insurers and providers. **Figure 6-1** places value-driven health care on this continuum. Despite the emphasis on competition, we have included it as an administered system because it is going to have to be buyer-driven at the onset.

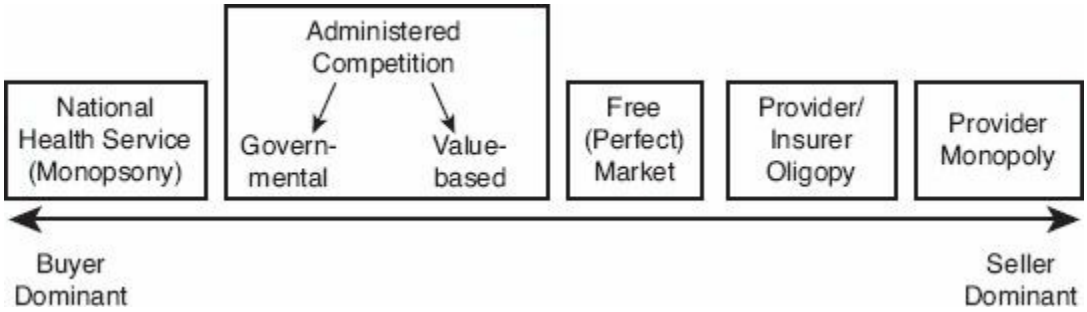

Figure 6–1 Modified stages of health care market power.

CONCLUSION

The health care marketplace is very complex. Many actors and many alternatives merit consideration as the system tries to strike a balance between overutilization and underutilization and as the commercial aspects of health care become increasingly apparent.

Case 6 Global Medical Coverage

BACKGROUND

Blue Ridge Paper Products, Inc. (BRPP) in Canton, North Carolina, is a paper company whose predominant product is food and beverage packaging. It was the largest employer in Western North Carolina in 2006, with 1,300 covered employees in the state and 800 elsewhere. Started as the Champion Paper plant in 1908, it was purchased by the employees and their union (a United Steelworkers local) in May 1999 with the assistance of a venture capital firm. Today it operates under an employee stock ownership plan (ESOP). To purchase the plant, the employees agreed to a 15% wage cut and frozen wages and benefits for 7 years. From the buyout through the end of 2005, the company lost $92 million and paid out $107 million in health care claims. It became profitable in 2006. Maintaining health benefits for members and retirees is a very high priority with the employees and the union, although retiree medical benefits have been eliminated for salaried employees hired after March 1, 2005. The venture capital firm that financed the

ESOP retained 55% ownership with 40% going to the employees and 5% to senior management. Profitability varied from year to year as the company expanded capacity and improved productivity of its single-serving drink carton lines and was caught up in a number of suits over water pollution problems at its Canton, North Carolina, plant.

The majority of BRPP employees are male, older than age 48, and have several health risk factors. Most employees work 12-hour, rotating shifts, making it extremely difficult to manage health conditions or improve lifestyle (Blackley, 2006). The ESOP has worked hard to reduce its self-insured health care costs. Health insurance claims for 2006 had been estimated at $36 million, but appeared likely to hold near $24 million, which is still 75% above the 2000 numbers. A volunteer benefits task force composed of union and nonunion employees worked to redesign a complex benefit system. After 2 years of 18% health care cost increases, the rate of growth dropped to 2% in 2003. It was 5% in 2004 and –3% in 2005.

Programs initiated in 2001 included a plan offering free diabetic medications and supplies in return for compliance, and a tobacco cessation plan with cash rewards. In 2004, the company opened a full-service pharmacy and medical center with a pharmacist, internist, and nurses. In 2005, it began a population health management program. Covered employees and spouses who completed a health risk assessment were rewarded with $100 and assigned a “personal nurse coach.” The nurse coach assisted those who were ready to change to set individual health goals and to choose from among one or more of 14 available health programs, which included reduced copays on medications, free self-help medical aids/equipment, and educational materials.

Where BRPP could not seem to make headway was with the prices paid to local providers. Community physicians refused deeper discounts. Even banding together in a buying cooperative with other companies could not move the local tertiary hospital to match discounts offered to regionally dominant insurers. This hospital was not distressed and had above-average operating margins.

Articles on “medical tourism” in the press and on television attracted the attention of benefits management. Reports were of high-quality care at 80% or less of U.S. prices with good outcomes. BRPP

contacted a company offering services at hospitals in India, IndUShealth in Raleigh, North Carolina, and began working on a plan to make its services available to BRPP employees.

INDUSHEALTH

IndUShealth provides a complete package to its U.S. and Canadian clients, including access to Indian superspecialty hospitals that are Joint Commission International accredited and to specialists and supporting physicians with U.S. or U.K. board certification. It arranges for postoperative care in India and for travel, lodging, and meals for the patient and an accompanying family member—all for a single package price. For example, it represents the Wockhardt hospitals in India, which are Joint Commission International accredited and affiliated with Harvard Medical International. Other Indian hospitals boast affiliations with the Johns Hopkins Medical Center and the Cleveland Clinic.

MITRAL VALVE REPLACEMENT

One of the first cases considered was a mitral valve replacement. IndUShealth and BRPP sought package quotes from a number of domestic medical centers and could get only one estimate. That quote, from the University of Iowa academic medical center, was in the $68,000 to $98,000 range. The quote from India was for $18,000 and included travel, food, and lodging for the patient and one companion. Testifying before the U.S. Senate Special Committee on Aging, Mr. Rajesh Rao, IndUShealth's CEO (2006), cited the following costs:

Procedure	Typical U.S. Cost	India Cost
Heart bypass surgery	$55,000 to $86,000	$6,000
Angioplasty	$33,000 to $49,000	$6,000
Hip replacement	$31,000 to $44,000	$5,000
Spinal fusion	$42,000 to $76,000	$8,000

EMPLOYEE PARTICIPATION

To encourage employee participation, BRPP prepared a DVD on its medical tourism initiative, which it called Global Health Coverage. It

outlined the opportunities and described the Indian facilities and credentials. The next step was to be a trip by an employee "due diligence" committee to India to inspect facilities and talk with doctors. Then they would discuss how to handle the option in the next set of union negotiations.

SENATE HEARINGS

On June 27, 2006, the U.S. Senate Special Committee on Aging held hearings titled "The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?" Both BRPP and IndUShealth testified for the committee. When testifying to the Senate subcommittee, Bonnie Grissom Blackley, benefits director for BRPP, concluded:

> 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 staph 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.

BLUE RIDGE PAPER PRODUCT'S TEST CASE

The test case under the new arrangement was a volunteer, Carl Garrett, a 60-year-old BRPP paper-making technician who needed a gallbladder removal and a shoulder repair. He reportedly was looking forward to the trip in September 2006, accompanied by his fiancée. A 40-year employee approaching retirement, he would be the first company-sponsored U.S. worker to receive health care in India. The two operations would have cost $100,000 in the United States, but would cost only $20,000 in India. The arrangement was that the company would pay for the entire thing, waive the 20% copayment, give Garrett about a $10,000 incentive, and still save $50,000.

However, the United Steel Workers Union (USW) national office objected strongly to the whole idea and threatened to file for an injunction. The local district representative commented, "We made it clear that if healthcare was going to be resolved, it would be resolved by modifying the system in the U.S., not by offshoring or exporting our

own people." USW President Leo Gerard said, "No U.S. citizen should be exposed to the risk involved in travel internationally for health care services." The USW sent a letter to members of Congress that included the following (Parks, 2006):

> Our members, along with thousands of unrepresented workers, are now being confronted with proposals to literally export themselves to have certain "expensive" medical procedures provided in India.
>
> With companies now proposing to send their own American employees abroad for less expensive health care services, there can be no doubt that the U.S. health care system is in immediate need of massive reform.
>
> The right to safe, secure, and dependable health care in one's own country should not be surrendered for any reason, certainly not to fatten the profit margins of corporate investors.

The union also cited the lack of comparable malpractice coverage in other countries. The company agreed to find a domestic source of care for Mr. Garrett, but may continue the experiment with its salaried, non-union employees. Carl Garrett responded unhappily. "The company dropped the ball … people have given me so much encouragement," he said, "so much positive response, and they're devastated. A lot of people were waiting for me to report back on how it went and perhaps go themselves. This leaves them in limbo too" (Jonsson, 2006, p. 2).

Discussion Questions

1. What difference did it probably make that BRPP is an ESOP owned by the union members or that the national union is busy recruiting health care workers as members?
2. What are the ethical implications of a reward of up to $10,000 for the employee to go to India for a major procedure?
3. If you were a hospital administrator, how would you react when a number of patients and companies began to ask to bargain about prices, including presenting price quotes from companies like IndUShealth?
4. What would be the difference in the bargaining position of an academic medical center and a large tertiary community hospital system?
5. How might state and national governments respond to this increasingly popular phenomenon?