome of the case, good money is on the status quo (that the original ruling stands). To date, the courts have been reticent to interfere with how the market generally operates, regardless of how dysfunctional it can appear. No matter the outcome, will this be the case that unravels the hospital payment model and end member balance billing for high charges? I highly doubt it. Candidly, it will take more than one case to do that; it would likely require sweeping regulatory reform on the scale of Patient Protection & Affordable Care Act.

So now what?

Travel insurers need not stare into the maze of US law to find ways to improve their bargaining position with hospitals; they need to look at their policy language. If the policy language agrees to pay whatever a hospital is offering (which one can improve the chances of getting a fair payment and ensure that the member is covered at 100 per cent (with no balance billing). In contrast, poor policy language exposes the payer to a weak bargaining position where the only option is to accept whatever the hospital is offering (which could be nothing). In summary, the case under review has given out-of-network travel insurers hope that they can improve their bargaining position with hospitals in court, but as discussed, this same outcome can be reached in a much simpler, straightforward and reliable manner by improving the policy language.

Could this be a crack in the foundation of the US hospital payment model?

This article does not purport on any level to offer legal advice or guidance on claim coverage in any situation.

5. Ibid
6. Ibid
7. Keep an eye on Massachusetts as they passed a cost-containment bill that could have far-reaching consequences once fully implemented. Implementing Health Care Cost Containment http://www.mass.gov/governor/agenda/healthcare/cost-containment/
Let’s get ready to bundle!

There is a growing propensity for bundled hospital billing in the US. Jason C. Davis considers how such an approach could help international travel insurance providers control their costs in US hospitals.

A bundle is all about getting something that is more than the sum of its individual parts. In light of reform pressures, US healthcare (particularly Centers for Medicare and Medicaid Services) is moving towards bundled pricing for certain conditions and services. What is bundling all about? And can it help travel insurers contain their costs?

The current state of affairs: fee for service
The US healthcare system is primarily delivered on a fee-for-service (FFS) basis, meaning that virtually every service to the patient is separately billable. It is well documented that this system rewards overutilisation of services, where the more you do, the more you get paid regardless of any ‘results.’ In fact, in an FFS model, mistakes or poor quality care often mean that a provider will get paid more money. As such, all agree that a proper market dynamic should have proper financial incentives to provide high-quality care.

Enter the bundle
Is a diagnostic related group (DRG) a bundled payment? Technically … yes and no. The DRG rate, though better than itemised billed charges, still applies only for the hospital bill, and so Medicare (in this case) would still have to pay everyone else that provided services for the patient for an episode of care. In the current industry speak, a ‘true’ bundled payment would typically include defined components of physician care, diagnostics, surgery, hospital care, and post-operative care after surgery; all for one fixed price.

Beyond the targeted cost savings, early results show that bundling will improve the quality of care. This makes sense, as the provider offering the bundled services now has control over the entire episode, which should reduce costly readmissions and reduce the unnecessary use of expensive ‘clinical pathways.’ Simply stated, the bundling model encourages the right care at the right time; anything more or less is penalised.

ACOs and dipping toes
At the outset of the reform discussion, accountable care organisations (ACOs) were all the rage. We all should have known that most providers would not be willing or well-equipped to dive headlong into a risk-sharing model. Perhaps this is the reason that the Medicare Bundled Payment for Care Improvement initiative (BCPI) is now the largest accountable care programme in the nation with 6,500 participating providers. Smartly, BCPI allows providers to move incrementally into taking more risk (four models). It may be worth saying explicitly that this is Medicare looking to pay less than before, and providers are onboard. This is bizarre for a programme that many providers say already does not cover costs.

At a high level, we can expect that the next decade of payment models will be marked with a steady and incremental shift away from FFS towards fee-for-value. These changes will range from pay-for-performance (already in effect), to more bundled payments (building momentum), to gain-sharing arrangements, and finally to the full transfer of the risk. As always, broad adoption to these changes will move at a glacial pace; FFS will not go quietly into the night.

You can’t bundle this!
Not all conditions are appropriate for bundling. Of the many conditions available, Medicare proposed 48 for its pilot programme. Clearly, some of the emergencies that travel insurers must deal with would be difficult to bundle, as the degree of trauma would be difficult to fit into common and generally reproducible episodes. The same applies for patients with multiple chronic conditions. In contrast, hip and knee replacements, and even some cardiac interventions, lend themselves easily to a bundling model as there is a consistent treatment cycle.

Conclusion
Though bundling is currently a model being built for public payers (i.e. Medicare), history has shown that commercial appropriations will not be far behind. In fact, some providers have already tried to offer bundles to the private market (primarily in the domestic medical tourism space), but with limited success. In time, expatriate insurers may have opportunities to utilise bundles, as well as major medical insurers (if they do not bundle already). Will there be any bundling opportunities for the emergency travel insurer? Not to any significant scale. That said, hospitals have been buying up physician groups at a record pace. As such, it may become increasingly possible to negotiate all-inclusive case rates with hospitals that include physician services, anaesthesiologists, follow-up care, and so forth. This will require a well-integrated case management team and knowledgeable negotiating staff to evaluate and initiate a bundled service and rate. In the end, bundling is a good idea that is part of a general wave of change in the US that is slowly moving away from fee for service towards fee for value.

Author
Jason Davis is an independent consultant with over 10 years’ experience in US health insurance and cost containment. A perpetual student of the US healthcare system, he has authored numerous articles on these topics and he is a consistent presence as a speaker at conferences all over the world.
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Patrick Lubbe  +27 (0) 11 259 5343  |  patrick@mso.co.za
Dr Glenn Staples  +27 (0) 11 259 5076  |  glenn@ga-healthnetwork.com
Kevin Thomas  +27 (0) 11 259 5347  |  kthomas@mso.co.za
The Ebola virus and other serious contagions notwithstanding, it can be argued that, generally, we no longer live in a world of communicable disease where treating sickness is the first priority. The major challenge for today’s healthcare providers is instead one of addressing and controlling non-communicable diseases, which to a large extent are lifestyle-related, and are thus preventable. Hence the concept of wellness, and the increasing impact of wellness programmes on the global health insurance industry. Such programmes are now offered widely as part of domestic health insurance in developed markets, and corporate international private medical insurance policies in economies around the world. Their aim is two-fold – to empower the employees to take an active interest in their health, thereby potentially reducing their premium, and to contain costs for the insurer later down the line, when the medical claims it receives are reduced in both severity and number.

An old idea in a new suit

“In its broadest sense, the wellness programme has been around for some 200 years,” maintains Bradley Cooper, CFO of US Corporate Wellness, which focuses its attention on working with employees to change their health behaviour. “It’s not just illness prevention; broader issues such as lifestyle, stress levels, and financial control are all part of the wellness concept. The wellness programme (WP), as we know it, got going in the late 1970s/early 1980s. Employers gradually became more aware of their existence, and by the 1990s, the WP had become more biomedically and data-driven. Now we are into a third stage, with a heavy emphasis on two aspects – the technology side and the coaching side.”

US governmental research suggests that between 50 and 70 per cent of deaths in the country can be directly attributed to poor lifestyle behaviours; research that is backed up by findings from other associations and providers. One such organisation is the Oxford Health Alliance, a UK-based charitable institution with participants around the world seeking to reduce the impact of preventable chronic diseases. Neville Koopowitz, CEO of UK-based PruHealth with Vitality, commented: “The Oxford Health Alliance’s 3-4-50 model clearly shows the impact of an unhealthy lifestyle. It highlights the three risk factors – tobacco use, poor diet (including harmful use of alcohol) and lack of physical activity – that contribute to four chronic diseases (heart disease, type two diabetes, lung disease and some cancers), which contribute to more than 50 per cent of preventable deaths. There is evidence that these negative chronic disease health trends can be reversed by motivating [people] and rewarding healthy behaviours.”

He believes the impetus behind WPs is gaining momentum on a global basis, but there are nuances on the focus areas; for example, in Asia smoking is still one of the biggest health risks, whereas for other areas obesity is the primary focus. Plan design is a complex business, and some policies are still not achieving what they are supposed to do, according to Koopowitz: “Many solutions of PMI products with wellness bolt-ons do not improve the economics of the healthcare market because they do not incentivise behaviour change and improve health.”

A 2010 Health Affairs review by Baicker, Cutler & Song (Workplace Wellness Programs Can Generate Savings) analysed 36 studies carried out...
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in the past three decades and concluded that employer medical costs fall by about US$3.27 for every dollar spent on WPs. Over 90 per cent of the WPs reviewed had been implemented by large employers (more than 1,000 employees); industries represented included financial services, manufacturing, municipalities and universities. The most frequently used method of WP delivery was found to be the health risk assessment, used in 80 per cent of the studies reviewed. Around 40 per cent of studies include the use of self-help materials, the same percentage offered individual counselling, and 35 per cent featured on-site group activities. The most common risk foci were obesity and smoking – the two leading causes of preventable death in the US. Other risk factors included stress management, back care, nutrition, alcohol consumption, blood pressure and preventive care. The review concluded that large employers adopting WPs can see substantial positive investment returns, even in the early years, along with the other benefits of improved employee health – fewer sickness absences, reduced staff turnover and lower costs for disability insurance and Medicare. Five years ago, The Actuary reported on studies concerning WPs and private medical insurance; data came from the programmes used by insurers in South Africa and the UK, and the risk-adjusted studies showed reduced healthcare expenditure for both the well and the chronically ill. The South African study, which used data from over 900,000 members of that country’s Vitality Wellness Programme, revealed that fitter people had 9.6 per cent fewer hospital admissions, and stayed in hospital roughly half a day less than inactive patients. Medical costs once hospitalised were R5,052 (€391) lower for the fitter category, indicating that WPs have a positive impact on health costs even during treatment. Similar results were highlighted by the UK study of 200,000 members of the PruHealth Vitality Wellness Programme – in-hospital private medical insurance costs came in at between 30 and 45 per cent lower than if the programme had not been in place and, depending on employee engagement, out-of-hospital costs were lowered by between two and 40 per cent.

Investment first
Meanwhile, the cost of providing employee medical benefits continued to escalate at double-digit levels according to a 2012 survey from Towers Watson. For its Global Medical Trends study, Towers Watson surveyed 237 leading medical insurers in 48 countries, finding that the global cost of employee medical benefits was expected to increase by 9.6 per cent that year. This forecast was slightly lower than 2013’s 9.8-per-cent increase and the 10.2-per-cent increase from 2009, but the survey was confident of future double-digit increases in four of the five global regions (it was forecast that Europe of outside partners.

One insurer developing a wellness offering for larger companies that post employees (and their families) to work and live abroad is AXA PPP International. While the programme is still in a formative stage with, as yet, no hard data to evidence the return on investment, the approach it is adopting is based on the one developed for large employer workforces in the UK by Dr Chris Tomkins, head of proactive health. A risk profile is drawn up for each employee, who is then made aware of key wellbeing and personal health risk management issues. “A lot of WPs are based on a customised angle, using logic trees, whereas a true personalised system works out what each individual needs,” says Tomkins. “My role is defined by better health outcomes; there is the potential for an insurance benefit, but our data is not yet ready for use by actuaries. Yet we can be sure that £600 is the saving on the average UK salary for removing one health risk.” He believes that a problem with WP development over the past 10 to 15 years is the impression given that it’s more of an entertainment or marketing issue (much like team bonding activities) rather than a health issue. The emphasis should always be on the health risk angle, and there is a lack of international coherence where wellness schemes are involved. In this respect, Tomkins believes that the WP has been a local agenda with varying degrees of priority. “Senior management are realising the benefit to their organisations, but it is unusual that they will have wellbeing expertise throughout their organisations at the corporate and local levels. Early adopter companies saw dozens of programmes implemented locally, not joined up, with no evidence of value.” He maintains that to drive health and wellbeing effectively in a multinational environment, there is a need for company-wide platforms with flexibility for local

“you can’t manage something you can’t measure, so you must understand the current state of health of your members”

should expect a single-figure hike). The three most common cost drivers cited for this situation were new medical technology causing overuse of care (52 per cent of survey respondents), practitioners recommending too many services (50 per cent) and providers’ profit motives (31 per cent). The most popular methods of medical cost management for insurers, as identified by the survey, continued to be contracted provider networks and pre-approval for inpatient services (57 per cent of respondents), although 29 per cent of the insurance companies surveyed were also using wellness programmes. The most common prevention feature in policies remained the second medical opinion service, but the survey certainly demonstrated that insurers were increasing wellness services, such as health risk assessments and chronic condition/disease management programmes, whether in-house or through the use
markets to have a measure of control within a shared framework. It is undeniable that WPs help individuals and insurers to learn, at an early stage, of possible medical conditions before they become very expensive to treat. “This is a benefit that can really help in ensuring that anyone with limited access to treatment facilities or advice can then work with their provider in finding a solution,” notes Sarah Dennis, head of international at The Health Insurance Group, based in the UK. “Wellness benefits have, in general, been built into IPMI for quite some time, as it was deemed important to offer a basic cover for procedures such as PAP and smear tests to anyone away from their home country. [For the policyholder, such benefits offer] peace of mind if you want access to tests, screening or annual health checks that are normally accessible at home.”

Prevention better than cure
Until recently, WPs were viewed as an underutilised benefit, as many expatriates would never really engage with it, or would seek the opportunity to obtain care or undergo tests when they returned to their home country. “However, with the expatriate population on the increase and with individuals relocating to remote locations where medical treatment access can be limited, or travelling with pre-existing conditions, there has been a trend towards ensuring access to preventative treatment,” says Dennis.

A key benefit to policyholders is that a wellness programme is very likely to instigate a behaviour change to better health and thus decrease the likelihood of being admitted to hospital. “They get immediate value from their health insurance from day one, rather than having to wait until they make a claim,” argues Koopowitz. “Traditional private medical insurance benefit design only provides value to one extreme of the population – the sickest 20 per cent. This leaves a significant under-served population that sees little value from such products.” Healthier customers are obviously good news to insurers, because of the sustainable and significant cost savings realised through reduced incidence, faster recovery and ultimately lower claims costs over time.

What about the expense and complexity of establishing and integrating a WP? Is it worth the insurer’s investment? As an example, Vitality has been continually developed and refined since 1997 in conjunction with a number of the world’s leading academic institutions, and is based on the science of behavioural economics. Such investment and development means that it has grown to be the world’s largest incentive-led wellness programme, being used by over six million people in the US, South Africa, China, Singapore and the UK. A number of providers have started to introduce some form of wellness and member discount programmes alongside their health insurance but, according to Koopowitz, they are missing the point. These tend to be unco-ordinated, standalone programmes that are disconnected from their core health insurance policies. “They do nothing to drive healthy behaviour, don’t improve health outcomes over the long term and therefore don’t improve the economics of the healthcare market. People respond to different behavioural motivators and an effective WP needs broad appeal, as well as being financially sustainable so that it can be continued over the long term. You also need to be able to measure any impact; you can’t manage something you can’t measure, so you must understand the current state of health of your members.”

Power to the people
The more insurers can evolve their propositions to help existing customers reduce their own health risks, as well as attracting healthier customers back into the market, the more the industry can dilute the impact of claims made by a few on premiums as a whole. Allied to the risk assessment focus of wellness programmes, more proactive insurance providers can implement adjustments to patient care and co-ordinate its management, creating bespoke benefit programmes, monitoring treatment plans and seeking second opinions where necessary. Together with careful analysis of claims to detect inappropriate levels of treatment, overcharging, or fraud, all such endeavours should result in significant cost containment for health insurance providers in the international marketplace.

“There is evidence that these negative chronic disease health trends can be reversed by motivating [people] and rewarding healthy behaviours”
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Cawston says that the quarterly and annual reports companies assess the pitches made by third party cost containers? How can they know that the savings promised will be delivered? “Measuring savings can be a multifarious exercise,” says Reid Cawston, vice-president of sales for the ITPA (international third party administrator) division at Europ Assistance-Global Corporate Solutions (GCS). “Ten years ago, the average savings rate was the gold standard, but it quickly became a bait-and-switch situation with some companies’ definition of gross savings versus net savings. Calculations using discounts might have a tenuous legitimacy. The only approach I have seen that actually works is when the insurer takes a holistic view of their risk, and samples similar groupings year-over-year to see if costs are holding steady when adjusted for inflation.” He explained further: “An insurer’s book of business fluctuates in size. There will be catastrophic cases every couple of years that can make the numbers swing dramatically, but when reviewed and adjusted for these factors, most insurers would be happy with a predictable loss ratio rather than large annual variations.”

Cawston says that the quarterly and annual reports
his division sends to clients focus more on metrics that demonstrate the efficiency and satisfaction levels of customer services, rather than on the percentages saved. “This is what our clients have asked for and this is what we deliver. They want to know that the members are happy, calls are being answered quickly, issues are being resolved in one call, calls are not being abandoned, wait times are at a minimum, claims do not need to be re-worked, members are not being balance billed, and so forth.” By using such data, he continued: “The insurers and their actuaries will quickly determine if a cost containment company is stabilising their risk; it takes only about 90 days for the claims lag to catch up with the IBNR (incurred but not reported). But no insurance company wants their cost containment partner running roughshod over providers or neglecting members while operating under the name of the insurer.” He says insurers look not only at a cost container’s results, but also its reputation. Reputation in this business, says Cawston, is ‘everything’. “Of course they look at reputations. More and more, these decisions are not being handled by one person overseeing all of the claims operation. Frequently, there is a formal request for proposal process, and there might also be a procurement department responsible for vetting the bidders, reviewing references, and looking into the details.” Such efforts to increase transparency have prompted improvements, he added: “This level of diligence has forced our industry to get far better at measuring what we deliver on and ensure that fly-by-night operators are not tolerated. In many cases, third-party administrators private-label their services to insurance or assistance companies, so we are answering the phone as the insurer, acting as their agent, and speaking to their members. In business, it doesn’t get much more intimate than that, so you want to make sure the company you choose demonstrates the level of professionalism you demand of your own organisation.” If the TPA or assistance company mishandled a case, he says, and a patient died or was left without appropriate support, ‘very real brand and reputational damage’ would ensue against the insurer. “The member has bought the insurance, and that is who they will hold accountable if things go wrong.” Furthermore, there is also a legal liability for insurers to think about when looking at cost containers, says Cawston: “When we are working with business travel insurance, there is the doctrine of duty-of-care – which is law in many countries – forcing employers to ensure employees are safe from harm that is ‘reasonably foreseeable’. If you send your employee to a hazardous location without appropriate oversight and pre-travel advice, you might be found liable not just for medical bills, but for negligence.”

**Added value services**

Martin Weintz, group head of assistance, spoke to *ITIJ* on behalf of the UK-based Collinson Group – which includes the Intana assistance and cost management operation – and its US cost containment/assistance partner, Global Excel. He agrees that savings and discount statistics might not be the best and only guide to a cost container’s worth: “A percentage of savings value is a very common way the industry uses to measure a cost container’s efficacy – and it’s also the traditional method that’s used over the years. Unfortunately, it’s also a number that can be misleading; it tells only a small part of a very complex story.” He warns that relying on that particular number alone as a measurement of success – or failure – can be extremely unrepresentative, especially with regard to the US healthcare system: “The billing structure there is unique in that prices charged are unregulated and, because of that, providers rarely get paid what they bill. Instead of asking ‘what kind of a discount did you get’, insurers should be asking ‘how much did I pay over cost’?” Ultimately, he says, a cost containment company should be focused on driving true bottom line value to the insurer, and that can’t be measured only by a percentage of savings number. “Unfortunately, most cost containment companies still measure their performance based on a savings percentage value. If that’s all the information they’re providing to an insurance company, then it’s pretty much impossible to assess their efficacy. Getting an 80-per-cent discount on a bill where the provider has billed 30 times their costs is hardly a great measure of success – you’ve still paid six times the actual cost of the service! But without knowing the actual costs, or what you’ve paid over cost, an insurer probably wouldn’t be able to challenge...”
Cost Containment Review 2014

the cost container.”

Intana and Global Excel give a number of different measurements to their clients. Probably the most important set of numbers, according to Weintz, compares what they’re paying in the US to Medicare rates. “This provides a true benchmark for how well we’re succeeding in driving their paid amounts to a provider’s actual costs,” he said. Other benchmarks include case severity and average length of stays against Medicare and, in certain cases, Milliman Care Guidelines. The firms also provide trended results on inpatient and outpatient case sizes, geographical distributions, cases opened, and patient demographics.

International Variety

Kevin Thomas, director of Interhealth’s cost management division in South Africa, says Americans have stuffed up the market with their exorbitant discounts – 50, 60, 70 per cent’.” That has messed up a lot of people’s perceptions of cost containment,” he claimed, “because many seem to base their models on that kind of US principle. In a number of countries around the world, discounts are flying out of the window. You get some sort of preferential pricing, but that’s only one aspect of cost containment.”

In addition to bills for the basic hospital services, he explains, there are separate bills from pharmacies, doctors, and radiologists. “From a cost containment point of view, you’ve got to manage all of those different components and get the best pricing. When you’re talking to a foreign client, they think you’re getting a good price from the hospital and that’s the deal, but we’ve got to go through each and every bill from all of the providers, make sure they’re in line with what we’d agreed with them, and run medical and financial audits.”

All that is part of cost containment, he emphasised, and a lot of overseas companies don’t quite understand the value of it. “It’s an immensely complicated operation, but the problem with the whole industry is that its backbone is run by people who have no clue about the business … people behind the scenes – underwriters, auditors and people like that – who don’t understand and don’t take the time to understand what the variations are in the different parts of the world.”

As an example, Thomas clarified: “You’ve got a guy – an underwriter – sitting in New York, and he’s got to justify an ‘x’ per cent saving. That’s what he wants. He gets the bill, he looks at that number in the bottom right-hand corner, and that’s what he wants to see there: that magical discount. Most of them have an idea of what that magic number should be before they’ve even talked to me. All that does is put the pressure on certain cost containment companies to do what I call double billing. You get a bill for £1,000. You get back to them and ask them to up it to £2,500. You then get a second bill for £2,500. Some hospitals will do that. They give you a 30-per-cent discount, and you get back to your client and say ‘I’ve managed to get you a 20-per-cent discount’, you put 10 per cent in your pocket, you still charge them a fee, and the underwriter guy in New York is happy because he’s got what he thinks is a 20-per-cent discount! It’s a crazy business!”

Thomas says Interhealth/MSO doesn’t get mega discounts from hospitals, but adds: “From the data we’ve collected in the years since MSO has been operating, we can quite comfortably say our estimated overall savings are in the region of 15 to 20 per cent. There’s the clinical audits, and the financial audits … you can’t really show all those things. They’re intangible, but we’ve got access to that kind of data, and you can show trends.”

In New York, Gigi Galen Grobstein, founder and president of Star Healthcare Network, highlights the ‘very fine line’ walked by cost containers between their clients and hospitals, many of which in the US, she says, are going out of business or being swallowed in mergers or acquisitions. “You’re judged by your discounts,” she told ITIJ, “and we’re proud of the discounts we get. The average discount is 36 per cent, but in North Dakota it’s going to be much less, and in, say, California and Florida, much higher. You just can’t predict now what you’re going to get with the provider. Clients
judge us by our percentage of savings, our average savings, but we do look at charges, and make sure a provider is not over-charging. As I said, you walk a fine line.”

A recent development, she added, has been the entry of collection companies into the sector. “In our business now, there are a lot of collection companies. There are times when a bill we would have gotten from a hospital goes straight to a collection company. Instead of negotiating with the hospitals, we are negotiating with the collection companies.”

More than meets the eye
For Magdi Riad, president of SelectCare Worldwide, there’s more – much more – to cost containment than simply negotiating price deals and discounts with providers: “You’ve got a lot of people in this business who say they are cost containers, but the question always is: have they been sucked into the American healthcare system? And when I say sucked in, I mean, have they got tied into a lot of contracts with companies that own 50 or 100 hospitals, particularly bad contracts that in some circumstances – depending on the age and condition of the patient – means you get absolutely no discount … you pay the bill in full, regardless of how much it is.” Also, he added, there are a lot of cost containment companies that do not have the systems that would enable them to track the diagnosis-related group (DRG) codes on hospital invoices. All cost containers were not created equal, then, as Riad showed: “To me, a company that says ‘we have five PPO networks, and we can give you this discount’, is not a true cost containment company; I consider them middlemen.” As far as he is concerned, a cost containment company is one that takes a medical invoice coming from the US, and understands what the DRG codes on that invoice mean. It also has a history with that hospital, so they see the movement of the DRG coding. “Cost containment is about in-depth analysis of invoices and reaching a mutually agreed outcome that satisfies both the hospital and the payer,” he concluded.
It’s not only hospital bills that have to be watched, though, warns Riad. “Doctors can make mistakes or overcharge, too. Doctors might use codes that will allow them to bill the maximum for a specific procedure – some procedures will be $5,000, or it could be $11,000 – but that code might not reflect what was actually written in the medical records. As a cost container, you need a manual intervention – you need to go back and verify who is billing for it and that it’s billed appropriately: the admitting physician or the specialist?” Whether or not such mistakes are deliberate or not is debatable, but Riad is clear in his view: “Doctors use billing agencies, and there are some agencies that do courses in how to over-bill. To identify over-charging, I employ one of their teachers who was actually teaching how to over-bill. Given our location in North America, we live and breathe the American healthcare system. It crosses the border, but we are foreign enough to raise our eyebrows when we see something unusual. You say, how the heck could they spend $35,000 on medication? If you gave this medication to a horse, it would have died!”

In or out?
Reid Cawston at Europ Assistance-GCS suggests the barbecue test when choosing cost containers. “In the end, almost anyone can get you a discount … at least once. A truly effective cost containment partner, of course, must have good discounting in place, but they must also be focused on containing costs at every opportunity while managing the welfare of your members wherever they are in the world. If your cost containment partner isn’t someone you’d invite to your family BBQ, do they really represent your best interests?”

With a 25-year track record in the business, Dr Colin Plotkin says insurers should have three yardsticks to measure against when selecting cost containers: the ‘access’ fee charged should have no role in attainment of getting the best results; balance billing should be completely eliminated – disputes over the discount or any form of deferred liability to the payer should be non-existent; and the welcome return of an insured person to any given provider who has agreed on a prior rate of reimbursement for a similarly insured person. “These three parameters,” he says, “must be viewed as being inextricably entwined, and cannot be separated one from the other. It’s what we abide by, and we’d suggest that every cost containment company, whether affiliated to an assistance company or not, should meet those criteria.” Insurers need to pay attention to what the company is really achieving in its efforts at cost containment, added Dr Plotkin: “What a lot of insurance companies say is, ‘Oh, but he charges only 10 per cent.’ I get asked this all day. ‘How much is your access fee?’ The person who asks me that question is obviously more concerned about how much money I’m going to make than he is about his job and function at the insurance company to get the best net result. You could call me, and I could say, ‘yeah, I can get you a 98-per-cent discount.’ I can also fly to the moon!”

Opposing views
Unsurprisingly, the above approach is not savings and discount statistics might not be the best and only guide to a cost container’s worth.

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endorsed by the conglomerates that operate combined insurance, assistance and cost containment services. Magdi Riad at SelectCare Worldwide, a subsidiary of Canada’s Co-operators Life Insurance, said: “Being a subsidiary of an insurance company is not only an advantage to the insurer, it’s also an advantage to a cost container’s client. I’d rather go to somebody who had created an infrastructure to suit themselves; that would be a better choice than somebody who’s doing it simply to make money out of it. When you look at PPO networks, you find that the most successful at negotiating really good deals with hospitals are those owned by insurance companies. Think about it this way: nothing can scratch your back better than your own nail. We do cost containment for other companies; we’re scratching our own back and other people’s, too.”

Gigi Galen Grobstein also likes to be involved from the beginning of a case: “Our work starts when the case starts. It’s always easier to have a case when the patient is heading to the hospital, then we can pretty much watch it and what’s going on with the patient from start to finish. We don’t just do cost containment; we give a white glove-type of service. A lot of times we can give assistance companies information on what’s going on with their case and allow them to decide what they need to do for their patient.”

Reid Cawston reckons that Europ Assistance’s global reach can help to reduce claim costs: “Policy design such as limits and sub-limits can control an underwriter’s exposure, but might cause disputes if the member isn’t aware of the limitations. Member Education such as travel warnings to get vaccinations, take prophylactic medications, stay away from hostile areas, and pushing security and health alerts, are forms of cost containment, but the ‘savings’ are hard to measure, particularly over the short term. Medical case management and member steerage are very effective cost containment tools. Companies that employ medically trained personnel to actively communicate with the treating physician to provide oversight, and when appropriate arrange repatriation, can dramatically reduce an insurer’s exposure. Member steerage involves the member seeking assistance being sent to an in-network provider that the cost containment company has identified as high quality and willing to work with the assistance company to manage the member’s care.”

Martin Weintz of the Collinson Group’s assistance division said the end-to-end approach works well for them: “At Intana, we believe that active case management is the key not only to effective cost containment, but also more importantly to better patient/customer care. While the majority of cost containment companies get involved in the latter stages of an assistance case, our innovative approach ensures that the member benefits from direct case management and that there is no double entry in terms of the logistics of case handling and administration. The benefits we have seen of this approach have been that costs that might otherwise be incurred are either much reduced or avoided by virtue of our partner’s knowledge of local regulations, billing structures, and so on.”

Conclusion
Cost containers are involved in the travel insurance business whether some parties in the industry like it or not, but what’s important moving forward is that there is a higher level of understanding between hospitals, insurers, assistance providers, and cost containers. By making clear exactly what the services on offer, are cost containment providers can show insurers the value of their proposition, but endlessly promising discounts that are unattainable do the industry a disservice in the long run. Whatever method or process of cost containment is used when navigating the global healthcare system, one thing is for sure: insurers and assistance providers are using more detailed and varied methods to assess the value of the proposition offered by their cost containment partners.
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The above is neither a mathematical equation nor a kind of relativity formula. It is a heading that reveals the difference between the conventional CC (cost containment) and the contemporary MCC (medical cost containment). Dr Ege Unalcin of Eurocross Turkey underlines the importance of applying in-depth medical knowledge to travel insurance cases in order to control costs.

It is not enough to cost contain through discounts and price agreements (which is hard enough in the travel insurance business given the problem of patient steerage), but in order to support and strengthen existing cost containment methods, an additional medical approach is needed. Assistance companies and cost containment providers employing medical as well as local knowledge to lower costs for insurers results in satisfied clients with protected books of business.

Performing cost containment on medical bills is not describing MCC. ‘Medical’ should not be just a term in the name of MCC, it should in fact inspire all the MCC activity and change it into a more transparent, reasonable, rational and explicable style. A consensus over the results of MCC by all the parties (the MCC company, insurance company, medical facility and patient) is easier to achieve using this approach.

For example, a 13-year-old male tourist from a Nordic country visited a hospital in Turkey suffering from abdominal pain and fever (38°C). He had had this kind of complaint before at home, where it was diagnosed as viral enteritis several times. The pre-diagnosis was the same as previous ones – acute gastroenteritis. However, what occurred next was different – the treating doctor wanted to perform more tests to disregard the FMF (Familial Mediterranean Fever) Disease, which is a chronic genetic disease that usually presents with fever and abdominal pain attacks. It is endemic in Mediterranean countries. The doctor’s request was approved, not only because the patient had south Mediterranean family roots, but also because physicians in Turkey are more experienced in this disease than the patient’s home land doctors, as Turkey is one of the endemic regions for this particular disease. The patient was diagnosed with FMF and colchicine medication was started immediately. Hopefully, that medication is now preventing the patient from suffering similar attacks in the future, from which he would have ended up in another emergency room. It would have been very difficult, if not impossible, to distinguish this case from a simple case of tourist diarrhoea using conventional cost containment methods, and could have upset every party at the same time in trying to keep the costs low in order to remain within the simple acute gastroenteritis claim limits.

In another example, a 45-year-old male patient was diagnosed with non-perforated appendicitis and underwent appendectomy surgery. When the pre-invoice was received, it was noticed that the total cost was far more than expected. It was detected that there was an additional adhesiolysis (cleaning and separation of post op adhesions) operation charged in that case. The patient did not have a history of any abdominal surgery, and the amount was deducted from the bill by the MCC specialist, even though the doctor insisted that he had performed that additional surgery besides the appendectomy. The reason for omitting that fee from the invoice was not that the general surgeon did not perform it, but because it was something that the surgeon did in order to reach the appendix, and it should be part of the surgery. Surgeons may perform small adhesiolysis in any abdominal surgery, but the major ones such as in ileus cases (obstruction of bowels) should be priced. Through that reduction, the case cost was kept within the limits of appendectomy surgery.

Satisfaction for all

Both cases listed above were finalised with full consensus of all the parties. Such an approach, though, can only be successful as a result of MCC experts who have an adequate medical background, and not just with knowledge, but also some experience of working in medical facilities in tourist areas. Inevitably, ethical and local rules and legislation should be considered during MCC activities, but globally accepted approaches and guidelines should be kept as references. This requires the cost containment organisation to constantly keep its staff up to date with the latest developments and methodology in medicine.

Evaluating medical reports is the most crucial point in MCC. It is the main line of communication with the medical facilities regarding a case, and thus should be clear and detailed – a fact that treating doctors unfortunately neglect most of the time. The MCC expert evaluates the medical report not only to check for indicators of overtreatment or overcharging, he also has to understand the case and follow the process through, starting from admittance to discharge or from complaint to diagnosis. This helps him to classify the complexity of the case and the quality of the medical service provided. At Eurocross Turkey, we are aware that medical facilities are nowadays putting a greater emphasis on providing adequate medical reports to assistance and insurance companies.

Another advantage of MCC is that the majority of the disagreements are discussed on medical grounds, which enables discussions to be finalised more swiftly than if they were purely related to costs. One should be aware that medical facilities only accept reductions when there are medically acceptable reasons.

Of course, the cost of having MCC services is more expensive compared to standard CC services due to the need for high intellectual human capacity, but as the profit and loss balance is always significantly on the positive side, this is not an issue.

It should also be taken into account that medical treatments are getting more complicated and more expensive as a result of new discoveries and use of technology in diagnostics and treatments. Even DRG (Diagnosis Related Groups) systems need MCC experts to evaluate the cases in order to be sure that the case was classified in the right DRG.

Each to their own

There is a common saying that medical practitioners use: “There is no illness, there are only ill people. Do not try to cure the illness, just concentrate on curing the patient in order to succeed.” This is the same with cost containment, and every case should be evaluated separately by experts in order to give the right price for the right service.
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International interests

*ITIJ* spoke to Raija Itzchaki, chief operating officer of GMMI Inc., about her experience in the cost containment industry, and what effect healthcare reform has had on pricing in US hospitals.

Where were you born, where were you educated, and where do you live now?
I was born in the small town of Forssa in Southern Finland, and after school I earned my bachelor’s degree in international business and business communications in Finland. During my studies, I participated in an exchange programme in Haarlem, Netherlands, where I met my current husband, who was from Florida. Shortly after my graduation, I moved to the US, and today I live in the town of Davie in sunny Southeast Florida.

How did you first become involved in the travel health insurance industry, and how did your career progress to your current position?
Soon after my arrival in Florida, I found a newspaper advertisement from a company that was looking for international people with language and cultural skills. It happened to be GMMI and I was hired. Coincidentally, two other current senior management team members at GMMI were hired from the same newspaper ad – I would say it was a rather successful HR campaign! When I started in 1996, I was hired as an account manager, managing many of our international client accounts, some of which are still our clients today. I was eventually promoted to sales and marketing manager, and in 2005 to chief operating officer. My growth within GMMI has given me the opportunity to completely understand our business from a day-to-day operations standpoint through to a management perspective.

What does your role involve on a day-to-day basis?
As the leader of the senior management team at GMMI, I am responsible for all aspects of GMMI’s business. In addition, I am a member of the Europ Assistance Global Corporate Solutions division’s executive leadership team.

GMMI is a Europ Assistance Group company; what benefits does being part of a larger entity offer GMMI’s clients seeking to manage their medical claims costs?
In 2008, GMMI transformed from a small privately held company to being part of a large multinational corporation, Europ Assistance. For our clients, the biggest impact was the considerable increase in buying power in both our traditional US markets as well as internationally. In the business of cost containment, increased buying power directly translates to increased discounts. The more you spend, the better savings you can achieve. Together with our sister company in Toronto, we are the largest cost containment entity in the US for international payers. Furthermore, the Europ Assistance ownership has brought a portfolio of new services available to our clients, such as access to truly international assistance and network solutions.

Right now the biggest challenge in the US is hospital and provider consolidation through mergers and acquisitions.
We truly believe that GMMI is the market leader in providing quality services in the cost containment industry. We have always offered a very boutique-service approach to our clients. We cater to our client’s needs and will accommodate our programmes to fit theirs. There is no one-size-fits-all model at GMMI! Furthermore, the high customer satisfaction ranking we have received over the years from our clients (i.e. measured by means of our ISO 9001:2008 Quality Management Systems Client Satisfaction Surveys) and the quantity and quality of patient and client compliments, notes of gratitude and such, are real-life testaments to the high quality of services we not only aim to provide, but that we actually deliver.

The need to direct patients towards in-network medical facilities is an issue that affects everyone in the travel health insurance sector. How do you think the situation could be improved upon?

The actual insurance policy language is the main driver in affecting customer behaviour and in reducing claims costs. If the insurance policy states that it will pay 100 per cent of any costs anywhere, then the capabilities to reduce the costs are limited. The most effective way to drive customer behaviour and lower claims costs is through financial incentives, such as reduced deductibles, co-pays and co-insurances. However, while we understand that most of our international clients cannot enforce US-style financial incentives, we do firmly believe that there are ways to introduce these drivers through service solutions and some simple changes to the policy language. We take a consultative approach with our clients and help them protect their interests through policy and service design options.

What do you think is the biggest challenge facing US-based cost containers now, and in the next 10 years? How do you envisage the industry adapting to these challenges?

Right now the biggest challenge in the US is hospital and provider consolidation through mergers and acquisitions. Since the US healthcare model is based on open competition, monopoly situations are changing the marketplace by providing fewer opportunities to negotiate. In the years to come, I believe the US healthcare reform, aka Affordable Care Act (ACA), aka Obamacare, will in some way change the current healthcare model. While the current goal for ACA is simply to address accessibility to healthcare for US citizens and residents, eventually the continuously growing healthcare costs will have to be addressed. According to some analysts, hospitals in the US are reporting their first quarter 2014 results improving due to the ACA implementation and having a larger percentage of the population gain access to healthcare programmes such as Medicaid and the Healthcare Exchanges. It is, however, too early to predict the full effect that ACA will have.

How has US healthcare reform affected cost containment in US hospitals? Is it more difficult now, or has transparency of costs improved?

So far, healthcare reform has had very little direct effect on cost containment. However, the new law has only been in effect since January 2014. Initiatives for cost transparency have been rolled out, but they are still very state-specific (the majority of states do not have transparency laws still today), and the information available is still quite scattered and confusing. If anything, we believe that cost containment is more important today than ever before for anybody who is responsible for paying healthcare costs in the US.

What do you enjoy most about your current role?

I truly feel blessed working with some of the greatest colleagues. I believe that a lot of people at GMMI would agree with me in saying that at GMMI we are a family. I also enjoy the scope of my duties, no two days are alike. Cost containment is a dynamic, fast-paced and competitive industry, which demands quick and smart solutions, as well as continuous improvement.

If you could do any other job in the world, what would it be?

I would be a horse breeder, breeding the German half-blooded sports horse, the Holsteiner. Horses, as you may have guessed, are my passion.

If you were having a ‘dream’ dinner party, and could invite anyone you wanted from history, who would be there?

I would invite Marshal Mannerheim, who was one of the most important people in Finnish history and to whom I believe every Finn should be thankful for our country’s independence. I would also invite his highness the Dalai Lama, as I would love to learn from his perspectives on life. Finally, I would invite a die-hard horse person such as Kyra Kyrklund, an Olympic medal winner in dressage. And I would add a bunch of my friends and family, the more the merrier.

What are you most proud of, personally and professionally?

Personally, I am most proud of my family, my husband for the support that he has given me throughout the years, and our two sons – now six and eight years old – who amaze me every day by how smart they are. I can only wait with great anticipation as to what their futures will bring. Professionally, I am very proud of having had the opportunity to be part of what we have accomplished at GMMI. Our rapid growth, combined with a commitment to excellence while preserving a family atmosphere, requires a lot of hard work and has not always been easy to achieve.
Inbound – quality, but at what cost?
Public hospitals in Russia tend to fall well short of Western expectations when it comes to quality of facilities and treatment (see ITIJ’s 2014 Hospitals Review, Global Care, but keep it local). But even the local population realise hospital standards leave a lot to be desired: a 2011 survey by the Russian Ministry of Health and Social Development found that 66 per cent of Russians were not satisfied with the provision of public health services overall; and even in Moscow, the satisfaction rate stood at just 33 per cent. According to MD Medical Group, which has clinics across the country, the Russian government is ‘taking steps to support the development of the private healthcare sector in order to relieve the stress on the public facilities,’ which are also often over-crowded. It’s not surprising, then, that most foreign visitors to Russia end up seeking medical treatment – whether directed by their insurer or otherwise – in private medical facilities. However, private hospitals can be unwilling to enter into direct billing arrangements with international insurers, and are notoriously difficult to negotiate with. The situation in Russia for international insurers and assistance providers, then, is far from ideal.

For Laura Hilton, director of global health at HTH Worldwide, achieving cost containment of medical bills in Russia is challenging, to say the least. In fact, she told ITIJ: ‘I still refer to Russian private healthcare as the ‘Wild, Wild East’, where the underlying cost containment concepts of ‘usual, customary and reasonable pricing’, ‘standards of care’ and ‘compliance with best clinical practice’ seem all too often completely foreign to this market.’ Even for local experts, she said, it can be difficult to achieve cost containment.

Carl Carter, chairman of the Association of International Medical Insurance Providers and director of Voyager Insurance, reveals a similar
The reason is (so they say) that this way they are calculated per hour instead of per kilometre. It seems strange – for instance, an ambulance ride doesn’t have very many cases in Russia, when we would. He told ITIJ that while the company can be better equipped to deal with weather conditions, pricewise. A ride in heavy snow of 10 kilometres can easily take more than three hours.”

Cigna Insurance Services also has an agreement in place with a local assistance partner – AP Companies – under which Cigna’s customers work directly with AP to access healthcare services, and any subsequent payments for the services are dealt with by AP. “This relationship,” said a Cigna representative, “makes it easy for all those involved, including customers, healthcare professionals and Cigna.” While saying that it is not impossible to work directly with Russian healthcare providers, Cigna encourages its clients to utilise the services offered by AP Companies. Having local agents or a local partner on the ground in Russia is not just useful, it’s pretty much imperative for international insurance companies with policyholders in Russia. Containing treatment costs for those customers who end up in hospital in the country is an ongoing battle that requires a depth of knowledge and experience that only those truly in the know can provide.

Outbound troubles
Meanwhile, outbound Russian travellers injured abroad are finding it harder than they thought to obtain cashless care, with reports coming in that some major hospitals in popular tourist regions are unwilling to negotiate direct billing arrangements with Russian assistance companies. Such agreements, though, are one of the tools most frequently utilised for cost containment purposes, making life difficult for Russian assistance companies trying to control spiralling medical costs on behalf of their clients – the insurers. The problem has mainly been identified in Asia, where assistance providers are finding that some hospitals are requesting large cash deposits before treatment will be given to Russian visitors. Maria Berkova, general manager of Savitar, a Russian assistance company, told ITIJ: “Not all hospitals in Asia are willing to accept patients and make direct billing arrangements. It seems like this is becoming more and more individual and depends on the mood/opinion/past experience of a hospital’s management.” She noted that hospitals that have previously agreed to direct billing contracts have sometimes found themselves out of pocket when the time comes for the payment to be made, suggesting that there have been cases where assistance companies have refused to honour the agreements. Once burned, twice shy, as they say. Belinda Chun of Matilda International Hospital (MIH) in Hong Kong said that the facility does in fact accept patients making claims through MIH: “Not all hospitals are willing to accept patients and make direct billing arrangements. 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However, not all hospitals have problems working with Russian assistance providers. Masha Zhigunova, regional division manager of Vejthani Hospital in Thailand, told ITIJ: “Vejthani Hospitals works with all the Russian assistance companies. As [far as I am aware, in Bangkok we are the only one that works with so many as we have many referrals for other cities for patients that they are not able to treat.” Naming the assistance companies with which Vejthani works, Zhigunova mentioned Class, GVA, Europ, Savitar and LDM. (LDM is the Liga of Defence and Medical Assistance, an initiative of the Russian parliament to provide assistance to Russians abroad, as well as foreigners in Russia.)

Cost of treatment
Controlling the cost of medical care is part of the work undertaken by the majority of medical assistance companies, and there are many ways in which this can be achieved. However, concerns have been raised about some of the methods utilised by some such companies. The problem stems from the strict underwriting of Russian travel insurance policies, which are often designed to be low-cost and therefore have limited benefits. The result of which is that the insurer has extremely slim margins to protect, and thus has to keep claims costs as low as possible.

Elena Kopteva, provider network specialist for AP Companies, agreed that the current status quo with many hospitals in Asia, and especially in Thailand, is ‘rather challenging’. “The challenge is faced,” she explained, “when it comes to the cost of medical services. Russian insurance companies used to save every penny, mostly due to the very low price tourists pay for their insurance policies. Russian insurance companies would like for their members to get care at the best and hence most expensive (international) medical providers in Thailand, but at the price charged by the local (locally-owned) hospitals, which is not always possible.” This means that the assistance company has to then try and deal with medical providers wanting to treat their clients, but being limited by what the insurer will pay for. Examples of this given to ITIJ included: medication being authorised but in too low a dose or frequency; denying materials like bandages as ‘the hospital changes them too often or uses too many’; or even denial of pain medication if the assistance company medical director thinks a condition should not be very painful.

As Kopteva of AP Companies noted: “Assistance companies always have to deal with a dilemma: send a tourist to the Western-orientated hospital and upset the insurance company, or send the patient to the local hospital and get a chance to receive a big complaint from the insured member.” Trying to manage expectations is an almost impossible task, and transparency is key. “At AP Companies, we do our best to get clear instructions from our clients – Russian insurance companies – as to which level of medical facilities they expect AP to refer their members to. We keep them well informed about the price levels charged by both Western-orientated and local hospitals and setting rules to follow clearly (and) ahead of time helps us to fulfil our obligations towards our clients and the providers.”

GOPs
The crux of the issue, according to Dr Rafi Kot of the Family Medical Practice in Vietnam, is the fact that some assistance companies do not want to issue a guarantee of payment (GOP), as the company can’t be sure that the insurance company will pay them later on. Of course, without a GOP in place, hospitals are hesitant to provide expensive treatment to patients. Dr Kot cites a case of a young Russian traveller who was so ill she ended up on ECMO – extra-corporeal membrane oxygenation – where the assistance company, he says, ‘pleaded’ with the hospital to believe that they would be paid for their services, but was unable to
provide a GOP. He concluded: “We became the bank for the case – what choice did I have?” Danny Quaeyhaegens at Bangkok Hospital Pattaya confirms that GOPs can be a serious obstacle in the path of treating a Russian visitor: “Denied cases by themselves wouldn’t be a real problem if they were immediately denied so that the provider could make the necessary arrangements with the patient prior to delivering the service.” However, he said that it has been known for providers to get an ‘initial GOP’, confirming that the patient has valid travel insurance and the request to render treatment for a certain complaint but then the insurance company later denies coverage.

If the assistance company can’t, or won’t, issue a GOP, their negotiating power with regards to medical bills declines rapidly, hampering their ability to contain costs. Even where coverage has been guaranteed, though, obtaining the money for services rendered can take longer than expected, said Quaeyhaegens: “Payments can take a long time. Where for other international third parties the maximum credit term is 30 days, for Russian companies 60 days is often the soonest that payment is received, but some cases take several months, or even up to one year.”

Dr Kot has suggested that one way to improve the situation is for Russian assistance providers to use their own credit cards to offer a GOP and thus put a third party (the credit card company) between themselves and the hospital. Quaeyhaegens, meanwhile, also had some advice that could help hospitals who work with Russian assistance companies: check the financial background of the insurance or assistance company; only extend limited credit lines that are related to the background checks, so the more reliable and solvent the assistance company is, the more credit can be extended to them; and educate back-office staff about the situation so they know when to insist on a deposit being made. Finally, he said that the use of less expensive medical supplies can be offered, as, quite frequently, administration of the more expensive painkiller won’t be covered under the policy. Hospitals, he added, need to talk to each other about which assistance companies are easy to work with, and which can be slightly more problematic.

With tough competition in the Russian market between assistance companies, insurers can shop around until they find an assistance provider who promises the right service with the right cost savings. Tough competition means that some companies don’t last, however, as they get caught out making promises that turn out to be untenable. Quaeyhaegens commented that one result of this situation is that it becomes difficult for medical providers to start, build up and then maintain a trusted relationship with an assistance company. Long-term affiliations between insurers, assistance companies and hospitals are essential if all parties in the chain of international healthcare delivery are to be improved, he said.

**Egyptian situation**

Another popular area in which Russians like to travel is the Red Sea resorts region including Sharm el Sheikh and Hurghada. Do hospitals there have a similar issue with late or non-payment of claims by Russian assistance companies? It seems so.

A doctor working in private hospitals in Egypt, who spoke to *ITIJ* on condition of anonymity, said that there are concerns about the ways in which some Russian insurers and their partner assistance companies try to achieve cost savings on their clients’ medical bills, including pushing patients towards public hospitals to try and save money on treatment, without considering the potentially low quality of the services on offer. Physicians, he said, can also sometimes be put off treating Russian travellers because they know that payment for their services might be an issue, with tough negotiations with the assistance company a possibility, and offers of a bill settlement that falls below the value of services rendered.

**Moving forward**

International relations between Russian assistance companies and the medical providers who treat their clients are, it’s fair to say, a mixed bag. While there are hospitals that will engage in direct billing contracts with Russian companies – Vejthani in Thailand and Thebes Hospital in Hurghada are just two – it certainly seems, from the people who have spoken to *ITIJ* about this topic, that for the hospitals in regions treating high numbers of Russian tourists, negotiations are fraught with difficulty. And for international private medical insurers with expats in St Petersburg or Moscow, achieving meaningful savings on medical bills is an ongoing battle. Considering the future, Laura Hilton suggests: “There is a lot of opportunity for a Russian private medical facility that demonstrates it wants to provide evidence-based medicine at a reasonable cost in a professional, long-term relationship with its payers. In the meantime, though, most seem content to repeatedly get caught with their hand in the cookie jar.”

With international relations between Russia and the West currently cooling slightly, it doesn’t look like the status quo will change any time soon. Economic sanctions placed on Russia by Europe and the US could, in fact, make it worse, if Russian companies are further limited in their ability to pay international providers. However, what must be kept in sight is the fact that there are patients whose treatment is dependent on transparent and healthy working relationships between insurers, assistance companies and medical providers. The global travel health insurance industry has a responsibility to these patients to ensure they are treated in a timely manner and in facilities that are suitable for their medical needs.
Stranger in a strange land

In the Near East, is it possible for a client needing emergency treatment to have both a better medical care experience and also look after the insurer’s bottom line? Ori Karev and Dr Gabriel Pollack consider the emergency care options for insurers with travellers in the region.

Let’s start with a real-life (names changed) scenario that we can all relate to: Joyce was on her fifth day of travel throughout the Near East with her two kids, Emma and Peter. She started her tour at Jordan, visiting Amman, the Jordanian capital, and then Petra, the ancient city built within the Red Rock Mountains of Southern Jordan. Five days into the tour, Joyce, Emma and Peter crossed the border between Aqaba and Eilat to do some diving. It was on the fifth day that they chose to travel by car from Eilat to Jerusalem, through the Dead Sea. By the time they left for Jerusalem, only a 45-minute drive from the northern beach in the Dead Sea, everyone was exhausted. They planned to stay in Jerusalem for three days to be able to visit all the sites. They reached the hotel at 6:30 pm, just in time for dinner …

Onset of symptoms
At 8:30 pm, Emma started complaining about a strong stomach ache, and Peter was suffering from a rash that had developed on his chest and face, and was bothering him. Unsure about the best course of action, Joyce called the hotel concierge and asked whether he could recommend a doctor that would make house calls. As luck would have it, George, the concierge, had just the right doctor. The night before, he was at home with some friends who are concierges at other hotels, chatting about which house doctor was the best. They didn’t, however, refer to their medical skills or professionalism. Unfortunately, the ‘best’ doctor was the one paying them the most as a finder fee. Furthermore, it was a well-known fact that the one paying the most was the one that otherwise could not find any employment: people simply stopped using him.
[ECCs] have sprung up in the Near East in recent years as an alternative to overcrowded emergency rooms (ER), where there is a lack of primary medicine services ‘out of hours’.

because of his lack of skills and professionalism. The doctor showed up promptly, which was very considerate, Joyce thought to herself. He wanted to know if they had any travel insurance, and Joyce assured him that they did, but that he should not be concerned about that because she would pay him with British pounds. He seemed reassured, Joyce thought to herself – but he was only thinking about how much more he could charge for his services. The doctor proceeded to examine Emma and when he was done, he suggested that there was really nothing to be done. She should simply be treated with hot tea and a good night’s sleep. He then proceeded to check Peter, and his diagnosis was that this was simple sunburn and he should apply some moisture lotion. He then proceeded to request $350 for his visit, which Joyce paid promptly.

Emergency care needed
At 02:00 am, Emma woke up screaming, crying because of her stomach pain, and started vomiting. She also developed troubling diarrhoea, and had a fever. Peter was also woken up, and his rash seemed to have doubled in size, only now it seemed like large red circular areas, and he had a terrible itch. His face also seemed somewhat swollen. Joyce called an ambulance, and the three of them were taken to a nearby hospital. Emma’s blood test and clinical situation proved that she had contracted a gastrointestinal disease, leading to dehydration. She was treated with intravenous fluids, an antiemetic, and medication to lower her temperature. Peter’s rash turned out to be an allergic reaction that should have been treated with an anti-allergy medication, at an earlier phase, when he was first seen by a doctor. Early diagnosis and treatment would have prevented the later, more serious symptoms developing in both cases. The hospital’s charge was $2,500. Joyce paid gladly, notwithstanding that they had to wait in the ER before being seen by a doctor, who was a sleepy intern doing his best to handle the constant inflow of patients. Thankfully, by the morning, both patients were feeling much better.

Client choice
This entire story could have had a vastly different impact on the family if their first choice had been to use a 24/7 emergency care clinic (ECC). Such private clinics have sprung up in the Near East in recent years as an alternative to overcrowded emergency rooms (ER), where there is a lack of primary medicine services ‘out of hours’, and in response to the growing number of greedy, and often less knowledgeable, hotel doctors. As a general rule, most ECCs are staffed with emergency and family care physicians whose practice is to conduct a clinically quick and knowledgeable triage, and apply their knowledge to the patient’s specific medical condition. They are a similar concept to the clinics now found in popular tourist regions of Europe, and have evolved out of similar needs.

In recent years, that urgent care segment of clinical services has come to realise that ERs are not always the best choice for patients throughout the Near East. They have become renowned for being overcrowded, lacking in physicians with sufficient emergency care training, carrying out unnecessary diagnostic tests, and keeping patients waiting for care. ECCs, alternatively, specialise in urgent ambulatory care. Their staff are educated and constantly trained in the identification and treatment of specific common diseases. The larger ECCs work on high-volume, speedy, effective and knowledgeable triage, and targeted diagnostic tests. The ECC’s main objective is to determine whether the patient can and should be treated by there referred to his primary physician, or whether he should be referred to (and in some cases be transported to) the nearest ER. The vast
majority of cases, though, are resolved in the ECC. Fast triage is essential, and at ECCs in the Near East region, the patient’s time of arrival will not necessarily be the work-up order. This is most important, and should be explained to all patients upon arrival. Once the triage has been performed, the patient usually undergoes preliminary diagnostic tests in relevance to his chief complaint, and then he will be seen by a qualified and suitable doctor within a few minutes of his arrival. Mostly, these tests are well embedded in the clinical protocols of the ECC, as part of the quest for a fast and effective work-up. Most patients will be out of the ECC following the diagnosis and the treatment solution (whether casting a fracture, suturing a laceration, or the first dose of antibiotics) within one to two hours of their time of their arrival. Costs at ECCs are also often significantly lower than average ER costs; and clinical data is well documented in electronic medical records at many ECCs, meaning they can be accessed remotely by the patient or his treating physician. It is important to explain, however, that ECCs are not a complete alternative to emergency rooms, and nor are they meant to be. Their abilities depend on the level of equipment and laboratory sophistication of the particular facility. An efficient and competent ECC, though, should be equipped with an X-ray machine, and have the capability to perform immediate blood and urine analysis as well as an ECG, to support the clinical needs of the attending physician. There should also be a resuscitation room with all the necessary equipment, devices and medications, and a procedure room for suturing, fracture fixation, cardiac work-up, and so forth. The skills and ongoing training of the staff, and the in-house medical supervision and quality assurance measures, are priceless and critical, and determine the overall outcome and level of diagnosis and treatment.

What might have been?
In our scenario, if at the time the kids started complaining, the hotel concierge had directed them to the nearby ECC, a smoother patient journey would have ensued. First and foremost, clinical staff that was well acquainted with the common diseases seen in this region – especially common travellers’ diseases – would have treated them. Second, Emma and Peter would not have had to endure an inappropriate examination by a less-qualified physician who was completely wrong in his diagnosis. Thirdly, they would have undergone blood and urine analysis hours before they started seriously suffering, which would have stopped their pain and symptoms at an early phase. Last but not least, they would have paid around $450 for everything, instead of the $2,850 (which was paid by you know who!). In summary, where these ECCs exist, they exist for a reason, and for the wellbeing of tourists. Importantly, though, they are of key interest for global insurers who ultimately pay the medical bills of those seeking medical care in the Near East.

Authors

Ori Josef Karev is an entrepreneur and stakeholder within several industries, primarily eHealth and insurance risk placement and management. He previously held senior positions with UnitedHealthcare Group, MedSave USA, Olympus and several other companies and start ups.

Dr Gabriel Polliack, MHA, is a radiologist specialising in healthcare management, global telemedicine, and innovative technology implementation in medical services in Israel and abroad. Currently, he is the director of strategy development at the TEREM group of urgent medical care centres in Israel.
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corpinfo@globalexcel.com
globalexcel.com