

HOW IT WORKS: *Understanding the realities of medical tourism benefit introduction to Health Insurance Plans in the United States*

A Special Report by Maria K Todd, MHA PhD, CEO, Mercury Healthcare



Almost weekly, I receive questions from our international network providers about why it takes so long for U.S. health insurers to approve medical tourism coverage for medically necessary and routine care for patients.

On one hand, I have listened to a handful of speakers from the U.S., some that have neither the expertise or education to present this subject. Others, who are novice facilitators lacking any work experience or professional education in the insurance sector have announced to hospitals and providers abroad that they intend to "market" their provider network to insurance plans and employers in the U.S. I heard one that was neither qualified to present this subject, nor was he a facilitator, but was instead a public relations consultant who stated that he intended to bring his client list of represented providers to more than ten million insurers and employers in the U.S. ready to seek services abroad. To add insult to injury, the Associated Press syndicated the story without vetting the facts so that this impossible and confusing assertion was echoed around the world.

Strategic Implications for International Providers

While I am sure that some of these speakers and so-called experts were simply misinformed and uneducated with no nefarious intent, such claims and predictions can create problems for hospital administrators, doctors and dentists charged with the responsibility for strategic development of a medical tourism program. This is especially true if those responsible may not be as familiar with the myriad of U.S. healthcare reimbursement systems and benefit models offered through insurers and other plan designs and options available to self-funded health benefit trusts under the Employee Retirement Income Security Act of 1974 ("ERISA"). Without this knowledge, it would be unfair for me to judge those providers too harshly for their failure to apply critical thinking skills to evaluate those discussions and interviews before making costly errors in strategy and precious financial investment in further counsel from them.

To begin, one must first understand critical thinking, and what it entails. Critical thinking calls for a persistent effort to examine any belief or supposed form of knowledge in the light of the evidence that supports it and the further conclusions to which it tends. It also generally requires the thinker to gather and marshal pertinent(relevant) information, to recognize unstated assumptions and values, to comprehend and use language with accuracy, clarity, and discrimination, to interpret data, to appraise evidence and evaluate arguments, to recognize the existence (or non-existence) of logical relationships between propositions, to draw warranted conclusions and generalizations, to put to test the conclusions

and generalizations at which one arrives, to reconstruct one's patterns of beliefs on the basis of wider experience, and to render accurate judgments about specific things and qualities in everyday life.

Understand the benefit addition process

Next, one must understand benefit design in a number of settings: First, the insurance benefit setting, and second, the ERISA benefit setting. In the insured setting, in order for a benefit to be added to a health coverage plan, many things must happen.

Long before (possibly 2-3 years) the benefit is available for use by an insured plan member who has a policy that includes this benefit, the health plan must prepare to manage and administrate the new benefit through a step-by-step process. If the process is not followed, or doesn't meet the requirements to advance to the next step, the process stops until the requirement is met or the attempt to add the benefit is abandoned.

The first step in adding a medical tourism or global medical care benefit to a plan benefit design is to determine if there is a real need to add this benefit. In a country where insurance benefits are provided under a system of managed care, insurance companies and health plans work with designated providers who are contracted to be "in-network". These providers of care negotiate discounts and maximum allowable fees for the services rendered. While the billed charges may be high, the payer exerts market force and often drives down the actual amount paid to 45-55% of billed charges. Therefore, while a hip replacement may be billed at \$60,000 dollars, the actual revenue is somewhere between \$27,000 to \$33,000. When the provider adds in the cost to collect deductibles and copayments, which are often contractually stipulated to be billed only after the claim is adjudicated, the provider must invest in an entire revenue management department to manage billings and collections to the patient or responsible party long after the service is rendered, and perhaps also deal with payment variances and appeals for additional payment if the claim was paid at an amount that was less than the negotiated rate.

Once a determination is made to begin the investigation of adding this benefit, an investigative task force is assembled to have a high-level discussion about the addition. The task force may include brokers, marketing department representatives, claims managers, information systems representation, the medical director and utilization management and quality management managers, actuaries, underwriters, and provider relations managers. The task force is then charged with the responsibility to research and report back: the validation of the financial risk associated with adding the benefit, the benefits to the plan, the ability to manage and administrate the process, the plan licensure and accreditation requirements, which standards and metrics will be used to measure quality and provider competency, and finally to draft the benefit for presentation to decision-makers at the executive level of the plan. This process could take four to six months, minimum.

There are many difficult hurdles to overcome at this first step because in addition to validating the argument that the benefit should or should not be added, certain assumptions and predictive models must be developed. For years, managed care companies and insurers have long used some form of experience rating (claim dollars paid out/premium dollars paid in) to help price their products for large companies.

Every few years, the health care insurance community comes up with the latest and greatest "silver bullet" to address the rising cost of health care. Most of them have familiar acronyms: PPO (preferred provider organization), FSA (flexible spending account), HMO (health maintenance organization), POS (point of service), MSA (medical savings account), HRA (health reimbursement account), and most recently, HDHP (high deductible health plan) and HSA (health savings account)... and now, medical tourism and globally integrated healthcare.

The industry has also tried self-funding, wellness programs, disease- and case-management programs, health-risk assessments, provider profiling and more. All of these ideas and strategies helped ... for a while ... then typically were abandoned or placed in the background as costs once again started to escalate.

Cost Benefit Analysis

Statistics show that approximately 80 percent of health-care costs are being generated by less than 20 percent of the population. In addition, a high percentage of those costs tend to come from individuals with comorbidities (people with two or more disease states; i.e., a person with heart disease and diabetes). One of the primary hurdles for the task force is to accurately estimate how many people might actually be inclined to use such a benefit if it were offered and what the actual cost benefit would be to the plan to put in place all the necessary elements to offer and manage the benefit.

To understand this more completely, one must first understand what is at stake for the insurer and the cost of network development. Insurers seek accreditation under an accrediting body known as the National Committee for Quality Assurance, (NCQA). The NCQA seal is a widely recognized symbol of quality. Organizations incorporating the seal into advertising and marketing materials must first pass a rigorous, comprehensive review and must annually report on their performance. For consumers and employers, the seal is a reliable indicator that an organization is well-managed and delivers high quality care and service. The cost for a health plan to undergo an NCQA accreditation survey is many times the cost of a typical hospital accreditation survey and preparation and must be repeated every two years.

NCQA has helped to build consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what's important, how to measure it, and how to promote improvement. Their programs and services reflect a straightforward formula for improvement: Measure. Analyze. Improve. Repeat. NCQA makes this process possible in health care by developing quality standards and performance measures for a broad range of health care entities. These measures and standards are the tools that organizations and individuals can use to identify opportunities for improvement. The annual reporting of performance against such measures has become a focal point for the media, consumers, and health plans, which use these results to set their improvement agendas for the following year. In short, employers who purchase healthcare for their employees demand accreditation for the plans they offer to their employees. That accreditation comes with some very specific standards of network development, credentials verification and privileging of the medical and dental panel. To fail to meet those rigorous standards means to face the threat of loss of accreditation. Loss of accreditation by NCQA can result in employers dropping a plan mid-year and purchasing coverage from another insurer that meets that standard.

To prepare to manage a new benefit such as medical tourism, a provider panel of international hospitals, laboratories, physicians, allied health practitioners, dentists, and others must be developed in

accordance with the standards set forth to maintain health insurance plan accreditation. This includes professional credentials verification. Before a network can be empanelled, professional providers must submit lengthy applications, answers to very personal questions about their lifestyle, professional liability history, drug use, psychosocial profile, and more and agree that the information may be verified by primary source verification from educational institutions, clinical training programs, medical education institutions, and peer recommendations. This must be done initially prior to granting privileges and repeated every two years.

As for the hospital, the plan's provider network development team must review certain documentation of the hospital, and perform an annual site inspection. There is no NCQA requirement that the hospital be Joint Commission International (JCI) accredited.

These two requirements present a serious challenge to the task force. As a CEO of a global PPO that has chosen to implement and follow these NCQA network development standards, I am very familiar with the costs associated with the professional provider recruitment and credentials verification process. For physicians and dentists, the costs to recruit and process the credentials verification for one physician is in excess of \$100.00. The cost to engage a hospital into our network inclusive of the contracting process, the site inspection and the due diligence review can escalate to an investment of more than \$15,000.00 in time staff involvement and travel costs. For any other health plan, the cost is the same if they do it, a little less per hospital or physician/dentist because of the efficiency and economies of scale if they outsource this process to Mercury Healthcare, one of only a handful of entities both qualified and capitalized to do it for them.

One very distinct difference for health plans quality metrics that is not present in international hospital accreditation programs is the measurement of provider satisfaction and patient satisfaction. This is measured externally by a contracted outside vendor-performed survey of the plan's participants and participating providers. These two surveys also come with a hefty price tag on the domestic side, but can escalate dramatically if the survey takes on international translation, cultural sensitivities, and international communications costs to perform the survey.

Finally, it would be inadequate for the plan to offer providers in only one nation, or have only one option of a sole provider in a city or country so the network development that must be undertaken must be done according to a contracting strategy of global proportion.

All this would be very costly if the employers and the covered employees are primarily the 20 percent of that population that is responsible for the high cost utilization, and even more costly if those 20 percent were not of the ilk to utilize services from a hospital or healthcare professional in another country, or might be willing, but the medical appropriateness of their condition finds them an unfit candidate for such travel.

Concerns about Regulatory Compliance

Health insurance companies must be licensed in the state in which policies are sold. This means that while the major insurance companies, Blue Cross, CIGNA, AETNA, United HealthCare, and others may be recognizable brands, each must operate their company in accordance with certain insurance laws that differ from state to state. Each of the fifty states and the various territories in the U.S. requires that the plan be licensed and that

certain standards be met in order to protect the interests of the consumer that has purchased the policy.

Each year, each licensed insurance company files an annual audited financial report, market conduct statistics, and files an application to increase or decrease rate structures. They also file the results of audits and projections prepared by actuaries. Actuaries are experts in: evaluating the likelihood of future events, designing creative ways to reduce the likelihood of undesirable events, and decreasing the impact of undesirable events that do occur. In order to prepare for a rate increase or a benefit design change, often these filings must be prepared two years in advance. This allows the state regulators and actuaries to verify the risk projections, determine the provider network adequacy to manage the benefit, determine that the premium increase or decrease supports the risk projection, and if not, adjust the cash reserves and/or excess loss insurance to cover the projected cost of claims. If all is reconciled, the state will then authorize the inclusion of the benefit.

Other regulatory concerns for which the plan must deal with operationally, include compliance with patient privacy and personally identifiable health information (PHI) under HIPAA must be addressed and the providers required to uphold the privacy standards, fraud prevention requirements, billing standards, pricing transparency standards, and other regulatory concerns, regardless if they are located in or out of the United States. While there is a reasonable expectation that most U.S. providers are prepared for such compliance, the plan or its agent (such as Mercury Healthcare) must be prepared to train the provider to satisfy any deficiencies in education, training, process and procedure. While the cost of the training is the financial burden of the provider (similar to how it is in the U.S.,) there is still a matter of the delay and time involved to ensure compliance by both contract and in practice. In addition, the provider must also be willing and able to submit bills in the required format using proper standardized U.S. claim forms, procedure and diagnosis coding nomenclature, and other revenue cycle requirements in order for claims to flow smoothly through the system at the insurance plan in order to get claims paid.

Education of the Brokers and Employers about the Benefit

Once the provider network is empanelled, and the benefit authorized, the brokers who will sell the plan must be educated about medical tourism and the specifics about the benefit and its advantages to the purchaser whether it is an employer or an individual purchaser. Brokers sometimes work as consultants that educate their clients, and sometimes work as policy sellers either individually as an agent or as an employee of the insurance plan.

The brokers work on a sales cycle that is determined by the period of "open enrollment" for most employers. This open enrollment period often occurs from 01 October to 31 December each year. In some cases, that open enrollment period can also happen from 01 April to 30 June depending on how the company closes its financial books.

If an employer group is likely to evaluate a new benefit such as medical tourism and international healthcare access, the broker must receive the training about the new benefit and be able to answer questions about the providers, quality standards, and other plan participant and employer concerns prior to these dates. In addition, the insurance plan marketing collateral must be developed and printed and prepared for distribution by the brokers so that employees can review the options with their families, make the necessary elections, submit the paperwork to the human resources department and be issued a benefit booklet or "Evidence of Coverage" and a membership card.

Success or failure of medical tourism plan design implementation is dependent on many factors.

If the benefit design preparation, regulatory compliance and other arbitrary deadlines are missed, the process could take an additional year to bring to market. If this happens, the actuarial projections must be restated or adjusted in accordance with current economic realities, market trends, underwriting conditions and any new laws or requirements that impact rate setting and premium increases or supplemental costs for excess loss coverage and/or reinsurance for the plan.

Without a thorough understanding of the entire process described above, it is unlikely that a novice well-intentioned facilitator without the requisite education and experience could make good on a promise to steer insurance and employer business to a foreign hospital, or medical or dental professional, in the near term.

Strategic implications for foreign hospital administrators, doctors, dentists and investors.

Now that you have read this high-level explanation of the benefit development process, you must listen and apply those critical thinking skills to examine any assertion or promise of directed patient volume for the near term in large numbers from insurers and employers.

Mercury Healthcare has determined that it invest in the network development necessary to create a globally integrated health delivery system™ and has taken steps to apply for a trademark registration to differentiate this phrase with the United States Patent and Trademark Office (USPTO). The network will function as a Preferred Provider Organization (PPO) with providers located not just in foreign countries, but all over the globe. We encourage our prospective providers to ask questions, and to gather and marshal relevant information, to recognize overstated assumptions and values. We invite you to make your best effort to seek to comprehend the language used in seminars, news articles and press releases with accuracy, clarity, and discrimination. We challenge you to interpret and validate data, to appraise evidence and evaluate arguments, to recognize the existence (or non-existence) of logical relationships between business proposals, and to draw warranted conclusions, to put to test the conclusions at which you and your executive team arrives.

Mercury Healthcare welcomes you to join our provider networks in preparation of this rising interest and percolating benefit expansion by insurance companies and employers. We strongly believe that if we have the network fully vetted and the site inspection done, and if we have the pricing models available for the actuarial modeling, that we can assist the forward movement and preparation to ensure that the deadlines are met by those insurers and employers wishing to move ahead with globally integrated healthcare benefits.

Your cooperation in the network development process and required compliance training will go far to produce the mutually beneficial goals and objectives that we share as a team. I hope that this informative white paper will help you to understand why it is necessary to move forward with network development without a lengthy roster of contracted payers "ready" to send patients. They simply are not there ...yet. If we build it, and it is cost effective and efficient and of high quality ...they will come!

Today, maintaining one's health requires a creative approach to helping everyone make the most affordable, accessible healthful lifestyle choices available.

Mercury Healthcare enables those lifestyle choices by connecting providers located in the U.S. and abroad who welcome you with caring and compassion, and offer highly-trained clinicians and advanced technologies. This



combination of provide specialized programs, tools and resources are here to help you to take control of your personal health and wellness.

Mercury Healthcare is a Globally Integrated Health Delivery System™ including a Preferred Provider Organization (PPO) which offers seamless, globally integrated access to medical dental professionals, treatment and diagnostic facilities and wellness and medical spa providers located worldwide.



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