

## **“Refining the medical tourism market and delivery system”**

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Medical Tourism (as we are all familiar with the term) has been evolving since its inception. The concept of medical tourism was initiated by the need to improve access to care or to provide affordable care. As medical tourism has evolved, so have the conditions that have driven the need.

There are several areas in the world that have a need for medical tourism, but for the purpose of this paper I will focus on one of the largest emerging markets for patients: the United States. Medical tourism has advanced through the growth in patient volume and outcomes, supporting papers from Deloitte and NCPA, and acceptance of managed care companies, but conditions that affect the U.S. healthcare system could negatively impact medical tourism facilities. This paper will focus on the pricing, clinical and legislative issues that will affect the medical tourism industry over the next five years.

### **Pricing Issues**

#### *Transparency in pricing – Charges vs. actual reimbursement in the U.S. healthcare system*

Nearly all medical tourism companies define that a patient’s primary reason for considering medical tourism is cost. The standards of care in most medical tourism hospitals are excellent and the outcomes are improving such that they exceed US standards. Currently, however, there is one very clear miscommunication of the reason for the cost variance between the typical U.S. hospital and a medical tourism hospital: the actual reimbursement to U.S. hospitals. U.S. hospitals are **not** paid what they charge for procedures, although this misconception is promoted by nearly every medical tourism program. In the U.S. healthcare system the term “gross charge” is what is utilized to define the total charges of the admission or procedure. All U.S. hospitals enter into contracts with payer sources, and these contracts stipulate the hospital’s reimbursement. The reimbursement is far less than what hospitals report as gross revenue, and the actual reimbursement is referred to as “net revenue.” Nearly all of the medical tourism sites are utilizing U.S. hospitals’ gross charges in their advertising.

As the medical tourism market primarily appeals to the underinsured or uninsured, I will focus on the price that is quoted to these patients. In most cases, hospitals classify these patients as “cash paying” or “self paying.” For example, following are a total knee replacement charge, net reimbursement and cost for a U.S. hospital:

Procedure:	Arthroplasty, Knee (Total Knee Replacement)
Average Length of Stay	3 days <sup>1</sup>
Average Charge:	\$26,000 to \$40,000 <sup>2</sup>

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<sup>1</sup> The mean length of stay as defined by Medicare DRG guidelines

<sup>2</sup> The gross charge varies by the length of stay, implant cost, rehabilitation, adverse outcomes, etc

Medicare (payer) Reimbursement: \$8,500 to \$12,500<sup>3</sup>

Hospital Costs:

Implant Cost \$2,500 to \$10,000<sup>4</sup>

Direct Cost \$2,400 to \$4,000<sup>5</sup>

Total Costs \$4,900 to \$14,000

**\*Note for the purposes of this example we will remove fixed expenses to determine a direct contribution margin**

Each hospital or hospital system maintains its own charging method for cash paying patients. Most U.S. hospitals utilize a tiered approach based on the economic status of the patient. As stated earlier, most U.S. hospitals are paid based on Medicare reimbursement rates or methodologies; specifically, most U.S. health insurers (payers) pay some percentage more than Medicare's reimbursement. When a hospital quotes a price to a cash paying patient, the hospital utilizes the prevailing rates or prices of its health insurance (payer) agreements as a basis. The following is an example of the tiered considerations and conditions of cash price quotes:

Initial Quote	A discount from the Gross charge equivalent to the best health insurance (payer) contract rate <sup>6</sup>
Second Quote	A discount equal to the prevailing or largest payer contract rate <sup>7</sup>
Final Quote	Direct cost plus 10%

Based on the second quote method the following represents what is quoted to a cash paying patient:

Total amount quoted to the patient **\$10,000 to \$16,000**

Advertized price for medical tourism patient \$6,000 to \$16,000

The price quoted to a US patient paying cash is equivalent to 120% of the Medicare rate (approx). The amount a patient will actually pay in the U.S. is **far less** than what is currently being stated in the medical tourism websites. In a Deloitte survey, two in five respondents stated they would consider medical treatment abroad if the savings was in excess of 50%. (Heckley Ph.D., 2007)

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<sup>3</sup> The Medicare reimbursement range defined utilizes the Harris County Metro Service area and the Dallas County Metro Service area. The Medicare reimbursement is inclusive of the implant cost.

<sup>4</sup> Implant cost varies by the implant size, demand and manufacturer

<sup>5</sup> The direct costs are defined as the nursing, patient room, supply, pharmaceuticals and equipment usage

<sup>6</sup> PPO networks are not direct insurers and are typically offered a percentage discount from the gross charges

<sup>7</sup> Large payer contracts are paid at per diems based on Medicare reimbursement, typically ranging from 100% to 120% of Medicare

As the under- and uninsured market grows, patients will become more familiar with the true pricing differential and conclude that they **will not** realize an 80% savings by going overseas for medical care. Medical tourism patients will evaluate their options based not only on cost but upon convenience, as well. Later in this paper I will discuss the variances between elective vs. acute conditions and the decisions that will drive patients to consider seeking medical care overseas.

### *Implementation of Managed Care into the Medical Tourism Market*

The U.S. “managed care” delivery system was developed by health insurance companies (payers) to provide health care coverage and services to the patient through a central health care provider, the “primary care” physician. The concept of managed care began as a way to encourage preventative care and reduce unnecessary/redundant diagnostic services, but in reality managed care has caused a large part of the decline of the U.S. healthcare system. One of the key problems with managed care is that payments to healthcare providers are now based upon Medicare’s reimbursement methodology. Medicare’s reimbursement methodology for surgical procedures does not effectively take into consideration the cost of procedures. If this methodology of reimbursing domestic (U.S.) hospitals is already flawed, then how will U.S. health insurance companies (payers) determine a reimbursement structure for medical tourism hospitals? Many large U.S. insurers do not consider (or care) if a hospital can cover its direct costs. Some insurers take the position that the contractual (reimbursement) rate offered is the market price and therefore that is all that they are willing to pay. If the U.S. insurance companies are aware that the cost basis for medical tourism facilities is materially less, than their reimbursement methodology is sure to follow. Although U.S. insurance companies will provide a volume of patients for medical tourism hospitals, the reimbursement for those services will likely be poor.

Most U.S. insurance companies are no longer in the business of actually providing health insurance. The majority of these insurers now provide administrative services only (ASO) to large employer groups. Most large companies are “self- insured” and look to the U.S. insurance companies to administer their benefits through utilization management, claims processing, access to contracted provider networks and reinsurance administration. Medical tourism hospitals will need to promote their services and advantages directly to these employer groups. To reduce or even maintain the cost of health insurance, employers in the U.S. are being advised through their insurance carriers to reduce benefit coverage, shifting the risk and cost to the patients. This activity will only increase the number of potential medical tourism patients and, in effect, drive healthcare consumerism. Healthcare consumerism, (where patients make educated choices about where and when to obtain healthcare services,) will be the greatest stimulus for success of medical tourism.

## **Clinical Considerations**

### *Elective vs. acute conditions*

Elective procedures, such as a total joint replacement, do not represent the whole of the medical tourism patient base. A total joint replacement is an elective procedure and is typically performed on patients with few, if any, co-morbidities. Acute conditions such as heart or liver failure fall into a higher acuity and a more urgent need for care. Patients suffering from these acute conditions will require extensive services that are currently unavailable in medical tourism sites closer to the U.S. The difficulty these patients face is the clinical stability of their condition and the ability to travel great distances.

The cost structure of hospitals in India and Thailand are far less expensive than those of either hospitals in the U.S. or the medical tourism destinations in Latin America. Patients with acute conditions are prone to longer lengths of stay, higher utilization of services and require extensive physician subspecialty access. All of these conditions are met within the hospitals of India and Thailand. The low costs of these hospitals represent a substantial discount in comparison to U.S. hospitals. Latin American facilities have not excelled in the treatment of these conditions, providing the hospitals in India and Thailand an opportunity to capitalize on their strong reputations as capable, high-quality medical institutions. Although the actual cost savings for elective procedures is not as great as advertised, the cost savings for acute procedures at these facilities is worth pursuing.

### *Clinical Limitations for Travel affecting the medical tourism decision*

There are many clinical conditions that limit the patient's ability to travel after surgery. Patients who are seeking joint replacement or spine surgery are required to maintain a specific level of mobility post operatively. In addition to mobility, patients who are undergoing open procedures<sup>8</sup> -either acute or elective- will be prone to infection during their return travel home. The only way to limit the risk of infection is to let the wound heal over time at the medical tourism location. For patients with the means of taking this additional time to heal, that may be acceptable. For most patients, however, acute such an extended stay due to healing can be very inconvenient or even impossible.

## **Regulatory Conditions**

With a new presidential administration in the U.S., new attention will be given to repairing the U.S. healthcare system. The following is a summary of the current legislative activity and its perceived impact on the U.S. healthcare system.

SCHIP Bill (State Children's Health Insurance Program) (Andrews, 2009)

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<sup>8</sup> Open procedures are defined as procedures requiring a large incision and wound to manage post operatively

In summary, the program will provide federally subsidized state health insurance coverage to all uninsured children. The plan is based on the theory that if every child has coverage, every child will have access to healthcare. There are multiple issues with the plan and concerns of whether it will work. The program is to serve as an extension of each state's Medicaid program, the insurance program for poverty-level or near-poverty level residents. Not all healthcare providers accept or treat Medicaid patients and the state or federal government cannot force a provider to do so. The program will provide coverage to every uninsured child and, at minimum, provide access to basic preventative care. It is not preventative care that everyone notices; it is the acute conditions that catch the media and public's attention. The current Medicaid reimbursement for treatment of many acute conditions does not cover the direct costs of the services/procedures. This patient population represents an opportunity for medical tourism destinations with their ability to provide quality care to the Medicaid patients at a lower cost than their U.S. counterparts. It is unlikely that each state will immediately approve the medical tourism delivery system as each state regulates its respective Medicaid program, including contracting with healthcare providers.

### Hospital Investment Act

Since 2003 the US Congress has attempted on five (5) occasions to pass a bill that will eliminate the whole hospital exception under STARK II law. Currently STARK II law includes the whole hospital exception that allows physician investment in hospitals that participate in the Medicare program. The growth in specialty hospitals and the financial damage they have caused to the tertiary and general acute care hospitals has motivated several legislators to attempt to amend the STARK law. On all five occasions the amendment to the STARK law was included in larger legislation and, in consideration for trying to pass the larger legislation, the language was removed. Most recently House Bill 2 passed through the House, and the Senate is currently evaluating their version of the language. The House version of the bill includes a grandfathering clause that defines the following provisions:

If a joint venture hospital obtains its Medicare Provider number by January 1 of the year the bill is passed then the venture would be subject to the following:

1. The aggregate of the physician ownership will not exceed forty percent (40%)
2. No individual physician will own more than two percent (2%)
3. The facility partnership will not be permitted to add any additional partners as of the January 1 deadline
4. The hospital will not be allowed to increase the number of beds

Should the bill pass as-is, it is estimated that it will directly impact over 300 physician-owned hospitals. In some cases this will place a significant burden on the financial institutions which have financed these facilities. As it pertains to Medical Tourism, the access to surgical care will be affected even more as these facilities are currently providing elective and acute surgical procedures.

In addition to the effect on access the physicians themselves will be financially burdened. U.S. physicians have experienced significant, long-term, downward pressure on their reimbursement. The combination of income reduction and elimination of hospital ownership ancillary income will force U.S. surgeons to look elsewhere to perform surgery. Latin America and other markets not burdened with the regulatory

requirements as imposed in the U.S. will provide opportunity for highly trained U.S. surgeons to practice in emerging medical tourism markets.

### **Summary**

There are many conditions that will drive the success of medical tourism. As medical tourism and healthcare consumerism grows there will be a clear division of care delivery for elective and acute conditions. The division will be created by the **real** savings to the patient, the clinical condition of the patient and the capabilities of the medical tourism hospital.