"We can’t solve problems by using the same kind of thinking that created them."

Albert Einstein

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EDITORIAL COMMENT

The 2017 edition of ITIJ’s Cost Containment Review brings together a collection of articles specifically for the international travel and health insurance audience, to shed light on some of the key issues facing this industry with regards to the control of costs. There are a number of common themes throughout the articles, one of which is the growing problems faced by assistance providers with patients in Mexico. Increasing costs and controversial billing practices at some Mexican medical institutions, together with issues surrounding the involvement of third-party US billing agencies, are giving the industry real cause for concern. Bringing some clarity and a broader perspective to this topic is Scott Rosen’s article Latino laments on p. 26. You can also catch Scott talking about the issues in Mexico at ITIC Americas next March – this is sure to be a lively session, not to be missed!

Another common theme is the use of technology and its development in the cost containment arena. Our feature Outsourcing cost control software on p. 30 takes a fascinating look at today’s software capabilities when it comes to managing claims, gets to grips with some of the software systems on offer to the cost containment industry, and assesses how this technology works in conjunction with the human element. And lastly, the issue of outsourcing crops up across a range of areas in this issue. I’ll let you get on with discovering those for yourself, though …

I hope you enjoy this issue!

Sarah Watson
Editor, ITIJ
The mission of AIMS is to become the premier provider of medical management and assistance within South Africa and neighboring countries.

We are committed to ensuring our clients that Humanity, Dignity and Respect is maintained at all times. AIMS provides an excellent needs-led service offering the most appropriate medical care and attention to the foreigner in crisis.
Taking everything into account
Ian Jones explains how a more holistic approach to cost containment can result in better savings and happier providers

Cost containment is not just about negotiating down the cost of medical bills, although this is undoubtedly an important work stream. It should be viewed as a holistic exercise encompassing all aspects of the assessment and assistance process, beginning with the notification of loss, through directional care, network access, bill auditing, fraud screening, third party recoveries and contributions, then finally ending with post-settlement closed-file audits. At AXA, all aspects of cost containment are conducted in-house and this is achieved by having excellent, co-ordinated communication across the globally located teams. Make no mistake, though: none of this is easy and many challenges are faced on a daily basis, beginning with probably the most difficult aspect in which to achieve good cost containment – directional care.

Keeping it in the family
Over the years, AXA has developed a comprehensive global medical network supported by a dedicated team of regional and local network managers who ensure the clinical excellence of our network partners. So how, when dealing with visitors to foreign countries who often require emergency medical treatment, do we ensure that they are treated in a network facility? Considerable work has taken place to analyse where our customers are travelling to and in which locations they are receiving treatment. We have positioned the network effectively to ensure that in areas of high tourist traffic, over 90 per cent of customers are treated in network facilities.

Customers’ travelling patterns change, though, so it is essential to maintain annual reviews of network utilisation, but of equal importance is trying to pre-empt this change in behaviour. Utilising industry data and keeping abreast of geo-political situations, currency fluctuations and advanced booking information helps to give an indication of which new destinations, regions or even resorts are becoming more attractive. Having the details of our network at the fingertips of our agents is crucial, and with over 40,000 facilities outside the US alone, our network team has to work very hard to make sure the information is up to date and accurate.

Communication with the customer at the time of purchase and prior to departure is hugely important, especially when it comes to ensuring timely payment of medical bills. If you don’t pay your bills in a timely fashion, all the talk and goodwill in the world will have very little effect.
important in reminding them of the need to call us first. When they do this, we have the opportunity to triage the route of treatment they require, which can range from direction to a cashless outpatient centre, to a doctor visit, teledmedicine consultation or referral to a network hospital. Showing the medical providers that you are able to direct your clients towards their institution greatly improves your negotiating position in respect of pricing. Volume is always king, but saving €10 on the bottom line is useless if the top line has gone up by €15.

On the paper trail
Cost containment or bill auditing carries with it a specific skillset, and to achieve the desired results it must be treated as a specific task, ideally outside of business-as-usual operational duties. A successful auditor must have awareness of medical practices – they do not necessarily have to be a doctor or a nurse, but they should be experienced enough to be able to identify anomalies in levels of reimbursement and over-treatment. They must be capable of conveying strong messages over the telephone and hold a certain entrepreneurial flair to recognise when a deal can be done. Holding a gun to the head of the provider is never a sound negotiating tactic. It might work once, but what happens when your next customer is admitted? Developing and building lasting relationships built on mutual trust and respect is what should be strived for, and this is where the skills and hard work of the network managers come to the fore. To support them in this task, there must be an efficient operations team. If you don’t pay your bills in a timely fashion, all the talk and goodwill in the world will have very little effect.

Cost negotiations must also be supported by having strong policy wordings that give the negotiators some teeth. Having policy wordings online so hospitals around the world are very familiar with their content – even their limitations and weaknesses – is beneficial. Strong wording around what you will and will not pay for, ability and flexibility to move patients to alternative facilities, and clearly defined benefits, are essential. Thankfully, fraudulent activity amongst medical providers is comparatively rare, but it does exist. It is also important to differentiate between when a provider has attempted fraud, and when they are simply overstating charges. Some may say that a provider who knowingly inflates their medical bills, padding them out with excessive charges and treatments that have not been carried out, is committing fraud. We all have our own opinions on this, and the concept and interpretation can and will vary country by country, culture by culture.

Regional challenges
Regrettably, many of us are experiencing a worsening landscape of medical care in Mexico. Excessive charging, refusal to enter into meaningful negotiations, and the eagerness of US collection agencies is creating a situation that must be addressed. Mexico is continuing to be a burgeoning tourist destination and this has not been lost on the medical supply chain. Private ambulances charging hundreds of dollars per mile are not uncommon. What is more concerning, though, is the increasing instances of ‘medical kidnapping’. This was an issue that had largely gone away and has not been subject to discussion for a number of years, but in the last 18 months cases are becoming more and more frequent. Coercing customers to hand over credit cards and passports, sign blank forms in Spanish and so on is definitely on the rise. This whole experience is frightening for the patient and their family, and in turn heaps a huge amount of stress on the medical managers and their families.
of pressure on the assistance co-ordinators. We have even had cases where the customers required urgent transfer for life-saving treatment to better-equipped facilities but this process was blocked, delayed and hampered by the first facility until guarantees were in place to pay the ridiculous medical charges. The British Embassy and the Mexican Ministry for Health are now engaged in challenging one facility that is engaging in this practice.

Mexico shouldn’t take all of this inglorious limelight though. Many of its neighbours in the Caribbean and South and Central America are also making hay while the sun shines. On some of the smaller Caribbean islands, local clinics are cashing in and have been obstructive in discharging patients requiring urgent transfer, unless the exorbitant charges are agreed and paid. We have even had patients in their sick beds threatened with arrest by the medical staff if they do not pay before they leave.

The customer’s health is, sadly, a long way down the list of priorities for these facilities. Thankfully, there are many dedicated, highly skilled and professional medical staff in these regions that will still go the extra mile for our customers, and although negative and troubling experiences are becoming more commonplace, they remain exceptions to the rule. As our customers travel to more remote and poorer parts of the world, we will continue to be faced with the challenges of travellers and their insurance policies being viewed as golden eggs. The proliferation of helicopter rescue companies in Nepal in recent years is a prime example of this. A relatively sophisticated supply chain has been created encompassing the tour agents, guides, helicopter companies and hospitals. Commonality among the companies in reporting flying hours, billing, diagnosis and a lack of accurate recording of the number of passengers flying all point to the fact that this is organised and co-ordinated abuse. Drawing together the experience of internal medical support, network managers, bill auditors and operations agents is key to identifying those facilities that are abusing the trust placed in them. These facilities are then black marked in the system so that the agents can be made aware of them. We are all striving to make our operations more efficient, trying to pay low level bills faster with less touches and removing many of the historic checks we would have conducted in the past. This has not gone unnoticed by some providers. Through the consistent and co-ordinated auditing of closed files and random service calls to customers we have identified providers who will receive a genuine patient, but then also proceed to submit claims for the rest of the family. The family may or may not receive inducement in these instances. We have also been made aware of tourists in some resorts being approached to sell their travel insurance details.

Careful analysis of claims management information can give excellent insights to help identify sudden spikes of activity out of sync with historic claim patterns from a particular provider, although complete fabrication of an inpatient admission is, thankfully, rare. This is simply because there are so many people involved in the process. In most instances, the companies will be in regular communication with the insured, and treating doctors will be talking to medical staff from the assistance company.

**A two-pronged approach**

Much has been written over the years about the best methods of cost containment in the US and the complications faced in achieving reasonable levels of billing. We at AXA face the same challenges, but have had great success in containing the costs of our medical bills through two channels. Firstly, we have partnered with companies, allowing unlimited and unrestricted access to the largest medical networks in the US. This now provides network penetration in excess of 92 per cent of our cases. Secondly, a great deal of time and care has been paid to the development and nurturing of relations with a select number of facilities that understand the needs of travel insurers. This is of particular relevance for cases needing to be transferred into the US from neighbouring regions – rather than carrying out the usual barrage of expensive diagnostic tests utilising every one of their new shiny expensive machines, they will instead simply prepare the customer for repatriation back to their home country. Of course, this is always dependent on the medical condition. This level of co-operation is uncommon, but we are extremely appreciative of the principal doctors’ understanding of our requirements, and as a result we are able to specifically direct customers to these hospitals.
Tatum Anderson evaluates the nature of second medical opinion services and the role providers of these services are playing in the international travel and health insurance world

Let’s start with a scenario in which obtaining a second medical opinion (SMO) meant a significant change to diagnosis, treatment and cost. A 55-year-old woman was diagnosed with a malignant spinal tumour. A diagnosis of cancer is distressing enough, but her doctors have recommended chemotherapy, radiotherapy and invasive surgery that carries the risk of permanent paralysis. It’s a terrible diagnosis. So, the patient seeks a second opinion. This particular one is outsourced to an independent specialist company that is able to draw on a database of specialists in complex cases.

This new specialist not only looks at her test reports, to check the diagnosis, but sends her biopsy for testing at an independent laboratory. The result? The tumour is benign. Had the woman gone ahead with the previous set of treatments, her life would have been very different, according to Dominic Howard, director, European sales and accounts at Best Doctors, the company that conducted the second opinion. “She didn’t need the chemotherapy, radiotherapy or the type of surgery that they were going to do to remove it,” he said. “There is a lot of misdiagnosis out there.”

Common practice becomes more crucial
Gaining an SMO is a well-established practice. Cancer treatments and cardiac treatments are common second opinion requests, say assistance companies. In fact, they have been in use for so long, that some remember when wedges of medical documents on individual cases would be couriered to doctors for second opinions. These days, most things are done by email conference call, and there are cloud-based applications so doctors can even communicate with each other and view medical reports at the same time.

But, SMOs could become more crucial. A report from the Mayo Clinic released earlier this year said diagnostic errors are now rife, and costly. Researchers there studied 286 patients referred to its clinic over a two-year period and compared the referring diagnosis to the final diagnosis. They determined the level of consistency between the two and, thus, the level of diagnostic error. The results were worrying. In 21 per cent of the cases assessed, the diagnosis was completely changed; and 66 per cent of patients received a refined or redefined diagnosis. Surprisingly, only in 12 per cent of the cases was the diagnosis confirmed.

Raija Itzchaki, president of GMMI, Inc., told the Cost Containment Review that in a study conducted by the company’s contracted vendor, 26 per cent of cases that had been sent for a SMO had a change in diagnosis, while 75 per cent warranted a change in treatment plan. Diagnostic error could lead to treatment delays, complications leading to more costly treatments, or even patient harm or death, said James Naessens, a Mayo Clinic researcher. And, said the Clinic, the costs associated with these mistakes have been largely unappreciated, despite the fact that they are a direct result of efforts to manage increasing healthcare costs – health insurers often limit access to care outside their network, effectively limiting referrals. What makes things worse is that doctors may be more confident in their diagnostic expertise than warranted in a particular case (although the paper did not follow up on the progress of patients with a second diagnosis to see if it was correct). Patients, without medical expertise, are not aware that there might be a different opinion.

And in January, The Right Care Series of papers
commissioned by The Lancet highlighted underuse and overuse of healthcare around the world. Underuse leaves patients vulnerable to avoidable disease and suffering. Overuse causes avoidable harm from tests or treatments and wastes resources, said authors led by the Lown Institute in Boston with international experts from Harvard, Stanford, Dartmouth and other institutions. The study found that rates of inappropriate total knee replacements were 26 per cent in Spain and 34 per cent in the US; rates of inappropriate hysterectomies were 20 per cent in Taiwan and 13 per cent in Switzerland. And that 6.6 million C-sections around the world are excessive — for more on this, see the article Million-dollar babies on p18.

The use of expensive and sometimes ineffective technologies was blamed. Shannon Brownlee, senior vice-president at the Lown Institute, said billions of dollars are currently being wasted in the US alone.

And a report by the US Institute of Medicine released in 2015 stated that most people will experience at least one diagnostic error in their lifetime, and that efforts to improve diagnosis and reduce diagnostic errors have been quite limited.

SMOs in travel

Assistance companies say SMOs, then, might act as a vital break on an inaccurate diagnosis. Specialists able to look through medical notes, scans, prior surgeries, and any other critical information leading to future care plan or a diagnosis can help change the patient’s prognosis or quality of service provided. Additionally, they can reduce exploitation, when consumers have inadequate medical knowledge and are dependent on others to determine their needs. An SMO can empower patients because it gives them more information with which to make decisions, according to Brenda Durow, general manager of MSO in South Africa. MSO is the local service partner to Mediguide International, whose members have access to a remote SMO service from a team of top specialists. “A medical second opinion levels the playing field from the funder and consumer perspective to provide a rational and affordable option based on best practice,” she said.

Raija Itzchaki highlighted three main benefits of second medical opinions: “Confirmation of diagnosis (avoiding a misdiagnosis), having additional information available about possible alternative treatment options and possibly the most important is having peace of mind. If the patient has more than one person agree on a diagnosis and treatment plan, the patient will feel more secure and at ease knowing that the necessary steps have been taken to secure optimal care.”

But, crucially, SMOs have the potential to provide cost savings. “There is definitely a place for medical second opinions, especially in areas of high cost and where there is the potential for overtreatment or abuse,” said Durow. A second opinion might be sought for a patient before they receive treatment or go to the US for care, for example. Best Doctors is so certain that alternative diagnoses tend to result in significant cost savings, it can prove it. It regularly measures the number of cases where it has recommended a change in diagnosis and treatment, and verifies the cost implications. “About 60 per cent of the contracts with employers in the US will have return on investment commitments whereby, at the very
least, what they pay us will be equalled by the savings they make,” said Howard. The plan is to introduce cost containment measures in Europe, he said.

With savings likely, SMOs can sometimes be an effective cost containment tool, say assistance companies. “The value of a medical second opinion as a cost containment tool is usually only evident in a potentially high-cost case, and where the opinion provided is used to ensure best medical outcomes at an appropriate cost,” said MSO’s Durow. “It cannot be used in isolation and needs to be backed by the application of evidence-based protocols.”

Of course, assistance companies already employ medical audits — analysing bills after the event — as a form of cost containment. But SMOs can determine the necessity of care — before the bill is even produced.

Gigi Galen Grobstein, CEO of Star Healthcare Network, says SMOs are used by cost containment companies working with an international patient who feels they need a US physician within the specialty to review the medical records, scans, notes and either agree or disagree with the diagnosis or treatment plan. They are also used in international cases that are pre-planned and where the patient is looking for a US doctor to evaluate the case and confirm whether the treatment should be referred to the US for continuation of treatment or a different treatment plan.

Importantly, they are also vital for flagging potentially fraudulent claims, she said. “Star Healthcare had a case outside the US where we received a bill, saw red flags on the bill (over utilisation, over charges, several diagnoses that did not fit), sent to our second opinion company that agreed with our findings but also found out that the doctor was not even on staff,” she said. “Star informed the client not to pay the bill and considered the bill fraud.”

She adds that one case can inform other similar ones in future. “Second opinions, I believe, can help prepare the PPO and insurance company on the future costs due to the treatment plan which can be outlined for the insured,” she said.

Cai Glushak, chief medical officer at AXA Assistance USA, says SMOs can help avoid unnecessary costs by determining fitness to fly – to curtail care and repatriate a customer. “[These] are more useful for cost control to be able to challenge a live case or a bill,” he said. “When a treating doctor is prolonging the local care for self-serving reasons, patient/family pressure or just because they’re afraid of taking risk, the specialised expertise of an SMO doctor can help resolve.”

After all, it’s an expensive decision to take on whether or how a patient can go home, especially when many treating doctors do not have specialist knowledge on flight physiology. For instance, a patient with a brain injury may benefit from a specialist in flight physiology to determine whether this person can be moved, using normal air evacuation or a low-flying – but more expensive – dedicated plane.

Tanja Roug Wijnen, business development and network manager at assistance company Euro-Center in Cape Town, agrees that second opinions are vital, especially in places where there is corruption, a tendency to keep patients for longer, or to order more tests than is absolutely necessary. “In one medical tourism destination where Euro-Center operates, it has even employed a doctor whose job is solely to check medical opinions. That’s because, said the company, some medical facilities are increasingly inflating prices after a significant dip in tourist visits. It discovered that if a second opinion doctor is stationed in the country where these issues happen most frequently, and that doctor can regularly pick up the ways in which hospitals inflate bills, there is an improvement. “If you really monitor the same provider, they give up. They know it’s not worth the hassle,” she said. “The more you do it the less you have to do it.”

But, requesting a second opinion is not as simple as it sounds, and ensuring that cost containment doesn’t trump clinical decisions is vital. Best Doctors says it does not look for the cheapest options, despite its ROI commitments, but the best clinical decision.

And it is important to ensure the doctor conducting the SMO is appropriately trained. They should be independently chosen and checked for appropriate expertise, not doctors who have volunteered their own services as specialists. And, they shouldn’t be old college friends, either. “We see sometimes that the second opinions go to a physician that the international physician studied with in the US rather than the necessary physician for someone’s diagnosis,” said Grobstein of Star Healthcare. “That delays the process of the second opinion and sometimes proper diagnosis. That doctor isn’t necessarily the right doctor, although [they are] trusted by the doctor that the insurer uses.”

Izhaki of GMMI said: “In my opinion, it is important that the second opinion is done by a reliable vendor with an excellent reputation in the marketplace. When seeking opinions from hospital systems, I would also recommend utilising centres of excellent that match the specific specialty you
Euro-Center’s Roug Wijnen says second opinions are embedded into all of its systems. Doctors are on hand at its emergency and central hubs, for example, and double-check all medical reports that come through on complex cases where quick decisions must be made – especially relating to evacuations. Here, conference calls are done as a matter of course.

Importantly, however, it carries out extensive vetting of providers in each country that it serves, and rates them using a complex system of visits, on-site inspections, questionnaires, cross-referencing, and inspections. It maintains a database of all providers classified according to medical and operational quality criteria; doctors and hospitals are rated as ‘partners’, ‘preferred providers’, ‘neutral’, or are blacklisted. Those it rates as partners and preferred providers are consistently better at diagnosing and treating patients – and are less likely to have differing second opinions, it says. Hence, it trusts the doctors within these providers with higher ratings more and steers its customers to them, because then it is more reassured that the initial decisions made are the correct ones.

And research carried out recently in the Greek islands suggests that for patients with insurance policies that stipulate they visit preferred providers, the resulting claims are far less than patients with policies that do not stipulate exactly which preferred providers the customer may go to. “The best cost containment is steerage. Getting people to the right facility in the first place. And once you are there, things generally run quite smoothly,” said Roug Wijnen. “A lot of expatriates want to go to where the local king or president goes to, the expensive one and fancy, but it’s not necessarily the best quality one.”

Market responds to demand
Raija Itzchaki told the Cost Containment Review that GMMI has seen fluctuations in terms of demands for SMOs over the last 25 years, but recently has noted an increase in such requests from the Asia Pacific market. And, she said, the demand is going to grow. “I anticipate this to be especially true for the under-40 age group. Using SMO services is especially a growing trend with treatment in the US, where payers want to confirm that the treatment plan suggested has the best cost and outcome for the patient.”

Second medical opinions, then, form part of a bigger system of cost containment for most assistance companies. They certainly have an important role to play, though, and in many areas of the world can be a valuable money-saving tool.
Reid Cawston takes a look at the numerous US laws, regulations, rules and pending legislation and how they may impact international patients and payers

Let’s start with a brief overview of some of the most important health-related laws passed in the US (a bit of an alphabet soup of acronyms) with impact on our industry, in chronological order:

Medicare was signed into law by President Lyndon B. Johnson in 1965
Designed to provide government-funded health insurance coverage for US citizens over the age of 65 years old, it also covers individuals from all ages with certain disabilities and those suffering from ESRD (End Stage Renal Disease). The Medicare programme is a completely federally funded programme, strongly and tightly regulated and administered by the CMS (Centers for Medicare and Medicaid Services), a governmental agency. Although it is federally funded, the CMS relies on private insurers to administer some of its plans under Medicare Part C.

Medicare Part A is hospital insurance
Medicare Part B is medical service insurance (including doctors’ services and some supplies)

Medicare Part C is a combined A and B, plus supplementary insurance. These plans are provided by private health insurers, generally utilise HMO or PPO networks, and provide prescription drug coverage as an included benefit.

Medicare Part D uses the original Medicare Parts A & B and adds a prescription drug benefit to those plans; these plans may be offered by insurance companies and other companies as approved by CMS.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law by President William Jefferson (Bill) Clinton.
The law has three main components. It included a very strong privacy and security mandate, a system codification change that allowed all providers in the US to codify all of their procedures and services in a way that will be recognisable by all payers and regulators, and finally, standardised access and portability to healthcare benefits (for example, no pre-existing conditions exclusion when moving from one group coverage to another; or during open enrolment provides insureds with greater access to changing their insurance plans across the US system).
The privacy and security components of the law impacted the international health industry substantially, for example requiring waivers be signed by foreign patients before receiving services in the US. One interesting note related to HIPAA is that subsequent revisions to the Act have recognised all types of foreign healthcare coverage, including foreign national systems, as counting towards time in which individuals have been covered for purposes of portability in the US.

The Patient Protection and Affordable Care Act (PPACA), also known as the ACA (or ‘Obamacare’) was signed into law by President Barack H. Obama in 2010.
The law made several changes to the US health system, but two changes implied cultural shifts that shook this system and created controversy and disagreement in the way Americans think about their healthcare:
• The health insurance mandate – a legal obligation for all US citizens and permanent residents to have qualified health insurance coverage (Universal Coverage).
• A prohibition on medical underwriting by insurers (Universal Acceptance).
The ACA was intended to provide affordable access to health insurance. In attempts to ensure universal coverage was obtained, the ACA provided premium subsidies for people that cannot afford the total cost of healthcare insurance; conversely, with the mandate, the ACA also imposes fines on those that do not purchase qualified coverage
(in effect, forcing those that can contribute to do so). The issuance and administration of health insurance policies is provided by private health insurance companies; however, the cost (or the amount of profit) is controlled by government regulation, setting minimum loss ratios and restricting price increases.

The ACA is incredibly complex. It is governed and regulated by multiple government agencies (CMS, Internal Revenue Service, and the Department of Labor), administered by private healthcare insurers and applied to nearly every provider and consumer. This ‘system’ requires ongoing monitoring, periodic federal funding approvals, and constant tweaks to ensure it runs properly.

In our international cross-border health industry, the ACA initiated an era of confusion over the applicability of ACA rules for short-term/long-term and inbound/outbound health insurance. In 2014, four years after the signing of the ACA, the Expatriate Health Coverage Clarification Act (EHCCA) was signed into law by the Obama administration in hopes that it would help address many of the questions in our industry that the ACA created.

Amongst many points and rules for expat health insurers, this Act provided clarity and relief by stating that many of the most restrictive requirements of the ACA, such as minimum loss ratios and guaranteed issue, would not be required for expatriate health plans filed onshore in the US by qualified insurers. While the EHCCA regulations came into effect on 1 January 2017, with the fate of the ACA being hotly debated under a new presidential administration just a few weeks thereafter, not much attention has been paid to the EHCCA requirements. Most insurers are taking a ‘wait-and-see’ position before adapting to the new rules.

One significant aspect of the EHCCA requires that qualified expat plans sold in the US must be filed, approved and sold by a licensed US insurer. This may leave foreign insurers with non-compliant (offshore) plans at a disadvantage, and their group and individual clients exposed to fines.

‘Trumpcare’

It is not clear whether new laws repealing all or any of the ACA will be passed. For now, the US health industry – including employers, providers, insurers, brokers, and consumers – is following ‘the law of the land’. The lack of legislative certainty is a frustrating reality for all constituents, domestic and international. If repeal legislation is passed, the immediate consequences for the system will be disruptive. The knock-on effects for US carriers, TPAs, international underwriters and service providers are not clear.

So how will future legislative changes impact international patients and payers and the important role of control cost in the US on healthcare spending?

Substantial impacts to international market dynamics, regardless of whether the ACA stays, gets repealed or replaced, are not to be expected. When the ACA was first being implemented (even today some portions of the law will still need to be implemented) there was great concern from many in the international market that with the mandate for all US citizens and permanent residents – approximately 50 million more Americans – being able to access healthcare insurance, hospitals and clinics would struggle with capacity and they would have to start rejecting international patients; or that providers would be working at such full capacity that they would be less flexible in discussing cost management or negotiating rates.

I think that most in our industry would agree that not much has changed since the ACA was passed, at least in the areas of capacity, access, or cost containment mechanisms. However, I did say ‘not much’. If we instead compare to 10 years ago, the large US carriers/Health Maintenance Organisations (HMOs) and their networks have been busy on the international market. There has been consolidation of smaller US Preferred Provider Networks (PPOs) networks; many were acquired by the big four (Cigna, United, Blues and Aetna). With this, they have introduced strong networks to provide cost containment on international claims, in some cases for their own insureds, and in some cases on an administrative services only (ASO) basis. The big four have also expanded internationally outward from

**AN ACQUISITION OR MAJOR NEW CLIENT CAN BRING AN ENTIRELY DIFFERENT POOL OF CLAIMS EXPERIENCE INTO YOUR WORLD**

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the US, purchasing health insurers abroad in Brazil, Europe and Canada and joint ventures in China the Middle East.

On the out-of-network claims side, there have also been only minor alterations resulting from the changes in US health legislation. Some payers opt for a ‘wrap network’ solution to their out-of-network claims, essentially accepting lower discounts in exchange for network access requirements that are flexible enough to meet their administrative and financial needs. There are also the ‘guaranteed savings solutions’, whereby some companies are successfully able to control cost securely by negotiating directly with providers to obtain signed settlement agreements.

So, if not much has changed and not much is likely to change, what is the best approach to take to contain and control medical claims cost in the US?

Crunch data. The best approach is to analyse each individual segment of your business against the entire market of available solutions – and combinations of solutions – to optimise your cost containment performance for your unique client and patient mix. Analysing your claims data, understanding your insured’s travel trends, predicting your exposure, benchmarking against third party industry data, and finding expert cost containment partners for your business is the key to success.

It is important to continue to stay ahead of where your customers are going. An acquisition or major new client can bring an entirely different pool of claims experience into your world.

Travel will always be a dynamic industry; as tourist destinations develop or wane or expat communities change locations to follow new economies, your claims will tell the story. A new product or service can come to market in months instead of years, needing expats to relocate to greenfield operations at a moment’s notice. Often these operations are in locations not previously frequented by expats, but encouraged by local tax incentives, lifestyle, or cost-of-living inducements. Changes in claims patterns and experiences are happening faster today than in the past.

Complexity and the continuous change in claims experience

More and more, I see that the best solution is not one solution. In the past, it was very common for a payer company to have a single cost containment solution, and all the claims flowed through the same strategy. Today, I frequently recommend solutions that incorporate multiple cost containment strategies and the business is routed according to the plan type – Emergency Travel Accident (ETA), Business Travel Accident (BTA), International Private Medical Insurance (IPMI), Travel For Treatment (TFT) – or even a solution unique down to specific plans or groups.

These solutions may include any combination of HMO/carrier networks, PPO networks, regional PPOs, guaranteed savings solutions firms, and specialty networks.

The key to making this work in today’s industry is to continuously analyse the performance for each segment or client. If the claims experience changes, the cost containment solution needs to be adapted to suit. It is not enough to look at the results after the travel season or at the end of the fiscal year; major cost containment changes can be made as the ongoing claims analysis guides us.

Trumpcare: what does it mean to us?

The healthcare debate and very particular circumstances in the US political arena today are not (yet) slowing tourism or growth in the US. Travel across and to the US will continue. Be sure to choose partners that you trust, with the expertise to work with you to continuously monitor and improve upon your results.

Author

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We take your complex challenges in Turkey
and turn them into simple, high quality and low cost solutions!
Whether it’s through educational wellness plans that encourage expectant mothers to make the right decisions, or through smart policy language, international health insurance providers have the chance to limit their exposure to increasing maternity costs.

Since 1985, according to the World Health Organization (WHO), the international healthcare community has considered the ideal rate for caesarean sections (C-sections) to be between 10 and 15 per cent. Since then, C-sections have become increasingly common in both developed and developing countries. When medically necessary, the procedure can effectively prevent maternal and newborn mortality – in fact, two new HRP studies show that when C-section rates rise towards 10 per cent across a population, the number of maternal and newborn deaths decrease. When the rate goes above 10 per cent, there is no evidence that mortality rates improve. A 2015 WHO statement into caesarean rates also found that they ‘represent a significant expense for overloaded – and often weakened – health systems’.

**Where in the world?**

A report entitled *The Increasing Trend in Caesarean Section Rates: Global, Regional and National Estimates: 1990-2014* considered the variations between geographic regions. It found that Latin America and the Caribbean has the highest C-section rate with 40.5 per cent of births, followed by North America (32.3 per cent), Oceania (31.1 per cent), Europe (25 per cent), Asia (19.2 per cent) and Africa (7.3 per cent). Another study published in 2015 in the BJOG journal took in C-section rates in 26 European nations and found wide variations – 25 per cent of births in the UK are C-sections, while in Cyprus the figure is 52 per cent and in Sweden it is 17 per cent. When narrowed down to take into account C-sections planned before labour started, Cyprus still took the top spot with 38.8 per cent, followed by Italy with 25 per cent.

A report from Aetna International (Striking the right balance: Global caesarean delivery rates in an era of controversy) has highlighted how the lack of effective pre-natal guidance is impacting global caesarean rates. Data from Aetna International’s Beginning Right International Maternity Program revealed that in 2015, the rate of caesarean delivery amongst insured members in Dubai, for example, was 25-per-cent higher than the average of 19 per cent recommended by a recent *Journal of the American Medical Association* (JAMA) article. Factors such as...
Medical liability law and the medical malpractice environment, financial incentives and scheduling convenience have contributed to this global surge in caesarean deliveries, according to Aetna.

**Regional differences in caesarean rates highlight a medical imperative – to give expectant mothers consistent guidance on when surgical delivery is necessary**

“Regional differences in caesarean rates highlight a medical imperative – to give expectant mothers consistent guidance on when surgical delivery is necessary,” said Dr Lori Stetz, Aetna’s senior medical director. “For this reason, Aetna International’s Beginning Right International Maternity Program provides expectant mothers with information and counselling on caesarean sections to ensure that any decision is made for the right reasons.” Dr Stetz noted that the Middle East, India and China are seeing greatly increased rates of C-sections. The increased availability of the procedure is certainly one aspect of why this change is taking place. It’s vital that pregnant women are getting the information and advice they need, and from the right sources, Dr Stetz added: “Women need comprehensive prenatal and maternity support, and that can only be achieved when medical professionals listen to their needs, outline various birth options, and explain the risks and benefits so that the most suitable approach is identified. With this kind of respectful support, women can understand when recommendations are driven by medical necessity and when they are influenced by hospital, practitioner or other cultural factors.”

The hospital, for instance, could have a certain vested interest in encouraging its patients to have a C-section. For the physician and facility, a C-section means that a birth is controlled, timed and risk-managed, not to mention the benefits of the procedure being significantly more expensive. Cultural factors, though, also have a role to play. Dr Stetz noted that a colleague in China had told her that in their hospital, the C-section rate stands at around 50 per cent of all births. While this is partly due to a rising middle class income and higher levels of medical care and thus availability of the procedure, Dr Stetz also suggested that the former one-child policy could have a part to play. One of the downsides to having a C-section for a first baby is that it is recommended by physicians that a woman has the procedure again if she has a second or third child, as it can be more difficult for a woman to carry a baby safely to term and have a normal delivery if she has had a C-section. However, China’s past one-child policy means that now, culturally, there is an expectation that there will only be one child, so this aspect of a C-section would not act as a deterrent to women considering this procedure.

**First, do no harm**

Dr Stetz was keen to highlight that ensuring appropriate caesarean section rates around the world are achieved is vital, as it avoids unnecessary harm to mothers and babies and lessens the impact on the wider healthcare community – not just on cost, but also on social care needs afterwards. “As it stands,” she said, “caesarean births [in the US] cost the healthcare system two-thirds more than vaginal births, and the increased recovery time from the surgery has a greater impact on wider society – for example, in terms of social care.”

Denise Buckland, senior vice-president of operations at International Medical Group (IMG) and a former obstetrics nurse, told the Cost Containment Review: “The costs of a caesarean... >>
Vary worldwide and are relative to the cost of all medical care in a particular geographic location, but it remains that a C-section is more expensive than a vaginal delivery.

And the cost can be seriously high, no matter what kind of cost containment practices are employed, or what kind of agreement an insurer has with a hospital. A five-night pre-booked C-section package in Matilda Hospital in Hong Kong starts at HK$34,100, and can climb as high as $100,900. A straightforward vaginal delivery with an epidural costs $7,300. Little wonder, then, that health insurance providers are keen to offer women every opportunity to avoid an unnecessary C-section.

So what are they doing to this end?

“Countries and healthcare partners need to look at how to provide high-quality care in all settings and achieve the right proportion of intervention, resulting in healthy mothers and babies,” said Aetna’s Dr Stetz. “We believe the key to this is working at a local level with the needs of individuals in mind, encouraging the appropriate development of emerging healthcare systems, and fostering the safe and effective use of medical technology all over the world.”

Insurance measures in place

Addressing the development of healthcare systems in emerging economies and changing cultural perceptions are enormous tasks, though, and ones that will take many years to implement and come to fruition. So what can insurers do now to minimise the costs incurred by medically unnecessary C-sections?

To avoid the costs of paying for a planned C-section that in many cases is scheduled for convenience, insurance providers could implement a precertification process in which coverage for a caesarean is evaluated based on medical necessity,” said Denise Buckland. “Everybody considers the review of medical necessity as red tape, but it’s a key component in containing costs. This practice may not be popular, but it’s the only way to mitigate the cost of scheduled C-sections. IMG has this precertification in place under our long-term IPMI products that provide maternity benefits.”

Dr Stetz told the Cost Containment Review that while Aetna’s IPMI policies didn’t used to contain any exclusions relating to C-sections, they do now, as the general policy language used previously meant that there was some room for abuse by a medical professional or a client. Now, the medical necessity of a C-section has to be justified by the treating doctor. The company has a list of medical conditions that must be met for a pregnant woman to be approved for a C-section. If the insured doesn’t meet with the requirements, then the company will pay for the cost of a vaginal delivery, but should the client choose a C-section anyway, then they will meet the cost difference.

Buckland added: “Our long-term IPMI products that include maternity benefits offer prenatal advice that encourages a healthy lifestyle during pregnancy. We also offer case management for members who are experiencing a complicated pregnancy and need more assistance in managing their health. In theory, good prenatal advice could help decrease the rate of C-sections. For example, by providing prenatal advice regarding appropriate levels of weight gain and dietary habits during pregnancy, a woman can more appropriately control her blood sugar and eating habits, allowing the foetus to develop at a normal size and decreasing the need for a planned C-section.”

Small print, big impact

At the end of the day, insurance companies are not going to deny coverage for a medically necessary C-section for anyone. However, there is little doubt that the rate of medically unnecessary procedures is increasing, and the cost to insurers is high, hence the introduction of policy language that will minimise abuse of benefits and encourage women to get the right education about the choices they face during their pregnancy and birth. All surgical procedures come with some risk, but major abdominal surgery is not to be taken lightly. By engaging early on with their insureds, as well as their treating physicians, insurers can make sure that their clients are treated appropriately and according to their best interests while ensuring policy guidelines are adhered to.

References

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4743929/
The 2017 ITIJ’s Finalist Nomination for Best Cost Containment/Claims Management Company of the Year Award is the Icing on the Cake!
Is this the end of Preferred Provider Organisations (PPOs)? Jason Davis examines the opportunities that exist for international insurers in the brave new world of reference-based pricing

I was recently in a meeting with a room full of affiliated US hospital CFOs to discuss their cost containment model for their employee benefits. The CFO panel was reviewing the ‘savings’ outside their facilities that were being ‘re-priced’ in several ways by their cost containment solutions and the room rumbled with general comments like ‘hmmm’, ‘ok, not great’, ‘not terrible’. I will never forget the exchange that followed:

CFO: “How much are we paying for this anyway?”
Adviser: “We pay them 25 per cent of the savings.”
CFO: “Wait, I have a question, by savings … what do you mean? Are you saying the difference between charges and the payable amount, or is there another number considered, like average actual allowable or anything like that?”
Adviser: “It’s the difference between the billed charges and the payable amount; if they save you $100 off the billed charges, they keep $25.”

Crickets: chirp chirp

CFO: “Well, that isn’t good!” (and laughter filled the room).

Remember, these are hospitals, so they know that chargerater billed charges and anything tied to them are meaningless1, but for this meeting they were paying, and so their perspective was different. After the laughter passed, the rest of the meeting involved cancelling all PPOs, applying reference-based pricing (RBP) (more on that later) instead, and removing all per cent of savings contracts … and that’s how they ‘saved’.

There are three major trends that are illustrated in this story worth noting:

• The pressure on PPOs has never been higher.
• Employers (big and small) are implementing alternatives away from PPOs.
• Percentage of savings contracts are being challenged.

PPO pressure cooker

A documentary is coming out soon targeting provider charges and the PPO industry as a whole. The film is slated to be called The Great Heist. The following captures the essence of the project:

“There are a number of tricks the industry plays on healthcare purchasers but none is more pervasive, yet easy to fix, than PPO networks. This has caused Americans to spend 30 to 50 per cent (over $1 trillion per year) more than necessary, resulting in nest eggs getting crushed and putting millennials on the path to be indentured servants to the healthcare industry.”

This is not the first time we have had controversial comments about PPOs or provider charges (e.g. Time’s Bitter Pill!), and so why could this be any different?

The main difference now is how much out of pocket (OOP) costs have increased for the average American in the last few years with no end in sight. The national average deductible is roughly $1,500, but can be as high as $7,150 for individuals and $14,300.00 per family1. Can you imagine? Because of this, I am seeing a ground swell of articles on the healthcare re-pricing industry (also blog posts, tweets, yelp reviews, and so forth). Beyond the compounded negative sentiments about healthcare costs, a well-timed documentary on ‘where the money goes’, couched as an elaborate heist, could have profound and far-reaching effects.

Carve-in versus carve-out

Believe it or not, right now many American payers are looking to dump all PPOs from their models and use RBP for all services, but admittedly (to date) this has mostly been seen in the small group market. Some payers are keeping a physician-only network, and using RBP to curb crushing hospital costs. They manage the limited balance billing with pre-negotiations, patient advocacy, and legal resources, as needed. Over time, these payers look to ‘carve-in’ some direct relationships if they make sense (based on quality and value).

On the other end of the spectrum, large carriers have been using RBP for out-of-network claims for many years. Recently, large and jumbo employers (and their brokers) are talking to their PPO networks and saying they want to ‘carve-out’ certain providers because they don’t think they are getting a fair price (for example, dialysis providers2). However, PPOs are saying ‘if you buy the network, you need to use all of it, even providers you feel are overcharging’. This is not going over well anymore, and I am seeing some large networks with no choice but to give in to these requests – or risk the employers moving to RBP. Here is an excerpt from an email I recently received from a large TPA:

“We have been getting more and more RBP requests recently to the point where we can no longer say ‘we don’t like that approach’. We don’t, but we are also in business to be in business … if you follow.”

To summarise, PPOs are being abandoned altogether, narrowed, limited to physician only, or being picked apart per provider or claim type, and that’s a big deal.

So what?

We were told for years that international payers could not access major carrier PPOs like American payers, and then they did. Now we are being told that international payers will never walk away from PPOs and look at RBP. Really? I am already seeing many international payers discussing RBP and with the prospects of 20 to 40-per-cent deeper savings, lower fees, and minimal/ manageable balance billing. If they can, why wouldn’t they?

In with the new: the emergence of RBP

Few would disagree that the use of fixed-fee schedules, like RBP, instead of traditional cost containment methods like PPOs, is one of the most hotly debated and misunderstood topics in our industry. But, increasingly, payers everywhere (domestic and international) are looking at RBP as a solution to escalating claim costs and associated high fees for ‘savings’. I have been doing RBP for four years and work with over 500 US employer groups, and so allow me to provide a front row look at this controversial cost containment model.

Top tips for insurers seeking to take advantage of RBP:

1) Make sure your policy language gives you the ability to pay a negotiated rate or a reasonable and defined reference-based price (I recommend a percentage above the Medicare rate). Almost no one has good language – an ongoing tragedy that I have been harping on about for years.

2) Try to work with providers towards a reasonable settlement (before or during admission is best). If the terms are reasonable, accept the settlement and move on. The goal is not to be a bully; you just want a fair shake.

3) If facing an ‘unreasonable’ provider or one that basically tells you ‘buzz off’ … you need to pay your RBP rate. In a world where one party can just say flat-out ‘No’ to a reasonable settlement, and get paid more money, why would they ever say yes? Your negotiation is only as good as your end-game.

As for balance billing the member, you will experience it more rarely than you might expect. Most providers follow the trend of high billing (since ‘everyone else is doing it’) to maximise payments from payers, but rarely intend to squeeze hapless patients directly. If they do want to go down this route, there are ways to enforce the consumers’ rights and get the ‘balance’ (that no one ever actually pays) absolved. Worst case, you may find the provider more malleable for negotiation after you have paid out the benefits spelled out in the policy; and settlement is always recommended.

RBP results?

I had a client that had 46 per cent combined ‘savings’ from their PPOs. Dissatisfied with the results and hearing about the success story of RBP, the employer switched to paying all claims at 140 per cent of Medicare and the programme provided support for members to make sure they were not caught in the crossfire from a provider attempting to collect abusive charges. This past July marked their first year. The results? This employer saw 71-per-cent savings from paying 140 per cent of Medicare, totalling an additional $3.2 million in savings compared to traditional PPO solutions. Though the client was initially concerned about ‘noise’ from the consumers, pre-negotiations and patient advocacy services ensured that there was minimal disruption, which represented less than two per

THE PRESSURE ON PPOS HAS NEVER BEEN HIGHER

TO SUMMARISE

International Travel & Health Insurance Journal

COST CONTAINMENT REVIEW 2017

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Balance-billing boogey man
The most controversial part of RBP is undoubtedly the possibility of balance billing. If a provider receives a payment it does not want to accept as payment in full they have two options:
1) They appeal or sue the payer(s) for underpayment (which is virtually futile if the policy is well drafted), or
2) They balance bill the consumer.

I understand what I am about to say is difficult to believe, but once US providers have confirmed insurance benefits have been liquidated, they rarely balance bill consumers directly, and if they do, they offer significant discounts on the balance. Obamacare added IRC § 501(c)(3) applies to a facility, upon billing self-pay patients directly, the law requires providers to not `engage in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for … financial assistance’. The law explicitly prohibits the use of gross charges. Providers may only bill the qualified self-pay patient at the `best’ (meaning lowest) negotiated commercial rate, average of the three `best’ (lowest) negotiated commercial rates, or the applicable Medicare payable rate. Overall, providers have updated their uninsured and `under-insured’ collection policies. It is worth noting that most providers have a surplus of beds and so they do not like the idea of angry consumers telling their friends (in person or online) how they are being overbilled and mistreated, so, for purely business reasons, they either write off the balance or they greatly reduce it.

Bear in mind, what I have described so far is US payers paying RBP to US providers dealing with US consumers. Would RBP be different with international clients? Likely, yes.

International collections
International travellers typically cluster in the sunbelt or touristic areas in the US. Consequently, these hospitals have enjoyed some high-dollar reimbursements, which they do not want to lose, and so many specialty companies have sprouted all over the world to collect from international consumers. Though a US hospital (most are not-for-profit) may shy away from openly balance billing someone living in their backyard (out of a sense of community commitment or fear of public backlash), it can be argued that they could be more inclined to pursue a non-resident/citizen. I think this is generally true and so international buyers should keep this in mind as they consider RBP. All said, when faced with defined benefits, whether a domestic or international payer, a provider should be motivated to settle at a reasonable rate; and isn’t that the point of a balanced negotiation?

Is RBP a good idea for international payers? RBP is not for everyone, and I would never recommend it for expatriate plans, but RBP is a highly effective way of reducing US travel emergency claim costs, and if managed appropriately, it could be a differentiator. Keep in mind that many administrators will not be able to handle RBP plans because they may perceive it to disrupt their core business (non-RBP). In a price-sensitive market, with aggregators showing the lowest priced policies, perhaps a new RBP travel plan, with its 20 to 40-per-cent lower claim costs and lean administrative expenses, can be priced much lower than the competition. If the RBP travel plan actively works to settle claims, and provides consumer assistance as needed, there is no reason that this model cannot be the next big thing in US travel cost containment.
Scott Rosen gives his opinion on why there are so many misunderstandings and misconceptions around third party billing from hospitals in the Americas, addressing the problem of rogue billing agents and what insurers can do to identify them.

For years now, the international travel medical insurance sector has been comfortable slinging mud at the integrity of medical claims and third-party billing agents who operate ‘south of the border’. The ease with which this attitude is taken is based on two key misnomers:

a) Cost of care is expected to be dramatically cheaper in the Americas, excluding the US, and
b) Cultural bias that holds that the business culture in the region is ethically and morally incompatible with the US/Anglo-European business culture. Consequently, neither provider, nor third party originated claims, are to be trusted – so say some insurers.

Experience in-situ

After 17 years in the third-party billing business in Latin America, my sense is that the non-Latino payer community bases their negative views on a foundation that consists of the usual small per cent of billing fraud (which, unfortunately, does exist – we know the players), a very large dose of cultural bias, and minimal expertise with which one can detect patterns of irregular, abusive and/or fraudulent claims of unethical providers and fraudulent third-party billing entities. It is important to view the international medical claims market in two broad segments: tourist and expatriate. Overall, expatriate claims are typically incurred at large, best-in-class facilities where international patients comprise only a small percentage of total patient volume and revenue. These large facilities are typically accredited by local and international bodies, serve as academic institutions engaged in research and education, and are part of universities.

The facilities in this segment and affiliate physicians in the free market environment consequently attract international patients, who are generally well-insured and demanding in terms of quality and service, as evidenced by their certifications, such as ISO, Joint Commission or other local or regional accreditations. Tourist claims, on the other hand, are generated in markets that have a dependency on a patient mix comprised of internationals and locals. Facilities in tourist-heavy areas are generally smaller, they run at a lower utilisation rate, and are seasonal. International patients, particularly tourists, typically arrive at the hospital as the result of an urgent need or an emergency after a complex referral pattern that would begin with the hotel concierge contacting a physician or company in a process fraught with kickbacks that are almost certainly priced into the cost of care.

One of the very well-founded arguments that the facilities have for high pricing is that the scattered demand of seasonality and cost of equipping a facility generate inefficiencies in managing the operation, resulting in higher expenses to make its presence feasible. Without these hospitals, there would be no complex care available, which would lead to poor outcomes and, ultimately, higher financial and human cost. This market, then, represents many significant and legitimate challenges.
Rogue billers

Some useful tips to detect and avoid dealing with rogue billers:  
- Authenticity: if there is no official hospital invoice, in full and without the cover page of some rogue entity, question the bill and speak directly to the hospital and the physicians.  
- Screening tool: MDA and MDC have a screening protocol for payers and providers.  
- Travel insurance risk holders, such as AXA, Allianz, Acma, and GeoBlue, have exposure to this problem.  
- Purchasing debt – aka claims A/R – is NOT a crime, but ‘doctoring’ the bill is.  
- Agency law must be respected when it is clear that the billing entity is acting in a questionable, inappropriate, or fraudulent manner.  
- In some countries, medical bills are subject to VAT (IVA). Mexican bills are subject to IVA; however, only the business owner can issue an invoice with an IVA number.  

for payers to adjudicate, as there is, undoubtedly, price integrity and other issues to contend with.

Taking the third

One of the major issues is, in fact, third party billing agents. While the benefit of the doubt should be given to billing agencies, it is generally not – under the rationale that one bad apple spoils the bunch. In an attempt to lower the generally high fixed overhead costs associated with managing an international department – which requires meticulous verification of benefits/eligibility, risk management and rigorous follow-up, both during and after the treatment period – many providers elect to work with a billing agent on a variable cost basis. Payers, though, can insist upon dealing with facilities directly, under the impression that a third party inherently translates into higher cost as they will take a portion of the bill, which the insurer wanted as a discount for themselves. However, if the provider is billing with integrity, the cost of outsourcing to the billing firm would already be factored into the equation. It may be viewed that the imposition of rules by the payer community has created a self-perpetuating cycle of competing interests that ultimately results in higher charges: the provider overprices claims in expectation of insurers causing additional cost in terms of time and extracting discounts, very similar to what we see in the US, where there is now a total lack of pricing transparency and integrity. Billing agents, in a perfect world, are simply meant to do the work the hospitals elect not to do, while the cost of using this third party to the hospital is not the concern of the payer, and thus circumvention of the billing representative should simply be regarded as unacceptable. However, this has not been the case, with some reason.  

In our industry, we see the sporadic emergence (and disappearance) of rogue billing companies. These entities entice Latin American medical providers by promising higher reimbursement from international payers, which they achieve through submission of UB and 1500 forms, the claims standard in the US, applying the US coding system of ICD and CPT codes and US commercial UCR pricing as a benchmark for their charges. While this approach is controversial and this pricing methodology is clearly unacceptable from a payer standpoint, there is a very valid question of the appropriateness of charging international payers higher rates than local pricing. The debate now shifts towards whether or not the employment of this practice is the fault of the billing entity, or simply the wish of the hospital that is being carried out by a third party? If the latter, is it really the fault of the billing entity? If we view the international pricing issue from an ethical equivalency standpoint comparing Latin American medical provider behaviour to that in the US, we know that unless they are utilising the cost containment service of the large carriers in the US who achieve discounts that average around 50 per cent, the practice is generally the same in the US, where pricing for international insurers is higher than what is paid locally. We also know that hospitals and other providers do use billing agents, whose role is largely respected by payers as valid representatives for the providers. There are many examples of this in the industry that we are well aware of, specifically Global Recoveries, OVAG, Parallon and many others.  

The perception by which Latin American providers are now tainted concerning the integrity of billing agents is not congruent with the view of US billing practices. In the US, it is the exception, not the rule, to see many providers use third parties and complex software to ‘optimise’ reimbursement levels. Most providers in the US will not allow circumvention of the billing company. Most payers would, in fact, agree that the interpositioning of such entities is not inappropriate and does not have an effect on the amounts billed. Why is it not so in Latin America?

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<td>Ease in adjudication large claims</td>
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<td>Yes, but limited to a handful of known opportunistic providers and billing agents that target foreign patients</td>
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Pauline Vadood  
Manager of client services  
New Frontier Group

The Cost Containment Review caught up with Pauline Vadood, manager of client services for New Frontier Group, to talk tech, PPOs and today's market challenges.

How long have you worked in the cost containment industry, and how did you progress to your current position as client services manager?

I started my career with New Frontier Group in 2011; thus, I have been in the cost containment industry for six years. My initial position was claims co-ordinator and from there I quickly moved to arbitration. From there, I landed my position as lead Onyx™ case analyst and I stayed in this role for about three years, experiencing a lot of changes regarding claim adjudication efficiencies. Due to our rapid growth, I was afforded the role of supervisor of all the claims co-ordinators. Recently, it was my pleasure to accept the responsibility of manager of client services.

Can you tell us a bit about what your role entails on a day-to-day basis?

My days consist of managing my team to ensure we are performing at the high level we expect of ourselves and that our clients have grown to expect from us. This means at any given time I can be implementing new policies and procedures, holding training sessions, analysing a difficult case and offering advice to my team. Truthfully, no two days are ever the same.

You previously worked as case analyst for Onyx™, New Frontier Group’s proprietary technology platform. What are the advantages of such a platform, and do you foresee similar systems becoming the norm for cost containment and related companies going forward?

Onyx™ is unique to New Frontier Group. The system was created on the basis of many years of experience in the international insurance, assistance and cost containment sector and it is the source of where many decisions are made. A main advantage to Onyx™ is that it is totally customisable for our clients’ individual needs. I have not heard of any other cost containment company that can provide this high level of customer service. Also, our V2V arbitration strategies are to most cost containment companies something of the past, but at New Frontier Group we are thriving and continuously providing outstanding results for our clients. While the advantages are enormous, it may not always be practical for an existing company to develop such a complex platform that can maintain compatibility with their current systems. It takes a large commitment both from a resource and economic perspective.

How have cost containment companies’ approach to dealing with cost containment, and the wider industry around them, changed over the years?

The approach has changed to being proactive instead of reactive, meaning we are able to identify up front the best way to adjudicate a claim to secure the greatest savings. The clients of New Frontier Group have expectations of us to provide the best customer service and the best discounts possible and I am pleased to report that we do meet and exceed these expectations consistently. Concerning travel patients, it has become more difficult to cost contain, but we have many avenues in which we can choose to achieve an outcome that is attractive for our clients. New Frontier Group strives to always provide our clients with alternative solutions. As such, we are Urgent Care Clinic experts in that we assist our clients in accessing Urgent Care Clinics instead of sending the patient to an Emergency Room. This is an extraordinary way of limiting cost and at the same time avoiding out-of-pocket expenses.

Are PPO networks still a valuable part of a cost containment strategy in the US?

In order to compliment New Frontier Group’s exceptional V2V arbitration results, we have recently added a multiple carrier network solution. This allows easy provider access for...
both international travellers and expatriates. For any international client, the primary request is accessibility for their policyholders. To provide a logo on the card of the policyholder assures treatment and allows a good outcome for the client. This simply could not be achieved without the PPO networks.

What are the biggest challenges currently facing the global cost containment industry, from your perspective?
Increased economic globalisation means there are more and more travellers requiring medical care. As hospital systems become more sophisticated, many of them are modifying their billing practices, particularly for international patients, meaning they are less likely to honour an existing or accept a new agreement or contract. On a daily basis, New Frontier Group sees that more and more people are travelling and requiring insurance as they do. The competition is fierce on all assistance and insurance providers, which automatically affects the cost containment companies. The demands are high since the insurance industry needs to reduce its cost per claim to remain profitable.

The Cost Containment Review has heard about problems with overcharging by Mexican hospitals, which are using third party billing companies in the US, what is your experience of this?
New Frontier Group services policyholders in many different countries. Our experience in Mexico is that we receive generic bills without standard and required details. For example, without a tax ID, CPT codes, or rev. codes it is near impossible to reprice claims or negotiate to secure a discount. When a Mexican hospital accesses a US billing agency, it is extremely hard to obtain the required treatment details or medical information. In many cases, New Frontier Group has found it helpful to obtain the services of a local representative that can interact on our behalf and make certain that the expectations listed with a Verification of Benefits are actually met by the provider in question.

Congratulations to New Frontier Group on winning the 2016 ITIJ Award for Cost Containment Company of the Year. What did winning this title mean to you and the company?
The goal in our organisation is to achieve excellence every day. These standards were set many years ago when Ms Bach founded New Frontier Group. Our mission is always to provide exceptional customer service and create incomparable savings. The award is confirmation of the team’s hard work as acknowledged by our peers and clients, and we are honoured and pleased to provide the exceptional service that comes with such a prestigious award.

What do you enjoy most about your role — and what are its most challenging aspects?
I truly enjoy working with my staff, monitoring their development each day and watching how each individual contributes to the common goals and expectations of our clients. As we have been staffing 24/7/365 for a couple of years now, in any single week we may have up to a handful of new colleagues initiating training on Onyx™, the MEA Center or on the floor handling a myriad of phone calls with patients, their family members, providers and our clients. One of the more challenging aspects is to continually implement new methods and technology to better streamline the processing of claims. New Frontier Group has recently initiated a multiple carrier network solution. It has been an exciting process in understanding the expected protocols and integrating them into Onyx™ and our day-to-day processes.

If you could do any other job in the world, what would it be and why?
If I had to choose a different job, I would have liked to be a detective. While this field may be emotional and very difficult at times, the gratification to bring justice to those that have done wrong would be rewarding enough to outweigh the difficult times that I might have to endure. On a different scale, I do perform some of these services together with my colleagues at New Frontier Group. We participate actively in cases where the client needs information such as police reports or active motor vehicle accident reports. There is a certain satisfaction in knowing that you have provided your client with the details they needed in order to move the case forward.

What are you most proud of – both personally and professionally?
I am personally proud of having a special skill that allows me to adapt quickly to each new role that has been presented to me at New Frontier Group. I am proud to be a determined person that is always striving to better myself and those around me. I have moved rapidly during my tenure with New Frontier Group and I am fortunate to have been provided with the support and help from the executives that have recognised my talents. Thus, it is a true pleasure for me to now be in a position to offer my encouragement and expertise to my colleagues and the team, when needed. I am proud to be the manager of client services!
The decision to outsource has to be a carefully considered, and when it comes to cost containment software functionality, it’s especially important, as David Kernek reports.

The process of containing costs in the global travel and health insurance industry is constantly evolving, and with the advent of more advanced technology and data management software, companies are better equipped to ensure they pay the right costs at the right time. Outsourcing cost containment functions is also popular, and looking at a third-party’s technology offering in this respect is now a critical factor in determining cost containment partners. So, what is technology capable of when it comes to helping contain costs, and what are the advantages and challenges of using third-party systems?

Options aplenty

“There are many different systems available and generally they are designed to manage claims and have functions to assist with cost containment,” said Steve McClung, assistant vice-president of Global Excel Management, the Quebec-based cost containment, claims handling and medical assistance company. “They do normally offer integration options with most finance systems and networks. Some will include code editing and fraud detection, while others might include integration options to connect to these essential functions as separate services. The important thing to keep in mind is that these are systems or platforms; they provide a background upon which one must develop processes and strategies to manage costs, they do not manage costs on their own.” And he cautions: “Most of the systems are US focused, which tends to limit their ability to effectively manage the complexities of claims from countries that do not follow standard US billing and coding practices.”

Outsourcing cost control software

The difference between billing and coding practices in the US and those in the rest of the world is a point echoed by CEGA, where James Walker leads its international network for claims, global assistance and risk management. “Traditional cost containment systems are most prevalent in the US, where what are often referred to as SaaS [Software as a Service] systems are effective discount negotiating tools for those handling US medical expenses,” he told the Cost Containment Review. “They offer real transparency about how good a discount is, and provide an effective cost containment benchmark. SaaS tools can calculate specific reimbursement rates for US medical services, based on any given reference point, such as Medicare or workers’ compensation reimbursement rates. They enable those handling US medical bills to identify costs on any one bill easily, and to negotiate by creating a factual argument backed up by real data.” Elsewhere, he said, many cost containment systems are bespoke. “For example, here at CEGA we draw on years of historic data to formulate...
our own programmes. These internal tools can calculate factors such as average outpatient and inpatient costs, as well as average length of stay and associated costs. They promote understanding of typical costs in any one territory, providing a starting point for contract and individual bill negotiations and a real-time benchmark.” He highlights electronic case notification as another method of cost containment that is also becoming available, which can drive higher discounts by creating time efficiencies. “It allows medical providers with high volumes of cases to submit these cases via an online portal, without the need for manual entry,” he explained. “These populate the insurer’s operating system and often save the provider a great deal of administrative time and effort. And beyond traditional cost containment tools, Skype-a-doctor or chat-bot style medical applications can proactively reduce costs by providing remote medical consultations, producing savings from non-physical contact. Tools like these will ultimately shape the future of medical assistance and travel insurance products by providing immediate medical attention before onward assistance is given.”

Gitte Bach, founder, president and CEO of the independently owned US-based New Frontier Group (NFG), said that the demands of modern medical cost containment are such that managing claims, people and processes while maintaining the highest performance standards can be ‘daunting’.

“The days of ad-hoc case management, paper files, and brainstorming claim strategy on a white board are gone,” she told the Cost Containment Review. “Today’s market requires a reliable software solution that promotes efficiency, customisability and transparency.” NFG’s offer is Onyx, a claims adjudication workflow management system that Bach said embodies her company’s DNA. Efficiency, she said, is one of the major challenges facing cost containment companies. “Not only must claims be adjudicated quickly, but they must be accurately managed with special consideration for policy limitations, coverage verifications and policyholder concerns. This can be constantly assured only through the use of workflow management software.” She said that thanks to the complexities of international medical claims management, and the variety of different requirements for individual clients, no off-the-shelf software can provide the necessary support. Instead, she said, any cost containment software must be adaptable and flexible. “When reviewing new business opportunities, a key consideration is how the new business will fit in with the existing model. Many companies are limited by their processes, structure, labour force, technology, and software. In an effort to keep up with changing markets, companies can alter processes, re-structure tasks, hire additional labour, and upgrade hardware, but if the software managing these tasks is stuck in the past, it is near impossible to implement long-term change. The ability to constantly customise the nucleus of the organisation, in very little time, allows strategic decision-making to be accomplished with fewer constraints and increased efficiency.” In short, said Bach, as the world gets smaller and companies continue to evolve, so software evolution must keep pace.

>As more policyholders, medical providers,
claims, and data continually roll in with different expectations,” added Bach. “Workflow management software is fundamental to an organisation’s success. As our software is unique to NFG, it is constantly fine-tuned to create an efficient workflow. Each new challenge provides an opportunity to expand its capabilities and increase customisation. Utilising a single source to manage the entire adjudication workflow process – from initial policyholder notification to case resolution and to reporting and analytics – creates confidence internally and externally.”

Timely access to information is paramount in the travel and health insurance sector and ITIJ has often written in the past about assistance problems arising due to different time zones, working patterns and shift changes, when information can go astray or its delivery can be delayed. The right software solution, said Bach, can help to solve the information flow problem through providing transparency: “Operationally, we rely on Onyx to meet transparency needs of all staff at all times. Case notes allow all personnel to give updates and make time-sensitive decisions regardless of prior involvement with a case. Externally, Onyx Online offers secure access to relevant case information and real-time information reporting for all of our clients. The user defines their search criteria, which puts an end to artificial limitations created by standard or pre-determined reports. With access to real-time information, our clients get the ability to be more efficient in everyday tasks and deeper analysis.”

Systems need human support
Sylvain Charpilienne, medical network and cost containment director at APRIL International’s health business division in Lyon, France, believes that cost management isn’t just about cutting-edge IT. “We have more than 30 years of experience of designing and running international medical insurance and assistance services both for our own in-house companies and third parties around the world. We have a network of agents and affiliates globally, all supported by call centres and logistics handling, so it is both an extensive human and IT systems network. One thing we have learned is that soft people skills on the ground, such as the ability to negotiate a solution on a one-to-one basis, are often as important as effective IT systems.”

However, controlling your own data is, he believes, ‘vitaly important, as it can help to drive future product innovation and reviews of systems to identify cost saving opportunities’. Data gathered by insurance providers is incredibly valuable, so keeping a tight hold on it, and analysing it regularly, means it can provide a strong base for future decision making. Charpilienne said: “We believe the data that flows from our global assistance and administration platform is a vital asset, both for our own companies and for any who use our systems, so reporting is designed with management planning in mind. At APRIL, it’s important that we understand how operational claims money is spent, what new areas of expense are emerging and, in general, how the assistance and administration processes are changing over time. This allows us to look at the range of benefits we offer and to adjust these as the market demands. Reacting to market trends in this way helps insurers stay relevant and competitive too, as well as making insurance easier for our clients.”

At Global Excel Management, McClung sets out the arguments for and against using a third-party’s proprietary system, thereby outsourcing cost containment functions: “The disadvantage with outsourcing is that you lose some control over how your claims are managed. That said, unless you are willing and able to invest considerable capital and human resources in maintaining
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the networks and rules that govern how claims are routed through the system – assessed, re-priced and/or negotiated – you might be much better off using an expert to manage those claims. A cost containment system is merely a framework on which you actually build your cost containment strategy. Anyone can buy the framework, but leveraging the framework for maximum results requires building the strategy, and that takes expertise.”

Running an in-house system, he said, ‘allows a tremendous level of granularity on how claims are managed, and ensures that all aspects of the claims management are optimised according to the insurer’s expectations’. That only works, he cautions, ‘when you also have a team dedicated to contracting with networks and providers around the world’. Such a team would comprise a group of experts who know the different health systems inside and out; a special investigation unit that knows how to look for signs of possible fraud and how to investigate and resolve suspect claims; and a crew of skilled negotiators who have access to the appropriate benchmarks to determine the fair amount for services provided. McClung added: “Also needed is a high enough volume and concentration of claims to maintain the skills and grow the experience. The critical factor here is not the system, it is the expertise and volume of work with which to maintain and build on that expertise as the industry evolves.”

So, it seems for now, humans are safe from robots taking over the world of cost containment – no matter how sophisticated the system might be, the human touch is still vitally important. That said, technology is now an intrinsic part of the cost containment process and sophisticated IT systems are generating more efficient and effective workflows for this sector of the industry. Working hand in hand with data management software – whether in house or outsourced cost containment experts can achieve the best outcomes for the patients and still look after insurers’ bottom line.
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