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COST CONTAINMENT REVIEW 2015

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Introduction

This is our 10th anniversary edition of the Cost Containment Review. Yes, 10 years of rounding up, exploring and debating the topics crucial to the cost containment industry. I say ‘industry’, but today, cost containment is much more of an ‘ethos’ that spreads throughout the global insurance and assistance business. Certainly, there are specialist stand-alone cost containment companies that use their in-depth knowledge to reduce claims costs for insurers, but nowadays the notion of cost containment has spread into every nook of the travel insurance process, and it has become a mantra that is practised by insurers and their assistance partners throughout each step of their interaction with policyholders – pre-travel, during travel, as well as throughout the assistance and claims process and even beyond. There are several factors that explain this evolution, and just two of these are the continuing rise of medical costs and enhanced communication capabilities. These are both touched upon throughout this year’s Cost Containment Review, as we explore some of the key issues influencing cost containment development today and into the future. Look out for features on controlling costs in Latin America, North America and Asia; the importance of pre-travel cost containment; hospital bill auditing; and the crucial role that education plays in ensuring cost control at every turn. This issue, we also feature a range of case studies that showcase how the industry manages costs, and we speak to Steve McClung, director of managed care at Global Excel, to get his insights on current issues.

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The NEXT GENERATION of Travel & Health Insurance Cost Containment Services will be unveiled to the world @ ITIC Global Conference Athens - Nov, 2nd - 5th, 2015.
Cutting costs is a common aim in most industries; but for travel insurance and assistance providers, with their low profit margins, it’s a must. Tatum Anderson looks at how these companies are building their own cost containment tool chests, with the education of staff, clients and customers at the top of their list of priorities.

Customers generally pay fairly low premiums for travel insurance, but with exorbitant healthcare costs in popular travel destinations such as the US, insurers face massive liabilities. As a result, the global insurance industry has had to maintain a vigilant focus on how much it spends. But the squeeze is only getting worse; medical inflation is outpacing general economic inflation, so proper cost containment has become vital for businesses to survive, says Mike Starko, chief claims officer, Claims at TuGo: “As a company based in Canada, with most of our travellers headed to the US, cost containment has always been at the forefront for us. Without comprehensive strategies for the US, the risk we face is not sustainable,” he said. “It makes sense that other jurisdictions are taking a more aggressive approach to cost containment.” Specialist cost containment companies, of course, have played a role in managing claims costs for insurers for a quite a while. But reliance on such firms could wane if the industry becomes better at controlling costs itself, according to Ian Jones, head of technical claims management at AXA Travel Insurance in the UK. “I think we have been over-reliant on [specialist cost containment companies] in the past due to a lack of knowledge and understanding within insurance companies,” he said. “The mystique of what cost containment companies do is no longer there as it was.” Insurers are instead focusing more on what they can do, in-house, to save costs, and key to this is education – not just of staff, but by reaching out to clients and insureds to educate them on company processes and coverage conditions to ensure cost savings are made at every possible turn.

Doing it for themselves
The insurance and assistance industries are putting in place creative strategies across the ecology of claims handlers, network managers, and customer-facing teams to help save on costs. Allianz Worldwide Care, like many other insurance and assistance providers, pre-authorises certain proposed treatments (primarily in-patient), to enable it to check that the care that has been proposed by the treating hospital is appropriate and necessary, and that costs are in line with the customary charges for that region. The company also offers preventative routine health checks to its international private medical insurance (IPMI) customers that screen for conditions such as cancer.

The mystique of what cost containment companies do is no longer there as it was
it routinely visits its worldwide network of medical providers to ensure high standards; and it liaises with regionally based doctors to facilitate in-patient and out-patient direct settlement agreements with local medical providers.

To make these processes more efficient, many assistance companies split their staff into sections or teams that specialise in the geographic regions they serve – whether these staff are based in a central location or are located physically in the relevant regions. Allianz Worldwide Care, for example, ensures call handlers within its central claims and medical services teams come from the region they are assigned to. It also hosts regular staff development training sessions, says Susan Landers, head of marketing and client management with the company. “Team members develop and maintain strong relationships with local medical providers,” she told the Cost Containment Review. “The benefit of this approach, from a cost containment perspective, is that our local teams are in an excellent position to review and challenge proposed treatment paths and tariffs, when necessary, removing any excessive and unnecessary costs.”

This active case management is seen as far more effective than simply negotiating the cost of bills when they arrive. As AXA’s Jones said: “You need to get on the front foot and be active from admission. Challenge the treating doctor, question the utilisation and understand the length of stay. Be aware of lower-level, lower-cost facilities for step-down care prior to repatriation.”

Some experts also advocate that post-claim care should even ensure that customers are aware of the benefits of cost containment so that they are informed about how much hospital treatment can cost – even for minor out-patient treatments. Crucially, the industry is making education a priority in cost containment. Not only is it educating itself about where it can cut costs, it is looking at strategies to educate its employees and customers on how to be more cost efficient. Some are doing this by investing in research and sharing their findings with others in the industry. For example, International Assistance Group (IAG) has engaged an international panel of experts, called a Cost Containment Panel, dedicated to studying trends on costs in specific tourist markets such as Greece, Spain, Thailand, Turkey, and the US. Cécile Hermetz, general manager at IAG, says this research has reaped considerable rewards.

If consumers understand the terms of their policy before they travel, for instance, and avoid riskier behaviour, they are less likely to require assistance.
already: “For the last five years, the Panel’s policy of pooling their volumes has resulted in significant reductions in medical expenses for our partners,” she said. “Insurers in a number of countries are extremely conscious of amounts paid to facilities. Combined purchasing will be more and more important in the near future.”

Claims handling is another area in which the insurance industry has focused its cost containment efforts; although it could be said that claims handling has previously been neglected, in terms of cost containment education. According to industry experts, this is partly because many companies have thought it too costly to train claims handling staff in such areas. Yet training a competent claims handler who is able to weigh up the purpose and benefits available under a policy, cost of treatments, and still ensure the customer receives all they are entitled to is vital, because not spending enough on training is expensive too – after all, if claims handlers make mistakes and inaccurately assess claims, the financial ramifications of dealing with complaints can be huge, not to mention the adverse press coverage that can result from such a mistake. Most important, though, is the way companies react to mistakes, says Jones: “The cost of making a mistake needs to be understood, but without fear of retribution,” he said. Companies that educate staff who have first contact with the customer at the outset of the claim are able to give correct and efficient permissions for the treatments required, ensure the customer knows what treatments they are entitled to, and make sure the treating facility is aware of exactly what will be paid for and by when.

Educating claims handlers means covering all aspects of the value chain and the costs associated with the component parts agrees Sharon Tan, managing director of AA International, IAG’s core partner in Malaysia and Singapore. She reckons claims handlers need to be trained not just in case management skills, but in technical aspects of an insurance policy. “Teams of claims handlers dedicated to managing certain products or clients are useful, as they would be familiar and understand the policy terms and conditions much better,” she said.

Luckily, there are moves afoot to make claims handling a more attractive and viable career. “We insurers have been guilty over many years of dumbing down the claims handling role,” said AXA’s Jones. “I think that trend is showing signs of being reversed, with more emphasis being placed on staff training, education and role functions.”

Customer focus

Education in its many different forms, then, is becoming a key tool in optimising cost containment – and another important element in

mobile technology is providing new ways to educate travellers before and during their trip
This drive is education of the customer. The name of the game here is avoiding unnecessary costs. If consumers understand the terms of their policy before they travel, for instance, and avoid riskier behaviour, they are less likely to require assistance. And if the traveller’s insurer or assistance company has been in touch to let them know what to do in case of a medical emergency when abroad, educated customers will also know to call their insurance company as soon as is possible following an injury or in the case of illness. This, in turn, will likely mean the traveller will be directed into one of the insurer or assistance provider’s networked hospitals with which they have a direct billing agreement, an ongoing trusting relationship, and have pre-negotiated rates for various treatments, reducing the likelihood of over-treatment or over-charging. Insureds will also know to carry their insurance details with them when heading to the hospital, making for a more efficient authorisation and treatment process. To these ends, the global insurance industry has been working hard over recent years with government agencies to educate travellers about safety abroad and the proper use of travel insurance. Examples of such collaborations include the Smartraveller campaign in Australia, and the work of the UK insurance industry with the country’s Foreign & Commonwealth Office (FCO). AXA, for instance, has published advice to its customers on things to do before they go on holiday, such as leaving contact and travel insurance details with friends and family, researching health risks and visiting the GP, and becoming knowledgeable about their destination using the FCO’s travel advice website.

Education can work wonders, especially for those who are most receptive. Scandinavian, German and Japanese customers are all excellent at following instructions, says AXA’s Jones. “They understand what they are insured for and what they are not,” he said. Elsewhere, Canadians tend to be well-informed too, usually because they have been well educated about how expensive the neighbouring US healthcare system is. But educating consumers has limits. Despite being prompted to do so, many travellers don’t read the fine print of their policies, and don’t think about being ill or having an accident until it happens. Most, thus, don’t have a clue about where to go or whether to contact their assistance provider or insurer when they are ill, either. And the situation is similar – sometimes worse even – regarding well-travelled customers, say experts. “A little knowledge is dangerous and this travelling group is a case in point. Contact is usually made when everything had gone wrong or they have preconceived ideas about what the right course
of action is,” said one. Luckily, mobile technology is providing new ways to educate travellers before and during their trip. Apps created by assistance providers and insurers are giving pre-travel security, health and policy tips, as well as providing clinic-finding capabilities, real-time assistance notifications, and telemedicine. Such apps can help to direct insureds to a networked hospital in case of a medical emergency, thus avoiding potentially more expensive bills from non-networked hospitals. Allianz Worldwide Care’s MyHealth App, for example, utilises GPS technology to provide directions to hospitals selected within the app. To prevent costly misunderstandings with medical professionals, its ‘medical term translator’ shows key medical terms in 17 different languages, while the pharmacy aid tool provides the internationally recognised names for a wide range of branded drugs so that a pharmacist can source and offer a local equivalent if a member is abroad. Elsewhere, AIG Travel Guard’s application notifies customers of any adverse events that may affect their trips, helping to reduce travellers’ exposure to security and travel risks. Such applications do help cut costs, according to Claims at TuGo’s Starko. “All these perceived customer experience benefits have an inherent cost containment benefit that insurers are benefiting from, helping to partially offset the increased cost of care,” he said.

Policy language
Experts believe it’s also crucial that actuaries receive further advice on how policies can help to contain costs too. Although policy wording is generally clear in a significant number of countries, and much effort has gone into refining policy wording over the years – especially in light of conflicts with regulators and regional differences in medical care pathways – there are still areas in which the tightening of policy wording could help to contain costs for insurers. According to AA International’s Tan, policies are sometimes not well written, and this can be costly. “In cases where policy wording is not well written and clearly defined, we do not only face challenges dealing with the patient and family, we would also face challenges dealing with the claims person of the insurance company, due to multiple interpretations of one policy clause,” she said. Ambiguity is one problem, but the omission of crucial details from a policy document is another. Many policies won’t specify usual, customary and reasonable (UCR) prices, for instance, or won’t detail non-payment for hospital errors. And in an effort to prevent loss of sales, policies often do not point out clearly enough what companies will not pay for or what they will not sanction. “This puts us totally on the back foot when it comes to negotiations with hospitals as our policies have no teeth when we are debating contract law,” said AXA’s Jones. Given that the policyholder rarely reads the policy wordings, it might make more sense for actuaries to be educated to write more in favour of the insurer, he advises, to give absolute clarity that insurers will not pay for unauthorised or over-utilised services. So, given the tight margins within which the industry operates, making sure costs are necessary and reasonable seems like a sensible ethos. Instilling this throughout the chain of companies, people and processes that are involved in each individual case, and protecting insurers through innovative cost containment strategies that include the harnessing of mobile technology, and better use of policy wording, are key. Only through educating insurance industry staff and customers alike can the full effect of cost-saving processes be realised.
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Auditing US hospital claims can be an important cost containment tool for the travel insurance community, but much is misunderstood in this space. Amazing statistics and stories abound, promoting billing or auditing rules that sound convincing at first, but that actually have no substantial basis. Jason Davis takes a whirlwind tour of the wild and wacky world of auditing.

The king of audits: Medicare and Medicaid
The Centers for Medicare and Medicaid Services (CMS) is the largest single payer of medical services in the US, and is therefore the largest claim auditing entity. CMS publishes extensive rules and policies that hospitals must follow, and engages with privately owned recovery audit contractors (RACs). These RAC auditors are paid a contingency fee for all the money they are able to save the programme. In 2013 alone, RAC auditors found approximately $3.75 billion in savings. Wow! Impressive, right? Yes, until one realises that (between Medicare and Medicaid) CMS pays hospitals across the US about $270-$280 billion per year. That means that the biggest, most robust, most authoritative and well-funded auditing programme in the country yields approximately one per cent in savings. I’m not saying it’s not real money – it is – but that puts things in perspective in terms of dollars and cents. An argument could be made that CMS pays fixed rates and thus the potential to drive savings is less, but at least they have a regulatory basis to audit claims – which many payers do not have. It’s also important to understand that $3.5 billion of the $3.75 billion in recoveries were for inpatient claims (Medicare Part A) as opposed to outpatient claims (Medicare Part B), where coding is more prevalent and well established.¹

Don’t overlook professional or outpatient claims
CMS focuses on inpatient hospital claims because it already has a strong programme for professional and outpatient claims. Yes, this article is about hospital claims, but it would be remiss of me not to mention the importance of reviewing physician claims as well. There are two major claims types in the US: professional claims (CMS-1500s, often called HCFAs) and facility claims (aka UB-04s or just UBs). Both are published by CMS. The CMS-1500s feature ICD-9 diagnosis codes (soon to be ICD-10) and correct procedural terminology (CPT) codes. These CPT codes are essentially definitions of care. Now, if there are multiple CPT codes on one claim, there is often an overlap in these definitions, which means if they’re left unaccounted for, there would be overlap or duplication in the reimbursement. A simple way to describe it is to say that
the biggest, most robust, most authoritative and well-funded auditing programme in the country yields approximately one per cent in savings.

two or more codes may include the same surgical incision point, and so realistically only one incision (and subsequent closure) is actually performed and so only one should be payable. In this example, the codes are ranked, and the secondary code would be paid at 50 per cent. Another popular example is assistant surgeon claims (look for code modifiers 80, 81, 82, and AS), which are often billed using the same codes and rates as the actual surgeon, despite their only doing 10 per cent of the work as defined in the CPT code. On these claims – which can be very expensive – you can save between 80 and 84 per cent even before applying a discount. For these reasons, there are numerous detailed industry-recognised coding rules sourced from CMS, the National Physician Fee Schedule (NPFs), and the American Medical Association’s (AMA) CPT Professional Edition codebook and CPT Assistant.

I have heard it said that the international travel insurance community has no right to apply US industry coding and reimbursement standards on professional claims. I respectfully disagree. By using a uniform billing format, I would argue that the provider has willingly submitted to this standard or review. These codes quite literally report an overlap in the definitions of care, so it stands to reason that reimbursement should be reduced. If a provider gets sticky on this point (and some occasionally do), ask them if their intent is to misrepresent to the insurer the services rendered in order to maximise their reimbursement – that will get their attention. Incidentally, my American clients apply these coding reductions without any balance billing whatsoever. If you are nervous about balance billing, include a sign-off requirement on the CPT coding reductions as part of the claim settlement process.

So you want to audit a claim?

As an insurer, your rights are only as good as your policy language. Travel insurers are well advised to add a few provisions to their policies stating that they will audit and pay claims in accordance with established industry coding and billing standards. It is also important to highlight non-payment for medically unnecessary or inappropriate services or charges linked to a medical error or misadventure (e.g. never events, preventable hospital-acquired conditions, and so forth).

However, even with a well-written policy, travel insurers clearly do not have the clout of government agencies like CMS when it comes to auditing claims. Absent strong auditing rights in a direct contract, and most hospitals won’t acknowledge auditing results unless the payer has followed the hospital’s audit policy. Typically, these policies require that all – or a high percentage at least – of the claim be paid in advance, and the audit must be performed onsite at the hospital. Audits not done at the hospital are known as desktop audits; often these are neither allowed nor recognised by the audit policy. Some hospitals even bill a fee to audit their claims. Travel insurers want claims to be paid without a balance being billed to members, and often the only way to accomplish this is to abide by the hospital’s auditing terms.

The basis for audit

A hospital’s chargemaster or rate card (a list of billable items) can range from 12,000 to 45,000 items. People are often surprised to discover how few billing standards are actually in play with respect to these charges and how they must be structured, which is why we see such disparity in the range of items included on the chargemaster and their associated expenses (consider all the articles written about the wide disparity of prices for services in a given geographic area).

Even CMS does not regulate hospital charges, per se. The CMS Provider Reimbursement Manual (PRM), section 2203, states: “While the Medicare programme cannot dictate to a provider what its charges or charge structure may be, the programme may determine whether or not the charges are allowable for use in apportioning costs under the programme.” One hospital may include many charges in the room rate (like central supplies); some may choose to unbundle services or supplies so that they are billed separately. Payers seem bothered by both billing practices. Some auditing vendors argue that ‘bundling’ is bad because one cannot be sure the hospital even used the supplies (e.g. mucous recovery device or tissues) that were assumed in the room charge (which the insurer paid for); other vendors argue that some charges shouldn’t be unbundled from the room as the room acuity designation assumes a certain level of required equipment and supplies. I have even seen some auditors use both arguments within the same claim review!

There seems to be a general impression that there are secret billing rules around unbundling, and when hospitals are presented with them, they say, ‘Oh, you got me! You’re clearly among the billing intelligentsia; okay, I’ll write off these charges’. Many articles have been written about vendors challenging providers using unbundling logic and getting ‘amazing savings’. If a provider writes off items that are denied as unbundled, it isn’t necessarily because the provider agrees with the audit findings; it’s more likely that they can’t chase every account for payment, so some ‘audits’ get written off for purely administrative reasons (although these often come back many years after the fact when the debt is sold). Crediting unbundling logic for valid savings is a classic case of correlation versus causation. Also, I have reviewed many so-called audits for unbundling issues and most of the savings (over 90 per cent) on these claims are from adjusting prices to reasonable levels, which is no different from repricing a
claim without a contract. There is a lot of bait and switch in this space. The actual substantive basis or valid standard for auditing hospital claims is much more boring and straightforward than unbundling. Once again, we can look at CMS for general guidance, with audits being broken into three categories:

1) Denials for services that did not meet coverage requirements or were deemed not medically necessary or appropriate.
2) Payment made for services that are incorrectly coded and need to be adjusted.
3) Poor or non-existent documentation for the ordered service.

In general, I would say the most relevant audits for the travel insurance community are to reconcile the charges to the medical record (charge audit – ‘hey you never did this or it looks like you billed me twice’), or to challenge inappropriate or unnecessary care (clinical audit – ‘hey, this person broke their wrist while under your care, I should not have to pay for that’).

**Select inpatient claims**

It is common to hear that over 90 per cent of hospital claims have errors, and I am sure this is true. However, many of these errors are not significant, and if you aren’t careful, you might be spending dollars to save pennies. If you are paying via DRG (diagnosis-related group), a DRG validation – whereby ICD-9 codes are confirmed via a review of the medical record – may be a good investment; if the diagnosis and procedure codes are wrong or exaggerated (aka ‘upcoding’), the DRG assigned to that claim may increase the reimbursement.

However, and more commonly, international travel insurers are stuck paying a percentage off the hospital’s chargemaster. If you have a good agreement with the provider, you might want to pass on an audit altogether. For example, you may have a 40-per cent discount agreement, which on its own is meaningless, but what if you benchmark the agreement and discover that you’re paying 140 per cent of the Medicare DRG rate? If it were my claim, barring any other issues, I would take the deal and move on.

That said, I’ve often seen high-dollar and complex hospital claims with many errors, such as services never being rendered, multiple billings for the same item, and basic mathematical or data entry errors. I once had a claim where the anesthesia charge was higher than the operating room (OR), so I called the provider; after a lecture about audit policies they admitted they’d accidentally added a zero to that line item. Beyond just a dollar threshold, here is a sampling of some things to be watchful for:

- Claims where the care was rendered by many departments at the hospital – the more departments involved in an episode of care, the more mistakes can occur.
- Claims where the actual length of stay is significantly longer than the Medicare average length of stay.
- Claims with extensive OR charges or multiple surgeries.
- Claims with multiple step-downs in room acuity levels.
- Ensure decreasing charges as patient nears discharge.
- Review all diagnoses not present on admission (POA). POA indicators should alert you to conditions that were acquired at the hospital. I’ve often found claims where the patient fell and was injured at the hospital, and I was able to write off the associated charges in these cases. Between 700,000 and one million patients suffer a fall in US hospitals each year, according to the Agency for Healthcare Research and Quality, and 30 to 51 per cent of falls result in an injury:
  - All implant cases (revenue code 278) if allowable for implants equal to or less than $10,000.
  - Claims with extensive step-down levels (5-1) or discharge home from high-levels of ICU.
  - All cases with a trauma activation code (revenue codes 681-684).
  - All cases where the patient is an unplanned ‘re-admit’ within 30 days of another episode of care.
  - All cases where the patient expires.

For travel insurers, a small percentage of claims (under one per cent) can often represent 30 per cent or more of their entire claims value. These high-dollar claims warrant any and all resources for claim reductions, including audits if they make sense, because on a few claims you may find some startling savings. I had a claim where we found over $500,000 in charge errors; the provider was so embarrassed that they paid the cost containment fee. Good cost containment programmes will have detailed criteria for when it makes sense to audit.

**Audit it**

If you want to (or are forced to) do an onsite audit, you’ll need to co-ordinate with the provider and start jumping through the hoops in their audit policies. If you’ve ever looked at medical records, you already know it’s a highly specialised space where you’ll need the professional assistance of a vendor with the following experts: medical doctors, registered nurses, registered health information technicians, certified coding specialists, and so forth.

There are many vendors available to do this (your cost containment vendor probably outsources this too) on your behalf, but they’ll often bill a minimum fee; you may actually lose money if the audit doesn’t bear any results. It’s also worth noting that the audit may uncover changes that were missed on the original claim, so it’s not impossible, that your claim charges will be higher after the audit (I have seen this on a few occasions). Some auditing vendors may be willing to do a pure contingency fee payment model with no minimum fee, but they will want to approve the claims they audit (as they often bundle your audit with those of other clients at the same facility to save on travel costs). Once the vendor completes the audit, they will get the provider to sign off on the findings, you will get a cheque, and you will need to pay the vendor fee.

If your intent is to perform a desktop audit, you’ll need to request the complete records from the provider. For this, most hospitals will require a release of information form signed by the patient, and may charge you to send the records. It’s also worth noting that although you request the complete record, you will likely not get it all. I have seen many audits performed with the alleged full records only to be challenged later by records that weren’t included with...
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the initial request. It seems like the only place to get a complete record is onsite at the provider. Ideally, all audits should be sealed with a signed agreement and payment should be finalised or a refund needs to be initiated.

Final thoughts
A recent study found that that up to 50 per cent of patient safety errors that occur at a hospital are never reported in the medical record. I bring this up because audits are based on reviewing the medical record that the provider has produced. As the saying goes, history belongs to those who write it. Audits are messy and rarely produce strong results on the aggregate (unless you just deny charges that become the patient’s balance), which is largely due to the fact that the hospital holds a lot of the cards (even the mighty CMS only gets one per cent, after all). That said, on certain claims, they can yield very strong savings. The trick is to know when to use audits and when to move on. In general, I advise that audits are best done before payment (desktop is fine) and recommend leveraging the findings into a final settlement agreement. This won’t work 100 per cent of the time, but overall it will outperform a post-payment option. This approach should only be used on claims where the expected payment is deemed too high. As for post-payment on-site audits, I would reserve these for high-dollar claims only that meet your criteria. And please ensure you have a good vendor that agrees to a contingency payment model with no minimum fee. At the end of the day, we are well served to recall the great 2003 article from Gerard Anderson, Professor at Johns Hopkins Bloomberg School of Public Health, about the real problem in US healthcare: ‘It’s the Prices, Stupid: Why the United States is so different from other countries’. Happy auditing!

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


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THANK YOU
– Honored to be a Finalist...
Cost containment in Latin America is becoming an issue of increasing importance for travel and health insurance companies with clients in the region. Femke van Iperen investigates why, and considers what can be done to combat rising costs.

International assistance and insurance-related companies working in Latin American countries have witnessed rising medical costs in tourist hotspots in recent years, with such costs now reportedly often exceeding Western European and Northern US rates. This new situation has led to the development of new cost containment procedures for dealing with hospitals in the region; and although assistance providers and insurers have faced challenges in their dealings with local hospitals, cost containment efforts are proving successful.

Cost control

Although ‘sky-rocketing’ might be a slightly strong term to describe the increase in medical costs in Latin America, it can certainly be said that medical costs in popular tourist hotspots such as Cancun (Mexico), San Jose (Costa Rica), and Punta Cana (Dominican Republic) have been ‘showing an alarming rise’, said Pablo Castillo, CEO of MedBrick Inc., a cost containment vendor in Canada that specialises in managing medical costs in Latin America.

Ignacio Cesar Marquez from MDbroad, who is involved with revenue cycle management, cost containment and case handling in the area, has also witnessed such price increases, and says they fall in line with a ‘deepening of world globalisation’. He’s noticed regional price increases since the 1990s; but the scale of cost increases seems to be ramping up. Castillo called recent developments ‘notorious’ and ‘a major concern for us and our clients’.

The forces at play behind this increase in costs are varied. Although in the past Latin America has not represented a significant percentage of total medical claims expenditure for US and European insurers, professionals like Marquez have witnessed a ‘growth in traveller numbers, particularly expatriate and tourist travellers’, pushing the demand for local healthcare higher in recent years. The increasing numbers of visitors to these areas expect medical facilities to meet certain minimum standards of comfort, but they also expect the ‘enduring low price of cosmetic and similar procedures’, which has made these regions attractive for elective care and medical tourism. Such expectations of quality care have been pushing prices up, explained James Page, senior vice-president and chief administrative officer of AIG Travel. Meanwhile, an ‘inundation of local medical insurance companies’ and ‘staggering growth of local insureds’, who are requesting ‘fixed rates and regular and prompt
payment terms with local insurers’, are also playing a role in driving prices upwards, added Marquez. Naturally, these price increases have been seen in the private healthcare sector, as opposed to the public sector, which is generally only used by the local population, and is no match for the quality available privately thanks to only a small percentage of GDP being dedicated to it. The demand for private hospitals in these tourist areas to modernise their equipment and facilities to bring them up to scale with the norms and protocols of first-world standards has meant they have had to import medical devices, paying in expensive US dollars, Marquez said. Comparing the situation to that of 10 or 20 years ago, Castillo agreed: “Most medical providers in these areas now need to make big investments in order to purchase state-of-the-art technology to remain competitive in their local market.” This has led to Latin America housing some of the best hospitals in the world, but this comes at a price. “More and more Latin American institutions are Joint Commission International accredited,” Marquez continued, explaining that concurrently, there has been a rise in the cost of educating medical practitioners. “Over the last 10 years, physicians have needed more and better specialisation.” Further increasing medical provider costs is the employment of foreign physicians, according to Page, who added: “Many of these medical providers have begun to hire more American- or European-trained doctors.” Combine this with what Marquez referred to as ‘a profound change in the paradigm of practising medicine’ in the region, which has led to an ‘in-depth investigation of the origin of the ailment, as opposed to just treating the acuteness of the event’, and we can see the picture of increasing costs developing further. Many hospitals in Latin America are also faced with a range of external challenges that have been driving medical costs upwards, and the ‘currency exchange fluctuations in countries such as Argentina and Venezuela’, is listed as one of them by Pedro Espinoza, manager of LATAM assistance services for Intrepid 24/7, an assistance company within the Ingle Group of Companies, based in Canada. Currency devaluation has impacted the cost of imported supplies and machinery, an issue also noted by Marquez; as has the ‘cost of money’ in Latin America, which, said Espinoza, is ‘up to 15 per cent (compared to only three per cent in the US)’, and medical inflation, which ‘from 2012 to 2014 has been increasing 10 per cent annually’.

Hampering cost containment

With costs rising, insurance companies that work in the Latin American region have been looking for ways to contain them. But, having to work in a vast region with different standards of medical care, and some significantly remote tourist locations, is not without its challenges. Take, for example, the potential for communication and business culture differences between insurers and medical providers, which can leave insurance companies feeling they are unable to manage and evaluate costs from the moment an insured needs medical care. Although, according to Castillo, ‘some countries in the region have hundreds of reliable hospitals and medical providers that can treat any type of patient’, he also explained that several Latin American countries have a limited number of adequate facilities that can treat international...
Medical providers are always looking for reasonable payments for their services, but they are unaware of what the billing agencies are charging due to contractual secrecy.

A reported lack of market regulation is also having an effect on cost containment, which, as Marquez explained, is particularly the case in the private healthcare industry. “There generally are no ‘rules’ or government-mandated fee schedules governing pricing in the region,” agreed Page. “In many instances, the advanced equipment, expertise and personnel are centralised, so there may also be a lack of true competition.”

In addition, medical facilities in these areas have been seen adopting a change to US-style billing to their advantage. “In North America, a growing number of health and travel insurance carriers prefer to receive claims that are issued under the US coding and billing guidelines, and many [Latin American] providers have seen the opportunity to ‘disguise’ their rates by using bills and codes that can play out to their (financial) advantage,” said Castillo. Raffy Karagossian, manager of provider networks for Intrepid 24/7, also noted: “As medical providers understand the nature of insured international patients and their insurance coverage limitation, they have increased their charges to maximise their revenue.”

For Karagossian, it is actually ‘easier to contain costs in Latin America than in Europe or Canada’. However, it is the influence of ‘unethical billing agencies’ that often creates a dramatic pricing difference as far as Intrepid 24/7 is concerned. “Medical providers are always looking for reasonable payments for their services, but they are unaware of what the billing agencies are charging due to contractual secrecy,” said Karagossian, describing the actions of some such agencies as ‘exponentially increasing the value of the services in comparison to US billing codes, and demanding that the insurance companies pay those prices’.

The Ingle Group of Companies has offices in Mexico City, Santiago, Rio de Janeiro, São Paulo, Buenos Aires and Bogotá and, over the years, people working for the company have witnessed medical providers in Latin America becoming more accustomed to billing insurance companies instead of charging patients, in new, cashless ways, explained Espinoza. Some have also been forced to find ways to deal with unpaid accounts by increasing charges or, in some cases, ‘forcing clients to pay cash up front, or billing insurance companies high prices for the services provided on a guarantee of payment’.

To which Castillo added: “Let’s not forget that many hospitals are ‘for-profit’ organisations. Most of these facilities are clearly focused on attracting international patients who, for obvious reasons, hold an insurance plan.” Putting things in a wider perspective, Marquez pointed out: “Though there is certain speculation [that] with foreign admissions it pays to be make sure you understand and adapt to the local business culture and political and cultural landscape.”
[come] over pricing and over-practised medicine, this is not more scandalous in Latin America than it is in the US."

For Castillo, worsening the ‘snowball effect’ concerning increasing health costs in tourist areas in Latin America, which has been ‘raising a red flag in the international insurance industry for the last three years’, are ‘claim denials and long delays for claim payments’, which push medical providers to hire a billing agent in the first place.

Overcoming challenges
To make sure that cost containment challenges are overcome and that bills are fair, for insurers and assistance providers with customers in the tourist hotspots of Latin America, it pays to make sure you understand and adapt to the local business culture and political and cultural landscape. Ingle International, for example, has an assistance and insurance team that speaks Spanish, and it produces its printed materials in both English and Spanish; and for Karagossian, one of the biggest steps such companies should take, especially to avoid a rise in billing agency utilisation, is ‘to work more closely and reasonably with medical providers’.

It also pays to understand the different options of healthcare available. “Not all admissions require top-notch institutions, and second-tier healthcare providers in Latin America (often) account for the right medical and technical infrastructure to deal with non-acute admissions,” said Marquez. Castillo also noted: “If you have a solid provider network and you know where to steer your patients, you will accomplish more than dealing with unreasonable costs that are being billed to you by predatory medical providers that are doing everything in their hands to attract your insureds to their facilities.” It’s therefore no surprise that insurance and assistance companies have started making more use of networked hospitals in the tourist areas of Latin America.

Page has thus found benefit in working with smaller regional clinics, which, he explained, are often privately owned. “This allows the opportunity to set in place cost containment practices,” he said, comparing such facilities to urgent care centres in the US, which tend to use fewer staff and thus have lower overheads, but not necessarily a lower level of treatment. “Just like many hospitals, these clinics have vastly improved in recent years and continue to grow.” Discussing the benefits of using such clinics, Page also explained that ‘doctors typically have significant input on appropriateness of tests and treatments’. They can help ensure that patients are not subject to unnecessary treatment or procedures, and decisions can be made as to whether a client should be admitted, or be treated at home. Assistance companies’ in-house medical case managers also have a significant role to play here. “They can and should play a role in reviewing medical cases for appropriate and necessary medical treatment,” Page added. For Marquez, meanwhile, obtaining a cost estimate is invaluable: “Though a medical institution cannot be held to a specific initial estimation of costs or duration of care, it keeps everyone engaged and usually final charges cannot skew very far from an initial estimation,” he said, also mentioning the benefit of steering insureds to the company’s or local case handler’s preferred hospitals by encouraging them to use the company’s 24-hour helpline.

To successfully manage claims, a local presence is another strategy that can help save money, as can working with local assistance providers and specialist cost containers who have the benefit of local knowledge and who can negotiate on your behalf.

The only way is up
Most Latin Americans rely on the public healthcare system – only 25 to 30 per cent of the population has private insurance, Marquez explained; but although the public health system may improve and modernise in the next 10 years, it is unlikely to match the infrastructure and hospitality level of private institutions, he argued, so costs in the private healthcare sector are set to continue to rise.

Espinoza agreed: “In the future, we can expect a rise in the cost of healthcare in tourist areas, due to the increase in utilisation.” Castillo concurred that price increases are ‘not getting better any time soon’. And since the need to address cost containment in Latin America is now more necessary than ever before, most would say that without a doubt, it pays for insurance and assistance companies working in Latin America to be aware of the challenges within the marketplace and know how best to address them.
While most cost containment practices are focused on controlling medical claims costs either during or after a medical emergency, some companies are doing their utmost to educate travellers and expatriate workers about matters affecting their health and wellbeing ahead of their departure in an effort to prevent and reduce claims costs. Mandy Langfield looks at what can be done to control costs in advance.

In the IPMI arena, such an approach to educating travellers is arguably more important than in the leisure travel insurance arena, as employers – who often provide the cover for their workers – need to become familiar with the local healthcare infrastructure in the countries where their staff reside, and empower their employees to take more control and responsibility over their healthcare, so they can have some measure of confidence that a policyholder won’t just head, for example, straight to the ER in New York for an earache. And policyholder education pre-travel is not just about controlling medical claims costs. Return on Prevention, a report commissioned by the International SOS Foundation in 2015, notes that ‘many assignees and accompanying family members find it challenging to adjust to life abroad’. “However,” continues the report, “organisations spend relatively little in pre-departure learning and development, compared with the amounts paid in relation to on-assignment allowances.” Indeed, according to a 2006 study by PricewaterhouseCoopers, the total sum of employee reward and benefits paid to an employee on an international assignment was US$190,000 per annum.

Given the investment made overall in an international employee, it is important that such assignments are successful. Studies cited in the International SOS (I-SOS) report show that premature departure rates for international employees range from eight per cent to 12 per cent, with reasons given including leaving for a position with another company, spouse/partner dissatisfaction, and family concerns. The cost of a failed assignment is estimated in the report to be between $50,000 and $1,200,000. By properly preparing the employee, and their family, for the risks that the relocation carries, the risk of the assignment failing is minimised. Included in these risks are health-related matters – an emotive and important concern for overseas employees and their families.

So, what are the key risks for which the policyholder and their family should be prepared, and how can these be mitigated? “Travel may exacerbate pre-existing or underlying conditions,” says the I-SOS report. “Although specific categories of disease would be expected to be greater among travellers (travellers diarrhoea and other infectious diseases), many additional categories of illness may be directly related to travel due to physical and mental stress.” Employees being sent abroad have to deal with myriad challenges that could translate into a negative effect on their mental or physical health, from communicating in a foreign language and operating in unfamiliar business and regional cultures, to long working hours, and separation from friends and family.

Stress
Bernhard Liese’s study into medical insurance claims associated with international business travel (1997) found that there was a significant number of claims made for psychological disorders by international employees. The study, which was conducted among World Bank employees and consultants, suggests that the higher rate of psychological-related claims found among travellers may be related to a perceived excessive workload, multiple and competing demands on travellers’ time, and separation from family and friends. A study by William Bunn in 2001, published in the Journal of Travel Medicine, found that, on average, five to seven per cent of international employees are unable to complete their assignment for medical or psychological reasons.

When considering what a company can do to minimise the risk of an employee suffering poor mental health as a result of their relocation, I-SOS advocates a clear policy to promote the health and wellbeing of international assignees, provision of access to information about the intended destination, and the implementation of cross-cultural training programmes that will inform the employee about the culture they are entering. A pre-departure medical evaluation, which includes a psychological aspect, is also important.

David Wightman, former business development manager for Crown World Mobility, wrote 20 tips for easing the stress of international employee relocation in 2013, and they’re all still relevant today. These include the importance of empowering the employee to understand the benefits available to them through the company’s health insurance policy, and helping them to understand the infrastructure of the healthcare...
system into which they are being placed. Visiting a local physician soon after arrival for a ‘well’ visit was also important, said Wightman, as it gives the employee an insight into where the doctor is located, what sort of ailments can be seen and managed, and give them confidence in the local healthcare system.

**Diseases**

As the I-SOS report notes, ‘there are multiple components of successful international health programmes, one of the most important [of which] is immunisation’. Vaccination is a relatively cheap and simple way of protecting employees from a variety of nasty diseases — routine vaccines recommended by the WHO include diphtheria, flu, TB, and the MMR. Less routine vaccinations given to travellers heading to certain areas include cholera, hepatitis A, Japanese encephalitis, rabies, typhoid and yellow fever.

Malaria is considered to be a serious problem for travellers and expats, as despite the presence of prophylactic drugs on the market, not one is considered to be 100-per-cent effective, although the risk of infection is minimised. According to a study published by the Centers for Disease Control and Prevention in the US, long-term travellers are at higher risk of malaria infection than short-term travellers — some can’t be bothered to continue a long course of prophylactic medication, and occasionally others can fall victim to locally produced, counterfeit versions of the drugs, which highlights the importance of the employer providing access to correct and quality medication.

There are several malaria prophylactics on the market that are deemed safe to take, while others are not. The British Army was in criticised in April 2015, for example, for continuing to distribute Lariam to soldiers overseas, despite warnings from the manufacturer that it could cause severe psychotic episodes. At the time of writing, over 1,000 British servicemen and woman had required psychiatric treatment after taking the drug. The Ministry of Defence has reportedly rejected appeals from families and retired military personnel to stop sending the drug to its employees. The US Special Forces Command has banned the use of Lariam, and the US military in general has termed it ‘a drug of last resort’.

The management of risk is key to helping international employees to remain healthy and happy, and able to do their jobs. Even by providing simple medications, such as that to stop travellers’ diarrhoea, companies can prevent common ailments, keeping employees healthy, and ensuring their attendance at work.

**An employer’s duty of care**

According to ACAS, the UK organisation promoting ‘employment relations and HR excellence’, says: “Employers have a duty of care to their employees, which means that they should take all steps which are reasonably possible to ensure their health, safety and wellbeing. Demonstrating concern for the physical and mental health of your workers shouldn’t just be seen as a legal duty – there’s a clear business case, too. It can be a key factor in building trust and reinforcing your commitment to your employees, and can help improve staff retention boost productivity and pave the way for greater employee engagement’.

It continued: ‘Legally, employers must abide by relevant health and safety and employment...”
law, as well as the common law duty of care. They also have a moral and ethical duty not to cause, or fail to prevent, physical or psychological injury, and must fulfil their responsibilities with regard to personal injury and negligence claims.”

By not doing their utmost to prepare globally mobile employees for their assignments overseas, employers could be exposing themselves to more than just the cost of a medical claim or evacuation – duty of care law applies internationally, and therefore if an employer is found to have been negligent in its preparations, the effects could have far-reaching consequences.

Communication

There are many risks to consider when preparing travellers or expatriates for trips overseas, and whatever the motivation of the employer or the insurer to keep travellers safe and healthy, there is a clear benefit in terms of controlling claims costs. Investment in wellness and the prevention of illness has often been proven to be a sound one, and insurers and assistance providers continue to invest in systems and technology that will hopefully further improve employee wellness. Take, for instance, the growth in the development of wearable gadgets that monitor health – the use of such devices to monitor and steer policyholders with pre-existing medical conditions into appropriate medical care at the appropriate time, if required, is something that is predicted to become an increasingly viable cost containment tool in the not-too-distant future (see also ITIJ 172, May 2015, The eHealth revolution).

Communication with policyholders, then, is vital. Push notifications to smart devices regarding local disease outbreaks or security threats are simple but effective ways to ensure travellers know what to look out for ahead of their departure as well as while they’re away. Knowing where to go in the case of a medical emergency is also key, and educating policyholders on such matters pre-travel is wise: encouraging policyholders to contact insurers or their assistance provider prior to heading for the hospital if a medical emergency arises is the best way to ensure in-network and/or appropriate care is received and at a reasonable cost. For expatriates, especially, communication and support ahead of travel, as well as keeping in touch throughout the course of their placement abroad, to ensure their health needs are met and managed is especially important due to the length of time the policy is active for, and due to the myriad of unique risks they face and pose. With the proliferation of targeted pre-travel advice, insurers have yet another effective cost containment tool that ensures the best for both policyholders and their own bottom line.

Top tips to reduce the stress of an employee’s relocation:

Set realistic expectations
Make informed decisions
Communicate the company’s policy and benefits early in the process
Ensure the employee undergoes a medical check-up
Understand medical care available to the assignee in the host location
Encourage the employee to have a ‘well’ visit on arrival so they can meet their new physician
Arrange a ‘look see’ trip prior to making the final decision about relocation
Offer cross-cultural training
Offer support in the destination
Provide a ‘moving day’ timeline
Send an initial shipment of personal belongings to help the employee and their family feel at home straight away
Offer support to the spouse/partner of the employee
Language training
Help understand education options in destination

(Wish thanks to HR Zone for the above)
Medical inflation in North America is one of the key factors influencing cost containment efforts in the region. Jonathan Connelly looks at how the challenge of keeping insurers' costs down can best be met by IPMI providers.

There are no prizes in this game for speculation or rough estimates. The complex, diverse, and cut-throat nature of the health insurance industry in North America has left the market's big players with a simple ultimatum from a finance perspective: be precise, or lose. Year after year, we've seen medical inflation far exceed general inflation, creating a major problem in terms of the affordability of medical care. The Affordable Care Act (ACA) in the US has sought to tackle this issue, but it cannot do so overnight, and the complex make-up of the healthcare system has led some to believe that a one-size-fits-all approach may not be effective.

The individual private medical insurance (IPMI) market has its complexities, as its big players strive to meet the needs of expatriates all over the world. The diverse US system creates challenges on the cost containment front, but success can be sustained if a wide and thorough enough bank of knowledge is maintained on the subject. While the healthcare system in Canada is structurally less complicated, the Canadians too are not exempt from the scourge of medical inflation, as well as other issues like sustainability and an ageing population.

The US and Canada are similarly afflicted, in that medical inflation is over five times and four times the rate of normal inflation, respectively. With medical inflation in North America running at around 8.5 per cent, and wages increasing by just 2.8 per cent, it's clear that affordability is becoming a real issue, for both consumers and suppliers.

As the above graphic shows, expenditure per head on healthcare in the US is often double, and sometimes even quadruple that of other countries across Europe and Asia. A whole host of factors contribute to this, and with so many diverse social, political, and economic variables to consider when looking to balance the books, an effective cost containment strategy has never been more important. But where do you start?

**Know the facts**

Well, to create and maintain an effective cost containment strategy, those with the decision-making power must have a detailed knowledge of what cost containment actually entails. Some would argue that the fervent political climate in the US was sparked by uncertainties around healthcare. In the chambers of the public sector and boardrooms of the private sector, the ability to distinguish between reducing healthcare benefits and simply controlling costs can often be lost. Across the board, providers are understandably...
One person’s cost containment is another person’s revenue, so controlling healthcare costs will always be a challenge.

opposed to reducing healthcare benefits, while also coming under incredible pressure from key stakeholders to control outgoing costs. One person’s cost containment is another person’s revenue, so controlling healthcare costs will always be a challenge. It’s also vitally important to keep the expatriate’s needs at front of mind while attempting to balance the books. When the level of service slips, or a section of your expatriate IPMI customer base becomes disgruntled, the financial implications can be disastrous, so service and cost containment must always go hand in hand.

When considering the direct implications of any cost containment strategy, particularly in the volatile US market, key questions must be asked:

- **Who or what is being targeted?** Precision on exactly where the savings are coming from is key.

- **Are costs being reduced, or merely shifted?** Depending on the nature of the business, and indeed the cost that’s due to be contained, it may be necessary to take a wider financial view of the implications of the decision. A cost saving is only obtained when there’s a reduction in overall financial output. Shifting a cost from one area of the business may look good at a departmental level, but when scrutinised from the view of the overall company, the false economy becomes apparent very quickly.

- **Are these one-time or long-term savings?** While a one-time saving might help a business meet its quarterly targets, this is very much a short-term fix. Long-term savings can come from adjustments to pricing/excess, and so forth, that have been put in place as part of a wider strategic move by the business, but the implications on how this affects market positioning should be considered.

- **Who or what is at risk if it doesn’t work?** Possibly the most important question to consider, is: what’s ‘Plan B’? Due to the high level of competition, and the ever-changing landscape of the expatriate customer base, cost containment actions can have repercussions.

Of course there’s an element of risk in every decision, but how you recover from mistakes could make or break your business; making a strong ‘Plan B’ a necessity.

**Demands and expectations**

The demand for continued industrial and economic development in North America continues to be a magnet for expatriates of all nationalities, which in turn leads to a buoyant interest for high-quality IPMI. While things like inflation remain an issue, there are a number of measures that can be explored to allow IPMI providers to contain their costs, while retaining a high-quality product for customers. Once a sound understanding of the theoretical reasoning around cost containment has been reached, a targeted approach to identifying troublesome cost drivers must be undertaken.

Across the board in the IPMI market, the basic product design can have cost implications, and for that reason, it’s essential to build cost containment measures into your product design. There are many ways to factor this in, such as adjusting benefit levels, altering geographical coverage boundaries, introducing cost shares/deductibles, and raising the excess on policies.

The specific financial outcome of changes like these will vary substantially, as each provider will...
have a different product range and customer base. Generally speaking, adjusting benefit levels is a tactic deployed by the provider to cap the amount a customer can claim for in any policy year. The upshot of this is that the provider can successfully contain their claim costs. However, when taking this approach to cost containment, the market competitiveness of the provider can be adversely affected.

The most effective way to cut costs depends on the clients’ circumstances and differs depending on whether the cover is for a group scheme or for an individual expatriate. In both cases, however, adjusting the level of benefits, managing the geographic area of cover and accepting a higher level of excess can offer internationally mobile and expatriate clients and their employers significant savings on their insurance premiums.

Beyond the product
Aside from the product itself, technological advances have also presented opportunities for health insurance providers to contain their costs in recent years. Remote access to doctors and medical professionals via video calls are becoming very popular across the industry, making a single medical professional accessible to patients all across the country, or indeed, the world. Face-to-face engagement with a doctor is more costly in the long run for health insurance providers, while there’s also a tangible benefit to the customer in terms of immediacy and flexibility of the service. The investment in technology can be a substantial outlay initially, but it more than pays for itself over time if properly embedded in the service the health insurance provider offers. Technology is now also being used for prevention rather than care in the case of things like medical screening. Ultimately, the cost containment benefit for the provider is the same, as healthier customers will cost the provider less over time.

While these factors help contain costs, by far the biggest financial threat to health insurance providers in North America continues to be the payment of claims. An improved claims record and loss ratio are imperative for IPMI businesses to survive, let alone thrive. A close eye on fraud, and loss ratio are imperative for IPMI businesses paying of claims. An improved claims record providers in North America continues to be the biggest financial threat to health insurance over time.

As healthier customers will cost the provider less containment benefit for the provider is the same, as additional fees are often charged for out-of-network claims. The benefits also reach customers, as in-network hospitals will often provide a more hassle-free service.

The pressures and opportunities for each health insurance provider will continue to vary from one to another, which will ultimately drive each provider to adopt a unique cost containment strategy. Although there is no ‘one-best-way’ approach to cost containment, much of the best practice cost containment areas we’ve covered will be included in the vast majority of cost containment strategies. While getting the strategy right from the get-go is important, what’s equally important is staying ahead of the game. The healthcare market, and in particular the IPMI market, will continue to evolve, presenting new challenges at every turn. The health insurance providers who monitor these variables, plan ahead, and adjust their strategy accordingly, will be the ones who come out on top in the long run.

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Recent years have seen the concept of ‘cost containment’ hit hot-button status for insurers, particularly as it applies to healthcare provision for insured parties travelling in the Asia Pacific. Mark Kopec of Zurich Insurance unpacks the issue.

Cost containment has had currency in the insurance sector for some time now, but its importance in the Asia Pacific (APAC) region has gathered weight in recent years. In a nutshell, a number of factors in the region are contributing to rising medical costs and the associated need for insurers to contain them. Medical inflation and increased uptake of medical and travel insurance are overarching factors driving cost uplifts in the Asia Pacific region, and a closer look reveals the grain of just some of the forces at play.

APAC – a cost containment hot spot?
To explain how cost containment is affecting the region, let’s put things in context. Cost containment is essentially an endemic phenomenon in the US healthcare system, where expensive procedures and treatments have, for many years, created cost rises that are passed on to insurers. The PwC Health Research Institute has seen the $2.9 trillion in medical costs in the US increase 6.5 per cent to nine per cent every year for the last five years; when compounded this sees medical costs 45-per-cent higher in 2015 than 2010.

The game change for the APAC region is that, in recent years, US-based health providers have increasingly exported their offerings throughout the region. This means that, while healthcare costs in the Asia Pacific have traditionally been reasonable, many healthcare facilities there are now developing international administration processes and upgrading and renovating their facilities. As a result, costs such as bed rates and treatment prices have increased year on year.

According to Sharon Tan, group managing director of health service provider AA International Inc. in Malaysia, rises in medical costs in the APAC region are beyond doubt. “Costs are definitely increasing and in certain countries, we are seeing an increase of 10 per cent to 25 per cent per annum. Contributing factors are advances in medical technology, new procedures and financial or policy changes; for example in Malaysia, the implementation of the goods and services tax.”

And while trends vary from one country to another, Tan believes that the overall uptick of costs will accelerate going forward. She adds that it is possible to zero in on areas where cost increases are most evident. “The main area where increases are most evident would be the introduction of new and advanced procedures, meaning procedures...”
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that are less invasive and offer enhanced precision. We’re also seeing advancements in medical equipment that focus on speed and accuracy, for example, offering multi-angle views and increased definition of lesions, masses and so on.”

Indeed, advances in some markets have led to the rise of cost containment ‘hotspots’ in the region, one of which is Thailand. The level of care is excellent in Thailand, and insured parties are often sent there for treatment from other locations. If an event happens in Myanmar, it’s highly likely that the insured will be flown to Bangkok for assessment and treatment. Advances in Thai medical practice have boosted demand for services there considerably, resulting in a concomitant upswing of costs.

Meanwhile, cultural practices and beliefs can also have a bearing on cost increases. China is an example of how cultural influences can create an environment in which cost containment is necessary. While the cost of care in China is not high in itself, the family of the patient traditionally takes on the ‘caring’ role of providing meals and other support while the patient recovers. However, if a foreigner travelling in China is hospitalised, this can’t be the case, and such ‘caring’ services can result in extra costs. In addition, hospital stays in China are typically long, due to a cultural predisposition to ensure that the patient is completely recovered when discharged. The result is that, as a rule, the overall cost of hospital stays in China can be higher than expected.

**Challenges to cost containment**

A key challenge, particularly in the healthcare arena, is that while planned admission cases are usually referred to the insurer for a decision first, a large number of the bills that come through an insurer’s office are presented after treatment has been given.

Another growing challenge is the increasing frequency with which travellers are visiting more remote areas of the region where service provision is at best minimal, and at worst non-existent. For example, if someone has a medical event in northeast Cambodia, there are no Western standard hospitals in that area. As a result, they would have to be flown to a Western standard medical hub for treatment.

**How are costs being contained?**

One solution to such challenges lies in recognising
those costs and being able to pre-negotiate the relevant components of the risk to ensure coverage without cost blow-outs. Some insurers are also introducing tighter limits to policies, direct billing agreements and extensive medical provider networks. In fact, such networks are proving useful in establishing relationships with leading edge and high usage providers. Bangkok Hospital is an excellent example of this; it has great specialists, facilities and outpatient care, as well as a comprehensive network covering key geographical points throughout Thailand. Insurers are able to negotiate better rates with such facilities due to the cost efficiencies created by the networks involved. Another approach is to group several markets in the region to create efficiencies. For example, at Zurich, we’re currently putting together a cost containment arrangement for Hong Kong, Singapore, Taiwan, Indonesia and Malaysia.

Gathering data from claims by benefit, by country, by size, or by insured type, also plays an important role in analysing and forecasting where cost containment is needed and how it can be implemented, as well as empowering insurers to negotiate appropriate rates.

The role of data and technology
Increasingly key to cost containment is the shrewd use of data, which provides insurers with the ability to mine the relevant statistics of a given region in order to assess potential costs and savings. At Zurich, we’ve been consolidating and assessing our data over the last year or two, and we’re also looking at how technology can be used to provide such data, usually in electronic form at the point of sale. Technology can also be very useful from the perspective of the insured. Smartphones and similar devices allow for push notifications and alerts to be quickly disseminated, meaning travellers are more aware of travel warnings or health risks and are able to avoid them. They can also receive tips about staying healthy, as well as recommendations for which hospitals to go to in the event of an emergency.

Conclusion: cost containment is here to stay
Cost containment is like a constant ‘cat and mouse’ game, in which medical expenses continue to increase, while insurers continue to battle to keep them down. However, there’s a strong likelihood that insurers can stay on top of this game if they continue to deploy tried and tested cost containment strategies, as well as persisting in their efforts to find new ones.

The use of data to negotiate rates, as well as creating workable groupings of markets within the APAC region, are proving useful tools in cost containment. There are also some great tricks at our disposal. For example, going back to the context of the US, in the last five years or so, thanks to the arrival of the ACA, we’re now able to measure what we’re paying against standard Medicare rates. Clearly, given that non-US citizens who travel in the APAC region, aren’t paying US taxes, along with a number of other factors, we wouldn’t expect rates to be completely on par with Medicare. The bottom line is cost containment is top of mind and an issue that is here to stay!

Mark Kopec is head of travel insurance – Asia Pacific for Zurich Insurance.
ITIJ spoke Steve McClung, director of managed care for Canada’s Global Excel Management (GEM) Inc., about the influence of the Affordable Care Act on international insurance providers, why communication is key to successful cost containment, and how travel insurers could better protect themselves from US hospital bills.

For how long have you worked in the cost containment industry, and how has your career progressed to your current position as director of managed care at Global Excel?

I’ve been in cost containment for over 15 years, having started my career with Global Excel in our case management department, providing assistance services to travellers and by putting my language skills to work with medical providers around the world. After that, I moved into our negotiations group and learned some of the more detailed aspects of the US health system. At that time, I was able to entertain my own personal passion for efficiency, creating tools to help streamline the processes and ease many of the manual calculations required to benchmark claims against costs. Ultimately, that brought me to the role of director of information systems, where I oversaw the remarkable team at GEM through the implementation of our new systems. While I enjoyed my time with the information systems group, at my core I have a deep-seated desire to fight for what is fair in a healthcare system that is very complex and fraught with problems. When the opportunity arose to re-join the cost containment division, I was very happy to make my way back to the heart of Global Excel and help lead the charge for equitable payment for services rendered.

How have your previous job roles with GEM contributed to your understanding of the wider travel insurance industry, and the need for a wide variety of cost containment initiatives to be implemented by travel insurers?

The challenge of containing costs is often about numbers, reviewing the bill, referencing the benchmarks available, finding the right person to engage in a discussion, and pushing to get points across. It is easy to lose sight of the bigger picture – the fact that travel insurance is ultimately about providing peace of mind to someone who is probably far from home and in need of a helping hand.

Having been on the front line and taking the calls from concerned travellers, I’ve always kept my focus on the need to create a seamless experience for the insured. Initiatives aimed at bringing value to our corporate clients while keeping the customer experience in mind at all times are key. GEM is always focused on the bottom line, but we want to find a way to reach that equitable payment in a way that ensures the experience is as simple as possible for our clients and their customers.

Part of your role is to develop new strategies for controlling costs; how do you think such strategies have changed over the years, and how do you see them developing in the future?

With the evolution of the health system in the US we’ve seen significant changes in that landscape: provider and network consolidation, an explosion of new expensive technologies, massive increases in pharma costs, the roll out of the Affordable Care Act and its far-reaching impacts, and so forth. The challenges have shifted and increased. The definition of what is an equitable payment has become clearer since my early days in negotiations, and the movement toward pricing and costing transparency has forced the discussion in different directions.

As the number of parties involved in healthcare transactions continues to contract, those discussions will continue to change and market pressures will mount. Finding ways to differentiate...
What does GEM’s recent acquisition of Olympus Managed Health Care mean for travellers heading to the US from Canada? Regardless of the origin of that traveller, be they an Olympus or a GEM supported individual, they are in good hands with a very reliable, well positioned, financially strong company that continues to evolve with the changing US healthcare landscape.

For medical providers, what do innovations such as Global Excel’s Claim Pay Card and electronic data interface offer over traditional payment techniques? Less hassle – payments can be received in real time rather than waiting for mail and needing to deposit cheques. GEM is always looking for ways to provide efficient interactions with providers and ensure timely and accurate payments for our partners.

In your opinion, are provider networks essential to effective cost containment in US hospitals? The movement towards reference-based pricing and doing away with the traditional provider network is an interesting trend. However, simply issuing payments based on a reference price does not alleviate all responsibility from the patients. This is a very unilateral, payer-focused approach that does not facilitate open dialogue with the providers. At the end of the day, a fair payment for services rendered is the foundation on which the transactions between a healthcare provider and a payer should be based. There are circumstances when a reference-based pricing approach might make sense. But when a pre-arranged equitable payment term can be set up and a mechanism can be put in place that ensures fairness to both parties, this should always be the preferred option.

What has changed for GEM since the introduction of the US Affordable Care Act? Have you found that hospitals are changing the way they deal with international insurance providers? Interestingly, there have been varied responses to the ACA in relation to international payers. In some instances, providers that historically did not want to discuss fair payment on international claims have opened up the discussion to see if they can encourage international patients to come to their facilities. The drive to keep domestic patients out of hospital through accountable care organisations has left some traditionally full hospitals now faced with the need to fill empty beds. Additionally, the pressures on many hospitals to maintain profitable growth/revenue targets has made discussions with some providers much more difficult. Despite more coverage being available, there has been a trend towards less hospital usage and therefore lower revenues. Low cost plans in the US have forced payments to providers downwards for some of the newly insured. In turn, it seems there has been a sense that those lower revenues could be made up for through the international market. Ultimately, I think the level of uncertainty that GEM’s job much more difficult, but that difficulty is where the true challenge can be found, and we love a good challenge! Over the years, we have consistently been able to develop innovative solutions, with some that have seen our results improve despite market trends.

Do you think that international travel insurers could protect themselves more effectively from costly US medical bills if they were to modify the underwriting in their policies and make the wording more appropriate to the US healthcare landscape? Absolutely, there are many factors around the US health system that are very different from the rest of the world. Given that US healthcare is the most expensive, making a few key modifications to ensure better protection in the policy would be prudent. Setting a defined benchmark, determining forum selection, and indicating a need to seek care at a preferred facility, or to consult with an assistance company prior to seeking care when possible, would all be good protections to have in any policy that covers someone travelling into the US.

What do you enjoy most about your role, and is there anything that you would change about the cost containment industry in an ideal world? What I enjoy most is, without doubt, the people. Both GEM and Olympus have managed to put together remarkable teams. Given the diversity of new challenges we face on a daily basis and the amount of pressure created by some of the changes we have seen in the US healthcare system over the past few years, it’s a pleasure for me to work with the dynamic, creative high-energy teams that we have. In terms of something I would change about the industry … in an ideal world, cost containment would not be about bridging the divide between bill and payment, rather the focus would be on ensuring that billed charges are fair from the outset and that payments are reflective of costs. The focus would be completely shifted to making sure that people stay healthy and get the care that is necessary. Utilisation trends and disease management would be areas of intense activity, geared towards reducing costs by managing health rather than treating sickness. I believe this is the direction we are moving in, albeit slowly.

If you could do any other job, what would it be? I have always been fascinated by the world of particle physics. The math involved is generally quite elegant and the implications to the rest of science are fascinating. That said, I would probably choose to run a restaurant somewhere along the southern coast of Spain. I love to cook and you can’t go wrong on the beautiful Costa del Sol! Besides, if I am allowed to choose anything, I might as well get some sunshine in the process.

What are you most proud of – both personally and professionally? My children. My daughter Emilia and my son Gabriel are 11-year-old twins. My wife and I have managed to raise two smart, healthy, good-hearted young adults. They are very well positioned to tackle all the challenges that life brings.
A case in point

The Cost Containment Review asked a number of companies for examples of medical cases where careful cost containment practices had led to significant cost savings. Here, we share details of these cases, providing for each: details of the patient’s situation, how bill or case negotiations were managed, and the sums involved.

Case study 1  GMMI, Inc. (dba. Global Medical Management) employed the expertise of its legal team to slash the cost of a padded bill

A 29-year-old international student ambulated to emergency room (ER) with swollen lips after eating cake. There was no concern for airway compromise, no concern for anaphylaxis, stable blood pressure, no vomiting or diarrhoea, and no evidence of a rash. The patient was admitted for one day with a diagnosis of anaphylaxis.

Upon receipt of a hospital bill for US$56,000, GMMI’s claims processor sent the bill through to the company’s internal auditing department. The ER charges alone were $40,702 and intensive care unit charges for a single day were $14,063 – both of which appeared to be excessive. Medical records were thus forwarded to our medical director for his opinion regarding the level of care provided. It was his opinion that the billing on this claim was not consistent with the level of care the patient required.

Despite the fact that a network contract was available, the discount was not taken, as GMMI determined the charges to be excessive and grossly above ‘usual and customary’ for the area in which the hospital operates, and because the medical information provided did not justify the charges being presented.

Our experts found that services rendered were padded – the level of care was excessive for the patient’s condition. GMMI thus contested the charges due to medical necessity not being met; our in-house legal counsel was able to utilise the medical records to prove that level of care billed for was not appropriate for the patient’s condition. The facility agreed to accept 10 per cent of billed charges as payment in full.

Case study 2  ChargeCare International successfully negotiated for the re-billing of a two-day operation as a single surgery

ChargeCare International had a case for an elderly gentleman who had been admitted for cardiac treatment whilst on holiday in Spain; his medical condition was such that he required surgery to insert a number of stents. The ChargeCare doctor who audited this case is a reputable cardiac surgeon in Spain – and therefore extremely well qualified for this medical review.

We could see that the hospital had stopped the operation on the initial day of surgery, and had then continued with it the following day (meaning that the treatment was extended over two days) and the hospital was charging for two separate surgeries. When questioned, the hospital advised us that the patient had been too weak to continue the surgery on the first day (hence the two surgeries). However, we could see no medical evidence of this, and the hospital was unable to provide us with factual evidence to support their assertion, despite ongoing discussion and case review.

Whilst our doctor was very firm in his opinion, the hospital was adamant that their process and charging was correct. However, they were unable to provide evidence to support the action taken by their doctor. At this point, we chose to involve our client and their own medical team, who reviewed our opinion and confirmed that they agreed with our stance.

By working collaboratively with our client, being very open with the hospital, utilising a local cardiac specialist, and putting forward a consistent and well-qualified argument, we were able to work with the hospital to eventually agree a fee that all parties could accept (although the hospital continued to state that the break in the process was medically necessary). ChargeCare International obtained a 28-per-cent discount, based on re-billing the treatment as a single surgery, in combination with our existing negotiated savings with this particular facility.
In this complex case, which recorded the highest amount of savings on an invoice in the company’s 2015 records, a 73-year-old male patient was brought to hospital in Antalya, Turkey, by ground ambulance with complaints of dyspnoea, coughing and chest pain. The pre-diagnosis was pneumonia and the patient was admitted to the intensive care unit (ICU). The patient was intubated within a couple of hours of admission and hooked up to a mechanical ventilator. Sadly, the patient’s condition kept deteriorating and the diagnosis turned into sepsis along with multiple organ failure. Following 35 days of ICU admission, the patient was repatriated to his home country via air ambulance.

The initial invoice amount was €235,497, which corresponded to approximately €6,500 per day for an intubated multiple-organ failure patient in ICU with sepsis. Eurocross Turkey doctors made the preliminary judgement that this amount could be brought down marginally. Upon investigation, medicine and material costs were all found to be higher than expected and a significant amount of the bill was reduced through a re-calculation based on Eurocross Turkey’s knowledge of local prices. Additionally, the billed quantity of certain items coming from some of the interventions such as hemo/filtration, blood product infusions, and culture tests, were found to be either over-used or to not match the medical report. These were also corrected based on the correct figures, and the daily cost was reduced to €2,755.

The final invoice amount was €96,450, meaning Eurocross’s intervention resulted in savings of €139,047 – €26,292 of which came from pre-negotiated discounts, and €112,755 of which came from post-billing reductions. Such reductions were performed in accordance with the Turkish Medical Doctors Association Minimum Pricing Booklet rules; added to which, Eurocross Turkey’s individual hospital agreements came into play and significantly reduced the final cost to the insurer.

Case study 3
Eurocross Turkey used local medical expertise, careful investigation, and negotiation to reduce the bill for an ICU patient in Antalya

Billed: €235,497
Saved: €139,047

Case study 4
Orion Assistance stepped in to make a 68 per cent saving on a bill for treatment where prosthetics and surgeon costs had been vastly inflated

An elderly lady on holiday in the Antalya region of Turkey broke her hip following a fall; she was collected by a private hospital ambulance and taken to the related medical facility. Following numerous investigations, the treating doctors decided that the patient should undergo a total prosthesis operation for her broken hip. The patient underwent the operation in the hospital without any consultation with a local assistance partner, and a day after the operation, Orion received the case from the insurance company, which requested strict cost containment be performed.

We found out that the total costs billed by the hospital neared €70,000. The patient’s insurance company informed us, however, that the cost of such an operation should not have exceeded €20,000. The Orion Assistance cost containment team requested the proformas for every single item used in the operation, including the prostheses, plates, screws, and so forth, whereupon it was deduced that the cost of the operation had risen so high due to the price of the prosthetics having been manipulated and the operating doctor having charged an astronomical price for performing the operation. Utilising our pre-determined prices according to the Turkish Physicians Association booklet (with the specific quotients for different regions of Turkey, which is multiplied by the unit price for specific interventions and prosthetic use), Orion doctors went through a long and difficult ordeal in order to negotiate and reduce the price to €23,000. Although the final figure was in excess of €20,000, Orion had managed to save the insurance company 68 per cent of the original cost. Timely relay of hospitalisation information to the local assistance company by the patient’s insurance company will undoubtedly decrease the costs of major procedures, but in this case, despite delayed notification by the insurance company, the experienced cost containers at Orion Assistance succeeded in bringing down the costs to a reasonable level.

Billed: $€70,000
Saved: €47,000
Case study 6  AP Companies used active case management to uncover a fraudulent GOP request for an ICU stay

In July 2015, a medical provider in Almaty, Kazakhstan, contacted AP informing us about high-dollar hospitalisation in their clinic and requesting a guarantee of payment (GOP). The patient was a small child with acute gastroenteritis, hemolytic-uremic syndrome, renal insufficiency, and anemic phase. After monitoring closely by the assistance provider’s medical team to ensure adequate, optimum and complication-free intervention and recovery, a surgical intervention was planned to reduce the patient’s fractured bone fragments and an overall cost estimate was obtained. Appropriate repatriation arrangements were made following treatment, considering all necessary precautions relevant to the patient’s big-bone fracture recovery and the effects of flight (i.e. deep vein thrombosis prevention).

After keeping an eye on the interim cost reports during the hospitalisation for any billing anomalies (unnecessary/over-applied labs, radiological investigations and therapeutic modalities), marm saw that it was necessary to begin a dialogue with the medical provider in order to cut the billed costs back to reasonable proportions. The company’s multi-stage cost containment procedures were initiated, and its benchmark reductions applied straight away. This was followed by a re-calculation of the bill based on relevant local pricing standards. As is the case more often than not, miscalculations were identified in the operating costs, especially involving assistance and anaesthesia fees, so these were adjusted accordingly. In the next phase, a comparative study was run between the medical report and the expenses to eliminate all unnecessary, over-applied and uncovered services. With strict adherence to the latest evidence-based medicine guidelines, the marm medical doctors carefully excluded all anomalies. Keeping the diagnosis-specific cost targets (based on the relevant data accumulated over the last three decades) in mind, the pre-agreed discount was applied in the last phase and the final amount was approved for payment.

Billed: €72,000
Saved: €60,000
(in theory)
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