

UnitedHealth International in print

Saving on Surgery by Going Abroad

Medical tourism or medical travel can produce discounts of 80 percent

By Avery Comarow

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If he could have, Brad Barnum would have kissed the ground when he climbed out of the car in Ruidoso, N.M., at the end of March. But the 53-year-old building contractor had undergone major remodeling himself—and his new knee and two new hips ruled out kneeling for a few more weeks. Still, he was ecstatic. More than two months after leaving for the hospital, he was home, and he had afforded the otherwise unaffordable. By having the work done in India, at Wockhardt Hospital in Bangalore, he'd gotten his new joints for just \$23,000. Even after adding about \$5,000 for airfare, passport, visa, and incidentals, the total was nearly 80 percent less than the \$125,000 or more he easily could have been charged by a U.S. hospital. And that bill wouldn't have included physician fees and "ancillary charges."

Barnum is one of thousands of Americans—estimates range from an ultraconservative 5,000 to 500,000 annually if minor procedures are counted—who are leaving the States for surgery when they have to come up with funds themselves. They may be self-employed or work for a small business and lack health insurance, for example, or their procedure may not be covered. More than 1 in 4 workers earning at least \$60,000 a year went without insurance in 2006, according to a Census Bureau survey; too well-off to be eligible for medical assistance, they can often wring tens of thousands of dollars out of hospital "rack rates" by going abroad. Some employers and big insurers like UnitedHealth and Blue Cross and Blue Shield are so intrigued by "medical tourism" that they're beginning to sniff for signs that it might be smart to cover it. "I was totally amazed not just at the quality of the medical care but at the quality of the service," says David Boucher, an assistant vice president of healthcare services at BlueCross BlueShield of South Carolina who

has visited many facilities abroad. "The initial driver may be price, but patients' positive experiences will do a lot to advance the movement."

So far, there's been mostly talk, with little action from employers and health carriers. In fact, the first verified case of major surgery abroad as an employee benefit took place only earlier this year. (The patient reportedly paid nothing out of pocket for a knee replacement—in fact, the company, a North Carolina manufacturer, paid him a tidy sum for saving so much money.) Wockhardt, where the procedure was done, won't name the company.

Meanwhile, patients are finding their way abroad on their own. Wockhardt's hospitals in Bangalore and Bombay operated on about 850 U.S. patients in 2007, more than double the 2006 total. In Thailand, Bangkok's Bumrungrad Hospital says it treats more than 38,000 Americans a year—a somewhat inflated figure that represents "patient encounters," not individual patients, and includes expatriates. Other hospitals in India and Thailand, as well as centers in Singapore, are actively courting Americans, and the governments of South Korea and Taiwan are about to launch campaigns.

Low-budget dentistry, Botox-ing, lipo, and other cosmetic work have for years drawn Americans into Mexico and to other Latin American countries. But the growth in serious elective surgery halfway around the world is new. Josef Woodman, who publishes the Patients Beyond Borders series of guidebooks to finding good care, thinks about 50,000 patients a year leave the country for major noncosmetic elective procedures such as joint replacement, coronary artery bypass, new or repaired heart valves, or back repair.

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Peddling medical getaways cont.

The globalization of health care is prompting insurance companies to explore overseas medical options.

As chief executive of UnitedHealth International, **Ori Karev** is more accustomed to people coming from other countries to the United States for their health needs. UnitedHealth, the company that just took over a majority of the Las Vegas health insurance market with its acquisition of Sierra Health Services, is “exploring” the subject of global health care, Karev said.

The high cost of health care in the United States is causing consumers and employers to look to other countries for solutions, he said. And the U.S. population’s growing percentage of immigrants suggests more Americans who would be willing to leave the country for treatment. In some cases, a person may have a better support network in a place like Mexico City than he does in the United States, Karev said.

In addition, Karev noted, more than half the companies listed on the S&P 500 have a majority of their employees in other countries. The health care provided to those employees could someday be offered to American employees of the same companies, he said.

There are several fundamental roadblocks to the expansion of medical travel, though, Karev said, including the lack of standardized medical and billing records to support insurance plans.

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Many, like Barnum, do the legwork on their own. But concierge services like MedRetreat.com and IndUSHealth.com are multiplying, to help with lists of potential hospitals, appointment scheduling, arranging airport pickup and drop-off, and general hand-holding. (Information from Woodman's annual hospital survey has been incorporated into the World Hospital Finder, a U.S. News search tool for people who are seeking care abroad.)

Large insurers and employers are watching with interest—and skepticism—to see what happens as demand grows. “It’s very nice to say that India, to take one example, can handle Americans, but there are only three to five hospitals there” with enough capacity to absorb a surge, says **Ori Karev**, CEO of UnitedHealth Group International, an arm of UnitedHealth that offers health consulting services to companies abroad. Moreover, he wonders, can high quality be sustained “with hundreds of thousands of patients traveling for care? I have my doubts.” Then there are fundamental questions of safety and postoperative care back home. “Say I get treated overseas and something goes wrong,” says Karev. “Who do I sue? Where do I sue? Who owns that hot potato of accountability—my insurer? My employer?”

The questions are just as relevant to solo travelers. Woodman tells of a Vietnam veteran who had a hip replaced, developed complications on his return, and found his doctors here unwilling to help. “There’s a lot more burden on the consumer to have a successful medical journey,” says Woodman.

Doing the sort of advance research that makes this possible can be arduous. You might or might not get answers if you ask about a hospital’s mortality rates or a surgeon’s credentials and how many heart valves he has replaced, for example. “Getting data out of some of these places is like pulling teeth,” says Woodman—and even if you do, the answers are not necessarily trustworthy. Not that stateside hospitals cheerfully

volunteer such information. But they are being monitored by the federal and state agencies and professional and trade organizations that collect such data. “Our system is subject to extreme scrutiny, for better and for worse,” says Karev. Overseas, he says, similar monitoring is largely absent. That is especially true in developing countries such as India and Thailand, which offer the least-expensive options.

So far, however, no reports of patterns of botched operations, rampant infections, or other warning signs have surfaced. In March of last year, the Singapore National Eye Center suspended laser eye surgery after 17 patients developed an inflammation, but it was the first interruption of the kind at the center. A few weeks later, surgery resumed. Overall, medical standards in Singapore, where prices are somewhat less attractive but English is universal, are very high, especially at western-oriented hospitals such as Mount Elizabeth and Gleneagles.

One precaution Americans can easily take is to choose a hospital accredited by the Joint Commission International, the global arm of the Joint Commission, which makes sure U.S. hospitals meet specific standards. In early March, as Barnum was recuperating from his two hip surgeries and faced his final procedure, Wockhardt’s facility in Bangalore was recovering from a grueling JCI accreditation survey. (Accreditation was awarded in mid-April.) The hospital is immaculate but makes no attempt to look fancy; it’s a Wal-Mart next to the soaring atrium and opulence that make Bangkok’s Bumrungrad Hospital especially popular with medical travelers.

Accreditation does not ensure good care, but it does offer important evidence of safety; Karen Timmons, president and CEO of the JCI, says going to an accredited hospital is “essentially a risk-reduction activity.” Physicians must be adequately credentialed and their patient data examined at least once a year to pick up a spike in deaths or complications, for example, or longer hospital stays. And

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as a patient moves through the hospital, a formal system must track him to avoid treatment mix-ups. A transfer from the or to intensive care at Wockhardt, for example, is documented with a written transfer statement and verbal confirmation by a physician and compiled into an ongoing summary. Computerized tracking, with supermarket-type bar codes that can be scanned from patient wristbands and stickers on their records, is coming soon.

JCI standards also call for various means of minimizing infections, including collection and review of infection statistics and any necessary corrections. At Wockhardt, water used in surgery and laboratories is filtered and regularly tested. Western patients always get bottled drinking water (“for comfort,” says Arshanapalai Malathi, head of medical services). Dispensers of disinfectant alcohol gel at the foot of each bed for hand cleaning are hard to miss.

A safe blood supply cannot be assumed—especially in a developing nation. “When we started watching the development of medical tourism,” says Karen Lipton, CEO of the AABB, the association that represents American blood banks, “we asked ourselves, ‘Where is the blood coming from? How well do they screen donors? Who’s making the judgment about the safety of these products?’ “ Patients can and should ask a hospital representative these questions, but there is no way to verify the answers. On the other hand, says Lipton, the hospitals “don’t want to do anything bad—the last thing they want is for people to go back home and have problems.”

Bar-coded blood. Lipton urges patients to also ask a hospital how blood gets to the right patient. She strongly advocates a bar-coded bracelet or other wearable accessory that is scanned before a transfusion. At Wockhardt, which tracks blood in ledgers and on paper slips, there have been two near misses in which patient and blood did not match, says blood bank director Jyoti Balani. Both errors were caught in time, she says, and blood-borne infections are nonexistent. “We try to

avoid transfusions,” says Balani. “I can’t remember any international patient in the last six months who needed blood.” Banked blood comes largely from “replenishment donors”—local residents with a hospitalized relative are expected to donate. All blood is screened for HIV, hepatitis, syphilis, and malaria.

Joint-replacement patients are a special class in all hospitals because of the consequences of infection: An artificial joint that harbors a deep infection often must itself be replaced. For Barnum’s operation, surgeon Sanjay Pai and his team, like those at good U.S. hospitals, sealed off their skin, even breathing filtered air pumped into hoods covering their heads. Wockhardt, like its competition, has to be persuaded to go public with its rates of postsurgical infection. Says Pradeep Thukral, head of international marketing, “Our competitors can claim that their data is better, and who can prove them wrong?” But the statistics are comparable to those of good U.S. hospitals—a 1.1 percent rate of surgical infection for heart-bypass patients, he says, and zero for joint replacements.

In Asia, nurses play a much smaller role in care than they do in U.S. hospitals. Emily Slaback, a former ICU nurse from Haslet, Texas, whose left hip and knee were replaced at Wockhardt in February, says they are more like nurse’s aides. They are not expected to check patients as often or as closely, so patients have to take responsibility. Calling a doctor’s attention to a bruise, for example, could prevent a bedsore that might become infected and prolong the stay. And while nurses who care for Americans are trained in English, their command is often incomplete. After his first surgery, Barnum was given a special mattress to prevent bedsores. He asked the nurses for the same mattress after his second surgery but couldn’t make himself understood—or, as he says, perhaps they felt he didn’t need it.

There would be no need for uninsured patients to go abroad at all, of course, if the prices they were quoted in

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the United States were more in line with what insurers and Medicare pay. In U.S. hospitals, the uninsured and wealthy foreigners are the major groups charged full price for an elective procedure. (People who come in through the ER for nonelective surgery will get a list-price bill, but few hospitals expect to be fully repaid.) There should be plenty of room for price cutting—for routine heart-bypass surgery in Texas, the list price is about \$70,000 at one hospital in Abilene and \$47,000 at one in Austin. But commercial health plans typically pay at least 60 percent below list. And Medicare pays even less—\$18,609 to \$23,589 on average for an uncomplicated bypass.

Would a U.S. hospital be willing to negotiate a heavily discounted price in advance with an individual patient? “If you go in and say, ‘I’m paying for it myself, I’m not covered,’ “ says Richard Schirmer, vice president for healthcare policy analysis at the Texas Hospital Association, “they’ll give you maybe 10 or 20 percent off if you pay cash upfront for the whole thing—at most, 20 percent off the rack rate.” Rick Gundling, a vice president of the Healthcare Financial Management Association, which represents hospital financial administrators, can’t name a hospital willing to go further, but he sees the day drawing closer. “Hospitals should embrace the retail market,” he says. “As patients start calling around to shop prices, hospitals will have to start to compete on price, and medical tourism will add a whole new level of competition.”

Coming in with a concrete “let’s make a deal” proposal can’t hurt. “Ask to pay the Medicare reimbursement, and offer a very, very aggressive payment plan,” suggests Gwynn Smith, a partner with HFS Consultants, an Oakland, Calif., group that works with healthcare organizations. “Offer to put a lot down—20 or 25 percent, more if you can—and pay it off as fast as possible.” (Average Medicare payments for many common procedures are available at www.hospitalcompare.hhs.gov.) Your best shot at success, Smith says, is to get in to see the chief financial officer. Lower-level financial counselors “have no idea of the costs,” she says.

In a sign of market forces at work, a handful of American hospitals have struck deals with North American Surgery, a Canadian company formed last August to match U.S. hospitals in Kansas, Michigan, New York, Oklahoma, and Washington that are willing to provide certain procedures inexpensively with American patients who need them. Only travel and lodging are extra. Hip or knee replacement or heart-bypass surgery is \$14,000; weight-loss surgery is \$10,000 or \$15,000. The service is free; the company is paid by the hospitals.

Agreeing to offer low prices is mostly what qualifies hospitals to make the list, says Richard Baker, the entrepreneur behind North American Surgery. He says he also makes use of HealthGrades.com, a service that gives hospitals one, three, or five stars for performance. But in the latest ratings, Oklahoma Heart Hospital, one of those on Baker’s roster, gets one star (“poor”) for bypass surgery death rates in the hospital, at 30 days, and at six months. Baker doesn’t concern himself with physicians’ performance; he relies on the hospitals to find good surgeons and monitor them.

People who in the end decide to head abroad might consider a last bit of wisdom from those who have gone before: Think of it as medical “travel,” and don’t count on much “tourism.” Few who arrive with a bad back or heart will be up to wandering through Bangkok or New Delhi. And after surgery and one or two weeks of recuperation, will you have the time, money, and energy to extend your stay? Oh, and on flights where coach will cramp your debilitated body and challenge your sanity, spring for business class.

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Peddling medical getaways

Salesmen beat drum for overseas operations on the cheap

By Marshall Allen

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With signs promoting trips to Singapore, Thailand and Monterrey, Mexico, the gathering might have been for travel agents.

But instead of hyping five-star resorts and day spas, these salesmen were offering travel packages for angiograms, knee replacements, spinal fusions and, well, even colonoscopies.

Welcome to the world of medical tourism, or “global health care,” as those in the industry prefer to call it.

And by one measure, the economy is helping their business.

The growing number of uninsured Americans, combined with skyrocketing health care costs, is leading patients to seek medical care in other countries. If you're uninsured and need a hysterectomy, which could cost about \$13,000 out of pocket in Las Vegas, the folks at Min-Sheng Hospital in Taiwan want to offer you the procedure for \$3,000. (They're also happy to add a cultural side trip to the package, although they say you may not feel up to it.)

People considering elective procedures that aren't covered by insurance, such as bariatric bands that shrink the stomach, cosmetic procedures or laser eye surgery, may also be drawn to doctors and clinics overseas because of lower prices.

Medical tourism boosters, who were in Las Vegas this week for the Consumer Health World annual conference at the Venetian, loosely claim that about a half-million Americans leave the country annually for medical procedures. The McKinsey Quarterly, a management

journal, estimates the number of medical travelers at between 60,000 and 85,000 inpatients annually, but predicted the number would grow to 700,000 a year if insurance companies covered international procedures.

At the conference, representatives of international hospitals were eager to explain that their facilities are accredited by the Joint Commission International, an affiliate of the Joint Commission, which accredits American facilities. And many of the doctors at the international hospitals are trained in the United States, the representatives said.

U.S. patients still must be cautious about medical liability.

Medical representatives from other countries said suing a doctor in a foreign country can be complicated.

Min-Sheng Hospital's literature describes a menu of procedures: knee and hip replacements, minimally invasive spine surgeries, cosmetic procedures in a “spa-like” setting and infertility treatments. A bariatric lap band procedure, at \$10,500, is substantially less expensive than the Las Vegas procedure, at \$16,000.

Steven Neeley, a business development specialist for Min-Sheng Hospital, said global health care is especially attractive to immigrants, and that his hospital targets Chinese-Americans. After the stop in Las Vegas he and his Taiwanese colleagues planned to visit Chinese-Americans in Los Angeles.

“We're really going to be promoting to them to go back and get some of these elective procedures in Taiwan,” Neeley said.

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