Speakers:

JH: Jen Haas, Corporate Marketing Manager at GeoBlue

MW: Malcolm Wright, Chief Commercial Officer at GeoBlue.

SP: Shirley Puccino, Senior VP of Global Health Care Management at GeoBlue

GC: Greg Cain, Director of Global Networks at GeoBlue

DP: Dave Richter, Area Senior Vice President of Gallagher's Global Risk Solutions COE

Opening Remarks:

JH: "I'm pleased to introduce Malcolm Wright, our Chief Commercial Officer, who will provide a few opening remarks to kick us off today. Malcolm leads our group and individual sales, sales operations and account management functions. With over 25 years of experience in the international health insurance industry, Malcolm has helped sales leadership roles at Bupa Global, Aetna International and Cigna Global. Hailing from the UK, Malcolm has lived and worked as an expat in Europe, the Middle East and the U.S. And with that, Malcolm, I turn it over to you."

MW: "Great. Thank you, Jen. Happy to be with you today. So as an expat for two thirds of my life, the importance of a quality network is paramount, which I experienced first-hand on two separate occasions as both of my children were born in Dubai, United Arab Emirates. At the City Hospital, a preeminent provider and as some of you may know, the first multidiscipline state of the art health care facility in Dubai Healthcare City. For the purposes of our discussion today and taking into consideration the significant amount of expat insurance is placed on behalf of U.S. based companies, it's only natural and not surprising that we tend to use a U.S. lens to evaluate a global network. That's why we're here today, to discuss why and how using a U.S. centric approach can be misleading and what really matters when evaluating global networks.

I'd like to introduce you to Shirley Puccino, who, as mentioned earlier, will be our moderator today. Shirley oversees GeoBlue's Global Health and Safety, Global Provider Relations and Cross-country Compliance Departments. Shirley leads the teams that help GeoBlue members access and manage their health care when abroad. Shirley has been in international arena for some time, having held leadership roles at One Hundred Years and at Cigna Global. Shirley, over to you."

Webinar:

SP: "Thank you, Malcolm. I like that you just said for some time and didn't quantify exactly how long that is I appreciate that. I'm pleased to be joined today by two other colleagues with a lot of experience interacting with the U.S. and global network, both personally and professionally. Greg Cain is GeoBlue's Director of Global Networks and has been with GeoBlue for almost four years. In this role, Greg is responsible for managing GeoBlue's international medical and dental provider network, as well as coordinating medical assistance and evacuation centers.

Greg has 30 years of experience. I wasn't so kind, Greg, in the employer sponsored health plan and emergency assistance space, where he served in a variety of roles including operations, account

management, sales and consulting. He also has direct on the ground experience managing crisis response situations in high-risk locations like Afghanistan and Pakistan.

I'm also pleased that Dave Richter is joining us today. Dave Richter is the Area Senior Vice President of Gallagher's Global Risk Solutions' COE. Dave has more than 25 years of experience in the international benefits field. Dave began his career working for the U.S-China Business Council, followed by Asia Emergency Assistance in Beijing, managing medical operations and evacuations and overseeing the set up and staffing of a medical clinic. For the 17 years prior to joining Gallagher, Dave ran his own company, Richter International Consulting, which some of you may be familiar with. He helped multinational companies and non-government organizations or NGOs with tailored duty of care programs that integrated medical and security assistance programs with their insurance.

So welcome to both of you and thank you for taking the time to further educate all of us on this very important topic. Everyone is familiar with the U.S. networks and the key drivers, volume, the number of contracted providers in the geographic location and the negotiated rates that these contracted providers agree to so that the health care costs are more manageable and affordable. But let's start our discussion by getting grounded in how health care is utilized in the rest of the world and how that differs from the U.S. and ultimately how that impacts network composition. Greg let's start with you."

GC: "Thanks, Shirley. Before I get started, I just want to say what a pleasure it is to be presenting with Dave Richter. I actually learned the art of assistance operations from Dave back in 1996. So, it's a real pleasure to be here with him today. And I'm going to be making some general statements kind of throughout the course of my talking points. And general statements, kind of like assumptions can be sometimes overly broad, and people can take exception with what's being said. And certainly, as I talk about networks in the U.S. and characterize them, I don't mean to demean how networks in the U.S. operate, but I think we want to be able to draw a contrast between them and the international network.

So, my first general statement is, networks in the U.S. have a very different connotation than outside the U.S. And really, networks in the U.S. are primarily about maximizing the value of the health care spend through competitive pricing arrangements. And those pricing arrangements can take many different formats. DRGs, discounts, some very complex types of algorithms. But just for the sake of simplicity, I'm going to refer to them broadly as discounts. And now I think we've all had the experience of receiving care in the U.S. setting like an emergency room, receiving the bill, seeing what the original bill charge was, the discount that the insurance company takes and ultimately what we're responsible for paying.

And like you, I marvel at just how expensive these bill charges can be. And the reality is that bill charges in the U.S. are somewhat mythical. I mean, the only unfortunate people that really have to worry about the bill charge are the uninsured or international travelers that perhaps aren't able to access any sort of cost containment program in the U.S. Outside the U.S., networks are about identifying the most appropriate care providers and creating relationships between the insurer and the provider to support the patients. Discounts are not the norm. Why is that?

Well first, there's the familiarity with the role of the private payer. And international providers tend to be familiar with their respective national health care programs as the primary payer of service. The bulk of patients will have local health care coverage. Even in countries where we tend to think of as being medical tourism destinations like Singapore and Bangkok, the vast majority of patients being seen are locals, even by those hospitals like Bumrungrad and Bangkok General Hospital that we kind of think of as being expat magnets. The vast majority of their patients are indeed locals. Of course, there are exceptions such as Dubai and London, but the world's a very large place and in most places, the international expat business traveler makes up a very small percentage of the patient volume.

Next is the competition for patients. It exists in some markets, but not in most. Part of it goes back to the single payer orientation the provider may have. But there's also the way certain providers know that they appeal to the expat community. And this could be based on their reputation or their ease of use. A lot of it is word of mouth. Places like Tokyo, Johannesburg or Rio de Janeiro, there's key providers there that know they will always be attracted to the expat population, irrespective of whether they're in your network or not and those providers know that. Finally, there's the cost sensitivity of the patients themselves.

Now in the U.S., insurers and employers have put a lot of energy into designing products to make the patient more aware and sensitive to the cost of care so the patient can make the best economic choices. This kind of network and plans steerage elements are a major component of that. While at the same time, patients tend to be less concerned about other factors such as accessibility, quality of care, treatment standards, experience, recovery, support, etcetera. These other factors are of primary importance to those persons seeking care abroad, not the cost of care. Shirley, we'll talk more about the importance of the patient experience as you guide us through the conversation further. But Dave, what's your take?"

DR: "Thanks, Greg. And I echo my pleasure of being on this panel with you. We've got a lot of experience together and a lot of respect for you. So, thank you. I think this is a great topic. And I think this is where a lot of U.S. brokers run the risk of doing a disservice to their clients we focus on. We're asking questions like, 'How many contracted providers do you have outside of the United States and what sort of discounts can you deliver to us?' That's really using a U.S. lens. And the requirements of the network overseas are very different. Expats don't care about discounts. They want to receive the care that they and their families need with as little hassle as possible. So, referral to a quality provider that will accept their insurance or a guarantee from the insurer or the assistance company is what they're looking for.

And then they're looking for something that's going to be familiar. But oftentimes that's hard to deliver. So just a quick personal story. My wife and I moved to China in 1992 when our daughter was three months old. And as new parents, that was quite a flier we took, but no problem. She was healthy, everything was going great until she got sick the first time and we needed to get her to a doctor. It wasn't serious, but it was still high fever, and we were just concerned. So, we asked in the community, who did expats go to? And the response was the Sino-German Polyclinic. So, we grabbed our daughter, we hustled over there. The nurse was very excited. She ushered us into the doctor's office. And there he was, head down on his desk, fast asleep. And it wasn't exactly the experience that we were hoping for. He woke up, he did a great job treating our daughter. Everything worked out okay and we went on our way.

But on the taxi ride home, we were really shaken because what we went in for was very simple. If we really had an emergency, what would we have done? The clinic had very basic facilities. It just really jarred us. In 1992, that was really one of the only options for expats in Beijing. The alternative was to go to a Chinese hospital. And both my wife and I were fluent in Mandarin so that seemingly shouldn't have been a problem for us. But the Chinese hospitals have many, many other patients. As Greg said, most of the people using the facilities are locals. So, it was just a real concern for us. And I think I was lucky in that, shortly thereafter, I was hired by Asian Emergency Assistance to build a clinic in Beijing and provide an option for expats.

And [inaudible] saw that as an opportunity, a large expat population in Beijing that really wasn't being served. So, we ended up building a clinic that had an ambulance and emergency room, X-rays and Western physicians that really filled the void. And if you fast forward to today where Beijing has many other options, Beijing United, some of the Chinese hospitals have really stepped up, Beijing is not an issue anymore, Shanghai is not an issue.

But the issues are still the same scarcity of quality providers when you get outside of the major cities in China and India and elsewhere. And its companies are expanding into other countries like Vietnam. When you get outside of Hanoi and Ho Chi Minh City, you have the same problem trying to locate quality providers. I think the other thing to recognize is that you may fly into a city like Beijing but then when your travels take you further on, you fly to some place like Hangzhou, the factory you're visiting is 50 miles away, you're on the road, you get in a car accident. The hospital that you're taken to isn't going to be in anybody's network.

So, we had an example of a Japanese tour company that had a minivan full of tourists roll west of Kashgar, so they're between Kashgar and Pakistan. There are no network hospitals anywhere there. Seven of the tourists were really badly hurt and they were taken to the closest Chinese military hospital where they were treated. We were able to collect them, medevac them to Beijing and take one somewhere to Tokyo. But that was a situation where the insurance company had to enlist the help of an assistance company to actually pay the bills locally so that the patients didn't have to pay and then settle the bill in the background.

But I think it's just speaks to the risks out there are many. I think the networks where the largest number of expats congregate are very important, but I think the need to have flexibility in your network is also important. So, two key considerations are identifying network providers that provide quality care and really that just means the best available in that market. And then having direct settlement of the bill, whether it's direct to the provider or through an intermediary. So Shirley, I'm going to hand over to you there. Those are my comments."

SP: "Well, thank you, Greg and Dave, for your thoughts. A lot to digest here. And also, Dave, for your personal sharing of some of your personal stories, because I think that really makes it help to come alive for people. But at this point, what we'd like to do is ask the audience what their experience has been, utilizing care while traveling or living outside. So, you should see, hopefully, on your screen three options. For have you ever had to access health care outside the U.S.? And was it positive or negative experience? And then the ability to respond, select one of those answers and we'll just give you a moment to do that and then we'll tally and share those answers. Everybody on the line should be able to see those responses as soon as they're tallied. (silence)

Just give it a moment here. Okay. The poll has ended, and they are being tallied, I believe. So, can we've one second, please? Okay. So, this is very interesting. So, it appears that the vast majority have not had access to care outside the U.S. and perhaps that's a good thing. And it looks like for those who had to do that, that they fortunately had some very positive results. So, it's a bit of a mixed response. A few people, unfortunately, didn't have a good experience. But we hope that really what we're trying to do here with today's discussion will help to enlighten and inform all of us as we evaluate the global networks so that in the future, should the situation occur, you will be well prepared for that and certainly also in advising your clients.

So, let's dig a little deeper into some of the common network levels. And honestly, we've already touched on a few of these with quality and access as Dave mentioned and certainly, the cost containment features as well. So, Greg, let's explore this a little bit further. How should these [inaudible] key factors into evaluating the effectiveness of a global network?"

GC: "Thank you. I'll start with quality. And you probably, like me, were horrified to see the California plastic surgeon show up to traffic court midway during a surgery on the news recently. And that wasn't quite as cute as the lawyer who showed up as a cat. I think people are horrified that somebody would do that during the course of a surgery. So, I was going to start off by saying we tend to take provider quality

in the U.S. for granted. But there's obviously exceptions such as that gentleman. And I'm sure the California Medical Board will be looking into that further.

But generally speaking, when you go to a doctor in the U.S., you have a fairly high degree of security that this person is fairly competent, properly licensed, insured, things of that nature. He's monitored, he or she. But in the rest of the world, finding a provider that you can trust to deliver good care and a good overall experience isn't always that easy. There are fairly strict licensing and liability insurance requirements here in the U.S. and in our territories designed to protect patients. And that may or may not be the case abroad.

Countries have different regulatory frameworks and professional standards. And insurers really have to decide if they will take an absolute or relative approach to a provider's quality and capability in their networks. Now particularly in areas where if they were to apply an absolute standard of quality and capability, there may actually be no providers there that meet that standard. So, the insurer could be left with essentially no one to direct patients to. If they take a relative approach to say or the best providers of those available in a given area, then they need to also to be able to communicate to their membership what those limitations are and when to seek care elsewhere.

So, important to the development of provider networks is incorporating local expertise. Providers may present themselves well physically and on paper, but it's important to understand their capabilities and their reputation on the ground perspective. And I'm happy to say that we at GeoBlue employ a number of approaches to get this perspective and the most important of which is our regional physician advisory role. We have approximately 170 well-respected contracted physicians around the globe who work with us as partners, and they're able to share their view of a provider's appropriateness to be in the network. That's very useful.

One of the most common RFP questions we get is with respect to the size of the contracted network that we have in a given city or country. And it certainly has a place in evaluating insurers, but it tends to obscure some related important topics. And those are things such as whether or not non contracted but qualified providers are included in any directory that the insurer puts out there. So, is the insurer limiting it to just those that they've got contracts with, or is it a more broad directory that also includes non-contracted but appropriately qualified providers? How the insurer supports direct billing with non-contracted providers. Workarounds that the insurer has, should the provider not accept a settlement from the insurer.

We think these concepts provide a more complete view of what the members experience will be. They're also relevant to longer term assignees who have established their own relationships with health care providers in a given location. But a quality experience is more than just the provider delivering good care. It's also about how easy it is for the patient to utilize the care that they're seeking. And with that in mind, let's consider access. When you go to a doctor or a hospital in the U.S. and you show your insurance ID card, the provider tends to recognize the insurer and the product. There's lots of great online benefits and eligibility capabilities to be able to confirm those details. And it's a fairly simple process. Outside the U.S., providers may be much more skeptical about the patient's private insurance and their ability to pay.

So, let's talk a little bit more about some of the concerns that insurers encounter when they're trying to contract with providers. First is the familiarity with the brand. The industry spends a lot of time and resources promoting our brands of providers. But the reality is even the largest insurer in a given market has a relatively small footprint. And that presents challenges with provider recruitment, particularly since we're not employing any sort of plan steerage elements to ensure that the flow of patients is large to any given provider. And the challenges don't end once the provider is in our network. So just like in the U.S.

doctor's office, we're highly reliant on the provider's front office staff in recognizing and recalling that they actually work with the insurer and how to go about supporting the direct settlement process.

Next is just the perceived credit risk by the provider. So, if you were to poll providers on their experience with insurers, I'm pretty certain that there would be a large component that would come back and tell us that they're their greatest experience is having balances left on pay by such insurers. And whether that's because the insurer was truly shady or if there was simply a misunderstanding by the provider over what they should be expecting as a payment. The reality is providers are taking considerable risk in allowing the patient to walk out the door with any sort of balance owed. Their ability to go back and balance the bill of that patient or the insurer after the fact is very limited. So as a consequence, providers are very concerned about the risk they're accepting when they take a promise of payment or a guarantee of payment from the insurer.

Finally, there's the complexity of our contracts and Americans have a well-deserved reputation for the complexity of our legal contracts and our benefit plan designs. Both tend to be a turnoff to providers and can make network recruitment and direct settlement a real challenge. And we've worked a lot to simplify our own agreement forms with providers. And we'll even work with the provider's own preferred agreement format if they have one. And we also recognize the desire of clients and brokers to mimic U.S. plan designs, because you want there to be equity between the domestic population and the international population. But the reality is those complex plan designs create a lot of problems for the providers. So we really encourage the use of simple plan designs and limited cost sharing features. Shirley, back to you."

SP: "Thanks, Greg. Just because you were just talking about the complexity of contracts, we did have a question that just came in that I'll just toss out to you quickly. Recognizing that, of course, it's very difficult to pursue, in a lot of foreign places from a legal perspective. But the question is, do most of the doctors have liability insurance?"

GC: "That's hard to say. I would say there are certainly locations where that is not the market norm. There is large swaths of the earth where a bad outcome is simply bad luck. And it's really unfortunate but there isn't necessarily any sort of indemnification or professional liability. Where it is the market norm, we do expect our contracted providers to have liability insurance and we do collect that information. So, it's hard to say kind of on a percentage basis. But in kind of high traffic destinations for business travelers in particular, for instance, we do tend to see providers having liability insurance."

SP: "Okay. Thank you. So moving on then, if the quality and the ease of access are really critical factors because of the supply of quality providers is potentially lower in certain global markets. What does that mean for providers and how they're actually going to be compensated? We know that in the U.S., carriers seek to contract with providers to manage their costs, but how do global networks really deliver cost savings? Dave, would you like to respond to that?"

DR: "Sure, I'd love to. Thank you, Shirley. I think this is a really important question because so much of the U.S. network model is built on cost containment with considerable emphasis on the patient responsibility and accountable care model. Mostly as brokers, we get lost in trying to apply these concepts to a global model. It's just because what we're familiar with. But it really doesn't make sense because the same level of supply and demand just doesn't exist overseas. I think there are two components to this question, and one is provider supply and then the other is providers the patients become people seeking care for them.

And I think when you think about what it's like to be a foreigner in another country and you need to seek care, it's not something that you wanted to do. You didn't go on assignment hoping that you get a chance

to try out a foreign hospital. And so, I've been telling a lot of China stories, but I think that they illustrate this point well. If you walk into a Chinese hospital, it's likely that you will see in the waiting area, 10 to 15 people sitting in chairs with IVs in their arms, receiving IV medication. That's something that we would never see in the West. And it's just a norm in China. That's how they start people with care.

Very jarring, you might turn around and walk out the door again, but that might also be the only hospital in your area. And so that's really where you need to start care. In another experience, we were visiting a patient that we were responsible for who had been in a serious accident within the ICU unit of one of Beijing's better hospitals, this was in 1994. And when we went in to see the patient, I was with our medical director. They wouldn't let us into the ICU until we put on boots, gowns and masks, which for us was sort of validating that this was indeed a Center of Excellence hospital, that they really took hygiene seriously.

And while we were gowning up, the washer woman with the bucket that she'd been mopping all the floors with elsewhere in the hospital, throws open the door to the ICU and just wanders in. And so, I think it outlines or demonstrates that there are standards that we are used to in the West that are slowly being adopted overseas. And I imagine today in Beijing that would not happen, but it certainly happened then and that was eye-opening for all of us. We've set up a very, what I think is an innovative program for one of our clients in China who travels far beyond the normal Beijing and Shanghai.

They travel to additional 22 cities in China. And we've put in place a number of patient advocates that will help the patient navigate the Chinese system. If they aren't hospitalized, that advocate will bring them meals, make sure that they've got toilet paper in the toilet and things like that. And just help translate the experience for them, literally translate, but then also just help them with the cultural pieces that are uncomfortable for them. And we found that, that has really helped make the patient experience much better.

I'd like to balance out my China-heavy examples with an example from India. I traveled to India in 2005 on behalf of a client. And one of the things we were doing was evaluating hospitals. They were looking to build an office of potentially a large plant in India and wanted to understand what the medical facilities were in the cities that they were looking at. And I was taken into some of the brand-new Indian hospitals, private hospitals that were gorgeous. And then I was also taken into Delhi's largest public hospital and then walked me into the emergency room. It was a 120 bed, vast expanse that was really intimidating for an American. I mean, it really was sort of shocking.

But on the way out and sort of through the course of the next couple of days when we were in traffic and we were in these large traffic jams and I'd see an ambulance next to me with its lights flashing and siren blaring, sitting next to me for 30 minutes trying to move through the traffic. And so, I think one of the network concerns is you want to identify the best hospitals and in some of these private Indian hospitals, any American walking in there will feel very comfortable. They really receive you very graciously and everything would be a great experience.

But if you're on the wrong side of town and it's going to take you 45 minutes to an hour to get to that hospital, it's very likely that you might need to go someplace else. And so, I think that's where Greg was talking about the ability to pay. You'll have your network providers who you are contracted with, but it's likely that you may have patients show up somewhere else and need to get care and have to settle the bill directly, through an intermediary, through assistance company. So, I think those are very important considerations.

And now that we've spoken about that, I think it's also very important to sort of flip the switch a little bit and recognize that for U.S. outbound expats, they really get the majority of their dollar-spend care in the United States. Which means that the effectiveness of the U.S. network is very, very important. We have most of my clients assume that they're going to get between 60 and 70% of their care in the U.S. and they also will save up annual checkups, elective care, things like that for home leave. And then, if anyone gets really sick, if they've got cancer diagnosis or something else like that, they will come back to the States to receive their care.

When I was in Beijing in '94, I thought I was very athletic, turns out I wasn't. But anyway, I hurt my knee and I had two choices. Have the surgery in Beijing, sort of check out the Beijing Orthopedic Center or wait until '95 when I came home to Seattle and have the surgery here. So, I had the surgery here and again, fluent Mandarin and traveling to China for 40 years now. And it just was a decision that I made to come home to receive that care. So, I think you can't over-emphasize the importance of the U.S. network. And I think when you've got patients that are outside of the U.S. and they're receiving care, I think it's very important to have the plan design to be very simple.

I'd like to recommend pays 100%, zero deductible outside the U.S. That way, the providers are very clear about what they're supposed to collect and it's all clear. On the other hand, then when they come back into the U.S., I think it's perfectly appropriate to put some steerage into the plan and reward patients for going to network providers and have a lower pay percentage going into network providers. Thank you, Shirley."

SP: "Thanks, Steve. I think it's very interesting that you shared the story about your decision to return to the U.S., albeit several years ago. But I think it's quite a testimony to somebody who has the experience, the exposure and the relationships abroad that you have to still make that decision that, 'I think I'll just come home and get this done.' And sometimes it's for the immediate care and sometimes it's also for, I assume, the ongoing care that you anticipate you might have to have too [inaudible] continuity. So, we certainly do see that.

But I think really what it does come down to is using a U.S. lens to evaluate a U.S. network and then using a global lens to evaluate a global network. So, having said that, let's move on to another U.S. centric network concept. And that's negotiated contracts that results in preferred pricing for carriers. We know that in the U.S., the negotiated contracts can provide savings for carriers and for members. Sometimes their steerage, as you suggested, in high performance or narrow networks. Greg, let me ask you. Knowing that payment through private health insurance is not as common as it is in the U.S. because many countries offer a government health system, for example, is there a place for preferred pricing in a global network?"

GC: "Yeah, I think there is, Shirley. And I think it's just a matter of defining what you mean by preferred pricing. We've talked a bit about the lack of levels that we may have on the international level with respect to plans steerage and things of that nature, as well as some of the resistance that providers would have to network arrangements. And also, this example of receiving the U.S. emergency room bill and being shocked at the billed charge amount and being relieved that your responsibility is much less because the insurance company has negotiated for price.

That just doesn't exist outside the U.S. for the most part. When an international provider bills, they expect by and large to get paid on the basis of the charges that they're billing. And in the international context, I think preferred pricing really ought to be more about ensuring that the price list the provider is actually using bears some semblance and is in the consistent with the local market context. What are local

patients being charged? Is there a large premium being placed or a large margin on those price lists because the patient is an international patient?

So, we think that is very important. We want to avoid that premium pricing element simply because the patient is an expat or a business traveler and not locals. There's certainly a place for the concept of discount pricing meaning actual discounts where the dynamics exists. But these are exceptions rather than the rule. And we've discussed many of the challenges in provider contracting. Again, lack of familiarity with the insurer, relatively small footprints, lack of plan steerage, lack of competition for patients. Those along with the local market practices on pricing medical services can make obtaining discounts difficult.

To be very clear, though, meaningful discounts do exist in some markets. And these would be very sophisticated markets with lots of international patient volumes and lots of competition among providers. And I've mentioned Dubai and London as a couple of great examples. There are others, but it's a relatively short list. We also see the discount arrangements and preferred pricing where we've attached our populations to a local insurance product. And sometimes that's for compliance purposes. But a side benefit is the fact that our patients now are participating in that local market and appearing essentially as a local consumer of health care services. So, we're able to take advantage of the economies of scale that the local market can offer and the competitive domestic market amongst providers.

But if you're seeking discounts in our world for the sake of showing a discount. That can lead both the insurer and the provider to engaging in a paper exercise that actually doesn't reduce the true costs but does purport on paper to be a discount. And this could result in the insurer actually paying more for the services while it's appearing to be a discount than if they had just paid what the normal retail rate is of a given market. So, we want to avoid that type of gamesmanship.

And for us, our orientation is to first start with what is the provider actually proposing their price list is and is that appropriate for the local market? In many cases, it is due to how the market operates. Now, you can have exceptions too. You can have places that have a very high volume of tourists and a very small supply of providers in that immediate area. That can produce some very high-priced lists. But for the most part, providers, because international patients aren't a large part of their practice, they're not maintaining multiple different versions of a price list. They've got one. If that price list, in our view, is too high or if discounts are customary in that market, then we will propose and negotiate discounts or we just may decide not to have a contractual relationship with that provider. So that's kind of our approach to the idea of preferential pricing."

SP: "Thanks, Greg. And Dave and Greg, you've given a lot of terrific insights here today, but I suspect that our audience may also be wondering about the practical side of how do they take this new information and then really convert that into action. And Dave, I'm going to ask you, what are some of the key questions that a broker can use to more effectively and really accurately evaluate a global network?"

DR: "Thanks, Shirley. I think we've made a clear distinction here about the U.S. lens looking at steerage and contracted pricing in the U.S. And I think outside the U.S., the experience is really more defined by the member experience and the ability of the insurance to find the providers and get them to experience that's good quality care and as few hassles as possible. So, I think the questions that we should really be asking is about direct settlement rates. What percentage of your claims are you paying directly to providers, whether they're contracted or not. And that reduces the need for the employee to pay a claim. And that is, in fact, the high driver of member satisfaction. And I think for plan sponsors as well, if I'm the benefits manager of the company, I've got an expat saying, 'Hey, I got to pay this $37,000 bill in Shanghai Hospital,' that doesn't sit well on the desk of that person either.

And so direct settlements are very, very important. Are there certain circumstances when providers will offer direct settlement? Of course, there are places that are just a little bit too remote. And the first sort of patients they've seen, they're not going to let the guy walk out the door without collect the money because they know that Louisiana is a long way from Shanghai and they're not going to see that guy again. And so, that's where if the insurer can't do the direct settlement, then they should ideally have local consultants or facilitators that can help make that payment for them. That maybe the assistance company that the employer has.

And so, we talked about the composition of the network, ideally they are contracted providers so that it just makes it that much easier. But I think as I've talked about the Chinese military hospital west of Kashgar. it's again, it's not in anybody's network but the ability to pay into that or to somehow figure out how to settle the bills is going to be very important. So, I think understanding who the players are, the providers are in a market are very important. You might have contracted with some of those because they're the ones that are probably going to see the highest volume of patients, but also recognizing that direct settlement with others is going to be important.

And the other thing is talking with the insurer about how they gauge the quality of the providers and their network. Have they visited them? Are they familiar with who they are? And I think that when I was in Beijing and one of my first visits when I was in Beijing was to the city called Wuhan. And many people hadn't heard of Wuhan before coronavirus. But again, we had a client that had a factory near Wuhan. And so, it was very important that we identify providers in Wuhan that we could work with. Prior to that company showing up there, Wuhan hadn't been on our radar. So, I think building your network, understanding how the insurance company is, that's the network. I think is going to be very important.

And then pricing. I think one of the things that's also interesting is what the hospitals are charging for. If I go in for a broken ankle, I probably don't need an MRI of my brain. So, I think that helping the hospitals focus on what they should be focusing on and that, I think, is something that should be up for discussion when the bills come out. And then, I think it's interesting we talked about the idea of key markets and Greg has mentioned some. I think I've a number of NGO clients that are active in Africa. And if anything happens in sub-Saharan Africa, they're either headed to Nairobi for care or Johannesburg, depending upon which is closer.

And one of the interesting things that's happened during COVID is it's harder to travel to some of these places. And so, we had a case in Zambia recently where we wanted to transfer the person to Johannesburg, but the hospitals were full. And so, then it was a question of finding the best appropriate care, either in Zambia itself or possibly switching the person and moving them up to Nairobi, a little bit further but still would receive appropriate care. So, I think just understanding how some of those markets work. Obviously, Singapore captures a lot of patients in Southeast Asia, Hong Kong, a lot of Southern Chinese cases get transferred to Hong Kong, Bangkok, Dubai, Greg mentioned Rio de Janeiro.

So, I think these are important markets. And as a broker and you're working with a client, you should understand how the insurer's market network matches your client's footprint. And so, I think that's for me, that would be sort of like the final thing, is the value of the network where your people are."

SP: "Great, Dave. Thank you so much for your feedback and yours as well, Greg. At this point, we're going to open up for questions and maybe put you two on the hot seat a little bit. There's actually been a few that have come in through the chat, so while I'm waiting to see if there's any more that will come in through the Q&A section, I'm going to toss these grenades out there to you two, if you don't mind. The first one is an interesting one. Greg, I'll start with you on this one. I know as an international insurer, we're sometimes challenged even around the data that we have to do the evaluation of the quality as well as

the reasonableness of pricing, etcetera. So, I can appreciate that for some of our audience who are working more on the domestic space, they are even more challenged because of the lack of data. So, one of the questions is, doesn't that data scarcity pose a bias in the work that we're doing and how we're applying that information?"

GC: "That's a great question. Does it pose a bias? I mean, potentially it does. But there's only a limited amount of data that you could have depending on what the exposure is in a given country. We've got claims data. So, what we've actually seen charged over the course of several years, potentially. We've got the actual price lists from the providers, some of whom we've contracted with, others we've decided not to contract with. So, we do have different data elements that we can look at and come up with what is reasonable.

We can also look at the increase in costs over a period of time too. So, do the costs appear to be rising at a faster than the normal medical trend would suggest it should? And there may be other kind of competing issues like foreign exchange, general inflation in the country, things of that nature. So, there's definitely not as rich a data as you would have, for instance, looking at PPO options in Scottsdale, Arizona. Where the entire market is well defined, there's lots of data, everyone has kind of the same access to data and it's very scientific. It can be more of an art on our side."

SP: "Great, thank you. Another question, also an interesting one. It's an important issue, can we address this? I think maybe Dave, you can answer from a broker side and then Greg from also from the insurer side. But how are we handling COVID claims and the requirements for coverage for COVID to enter into countries? Dave, have you seen that as a broker and have you any thoughts about that?"

DR: "Yeah, it's interesting Shirley. There are a number of layers to this. So, I think one of the questions is, if one of my employees gets COVID, does the insurance cover him? So, if he's actually diagnosed with COVID, are you covered? And I would think, and I'll let Greg answer, but I think the answer is yes. Another question is, 'I need to go to a country for business. I need to get tested for COVID within 72 hours before I board my flight but I'm showing no symptoms whatsoever, is that covered by my insurance?' And my guess would be the answer would be no, because there's no medical requirement. It's just the country said you must be tested, or the airline said you must be tested.

On the other hand, if you are immunocompromised, you have a high fever and you're going on an international business trip and your doctor says you should get a COVID test, I think that would be something that would be covered under insurance. And the more complicated question is, you arrive in Shanghai or New Delhi or Johannesburg or wherever you're headed to. And they say, 'Okay, you have to be quarantined for two weeks and we're going to test you for COVID every other day.' But you have no symptoms. Again, I don't think that's a medical expense and I don't think medical insurance would cover that. That should be a business expense covered by the employer because they're the ones that sent you there. And if you develop symptoms while you're in quarantine and then need to seek medical care, that's where the insurance kicks in. How did I do?"

GC: "That's right, Dave. Spot on. And I think from our perspective, what we've seen mainly are the countries that require visas and have requirements around a letter certifying coverage are asking to confirm that, in fact, COVID is not excluded. So, we've seen that occur. We are familiar with Costa Rica requiring that there be benefits to cover up to two weeks of quarantine accommodations. And that is something that our policies at this point have not been modified to cover. We don't view that as a medical expense under our policy. So far, we have not seen other countries adopting that. It's possible some are beginning to, but I think for the most part, countries are very interested in encouraging business and leisure travel to resume and don't want to put up know further obstacles to that.

DR: “Greg, we've developed the certificate of coverage tool that we have developed for our clients and so we were able to send the COCs to them in order for them to get their visas. And so, we have added the language about coverage for COVID, if someone's diagnosed with COVID. And with Costa Rica in particular, we worked with our clients to say that you need to get a letter from your employer saying that they will cover those expenses as a normal business expense for the two-week quarantine. So, it's been very interesting to see the way that we have to be agile in responding to different countries requirements. And we often find out about them from a traveler. One of our clients will say, "Bill is going to Costa Rica and they threw us a curve ball. What do we do with this one?" So anyway, it's an interesting time and it's fun to be able to adapt and support.”

SP: “While we're on the cover topic, another question that came in and maybe, Greg, we could start with you on this one. But the question is in terms of accessibility, has the rise of telehealth during the COVID pandemic reached globally an increased number of demands for that benefit?”

Greg Cain: “Yeah, we've certainly seen the popularity of our global telemedicine services. And there was a very steep spike in registrations very early on. It's kind of diminished over time, probably as health care systems have become less stressed and have kind of seen a lowering of patient demand from COVID. Interestingly enough, a lot of these services were still not specifically COVID related as far as symptoms or diagnosis, but just the things that you would normally expect somebody to want to go see primary care providers for. So, it's still, I think, was driven though by the demand and supply issues created by COVID.

SP: “Great. Just being a little cognizant here of time, there's a couple of other questions here. I don't know that we'll get to all of them. I do want to remind everybody that if you have any questions after the event, you can email them to events@geoblue.com or you can contact your GeoBlue sales rep. But perhaps we can close with one other question, because there is an issue or an observation about trying to use the concepts of networks in the international arena at all. But Dave, the question I'll direct it to you. So, if an international network in the traditional sense isn't really that important, why does everyone talk about them and have one?”

DR: “That's a great question. And I think the simple answer, or the answer is you want to make sure that you have. When you have a member show up someplace and they need medical care, you want to make sure that you have thought about it in advance and prepared and have and can send them somewhere where they'll receive the best care available. And I think the last thing you want to do is to just have someone arrive in Shanghai, go into the Yellow Pages and find a provider or ask the taxi driver what a good hospital is. And so, I think it's incumbent upon the employer and the insurance company to have thought in advance about where your people are going to seek care when they go out. And I think it's the basic duty of care, responsibility on both sides to make sure that you've done your planning in advance. And that doesn't mean it's going to be discounts. It's just going to be getting the person to the best provider available locally.”

SP: “So just as a follow up to that, Greg, how do people find a provider and the things that Dave and you have talked about, the letters of continuity of care and things like that. How do people find those resources to find out what they need when traveling?”

GC: “Ideally, it's the insurer that is making those tools available. So, for us, we have both an app and a website that provides a great deal of information about destinations, but most importantly, has detailed information about the provider network there. And as I mentioned before, it includes providers that aren't contracted with GeoBlue, for instance. Because we want to make sure that the member is able to see the full range of providers that we think are qualified irrespective of any sort of contractual arrangement. Although we certainly try to highlight those that do have a contract with us

And we also are taking the approach of the relative quality approach. So, a traveler and Georgetown, Guyana, if they have a very simple need, we want to be able to direct them to the appropriate hospital there, even though that isn't the place that you want to have an invasive surgery at. So, we also have information about, at what point should you be considering care outside of that country. So, it's really the tools that should be at the fingertips of the expat and the traveler."

SP: "Great. Well, Greg and Dave, thank you. We have two minutes left. So, at this point, Malcolm, I'd like to turn it back over to you for any closing comments or thoughts you might have."

MW: "Yeah, great. Thank you. Thank you, all. Now, with that, I think we just really like to thank the panelists today. To Dave, Greg and Shirley, for moderating today. I believe the insight opened our eyes to an important difference and nuances of the global networks and how to evaluate them with the globally mobile in mind. I'd also like to thank all of you for joining us today. I know an hour of your time is an ask from us. But appreciate you joining us today. Please be sure to complete the survey that would appear on your screen immediately after this when we put an end to the webinar. Be on lookout for a guide to evaluating global networks that you receive by email at the address with which you registered for your webinar. Stay tuned for details about our next Pulse Live event coming soon. So, until then, stay healthy, stay well and we hope to see you again at our next event. Thank you."

SP: "Thank you."

DR: "Thank you".