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Part 2. The US Insurance market & medical travel: Obstacles and opportunities

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In the second part of this two-part series, recent changes in the US health insurance markets as well as opportunities that exist are discussed. The goal is to offer a balanced perspective on this misunderstood topic between what is realistic and what is hype. The true opportunities exist and are identified. *Click here to read Part 1*.

Changes in the US insurance markets

The passage of the Affordable Care Act (ACA or "Obamacare") in 2010, marked the greatest change in the health insurance markets in the United States since 1965. Then, running on the campaign to abolish the ACA, President Trump and the Republican administration have tried and failed over 70 times to repeal and replace the law. This anti-ACA agenda has included many additional attempts to destabilize the insurance markets, creating problems for both consumers and companies. The law remains very popular with consumers.

Regardless of the political party in charge and uncertainty generated by political posturing, it is likely that certain features of the ACA which will survive. Yet changes are underway in healthcare which will be important to medical benefits plans and medical travel.

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Current trends are driving opportunities healthcare opportunities in the US for both residents or medical travelers. These trends are collectively referred to as the "Triple Aim".

The initiatives focus on:

- Improving the patient experience
- Improving population health
- Reducing costs of healthcare[i]

These trends are part of a larger transformation in the way that medical services will be paid for which is called "value-based payment".

The shift from "fee for service" to "value-based payment"

Since the beginning of organized medicine in the late 19th century, government efforts to monitor and control quality as well as to control payments have centered on the "service transaction". Each visit with the doctor, prescription and every visit to the hospital is recorded and this is what triggers a payment to the provider of care. This method for tracking quality and paying for care, usually referred to as "fee-for-service" is deeply embedded in the healthcare systems of the United States and virtually every other country with a developed healthcare system.

Research demonstrates that fee-for-service healthcare encourages unnecessary services resulting in very high rate of unnecessary injury and deaths as well as the very high costs. Value-based care is an attempt in the United States and other countries to look at the delivery of care more broadly for the overall population as well as for specific segments of the population.

Here is an example. Instead of paying the doctor and hospital for each knee replacement surgery under the fee for service model, the doctor and the hospital will now be paid a fixed amount to manage the "orthopedic health" of the population in a community who may be at risk of needing knee replacements. This immediately changes the incentive from doing *more* knee replacements to performing *fewer* surgeries and looking for lower-cost, lower-impact alternatives.

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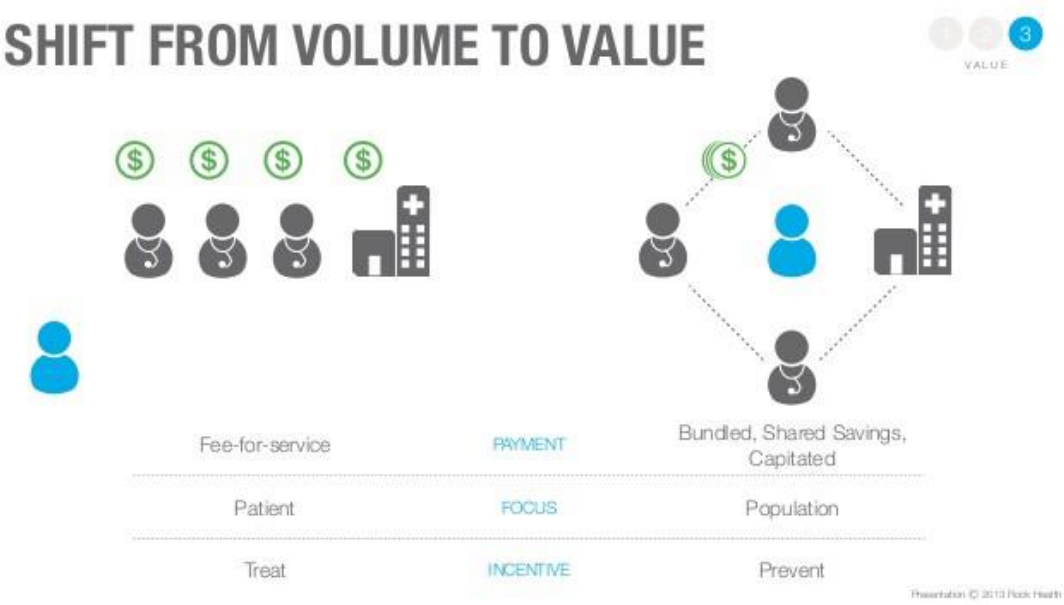

https://medium.com/@samudzis/the-dncs-best-strategy-for-stopping-trumpcare-do-nothing-35933d743aa, accessed 15 Feb 2018

This shift to value-based payment (VBP) represents a huge paradigm shift for providers and insurance companies. As hospitals and insurance companies work through the details of how to manage and pay for healthcare and medical services in this new environment, the appetite of the insurance companies to save money and reduce the amount of care increases.

So-called "Centers of Excellence" are emerging as one model for achieving improved quality and outcomes as well as lower cost. There is overwhelming evidence that the more a doctor or hospital performs a specific service, the better the outcomes associated with that service. Expert or specialist care, when performed with high frequency, improves outcomes and lowers costs; two of the three targets in the Triple Aim.

Employers and insurance companies are encouraging their insured beneficiaries to travel in order to receive high value services at a Center of Excellence for cardiac care, orthopedics, cancer treatment, etc. This "travel to receive care" model associated with Centers of Excellence has the potential to disrupt the usual pattern of receiving healthcare services by consumers.

Should it matter if the patient and her family are traveling from Dallas to Cleveland or Dallas to Cancun? US medical services consumers and the organizations that pay for those services will answer this question. Value-based payment and the pursuit of the Triple Aim are opening the door ever so slightly to the concept of medical travel to more consumers in the US, - even if that travel is domestic.

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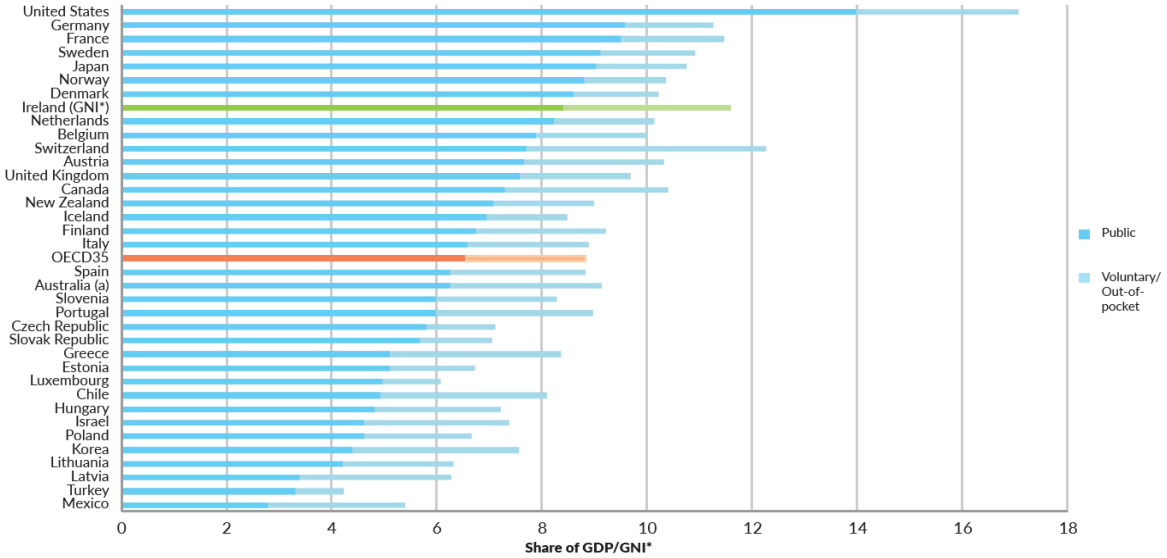
Musical chairs: insurance companies, providers & employers

To state the obvious: Healthcare in the United States is big business. The total value of healthcare expenditures in the United States is estimated at $3 trillion, larger than the nominal gross domestic product (GDP) of the UK, India or France. Because healthcare is such big business, for-profit healthcare companies actively acquire, divest and merge.

Health care mergers and acquisitions make sense and offer insights to analyze and predict the future of medical travel.

Figure 6.4

Health Expenditure as a share of GDP for selected OECD Countries and GNI* for Ireland, 2017 (or nearest year)



Source: OECD Health Statistics

Notes:
(i) a: Australian expenditure estimates exclude all expenditure for residential aged care facilities in welfare (social) services.
(ii) Modified Gross National Income (GNI*): adjusted for retained earnings of redomiciled firms and depreciation on foreign-owned domestic capital assets.
(iii) Voluntary/Out-of-pocket includes private insurance.

Why would a retail distributor purchase a pill packaging company? Amazon recently disrupted the retail pharmacy market by purchasing PillPack, a service that sorts, packages, and delivers prescriptions directly to consumers. Amazon is going through the expensive and laborious process of obtaining pharmaceutical distribution licenses in every state in the USA. This model makes sense because Amazon has the necessary distribution infrastructure and, by adding capabilities, proper licenses and systems, it can adapt that distribution system to the level of sophistication needed for prescriptions.

But why would Amazon join forces with J.P. Morgan Chase, a bank, and Berkshire Hathaway, a retail & utility conglomerate? And what does this partnership mean for medical travel?

Growing clout of employers

These three large companies have created a new enterprise to control healthcare costs. As described in detail in part one of this two-part series, 65% of the US population receives its health insurance coverage through employers. Many medium to large-size employers create self-funded health insurance benefits packages. This size and scale of these self-funded employers gives them enormous of clout with providers to reduce costs and tailor health and medical care to the precise needs of their employees and businesses.

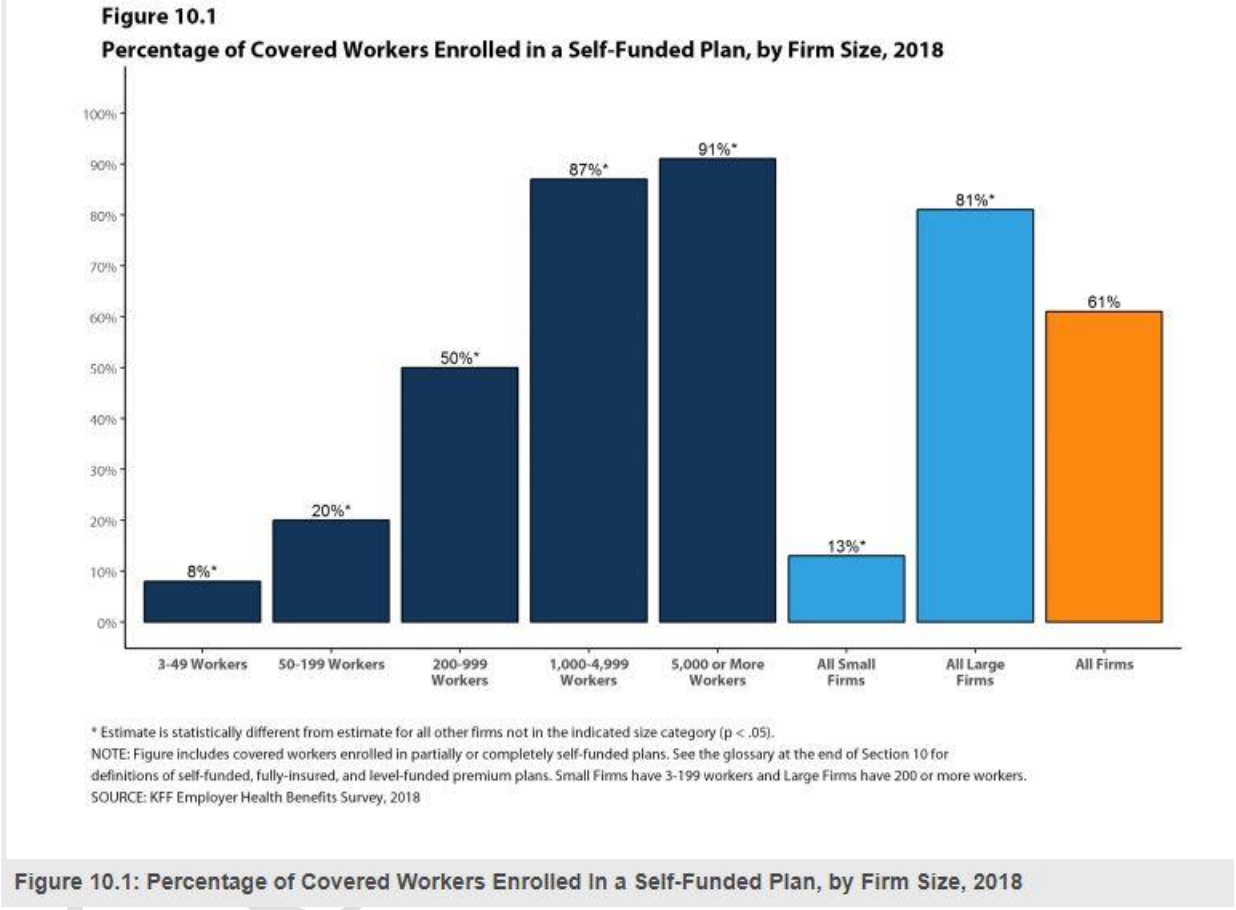


Figure 10.1: Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 2018

Self-funded health insurance plans have been targeted by medical tourism destinations and providers for at least 10 years. Because these types of insurance plans are exempt from many state regulations, the hope has been that large self-funded employers would be among the first to adopt medical travel as a benefit in order to control costs. Up to this point, this result has not materialized. Few self-insured plans have adopted medical travel benefits and for those that have, employees are slow to choose the medical travel option. While the early results are promising, achieving scale acceptance has been a challenge.

What is different now is the size of these alliances attempting to reduce costs and the convergence of the employers' willingness to innovate. What could be more innovative than medical travel?

Maybe all healthcare is not local after all

It is a truism that "healthcare is local". Past research on patient/consumer choices in healthcare and medical services confirm that, even when given evidence that the hospital or doctor farther away is better and/or less expensive, consumers tend to choose local options. With their employers and their insurance companies urging them to travel, more and more consumers may find quality, value, and even adventure in traveling elsewhere to receive medical services.

Employers are steering employees to Centers of Excellence farther away from home. Employees have to be educated about the health, financial, and other benefits of traveling for healthcare services. In the US, the education process is slow. Most Americans have never traveled outside the US, do not have passports, and are cautious about traveling. These attitudes are substantial barriers for the age group most likely to need health care – older individuals. Those obstacles may be lower for younger people who tend to consumer less medical care. The US market may have to "age" before medical travel is taken up to a greater extent.

The slowly growing role of the consumer

One of the obstacles to achieving the Triple Aim has been the passive, disengaged consumer. If healthcare is business, then consumer choice and market forces are the surest ways to make the markets for health and medical services more efficient. While Americans are savvy consumers in virtually every category, when it comes to medical care, there is a tendency to become passive and accepting. Only about 12% of patients request a second surgical opinion.[ii]

Middle-age and older consumers are following traditional provider choice patterns, consuming health care services locally.[iii] Younger consumers are pushing for change; they want to know as much as possible about their conditions, how much things cost, data about outcomes, and how to access providers online. They are forcing insurers and providers to adapt. And this trend represents an opportunity for medical travel.

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The opportunities

What do these trends represent for destinations and providers who want to see an increase in the health and medical travel markets? Here are some key concepts and opportunities for those looking to expand the international medical travel market.

Direct to consumer channel: With more access to more information available via more devices and channels, consumers in the 21 - 38 years of age group (so-called millennials) are more receptive to messages about health and medical services. Because these younger consumers place more weight on facts and data than on older consumers, they are more accepting of medical travel than any previous generation. Millennials are willing to go to their employers and request – even insist – on changes to medical benefits plans if they are convinced of the value in those changes.[iv] The consumer marketing channel may be a very efficient way to reach the markets for employer-sponsored health plans.

Employer channels: With the growing number of self-funded health insurance plans among employers as well as the increased acceptance of the "Centers of Excellence" model, employers are becoming more open to disruptive change. Employers are conservative in their thinking about medical travel; however, the tremendous pressure to control cost and improve efficiency may produce modest results in terms of broadening the medical travel option.

Hybrid Management Options: In the space between the employee, the employer, and the insurance company, a group of hybrid benefits management firms is emerging. These organizations take on many different shapes and sizes. Some target specific illnesses or disease states like orthopedics or cancer care, while others target specific workplace issues, such as injuries or obesity. These hybrid benefits management firms are open to exploring the benefits of medical travel to their customers (employers or insurance companies) and consumers (employees/patients). Combined with the Centers of Excellent model, these management approaches can look outside the United States for viable options for their clients.

Looking ahead

The enormous complexity of the US health insurance market has been responsible for the lack of acceptance of medical travel. Insurance companies are focused on controlling risk and the risks associated with medical travel have not been well defined.

The growing pressure to achieve the Triple Aim is creating new market dynamics, such as the emergence of value-based payment, the growing clout of employers who pay for health insurance, as well as emerging hybrid benefits management models. These forces are creating greater opportunities for medical travel to be accepted as a mainstream benefit within US health insurance plans. While opportunities do exist, they remain modest, requiring patience and continued learning as the landscape changes, creating further disruption and additional opportunities.

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[i] Institute for Healthcare Improvement; See: http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

[ii] Patient-Initiated Second Opinions: Systematic Review of Characteristics and Impact on Diagnosis, Treatment, and Satisfaction. See: https://www.mayoclinicproceedings.org/article/S0025-6196%2814%2900245-6/fulltext

[iii] Bhandari, N., Scanlon, D. P., Shi, Y., & Smith, R. A. (2018). Why Do So Few Consumers Use Health Care Quality Report Cards? A Framework for Understanding the Limited Consumer Impact of Comparative Quality Information. Medical Care Research and Review. https://doi.org/10.1177/1077558718774945

[iv] Moore, et al., Choice Matters: How healthcare consumers make decisions, (and why Clinicians and Managers should care). Oxford University Press 2018

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