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International Healthcare
Insurance Consulting
&
Brokerage

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Insurance Penetration as a
Percent of GDP (2007)

U.S.: 8.9%

China: 2.9%

Insurance Density per
Inhabitant (2007)

U.S.: \$4,087

China: \$70

Finance & Insurance
Sector Percent of Total
Employment

U.S. (2007): 4.6%

China (2002): 0.6%

Source:

World Trade Association
Statistics Database
(<http://stat.wto.org>)



Accessing International Healthcare Insurance in the Global Economy:

*Solutions for Public, Private and Governmental Entities
Having a Multinational Presence*

by

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March , 2010

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“International healthcare insurance is not a luxury. It is an absolute component of multinational commerce. It should be treated as capital. It is just as much an investment as plant, equipment, inventory, diplomatic missions or the development of the brightest students and most dedicated faculty members.”

— Robert Murphy

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Executive Summary

- ✓ A decisional framework
- ✓ Why, how and who addressed
- ✓ Financial as opposed to altruistic
- ✓ Equally applicable to both U.S. employers and non-U.S. employers
- ✓ Equally applicable to commercial and not-for-profit organizations.
- ✓ Solution oriented

This white paper has been written for decision makers and those who influence decision makers via their recommendations. It provides a decisional framework from initial determination of international healthcare insurance needs, to products that can address those needs, and then to decisions regarding how to secure those products most efficiently and at fair value in a world market. It addresses human investment protection from a financial perspective. It leaves the altruistic arguments about healthcare to the politicians.

The decision makers are most often commercial employers and their staffs. The headquarters location can be virtually anywhere in the world. This paper emphasizes those organizations which are deploying human assets to the United States where a certain decision matrix exists. However, it also provides a decisional framework for organization which are deploying assets to other countries where a distinctly different decision matrix may be appropriate.

This paper also addresses other non-commercial entities where deployed human assets are critical (e.g., universities, religious missionaries, not for profit companies, and sovereign governments). As an example, Boca Benefits Consulting Group, Inc. ("BBCG") has found the diplomatic missions of some countries to have strong demand for healthcare products which can cross national borders. Whether it be a systemic stability concern, a remote posting or specific resources to treat a known or anticipated illness, these foreign service officers have defined cross-border portability as one of their most important decision factors.

The paper concludes with representative situations where solutions that are discussed in the paper have proven to be particularly effective.

The Issues

- ✓ Greatest concern is almost always financial
- ✓ The issue which impacts most negatively is aborted assignments
- ✓ Opportunity costs associated with "getting it wrong"
- ✓ Communications has changed the decision paradigm
- ✓ Carrier and broker innovations
- ✓ The new standards

When we ask clients to describe their greatest concern regarding the physical protection of the human assets they deploy abroad, we get a broad swath of answers. However, as we drill down during our questions we almost invariably find that employers are not completely happy with the investment they have made in personnel relocation, incremental training, compensation adjustments, time and the opportunity costs of "just not getting it right" when they sent a certain individual to a new country to accomplish a key task.

The research of major international insurance carriers further shows that the most frequently specified cause for poor performance, or outright failure, during a deployment

- ✓ Perception regarding quality of care actually available
- ✓ Employee's concerns about his/her own health
- ✓ Employee's concern about dependent's health
- ✓ If allowed to fester, deployment enters the "death spiral"
- ✓ Request for assignment termination becomes likely

- ✓ U.S. healthcare insurance market is one of the most fractured in the world
- ✓ Requires substantial experience to navigate effectively
- ✓ Multiple financial and risk options for international employers
- ✓ Emergence of the "world broker"
- ✓ A set of solution standards to consider

is healthcare. Whether it be the perceived overall quality of care available, specific known or emerging conditions of the employee, or possibly special requirements of accompanying dependents, once the specter of inadequate care emerges, the deployment has entered the early stages of a death spiral. Rarely, will an employee change his/her mind about their health risk. More than often they want the deployment to end and they want to be repatriated to their home country. In some instances temporary medical evacuation to a location where the employee perceives the healthcare resources to be more adequate will suffice. All the costs of getting that key employee up to speed and in-country are forever lost. However, that is a financial risk that is absolutely avoidable. Front-end investment in deployment success makes much more sense.

This phenomenon is not unique to the employers of any single country. It is a truism for virtually all employers throughout the world. Even when deployed to countries with the highest standards of medical care, if the health plan is not designed in such a way as to instill complete confidence, a gnawing doubt will eventually transform into something more tangible, again putting the entire investment at risk.

Hardly least when discussing greatest concerns with employers is the actual cost of protecting the investment (i.e., how much will the international insurance plan cost). When the number of people involved is small, frequently the cost concern also remains small. In that case it is simply a decision based on services and quality. However, if an employer is sending a relatively large group of expatriates abroad, or it is planning on establishing a manufacturing/service presence there, the type of plan, which insurance carrier is utilized, and what type of financial controls are brought to bear all have much higher significance.

The United States has an almost unfathomable selection of options from which to choose when locating there. Insurance carriers have different fundamental levels of quality, both generally speaking, and absolutely from market to market (i.e., from one city to another). Plan types (i.e., HMO, PPO, POS, EPO, VMO and hybrids of each), financing vehicles, regulatory considerations (i.e., both national and state), level of risk assumption desired on the part of the employer (i.e., some level of self-insurance) all have significant impact on how an employer addresses the domestic insurance needs in a new location. If portability to third countries is important, than virtually none of the common domestic solutions offered by most U.S. brokers will be adequate.

Clearly, all countries have a unique set of circumstances when it comes to providing healthcare protection for your deployed human assets in-country there. Historically, there have been few healthcare insurance carriers with a true "world view." Most solutions were in fact only partial solutions offered by relatively myopic domestic insurance companies via domestic brokers with similar vision. However, the interconnectivity of the world via broadband communications has changed that paradigm. We now have truly "world insurers" and "world brokers" who can do business in virtually any part of the globe they might choose. Negotiating day-to-day with a client thirteen time zones ahead of local time has become routine (n.b., the lost time differential when dealing with carriers on local time remains an issue that is more physics related than business). It is this innovation in communications that has caused a whole class of product innovation to emerge. It speaks well for the value an international purchaser should expect. Any solution must address investment protection, quality of care (i.e., access, timing, perceived quality, etc.), cost, portability, and the most efficient delivery of all those.

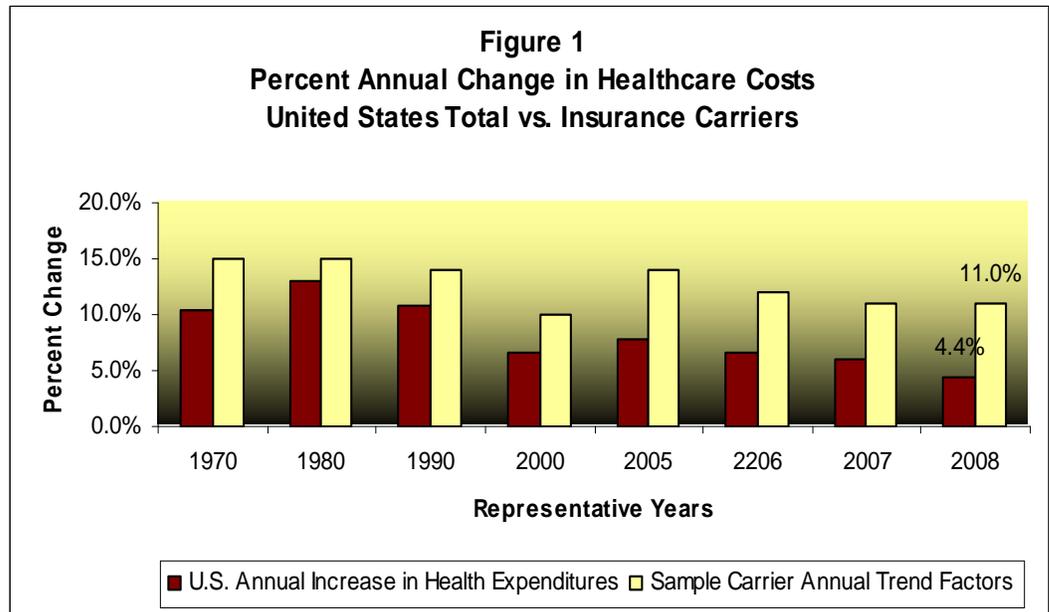
A_n E_{volutionary} P_{rocess}

- ✓ Concerns tend to remain constant regardless of location
- ✓ The methods of addressing concerns are variable based on location
- ✓ Each solution is country-dependent

- ✓ Cost control is unquestionably the biggest concern when entering the U.S. market
- ✓ The commercial segment of total healthcare annual cost increases in the U.S. far surpasses the published total healthcare costs statistics
- ✓ Provider (i.e., doctors, hospitals, etc.) cost shifting to employers when public expenditures are restrained is the primary cause
- ✓ Insurance carriers build in a cost-shifting anticipation in their rating "trend factors" that exceeds actual cost-shifting impact

There are multiple solutions required depending on which direction you deploy your human assets. The basic concerns discussed above do not vary significantly based on location. However, the methods with which you address them are very country-dependent.

Take for instance Figure 1 below. Clearly, an international employer entering the U.S. market needs to be concerned about cost control. Although the most recent health expenditure annual increase appears to be a manageable 4.4% in 2008, these statistics



Source: U.S. Centers for Medicare and Medicaid Services and insurance company data

mask underlying trends. First: they are not the actual numbers that an employer sees. These numbers are aggregated from all sources. Second: in every year health expenditure increases surpassed broader cost of living and GNP growth indices. Scarce capital seeks highest yields and that absolute points to the long-term relationship of U.S. healthcare to its aggregate economy as being unsustainable. The wisest investment would appear to be in non-productive healthcare itself (i.e., other than protecting a factor of production). The statistics above do not depict internal cost shifting from one payor to another. The most recent numbers also reflect a known "recession effect" reduction in health care spending. Although the total might appear to be dampened, in fact, the unexpected loss of revenue, especially by hospitals, must be shifted to the most likely payors. Employers in the U.S. have very little bargaining leverage in these matters and are usually the recipient of the cost shifting phenomenon. The insurance carriers with which major employers do business have some leverage with providers of

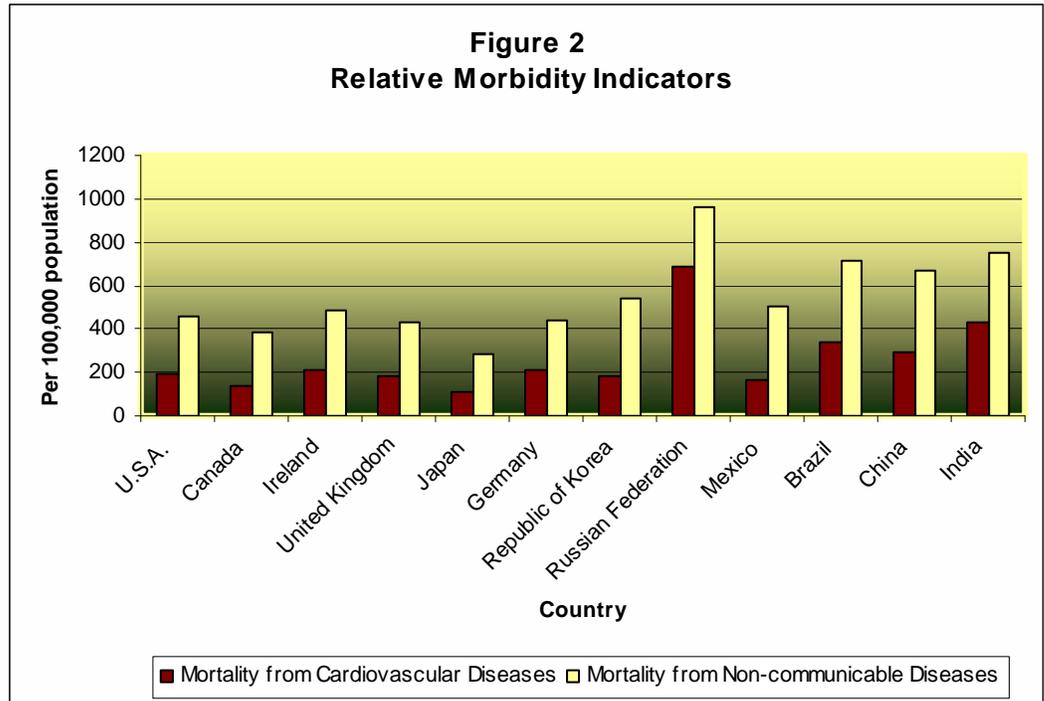
- ✓ In the U.S. managed care market contractual battles often erupt over costs of services between providers and financial intermediaries (i.e., insurance carriers).
- ✓ Often is played out in newspapers and other media
- ✓ When hospitals versus carriers, carriers rarely win
- ✓ Hospitals have emotional high-ground in their communities
- ✓ Result is significant impact on employers
- ✓ Impact greatest when public expenditures are being held constant

- ✓ Cost control lower priority in other countries
- ✓ Access, quality and payment methods may take precedent

healthcare but in the toe-to-toe contract battles the carriers rarely win and the employer rarely fails to be effected. These are serious battles. Hospitals often have huge capital overhead that requires servicing. Carriers exist in a relatively homogeneous world where their competitors are poised to take large blocks of business from them quickly if they become price uncompetitive. Yet, after the public advertisements of unfair treatment by both sides, where they seek public relations advantage, there have been few instances where major hospitals and major carriers have not found a way to compromise. That compromise is what finds its way downstream to employers

When entering a less developed healthcare market than the U.S., cost control might be much less an issue. More than likely physical access to providers, availability of specific services and the perceived quality of the providers will be most important. Following closely will be how services get paid. Is there a direct relationship with the provider of services, where they will bill and expect payment from the insurance carrier, or will the deployed employee/dependent have to pay at time of service and retrospectively file a claim with the insurance carrier for reimbursement?

Figure 2
Relative Morbidity Indicators



Source: World Health Organization

We have mentioned perception frequently in this paper. Ultimately, no matter how well a program is structured, if the employee does not see it that way, it is more likely the assignment will be effected before the employee/dependent is persuaded to change their mind. Where morbidity indicators are high (see Figure 2 above) there is a higher likelihood for perception issues to arise.

Word of mouth effects that perception greatly. In relatively small commercial and diplomatic compounds there is a regular ebb and flow of information among deployed persons from multiple employers and multiple home countries. It is critical that when these

“war stories” are being told over cocktails, that your plan always be the benchmark upon which all others are measured.

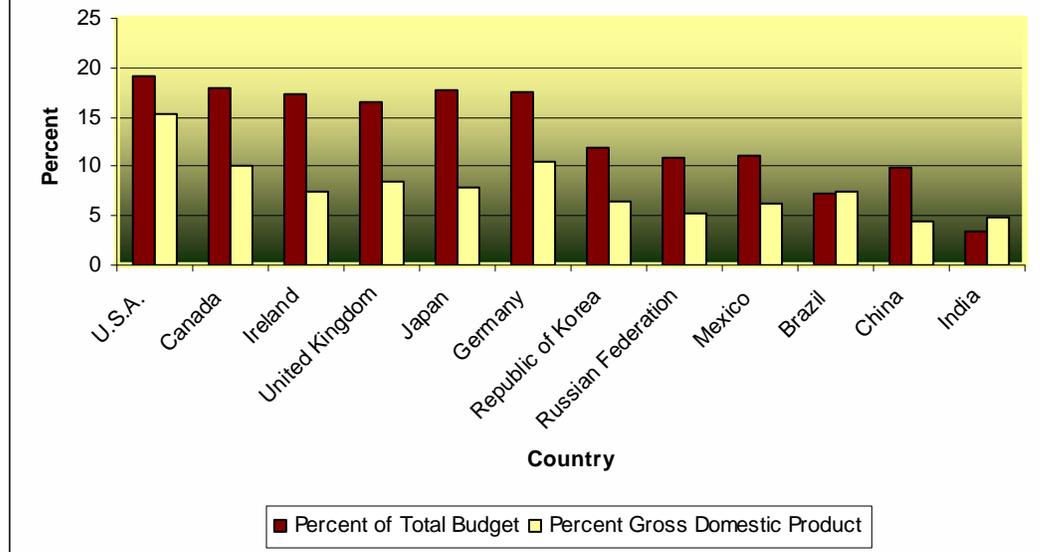
Often we are asked the open-ended question, “How did we get to this point?” In the case of international healthcare insurance, the answer does not have a long history. Advances in the quality of healthcare have pushed the expected lifetimes of people throughout the world to much higher levels. Clearly, there is significant skewing in the distribution worldwide. However, it is inarguable that it has occurred in the aggregate. Couple that with shifting economic centers of influence and with changing expectations of quality of life. Satisfaction requirements have been pushed higher on Maslow’s hierarchy of needs pyramid in those economies which presently have the highest level of per capita disposable income in their histories. Take those basic changes in worldwide economics and add instant knowledge of how others live via Internet connectivity and there leaves little doubt why the healthcare paradigm has shifted. People want to live longer and better. It is unlikely that the relationships shown below in Figure 3 will remain the same during the next decade.

- ✓ Perception of employees and dependents key
- ✓ Impact of word of mouth is significant

- ✓ Satisfaction requirements have been pushed higher in developing economies
- ✓ Virtually realtime broadband communications greatly effect expectations
- ✓ Shifting economic centers has raised quality of life expectations

- ✓ The U.S. “managed care” model is being exported internationally
- ✓ Supply and demand models may face social and/or political resistance in certain countries

Figure 3
Relative Investment in Healthcare



Source: World Health Organization

Above is the current broad view from the top of the mountain. At a lower level we note with some surprise a form of exportation of the U.S. healthcare model to emerging economic centers. Is contracted “managed care”, via a U.S.-type system, in the best interest of those countries? Certainly from the perspective of setting a high standard for quality the answer is yes (some of the U.S.’s unflattering World Health Organization statistics aside). However, the allocation of services model in the U.S. is extremely market driven with an underlying profit motive by a large segment of the entire system (n.b., there are indeed some non-for-profit entities which make up a small percentage of the whole). Supply and demand may not fit the long-term political needs of countries with a more socially based healthcare philosophy.

"CIGNA & CMC's new health product in China demonstrates CIGNA's strategy to be a truly global health service company. CIGNA is well positioned to take advantage of growth opportunities in China and around the world."

—William L. Atwell,
President
CIGNA International

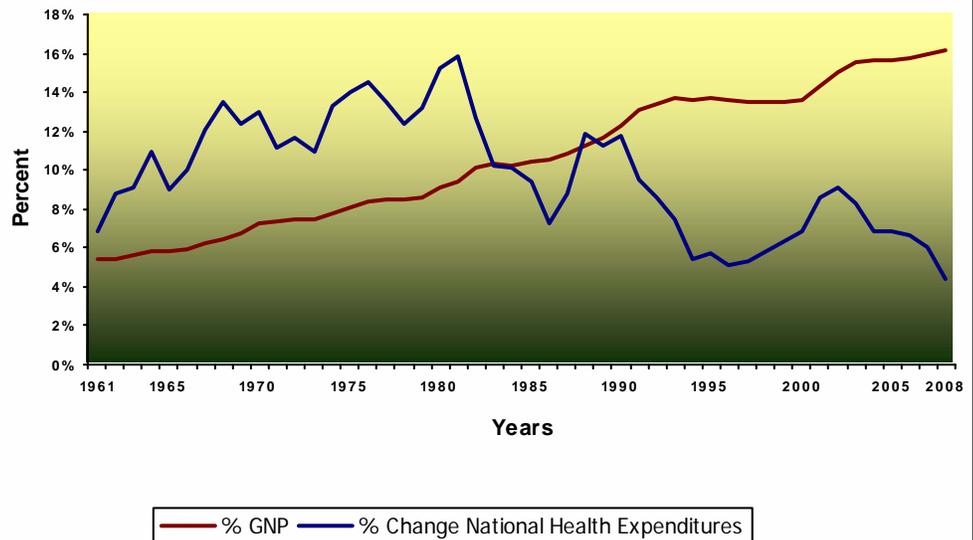
"...is supported by a new service center in China that is linked to CIGNA's existing health service centers and networks across the globe. Employees in China will be served from China while employees based elsewhere will be served in the region where they are assigned, ensuring that service is seamless for all customers."

— Press Release
(No Attribution)

Source: [Press Release]
SHANGHAI &
PHILADELPHIA, November
11, 2009 - CIGNA & CMC
Life Insurance Company
Limited, a joint
venture between CIGNA and
China Merchants Group

Figure 4 below shows that the United States has most recently significantly reduced the runaway annual increases in costs of the early 1980's and slightly lesser so in the early 1990's. However the increase in the percentage of gross national product continues to have an economically dangerous upward slope. It masks the lack of infrastructure (and other factors of production) reinvestment that every economy needs to efficiently make in order to stay vital and competitive in the world economy over time. This is one of the key issues which makes a U.S. healthcare model problematic in many developing economies. In some cases there is just not the luxury of time (i.e., delayed reinvestment) or GNP component trade-offs (e.g., non-productive social protection versus machinery).

Figure 4
U.S. Annual Percent Increase in National Health Expenditures
&
Percent U.S. Gross National Product
1961-2008



Source: U.S. Centers for Medicare and Medicaid Services

All the above being said, insurance remains insurance. However, there is a new class of participants in international healthcare. It has emerged due to:

- The worldwide deployment of broadband technology where communications travels over vast intercontinental distances at affordable transactional pricing
- The demand of emerging economies for advancement in their domestic population's supply and quality of healthcare services
- A steady breaking down of long-standing parochial barriers associated with local national insurance and healthcare regulations as well as the barriers of existing distribution networks to date
- Identification of willing joint venture partners

There is also a whole new lexicon which is emerging as this new class of participants evolves and matures in the “Transjurisdictional Health Insurance Market”. Consider for instance some of the terms in Figure 5 below:

Figure 5	
THIM	Transjurisdictional Health Insurance Market
GRIP	Global Reciprocal International Producer
SLIP	Surplus Lines International Producer
GRIPCOR	GRIP Correspondent
SLIPCOR	SLIP Correspondent
GMCO	Global Managed Care Organization
H-JVP	Healthcare Joint Venture Partner
HI-FTZ	Healthcare International Free Trade Zone
ICA	In-Country Authorization
TCCS	Third Country Contract Situs
FSOP	Diplomatic plan for countries with a U.S. embassy
IRH	Internationally Resourced Healthcare policy provisions

- ✓ The new class of participants in international healthcare insurance also has an entirely new language
- ✓ The new paradigm transcends historical domestic insurance functions
- ✓ Greatest challenge is domestic regulations in various countries
- ✓ Contract situs choice is a key decision when multiple countries are involved
- ✓ Sensitivity to all on-shore domestic regulatory issues is a critical factor

The term “insurance broker”, in its most common historical usage, almost seems an anachronism in this new high speed, long distance, business environment. The dynamics of the new class transcend the traditional functions of domestic intermediaries in a fundamental way and require emerging specialized skill sets and relationships.

The most significant characteristic of the class is the requirement to bring to bear the resources of major international insurance carriers, sometimes simultaneously in multiple jurisdictions, without violating the domestic regulations of any one of the countries where your deployed human assets may be located. At times that task can become a very fine balancing process. The GRIP (see Figure 5 above) must be able to sell and service an insurance policy in the country of contract situs, either directly or, if required, through a GRIPCOR (i.e., a legally licensed domestic agent in that country with whom the GRIP has established a co-sales relationship for such a purpose). One of the key functions of the GRIP is therefore assisting with the establishment of an appropriate situs for the insurance contract where various alternatives might exist. At times, where an appropriate situs becomes problematic, a SLIP may be used as an intermediary to put in place a “surplus lines” contract where the only major concern of the jurisdiction is receiving the equivalent taxes they would receive if the insured persons were covered under a domestic contract. Clearly, these processes must be approached with both specific market knowledge and tact. The minimum standards for a GRIP should be significant insurance experience, regulatory sensitivity, and the appropriate carrier and correspondent (i.e., if required) relationships. Where compensation associated with a policy sale appears to be a major consideration, employers should be wary of potential regulatory issues arising. **BBCG**’s philosophy has always been to place the appropriate coverage in place first and determine the compensation consequences later.

Key Considerations

- ✓ Traditional methods of rating insurance carriers not best indicators
- ✓ Target markets and other considerations vary
- ✓ Management philosophies also vary
- ✓ Experience
- ✓ International breadth
- ✓ Political presence in key countries

- ✓ The “dabblers” versus the GMCO investors
- ✓ High capital costs for entry and long-term presence
- ✓ U.S. style “managed care” requires extensive capital
- ✓ Capital requirement is the primary underlying factor in the evolution of the “mutual” insurance carriers to the “for profits” in the U.S.

In the prior section we discussed some of the functions of the GRIP. This section will discuss other things for which you should look when accessing the international healthcare insurance market (i.e., from this point forward referred to as THIM).

Just as all GRIPs are not created equal, nor are insurance carriers which do business in the THIM. Many employers are familiar with insurance company rating agencies such as A.M. Best or Standard & Pools. However, those agencies look for financial stability more than anything else. An insurance carrier that is properly capitalized and properly reserved against its outstanding risk will almost invariably receive relatively high ratings.

Regardless of financial stability, insurance carriers have different target markets, international breadth, underwriting standards, management philosophies, sales networks, post-sale support, experience and political presence. The emergence of the GMCO (i.e., global managed care organization per Figure 5) adds multiple new dimensions to the character of insurance carriers doing business in the THIM.

If indeed U.S. style “managed care” is to be utilized in other countries, there has to be an investment in international infrastructure that many carriers dabbling in THIM are unwilling to make. One of the earmarks of U.S. “managed care” in the past two decades has been a high capital requirement derived from the vast amount of investment required to be in that business sector. From a historical perspective, both expense loads and margins have almost tripled as a percentage of total premium since the late 1970’s (i.e., effectively prior to the emergence of the “managed care” model). Top insurance carrier executives point to the fact that access to capital has been an absolute requirement since the late 1980’s. A draw down of reserves in “mutual” companies (i.e., non-profit and ultimately owned by the policyholders where net margins are placed in reserves) could not fulfill the huge need for investment. In the late 1990’s there were many carriers which converted from “mutuals” to “for-profit” status with the driving force being capital requirements to remain in the health insurance business. It also forced a huge consolidation among the U.S. health insurance carriers. The consolidation had other drivers including the potential for reduction in per unit expenses resulting from economies of scale and, in some cases, carriers which were more agent and life insurance oriented and were unwilling to radically change the course of their respective organizations. In the latter case, a sale of the health insurance unit to another carrier with a more health-oriented business model resulted. As an example, Prudential and Equitable sold health insurance books of business to Aetna and CIGNA respectively. Both were leading edge innovators in managed care (i.e., PruCare and EQUICOR, respectively) prior to their divestitures.

The question for an employer is whether carriers are dabblers or true GMCOs. One carrier comes to mind. It is an international dabbler by definition. However, it has hired an aggressive front-end organization to handle relatively simple administration. It does not have the appearance of wanting to make substantial investment. Its business model is pure joint venture oriented with limited healthcare benefits keeping pricing in-line.

- ✓ Today there are emerging GMCO's with a world vision
- ✓ A philosophy of long-term delivery system intermediary versus short-term profit
- ✓ Market entry commitment recognizes difficulty in reversing capital investment decisions

- ✓ U.S. markets have great variation among insurance carriers
- ✓ Traditional U.S. broker functions
- ✓ There is a self-insurance broker subspecialty that requires more sophisticated knowledge
- ✓ In addition to traditional broker functions, the required GRIP skill set is unique
- ✓ Brokers must address constantly emerging new matrices of issues

Compare that to carriers which have a world vision based on the ultimate societal impact of their company in a region as much as the marginal investment yield of a new business opportunity and the differences in carrier philosophy are clearly visible. One participates in THIM for profit and one participates in THIM to be an integral piece of the international healthcare delivery system. (i.e., IHDS). One may be a flash in the pan. The other, through substantial investment with problematic spin-off potential, may be a long-term and valuable part of an emerging economy. The latter may also have a political dimension associated with it.

Minimum standards need further exploration. The above discussion has focused somewhat on carrier evaluations in non-U.S. markets. However, many of the same issues apply when employers set up a U.S. operation. As with GMCO's, domestic U.S. carriers are substantially different amongst themselves. Traditionally, with larger employer groups, domestic brokers (1) write up specifications, (2) go to market, (3) evaluate offered plan terms and pricing, (4) bring their intermediary and personal underwriting experience to bear, (5) write a report to clients with a recommendation of a carrier, (6) assist with ultimate carrier selection and final pricing, (7) suggest optimum financial devices, (8) assist with communications and enrollment, (9) monitor carrier service, (10) assist with regulatory compliance, and (11) negotiate renewal actions at plan year-end. Smaller groups tend to have less flexibility in plan design and financing methods. In that case brokers orient themselves more to simple pricing and service. Again at the larger end of employer size, a sub-specialty of brokers with a more sophisticated knowledge of using self-insured methods also exists. These are the very minimum standards. Additional services are often packaged as needed. In the broader THIM market, a GRIP must have all the above skills in addition to incremental ones demanded by the new paradigm.

The essence of **BBCG** reflects the principal's thirty years of business experience in the health insurance industry not only in brokerage/consulting but in carrier underwriting, sales and management positions. The technical and service requirements articulated above are part of our everyday lives. However, we have put new focus on the international piece of **BBCG's** business model in recognition of the sea change we see so clearly occurring. In addition to all the requirements of a domestic broker, our intent is to deliver to clients the unique skill set of a GRIP thus substantially differentiating our firm from others which might seek the same clients.

W hich **S** olution **A** pplies

In high technology industrial sectors white papers often first address the "generic" solution and then how the advances touted by the white paper either incrementally surpass old methods or provide a quantum leap into a completely new solution paradigm. As this paper was being written, it became clear that such a format was untenable relative to this particular discussion. Issues of aesthetics, ethics and prose effect all aside for a moment, the sole underlying reason is that there is no single "problem" to define and therefore there is no single existing generic solution upon which to improve. As the THIM constantly matures and changes dimensions newly emerging matrices of issues must be addressed. It is a constantly evolving and moving target.

- ✓ The THIM is dynamic with constantly emerging new issues
- ✓ Most often no single solution
- ✓ The basic process of drawing up specifications and going to market remains

- ✓ A complex set of elements make up the THIM decision matrix
- ✓ Includes commercial as well as non-commercial considerations
- ✓ The commercial questions hone in on corporate purpose

The generic solution might be thought of as the historical functions of insurance brokers throughout the world. Indeed, they have not changed significantly in a long time. Communications advances have certainly altered transaction speed, volume and some interface functions. However, in the end, it is still the same basic functional structure of drawing up specifications and going to market on behalf of a client.

When looking at the THIM, decision points can be placed into many niches. We will depart somewhat from our employer orientation and bring other considerations into the discussion. Below is just a sample of how a matrix might start to be developed:

- Commercial versus non-commercial
- Which country will be the host country
- Large presence abroad versus minimal presence
- Private sector (i.e., non-governmental) versus public sector (i.e., gov't.)
- Short timeframe abroad versus longer timeframe
- White collar versus gray/blue collar risk exposure
- Religious based
- Academic based
- Non-employer sponsored commercial coverage
- Non-employer sponsored individual coverage
- Tourism based
- Western based healthcare expectations or other
- Existence of special employee/dependent needs
- Existence of healthcare billing and related banking issues
- What degree of carrier sophistication and support will be required
- What are the political consequence of one carrier versus another

The first slice above, commercial versus non-commercial, addresses the basic purpose of the coverage. In essence, is it an employer protecting an investment in human assets or is it some other form of protection (i.e., tourists, expatriates, etc.)? If commercial, below are additional matrix variables:

- Does your firm send U.S. or non-U.S. employees overseas as temporary business travelers?
- Does your firm presently pay for expatriate medical care actually incurred overseas using your domestic plan's claims payor (i.e., carrier or other payor)?
- If a U.S. based employer, does that claims payor have knowledge of the local payment arrangement in your foreign locations or do they essentially pay at the U.S. "usual and prevailing" (i.e., also sometimes called "usual and customary" or "usual customary and reasonable") fee levels for comparable services?
- Do your overseas employees have access to the facilities they most want to utilize and at reasonable cost. If not, do you have an explanation as to why (e.g., the lack of need for extreme high-end providers to ensure reasonable care in that country)?
- Have any unique medical needs of an employee and/or dependent ever been an issue prior to a previous assignment?

- Has your firm ever been forced to repatriate an employee on assignment due to a health reason?
- Does your firm have a domestic payroll that periodically needs to be accessible to those who reside outside the United States for healthcare, or other, reasons?
- Has your firm ever been forced to cover evacuation from the host country of a critically ill employee/dependent on assignment? Has the evacuation and replacement cost been determined?

For simplicity, we have categorized the purchasers of international healthcare insurance into six primary segments. There are likely other sub-categories that would fit comfortably under each of the primary ones .

- ✓ The six major primary categories
- ✓ Commercial
- ✓ Government
- ✓ Academic
- ✓ Religious
- ✓ Tourism
- ✓ Retired and active expatriates

Commercial coverage has been dealt with at length above. The solution for employers is in the sophisticated range. Many of the old solutions, including carriers who have handled the prior requirement of international healthcare insurance quite well, are no longer quite as well positioned. As U.S. style managed care continues to be exported to emerging economies, only a select few relationships will be appropriate for the commercial purchaser. Quality and cost efficiencies will be the differentiating factors. This will be a sea change for other carriers which will be forced to compete on a set of standards for which they will be increasingly unprepared. Domestic versus foreign carrier disputes can be expected to increase and political relationships will be key for the successful carriers. Commercial employers will look to the GRIP to assist in making critical decisions.

Government coverage is a unique primary category. In Figure 5 above the concept of **FSOP** was listed as one of the new acronyms emerging in the THIM. It stands for Foreign Service Officers Plan. This is a solution for governments who have highly transient diplomatic and staff officials in missions throughout the world. It is virtually one hundred percent white collar. It demands many of the same high quality considerations as the commercial coverage primary category. Often, pricing is less a factor. It demands top quality coverage that can be ported outside of the country of assignment if required. Economies of scale may allow more favorable contract terms. Flexible, single contract, approaches that can incorporate covered employees in multiple countries can be valuable. Selection of an appropriate central contract situs is the key to appropriate placement of this type of business. These plans can be written by high quality carriers for any country having a Washington D.C. embassy and offered to the foreign service corps regardless of the location of officer assignment. Although many carriers can provide a basic set of insurance services, the utilization of a GMCO with the appropriate quality and global service standards is recommended.

- ✓ The commercial category is the most sophisticated
- ✓ Government plans include the FSOP concept for diplomatic personnel
- ✓ Academic coverage is usually more short-term

Academic organizations coverage is also somewhat unique. Often this is shorter term coverage than with the prior two primary categories. It requires plan design flexibility and is very price sensitive. It is also often purchased individually or with minimal involvement from a plan sponsor (e.g., an employer). If the number of covered individuals is to be relatively large, a GMCO might be considered in order to tailor the contract terms under a group policy. However, there are specialty carriers which are very well positioned to handle this primary category effectively with pre-designed plans. This category also requires additional knowledge on the part of the GRIP relative to various student and/or faculty visa requirements and how they might be best met. Emerging institutional requirements point to this category as growing in size.

- ✓ Religious coverage requires sensitivity to local beliefs and politics
- ✓ Political tact of carrier key consideration
- ✓ Tourists often unaware of lack of coverage
- ✓ Lack of U.S. Medicare coverage outside the borders of the U.S. key consideration for both tourists and retired expatriates
- ✓ The broker or GRIP must be aware of these considerations when making recommendations

Religious organizations coverage may seem a small segment of the international healthcare insurance global market. Like academic organization coverage, it has unique requirements that differ from both the commercial and governmental primary categories. It is listed as a primary category due to the political sensitivity and unique service requirements that can be present. There are specialty carriers which are well positioned to address these needs from the experience gained in providing coverage to missionaries and other deployed religious persons. Political tact (i.e., not being perceived as crossing certain non-proselytizing domestic laws in a host country) may be a key consideration. Local quality may be less a factor initially. Similarly, low price might also be appropriate initially. However, medical evacuation to a third country with the availability of higher levels of care is a critical factor. There are often minimal support and communications structures available to these persons via their sponsoring organizations and the carrier's methods of providing around the clock service can be crucial.

Tourism related coverage is almost always non-commercial in nature (i.e., privately purchased by individuals or small groups). Persons purchasing this coverage often have come to realize that the healthcare coverage in their home country of citizenship does not travel with them to their destination country (e.g., U.S. Medicare or other state systems). Travel companies often provide a packaged minimal amount of healthcare coverage for emergencies when tours are purchased from them. This primary category consists of those traveling persons who demand more comprehensive coverage (e.g., beyond emergency only and at higher dollar limits). It also consists of limited individual commercial travelers who may be abroad on relatively short assignments where this kind of coverage is perceived as adequate. Specialty carriers with pre-designed plans are best positioned to address the needs of this category. Around the clock service and effective provider interfaces in the highest number of countries are key considerations. Medical evacuation coverage is also a major consideration for those persons traveling to relatively remote destinations.

Retired expatriate coverage can fall into both the commercial and the non-commercial segments. It is dependent on the ultimate payor. If a commercial employer is obligated for post-retirement healthcare benefits, regardless of the country of residency of the retiree, it falls into the commercial segment. In that case, a GMCO approach is likely in the best interest of the sponsoring employer. All the same considerations of the commercial primary category would apply. If the expatriate is purchasing coverage individually (i.e., not as a covered retiree under an employer sponsored plan) in order to supplement lost home country healthcare (i.e., U.S. Medicare or other home country coverage) then it falls into the non-commercial segment. In that case, a specialty carrier with experience in providing long-term individual international healthcare plans with a substantial service infrastructure would be appropriate.

As was noted above, there are more than likely many sub-categories to each of the above six primary categories. However, overall, these six make up the bulk of the international healthcare insurance market. There are only a handful of carriers positioned to provide the sophistication that some of them require. At the opposite end, there are many carriers in the tourism related primary category which market their product to less informed buyers. At that end of the spectrum, products are often erroneously perceived as being homogeneous in nature from carrier to carrier. The purchase decision is frequently price driven. One of the responsibilities of the GRIP is to be aware of the differentiating plan provisions and quality standards between carriers and make the appropriate recommendations to persons who have limited insurance knowledge.

The **C**utting **E**dge

It is reasonable to say that the highest degree of innovation is presently coming from the delivery side of the model (i.e., the side that actually provides healthcare services). There is indeed movement on the financial side (e.g., insurance carriers maturing as GMCO's). However, **BBCG** strongly believes that the most fundamental changes will come from entirely new supply dynamics.

Today few eminent economists argue against the value of open global markets among trade partners. Most mature and developing economies have become inextricably interconnected with others. Hardly a product is made where 100% of its components or its machine tools originate in a single country. A laptop computer may have components from as many as forty different countries because overall efficiencies dictate they are best manufactured that way.

Reduced barriers among trade partners are an essential means of allowing various forms of capital to seek their most efficient usage in a broader economic system. In total, the balance of capital movement among markets constitutes a sort of equilibrium point which balances the value of various forms of capital (e.g., human versus technological or natural resources versus hard currency). Truly open markets, with their hard to break interconnectivity, also balance the rate of acceleration and direction of capital movement (e.g., weak currency and sales of goods on one side and return of financial capital to ensure a strong purchasing economy on the other). It is very much a closed loop system unless something cataclysmic comes along to cause a major structural shift (e.g., war, waning of valuable capital resources, etc.).

It would be disingenuous to indicate here that there are not ideological and economic realities that must be taken into consideration when discussing open markets. In addition, open markets, regardless of the long-term potential positive economic value to a given country, can be perceived as an immediate pariah if interest groups are negatively impacted in the short term, if religious groups are affronted, or if predominant political systems are challenged too quickly.

During a weeklong class in March 2004 at Harvard University entitled "Skills for the New World of Healthcare" **BBCG** (i.e., Robert Murphy) postulated in a presentation to the faculty as a portion of a solution to a certain problem that efficient healthcare delivery is ultimately less a social issue than an economic one. It is equally arguable that just as human assets are capital, so too are the means of insuring their value (i.e., all the elements of high quality healthcare available from any source).

One of the acronyms that was introduced in Figure 5 is **IRH** (i.e., Internationally Resourced Healthcare policy provisions). Some employers might know the concept as "medical tourism." It essentially refers to persons traveling to a foreign country where they can purchase a given set of medical services at a substantially lower price than available in the person's home country. For the most part this is an unregulated cottage industry in 2010. Naysayers point to quality differentials that come with foreign training and discounted pricing. However, the fact is that pricing differentials do

- ✓ The greatest innovations have been on the delivery side of the model
- ✓ How to make healthcare capital seek its most efficient utilization
- ✓ Open markets are actually a closed loop system
- ✓ Ideological and economic resistance to change is a reality
- ✓ Healthcare as an economic versus a social imperative

- ✓ The IRH concept is only a first step
- ✓ Current provider pushback relative to the IRH concept may be self-serving and excessive
- ✓ Broadband communications underlies most significant advances

- ✓ The HI-FTZ concept is the true cutting edge
- ✓ It must be made a win-win proposition for all participants
- ✓ Applies to mature as well as emerging systems
- ✓ Takes the best of all systems and proscribes weaknesses
- ✓ International as opposed to local domestic regulation

not always exist due to substandard care. There can be other efficiencies bearing on the cost structure that underlie the ultimate pricing (e.g., a moderate tort environment relative to an aggressive tort environment). IRH's have failed to find their way into most U.S. domestic policies not so much due to low standards of care in non-U.S. provider locations as due to the *real politic* of interest groups which would be disenfranchised by such a radical change in the presently available delivery system (i.e., as defined by what is covered by domestic healthcare insurance and Medicare). However, the further maturation of GMCO's would point to that boycott-type behavior giving way to a reluctant acceptance of IRH terms in domestic policies. Those carriers which refuse to accept the new paradigm will be increasingly at a pricing disadvantage. When **BBCG** looks for the most fundamental driving forces we again point to broadband communication which allows a degree of quality control and a virtually realtime rate of information sharing that has not been possible heretofore. Careful use of IRH's, with the open market argument in mind, increases the efficient allocation of healthcare capital worldwide.

Healthcare International Free Trade Zones (i.e., "HI-FTZ" per Figure 5) have the potential of far transcending the limited usage of IRH's to date. IRH's depend on the best of certain "offshore" healthcare delivery systems, and an associated pricing differential, to induce travel to that foreign country for services. The newly emerging concept of HI-FTZ melds the best practices of nations from all over the world and proscribes as many negative factors as possible. The result: highly concentrated unique locations of world-class services at optimum cost. The thought of emerging economies with lagging healthcare systems comes immediately to mind as the logical location for a HI-FTZ where high levels of quality can be imported at world median costs over short periods of time. However, even the most mature and highly integrated healthcare systems in the world have negative factors which come from a laissez-faire approach to healthcare delivery (e.g., inefficient utilization of healthcare assets, duplication of resources leading to low rates of service area capacity usage, defensive practice protocols, end-of-life utilization of assets skewing, local parochialism of institutional trustees, high barriers to entry for new financial intermediaries, institutional end-user demand selling to persons not equipped to differentiate, rationing of services associated with ability to pay, costly entrenched low marginal return government entitlement programs, lip service to best practices by those without oversight, an onerous jurisdictional environment, institutionalized cost increments associated with legal payouts, the perception that medical perfection is to be expected and when not achieved is a compensable event, etc.). Clearly, even the most mature systems can be both more cost and quality efficient when these factors are minimized in a HI-FTZ environment.

Things like high rates of tort litigation in the U.S. and the commensurately high cost of malpractice insurance in key specialty areas like OB-GYN and neurosurgery, will not exist in the HI-FTZ. Locally enacted statutes will be prohibited from enforcement within the HI-FTZ by its enabling constitution and by-laws. The legal jurisdiction of the HI-FTZ will evolve over time but without question it will be international in nature where the highly skewed legal and political environments of individual countries are dampened. A newly established world body at The Hague exercising international jurisprudence is a likely choice. Conversely, the U.N. is an unlikely choice due to the degree of imbedded politics with which it would be forced to contend. Clearly, western European legal standards may not apply in other parts of the world where the HI-FTZ concept would otherwise have great value. A certain degree of regionalization reflecting cultural differences is an absolute requirement.

Several questions immediately come to mind:

- Where will HI-FTZ's be located?
- Are physical and/or geographical demarcations required?
- Why would employers and various domestic regimes support the HI-FTZ concept?
- Why would individual employees (and others) embrace the HI-FTZ concept?
- Will the highest quality providers from my country participate?

Addressing the first two questions in reverse order, no "brick and mortar" type demarcations are absolutely required. The HI-FTZ is more a regulatory, legal, protocol and asset driven model that requires only the absolute protection of the host domestic regime against co-option and local jurisdictional reach. Minimum licensing standards associated with facilities and providers may initially have some local oversight in the nascent stages of local HI-FTZ development. However, ultimately the international jurisdiction of The Hague-based entity will supplant all local jurisdiction. In some cases, a physical isolation may make pragmatic sense (i.e., similar to existing economic free trade zone approaches in many port cities). However, it is not an absolute requirement. There need not be any fences around a compound unless physical security is a problematic issue.

Where there is a physical demarcation, it is reasonable to consider the concept of a special HI-FTZ travel visa whereby ease of ingress and egress to and from the HI-FTZ is facilitated by participating countries. Clearly, there is a security challenge associated with initial host country entry into an international holding area and subsequent transport to/from the HI-FTZ which must be addressed in this scenario. Where there is no physical demarcation, the HI-FTZ visa may still be viable if proper controls over movement can be put in place.

There are multiple reasons for employers and various domestic regimes to support the HI-FTZ concept. For instance, in the U.S. it would provide employers sponsoring employee health plans with a significantly lower cost alternative than those which now exist. It would ease pressure on long-distance travel and the relatively unknown quality of certain IRH modalities. It could be offered to employees on an "opt-in" basis whereby all the limitations (e.g., non-U.S. legal environment with significantly reduced tort remedies, non-HIPAA medical information protocols, etc.) were properly disclosed per the intent of ERISA (i.e., U.S. employee benefit regulatory statutes).

For some countries the HI-FTZ concept might actually be a source of income and indirect tax revenue. Attracting thousands of medical patients to a new world class facility would cause local payrolls to substantially increase, associated local economic activity to increase, consumption and/or income tax revenue to increase, and lease payments to be established (i.e., in the case of a HI-FTZ compound approach). Training infrastructure and jobs would ultimately increase as internationally imported employees were transitioned to more locally trained professionals over time. However, the real driver is the potential for a quantum increase in the available quality of care to a domestic population over the short-term.

- ✓ No brick and mortar facilities are required
- ✓ HI-FTZ is a regulatory, protocol and asset driven model
- ✓ Physical isolation is not required
- ✓ Concept of the HI-FTZ travel visa

- ✓ Reasons for various stakeholders to support the HI-FTZ model
- ✓ Positive implications of various countries
- ✓ Potential for quantum increase in quality of care in certain countries

- ✓ HI-FTZ support in the U.S. will be cost-driven
- ✓ The shortfalls of more socialized systems will also drive the HI-FTZ concept
- ✓ In some countries the HI-FTZ may become an exportable asset
- ✓ There will likely be negative pushback from reactionary interests in various countries
- ✓ The HI-FTZ and other cutting edge concepts will continue to evolve

Will individual employees, and others, support the HI-FTZ concept? The answers are as myriad as the number of countries that might participate. In the U.S. the answer is a qualified “yes.” It is hard to conceive of American employees not wanting to consider a significantly lower cost alternative that has reasonable controls and quality even if they have to accept certain trade-offs. In highly socialized systems there might be more reluctance to participate. However, waiting time for services, the carrying cost of duplicate insurance, and quality might be adequate drivers. In developing countries, pure access to services, heretofore practically unavailable, and newly emerging employer concerns about workforce health will likely be adequate. It should be noted that in some emerging economies the HI-FTZ cost basis may actually exceed the present domestic cost basis due to lagging quality, technology, training, protocols, etcetera. In that case, the host country may consider either a slow upgrade to world medians or the HI-FTZ as an “export” asset only until pricing normalization is achieved.

Will the best providers in my country participate? Again, the answers are myriad. However, there are some which are more clear than others. In mature healthcare delivery systems like the U.S., there will likely be a fairly significant backlash from physicians and hospitals which stand to lose revenue that migrates out of the domestic system into the HI-FTZ system. The reaction will likely be akin to that seen during the explosive growth in HMO-like managed care from 1985-1995 (n.b., preventive care and medical result HMO altruisms aside, also completely cost driven at the employer level). Providers will point to damage that will occur to the domestic system as the result of revenue shifts. They will further point to a degradation of quality and incremental risk of medical procedures in the HI-FTZ. As an odd bedfellow, they may even point to the removal of tort litigation as a remedy for improper medical performance. They will enlist political power to fight the HI-FTZ concept. However, in the end demand will be the deciding factor, as it was from 1985-1995. Ultimately, these same voices will either become part of the HI-FTZ concept as it evolves or the internal and external negative factors mentioned above will be marginalized by necessity, making the domestic system virtually as efficient as the HI-FTZ system and thus attaining a new equilibrium point between the domestic system and the HI-FTZ system. In less mature, more socialized, or less politicized healthcare delivery systems this will be a negligible consideration. As noted above, in some cases a higher quality level will actually be imported than presently exists in certain countries. In those countries, it will be critical to invest the present healthcare establishment relative to the success of the concept.

The Hi-FTZ concept is the very cutting edge of international healthcare delivery system development. It requires strong trans-border leadership of all the stakeholders for its ultimate success. Politicians and present vested interests may work to undermine the concept if it does not suit their short-term agendas. As was mentioned earlier (p. 15), **BBCG** feels strongly that the social implications of high quality and available healthcare aside, the economic realities of a healthy workforce (i.e., both from a productivity and a personal satisfaction perspective) indicate that commercial interests are best positioned to be the advocates of HI-FTZ development.

Cutting edge concepts are dynamic in nature. There will be additions and others will fall by the way. We have attempted here to indicate to the reader some of the influences that presently effect various international healthcare solutions. So too will the solutions change as new variables require consideration.

Security in the **B**roadband **W**orld

- ✓ Security is a critical concern in the broadband world
- ✓ Basic GMCO infrastructure must be stable and secure
- ✓ Implications of the “faceless” transaction
- ✓ Broker functions may remain relatively similar but are handled electronically
- ✓ Identification authentication is a critical element
- ✓ Both persons and representations need to be authenticated

This subject might seem out of place with the broader objectives of this paper. However, **BBCG** feels that it is actually an integral part of the new THIM environment (per Figure 5). The basic concepts of data security at the GMCO level are virtually self-evident. When a complicated and inter-related healthcare intermediary (i.e., insurance carrier) processing system spans continents and political regimes, stability is an absolute requirement for the long-term success of the GMCO. We assume here that the system in total and each of its supporting sub-systems are technically adequate. The most important consideration in that case is the projected “up” time of the system and the potential for presently unforeseen circumstances to effect that projection. Any solution chosen, should consider such variables at a minimum.

BBCG has had other security issues arise as well. The Internet has proven to be an unprecedented resource for the purpose of telling the world our story and how we might be of assistance in developing solutions for specific challenges. It is no longer a telephone call into our office, a quick hop onto an airplane and a subsequent face-to-face visit with a potential client. The time to solution is also no longer days to weeks. It is often minutes and hours. The client may remain faceless during the entire process with only an electronic form of identification (e.g, email address, server IP address, etc.). The average distance to a client is no longer measured by in-flight hours. Broadband communications makes the entire wired world a market in one form or another and distance has become a negligible consideration.

Take for example a relatively recent successful interaction that might have had more problematic results. Following on an electronic marketing effort conducted by **BBCG**, we were contacted via email by a potential client which described a series of needs. The client was literally on the other side of the world. We traded several initial emails, got to know each other somewhat, and we each assumed that the identities on both ends were what they appeared to be. It was a client that we wanted to secure. Multiple solutions were available and we began to line up proposals to present to our new “electronic client” sight-unseen. We electronically introduced international insurance carriers to this new client the same way we might have previously invited them to physically present a proposal in our client’s office. Up to that point there was little risk to **BBCG** other than embarrassment with the carriers if the “client” was actually spoofing us. However, as we got closer to contractual commitments, licensing issues, international regulatory considerations and substantial investment of resources by all the involved parties the risk rose exponentially and we felt we had to know for sure just who this client was. We should have had a prospective methodology in place versus the defensive process we were forced to utilize. Using various WHOIS services that allow the tracking of IP addresses, we analyzed several emails to ensure the originating IP was where we would expect it to be. In this case, each one checked out. There were multiple IP’s that represented office servers versus home laptop access to an ISP but the origins were all in the city we expected.

The American College (Bryn Mawr, PA, USA) Canons of Ethics

- Conduct yourself at all times with honor and dignity
- Avoid practices that would bring dishonor upon your profession or The American College
- Publicize your achievements in ways that enhance the integrity of your profession
- Continue your studies throughout your working life so as to maintain a high level of professional competence
- Do your utmost to attain a distinguished record of professional service
- Support the established institutions and organizations concerned with the integrity of your profession
- Assist others in career development
- Comply with all laws and regulations, particularly as they relate to professional and business activities

Accessing International Healthcare Insurance

The IP address location being resolved gave us some degree of comfort that we were dealing with a legitimate client. However, two additional concerns had to be resolved: (1) has the client vetted **BBCG** in a similar way to ensure that all representations at this end are legitimate and (2) are we actually communicating with a person with the authority to buy? We assumed a level of client due diligence on the former (i.e., our web hosting IP is public and easy to verify) and in the late stages of the process we struggled with the latter. Were we dealing with a top management person at the IP address as was being represented to us or were we dealing with a lower level disaffected employee with access to an email account? We considered this issue to be so critical that in a series of emails we began a “de-lousing” process. We were looking for a telltale sign that the “client” was not what we thought it to be. We never discovered any information that would lead us to that conclusion. We provided the required solution. Today we have both a happy carrier and a happy client. However, it could certainly have gone the other way.

We feel our own internal performance was less than it should have been in the above scenario. We allowed the risk potential to become too high before we proactively addressed the security issue. The implications of securing an internationally high visibility client clouded our judgment just enough for us to minimize a risk which was actually much greater than we were allowing. We have since established identification protocols that begin in the very early stages of work with a client secured electronically.

Security, for the purposes of this paper, is actually a bi-lateral process. When no physical interaction takes place, clients need to be sure that they are dealing with legitimate brokers or GRIPs (i.e., need specific). They also must ensure that insurance carrier representations made electronically are legitimate. Conversely, clients should not feel imposed upon if some form of authentication request is made relative to their own identity. Electronic commerce is relatively easy when it is no more than a pay and ship process. It has become routine worldwide. Data security of transaction information (i.e., credit card numbers, PINs, etc.) on one end and receipt of expected product on the other end are the major considerations. The prospective provision of services and retrospective payment environment of international healthcare insurance dictates a completely different paradigm. We at **BBCG** have come to believe strongly that one of the very first steps in a faceless client process is identification authentication. Clients should expect nothing less from the professionals with whom they work to provide other solutions.

The BBCG, Inc. Method

Every client has a unique set of needs. However, the principals of **BBCG** have found over thirty years of experience in the U.S. domestic and international health insurance industry that there are common elements that occur in each of our successful brokerage and consulting assignments.

The BBCG Method**Accurate assessment of needs****Ethics**

- Honesty
- Forthrightness
- Fair compensation
- No carrier bias
- No marginal areas
- Dual loyalty to clients and markets
- Full regulatory compliance

Core Values

- Client first
- Eclectic approach
- No parochialism re carriers
- Sharing of resources
- Long-term vision
- International networking
- Conservatism
- Accountability

Image

- Responsive to change
- Forward thinking
- Technology based
- Community involvement

Clear Expertise

- Experience
- Education
- Licensing
- Professional certifications
- Market accessibility
- International networking

For the most part, **BBCG** takes as a given an accurate assessment of each of our clients needs. At times, this may be an exploratory process whereby perceived needs are expanded or modified. In that regard, it is critically important for **BBCG** to fully understand the result our clients expect. To that end, **BBCG** further assists clients in the equally important task of synthesizing various objectives that they might have into a cohesive set of priorities and at times resolving inherent conflicts that might arise.

Without question, the first and foremost element is honesty. It is the cornerstone of the more broad professional ethics to which **BBCG** publicly subscribes via the participation of its principals in organizations such as the (U.S.) National Association of Insurance and Financial Advisors (“NAIFA”) and via the requirements of (U.S.) The American College (i.e., for numerous advanced financial services designations). In the case of NAIFA, **BBCG** has been represented at the local Board level for five years.

Honesty crosses over into many of the other elements of successful client relationships. The first is forthrightness. The bottom line: not everything goes as planned. When something goes awry, we have found over the course of many assignments that our best course of action is to acknowledge all problems and provide adequate solutions for our clients.

It may seem somewhat out of relation to put compensation among the honesty elements. However, the insurance industry is rife with hidden compensation deals which at time lead to disservice being rendered to clients. Financial inducements to place new or additional business with only certain insurance carriers has been common (e.g., hidden volume-based override deals, advanced commissions, etc.). **BBCG** is totally open with clients regarding all sources of income it may be receiving and how those sources of income could potentially impact certain recommendations. Our target is zero impact via full disclosure with our clients. Our mantra is “no parochialism” whereby we bring the best resources to our clients regardless of the potential financial impact on **BBCG**.

Another key element of success that **BBCG** has found to be associated with honesty is acknowledgement when **BBCG** might not be the best vendor for the anticipated assignment. The corollary is that we are excellent at some things but cannot claim to be excellent at everything. There are marginal areas in our expertise. Instead of attempting to convince a potential client otherwise, we secure the proper level of talent from our vast network of professional associates and approach the assignment on a joint venture basis.

Clearly the first loyalty of **BBCG** is to its clients. The insurance market, however, requires a degree of dual loyalty from the brokers and consultants who function as a part of it. That requirement transcends the informal ethical responsibilities to the parties. Indeed, the broker/consultant often has a legal obligation to both parties (e.g., a contractual agency relationship with the carrier and the requirement to act in the best interest of clients as demanded by licensure in many jurisdictions). One of the clearer elements of success for **BBCG** has been when it has established a win-win situation for both the purchasing client and the selling insurance carrier. By attempting to develop long-term win-win relationships we feel we serve the best interests of both parties and fulfill the dual loyalty requirement. Short-term strains on such relationships are much less problematic when both sides can take a long view. Negotiations are facilitated when both parties recognize the prior historical give and take. At times it puts pieces of **BBCG**'s

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business at risk (i.e., when a **BBCG** competitor approaches a client with a purely lowest cost philosophy). However, on balance, **BBCG** has become comfortable with its dual loyalty approach.

Regulatory compliance may be hard to perceive as an element of success. It is included here because **BBCG** has found it to be an absolute component of the ethical conduct of business. Further, it maintains an orderly marketplace which ultimately benefits our clients in many ways. Our intent is to be 100% compliant with all relevant regulations in a given jurisdiction and to never operate on the margins. **BBCG** has sought the advice of competent legal counsel whenever it has been unsure of the proper course of action on such issues.

The dual loyalty discussion above actually goes to **BBCG**'s core values. We have found another element of success to be the fortitude to take a stand when required. If forced to make a no-win decision between the best interests of a client and the best interests of an insurance carrier, **BBCG** will unflinchingly fall on the side of our clients. That being said, **BBCG** always attempts to facilitate mutual understanding in disputes.

A clear element of success for **BBCG** is the manner in which it operates eclectically. **BBCG**'s slogan is "Establishing the Best Team for the Task at Hand." At times that means introducing non-**BBCG** resources for which **BBCG** receives no compensation. We have found that, over the long-term, that bringing the best team to bear on behalf of clients far surpasses short-term revenue potential associated with trying to do all jobs in-house. It further reduces any tendency toward parochialism, shares the best professional resources available in the marketplace and keeps **BBCG** attuned to its stated long-term vision.

Associated with the eclectic approach is networking. **BBCG** has found that the most successful assignments, where an eclectic approach is used, have a common element. Our professional partners are known, share our ethical values, and perform at an exceptionally high level of quality. In order to maintain such relationships, **BBCG** has established both domestic (U.S.) and international networking as a primary corporate objective.

The above likely has established the picture **BBCG** wishes to represent. Our successful assignments have the common element of a conservative approach. We make no grandiose promises of results (e.g., financial savings) unless we indeed can introduce a unique concept. We do not compare ourselves to the competition in a way that belittles their competency. We do not share negative knowledge we might have about a broker/consultant competitor with any of their clients. We rarely solicit an "agent/broker of record letter" in an attempt to finesse someone else's business away from a client without **BBCG** doing the actual work. We believe in rolling up our sleeves, performing at an excellent level on behalf of clients and making our value self-evident.

Accountability has shown itself to be a key element of success as well. **BBCG**'s clients know they can depend on **BBCG** to be responsible for all its actions. It goes back to the loyalty issue once again. When clients are aware that **BBCG** takes its accountability responsibilities seriously, the degree of trust is enhanced by a quantum factor.

Another common element of success in assignments is how **BBCG** positioned itself relative to its competition and how that solidified its relationship with clients. First and

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foremost, many clients are unnerved by the degree and acceleration of change (i.e., including regulatory changes, product changes, and overall industry changes). **BBCG** has established a triad of sorts to address these concerns: (1) rapid response to change; (2) continuous forward thinking; and (3) cutting edge technology based. We want to be the first organization to present a viable solution to our clients. If the same ideas arrive later from a competitor we trust our clients will view it as "old news."

The subject of expertise as a common element of success has been deliberately left for last in this section of the paper. We are disinclined to brag about the expertise of **BBCG**. However, it is, indeed, that expertise which has been the nexus binding all the other elements of success. The founder of **BBCG** has 30 years of health insurance industry carrier and broker experience, having begun his career as a home office underwriter in a regional home office of one of the largest U.S. health insurance carriers in 1980. We also feel strongly about the differentiation with our competition that education represents. In the U.S. the gold-standard for advanced financial/insurance certifications is The American College (Bryn Mawr, PA). In addition to the Registered Health Underwriter designation ("RHU"), The American College has issued **BBCG's** founder the Registered Employee Benefits Consultant ("REBC"), Chartered Financial Consultant ("ChFC") and the Certified Life Underwriter ("CLU") designations. He also holds a Masters of Business Administration degree ("MBA"). In 2004 he received a certificate from Harvard University for participating in an executive course entitled "Skills for the New World of Healthcare" where he brought to the process insurance knowledge to complement that of the other participants (i.e., primarily thoracic surgeons and hospital administrators).

BBCG conducts no business outside its established licensing parameters. If additional resources are required to deliver the proper degree of expertise to a client, **BBCG** will bring to bear one of its strategic relationships.

Expertise is often measured by which markets (i.e., insurance carriers) a broker represents. As noted above, **BBCG** is averse to any parochial relationship which might cause our recommendations to be suspect. We have structured our industry approach in such a way as to be an independent broker with access to virtually all relevant insurance carriers. In the U.S., the number of healthcare insurance carrier "appointments" are sometimes considered a measure a broker's breadth. However, virtually all healthcare carriers in the U.S. will issue a proposal prospectively and then make the proper appointments retrospectively if a sale is made. It is the prime reason that **BBCG** does not enter into client relationships where we are bidding against other brokers with access to the same carriers. There are exceptions to this policy. However, they are rare. Where there are international restrictions on our access to carriers, we utilize certain carriers via the strategic relationships noted above.

In order to be successful in the international healthcare insurance industry, strong networking relationships are required. **BBCG** has found that to be true domestically as well. **BBCG** continually leverages thirty years of experience and personal relationships worldwide to keep our network superior to our competitors. When a solution is required, we feel comfortable that we can deliver it either directly or via one of our network partners.

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Please See BBCG Contact Information on the Following Page

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