MEDIA PLANET

HEALTH CARE

DECEMBER 2008

YOUR GUIDE TO HEALTH INSURANCE

CONTENTS

MEDIA PLANET

HEALTH CARE
A TITLE FROM MEDIAPLANET

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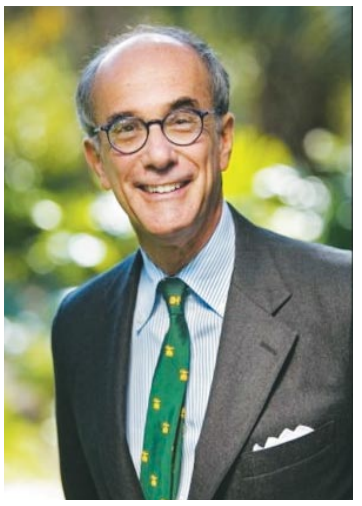
A Health Care System that Works for All Americans

The 2008 election was about change. Democrats and Republicans alike promised to fix the many problems facing the United States. As we welcome President-elect Obama and the new Congress, we need to ensure that health care reform is among the changes delivered.

I am writing on behalf of the American College of Physicians (ACP), the largest medical specialty organization, and the second-largest physician group in the United States. ACP members include 126,000 internal medicine physicians (internists) and medical students. Internists are trained in preventing, detecting and treating illness in adults and adolescents. They see first hand results of a health care system that does not work for everyone:

- Too many people do not have health insurance. They are less likely to have a regular doctor and more likely to miss getting needed care.
- Within a few years, middle-class persons might have to spend as much as four out of every 10 dollars they earn on health care. This will put health care out-of-reach for all but the well-off. It will be affordable to others only when co-pays and deductibles are so high that people are left with little more than catastrophic coverage.
- Many people can't find a primary care doctor—an internist, family physician, or pediatrician—to care for them. Few young doctors are entering primary care. Many established primary care doctors are leaving or closing their practices. Programs like Medicare pay primary care doctors less than other specialists. This is not lost on medical students, who graduate with average student loan debt of $140,000, when they choose a specialty. The United States faces a shortage of 45,000 or more primary care doctors.
- Yet studies show that primary care leads to better quality and lower health care costs. People who live in communities with more primary care doctors tend to live longer. They are less likely to be admitted to the hospital for a condition that could have been prevented or treated earlier.



Jeffrey P Harris, MD, FACP

What can be done to make health care work for all Americans?

First, we need to make sure that everyone has health care coverage that can't be taken away:

- Provide families with assistance, based on how much they earn, to make coverage affordable. They should be able to enroll in the same kinds of good health plans now offered to federal employees.
- Strengthen programs like Medicaid, the Children's Health Insurance Program, and Medicare.
- Provide guarantees that people won't lose their coverage, even if they lose their job or develop a serious health condition.

Second, we need to lower costs and improve quality, starting with reforms to make sure there are enough primary care doctors.

- Medicare and other payers should pay primary care doctors more for providing care. This will pay for itself with overall savings and better health outcomes.
- Medical students who practice primary care in areas with a shortage should have medical school debt alleviated. The federal government should provide primary care and other doctors with financial help to purchase electronic health records.
- Innovative primary care models, like the Patient-Centered Medical Home, should be widely adopted.

This Washington Post supplement will give you information on improving health care. You will learn about ideas to expand coverage, assuring there are enough primary care doctors, and about exciting new models like the Patient-Centered Medical Home.

Let's work together to create the changes we need in American health care.

Jeffrey P. Harris, MD, FACP
President of the American College of Physicians

Health Care System Transformation

BY: MARLENE PITURRO, PHD

Health care reformers have broadly outlined what measures, implemented alone or in combination, would reduce waste and inefficiency, increase access to medical care, and improve the quality of care. Each of these measures would save the health care system and, ultimately, the taxpayers, multi-billions annually:

- Implementing electronic medical records system-wide
- Reducing insurer's administrative costs
- Increasing prevention and wellness initiatives
- Coordinating care through disease management and other programs
- Practicing evidence-based medicine, thereby giving just the right amount of care
- Increase access to care through affordable insurance products, or offer universal coverage
- Reforming malpractice liability issues
- Promoting competition among insurers
- Requiring hospitals and other providers to publicly report measures of health care costs and care quality.

Despite widespread agreement in principle that adopting most or all of these major change initiatives would improve the system dramatically, one stakeholders waste is another's profit center. MP

A special thanks to...

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Colorado Clinical Guidelines Collaborative (CCGC) is a unique non-profit coalition of health plans, physicians, hospitals, employers, patient groups and others working together to reduce fragmentation and transform healthcare delivery using evidence-based guidelines, systems and processes to improve healthcare in Colorado. For more information visit: www.coloradoguidelines.org

ACP
American College of Physicians
Internal Medicine | Doctors for Adults

The American College of Physicians (ACP) is a national organization of internists—physicians who specialize in the prevention, detection and treatment of illnesses in adults. ACP is the largest medical-specialty organization and second-largest physician group in the United States. Its membership of 126,000 includes internists, internal medicine subspecialists, and medical students, residents, and fellows.

WellPoint X Prize:

$10 Million competition For The Best Health Care Innovations

BY: MARLENE PITURRO, PHD

The X PRIZE Foundation's game plan is harnessing individuals' and teams' competitive spirit to revolutionize industries to benefit humanity. In addition to spurring the development of the first private sub-orbital flight, lunar exploration, rapid human genome sequencing, and a 100 mile per gallon car, the foundation has also embraced a monumental new challenge—improving America's health care system. By partnering with WellPoint, Inc. the nation's largest health insurer by medical membership; and the WellPoint Foundation, a private, non-profit organization wholly funded by WellPoint, Inc to enhance health and well-being in the communities it serves; the X PRIZE Foundation's next $10 million competition will likely generate new ways to address the American health care system's serious problems.

By offering at least $10 million to winners of the new competition, the X PRIZE Foundation's chairman and CEO Dr Peter Diamandis believes that significant innovation is achieved when companies and individuals are motivated by the chance to compete among their peers to design and implement groundbreaking solutions to significant challenges. Of the collaboration WellPoint President and CEO Angela Braly said: "We've chosen to partner with the X PRIZE Foundation to solicit the best ideas from all parties. We believe that the stakes are too high and the opportunity too great to not do everything we can with any and all willing partners that may identify the next great solution in health care."

> **"I think the time is right for innovation and bright, new, imaginative ideas"**

The WellPoint Foundation and the X PRIZE Foundation are currently soliciting participation from employers, health care providers, consumers, public partners and other interested parties to develop competition guidelines reflecting health care's most pressing challenges. As a leading national health care provider, WellPoint will test selected finalists' project entries in appropriate state markets. Various industry experts will then evaluate whether the proposed solution will drive viable, creative and achievable change in the health care system. The co-sponsors will emphasize transparency throughout the process, from development of the prize to the competition's conclusions. All results will be shared publicly and the knowledge gained considered non-proprietary.

The potential health care X PRIZE is generating excitement among stakeholders committed to transforming health care. Virginia Proestakes, GE's health benefits program leader says: "I think the time is right for innovation and bright, new, imaginative ideas," while former House Speaker and founder of the Center for Health Transformation Newt Gingrich sees "thousands of people talking among themselves about the fact that the X PRIZE Foundation, WellPoint and the WellPoint Foundation come together to fundamentally rethink the financing and payment of health care. This is a profound application of the prize concept to social public policy." Former Senator Bill Bradley adds: "The results of the competition could positively impact the direction of health care reform in the next decades."

Although naming the X PRIZE winner in health care is likely several years down the road, one thing is certain—every American will benefit from this competition with better ideas for better health. For more information: www.xprize.org/wellpoint.

Healthcare For The Consumer:
Making Good Choices

BY: MARLENE PITURRO, PHD

Would you buy a house, car or refrigerator without knowing its costs? Most of us wouldn't, but when faced with a serious medical situation your bills can easily cost as much as these big ticket items. Chances are you wouldn't find out until hospital and doctor bills poured in.

Until recently, knowing in advance a hospital stay or doctor's fee was impossible but with the advent of consumer-directed health plans (CDHPs) that is changing as consumers shoulder an ever-growing share of insurance premiums and medical expenses. Many large health insurers now have web-based tools that allow doctors and hospitals to go online and within 10 seconds know exactly how much they will be reimbursed for a procedure and how much the patient will pay out-of-pocket. Based on this information presented, physicians and patients are learning how to negotiate treatment based on cost.

Another major component of patient cost-sharing is the CDHP. A CDHP is a high-deductible health plan (at least $1100 for an individual and $2200 for a family) coupled with either a Health Savings Account (HSA) or Health Reimbursement Account (HRA), savings accounts that allow their owners to pay for qualified medical expenses, tax free. According to consultants at Mercer, 20% of large employers had such plans in 2008 compared to 14% in 2007. Since high-deductible plans cost employers an average of $6207 per employee versus $7815 in 2008 for a conventional plan, their adoption is growing exponentially.

With consumers now paying more of their own money for medical expenses, they are proving to be savvy shoppers, supported by tools that assist them in making more intelligent choices. Starla Scruggs, for one, a Blue Cross/Blue Shield Tennessee employee, lost 30 pounds and learned better nutrition to control her diabetes when her employer introduced a consumer-directed plan. Using Flexible Wellness Dollars from her HRA, she works with a local health club, gets fitness coaching and substantially reduces her premium costs.

For the independent-minded health care consumer, online tools can help them comparison shop, even for expensive surgical procedures. Vimo.com, for example, offers this information for a customer searching for a hospital within 10 miles of the 20004 Washington, DC. zip code, for knee replacement surgery:

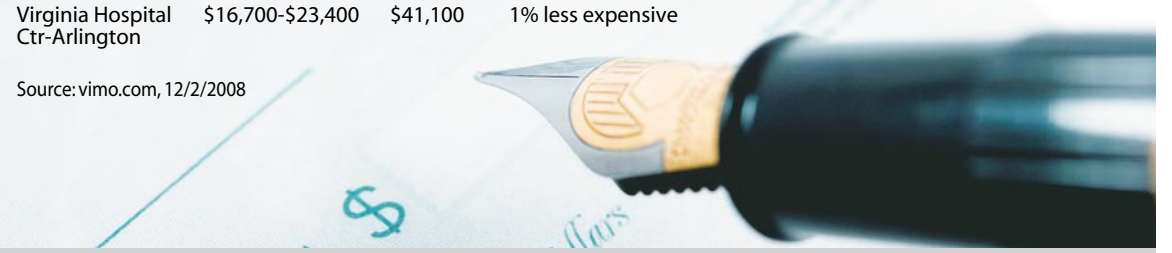
Armed with this type of information, the cost conscious health care consumer can avoid the sticker shock of a 'list price' bill, which is substantially higher than the negotiated rate paid by major insurers. With information, the consumer has leverage to work with the hospital on payment terms.

But cost is only part of the equation. Quality is equally important, and consumers have resources to get objective data on a hospital's quality track record such as the Hospital Care Quality Information from the Consumer Perspective (www.hcahpsonline.org). Shopping for health care on cost and quality might be scary, but it is empowering, and it is here to stay.

Table: **Comparing Costs for Knee Replacement Surgery**

Hospital	Negotiated Price	List Price	National Average Comparison
GWU Hospital	$21,200-$29,600	$48,000	16% more expensive
Howard University Hospital	$26,500-$37,100	$52,500	27% more expensive
Washington Hospital Center	$19,600-$27,400	$52,100	26% more expensive
Sibley Memorial Hospital	$15,300-$21,500	$24,800	40% less expensive
Virginia Hospital Ctr-Arlington	$16,700-$23,400	$41,100	1% less expensive

Source: vimo.com, 12/2/2008



Innovative Plans For Those Who Need Coverage The Most

BY: MARLENE PITURRO, PHD

Sometimes simple but radical solutions to intractable problems work. For providing health care benefits at a price the self-employed, small business employees and low wage earners can afford, the state of Tennessee and the giant retailer Wal-Mart have surmounted the obstacles of cost, access, and complexity to give the previously uninsured employed health benefits they desperately needed.

Instead of comprehensive, mandate-laden 'perfect' health insurance, both innovators crafted plans that give people the basics that they want, need and will use. Tennessee's CoverTN plan, implemented in 2006 after a competitive bidding process among insurers, splits the monthly premium of $150 equally among employer, employee and the state. Plan members get free physicals and mammograms, $15 doctor visits, a largely generic prescription drug program, limited hospital stays, and a $25,000 benefit limit per year. For the miniscule number of beneficiaries exceeding the annual $25,000 benefit (four of 15,000 enrollees), Tennessee negotiates lower rates with large providers

Tennessee governor Phil Bredesen touts the 2008 plan as being so effective at giving consumers what they want without breaking the state's budget that the 2009 plan includes 12 doctor visits, up from six, at no increase in premium. CoverTN sounds simple and it is, challenging the entrenched notion that good medical care has to be onerously expensive. Emphasizing prevention, basic primary care, easy to understand costs and benefits, and consumer education has worked.

Retailing giant Wal-Mart, long criticized for not offering health insurance to 125,000 part-time associates, expanded health care coverage this year with its innovative low-cost Value Plan. Each employee or family enrolling in the plan receives a grant of $100, $250, or $500 to defray health expenses. Value Plan eliminates high hospital deductibles; offers $4 prescriptions for 2400 generic drugs; and 50 ways of customizing coverage by deductibles, health care credits, drug plans and premiums. For example, an associate choosing a $1000 deductible and $250 credit, would pay from $12-$24 monthly premium; or a $2000 deductible and $100 credit would be $5 to $8 per month. Out-of-pocket expenses are capped at $5,000.

> **"Emphasizing prevention, basic primary care, easy to understand costs and benefits, and consumer education has worked."**

Wal-Mart critics such as Wal-Mart Watch say that Value Plan's high deductibles and a 12 month waiting period for part-time workers and six months for full-timers are stingy health care benefits. However, 100,000 more Wal-Mart employees have opted for employer-sponsored health insurance in the last three years. The Kaiser Family Foundation's survey of retailers' confirms Wal-Mart's successful expansion of health care coverage; a 2008 study showed that only 57% of the average retailer's employees are eligible for health coverage while 76% of Wal-Mart employees qualify. Dr. Sanjit Bagchi of the Heartland Institute said that with its Value Plan Wal-Mart has offered a replicable template for consumer-friendly health care reform.

UNLEASHING THE POWER OF CONNECTIVITY IN HEALTH CARE.

A health care crisis of communication.

Over the last 50 years medical science has advanced exponentially. Yet the ability of caregivers to access and apply both science and complete patient information is repeatedly impeded by the paper system that contains it. Patient data typically sits in static, inert and functionally truncated paper records. Paper medical records are often incomplete and out of date. Sharing evidence, research findings and simple patient information is usually an arduous, inconsistent and often inaccurate task when paper records produce the data.

Handicapped by a paper-based information non-system that just about every other industry has left behind, health care is in a massive communication morass that cries out for technological intervention and help.

Connectivity. The overdue next step.

Caregivers should be linked to one another for every patient. Patients should have consistent access to both caregivers and medical information. The 21st century health care system should build a continuous loop of information around the patient that will give clinicians secure access to all data, on all relevant patients, all of the time.

The power and value of complete connectedness should be self-evident. Full and secure access to data will give physicians visibility into patient status and health history, improving diagnosis and delivery of care. Information retrieval that took days, will take minutes. Or less.

The future system should open unprecedented new diagnostic tools. Physicians should be able to instantly share imaging and test results with colleagues across the hall or across the country. Patients should have instant access to their own records and be able to send, transmit or carry it from one provider to another. Secure, computerized data sharing can reduce errors, redundancies, lost information and costs.

A culture of continuous learning and connected care.

Today, we're a mobile and connected society in everything except health care. At Kaiser Permanente we believe in a future health care system where patient information is accessible, instantaneous, constantly improving, secure and accurate. And we've invested $4 billion to build and install a system that we believe this generation of patients and caregivers needs.

Our integrated system now connects 8.6 million members with their clinicians. It allows care to be focused on the patient. Our clinical teams are using our new systems and processes to help prevent manageable diseases from becoming life threatening crises. In one computer supported pilot study, we reduced coronary artery disease deaths by 76 percent. Chronic conditions like coronary artery disease account for 75 percent of health care costs and most deaths.

A new standard of personalized care.

We believe our path will take personalized care to new levels. Our goal is to use a full array of data — ultimately including secure DNA databases — so that doctors will be able to focus better on each patient. We will also use customized computer models tailored to individual patients to predict risk factors and treatment benefits. Our members can already go online at kp.org to view their health histories and lab results, schedule appointments and e-mail clinicians. More than 160,000 Kaiser Permanente members connect electronically every day — including more than 20,000 secure e-messages between clinicians and patients every single day.

Maximizing information for the clinician means optimizing care for the patient. Done well, we believe a computerized care support system can help both to restore and enhance each physician's original mission. The right system provides more time with patients, better information about care and less time with traditional paperwork. The right system also needs to be focused on the patient's need for affordable, well informed, customized and compassionate care. We believe new computer systems are needed to lead our nation's health care reform agenda into the 21st century. For us, right now, it's a work in progress and progress is being made.

Get more information at kp.org/future

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Fixing the Hospital Business Model

BY: CLAYTON CHRISTENSEN, DBA AND JASON HWANG, MD

The great debate in health care today is how to achieve better results while making care more affordable— especially for the unlucky Americans who find themselves uninsured, underinsured, or under threat of losing their coverage along with their jobs. Any proposal that aims to provide care for all Americans will inevitably struggle with the task of paying for a costly and underperforming system unless we fundamentally alter the way our health care system works.

We suggest that a force exists to make health care affordable, while improving quality, accessibility, convenience, and safety: disruptive innovation. Disruptive innovation is the predictable, proven process by which an industry delivers more value by allowing new technologies and innovative business models to take root, even encouraging them to displace longstanding and successful ones, and gradually achieving higher quality at lower cost by supplanting the existing system altogether.

Disruptive innovation is the first step toward successful health system reform, and a key part of this step requires that our advances in technologies be merged with innovative business models. Despite a level of technological innovation unseen in practically any other industry, health care costs have only increased because we continue to employ new technologies in business models that are decidedly dysfunctional and outdated. And the most dominant of these business models, that of the general hospital, is simply broken.

But it can be repaired. Disruptive innovation can fix it.

The problem is that hospitals today try to do everything for everybody. By absorbing any new technology that comes along, they have become extraordinarily capable of dealing with even the most complicated cases. But maintaining that capability is extremely costly. For patients with straightforward problems, hospitals far overshoot their needs.

All successful businesses deliver only what their customers really want. Hospitals, however, attempt to address two distinct customer needs. One "job" of a hospital is to use technologies like CT scans to develop hypotheses for why patients are ill. Another "job" is to prescribe and administer treatments for established diagnoses, such as bypass surgery for heart disease. For complex conditions, these jobs are often intertwined, as practitioners use treatments to test and validate their diagnoses. When these jobs can be separated, however, different resources and distinct profit formulas are required to do them well. Housing fundamentally different business models within the same business unit creates great economic strain and managerial chaos. But that's exactly what is happening.

Hospital care needs to be disaggregated into two independent, disruptive business models: "solution shops" that focus on nailing down diagnoses and "value-adding process facilities" that fix problems after a diagnosis has been made. Only when an organization is focused on a specific customer job can it do the job perfectly and cost-effectively. Once the system begins to change the way it delivers care, payers and regulators can worry less about simply clamping down on escalating costs and begin rewarding innovative providers who exceed the expectations of patients by using disruptive models of care.

Clayton M. Christensen, DBA is a Professor of Business Administration at Harvard Business School. Jason Hwang, MD is Senior Strategist for the Healthcare Practice at Innosight LLC. They are co-authors of The Innovator's Prescription: A Disruptive Solution for Health Care (McGraw-Hill, Jan. 2009).

"Medical home" Initiative Aims To Improve Care, Lower Costs

BY: RICHARD LEONARD

A broad-based group of Colorado stakeholders is launching a two-year pilot program, one of 20 national pilot projects, to test the "patient-centered medical home"-an innovative model for tackling health care's rising costs and decreasing quality. "Our current healthcare system is unsustainable," says Marjie Harbrecht, MD, Medical/Executive Director of Colorado Clinical Guidelines Collaborative (CCGC). "The medical home is not a place but an approach to providing continuous, comprehensive, coordinated care, with a partnership between patients and their health care team, as part of an integrated medical neighborhood. It puts patients at the center of care."

CCGC, a coalition of healthcare stakeholders working together to reduce fragmentation and improve healthcare in Colorado, is convening employers, health plans, primary care professional associations, and patient advocacy organizations for the two-year initiative, beginning in spring 2009. The Colorado Trust and the Commonwealth Fund are funding the pilot.

The "medical home" will give patients an ongoing relationship with a primary care doctor and a team approach to delivering comprehensive, coordinated care across the health care system. PCMHs will give patients expanded access to care, with extended office hours, e-mail and/or telephone consultations. Tools such as electronic medical records will help providers prevent redundancy and medical errors.

The initiative will pay for up to 30,000 people served by 17 internal medicine and family medicine clinics, but will reach many more as entire practices transform into medical homes. Participating health plans include Aetna, Anthem-Wellpoint, CIGNA, Humana, United Healthcare, Colorado Medicaid and Colorado Access. The aim is upgrading the quality and safety of medical services, improving patient health, and reducing payers' costs and premiums through efficiency.

Health plans will provide a three-tier reimbursement to the practices: a standard fee for service, a monthly care management fee, and a bonus for meeting quality indicators. The goal is shifting the focus from episodic care towards more comprehensive, holistic care, while ultimately lowering costs and achieving better outcomes. CCGC PCMH Manager Julie Schilz, RN, MBA explains: "The common fee-for-service payment system creates treadmill medicine, which is not giving us the results we want! In fact, it increases costs by concentrating efforts on patients that already have a problem instead of preventing those problems in the first place."

The medical home model is endorsed by the nation's major organizations representing 333,000 primary care doctors through American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, and many large national employers through the Patient Centered Primary Care Collaborative.

With the healthcare system as broken as it is, Dr. Harbrecht cautions that "when a model like PCMH sweeps the country, we may put all of our hopes and dreams into it, but we must be careful. The pilot tests are a period of discovery. Some things will succeed and others may fail; both are crucial to learning and moving us forward. The greater risk is continuing the status quo which is no longer an option!" She congratulates the stakeholders in Colorado initiative for "stepping up to the plate and taking the chance to build a better health care system."

Panel of Experts

MARJIE HARBRECHT MD
MEDICAL/EXECUTIVE DIRECTOR OF
COLORADO CLINICAL GUIDELINES
COLLABORATIVE (CCGC)

Too often patients feel their care is fragmented, with poor coordination between busy doctors leading to confusion and frustration. Some patients may see 10 physicians, each with a different care plan. The Patient Centered Medical Home (PCMH) seeks to address this fragmentation by centralizing fundamental services through a primary care team, which then coordinates all of the patient's care when they need specialized services such as cardiology, mental health or hospitalization. The goal of the Medical Home is to provide patients with easy access to a personal health care team that knows who they are, what their history is and are dedicated to helping them navigate our complex healthcare system when they're sick and more importantly, work with patients pro-actively to stay healthy!

To do this, patients and their personal physicians work together through "shared decision making" to develop a care plan, then on-site Care Plan Managers/Care Coordinators help patients implement that plan. When possible, services are integrated in one location. For other services, community networks can be developed using agreements among collaborating clinicians that define what key information needs to be shared to maximize a patient's care. Technology can then be utilized to provide secure, efficient and timely exchange of clinical data among all those in the patient's "medical neighborhood". Based on growing evidence, PCMH has excellent potential to improve patient outcomes, reduce costs, and improve satisfaction for patients and their health care teams by bolstering and transforming how primary care is delivered, how it is paid for, and how it can be part of the larger medical neighborhood to ensure care is truly coordinated between all healthcare entities.

CHAD POMEROY
VICE PRESIDENT FOR INNOVATION,
WELLPOINT, INC.

WellPoint Continues Commitment to Transparency with Zagat Health Survey Tool

Americans looking to buy a new car, purchase a TV or consider a new school for their children can search hundreds or thousands of Web sites for information about others' experiences. However, if they're looking to select a doctor after moving to a new community, similar information was hard to find or did not exist – until now.

Earlier this year, WellPoint, Inc. and Zagat Survey, LLC launched the Zagat Health Survey for members to provide reviews of doctors in WellPoint's Blue Cross and/or Blue Shield subsidiaries in Connecticut, Ohio and greater Los Angeles. This partnership, the first of its kind in health care, is addressing a need for peer-to-peer information among health care consumers.

Using Zagat Survey's trusted methodology for surveying consumers, the new tool enables members to review their doctor visits based criteria, including:

- Trust
- Communication
- Availability
- Environment

In addition, consumers can indicate whether they would recommend the doctor and add comments to their ratings. These categories are designed to solely reflect a consumer's experience with a physician, not to reflect their quality of care. The survey and results are available free of charge to members via their health plans' Web sites.

WellPoint is expanding the availability of the Zagat Health Survey to additional affiliated health plan markets next year, as well as to other non-WellPoint plans. The Zagat Health Survey is one part of WellPoint's aggressive strategy to provide consumers and providers with the data and tools they need to make informed health and health care spending decisions.

BOB DOHERTY
SENIOR VICE PRESIDENT GOVERNMENTAL
AFFAIRS AND PUBLIC POLICY
AMERICAN COLLEGE OF PHYSICIANS

Too Much Debt For Gratitude at Graduation

"We are the new generation of physicians that your elderly and disabled constituents will be counting on for their primary care," Vineet Arora, MD, MA told the Subcommittee on Health of the House Energy and Commerce Committee. "Unfortunately, there won't be enough of us. A combination of high student debt and an unfavorable economic environment is causing many of us to choose careers other than general internal medicine." The steady decline of residents pursuing careers in primary care has already caused shortages in many parts of the country

Dr. Arora, chair of the Council of Associates of the American College of Physicians (ACP) and a member of the College's Board of Regents when she testified, shared the views of a physician at the beginning of her career.

According to the Association of American Medical Colleges, the average medical student debt in 2007 was $139,517. ACP contends that medical school scholarships and loan repayment programs for those pursuing careers in primary care will help ease the primary care physician shortage.

When Dr. Arora spoke at the 2006 State of the Nation's Health Care briefing she cited this story:

"Many of us are entering practice at the same time we are getting married, buying homes, and starting families. Several weeks ago, I was visiting my friend, a new mom, who is completing her family medicine residency in New Hampshire. She is married to another medical trainee and together, they have nearly $400,000 in medical school debt, and another baby on the way. When interviewing for jobs, she realized that she could not accept a job in office-based primary care, and expect to pay for child care while continuing to pay off their debt. And there are countless others like her."

ROBERT PEARL, MD
EXECUTIVE DIRECTOR AND CEO
THE PERMANENTE MEDICAL GROUP
KAISER PERMANENTE

Kaiser Permanente provides comprehensive health care for eight and a half million patients, a population larger than forty-two states and a hundred and thirty countries. As the nation's largest integrated program with advanced technology systems, we are able to provide superior, quality medical care and offer personalized service in the most efficient and effective ways possible.

Our electronic medical record assures that all of our patients' information is available regardless of whether they are seeing their personal physician or a specialist. Our on-line tools allow our members to e-mail their physicians, check their laboratory data, and obtain state-of-the-art medical information. Our research programs are world renown, and across the nation we have been recognized for our innovative programs to maximize patient safety.

Together these approaches help clinicians to better diagnose medical problems, improve patient outcomes, and make health care more affordable. Together they serve as a model for the nation.

KEN ERICKSON
FOUNDER AND CHIEF EXECUTIVE OFFICER
HEALTH PLACE AMERICA

Healthplace America was organized to provide cost, quality and experience management for the $700 billion surgery industry that has remained generally unmanaged. Our flagship product, the Healthplace Benefit™, supplements employers' health plans with world-class U.S. healthcare facilities and surgeons who offer low, fixed-rate pricing in order to attract pre-paid patients from around the country.

As a result, employers typically realize 30%-50% savings on major medical procedures — such as heart surgery, joint replacement, spine surgery, cancer care, bariatric surgery and more — while reducing re-operations through high-quality outcomes the first time around. Additional cost savings are realized by eliminating unnecessary procedures with our unique Expert Opinion Program.*

With the Healthplace Benefit™, health plan members share in the savings with no co-pays, deductibles or coinsurance while receiving superior medical care.* And in many cases, members receive a recovery benefit that translates into significant personal out-of-pocket savings.

What's more, members receive personalized attention from a Concierge Care Coordinator who guides each patient through the entire surgical process while providing all administrative, case management, travel and logistics services.

Ken Erickson is an entrepreneur who has specialized in developing new business opportunities in emerging markets.

Medical Travel: High Quality + Lower Price = High Value

Global Option Good for Insured and Uninsured Alike

BY JOHN LINSS

With health care costs rising, initiatives such as the X Prize are laudable and the goals and initiatives of the Obama administration with respect to the uninsured are much needed. While those with insurance are facing costs that are spiraling out of control, for many Americans that do not have health insurance, it may be too little too late.

Uninsured Americans do not have access to negotiated rates and deep discounts. They typically must pay the retail price – effectively subsidizing those who do have insurance!

Increasingly, they are discovering that there is an alternative to the dilemma of choosing between bankruptcy and pain. Many are traveling to safe, clean destinations such as Singapore for procedures ranging from heart bypass surgery to knee replacements.

More importantly, these destinations frequently have transparency of price and quality with US board certified surgeons operating in Joint Commission Accredited hospital facilities. These facilities rival and often exceed the average quality standards found here in the United States. What is more, the service standards are extremely high with staff being trained by hospitality organizations such as the Ritz-Carlton.

In addition, patients often have the cell phone numbers of their doctors and are taken care of by Registered Nurses rather than nurse assistants. Hospital room appointments typically include flat screen TVs, laptops with wireless internet, US newspapers, and comfortable companion suites. For those that are interested, tourism options can also be selected.

The technology found in these hospitals is also state of the art. Innovative and unique "Brain Suites" for quick MRIs during surgery, and advanced imaging such as 320 CT slice scanners, rather than the 64 slice commonly found in US hospitals, are used in these facilities.

Prices often range from 1/8 to 1/10 the cost of the same procedure here in the US. For example, a knee replacement normally costing more than $50,000 in the US can be had for between $7,500 and $13,000. Often, patients with high deductible insurance plans can pay less out of pocket without even involving their insurance company.

In addition, programs that "wrap around" traditional health plans have become available that allow fully insured patients to have their procedures at their local hospital with the normal co-pays and deductibles or to travel overseas with their spouse for $0 out of pocket. This is good for both the patient and the health plan or self-insured employer because the savings can be so significant.

There are a few extras that are recommended. For example, a Continuity of Care program that links stateside doctors with offshore surgeons ensures that the patient has high quality of care from pre-op to recuperation and frequently provides up to 12 months of primary care – effectively providing healthcare where there was none before.

> **"A knee replacement normally costing more than $50,000 in the US can be had for between $7,500 and $13,000 overseas."**

These programs provide for electronic medical records to be stored in a secure collaborative environment where both physicians can collaborate over the case. Surgical complications and travel insurance is also available to cover most eventualities related to travel and health care procedures.

The Global Economy that has impacted so many other industries is now coming to healthcare and competitiveness will ultimately result in improved options for companies and patients. Recent analyst predictions estimate that up to 6 million people will travel for healthcare by 2010.

This means that people will get the care they need at a reasonable price and we will start to see US healthcare providers become more efficient and competitive as well as their patients seek treatment elsewhere.

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