Lost in Translation: How Evaluating a Global Network With a U.S. Mindset Can Lead to Misinterpretation

by **Greg Cain** | *GeoBlue*

Taking a U.S.-centric approach to global health care is like taking a Ford Taurus off-road driving. That's not a knock on the Taurus. It certainly had its heyday in the '90s with its few perks like great gas mileage, plenty of trunk space and a sleek exterior (just look at those headlights). But roll up to an off-road driving event and start bragging about its spacious interior, and you'll be laughed off the mountain. Because what makes sense for carpooling to soccer practice doesn't make sense for traversing boulders in the backcountry. It's easy to see why a Taurus can't be a trail boss, but why can't domestic health care philosophies work globally? This article will discuss ways to better compare domestic and global health networks and learn about the major differences between what matters in the U.S. and what matters overseas. Spoiler alert . . . it's not heated seats.

The Deal With Discounts

Inside the U.S.

Health care networks in the U.S. are built to maximize value. Everyone wants a deal. That's a natural consequence of the quality of medicine available here in the U.S. and how it's financed. When the quality of health care is generally comparable within a market, consumers start to analyze price tag more than prowess. Because of that, health care providers and insurance carriers work hard to develop partnerships on the basis of negotiated rates. These contracted rates add layers to a bill. We see the original charge, the negotiated rate through the insurance company's contract and the remainder we owe. That is a very U.S.-centric approach and a method specific to a country with a private health insurance

AT A GLANCE

- Failure to recognize the differences between U.S. and global health insurance networks can make it difficult for global employers to evaluate an insurance carrier's international network.
- In the United States, health care providers and insurance carriers work hard to develop partnerships on the basis of negotiated rates, but in many other countries, health care costs are paid by the government, so networks aren't built around cost containment.
- Factors that employers may want to consider when evaluating global networks include quality of care and direct settlement between the insurance carrier and the health care provider.

system. It encourages affordability for in-network care and offers the convenience of a mostly cashless experience for members.

Outside the U.S.

Global network models vary greatly by country since there is no singular regulated health care model and payer system throughout the 190+ countries around the world. Discounts, therefore, don't readily exist in most global health care markets. That's because most global networks aren't built around cost containment. In many countries, health care costs are paid by the government. This model can instill a sense of security in health care providers since they can be fairly confident in their national government's ability to pay for medical costs. Many of these health care providers may have little to no experience working with private-paying insurance companies. Because of this, they may have concerns over whether the foreign insurance company will cover the costs in a timely manner. When it comes to global networks, the goal is to develop strong relationships between insurers and high-quality health care providers in order to support patient needs. There's no concept of *in network* and *out of network*, and most countries don't steer patients in a direction based on financial considerations (Tables I and II).

TABLE I

Network Model Comparison

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 copays)	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, provider 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 terms and carry perceived risks. Providers may be concerned about unintended consequences of contracts as well as in legal enforceability. Without any certainty of increased patient volumes, a contract may not be viewed as worth the time, effort and legal exposure.

The Wrong Questions Can Lead to the Wrong Answers

When trying to compare global insurance carriers, many decision makers at U.S.-based companies end up asking the wrong questions—questions that stem from a domestic outlook. When that happens, it's easy to see how companies can end up springing for a Ford Taurus instead of a Jeep. So which questions should you avoid asking, and which ones can you not afford to miss?

Wrong Question: How Many Contracted Providers Does the Carrier Have Outside the U.S.?

We know that the concept of *contracted providers* doesn't carry the same weight overseas as it does in the U.S. This is because domestic insurance companies use in-network providers to establish more affordable care in the U.S., whereas overseas, health care providers are compensated numerous ways—primarily by the government—so establishing agreements with private payers is not a priority or literally may be a foreign concept. Because of this, the number of contracted providers is somewhat of a moot point. While one health insurance company may tout a large overseas network, another may not. The fact is, that question doesn't provide any real insight into the organization's ability to provide top-quality service and support overseas. So, what does?

Right Question: Is the Carrier Able to Help Members Identify Local Sources for Quality Care, No Matter the Providers' Contract Status?

Quality of care along with direct settlement are the two biggest concerns for expats,[1] a 180-degree difference from those seeking care in the U.S. While domestic patients reasonably assume they're going to receive competent care, expats may not be so confident. They want to know that the local facility uses modern technology, techniques and practices; employs highly skilled physicians; and can provide a wide range of specialized services. Because of this, global insurance carriers may refer members to a list of top-quality providers that are not contracted. That's because they understand where the value lies for their global members. These insurance companies should ascribe to a philosophy that steers their members toward the highest quality care and takes into consideration their desire for choice. Expats want to know that their network is not limited to contracted providers but includes as many high-quality treatment facilities or physicians as possible. That gives them the ability to choose the right provider, in the right location, without worrying about in-network and out-of-network benefit differentials.

Wrong Question: What Is the Carrier's Average Provider Discount Outside the U.S.?

As explained earlier, discounts aren't emphasized overseas the same way they are in the U.S. That doesn't mean global insurance carriers won't try to negotiate or establish discounts overseas. In fact, insurance carriers may even try to use these discounts to appeal to U.S. decision makers. However, discounts may be the result of various aspects that don't make much of an impact. For instance, 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 might be calculated as 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.
- The real value of a discount is the net cost of the service. It is a function of both the starting point of the negotiation and the percent value of the discount; however, the only statistic that may be quoted is the discount percentage. And the net cost at one discounted provider might still be higher than the retail cost of another provider without a discount. (You don't buy a house on the basis of a seller's purported discount percentage, but rather on the final sales price.)

These factors may make the discounts seem more appealing. But, in reality, they do not strengthen an insurance carrier's network position overseas or necessarily suggest whether the insurer is getting the best value for their health care spend.

Right Question: What Is the Insurance Carrier's Direct Settlement Rate?

When push comes to shove, global health insurance solutions are designed to serve the expat. This boils down to making it as easy as possible for policyholders to use the services when they need them the most. What separates carriers is their reputation with local health care providers and their ability to help members manage foreign health care systems. A quality carrier has solid relationships with treating facilities/physicians and has built a favorable reputation around the world.

TABLE II

Network Model Comparison

Market Dynamics

	Inside the U.S.	Outside the U.S.
Provider supply	A fairly homogeneous 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 U.K. 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 nonurgent, elective care.
Channeling demand	A 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 are of minimal interest to providers. Most plan designs do not have in- or out-of-network benefits or penalize patients for using a nonnetwork 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, usual, customary and reasonable (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.

These relationships and reputation foster a level of trust that simplifies a member's international health care experience.

Strong relationships and a good reputation can also allow for customer-centric services like direct settlement, which eliminates the need for members to handle any financial transactions at the time of care. This can be a major advantage for expats trying to navigate foreign cities, foreign languages and foreign currencies. They walk in, receive treatment and walk out, while the insurance carrier manages payment on the back end.

Conclusion

There are a number of ways that global health care networks differ from those in the U.S. For that reason, there are many more questions that one should ask when comparing global insurance providers. This article covers some of the most glaring differences in order to show how evaluating carriers with a U.S. mindset can be misleading. BQ

Endnote

1. Benenson Strategy Group research, April 2018.

AUTHOR

Greg Cain is director of global networks for GeoBlue. He leads the company's provider network department, which is responsible for managing GeoBlue's international medical and dental provider networks as well as coordinating medical assistance and evacuation vendors. Cain has 30 years of experience in the employer-sponsored health plan and emergency assistance space where he has 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. Cain's diversity of roles and experiences has provided him a cross-functional perspective on managing care for global travelers and expatriates. Prior to GeoBlue, he served as President of HX Global, Inc., the U.S. subsidiary of Healix International. He holds a bachelor's degree in business administration in management from the University of Texas at Austin.

International Society of Certified Employee Benefit Specialists

Reprinted from the Fourth Quarter 2021 issue of *BENEFITS QUARTERLY*, published by the International Society of Certified Employee Benefit Specialists. With the exception of official Society announcements, the opinions given in articles are those of the authors. The International Society of Certified Employee Benefit Specialists disclaims responsibility for views expressed and statements made in articles published. No further transmission or electronic distribution of this material is permitted without permission. Subscription information can be found at iscebs.org.

pdf/921