BlueCross BlueShield Global

Lost in Translation

A Guide on How Evaluating a Global Network with a U.S. Mindset Can Lead to Misinterpretation

Introduction

As a broker in the international benefits industry, a key consideration for your clients is the global network that will support the needs of their expatriate populations. Based on research conducted among international group decision makers, 71% ranked high-quality providers being available globally as a top need when evaluating carriers for their expatriate programs.[1] This need was ranked higher than cost management and price.

Given the importance of the network to corporate decision makers, understanding a carrier's capabilities is essential to ensuring your client's needs are appropriately met. A significant amount of expatriate insurance is placed on behalf of U.S.-based companies, so it's natural and not surprising that these clients will approach their evaluation of the global network with a U.S. lens. However, this U.S.-centric approach can be misleading, putting a focus on criteria which are not relevant outside the U.S., while completely missing the most important aspect for both employers and their expatriates—quality of care and how easily they are able to obtain that care.

This guide is designed to:

- Outline the differences between healthcare networks in the U.S. compared to the rest of the world
- Provide guidance on how to better evaluate a carrier's international network

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Healthcare Models Around the World

HEALTHCARE MODEL INSIDE THE U.S.

Networks have been a backbone of private health insurance coverage in the U.S. for decades. Networks give members access to a broad range of hospitals, physicians and other providers along with financial incentives for members to obtain medical care within the plan's provider network. In addition, networks enable health plans to make care more affordable for consumers by negotiating better prices with physicians and hospitals in the network, as well as helping health plan carriers better manage and stabilizable costs. Network providers agree not to bill consumers for more than the amount agreed upon between the health plan and provider, protecting consumers from "balance billing" and extra costs.[2] Inside the U.S., provider networks are a key to delivering the right balance of quality, affordability and choice where insured members receiving in-network care encounter less cost-sharing, enabling a mostly cashless experience.

Medicare introduced pricing pressure into the U.S. healthcare system, particularly for hospitals, and since the 1980s, costs charged to patients have become increasingly irregular. Federal programs and powerful carriers pay lower rates by contracting in-network arrangements, while smaller payers pay more.

HEALTHCARE MODELS OUTSIDE THE U.S.

Outside the U.S., the concept of a provider network is very different largely because markets have not evolved the "list price and discount model" that is dominant in the U.S. In many countries, the government is the primary payer and there may be very limited experience with the role of private insurers or third-party payers. Networks don't play the same role in markets that have a national healthcare system. There is no concept of in-network versus out-of-network as most countries don't "steer" patients based on affordability. Healthcare services are far more likely to have a single price, grounded more in the actual cost, regardless of the payer.

INSIDE THE U.S.

Today we have a range of pricing for patients for the same healthcare services in the U.S. that is unique in its scale, making networks—and the negotiated contract they provide access to—all important to buyers and of greater fiscal significance than in other markets.[3]

OUTSIDE THE U.S.

Network models vary because there is no singular or common regulated healthcare model and payer system across the more than 190 countries that comprise the rest of the world.

Common Misconceptions in Comparing Networks

COMPARING U.S. NETWORKS TO INTERNATIONAL NETWORKS

There are fundamental differences between the U.S. healthcare system and the rest of the world, yet many of the questions asked during the pre-sales process focus on criteria that have little relevance to how care is accessed and paid for outside the U.S. Specifically, the two questions commonly asked that don't necessarily apply to global networks are:

- X How many contracted providers does the carrier have outside the U.S.?
- X What is the carrier's average provider discount outside the U.S.?

While these questions make sense in a U.S. domestic context, they miss some very important aspects of how care is delivered, priced, paid for and experienced internationally. As such, using these questions as a measure of a global network's effectiveness in supporting the needs of expatriates can be misleading. These questions also don't address the factors that are most important to expatriates when accessing healthcare outside the U.S.—obtaining quality care on a direct settlement basis.

HEALTHCARE FACTORS MOST IMPORTANT TO EXPATRIATES OUTSIDE THE U.S.

QUALITY CARE
& DIRECT SETTLEMENT

MISCONCEPTION #1

Formal contracts are a key component of network strength outside the U.S.

REALITY

In the U.S., healthcare networks are built around contracting with providers, so that health plans can better manage costs that may ultimately be passed on to the member. By seeking care with in-network providers, insured members enjoy access to quality providers, negotiated contracts and direct settlement (payment by health plans on members' behalf). This can result in cost savings and a generally cashless transaction at the point of service thanks to direct billing arrangements between the health plan and provider.

Outside the U.S., providers deliver care and get paid in a variety of ways. This makes a direct comparison using U.S.-centric criteria, such as the number of contracted providers, misleading.

The charts on the following page outline some fundamental differences between how care is provided and paid for in the U.S. compared to the rest of the world.

NETWORK MODEL COMPARISON CHART

Provider Acceptance of Insurance Carriers

	Inside the U.S.	Outside the U.S.
Provider familiarity with private or third-party payers (those financing care)	Very familiar with various private insurers as a primary means of paying for care.	Varies by market, but in many countries, the government is the primary payer, and there may be very limited experience with the role of private insurers.
Provider familiarity with U.S.-style health plans (e.g., patient cost-sharing features such as deductibles and co-pays)	Very familiar with the concept and ability to collect such cost-share at the point of service.	Varies by market, but concepts beyond deductibles are not widely known or used.
Credit risk concerns	Highly efficient processes for collecting any remaining patient balances after payer's payment.	Given the limited understanding and familiarity, providers may lack confidence in private international insurance carriers and view them as a credit risk. Once the patient walks out the door, there may never be another opportunity to collect balances.
Legal concerns	Contracts follow common formats using familiar language. It's worth the provider's time and effort to contract with carriers in exchange for patient volumes and predictable payments.	The carrier's contract may have unfamiliar clauses and carry perceived risks. Providers may be concerned about unintended consequences of contracts as well as legal enforceability. Without any certainty of increased patient volumes, a contract may not be viewed as worth the time, effort and legal exposure.

NETWORK MODEL COMPARISON CHART

Market Dynamics

	Inside the U.S.	Outside the U.S.
Provider supply	A fairly homogenous supply of medical providers across similar markets, due to licensing and regulation.	Similar to the U.S. within developed countries; highly variable in less developed countries.
Competitiveness amongst providers	Competitive marketplace with medical providers competing for patients and facilities incentivized to fill beds and utilize expensive technology.	Competitiveness exists in only a limited number of highly localized markets with a high concentration of private payers seeking care. In some countries, such as the UK and Canada, some demand comes from supplemental private insurance that is available to address coverage and service gaps in national systems. This tends to be limited to non-urgent, elective care.
Channeling demand	Large volume of patients covered by carriers, coupled with plan designs that steer patients to specific providers, leads to purchasing power. Pressure on large groups of patients incentivizes providers to raise prices for other groups to gain more revenue resulting in large rate disparities and a higher perceived value of networks.	Unless working with a local carrier/intermediary, small international patient populations in any given country is of minimal interest to providers. Most plan designs do not have in- and out-of-network benefits or penalize patients for using a non-network provider.
Pricing context	**Virtually no one except the uninsured pays billed charges.** **A highly evolved coding scheme is designed to facilitate hospital and provider billing. For example, UCR databases down to ZIP code and service/procedure enable carriers to have considerable insight on price.**	**In many markets the provider has a single price schedule, which may even be regulated by the government. The price is the price. Any medical coding is predominantly for epidemiological purposes.**

MISCONCEPTION #2

Networks outside the U.S. are drivers of cost savings and cost containment.

REALITY

The U.S. is unique in its reliance on networks to manage the wide price disparity for payers. At the same time, it's a key destination for healthcare. In other countries less dependent on payer pricing, access and quality are key determinants.

A common misconception, when evaluating global networks, is that cost-effectiveness, in terms of premium, is driven by a carrier's international provider network. While affordability is one component of an international network, the reality is that most U.S.-based corporate clients incur the majority of claim spend within the U.S. by either trailing dependents, inpats and/or expats who choose to come home for treatment. Therefore, the U.S. network offering is likely the bigger contributor to a plan's overall cost-effectiveness.

When evaluating networks, it's important for brokers and employers to consider both network models—the U.S. as well as the rest of the world—and to recognize that they can't be evaluated in the same way.

OVER **70%** of the healthcare spend for U.S.-sold international plans happens in the U.S.[4]

AND **40%** of all international healthcare policies originate from North America.[5]

Expats like to return home for medical treatment, so for Americans, that will often mean much higher medical costs back in the U.S. The U.S. coverage option in most global health plans is key.[6]

MISCONCEPTION #3

Discounts are meaningful outside the U.S.

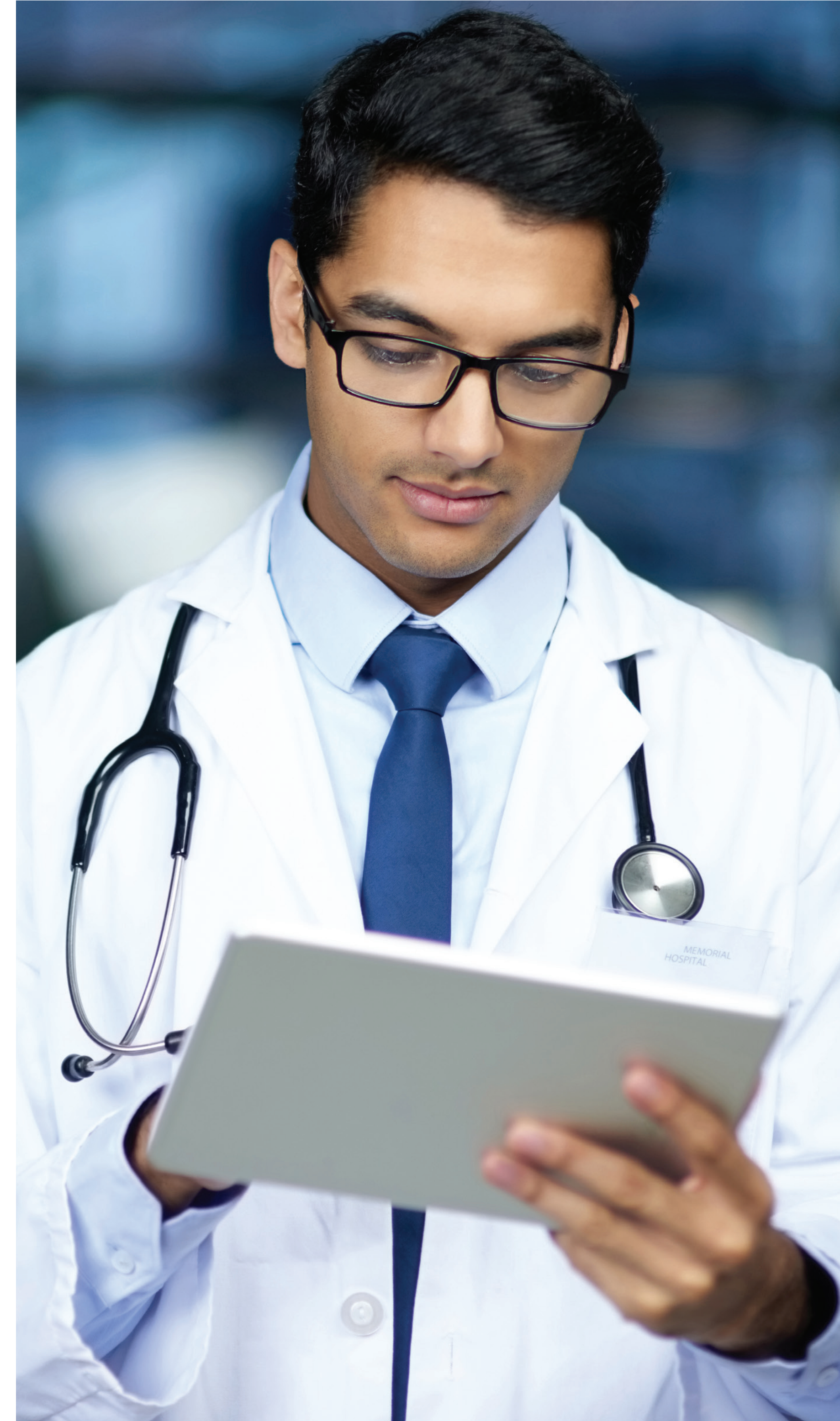
REALITY

The necessary ingredients for meaningful discounts are not readily available in most international markets. Does this mean discounts are impossible? No, discounts can still exist. But they are valued differently and may be the result of things such as:

1. Prompt pay discounts by the carrier
2. Large population of covered patients in a specific location
3. Expensive and sophisticated providers giving the impression of discounts
4. International populations combined with local ones on similar products or networks

When discussing and evaluating discounts with international carriers, it's important to consider the following:

What base price is being used to achieve the discount? It's important to note that the base price can vary based on whether the member pays cash or is a local or a foreigner.



DISCOUNTS OUTSIDE THE U.S.

Since there aren't sophisticated UCR databases for most markets, the starting point of negotiations related to a discount may have no resemblance to what one would have been charged in the absence of a discount. In other words, it's to both parties' benefit to start out high. This means the resulting fee level will be higher to the benefit of the provider and the resulting discount percentage will be higher, a perceived benefit to the carrier.

In some regions, only a few providers offer discounts, which can skew the perception of an "attractive" discount. Consider the following:

- If there are 100 contracted providers and only two have discounts, the average discount for that country is going to be the average of the two.
- A calculation of average discounts at a given provider may be based only on the limited number of services to which a discount has been negotiated.

It's possible that "discounted prices" from one provider are still considerably higher than the retail prices of another. As such the "discounted" services are more expensive than the non-discounted services.

LET'S LOOK AT AN EXAMPLE

An international carrier claims the average discount is 15% in a country or specific region. On the surface this might sound positive, but 15% compared to what? The UCR market price for the services or the provider's starting point of negotiations? It's possible to wind up with a net price higher than what is normally charged in the market, yet everyone's happy because it's "discounted."

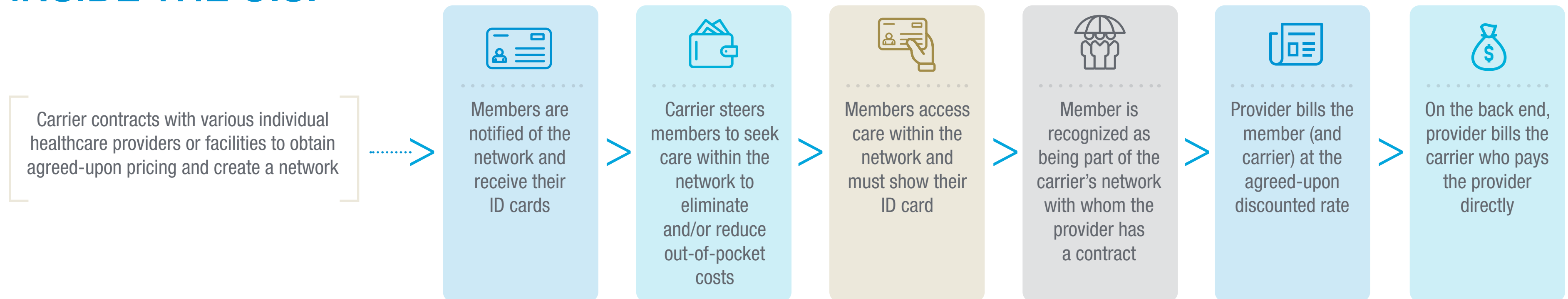
Usual, Customary and Reasonable (UCR)

UCR is the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount. You can think of it like "comps" or comparable sales in the real estate market.

THERE IS NO ONE GLOBAL NETWORK MODEL

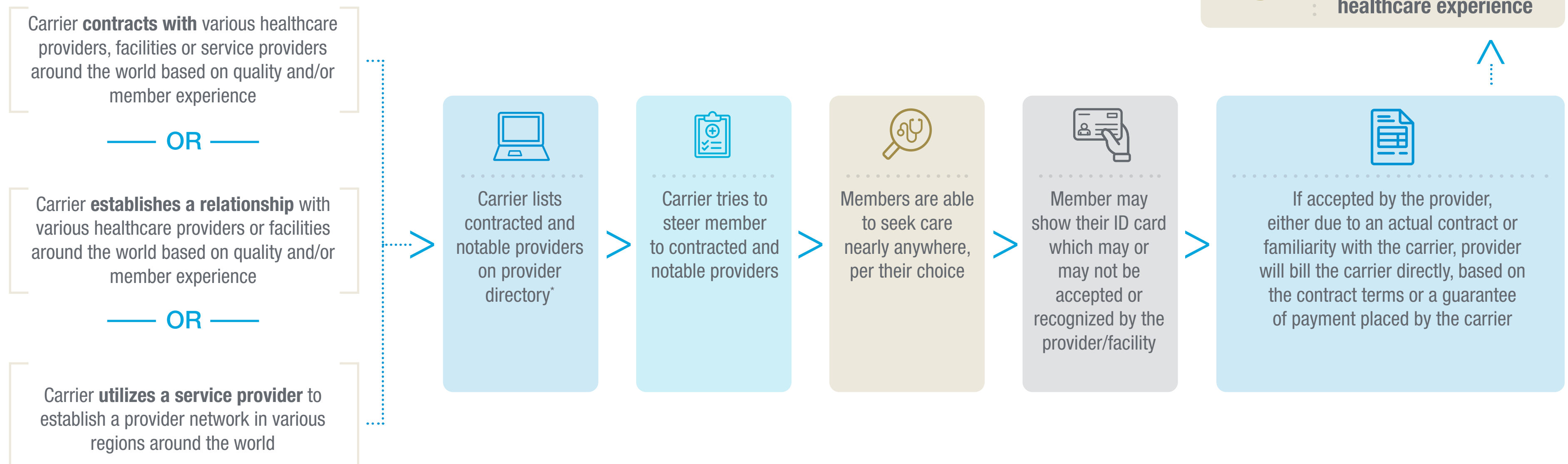
There are multiple ways carriers can provide a claimless experience for expatriates

HOW A NETWORK FUNCTIONS INSIDE THE U.S.



RESULT
Member has a claimless healthcare experience

HOW A NETWORK FUNCTIONS OUTSIDE THE U.S.



**Notable providers have been identified as a facility that is reputable and provides care that meets the local standards of care.*

How Does One Better Evaluate a Carrier's International Network?

KEY CONSIDERATIONS

As you weigh the criteria on which to evaluate a carrier's global network, it's critical to ensure that the questions asked are grounded in the understanding that there is no singular healthcare model outside the U.S. and that many of the U.S.-centric criteria don't apply outside the U.S. Ultimately, when outside the U.S., expatriates' and their employers' top concern is quality care and member service.

Of course, cost containment is always a factor, even if not the top one, but conventional understanding doesn't apply. Traditionally, in the expatriate insurance market, very little attention has been paid to the role that the U.S. market plays in driving costs. As noted on page 11, **over 70% of expatriate claims are incurred in the U.S. which is the most expensive healthcare market in the world.** Rather than asking about discounts outside the U.S., savvy consultants and employers will want to pay attention to the number of claims incurred in the U.S. and ensure they have a network that offers the greatest affordability domestically.

How does a broker or employer evaluate the value of a carrier's international network?

Much of the value lies in the QUALITY OF CARE and how easily members are able to obtain that care

The top consideration by group decision makers when selecting a global healthcare carrier

Accessibility to quality care for my organization's employees is what matters most when selecting a carrier.[7]

CONSIDER ASKING THE FOLLOWING QUESTIONS

Direct Settlement

Question	Why is this important?
What is the carrier's direct settlement rate in a country (inpatient and outpatient each reported separately), regardless of providers' network status?	If you ask no other question, this may be the most important one. The direct settlement rate gets to the heart of what the member's claim experience is likely to be. Members, particularly those from the U.S., have a high expectation of paying only their share at the point of service. This is a very large driver of member satisfaction. How many contracted providers a carrier has, or what the supposed average discount rates are, pale in importance to this answer.
Are there limits or conditions placed on a carrier's willingness to support direct settlement (e.g., only with contracted providers, only for inpatient services, etc.)?	Not all carriers take the same approach. The limitations a carrier places on supporting direct settlement may make their administrative burden easier, but it transfers the burden to the member who may have to pay and submit a claim for reimbursement. For example, some carriers require a minimum claim cost in order to directly settle.
What capabilities does the carrier have to support direct settlement (e.g., can they call upon local agents or a third party to assist)?	This is relevant for carriers who are willing to support direct settlement with non-contracted providers. No carrier has name-brand recognition in every corner of the world. A further complication is the poor experience some providers may have had with other international carriers, making them leery of the perceived credit risks in accepting a "promise to pay" from a third-party payer. Carriers may have local or regional intermediaries they can turn to for assistance with overcoming the provider's reservations and completing the direct settlement process. These will also be reflected in the carrier's overall direct settlement rates in various countries.

CONSIDER ASKING THE FOLLOWING QUESTIONS

Network Management and Accessibility

Question	Why is this important?
What is the network comprised of? Does it only include providers who are contracted with the carrier or does it also include qualified (non-contracted) providers?	This is important because members want choice and as broad a selection of qualified providers as possible, not just those with contractual relationships with the carrier.
What happens when members seek care with non-contracted providers?	It's important to understand if the insurer supports direct settlement with non-contracted providers and if there are any value (cost) thresholds before such support is provided.
How does the carrier confirm the contracted providers are charging reasonable prices? What happens if a provider has been identified as consistently overcharging?	Separate from the usual fixation with discounts, it is very important for the carrier to have means to determine if a provider's price list is in line with the local market.
How are providers vetted and qualified, both contracted and non-contracted?	The level of familiarity the carrier has with its contracted providers is important. How frequently are the capabilities and availability of the providers verified? If the carrier also lists information on non-contracted providers, the same concerns apply.
Is the provider directory easy for members to navigate on the web or mobile app?	This capability is important for expatriates who are often in unfamiliar locations and may not know the best providers and/or those they can even access as a non-resident of the particular country. A well-designed provider directory provides a simple experience for members when they need to obtain healthcare services.
U.S. CONSIDERATIONS	
What is the U.S. network offering?	**Given the impact of U.S. spend on most expat clients' experience, it's important not to overlook the U.S. network offering. This is where you can apply all of your U.S. domestic evaluation criteria.**

KNOW YOUR PRIORITIES

Common objectives that may be prioritized differently by employers include:

Striking the right balance requires prioritization and carrier selection that aligns with employers' business objectives. It's key to remember that the healthcare system and subsequent member journey is very different in the U.S. versus the rest of the world.

Why Choose Blue Cross Blue Shield Global

RECOGNIZED AROUND THE WORLD, TRUSTED AROUND TOWN

Leveraging the reach and reputations of the two largest names in healthcare

Healthcare providers recognize the Blue Cross Blue Shield name in the U.S. and Bupa overseas—brands known and trusted for quality and healthcare expertise. Blue Cross Blue Shield Global offers access to more than 1.7 million providers worldwide in over 190 countries. Inside the U.S., members have access to the Blue Cross Blue Shield PPO network, providing in-network access to 96% of all hospitals and 95% of all physicians. **Outside the U.S., our members access the Bupa Global network – one of the largest and most respected healthcare brands, offering a 74% global direct settlement rate.**

Bupa is an international health insurer and provider of care, with businesses and operations tailored to local market conditions, healthcare systems, in-market regulations and member needs. With strong domestic health insurance presence in the UK, Australia, Spain, Saudi Arabia, Chile, Hong Kong, Turkey, India and Brazil, Bupa also manages hospitals in Spain, Chile, Poland and the UK with additional medical clinics, aged care homes and dental centers located around the world. This benefits our globally mobile members with access to a highly recognizable brand and a network of quality facilities and healthcare professionals outside the U.S.

Bupa's presence around the world guarantees our members high direct settlement rates with providers and facilities ensuring a seamless and simple member experience, regardless of provider contract status. This combined with the Blue Cross Blue Shield network in the U.S. offers employers and members the optimal blend of access to quality care around the world and meaningful cost savings where it matters most—in the U.S.

PROVIDERS FEEL MORE **COMFORTABLE** WORKING WITH BRANDS THEY **TRUST,** WHICH ENSURES A MORE POSITIVE **MEMBER EXPERIENCE**

Blue Cross Blue Shield Global clients enjoy an extensive national PPO network—which reduces disruption (for trailing dependents and those who prefer to return home for care)—and benefit from competitive prices, delivering sustainable savings where the majority of the claim spend happens.

Bupa is an international health insurer and provider of care, whose footprint has evolved over the past 70 years. Health insurance is the core of Bupa's business. They own provision of care businesses which complements their health insurance offering and enhances the member experience.

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6 Coverage for medical treatment in the USA is important for many expats.

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We hope you find this resource useful and we welcome the opportunity to discuss your clients' unique healthcare challenges, needs and opportunities. Visit about.geo-blue.com to learn more about our products and services and to find your local sales representative.

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