



Bending the curve:
Addressing rising costs in health care

White paper:
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aetna[®]

British dramatist Christopher Bullock is all but forgotten today. In fact, he is chiefly remembered for a single sentence he wrote in 1716: “Tis impossible to be sure of anything but death and taxes.”^{1,2}

Appropriated by many famous people over the years, that line has become proverbial. It’s not completely accurate, however, because one also can be almost as sure of medical cost inflation. Continuing a decades-long phenomenon, global health care costs are rapidly rising as populations age, chronic conditions become more prevalent and the demand for health care services outpaces the supply. Consumers, employers and brokers are bearing the brunt of this rise through increased health insurance premiums and out-of-pocket costs. Moreover, increased costs lead to difficulty accessing quality treatment worldwide and could even imperil national economies.^{3,4,5}

Identifying and addressing the causes of medical cost inflation is essential to securing the future success of health care for individuals, organisations and even entire countries. While it is impossible without major intervention to halt the worldwide rise in costs, Aetna International is taking important steps to bend the trend curve. By doing so, we are pursuing strategies we believe will change health care for the better, benefiting both our customers and health care providers, as we’ll discuss in this white paper.

Value-based Care

At Aetna International, we are transitioning from being a health insurance provider to being a health and wellness partner. We are using value-based approaches — centred around the individual — to address rising health care costs, clinical inefficiency and duplication of services to help ensure our customers can access quality care, whether preventative, chronic or acute, and attain the health outcomes they need.

Our strategies focus on helping to coordinate quality care and delivering technologies that connect individuals and health care providers to actionable information. These strategies help individuals receive the right care, at the right time, in the right place, through the right provider and at the right price to help ensure the right health outcome.

Cost containment 101

Every business faces a host of expenses, from materials costs to electricity bills. A smart business regularly reviews those expenses to ensure that they are necessary and appropriate. Through cost containment — the practice of managing expenses — any business can ensure that its costs remain within budget and within reason.

1 [https://en.wikisource.org/wiki/Bullock,_Christopher_\(DNB00\)](https://en.wikisource.org/wiki/Bullock,_Christopher_(DNB00))

2 [https://en.wikipedia.org/wiki/Death_and_taxes_\(idiom\)](https://en.wikipedia.org/wiki/Death_and_taxes_(idiom)) 15 October 2017

3 <https://www.ahrq.gov/research/findings/nhqrd/r/2014chartbooks/careafford/careafford-measures1.html>

4 <http://www.mmc.com/content/dam/mmc-web/Files/APRC/aprc-societal-agings-threat-to-healthcare-insurance.pdf>

5 <https://www.rand.org/blog/2013/01/health-care-costs-are-killing-us.html>

Value-based care still requires an innate understanding of the forces that actively contribute to medical inflation. However, we believe it is only through coordination of services centred around value-based care that cost containment measures can truly have an impact on medical inflation.

Measuring the increase

Just how fast costs are rising is a bit unclear, although no one would argue that they aren't. Business consultancy Willis Towers Watson estimated a 7.8 percent medical inflation rate for 2017, just above a 7.3 percent rate of 2016 and a 7.5 percent rate of 2015. Aon Hewitt Global Benefits pegged the global rate at 8.2 percent, well above a general IMF cited inflation rate of 2.8 percent. According to Mercer Marsh Benefits, the medical inflation rate was even worse: 9.9 percent, compared with a 3.1 percent increase in the underlying inflation rate.^{6,7,8}

Another way to look at the increase in health care costs is to consider the share of gross domestic product (GDP) that health care spending accounts for. (GDP is a measure of the total value of a country's goods and services over a given period of time.) According to the U.S. Centers for Medicare and Medicaid Services, health care expenditures in America ballooned from 5 percent of GDP in 1960 to 17.4 percent in 2013. Although the U.S. is an outlier given the structure of its health system, health spending among non-U.S. members of the Organisation for Economic Co-operation and Development (OECD) more than doubled during the same period, growing from 3.7 percent to 8.7 percent of GDP.^{9,10}

Why costs rise

So why does the cost of care continue to rise? To some extent, the reasons depend on where one lives. Willis Towers Watson's 2017 Global Medical Trends Survey Report, cited earlier, offers snapshots of countries and territories across the globe. Consider these examples:

- **Hong Kong:** "The high trend rate is mainly attributed to overprescribed medical services, including preventive and diagnostic tests covered by insurance."
- **Mexico:** "Lifestyle diseases and pathologies like diabetes, obesity and hypertension continue to increase utilization rates."
- **Canada:** "Of particular concern to medical plans are the rise in behavioural health claims and utilization of high-cost drugs coming to market."
- **Nigeria:** "The local recession has caused a significant escalation in medical costs because Nigeria, like many African countries, is a net importer of drugs and medical equipment."
- **Brazil:** "Increases in health care expenses continue due to a number of factors, including the economic downturn (GDP contraction) in the last two years, higher unemployment and, subsequently, lower participation in employer-provided health care plans. In addition, the number of claims has risen due to government expansion of minimum coverage requirements for new procedures and medicines, and the recent crisis of mosquito-borne illnesses (dengue, Zika and chikungunya)."

6 <https://www.willistowerswatson.com/en/insights/2017/05/2017-global-medical-trends-survey-report>

7 http://www.aon.com/attachments/human-capital-consulting/2017_GB_Trends_brochure_20170105.pdf

8 <https://www.mercer.com/our-thinking/health/mercerc-marsh-benefits-medical-trend-survey-2017.html>

9 <https://www.britannica.com/topic/gross-domestic-product>

10 <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf>

Setting aside factors of localised impact like Nigeria's recession and Brazil's pandemics, the two main influencers are:

- unit cost (the prices charged for those services) and
- utilisation (how often medical services are used).

One need not be a mathematician or an economist to predict what will happen when more people use more services and those services cost more than they did the previous year.

Understanding unit costs

Every consumer is familiar with the impact of rising prices; what cost one price last month will cost a little more today due to rising costs for labour and materials. The picture is more complicated with health care. Not only do health care costs vary wildly across the world, they vary from town to town and provider to provider. (This is where our local knowledge, coupled with our global perspective, is invaluable in helping us manage costs and steer an individual's care in the right direction.)

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- the underlying cost to provide services and
- the entrance into a market of higher-priced providers.

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The effect of unit cost increases in medical inflation tends to be higher in developing countries, where costs are relatively low, than in the developed world. Consider, for example, a hypothetical service that costs \$100 in Indonesia. If that \$100 cost increases to \$110, the inflation rate is 10 percent. However, if the

same service costs \$200 in Abu Dhabi, an increase to \$210 would only equate to a 5 percent increase. This is where our skill in medical and network cost management comes into play as we seek to balance the impact across our network.

Medical inflation is also affected by the expansion of large U.S.-based medical providers across the world. In 2015, for example, Cleveland Clinic, a U.S. health care provider, built a facility in Abu Dhabi. Many Americans in Abu Dhabi want access to trusted health care brands through their insurer networks, and that creates a challenge for insurers because Cleveland Clinic's charges are significantly higher compared to those seen across our global book of business.

The expansion of high-end health care brands is being seen in Singapore, China and other key health care markets around the world. Inevitably, such expansion can lead domestic providers to raise their rates, further adding to cost pressures.

Understanding utilisation

At Aetna International, we believe that health care systems need to change from being demand driven to being need driven with a focus on holistic care and wellness.

In support of that vision, we regularly review our broader portfolio. The latest analysis across our commercial U.S. business indicates an increase in utilisation of just under two percent across our medical benefits; this is consistent with analysis performed across our entire global portfolio, although being a more mature market, the medical inflation trend in the U.S. is lower than international developing markets. While some of the increase is for preventive care, which has a positive long-term impact (although one that is hard to quantify), much of it is not.¹¹

Here is an overview of some key factors that drive increases in utilisation.

¹¹ https://en.wikipedia.org/wiki/List_of_countries_by_total_health_expenditure_per_capita, 1 July 2017

Lessons from the U.S. health care system

The U.S. health care system is unique, both in its structure and in the amount of money it spends — more than double the OECD per-capita average. (In 2015, the U.S. spent \$9,451 per capita, while the UK spent \$4,003.) That said, the world can draw lessons from that system that apply more broadly.¹²

According to Dr Peter Attia, a physician renowned for focusing on longevity, nutrition and physical performance, the fundamental problem with the U.S. system is that it is demand driven, not budget driven. The more services doctors and hospitals deliver and the greater the demand from patients, the more the health care providers earn. Furthermore, they receive higher reimbursements for treating sicker patients and for ordering more procedures, even if those procedures are

unnecessary and if no one has weighed the costs, benefits and risks.¹³

In this model, payers (whether they be the government, insurance companies or employers) bear most of the risk. “Tomorrow, if we have any chance of fixing this system, we have to transfer that risk to the hospital, the provider and the patient,” Dr Attia says. “That trio must carry the lion’s share of the risk somehow.”¹⁴

The real goal, of course, is not to shift financial responsibility but to focus on care that produces better outcomes. This is something we strive to do both by being proactive with at-risk customers, aligning the interests of health care providers, payors and customers, and by finding geographically appropriate solutions to medical problems.

This is why we believe the future lies in value-based care; where doctors and health care providers are paid for helping to keep people healthy and for improving the health of those who have chronic conditions in an evidence-based, cost-effective way.

Fee-for-service flaws

In fee-for-service environments — where physicians are paid based on the service they provide, as opposed to being salaried and focussed on individual needs — anecdotes abound concerning high variations in utilisation rates. Such anecdotes hint at the scope of the utilisation problem. In fact, the Institute of Medicine states that 30 percent of all health care services provided in the U.S. alone are unnecessary, wasteful or have no benefit for treatment.¹²

Drilling down a bit further, we find that half of all hospitalised patients receive an antibiotic during their stay, while approximately 13 percent of all outpatient office visits in the U.S. — about 154 million visits annually — result in an antibiotic prescription.

Thirty percent of these, or some 47 million prescriptions, are unnecessary and contribute to medical inflation. Moreover, as we’ll discuss in a 2018 white paper, they contribute to a perilous rise in antimicrobial-resistant bacteria.¹³

Shifting from fee-for-service to value-based care models could take generations as, despite a recognition the approach will improve care outcomes and reduce costs, many physicians are sceptical. However, there is evidence to suggest physicians are eager to assume a more hands-on role in identifying models that will help balance costs and patient care.

“Doctors are steeped in a field that requires lifelong learning, so of course they are wary of new, unproven approaches,” says Josh Weisbrod, one of the authors

¹² <https://www.healthaffairs.org/doi/10.1377/hpb20121213.959735/full/>

¹³ Source: <http://www.pewtrusts.org/en/multimedia/data-visualizations/2015/antibiotic-use-in-human-health-care>

of the Front Line of Healthcare report. “In the push to infuse more protocols into healthcare and make it value-based, the industry should not underestimate the importance of helping physicians combat their skepticism so they can take a more active role in shaping and leading change.”¹⁴

Overutilisation

Sometimes the best way to identify overutilisation is to compare countries and communities. In the United States, for example, the Dartmouth Atlas of Health Care tracks variations in the distribution and use of health resources. In one recent study, it found that children in Bennington, Vermont, were three times more likely to have undergone a chest or abdominal CT scan than children in Brattleboro, Vermont, a comparably sized town just 40 miles away. It found a four-fold difference in the prevalence of tonsillectomies between cities in Maine and New Hampshire. “While there are many examples of excellent care for children, the inconsistency in care across a relatively small geographic region raises troubling questions about whether medical practice patterns reflect the care that infants and children need and that their families want or whether they are primarily the result of differences in physician and hospital practice styles,” wrote Dr David C. Goodman, the study’s lead author and a professor of paediatrics at Dartmouth College. Such variations point to a greater need for stewardship and standardised protocols at both the national and international level.¹⁵

Rates of caesarean sections show similar variability on a global scale. The World Health Organization recommends that the optimal rate for caesarean deliveries should not exceed 15 percent across a

population, yet one recent study found rates of up to 40 percent in Latin America and the Caribbean. In Brazil, more than 55 percent of all births are surgical, more than triple the rate the WHO recommends. Of course, caesarean deliveries cost more than vaginal deliveries, driving up the overall cost of care. (For more information, see our white paper “Striking the right balance: Global caesarean delivery rates in an era of controversy.”)^{16,17,18}

An older, sicker population

Another factor is the globe’s rapidly ageing population. Soon, the world will have more people aged 65 and older than under age 5 — a remarkable milestone.

With ageing comes both increased risk of debilitating conditions and non-communicable diseases and alarmingly high treatment costs. An analysis of Aetna International’s 700,000 globally mobile members revealed that medical spending on people over 70 is almost three times higher than on those in their 50s. Conditions from heart disease and stroke to osteoarthritis and dementia are becoming more prevalent as the population ages. This situation will only escalate as life expectancy continues to outpace people’s healthspan — that is, the number of years people remain healthy and free from serious disease. (For more information, see our white paper “The ticking time bomb: Ageing population.”)^{19,20,21}

14 <https://www.fiercehealthcare.com/practices/report-docs-skeptical-value-based-care-transformation?>

15 http://www.dartmouthatlas.org/downloads/press/Pediatric_Atlas_Press_Release_121113.pdf

16 http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/

17 <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0148343>

18 <https://www.aetnainternational.com/en/about-us/explore/future-health/global-caesarean-rates-in-an-era-of-controversy.html>

19 http://www.who.int/ageing/publications/global_health.pdf

20 <https://www.aetnainternational.com/en/about-us/explore/future-health/ageing-population.html>

21 http://www.who.int/medicines/areas/priority_medicines/BP6_12Osteo.pdf

Case management in action

Our involvement does not end after treatment. Recovery and discharge planning are a core activity for our clinical teams. And given our worldwide network, that can mean helping patients move to a more appropriate place where they can receive both value and the best possible quality care.

Consider, for the example, the case of Ann, an Aetna International customer from the UK who developed encephalitis (brain swelling due to infection) while

living in Dubai. She received urgent care in Dubai and was told to expect a 12- to 18-month recovery period, which would have been difficult so far from her family back home. We coordinated with the UK National Health Service, the government's system of universal health care, to secure a bed in a leading neurological facility and flew Ann there via air ambulance. (As a UK citizen, Ann was entitled to NHS treatment, which her tax dollars paid for.) She was able to get care at least as good as she would have received in Dubai and to receive it with family support nearby, which undoubtedly aided her recovery. This move reduced the overall cost of her care, but more importantly it demonstrated our commitment to holistic care, where patients are treated as people first.

These non-communicable diseases — often giving rise to comorbidity — can last a long time, meaning years in and out of hospital and lengthy treatment plans, presenting huge capacity and cost related problems for hospitals across the globe as they seek to provide the effective treatment that these individuals need. For example, according to the World Health Organization, obesity, a prime contributor to such leading causes of death as heart disease and stroke, has nearly tripled since 1975; today, 39 percent of adults are either overweight or obese. (For more information, see our white paper “Globesity: Tackling the world's obesity pandemic.”)^{22,23,24}

Awareness of benefits

Mandatory health insurance is another factor that affects utilisation. The UAE and some other countries in the Middle East have established a regime of mandatory health insurance, making people more aware of the health care benefits available to them and, in turn, encouraging greater usage levels. If

people understand what services they have access to and the price of those services, they become more confident in accessing that medical treatment.

In Abu Dhabi, which moved toward mandatory health insurance a decade ago, the health sector is growing twice as fast as the population. As the CEO of one insurance company said, “With all this new capacity it allows for patients to easily seek out medical attention, and hospitals are aggressively marketing products and services to prospective patients. This results in more patients receiving care, which drives up insurance utilisation and, consequently, health insurance premiums.”²⁵

Supply-driven demand

Of course, a country, region or territory doesn't have to mandate health insurance in order for medical providers to aggressively market their services. In Hong Kong, we see instances of celebrity doctors advertising on billboards. Hospitals in other parts of the world encourage people to call for an explanation

22 <http://www.who.int/mediacentre/factsheets/fs311/en/>

23 <http://www.who.int/dietphysicalactivity/publications/fiscal-policies-diet-prevention/en/>

24 <https://www.aetnainternational.com/en/about-us/explore/future-health/globesity-tackling-world-obesity-pandemic.html>

25 <https://www.oxfordbusinessgroup.com/overview/expansion-medical-coverage-has-seen-uptick-provision-health-care-services>

Embracing new technologies and processes

We're also committed to generating fresh ideas and embracing innovative new tools, all while keeping

health at the heart of everything we do. Our vHealth offering allows customers to have remote, face-to-face appointments with doctors via mobile phone, tablet or Skype. This immediate and powerful offering is also a gateway to a health and wellness ecosystem where customers can access tools, resources, prescriptions, insurance documents and claims tracking. Work is well underway to make vHealth the focal point of care management at Aetna International.

of benefit entitlements and how best to use them. (One hospital's advertisements point out that most people underutilize their hospitalization benefits and offer consultations.) In the U.S. advertising prescription drugs is an everyday phenomenon that drives patients to request specific drugs for self-diagnosed conditions.²⁶

In 2014, health reporter Martha Rosenberg cited the impact of such advertising: "Seventeen years after direct-to-consumer (DTC) drug advertising was instituted in the U.S., 70 percent of adults and 25 percent of children are on at least one prescription drug.... Twenty percent of the population is now on five or more prescription medications."²⁷ Not only can drug usage fail to address the causes, the lack of adequate oversight can also lead to drug addiction, as in the case of the current opioid epidemic in the U.S. and disease resistance resulting from the over-prescription of antibiotics.²⁸

There are few hospitals closing down, but plenty more are being built. New facilities tend to be higher-end providers, offering high-tech machinery and better quality care. Each hospital has to work commercially and will aggressively drive up demand where it can, not least when new equipment has been purchased or

new facilities have been opened. For example, Singapore's sparkling new Mount Elizabeth Novena Hospital, which opened in 2012, combines hospital services with hotel-style amenities. As the facility's lead designer told Healthcare Design Magazine, "The owner wanted a hospital that was glistening and gleaming, high-tech and state-of-the-art, but he also wanted it warm, inviting and spa-like." The \$250 million facility features marble bathrooms, cherry and teak finishes in the lobbies, kitchens on each floor and even "proprietary scent diffusion technology" to mask unpleasant odours. Three in 10 patients at the hospital are so-called medical tourists who can afford to pay for the added amenities.^{29,30,31}

Innovation

Innovation, especially in drug development, also drives utilisation. New drugs can drive usage in the short and medium terms before levels reduce back down to normal levels. Patent laws encourage pharmaceutical companies to maximize their returns before generic equivalents are allowed to enter the market. To get a sense of how much money prescription drugs generate, consider that AstraZeneca earned \$300 million in 2017 for selling the European rights to just

26 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278148/>

27 <https://prescriptiondrugs.procon.org/view.answers.php?questionID=001603#answer-id-012094>

28 <https://news.aetna.com/2016/08/opioid-super-prescribers/>

29 <https://www.healthcaredesignmagazine.com/architecture/mnh-hospital-future-four-seasons-twist/>

30 <http://allsense.com.sg/parkway-mount-elizabeth-novena-hospital-case-study/>

31 <http://www.todayonline.com/singapore/hotel-or-hospital?singlepage=true>

one of its drugs, Seloken, which treats hypertension, angina and heart failure.³²

Drug improvements can reduce the number of hospital inpatient days, but, with so many factors involved, there is no easy way of measuring this. Analysis in the U.S. is less of a problem because clean, structured data is available in abundance. With the exception of Dubai, Singapore and Hong Kong, this is much less the case elsewhere, not least because the population groups are smaller.

Technology improvements

The majority of technology improvements are in the form of new drugs, although there is an ongoing debate over the role of big pharma companies in driving up medical inflation. Dr. Zeke Emanuel, a bioethicist at the University of Pennsylvania and former Obama administration adviser, noted that “pharmaceutical companies’ profits are higher than those of carmakers, big oil and even insurance companies.” In recent years, he says, drug costs have risen at triple the rate of hospital costs and doctor visits.”

On the other hand, Paul Howard, a senior fellow and director of health policy at the Manhattan Institute, argues that if we don’t continue to innovate, we will have fewer medicines and people will suffer and die unnecessarily. Besides, he says, “Medicine keeps us out of the most expensive part of the medical system: hospital beds and nursing homes.” However, given that the majority of medicines don’t prevent the onset of disease but delay, mask or manage the symptoms, it’s easy to see that the future of health care lies in the development of wellness and disease prevention programs.³³

Other technologies also have a big effect, sometimes in less-than-obvious ways. For example, instead of recommending a simple X-ray, a clinician may recommend an MRI scan. The unit cost for an X-ray may have gone from \$100 to \$104, but the unit cost

difference between an X-ray and an MRI might mean a rise from \$100 to \$700. And PET scans are on another level altogether. Advancement right across the health care divide has improved treatment levels, and demand has risen as a result.

Where hospitals have invested in new equipment, they are keen to use it, especially if they are smaller hospitals in developed countries. This type of scenario makes it difficult to monitor for abnormal variations in usage statistics. In the U.S., for example, spotting when uses of MRI or PET scans are outside of normal usage patterns is relatively easy. In developing countries, where utilisation is small, benchmarks are limited.

Innovations in medical care typically come with a higher price tag. And when the internet and aggressive marketing raise awareness, utilisation will rise.

Unit Costs

Every consumer is familiar with the impact of rising prices; what cost one price last month will cost a little more today due to rising costs for labour and materials. The picture is more complicated with health care. Two major factors are the underlying cost to provide services and the entrance into a market of higher-priced providers.

In certain parts of the world the unit cost of medical treatment is controlled by regulators. Where such controls exist, maximum annual unit cost increases will be pegged at relatively low levels, typically in the 3 or 4 percent range. In other areas, only market forces control whether and how fast costs will rise.

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32 <https://www.astrazeneca.com/media-centre/press-releases/2017/astrazeneca-enters-agreement-with-recordati-for-seloken-in-europe-22052017.html>

33 <https://www.forbes.com/sites/nextavenue/2016/10/18/is-big-pharma-to-blame-for-soaring-health-costs>

same service costs \$200 in Abu Dhabi, an increase to \$210 would only equate to a 5 percent increase. This is where our skill in medical and network cost management comes into play as we seek to balance the impact across our network.

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Medical cost management at Aetna International

At Aetna International, we are placing increasing emphasis in our strategic cost containment plans on value-based relationships with individuals, providers, hospitals, health systems and physicians. We believe this direction will result in increased focus both on outcomes and on how care is ultimately delivered to each and every individual. This approach rewards quality and puts the emphasis not on volume but on value.³⁴ To this end, we have embarked on a medical cost management initiative that not only addresses fast-growing health care burdens but also focuses on access and quality.

This move places us at the forefront of health ecosystem development with a suite of services and products that benefit brokers, clients and individual customers. We have always believed cost management is a discipline, not just an activity; it's a holistic approach to looking at costs before, during and after a health episode, as opposed to simply reactively managing customers' care or conditions or

establishing strong fraud, waste and abuse practices. Now, we're adding a value-based filter across the entire strategy to give individuals access to better quality care that's more affordable.

Before an episode occurs

Recognising that the most impactful cost mitigations can occur long before a health episode happens is critical to cost management. Activities that are key for Aetna International's pre-episode strategy include product design and network strategy, excesses and deductibles and condition management.

Product design and network strategy: Efficient health care insurance products are at the core of Aetna International's vision. Our innovative product designs for every market and customer size and our mature, global network of over a million health care providers enable us to produce the most cost-effective health plans possible. In addition, we have invested heavily in cutting-edge technologies and provider partnerships to further advance product offerings.

Product design works in concert with network strategy. Insurers need to build medical networks that are big enough to give their customers broad access to suitable facilities wherever they are, but not so big that the network is too difficult to manage.

Take Dubai as an example. This is a small geography, and many of Aetna International's claims go through five health care providers (although the network is still broad enough to manage needs). We have developed a deep and trusting relationship with each provider, and detailed contract negotiations together with post-payment audits allow us to have a very good idea of our financial position year on year.

These audits also allow us to review relatively large claims volumes in order to see different patterns in utilization. Comparing utilization among peers instead against benchmarks often reveals incidents of subpar performance. Identifying overtreatment and unusually high prescription volumes is possible because we have a focussed network that allows us to make suitable comparisons.

34 <http://www.ajmc.com/interviews/dr-harold-l-paz-discusses-aetnas-vision-for-the-future-of-value-based-relationships>

Excesses, deductibles and benefit sub-limits:

Excesses and deductibles are proven to influence behaviour, particularly when it comes to elective treatments such as vision and dental. Sharing costs with customers encourages individuals to make more informed decisions about the care options they choose.

Studies and surveys regularly report that individuals want to have clearer information about the cost of care. In a 2014 survey conducted by Mass Insight, 87 percent of respondents said it's important to have clear information about the cost of medical care ahead of time. But 82 percent said they did not have information allowing them to compare cost and quality before getting a medical procedure. William H. Guenther, CEO and founder of Mass Insight, said, "The good news is, consumers want more information.... So you've got a willing public. We just have to make it more transparent and easier for them to gain access."³⁵

This insight becomes more important in an international setting since costs vary wildly across the globe based in part on whether countries negotiate aggressively with providers and set rates. For example, an MRI can cost \$1,081 in the U.S. and \$280 in France. (Prices of goods and services are more costly in the U.S. than in any other OECD country.³⁶) Moreover, hospital bills are uninterpretable and research shows the majority of individuals don't understand what they're getting for their money. That's not surprising given that published prices rarely relate to final invoices as there can be numerous providers and specialists involved in the final bill.

But addressing the cost of care won't cure all if we don't address the rate of growth or demand. Our preauthorisation and care management strategies help to ensure individuals are accessing the right care at the right time for the right price. When coupled with more recent advances such as vHealth (our virtual health offering), patients have more control in a more cost-effective environment.

Maternity is a good example of the impact of cost sharing. The length of stay and facility choice tend to be quite elective; if a patient knows she needs to pay 20 percent of the fee, she may decide to leave as soon

as she has been medically approved to do so. Moreover, As health care consumers, many individuals are paying more of their health care costs and getting involved in making health care decisions in an evidence-based, cost-effective way.

Benefit sub-limits for elective treatments help to protect against excessive levels of treatment and ensure that we can get involved early in the process. For example, a traditional Chinese medicine benefit, where the medical efficacy is difficult to prove, will have a sub-limit. Similarly, a physiotherapy benefit may be restricted to a maximum of 10 sessions before the insured has to call us, facilitating faster intervention for a bigger issue. If the course of treatment has ended with no sign of improvement and more treatment is applied for, it's probably time to look at other courses of action.

Condition management: While product design is a good foundation, it does not guarantee customer health or that the customer shares the benefits of cost savings. That's why we focus on condition management more than cost containment. We have advanced care management processes and algorithms to identify and proactively manage customers who are at risk or have pre-existing chronic conditions. We also work proactively with customers, helping them to understand how their behaviour can influence their health and well-being, empowering them to take charge of their own health, rather than waiting until they become unwell.

During an episode

We react quickly to our customers' health episodes when they do happen and proactively manage any related recovery. Our well-defined utilisation and care management processes come to the forefront as an event is happening. By working hand in hand with health care providers to quickly analyse and approve appropriate procedures, we ensure that the customer receives the right treatment, at the right place, for the right cost. Key competencies include preauthorisation, concurrent review, case management and policy and operations.

35 <https://www.bostonglobe.com/lifestyle/health-wellness/2014/07/04/consumers-want-know-cost-health-care-poll-finds>

36 <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.22.3.89>

Preauthorisation: Also known as precertification, preauthorisation is more often applicable to higher impact, but easier to administer, outpatient treatments. A good example is diagnostic tests such as MRI and PET screenings and blood tests, which are easy to prescribe and relatively simple to overprescribe. Insurers will generally not look to refuse this type of claim, but if a physician knows they have to call for authorisation, there is a degree of deterrent to overprescribing.

At Aetna International, customers must seek preauthorisation and give the medical rationale for in-patient hospitalisation, outpatient day surgery and high-cost outpatient treatment. The notification allows us to gauge medical necessity, check remaining benefits and authorize payment or recommend alternate courses of treatment. We can also look at statistics for the provider or facility to see if they lie outside the norm for the specified procedure. This way, we can ensure that customers are receiving medically appropriate treatment and that the cost of treatment is reasonable and customary, before treatment is received or costs are incurred. This can save money for our customers as well as our business, thereby helping to keep medical inflation in check.

Concurrent review: During a patient's hospitalisation, we review the treatment plan to ensure that it meets established medical criteria in a timely manner and certify the necessity, appropriateness and quality of services being provided. Where appropriate, we encourage observation stays vs. inpatient care and levelling of care (where patients are moved to less acute beds).

Case management: Case management involves coordination of services to help meet a patient's healthcare needs, usually when the patient has a condition which requires multiple services from multiple providers. We work to steer patients to participating providers, reduce hospital admissions and re-admissions and eliminate unnecessary emergency room visits.

Policy and operations: Our Medical Clinical Policy Bulletins (CPBs) state our policy regarding the experimental and investigational status and

medical necessity of medical technologies and other services. In making coverage decisions, our professional staff refer to the customer's plan of benefits, and if necessary the CPBs and other Aetna-recognized criteria.

Post episode

Even long after a health event has happened, we continue to combat medical inflation through effective fraud, waste and abuse (FWA) processes, subrogation activities and policy and operations optimisation.

Fraud, waste and abuse: In 2008, the World Health Organization found that more than seven percent of all health care costs — a staggering \$415 billion — were the result of fraud and error. Our dedicated global special investigations unit combats FWA through a variety of methods, including proactive data mining and analysis, customer and provider referrals and recovery processes.³⁷

In one case, our existing FWA processes surfaced a number of unusually high claims (over \$2,500 each) for a customer in Argentina. We notified the local broker, who couldn't locate the associated provider. When the customer continued to file claims related to various providers across Argentina, our investigators were able to uncover an ongoing fraud scheme that was affecting all insurers and plan sponsors in the area. We ended up preventing \$500,000 in fraudulent payments and subsequently adjusted our FWA processes to flag similar behaviour across all geographies.

As members of the European Healthcare Fraud and Corruption Network (EHFCN) and similar bodies around the world, we take seriously our responsibility to fight FWA. Operating at an international level, we are respected experts in our own right, often presenting at global fraud summits and working with other fraud-preventing bodies.

Subrogation: Subrogation — determining that the right party is paying for care — is another key facet of our cost containment. Often globally mobile populations will have multiple coverages; ensuring that the right one is paying is a significant source of savings for customers.

³⁷ <http://www.who.int/bulletin/volumes/89/12/11-021211/en/>

We are strongly committed to ensuring our customers' premiums are used in the right way, and we apply an across-the-board approach and access to a huge amount of data. It's a matter of having the systems in place to get the information we need, and then having the power and experience to pursue abuse of funds, wherever we find it. For example, when someone's claim or claims reach a certain threshold, this can trigger a referral to ensure that funds aren't misused and honest clients can get the level of cover they've paid for. We also apply sanctions on proven FWA cases, including recoveries of paid claims and non-payment of claims, criminal reporting and legal action.

Conclusion

At Aetna International we can't stop global medical costs from rising, nor can we eliminate death and taxes, which, as Christopher Bullock said, are guaranteed. We can, however, work effectively to temper the impact of rising costs through early intervention, care management, innovations like vHealth and proactive engagement with our customers and providers.

Bending the cost curve first means ensuring that people are aware of the significance and impact of healthy living. Despite oceans of clinical data, many people still aren't aware of how profoundly their everyday decisions — from what they eat and drink to whether they smoke to how often they exercise — impact their health.

Many others are well aware of these issues but need help in making appropriate changes. That's why it's

critical that doctors, insurers and governments arm individuals with tools and advice that will help them improve their lifestyles. And that means radically transforming how health institutions function so that they focus more on proactive health and wellness interventions and less on episodic, reactive care that only treats people once they get sick. The onus cannot just be on the individual to make the changes. It is incumbent on the whole health care system — governments, payers, pharmaceutical companies, insurers, physicians and other health care providers — to collaborate, provide guidance and promote overall health and wellbeing.

There are a number of proven strategies that health care entities should implement. First, we must continue to embrace technology. We can use predictive analytics to find high-risk individuals, data mining to improve patient profiling and electronic health records to better inform care.

Second, we must improve collaboration across the health care ecosystem. Physicians need to work more closely with psychologists. Nurse practitioners need to work more closely with nutritionists. Hospitals need to work more closely with community care providers. And across the board, the focus must be on outcomes achieved, not services rendered.

Finally, we must never lose sight of our ultimate goal. As important as it is to bend the cost curve, it's even more important to reduce pain and suffering and improve quality of life. If we all work together, achieving that goal will be as assured as death and taxes.

The promise of healthy... anytime, anywhere

Aetna International is part of Aetna, one of the leading diversified health care benefits companies in the U.S., serving an estimated 46.5 million customers with health benefits and resources to support them in making better informed decisions about their health care.

Aetna International is committed to helping create a stronger, healthier global community by delivering comprehensive health care benefits and population health solutions worldwide.

One of the largest providers of international private medical insurance services, Aetna International serves more than 700,000 members worldwide, including expatriates, local nationals and business travellers. Its global benefits include medical, dental, vision and emergency assistance and, in some regions, life and disability.

Aetna International also offers customised programs, technology and health management solutions to support health care systems, government entities and large employers in improving access to quality care and health care outcomes in tandem with controlling associated costs.



Meet the authors

Continue the conversation by getting in touch with one of our medical experts:



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