MEDICARE AND MEDICAL TOURISM: SAVING MEDICARE WITH A GLOBAL APPROACH TO COVERAGE

Jennifer Conley

The Medicare Hospital Insurance (HI) Trust Fund faces a fiscal crisis. HI Trust Fund expenditures have exceeded income since 2008. Current estimates indicate that the HI Trust Fund will not be adequately financed over the next ten years and will be drained by 2024. Medical tourism, however, can provide Medicare much needed savings. Opening the way for medical tourism, the practice of traveling to another country to obtain medical care or treatment, would allow Medicare beneficiaries to seek out less expensive care in foreign nations. Quality of care, safety, and malpractice concerns can be effectively addressed by integrating stateside pre- and post-operative screenings with overseas care, utilizing the system of international accreditation already implemented by the major American accreditation body, requiring that medical professionals in foreign facilities catering to Medicare beneficiaries pass licensing exams, and modifying American malpractice jurisdiction law. Finally, the foreign exclusion provision, which prevents Medicare from providing benefits for overseas care, should be amended or repealed. Other federal programs already provide coverage to citizens outside the United States, and Congress has offered no coherent rationale for denying such coverage to Medicare beneficiaries. Medicare can use these programs and the systems they employ to smooth the transition to a medical tourism regime and thereby realize the significant cost savings such a program offers.

Jennifer Conley is Articles Editor 2012–2013, Member 2011–2012, *The Elder Law Journal*; J.D. 2013, University of Illinois, Urbana-Champaign; B.A. 2010, Indiana University. This Note is dedicated to my family for their unwavering love and support in all my endeavors.

I. Introduction

Ralph is a sixty-seven-year-old Medicare beneficiary with degenerative osteoarthritis of the hip. His arthritis has rendered him practically immobile, and his physician recommends hip replacement surgery to help him walk again. The average cost of a hip replacement in the United States is $75,399.[1] While Medicare covers about 75% of this surgery, Ralph is left with 25% of out-of-pocket costs—$18,849.[2] The cost of this surgery in India is alarmingly lower than in the United States, averaging about $9,000.[3]

Unfortunately, because Ralph is a Medicare beneficiary, he will not be able to travel to India and have his hip replacement covered by Medicare. The surgery cannot be covered even though the cost is significantly lower than if the procedure were performed in the United States. Medicare contains a "foreign exclusion" which only provides coverage for procedures outside the United States in very limited circumstances.[4] The Medicare foreign exclusion provision is an insurmountable obstacle that prevents Medicare and Ralph from engaging in medical tourism to control costs.

Forecasts predict the Medicare Hospital Insurance (HI) Trust Fund, the trust that funds Medicare Part A for acute hospital care,[5] will go bankrupt in the very near future.[6] A World Bank study found that Medicare could save $690 million if just 10% of patients traveled

1. I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1473 (2010) (displaying results of a report from the National Center for Policy Analysis of price differentials for several common surgeries in different countries).

2. LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 65–70 (5th ed. 2010).

3. Cohen, *supra* note 1.

4. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE COVERAGE OUTSIDE THE UNITED STATES 11037 (2010), *available at* http://www.medicare.gov/publications/pubs/pdf/11037.pdf [hereinafter COVERAGE OUTSIDE THE U.S.].

5. CTRS. FOR MEDICARE & MEDICAID SERVS., HOW IS MEDICARE FUNDED? NO. 11396 (2009), *available at* http://www.medicaresupplementplans.com/publications/How_is_Medicare_Funded.pdf [hereinafter HOW IS MEDICARE FUNDED?].

6. Estimates range from 2019 to 2024. *See* BARRY FURROW ET. AL., HEALTH LAW CASES, MATERIALS AND PROBLEMS 768 (6th ed. 2008); *see also* THE BD. OF TRS, FED. HOSP. INS. & FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, 2011 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 4 (2011), *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2011.pdf [hereinafter 2011 ANNUAL REPORT].

to other countries for fifteen common, "low-risk, non-emergency treatments with quick recovery periods."[7] Medical tourism, "the travel of patients who are residents of one country . . . to another country for treatment . . . [,]"[8] while primarily used by the uninsured and underinsured at this point,[9] could be a mechanism for substantial cost savings to the Medicare program.

Authors have discussed medical tourism, possibly through insurance providers, as a vehicle for alleviating the burdens on the U.S. health care system in general.[10] Given the financial crisis that Medicare faces concerning its ability to pay Part A entitlements, however, this Note will focus solely on the savings medical tourism can accrue to Medicare. To that end, Part II presents an overview of Medicare, the current financial state of Medicare, and the foreign exclusion provision. Part II also provides background on the development of medical tourism, as well as the current state of medical tourism and some associated concerns including usage and growth, costs, and quality of care. Part III analyzes the integration of medical tourism into the Medicare system. This analysis will focus on the issues of overcoming the foreign exclusion, cost saving effects, quality-of-care concerns, medical malpractice liability, and overall effects on the U.S. health care system. Part IV recommends that to control costs, Medicare should amend the foreign exclusion and engage in medical tourism for common, non-emergency procedures that cost significantly less abroad than in the United States, so long as transparency exists regarding the quality of care and licensing. Finally, Part V concludes that amending the foreign exclusion to allow for a medical tourism program will help save the Medicare HI Trust Fund from going bankrupt[11] and usher in an era of positive changes to the U.S. health care system.

7. Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L. J. 71, 80–81 (2008).

8. Cohen, *supra* note 1, at 1471; *see* Mark S. Kopson, *Medical Tourism: Implications for Providers and Plans*, 3 J. HEALTH & LIFE SCI. L. 147, 147 (2010).

9. Cohen, *supra* note 1, at 1473.

10. *See generally* Heather T. Williams, Comment, *Fighting Fire with Fire: Reforming the Health Care System Through a Market-Based Approach to Medical Tourism*, 89 N.C. L. REV. 608, 608 (2011).

11. The recommendation does not posit that medical tourism alone will save Medicare from bankruptcy. Rather, it suggests that medical tourism, coupled with other cost controls, could help create significant financial savings to the Trust Fund.

As the uncertainty surrounding the U.S. health care system and its ability to provide all Americans with access to high-quality health care continues to dominate the political stage, it will be increasingly important to consider the benefits that the globalization of health care can bring to the United States. With that in mind, this Note will provide a novel perspective to the debate.

II. Background

A. Medicare Overview

Medicare provides health insurance for specific groups who are entitled to benefits: individuals age sixty-five or older, individuals under sixty-five with certain disabilities, and individuals of any age with "permanent kidney failure" requiring dialysis or transplant.[12] Today, the program covers about 47 million Americans.[13] Medicare Part A is funded by payroll taxes and other sources[14] secured in the HI Trust Fund.[15] Only those who did not pay payroll taxes while working are required to pay a premium.[16] Part A is known as hospital insurance, covering inpatient hospital care, inpatient skilled nursing home care,[17] hospice care, and home health care services.[18] Part A is subject to a deductible and coinsurance.[19]

12. *Medicare Basics: Medicare Benefits*, MEDICARE.GOV, http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/medicare-benefits-overview.aspx (last visited Feb. 28, 2013).

13. THE HENRY J. KAISER FAMILY FOUND., MEDICARE: MEDICARE AT A GLANCE, NO. 1066–13 (2010), *available at* http://www.kff.org/medicare/upload/1066-13.pdf [hereinafter MEDICARE AT A GLANCE].

14. These sources include: "income taxes paid on Social Security benefits, interest earned on the trust fund investments, and Part A premiums from people who aren't eligible for premium-free Part A." HOW IS MEDICARE FUNDED?, *supra* note 5.

15. *Id.*

16. *Part A Costs,* MEDICARE.GOV, http://www.medicare.gov/your-medicare-costs/part-a-costs/part-a-costs.html (last visited Feb. 28, 2013).

17. This does not include a long-term or custodial care nursing home. HOW IS MEDICARE FUNDED?, *supra* note 5.

18. *Id.*

19. MEDICARE AT A GLANCE, *supra* note 13. The deductible in 2010 was $1,100. *Id*.

Medicare Part B, financed through premiums[20] and funds authorized by Congress, is known as medical insurance.[21] The funds are secured and distributed through the Supplementary Medical Insurance (SMI) Trust Fund.[22] Part B helps cover doctor visits, outpatient care, home health services, and some preventive care.[23] Most beneficiaries under Part A must also purchase Part B,[24] and if an individual does not enroll when first eligible, there is a penalty.[25] Additionally, the beneficiary must also pay a deductible for services, and benefits under Part B are subject to cost-sharing.[26]

Medicare Part C, or Medicare Advantage (MA), is a Medicare health insurance plan option offered by private companies that will cover Part A and Part B and sometimes provide supplemental coverage.[27] These health care plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service insurers, and Special Needs Plans.[28] Each plan has its own rules for administering services and out-of-pocket costs, but, in order to receive payments from Medicare, the plans must abide by Medicare rules.[29] Most of the 11 million[30] beneficiaries enrolled in MA pay a monthly premium for services.[31]

Medicare Part D provides prescription drug coverage to any

20. HOW IS MEDICARE FUNDED?, *supra* note 5. The premium in 2010 was $110.50 per month. MEDICARE AT A GLANCE, *supra* note 13. The premium increases as the beneficiary's income increases starting at $85,000 for individuals and $170,000 for couples. *Id.*

21. *Medicare Benefits: Medicare Part B (Medical Insurance)*, MEDICARE.GOV, http://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/original-medicare/how-original-medicare-works.html (last visited Feb. 28, 2013).

22. HOW IS MEDICARE FUNDED?, *supra* note 5.

23. *Id.*; MEDICARE AT A GLANCE, *supra* note 13.

24. *Part A Costs*, *supra* note 16.

25. *Part B Late Enrollment Penalty*, MEDICARE.GOV, http://www.medicare.gov/your-medicare-costs/part-b-costs/penalty/part-b-late-enrollment-penalty.html (last visited Feb. 28, 2013).

26. MEDICARE AT A GLANCE, *supra* note 13. The deductible in 2010 was $155. *Id*.

27. *Medicare Advantage (Part C)*, MEDICARE.GOV, http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html (last visited Feb. 28, 2013). Supplement coverage can include: vision, hearing, dental and prescription drug coverage under Part D. *Id.*

28. *Id.*

29. *Id.*

30. MEDICARE AT A GLANCE, *supra* note 13.

31. *Monthly Premium for Drug Plans,* MEDICARE.GOV, http://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html (last visited Feb. 28, 2013).

Medicare beneficiary through private insurers or companies approved by Medicare.[32] Beneficiaries pay a monthly premium,[33] yearly deductible, copayments or coinsurance, and costs in the "coverage gap."[34] These funds, like Part B, are secured in the SMI Trust Fund.[35] Between 2006 and 2010, "Part D enrollees were required to pay 100% of total drug costs after their spending exceeded the initial coverage limit and before reaching the catastrophic coverage limit."[36] Starting in 2011, "price discounts and government subsidies included in the Patient Protection and Affordable Care Act . . . are reducing the amounts enrollees must pay when they reach [this coverage] gap, and the gap will be phased out entirely by 2020."[37]

Although Medicare provides medical coverage to those who have earned it, it does not come without a price. There are still many coverage problems plaguing the system, including high deductibles, cost-sharing, the absence of a limit on out-of-pocket spending, and coverage gaps for services important to the elderly.[38] Some options exist to help with these extra costs:[39] employer-sponsored retiree health plans, Medicare supplemental policies such as Medigap, and Medicaid for those who qualify.[40] While Medicare enrollees continue to struggle to pay rising out-of-pocket costs, the program itself is also struggling to stay afloat as health care costs in the United States skyrocket.

32. *Glossary*, MEDICARE.GOV, http://www.medicare.gov/glossary/m.html (last visited Feb. 28, 2013).

33. As with Part B, premiums are higher as income increases. *Monthly Premium for Drug Plans, supra* note 31.

34. *Costs for Medicare Drug Coverage,* MEDICARE.GOV, http://www.medicare.gov/part-d/costs/part-d-costs.html (last visited Feb. 28, 2013).

35. HOW IS MEDICARE FUNDED?, *supra* note 5.

36. KAISER FAMILY FOUND., MEDICARE PART D 2011: THE COVERAGE GAP, 8222 (2011), *available at* http://www.kff.org/medicare/upload/8222.pdf.

37. *Id.*

38. MEDICARE AT A GLANCE, *supra* note 13. Services important to the elderly include dental, vision, and long-term care. *Id.*

39. *Id.* (explaining that "median out-of-pocket costs for premiums and other health spending . . . as share of income has increased from 11.9% in 1997 to 16.2% in 2006).

40. *Id.*

B. The Current State of Medicare

1. FINANCIAL SOLVENCY OF THE HOSPITAL INSURANCE TRUST FUND

In 2010, Medicare paid total benefits of $516 billion, "[i]ncome was $416 billion, expenditures were $523 billion, and assets held in special issue U.S. Treasury securities were $344 billion."[41] Further, "[a]verage annual Medicare spending growth is anticipated to be 6.3 percent for 2013 through 2020, reflecting increasing enrollment" as baby boomers become eligible for Medicare.[42] As a result, the HI Trust Fund will be drained by 2024, and "the fund is not adequately financed over the next 10 years."[43] HI expenditures have surpassed income since 2008 and will continue to do so annually until the fund is exhausted in 2024.[44]

While the shortfall between income and expenditures is partially attributable to the size of the population eligible for Medicare (baby boomers) and the rising cost of health care services,[45] the structure and maintenance of the HI Trust Fund exacerbate the problem.[46] Some argue that referring to the HI Trust Fund as a trust fund is a "misnomer."[47] Trusts are funded with assets that are legally owned by the trustee, but "inure only to the benefit of the beneficiaries."[48] In the case of the HI Trust Fund, however, the federal government "borrow[s]" the funds contributed by payroll taxes "in exchange for its promise to repay in the future."[49]

The real problem stems not from the "borrowing" itself, but rather from the fact that the government does not invest the "borrowed"

41. 2011 ANNUAL REPORT, *supra* note 6, at 4.

42. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEPT. OF HEALTH & HUMAN SERVS., NATIONAL HEALTH EXPENDITURE PROJECTIONS 2010–2020 (2010), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2010.pdf [hereinafter 2010 NHEP].

43. 2011 ANNUAL REPORT, *supra* note 6, at 4.

44. *Id.* "In 2010, $32.3 billion in trust fund assets were redeemed to cover the shortfall of income relative to expenditures." *Id.*

45. *See id.* at 11 (explaining factors that will have an effect on future expenditures and income).

46. *See* Susan Adler Channick, *The Ongoing Debate Over Medicare: Understanding the Philosophical and Policy Divides*, 36 J. HEALTH L. 59, 66–67 (2003).

47. *Id.* at 67.

48. *Id.*

49. *Id.*

funds to meet future obligations.[50] Instead, "the revenue is used for current consumption," and "the government's obligations to Medicare beneficiaries are shifted forward and burden future revenue."[51] Thus, the government's "borrowing" from the HI Trust Fund makes the "trust fund" more like a "loan" to the government to support current Medicare beneficiaries, with the implicit assumption that those paying into the fund now will be repaid with health insurance in the future. Unfortunately, the rising cost of health care coupled with the failure to invest for future Medicare obligations will ensure that those paying into the fund now will not receive the benefit of their "loan."[52]

2. THE FOREIGN EXCLUSION PROVISION

The current Medicare eligibility scheme is premised on the idea that services covered must be rendered in the United States,[53] with a few qualified exceptions. The reasoning behind the foreign exclusion remains a mystery due to lack of congressional discussion or debate.[54] The dearth of evidence regarding congressional intent leaves one to simply speculate as to why Congress excluded foreign coverage under Medicare.

The exceptions to the foreign exclusion demonstrate the congressional unwillingness to expand coverage for care received outside the United States, but they still do not fully explain the intentions behind this restriction. The original House proposal included a complete ban on any services rendered outside the United States,[55] but the Senate amended the proposal to include an exception for emergencies that occur within the United States where the beneficiary was taken to a foreign hospital because it was closer or more accessible than a U.S. hospital.[56] Further, in 1972, Congress added two more exceptions:[57] 1)

50. *Id.* (explaining that if the government were "to invest this revenue so as to enhance the productive capacity of the nation, then the government's ability to meet its obligations has been enhanced").

51. *Id.*

52. *See id.* at 67–68.

53. James R. Whitman, Note, *Venturing Out Behind the Great Wall of Medicare: A Proposal to Provide Medicare Coverage Outside the United States*, 8 ELDER L. J. 181, 187 (2000); *see* 42 U.S.C. § 1395y(a)(4) (2006).

54. Whitman, *supra* note 53, at 188 (concluding that a search of the committee hearings and legislative reports regarding the original passage of Medicare in 1965 reveals "nothing more than a mere recitation of the proposed language of the foreign exclusion . . . .").

55. H.R. REP. NO. 89-213, at 42 (1965).

56. S. REP. NO. 89-404, at 30 (1965).

if a beneficiary is traveling "without unreasonable delay" between Alaska and Canada when a medical emergency occurs, and the Canadian hospital is closer than any U.S. hospital,[58] and 2) if a beneficiary lives in the United States and the foreign hospital is closer than any U.S. hospital, regardless of an emergency.[59] These limited exceptions were passed to address very specific problems for a small number of beneficiaries.[60]

In speculating about congressional intent for the foreign exclusion, it seems intuitive that Congress would only want to cover those services rendered in the United States. Medicare was landmark legislation that provided health care insurance benefits as entitlements from the federal government for the first time. Providing coverage for only U.S. services promotes national goals by channeling funds back into the U.S. health care system and economy.[61] Another possible concern may have been the "difficulties of administering and monitoring medical services abroad."[62] Such difficulties include language barriers, standards of care, licensing requirements, and distinct differences in the delivery and administration of health care services.[63] Additionally, Congress may have had concerns of fraud by "foreign providers or beneficiaries" due to the absence of a method for monitoring foreign providers or "dishonest beneficiaries."[64] Congress appears quite adamant in its policy to exclude payments to foreign health care providers; but absent any definitive context for this inflexibility, it is unclear whether Congress would be willing to relent to reduce costs.

57. Whitman, *supra* note 53, at 189.

58. 42 U.S.C. § 1395f(f)(2)(A)(ii) (2006). This exception covers Part A payments for emergency inpatient services. *Id.*

59. 42 U.S.C. § 1395f(f)(1) (2006). This exception covers Part A inpatient hospital services. *Id.*

60. *See* S. REP. NO. 92-1230, at 223 (1972) (discussing that the exception deals with "a unique problem faced by U.S. residents" traveling to or from Alaska through Canada); *see also* H.R. REP. NO. 92-231, at 77 (1972), reprinted in U.S.C.C.A.N. 4989, 5064 (explaining that the exception will address the "special problems of border residents").

61. *See* Whitman, *supra* note 53, at 203 (speculating that Congress might want to "deliver . . . payments to the businesses that would most directly contribute to the American economy").

62. Milkson v. Sec'y of Dep't. of Health & Human Servs., 633 F. Supp. 836, 838 (E.D.N.Y. 1986).

63. *See* Whitman, *supra* note 53, at 202.

64. *See id.*

C. Medical Tourism Overview

Medical tourism is "the practice of traveling from one country to another for the purpose of obtaining medical care or treatment."[65] Currently, medical tourism is predominantly used by the uninsured and underinsured, but other patient groups have the potential to become "major users."[66] Users seek medical care abroad for different reasons, ranging from access to medical procedures that are not available or even illegal in their home country[67] to significant cost savings.[68] The types of services sought abroad include invasive,[69] diagnostic,[70] and lifestyle[71] procedures and treatments.

The reasons for engaging in medical tourism and the type of services sought may lead one to believe that the countries attracting medical tourists are world powers with highly developed health care systems and the latest medical technology. Surprisingly, however, lesser-developed countries (LDCs) are the major destination sites for medical tourists.[72] Some of these countries include "Argentina, Chile, Costa Rica, Cuba, India, Jordan, Malaysia, the Philippines, Thailand, and South Africa."[73] Substantial industries also exist in "Greece, Romania,

65. Kopson, *supra* note 8, at 150; *see also* Cohen, *supra* note 1, at 1478–81. While medical tourism can mean travel from any one country to any other country, this Note focuses only on travel from the United States to another country.

66. Cohen, *supra* note 1, at 1473; *see* Kopson, *supra* note 8, at 159 (listing other users as employees of self-funded employers and the fully insured with high-deductible plans).

67. Cortez, *supra* note 7, at 77. For example, certain in vitro fertilization procedures are prohibited in many European countries, so many choose to travel to Italy and Belgium due to the lax laws concerning in vitro fertilization. *Id.* Similarly, in the U.S. certain treatments may not be available because they have not been approved by the Food and Drug Administration. *Id.*

68. *Id.* at 80–82. A World Bank study found that the costs of several common surgeries cost significantly less abroad as compared to the U.S. Aaditya Mattoo & Randeep Rathindran, *Does Health Insurance Impede Trade in Health Care Services?* 20, tbl.4 (World Bank Policy Research, Working Paper No. 3667, 2005). As a real life example, before a Senate committee, one medical tourist stated that she traveled to India so her husband could receive a $6,700 heart surgery that would have cost $200,000 in the United States. *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the S. Special Comm. on Aging*, 109th Cong. 3–5 (2009) (statement of Maggi Ann Grace).

69. Cohen, *supra* note 1, at 1479. Invasive procedures include dental, plastic surgery, eye care, cardiac, joint replacement and certain cancer treatments. *Id.*

70. *Id.* Diagnostic services include blood screening, bone density testing, heart stress tests, lipid analysis, and electrocardiograms. *Id.*

71. *Id.* Lifestyle services include "nutrition, weight-reduction, and anti-aging treatments." *Id.*

72. *Id.*

73. *Id.*; *see* Cortez, *supra* note 7, at 90–95 (examining the countries that medical

the former Soviet Baltic states, and Singapore."[74]

Certain countries serve as regional "hubs" that draw medical tourists from surrounding countries.[75] Moreover, certain countries do not aggressively seek to attract foreign patients, but attract them nonetheless.[76] Those that do seek to attract patients often do so through a so-called "luxury factor."[77] The luxury factor adds to the patient's medical experience with non-medical amenities such as five-star accommodations, meals, and excursions.[78] In addition to the luxury factor, some countries promote medical tourism through tourism ministries or by forming bilateral agreements with other countries to provide health services.[79]

Traveling across jurisdictions for medical care has ancient roots.[80] While the concept seems simple, advances in technology, health care, and science have brought a myriad of concerns to the forefront of the medical tourism debate. To gain a better understanding of the benefits medical tourism can bring to Medicare and the American health care system, it is necessary to understand medical tourism in the twenty-first century, and the problems that surround it.

tourism patients visit).

74. Cohen, *supra* note 1, at 1479; *see* Cortez, *supra* note 7, at 90–95 (including the United Kingdom, United States, Turkey, Colombia, and China as other major destinations).

75. *See e.g.*, Cortez, *supra* note 7, at 90 (citations omitted) (explaining that Chile is a "regional medical hub in Latin America.").

76. *Id.* at 89; *see* Cohen, *supra* note 1, at 1482–83 (discussing that specialization in certain treatments or procedures is one reason why foreign patients may be attracted to a country).

77. Williams, *supra* note 10, at 623.

78. MILICA Z. BOOKMAN & KARLA R. BOOKMAN, MEDICAL TOURISM IN DEVELOPING COUNTRIES 41 (2007). Bookman and Bookman discuss several different types of "tie-ins" patients have experienced in relation to their medical services including wilderness safaris, tours of the cities, and hospitals that provide room services from familiar restaurants such as McDonalds and Starbucks. *Id.* at 91–92.

79. *See* Cortez, *supra* note 7, at 90–95. For example, India's Ministry of Tourism "formed an interagency task force to promote the [medical tourism] industry." *Id.* at 91.

80. Cameron MacIntosh, *Medical Tourism: Need Surgery, Will Travel*, CBC NEWS (June 18, 2004), http://www.cbc.ca/news/background/healthcare/medicaltourism.html. For thousands of years in ancient Greece, people traveled "from all over the Mediterranean to the sanctuary of the healing god, Asklepios . . . ." *Id.* People would also take waters from a shrine in Bath in Roman Britain. *Id.* Spas "from Germany to the Nile" used to attract wealthy Europeans in the 18th century. *Id.*

D. The Current State of Medical Tourism

1. USAGE AND GROWTH PROJECTIONS

The Deloitte Center for Health Solutions estimated that 750,000 U.S. patients traveled outside the country for medical care in 2007.[81] The study projected that the number would increase to six million by 2010, with an estimated growth of 100%.[82] Due to the "slumping economy," however, Deloitte modified its projection to 1.6 million in August 2009.[83] Some factors affecting growth of the industry include: rising health care costs in the United States,[84] the large percentage of U.S. residents lacking health insurance,[85] the increase in health care consumerism,[86] and significantly lower costs of services in foreign countries.[87]

A 2011 Deloitte health study found that 25% of those surveyed would be willing to travel outside the United States to have a necessary hospital procedure.[88] Willingness to travel is highest among young people at 31%.[89] While seniors were least willing to travel with only 17%, baby boomers were willing to travel at 21%, only 10% less than Generation Y.[90] The uninsured are more willing to travel for a necessary procedure; this willingness may be due to a perception of lower costs and superior quality of care.[91]

Thus, these findings provide hope for the future of medical tour-

81. DELOITTE CTR. FOR HEALTH SOLUTIONS, MEDICAL TOURISM: CONSUMERS IN SEARCH OF VALUE 3 (2009), *available at* http://www.deloitte.com/assets/Dcom-croatia/Local%20Assets/Documents/hr_Medical_tourism(3).pdf [hereinafter DELOITTE MEDICAL TOURISM].

82. *Id.*

83. Tom Murphy, *Insurers Aim to Save from Overseas Medical Tourism*, USA TODAY (Aug. 23, 2009), http://www.usatoday.com/news/health/2009-08-22-medical-tourism_N.htm.

84. Kopson, *supra* note 8, at 153.

85. *Id.*

86. DELOITTE MEDICAL TOURISM, *supra* note 81, at 4. "Health care consumerism is premised on the idea that individuals should have greater control over decisions that affect their health and their medical care." *Id.*

87. Kopson, *supra* note 8, at 153.

88. DELOITTE CTR. FOR HEALTH SOLUTIONS, 2011 SURVEY OF HEALTH CARE CONSUMERS IN THE UNITED STATES: KEY FINDINGS, STRATEGIC IMPLICATIONS 17 (2011), *available at* www.deloitte.com/assets/Dcom-Unite-States/Local%20Assets/Documents/US_CHS_2011ConsumerSurveyinUS_062111.pdf [hereinafter DELOITTE 2011 HCC SURVEY].

89. *Id.*

90. *Id.*

91. *Id.* The figures showed that 31% of the uninsured would be willing to travel abroad for a necessary procedure compared with 24% of insured. *Id.*

ism, and for the likelihood that Medicare beneficiaries will take advantage of these opportunities. This hope is furthered by the finding that 39% of those surveyed by Deloitte said they would be willing to travel to a foreign country for an elective procedure if they could save half of the cost and not lose quality of care.[92] If significant cost savings can encourage travel for elective procedures, such savings may give patients incentive to travel for necessary procedures as long as they are satisfied that quality of care would not be sacrificed.

2. COST SAVINGS

Today, the principal reason for engaging in medical tourism is the significant cost discrepancy for treatment between the home country and the destination country.[93] Estimates suggest that patients paying out-of-pocket outside the United States could pay up to twenty times less for treatment than they would in the United States.[94] While the studies may differ based on the variables used, "all agree that the potential cost savings are significant."[95]

Americans spend drastically more on health care than those in most other countries.[96] The national health care expenditure, which is primarily based on spending by private payers such as insurance companies and out-of-pocket payers,[97] was 17.6% of Gross Domestic Product (GDP) in 2009.[98] Medicare accounted for 3.6% of GDP or one-

92. DELOITTE MEDICAL TOURISM, *supra* note 81, at 5 (stating that 29.1% of seniors and 36.7% of baby boomers would be willing to travel for the elective procedure).

93. Cohen, *supra* note 1, at 1479.

94. *Id.* (comparing the price of a cardiac bypass surgery in India and the United States); *see* DEVON M. HERRICK, NAT'L CTR. FOR POLICY ANALYSIS, MEDICAL TOURISM: GLOBAL COMPETITION IN HEALTH CARE 11 (2007), *available at* http://w.medretreat.com/templates/UserFiles/Documents/Medical%20Tourism%20-%20NCPA%20Report.pdf (comparing the prices of several common procedures in the United States with India, Singapore, and Thailand).

95. Cohen, *supra* note 1, at 1480.

96. *See also NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp#TopOfPage (last modified Apr. 11, 2012); *see also* Mattoo & Rathindran, *supra* note 68, at 2.

97. CTRS. FOR MEDICARE & MEDICAID SERVS., PROJECTIONS OF NATIONAL HEALTH EXPENDITURES: METHODOLOGY AND MODEL SPECIFICATION 3 (2011), https://www.cms.gov/NationalHealthExpendData/downloads/projections-methodology.pdf.

98. CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURE PROTECTIONS 2008-2018, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2008.pdf (last visited Feb. 28, 2013).

fifth of total health care spending.[99] In comparison, France spent 11.2% of GDP, Switzerland 10.7%, Sweden 9.4%, United Kingdom 8.7%, and Japan 8.1%.[100]

There is no single answer as to why health care costs are higher in the United States.[101] A combination of several factors creates the large discrepancy between the United States and other countries, some of which include high administrative costs, pharmaceutical spending, outpatient care costs, and significantly higher physician salaries.[102] Unfortunately, this higher spending does not equate to better quality of care, better access, or higher efficiency.[103] Significantly higher costs and spending, that do not necessarily increase the quality or quantity of health care services available, may encourage U.S. citizens to start looking elsewhere for their health care needs.

The World Bank conducted a price comparison between the United States and LDCs of fifteen low-risk, non-emergency, and routine surgeries.[104] Even after factoring in travel prices, the cost savings are astounding. If only 10% of U.S. patients traveled abroad for these procedures, the estimated cost savings would be over $1.4 billion annually, with $690 million accruing to Medicare.[105] With savings this vast, it is a wonder that the federal government has not even remotely promoted medical tourism to the American public.

99. 2011 ANNUAL REPORT, *supra* note 6, at 7.

100. *Health Care Spending in the United States and Selected OECD Countries*, HENRY J. KAISER FAM. FOUND. (Apr. 28, 2011), http://www.kff.org/insurance/snapshot/OECD042111.cfm (comparing health care spending in 2008 between the United States and selected Organization for Economic Cooperation and Development (OECD) countries).

101. Cortez, *supra* note 7, at 81.

102. *See Disparities in Health Expenditure Across OECD Countries: Why Does the United States Spend So Much More than Other Countries? Hearing Before the S. Special Comm. on Aging*, 109th Cong. 4, 7–8 (2009) (written statement of Mark Pearson, Head, Health Division, OECD). The Centers for Medicare & Medicaid Services (CMS) estimates that "70% of inpatient hospital costs are labor-related." Cohen, *supra* note 1, at 1481; Cortez, *supra* note 7, at 81. Logically, any country with lower labor costs can offer health care at "significantly lower prices." *Id.*

103. Karen Davis et al., The Commonwealth Fund, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, at vii (2007), *available at* http://www.commonwealthfund.org/Publications/Fund-Reports/2007/May/Mirror--Mirror-on-the-Wall--An-International-Update-on-the-Comparative-Performance-of-American-Healt.aspx.

104. Mattoo & Rathindran, *supra* note 68, at 25.

105. *Id.*

3. QUALITY OF CARE

On average, it is true that quality of care in LDCs is lower than in the United States and other industrialized countries.[106] Determining the quality of care that a U.S. medical tourist is likely to receive, however, requires a different assessment than that used to determine the average quality of care available from an LDC health care provider; a U.S. medical tourist is highly unlikely to deal with most LDC care providers because these providers are not engaged in medical tourism.[107] The correct comparison involves "the standard of a provider likely to be used by a patient from an industrial country."[108] The World Bank study found significant evidence that providers and physicians in LDCs at the higher end of the quality spectrum are "well above the minimum acceptable standard in industrial countries."[109] This high quality care is particularly reflected in the medical professionals and facilities that target medical tourists.[110]

International medical graduates are often considered "adequately qualified" to work in the United States.[111] International medical graduates account for 25% of the total physicians in the United States, a 160% increase from 1975.[112] The most common countries of origin for international medical graduates practicing in the United States are India, the Philippines, Mexico, Pakistan, and the Dominican Republic.[113] While all of these countries are considered LDCs, India, the Philippines, and Mexico are top destinations for medical tourists.[114] The prevalence of international medical graduates from top LDC medical tourism destinations in the United States is a significant indicator of the quality of physicians in those countries. It demonstrates the value of the education and training that LDC-physicians receive.[115]

106. *Id.* at 13.
107. *Id.*
108. *Id.*
109. *Id.*
110. *See id.* at 13–15.
111. *Id.* at 13.
112. *Id.*; *see* AMERICAN MED. ASS'N., INTERNATIONAL MEDICAL GRADUATES IN AMERICAN MEDICINE: CONTEMPORARY CHALLENGES AND OPPORTUNITIES 3 (2010), *available at* http://www.ama-assn.org/resources/doc/img/img-workforce-paper.pdf [hereinafter AMA-IMG 2010].
113. AMA-IMG 2010, *supra* note 112, at 4 tbl.2.
114. *See* Cohen, *supra* note 1, at 1479; *see also* Cortez, *supra* note 7, at 90–95; DELOITTE MEDICAL TOURISM, *supra* note 81, at 6 fig.5. Indian graduates accounted for almost 21% of the international medical graduate population in the United States. AMA-IMG 2010, *supra* note 112, at 4 tbl.2.
115. *See* Mattoo & Rathindran, *supra* note 68, at 13.

Furthermore, 14% of registered nurses in the United States are foreign-educated nurses.[116] Similar to the international medical graduate population of physicians in 2001, nurses from the Philippines accounted for half of all foreign-trained nurses sitting for the nursing licensure examination in the United States.[117] Indian nurses were the fourth highest population at about 4.5%.[118] Again, these figures are important for assuring the quality of care foreign nurses can provide due to their education and training.[119]

In addition to properly trained medical professionals, LDCs engaging in medical tourism have first-class facilities that rival some of the best hospitals in the United States.[120] The Joint Commission, the largest accrediting body for medical facilities in the United States,[121] has an international accreditation arm called Joint Commission International (JCI).[122] Facility accreditation by the Joint Commission in the United States ensures a minimum standard of quality.[123] For this reason, hospitals all over the world seek JCI accreditation to promote their facilities to potential medical tourists.[124] JCI has accredited or certified more than four hundred health care organizations in thirty-nine countries,[125] with a presence in over ninety countries.[126] Eighty

116. Barbara L. Brush, Anne M. Berger & Julie Sochalski, *Imported Care: Recruiting Foreign Nurses to U.S. Health Care Facilities*, 23 HEALTH AFFAIRS 78, 79 (2004) (discussing the population of foreign nurses in the United States since the mid-1980s).

117. *Id.* at 80 ex.2; AMA-IMG 2010, *supra* note 112, at 4 tbl.2.

118. Brush et al., *supra* note 116, at 80 ex.2.

119. These figures are also important because the rise in the proposition of foreign nurses starting in 1998 occurred despite an increase in the number of U.S.-educated nurses. *Id.* at 79; Mattoo & Rathindran, *supra* note 68, at 15.

120. Mattoo & Rathindran, *supra* note 68, at 15.

121. THE JOINT COMM'N, FACTS ABOUT THE JOINT COMMISSION, 1 (2011), *available at* http://www.jointcommission.org/assets/1/18/The%20Joint%20Commission%203%207%20111.pdf. The Joint Commission accredits 19,000 health care organizations in the U.S. *Id.* Accreditation by the Joint Commission satisfies CMS's requirements to participate in Medicare and Medicaid. BARRY FURROW ET AL., *supra* note 6, at 193. Accreditation is voluntary, but it often becomes a necessity due a facility's need to receive Medicare and Medicaid reimbursements. *Id.*

122. *About Joint Commission International*, JOINT COMM'N INT'L http://www.jointcommissioninternational.org/About-JCI/ (last visited Feb. 28, 2013).

123. Cortez, *supra* note 7, at 84.

124. *Id.*

125. *Joint Commission International Marks Ten Years of Global Accreditation*, JOINT COMM'N INT'L, http://www.jointcommissioninternational.org/JCInsight/Joint-Commission-International-Marks-Ten-Years-of-Global-Accreditation/ (last visited Feb. 28, 2013).

126. *About Joint Commission International: International Accreditation and Certification*, JOINT COMM'N INT'L, http://www.jointcommissioninternational.org/New-

of these facilities were in LDCs.[127]

For example, the Apollo hospital chain in India is the largest private health care provider in Asia with over 8,000 beds in forty-one hospitals.[128] This JCI-accredited hospital network[129] saw more than 60,000 international patients[130] and maintained a 99% success rate in over 50,000 cardiac surgeries.[131] This rate is "on par with surgical success rates of some of the best cardiac surgery centers . . . in the US."[132]

Another example is the Bumrungrad hospital in Bangkok, Thailand. Bumrungrad is JCI-accredited in over thirty specialties and sees 400,000 international patients a year from 190 countries.[133] Over 200 of Bumrungrad's doctors are U.S.-board certified, with many others trained and certified in Europe, Japan, and Australia.[134] Finally, Bumrungrad boasts several "special facilities" including "two cardiac catheterization laboratories and two cardiac operating theaters."[135] These facilities represent technological advances in "biotechnology created by American and European companies."[136]

In sum, the quality of care in LDCs is improving, and in some cases, is even equivalent to or higher than U.S. minimum standards of quality. Concerns still loom, however, regarding pre-operative and post-operative care. Medical tourists may not receive proper pre-operative screening and care because, even though foreign professionals can review charts and test results before a patient arrives, they cannot physically examine a patient.[137] Moreover, post-operative care

to-Accreditation/ (last visited Feb. 28, 2013).

127. Cortez, *supra* note 7, at 83.

128. DELOITTE MEDICAL TOURISM, *supra* note 81, at 18.

129. *Quality: Joint Commission International Accreditation*, APOLLO HOSPITALS, http://www.apollohospitals.com/about_accredition.php (last visited Feb. 28, 2013).

130. Mattoo & Rathindran, *supra* note 68, at 15; BOOKMAN & BOOKMAN, *supra* note 78, at 77. This estimate was for the years 2001–2004. *Id.*

131. Mattoo & Rathindran, *supra* note 68, at 15.

132. *Id.* An example of one of the best cardiac surgery centers in the United States is the Cleveland Clinic. *Id.*

133. *Overview,* BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com/en/about-us/overview (last visited Feb. 28, 2013).

134. *FAQs: Q1 Are Any of These Doctors Internationally Trained?*, BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com/en/hospital-faq (last visited Feb. 28, 2013).

135. *About Us, Factsheet: Special Facilities,* BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com/en/about-us/bumrungrad-factsheet (last visited Feb. 28, 2013).

136. Cortez, *supra* note 7, at 85.

137. *Id.* at 103; Joan C. Henderson, *Healthcare Tourism in Southeast Asia,* 7

raises a host of concerns. Due to travel arrangements, patients may leave the hospital sooner than they should for a proper recovery.[138] Once the patient returns to the United States, he or she may have trouble receiving follow-up care or procedures because U.S. physicians may be reluctant to provide these services for surgeries they did not perform.[139] Concerns surrounding the quality of care in medical tourist destinations will be discussed in more depth below.

III. Analysis

While medical tourism is a viable solution for reducing Medicare's financial burden, there are several hurdles that must be overcome in order to sell Medicare beneficiaries and the American public on the idea of traveling abroad for medical care. To begin, it is important to address the actual cost savings from medical tourism in relation to Medicare's finances because some may find the potential savings to be too little to justify implementation.[140] Second, and perhaps most importantly, the foreign exclusion must be amended or repealed to allow for the payment of medical services abroad. Determining the feasibility of an amendment will include a discussion of other federal programs that provide payment options for recipients living abroad.[141] Third, quality of care concerns regarding pre-operative and post-operative care, licensing requirements for medical personnel, and standards for medical facilities must be addressed with a uniform approach to accreditation for participation in a potential Medicare medical tourism program. Similarly, issues surrounding medical malpractice liability must be remedied. The American civil procedure system reduces the likelihood that a patient will be able to recover for malpractice damages suffered outside the United States.[142] Further, LDCs do not have malpractice laws comparable to those of the United States.[143]

TOURISM REV. INT'L 111, 117 (2004).

138. Cortez, *supra* note 7, at 104.

139. *Id.*; Henderson, *supra* note 137, at 117.

140. *See* Mattoo & Rathindran, *supra* note 68, at 3 (explaining that more cost savings could accrue if the number of hospitals and physicians engaged in medical tourism increased and they signaled their quality to attract more patients).

141. *See* Whitman, *supra* note 53, at 207–10.

142. Cohen, *supra* note 1, at 1494.

143. Cortez, *supra* note 7, at 106–07.

In addition to these potential hurdles, allowing medical tourism by Medicare beneficiaries will have consequences for the American health care system, including potential revenue loss,[144] increased price competition,[145] and protectionism issues.[146] These consequences could prove to be compelling reasons for denying medical tourism coverage.[147] Notwithstanding these drawbacks, changes to medical tourism rules could in fact improve health care access and delivery in the United States. This section will address the effects of medical tourism on the American health care system.

A. Some Perspective on Cost Savings from Medical Tourism

There is no doubt that the potential savings from medical tourism are considerable.[148] Not only can individuals realize these cost savings by choosing to have procedures abroad,[149] but an entire federal program can rein in costs with only a small fraction of beneficiaries traveling abroad for low-risk, non-emergency treatment.[150] Nonetheless, it is important to note that although the savings can be significant, medical tourism is not a complete cure for Medicare's current financial state. With total expenditures of $523 billion and a trust fund that is not adequately financed over the next ten years,[151] estimated savings of $690 million annually[152] will only make a small dent in Medicare's problems.

Whether medical tourism will grow enough over the coming years to sustain larger savings over a consistent period of time is uncertain and difficult to determine.[153] The estimated $690 million in savings, however, is premised only on one in ten patients traveling abroad for fifteen common, non-emergency procedures.[154] The cost

144. *See* Kopson, *supra* note 8, at 171.
145. *See id.*
146. *See* Mattoo & Rathindran, *supra* note 68, at 22.
147. *Id.* at 21.
148. Cohen, *supra* note 1, at 1480.
149. Cortez, *supra* note 7, at 96.
150. *Id.* at 98.
151. *See* discussion Part II.B.1.
152. Mattoo & Rathindran, *supra* note 68, at 19.
153. *See* Arnold Milstein & Mark Smith, *Will the Surgical World Become Flat?* 26 HEALTH AFFAIRS 137, 141 (2007) (concluding that seeking surgical care abroad will only provide "modest relief" from health care costs); *see also* Cortez, *supra* note 7, at 99.
154. Mattoo & Rathindran, *supra* note 68, at 3.

savings will grow if the list of procedures is expanded to include other surgeries.[155] Similarly, the savings will increase with a larger number of patients traveling abroad for treatment.

B. Overcoming the Foreign Exclusion

To make medical tourism a viable option for Medicare beneficiaries, the foreign exclusion must be amended or repealed. Compelling arguments exist both for and against doing away with the foreign exclusion, but the potentially substantial cost savings and the lack of definitive reasoning behind the exclusion tip the scale in favor of amending it. The following sections will discuss similar government benefit programs and how they handle foreign payments as well as the absence of a congressional justification for denying amendment.

1. SIMILAR GOVERNMENT PROGRAMS WITHOUT A FOREIGN EXCLUSION

There are three government benefit programs that are similar to Medicare but handle foreign services or reimbursements differently: TRICARE, Social Security, and Supplemental Security Income.[156]

i. TRICARE TRICARE is the military's managed care program serving active duty members, retirees, military families, survivors, and some former spouses worldwide.[157] TRICARE coordinates care between military and civilian health systems to "establish civilian preferred provider networks."[158] This effectively means that when a beneficiary cannot receive needed services from a military health facility, he or she can obtain the services through the civilian provider network.[159]

TRICARE operates similarly to Medicare, including the "level of benefits, . . . services covered . . ., and out-of-pocket costs . . . ."[160] Unlike Medicare, however, TRICARE has established preferred provider

155. *Id.* at 19.
156. Whitman, *supra* note 53, at 207.
157. *Welcome to TRICARE: Eligibility*, DEP'T. OF DEF., http://www.tricare.mil/Welcome/Eligibility.aspx (last modified July 16, 2012); *see also* Whitman, *supra* note 53, at 208–09.
158. Whitman, *supra* note 53, at 209; *see* 32 C.F.R. § 199.17(p) (2011).
159. Whitman, *supra* note 53, at 209.
160. *Id.* (comparing a Medicare guide describing benefits, services, and out-of-pocket costs with a similar TRICARE manual describing the same issues).

networks overseas.[161] Active duty members, retirees, and their families can receive care through an overseas provider.[162] Thus, TRICARE beneficiaries and their families can obtain health care services from a foreign civilian provider, and TRICARE (or, more broadly, the federal government) provides payments for these services.[163]

At first blush, TRICARE may seem sufficiently different from Medicare, because military personnel are often stationed abroad, and thus have no other choice but to receive foreign medical care. However, this is not the case. TRICARE provides worldwide coverage not only to personnel stationed abroad but also to military retirees and their families who do have a choice of whether to live abroad or in the United States.[164] Payment through TRICARE for services rendered by a foreign civilian provider to a military retiree is very similar to payment through Medicare for services received abroad because beneficiates of both programs have the option of either a foreign or domestic provider.[165] Consequently, even if TRICARE's creators had specific reasoning for allowing payment to foreign providers due to the special circumstances of active duty members stationed abroad, such reasoning would not apply to retired members who no longer must be stationed abroad. As a result, TRICARE serves as a strong model for foreign coverage implementation for Medicare.[166]

161. *See Welcome to TRICARE: About Us: Regions*, DEPT. OF DEF., http://www.tricare.mil/Welcome/AboutUs/Regions.aspx (last modified Feb. 5, 2013).

162. *TRICARE Standard Overseas*, DEPT. OF DEF., http://www.tricare.mil/Welcome/Plans/TSO.aspx (last modified Nov. 29 2012) [hereinafter *TRICARE Overseas*]. TRICARE Standard Overseas is not the only plan available to beneficiaries abroad; TRICARE Prime Overseas and TRICARE Prime Overseas Remote offer coverage to certain services members and their families. *See TRICARE Prime Remote Overseas*, DEPT. OF DEF., http://www.tricare.mil/Welcome/Plans/TPRO.aspx (last modified Feb. 5, 2013); *TRICARE Prime Overseas*, DEPT. OF DEF., http://www.tricare.mil/Welcome/Plans/TPO.aspx (last modified Nov. 29, 2012).

163. Whitman, *supra* note 53, at 210. Like Medicare, TRICARE shares in the costs of the services. *See id*.

164. *Retired Service Members and Their Families,* DEPT. OF DEF., http://www.tricare.mil/Welcome/Eligibility/RSMandFamilies.aspx (last modified Jan. 17, 2013) (listing military retirees and their families as eligible for TRICARE Standard Overseas).

165. The military retiree's choice is whether to live abroad or domestically, thus, he or she essentially chooses to permanently receive foreign or domestic health care services.

166. The author believes this would be the case even if TRICARE Standard Overseas was not offered to military retirees because TRICARE still provides the necessary framework for addressing the possible complications with making payments to foreign providers.

ii. Social Security Social Security provides benefits to individuals who have paid Social Security taxes for a specified period of time and who have reached age sixty-two.[167] Social Security taxes are similar to the taxes paid to Medicare; both are collected through payroll tax deductions.[168] Despite the similarities between Medicare and Social Security, the programs have a very noteworthy difference: Social Security beneficiaries can receive their benefits outside the United States as long as they are eligible to receive them.[169] Besides an exception for a few countries where benefits cannot be paid,[170] beneficiaries can live abroad indefinitely and still receive their benefits.

Another significant difference between the programs is the type of benefit received. Social Security payments, unlike Medicare benefits, do not pertain to health care costs.[171] Social Security payments are made directly to the recipient rather than to a service provider.[172] Direct, fixed payments to a beneficiary eliminate many potential complications inherent in making payments to a foreign health care provider.[173] Nonetheless, the comparison to Social Security payments is still favorable, because it supports allowing U.S. tax-funded payments in a foreign country. Social Security payments to a beneficiary living abroad will likely support the economic interests of the foreign country, whether directly or indirectly. As a result, these Social Security payments weaken economic protectionism as a reason for denying Medicare foreign payments.

167. SOC. SEC. ADMIN., RETIREMENT BENEFITS, 05-10035, 6 (2012), *available at* http://www.ssa.gov/pubs/10035.pdf [hereinafter RETIREMENT BENEFITS]. Sixty-two is the age of "early retirement." *Id.* Choosing to receive benefits at age sixty-two will result in a 20% lower benefit than if the beneficiary waited until "full retirement," which varies depending on the year the beneficiary was born. *Id.*

168. Whitman, *supra* note 53, at 208.

169. *Your Payments While You Are Outside The United States: What Happens to Your Right to Social Security Payments When You Are Outside the United States*, SOC. SEC. ADMIN., http://www.ssa.gov/pubs/10137.html#content (last visited Feb. 28, 2013).

170. *Id.* Payments cannot be sent to Cambodia, Cuba, North Korea, Vietnam or areas that were part of the former Soviet Union (except Armenia, Estonia, Latvia, Lithuania, and Russia). *Id.*

171. *See* RETIREMENT BENEFITS, *supra* note 167, at 5.

172. *See id.* at 12.

173. *See* Whitman, *supra* note 53, at 212.

iii. Supplemental Security Income Supplemental Security Income (SSI) is defined as "a Federal income supplement program funded by general tax revenues (*not* Social Security taxes)."[174] SSI pays benefits to low-income adults and children with disabilities and to individuals over age sixty-five who meet certain financial criteria.[175] While parts of Medicare are financed by general funds, the primary HI Trust Fund is funded through payroll taxes.[176] This makes SSI benefits different from Medicare benefits because eligibility is based on need rather than age.

SSI beneficiaries who are outside the United States for a period of thirty consecutive days are ineligible to receive benefits.[177] Once the beneficiary returns to the United States for a thirty-day period, however, the benefits are reinstated.[178] Additionally, if the beneficiary leaves the country for less than thirty days, the benefits still continue.[179] Thus, SSI does not have a complete foreign exclusion (as Medicare does), but after a certain period of time the exclusion does kick in to prevent benefit payments.

This thirty-day exclusion seems like an anomaly, considering that Social Security pays benefits even if the beneficiary lives abroad. The difference may stem from the way the benefits are funded; Social Security benefits function more as an "entitlement" program because beneficiaries pay Social Security taxes, while SSI benefits are paid through general funds. This explanation seems unlikely, however, because Medicare benefits are also funded through a payroll tax, and the foreign exclusion prevents Medicare benefits from being paid overseas but allows payment to Social Security beneficiaries abroad.

174. *Supplemental Security Income*, SOC. SEC. ADMIN., http://www.ssa.gov/ssi/ (last visited Feb. 28, 2013).

175. *What Is Supplemental Security Income*, SOC. SEC. ADMIN., http://www.ssa.gov/pgm/ssi.htm (last visited Feb. 28, 2013).

176. *See supra* Part II.A.

177. 42 U.S.C.A. § 1382(f)(1) (2012).

178. *Id.*

179. *See id.*; Whitman, *supra* note 53, at 202 (noting Azhavarian v. California, where a 30-day restriction on time spent outside of the United States was imposed).

2. CONGRESSIONAL JUSTIFICATION FOR DENYING AMENDMENT

It appears that Congress has no discernible rhyme or reason for the Medicare foreign exclusion.[180] The structure of Social Security and SSI provide little insight as to why Congress might have included the foreign exclusion in Medicare but not in Social Security. While one explanation for the difference between Medicare and Social Security might be that payments for Medicare are made to a health care provider rather than directly to a beneficiary, this justification makes little sense in light of the TRICARE payment system.[181] The Department of Defense's TRICARE managed care program already operates overseas and reimburses civilian foreign providers under specified health care plans.[182] Even if TRICARE foreign payments are necessary because of the military presence in those countries, it is still the case that Medicare has a practical system on which to model its foreign health care payments that can considerably reduce costs.[183]

Consequently, it would be difficult for the federal government to argue that reimbursement procedures for foreign services would substantially burden the system when the Department of Defense already has a process in place that could theoretically be adopted for Medicare foreign payments.[184] The analogy to TRICARE, coupled with foreign Social Security payments,[185] unravels the seemingly intuitive presumption that Congress included the foreign exclusion to protect domestic economic interests.[186] Ruling out this theory creates an even bigger question mark as to congressional intent behind the foreign exclusion. It also raises an additional uncertainty as to whether Congress would have a strong enough position to reject the substantial cost savings that Medicare could realize with an amendment to the foreign exclusion. This weakened congressional position, as well as the current overseas TRICARE system, will make overcoming the foreign exclusion to encourage medical tourism less daunting.

180. *See* Whitman, *supra* note 53, at 201 (stating that legislative history for the foreign exclusion is "sparse at best").
181. *See id.* at 212.
182. *Id.*; *see TRICARE Overseas*, *supra* note 162.
183. Whitman, *supra* note 53, at 212.
184. *See id.*
185. *See supra* Part III.B.1.ii.
186. *See supra* Part II.B.2.

C. Quality of Care Regulation

Regardless of the analogies to TRICARE and Social Security, there are still some potential obstacles that must be overcome to make medical tourism a viable Medicare option. The first of these obstacles is the regulation of quality of care in participating facilities. Although the quality of care that a medical tourist is likely to encounter in an LDC is well above the minimum accepted U.S. standards,[187] concerns regarding pre-operative or pre-screening care, post-operative care, licensing requirements, and medical facility standards still pose challenges for medical tourism.

1. PRE-SCREENING/PRE-OPERATIVE CARE CONCERNS

Traveling abroad for medical care makes any required screening, testing, or examination before a procedure rather difficult.[188] While physicians can review "histories, test results, and even communicate with patients," they cannot physically examine the patients themselves.[189] With only charts and records to guide a diagnosis or treatment plan, the possibility of missing a condition or symptom that could change the course of treatment increases.[190] The physician can only physically examine the patient when he or she arrives a few days before the procedure.[191] This could lead to postponement or cancellation of the procedure if the physician discovers a problem that was not detectable from records, test results, or history.[192]

While these are all valid concerns, there is a potential solution. Medicare could implement an "international provider network" to pre-screen patients.[193] Pre-screening care costs considerably less than the actual surgery or procedure.[194] Thus, by combining pre-screening care with outsourcing of certain surgeries and procedures, Medicare

187. *See supra* Part II.D.3.
188. *See* Cortez, *supra* note 7, at 103–04.
189. *Id.* at 103; *see* Michael Klaus, *Outsourcing Vital Operations: What If U.S. Health Care Costs Drive Patients Overseas for Surgery?*, 9 QUINNIPIAC HEALTH L.J. 219, 228 (2006). The broker, an agent who helps set up medical tourist trips for patients, "facilitates pre-consultations between the patient and surgeon via e-mail or telephone." *Id.*
190. Cortez, *supra* note 7, at 104. "The pre-screening process may not adequately replicate the in-person screening process that U.S. physicians perform." *Id.*
191. *Id.* at 103–04.
192. *See id.*
193. *Id.* at 104.
194. *See id.* at 122.

can still save money and lower the risk of inadequate pre-screening or pre-operative care for its patients.[195] For example, the Penang Adventist Hospital in Malaysia belongs to a network of over 500 hospitals and clinics worldwide, including Loma Linda University and Medical Center in California.[196] A patient traveling to Penang for surgery can visit a physician at Loma Linda before traveling abroad to ensure proper pre-screening care.

Even for hospitals without a previously established international provider network, Medicare could designate specific physicians or hospitals as "pre-screeners" for beneficiaries engaging in medical tourism. Thus, while pre-screening or pre-operative care concerns are legitimate and must be addressed before medical tourism can be integrated into Medicare, there is a feasible solution to assure adequate care and patient safety.

2. POST-OPERATIVE CARE CONCERNS

Another chief concern regarding patient care involves follow-up or post-operative care.[197] To begin, medical tourists may not receive proper post-operative care due to travel arrangements.[198] The patient may have to leave the hospital or clinic sooner than a proper recovery period would require in order to return home.[199] Further, once medical tourists return, they may have a difficult time finding U.S. physicians willing to administer follow-up care for a procedure he or she did not perform.[200] U.S. physicians may not be able to "obtain complete records for the patient's surgical procedure and post-operative recovery abroad."[201] Additionally, if complications arise, time zone differences could make resolving treatment questions very difficult.[202]

195. *Id.* at 104.

196. *About Us*, PENANG ADVENTIST HOSPITAL, http://www.pah.com.my/about/ (last visited Feb. 28, 2013). Harvard Medical School has collaborated with hospitals in more than thirty countries; the Cleveland Clinic owns hospitals in Abu Dhabi, Austria, and Canada; and John Hopkins International is affiliated with hospitals in Panama and Singapore. Cohen, *supra* note 1, at 1484–85.

197. Henderson, *supra* note 137, at 117.

198. Cortez, *supra* note 7, at 104 (explaining that patients may "underestimate recovery times when booking travel arrangements").

199. *Id.*

200. *Id.*; Klaus, *supra* note 189, at 226.

201. Kopson, *supra* note 8, at 172.

202. *Id.* at 172–73. Kopson also claims that language barriers could be an issue. *Id.* This Note does not include that issue because, as discussed earlier, the hospitals that would meet U.S. standards have staff that speak fluent English. *See infra* Part III.C.

These hurdles to appropriate post-operative care could have dire consequences for medical tourists; nevertheless, there are realistic solutions available. Again, Medicare could establish international provider networks to coordinate post-operative and continuing care for medical tourists.[203] This would also include a network for managing travel arrangements to assure sufficient recovery periods. Medicare staff would communicate with the physician abroad regarding a patient's care and provide a safe estimate regarding standard recovery periods. By managing travel arrangements, patients could also extend or modify visits if more time to recuperate is needed or if complications arise. Physicians abroad could utilize the networks to communicate with U.S. physicians about a patient's status, so Medicare staff could be certain that an extended stay is necessary before authorizing a change in travel.[204]

Similar to pre-operative care, the networks could provide a communication channel between a physician abroad and a U.S. physician regarding a patient's post-operative care. Charts, reports, test results and any other relevant information could easily be exchanged between physicians. Moreover, physicians could also discuss difficult treatment decisions or other complications in order to come to a consensus on how to administer care.[205] While time zones may pose a problem for communication, most physicians are used to being on-call all day and night.[206] Consequently, both physicians could be considered "on-call" to take any potential phone calls regarding a patient's follow-up care, particularly if complications arise after return to the United States. Implementing international provider networks can alleviate both concerns regarding inadequate recovery periods and U.S. physicians' worries about taking on post-operative care when they did not perform the surgery by facilitating communication between physicians.

203. *See infra* Part III.C.1.

204. It may seem slightly cumbersome to have physicians abroad go through U.S. physicians to authorize an extension, but the author assumes that an extension would only be necessary under emergency circumstances.

205. An agreement may not always be possible, but that is the case with any treatment plan involving more than one decision-maker.

206. Dale Alexander & Ian W. Bushell, *Coping with Night Call: Part I: Understanding the Benefits and Challenges of Traditional Call*, HOSP. PHYSICIAN NOV., 53, 53 (1999).

3. PROFESSIONAL LICENSING REQUIREMENTS

Medical professionals use licensing to signal to others their quality and competency.[207] But requirements for licensing vary across countries.[208] For example, in Mexico, the Secretariat of Health grants licenses that allow physicians to practice anywhere in the country, whereas in the United States licensing is handled at the state level.[209] Consequently, the problem that arises is how hospitals engaged in medical tourism can convey to U.S. patients that their staff is competent and well-trained when there are differing licensing requirements.

It is important to remember, as discussed earlier, that international medical graduates are often considered "adequately qualified" to work in the United States, and that they account for 25% of all U.S. physicians.[210] Nonetheless, this is probably not sufficient to convince the general public that foreign physicians and their staffs are just as qualified as American physicians. Fortunately, there are a few possibilities for increasing the credibility of licensing for physicians and others engaged in medical tourism.

The first option is for doctors and nurses in LDC hospitals engaged in medical tourism to take, respectively, the "United States Medical Licensing Exam (USMLE)"[211] and the "U.S. National Council Licensure Examination for Registered Nurses (NCLEX-RN)."[212] International medical graduates that practice in the United States are required to take these exams, so it follows that hospitals that want to

207. Bookman & Bookman, *supra* note 78, at 149.
208. *Id.* at 149–50.
209. *Id.* at 150.
210. *See infra* Part II.D.3.
211. USMLE is a three-step examination for medical licensure in the United States. *What Is USMLE?*, UNITED STATES MED. LICENSING EXAMINATION, http://www.usmle.org/ (last visited Feb. 28, 2013). "The USMLE assesses a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and disease and that constitute the basis of safe and effective patient care." *Id.* Both international and United States medical graduates are required to take USMLE before they can practice in the United States. *Do You Need More Information?*, UNITED STATES MED. LICENSING EXAMINATION, http://www.usmle.org/ (last visited Feb. 28, 2013).
212. The National Council of State Boards of Nursing "require [candidates for nursing] licensure to pass an examination that measures the competencies needed to perform safely and effectively as a newly licensed, entry-level nurse." *NCLEX Examinations: About the NCLEX*, NAT'L COUNCIL OF STATE BDS. OF NURSING, https://www.ncsbn.org/nclex.htm (last visited Feb. 28, 2013). Passing the NCLEX demonstrates competence to begin a nursing career. *Id. See Nursing Education, Licensure & Practice: International Licensure*, NAT'L COUNCIL OF STATE BDS. OF NURSING, https://www.ncsbn.org/171.htm (last visited Feb. 28, 2013).

engage in medical tourism involving U.S. patients should also require their physicians and nurses to pass these exams to signal their credibility and quality.[213] A second option would be for foreign medical programs to form partnerships with U.S. medical centers whereby foreign medical students could participate in residency programs through U.S. centers.[214] This would ensure that foreign medical professionals obtained practical experience in a U.S. hospital, and thus would increase their credibility with medical tourists.

Finally, the United States' familiarity with certain regions may alleviate some of the concerns regarding licensing.[215] For example, the British often travel to India for medical treatment because "they are familiar with the expertise of doctors of Indian origin in the UK."[216] This could also very well be the case for U.S. citizens who tend to regularly encounter doctors from places such as India, the Philippines, and Mexico.[217] Those who are willing to trust the expertise of these foreign doctors can return home with positive experiences to share with others, hopefully increasing confidence overall.[218] Although real problems exist for hospitals in LDCs wanting to convey the credibility of their medical staff to potential medical tourists, there are several options available to remedy these issues.

4. MEDICAL FACILITY STANDARDS AND ACCREDITATION

The problems that medical facilities face in communicating their standards and accreditation to potential medical tourists are similar to those regarding medical staff licensing. In the same way that medical tourists seek assurance of the credibility and quality of their physicians, they also want evidence that the facility they visit is meeting safety and quality standards.[219] Unfortunately, foreign facilities do not face many of the same regulatory requirements imposed on U.S. facilities.[220] Nevertheless, LDC medical facilities are striving to "abide

213. Bookman & Bookman, *supra* note 78, at 150–51; Mattoo & Rathindran, *supra* note 68, at 24.
214. *See* Mattoo & Rathindran, *supra* note 68, at 24.
215. *Id.* at 25.
216. *Id.*; Joanna Moorhead, *Sun, Sea, and . . . Surgery*, GUARDIAN, May 10, 2004, http://www.guardian.co.uk/lifeandstyle/2004/may/11/healthandwellbeing.health.
217. *See supra* Part II.D.3.
218. *See* Moorhead, *supra* note 216.
219. Bookman & Bookman, *supra* note 78, at 145–47.
220. *See id.*

by international standards and to ensure certification [and accreditation]."[221]

Medical tourists need easily accessible, "concrete and quantifiable signals of quality."[222] In the United States, this signal of quality is achieved through accreditation.[223] Accreditation in the United States is dominated by the Joint Commission,[224] an independent nonprofit organization that assesses the safety and quality of a wide range of health care facilities using on-site surveys.[225] These on-site surveys and assessments are based on standards that set "performance expectations for activities that affect the safety and quality of patient care."[226] Accreditation indicates that the facility promotes and maintains high quality care practices.[227] Joint Commission accreditation carries many benefits, the most significant of which is eligibility to receive payments from Medicare and Medicaid.[228]

Currently, there are no binding international standards for quality or accreditation.[229] The Joint Commission's international arm, Joint Commission International (JCI), is the leading source for accreditation in the international community.[230] JCI has accredited or certified 400 health care organizations in fifty countries since its creation in 1994.[231] International accreditation methods are essentially the same as those used in the United States, and the standards used for compliance are very similar.[232] As a result of the JCI's affiliation with the Joint Com-

221. *Id.* at 145.
222. *Id.* at 147.
223. Williams, *supra* note 10, at 631–32.
224. *Id.* at 632.
225. FACTS ABOUT THE JOINT COMMISSION, *supra* note 121. On-site surveys are used not only as an evaluation tool, but also as an opportunity to educate staff to continually improve the organization's performance. *Id.*
226. *Id.* These standards are developed "in consultation with health care experts, providers, measurement experts, purchasers, and consumers." *Id.*
227. Williams, *supra* note 10, at 632.
228. THE JOINT COMM'N, FACTS ABOUT FEDERAL DEEMED STATUS AND STATE RECOGNITION (2012), *available at* http://www.jointcommission.org/assets/1/18/Federal_Deemed_Status_1_25_11.pdf. Other benefits include qualification to receive payments from third-party payers, such as insurance companies. *See* Cortez, *supra* note 7, at 84.
229. Williams, *supra* note 10, at 632; BOOKMAN & BOOKMAN, *supra* note 78, at 146.
230. *See About Joint Commission International*, THE JOINT COMM'N INT'L http://www.jointcommissioninternational.org/About-JCI/ (last visited Feb. 28, 2013).
231. *Id.*
232. *See* Mattoo & Rathindran, *supra* note 68, at 23 (describing slight differences in standards to accommodate differences between health care systems of various

mission, JCI accreditation carries significant weight internationally.[233]

Health care organizations in LDCs wanting to attract medical tourists often signal that their facilities meet high standards of quality by advertising and communicating to patients their JCI accreditation.[234] For example, many accredited organizations place JCI's gold seal prominently on their Internet homepage.[235] For American medical tourists, this signal of quality can lessen concerns regarding the facility's commitment to quality and safety.[236]

Nonetheless, there are still concerns regarding patient access to and understanding of JCI accreditation and the related methods.[237] Potential medical tourists are likely unaccustomed to seeing Joint Commission accreditation advertised by hospitals in the United States.[238] Thus, without education on the meaning of JCI accreditation and its signal of quality, medical tourists may not be able to properly assess the quality of foreign health care facilities.[239] Fortunately, Medicare can pre-select hospitals and clinics with JCI accreditation to participate in the program, eliminating the need for patients to wade through information about quality of care. Essentially, Medicare will be responsible for communicating the quality of the health care organization to the patient.

Although differences in regulatory requirements for health care organizations across countries present several concerns for medical tourism, JCI accreditation serves as the dominant uniform standard for assessing quality. JCI accreditation methods are similar to those used in the United States, and accreditation is a strong international symbol of quality and patient safety. Moreover, Medicare can assure quality for patients by allowing only JCI accredited facilities to participate in the program. In sum, JCI accreditation alleviates many con-

countries); *compare* FACTS ABOUT THE JOINT COMMISSION, *supra* note 121 (explaining the standards and procedures for accreditation in the United States), *with* JOURNEY TO JCI ACCREDITATION, THE JOINT COMM'N INT'L (2011), *available at* http://www.jointcommissioninternational.org/Journey-to-JCI-Accreditation/ (describing the process and first-steps for international accreditation).

233. Williams, *supra* note 10, at 633; *see* Cortez, *supra* note 7, at 83–84.

234. Williams, *supra* note 10, at 633; Mattoo & Rathindran, *supra* note 68, at 23.

235. *E.g.*, *Quality: Joint Commission International Accreditation*, *supra* note 129; CLINICA ALEMANA, http://portal.alemana.cl/wps/wcm/connect/internet/home (last visited Feb. 28, 2013).

236. Williams, *supra* note 10, at 633; Mattoo & Rathindran, *supra* note 68, at 23.

237. Cortez, *supra* note 7, at 118–19.

238. *Id.*

239. *See id.*

cerns regarding facility quality and patient safety for medical tourists.

D. Medical Malpractice Issues

Although quality of care in health care organizations engaged in medical tourism is generally on par with quality of care in the United States, the question remains how patients will recover if and when an error occurs.[240] As was the case with accreditation standards, medical malpractice law varies considerably from one country to another.[241] The main concern associated with medical malpractice is that medical tourists will not be adequately protected because medical malpractice law in LDCs is "enormously different from that in the United States."[242]

For comparison, the standard for medical negligence in Malaysia and Singapore "heavily defers to physicians in determining the standard of care and whether that standard was breached."[243] Moreover, while Indian law has established some compensation for malpractice, it does not nearly measure up to payments received under the American system.[244] Similarly, the law in Thailand has a restricted payment scheme that does not include pain and suffering.[245] Mexico offers virtually no "real recourse to victims of medical malpractice."[246] As a result of these deficient malpractice schemes, medical tourists may not be properly compensated for negligent errors abroad.[247]

Further, while deficiencies and differences in the law create significant barriers to recovery, they are not the only relevant concern. The issue in many cases is whether the court in which the malpractice suit was filed can obtain personal jurisdiction over the defendant.[248] Health care organizations in LDCs often avoid creating minimum contacts necessary for jurisdiction with the United States by doing all business over the Internet rather than setting up a satellite office on U.S. soil.[249] Nonetheless, some courts have held that business over the

240. Cohen, *supra* note 1, at 1494.
241. *See id.*; Cortez, *supra* note 7, at 106–07.
242. Kopson, *supra* note 8, at 180.
243. Cortez, *supra* note 7, at 106.
244. *Id.*
245. *Id.* at 106–07.
246. Cohen, *supra* note 1, at 1502.
247. Cortez, *supra* note 7, at 106.
248. Kopson, *supra* note 8, at 181.
249. *Id.*; Cohen, *supra* note 1, at 1494–95.

web may be sufficient to obtain jurisdiction.[250] Additionally, public policy favors the public's need to receive proper medical care while traveling over permitting suits in a resident's home state for care received across state lines.[251] It is unclear if this same reasoning would apply to medical tourism.[252]

Another significant issue involves conflict-of-laws concerns. The problem, whether suing abroad or in the United States, will be whether the law of the foreign country or of the United States will apply.[253] As indicated earlier, if the law of the foreign country applies, the medical tourist will have a difficult time prevailing.[254] Further, even if he or she does prevail, recovery will be much more limited than if the suit occurred in the United States.[255] Unfortunately, even for suits in the United States, it is likely that the law of the foreign jurisdiction would apply because the law of the jurisdiction where the injury occurred normally controls.[256]

The conflict-of-laws and jurisdictional dilemmas could be resolved, however, by insisting that medical tourism providers submit exclusively to U.S. law.[257] Medicare could "approve" only those organizations that consent to jurisdiction in the United States and the primacy of U.S. law.[258] This would prevent any potential disagreements over applicable law and ensure that medical tourists receive adequate recovery. A possible downside of these agreements is that

250. Kopson, *supra* note 8, at 182; *e.g.* CompuServe, Inc. v. Patterson, 89 F.3d 1257 (6th Cir. 1996) (holding that exercise of jurisdiction was reasonable where defendant purposefully availed himself of the benefits of doing business in the state even though there was no physical presence in the state).

251. Kopson, *supra* note 8, at 82; Wright v. Yackley, 459 F.2d 287, 290 (9th Cir. 1972) (concluding that it is more important that doctors have the ability to render care based on a patient's needs rather than by geography due to fear of malpractice).

252. Kopson, *supra* note 8, at 177.

253. Cohen, *supra* note 1, at 1501.

254. *See supra* notes 242–50.

255. Cohen, *supra* note 1, at 150.

256. *Id.* at 1502.

> [T]he most common approach to solving is to resolve choice of law through state-interest analysis. Under the interest-based approach of the Restatement (Second) of Conflict of Laws, '[i]n an action for a personal injury, the local law of the state where injury occurred determines the rights and liabilities of the parties, unless, with respect to the particular issue, some other state has a more significant relationship. . . . '

Id.

257. *See* Kopson, *supra* note 8, at 182.

258. *See* Cohen, *supra* note 1, at 1517.

judgments in U.S. courts may be difficult to enforce "against a foreign physician or hospital without assets in the United States."[259] Strict liability for foreign providers engaged in medical tourism is also an option; however, it would still require overcoming many jurisdictional hurdles and may increase the cost of litigation.[260]

Medical malpractice in the context of medical tourism presents considerable problems for the potential medical tourist. Deficiencies and differences in the law, jurisdictional issues, and conflict-of-laws dilemmas make any solutions rather difficult to implement. Nevertheless, medical tourism providers and Medicare can agree to preemptively consent to jurisdiction and choice-of-law. Similarly, U.S. law may be moving in a direction that supports jurisdiction over businesses that use the Internet to target U.S. consumers, even if a business has no physical presence in the United States.

Finally, medical tourists, as well as Medicare itself, may find that the benefits of traveling abroad for medical care outweigh the risk of potential malpractice.[261] This is because foreign providers have great incentive to take extra precaution when caring for U.S. medical tourists so that they will continue to engage in medical tourism.[262] Also, when physicians in medical tourism health care organizations do not carry expensive malpractice insurance, they do not have to pass those costs on to the patient.[263] This may be a reason why medical tourists enjoy substantially reduced costs abroad.[264]

E. Consequences for the U.S. Health Care System

Patient safety is of vital concern when considering medical tourism, but medical tourism could also have significant effects on the state of health care in the United States. While empirical data is currently lacking in this area, discussing some of the underlying systemic problems in the American health care system can be instructive.[265]

259. *Id.* at 1503.
260. *See generally* Williams, *supra* note 10, at 649 (explaining that foreign medical providers are best punished for malpractice by their reputations, and suing then would increase costs).
261. *Id.*
262. Cortez, *supra* note 7, at 107.
263. Williams, *supra* note 10, at 649.
264. *Id.*
265. Cortez, *supra* note 7, at 108.

Cost is one of the largest problems the U.S. health care system faces.[266] Another important question to address is whether the United States should protect its own domestic health care interests at the expense of medical tourism.[267]

1. COSTS

In a society where rising health care costs are steadily increasing the national debt and bankrupting individuals,[268] medical tourism could help provide some relief.[269] Aside from the savings that Medicare will realize, medical tourism also has the potential to create competition for domestic providers.[270] Domestic providers will have a strong incentive to reduce costs and increase efficiency to compete with the significantly lower prices of medical tourism facilities.[271] This is especially the case because Medicare, along with Medicaid, accounts for a majority of income for health care organizations in the United States.[272] Further, domestic providers may have reason to become more transparent as to their quality measures and assurances, as medical tourism facilities must be transparent and outward with their quality standards in order to attract patients.[273] Thus, if Medicare approves medical tourism as a method for reducing costs, it may also have a systemic effect on U.S. health care in general by reducing costs and increasing competition.

266. *See NHE Fact Sheet*, *supra* note 96 (noting the high costs of medical care in the United States); *see also* Mattoo & Rathindran, *supra* note 68, at 2.

267. This Note does not discuss other fundamental concepts of the American health system, such as access to care, because in the context of Medicare all beneficiaries have high access to medical services by virtue of the program.

268. *See* Bonnie Kavoussi, *Ben Bernanke: 'The Elephant In The Room Is Really Health Care Costs*,' THE HUFFINGTON POST (Feb. 2, 2012), http://www.huffingtonpost.com/2012/02/02/ben-bernanke-health-care-costs_n_1249890.html.

269. HERRICK, *supra* note 94, at 19.

270. Williams, *supra* note 10, at 683.

271. *Id.*; HERRICK, *supra* note 94, at 22.

272. *See* John Commins, *Medicare Cuts Could Slash 278K Hospital Jobs, Warns AHA*, HEALTH LEADERS MEDIA (Jan. 20, 2012), *available at* http://www.healthleadersmedia.com/content/LED-275609/Medicare-Cuts-Could-Slash-278K-Hospital-Jobs-Warns-AHA.html.

273. *See* Williams, *supra* note 10, at 683.

2. PROTECTIONISM

There is no doubt that many will view a Medicare medical tourism program as an outsourcing of health care resources.[274] By outsourcing certain procedures and treatments, the government allows Medicare to spend money outside the United States and fails to "protect" our own doctors, nurses, and health care organizations. To the extent that the United States fails to "protect its own" by encouraging beneficiaries to receive care abroad, this failure is justified by the significant cost savings to both Medicare and taxpayers.[275] Until health care spending costs in the United States can be drastically reined in, protectionism should be the least of our concerns. If Medicare continues to promote protectionist policies, the program will not be solvent for much longer. Encouraging medical tourism, even only for certain procedures, will increase competition and reduce costs, making the American health care system a responsible financial choice for Medicare. While protectionism is often a useful strategy, it could have devastating effects in regards to the American health care system.

IV. Recommendation

Medical tourism is a viable way for Medicare to rein in out-of-control health care spending and costs. As such, Medicare should implement a medical tourism program for common, non-emergency procedures that cost significantly less abroad than in the United States. A potential medical tourism program for Medicare faces difficult hurdles, including overcoming the foreign exclusion, implementing a workable program format, addressing a variety of quality of care concerns, and assuring sufficient means for making patients whole when they are injured. Nevertheless, these hurdles can be overcome with a proper program structure that ensures quality, safety, and reduced costs.

274. *See* Dean Baker, *The Health Care Industry: Protectionism the Free Traders Love*, CTR. FOR ECON. POLICY & RESEARCH (May 18, 2009), http://www.cepr.net/index.php/op-eds-&-columns/op-eds-&-columns/the-health-care-industry-protectionism-the-free-traders-love.

275. *See id.*

A. Amend the Foreign Exclusion

Before Medicare can implement any type of medical tourism program, Congress must first amend or repeal the foreign exclusion. As discussed earlier, this may be no easy feat, even though there seems to be no clear reason for the exclusion's existence. Since repealing the exclusion completely may be less appealing to Congress, amending the exclusion for the limited purpose of a structured medical tourism program is probably best. Amending for this limited purpose would allow payments only for pre-approved medical tourism facilities and only for those beneficiaries who follow program procedures before obtaining treatment (i.e., only for certain treatments or surgeries). A limited amendment should alleviate many of the quality of care concerns surrounding foreign facilities and provide assurance that payment processes will not substantially burden the system. Congress must overcome its instinct for protectionist policies[276] in favor of vital cost savings and the potential for systemic change by amending the foreign exclusion.

B. Program Requirements for Participation

1. REQUIREMENTS FOR BENEFICIARY PARTICIPATION

A Medicare medical tourism program must be designed to pay only for certain procedures or treatments, both because of the nature of the patient and the tradability of the procedure. Due to the age, and sometimes frailty, of the average Medicare beneficiary, it is important that the program involve only common, non-emergency procedures. Similarly, those in particularly poor health should not be allowed to participate, even if the procedure is a common, non-emergency one.[277] These limitations ensure patient safety and reduce the risk of possible complications while abroad. Finally, emergency procedures, by their nature, must be performed "at home" and really have no potential for medical tourism.

Procedures included in the program must be highly tradable, meaning they must have a cost differential large enough to justify

276. *See id.*

277. The beneficiary's primary physician or another physician can determine whether a beneficiary is in too poor of health to travel abroad for medical care.

travel.[278] The cost differential will also have to include travel costs. This means that the cost of the procedure abroad must be substantially lower than in the United States, but placing an actual number or percentage on just what "substantially lower" means is rather difficult. Researchers have identified several common surgeries with significant price differentials between LDCs and the United States, some of which include: angioplasty, heart bypass, heart-valve replacement, hip replacement, knee replacement, gastric bypass, spinal fusion, and mastectomy.[279] These surgeries are a good start, but many more could be added depending on whether the cost savings will make the travel worthwhile to Medicare.

2. REQUIREMENTS FOR MEDICAL TOURISM FACILITY PARTICIPATION

Because quality of care concerns are at the heart of the fears surrounding medical tourism, participating medical tourism facilities will need to meet specific standards to be included in the program. First, Medicare should designate American "pre-screening providers." These pre-screening providers will conduct all necessary tests, history, and laboratory work and then communicate the results with the medical tourism facility the beneficiary will visit. The physicians can then discuss any relevant criteria or concerns before the patient travels abroad. Similarly, Medicare should designate American "post-operative care providers." These post-operative care providers will communicate with the physicians abroad regarding the patient's status, post-operative care instructions, and potential complications. The physicians can determine whether a visit needs to be extended due to complications, risk of infection, prolonged observation, or any other reason. They can also discuss the best way to proceed in uncertain cases by exchanging charts, reports, test results, and any other relevant information. To be safe, travel arrangements should be conservative to ensure that there is adequate time for recovery.

Procedures for the licensing of physicians and nurses in medical tourism facilities are difficult to determine. Medicare may decide that if a hospital has been JCI accredited, it will trust that its physicians and staff are adequately trained. Along the same lines, because so many international medical graduates now practice in the United

278. Mattoo & Rathindran, *supra* note 68, at 16.
279. Cohen, *supra* note 1, at 1473.

States, Medicare may decide to trust the education and licensing systems of the LDCs. This is especially the case if Medicare mandates that participating facilities have physicians take the USMLE and nurses take the NCLEX-RN. Nonetheless, if these facilities want to participate in the program, it is likely they would be willing to meet this requirement. To be absolutely sure of staff quality and credibility, only physicians and nurses who have passed the USMLE and NCLEX-RN, respectively, should be allowed to participate in the program. This way, the facility can determine if it will assign only certain physicians to medical tourism patients and have other physicians for only local patients.

Third, and perhaps most importantly, the participating facility must be JCI accredited. JCI accreditation is really the only trusted way to signal quality and safety in the medical tourism world. Due to the similarities of the accreditation processes used in the United States and abroad, Medicare can be confident that JCI accredited facilities are safe for beneficiaries.

Finally, all participating facilities must be required to ensure the availability of proper malpractice recovery for injured patients. Methods to accomplish this goal may vary, but the easiest way to do so is to mandate that facilities submit to jurisdictional and choice-of-law agreements. This approach is the only way to be certain that American patients will be protected if an injury occurs. These agreements will also provide large incentives for staff in participating facilities to practice caution when treating beneficiaries.

C. Program Structure and Format

By far medical tourism's greatest hurdle will be implementing a program structure and format that is not overly burdensome or difficult to administer. Fortunately, a program structure for providing payments to foreign health care facilities already exists in the federal government—TRICARE. Medicare can use a preferred provider network similar to the civilian provider network TRICARE uses. Medical tourism facilities that meet the program requirements will be included in the network. Health and Human Services can work with the Department of Defense to begin implementing the system for processing claims and payments. Medicare will have to fine-tune the procedures to fit the specific parameters of the program and facilities involved, but the overall establishment of the system can be modeled after

TRICARE. As with any new government initiative, there will undoubtedly be costs incurred to get the program started and running smoothly, but these upfront costs will be minimal in comparison to the savings the program will generate over time.

V. Conclusion

Medicare currently faces a financial crisis that could leave the HI Trust Fund inadequately funded for the next ten years and bankrupt by 2024. There is presently no cure-all for this crisis, but globalizing Medicare through a medical tourism program provides a substantial cost-saving measure. Prices for common, low-risk surgeries in lesser-developed countries are significantly lower than in the United States, even after factoring in the cost of travel. Although a medical tourism program faces difficult obstacles, a properly structured program can account for and address all of these hurdles. While the protectionist Medicare policies in place at this time may have noble intentions, they are actually exacerbating the financial calamity the HI Trust Fund faces. As a society, we must realize that the costs of health care in this country are out of control, and we may have to forgo protecting our own providers to save Medicare and hopefully bring about systemic change. A medical tourism program for Medicare will ensure that Ralph receives the high quality care he needs, and at the same time, help save the HI Trust Fund from insolvency so Medicare can make good on its promise to provide health care benefits to the elderly.