

Are Patients Still Packing Their Bags and Going Abroad for Their Medical Care? *What's the Role for U.S. Surgeons Providing Care to Patients From Other Communities/States or Other Countries?*

While the economic recession has eroded the growth rate for medical tourism by approximately 13.6 percent from 2007 to 2009, the economic recovery is expected to spur a sustainable 35 percent annual growth rate for the medical tourism industry by 2010, according to a new report released in October, 2009 by the Deloitte Center for Health Solutions.

According to the report, in 2007 more than 750,000 Americans traveled abroad for medical care. Since 2007, medical tourism has experienced a slow down driven by the economic recession and consumers putting off elective medical procedures over the past two years. Even in the downturn of the market, 540,000 Americans traveled abroad for their medical care in 2008 and a projected 648,000 Americans traveled abroad in 2009. Patients are traveling abroad for many elective surgeries such as cosmetic and dental procedures, but also for joint replacements and other orthopaedic procedures.

The Deloitte Report also indicated that over forty percent of respondents to the survey indicated that they would travel outside of their immediate area for care if their physician recommended it or for a 50 percent cost savings.

Paul Keckley, Ph.D., Executive Director of the Deloitte Center for Health Solutions states, "With health care costs increasing at the rate of 6 percent per year for the next decade, and medical tourism offering savings of up to 70 percent after travel expenses, there is no question that it will remain an important option for consumers who need care, but increasingly lack out of pocket funds to afford a procedure in the U.S." (Attached is the Deloitte Report entitled, "Medical Tourism: Update and Implications").

There has been much debate on how to regulate medical tourism, but little action. The American Medical Association has established guidelines that should be followed by employers, insurance companies, and other entities that facilitate or incentivize medical care outside of the U.S.

AMA Guidelines for Patients Traveling Overseas for Medical Care

1. Medical care outside of the U.S. should be voluntary.
2. Financial incentives to go outside of the U.S. for care should not inappropriately limit diagnosis and therapeutic alternatives, or restrict treatment of referral options.
3. Financial incentives should be used only for care at institutions accredited by recognized international accrediting bodies.
4. Local follow-up care should be coordinated and financing arranged to ensure continuity of care.
5. Coverage for travel outside the U.S. for care must include the costs of follow-up care upon return.
6. Patients should be informed of rights and legal recourse before traveling outside the U.S. for care.
7. Patients should have access to physician licensing and outcomes data, as well as facility accreditation and outcomes data.
8. Transfer of patient medical records should be consistent with HIPAA guidelines.
9. Patients should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities.

While medical tourism is still developing, it seems that more payors and patients are seeking medical care outside of their local communities in an effort to try and save costs or gain more ready access to the procedure. Blue Shield and Health Net are actively engaged in a pilot project sending patients from California to Mexico. Anthem Blue Cross and Blue Shield of Wisconsin sends patients to India, United Group Program in Florida is sending patients to Thailand and India, and Blue Cross and Blue Shield of South Carolina send patients to Thailand. The COA has been contacted by an entity representing self-insured employers in Canada, wanting to bring injured workers to California to obtain the medical care for the injured worker so they can get back to work more quickly. They indicate that some 850,000 Canadians are on surgical waiting lists – with a 26 week wait for a hip replacement.

Medical facilitators such as Bridgehealth.com and Healthbase.com work with patients and insurers to set-up arrangements for patients who seek their medical care out of the country or at least out of their local communities. Medical tourism is expanding to fill this need.

What's unclear is why U.S. surgeons have not offered an alternative for these patients... That is also changing.

The Mayo Clinic, Stanford and other academic centers, selected orthopaedic surgeons and other physicians have had patients traveling to their offices/facilities from other countries for many years. Other orthopaedic groups are also recognizing this new business opportunity and are developing strategies to market their services to these patients. Orthopaedic surgeons affiliated with an ambulatory surgery center, particularly those that can do a 24-hour stay are well positioned to competitively price their services and favorably compete with the foreign facilities or U.S. physicians using acute care facilities for the hospital stay.

Entities such as MediBid.com are beginning operations in January, 2010. MediBid is different from other medical entities arranging care for these patients in that they do not have facilitators who will help set-up arrangements for patients. They rely on the Internet to link physicians with patients needing a medical service. Patients go on-line and post a medical ailment for which they are seeking care. For \$250 per year for an individual doctor, orthopaedic surgeons can gain access to these patient listings and bid on the service. The bid should include the cost and an explanation as to what the bid includes (e.g., surgeon's fee, facility fee, implant costs, anesthesiologist fees, any follow-up care or rehabilitation, etc.) If the patient accepts the bid, the physician's office contacts the patient directly to obtain additional medical information such as: the local doctor's opinion, patient's medical history, diagnosis, and to get copies of their medical records and diagnostic tests – whatever the surgeons needs to determine whether the patient is an appropriate candidate for their practice setting. If you find that the patient is not a good candidate, either due to the patient's condition and/or co-morbidities, the physician has the ability to turn the patient down. If the practice accepts the patient, they communicate with them just like any other patient. It is important to have all of the screening tests performed prior to the patient traveling to your facility to help ensure that there will not be other health problems that will delay or make the patient a bad surgical candidate.

Orthopaedic Surgery Center of Orange County is an orthopaedic surgery center in California who is exploring the business opportunity of medical tourism is accepting patients from out of the area and/or other countries. Gabrielle White, Director of OSC, says that "Running a surgical center or a practice has its own challenges especially in California due to higher overhead costs, over-regulation and lower reimbursements, its more important than ever to not only keep up with change but to try to keep ahead of it. This brought me to explore an area of healthcare that has been around for decades but recently has been viewed as a threat to U.S. providers- 'Medical

Tourism.” OSC’s goal in medical tourism is to provide an affordable alternative with the U.S. for patients needing orthopaedic surgery, but who cannot afford the cost of a hospital stay in the U.S. and/or prefer not to have surgery in a foreign country. They are also an alternative for patients who prefer not to be treated as an in-patient in an acute care facility. Surgeries they perform include, but are not limited to, joint replacement including hip and knee, certain spine procedures, and other elective orthopaedic surgeries that can be performed in a 24-hour ASC setting. They pick their patients carefully to make sure they are appropriate, control their costs, and can perform the procedure(s) well under the costs charged by an acute care facility for the same procedure

The OSC selection patient criteria include:

- Less than 64 years of age
- ASA 1 – healthy with no systemic disease
- ASA 2 – healthy with system disease which is controlled, e.g., controlled high blood pressure
- Family/friend support system post op
- BMI (body mass index – height v. weight) of 32 or less

OSC is Medicare and AAAHC certified and has 16 credentialed orthopaedic surgeons who schedule procedures at their ASC at least weekly. They have 4 operating rooms, 10 post op recovery beds, and 2 private post op recovery rooms. The orthopaedists at the Center perform an average of 4,800 orthopaedic surgeries each year, mostly elective outpatient procedures with no more than 2 total joint or spine procedures in one day. This allows them to provide the highest quality of medical and nursing care to all their patients. The arrangements with the surgeons need to be properly structured so as not to be in violation of any of the Stark referral laws meaning there must be direct agreements with each provider and they cannot be compensated for the referrals they make to the facility. OSC evaluates whether the patient is appropriate for the ASC setting and if so, sends the patient information and contact to the surgeon’s office to move forward in the planning of care.

OSC points out in their marketing materials that the advantages for having surgery performed at their facility include:

- No high hospital bills
- No foreign travel with 20+ hour flights
- No need for passports or vaccinations
- No language barriers
- No cultural adjustments while trying to recover from surgery
- Travel to a beautiful area of California

To date, through their medical tourism program, OSC has been successful in attracting patients from other U.S. locales for surgeries ranging from total hip and partial knee replacement, to bunion and arthroscopic shoulder reconstruction. Some of these patients were not appropriate candidates for a 24 hour stay and; thus, they negotiated a rate with their partner hospital that was acceptable. OSC has only treated insured patients so the medical screening process was made easier by the involvement of the health plan. They have advertised in the Medical Tourism magazine which put them in touch with “facilitators” looking for surgeons who are willing to treat these patients. It remains to be seen how successful MediBid will be with patients going on-line to post their medical needs, but OSC has signed up with all of these services so that they are well-positioned to attract the medical tourism business to their practice. While the program has proved viable, they have not seen this market flourish as was projected. The downturn in the economy may have been a factor, but, at this point it does not appear that the travel market is as

large as the magazines and companies make it out to be. However, by going through this exercise, they are now prepared for the “episode of care” or “bundled pricing” models that appear to be on the horizon. Ms. White said, “We learned through this experience how to carve out a rate for all of the participants up front, including the implant vendors, anesthesiologist, the physical therapists, and even the local Hyatt hotel where patients would recover after discharge.”

If physicians use firms that utilize facilitators, it is important to structure the arrangement in such a way to not violate any Stark self-referral laws.

Other creative marketing plans cited in the medical tourism articles include: launching a website targeted to patients in other countries, developing relationships with foreign companies that provide private health insurance as an employee benefit, developing relationships with medical tourism facilitators who are placing patients, bidding for surgeries posted on the Internet, creating medical care packages with foreign travel agents or monitoring health-oriented social networking web sites. Most importantly, orthopaedic surgeons should develop creative joint arrangements with other partners in the health care delivery system such as third-party payers piloting or considering medical tourism offerings.

Medical tourism options will be discussed at COA’s 2010 Annual Meeting/QME Course, April 15-18, 2010 at the Ritz Carlton Highlands at Northstar, Lake Tahoe during the Economic Survival Course. We would encourage you to attend the meeting to hear more about how to set up this practice option.