

PAYING LESS FOR THE BEST

Will health care reform and the push for greater transparency in pricing set the stage for a boom in domestic medical travel? By Kevin Featherly Illustration by Eva Vázquez

Fifteen years ago, Laura Carabello was diagnosed with an acoustic neuroma, a nonmalignant tumor on the nerve running from her inner ear to her brain.

She lived in northern New Jersey, not far from New York City's best hospitals. Yet her primary care doctor urged her to seek treatment at the House Ear Clinic in Los Angeles. At the time, House's doctors had completed 5,000 of the specialized neuroma surgery Carabello needed—by contrast, the most experienced hospital in New York had performed just 50.

"My doctor was smart enough to tell me this is the hospital to go to because it is where they have the best outcomes," says Carabello, who took the

advice and had the surgery done in Los Angeles. The outcome, she says, was phenomenal. "Wouldn't I have been idiotic not to go?"

These days that question is more than academic to Carabello. A health care and technology-marketing consultant, she publishes a newsletter for the website USDomesticMedicalTravel.com, which covers the growing trend of Americans traveling outside their home cities and home states for better, often less expensive health care. Carabello has written for years about the more familiar trend of international medical travel, often dubbed "medical tourism." Readers and clients began asking her to look closer to home. Mostly, that's because several large American



employers had recently turned to domestic medical travel as an option for their insured workers.

“Employers realize they can get better outcomes at a more reasonable price if they don’t stick within a 10-mile radius of their offices,” Carabello says.

Walmart and Lowe’s are clearly thinking just that. They jointly announced last year that they were joining the Pacific Business Group on Health Negotiating Alliance and entering into a travel surgery program. Through the program, participating Lowe’s and Walmart employees and their dependents receive 100 percent coverage for hip and knee replacements performed at one of the four hospitals designated “centers of excellence”: Kaiser Permanente Orange County-Irvine Medical Center in California, Virginia Mason Medical Center in Seattle, Johns Hopkins Bayview Medical Center in Baltimore and Mercy Springfield Missouri Hospital.

Health Design Plus, a health care management company with experience administering travel surgery programs, handles logistics for the program, which pays for the full costs of the surgery, an initial remote evaluation of the patient to determine

suitability for the procedure, onsite preoperative work and imaging, and physical therapy and post-operative clinical care in the city where the surgery is performed. Travel expenses for the patient and a caregiver are covered, and a daily stipend for lodging and other expenses is provided.

“Employers have said people are thrilled about the program,” says David Lansky, CEO and president of Pacific Business Group on Health, who adds that his association’s business members have been casting about for years for ways to corral the spiraling costs of health care for their employees, all to little effect.

“There is not much evidence they are getting better value by spending more every year or that employees are getting better health care,” Lansky says. “So this travel surgery approach was a way to help employees get to the best quality hospitals and doctors and at least have a predictable cost. That was a big step for them.”

The four hospitals currently involved had to meet strict benchmarks for positive outcomes, low hospital-acquired infection rates, high patient satisfaction, advanced staff training and skills, thorough patient



Southeast Regional Stroke Center at Erlanger Medical Center Chattanooga, Tennessee



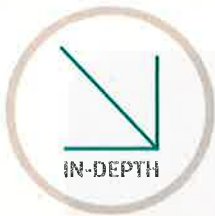
“About 2 million brain cells are lost every minute a stroke is occurring, so it’s very important to do everything very quickly to get blood flow reestablished. The motto ‘time is brain’ is the driving force behind everything we do.” —Dr. Tom Devlin

What: One of the busiest stroke hospitals in the world, the center serves an area of about 50,000 square miles, treats more than 2,100 strokes a year and is a hub for research on strokes, according to Erlanger Health System president and CEO Kevin M. Spiegel. Medical director Dr. Tom Devlin adds: “We’re one of the

busiest clinical trial centers, translating research into the clinical realm to bring new drugs to market.”

Where: Two hours north of Atlanta and two hours south of Nashville and Knoxville, its location puts it in the heart of the “stroke belt,” an area with the highest incidence of strokes.

Only here: A stroke neurologist is in the hospital 24 hours a day, every day of the year. “The stroke neurologist is perhaps the most important person in determining whether a patient is having a stroke, what’s causing it and how best to treat the patient,” Devlin says.
—Urmila Ramakrishnan



data capture and other factors. Some prominent names didn't make the list, including Mayo Clinic, Cleveland Clinic and Boston's noted Brigham and Women's Hospital. Lansky says that in the future more providers likely will be added (and more procedures covered), but for now, four geographically dispersed premium care providers are enough.

For all but a lucky few who happen to live in one of the four cities where the designated centers of excellence are located, taking advantage of the program involves travel, no small matter for relatively low-wage retail workers. That businesses are resorting to this option speaks to corporate America's lack of confidence that their employees will find comparatively good care in their own ZIP codes. There are some 54 industry groups like Lansky's, each exploring similar solutions to the health care conundrum.

PepsiCo launched a bundled-price travel surgery benefit for complex joint replacement and coronary procedures in partnership with Johns Hopkins Hospital. This program, too, is managed by Health Design Plus as part of its CliniFIT programs. "We all have to go out to find the best places to get quality care, then put together programs that give people the option to get there with less cost," Lansky says.

Where savings get realized in a program like Pacific Business Group on Health's might not be immediately obvious since employers must cover all the costs of expensive surgeries in addition to shouldering travel expenses. What's more, they're sending their workers off to premium care facilities, hardly the cheapest option. In fact, they're getting a good deal, says Lansky, who notes that there are basic offsets when purchasing high-quality care. Businesses figure they will save money by avoiding expensive re-admissions from infections and surgical complications. Meanwhile, additional cost containment is built into the agreement's bundled pricing structure.

"What the employer is paying the hospital and physicians is a predeter-

INDIA'S HEALTH CARE MODEL //



Vijay Govindarajan, international business professor at Dartmouth College's Tuck School of Business, has studied India's health care system and thinks it offers the United States some simple solutions to reducing costs and improving health care quality at home. One of his most compelling ideas: Model medicine after the airlines.

How does the cost of medicine in India compare to that in the United States?

"There is an Indian hospital that can do cataract surgery for \$200. In the U.S., it would cost \$4,000. Open heart surgery: An Indian hospital does it for \$3,000. In the U.S., an average would be \$150,000. Kidney dialysis: An Indian hospital does it for \$12,000 per year. In the U.S., it will cost \$87,000. This is the order of the magnitude of difference."

But the salary structure is different, right?

"We adjusted for salary structure. If Indian doctors were paid the U.S. salary, instead of Indian costs being 5 percent of U.S. costs, Indian costs become 20 percent."

Why is there such a difference?

"In part, the hub-and-spoke model. HCG Oncology is the largest cancer center in Southeast Asia. They have one hub [hospital] in Bangalore and about 19 spokes [i.e., ambulatory primary care centers]. In the spokes, they keep general practitioners and very low-tech, low-cost equipment. In the hub, they keep the specialists along with the most expensive equipment like the PET scans, cyberknives and cyclotrons. The hub and spokes are connected by technology. The hub does the diagnosis and prescribes the treatment, but the actual chemo is done at the spokes. They are concentrating the expensive equipment and doctors in one place."

So how does that reduce costs?

"Imagine if all 20 facilities were hubs. You would be replicating the expensive equipment and expensive doctors in all 20 locations. By concentrating them in one place, you bring down the cost of the whole system. Not only that, but because of the hub-and-spoke model—just like airlines—the volume gets very, very high. The spoke is just feeding the hub. Then there is high volume and you can utilize your PET scanner or your MRI machine or cyclotron very efficiently."

How does that improve quality?

"Volume. Indian cancer specialists see so many patients. When you see a lot of patients, you become an expert. This is how the hub-and-spoke model simultaneously decreases cost and increases quality. In the U.S., we have too many hubs and too few spokes. The result is that the equipment and the doctors are not utilized fully. There is not optimal location of resources. Instead, what you should do is keep specialists in a few hubs and open up a lot of spokes with a lot of general practitioners. They can do the basic procedures and patients needing complicated procedures can go to the hubs."

Wouldn't that force a lot of people to travel to another city for treatment?

"What is wrong with people traveling a little bit? There is nothing!"
—K. F.



mined total price that covers everything,” Lansky says. “All the doctors’ costs, all hospital expenses and their fees are part of one predictable price.”

Unpredictable pricing is possibly the greatest bugaboo of modern American health care, at least from the point of view of its purchasers.

Uwe Reinhardt, a professor of political economy at Princeton University, says he has yet to see domestic medical travel truly take hold in the United States. But the pumps are primed for it, he says, and he expects it will be a major industry push within five years. Employers (and individuals) are simply tired of not knowing until they get their bill just how much their health care costs, he says.

“The actual prices paid by health insurers to doctors and hospitals for even standard procedures—an appendectomy without complications, a normal vaginal birth—can vary from doctor to doctor and hospital to hospital by a factor of 10 within a state and even within a single city,” Reinhardt says. “I found that out in 2008 when I was chairman of the New Jersey Commission on Rationalizing Health Care Resources and I contacted a large health insurer in New

Jersey and another one in California. What actually is paid for a particular procedure depends on the relative bargaining strength of hospitals and insurers and also on the insurance product. If prospective patients for elective procedures knew these price differences, they might travel to take advantage of lower prices.”

Devon Herrick is a health economist at the Dallas-based free-market think tank National Center for Policy Analysis. “I could walk three or four blocks and could find a firm willing to do an MRI or CT scan priced anywhere from \$300 to probably \$3,000,” Herrick says. “My insurance company would pay any of these prices. That’s because my insurance company has done little to encourage me or to even communicate to me which facility has the lower prices.

“Hospitals have the highest prices, but no one has told me that. There may be a freestanding radiology facility a building away that has better rates, but no one had told me that, either. Employers are beginning to realize that this is crazy.”

Like Carabello, Herrick has been researching and writing for years on the topic of medical tourism, and he has toured hospitals in Costa Rica and Brazil



Center for Restorative Breast Surgery New Orleans, Louisiana



“We spare no effort, no expense to allow the patient to recover faster. Though it costs us more, patients actually leave the hospital after a shorter stay.”

—Dr. Frank DellaCroce

What: The only hospital in the world focused solely on breast reconstruction, it was started by specialized plastic surgeons who developed techniques for transplanting “living fat” from a patient’s stomach or hips to rebuild breasts lost to mastectomy.

Where: Encompassing an entire city block on historic St. Charles Avenue,

the center looks like a high-end hotel or spa with design elements intended to produce a calming atmosphere that hastens recovery. Medical equipment is cleverly disguised behind artwork. The radiology suite has warming blankets and soothing light features. For the many patients who come from outside New Orleans, a concierge helps coordinate travel arrangements and logistics.

Only here: The nurse-to-patient ratio is nearly 1:1 and there’s no wait for the operating room. “From the clinic to the hospital to the inpatient ward, everyone’s on a first-name basis,” says Dr. Frank DellaCroce, a co-founder with Dr. Scott Sullivan. “Everything’s a few steps away. That allows us to do more work in a more controlled environment with the same team every day.” —*U. R.*

to gauge their quality. Many of these hospitals are great, he says. But lately he has begun to shift his focus to the United States. "We can't all go to India or Costa Rica or Brazil," he says. What's becoming clear, he says, is that we don't need to.

Industry on the Rise

Domestic medical travel is not a new phenomenon. In 1939, ailing New York Yankees baseball great Lou Gehrig traveled to the Mayo Clinic in Rochester, Minnesota, where he was diagnosed with amyotrophic lateral sclerosis, which ultimately killed him.

More recently, less-prominent people have taken their medical conditions on the road—and not just to overseas facilities. Domestic medical travel didn't begin with big-box retailers or soda sellers, Herrick says. It began with a few self-insured and uninsured individuals who were encouraged by the relative ease of modern travel and who needed a way to cut down their medical expenses.

What began as a trickle is now a small stream, and an industry is rising up astride it. Companies such as North American Surgery and BridgeHealth Medical

popped up toward the middle of the last decade. At first these companies helped steer self-funded individuals to affordable quality care, wherever it existed in the United States.

While they did so, they were simultaneously assembling provider networks willing to work on terms their clients could live with. Then the firms took the next step by asking employers to sign on.

"The real money isn't just finding a million people individually," Herrick says, "because that means high transaction costs. It's going to 10,000 employers, each with 100 employees, and convincing them to give their workers an incentive. That way you can get better deals. It is not that hard."

MediBid represents another wrinkle in the burgeoning domestic medical travel business. The \$4.95 per month online subscription service is often described as an eBay for medicine. MediBid CEO and president Ralph Weber disputes that. "I think it's more like Match.com," he says.

MediBid customers create an online profile and generate a request for medical services, including up to five images and documents. Providers then submit

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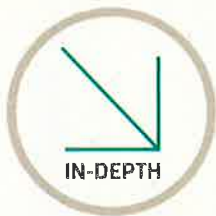
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bids that include the price they will charge and details on the services they will and will not provide. The point is not to provide the cheapest care but rather the best value for the patient's dollar, Weber says.

"What we are doing to medical care is introducing basic purchasing principles, with transparency and competition, that most companies follow when they purchase anything else," Weber says. "That is what is going to bring down the price."

The Obamacare Factor

Sources approached for this story are in agreement that the Affordable Care Act—Obamacare—may prove an unintended instigator to widespread domestic medical travel.

Dr. Marty Makary, author of the recent bestseller *Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care*, is one of those people. Makary is a pancreatic surgeon, a professor at Johns Hopkins School of Medicine and also Johns Hopkins' director of surgical quality and safety.

Because he works at one of the nation's great care providers, Makary has long been enmeshed in domestic medical travel. As many as half of his patients come from other states.

What has held the trend back from becoming truly widespread, he says, is a lack of industry transparency and surgical quality measures. In other words, people might be emotionally willing to travel for a better medical experience, but they can't be sure whom they can trust to provide it.

That will change, Makary says. As part of federal health care reform, the Medicare system next year will introduce new surgical quality measures comparing the performance of hospitals and individual surgeons—a level of transparency, he says, that will impact the entire health care industry.

Meanwhile, as Carabello points out, the Centers for Medicare and Medicaid Services has begun releasing comparative pricing data that details how much various hospitals charge for

The Doctor Will See You . . . Virtually

With telemedicine, traveling for health care means never leaving home. By Karen Springen

A century ago, doctors made house calls. Today, physicians at Stanford Hospital and elsewhere are virtually visiting their patients.

Stanford offers "eCare" to all of its 7,936 employees as well as to employees and their families at San Jose-based Cisco (for dermatology only) and San Diego-based Qualcomm (for primary care only). Using high-definition video cameras, nurses at workplace health centers simply beam employee patients onto the 50-inch screens at Stanford, where they are seen by a doctor.

"It's just like using Skype," says Dr. Sumbul Desai, associate chief medical officer of strategy and innovation at Stanford Hospital and Clinics. "We think care is moving out of the traditional brick-and-mortar setting."

The benefits to employer and employee are plenty, most notably in time and money saved, the emphasis placed on preventive care and the potential to reach patients in remote locations. Seeing telemedicine as a way to healthier employees and lower health care bills, Cisco is already talking with Stanford about adding orthopedic, ENT and cardiology to the list of eCare options.

"If you're diagnosed earlier because you have better access to care, the cost to take care of you is likely going to be less," says Katelyn Johnson, Cisco senior manager of integrated health.

"It's avoiding lost employee work time," adds dermatologist Dr. David Wong, who runs Stanford's teledermatology clinic. "Instead of a half day or several hours away from work, they're only gone for half an hour."

As a result, patients are less likely to put off needed appointments, he says. And since about 20 percent of Stanford's virtually visited dermatology patients require an in-office procedure, potentially dangerous conditions can be caught early. So far, Stanford dermatologists have diagnosed melanoma in two Cisco employees. Linda Harris is one of them.

In 2012, Harris was an executive assistant at Cisco when she got an email about her employer's new telederm program. A 15-year-old mole on the bottom left side of her bra strap had started to grow and bother her, so she had a live consultation with Dr. Wong. Two weeks later, he removed her mole, biopsied it and determined that she had an aggressive form of melanoma, found early enough that it had not spread to her lymph nodes or any of the tissues surrounding the tumor.

"I don't think there's any question that it saved my life," Harris says.

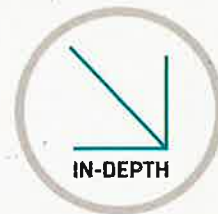


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the 100 most common inpatient procedures. Perhaps Obamacare's biggest influence, Makary says, will emerge as people opt to purchase so-called "bronze" health care plans from the federal health care exchange and its state-run online counterparts.

Bronze-level coverage represents the highest-deductible, lowest-premium, no-frills insurance category. On the other end of the scale, the platinum level represents the proverbial "Cadillac plans."

Makary expects that some people—even those in higher income brackets who consider themselves frugal—will purchase bronze plans in order to save on premium costs. When they eventually need care, they will discover that their deductibles are out of this world.

"I had a patient complaining to me about a \$2,000 deductible yesterday," Makary says. "Someone else told me they are planning to sign up for a bronze plan on the new health care exchange that has a \$5,000 deductible. I am hearing stories of \$10,000 deductibles. It's almost as if you are paying for medical care out of pocket and your insurance is just catastrophic."

Makary expects that a convergence of factors—high-deductible insurance and high copays under Obamacare, the easily accessible pricing and care-quality data being mandated by health reform—will generate a kind of perfect storm. It will dawn on individuals and companies alike that accessing affordable health care requires the purchase of a plane ticket. In the end, Makary thinks a lot of people will find that agreeable.

"Travel is easier nowadays," he says. "A generation ago flying from Baltimore to Houston was a big trip. You'd pack like you were going to emigrate or something. Now, heck, I travel once a week and with TSA PreCheck I show up 30 minutes before my flight leaves. So I think it's a smaller world." //

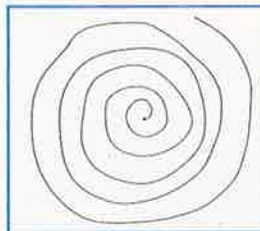
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Price Check

How average health care prices compare around the world.

Compiled by Urmila Ramakrishnan

	Coronary Artery Bypass Graft	Valve Replacement with Bypass	Hip Replacement	Knee Replacement	Spinal Fusion	IVF Cycle (Excluding Meds)	Gastric Bypass	Facelift	Rhinoplasty
United States	\$88,000	\$85,000	\$33,000	\$34,000	\$41,000	\$15,000	\$18,000	\$12,500	\$6,200
Brazil	\$35,000	\$33,000	\$15,000	\$12,000	\$22,000	\$4,800	\$12,000	\$5,200	\$2,600
Costa Rica	\$31,500	\$29,000	\$14,500	\$9,500	\$17,000	N/A	\$11,200	\$4,500	\$3,400
India	\$9,500	\$8,500	\$8,000	\$7,500	\$9,500	\$3,300	\$6,800	\$3,500	\$2,800
Malaysia	\$20,800	\$18,500	\$12,500	\$12,500	\$17,900	\$7,200	\$8,200	\$5,500	\$3,600
Mexico	\$27,500	\$23,500	\$14,300	\$12,500	\$16,200	\$4,600	\$11,500	\$5,400	\$3,500
Singapore	\$22,500	\$29,500	\$20,700	\$18,500	\$17,000	\$9,500	\$14,000	\$7,000	\$4,800
South Korea	\$29,000	\$33,000	\$15,500	\$15,000	\$18,000	\$7,500	\$12,500	\$5,900	\$4,700
Taiwan	\$21,000	\$18,000	\$10,500	\$12,000	\$18,000	\$4,800	\$13,000	\$5,600	\$3,500
Thailand	\$23,000	\$22,000	\$13,000	\$11,500	\$16,000	\$6,500	\$12,000	\$4,700	\$3,700
Turkey	\$20,500	\$20,000	\$11,800	\$12,000	\$16,500	\$9,500	\$13,000	\$4,800	\$3,300

Source: Patients Beyond Borders

Medical Travel Hot Spots

1 Mexico

Where to go: San José Tec, Hospital CIMA Monterrey, Hospital CIMA Chihuahua, American British Cowdray Medical Center.

Known for: Low costs, especially for Americans seeking dental procedures and cosmetic surgery.

2 Costa Rica

Where to go: CIMA San Jose Hospital, Clínica Católica, Clínica Bíblica.

Known for: Inexpensive travel to and within the country, proximity to the United States, abundance of recovery facilities and spas close to clinics.

3 Turkey

Where to go: Anadolu Medical Center, Kent Hospital, Liv Hospital, Memorial Hospital, Yeditepe, Acibadem.

Known for: More JCI-accredited hospitals (51) than in any other country in Europe. Low-cost LASIK.

4 Singapore

Where to go: Mount Elizabeth, National University Hospital, Tan Tock Seng, Gleneagles, Johns Hopkins Singapore.

Known for: Modern facilities, widespread use of English and having Asia's best health care system.