



Taking Health Care International – The Growing Trends of Importing Care and Exporting Patients

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Esteemed physicist Richard Feynman is remembered by many for the phrase

“If you think you understand quantum mechanics, you don’t understand quantum mechanics.” This sentiment rings true for the continually evolving landscape of our healthcare system as well, and the problems facing all of us, particularly as insurers, employers, and patients.

For those of us within the healthcare or health risk industries, the more we learn about the problems we face and what is causing them, the more we realize just how complex the landscape is and what an impossible task it would be for any single solution to reel in the cost of care.

In tow with the cost of care, health premiums as well as per capita healthcare spending in America steadily increase every year. This should not be news to anyone, and countless strategies have been proposed to slow and eventually reverse this inflation. But, for many, the immediate objective isn't to "fix" healthcare or undo the decades of developments which brought us here.

For many, the immediate goal is just to get care for their employees and families in an affordable way. Although this problem is not uniquely American, we spend more of our GDP on healthcare than any other country (by a wide margin), and care is more expensive here than anywhere else. As such, several newer strategies for cost containment are reaching beyond our borders into the international market – and doing so with impressive results.

One strategy aims to avoid the exceedingly high prices of some prescription medications in America by simply getting them from elsewhere. Countries designated as "Tier 1" countries (including Canada, the UK, Australia, and New Zealand) have safety and efficacy standards which equal or exceed American standards, and enjoy significantly lower prices for drugs which are often chemically identical.

So, why hasn't the American prescription drug market self-corrected due to this international competition? The simple answer, and the reason many employers are hesitant to take advantage of this option, is that the practice is illegal. Under federal law, drugs which are manufactured

for sale outside the country are not FDA approved, as there is no potential for oversight in the manufacturing process.

Additionally, even if the foreign version of the drug is chemically identical in every respect, FDA guidelines address more than just the chemical makeup of the drug – they relate to labeling, storage, and transportation as well. So, even a drug manufactured within the United States for sale outside of the country would be considered illegal if it was later re-imported into the country.

So, if importing foreign drugs is illegal, how is it a viable option for cost containment? It's possible, under the right circumstances, due to a well documented FDA policy of "enforcement discretion". Under this policy, the FDA does not prosecute individuals who import a limited quantity of prescription medications from abroad for personal use.

This discretion is based on several factors, including that the drug is for personal use only and that the amount imported is no more than a 3 month supply. So, if a program is set up correctly, the savings on many costly medications can be huge, with very minimal risk to the employer.

Two important things to consider, though, are safety and plan document design. Regarding safety, it's important to remember that just because a drug comes from a "Tier 1" country does not mean it is safe. Just as you (probably) wouldn't buy prescription drugs from someone out of a suitcase on the street, it's important to ensure that you are working with reputable people and pharmacies abroad when dealing with this type of program.



There have been incidents involving drugs which were imported from Tier 1 countries after being manufactured in other countries with more lax standards, as well as incidents where drugs were found to be outright counterfeits. Regarding plan document design, any given plan document likely has some existing barriers to making a seamless transition into reimbursing for expenses such as these.

Any exclusions or language which would conflict must be removed, and these changes should be approved by the plan's stop-loss carrier and TPA (and ideally the PBM as well). But again, when set up and run properly, this type of program can generate significant savings with minimal risk to the employer or patient.

Another trend picking up steam is specialized medical tourism. Medical tourism is certainly nothing new, both within the country and internationally, but we are seeing a new trend – providers gearing their business model to specifically target medical tourism, and sometimes even specific

conditions/illnesses. When a facility specializing in a certain surgical procedure or implant, or treating a disease with particularly costly treatment, sets up shop just over the border or just offshore, it's surely no coincidence.

A prime example of this is Health City Cayman Islands. Health City is a brand new facility (they took their first patient in 2014) that offers a broad spectrum of healthcare services, but none illustrate the savings potential better than their hepatitis C program. Of course, a medical tourism offering only helps an employer save money if patients want to utilize it. Health City seems to understand this – along with the appeal of their tropical location they offer travel planning assistance, transportation, and concierge services including arranging local activities and excursions.

The leading prescription hepatitis C medications can cost nearly \$100,000 in the United States for a single 12 week course of treatment. Many employers may be surprised to hear that in light of this, as compared to simply purchasing the drug at the local pharmacy, it can actually be significantly less expensive to put a patient on a plane (with a companion) and fly them to the Caribbean for treatment, including all ancillary services and testing and prescription medications dispensed onsite, all as part of what is essentially a free vacation. The same concept is being applied with increasing regularity to other treatment, including surgical procedures.

Just as with drug importation, there are some practical house cleaning tasks a plan must take care of before introducing any sort of medical tourism benefit, particularly if patients will be traveling internationally. A common barrier could be any existing plan exclusions for international treatment. This and any other conflicting exclusions must be removed and cleared with interested parties, just as with an importation reimbursement benefit.

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Another consideration with a medical tourism benefit is potential conflicts with the employer's network agreement. Many such agreements require that the in-network incentive be the "best" available, so if the in-network coinsurance is 20%, and the plan offers a "zero out-of-pocket" option to incentivize patients to use the new program, there could be trouble.

By that same token, the limitation could only apply within the network's service area, which would mean there is no problem. It is important to have a professional review these agreements to make sure the employer isn't creating any liability for itself.

While many great minds continue to grapple with the puzzle of bringing American health costs down, many patients and employers simply cannot afford to wait for a complete solution. These globally-minded strategies are just a few of the creative ways employer plans, vendors, and providers are attempting to make care more affordable and accessible.

The potential for savings is huge, and the quality of care can be just as high as or higher than comparable treatment domestically. Ultimately, those who reap the benefits will be those who are willing to innovate, and utilize new methods and strategies outside of the traditional employee benefit playbook. ■

Andrew Silverio joined the Phia Group, LLC as attorney Third Party Liability Lawyer in the summer of 2014, dealing with a variety of issues such as Medicare recovery and Medicare COB, class action recovery, and other opportunities to recoup funds for benefit plans. In addition to conducting research into novel and developing areas of the industry, his primary focus is on provider relations, dispute resolution, and cost containment. He handles many of the company's more challenging and complex cases involving disputes between benefit plans, participants, providers, insurance carriers, employers and brokers.

Andrew attended Berklee College of Music in Boston, earning his B.A. in professional music. He then attended Suffolk University Law School, graduating with an intellectual property concentration with distinction. There, he took the step into the healthcare realm of the legal world, serving first as an editor and content contributor, and then on the executive board of the Journal of Health and Biomedical Law. Andrew is licensed to practice in the Commonwealth of Massachusetts.

