

**Corporate Medical Travel: The Free Market Solution to Rising Health
Care Costs for Self-funded Corporations?**

by

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Abstract

Corporate Medical Travel: The Free Market Solution to Rising Health Care Costs for Self-funded Corporations?

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Globalization is the interaction and integration among the people, companies, and governments of different nations. With globalization comes international competition. As many U.S. manufacturing and service companies have come to find out, producing goods abroad and using international labor decreases costs. This has caused many U.S. companies to outsource their production to the lowest bidder who will provide goods and services of similar to equal quality. With high health care costs in the United States, why haven't corporations sought out the lowest cost of medicine? With the increasing pressures of health care costs on employers across the U.S., many corporations are finding that the cost of providing health insurance coverage to their employees is cutting more into their bottom line. Corporations that operate under a self-funded health plan have the opportunity to offer medical travel benefits to their employees to curb costs or share those savings with the employees receiving care. In the past year alone, premiums for employer-sponsored family health coverage increased 3 percent from the previous year. This continues a fifteen year trend of rapid premium growth. Many employees are now being faced with higher deductibles, encouraging individuals to take a more active role in their health. Both corporations and employees have a clear incentive to turn their attention to the global health care market. By analyzing the recent trends in the U.S. medical tourism market, is now the time for medical benefit managers to take full advantage of this innovative alternative to traditional and costly U.S. based care? Will a quality focused and cost-driven medical travel option be a widely accepted feature in self-funded corporations medical benefits package in five years' time? We will have to wait and see.

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THE MARKET FOR MEDICAL TOURISM

DEFINING MEDICAL TOURISM

Medical tourism refers to the act of traveling to another country to seek specialized or economical medical care of equal or greater value than what a patient would be receiving in their home country. Medical tourism can also be referred to as ‘medical travel’, while the industry commonly use the synonyms health care globalization, health vacation, wellness tourism, or medical outsourcing.¹ Outbound medical tourism is the specific term used to describe U.S. patients traveling to other countries to receive medical care. Inbound medical tourism denotes patients from other countries traveling to the U.S. to receive medical care. Lastly, intrabound medical tourism refers to U.S. patients traveling within the U.S. to receive care outside of their local community. Our focus will be on outbound medical tourism and its ability to be utilized as a cost-savings mechanism for U.S. corporations.

THE GLOBALIZATION OF HEALTH CARE

Health care is now a worldwide commodity. While costs continue to rise in the U.S., global competition is emerging in countries that were once considered to be “third world”. The U.S. health care system unlike the market for other goods and services, does not fluctuate its prices based on consumer demand. Because of this, consumers have been extremely inviting to the global competition of health care as it has proven its ability to reduce costs. Medical care in countries such as India, Cost Rica, the Grand Cayman Islands, and other medical tourism hot spots can cost just a fraction compared to what is offered in the United States. Deloitte Center for Health Solutions, KPMG International, McKinsey

¹ Khan, Maryam. "Medical Tourism: Outsourcing of Healthcare." Diss. Howard U, 2010. *ScholarWorks @ UMass Amherst*, 30 July 2010. Web.

and Company, and other management consulting firms and independent researchers have kept a keen eye on the medical tourism industry and its emergence in the U.S. market in the past decade as they see its potential impact on the U.S. system. What makes medical tourism attractive is its affordability, something U.S. corporations are foreign to hearing when discussing health expenditures.

“A Google Internet search on May 6, 2007 using the term ‘medical tourism’ returned 777,000 results.”² On April 1, 2015 the same search returned 35 million results. McKinsey and Company and the Confederation of Indian Industry put gross medical tourism revenues at \$40 billion worldwide in 2004, \$60 billion worldwide in 2006, while estimating the total to rise to \$100 billion in 2012.³ Outbound medical tourism from the U.S. has experienced explosive growth in the past decade. Rising U.S. health care costs have forced consumers to think globally when considering treatment. In 2003, approximately 350,000 patients from industrialized nations traveled to a variety of less developed countries for medical care.⁴ An estimated 500,000 traveled abroad for treatment in 2005.⁵ In 2007, it was estimated that 750,000 Americans traveled abroad for medical care. This number was also estimated to increase to 6 million by 2010.⁶ The prolonged U.S. recession in 2008 and 2009, caused estimates of medical tourism growth to drop as the economic downturn had a significant impact on patients’ ability to afford medical care (see Figure 1).⁷ In a Kaiser Family Foundation poll in October, 2008, 36% of respondents

² Michael, Horowitz D., and Rosensweig A. Jeffrey. "Medical Tourism - Health Care in the Global Economy." 24-30. Nov. 2007. Web.

³ Herrick, Devon M. "Medical Tourism: Global Competition in Health Care." *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

⁴ Michael, Horowitz D., and Rosensweig A. Jeffrey. "Medical Tourism - Health Care in the Global Economy." 24-30. Nov. 2007. Web.

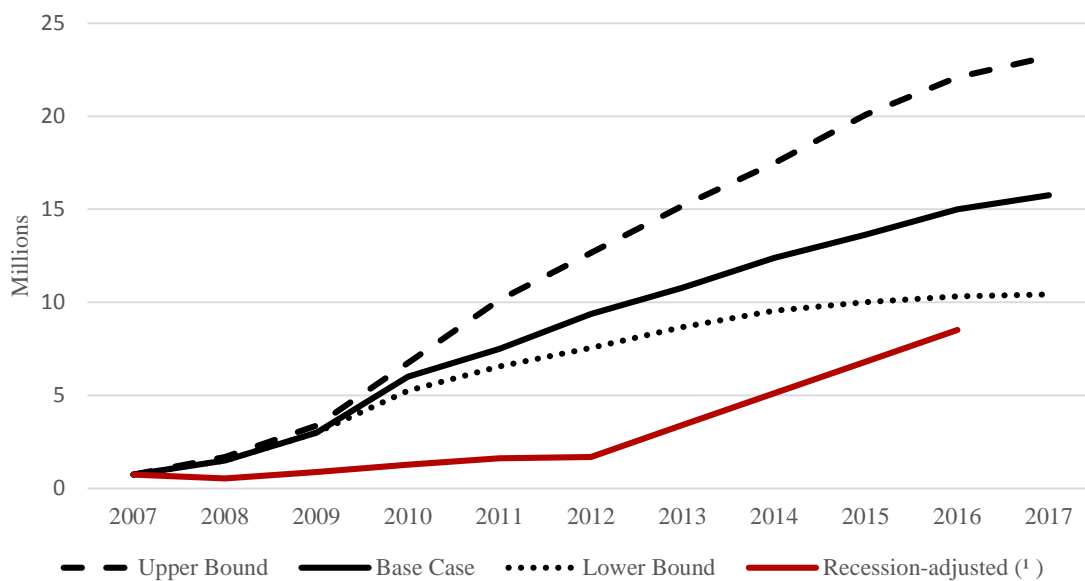
⁵ Herrick, Devon M. "Medical Tourism: Global Competition in Health Care." *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

⁶ Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." *Deloitte*, 2008. Web.

⁷ Deloitte Center for Health Solutions. "Medical Tourism: Update and Implications." *Deloitte*, 2009. Web.

said they or a family member had put off needed medical care, up from 29% in April, 2008.⁸ Another national survey of 686 consumers in July, 2008, found that 22% of U.S. consumers had reduced the number of times they saw the doctor due to the economic downturn.⁹ Patients don't all of the sudden decide to travel great lengths to receive care without having a reason. Why has medical tourism become a multi-billion dollar industry with patients from all different facets and backgrounds pursuing treatment? They see value.

Figure 1: U.S. Outbound Patient Flow, 10-Year Projection



¹ Recession-adjusted projection of the U.S. Outbound Medical Tourism Market assumes a resumption in sustainable growth in 2010.

¹ Source: Deloitte Center for Health Solutions. "Medical Tourism: Update and Implications." Deloitte, 2009. Web. Source: Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." Deloitte, 2008. Web.

THE EMERGENCE OF MODERN MEDICAL TOURISM

Before medical tourism was able to truly take off and gain market share, it faced several deterrents. Its potential was hindered by constraints such as communications,

⁸ Tanner, Lindsay, and Linda Johnson. "Patients Skip Medicine, Doctor Visits Due to Sick Economy." *USA Today*. Associated Press, 22 Oct. 2008. Web.

⁹ National Association of Home Insurance Commissioners. "Weakening U.S. Economy Takes Toll On Americans' Health." *InsuranceNewsNet*. 12 Aug. 2008. Web.

transportation, and water and sewer systems. With years of continued economic strides and improvement in these countries infrastructure, the resources and opportunities are now available for large health care centers.¹⁰ Outbound medical tourism emerged from market forces. It was shaped by the complex interactions of myriad medical, economic, social and political forces.¹¹ It was not employers or health insurers, but individuals who first sought out more affordable care. Even with the passing of the Patient Protection and Affordable Care Act (PPACA) in 2010, a reported 41 million people were still uninsured in 2013. Although the PPACA and its provisions have recently been reducing the amount of uninsured, 61% of uninsured adults reported that the high cost of insurance and job loss are the main reasons for going without coverage (see Figure 2).¹² The uninsured population in the U.S. had to seek care in places that were affordable to them. Instead of obtaining coverage through a costly U.S. insurance policy, many patients looked to the global health care market. Those that are uninsured are more willing to accept uncertainties about quality in order to obtain care at prices they could more comfortably afford.¹³ Many uninsured Americans that looked to countries like India for medical procedures they could not afford in the U.S. were met with open arms, transparent prices, and quality physicians with proven health outcomes. The model of profit-driven health care has been exported from the U.S. to medical centers overseas, and now these facilities are receiving their dividends in the form of increased patient loads.

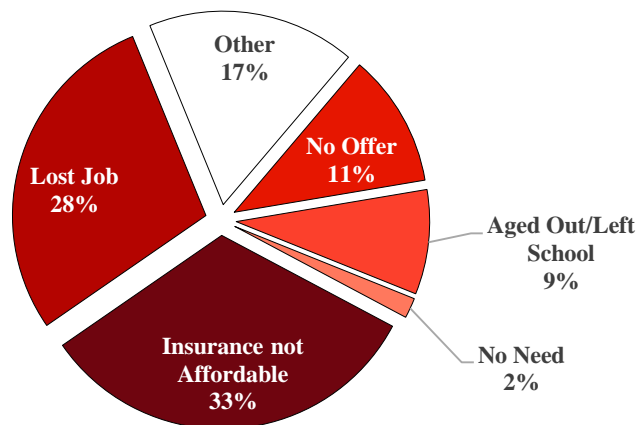
¹⁰ Stephano, Renée-Marie. "Medical Tourism Facilitators: The Good, the Bad, -- the Unknown." 1-8. *Medical Tourism Association*. Medical Tourism Association, 2013. Web.

¹¹ Michael, Horowitz D., and Rosensweig A. Jeffrey. "Medical Tourism - Health Care in the Global Economy." 24-30. Nov. 2007. Web.

¹² Kaiser Family Foundation, Health Research and Educational Trust, and NORC at the University of Chicago. 2014 Employer Health Benefits Survey. *Kaiser Family Foundation*. 10 Sept. 2014. Web.

¹³ Michael, Horowitz D., and Rosensweig A. Jeffrey. "Medical Tourism - Health Care in the Global Economy." 24-30. Nov. 2007. Web.

Figure 2: Reasons for Being Uninsured among Uninsured Nonelderly Adults, 2013*



* KCMY analysis of 2014 National Health Interview Survey

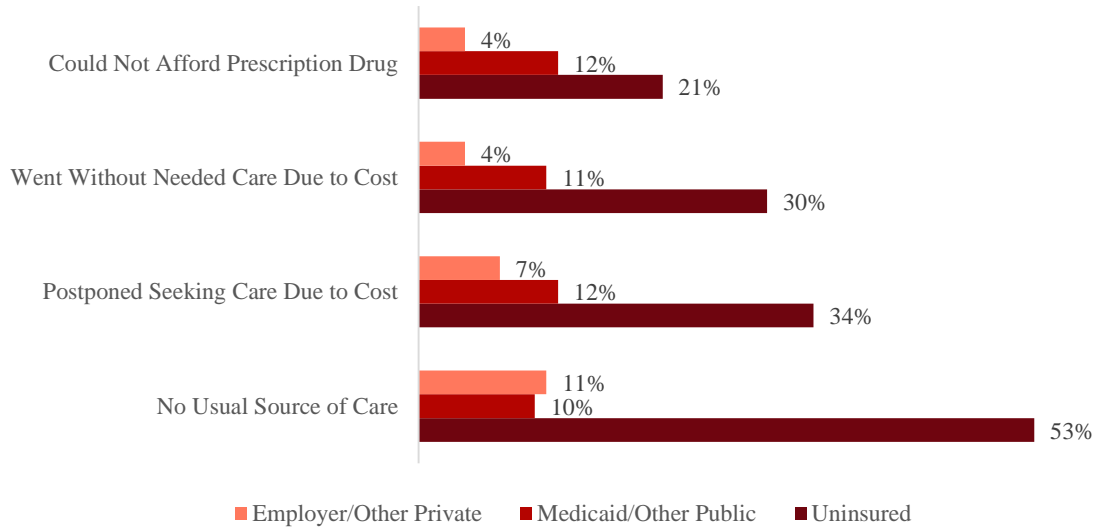
Source: Kaiser Family Foundation. "Key Facts about the Uninsured Population." 29 Oct. 2014. Web.

“Ultimately inequalities and failures in the health systems of sending countries largely drive the need to travel for care. The growing numbers of uninsured and underinsured people in the United States, exacerbated at the time of writing by job losses associated with the global financial crisis, mean that many have little choice but to travel for affordable essential health care.”¹⁴ It is commonplace in the U.S. for uninsured patients to postpone or go without care due to cost of treatment (see Figure 3).¹⁵ Medical tourism is an avenue that these uninsured individuals can still find quality care at affordable prices.

¹⁴ Andrea Whittaker, Lenore Manderson & Elizabeth Cartwright. “Patients without Borders: Understanding Medical Travel, Medical Anthropology: Cross-Cultural Studies in Health and Illness.” 2010. Web.

¹⁵ Kaiser Family Foundation, Health Research and Educational Trust, and NORC at the University of Chicago. 2014 Employer Health Benefits Survey. Kaiser Family Foundation. 10 Sept. 2014. Web.

Figure 3: Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2013*

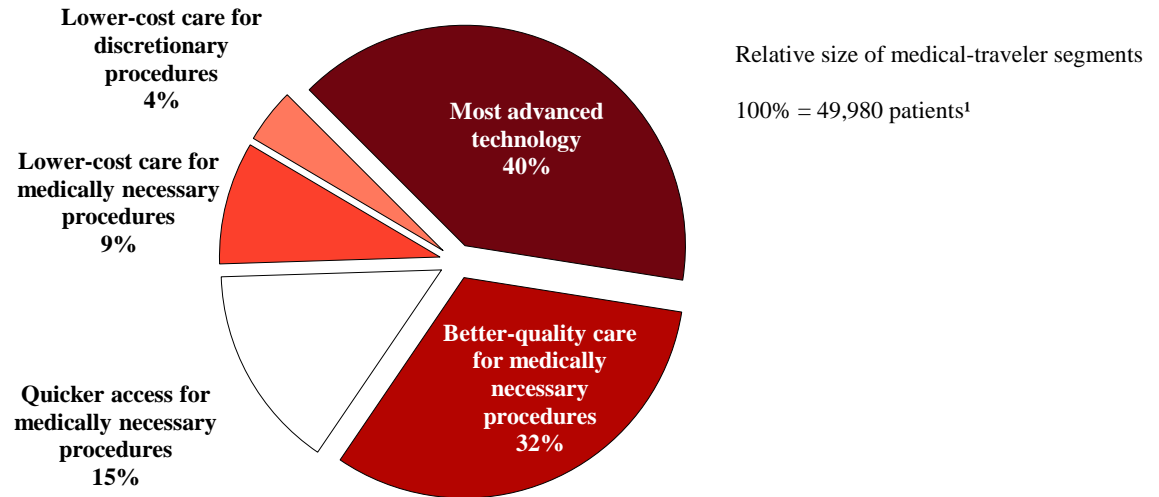


*Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between uninsured and insurance groups are statistically significant ($p < 0.05$).
Source: Kaiser Family Foundation. "Key Facts about the Uninsured Population." 29 Oct. 2014. Web.

CONSUMER ATTRACTION TO MEDICAL TOURISM

People travel abroad for medical care for a variety of reasons. For some, they cannot access certain services in their local communities, for others it is the cost. Taking a look at motivating factors allows us to better understand the profile of the typical medical traveler (see Figure 4). The largest group with 40 percent of all medical travelers is motivated to travel by the advanced technologies. These individuals seek high-quality medical care while giving little attention to the cost or proximity of the destination. The majority of these patients originate from Latin America (38%) and the Middle East (35%) and travel to the United States for care. The second largest segment comprises 32 percent of the market who seek better care than what they can find in their home country. Some of the patients in this category weigh the perceived increase in quality against cost, distance, and unfamiliar cult-

Figure 4: Quality Drives Most of Today's Market



¹ Number of patients come from providers that participated in research; total market size assumes that participating providers represent 60-80% of market.

Source: McKinsey & Company. *The McKinsey Quarterly: Mapping the Market for Medical Travel. Issue brief. May 2008. Web.*

ures. Others choose to look for the highest quality at the best available price, a value-based approach. The third largest segment are those that want quicker access to medically necessary procedures (15%). These patients are usually faced with long wait times at home for orthopedic or general surgery procedures and are seeking a quicker way to obtain treatment abroad. While only 9 percent of travelers surveyed seek lower costs for medically necessary procedures, this segment of the market has the greatest potential for growth. Because treatment prices vary greatly around the world, patients can see significant savings depending on the procedure. “U.S. patients make up 99 percent of the people in this group. In 30 percent of all cases, patients are traveling for orthopedic care, and in 16 percent, for general surgery.”¹⁶

¹⁶ McKinsey & Company. “The McKinsey Quarterly: Mapping the Market for Medical Travel.” Issue brief. *McKinsey & Company*, May 2008. Web.

Deloitte's *2008 Survey of U.S. Health Care Consumers* revealed the degree to which U.S. patients are considering traveling for medical care and how much cost is a factor (see Figure 5). The survey found that consumers are becoming more accepting of medical travel. If patient cannot get high-quality outcome assurances at reasonable costs locally, many agreed that traveling outside of their community was something they would consider. While the numbers in 2008 showed that only 12 percent of those surveyed have traveled outside their "community" for treatment and only 3 percent have traveled outside the U.S. for care, the survey shows signs of positive growth for intrabound and outbound medical tourism as consumers are looking for high-quality services at affordable prices. "As patients are exposed to greater financial burdens resulting from higher co-payments and price transparency efforts, they are likely to seek low-cost treatment alternatives such as medical tourism."¹⁷

39%

say they would go abroad for an elective procedures if they could save half the cost and be assured quality was comparable

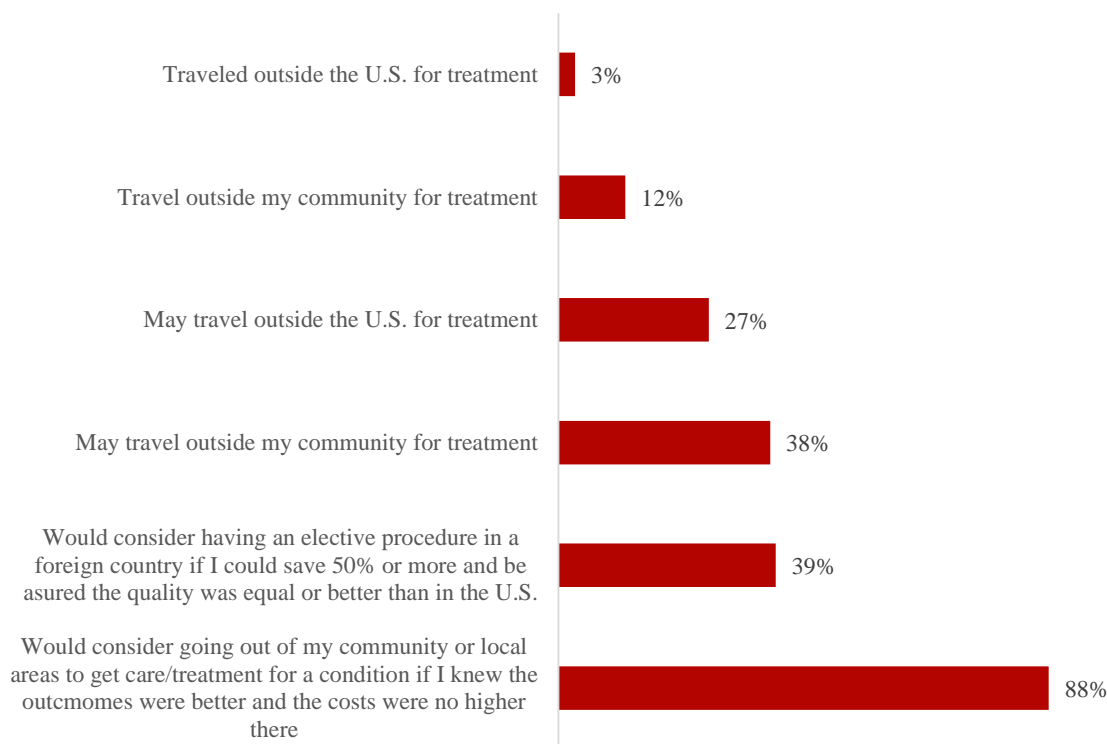
Deloitte continued to push for more information on consumers' willingness to travel for care and their motivations to do so. Deloitte's *2009 Survey of Health Care Consumers* included specific questions about intrabound and outbound medical tourism (see Figure 6). "Eight percent of 2009 respondents said they sought health care services outside their immediate community; over 40 percent said they would travel outside their immediate area for care if their physician recommended it or for a 50 percent cost savings; only 1 in 5 expressed concern about leaving the community based on a referral or potential to save costs."¹⁸ The 2009 survey showed a market that was less accepting to the idea of medical travel than the previous year's survey, possibly due to the recession. Deloitte still

¹⁷ Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." *Deloitte*, 2008. Web.

¹⁸ Deloitte Center for Health Solutions. "Medical Tourism: Update and Implications." *Deloitte*, 2009. Web.

remained positive with the outlook for medical tourism in the U.S. “Though the economic downturn prompted a temporary slowdown in medical tourism growth, as consumers elected to delay non-urgent medical procedures, its recovery is likely as is the substantial role it will play as a technology-enabled innovation with a strong value proposition for targeted patient populations.¹⁹

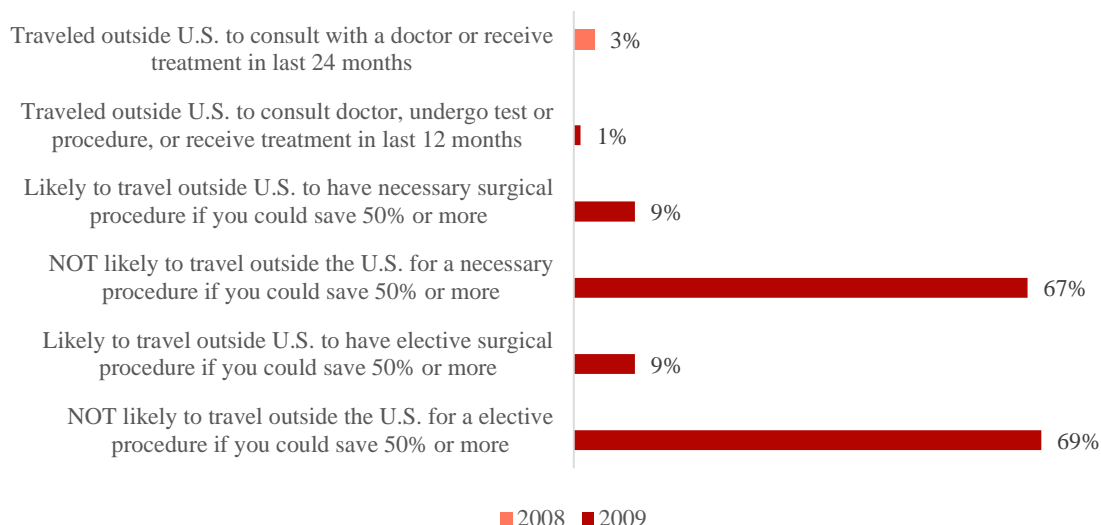
Figure 5: Consumer Interest in Outbound Medical Tourism



Source: Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." Deloitte, 2008. Web.

¹⁹ Deloitte Center for Health Solutions. "Medical Tourism: Update and Implications." Deloitte, 2009. Web.

Figure 6: Percentage Who Traveled Outside the U.S. for Care and Likelihood of Doing So



Note: "Likely" = % who gave rating of 8, 9, or 10 while
 "Not likely" = % who gave rating of 1, 2, or 3 on a 10-point scale

Source: Deloitte Center for Health Solutions. *Medical Tourism: Update and Implications*. N.p.: n.p., 2009. Deloitte, 2009. Web.

RESPONSES TO MEDICAL TOURISM

The first organization to formally address medical tourism was the American Society of Plastic Surgeons. They posted a briefing paper on their website in 2005 providing information to patients considering cosmetic surgery in foreign countries.²⁰ In 2008 the American Medical Association (AMA) released a set of guidelines for employers, insurers, and intermediaries that facilitate or incentivize medical care outside of the U.S. to follow.²¹ With medical tourism becoming more prevalent, the AMA wanted to ensure patients were protecting themselves and taking precautionary measures before deciding to embark on outbound medical tourism (see Figure 7).

²⁰ Michael, Horowitz D., and Rosensweig A. Jeffrey. "Medical Tourism - Health Care in the Global Economy." 24-30. Nov. 2007. Web.

²¹ Deloitte Center for Health Solutions. "Medical Tourism: Update and Implications." *Deloitte*, 2009. Web.

One of the main reasons why medical travel has not reached its full potential is due to the third-party payment system and consumers feeling locked into their “network”

Figure 7: AMA Guidelines for Patients Traveling Overseas for Medical Care

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

Source: Deloitte Center for Health Solutions. “Medical Tourism: Update and Implications.” Deloitte. Deloitte, 2009. Web.

providers that their insurance have negotiated payment with. Insurers and patients have cost-savings opportunities available to them if international networks were considered. “The expansion of medical tourism creates several opportunities for health insurers. The low-cost alternative of receiving care abroad enables insurers to develop plans that provide incentives for patients willing to travel for various procedures. As the cost of health care continues to rise in the United States, leveraging low-cost care abroad can help health insurers to increase profitability.”²² As medical tourism became increasingly prevalent, insurers like WellPoint and United began to see what they could obtain from broadening their provider network abroad. While patients may realize that traveling abroad for care can be significantly less costly than care received in the U.S., most patients are used to relying on their health plans to

²² Deloitte Center for Health Solutions. “Medical Tourism: Consumers in Search of Value.” Deloitte, 2008. Web.

determine which treatment options are available. Insurers have launched pilot programs within their benefit plans in hopes of reducing treatment costs and improving margins, at the same time providing employers with reduced health care costs.

In 2009, Anthem WellPoint setup a pilot program in Wisconsin with Serigraph, Inc. where they would cover 700 group members under their medical travel benefits package.²³ The plan would send employees to Apollo Hospitals in India for certain elective procedures. All medical and travel arrangements were managed by Anthem Wellpoint. Other insurance companies tested the market with their own pilot programs. United Group Program setup their own medical travel benefits plan pilot program in Florida. They covered 200,000 individuals through self-funded health plans and fully-insured mini-med plans (plans that allow employees to pay a higher premium to in return receive increased coverage).²⁴ Blue Shield and Health Net in California covered 20,000 patients while working with employers who had a large number of Mexican immigrants.²⁵ Blue Cross Blue Shield in South Carolina teamed with Companion Global, an independent medical tourism facilitator, and covered all procedures organized through their oversight. They also covered two follow-up visits if the patients were to use a Doctors Care, an urgent care facility in their area.²⁶ “Outbound medical tourism provides health plans additional network options for cost-effective care that can be incorporated as features in the group and individuals products. Health plans may need to decrease premiums for employers who send their employees abroad for major, non-urgent surgeries.”²⁷ The various pilots that have been launched provided many valuable lessons for insurers. Not until after the

²³ India PR Wire. "Apollo Signed an Agreement with US Based Insurance Company." 5 Jan. 2009. Web.

²⁴ Deloitte Center for Health Solutions. "Medical Tourism: Update and Implications." *Deloitte*, 2009. Web.

²⁵ Black, Thomas. "Mexico Gets Medical Tourists as Health Net Sends U.S. Patients." *Bloomberg*, 26 Mar. 2008. Web.

²⁶ Deloitte Center for Health Solutions. "Medical Tourism: Update and Implications." *Deloitte*, 2009. Web.

²⁷ Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." *Deloitte*, 2008. Web.

PPACA provisions have been widely implemented and accepted will insurance companies open their provider networks internationally. It is clear that offering patients more international options can in return produce savings for the insurance companies and patient.

OUTSOURCING HEALTH CARE SERVICES

U.S. health care is not foreign to the idea of outsourcing services. U.S. hospitals with a sweet-tooth for innovation and cost-savings have found that turning their attention to the global marketplace for health care can provide needed savings in a time when falling margins are of major concern. “Many medical tasks can be outsourced to skilled professionals abroad when the physical presence of a physician is unnecessary. This can include interpretation of diagnostic tests and long-distance international collaboration, particularly in case management and disease management programs, because of the availability of information technology.”²⁸ U.S. hospitals have already attempted to outsource laboratory services which are said to yield 20% savings according to hospital consultants and market analysis.²⁹ Although this may lead to a longer waiting period for results and loss of autonomy over lab services, the cost-savings are convincing to some hospital executives. For patients located in rural areas, it provides them with access to specialists and will probably become the preferred way to monitor patients with chronic conditions. Outsourcing often results in lower costs, higher quality and greater convenience.³⁰

Several hundred U.S. hospitals are using overseas radiology services. Teleradiology is the transmission of radiological patient images, such as X-rays, CTs, and

²⁸ Herrick, Devon M. “Medical Tourism: Global Competition in Health Care.” *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

²⁹ Lee, Jaimy. “Outsourcing Lab Services Can save Money, but It's Not That Simple.” *Modern Healthcare*. 30 Aug. 2014. Web.

³⁰ Herrick, Devon M. “Medical Tourism: Global Competition in Health Care.” *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

MRIs, from one location to another for the purposes of sharing studies with other radiologists and physicians. The hospitals use radiologists abroad that adhere to the American College of Radiology (ACR) guidelines with respect to licensure, insurance, and hospital privileges. The Center for Medicare and Medicaid Services (CMS) did not want to compensate physicians abroad for their services, an obstacle that many teleradiology companies and hospitals finesse by providing a ‘preliminary report’, which is later followed by a U.S. radiologist’s ‘final primary report’. The radiologists abroad are paid directly by the contracted teleradiology firm or the hospital at rates of \$50-75 per radiograph and the local radiologist bills CMS or other payer.³¹ Research has also shown that telemedicine can improve adherence to protocols and increase convenience for patients with chronic ailments. Outsourcing disease management services, remote health coaching, and radiology services to places where labor costs are lower seems logical for providers as long as U.S. guidelines are followed to uphold the same quality of services provided.

U.S. COSTS DRIVING MEDICAL TRAVEL GROWTH

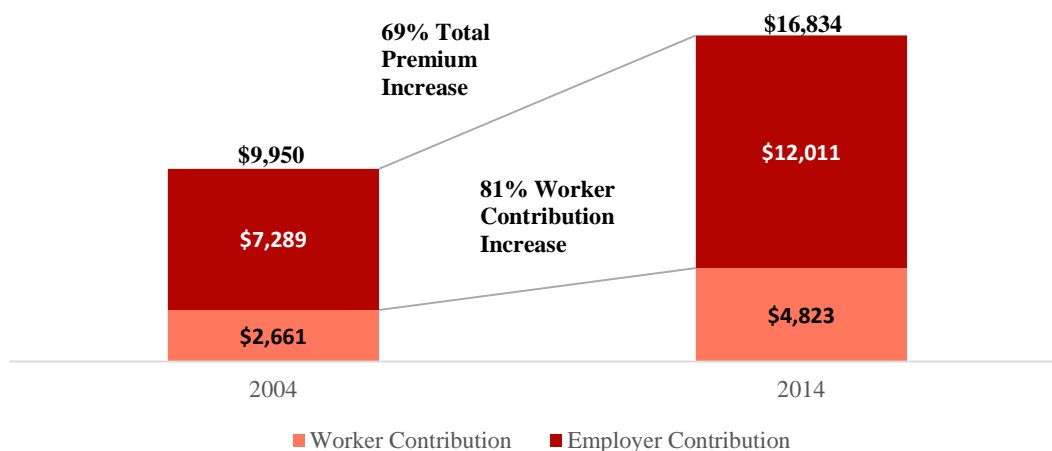
The growth of outbound medical tourism has been driven by a number of reasons. Employers have been faced with increasing health care expenditures that are cutting more into their bottom-line. Between 2003 and 2010, premiums for employer-sponsored health insurance grew 5.1% per year. Following the passage of the ACA, from 2010 to 2013, premiums grew at a rate of 4.1%. “Over the last ten years, the average premium for family coverage has increased 69% (see Figure 8 and 9). Premiums have increased less quickly over the last five years (2009 to 2014), then the preceding five year period (2004 to 2009) (26% vs. 34%).”³² Health care expenditures are not decreasing anytime soon. “In 2013

³¹ Wachter, Robert M. "International Teleradiology." *New England Journal of Medicine*. 16 Feb. 2006. Web.

³² Kaiser Family Foundation, Health Research and Educational Trust, and NORC at the University of Chicago. 2014 Employer Health Benefits Survey. *Kaiser Family Foundation*. 10 Sept. 2014. Web.

health spending growth is expected to have remained slow, at 3.6 percent, as a result of the sluggish economic recovery, the effects of sequestration, and continued increases in private health insurance cost-sharing requirements. The combined effects of the Affordable Care Act's coverage expansions, faster economic growth, and population aging are expected to fuel health spending growth this year and thereafter (5.6 percent in 2014 and 6.0 percent per year for 2015–23).”³³

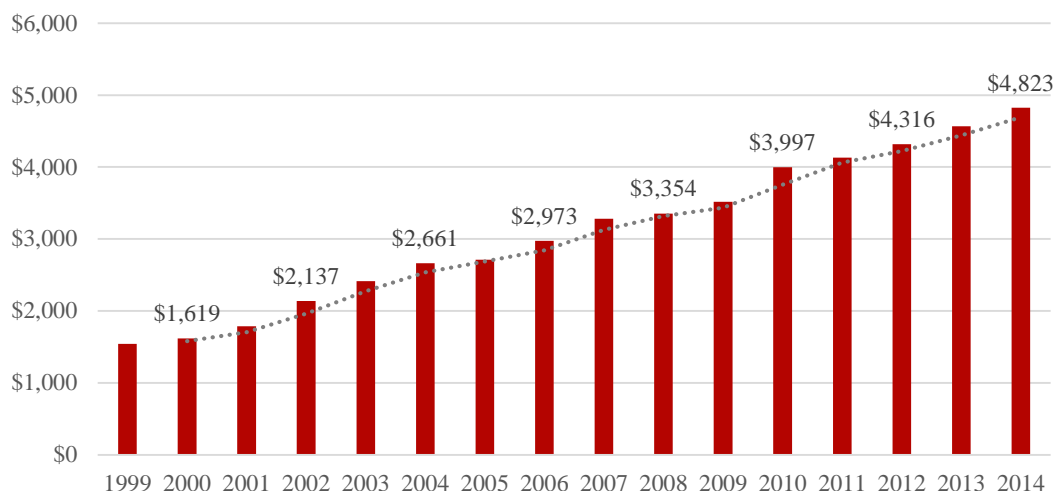
Figure 8: Average Health Insurance Premiums and Worker Contributions for Family Coverage, 2004-2014



Source: Kaiser Family Foundation, Health Research and Educational Trust, and NORC at the University of Chicago. 2014 Employer Health Benefits Survey. Kaiser Family Foundation. 10 Sept. 2014. Web.

³³ Sisko, Andrea M., Sean P. Keehan, Gigi A. Cuckler, Andrew J. Madison, Sheila D. Smith, Christian J. Wolfe, Devin A. Stone, Joseph M. Lizonitz, and John A. Poisal. "National Health Expenditure Projections, 2013-23: Faster Growth Expected With Expanded Coverage And Improving Economy." *Health Affairs*. N.p., Sept. 2014. Web.

Figure 9: Worker Contributions to Premium, 1999 to 2014



Source: Kaiser Family Foundation, Health Research and Educational Trust, and NORC at the University of Chicago. 2014 Employer Health Benefits Survey. N.p.: n.p., 2014. Kaiser Family Foundation. 10 Sept. 2014. Web.

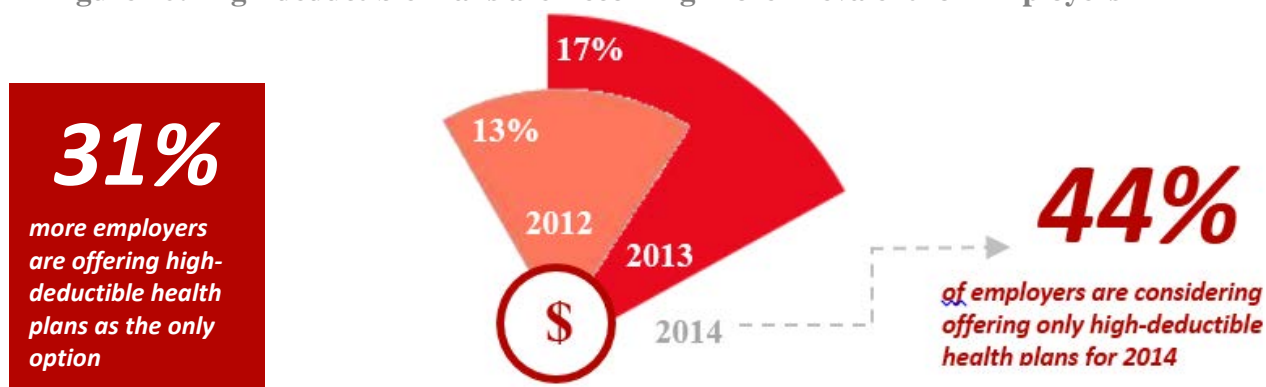
The same is true for employees deductibles which rose more slowly between 2010 and 2013, growing 7.5 percent per year compared to more than 10 percent per year between 2003 and 2010. An average premium for family coverage reached \$16,029 in 2013, or 23% of median family income, up 15% in 2003. The Commonwealth Fund President David Blumenthal, M.D. made a statement on the increasing cost trend. “As employers struggle to keep health insurance premium costs manageable, they are asking their workers to pay a larger share of their insurance costs. The recent slowdowns in overall health care costs are promising, but clearly they have not translated into relief for workers, who are spending more of their incomes on health coverage.”³⁴ Pricewaterhouse Coopers *2013 Touchstone Survey* of large U.S. employers confirmed that businesses are increasing cost sharing and plan to continue using this strategy to moderate spending growth (see Figure 10).³⁵ The

³⁴ The Commonwealth Fund. “Employer Premium and Deductible Cost Growth Slowed Post-ACA, But Employer Health Insurance Still Claiming Bigger Share of Workers’ Income.” *The Commonwealth Fund*. The Commonwealth Fund, 9 Dec. 2014. Web.

³⁵ PwC. “Medical Cost Trend: Behind the Numbers 2014.” 1-24. PricewaterhouseCoopers. *Health Research Institute*, June 2013. Web.

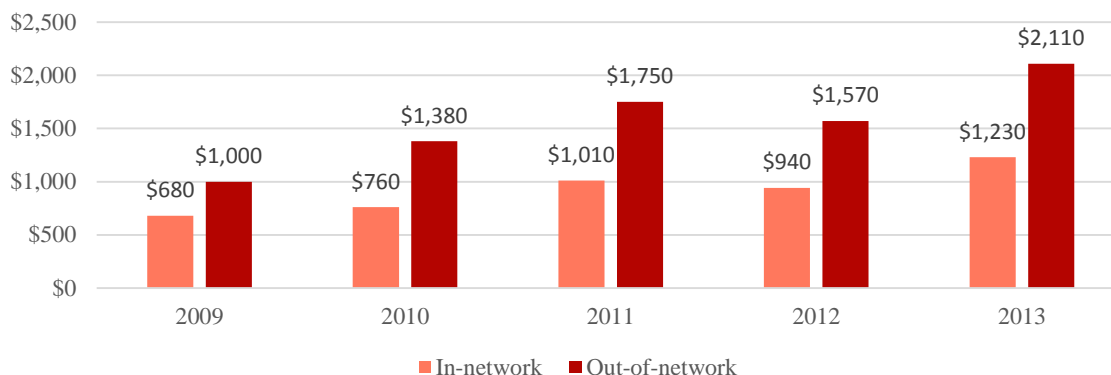
PwC survey also showed that high deductible plans were soon going to be the norm in employees' health plans, with 44% of employers considering offering only high-deductible health plans in 2014. The average deductible for in-network services was more than \$1,000, and out-of-network services was reported at more than \$2,000 in 2013 (see Figure 11).³⁶

Figure 10: High-deductible Plans are Becoming More Prevalent for Employers



Source: PwC. *Medical Cost Trend: Behind the Numbers 2014* (2013): 1-24. PricewaterhouseCoopers. Health Research Institute, June 2013. Web.

Figure 11: Average Deductible for In-network and Out-of-network Visits*



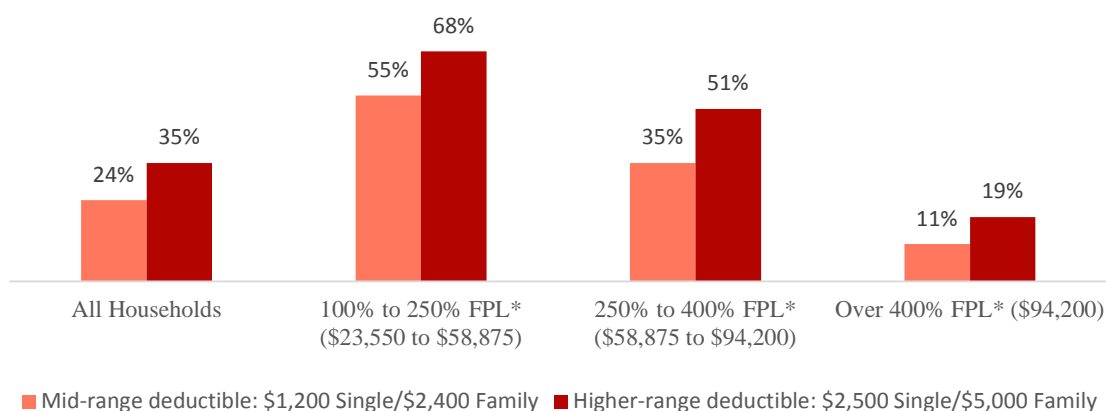
*Calculations are based on employee health plans with a deductible

Source: PwC. *"Medical Cost Trend: Behind the Numbers 2014."* *Medical Cost Trend: Behind the Numbers 2014* (2013): 1-24. PricewaterhouseCoopers. Health Research Institute, June 2013. Web.

³⁶ PwC. *"Medical Cost Trend: Behind the Numbers 2014."* 1-24. PricewaterhouseCoopers. Health Research Institute, June 2013. Web.

A more recent study released just this year by the Kaiser Family Foundation shows a disturbing story at a time when high-deductible plans are on the rise. With the increase in high-deductible plans and deductible rates in general, do consumers have enough liquid assets to pay for their medical bills before reaching their deductible limit? The results were surprising. The findings show that roughly a quarter (24%) of all non-elderly Americans with private insurance coverage do not have sufficient liquid assets to pay even a mid-range deductible, which today would be \$1,200 for single coverage and \$2,400 for family coverage (see Figure 12). More than one-third (35%) don't have the resources to pay for higher-range deductibles. As the income level of the household decreases, even fewer are able to meet the deductible amount. This begs to question whether cost-sharing has gone too far. Although this brings on a whole other discussion, it sets the foundation for an innovative solution such as the medical tourism industry to take root and grow at an exponential rate.³⁷

Figure 12: Households Without Enough Liquid Assets to Pay Deductibles



*Federal Poverty Level

Notes: Data among all-nonelderly households above the poverty line with private insurance.

Income ranges are for a family of four.

Source: Altman, Drew. "Health-Care Deductibles Climbing Out of Reach." *Washington Wire. The Wall Street Journal*, 11 Mar. 2015. Web.

³⁷ Altman, Drew. "Health-Care Deductibles Climbing Out of Reach." *Washington Wire. The Wall Street Journal*, 11 Mar. 2015. Web.

Employers have little choice but to shift some of this cost burden onto their employees in the form of higher deductible plans in hopes of changing consumer behavior. This past year, consumer-driven health plans (also known as high-deductible plans) have increased dramatically due to the overwhelming health care costs employers are facing. Higher-deductible plans place greater responsibility on consumers and are designed to promote cost-conscious decisions, something that has been lacking in years past. A recent study reported families that switched from a traditional health plan to a high-deductible plan spent an average of 21% less on health care in the first year.³⁸ Although these signs are inviting for health expenditure data, these high-deductible plans may be causing U.S. families to cut back on necessary care due to unbearable costs. With increasing premiums, deductibles, and the push towards high-deductible health plans, medical travel has and will see a steady increase in individuals seeking another way to obtain affordable care.

U.S. FEDERAL AND STATE REACTION TO MEDICAL TOURISM

Medical tourism was first largely noticed in the U.S. when a story broke in 2004. Howard Staab, a carpenter from Durham, North Carolina, learned that he was suffering from a life-threatening heart condition and would have to undergo surgery costing \$200,000. The surgery was not the only problem, Howard did not have health insurance and had no way of funding such a procedure. His answer? Outsource the job to India. His story goes on to show promising outcomes with affordability and quality being the highlighted features of his trip.³⁹ When he returned with his partner Maggi Grace, she was keen to share their experiences in the national spotlight. Howard's story had such a profound impact that Maggi Grace testified in front of the U.S. Senate when medical

³⁸ PwC. "Medical Cost Trend: Behind the Numbers 2014." 1-24. PricewaterhouseCoopers. *Health Research Institute*, June 2013. Web.

³⁹ Lancaster, John. "Surgeries, Side Trips for 'Medical Tourists'" *Washingtonpost.com*. 21 Oct. 2004. Web.

tourism was the topic of discussion in 2006. The U.S. Senate Special Committee on Aging held hearings on the issue of medical tourism and if it was a way to reduce health care costs. The reasoning was to have an in-depth look at the impact and safety of the lower cost health care abroad.⁴⁰ The committee recognized the safety, quality, and cost-savings that were presented to them in the hearing. Senator Ken Salazar of Colorado made a statement that shed light on the political impact and core issue with medical tourism for the federal government. “I find this topic both fascinating and disconcerting. I am pleased that quality of care in places like India, Thailand, and Malaysia has evolved so that Americans feel comfortable going under the knife for complicated surgeries like bypass surgery or more routine surgeries like knee surgery. However, I also believe that we must examine the root cause of this phenomenon: the rising cost of health care and frequent unavailability of affordable health insurance.⁴¹ “It is not likely that the government will direct enrollees (Medicare, Medicaid, FEHP) in the direction of outbound medical tourism, but it is plausible that barriers will not be created for commercial plans, employers and individuals.”⁴²

At the state level, some legislatures have considered options for encouraging their state employees to utilize medical travel options. The West Virginia legislature did just this in 2007. House Bill 2841 of the West Virginia Legislature set forth to amend the Code of West Virginia by “...providing incentives to covered employees to obtain treatment in low cost foreign health care facilities accredited by the Joint Commission International.”⁴³ The bills purpose was to reduce the cost of medical care that state public employees were

⁴⁰ Michael, Horowitz D., and Rosensweig A. Jeffrey. "Medical Tourism - Health Care in the Global Economy." 24-30. Nov. 2007. Web.

⁴¹ U.S. Senate. "The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?" Special Committee on Aging, 27 June 2006. Web.

⁴² Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." *Deloitte*, 2008. Web.

⁴³ State of West Virginia. "House Bill 2841." *West Virginia Legislature*. 5 Feb. 2007. Web.

causing by simply outsourcing medical procedures to foreign JCI accredited hospitals. The cost of travel, lodging, and the treatment would be paid in full by the Public Employees Insurance Agency (PEIA), the benefits manager for active employees of the State of West Virginia. To incentivize state employees to travel abroad for care, they would (1) waive all co-payments and deductible amounts, (2) reimburse the employee twenty percent of any savings, (3) pay for lodging and the travel cost of a companion, (4) pay for the cost of lodging for seven days of convalescence, and (5) pay the employer for seven days of paid sick leave for the employee.⁴⁴ The bill was one of the first forms of medical tourism legislature that pushed for government employees to seek care outside of U.S. boundaries. The bill later died in committee.

Colorado legislature was presented with a similar bill in 2007, with the same incentive structure for a covered state employee under a self-insured group benefit plan to obtain medical care in an accredited foreign health care facility.⁴⁵ At the Colorado House Committee on Business Affairs and Labor, discussions were held on the safety, cost, and value of medical travel. The prime sponsor for the bill was Representative Swalm. He argued that "...there is a debate on how health care should be funded: by the government or by private entities. He stated we should be focusing on value in the health care which consists of high quality and relative low cost."⁴⁶ This bill would have provided employees with an option of medical travel, an option that provides more value per unit cost than what they can be promised in the U.S. Although the bill would only provide an alternative option to state employees and not mandate their travel abroad, the bill was postponed indefinitely in committee until further information on the subject could be gathered.⁴⁷ West Virginia and

⁴⁴ State of West Virginia. "House Bill 2841." *West Virginia Legislature*. 5 Feb. 2007. Web.

⁴⁵ State of Colorado. "HOUSE BILL 07-1143." HOUSE BILL 07-1143 (2007): 1-7. *State of Colorado Legislature*. State of Colorado, 2007. Web.

⁴⁶ State of Colorado. "Bill Summary for Bill Number HB07-1143." 2007. Web.

⁴⁷ State of Colorado. "Bill Summary for Bill Number HB07-1143." 2007. Web.

Colorado representatives noticed the value in offering their employees this opportunity by bringing these bills to committee. Although the bills did not pass into law, they brought forth the concerns that state governments are having with their health care expenditures and there is now precedent for future propositions at the state level. It may seem like political suicide to outsource medical services, but the savings and pressure it would put on the U.S. system to decrease costs would be enormous. "Federal and state government should lead by example, by allowing Medicare and Medicaid programs to send willing patients abroad. Medicare would particularly benefit from cost savings since its pays for a large volume of orthopedic and cardiac procedures."⁴⁸ The cost-sharing aspect of the Medicare program could be waived for patients who pursue care abroad, allowing the consumers to share in the savings. Although these actions can be seen as far-fetched, these are options that would undoubtedly lower costs and increase competition in the global market for health care.

BARRIERS TO GROWTH

The medical tourism industry faces specific barriers that make individuals hesitant to pursue outbound medical travel. The quality of medical care offered abroad, the success rate of the hospital or medical center selected, post-surgical complications, travel regulations, medical privacy concerns, and medical malpractice are just a few concerns that medical tourists and employers considering offering medical travel benefits have.⁴⁹ Other concerns include language barriers, fluctuations in international currency exchange rates, and securing follow-up care.

⁴⁸ Herrick, Devon M. "Medical Tourism: Global Competition in Health Care." *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

⁴⁹ Khan, Maryam. "Medical Tourism: Outsourcing of Healthcare." Diss. Howard U, 2010. *ScholarWorks @ UMass Amherst*, 30 July 2010. Web.

The main concern for medical tourists should be selecting the best possible destination for the specific service they need. Patients face the daunting task in differentiating the desirable off-shore destinations from those with inadequate practitioners working in unsafe facilities.⁵⁰ Medical travel intermediaries or facilitators are valuable resources for medical tourists and employees to utilize when planning for medical care abroad. “Intermediaries investigate health care providers and screen patients to assess those who are physically well enough to travel. Some intermediaries are affiliated with specific medical providers and send patients exclusively to those providers. But most intermediaries seek to create a broad network of providers and destinations to meet the diverse need of patients.”⁵¹ A medical tourism intermediary will be able to identify reliable providers, understand the complex arrangements and medical procedures, and make critical preparations for the patients receiving care. “Traveling patients many of whom are college-educated with annual earnings from \$50,000-100,000, don’t seem to mind facilitators negotiating rewards on their behalf, and why should they. Using a medical tourism facilitator is more convenient and expedient than looking for a program on their own, especially for a patient trying health care travel for the first time. Plus, their medical expenses are dramatically reduced and, in the meantime, patients get to live at resort-like facilities with accommodations reserved for kings or queens and other VIP’s.”⁵²

In the early 1900’s it became clear that hospitals and their procedures should be standardized in order to ensure similar health outcomes. In 1910, Ernest Codman, M.D. proposed the “end result system of hospital standardization. Shortly after the American

⁵⁰ Michael, Horowitz D., and Rosensweig A. Jeffrey. "Medical Tourism - Health Care in the Global Economy." 24-30. Nov. 2007. Web.

⁵¹ Herrick, Devon M. "Medical Tourism: Global Competition in Health Care." *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

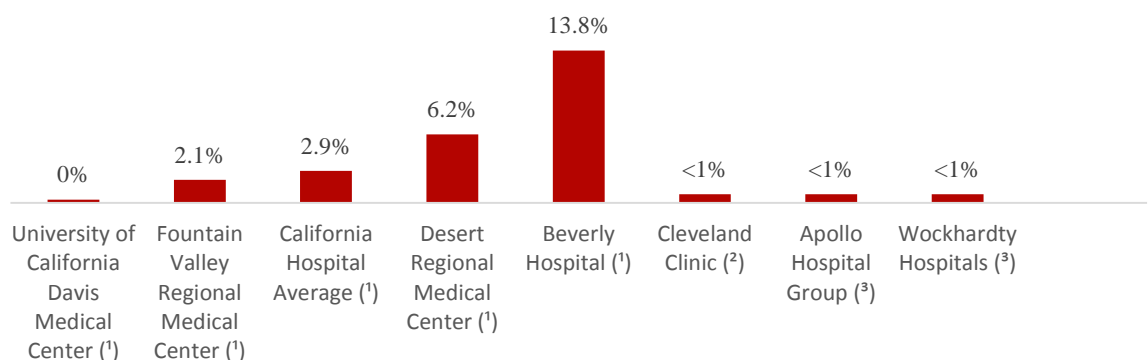
⁵² Stephano, Renée-Marie. "Medical Tourism Facilitators: The Good, the Bad, -- the Unknown." 1-8. *Medical Tourism Association*. Medical Tourism Association, 2013. Web.

College of Surgeons (ACS) was founded and adopted this “end result” system as one of their objectives. The ACS continued on this path by inspecting hospitals and standardizing manuals that noted how hospitals should conduct themselves. Not until the 1950’s did the ACS lead to the creation of The Joint Commission, formerly the Joint Commission on Accreditation of Hospitals (JCAH) and previous to that the Joint Commission on Accreditation of Healthcare Organizations (JCAH), an independent, not-for-profit organization, whose primary purpose is to provide voluntary accreditation. Over the years, this accreditation was seen to be so critical to ensure the safety and quality of hospitals that it is now required to receive reimbursement by the Medicare and Medicaid program. From its inception through the 1990’s, The Joint Commission expanded its accreditation circle as the health care industry expanded. Accreditation began to expand from hospitals to long term care facilities, mental health programs, ambulatory care, alcohol and substance abuse programs, and hospice care. It is the leading organization and continues to spearhead the standardization of hospital procedures, emphasizing organization performance, and highlighting safety and quality measures. In 1994, the Joint Commission International (JCI) was formed to provide education and consulting services to international clients. In 2000, the JCI published the first comprehensive set of international quality standards for hospitals and presented its first accreditation award. The JCI currently has 479 accredited hospital programs and 740 total accredited programs outstanding. Joint Commission accredited hospitals have to renew their accreditation every three years and must collect and report data on services provided and quality indicators. Other organizations that provide information on certain standards regarding hospital quality, health care and medical ethics include the International Society for Quality in Health Care (ISQua), the

National Committee for Quality Assurance (NCQA), the European Society for Quality in Healthcare (ESQH), and the International Standards Organization (ISO).⁵³

Individuals who are interested in seeking medical travel options should not do so with cost-savings as their only focus. The quality of care must be of main importance when seeking more affordable prices abroad. Prospective patients should seek providers or medical intermediaries that offer value-based care. Value-based care is when the best outcomes are achieved at the lowest cost. If consumers are convinced that medical travel is a way of maximizing the value for these prospective patients, the employers should see an overall reduction in health expenditures. Many international hospitals can provide care that is equivalent to some of the best hospitals in the United States (see Figure 13 and Table 1). Many hospitals involved in medical tourism employ doctors that have been trained in the U.S. or that have internationally respected credentials. Patients that align themselves with high-quality hospitals with proven success rate and low complications rates will be receiving the best value.

Figure 13: Cardiac Surgery Mortality Rates



¹California Hospital

²U.S. Center for Excellence

³International Hospital

Source: Herrick, Devon M. *Medical Tourism: Global Competition in Health Care*. National Center for Policy Analysis. National Center for Policy Analysis, Nov. 2007. Web.

⁵³ Mattoo, Aaditya, and Randeep Rathindran. "How Health Insurance Inhibits Trade In Health Care." *Health Affairs*. Mar. 2006. Web.

Table 1: Selected Offshore and California Hospitals' Status on Familiar Quality Standards for Elective Coronary Artery Bypass Graft (CABG) Surgery

Meet Standards for Hospitals <u>and</u> Surgeons				
<i>Hospital</i>	<i>Country</i>	<i>City</i>	<i>Quality Credentials - Hospitals</i>	<i>Quality Credentials - Cardiac Surgeons</i>
Apollo	India	Chennai	JCI accredited; and ISO 9000 and ISO 9002 certified*	Fellowships at Cleveland Clinic, Univ. Wisconsin-Milwaukee & Brigham and Women's Hospital; CABG mortality rate <1%
Bumrungrad	Thailand	Bangkok	JCI accredited	Half of cardiac surgeons are U.S. board certified; CABG mortality rate not reported
Wockhardt	India	Mumbai	JCI accredited	Residency/fellowships at Harvard and Lahey Clinic; CABG mortality rate <1%
Meet Standards for Hospitals <u>or</u> Surgeons				
<i>Hospital</i>	<i>Country</i>	<i>City</i>	<i>Quality Credentials - Hospitals</i>	<i>Quality Credentials - Cardiac Surgeons</i>
Angeles	Mexico	Mexico City	ISO 9001 certified*	Cardiac surgeons board certified in Mexico; CABG mortality not reported
California High Volume Hospital Average				
<i>Hospital</i>	<i>Country</i>	<i>City</i>	<i>Quality Credentials - Hospitals</i>	<i>Quality Credentials - Cardiac Surgeons</i>
Multiple	U.S.	Multiple Calif. Cities	All JACHO accredited None are ISO certified*	Most high volume CABG surgeons are U.S. board certified. California's CABG mortality rate is 2.91%

*The ISO 9000 family addresses various aspects of quality management and contains some of ISO's best known standards. The standards provide guidance and tools for companies and organizations who want to ensure that their products and services consistently meet customer's requirements, and that quality is consistently improved.

Source: Milstein, Arnold, and Mark Smith. "Will The Surgical World Become Flat?" *Health Affairs* 26.1 (2007): 137-41. *Health Affairs*. Jan. 2007. Web

Another main area of concern is medical malpractice and how patients will self-insured employers will need to consider the risk of malpractice suits.⁵⁴ "Patients may have little legal protection when pursuing treatment overseas. Countries differ in their

⁵⁴ Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." *Deloitte*, 2008. Web.

malpractice, willful harm and negligence laws, and in the accessibility of non-citizens to their legal process.”⁵⁵ Employers and medical facilitators can protect themselves and those pursuing care abroad by having liability insurance. Insurance brokers like Custom Assurance Placements, Ltd., have developed custom insurance solutions for the medical tourism industry. They offer individual protection and protection for employers, medical facilitators, and international hospitals through the specialty insurance program known as Global Protective Solutions.⁵⁶ The coverage that is of most interest to employers is their Employer Healthcare Management Liability offering. This covers possible liability resulting from the implementation of a medical tourism/travel benefit. They offer limits up to \$10 million with excess insurance options. Coverage is available for the health care management exposure of a health care insurance benefit arising out of an act, error or omission in the performance of professional services. Their coverage also extends for incidents where employer vicarious liability from medical malpractice associated with employee utilization of a medical travel insurance benefit. The coverage includes damages and claims expenses as well as defense costs.⁵⁷ This insurance broker in South Carolina is not the only niche group for medical tourism medical liability insurance. Compass Benefits Group out of Hanover, Massachusetts, offers very similar coverage and benefits as Global Protective Solutions above.⁵⁸

When patients go abroad to receive treatment, their complete electronic medical records (EMR) should be brought with and supplied to the international physicians. The process of collecting this information and transferring it to the international physician

⁵⁵ Andrea Whittaker, Lenore Manderson & Elizabeth Cartwright. “Patients without Borders: Understanding Medical Travel, Medical Anthropology: Cross-Cultural Studies in Health and Illness.” 2010. Web.

⁵⁶ Custom Assurance Placements, Ltd. “International Medical and Travel Insurance.” *Custom Assurance Placements, Ltd.* Web.

⁵⁷ Global Protective Solutions: Specialty Travel Insurance. “For a U.S. Facilitator.” For a U.S. Facilitator. Web.

⁵⁸ Compass Benefits Group. “Medical Tourism Facilitator Liability Insurance.” Web.

must be done in a secure and private matter. To assure that continuity of information flow exists between the patients' medical home and their medical tourism destination, patients should ensure that all information related to their procedure is indicated in their charts and sent back home. If patients fail to have their complete EHR available to the international physicians, this may lead to complications, longer stays, and increased cost if medications cause allergic reactions or negative symptoms post-surgery.

CORPORATE MEDICAL TRAVEL

SELF-FUNDED HEALTH COVERAGE

A self-funded health plan is where employers assume the liability and risk associated with their employees' health care costs in exchange for a number of significant financial benefits. Self-funded health plans can provide organizations with better cash flow, tax benefits, flexibility with plan design, and reduced administration costs. Under a self-funded health insurance plan, the employer no longer relies on a commercial insurer and creates its own coverage plan based on its needs. Employers can choose what procedures and services it wants and avoid paying for coverage it does not. The claims are paid by the employer out-of-pocket from collected premiums.⁵⁹ Self-funded plans are continuing to grow in popularity, particularly in firms with more than 200 workers (see Figure 14).

⁵⁹ National Insurance Services, Inc. "Understanding Self-Funded Vs. Fully Insured Health Plans." White Paper (2012): 1-6. *NIS Benefits*. 2012. Web.

Figure 14: Percentage of Covered Workers in Partially or Completely Self-Funded Plans, by Firm Size, 1999-2014



*Estimate is statistically different from estimate for the previous year shown ($p < .05$).

Note: Sixty-one percent of covered workers are in a partially or completely self-funded plan in 2014.

Source: Kaiser Family Foundation, Health Research and Educational Trust, and NORC at the University of Chicago. 2014 Employer Health Benefits Survey. N.p.: n.p., 2014. Kaiser Family Foundation. 10 Sept. 2014. Web.

“The ability to pay for actual claims incurred by the employee is often the primary motivation for an employer to choose a self-funded health plan. If a smaller employer also invests in employee wellness programs and adopts consumer-driven health plans, they have a greater opportunity to save more by helping to improve employee health and reducing overall claims. In addition, securing large discounts from hospitals and health care professionals can help lower overall claim costs and can result in additional savings with a self-funded health plan.”⁶⁰

According to the Kaiser Family Foundation, 35.2 percent of private sector firms with fewer than 50 employees offer health insurance coverage to their employees, while 95.9 percent of these firms with 50 or more employees offer coverage.⁶¹ With the passage

⁶⁰ Cigna. "Advantages and Myths of Self-funding." White Paper (2014): 1-9. Cigna. Feb. 2014. Web.

⁶¹ Kaiser Family Foundation. "Percent of Private Sector Establishments That Offer Health Insurance to Employees, by Firm Size." 2012. Web.

of the PPACA, employers will have to offer health coverage to any full-time employees who work a minimum of 30 hours per week or more on average. The percentage of workers in private-sector self-insured health plans has been increasing. In 2011, 58.5 percent of workers with health coverage were in self-insured plans, up from 40.9 percent in 1998. Massachusetts, the only state to have enacted similar reform to the of the PPACA by 2012 has seen an increase in the percentage of workers in self-insured plans among all-firm size cohorts, except among workers in firms with fewer than 50 employees. Massachusetts has the third-highest prevalence of self-insurance in the small-group market, behind Alaska and Hawaii.⁶² One reason we are seeing a sudden increase in self-funded plans since the passage of the ACA is because companies can avoid many provisions of the ACA by insuring their own employees instead of signing up with commercial insurers. A survey by Munich Health North America surveyed 326 executives and found that 70 percent of health insurance organizations plan to grow their self-funding portfolios by 2016. It is more important now than ever for employers to consider the options available to them to help reduce employee health claims and better manage their costs.⁶³

INTRABOUND MEDICAL TOURISM

Some critics believe that the barriers that outbound medical tourism pose are too overwhelming for employers which is causing them to offer intrabound medical travel (domestic) options as opposed to outbound medical travel (international). “Hannaford, a 9,000-employee supermarket chain the Northeast, wanted its work force to get low-cost knee and hip replacements in Singapore. In January 2008, the company offered to waive deductibles and copayments and pay for transportation costs for joint-surgery patients and

⁶² Fronstin, Paul. "Self-Insured Health Plans: State Variation and Recent Trends by Firm Size." 33.11 (2012): 1-23. *Employee Benefit Research Institute*. Nov. 2012. Web.

⁶³ Self Funding Employer Association. "The Rapid Growth of Self Funding." *Self Funding Employer Healthcare and Workers Compensation Conference*. Web.

spouses. One year later, not one employee had used the benefit.”⁶⁴ Although this could very likely be due to poor execution and marketing of the benefits to the employees, one can understand the added headache that international travel adds to consumer weariness. “Some companies are offering employees in need of expensive and complex procedures travel expenses to domestic health care facilities with proven quality and high volumes. Working with so-called ‘centers of excellence’ gives companies greater assurance that there will be fewer complications, better outcomes, and fewer hospital readmissions—all of which can run up the bill needlessly.”⁶⁵ Mercer Health & Benefits brokered domestic medical tourism deals for employers Lowe’s and PepsiCo. PepsiCo, a company that runs its own self-funded medical plan, signed an agreement with Johns Hopkins Medicine in December 2011 to provide its 250,000 employees the option to travel to Baltimore facilities for cardiac and orthopedic surgeries. PepsiCo waives deductibles and coinsurance for those employees who choose to utilize the domestic medical travel benefit and will also cover the travel and lodging expenses to Baltimore for the patient and a companion. Cleveland Clinic and Lowe’s signed a similar deal in 2010, where employees and their dependents could travel to the Ohio clinic to receive heart surgery while having their deductible, coinsurance, travel and lodging expenses for the patient and a companion, and concierge assistance waived. The Lowe’s program was taken advantage of by 25-30 percent of eligible employees in the first two years of the program.

“Walmart, Lowe’s, and other large employers joined the Pacific Business Group on Health Negotiating Alliance to launch a national Employers Centers of Excellence Network that will offer no-cost knee and hip-replacement surgeries for employees at four

⁶⁴ Jacob, Steve. "Medical Tourism Gets Domesticated." *D Magazine*. Mar. 2014. Web.

⁶⁵ Jacob, Steve. "Medical Tourism Gets Domesticated." *D Magazine*. Mar. 2014. Web.

U.S. hospital systems.”⁶⁶ Ventures like this are ways in which employers can deliver high quality care with predictable costs and less out-of-pocket spending for patients. “Domestic medical tourism addresses two issues that dog U.S. employers: differences in quality outcomes and the wide disparity in medical pricing nationally. By negotiating with health systems on specific treatments or procedures, companies address both.”⁶⁷ An Austin firm, EmployerDirect Healthcare identifies “surgeons of excellence” and negotiates rates directly with them. The company has operations in 40 U.S. cities, including North Texas where it contracts with two orthopedic surgeons and two general surgeons. “CEO Thomas Johnston says it can save clients 30 percent to 50 percent on specific procedures with a complication rate of less than 1 percent, compared with as much as 7 to 10 percent complication rates that are typical for spine surgery.”⁶⁸ However employers decide to cope with increased health expenditures, it is clear that they will be paying more for joint and cardiac surgeries as baby boomer workers are in need of more care. Surgery-related costs can consume up to one-third of an employer’s total health care budget and employers are in desperate need to demand more affordable care or setup ventures that ensure the best outcomes and few costly complications.

COSTA RICA MEDICAL TOURISM MARKET

Costa Rica’s medical tourism market comprises 0.8 percent of its gross domestic product, and it’s growing. Approximately 40,000 medical tourists visited Cota Rica in 2011, up from 36,000 in 2010, and 30,000 in 2009. Many of those seeking care are from Canada or the U.S. An estimated \$196 million of medical care was consumed by medical tourists in 2011, while bringing in an additional \$84 million in for hotels, meals, travel, and

⁶⁶ Jacob, Steve. "Medical Tourism Gets Domesticated." *D Magazine*. Mar. 2014. Web.

⁶⁷ Jacob, Steve. "Medical Tourism Gets Domesticated." *D Magazine*. Mar. 2014. Web.

⁶⁸ Jacob, Steve. "Medical Tourism Gets Domesticated." *D Magazine*. Mar. 2014. Web.

shopping. The close proximity to the U.S. gives Costa Rica an advantage over other medical tourist destinations.⁶⁹ Costs can be from 30-40 percent of what it costs in the U.S.⁷⁰

Although much of the care provided is dental and cosmetic surgery, the amount of services offered have expanded since its inception in Costa Rica.⁷¹ With the passage of the ACA, some medical tourist facilitators in Costa Rica worry that demand will decrease for surgeries that are now covering the previously uninsured population.⁷² However, dental coverage is not something the ACA covers, nor do typical medical insurance plans. By proving to have a successful dental and cosmetic surgery industry, Costa Rica may be able to open its door to more orthopedic and bariatric offerings.

“People travel to Costa Rica (and) receive the same quality of medical services for a fraction of the cost,’ said Jorge Cortés, president of the Council for International Promotion of Costa Rica Medicine and medical director of Hospital Bíblica.”⁷³ Costa Rica currently has two organization that are accredited by the Joint Commission International (JCI). Hospital Clínica Bíblica received accreditation in 2007 followed by Hospital CIMA San José in 2008.⁷⁴ Hospital CIMA is operated by the International Hospital Commission and is affiliated with Baylor University Medical Center of Dallas, Texas.

GRAND CAYMAN MEDICAL TOURISM MARKET

The Cayman Islands are located in the Caribbean Sea, only 430 miles south of Miami, Florida. If one was to describe the Cayman Islands, their pristine beaches and laid-back culture would come to mind. The Caymans may soon have the reputation for

⁶⁹ Reuters. "Costa Rica's Medical Tourism Boom." *Huffington Post*. 26 Nov. 2012. Web.

⁷⁰ Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." *Deloitte*, 2008. Web.

⁷¹ Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." *Deloitte*, 2008. Web.

⁷² Reuters. "Costa Rica's Medical Tourism Boom." *Huffington Post*. 26 Nov. 2012. Web.

⁷³ Long, Chrissie. "Why Rush Limbaugh Would Go to Costa Rica If Obama's Healthcare Plan Passes." *The Christian Science Monitor*. N.p., 11 Mar. 2010. Web.

⁷⁴ "JCI-Accredited Organizations." *Joint Commission International*. Web.

delivering high-quality and affordable health care.⁷⁵ The Cayman Islands is showing promising signs as a medical tourism destination. Building on India's \$1 billion business of medical tourism, Narayana Health (NH) started constructing a 2,000-bed multispecialty hospital that opened in 2014.

The chairman for the new facility is India's most renowned heart surgeon, Dr. Devi Shetty. He built his reputation in India and has continued to create "health cities" around India, and now his first international center. "Narayana is internationally regarded as a low-cost, high-quality health care provider. Its newest hospital, Health City Cayman Islands, is the organization's first development outside of India."⁷⁶ The hospital, Health City Cayman Islands, opened with a 104-bed tertiary-care center, providing services in cardiac surgery, cardiology and orthopedics. The largest private, not-for-profit health network in the U.S., Ascension Health, joined Narayana Health in the first phase of the project. In the next decade, the hospital will expand to a 2,000-bed facility and is expected to expand service offerings to include neurology, oncology and other cutting edge tertiary care services. High quality Indian providers offering procedures at a much lower cost at an internationally accredited hospital a mere hour plane ride from mainland U.S. may cause many employers and individuals to pursue outbound travel.⁷⁷

Dr. Shetty has plans of achieving higher quality at lower costs. His heart hospital in India charges \$2,000, on average, for open-heart surgery, compared with hospitals in the U.S. that are paid between \$20,000-100,000. He is able to perform such high-quality surgeries while offering them at such small rates by using the premise of economies of scale. "By driving huge volumes, even of procedures as sophisticated, delicate and

⁷⁵ Pearl, Robert. "Offshoring American Health Care: Higher Quality At Lower Costs?" *Forbes*. 27 Apr. 2014. Web.

⁷⁶ Pearl, Robert. "Offshoring American Health Care: Higher Quality At Lower Costs?" *Forbes*. 27 Apr. 2014. Web.

⁷⁷ Govindarajan, Vijay, and Ravi Ramamurti. "Delivering World-Class Health Care, Affordably." *Harvard Business Review*. 01 Nov. 2013. Web.

dangerous as heart surgery, Dr. Shetty has managed to drive down the cost of health care in his nation of one billion.”⁷⁸ Elective and necessary procedures are priced at least 50% lower than the U.S. cost, in hopes of appealing to uninsured Americans or procedures that are not covered by their health plans.

Because Dr. Shetty pushes so much volume through his hospitals, many are hesitant on the quality of care that is being provided. Jack Lewin, a chief executive of the American College of Cardiology, visited his hospital and observed an improvement in quality. Surgeons that perform more procedures and specialize are receiving more experience and generally receive better outcomes. Dr. Shetty’s surgical success rates also prove his quality is not subpar. Dr. Shetty’s quality metrics show a 1.4% mortality rate within 30 days of coronary artery bypass graft surgery, compared with an average of 1.9% in the U.S. in 2008, according to data gathered by the Society of Thoracic Surgeons.⁷⁹ Currently, the Cayman Islands do not have any JCI accredited hospitals, though Health City is seeking accreditation. Although the idea of sending employees to the Cayman Islands may be seen as a fantasy, if Dr. Shetty can match his performance of his hospitals in India, the Caymans may soon be known as Americans as a medical vacation home.

INDIA MEDICAL TOURISM MARKET

India is considered one of the top hot-spots for medical tourism. Despite its long travel time, India arguably has the best value to offer medical tourists, and English is widely spoken.⁸⁰ It has the important advantage of lower cost than most other destinations, at approximately 10 percent of the costs in the United States.⁸¹ A heart

⁷⁸ Anand, Geeta. "The Henry Ford of Heart Surgery." *The Wall Street Journal*. 25 Nov. 2009. Web.

⁷⁹ Anand, Geeta. "The Henry Ford of Heart Surgery." *The Wall Street Journal*. 25 Nov. 2009. Web.

⁸⁰ Herrick, Devon M. "Medical Tourism: Global Competition in Health Care." *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

⁸¹ Michael, Horowitz D., and Rosensweig A. Jeffrey. "Medical Tourism - Health Care in the Global Economy." 24-30. Nov. 2007.

bypass procedure costs \$10,000 in India and \$130,000 in the U.S.⁸² “Apollo Hospital in New Delhi, India, charges \$4,000 for cardiac surgery, compared to about \$30,000 in the United States.”⁸³ Apollo Hospitals in India, is one of the internationally-known hospitals that accepts many inbound medical tourists. It is the largest private health care provider in Asia, with over 8,000 beds in more than 41 hospitals, and the first Indian hospital to attain Joint Commission International (JCI) accreditation.⁸⁴

Spending on health care in India was estimated to be at five percent of GDP in 2013. Annual health care spending is expected to grow from 2012-2017 to \$201.4 billion, an average annual growth rate of 15.8 percent.⁸⁵ With the global demand for less-costly but still top quality care, the Indian medical tourism market is expected continued rapid grow. Deloitte reported 450,000 medical tourists in India in 2007.⁸⁶ Deloitte projected in its 2009 report, *Medical Tourism: Updates and Implications*, that “India’s medical tourism sector is expected to grow 30 percent annually from 2009 to 2015.”⁸⁷ While India does offer care to U.S. residents that chose to go abroad, the country has recently been faced with an influx of patients from Africa, Commonwealth of Independent States (CIS) countries, the Middle East, Pakistan, Bangladesh, and Myanmar. The medical tourism market in India was expected to reach \$3.9 billion in 2014 from the \$1.9 billion

Web.

⁸² Khan, Maryam. "Medical Tourism: Outsourcing of Healthcare." Diss. Howard U, 2010. *ScholarWorks @ UMass Amherst*, 30 July 2010. Web.

⁸³ Herrick, Devon M. "Medical Tourism: Global Competition in Health Care." *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

⁸⁴ Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." *Deloitte*, 2008. Web.

⁸⁵ Deloitte. "2014 Global Health Care Outlook: Shared Challenges, Shared Opportunities." 1-24. *Deloitte*, 2014. Web.

⁸⁶ Deloitte Center for Health Solutions. "Medical Tourism: Consumers in Search of Value." *Deloitte*, 2008. Web.

⁸⁷ Deloitte Center for Health Solutions. "Medical Tourism: Update and Implications." *Deloitte*, 2009. Web.

standing in 2011. In 2004, an estimated 1.2 million patients traveled to India for medical care.⁸⁸

While the number of foreign medical centers continues to grow, issues remain about how to best monitor quality and safety concerns. Joint Commission International (JCI) recently held an event in India for encouraging health care organizations to pursue accreditation. Financial Express spoke to Paula Wilson, President and CEO, JCI and Prabhu Vinayagam, Asia-Pacific MD, JCI to understand its plans for India.⁸⁹ “When explaining JCI’s interest in India, Wilson explained, “India got its first JCI accredited hospital in 2005, since then there has been steady growth in the number of organizations applying for JCI accreditation. Currently, there are twenty two organizations that have JCI accreditation, out of which 19 are hospitals and three are specialty centers,” added Dr. Vinayagam. JCI intends to increase its focus on accreditation and health care education in India.”⁹⁰ India has an accreditation agency of its own, the National Accreditation Board for Hospitals and Healthcare Providers (NAHB). Although this standard already exists, it will be important for Indian hospitals and specialty clinics to obtain JCI accreditation if their desires are to market their services to U.S. medical travelers more familiar with JCI standards and its brand. In 2008, there were only 10 Joint Commission International (JCI) accredited hospitals in India. With 19 total hospitals accredited in 2015, the India medical tourism market is offering more options for patients.⁹¹ “Accreditation is particularly important because it can give consumers and

⁸⁸ Khan, Maryam. "Medical Tourism: Outsourcing of Healthcare." Diss. Howard U, 2010. *ScholarWorks @ UMass Amherst*, 30 July 2010. Web.

⁸⁹ Kachhap, Neelam M. "There Is a Lot More Opportunity for JCI In India." *The Financial Express*. Express Healthcare, 11 Mar. 2015. Web.

⁹⁰ Joint Commission International. "JCI's CEO and Managing Director of the Asia-Pacific Office Discuss JCI's Future in India with Financial Express." *Joint Commission International*. Joint Commission International, 13 Mar. 2015. Web.

⁹¹ Joint Commission International. "JCI's CEO and Managing Director of the Asia-Pacific Office Discuss JCI's Future in India with Financial Express." *Joint Commission International*. Joint Commission International, 13 Mar. 2015. Web.

employers a level of confidence that the services provided are comparable to those in the U.S., particularly if accompanied by an affiliation with a reputable, U.S. teaching hospital.”⁹² It is clear however, that it is not only the cost that makes India an attractive medical tourist destination. Many Indian doctors either studied or worked abroad and hospitals accredited by either the NABH or JCI ensure that they are safe and are following international standards.⁹³

COST SAVINGS ANALYSIS

Savings will vary depending on the country and type of procedure being performed. Treatments abroad do however range from one-half to as little as one-fifth of the price in the United States. Apollo Hospital in New Delhi, India, charges \$4,000 for cardiac surgery, compared to about \$30,000 in the United States. Non-surgical procedures such as an MRI also provide noteworthy savings. An MRI in Costa Rica or India can cost from \$200 to \$300, compared to more than \$1,000 in the United States.⁹⁴

Arnold Melstein, M.D., of Mercer Health Benefits made a statement to the U.S. Senate Special Committee on Aging in 2006. “Several innovative large American employers asked me to assess the feasibility of using advanced hospitals in lower-wage countries to provide non-urgent major surgeries. They intend to add them to their U.S. hospital networks to incentivize U.S. employees and dependents to use them. Large employers are pursuing this option for three reasons: first, lower cost. The typical combined facility and physician charges per surgery in these hospitals is, based on my international shopping observations, 60 to 85 percent lower than insurer-negotiated charges in the U.S.

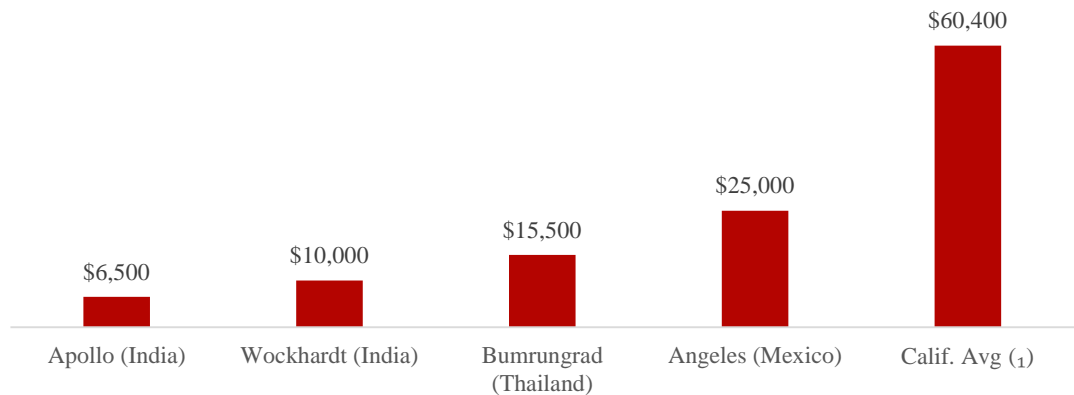
⁹² Deloitte Center for Health Solutions. “Medical Tourism: Consumers in Search of Value.” *Deloitte*, 2008. Web.

⁹³ KPMG International. “Issues Monitor: Medical Tourism Gaining Momentum.” Issue brief no. 11 - 007. *KPMG International*, May 2011. Web.

⁹⁴ Herrick, Devon M. “Medical Tourism: Global Competition in Health Care.” *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

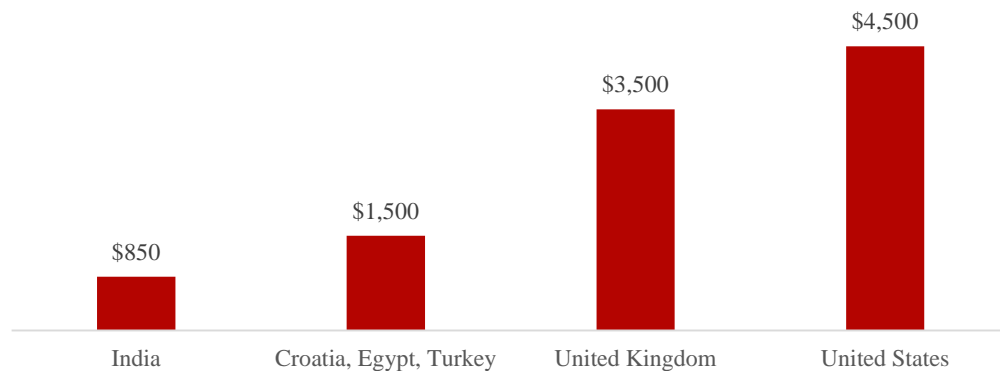
(see Figure 15 and Figure 16).”⁹⁵ Dr. Melstein noted that with the 60 to 85 percent savings would easily cover travel expenses, first-class hotel stays and other essentials for the patient and a companion.

Figure 15: Comparison of Hospital-Reported Combined Average Expected Facility and Professional Fees in 2005 for Elective Coronary Artery Bypass Graft Surgery



¹ Average allowable charges reported by a large PPO insurer and adjusted to exclude emergency surgeries
Source: U.S. Senate. "The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?" *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs? Special Committee on Aging*, 27 June 2006. Web.

Figure 16: Cost of Rhinoplasty (in U.S. dollars)



Source: Herrick, Devon M. *Medical Tourism: Global Competition in Health Care*. National Center for Policy Analysis. National Center for Policy Analysis, Nov. 2007. Web.

⁹⁵ U.S. Senate. "The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?" *Special Committee on Aging*, 27 June 2006. Web.

Prices for treatment are generally much lower in foreign hospitals than what patients are offered at a U.S. based hospital. One of the reasons for this, is the decreased labor costs in foreign countries. In the United States, labor costs equal more than half of hospital operating revenue. The going rates for physicians, nurses, and even janitors and orderlies in foreign countries is nowhere near the price tag that comparable workers in the U.S. are costing. These lower labor costs make it less expensive to build innovative high-tech facilities and provide services.

The U.S. payment system for health care services relies heavily on third-party payments. In the U.S. third parties pay for roughly 87 percent of health care. U.S. patients are only spending 13 cent out of pocket for every dollar they spend on health care. In every other market U.S. consumers take part in, they act as consumers who weigh the value for the price of the goods or services they receive. In health care, this is not the case. As a result, the providers who treat them never have to compete for their business based on price. It is proven that when patients control more of their own health care spending, providers are more likely to compete for patients based on price. In India for example, patients pay 78 percent of their health care spending out of pocket.⁹⁶ The increased out-of-pocket amount causes consumers to be price elastic and increases competition within the marketplace, leading to a decrease in prices while maintaining high quality services. This can be shown in the U.S. market for elective cosmetic surgery or vision correction. This market is extremely entrepreneurial and competitive because third-party payers generally do not cover such treatments, therefore, consumers have to pay for these services out of pocket. Because patients control the dollars that pay for such procedures, the physicians

⁹⁶ Herrick, Devon M. "Medical Tourism: Global Competition in Health Care." *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

compete with one another on price. The cost of vision correction dropped 20 percent over six years from 2001 to 2007, in part due to the competitive nature of the industry.

It is nearly impossible in the U.S. to obtain a price quote for medical services before services are rendered. With the hospital accumulating charges from several departments, and the physician having their own separate charges, price transparency is weak in the U.S. market for care. A Harris Poll found that 68 percent of those who had received recent medical care did not know the cost until the bill arrived, and 11 percent said they never learned the cost at all.⁹⁷ The global health care market, uses its price transparency and bundled pricing as a tool to entice patients to receive care abroad. By letting consumers know the price up front, consumers can compare prices and are not later blindsided by costly medical bill (see Table 2).

⁹⁷ Herrick, Devon M. "Medical Tourism: Global Competition in Health Care." *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

Table 2: Cost-Savings Comparison of Specific Orthopedic, Bariatric, and General Surgery Procedures

Procedures	U.S.* (1)	India*(2)	Grand Cayman**(3)	Costa Rica**(4)
Heart Bypass (CABG)	\$ 113,000	\$ 10,000	\$ 31,700	\$ -
Heart Valve Replacement	\$ 15,000	\$ 9,500	\$ 31,000	\$ -
Angioplasty	\$ 47,000	\$ 11,000	\$ 16,600	\$ -
Hip Replacement	\$47,000	\$9,000	\$ 15,800	\$ 12,750
Knee Replacement	\$ 48,000	\$ 8,500	\$ 15,800	\$ 15,250
Shoulder Arthroscopy	\$ 14,000	\$ 9,000	\$ 5,750	\$ 6,200
Gastric Bypass	\$ 35,000	\$ 11,000	\$ 17,600	\$ 14,250
Sleeve Gastrectomy	\$ 30,000	\$ 7,000	\$ 16,200	\$ 12,650
Spinal Fusion	\$ 43,000	\$ 5,500	\$ 19,000	\$ -

Note(s): The cost data does not take into account the costs incurred in case of medical complications, extended hospital stays, blood transfusions, etc. which although rare, can occur and therefore increase the final price.

* The price comparisons for surgery take into account hospital and physician charges, but do not include the costs of flights and hotel bills for the expected length of stay.

** The price comparisons for surgery take into account hospital and physician charges, as well as the costs of flights and hotel bills for the expected length of stay.

^{1 2} Source(s): Lunt, Neil, Richard Smith, Mark Exworthy, Stephen T. Green, Daniel Horsfall, and Russell Mannion. "Medical Tourism: Treatments, Markets and Health System Implications: A Scoping Review." (n.d.): 1-55. Organisation for Economic Co-operation and Development. Web.

^{1 2} Data compiled March 2011 from medical tourism providers and brokers online.

^{3 4} Source(s): Cost data was derived from anonymous industry medical intermediaries in April 2015.

FINAL THOUGHTS

Employers recognize that the U.S. health care system fails to meet their needs for information transparency, price transparency, and better value. With few insights as to why health care costs is so expensive, employers are seeking to actively manage their health care offerings and determine the best way to respond to the provisions of the ACA.⁹⁸ Employers are increasingly using high-deductible plans as a mechanism of cost-sharing with their employees. Medical tourism has proved to be a reaction to these rising costs. With increased availability of high quality health care at significantly reduced rates in developing countries, the industry is expanding and adapting to barriers. Its biggest hurdle will continue to be quality of care which will best be overcome by providing quality outcome metrics (e.g., success rates, complication rates, infection rates) that consumers can compare to their U.S. facilities and surgeons. International accreditation will also continue to grow and be a necessity for international centers to attract patients.

The increase of medical travel has the potential to increase competition and efficiency in the United States. Princeton University health economist Owe Reinhardt says the effect of global competition on American health care could rival the impact of Japanese automakers on the U.S. auto industry – forcing domestic producers to improve quality and to offer consumers more choices.⁹⁹ ¹⁰⁰ Outbound medical tourism offers a solution for both employers to cut back on health expenditures and employees to waive deductibles and share in the cost-savings. Inbound medical tourism will also continue to gain traction from employers if they are given the opportunity to narrow physician networks to high-

⁹⁸ Deloitte Center for Health Solutions. "Health Care Costs, Benefits, and Reform: What's the next Move for Employers? Results of Deloitte's 2013 Survey of U.S. Employers" 1-27. 2013. Web.

⁹⁹ Herrick, Devon M. "Medical Tourism: Global Competition in Health Care." *National Center for Policy Analysis*. National Center for Policy Analysis, Nov. 2007. Web.

¹⁰⁰ Price, Joyce Howard. "Under the Knife Overseas." *Pacific Research Institute*. The Washington Times, 3 Dec. 2006. Web.

performing, efficient and less-costly providers. Not all employers however can use their sheer size to negotiate rates with U.S. “centers of excellence” like the Cleveland Clinic. Medical tourism is a strategy that employers small and large can utilize, especially those without the ability to negotiate for intrabound medical tourism programs. As long as vast differences in procedure costs exist among countries, medical tourism will continue to develop and become more widely applied to employer health benefit plans.

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