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THE GLOBALIZATION OF HEALTH CARE: CAN MEDICAL TOURISM REDUCE HEALTH CARE COSTS?

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TUESDAY, JUNE 27, 2006

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in room 215, Dirksen Senate Office Building, Hon. Gordon H. Smith (chairman of the committee) presiding.

Present: Senator Smith.

OPENING STATEMENT OF SENATOR GORDON H. SMITH, CHAIRMAN

The CHAIRMAN. Good morning. We welcome you all, as we convene this U.S. Senate Special Committee on Aging. Our topic today is the Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?

We are glad you are all here. We are missing a few of my colleagues for one reason or another, probably also the difficulty of traffic in getting here today. Most of the routes into this place have trees laying over them right now.

Medical tourism refers to the practice of patients seeking lower-cost health-care procedures abroad, often packaged with travel and sightseeing excursions. Today we will hear about medical tourism from witnesses whose perspectives range from a patient who had heart surgery in India to a self-insured company that is considering adding overseas hospitals as an option in its employee health plan.

Time magazine reports that 55,000 Americans traveled last year to Bumrungrad Hospital in Thailand for a variety of elective procedures. Many patients report they would return again for care in the future.

Patients are not alone in exploring foreign health-care options. The West Virginia legislature presently is considering options for encouraging State employees to travel abroad for less-expensive medical care. Three Fortune 500 companies are investigating the best places to outsource elective surgeries.

With the globalization of health care evolving at a rapid pace, it is important that we pause to consider why this is happening.

The ease of international travel and the growth in quality health-care facilities in developing countries certainly plays a part. But I believe frustration with rising health-care costs in the U.S. is also

a contributing factor. American medicine is less and less competitive.

Americans should not have to travel overseas to obtain affordable health care. Yet health-care costs in the U.S. continue to grow at a rate higher than overall inflation. For the Nation's 46 million uninsured, traveling overseas for low-cost medical procedures, even with the added costs of travel and lodging, is now an understandably attractive option.

You can see on the chart behind me the cost of many surgical procedures in foreign hospitals is significantly less than in the United States.

While medical tourism may be attractive to patients who are unable to obtain health care at home, there remain many unanswered questions: Does lower cost equal lower quality? Could lower-priced medical care provided in developing countries drive down health-care costs in the U.S.? What will be the long-term impact of medical tourism on the U.S. health-care system?

To explore these and other related issues related to medical tourism, I am asking several Federal agencies, including the Departments of Health and Human Services, Commerce and State, to convene an interagency task force.

As globalized health care becomes an increasing reality, we must carefully consider the implications for U.S. health care, trade and tourism and economic policies. The interagency task force will enable U.S. policymakers to reach informed decisions in response to this new trend.

I am very pleased that our first panel of witnesses is Maggi Grace and Howard Staab. He traveled to India in 2004 for Howard's mitral valve replacement surgery. They will discuss their experiences in trying to negotiate costs with U.S. hospitals and also tell us of the care that he received in India.

So, Howard and Maggi, thank you for being here. We are anxious to hear your testimony and to ask you questions. Proceed.

STATEMENT OF MAGGI ANN GRACE, PATIENT ADVOCATE, CARRBORO, NC

Ms. GRACE. Thank you, Senator Smith and members of the U.S. Special Committee on Aging. I appreciate the opportunity to testify before you today regarding health—care and the outsourcing of medical care to the developing world.

We are here because in September 2004 I accompanied Howard to New Delhi, India, for the heart surgery he needed but could not afford in North Carolina, where we live only minutes from major medical centers of international reputation.

Dr. Naresh Trehan replaced Howard's mitral valve at Escorts Heart Institute for a total cost of $6,700 as opposed to the estimated $200,000 at our local hospital.

We stayed in India for 1 month. By early 2005, Howard was back at work full-time; his cardiologist in Durham reports that he is fine.

The fact that everything turned out well for Howard and that India provides extraordinary medical care is not why we are here today. I am here to tell you how our own country's health-care sys-

tem, supposedly the best in the world, failed us and why we were forced to travel halfway around the globe.

The research I did that led to our choosing India does not make me an expert. But in the past few years, I have stayed in the hospital with my parents and friends on seven different occasions. I became an eye-witness to the difference in patient care between several American hospitals and at least one hospital in India.

The discoveries I made compelled me to write a book entitled, "State of the Heart: A Medical Tourist's True Story of Life-Saving Surgery in India," which will be published in 2007 by New Harbinger Publications. In fact, I have asked Senator Clinton to consider writing the Foreword to my book.

Companies are springing up all over our country to help patients travel to India or Thailand for medical procedures at a fraction of the U.S. cost. While I continue to assist these patients, my sincere ambition is to see the U.S. health-care system improved so that none of us find it necessary to leave our families and our doctors to receive medical treatment.

In 2004, Howard went to his doctor for a routine physical. She was alarmed at the sound of his heart and ordered an echocardiogram immediately. The diagnosis: a flailing mitral valve with severe mitral regurgitation. We were shocked. Howard and his 31-year-old business as a carpenter/contractor were healthy, but Howard had chosen not to have health insurance.

Howard is not the only one who, though healthy and physically fit all his life, will face an unexpected, life-threatening diagnosis requiring immediate attention without health insurance in place. In fact, he is only one of over 46 million Americans who remain uninsured, either by financial necessity, denial of coverage, or by choice.

It is, of course, a mistake to say that our government does not provide these people with healthcare. We do. Only we do it in what may be the least efficient, the most expensive and least effective way possible: by refusing to provide any necessary care until a patient's illness becomes a medical emergency. Then we do not turn them away; only then do we foot the bill.

I came to understand the absurdity of this system when Howard and I faced his diagnosis.

I requested a meeting with the CFO of our local hospital to explore the entire cost of mitral valve surgery as well as a payment plan. Howard was encouraged to apply for Medicaid. But Howard was not broke; he is not indigent. He makes a living, and he pays his bills. We knew he would not qualify for Medicaid or any other hospital discount based on income.

The hospital bill alone was estimated at $100,000. They expected half up-front. The valve itself, the surgeon, cardiologist, anesthesiologist, radiologist and pathologist, all billed separately, would bring the total closer to $200,000 if there were no complications. The surgeon would also want half up-front.

I knew that hospitals and doctors contract with insurance companies and agree to accept whatever the companies deem the "usual and customary fee" for any given procedure. The CFO agreed that self-pay patients are responsible for inflated charges which are arbitrarily set by the provider.

I offered to pay the hospital the full amount that any insurance company would pay, with a substantial amount up-front and the rest on a payment plan. The CFO said they had no way to do that. They were simply not set up to compromise in that way.

I insisted that Howard could not be the only self-pay patient who faced the prohibitive cost of surgery. The CFO admitted he was not, but we were the first to come to him ahead of time and talk about it. Others, he said, "Well, they wait until they are brought to the emergency room in an ambulance."

Where were we, a carpenter and an artist, to come up with $200,000 or even half up-front? If we had chosen to wait or if we had not found any alternative by turning to another country, I would have watched as Howard's mechanical valve problem made his heart work harder and harder until the exertion actually damaged his heart muscle and it began to fail.

Of course, we would have preferred to stay in the Raleigh-Durham area to be near our family and friends, but we had no intention of waiting until he was in heart failure. Yet this is all our local hospital offered us.

I cannot imagine a worse way to pay for health care: to require our emergency rooms to take patients in and pay for healthcare for the uninsured and under-insured only when their health problems have worsened to the status of an emergency, when those problems are the hardest to fix and the care they receive will be as chaotic, expensive and risky as possible.

After learning Howard's diagnosis, we tried to obtain health insurance for him. His applications turned up astronomical premiums for policies that promised to disallow any claims regarding his heart for a year or longer. Howard's cardiologist said he could not wait a year for his surgery so that the insurance company would help pay for it; his heart would not last that long.

We explored every alternative suggested to us, from surgeons in Argentina, Mexico and Texas to a robot in North Carolina. We decided to put our trust in Dr. Trehan, a U.S.-trained surgeon and founder of Escorts Heart Institute and Research Center, a state-of-the-art facility in New Delhi.

He estimated the total cost of Howard's hospitalization, including all tests and doctors, would be under $10,000. We asked Howard's cardiologist for her blessing, applied for the appropriate visas, and flew to India.

A friend created a Website, howardsheart.com, so I could communicate with our family and friends while we were abroad. The Website still draws global attention of patients, doctors, entrepreneurs, policymakers and researchers interested in what most call "medical tourism" and what we still consider to be the best option we had. We were not tourists seeking an exotic vacation while having inexpensive medical treatments. We were fighting for Howard's life.

Our experience in India was successful. The total cost of our bill was $6,700 all-inclusive.

Howard was the first American to have heart surgery at Escorts. The world was watching. The media—CNN, "60 Minutes," Bloomberg Magazine, The Washington Post, the Times of India

and, most recently, Time magazine—would not be paying attention to an issue that was not of global concern.

Here are some relevant observations.

Insurance companies allow less than one-third of doctors' and hospitals' charges, and they pay only a percentage of that.

Even if doctors discount their fees for self-pay patients, the hospital bill is prohibitive.

The Center for Disease Control recommends innoculations for travel to specific countries. Insurance companies disallow claims for preventative immunizations for travel, yet they will cover treatment for those diseases if their insured subscribers might contract them overseas.

Procedures are often available in developing countries years before the FDA approves them in the U.S. An example is the recent hip resurfacing that has just been approved.

Highly skilled nurses in our hospitals are stretched beyond human limitations. Patients receive care based on degree of emergency. This means patients wait. During my seven stays in the hospital, I have changed bed linens myself, bathed and fed patients. I caught a disoriented patient climbing out of bed, tangled in her I.V. lines.

We, as a country, value longevity over quality of life. Legislation supports this position. Looming malpractice suits keep doctors ordering tests and introducing extreme measures that are often unnecessary, unwanted, and always inordinately costly. Individuals who do not believe in prolonging life at any cost devote enormous amounts of their time and money to fight for the rights of their loved ones to end their lives with dignity. Choice is replaced with unwarranted expense for patients and health-care providers.

In summary, if I were faced with the opportunity you now face, to heal a broken system of caring for the American people, I would begin with the end result. I would ask myself, what would a healthy nation look like? How can we make at least preventative care accessible and affordable? Why do we link employment with healthcare? What are the real costs of tests and medical devices? What is a reasonable margin of profit? How can we take the terror out of healthcare for everyone involved?

You have an opportunity to listen to and answer millions of Americans, not only the uninsured and the under-insured, but employers, insurance companies, hospitals, doctors, nurses, patients and family members who are screaming, "Crisis." We are calling for help. Please don't send us away.

Thank you.

The CHAIRMAN. Maggi, you ask what is a reasonable profit. I can't help but think that the difference between $200,000 and $6,700 will put a lot of pressure on the $200,000 if Howard's story continues to go out. I mean, that is a staggering difference.

I wonder if you can speak to the quality difference. I mean, obviously the result was as good as, I guess, you could hope for, because he was a U.S.-trained physician. I assume it was done in a hospital.

Ms. GRACE. An extremely state-of-the-art facility that is impeccable compared to the ones I have stayed in here.

The CHAIRMAN. So when you went into that, there was no quality diminution between that and others that you had seen in the United States?

Ms. GRACE. Only in the reverse.

The CHAIRMAN. It was better.

What was the cost in terms of travel and time, lost wages and things like that had it been done here? What do you add onto the $6,700?

Ms. GRACE. Well, the longer version, which is in my written testimony, is that we were in the hospital a total of 3 weeks, both of us with three meals a day—well, when he could eat. I stayed with him. The quote of the $200,000 estimate was for a 5- to 7-day stay and one surgery. So it would have been way more than that, had we been here to do that.

The quality of care over there was extraordinary. It was quick. Howard never waited once for a test or for a prompt response from the nursing staff or the doctors.

Of course, you know, he was the first American to be there, so there was this attention. But I never saw anything different for anybody else there.

The CHAIRMAN. Were your physicians here—I mean, you said they released you to go and do this. Obviously that must have included that they would take you back when you came.

Ms. GRACE. Yes, sir.

The CHAIRMAN. Did they warn you about anything that proved not to be true? I mean, were there things that they said, "Well, yes, but you are running a real risk if there is a complication. You won't have any legal recourse"? Or did you have legal recourse?

Ms. GRACE. People have asked us that since we came back. No one asked us in the few days before we left because we went in a very big hurry. I wasn't thinking about suing anybody if something happened to Howard, and I don't think he was. It was the farthest thing from our minds.

In answer to your question about Howard's cardiologist, we were relieved when she said she had done her homework with her colleagues and found out that we were right, that India was an exceptional choice and that they were all U.S.-trained doctors—a lot of them were U.S.-trained doctors, and Dr. Trehan was of the highest reputation.

She had no problem with us going, except Howard shouldn't have been traveling. So, we went with his medical records. I talked to all the pursers on the flight and made sure they understood that if he should go into some kind of shortness of breath or breathing problems or heart problems that they knew what to do.

The CHAIRMAN. What airline were you on?

Ms. GRACE. KLM was in there, but I forget what we started on. American? No, Continental and then KLM. But I had to speak to each one so they knew what we were doing.

The CHAIRMAN. Is this doctor in India and is India, as a nation, are they advertising to get more business like this?

Ms. GRACE. It is, in fact, just the opposite. I mean, I think they would like to think they are. But in terms of what we do in America to advertise, I don't think they are up to speed on it.

They have a Website, but the Website isn't geared to respond to you in 24 hours. I think we have been accustomed to immediate response when we e-mail somebody or contact a Website.

So they have patients from all over, from Britain and neighboring countries and Saudi and places like that. But we were the first Americans to actually persevere long enough to get through and go.

The CHAIRMAN. I am interested in your comments about insurance and what they would pay for and what they wouldn't pay for.

Now, you did not have insurance. Is that right, Howard?

Mr. STAAB. Correct.

The CHAIRMAN. Now, if you had had insurance, would they have discouraged you from going over? Were you told that by insurance companies, "Don't go to India; we won't pay for it"?

Ms. GRACE. Well, we learned that afterwards. But it didn't come when we applied for insurance. That was the first thing I did, was to try to see if we could get Howard a policy. Even if it would be, you know, enormous premiums, we thought it still could work out financially for the $200,000 and that it would be better. But then they would disallow anything related to his heart for a year, and he wouldn't have lived that long.

The CHAIRMAN. I would think an insurance company would be very interested in lower expenditures for health.

Ms. GRACE. Well, the premium for Howard was $300-and-something. I contacted my Blue Cross broker and just said, "What is it?" He said, "Well, it is about $300." Then I told him the mitral valve diagnosis, and he came back with $1,600 a month and no coverage for the heart for a year.

So, we did the math on that and tried to figure out, if he had been paying $300 a month for all this time, would it have still covered the $200,000? Anyway, it was——

The CHAIRMAN. But you paid out of pocket, and you got——

Ms. GRACE. With a credit card. They said, "Do you have a Visa?" So it was simple.

The CHAIRMAN. Well, yours is an amazing story. You have published it through all the outlets you spoke of, "60 Minutes" and—

Ms. GRACE. They contacted us, but yes.

The Website still is this huge magnet, people find us somehow. I don't know if they are looking under—I never called it "medical tourism" until the publisher renamed my book. But I don't know how they found us.

But as soon as the Times of India picked it up. The day after we arrived in Delhi, the Times of India picked it up. We had something like 2,000 hits on the Web site that morning. So it sort of spread like fire after that.

The CHAIRMAN. I read Tom Friedman's book, "The World Is Flat." Were you included in it? I don't recall.

Ms. GRACE. I don't know.

The CHAIRMAN. You may need to add another chapter.

Ms. GRACE. We have been in several books. The Cato Institute included Howard's story in their book last year. Researchers have been calling from all around. People are doing doctoral work on this issue. So I expect we have popped up in places we don't even know.

The CHAIRMAN. Well, you are making history here. We are thankful for your willingness to come and share this very remarkable story.

Howard, you look great. Are you back to work now?

Mr. STAAB. Thank you very much. I am working full-time building homes and loving my days.

The CHAIRMAN. Well, we wish you the very best.

Mr. STAAB. Thanks.

The CHAIRMAN. You have added a great deal to the meeting of this morning and the Senate record. We thank you very, very much.

Ms. GRACE. Senator Smith, you asked me a question that I realized I didn't answer.

The CHAIRMAN. Well, you can answer it.

Ms. GRACE. Well, it will just take me one second, and that was about the difference in quality of care.

I think one of the most impressive things I have learned to tell myself is that if I have an elective procedure that is required—"elective" meaning I am not in an ambulance—I will seriously consider going to India, even though I have Blue Cross-Blue Shield that would probably pay 80 percent. Because not only would it probably be cheaper than the 20 percent I would have to pay, but I believe the care would be far better than I would get here.

The CHAIRMAN. That is——

Ms. GRACE. Thank you.

The CHAIRMAN [continuing]. Quite a testimony. Thank you very much, both of you.

Ms. GRACE. Thank you.

Mr. STAAB. Thank you.

[The prepared statement of Ms. Grace follows:]

Written Statement of Maggi Ann Grace
June 27, 2006

Dear Senator Smith and Honorable Members of the U.S. Senate Special Committee on Aging:

I appreciate the opportunity to testify before you today on behalf of the increasingly vulnerable population of un- and under-insured Americans. We have a unique opportunity to discuss the well-being of our country – not only with regard to the healthcare of our people, but as I have come to learn over the past two years, with regard to the overall emotional, mental and economic health of our country as a whole.

In 2004, Howard Staab went to his doctor for a routine physical. She was alarmed at the sound of his heart and ordered an echocardiogram immediately. The diagnosis: "A flailing mitral valve with severe mitral regurgitation."

His new cardiologist described the heart valves as two halves of a parachute that must fill, then collapse, and then fill again, held taught by strings. And Howard's "anchor strings" had snapped…suddenly, and no one knew why. She explained that often people with mitral valve prolapse (bulging) or stenosis (blockage) can take medication and be watched by their cardiologist for many years. (Statistically, it is likely that some of you also have mitral valve prolapse.) But Howard's case was so severe, that he would require surgery as soon as possible, to either repair or replace the mitral valve. That was the *flailing* part. The *severe regurgitation* was blood backing up without the valve to keep it in the heart. We were shocked by the diagnosis. Howard and his 31-year-old business as a carpenter-contractor were healthy, but Howard had chosen to not have health insurance.

In September of 2004, I accompanied Howard Staab to New Delhi, India for the heart surgery he needed but could not afford in North Carolina where we live only minutes from major medical centers of international reputation. Dr. Naresh Trehan replaced Howard's mitral valve at Escorts Heart Institute and Research Center for a total cost of $6,700 (as opposed to the estimated $200,000 at our local hospital). We stayed in India for one month. In a few months, Howard was back at work full time, and his cardiologist in Durham reports that he is just fine. But the fact that everything turned out well for Howard, and that India is a good alternative for medical care, is not why I am here today. I am here to tell you how our own country's healthcare system (supposedly the best in the world) failed us, and why we were forced to travel halfway around the globe.

Researching alternatives to paying well above what insurance companies would pay for the heart procedure Howard required does not make me an expert. But in addition to become a sounding board for people who have limited or no access to healthcare, in the past two years I have also become an eye-witness to the difference in patient care between several American hospitals and at least one hospital in India. The discoveries I made compelled me to write a book which will be published in 2007 by New Harbinger Publications, entitled *State of the Heart: A Medical*

Tourist's True Story of Lifesaving Surgery in India. Perhaps you will pick up a copy to read, as Paul Harvey would say, *the rest of the story*.

Companies are springing up all across our country to assist patients who make the decision, as Howard and I did, to travel to India or Thailand for medical procedures at a fraction of the cost of what they would pay here in the U.S. While I have and will continue to do anything I can to help these patients, my sincere ambition is to see our own system of healthcare in the U.S. improve so that none of us find it necessary to leave our families, our doctors and our homes to receive medical treatment.

The Un-Insured:
We discovered that Howard was not the only one who, though apparently healthy and physically fit all his life, would face a life-threatening diagnosis requiring immediate attention without health insurance in place. In fact, he is only one of over 45 million Americans who remain uninsured, either by financial necessity, denial of coverage, or by choice. It is, of course, a mistake to say that these people do not receive healthcare. In fact, it is a mistake to say that our government, that we, as taxpayers, do not provide them with healthcare. We do provide healthcare for those 45 million people. Only we do it in what may be the least efficient, most expensive, and least effective way possible -- by refusing to provide any necessary care until it has already caused suffering and turned a patient's illness into a medical emergency. Then, we do not turn them away. Only then do we foot the bill. I came to understand the absurdity of this system when Howard and I faced his diagnosis.

The Cost:
I requested a meeting with the CFO of Durham Regional Hospital to explore the entire cost of mitral valve surgery, as well as a payment plan. Howard and I were told he could apply for Medicaid. But Howard was not broke. He was not an indigent patient. He makes a living and pays his bills. We knew he would not qualify for Medicaid or any other hospital discount based on income.

We were told that Howard should plan on a hospital stay of five to seven days, and the estimate for the hospital bill alone was close to $100,000. They expected "half up front, and the rest on a payment plan." If the stay were longer, the cost would increase. The surgeon, the valve itself, the cardiologist, anesthesiologist, radiologist, pathologist, and any prescriptions would bring the total up to the neighborhood of $200,000, ***if there were no complications.*** And the surgeon would also want half up front.

I knew from my earlier work in the department of surgery of a major medical center that hospitals and doctors contract with insurance companies and agree to accept whatever the companies deem the *'usual and customary fee'* for any given procedure. I knew a doctor could choose to "write off" the balance (the "non-allowable" part of the charges).

I asked the CFO to please accept what an insurance company would pay them for this surgery. He said they had no way to do that. I argued that the self-pay patient faces the total charges (instead of the allowable fees) which are arbitrary amounts, set by the provider. Again, I offered to pay them the same amount that any insurance company would pay, so they would not be out

anything. I said we could pay them a substantial amount up front, and then the rest on a payment plan. The CFO said they were not set up to compromise that way. They simply were not set up for that.

I insisted that, surely, Howard could not be the only self-pay patient who faced the prohibitive cost of surgery. He admitted he was not, but said we were the first to come to them ahead of time to talk about it. Others wait until they come in an ambulance to the Emergency Room.

Howard and I had no idea where to come up with $200,000, or even "half up front." Who has an extra $100,000 in their checking account? I began looking into alternatives to selling our homes. Of course, Howard and I would have preferred to stay in the Raleigh-Durham area in North Carolina to be near our families and friends, but I had no intention of compromising his chances for a successful outcome by waiting until he was in heart failure. Waiting would not only assure him the greatest medical risk, but would also be the most costly for everyone, including the hospital. Yet this is all our local hospital offered us.

Howard and I are resourceful, creative, determined people. Our trip to India was a solution to a problem -- our country's dismal failure to provide for patients like Howard. But we are not here today to applaud our resourcefulness or determination. It should not take such a determined individual effort to work around a broken system, to find, against all odds, a solution. What our system is set up to do is not only proof of a terribly unwise and financially irresponsible public policy, but more importantly, of a shamefully unacceptable way to treat the citizens of this country.

Had we followed the rules, instead of finding our way to the Indian private-sector, what would we have done? What does our system tell patients like Howard to do? Our system tells patients like Howard -- if they are fortunate enough to have a primary care physician who can identify a serious problem like his before it has disastrous consequences to his health -- to wait. To wait until it DOES have disastrous consequences. Only then will we take care of you.

If Howard had walked into an emergency room on the day of his diagnosis, he would have been sent home. The ER doctor might have told him, "Your condition, while serious, is not an emergency. It is not going to kill you today. Come back when it is about to kill you, when you collapse and come in an ambulance. Then, and only then, can I help you."

If we had chosen to wait – or, if we had not found any alternative by turning to another country – I would have watched as Howard's valve problem made his heart work harder and harder, like a pump trying to bail out a boat with a hole in the bottom, until the exertion damaged his heart muscle and it began to fail. Blood would have backed up in his circulation faster than the failing heart could pump it, fluid would have collected in Howard's lungs, and he would have begun to have trouble breathing.

If we had timed it perfectly, and we had then taken Howard to the Emergency Room in that tiny window of time between when his condition was *about* to kill him and the time it actually *did* kill him, then our system would have taken Howard in. They would have taken him into surgery and attempted to fix a problem that had been identified at a far earlier stage, a stage with a better

prognosis for successful repair.

Bill collectors might later have come after Howard to pay the bill. If, like millions of uninsured patients scared of financial ruin (especially since the bill sent to an uninsured patient is invariably higher than the bill sent to another patient's insurance company for the same procedures), we had given a different name when we showed up in the emergency room, those bill collectors might never had found us. The hospital would then have absorbed the cost of Howard's care.

I cannot imagine a worse way to pay for healthcare: to require our emergency rooms to take patients in and pay for healthcare for the un- and under-insured only when their health problems have worsened to the status of an emergency, when those problems are the hardest to fix and the care they receive will be as chaotic, expensive, and have the lowest chance of success possible.

Health Insurance:
In 2004, after learning Howard's diagnosis, I went to work on the research to obtain health insurance for him, to find out the cost of the surgery he would need, and to get him in and out of the hospital as soon as possible to begin his recovery and to get back to work. His applications to obtain health insurance turned up astronomical premiums for policies with deductibles of several thousand dollars that promised to disallow any claims related to his heart for a year or longer since it had become a pre-existing condition. Howard's cardiologist said he could not wait a year for his surgery so that the insurance company would help pay for it; his heart would not last that long. (We read later, in the medical records we hand-carried to Dr. Trehan in India that she was amazed that Howard was not already in heart failure.)

The Personal is the Political:
Reactions to Howard's news ranged from, "He was irresponsible to not have health insurance in the first place;" to "This kind of thing has been my worst nightmare… I also have no health insurance by choice;" to "I can't even afford health insurance for my children, let alone myself. I haven't been to a doctor in over a decade."

The press began calling. I handled the calls because Howard was still trying to work as much as he could. He was more fatigued than either of us recognized or wanted to admit. On September 22, 2004, we granted the first of many interviews with a reporter from ABC, Channel 11 News. Howard became the focus of global attention regarding what some insisted on calling "medical tourism," and what we still consider the best option we had. The media coverage, *CNN, 60-Minutes, Bloomberg Magazine, The Washington Post, The Times of India, ABC*, countless websites and local newspapers would not be paying attention to an issue that was not of national concern.

Alternatives:
My older son had gone to India the summer after his first year of medical school at Stanford for a brief rotation at a public hospital in New Delhi. He first planted the idea of traveling internationally for the surgery by U.S.-trained doctors at state-of-the-art facilities for a fraction of the cost.

I turned to the Internet. Friends called with suggestions for surgeons they knew in Argentina and Mexico. We discovered Howard could pay only $70,000 for robot-performed surgery in Eastern North Carolina. A doctor in Texas who trained at the Mayo and Cleveland Clinics came highly recommended. He would perform Howard's valve replacement surgery for a lump sum of $45,000 which included all tests, surgery, the hospitalization, and recovery.

Doctors in major U.S. cities encouraged us to bargain with hospitals. They sent explanations of any hospital's real costs, describing them as complicated and numerous. But they said any hospital can charge whatever they want to charge-- despite the national average or their real costs--to cover underpayment by insurance companies. They emphasized that ***insurers pay up to one-third of that amount.*** I imagined a bidding war: Who would fix Howard's heart for the least amount of money? We could start with $200,000 and hold a reverse auction.

We learned of Dr. Naresh Trehan, the founder of Escorts Heart Institute and Research Center in New Delhi. He came recommended as a surgeon and visionary of the highest caliber, trained in New York City. I investigated Escorts and Dr. Trehan, read articles about him, by him, and statements by patients who had traveled to have him operate on them. I finally got in touch with him. He called me at home and estimated the total cost of Howard's hospitalization, including all tests, doctors, surgery, etc. to be under ten thousand U.S. dollars.

We asked Howard's cardiologist for her blessing as we made our decision to travel for the surgery, knowing Howard would require follow-up care when we returned. We wanted her to continue to be his doctor. She was reluctant to see us go, but confirmed that all we had learned about the high level of care and the expertise of doctors in India was true. After much deliberation we applied for the appropriate visas to fly to India for the surgery.

My friend and designer of my own website, created a website, www.howardsheart.com, so I could communicate with our family and friends while we were abroad. Our story is outlined there for you to read. The website became and remains a global magnet for the attention of patients, doctors, policymakers and researchers of our healthcare system.

The Outcome:

Howard had a successful repair of his mitral valve. Then his body responded by obstructing the flow of blood (much the way some people develop scar tissue.) He was returned to the operating theater for replacement of his mitral valve. We were in Escorts Heart Institute for three weeks. The total cost of our hospital bill was $6,700, all inclusive. Of course Dr. Trehan generously kept the bill below $10,000 as he promised. Howard was the first American to have heart surgery at Escorts – the world was watching. But we were not tourists seeking an inexpensive, exotic vacation while having medical treatment. We were fighting for Howard's life. Howard recovered in a nearby hotel for one week before we returned home.

The Larger Picture:

The founding ideals of our country have included the pursuit of happiness and freedoms we have, if not memorized, at least come to expect. While none of us can justifiably consider physical health as a ***right***, and all of us have and will continue to face illness and death among

our families and friends, we cannot separate the access to affordable and adequate healthcare from our constitutional freedoms and rights.

The Vision:
You and I could probably agree that in an ideal world, our children would seek their life's work based on their talents and expertise, on what brings them a balance of personal challenge and satisfaction as well as the financial means to a relatively comfortable and safe existence. My personal vision has been that, if left to individual preference instead of salaries and benefit packages associated with specific jobs, people would seek jobs that provide that balance and all tasks would be taken care of. That is, the people who are good at teaching would teach, and people who took pleasure in crunching numbers would crunch, and those who felt the freedom of driving along long stretches of open highways would drive, and those who felt energized by cleaning or repairing houses would do that. I do not believe we would turn into another Lord of the Flies. I believe a higher percentage of people would attain job satisfaction; we would have fewer turnovers, happier teachers, and more motivated students, a greater number of adults driving to and from work with smiles on their faces instead of fists clenched or their hands on the horn.

What does this vision of mine have to do with the healthcare crisis in the US? Our personal story is one in which the exact opposite was achieved: Families and friends were separated at a time of greatest need. Howard had to leave his crew, I had to cancel my classes – therefore, his clients and employees and my students were all inconvenienced and disappointed. Howard had to travel across the globe at a time when his heart needed to rest – and we all know international travel is not restful. Not only was Howard without income during his surgery and recovery period, but I was also because we were away from home.

Do We Encourage Preventative Medicine?
Some thirty years ago when I was in my twenties, my dentist told me my constant headache and toothache were due to impacted wisdom teeth. I recall my disbelief upon learning that my insurance company, Blue Cross Blue Shield, would not help pay for the removal of the teeth until they were both ***impacted*** and ***abscessed***. I was young. I was incredulous that their policy would prefer that I became sicker than I already was, that my teeth become infected and more painful, requiring a procedure that was more complicated and a greater risk to me.

When Howard and I decided to travel to India for his heart surgery, I was similarly bewildered by communication with Blue Cross Blue Shield, my current insurance company. My research showed that The Center for Disease Control in Atlanta recommended that I get vaccinated against malaria, typhoid, hepatitis A and B, polio, and rabies before traveling to India. I called the County Health Department and Medical Travel Centers that I learned could provide these vaccines, only to discover that Blue Cross Blue Shield would not cover the cost of the office visit or the medications. They disallowed every charge because they were deemed "preventative." And in a country that claims to lead the world in healthcare advances, medical progress, with lower infant mortality rates, lower teen pregnancy rates, fewer epidemics, healthier kids due to vaccines, etc. shouldn't we be focusing on preventive medicine?

I was once again incredulous to learn that my health insurance company would pay for the hospitalization and treatment of any of these serious diseases if I returned to the U.S. and became ill, but they would not pay for the relatively simple inoculations and pills that might keep me healthy. Yet I was no longer twenty-something, and I knew my priority was to take every precaution available to remain healthy and helpful to Howard and to not bring back any communicable disease when we returned home.

But another, more current story has expanded this disillusionment of my vision even further. My friend, a PhD mechanical engineer, recently left a corporate job to become an independent consultant while he and his wife also pursued their love of renovating old houses. They had been covered by Blue Cross Blue Shield throughout his career. When they were told the premium to continue coverage under COBRA would be $1750 per month, they applied for their own health insurance through Blue Cross Blue Shield. Blue Cross denied their application. They did not write in a waiting period for pre-existing conditions at a high premium; they simply denied coverage. The reason? Because years ago, after September 11th, my friend and his wife chose to become foster parents as a way to help. Three sisters were delivered to their home straight off the school playground, which set their life into a whirlwind. My friend took an anti-depressant drug during this brief but difficult period of adjustment. His wife was denied because she takes a "maintenance drug" for high cholesterol.

Have any of you or your family members ever taken an anti-depressant? Do any of you take medication for high cholesterol? It seems a more reasonable decision than to wait for the symptoms likely in patients who do not take medication. So, is the message: Call the hotline if you notice symptoms of depression, seek medical attention, prevent heart disease -- but be prepared to pay for it yourself -- because our country would prefer to see our people trying to live and work and be good parents while they suffer from depression or high cholesterol and the implications of those diagnoses?

Because BCBS will not cover them, my friend is considering teaching somewhere in order to have group insurance. Is this the answer to our teacher shortage or to our country's quality of education?

What Is The Best Part of Your Job?

A few days ago I met a woman who was explaining her recent switch into the field of nursing by citing the two major advantages: 1) she can always get a job, and 2) the health insurance. Are these the motivations that will keep our hospital care up to the high standards of which we now boast? Does backing someone into a corner address their right to the pursuit of happiness? Does it address the objective of stress reduction? Of preventative medicine? The number of people who have answered the question: *What is the best part of your job?* with *The health insurance*, continues to astonish me. Try asking your friends. Ask your own children why they stay in their jobs. I hope the reality of their answers astonishes you as well.

Some Facts That Might Lead to Answers:

1. The "Usual and Customary fees" (i.e. the insurer's allowable costs) for the procedures my parents had this past year ranged from 5.7% to 26% of the doctors' and hospitals' charges that were billed to Medicare and their secondary insurance companies. (My parents have undergone

knee replacement, hospitalization and long term IV antibiotics-therapy for infection of that knee, spinal surgery, and mastectomy, to name a few.) Doctors are generally compassionate people. But even if a doctor chooses to discount the cost of a procedure for their self-pay patient, the hospital bill is prohibitive.

2. The hospital charged $8.34 per pill for Enalapril, a blood pressure medicine, which costs 25 cents under an insurance co-pay. Without insurance the pill would cost 77 cents each.

3. A childhood friend with mitral valve prolapse cannot afford the procedure Howard had because he has no health insurance. He cannot get health insurance because he has a heart condition. He cannot get a job to obtain group insurance because he has a heart condition which causes him to be fatigued and short of breath. He remains untreated and uninsured.

4. Insurance companies disallow any claims for preventative vaccines or inoculations to travel, as well as the charges for doctor's visits to obtain these vaccines. However, they would cover treatment and hospitalization for diseases their insured patients contracted overseas.

5. Procedures are often available in developing countries years before the FDA approves them in the U.S. (e.g. hip resurfacing; shots for macular degeneration; non-invasive heart surgery; CT angio -- a non-invasive way to determine blockage of arteries -- {Escorts had this Siemens medical device three years before it was available in Denver}, etc.)

6. I stayed in the hospital with Howard for three weeks in India, and since then, have slept in the recliner beside my mother and my father, Howard, and several friends during their hospital stays in North Carolina. Ironically, I would sooner leave my loved ones alone in the care of nurses and doctors in the Indian hospital than I would in any American hospital I have visited. Being able to say this is a source of great sadness to me.

7. Skilled nurses in our hospitals are stretched beyond limits that are humanly possible. Understandably, patient care is given according to nurses' schedule and availability and to level of emergency. This means patients wait. I have changed bed linens myself, bathed and fed patients. I have caught a disoriented patient climbing out of bed, tangled in her IV lines. My father awakened after complicated spinal surgery and announced he was hungry. I lobbied for food, any food. The nurse on duty apologized, but the kitchen was closed, and she couldn't find any soup.

8. Doctors do everything they can to keep patients alive. The means available to them to do that today have increased exponentially, and have resulted in a shift in our values. We, as a country, have adopted the position of valuing ***quantity*** of life over ***quality*** of life. Legislation supports this position. Looming malpractice suits keep doctors ordering tests and introducing extreme measures that are often unnecessary, unwanted, and always inordinately costly. Individuals who do not believe in prolonging life at any cost, devote enormous amounts of their time and energy and financial resources to fight for the rights of their loved ones to end their lives with dignity. **Choice** has been replaced with unwarranted **expense** for patients and healthcare providers.

9. Today, I am a card-carrying insured American, paying close to $400 a month for my Blue Advantage policy as a self-employed artist. I must admit that I would seriously consider flying to India for any elective medical procedure that I need in the future even if my insurance covers 80% of the cost.

IN SUMMARY

If I were faced with the opportunity you now face -- to heal a broken system of caring for the American people -- I would begin with the end result. I would ask myself, ***what would a healthy nation look like?*** What is your own personal vision for the well-being of our country – for your children and grandchildren? How can we take the terror out of healthcare for patients, nurses, doctors, hospitals, employers and insurance companies? How can we make at least preventative care accessible and affordable? How can we reduce the *profusion* of Malpractice lawsuits? Would a cap on awards be a step in that direction? What are the real costs of tests and medical devices? What is a reasonable margin of profit? Instead of paving a way to India or Thailand, why not examine their systems that are successfully attracting Americans away from our own country where cutting-edge medical advances and training often originate?

Senators, you have an opportunity to listen and answer the cries of millions of Americans – not only the uninsured or the under-insured. But the employees, employers, insurance companies, hospitals, doctors, nurses, patients and family members who are screaming CRISIS! We are calling for help. Don't send us away.

Thank you,

Maggi Ann Grace

REFERENCES:

Websites (by UniqueOrn Enterprises)

The India Story --www.howardsheart.com (with links to related press coverage)

My personal website -- www.maggigrace.com

My book -- www.stateoftheheart.name

State of the Heart: A Medical Tourist's True Story of Lifesaving Surgery in India
New Harbinger Publications, 2007

The CHAIRMAN. We will now call up our second panel.

They will include Dr. Arnold Milstein, who is the chief physician at the U.S. Health Care, Thought Leader at the Mercer Health and Benefits. He also serves as a MedPAC commissioner. He is consulting three Fortune 500 companies that are investigating options for offshoring elective medical procedures for their employees.

We will also ask Ms. Bonnie Blackley, who is the benefits director for Blue Ridge Paper Products in Canton, NC. Blue Ridge is in the process of expanding its employee insurance plans to offer overseas health-care options.

They will be joined by Mr. Rao. Mr. Rao is the CEO of IndUSHealth, a global health-care service company that arranges for Americans to obtain medical care in India. We are going to want to know about that advertising program.

Dr. Bruce Cunningham is the president of the American Society of Plastic Surgeons and will be discussing patient safety issues.

We appreciate so much all of you being here.

Dr. Milstein, why don't we start with you?

STATEMENT OF ARNOLD MILSTEIN, MD, MERCER HEALTH AND BENEFITS, SAN FRANCISCO, CA

Dr. MILSTEIN. Thank you, Mr. Chairman.

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 and 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.

The CHAIRMAN. Sixty to 85 percent?

Dr. MILSTEIN. Yes. In exhibit A, I have shared the international prices that I have been able to obtain through phone calls on behalf of these large employers.

Sixty to 85 percent cost reduction for major surgeries would easily offset travel, and first-class hotel costs both for the patient and an accompanying family member. It would also fund a sizable economic incentive for the patient and generate large residual savings for the sponsoring employer.

The second reason is trusted quality-of-care accreditation. The Joint Commission, or JCAHO, accredits most U.S. hospitals for participation in the Medicare program. JCAHO also has accredited 88 non-U.S. hospitals via its Joint Commission International affiliate. Many of these hospitals offer board-certified surgeons who trained at U.S. or UK teaching hospitals.

The third reason is their sense of fiduciary responsibility. American human resource executives feel obligated to pursue any solution that would benefit both employer and employee. This obligation is felt most strongly among employers and labor unions with substantial numbers of lower- and lower-middle-income workers who can least afford to pay more for health care or for health insurance.

The fastest percentage point rise in uninsurance among working adults is now in the middle quintiles of American working household incomes. In 2006, the average health spending for a working family of four exceeded the entire annual earnings of a minimum-wage worker. Two thousand four was the first year in which average state Medicaid spending exceeded state K–12 education spending.

The outmigration of Americans for surgical care is a symptom, not a solution. The emotional benefit of close access to familiar physicians, friends and family will remain important for major surgeries. In addition, many other countries do not offer consumers meaningful redress for healthcare negligence.

The interests of non-wealthy Americans and their employers would be far better served by a U.S. health-care system that aggressively and perpetually re-engineered its processes to deliver an internationally distinguished level of quality at a much lower cost.

In their joint 2005 report, the National Academy of Engineering and the Institute of Medicine estimated that 30 to 40 percent of current U.S. health-care spending is attributable to waste from insufficiently engineered processes of care delivery.

However, until America's major public and private payors better collaborate in creating a profoundly more performance-sensitive environment around American physicians and hospitals, well-engineered care delivery will remain purely conceptual and our hospitals will continue to fall short in international benchmarking of value.

The most important first collaborative step in creating a more performance-sensitive domestic healthcare environment is public access in beneficiary anonymized format to the physician-identifiable full Medicare claims database. Its analysis by the private sector would rapidly enable American consumers and purchasers to identify and better reward surgeons and other American physicians who excel in efficient total healthcare resource use, as well as in quality.

This, in turn, would send a transformative message throughout America's entire healthcare supply chain, including to hospitals and investors in new bio-medical technology. That supply chain is exquisitely sensitive to physician signals. It would be transformed by a new physician-mediated message that improvements in both affordability and quality will be rewarded best.

By creating a highly performance-sensitive environment around our domestic health industry now, we can staunch and eventually reverse the flow of Americans traveling abroad to find more affordable care.

The proximate root causes of American hospitals' loss of domestic market share are lower wages in less-developed countries and discriminatory pricing by global drug, device and equipment manufacturers. One step upstream in the causal chain is insufficient collaboration by America's public and private purchasers to mold a U.S. healthcare industry that delivers world-class value through superior process engineering.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Milstein follows:]

American Surgical Emigration is a Treatable Symptom

Global Travel by Americans Seeking Better Surgical Value Will Grow;
Better Coordinated Value Purchasing by the Federal Government, Large Employers and Health Insurers Would Improve Health Industry Performance and Reverse the Flow

Testimony of Arnold Milstein MD, MPH

U.S. Senate Special Committee on Aging

June 27, 2006

I am Arnold Milstein, Chief Physician at Mercer Health & Benefits and the Medical Director of the Pacific Business Group on Health (PBGH), which serves 50 large and over 7,000 small California employers. My testimony does not reflect the view of these or any other organizations with which I am affiliated.

Catalyzed by multiple media reports, several innovative large American employers asked me to assess the feasibility of using technologically advanced hospitals in lower wage countries to provide non-urgent major surgeries for their self-insured health benefits plans serving U.S. residents. They intend to add them to their U.S. hospital networks and use positive economic incentives to reward employees and dependents who use them.

Large Employers Are Pursuing This Option for Three Reasons

Lower Cost: The typical combined facility and physician charges per surgery in these hospitals are 60-85% lower than insurer-negotiated charges in U.S. hospitals (see Exhibit A). For example, an elective coronary artery bypass graft surgery typically cost insurers in California about $60,000 in 2005; a 60-85% cost reduction would easily (1) offset travel and first class hotel costs for a patient and accompanying family member, (2) fund a sizeable economic incentive for the patient to select this option, and (3) generate large residual savings for the sponsoring employer.

Trusted Quality of Care Accreditation: Over the several past years, a substantial number of offshore hospitals have obtained quality of care accreditation from one or both of two trusted accreditation organizations. Accredited ISO (International Standards Organization) certification bodies certify hospital quality control procedures. ISO certification serves as an internationally respected designation of supplier excellence in quality control for large American employers in many facets of procurement. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits most U.S. hospitals for participation in the Medicare program. It has also accredited 88 non-U.S. hospitals via its Joint Commission International (JCI) affiliate. In addition, at many of these ISO-certified and JCI-accredited hospitals, it is possible to select a surgeon and other physicians who trained at a U.S., UK and/or Canadian academic health center

and obtained board certification in the U.S. or other advanced Western health care system (see Exhibit B). Since the U.S. and most other countries do not yet require hospitals to measure and report outcomes or use internationally comparable measurement systems, more nuanced quality comparisons of our hospitals with advanced non-U.S. hospitals are not possible. However the low gross mortality rates reported in Exhibit B suggest that our outcomes advantage in this common, complex surgery may be negligible.

Fiduciary Responsibility: As health benefit plan fiduciaries for their enrollees, American human resource executives feel an obligation to pursue any solution that would dually benefit both employer and employee. This fiduciary obligation is felt especially strongly by employers with substantial numbers of lower and lower-middle income workers who can least afford to pay more for health care or health insurance. They have front row seats in observing the "upward" spread of unaffordable U.S. health care delivery; the fastest percentage point rise in uninsurance among working adults is in the *middle quintiles* of American household incomes (see Exhibit C). In some low wage industries, more than 75% of workers decline health benefits coverage. Their reluctance is not surprising: in 2006, the average health spending for a working family of four exceeded the entire annual earnings of a minimum wage worker.

Symptom or Solution?

The emigration of Americans for non-emergency surgical care is a symptom, not a solution. The emotional benefit of close access to familiar physicians, friends and family will remain important for major surgeries. In addition, many other countries do not offer consumers meaningful redress for health care negligence.

However real health care spending continues to outgrow real GDP by 2.5 percentage points annually. Since wealthier Americans have not been willing to pay enough more in taxes or income-adjusted health insurance premiums to make access to health care universal, non-wealthy Americans and their employers are actively searching for more affordable solutions. Their interests would be far better served by a U.S. health care system that aggressively and perpetually reengineered its processes to deliver an internationally distinguished level of quality at a much lower cost. In their joint fall 2005 report, the National Academy of Engineering and the Institute of Medicine estimated that 30-40% of current U.S. health care spending is attributable to insufficiently engineered processes of care delivery.

However until America's major public and private payers better collaborate in creating a *profoundly* more performance-sensitive environment around American physicians and hospitals, well-engineered care delivery will remain conceptual and our hospitals will continue to fall short in international value benchmarking. And more uninsured, underinsured and insured non-wealthy Americans will board international flights to obtain lower cost surgery at levels of quality that cannot be distinguished from American hospitals.

Creating a Profoundly Performance-Sensitive Environment Around American Hospitals and Physicians via Payer Collaboration

As I testified last month at a hearing of the Joint Economic Committee, the most important first collaborative step in creating a more performance-sensitive domestic health care environment is *Medicare claims data release*: access in beneficiary-anonymized format to the physician-identifiable full Medicare claims data base. It would rapidly enable American consumers and purchasers to identify readily and better reward physicians who excel in quality and efficient health care resource use. This, in turn, would send a constructive new message throughout America's entire health care supply chain, including to investors in new biomedical and health care information technology: *improvements in both quality and affordability will be rewarded best.*

Close behind in importance is *expanded performance transparency*: rapid expansion of publicly-reported standardized measures of quality and average total cost of care per episode of acute illness (and per 24 months of chronic illness) for every hospital, physician organization and individual physician in the U.S. A top priority should be public reporting of "NSQIP" (National Surgical Quality Improvement Program), the surgical outcome measures developed by the Veterans Health Administration (VHA). It was used by the VHA to drive outstanding reductions in surgical mortality for U.S. veterans. The American College of Surgeons now makes it available to all hospitals; but absent encouragement by public and private U.S. payers, few non-VHA hospitals participate. Full performance transparency is the fuel for public and private payers' two engines of performance-sensitivity: pay-for-performance and performance-tiered provider networks.

Even in advance of such strategic public and private collaboration, a few visionary American physicians and hospitals, such as the Virginia Mason health system in Seattle, are moving forward to delivery performance breakthroughs. They are demonstrating through comprehensive application of classic industrial engineering methods that "better, faster *and* leaner" can indeed apply to American health care delivery.

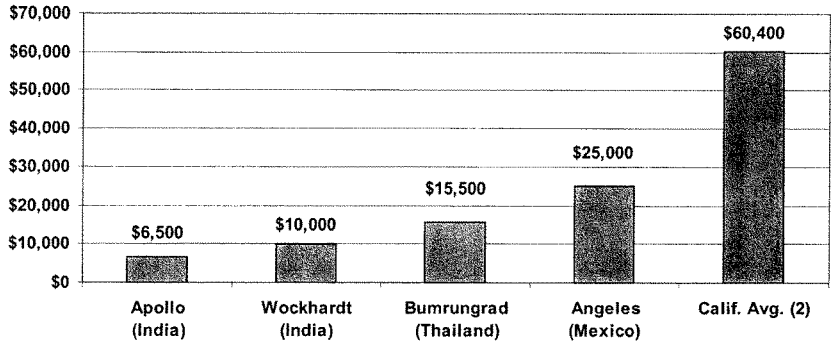
Advances in telemedicine will diminish the importance of a common physical location in health care delivery and eventually enable U.S. clinical teams to treat increasing numbers of non-U.S. patients in their home countries. By creating a highly performance-sensitive environment around our domestic health industry now, we can staunch, and eventually reverse, the flow of American's traveling abroad to find more affordable care.

The obvious proximate root causes of American hospitals' loss of domestic market share are lower wages in less developed countries and discriminatory pricing policies by drug, device and equipment manufacturers. One step upstream in the causal chain is insufficient collaboration by America's public and private payers to shape a U.S. health care industry that delivers world-class value through superior process engineering.

EXHIBIT A

Comparison of Hospital-Reported Combined Average Expected Facility and Professional Fees in 2005 for Elective Coronary Artery Bypass Graft Surgery[1]

These four advanced hospitals in low wage countries are among those that have attained either Joint Commission International accreditation and/or ISO quality certification



(1) Data gathering was enabled by a grant from the California HealthCare Foundation

(2) Average allowable charges reported by a large PPO insurer and adjusted to exclude emergency surgeries

EXHIBIT B

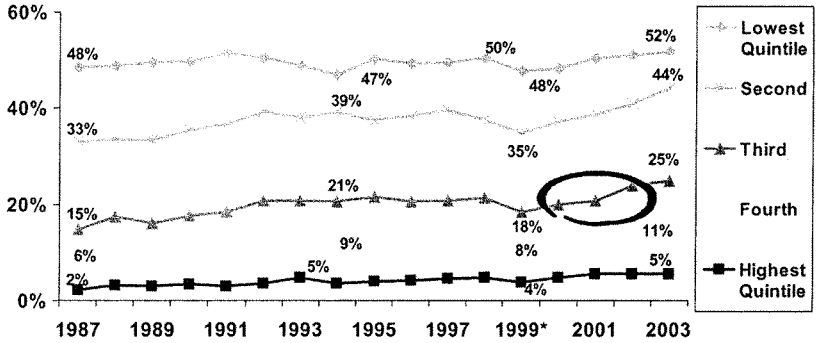
Hospital-Reported Status on Familiar Quality Standards for Elective Coronary Artery Bypass Graft (CABG) Surgery[1]

Meet Standards for Hospitals and Surgeons				
Hospital	***Country***	***City***	***Quality Credentials - Hospitals***	***Quality Credentials – Cardiac Surgeons***
Apollo	India	Chennai	JCI accredited; and ISO 9000 and IS0 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
Wockhardt	India	Mumbai	JCI accredited	Residency/fellowships at Harvard and Lahey Clinic; CABG mortality rate <1%.
Meet Standards for Hospitals or Surgeons				
Hospital	***Country***	***City***	***Quality Credentials - Hospitals***	***Quality Credentials – Cardiac Surgeons***
Angeles	Mexico	Mexico City	ISO 9001 certified	Cardiac surgeons board certified in Mexico
California High Volume Hospital Average				
Hospital	***Country***	***City***	***Quality Credentials - Hospitals***	***Quality Credentials – Cardiac Surgeons***
Multiple	U.S.	Multiple Calif. Cities	All JACHO accredited. None are ISO certified.	Most high volume CABG surgeons are U.S. board certified

(1) Data gathering was enabled by a grant from the California HealthCare Foundation

EXHIBIT C

Percent of working adults *uninsured*, by household income quintile 1987-2003



* In 1999, CPS added a follow-up verification question for health coverage.
Source: Analysis of the March 1988–2004 Current Population Surveys by Danielle Ferry, Columbia University, for The Commonwealth Fund.
Adapted from "A Need to Transform the U.S. Health Care System: Improving Access, Quality, and Efficiency," compiled by A. Gauthler and M. Serber, The Commonwealth Fund, October 2005.

The CHAIRMAN. Doctor, what do you think of what Howard did, going to India like that?

Dr. MILSTEIN. I think it was a wholly reasonable response by a well-informed, value-seeking American consumer.

The CHAIRMAN. The three Fortune 500 companies you are advising, would you advise them to look at Howard's option?

Dr. MILSTEIN. Yes, I would.

The CHAIRMAN. But the point of your testimony, though, is America ought to fix its system so Americans don't have to go abroad.

Dr. MILSTEIN. Absolutely.

The CHAIRMAN. Won't this growing competition have the downward pressure that will help to drive that?

Dr. MILSTEIN. I think it will. Although, you know, my sense of where we stand based on the Institute of Medicine estimates of 40 percent waste in current American health-care spending, you know, suggests we may need more than one source of pressure.

The CHAIRMAN. Yes, exactly. I will probably have another question for you, but thank you very much.

I think we are exposing to viewers on C-SPAN remarkable options that actually exist out there. Frankly, I can think of an awful lot of Oregon companies who are now looking to do these kinds of things and are negotiating union contracts where this is an option. They have no choice. Economically they can't sell enough of their widgets to pay for the rising cost of health care.

I think one of your points is that it is not just from one price pressure on the system. It is drug companies. It is equipment suppliers. It is obviously cost of litigation. All of these things have upward pressure on American pricing.

Dr. MILSTEIN. Yes. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Bonnie Blackley, take it away.

STATEMENT OF BONNIE BLACKLEY, CORPORATE BENEFITS DIRECTOR, BLUE RIDGE PAPER PRODUCTS, CANTON, NC

Ms. BLACKLEY. Senator Smith, thank you.

Blue Ridge Paper Products in Canton, NC, is a paper products manufacturer. Our company was built by Champion International Paper in 1908.

In May 1999, local union employees partnered with a venture capital fund to buy the assets. The employees' stake was financed through a 15 percent reduction in wages, and wages and benefits were frozen over the 7-year term of the buy-out agreement.

We have about 2,100 employees, predominantly male, over age 48, with decades of service and several health risk factors. They work 12-hour, rotating shifts, making it extremely difficult to manage health conditions or improve lifestyle.

Our health-care claims costs at the end of 2000 was just over $13 million. At that time, we projected that if left unchecked, 2006 year-end costs would be $36 million.

Since 2000, we have made plan revisions and developed and implemented several innovative cost-control programs. For example, we have an onsite medical center. We have put in population health management.

These actions will result in 2006 claims costs of $24 million. Though not the $36 million projected, health-care claims have increased over 75 percent since 2000.

What is the impact of these claims on our bottom line? Since the union buy-out in 1999 to the end of 2005, we have paid out $107 million in health-care claims. Our company has lost $92 million since the buy-out.

Even with our single-digit yearly cost increases, I can't help but think, if the provider community had responded to our requests for help over these past few years, we could have been a profitable company.

Clearly, continued medical cost trend is unsustainable, even for financially sound employers with younger, healthier employees. Ever-increasing health-care costs have contributed to slower profit growth, lower wage hikes, a delay in hiring new permanent workers, and an erosion of employee benefits.

We are very concerned about our ability to continue to provide retiree medical coverage, which is a bargained benefit for our hourly people. As a matter of fact, March 1, 2005, we eliminated retiree health coverage for our salaried employees.

Employers are angry. We are fed up. We are desperately seeking relief from a system that ranks 37th worldwide in quality of care, but it costs more per capita than other industrialized nations.

We do not get commensurate value for our health-care dollar. We are not treated as paying customers; are not reimbursed for medical errors and hospital-acquired infections. We are constantly told by health-care leaders that American health care is the best in the world, yet employees feel compelled to hire patient advocates. CMS announced in March that they plan to provide cancer navigators to certain patients as answers for coping with today's medical system.

Employees are so desperate for health care that they are willing to commit fraud on employment and insurance forms to obtain coverage for themselves or ineligible family members. Why do we tie health coverage to employment?

Running out of ideas on how to cut costs, a segment on "60 Minutes" several months ago caught my attention. I began seeing articles in trade publications about medical tourism, which we like to call global health care, the uninsured and the under-insured having surgery at outstanding surgical facilities in other countries.

The more I read, the more intrigued I became. Hospitals approved by Joint Commission International and compared to five-star hotels, surgeons credentialled in the United States, registered nurses around the clock, expenses 80 to 90 percent cheaper, and better outcomes. Why not?

After reading about IndUSHealth, I contacted them to see if they would be willing to work with us to make our services available to our employees. IndUSHealth agreed to meet with our benefits task force. Initial shock changed to curiosity, curiosity to interest, and interest to an "a-ha" moment.

IndUSHealth has helped us create a DVD that will soon be mailed to our employees. The DVD explains the process of having surgery in India and includes testimony from individuals that have been to India for surgery. The DVD message encourages interested

employees to be part of an employee group that will be traveling to India in the near future as a part of our due diligence process.

Surgery in India will not impact the benefit levels of our current plan. Whatever benefit plan is chosen by the employee, the option to have surgery performed in India is a personal choice. The benefit level for this option will be 100 percent reimbursement for expenses, plus an additional cash incentive to be used to cover the cost for a companion to accompany the member.

Employers compete in a global marketplace with a global economy. We can address our health-care crisis, or we can outsource it. With healthy competition, our health providers will become more efficient and productive, provide better services and products, be held responsible for inferior service, or go out of business just like the rest of us.

Thank you.

[The prepared statement of Ms. Blackley follows:]

Bonnie Grissom Blackley, Benefits Director, Blue Ridge Paper Products Inc.
ORAL TESTOMONY
June 27, 2006, 10:00 a.m.
Senate Special Committee on Aging
Senator Gordon H. Smith, Chariman

Issues/steps leading to exploration of "medical tourism"
Plans to offer as a benefit

"Our world" – the last manufacturer

Blue Ridge Paper Products Inc., in Canton, North Carolina is a paper manufacturer predominately making beverage and food packaging. Our company was built by Champion International Paper and began operations in 1908. On May 14, 1999, local union employees (of Local 507 of the Paper, Allied-Industrial, Chemical & Energy Workers International) partnered with a venture capital fund to buy the assets. The employees' stake was financed through a 15% reduction in wages *and* wages and benefits were frozen over the 7-year term of the buy-out agreement.

We are the largest manufacturing company left in Western North Carolina with 1,300 covered employees and another 800 in 4 other locations outside of NC. Our employees are predominantly male, over age 48, with decades of service and several health risk factors. They work 12-hour, rotating shifts, making it extremely difficult to manage health conditions or improve lifestyle.

Using the Tools at Hand – Wellness and Diabetes Management on-site

Rolled out our first wellness and on-site diabetes programs in 2001. The wellness program was based on cash rewards for obtaining preventive services. Under our on-site diabetes program members pay nothing for diabetic medications and supplies in exchange for compliance.

Redesigning the Health Plans

At the same time wellness and diabetes programs were introduced I worked with union and non-union volunteers, forming a Benefits Task Force to redesign very complex benefits programs. By the third year of change and program implementations, we reduced two straight years of 18% healthcare cost increases to 2%. New disease management programs were then added and we started a cash-reward based tobacco cessation program.

In 2004 with medical costs increasing 5%, BRPP opened our own full-service pharmacy and family medical center staffed with a pharmacist, Internist and nurses. In 2005, we actually saw a 3% decrease in overall medical costs. Because our task force was not sure about offering a consumer driven health plan, we added a high deductible plan with no employee premium contributions to our choice of programs.

Population Health Management (PHM Program)

After researching Population Health Management programs, I began rolling out our own program last year. Upon completion of a Health Risk Assessment, covered employees and spouses are rewarded $100 each, categorized by health risk levels, and assigned a personal nurse coach. The nurse coach acts as each member's health manager and based on readiness to change, assists the member with setting individualized health goals, and suggests member participation in 1 or more of 14 available health programs. The member is eligible for

cash rewards, waived or reduced copays on over 100 medications, free self-help medical aids/equipment, educational materials, etc.

Health Care Delivery at BRPPI – Past, Present & Future

In 2000, our claims were projected to be $36 million by 2006. Because of innovative programs, our cost at the end of this year will be around $24 million. Though not the $36 million projected, this does represent an increase of 75% since 2000. Continued medical trend twice CPI is clearly unsustainable, even for financially sound employers with younger, healthier employees. Half of U.S. companies have recently stated that increased health care costs have contributed to slower profit growth, lower wage hikes, and delayed hiring of new, permanent workers. What's the impact of health care claims on our bottom line? Since the date of the union buy-out to the end of 2005, our health care claims amounted to $106,951,200. Our company has lost $92 million since the buy-out.

We provide retiree medical coverage and as our aging workforce quickly reaches early and normal retirement, we are very anxious about our financial ability to provide those benefits. As a matter of fact, we have eliminated retiree medical benefits for salaried employees hired on or after March 1, 2005.

This leads me to address the one major area of innovation that has not been successful for us at BRPP – cost of services from medical providers. Even with the promise of patient steerage, we were unable to negotiate discounts with a large medical practice across the street from our mill. Even with partnering with six other large employers in our region, we were unable to negotiate more than a pittance of a discount with our local, tertiary hospital (don't even mention pay for performance!). Even though I appealed to the hospital to reduce its charges to help us stay in business, I was met with the same old come back from them - "hire healthier employees, exclude high-cost services from your programs, and put in wellness programs". This came from the same hospital that has expanded its profitable services, benefited from limited competition, strong population growth and the absence of a dominant managed care company, and according to Moody's Investors Service, has better margins and higher cash levels than other hospitals across the country.

Employers are angry, fed-up, and desperately seeking relief from a system that ranks 37th worldwide in quality of care but costs more per capita than other industrialized nations ($5,267 in US, $2,193 median, BRPP $9,000+). We do not get commensurate value for our health care dollar, are not seen as customers, must pay for medical errors and hospital-acquired infections, and are patronized by being constantly told by health care leaders that American health care is the best in the world. Yet our employees are having to hire "patient advocates" and CMS announced in March they plan to provide cancer "navigators" as answers for coping with today's medical system.

Since January of this year, we have provided a heart valve replacement for one employee and a kidney transplant for another. Both worked for us less than 3 months before their surgeries. They both indicated they had no medical issues on their post employment medical questionnaire. Fraud is rampant with employees desperate to cover themselves or ineligible dependents. Why should people in this country be so desperate for health care that they are willing to commit fraud? And, why are employers in the business of health care delivery anyway? Does it make sense anymore especially when our government has a proven delivery system already in place? Medicare could be expanded to provide health care to everyone.

About 18 months ago, I saw a segment on "20/20" about medical tourism. As months passed, articles in trade publications began reporting on outstanding surgical facilities and surgeons in other countries and how expenses were 80% to 90% cheaper than in the U.S. with better outcomes. I read a newspaper article about IndUShealth and was so impressed I contacted them to see if they would be willing to work with us to make its services available to our employees.

As I see it, we can address our health care crisis or we can outsource it. BRPP must compete in a global marketplace with a global economy, yet our health care providers have little or no competition resulting in monopolistic, ego-driven, self-serving, self-indulgent "health" care suppliers with no regard for their real customer – the paying employer. With healthy competition, our health providers will become more efficient, lean, cost effective and productive, provide better services and products, and reimburse customers for inferior products, or go out of business, just like the rest of us.

And yes, should I need a surgical procedure, provide me and my spouse with an all expense-paid trip to a Joint Commission International-approved hospital that compares to a 5-star hotel, a surgeon educated and credentialed in the U.S., no hospital staff infections, a registered nurse around the clock, no one pushing me out of the hospital after 2 or 3 days, a several-day recovery period at a beach resort, email access, cell phone, great food, touring, etc., etc. for 25% of the savings up to $10,000 and I won't be able to get out my passport fast enough.

Daily Health Policy Report from Kaiser Family Foundation

The *Seattle Post-Intelligencer* recently published an editorial and an opinion piece that addressed the issue of health care costs. Summaries appear below.

> *Post-Intelligencer*: **The U.S.** accounts for a "shocking" $1.7 trillion of the $3.3 trillion spent annually for health care worldwide and **ranks 37th worldwide in quality of care**, according to a *Post-Intelligencer* editorial. Other "advanced countries spend far less individually or as a society," but those nations have "guaranteed coverage for all," the editorial states, adding that "our problems of access, cost and quality are less alarming because they have incrementally grown as we lurch along with a unique, hybrid system haphazardly built around private care, employer insurance, inadequate federal dollars for the elderly and poor and the deadweight of insurance-industry bureaucracy." According to the editorial, "We must move beyond the Band-Aid fixes that politicians love to advocate for the interest of one group of consumers, doctors or campaign contributors," but "nothing will change until Americans decide our system doesn't have to be the way it is" (*Seattle Post-Intelligencer,* 12/11).
>
> John Newport, *Post-Intelligencer*: The current U.S. health care system "is clearly unsustainable," Newport, a health policy analyst and author, writes in a *Post-Intelligencer* opinion piece. According to Newport, the health care system "is wired backward, with preventative services taking a back seat to highly profitable, technologically based interventions" and health care costs "approaching $2 trillion per year." However, he writes "a large share of the blame rests squarely with you and me for abrogating responsibility for our health," adding that "we have adopted lifestyle choices that are abysmally out of balance: Witness our nationwide epidemic of obesity and sedentary lifestyles." He concludes, "I am firmly convinced that if we could effectively motivate people to embrace truly health conscious lifestyles, we could easily cut our health care costs in half" and "dramatically improve our collective life expectancy and quality of life, while enabling all Americans to have ready access to affordable, high-quality care" (Newport, *Seattle Post-Intelligencer,* 12/13).

Coverage & Access | United States Spends More Per Capita on Health Care Than Other Nations, Study Finds
[Jul 12, 2005]

The United States spends more on health care per capita than other industrialized nations but does not receive more services, according to a study published on Tuesday in the July/August issue of *Health Affairs*, the *Los Angeles Times* reports. For the study -- led by Gerard Anderson, a health policy professor at Johns Hopkins Bloomberg School of Public Health -- researchers analyzed the health care costs of 30 nations in the Organization for Economic Cooperation and Development. The study found:

- The nations examined spend a median of $2,193 per capita on health care;
- The United States spent $5,267 per capita for prescription drugs, hospital stays and physicians visits in 2002, compared with $3,446 per capita for Switzerland, the next highest spender;
- Health care spending accounted for 14.6% of the U.S. gross domestic product in 2002, a time when only two other nations -- Switzerland and Germany -- spent more than 10% of their GDP on health care;
- The United States has 2.9 hospital beds per 1,000 residents, compared with a median of 3.7 beds per 1,000 residents among the other nations examined;
- The United States had 2.4 physicians per 1,000 residents in 2001, compared with a median of 3.1 physicians per 1,000 residents among the other nations examined in 2002;
- The United States had 7.9 nurses per 1,000 residents in the United States in 2001, compared with a median of 8.9 nurses per 1,000 residents among the other nations examined in 2002;
- The United States has 12.8 CT scanners per one million U.S. residents, compared with a median of 13.3 scanners per one million residents among the other nations examined;
- The United States appears to have more magnetic resonance imaging machines per capita than many of the other nations examined, but the machines are used only 10 hours daily in the United States, compared with a median of 18 hours daily in other nations; and
- **The average medical malpractice payment, which included both settlements and judgments, was $265,103 in the United States in 2001, compared with $309,417 in Canada and $411,171 in Britain.** (Physicians in the US routinely blame malpractice insurance premiums for the high cost of providing care.)

Anderson said, "We pay more for health care for the simple reason that prices for **health services are significantly higher in the United States than they are elsewhere**." Karen Davis -- president of the Commonwealth Fund, which supported the study -- said that the **United States "does not get commensurate value for its health care dollar**" (Girion, *Los Angeles Times*, 7/12).

The CHAIRMAN. Bonnie, you described the employees' response to this. First, as I take it, it was somewhat shocked and offended maybe? Or necessity required that they listen and consider?

Ms. BLACKLEY. We have spent since 2000 educating our employees on the costs of health care. It is their company; the union actually bought our company. They are very aware of what our health-care costs are year to year.

We have been out-of-the-box, innovative. This was another opportunity for our benefits task force to take a look at some unusual responses to health-care costs.

After our task force meeting in which IndUSHealth was there and they explained the process, you could tell every slide that they showed, more and more people were going, "Oh, my gosh, we never knew about this." I even had one guy call me after the meeting, and he said, "Is it wrong to want surgery to go to India?" We really had some excitement there.

This sounds like a good deal. It sounds like excellent health care. It is affordable. This will save our company a lot of money.

The CHAIRMAN. Was it an ESOP that the union did?

Ms. BLACKLEY. Yes, it was.

The CHAIRMAN. The employees bought it.

Ms. BLACKLEY. Yes.

The CHAIRMAN. Generally unions are very down on outsourcing, but they are obviously encouraging this outsourcing.

Ms. BLACKLEY. It is very unusual to have union members that also are owners. So a lot of times, I think they are at conflict. Even as our health-care costs have gone up, they want to keep their benefits. They know we are struggling to be able to afford to do that.

As a matter of fact, we just bargained and negotiated with the union last week. I don't even know the outcome of those negotiations.

But our folks are hurting. They have not had any wage increases for 7 years. They gave up 15 percent of their benefits in order to finance the company. We are really searching.

We have had two employees in one of our locations that had to have major surgery. One was a heart valve replacement. The other was a transplant. They had worked for us less than 3 months. Obviously some questions on their post-employment information were not correct.

Folks are shopping for employers to see who has good health coverage so they can afford to have these surgeries. I think it is correct to say that people are putting these things off until it is absolutely an emergency.

The CHAIRMAN. Can you describe the procedures? Is it heart surgery, cancer?

Ms. BLACKLEY. The heart valve replacement, we actually got a proposal from IndUSHealth. Here it was going to cost anywhere from $68,000 to $198,000. That was the range of costs that we received from the hospital.

The proposal we got from IndUSHealth was for that patient and a companion. Here you would have been in the hospital 3 to 5 days; there, 10 days with an 8-day recoup period at a resort. Everything included, travel, food, was $18,000.

So we were looking at the difference between $18,000 and, best-case scenario, $68,000. So it is very attractive for employers to take a look at global tourism.

The CHAIRMAN. Have the numbers of your employees increased dramatically going to IndUSHealth?

Ms. BLACKLEY. That was the first actual proposal that we have gotten. We have not actually rolled this benefit out to our employees yet. We will be doing that in the next few weeks.

So until we actually roll this out to all of our employees, we have been looking at situations that we find out about on an individual basis to see if they might be a candidate for going to India. It is just a matter of time.

The CHAIRMAN. Very good. Thank you so much, Bonnie.

Mr. Rao.

STATEMENT OF RAJESH RAO, CEO, INDUSHEALTH, RALEIGH, NC

Mr. RAO. Thank you, Senator Smith. Thank you for the opportunity to testify on a topic that hits very close to home for us and why we have created this company called IndUSHealth.

I am the CEO of IndUSHealth. It is a company based in Raleigh, NC. It provides a global health-care service. It addresses the problem of growing lack of access to affordable health care faced by an increasing number of our citizens and employers throughout the U.S.

With health-care costs having grown to levels that were just unimaginable just a few years ago, there is a universal desire to exploit opportunities to stretch our health-care dollar.

IndUSHealth provides one such attractive opportunity, by unlocking the gates to affordable health care. We offer high-quality medical treatment and travel programs for U.S. patients desiring care in world-class hospitals in India as an alternative to what has become oppressively expensive care in the U.S.

Why India? Well, there are several reasons. India is rapidly emerging as a world leader in global medicine, with over 150,000 patients having visited India for medical procedures from overseas.

Super-specialty hospitals in India have made significant investments in the recent years to build and staff state-of-the-art facilities with the latest equipment and consumables, many of which are, in fact, sourced by American companies.

Not only have these hospitals introduced several amenities to cater to the unique needs of patients going from the U.S. and other international patients, they have also been able to attract several U.S.- and U.K.-trained physicians to return to India to practice at their facilities. With over 37,000 physicians of Indian origin practicing in the U.S., many Americans are already comfortable with the talent and expertise of Indian physicians.

The quality of care available at these leading hospitals is comparable to the best institutions in the U.S. With a focus on advanced research and having implemented processes that have helped them get accredited by the U.S. Joint Commission, these hospitals now boast outcomes that are amongst the best in the world.

Top-flight, one-on-one nursing care is made available to patients around the clock. Their fluency in English allows Indian doctors, nurses and administrators to communicate well with American patients.

Above all, India is able to offer a large and sustainable cost advantage. By bundling unique services that are geared to the unique needs of international patients, Indian hospitals are able to command premium price points, which, from our standpoint, still remain a mere fraction of the U.S. costs.

When it comes to cost differential, there have been numerous cases where, expensive procedures, as the previous panelists have described, are available at somewhere between 10 to 20 percent of the equivalent cost in the U.S.

So what is the IndUSHealth advantage? Recognizing the opportunity to provide a meaningful solution to a growing problem, IndUSHealth has now formulated a well-structured offering that connects individuals and companies to affordable, high-quality health-care facilities overseas.

We have established key partnerships with India's premiere hospitals and physicians that help us offer an integrated process while assuring the highest levels of service to our patients. We provide personalized case management and handle the complexities of dealing with health-care providers on the other side of the globe. We work with local physicians to assist with pre- and post-operative needs of the patients. We also take care of exchanging medical records and making travel arrangements for patients.

Making sure that each patient is well-informed and assured of the highest standards of care at the lowest cost possible is an important part of IndUSHealth's offering.

We have helped treat several patients overseas for a wide range of treatments. The majority of our patients have never traveled abroad, yet they have educated themselves and arrived at the conclusion that their needs will be best met outside our borders.

They are always delighted and provide glowing testimonials of the level of care and attention that they receive all throughout the process. Their collective experiences have proven that it is indeed possible to overcome the perceived difficulties and emotional barriers that many Americans face when first exposed to this new concept.

Our elderly patients are thrilled to have an option that keeps them from having to wait for Medicare benefits. Often taking care of their ailment sooner helps them improve the quality of their life and allows them to lead self-sufficient and independent lives.

We coordinate with self-insured employers seeking to lower expenses by offering our services as an option to their employees. Statistically, since a relatively small number of cases result in the biggest expenditures, employers are able to save up to 20 percent of their medical costs even if a relatively small subset of their plan participants elect to go overseas for care. This helps them avoid the less attractive alternatives of reducing head-count or reducing profitability.

So by paving the path for individuals and employers to access low-cost, high-quality health care in India, IndUSHealth is proud to play a key role in providing access to health care for a growing

number of our citizens and to help them lead healthy, independent and productive lives.

Thank you.

[The prepared statement of Mr. Rao follows:]

Written testimony to the United States Senate Special Committee on Aging

by

Rajesh Rao
CEO, IndUShealth, Inc.

June 26, 2006

GLOBAL HEALTHCARE OPTIONS

Written testimony to the U.S. Senate Special Committee on Aging
by Rajesh Rao, CEO, IndUShealth, Inc.

INTRODUCTION

IndUShealth is a global health care service based in Raleigh, North Carolina, that links North American patients to affordable, high-quality medical care in India. We offer seamless medical treatment and travel programs for U.S. patients desiring care in world-class Indian hospitals as an alternative to what has become unaffordably expensive care in the U.S. These inclusive programs begin with an initial physician referral and continue through treatment, recuperation, and return to the United States.

Rajesh Rao, Co-Founder and Chief Executive Officer of IndUShealth, offers testimony to the Senate Special Committee on Aging at June 27, 2006 at 10:00 a.m., regarding IndUShealth's experience helping Americans receive healthcare in India.

ORAL TESTIMONY

[BACKGROUND]

The U.S. health care crisis has spiraled out of control. Although we have the most advanced medical technology and lead the world in medical breakthroughs, our health care system ranks 37th in the world in terms of being accessible and providing care as and when required by our citizens.

There is also a major imbalance in spending with over half the U.S. health care expenditure being attributed to the wealthiest 5% of the population. And with our health care costs rising faster than any other developed country, we remain behind others in our life expectancy and infant mortality rates.

Our per capita expenditures are double the average of other developed nations and our health care spending represents a disproportionately large percentage of our GDP when compared to others, expected to reach an alarming 20% in the next five years. This will result in a growing competitive disadvantage for U.S.-based companies as they vie for economic growth opportunities in a global marketplace.

In this new era of globalization described so well in his book titled "The World is Flat" by New York Times journalist Tom Friedman, we are poised take advantage of the benefits of the shrinking-world phenomenon and to leverage the global marketplace to help reduce our health care expenditures while introducing elements of competitive pressures into the system.

With the introduction of its Global Healthcare Options, IndUShealth provides the opportunity for our citizens to avail of affordable, high-quality care overseas. With the firm belief that a healthy and productive society remains our best hope for America's continued leadership in the world marketplace, we are pleased to be able to offer high-

quality, low-cost viable alternatives to self-pay patients who may choose to otherwise remain unhealthy because they cannot afford a major medical procedure, and to employers who are self-insured and are forced to otherwise consider downsizing or reducing benefits to their employees.

[WHAT IS THE PROBLEM AND WHO DOES IT AFFECT?]

What problem does IndUShealth solve?

The rising costs of health care in the U.S. have resulted in several challenges.

There are now over 45 million uninsured American, over 12 million of who have annual family incomes of $75,000 or more. When faced with the need for expensive medical treatments, they often have to make the undesirable choice between certain bankruptcy and putting their life at risk. Many choose to take their chances until they face eventual admission to the Emergency Room and are obligated to be taken care of by the hospital. This in turn increases the burden on our hospital system that ultimately translates to even higher costs.

There is a marked reduction in the number of new physicians entering into our system. This shortage in supply will lead to longer wait times and increased costs for domestic medical treatment.

The size of our aging population is growing due to medical advances that have increased our life span. The number of centenarians is expected to grow from around 50,000 today to over a million by the year 2050. Drastic changes are being made to pension plans and retiree benefits to accommodate for the increased longevity. With shortages in supply and increasing costs, a growing number of elderly citizens will be forced to consider other suitable alternatives.

U.S. employers are squeezed between pricing pressures due to global competition and the increased costs of maintaining a healthy workforce. Many small-to-medium size employers can no longer afford to pay annual insurance costs of almost $10,000 per family. They are forced to reduce health benefits, downsize or consolidate their operations. Some are even driven to insolvency.

Federal and state governments are challenged with widening financial shortfalls associated with their obligations to fund Medicare and Medicaid programs.

Consumer Driven Health Plans and Health Savings Accounts are being rapidly deployed by employers as a way to contain costs and make patients more responsible for their health care decisions. However, these instruments will not be able to adequately fund each individual's eventual major medical expenses if the options available to them remain strictly within our borders.

Written testimony to the U.S. Senate Special Committee on Aging
by Rajesh Rao, CEO, IndUShealth, Inc.

[HEALTHCARE IN A FLAT WORLD]

If other business can effectively tap knowledge workers in other countries, why not health care?

India is rapidly emerging as the world leader in global medicine with over 150,000 foreign patients having visited India for medical procedures last year.

Super-specialty hospitals in India have made significant investments in recent years to build and staff state-of-the-art facilities with the latest equipment and consumables, many of which are sourced by American manufacturers. They have also introduced several amenities to cater to the unique needs of international patients. Several U.S. and U.K.-trained physicians are returning to India to practice medicine at these hospitals. With over 37,000 physicians of Indian origin practicing in the U.S., many Americans are already comfortable with the talent and expertise of Indian physicians.

The quality of care available at these leading hospitals is comparable to the best institutions in the U.S. With a focus on advanced research and having implemented processes that have helped them get accredited by the U.S. Joint Commission, these hospitals boast outcomes that are amongst the best in the world.

Top flight one-one-one nursing care is made available to patients around the clock. Their fluency in English allows Indian doctors, nurses and administrators to communicate well with American patients.

Above all, India is able to offer a wide, sustainable cost advantage. By bundling unique services geared to their international patients, the Indian hospitals are able to command premium pricing which still remain surprisingly low and a mere a fraction of corresponding costs at U.S. hospitals.

PROCEDURE	*TYPICAL U.S. COST*	*COST IN INDIA*
Heart Bypass Surgery	$55,000 - $86,000	$6,000
Angioplasty with Stent	$33,000 - $49,000	$6,000
Hip Replacement	$31,000 - $44,000	$5,000
Spinal Fusion	$42,000 - $76,000	$8,000

Written testimony to the U.S. Senate Special Committee on Aging
by Rajesh Rao, CEO, IndUShealth, Inc.

[THE INDUSHEALTH ADVANTAGE]

Recognizing the opportunity to provide a meaningful solution to a growing problem, IndUShealth has formulated a well-structured offering that connects individuals and companies to affordable, high-quality health care overseas,

We have established key partnerships with India's premier hospitals and physicians that help us offer an integrated process while assuring with the highest levels of service to our patients.

We provide personalized case management and handle the complexities of dealing with health care providers on the other side of the globe. We work with local physicians to assist with pre- and post-operative care in the U.S. We take care of exchange of medical records and make the necessary travel arrangements.

Making sure that each patient is well-informed and is assured of the highest standards of care at the lowest cost possible is an important part of IndUShealth's offering.

We have helped several patients receive treatment in India for a wide range of treatments. They are always delighted with the level of care and attention that they receive all through the process. Their collective experiences have proven that it is indeed possible to overcome the perceived difficulties and emotional barriers that many Americans face when first exposed to this new concept.

Our elderly patients are thrilled to have an option that avoids them having to wait for Medicare benefits which may often be too little, too late. Often, taking care of their ailment helps them improve their quality of life and allows them to lead self-sufficient, independent lives.

We coordinate with self-insured employers seeking to lower expenses by offering our services as an option to their employees. Statistically, since a relatively small number of cases result in their biggest expenditures, employers are able to save up to 20% of their medical costs even if a relatively small subset of their plan participants elect to go overseas for treatment. This helps them avoid the less attractive alternatives of reducing headcount or reducing profitability.

By paving the path for individuals and employers to access low-cost, high-quality health care in India, IndUShealth is proud to play a key role in providing access to health care for a growing number of our citizens and to help them lead healthy, independent, and productive lives.

The CHAIRMAN. Mr. Rao, what kind of medicine is provided to Indians? Is it a national health-care system?

Mr. RAO. It is not. It is basically a private——

The CHAIRMAN. Fee for service?

Mr. RAO [continuing]. Fee-for-service system. So most of these hospitals have an obligation to price their services in a way that obviously caters to the large array of circumstances, including local care as well as people coming from overseas.

The CHAIRMAN. Your facilities, have you built those and staffed them for the Indian nation or for this international market? Have you seen a niche here that you are trying to fill?

Mr. RAO. We built this primarily to serve the needs of Americans, because we noticed that we are becoming less competitive as a country because of the challenges that we face in our health-care costs and how that translates to a burden for all of us. We are all ending up paying the increased costs in one way or the other.

Employers, particularly, are challenged with having to make some very hard decisions on how to contain costs.

The CHAIRMAN. How competitive would your services be for an Indian as against a hospital on the other side of the city? Would yours be more expensive?

Mr. RAO. It would be more expensive. Mainly because it has got the added amenities built into it in terms of catering to typically a companion that goes with the patient, having a larger room at the hospital, providing for travel services back and forth, and creating an experience that basically makes the person feel like they have a concierge service, which the locals don't need because they have a support structure around them.

The CHAIRMAN. Do Europeans use this, or just mostly you are marketing this to the American people?

Mr. RAO. Our company's thrust is entirely in North America and for Americans and Canadians right now. There are others that serve other markets. For us, frankly, it is a whole different ball game if we want to try to enter and solve the needs of other citizens of other countries.

The CHAIRMAN. What percentage of Americans, what percentage of Canadians are you serving?

Mr. RAO. Right now, it is roughly 80–20, majority Americans, a smaller percentage of Canadians.

The CHAIRMAN. Bonnie, I am wondering if you think your employees are going to use IndUSHealth. Obviously they have a brochure, a program, a slide show that shows them a facility apparently that is very much like what they would find in North Carolina. Do you think they are apt to take that?

Ms. BLACKLEY. I think that the DVD that we are going to send out to our employees is going to go a long way in explaining the process, showing how it works.

We are also going to have a group of employees, volunteers that will be going to India in the next few weeks to take a look at it, to come back, so that employees, union members, management—we can actually get the word out as to what we saw, what we experienced, what did we believe is the quality of care in India.

The CHAIRMAN. Mr. Rao, what kind of increases have you seen in this niche that you are filling? I mean, you don't have to tell me your sales, but have you seen a lot of growth?

Mr. RAO. It has been tremendous. Compared to last year when it was in its infancy, just starting out, there has been a lot of interest now. The news stories are certainly helping people become aware of this faster. They are all anxious to know if, in their circumstance, they can take advantage of it.

The CHAIRMAN. You obviously know part of the overhead of an American facility relates to malpractice insurance. What kind of assurances do you give, and what kind of recourse do patients have?

Mr. RAO. Well, the Indian system also has a similar structure. The costs are much lower; the awards, in case of any kind of litigation, are also proportionately lower.

So we inform patients of what they do and don't get in that system, and the fact that there are problems in the way the care was delivered overseas, they would have to deal with a foreign court system in order to——

The CHAIRMAN. Well, your facility is subject to American law because you do business here and you have a headquarters here as well, I assume.

Mr. RAO. We do.

The CHAIRMAN. But your outcomes have been good?

Mr. RAO. Yes.

The CHAIRMAN. That is a very commendable model. Certainly, as somebody who believes in competition and who has dealt with it in his own industry, I salute you for your vision and your insight and your competitiveness.

Mr. RAO. Thank you. It is delightful to be able to help people who have essentially run out of options. It is always wonderful to get engaged with them and prove that there is a way out for them.

The CHAIRMAN. Would it be fair to say that most of your clientele are middle-class Americans? They are not necessarily—they are people who are running out of options who are looking, or who don't have health care, or who have a union plan that has this benefit but the cost is there, the co-pay is much higher, and then the union is saying to the company, "This is another option," and the cost is way down there. Are those your clients?

Mr. RAO. That is primarily our client base, the middle-class.

There are also some unique treatments available in India. We do have folks from, a different standpoint try to access services that are just fundamentally not available here because either they are not yet FDA-approved or they are undergoing trials at this stage.

So we do provide them a service, and we find that there is a lot of interest in that as well.

The CHAIRMAN. Are you coordinating any of your services with India Air or the airlines generally to——

Mr. RAO. Not yet. Right now we are keeping it very competitive because we find that, depending on when someone wants to go and what sort of specific travel preferences they have, it is very hard to get a single airline to really cater to all the needs out there. So we instead have a way to get them excellent, rates at any airline.

The CHAIRMAN. But are airlines aware of medical tourism? Are they taking any interest in it? Are they providing any services to cater to it?

Mr. RAO. The airlines, interestingly, have rules set up to take extra care of patients anyway.

The CHAIRMAN. Anyway.

Mr. RAO. So we can essentially piggyback on that.

We are looking at concierge services, obviously, at the airports, at the destination. We provide that to our patients. At the transit points, we are looking into how the airlines could go the extra step for them.

But they already have special services in place to cater to those that need extra care getting back and forth.

The CHAIRMAN. Can you describe the breadth of the procedures you make available at IndUSHealth? Is it plastic surgery? Is it heart surgery? Is it——

Mr. RAO. It has included plastic surgery. Although we had started out looking at cardiac, any orthopedic types of procedures, we have found that there has been a lot of interest in cosmetic and dental as well. There is a lot of interest in expensive dental surgeries.

The CHAIRMAN. OK. Macrofacial surgery as well.

Mr. RAO. That is right.

The CHAIRMAN. Are your physicians, are they by and large U.S.-trained?

Mr. RAO. They are. They are U.S.- and U.K.-trained for the most part.

The CHAIRMAN. U.K.-trained. It is an amazing model. Congratulations on your success.

Mr. RAO. Thank you.

The CHAIRMAN. Bruce Cunningham

STATEMENT OF BRUCE CUNNINGHAM, MD, PRESIDENT, AMERICAN SOCIETY OF PLASTIC SURGEONS, MINNEAPOLIS, MN

Dr. CUNNINGHAM. Chairman Smith, thank you very much for the opportunity to appear today. My name is Dr. Bruce Cunningham. I am a board-certified plastic surgeon. I am the chairman of the Department of Plastic Surgery at the University of Minnesota. I am currently the president of the American Society of Plastic Surgeons, ASPS.

I want to thank you for the opportunity to appear today. Perhaps as a provider, my viewpoint might be a little bit different than some of the viewpoints of the policymakers.

The American Society of Plastic Surgeons is the largest organization of board-certified plastic surgeons in the world, with over 6,000 members.

We have probably discovered cosmetic medical tourism long before these other movements have been described and have noted the attention that has been paid to it. We are concerned about the growth of it, particularly in the area of elective cosmetic surgery.

Although numerous factors are likely involved in the growth of medical tourism, there is at least anecdotal evidence to suggest that patients considering care outside of the States are basically doing it with the motivation of price-saving.

ASPS has a long-standing commitment to enhancing patient safety and improving the quality of care for our patients. We believe that some of the best plastic surgeons in the world are our board-certified members here in the United States.

For those who choose to go overseas for elective surgical procedures, however, there are a number of critically important issues to consider. We believe patients should make this decision very carefully, in essence, caveat emptor, buyer beware.

Without a complete understanding of the medical standards for the health institution or facilities, the medical providers, their surgical training and credentials, and also the post-operative care associated with surgery, a patient can be ill-informed and, worse, at significant risk.

Foremost, it is important to realize that surgery is serious business, and cosmetic surgery is no different from other surgical procedures. Every surgery, including cosmetic surgery, has a degree of risk. As a board-certified plastic surgeon, I manage and reduce these risks every day. It is part of my overhead.

Patients who choose to travel abroad for a cosmetic surgery vacation, with price as a driving force in their decision, may be making an exceptional decision that could increase their risk factors. These patients are susceptible to unwanted and, in some cases, disastrous outcomes.

I am personally well aware of cases which are reported in the media and which confront myself and my colleagues and other physicians of patients returning to this country with disfigurement and nearly fatal infections associated with unaccredited hospitals and unlicensed providers.

Patients simply cannot make informed decisions about medical care or establish a proper patient-physician relationship from a travel brochure.

Some medical tourism trips are marketed as vacations. Risks may increase as procedures are performed during cosmetic surgery vacations. Although enticing, vacation activities are often not appropriate for recovery after any kind of surgery. Precautions and appropriate care must be received in order for the patient to properly heal and reduce the possibility of complications.

Infections are the most common complication seen in patients that go abroad for cosmetic surgery. Other complications can include unsightly scars, blood collections, and unsatisfactory results. Travel combined with surgery can also significantly increase the risk of complications, such as blood clots following the long flights required to reach these overseas destinations.

Complications can also occur during surgery in even the best hands and may require acute care and hospitalization. An important consideration is whether the quality of the health-care institution and the medical provider is truly comparable to what the patient would receive at home. In some cases, as we have seen, the answer may well be yes. In other cases, the patient may be taking a large gamble with their health care and well-being.

As the profit margins of these overseas operations increase, less scrupulous and qualified individuals would be tempted to enter the market, which is certainly what we have seen in cosmetic surgery.

Also in many cases, post-operative care is nearly as important as the procedure itself. How will this care be given, by whom, and for how long following these surgical procedures?

The potential for post-surgical complications, as with any surgery, present particular challenges for the medical tourism patient. What happens to the patient once they have returned home if they have a complication or if they are unhappy with their results? Do they fly back to the site where they had their procedure? This is not likely in many cases.

Do they have insurance coverage for complications resulting from elective procedures overseas? Patients should be aware that their insurance company likely will not cover complications for their procedure, a fact that we have learned from elective cosmetic procedures.

Surgical training and credentials as well as facility standards may not be verifiable in all cases. In order for cosmetic surgery to be performed safely, it requires the proper administration of anesthesia, sterile technique, the latest instrumentation and equipment, as well as properly trained surgeons.

Patients need to ask a lot of questions and may not be able to get the answers.

Is the practitioner providing the medical procedure appropriately certified? For instance, in some cases we have become aware of, a physician with training and credentials in internal medicine should probably not be performing surgical operations like abdominoplasty, face lift, breast augmentation or breast reconstruction. In the U.S., the American Board of Medical Specialties provides the gold standard for verification and training.

For some developing third-world countries, there are no credible processes for verifying physician training, education and experience. Further, there are no U.S. laws that protect patients or mandate the training and qualifications by physicians or the facilities in which they practice. There may be no legal recourse for surgical negligence by the physician or the facility.

An important question to ask is whether the facility is accredited or licensed. In the U.S., there are rigorous rules.

Although there may be many skilled and qualified physicians practicing all over the world in outstanding surgical facilities, ASPS cautions patients to consider these critically important patient safety issues before making a decision based solely on price. Patients should have all the information they need to make a truly informed decision and one with their best health in mind.

So we hope that this discussion is helpful to the committee in considering this important issue. We commend you and the other committee members very soundly for initiating this very interesting discussion, which will hopefully lead to a greater awareness on the part of the public.

Thank you.

[The prepared statement of Dr. Cunningham follows:]

Statement of

Bruce Cunningham, MD, MS

President of
the American Society of Plastic Surgeons (ASPS)

Before the Special Committee on Aging
United States Senate

June 27, 2006

Good morning Chairman Smith, ranking member Kohl, and Members of the Committee. My name is Bruce Cunningham, MD. I am a board certified plastic surgeon practicing in Minneapolis, Minnesota, Professor and Chairman of the Department of Plastic Surgery at the University of Minnesota, and the current president of the American Society of Plastic Surgeons (ASPS). I want to thank the committee for inviting me to appear today to discuss medical tourism. The American Society of Plastic Surgeons is the largest organization of board-certified plastic surgeons in the world with more than 6,000 members.

There has been a lot of attention on the growth of "medical tourism" as patients explore crossing borders or continents for care. ASPS has become increasingly concerned about the growth of medical tourism, particularly elective cosmetic surgery. Although numerous factors are likely involved in the growth of medical tourism, there is at least anecdotal evidence to suggest that patients considering medical care outside of the United States do so primarily through a price-driven lens.

The ASPS has a longstanding commitment to enhancing patient safety and improving the quality of care for patients. We believe that some of the best plastic surgeons in the world are our Board Certified members, here in the United States.

For those who choose to go overseas for elective surgical procedures, there are a number of critically important issues to consider. We believe patients should make this decision very carefully. In essence, "buyer beware." Without a complete understanding of the medical standards for the health institution or facility, medical providers, surgical training, credentials, and post-operative care associated with surgery, a patient can be ill-informed and worse, at significant risk.

Foremost, surgery is serious business. Cosmetic surgery is no different from other surgical procedures. Every surgery, including cosmetic surgery, has a degree of risk. As a board-certified plastic surgeon, I manage and reduce risk every day. Patients who choose to travel abroad for a cosmetic surgery vacation with price as a driving force in their decision making can exponentially increase their risk factors. These patients are highly susceptible to unwanted and in some cases, disastrous outcomes. We are all aware of cases, which are reported

in the media and which confront some of my colleagues and other physicians, of patients returning to this country with disfigurement and nearly fatal infections associated with unaccredited hospitals and unlicensed providers. Patients simply cannot make informed decisions about medical care, or establish a proper physician patient relationship from travel brochures.

Some medical tourism trips are marketed as vacations. Risks may increase when procedures are performed during cosmetic surgery vacations. Although enticing, vacation activities are not appropriate for recovery after cosmetic surgery. Precautions and appropriate care must be received in order for the patient to properly heal and reduce the possibility of complications. Infections are the most common complication seen in patients that go abroad for cosmetic surgery. Other complications include unsightly scars, hematomas, and unsatisfactory results. Travel combined with surgery can also significantly increase risk of complications. Patients should be aware long flights and surgery combined can further increase the risk of developing pulmonary embolism and blood clots and thus should plan accordingly.

Complications can also occur during surgery in even the best hands, and may require acute care hospitalization. An important consideration is whether the quality of the health institution and/or medical provider is truly comparable to what the patient would receive at home. In some cases, the answer may be yes. In other cases, the patient may be taking a huge gamble with their health and well being.

Also, in many cases, post-operative care is nearly as important as the procedure itself. Follow-up care and monitoring is a critical part of any surgery. How, by whom, and for how long will those services be provided? Depending on the procedure, even routine post-operative follow-up such as dressing changes and monitoring healing takes place for up to several weeks. The patient should consider who will be providing this care once he or she returns home.

In addition, the potential for post-surgical complications--as with any surgery—present particular challenges for the medical tourism patient. What happens to the patient once they have returned home if they have a complication or are unhappy with their results? Do they fly back to where they had the procedure? Not likely in many cases. Do they have insurance coverage for complications resulting from elective procedures overseas? Patients should be aware that their insurance company likely will not cover complications for their procedure, as we know in the case of elective cosmetic procedures.

Surgeon training and credentials as well as facility standards may also not be verifiable. In order for cosmetic surgery to be performed safely, it requires the proper administration of anesthesia, sterile technique, latest instrumentation and equipment, as well as properly trained surgeons. Patients need to ask a lot of questions.

Is the practitioner providing the medical procedure appropriately certified? For instance, a physician with training and credentials in internal medicine probably should not be performing abdominoplasty, face lifts, breast augmentation, or breast reconstruction post-mastectomy among others. In the US, the American Board of Medical Specialties provides the Gold Standard for

verification of training and credentials. There are 24 member specialty boards, one of which is the American Board of Plastic Surgery.

For some developing or third world countries, there is no credible process for verifying physician training, education, and experience. Further, there are no US laws that protect patients or mandate the training and qualifications of physicians who perform plastic surgery outside of the US. There also may be no legal recourse if surgical negligence by the physician or facility occurs.

Another important question the patient should ask is whether the facility is accredited, licensed, or appropriated certified. In the US, there are rigorous rules and regulations regarding the availability of emergency equipment and appropriately trained staff. Standards overseas are highly variable and patients may take unnecessary risks when they unknowingly do not have adequate information.

Although there are many skilled and qualified physicians practicing all over the world in outstanding surgical facilities, ASPS cautions patients to consider these critically important patient safety issues. Patients should have all the information they need to make a truly informed decision and one with their best health in mind.

We hope this discussion is helpful to the committee in considering this important issue.

Thank you.

The CHAIRMAN. Well, Dr. Cunningham, you make some very important points, and we value those.

I am wondering, do you ever—now, as I understand it, the American Society of Plastic Surgeons, you are the board, you are the one that certifies the competence of a physician.

Dr. CUNNINGHAM. We only accept board-certified plastic surgeons as members.

The CHAIRMAN. In your association.

Dr. CUNNINGHAM. It is the board, which is one of the 24 American Board of Medical Specialty Board, which actually certifies throughout the country.

One of the issues we have, even in this country, is that there are boards that aren't AKC-registered boards, if you will. A member of the public cannot determine from the colorful language written in Latin on the diploma on the wall whether this is a real certification or not.

Perhaps in these smaller pilot programs, very highly licensed and credentialled organizations and surgeons are being used. But as the profit spreads through this nascent industry, there will be much greater temptation for less-qualified partners. How will we verify that?

The CHAIRMAN. Does the board certify plastic surgeons who later go and practice in places like India?

Dr. CUNNINGHAM. We certainly certify plastic surgeons who go on volunteer missions throughout the world. I would imagine, with respect to the issues of licensure, an American-trained plastic surgeon could receive licensure in India or any European——

The CHAIRMAN. So that doesn't disqualify them, moving and practicing in another country?

Dr. CUNNINGHAM. Absolutely not, not at all.

The CHAIRMAN. That is a very, very good point.

Mr. Rao, do you have board-certified surgeons, plastic surgeons?

Mr. RAO. Absolutely.

I think Dr. Cunningham brings up some excellent points in terms of why the public needs to be aware of the quality issue and the safety issue. That is one of the reasons we have taken express steps to assure that in all aspects of our relationships with our providers we are dealing only with the best of the best. We don't allow for any kind of lapses in terms of quality at any given point.

But, yes, indeed, many of the physicians are indeed U.S. board-certified. They have, in fact, gone back to India and helped raise the bar over there, which is an important aspect of why it has become more attractive in recent years.

The CHAIRMAN. I imagine you recognize the value for American patients of having American certification from the different boards that provide this assurance, quality assurance. I assume that that is the case if America is your niche.

Mr. RAO. Absolutely. That is why I think the Joint Commission has played an important role in making sure, at least at all touch points with the patient, that the hospitals have processes in place that match, if not exceed, you know, the average hospitals here.

The CHAIRMAN. Dr. Cunningham made a very good point about the value of a relationship with a patient and knowing them. Do you do teleconferencing before a patient ever goes to India? Do you

ever have a teleconference where they know who is going to be doing the surgery and it is discussed with them?

Mr. RAO. Absolutely. That is one of the things that some of the patients like to do, is be able to talk to their doctor via teleconference and make sure they are comfortable with who they are working with——

The CHAIRMAN. OK.

Mr. RAO [continuing]. What their credentials are.

The CHAIRMAN. Mr. Milstein, are those the kind of things that you advise Fortune 500 companies to insist upon as they consider some of the medical tourism?

Dr. MILSTEIN. Yes, that is part of our due diligence process, verifying the hospital is, for example, Joint Commission-accredited and that the physicians performing the procedures can indeed document board-certification status in an advanced country.

The CHAIRMAN. Bonnie, does the union member ask those questions? I mean, Dr. Cunningham makes a really good point. We don't know what to ask. I mean, half of it is written in Latin up there on the——

Ms. BLACKLEY. Oh, they certainly do. I think that they are very savvy medical customers, much more so than you would think.

What has been the length of time that you have spent with your doctor at your last physician's visit?

The CHAIRMAN. Your point is that that hasn't been so great either?

Ms. BLACKLEY. I think the normal visit is from 4 to 6 minutes. You probably waited for a couple hours before then.

Why is alternative care so popular and billions and billions being spent? People are searching. Even in my family, I went misdiagnosed for several years—so did my daughter—and had severe ramifications because of not being diagnosed correctly.

I have story after story after story from my employees on the poor quality of treatment that they have received, either no diagnosis or a misdiagnosis. We really have a crisis in this country. We are not getting quality health care. Yet it is unaffordable.

We are searching. We are looking in other areas. We have got to work with providers and hospitals here to make our system better.

We have tried to do that at Blue Ridge Paper Products. We met with a medical practice across the street from the mill before we put in our medical center. The first thing they told us when we walked in the door was, "Don't ask us to discount our prices any more. Oh, by the way, we have got a problem with your onsite diabetes program." We worked with six other large employers in western North Carolina to try to work with our local hospital on a better discount. At least give us the same discount as you give the large carriers that are in that region. They told us if our utilization did not remain where it was, they would even take away that discount.

We have done a lot to try to work locally with our providers, to no avail. They don't have to work with us. They will readily admit that they do cost-shifting and that they don't have the answer. I had one physician tell me, "Well, if it is a death spiral, then I am going to make all the money I can while I can." We need our system here in the United States to wake up. We need it to become

better. We need to work as a team. If the carriers and the providers, the employers and the employees can all work together—we have tried that approach. It has not worked in our community.

The CHAIRMAN. Dr. Cunningham, obviously your association is aware of this new and apparently growing competition. Is that the case?

Dr. CUNNINGHAM. Certainly, we are aware of it. We have seen it for many years with patients, again, opting for better price and going to Mexico, going to Costa Rica and elsewhere, Brazil, to get cosmetic surgery.

Frankly, the risk/patient-safety side of it is becoming a global problem, just as the world is flattening, and we have heard that part of it discussed today.

This issue of people from Germany leaving a higher-cost, higher-provider network and going to, say, emerging Russian republics, Turkey and other countries, where the standards, as I have said, just cannot be verified to have this kind of surgery, and then coming back to Germany, to France, and being a burden on that health-care system.

I am touched by the economics of it. I am touched by the stories that we have heard today. We clearly need to change the system. I agree with Dr. Milstein. This is a symptom, not a solution.

A hundred and fifty thousand patients going to India hardly touches the surface of the problem we meet here. But, you know, on the other hand, these people are coming back. They are presenting a burden for our health-care system. They are prevailing on the goodwill of everyone to take care of them, and that is probably not fair either.

The CHAIRMAN. I understand, Doctor, that ironically your segment of medicine, plastic surgery, really does not have an insurance overlay. It is really fee-for-service all the time, isn't it? I don't know of many insurance policies that cover plastic surgery.

Dr. CUNNINGHAM. Well, plastic surgery has two major components: the cosmetic part, in which case, you are absolutely right.

The CHAIRMAN. I should clarify. I mean cosmetic.

Dr. CUNNINGHAM. Then the reconstructive part——

The CHAIRMAN. Reconstructive is usually related to cancer and things like that——

Dr. CUNNINGHAM. Right.

The CHAIRMAN [continuing]. It would include those.

Dr. CUNNINGHAM. In the reconstructive part, we are in the same boat. You know, we are finding it is harder to provide services for our patients because frequently they are denied coverage or their coverage is marginal, and they have to make difficult decisions about whether to have a breast reconstruction.

I mean, we recognize clearly that the problem is in the system and that it is a system problem that needs to be dealt with on a system level.

The CHAIRMAN. We have all seen these T.V. programs of horror stories of plastic surgery outcomes, of people who are addicted to having plastic surgery.

I wonder, Mr. Rao, do you see people coming over with that addiction? Do you stop and tell them, "There is enough here already; stop"?

Mr. RAO. We do. We tend to, you know, be conservative and err on the side of trying to make sure that we don't have people that are going there, that basically shouldn't be going there, such that it could be almost risky for them.

But another very important point is, that fundamentally we are facing a situation where, to whatever degree medical tourism grows, it is never going to create the level of competition that physicians and hospitals here will ever have to worry about.

Because, as it is, we know that the providers are busy today, and they are going to get busier because we are all growing older and we are all relying more on the system to take care of our needs. The number of doctors entering into the system is shrinking. It is not growing proportionately.

So given that, I don't believe we will ever run into a situation where everyone just chooses to go. It is always going to be a smaller percentage of folks that will go. Those that have needs that have emerged to the point where they have no other options will go.

So, in essence, it will be a healthy form of competition that gets introduced into the system and not one that basically goes out of control.

I do agree with the fact that there may be some unscrupulous operators that come in and start lowering the bar. But we, as an organization, take it as our responsibility to make sure that anyone that comes through us is not going to face any such circumstance.

Because the doctors themselves are very, very risk-averse. We are finding that in cases where we feel something might be acceptable, the doctors in many cases have pushed back and said no.

So that is a very good sign, because they are saying, "We don't want to take chances with this. You know, our reputations are on the line. Our hospitals' brands are on the line. We don't want to take any chances."

So it is going to be self-governing from that standpoint. But that doesn't mean that we don't need regulation to look closely at how this trend evolves.

The CHAIRMAN. Well, let me conclude this hearing with just an expression of real appreciation for the contribution each of you have made here.

This is a very important topic. You should know that, thanks to C-SPAN, there are many people watching you today. A large number of seniors follow the work of this committee. You have added measurably to their understanding and their options.

We also want to say how glad we are that Howard Staab had such a great outcome and that he is here and healthy.

We thank you, Maggi, for your testimony here today, as well.

All the best. Have a great afternoon. Try to stay dry. We are adjourned.

[Whereupon, at 11:35 a.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR HERB KOHL

Thank you, Mr. Chairman, for holding today's hearing. We welcome all of our witnesses and look forward to their testimony.

"Medical tourism"—or the practice of traveling to other countries to receive discounted medical procedures—is taking off in the United States, raising a number of questions for this panel. What is driving health care costs to such a height that Americans are seeking care overseas? How has the crisis of the uninsured in this country reached such a peak that some find foreign travel for medical procedures more practical than health insurance? Finally, how are we protecting Americans who do travel overseas from fraud, incompetent providers and most importantly poor health outcomes?

The United States accounts for $1.7 trillion of the $3.3 trillion spent annually for health care worldwide yet ranks 37th worldwide in quality of care. Even more unsettling: there are 45 million Americans without any form of health insurance. As we hear from our witnesses today about Americans who have chosen to escape our health care system, we are also reminded of the how much we have left to do to provide every American with affordable, quality health care here at home.

I look forward to hearing from our panel on both the benefits and risks of medical tourism. Again, thank you, Mr. Chairman, for holding this important hearing.

PREPARED STATEMENT OF SENATOR KEN SALAZAR

Chairman Smith and Ranking Member Kohl, thank you for organizing yet another hearing on an emerging phenomenon: medical tourism.

It is clear that the emerging industry of medical tourism not only impacts America's seniors but thousands of others who travel abroad to obtain both elective and non-elective surgery. It also impacts the families of these patients, their American doctors (if they have access to regular medical care), and the U.S. health care and health insurance industry.

I find this topic both fascinating and disconcerting.

I am pleased that the 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.

I have introduced legislation with Senator John McCain, the National Commission on Health Care Act (S. 2007), which will undertake a fresh review of health care in the U.S. with one goal: implementing the best ideas to provide real solutions for the millions of Americans trapped in this Nation's health care crisis.

While medical tourism may be included in the discussions of the Commission, I believe there are additional policies that we can implement that are not as drastic as encouraging individuals to travel across oceans for a hip replacement.

Today, over 46 million Americans, including over 766,590 or 19% of Coloradans, lack health insurance. Despite this, the cost of health care is rising—pricing out more and more Americans. By 2015, we are expected to spend $1 of every $5 of our GDP on health care.

Of course, not all of the 46 million are able to catch a flight to Delhi or Bangkok for medical care. That said, I do realize that our health care crisis has caused thousands of middle class Americans, who cannot afford health insurance and do not qualify for Medicaid and Medicare can, to travel abroad.

I am very interested in hearing from our first panel—Mr. Howard Staab and Magi Grace—about they came to travel to India for cardiac surgery.

In this week's Time Magazine, the cover story "India Inc." illustrates the intensity of the growing medical tourism industry, by documenting the growing number of medical schools and hospitals that have popped up in the last decade.

It has led to a dramatic transformation of mid-sized cities like Mangalore, India, where the medical schools number five, and there are at least four dental schools and 14 physiotherapy colleges.

These new hospitals are fueling an industry that is expected to be at least a $2 billion annual industry by 2012. Today, according to the best statistics available to us today, over 100,000 foreign patients traveled to India in 2005 up for just 10,000 in 2000. These may not all be Americans, but we have every reason to believe that Americans are a significant percentage of this number.

In the West, a country that is closer in proximity—Mexico—provides Americans retirees, including Coloradans, with access to access to inexpensive cosmetic and dental procedures.

What does this mean to our health care industry? What steps are we taking to ensure that Americans are protected and accessing high-quality care? How is the health insurance responding to this growing trend?

I hope that the panelist on our second panel will help us reveal answers to these questions. Most importantly, I hope we can better determine if medical tourism can help us in solving the root cause of our health care crisis: the rising costs of health care.

Again, thank you Chairman Smith and Ranking Member Kohl for holding this hearing.

U.S. SENATE SPECIAL COMMITTEE ON AGING
June 27, 2006 Hearing on Medical Tourism

Recommendations for Ensuring the Quality of Healthcare Obtained by U.S. Residents Abroad

Comments From The:
The Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of Healthcare Organizations appreciates the opportunity to submit comments on the issue of "medical tourism." Partially because of rising U.S. healthcare costs, decreased insurance coverage, and the increased availability of reliable information on the Internet, more and more Americans are traveling abroad to obtain healthcare. In addition, a growing number of ex-patriots are finding it highly inconvenient, and sometimes risky to their health, to return to the U.S. for certain medical services. Together, these Americans are seeking everything from life-saving operations (e.g., coronary bypass), to elective procedures like cosmetic and LASIK surgery. Nevertheless, U.S. citizens should only seek healthcare in facilities that focus on quality and safety, whether domestic or internationally based. Thus, the Joint Commission would like to offer a perspective on how U.S. citizens and payers can ensure the quality of internationally-obtained healthcare services by utilizing accredited facilities.

Background

Founded in 1951, the Joint Commission is a private sector, non-profit entity dedicated to improving the safety and quality of healthcare provided to the public. Our member organizations are the American College of Surgeons; the American Medical Association; the American Hospital Association; the American College of Physicians; and the American Dental Association. In addition to these organizations, a 29-member Board

of Commissioners includes nurses, consumers, medical directors, administrators, providers, employers, a labor representative, health plan leaders, quality experts, ethicists, a health insurance administrator and educators. Furthermore, the Board includes liaison members from the federal government.

The Joint Commission is a highly trusted name in quality oversight, and accredits approximately 15,000 healthcare organizations in the U.S. About one-third of Joint Commission accredited healthcare organizations are hospitals (both general acute and specialty) and critical access hospitals. Other types of U.S. healthcare entities accredited by the Joint Commission include ambulatory care organizations, office-based surgery providers, clinical laboratories, behavioral healthcare programs, home healthcare agencies, home medical equipment suppliers, hospices, assisted living facilities, and long term care organizations. The Joint Commission also awards Disease-Specific Care (DSC) Certification to health plans, disease management service companies, hospitals and other delivery settings that provide disease management and chronic care services including, but not limited to, asthma, diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, wound management and primary stroke care.

The Joint Commission, through its subsidiary Joint Commission International (JCI), has extensive experience working with public and private healthcare organizations and local governments in more than 60 countries. In fact, JCI accredits more than 90 healthcare facilities internationally. This includes the well-known and respected Bumrungrad Hospital in Bangkok, Thailand – a hospital that treated more than 55,000 U.S. citizens last year. In addition to international accreditation, JCI also operates disease- and

condition-specific certification programs for international healthcare providers and systems.

Defining Private Accreditation

Private accreditation assesses healthcare organizations to determine if they meet a set of standards requirements designed to improve the quality of care. Joint Commission and JCI accreditation are usually voluntary, and the standards are regarded as optimal and achievable. Joint Commission and JCI accreditation provide a visible commitment by an organization to improve the quality of patient care, to ensure a safe delivery environment and to continually work to reduce risks to patients and staff. In the U.S., both federal and state government regulatory bodies recognize many of the Joint Commission's accreditation programs and rely upon its accreditation findings and decisions for Medicare participation and state licensure purposes. Foreign governments are beginning to follow suit with JCI accreditation.

International Accreditation and Certification

Over the years, Joint Commission accreditation in the U.S. gained worldwide attention as an effective quality evaluation and management tool. In response to the desire of many internationally based hospitals to attain higher standards than existed in their home nation, the Joint Commission launched its international accreditation programs in 1999. To date, JCII operates accreditation programs that affect hospitals, clinical laboratories, ambulatory care settings, medical transport organizations, and a multitude of providers involved with the continuum of care (home health, long term care, assisted living, rehabilitative care, and end-of-life care). JCI has also developed certification programs for disease- or condition-specific care. These certification programs include:

primary stroke programs; maternal and well child care programs; chronic kidney disease programs; oncology care programs; cardiac disease programs; and diabetes care programs.

JCI accreditation standards are based on international consensus standards, and are intended to set uniform, achievable expectations for structures, processes and outcomes for international healthcare providers. The JCI accreditation process, endorsed by the World Health Organization, is designed to accommodate specific legal, religious and cultural factors within a specific country. In fact, JCI accreditation standards were developed by a 16-member international task force, representing seven major world regions: Western Europe; the Middle East; Latin and Central America; Asia and the Pacific Rim; North America; Central and Eastern Europe; and Africa.

Many international healthcare providers and facilities believe that JCI standards create a common language, like that used by air traffic controllers. A hospital, in the Middle East for example, may have up to 50 nationalities represented on the staff, but JCI accreditation helps to establish a common process framework (i.e., marking the correct site before surgery). JCI standards seek consistent improvement in: access to care; assessment and care processes; the education and rights of individuals; management of information and human resources; quality leadership; infection control; collaborative integrated management; and facility management.

Quality and Safety Considerations

The Joint Commission and JCI acknowledge that a major influence on the quality and safety of healthcare services involves the proximity of competent providers to the patient. Increasingly, for various reasons, U.S. citizens are finding themselves living in foreign countries. Needless to say, it can be extremely difficult for these individuals to

trek to the U.S. for certain medical services. The travel alone carries with it its own inherent risks, as evidenced by the higher probability of embolism for some compromised patients during long flights. It is therefore a benefit to U.S. citizens living abroad if they can receive their care locally in a safe, quality environment. JCI accreditation provides assurance that a foreign healthcare provider has met internationally-recognized standards for safety and quality. Not only has this been extremely important to many U.S. ex-patriots, but many U.S. payers as well, who are covering more and more internationally-provided services for U.S. citizens living abroad.

One concern for care provided overseas is the adequacy of discharge planning, such as directions for recovery and proper post-procedural monitoring. Fortunately, JCI accreditation mandates that the international facilities it accredits provide proper post-procedural monitoring and services.

Finally, it is important to the Joint Commission and JCI that international healthcare facilities not ignore the needs of their own residents. U.S. healthcare providers, especially hospitals, are devoted to providing quality care to all populations, regardless of their ability to pay or level of insurance coverage. The Joint Commission and JCI discourage the accreditation of international facilities that only cater to the foreign consumer.

Conclusions and Recommendations

No doubt, the U.S. healthcare delivery system will remain the gold standard for quality, and the primary source of exciting new medical technologies and treatments. Nevertheless, the fact that U.S. citizens will continue to obtain healthcare services abroad is an inevitable outcome of a growing global economy. Thus, the Joint Commission and

JCI encourage U.S. consumers to make informed decisions when seeking healthcare in international facilities - always mindful of external quality assessments of international facilities, especially those provided by JCI. JCI accreditation affords international healthcare providers practical solutions to develop better services, improve patient care, and reduce costs. JCI accreditation also remains the only true recognized, international accreditation standard.

Aside from the promotion of improved international provider quality through private accreditation, fewer U.S. ex-patriots will be able to obtain services overseas unless those services are covered and proper payment is made available. And, for U.S. seniors living abroad, Medicare is often the only major source of coverage. Thus, the Joint Commission and JCI request that the federal government honor its commitment to American seniors living in other countries, and examine ways in which Medicare benefits can be delivered to eligible candidates at certain international facilities. A federally-monitored demonstration could be modeled after a relatively recent program supervised by the Department of Veterans Affairs. From 1996 through 1999, military retirees under Tricare Standard were able to receive 75 percent reimbursement for covered healthcare charges incurred in Mexican clinics. Furthermore, for an international Medicare demonstration program to be the most effective, the Department of Health and Human Services should only provide payment when the safety and quality of the international provider of covered services is closely monitored, such as requiring JCI accreditation. A rigorous and respected private accreditation process would be an important part of any valid oversight.

Most Honorable Senators of the Senate Committee On Aging:

It was with great interest that I reviewed your hearing on June 27, 2006 in reference to *medical tourism* and, as the largest company in this field (based upon capital and patient volume), I felt it was prudent to add my comments for the record.

First of all, I applaud Senator Smith in wanting to set up an intra-agency task force to explore the economic impact and safety of patients seeking low cost health care procedures abroad. PlanetHospital's prime focus is to make sure that people who consider going abroad for surgery do so safely. To that end, we have hired registered nurses, MDs, and physician's assistants to review a client's medical intake form, to determine if a client is safe enough to travel for surgery and could expect a reasonable outcome. In some cases, we have proposed to clients not suited for long flight times and distances that they choose another destination closer to home, or that they seek treatment in the United States. We work diligently to ensure the safety of each of our clients.

In addition to the initial risk assessment, PlanetHospital has contracts with hospitals and clinics in Thailand, Singapore, Mexico, Costa Rica, Belgium, as well as India. This not only provides our clients with choice but also, in some cases, proximity; some clients may not feel comfortable going too far from home for surgery, and for others, it may not be entirely safe to go abroad for surgery.

The concept of *medical tourism* often brings up strong feelings for many health care professionals, governmental officials, and industry leaders. While many would rather avoid the controversy entailed in admitting that Americans are traveling abroad for medical care, this will only lead to injury. We must confront the issue and approach *medical tourism* like any other consumer product which must be regulated and made safe for the public. It is in our best interest to open a dialog among all parties which overviews not only the benefits of Medical Tourism, but also the dangers, and actively advocate for the creation and implementation of standards to regulate this growing industry. I am comforted by the initial steps being taken on June 27 to begin this process, and am available to assist in any means necessary.

Warm and healthy regards,

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