

VENTURING OUT BEYOND THE GREAT WALL OF MEDICARE: A PROPOSAL TO PROVIDE MEDICARE COVERAGE OUTSIDE THE UNITED STATES

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One of the greatest dangers awaiting mature Americans traveling abroad does not stem from political unrest, but rather from the possibility of a medical emergency occurring in a foreign land. Relatively few older Americans realize that Medicare coverage will not follow them once they leave the United States. In addition, because there are few exceptions to the Medicare foreign exclusion, many older travelers have no choice but to purchase Medicare supplemental policies or risk sizable out-of-pocket expenses in the event of a medical emergency while abroad.

Mr. Whitman's note first introduces the Medicare program, discussing its history and operation, and the puzzling lack of attention given to the Medicare foreign exclusion by scholars and legislators alike. Problems like the U.S. government's inability to monitor and ensure the quality of foreign medical care and the desire to spend Medicare dollars in America, Mr. Whitman argues, have led to the erection of a "great wall" around the United States, beyond which Medicare coverage does not extend, except in limited circumstances. In contrast, Mr. Whitman observes, other governmental programs like Social Security, Supplemental Security Income, and TRICARE, which provides medical coverage to military personnel and their dependents, have no analogous foreign exclusion. To resolve this anomaly and suggests amending the Medicare foreign exclusion in two ways: first, to expand

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ordinary Medicare coverage for services received outside the United States from any American-owned health care provider and, second, to include benefits for medically necessary emergency services received from any foreign provider while the beneficiary is outside the United States for a limited time.

I. Introduction

“If you earned the privilege to have Medicare when you’re retired, you should enjoy it wherever you go.”¹

Medicare beneficiaries planning to travel outside the United States need not look any farther than their passports to realize that they had better pack extra health insurance because their Medicare coverage will not accompany them on the trip.² Despite this clear warning of the Medicare foreign exclusion, the fact that Medicare excludes coverage for health care services received outside the United States continues to exist in near obscurity and remains one of the best kept secrets of the Medicare program.³ This may be understandable as a matter of experience because Medicare beneficiaries would not need to know about the foreign exclusion unless and until they decide to travel overseas. But it is exactly because of this practical reality that most such older travelers, after making the carefully considered decision to leave the familiar terrain of the United States behind and seek an adventure in a foreign country, probably will be quite surprised and angered to learn that Medicare will not go with them.

Apart from these pragmatic considerations, one might still expect to come across discussions of the foreign exclusion in judicial opinions or in the legal literature. Yet here too it is oddly absent. In

1. Evelyn Tan Powers, *In Congress, Few Changes for Expats*, USA TODAY, Dec. 9, 1994, at A8 (quoting Leo Packer, past president of the Association for American Resident Overseas).

2. The second page of a typical American passport contains the following language: “HEALTH INSURANCE. Medical costs abroad can be extremely expensive. Does your insurance apply overseas, including medical evacuation, payment to the overseas hospital or doctor, or reimbursement to you later? . . . Medicare . . . does not cover health care costs outside the U[nited] S[tates].” (emphasis added).

3. Even the fact that it is printed on a passport would seemingly do little to remove the shroud from the foreign exclusion because it is unlikely that people actually read their passports. But this simple example about the passport is indicative of the larger problem concerning the low visibility of the Medicare foreign exclusion: it is hardly mentioned at all and, where it is mentioned, it is tucked away in a spot where no one is likely to find it.

fact, since Medicare became effective almost thirty-five years ago,⁴ a search through the case reporters (both state and federal, reported and unreported cases) reveals that the foreign exclusion has been the subject of litigation just once.⁵ In addition, extended commentary of the foreign exclusion in law reviews or legal journals cannot be found at all.⁶ This is even more surprising when considering the absolute and far-reaching consequences of the foreign exclusion: it completely bars payment under Medicare for any services, *even if medically necessary*, received anywhere outside the United States.⁷

Given the paucity of analysis concerning the Medicare foreign exclusion, the primary purpose of this note is to develop a better and fuller understanding of this relatively unknown Medicare provision by not only serving as a comprehensive, practical guide to its real world applications, but also exploring and critically examining the broader implications of having a foreign exclusion in the Medicare statute. In short, this note will explain how the foreign exclusion works, why it works the way it does, and suggest how it might be amended to work better. To that end, Part II of this note will offer a survey of the legislative history surrounding the foreign exclusion's enactment, a brief overview of Medicare supplemental insurance policies (commonly referred to as "Medigap"), and a profile of today's older American traveler. After providing a comprehensive, in-depth analysis of the substantive provisions of the foreign exclusion and its limited exceptions, Part III will review a constitutional challenge brought against the foreign exclusion and compare it within the broader context of other federal benefit programs. Part IV then pro-

4. Medicare became effective in July 1965. See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified in scattered sections of 42 U.S.C.). At that time, it already included the foreign exclusion. See *id.* § 1862(a)(4) (codified at 42 U.S.C. § 1395y(a)(4) (1994)); see also *infra* notes 35-47 and accompanying text.

5. See *Milkson v. Secretary of the Dep't of Health & Human Servs.*, 633 F. Supp. 836 (E.D.N.Y. 1986); see also *infra* notes 153-55 and 185-88 and accompanying text.

6. A handful of sources merely state that the foreign exclusion exists and provide only a one-line description of it. See, e.g., Joe Baker, *Medicare: Nuts and Bolts*, 263 PRACTICING LAW INSTITUTE/EST 65, 71 (1998). Somewhat surprisingly, the most extensive review of the foreign exclusion is contained in a practitioner's handbook on elder law. See LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUTSHELL* 81-82 (2d ed. 1999). Of course, describing the analysis of the foreign exclusion in this work as "extensive" is rather dubious as the discussion is limited to a single paragraph. Nevertheless, the fact that a commercial study aid contains the most information on a subject only reinforces the notion that substantive, in-depth analysis is severely lacking.

7. See *infra* notes 100-15 and accompanying text. There are, of course, limited exceptions, as discussed *infra* at notes 116-28 and accompanying text.

poses an amendment to the foreign exclusion that would allow payment for services received outside the United States from any American-owned provider and for emergency services from a foreign provider for a limited period of time. Finally, Part V concludes that such an amendment would provide symmetry between Medicare and other federal benefit programs and better serve the beneficiaries who have paid into the Medicare system.

II. Background

A. Medicare Overview

Originally enacted in 1965 as an amendment to the Social Security Act,⁸ Medicare is a federally funded health insurance program designed primarily for U.S. citizens or permanent residents aged sixty-five and over.⁹ Usually these individuals are automatically entitled to Medicare if they are eligible for Social Security benefits.¹⁰ As it currently exists, Medicare is divided into three parts, with Parts A and B providing the substantive benefits of the program¹¹ and Part C offering a newly enacted “Medicare Medical Savings Account” option.¹² In

8. See Social Security Amendments of 1965, Pub. L. No. 89-97 (codified in scattered sections of 42 U.S.C. (1994)).

9. See 42 U.S.C. § 426(a). However, certain individuals younger than 65 years old may also qualify for Medicare if they are either disabled or have end-stage renal disease. See *id.* §§ 426(b), 426-1, 1395c.

10. See *id.* § 426(a); 42 C.F.R. § 406.6(a) (1998). Eligibility requirements for Social Security are found at 42 U.S.C. §§ 402, 413-414. Read together, these sections provide that only “fully insured individuals” are entitled to Social Security benefits and that a “fully insured individual” is one who has at least “40 quarters of coverage.” 42 U.S.C. §§ 402(a)(1), 414(a)(2). A “quarter of coverage” is then further defined as a period of three months in a given calendar year during which the individual has earned a statutorily set minimum amount of wages. See *id.* §§ 413(a)(2)(A)(ii), 413(d). The government normally increases the minimum wage requirement each year because of inflation and an increase in the cost of living index and publishes these changes in the Federal Register. For example, the amount of earnings needed to be credited with a quarter of coverage in 1999 was \$740.00. See Notices, Social Security Administration, 63 Fed. Reg. 58,446 (1998). Typically, individuals become eligible for Social Security benefits and, thus, Medicare benefits, if they have worked for at least ten years in covered employment—i.e., four quarters of coverage in each calendar year for 10 years will result in 40 quarters of coverage.

11. See *infra* notes 14-30 and accompanying text.

12. Medicare Part C, “Medicare+Choice,” took effect in November 1998. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified at 42 U.S.C. §§ 1395w-21 through w-28 (Supp. 1998)). Part C gives certain Medicare beneficiaries the option of setting up a “Medicare Medical Savings Account” plan, but these plans provide the same substantive benefits available under Parts A and B. See 42 U.S.C. § 1395w-21(a)(1)(A) (Supp. 1999). Thus, Part C does not drastically alter the type or amount of benefits provided by Medicare, but simply the way in which Medicare

general, the traditional Medicare program is a pay-per-visit arrangement, with set deductible and co-payment amounts, that allows beneficiaries to visit any health care provider that accepts Medicare payments.¹³

Part A¹⁴ helps pay for the institutional costs associated with inpatient care received in hospitals and skilled nursing facilities, as well as home health services and hospice care.¹⁵ Because it is financed by the Social Security payroll withholding taxes collected from employers and employees, including those withheld from the beneficiaries themselves while they worked,¹⁶ Part A is “premium-free” for eligible beneficiaries.¹⁷

On the other hand, Part B¹⁸ is a voluntary supplemental plan that is available to Part A beneficiaries, who are automatically entitled to Part B, and all other citizens or permanent residents over the age of sixty-five.¹⁹ An individual who decides to enroll in Part B (or is enrolled automatically)²⁰ must pay a monthly premium.²¹ Part B will then help pay for many of the services not covered under Part A, such as outpatient hospital services, physician’s fees, physical and occupational therapy, x-rays and laboratory services, certain ambulance services, durable medical equipment (e.g., wheelchairs and hospital beds to be used at home), and certain preventative services.²²

Although it is voluntary, any person, upon becoming eligible for Part A, is “deemed to have enrolled” in Part B unless the individual expressly declines such enrollment.²³ If an individual elects not to

payments are distributed to beneficiaries. See generally *Your Guide to Medicare Medical Savings Accounts* (visited Feb. 1, 2000) <<http://www.medicare.gov/publications/pdfversion.pdf>>.

13. See *Medicare & You 2000*, at 3 (visited Jan. 25, 2000) <<http://www.medicare.gov/publications/mandy.pdf>> [hereinafter *Medicare & You 2000*].

14. 42 U.S.C. §§ 1395c through 1395i-5.

15. See *1999 Guide to Health Insurance for People with Medicare*, at 5 (visited Feb. 1, 2000) <<http://www.medicare.gov/publications/guide.pdf>> [hereinafter *Medicare Guide*]. For a brief overview of specific items and services covered under Part A, see *id.* at 8 and *Medicare & You 2000*, *supra* note 13, at 5.

16. See 42 U.S.C. § 3101(b).

17. See *Medicare Guide*, *supra* note 15, at 5; *Medicare & You 2000*, *supra* note 13, at 3.

18. See 42 U.S.C. §§ 1395j through 1395w-4 (1994).

19. See 42 U.S.C. § 1395o.

20. For enrollment procedures and periods, see 42 U.S.C. § 1395p.

21. The 1999 premium was \$45.50. See *Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Rate Beginning January 1, 1999*, 63 Fed. Reg. 56,201, 56,202 (1998).

22. See 42 C.F.R. §§ 410.10–78 (1998); see also *Medicare & You 2000*, *supra* note 13, at 7; *Medicare Guide*, *supra* note 15, at 9–10.

23. 42 U.S.C. § 1395p(f).

take Part B when first becoming eligible for Part A, she still may purchase Part B coverage but only during certain “enrollment periods.”²⁴ Moreover, an individual’s premium under Part B may increase ten percent for each year that the individual could have enrolled in Part B but did not do so.²⁵

As with most insurance programs, Medicare has a number of general exclusions that limit the benefits available under both Parts A and B.²⁶ For example, Medicare does not pay for personal comfort items,²⁷ cosmetic surgery (in most cases),²⁸ any costs that are not “reasonable and necessary” (including experimental procedures),²⁹ and, of particular importance to this note, any services provided outside the United States (with limited exceptions).³⁰ Turning to this last exemption, the following two sections explain how the foreign exclusion evolved and what options are available to Medicare beneficiaries who wish to travel overseas but do not want to take the risk of traveling without medical insurance coverage.

B. The Silent History of the Medicare Foreign Exclusion

Attempting to trace the legislative development of the Medicare foreign exclusion is something like trying to find a needle in a haystack. When originally passed in 1965, the Medicare bill, known then as the “Social Security Amendments of 1965,”³¹ filled over 136 pages in the Statutes at Large.³² Within that massive legislation, the foreign exclusion and its single exception amounted to nothing more than a

24. 42 U.S.C. § 1395p(i); *see also Medicare & You 2000, supra* note 13, at 43; *Medicare Guide, supra* note 15, at 6. In most cases, the individual will be required to apply during the general enrollment period, which runs from January 1 through March 31 of each year. *See* 42 U.S.C. § 1395p(e); 42 C.F.R. §§ 407.12(a)(1), .15(a). If an individual enrolls during such a general enrollment period, entitlement for benefits will commence the following July 1 of that same year. *See* 42 U.S.C. § 1395q(a)(2)(E); 42 C.F.R. § 407.25(b)(1). In some limited circumstances, an individual may be eligible to enroll during a “special enrollment period.” *See* 42 U.S.C. § 1395p(f); 42 C.F.R. §§ 406.24, 407.20(e).

25. *See* 42 U.S.C. § 1395r(b); 42 C.F.R. § 408.22; *see also Medicare & You 2000, supra* note 13, at 4; *Medicare Guide, supra* note 15, at 6.

26. *See generally* 42 U.S.C. § 1395y; 42 C.F.R. §§ 411.4–.15.

27. *See* 42 U.S.C. § 1395y(a)(6).

28. *See id.* § 1395y(a)(10).

29. *Id.* § 1395y(a)(1).

30. *See id.* § 1395y(a)(4).

31. Pub. L. No. 89-97, 79 Stat. 286 (1965).

32. *See id.*

few sentences.³³ Perhaps it is not surprising, then, to learn that the committee reports on the Medicare bill contain very little discussion about the foreign exclusion.³⁴ But it is for this very reason that a brief examination of the legislative records provides a fuller appreciation for the dearth of attention paid to the Medicare foreign exclusion, both in its infancy and then later when Congress specifically amended the exclusion.

1. THE ORIGIN OF THE FOREIGN EXCLUSION

When Congress first commenced hearings in 1963, seeking to provide a health insurance program for the aged under the Social Security Act,³⁵ the foreign exclusion had already made its way into the original proposals.³⁶ Couched in terms of an eligibility requirement, the idea was that an individual's entitlement to benefits would be conditioned upon the services being furnished within the United States.³⁷ When Congress finally passed the Medicare bill two years later, it had undergone various drafting changes, but the final version retained the entitlement language.³⁸ In addition, though, the House of Representatives devoted a separate section to exclusions from cover-

33. *See id.* §§ 1814(f), 1816(a)(4).

34. In fact, all of the legislative reports do nothing more than set out the language of the foreign exclusion with no further commentary. *See, e.g.*, H.R. REP. NO. 89-213, at 42, 169 (1965); H.R. CONF. REP. NO. 89-682, at 37 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2231; S. REP. NO. 89-404, at 48, 163-64 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1989, 2103.

35. *See Medical Care for the Aged: Hearings Before the Comm. on Ways & Means on H.R. 3920, a Bill to Provide under the Social Security Program for Payment for Hospital and Related Services to Aged Beneficiaries*, 88th Cong. 1-2502 (1964) (hearings held Nov. 18-22, 1963, and Jan. 20-24, 1964) [hereinafter *Hearings*].

36. *See* H.R. 3920, 88th Cong. § 1705(b)(1) (1963), *reprinted in Hearings, supra* note 35, at 8 [hereinafter H.R. 3920]. Other proposals by both the House and the Senate contained identical provisions. *See* S. 2431, 88th Cong. § 1805(b)(1) (1964), *reprinted in Hearings, supra* note 35, at 1246 [hereinafter S. 2431]; H.R. 9732, 88th Cong. § 1703(b)(1) (1964), *reprinted in Hearings, supra* note 35, at 1815 [hereinafter H.R. 9732].

37. *See* H.R. 3920, § 1705(b)(1), *reprinted in Hearings, supra* note 35, at 8. The original version of this section read as follows:

Entitlement of an individual to insurance benefits under this title for a month shall consist of entitlement to have payment made under, and subject to the limitations in, this title on his behalf for inpatient hospital services, skilled nursing facility services, home health services and outpatient hospital diagnostic services furnished him *in the United States* during such month.

Id. (emphasis added); *see also* S. 2431, § 1805(b)(1), *reprinted in Hearings, supra* note 35, at 1246; H.R. 9732, § 1703(b)(1), *reprinted in Hearings, supra* note 35, at 1815.

38. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) § 226(b)(1) (codified at 42 U.S.C. § 426(c)(1) (1994)).

age and explicitly imposed a flat prohibition on any services received outside the United States.³⁹

Upon reviewing the House proposal, the Senate added a section to pay for emergencies occurring near the United States' borders.⁴⁰ Specifically, it amended the House bill to provide benefits for emergency hospital services furnished in hospitals located outside the United States if the emergency occurred within the United States, and the foreign hospital was closer or more accessible from the site of the emergency than a domestic hospital.⁴¹ The House approved the Senate's amendment without comment.⁴²

Remarkably, Congress never discussed or debated the original general exclusion or its exception. In fact, a search through the various committee hearings and legislative reports of the 89th Congress relating to the Social Security Amendments reveals nothing more than a mere recitation of the proposed language of the foreign exclusion and the exception added by the Senate's amendment.⁴³ The exclusion appears to have simply slipped into the statute without notice or question. It is hard to imagine that Congress would have given so little thought to the impact such a broad and absolute denial of benefits would have on the landmark Medicare bill. But congressional voices were strangely silent, providing no insight as to Congress's reasons for restricting Medicare benefits to such a degree.⁴⁴ (Perhaps it is this initial congressional silence on the foreign exclusion that partly explains the subsequent lack of comment by courts and commentators in the thirty-five years since its passage.)⁴⁵ As a result, the foreign exclu-

39. See *id.* § 1862(a)(4) (codified at 42 U.S.C. § 1395(y) (1994)). The House limited the extent of its commentary regarding the foreign exclusion under this general section of exclusions to the following cursory remark: "Payments would only be made for items and services provided in the United States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa." H.R. REP. NO. 89-213, at 42 (1965). See *infra* notes 100-52 and accompanying text for a more detailed and comprehensive review of the general foreign exclusion.

40. See S. REP. NO. 89-404, at 30 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1971.

41. See *id.* at 163-64, reprinted in 1965 U.S.C.C.A.N. at 2103; see also *infra* notes 123-25 and accompanying text for an extended analysis of this exception.

42. See H.R. CONF. REP. NO. 89-682, at 32 (1965), reprinted in 1965 U.S.C.C.A.N. 2228, 2231.

43. See generally H.R. CONF. REP. NO. 89-682 (1965), reprinted in 1965 U.S.C.C.A.N. 2228; S. REP. NO. 89-404 (1965), reprinted in 1965 U.S.C.C.A.N. 1943; H.R. REP. NO. 89-213, at 169 (1965).

44. But see *infra* notes 137-52 and accompanying text (speculating as to various reasons why Congress may have included the foreign exclusion).

45. See *supra* notes 4-7 and accompanying text.

sion,⁴⁶ with its single exception for emergencies originating within the United States,⁴⁷ quietly became a part of Medicare in 1965.

2. TWO MORE EXCEPTIONS

Congress again amended the Social Security Act to enhance services under Medicare in 1972.⁴⁸ This time, however, it specifically addressed the issue of services provided outside the United States and the “special problems of border residents.”⁴⁹ It was particularly concerned that beneficiaries living in remote areas near United States’ borders were unable to take full advantage of Medicare and protect themselves from the costs of inpatient, *non*emergency hospital services because the hospitals nearest to them were outside the United States.⁵⁰ For this reason, the House proposed a second exception to the foreign exclusion, providing Part A benefits for inpatient hospital services furnished by a hospital outside the United States if the beneficiary was a resident of the United States and the foreign hospital was closer or more accessible from the beneficiary’s residence than a hospital within the United States.⁵¹ In addition, the exception included payment for any necessary physician and ambulance services connected to the inpatient stay, as would normally be paid under Part B.⁵²

The Senate approved the proposal and added a third exception “to take care of a unique problem faced by U.S. residents” who must travel through Canada to reach Alaska from the continental United States or vice-versa.⁵³ Under the Canadian travel exception,⁵⁴ Medicare coverage extends to inpatient hospital services resulting from an

46. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 1862(a)(4), 79 Stat. 286, 325 (codified at 42 U.S.C. § 1395y(a)(4) (1998)).

47. See *id.* § 1814(f) (codified as amended at 42 U.S.C. 1395f(f)(2) (1998)).

48. See Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, reprinted in 1972 U.S.C.C.A.N. 1548 (codified in scattered sections of 42 U.S.C.).

49. H.R. REP. NO. 92-231, at 77 (1972), reprinted in 1972 U.S.C.C.A.N. 4989, 5064.

50. See *id.*

51. See *id.* The House report made clear, though, that the “present provisions covering emergency inpatient hospital services outside the United States would be retained.” *Id.*; see also *infra* notes 126–28 and accompanying text for a fuller discussion of this exception.

52. See H.R. REP. NO. 92-231, at 78, reprinted in 1972 U.S.C.C.A.N. at 5064.

53. S. REP. NO. 92-1230, at 223 (1972).

54. See 42 U.S.C. § 1395f(f)(2)(A)(ii) (1998).

emergency occurring in Canada while traveling on land between Alaska and the continental United States.⁵⁵

In summary, since 1972, Medicare's foreign exclusion has remained untouched. It generally denies payment for all medical services received outside the United States, subject only to the Canadian travel exception and the exceptions for emergency inpatient care where a foreign hospital is closer to the site of an emergency occurring within the United States and nonemergency inpatient care where the foreign hospital is closer to the patient's U.S. residence than a domestic hospital.⁵⁶

C. Not Filling the Gaps: A Medigap Overview

The fact that Medicare provides no medical coverage for beneficiaries receiving services in foreign countries causes a serious problem for many Medicare beneficiaries who wish to travel overseas.⁵⁷ It leaves elderly travelers "especially vulnerable" to inadequate health care insurance while traveling abroad⁵⁸ and makes it necessary for these individuals to search for alternate methods of protecting against medical costs incurred while in a foreign land.

Given the many deductibles, cost-shares, exclusions, and other services not covered by Medicare,⁵⁹ besides the general foreign care exclusion, it is not surprising that many Medicare beneficiaries rely on supplemental insurance policies to offset the out-of-pocket costs for services Medicare does not cover.⁶⁰ Medicare supplemental insurance, commonly referred to as "Medigap," is, as its name suggests, specifically designed to fill in the gaps of Medicare coverage.⁶¹ Like other

55. See Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (codified at 42 U.S.C. § 1395f(f)(2) (1998)); see also *infra* notes 119-22 and accompanying text for a fuller discussion of this exception.

56. See *infra* notes 100-28 and accompanying text.

57. See Richard Epstein, *Staying Insured While You're Abroad*, THE RECORD, N. NEW JERSEY, Apr. 13, 1998, at H2.

58. Harry Shattuck, *Address Medical Concerns Before Traveling Outside U.S.*, FT. LAUDERDALE SUN-SENTINEL, June 22, 1997, at J12.

59. See *Medicare & You 2000*, *supra* note 13, at 8.

60. In 1996, only 19.3% of all Medicare beneficiaries had no supplemental insurance. See Franklin J. Eppig & George S. Chulis, *Trends in Medicare Supplementary Insurance, 1992-96*, 19 HEALTH CARE FINANCING REV. 201, available in 1997 WL 19652421. Of the remaining 80.7% with some form of supplemental insurance, 63% of these individuals had private Medicare supplemental policies and, more specifically, 28.4% purchased individual Medigap policies. See *id.*

61. See *Medicare Guide*, *supra* note 15, at 12.

supplemental policies, Medigap policies are sold directly to beneficiaries by private insurance carriers for a premium.⁶² As explained below, the difference between Medigap and other privately issued supplemental insurance policies is that the federal government extensively regulates Medigap policies.

Realizing the importance of Medigap insurance to many Medicare beneficiaries, Congress enacted legislation to regulate and control the types of Medigap policies that private insurance carriers may sell.⁶³ Under federal law, no more than ten standard Medigap policies may be sold in a state.⁶⁴ These ten Medigap plans have letter designations ranging from “A” through “J,” where plan “A” provides the least amount of benefits and plan “J” the most.⁶⁵ Plans “B” through “J” offer various combinations of benefits, with some packages offering benefits that others do not.⁶⁶ And, although Medigap plans vary as to the types of benefits offered, they remain standardized so that insurance companies may not change the core set of benefits any particular plan provides.⁶⁷ As a result, purchasers of Medigap plans may not pick and choose which benefits they want.⁶⁸ If only one benefit is needed but is only offered in a plan combining it with other benefits, the entire package must be purchased.⁶⁹ Such standardization is intended to make it easier for consumers to compare policies sold by

62. See *id.* at 12, 20.

63. See 42 U.S.C. § 1395ss (1999).

64. See *id.* § 1395ss(p)(2)(c); see also *Medicare Guide, supra* note 15, at 12. Minnesota, Wisconsin, and Massachusetts are exempt from the requirement of carrying the 10 standardized plans because they already had alternate programs in effect when the federal law was passed. See 42 U.S.C. § 1395ss(p)(6); *Medicare Guide, supra* note 15, at 12.

65. See *Medicare Guide, supra* note 15, at 13. Plan “A” is the “Core Package.” For a description of the benefits available in this package, see *id.* While all plans provide the basic package in addition to other benefits, plan “A” provides only the basic or core set of benefits. See *id.* In addition, all insurance companies that sell Medigap policies are required to sell Plan “A.” See 42 U.S.C. § 1395ss(p)(2)(B) (1999); Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act § 8(B), reprinted in *Medicare Program; Recognition of NAIC Model Standards for Regulation of Medicare Supplemental Insurance*, 63 Fed. Reg. 67,078, 67,088 (1998) [hereinafter NAIC Model Standards]. In addition to the “core package,” eight other separate benefits are available in varying combinations under the Medigap standardized plans. See *Medicare Guide, supra* note 15, at 14.

66. See *Medicare Guide, supra* note 15, at 14.

67. See NAIC Model Standards, *supra* note 65, § 9, reprinted in 63 Fed. Reg. 67,078, 67,090.

68. See *id.*

69. See *id.*

different companies based on price and reliability of the company, rather than on the quantity of benefits.⁷⁰

Federal law guarantees enrollment in Medigap, but it is contingent upon the purchaser being at least sixty-five years old and enrolled in Medicare Part B.⁷¹ A beneficiary who declines to accept Part B coverage when initially becoming eligible for Part A must wait for a general enrollment period to enroll not only in Part B, but in Medigap as well.⁷² In addition, a beneficiary normally may purchase a Medigap policy only during a six-month “open enrollment period,” which begins from the effective date of enrollment in Part B.⁷³ Thus, a patient who enrolls in Part B but does not enroll in Medigap during the open enrollment period may be unable to purchase a Medigap policy in the future.⁷⁴

Under Medigap’s standardized packages, eight plans—“C” through “J”—offer a “Foreign Travel Emergency” benefit.⁷⁵ This benefit pays eighty percent of emergency medical costs received in a foreign country after the patient pays a \$250 deductible.⁷⁶ Payment under this benefit, however, is limited to care that began during the first sixty days of each trip outside the United States and is subject to a \$50,000 maximum lifetime cap.⁷⁷

The laudable goal of standardizing Medigap plans for consumer convenience notwithstanding, Medicare and Medigap are extremely

70. See *Medicare Guide*, *supra* note 15, at 13.

71. See 42 U.S.C. §§ 1395ss(s)(2)(A), (D)(i) (1999) (providing that, during the initial six month open enrollment period after a beneficiary turns 65 and enrolls in Medicare Part B, the Medigap insurer may not refuse to issue a Medicare supplemental policy to such a beneficiary because of the individual’s “health status, claims experience, receipt of health care, or medical condition” or because of a preexisting condition if the individual had a “continuous period of creditable coverage” for at least six months prior to applying for the Medigap policy).

72. See *supra* notes 24–26 and accompanying text.

73. See NAIC Model Standards, *supra* note 65, § 11, *reprinted in* 63 Fed. Reg. 67,078, 67,092–93.

74. Limited exceptions allow enrollment in Medigap outside the open enrollment period. See *id.* § 12, *reprinted in* 63 Fed. Reg. at 67,093.

75. *Medicare Guide*, *supra* note 15, at 14. As already mentioned, the respective letter designations of the standardized plans correspond to an increase in benefits offered under the plans. See *supra* note 65 and accompanying text. Thus, those looking for the Foreign Travel Emergency benefit will begin with Plan “C,” which combines this benefit with the least amount of other benefits (for a total of five separate benefits), and work up to Plan “J,” which offers the Foreign Travel Emergency benefit along with eight other benefits. See *Medicare Guide*, *supra* note 15, at 14.

76. See NAIC Model Standards, *supra* note 65, § 8(C)(8), *reprinted in* 63 Fed. Reg. 67,078, 67,088.

77. See *id.*

inefficient and impractical for retirees who desire only to have medical insurance coverage while vacationing overseas. Not covered under traditional Medicare, a senior planning to travel abroad will need to consider purchasing a supplemental insurance plan. This expense alone can be almost as much as the trip itself.⁷⁸ Moreover, a beneficiary looking only for the Foreign Travel Emergency benefit must purchase an entire Medigap policy, requiring her to pay for many benefits she neither needs nor wants.⁷⁹ All of this assumes, of course, that the beneficiary will actually still be able to enroll in Medigap in the first place, or at least will be able to enroll before the trip, which is, in reality, quite unlikely if the beneficiary declined automatic enrollment in Part B.

D. A Profile of Today's Older American Traveler

After spending thirty-five or forty years on the job, one of the greatest rewards of growing older and retiring is having the time and freedom to travel.⁸⁰ In fact, with eighty-five percent of the senior

78. For example, the State of Illinois Department of Health recently conducted a survey of all insurers who offer Medigap plans for purchase in Illinois. As of March 1999, only one of the 42 companies selling Medigap plans in the Chicago area offered Plan "C" for under \$800 to someone between the ages of 65 and 69. See *Illinois Department of Insurance, Medicare Supplement Premium Charts—Chicago Area* (visited Jan. 25, 2000) <<http://www.state.il.us/ins/medsup/default.htm>>. The most expensive Plan "C" for someone in the same age group costs over \$1500. See *id.*

The Health Care Financing Administration (HCFA), which is the federal agency responsible for regulating the Medicare program, has developed a similar service that allows persons to compare the cost of Medigap policies and the insurance ratings of Medigap insurers across the country. "Medigap Compare" is available online at Medicare's web site and provides a searchable database as well. See *Medigap Compare* (visited Feb. 1, 2000) <<http://www.medicare.gov/medigap/home.asp>>.

79. As previously noted, Plan "C" is the entry-level package for someone who is interested in the Foreign Travel Emergency benefit. See *supra* note 75. Yet even this package includes four other benefits for which the beneficiary may have no need. Because federal law does not give either the insurer or the beneficiary any choice in selecting which benefits to buy or sell, senior travelers must pay for additional, unwanted benefits to get what they want—the Foreign Travel Emergency benefit. The inherent inefficiency in this system is obvious: it fails to take into account the individualized needs of Medicare beneficiaries and requires them to choose among predetermined and "closed set" benefit groupings, many of which will probably be ill-suited for a particular beneficiary's lifestyle and economic circumstances. Although an in-depth critique of the Medigap system is beyond the reach of this note, the important point to recognize is that, as it now exists, Medigap is simply too inflexible to adapt to a Medicare beneficiary's specific needs and is therefore a highly unsatisfying way for older travelers to provide health insurance to themselves while traveling overseas.

80. See *Retirement Means the Freedom to Travel*, CHARLESTON GAZETTE & DAILY

population fit to take advantage of travel opportunities,⁸¹ the focus of many older Americans today is to enjoy their retirement years by exploring the world.⁸² Even those recuperating from major operations and whose health is not perfect seem to share this attitude.⁸³ It is a “new and different” generation of seniors that sees a trip to another country not merely as a vacation but as a chance to learn new things.⁸⁴ It is an adventure for the mind—something that is appreciated more as one grows older.⁸⁵

Besides a growing enthusiasm for global travel, external factors also make the senior citizen market particularly appealing to the travel industry. For example, the large size of this market translates into major purchasing power.⁸⁶ Other distinctive features are that retirees may travel at any time, including the off-season, and stay for longer periods of time.⁸⁷ For these reasons, the emergence of retired travelers is seen as the next main growth market in international travel.⁸⁸

In response, the travel industry has begun to directly target elderly travelers with special discounts and programs.⁸⁹ Many airlines now offer reduced fares and senior-discount coupon books, and just as many major hotel chains have special rates for guests over a certain age.⁹⁰ Several businesses cater exclusively to this group by putting together tour packages for older people who want to travel abroad.⁹¹

MAIL, July 5, 1998, at P9E.

81. *See id.*

82. *See* Saul Friedman, *Gray Matters: New Adventures in the Old World*, NEWSDAY, July 5, 1997, at B03.

83. *See Less Than Perfect Health Shouldn't Prevent You from Seeing the World*, PITTSBURGH POST-GAZETTE, June 2, 1998, at D6.

84. Paula Voell, *Traveling Smart with a Little Forethought, There's No Adventure That's Off-limits to Seniors*, BUFFALO NEWS, May 30, 1997, at C7.

85. *See* Friedman, *supra* note 82, at B03.

86. *See* David Ing, *Potential for Senior Travel Escalates*, HOTEL & MOTEL MGMT., June 7, 1993, at 4.

87. *See id.*

88. *See id.*

89. *See* Kristin Jackson, *Programs and Discounts for Older Travelers*, SEATTLE TIMES, July 26, 1998, at K2.

90. *See id.*

91. *See id.*; *see also* Robert N. Jenkins, *Older, Wiser and Ready to Go*, ST. PETERSBURG TIMES, Oct. 9, 1997, at E1. In addition, many organizations maintain websites that are devoted exclusively to providing older persons with information and resources about vacationing overseas. In fact, some of these organizations have created tour packages designed specifically for elderly travelers planning a trip abroad. *See, e.g., Elderhostel* (visited Mar. 22, 2000) <<http://www.elderhostel.org>>.

Together, the new financial incentives, organizational support, and travel-oriented attitude have transformed the socioeconomic demographics of the older traveler. No longer is international travel reserved for the affluent elderly; many “blue-collar” retirees are experimenting with vacations around the world as well.⁹² As a result, it is not surprising that predictions call for increasing numbers of older travelers.⁹³ International travel among Americans was already at a record pace in 1998, with 55.2 million people traveling outside the United States, and was expected to grow again in 1999.⁹⁴ It is also estimated that twelve percent of all Americans aged seventy-five or older travel overseas.⁹⁵ With the resources, knowledge, and ability to travel abroad, the elderly have become familiar faces in the market of global travel.⁹⁶

Unfortunately, the reality of inadequate health care coverage often tempers a retiree’s wanderlust.⁹⁷ Even the Department of State cautions seniors traveling overseas to obtain additional insurance coverage before leaving to avoid Medicare’s foreign exclusion.⁹⁸ As a result, older travelers, unlike their younger counterparts, are usually advised to add the cost of additional health insurance to trip budgets.⁹⁹

III. Analysis

A. Understanding the Medicare Foreign Exclusion

The Medicare foreign exclusion generally prohibits payment for services received outside the United States. However, it does provide some limited exceptions under which beneficiaries may be reimbursed for health care obtained in Canada or Mexico. The following three sections provide an analysis of the technical and substantive rules that apply to the foreign exclusion.

92. See Friedman, *supra* note 82, at B03.

93. See Voell, *supra* note 84, at C7.

94. See Gene Sloan, *Travel Forecast: Mostly Sunny, Chance of Clouds*, USA TODAY, Oct. 27, 1998, at D01.

95. See Voell, *supra* note 84, at C7.

96. See Friedman, *supra* note 82, at B03.

97. See *Insurance Can Fill Gaps in Medicare for Older Travelers*, ATLANTA J.-CONST., Aug. 15, 1993, at K3.

98. See *Travel Tips for Older Americans* (visited Jan. 25, 2000) <<http://www.travel.state.gov/olderamericans.html>>.

99. See David C. Beeder, *Going Abroad? Get Medicare Supplement*, OMAHA WORLD-HERALD, May 3, 1998, at B6.

1. THE GREAT WALL OF MEDICARE

As it was when originally passed in 1965, Medicare's foreign exclusion can be found in two separate titles of the Social Security Act.¹⁰⁰ In a rather roundabout way, Title II conditions Medicare entitlement to hospital insurance benefits on those services furnished in the United States.¹⁰¹ More explicitly, Title XVIII spells out the various exclusions from coverage under Medicare, including those services "which are not provided within the United States."¹⁰² For Medicare purposes, the "United States" includes the fifty states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.¹⁰³

The foreign exclusion essentially erects a virtual wall around the borders of the United States and cuts off Medicare coverage for medical services received on the other side of this wall.¹⁰⁴ For example, medical care provided in a hospital that is not physically situated in one of the above-named jurisdictions is considered outside the United States, even if it is owned or operated by the U.S. Government (such as an American military hospital located in a foreign country).¹⁰⁵ Similarly, payment for Durable Medical Equipment (DME) will be made only if the beneficiary was within the United States when the item was delivered or purchased.¹⁰⁶ Thus, the statute excludes coverage for any piece of DME delivered or provided to a patient outside the United States, even if the beneficiary contracted to purchase it while within the United States,¹⁰⁷ purchased it from an American firm,¹⁰⁸ or later used it inside the United States.¹⁰⁹

100. See 42 U.S.C. §§ 426(c)(1), 1395y(a)(4) (1994).

101. See *id.* § 426(c)(1).

102. *Id.* § 1395y(a)(4).

103. See 42 C.F.R. § 411.9(a)(1) (1998).

104. This, however, is where the metaphor ends. Unlike the Great Wall of China, which was built to protect against invasion, the "Great Wall of Medicare" has just the opposite effect. That is, rather than keeping people out, the Medicare foreign exclusion keeps people in by discouraging older Americans from traveling abroad. See *infra* text accompanying note 248.

105. See 42 C.F.R. § 411.9(a)(3). Medicare, in fact, separately prohibits payment to any federal provider of services. See 42 U.S.C. §§ 1395f(c), 1395n(d).

106. See *Medicare Intermediary Manual* § 4105.3, Medicare and Medicaid Guide (CCH) ¶ 10,281.03 (Apr. 9, 1998) (visited Feb. 1, 2000) <<http://www.hcfa.gov/pubforms/pub13/pub13toc.htm>> [hereinafter *MIM*].

107. See *Medicare Carriers Manual* § 2312 (visited Feb. 1, 2000) <<http://www.hcfa.gov/pubforms/pub14/pub14toc.htm>> [hereinafter *MCM*].

108. See *id.*

109. See *MIM*, *supra* note 106, § 4105.3.

The general foreign exclusion covers services received on board a ship in limited circumstances.¹¹⁰ Shipboard services must be provided within U.S. territorial waters, which means the ship was either in a U.S. port, or within six hours of arriving at or departing from a U.S. port.¹¹¹ The ship also must be of American registry.¹¹² Although not expressly stated, this rule presumably applies to airplanes as well,¹¹³ but a plane is no longer considered within the United States once it departs U.S. airspace (i.e., is not above the land area of the United States).¹¹⁴ When a ship or plane leaves American waters or airspace, services rendered on board will be denied, even if the craft is of American registry.¹¹⁵

2. ON THE OTHER SIDE OF THE MEDICARE WALL

Apart from the shipboard services covered under the basic rule, Medicare provides three specific exceptions to the foreign exclusion.¹¹⁶ The first two pertain to emergency care¹¹⁷ and the third to nonemergency care.¹¹⁸ These are discussed in turn below.

a. Canadian Travel Exception The most limited of the three statutory exceptions is the Canadian travel exception. Under this exception, Medicare will pay for emergency hospital services provided by a Canadian hospital when the emergency occurred in Canada, the patient was traveling “without unreasonable delay by the most direct route” between Alaska and another state, and the Canadian hospital was closer than any available American hospital.¹¹⁹ In contrast, payment will not be made if the emergency occurred while the patient was merely vacationing in Canada.¹²⁰ Instead, coverage is available only if the patient received medical attention while enroute between Alaska and another state by the “shortest practicable route” or while

110. See *MCM*, *supra* note 107, § 2312.

111. See 42 C.F.R. § 411.9(a)(2) (1998).

112. See *MCM*, *supra* note 107, § 2312; Medicare and Medicaid Guide (CCH) ¶ 4065 (Jan. 18, 1996).

113. See Medicare and Medicaid Guide (CCH) ¶ 4065.

114. See *id.*

115. See *id.*

116. See 42 U.S.C. § 1395f(f) (1998).

117. See *id.* § 1395f(f)(2).

118. See *id.* § 1395f(f)(1).

119. 42 U.S.C. § 1395f(f)(2)(A)(ii).

120. See *MIM*, *supra* note 106, § 3698.4(2).

making a “necessary stopover” in connection with such travel.¹²¹ When submitting a claim for such services, regulations also require a beneficiary to file a statement documenting the point of entry into Canada from the United States, the intended point of departure from Canada, the route traveled at the time of the emergency, and explanations of any apparent deviations from the intended route or of non-routine stopovers.¹²²

b. Emergencies Near U.S. Borders The second exception provides benefits for services connected to an emergency occurring within the United States if the foreign hospital was “closer to or substantially more accessible” from the site of the emergency than the nearest hospital within the United States.¹²³ This exception has been interpreted to require a subjective intent component, such that benefits are not available for an individual who left the United States for purposes other than to obtain medical treatment.¹²⁴ In other

121. *Id.* This section also provides that an emergency occurring in the Canadian inland waterway between the States of Washington and Alaska is considered to have occurred in Canada. *See id.* This is a rather peculiar guideline because it presumably applies regardless of whether the ship is of American registry or regardless of whether it is within six hours of departing from or arriving at an American port. It is even more inexplicable because these same guidelines contemplate payment of services in this very situation and state that covered physician services include those of a “Canadian ship’s physician who furnishes emergency services in Canadian waters on the day the patient is admitted to a Canadian hospital for a covered emergency stay.” MCM, *supra* note 107, § 2312.2(C).

The “shortest practicable route” is defined as one that “results in the least amount of travel in Canada,” but allows for such factors as road or weather conditions, age of the traveler, and the need to obtain acceptable accommodations. MIM, *supra* note 106, § 3698.4(2). A person would be considered to have deviated from the “shortest practicable route” if the detour was unrelated to the purpose of reaching the destination (e.g., sightseeing). *See id.* Finally, a “necessary stopover” is a routine stopover for rest, food, or servicing of a vehicle. *See id.*

122. *See id.* “Nonroutine” stopovers are those, even of significant duration, caused by the same factors that are considered when determining the shortest practicable route, such as unsuitable road or weather conditions, the health of the traveler, and obtaining accommodations. *See id.*

123. 42 U.S.C. §§ 1395f(f)(2)(A)(i), 1395f(f)(2)(B) (1999). Factors used to determine if a foreign hospital is “more accessible” include the relative distances of domestic and foreign hospitals in the area and whether the foreign hospital was nearest to the point where the emergency occurred, transportation facilities available, and the quality of roads. *See* 42 C.F.R. §§ 424.106(b), (d) (1998).

124. *See MIM, supra* note 106, § 3698.4(1); *see also* Medicare and Medicaid Guide (CCH) ¶ 1239.69 (Feb. 2, 1999). For example, suppose an individual boards a plane to leave for vacation or a business trip. Shortly after take-off, he suffers an injury. The plane lands in a foreign country and the individual seeks medical attention at the nearest hospital. Because the patient’s original purpose was not to obtain medical treatment, he is not covered under this exception, even though the situation techni-

words, the exception requires that a linear sequence be met: the individual must suffer an emergency within the United States and then leave the United States for the sole purpose of obtaining medical treatment in a foreign hospital because the foreign hospital is closer than a U.S. hospital.¹²⁵

c. Nonemergency Care for Border Residents The final exception applies to nonemergency inpatient care received in a hospital outside the United States when that hospital is closer or substantially more accessible from the residence of the individual than any hospital within the United States.¹²⁶ “Residence” is defined as either the beneficiary’s fixed and permanent home to which she intends to return whenever she is away or a dwelling where the beneficiary periodically spends some time (e.g., a summer home).¹²⁷ Factors used to determine if a foreign hospital is “closer” or “substantially more accessible” from a patient’s residence include the physical distance between the residence and the hospital and whether a U.S. hospital would be impracticable due to the unavailability of beds or shortages in staff or equipment.¹²⁸

3. TEXTUAL AMBIGUITIES AND ADMINISTRATIVE MATTERS

Despite the specificity of the foreign exclusion statute in spelling out the various exceptions, its language is susceptible to an interpretation that could allow benefits to be paid for services beyond the scope of its framer’s intent. For example, under the nonemergency inpatient care exception, the statute provides that payment shall be made for services received in a “hospital located outside the United States” if the individual is a “resident of the United States” and “such hospital was closer to . . . the residence of such individual than the

cally complied with the language of the statute (i.e., he was in the United States when the emergency occurred, and the foreign hospital was closer than any hospital within the United States.) See Soc. Sec. Rul. No. 70-50, Sept. 1970, Medicare and Medicaid Guide (CCH) ¶ 29,194 (Nov. 30, 1970).

125. See Soc. Sec. Rul. No. 70-50, Sept. 1970, Medicare and Medicaid Guide (CCH) ¶ 29,194.

126. 42 U.S.C. § 1395f(f)(1).

127. See *MIM*, *supra* note 106, § 3698.5.

128. See *id.* § 3698.13(B)(2). A variety of other criteria figure into the determination whether the foreign or domestic hospital was the most accessible, depending on whether the foreign hospital was located in a rural or suburban area. See 42 C.F.R. §§ 424.106(b), (c).

nearest hospital within the United States.”¹²⁹ Presumably, an individual could be a resident of the United States but maintain another residence overseas because, as explained previously, “residence” is defined to include a dwelling where the beneficiary spends a substantial amount of time.¹³⁰ Nevertheless, all of the exceptions to the foreign exclusion provide benefits for services received in only those countries “geographically adjacent” to the United States (i.e., Canada and Mexico).¹³¹

The government has set up specific procedures to be used in paying for services received under the foreign exclusion exceptions.¹³² For instance, it has designated specific “fiscal intermediaries,” or claims processors, to process claims for services received in foreign institutions.¹³³ These fiscal intermediaries must follow specific guidelines when approving and making payment for charges received in Canada and Mexico.¹³⁴ Additional filing requirements have also been imposed on both beneficiary- and provider-submitted claims when the services originate outside the United States.¹³⁵

129. 42 U.S.C. § 1395f(f)(1).

130. See *supra* text accompanying note 127.

131. See Health Care Finance Administration Ruling No. 79-11, Medicare and Medicaid Guide (CCH) ¶ 1239.11 (May 25, 1997); see also *MIM*, *supra* note 106, § 3698.5 (“Coverage is provided for inpatient hospital services furnished in a *Canadian/Mexican* hospital . . .”) (emphasis added). This interpretation avoids the possibility of a situation like the following from occurring. Suppose a Medicare beneficiary owns a summer home in Germany and spends a substantial amount of time there every year. Under Medicare guidelines, this would be considered a residence. The individual also needs an operation while he is in Germany and decides to have it in Germany. The German hospital is obviously closer to his German residence than any American hospital, thus satisfying the technical requirements of the nonemergency exclusion. Limiting the exclusion to services received in geographically adjacent countries not only avoids problems like this, but is also consistent with the legislative history, which was to address the unique problems faced by “border residents.” See H.R. REP. NO. 92-231, at 77 (1972), reprinted in 1972 U.S.C.A.N. 4989, 5064. In addition, as the emergency exception has been interpreted to require a “sequence” of events to occur before payment is made, and the Canadian travel exception applies only to services received in Canada, the possibility of receiving benefits for services in a country other than Canada or Mexico is eliminated.

132. See generally *MCM*, *supra* note 107, § 2312.

133. See *MCM*, *supra* note 107, §§ 2312.3–2312.4.

134. See *id.* § 2312.5. For example, if services received in Canada qualify under one of the foreign exclusion exceptions, fiscal intermediaries must pay the services at the lower of (1) the charge for similar services in a U.S. locality closest to where the services were furnished, as determined by the intermediary, or (2) the Canadian Provincial fee. See *id.* Thus, the fiscal intermediary is additionally required to obtain the most recent schedule of fees published by the appropriate Canadian province. See *id.*

135. See *MIM*, *supra* note 106, § 3698.11.

As a final note, coverage under all three statutory exceptions includes payment for any physician and ambulance services connected to inpatient care received in a foreign hospital that would normally be covered under Medicare Part B.¹³⁶

4. POSSIBLE POLICIES BEHIND THE FOREIGN EXCLUSION

As already discussed, the legislative history surrounding the foreign exclusion is sparse at best.¹³⁷ Apart from the limited exceptions added to address the unique problems of Medicare beneficiaries living near the U.S. borders¹³⁸ and those traveling between the continental United States and Alaska,¹³⁹ the denial of benefits for any services received outside the United States appears to have been accepted without question.¹⁴⁰ Even if there was no interest in challenging or overturning the foreign exclusion, one might still expect to find some explanation for restricting Medicare benefits to such a large degree in legislative reports or committee hearings. Yet no such answers are forthcoming. In the face of congressional silence and the tacit acquiescence of the legal community, it will be necessary to speculate, rather than report, as to Congress's reasons for drafting and approving the Medicare foreign exclusion. However, some of the possible policies that might have led Congress to prohibit payment for services provided in a foreign country may be gleaned from cases and other materials.

Perhaps one of the most important concerns of Congress in limiting benefits to services provided within the United States was the difficulty of administering and monitoring medical services in foreign countries.¹⁴¹ In particular, practical considerations such as physical distance, linguistic and fiscal differences, and major variations in the level of health care may have persuaded Congress that it was simply not feasible to extend Medicare coverage beyond the water's edge.¹⁴²

136. See 42 C.F.R. § 424.124. Return ambulance trips from a foreign hospital, however, are not covered under the exceptions. See *MIM*, *supra* note 106, § 3698.6.

137. See *supra* notes 32–56 and accompanying text.

138. See *supra* notes 126–28 and accompanying text.

139. See *supra* notes 100–15 and accompanying text.

140. See *supra* notes 43–47 and accompanying text.

141. See *Milkson v. Secretary of the Dep't of Health & Human Servs.*, 633 F. Supp. 836, 838 (E.D.N.Y. 1986).

142. See Health Care Finance Administration Ruling No. 79-11 (1979).

In one sense, the three exceptions to the foreign exclusion¹⁴³ fit this theory quite well. Those exceptions strictly limit payments to Canadian or Mexican health care providers.¹⁴⁴ More importantly, they require that Canadian or Mexican providers be licensed in their respective countries by the appropriate licensing agency *and* be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)¹⁴⁵ or by a similar “program of the country where [they are] located under standards” that are “essentially equivalent to those of the JCAH[O].”¹⁴⁶ Because of this requirement for similar accreditation standards, it is presumably easier for the U.S. government to ensure that these foreign hospitals provide a uniform standard of care to Medicare beneficiaries. Moreover, the other practical concerns that arise when providing Medicare benefits in foreign countries are not nearly as problematic with Canada or Mexico. Both are geographical neighbors of the United States, and perhaps because of this close proximity, the federal government is arguably more familiar with the currencies and languages (obviously at least with respect to the English-speaking portion of Canada) of these two countries. For these reasons, the limited exceptions to the foreign exclusion seem quite reasonable in light of the above discussion.

A related source of concern might have been the inability to control fraudulent claims by foreign providers or beneficiaries receiving services in a foreign country.¹⁴⁷ Lack of an authority to monitor the internal activities and procedures of foreign providers, as well as dishonest beneficiaries submitting their own claims from overseas for services they never received, may have led Congress to believe

143. See *supra* notes 116–28 and accompanying text.

144. See generally *supra* note 131 and accompanying text.

145. The JCAHO, once called the Joint Commission on Accreditation of Hospitals (JCAH), is a national accrediting agency that sets minimum standards for patient care. See Timothy Stoltzfus Jost, *Medicare and the Joint Commission on Accreditation of Healthcare Organizations: A Healthy Relationship?*, 57 *LAW & CONTEMP. PROBS.* 15, 16–17 (1994). Medicare generally requires domestic providers to obtain JCAHO accreditation in order to participate in and receive payment under the Medicare program. See 42 U.S.C. § 1395bb (1994). The article by Professor Jost cited in this footnote contains an excellent general discussion of the JCAHO accreditation requirement under Medicare.

146. 42 C.F.R. § 424.123(c)(2) (1998); see also *id.* § 409.3(e); *MCM*, *supra* note 107, § 2312.2(B).

147. Cf. *Aznavorian v. Califano*, 440 F. Supp. 788, 797 (S.D. Cal. 1977), *rev'd*, 439 U.S. 170 (1978) (similar federal benefit program, which imposed a 30-day restriction on time spent outside the United States, defended on grounds that it was necessary to prevent fraud).

that it could not effectively deter and punish fraudulently filed claims.¹⁴⁸ Again, this argument makes a certain amount of sense with respect to the limited exceptions for services provided in Mexican and Canadian hospitals. The physical proximity to these countries and the requirement for JCAHO-type accreditation may have prompted Congress to believe that it could legitimately enforce Medicare regulations, filing requirements, and claim submission guidelines, as well as punish violations of these procedures to the extent that the Medicare statute would allow.

Finally, various economic concerns may have also prompted Congress to limit Medicare benefits to American providers and appear to provide the best explanation for the foreign exclusion and its limited exceptions. First, Congress may have decided that the limited Medicare funds should be spent only within the borders of the United States.¹⁴⁹ Because the net effect of Medicare is to subsidize health care for elderly patients, Congress would likely prefer to deliver those payments to the businesses that would most directly contribute to the American economy—namely, American-based health care providers and those non-American providers nearest the U.S. borders—rather than subsidizing foreign economies vis-à-vis Medicare payments to foreign health care providers.

Second, and perhaps the most compelling reason, may be the sheer cost of providing health care benefits worldwide.¹⁵⁰ Yearly Medicare expenditures have already reached the \$200 billion mark.¹⁵¹ And, although no estimates are available, it is likely that removing the foreign exclusion would add significantly to an already overburdened Medicare budget.¹⁵²

148. See *Milkson v. Secretary of the Dep't of Health & Human Services*, 635 F. Supp. 836, 838 (E.D.N.Y. 1986).

149. See *id.*; see also *Aznavorian*, 439 U.S. at 178 (speculating that “Congress may simply have decided to limit payments to those who need them in the United States”).

150. See Pete Stark, *Republican Medical Savings Account Proposal Provides Windfall to Those Retiring Overseas. Could Cost Medicare Hundreds of Millions Extra*, GOV'T PRESS RELEASE (Federal Document Clearing House), Feb. 14, 1996, available in 1996 WL 8783267 (noting that Medicare is not “wallowing in money” and that providing benefits for retirees living overseas would cost Medicare billions of dollars).

151. See *Health Care Spending Growth Rates Stay Low in 1998; Private Spending Outpaces Public*, U.S. NEWSWIRE, Jan. 10, 2000, available in 2000 WL 4140156.

152. See Stark, *supra* note 150.

B. The Constitutionality of the Foreign Exclusion and the Right to Travel Abroad

Although not obvious at first glance, the foreign exclusion does have a constitutional dimension, which was played out in *Milkson v. Secretary of the Department of Health & Human Services*¹⁵³—the only case to actually discuss the foreign exclusion.¹⁵⁴ Specifically, by leaving Medicare beneficiaries without health care coverage once they leave the United States, the foreign exclusion deters these same individuals from traveling overseas and consequently infringes on their constitutional right to travel abroad.¹⁵⁵ In order to more fully appreciate this argument, it is helpful to review the constitutional right to international travel itself, along with its origins, history, subsequent development, and application in analogous contexts.

The U.S. Supreme Court first recognized and subsequently developed the right to foreign travel in a trilogy of cases during the 1950's and 1960's. In the first of these, *Kent v. Dulles*,¹⁵⁶ the Secretary of State had promulgated a regulation that authorized the denial of passport applications on the basis of a citizen's political associations.¹⁵⁷ Pursuant to this regulation, the State Department refused to issue a passport to Kent because it found that he was a Communist and adhered to the Communist Party line.¹⁵⁸ In passing on the Secretary's authority to enact such a regulation, the Court began with a detailed exposition on the right to travel abroad.¹⁵⁹ It traced the "freedom of movement across frontiers" as part of the national heritage¹⁶⁰ and even stated that it "may be as close to the heart of the individual as the choice of what he eats, or wears, or reads."¹⁶¹ The Court then declared that "the right to travel is part of the 'liberty'" protected by the Fifth Amendment's due process clause.¹⁶² Although unclear from this dictum,¹⁶³ it appeared that the Court originally interpreted the right to

153. 633 F. Supp. 836 (E.D.N.Y. 1986).

154. As mentioned before, the Medicare foreign exclusion has been at issue in a case just once. In *Milkson*, the exclusion was the *only* issue discussed. *See id.*

155. *See id.* at 838.

156. 357 U.S. 116 (1958).

157. *See id.* at 117 n.1.

158. *See id.* at 118.

159. *See id.* at 121.

160. *Id.* at 126.

161. *Id.*

162. *Id.* at 125; *see also id.* at 129.

163. The Court's actual holding rested on a narrow construction of the statute which the Secretary relied upon to enact the regulation at issue. It interpreted the un-

international travel as a fundamental right and was willing to subject it to strict scrutiny.¹⁶⁴

A few years later, in *Aptheker v. Secretary of State*,¹⁶⁵ the Court was forced to confront the very issue that it had deftly avoided in *Kent*: whether Congress could deny passports on the basis of an individual's political affiliations.¹⁶⁶ In *Aptheker*, Congress had passed a statute that expressly prohibited members of Communist organizations to hold or be issued passports.¹⁶⁷ *Aptheker* subsequently challenged the statute on the grounds that it violated his right to travel abroad.¹⁶⁸ True to the holding in *Kent*, the Court reaffirmed its earlier opinion by declaring that the right to travel abroad was a constitutionally protected right¹⁶⁹ and that regulation of such a "basic freedom" must be "narrowly drawn to prevent the supposed evil."¹⁷⁰ It thus seemed clear after *Aptheker* that the Court would subject any law infringing on the right to international travel to strict judicial review similar to that used in assessing restrictions on fundamental rights or affecting suspect classes in equal protection analysis.¹⁷¹

However, contrary to the outcomes in *Kent* and *Aptheker*, the Court upheld a direct restriction placed on the use of passports in *Zemel v. Rusk*¹⁷² just one year after it decided *Aptheker*. In the wake of the Cuban missile crisis, the Secretary of State imposed a so-called area restriction on the use of passports, which allowed him to invalidate all U.S. passports for travel to Cuba.¹⁷³ In rejecting the plaintiffs' argument that the area restriction impermissibly infringed on their constitutional right to travel abroad, the Court held that the national security interests involved during the Cuban missile crisis were enough

derlying statute narrowly and found that it did not delegate authority to the Secretary to deny passports on the basis of political association. *See id.* at 129. By doing so, the Court avoided the more serious question of whether Congress could constitutionally deny passports on such a basis. *See id.* at 129–30. However, as will be seen, the Court faced this exact issue only a few years later in a subsequent passport denial case. *See Aptheker v. Secretary of State*, 378 U.S. 500 (1964); *see also infra* notes 165–71 and accompanying text.

164. *See* Thomas E. Laursen, Note, *Constitutional Protection of Foreign Travel*, 81 COLUM. L. REV. 902, 907 (1981).

165. 378 U.S. 500 (1964).

166. *See id.* at 506.

167. *See id.* at 501–02.

168. *See id.* at 503–04.

169. *See id.* at 507–08.

170. *Id.* at 514 (internal quotation marks and citations omitted).

171. *See* Laursen, *supra* note 164, at 907.

172. 381 U.S. 1 (1965).

173. *See id.* at 3.

to justify the area restriction.¹⁷⁴ However, the Court's opinion failed to clarify a number of lingering issues: (1) the appropriate standard of review for the right to travel abroad, (2) whether international travel is a fundamental right, and (3) the constitutional basis for the right to travel abroad.¹⁷⁵

After two decades of silence, the Court again addressed the right to travel abroad in *Califano v. Aznavorian*,¹⁷⁶ a case which has particular significance for the Medicare foreign exclusion. The Supplemental Security Income program (SSI) is a federal program that provides monthly monetary benefits to the aged, blind, and disabled.¹⁷⁷ However, recipients lose benefits for any month that they spend entirely outside the United States and, if they remain out of the country for a period of more than thirty consecutive days, they also forfeit subsequent monthly benefits until they return to the United States for a period of thirty days.¹⁷⁸ Aznavorian, an SSI beneficiary, challenged these provisions, claiming that they infringed on her right of international travel.¹⁷⁹ The Court, however, disagreed and held that the provisions were valid.¹⁸⁰ More importantly, the Court carefully articulated the theoretical basis for its holding by explaining that "the 'right' of international travel has been considered to be no more than an aspect of the 'liberty' protected by the Due Process Clause of the Fifth Amendment. As such this 'right' . . . can be regulated within the bounds of due process."¹⁸¹ Thus, the Court retreated from its earlier position in the passport cases and relegated the right to international travel to a lesser standard of review.¹⁸² Specifically, the Court applied a rational basis test and explained that a law imposing an "incidental effect" on the right of international travel would be valid unless "wholly irrational."¹⁸³ Under this deferential standard, the SSI provision easily survived judicial scrutiny.¹⁸⁴

174. *See id.* at 15.

175. *See* Laursen, *supra* note 164, at 907-08.

176. 439 U.S. 170 (1978).

177. *See id.* at 171.

178. *See id.*

179. *See id.*

180. *See id.* at 178.

181. *Id.* at 176.

182. *See id.*

183. *Id.* at 177.

184. *See id.* at 178. Specifically, the Court found that the possible justifications for the 30-day limitation—the fear that a person who remains outside the country for more than 30 days is no longer a resident, the difficulty of monitoring the continuing

In light of *Aznavorian*, it is easy to understand how the district court in *Milkson* found the Medicare foreign exclusion to pass constitutional muster.¹⁸⁵ The court reasoned that the difficulties of administering medical services abroad and the concern that Medicare funds be spent within the United States were not particularly compelling,¹⁸⁶ but were rationally based.¹⁸⁷ It thus concluded that the foreign exclusion satisfied the rational basis test and summarily dismissed the plaintiff's claim.¹⁸⁸

C. Comparing the Medicare Foreign Exclusion with Other Federal Benefit Programs

To provide a fuller and more complete critique of Medicare's foreign exclusion, it is helpful to see how other federal benefit programs deal with the problem of receiving services or providing payments outside the United States. In particular, this section surveys the relevant portions of three programs funded by the federal government that provide benefits comparable to those provided through Medicare: Social Security, Supplemental Security Income, and TRICARE.

1. SOCIAL SECURITY

Title II of the Social Security Act¹⁸⁹ provides individuals over the age of sixty-two¹⁹⁰ and who have worked for a minimum number of years¹⁹¹ with monthly benefit payments.¹⁹² Social Security is essentially a federally funded retirement insurance program for workers

eligibility of persons outside the country, and Congress's desire that SSI funds be spent in the United States—were not necessarily compelling, but were at least rationally based. *See id.*

185. It is worth noting that the most extensive (and only) judicial analysis of the Medicare foreign exclusion is the *Milkson* case. Yet this case fills less than three complete pages in the Federal Reporter. *See Milkson v. Secretary of Dep't of Health & Human Servs.*, 633 F. Supp. 836 (E.D.N.Y. 1986). This is simply another indication of the complete lack of in-depth, comprehensive analysis on this important Medicare provision.

186. *See id.* at 838.

187. *See id.*

188. *See id.*

189. 42 U.S.C. §§ 401–433 (1998).

190. *See id.* § 402(a)(2).

191. Again, this calculation is based on the number of “quarters of coverage” as defined in 42 U.S.C. §§ 402, 413–414. And, once again, the average minimum number is 10 years. *See supra* note 10 and accompanying text.

192. *See* 42 U.S.C. § 402(a).

and their dependents.¹⁹³ Like Medicare, Social Security is funded through payroll tax deductions withheld from both employees and employers.¹⁹⁴ Unlike Medicare, however, Social Security checks generally follow recipients wherever they go around the world, subject only to a few exceptions.¹⁹⁵ In fact, Social Security payments continue no matter how long a beneficiary stays outside the United States¹⁹⁶—even if the individual retires overseas.¹⁹⁷

2. SUPPLEMENTAL SECURITY INCOME

Supplemental Security Income (SSI)¹⁹⁸ is a “need-based” program designed to help individuals who are over the age of sixty-five, blind, or disabled.¹⁹⁹ Basically a welfare program, all recipients must meet income and resource requirements before becoming eligible.²⁰⁰ Unlike Medicare or Social Security, SSI is not dependent upon wage contributions made during the recipient’s lifetime.²⁰¹ Additionally, as discussed previously in the *Aznavorian* case,²⁰² SSI benefits cease once a recipient remains outside the United States for more than thirty days, although the benefits may be reinstated once the recipient has returned to the United States for a period of at least thirty days.²⁰³ This means, of course, that SSI payments do not stop simply because the recipient has left the United States—so long as the recipient returns to the United States within thirty days, SSI benefits will continue as before.

3. TRICARE

TRICARE is the equivalent of a Medicare program for the U.S. military²⁰⁴ and provides medical coverage to both active duty and re-

193. See Sarah H. Bohr, *Overview of Social Security Insurance Benefits and Supplemental Security Income (SSI)*, 40 SOC. SEC. REP. SER. 685, 687 (1993).

194. See 42 U.S.C. § 401(a).

195. See *Social Security—Your Payment While You Are Outside the United States* (visited Feb. 1, 2000) <http://199.173.225.3/international/your_ss.html>. Restrictions prohibit sending Social Security checks to Cuba, Cambodia, North Korea, Vietnam, and some areas that were formerly part of the Soviet Union. See *id.*

196. See *id.*

197. See *id.*

198. 42 U.S.C. §§ 1381–1383c.

199. See Bohr, *supra* note 193, at 687.

200. See *id.*

201. See 20 C.F.R. § 416.202 (1998).

202. See *supra* notes 176–84 and accompanying text.

203. See 42 U.S.C. § 1382(f).

204. See generally 10 U.S.C. §§ 1071–1106 (1998); 32 C.F.R. § 199 (1998). TRICARE

tired members of the uniformed services and their dependents.²⁰⁵ One important difference between Medicare and TRICARE, however, is that, whereas Medicare derives its funds principally from payroll withholding taxes, funds for the TRICARE program come from general revenue that is appropriated for the Department of Defense.²⁰⁶

The purpose of the TRICARE program is to coordinate health care between military medical treatment facilities and civilian sector health care providers.²⁰⁷ It does so by allowing the military to enter into agreements with civilian health care providers and establish civilian preferred provider networks.²⁰⁸ Thus, when a TRICARE beneficiary is unable to obtain medical services from the local military treatment facility, TRICARE will share in the cost of obtaining those services from one of the civilian network providers.²⁰⁹

In terms of the level of benefits, the types of medical services covered (and not covered), and out-of-pocket costs to TRICARE beneficiaries, coverage under TRICARE is actually quite similar to coverage under Medicare.²¹⁰ Unlike Medicare, however, TRICARE has

was once known as the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), which has been gradually phased out over the last few years. TRICARE derives its name from the fact that an eligible beneficiary has three options to choose from when enrolling: TRICARE Standard, TRICARE Extra, and TRICARE Prime. *See* 32 C.F.R. § 199.17(a)(6)(ii). These three options offer varying levels of benefits and out-of-pocket costs, with TRICARE Prime offering the lowest amount of beneficiary out-of-pocket costs and TRICARE Standard the highest. *See id.* §§ 199.17(d), (e), (f). TRICARE thus works effectively like a private managed-care health plan, where beneficiaries may choose among various plans, depending on the out-of-pocket costs they are willing to incur. *See id.*

205. *See* 10 U.S.C. § 1072(2); 32 C.F.R. §§ 199.3(b), 199.17(b).

206. *See* 32 C.F.R. § 199.1(e).

207. *See id.* § 199.17(a)(1).

208. *See id.* § (p).

209. *See id.* § 199.4(a).

210. *Compare Medicare Guide, supra* note 15, at 9–10 (describing benefits, services, and out-of-pocket costs under Medicare), *with* TRICARE/CHAMPUS Policy Manual 6010.47-M, ch. 13, § 11.1, tbl.1 (visited Feb. 1, 2000) <<http://www.tricare.osd.mil>> [hereinafter TRICARE/CHAMPUS Policy Manual] (describing benefits, services, and out-of-pocket costs under TRICARE). For the most part, TRICARE benefits track those of the basic CHAMPUS program. *See* 32 C.F.R. § 199.4(a)(1)(ii).

That TRICARE and Medicare are meant to complement each other is evidenced by the fact that TRICARE eligibility usually ends when Medicare eligibility begins. That is, TRICARE provides coverage to military retirees and their dependents until they turn 65; once they turn 65 years old, their TRICARE eligibility automatically ends and Medicare eligibility begins. *See* 10 U.S.C. § 1086(d)(1)-(2) (1998). Interestingly, Congress has recently initiated a demonstration project to test the desirability of allowing individuals who have lost their TRICARE eligibility by virtue of becoming eligible for Medicare to continue using TRICARE, not as a replacement of Medicare, but instead as a supplement to Medicare. *See* 42 U.S.C. § 1395ggg (Supp. 1999).

been implemented outside the United States by virtue of the "TRICARE Overseas Program" (TOP).²¹¹ In fact, the Department of Defense has developed preferred provider networks in foreign host nations around the world,²¹² and the TRICARE Europe network itself totals more than 1200 individual and institutional providers throughout Europe and the United Kingdom.²¹³ To be clear, this means that TRICARE beneficiaries who are stationed or residing in another country can obtain medical care from a civilian foreign health care provider, and the federal government shares in the cost for those services.²¹⁴ In 1996, for example, the Department of Defense spent approximately \$35 million on health care delivered by host-nation medical providers in TRICARE Europe alone.²¹⁵

In order to overcome variations in standards of health care practice between the United States and foreign countries and carry out the everyday, practical functions of providing payments for services rendered by a foreign health care provider, the Department of Defense has enacted special rules and regulations that apply only to TOP.²¹⁶ For example, JCAHO accreditation is not required of foreign providers, and the strict certification requirements imposed on stateside

211. See TRICARE/CHAMPUS Policy Manual, *supra* note 210, ch. 12, § 1.1(IV) (stating that "TOP is effective in all geographical areas and territorial waters outside the United States"). The TRICARE regulations specifically give the Assistant Secretary of Defense (Health Affairs) this authority. See 32 C.F.R. §§ 199.17(a)(3), (u). The CHAMPUS regulations, on the other hand, mandated that CHAMPUS would apply "in all foreign nations," unless specifically exempted. See *id.* § 199.1(b)(1).

TOP is divided into three regions: TRICARE Europe, TRICARE Pacific, and TRICARE Latin America and Canada. See TRICARE/CHAMPUS Policy Manual, *supra* note 210, ch. 12, § 1.1(I). Unlike its stateside counterpart, however, TOP currently does not offer all three TRICARE options; instead, it offers only TRICARE Prime and TRICARE Standard. See *id.* § 1.1(III). For a description of the different out-of-pocket costs that apply to TOP, as opposed to TRICARE in the United States, see *id.* § 2.1(II).

212. See *id.* § 1.1(II).

213. See *TRICARE Europe Benefits Explained* (visited Jan. 25, 2000) <<http://webservice.europe.tricare.osd.mil/main/Customersupport/Benefits/tesobene.html>> [hereinafter *TRICARE Europe Benefits*].

214. It is worth reemphasizing that TRICARE benefits are available for retired military personnel and their dependents. Thus, a retired officer and his or her spouse, who decide to retire overseas, can continue to receive medical care from civilian health care providers and have TRICARE pick up the tab (assuming, of course, they are both TRICARE eligible.) See TRICARE/CHAMPUS Policy Manual, *supra* note 210, ch. 12, § 1.1(VI).

215. See *TRICARE Europe Benefits*, *supra* note 213. TRICARE Europe includes Europe, Africa, and the Middle East. See *id.*

216. See generally 32 C.F.R. § 199.17 (1998); TRICARE/CHAMPUS Policy Manual, *supra* note 210, ch. 12.

TRICARE network providers are also relaxed for foreign providers.²¹⁷ In addition, these regulations also require the TOP claims processor to have the ability to translate claims submitted in any foreign language and to pay foreign providers in the foreign currency of the country in which the services were rendered.²¹⁸ As a result of these and other generally applicable regulations, TOP is a carefully crafted system that protects the host nation's providers,²¹⁹ gives the United States military authority to monitor and control the quality of the medical care provided,²²⁰ confers upon the government the right to recoup erroneous or fraudulent payments made to foreign providers and delineates the procedures for doing so,²²¹ and provides easy access for TRICARE beneficiaries to a network of foreign providers who are familiar with American patients and are willing to accept payment from the U.S. government.²²²

4. PUTTING THE FOREIGN EXCLUSION IN CONTEXT

As viewed against other federal benefit programs, the Medicare foreign exclusion emerges as an anomaly. Both Social Security and Medicare are premised upon the idea that "you get out what you put in" because funds for each program are paid out of employee and employer payroll withholding taxes.²²³ Both utilize the same criteria to determine eligibility.²²⁴ Yet, Social Security payments follow beneficiaries overseas, no matter how long they remain outside the United States, while Medicare benefits stop at the border.²²⁵

The foreign exclusion becomes even more inexplicable when contrasted to SSI. Unlike Medicare, SSI is purely a welfare program

217. See TRICARE/CHAMPUS Policy Manual, *supra* note 210, ch. 12, § 2.1(I)(B). In general, to become a TOP network provider, the foreign provider need only comply with the credential standards of the host nation. See *id.* § 11.1, enclosure 1.1; see also *id.* § 12.1(II)(B)(1)(f)(3) (stating that licensure or certification of TOP providers is necessary only if the foreign providers' services or practices are "questionable").

218. See *id.* §§ 12.1(II)(B)(1)(c), 12.1(II)(F). Besides the host of other regulations that apply to TOP claims in general, a number of special requirements apply exclusively to TRICARE Europe claims and, even more specifically, to German claims. See *id.* §§ 12.1(II)(C), 12.1(II)(D).

219. See *id.* § 11.1, enclosure 1.1.

220. See *id.*

221. See 32 C.F.R. § 199.11.

222. See *id.*

223. See 42 U.S.C. §§ 401, 1395I (1999).

224. See *supra* notes 189–92 and accompanying text.

225. See *supra* notes 196–97 and accompanying text.

that does not condition receipt of payment upon prior contributions.²²⁶ SSI is entirely funded by the federal government without the help of payroll withholding taxes.²²⁷ Yet the government allows beneficiaries to receive SSI benefits even if they remain outside the United States for up to thirty days.²²⁸

Perhaps these differences between Medicare on the one hand and SSI and Social Security on the other hand can be explained by the fact that SSI and Social Security payments are sent directly to beneficiaries,²²⁹ whereas Medicare payments are normally sent directly to the health care providers.²³⁰ In addition, Medicare benefits depend, of course, upon services being rendered, and the problems of monitoring foreign providers do not exist when the government does nothing more than send a monthly check to a beneficiary. However, this does not explain why benefits under TRICARE extend to services rendered in foreign countries. Providing benefits to foreign providers under TRICARE presents exactly the same types of risks that doing so under Medicare would present.²³¹ One could surely argue that permitting payment to foreign providers under TRICARE is necessary because of American military presence in the countries of those foreign providers. But this argument fails to recognize that, if the government *already* has a system in place to ensure the quality of care and prevent fraud in other countries, there is no reason why Medicare could not utilize that same system to provide benefits to civilian travelers in those same countries.²³²

IV. Resolution: A Proposal to Amend the Medicare Foreign Exclusion

Given the many flaws and inconsistencies inherent in the Medicare foreign exclusion, it is rather remarkable that it has remained largely unchallenged and unchanged in its thirty-five year history. The unspoken premises upon which it is based are an affront to fundamental notions of fairness and reasonableness. The idea that one

226. See *supra* note 201 and accompanying text.

227. See 42 U.S.C. § 1381 (1998).

228. See *id.* § 1382(f).

229. See *id.* §§ 405(l) (Social Security), 1383(a)(2)(A)(l) (SSI).

230. See *id.* §§ 1395f–1395g, 1395l–1395n, 1395cc (1999).

231. See *supra* notes 137–52 and accompanying text.

232. See Powers, *supra* note 1, at A8.

gets out what one puts in strikes at the heart of Medicare, but the foreign exclusion openly violates this very principle.²³³

First, some of the services prohibited under the foreign exclusion bear absolutely no rational relation to any of the possible policies discussed previously for keeping Medicare funds within the United States.²³⁴ That is, no satisfying explanation exists as to why Medicare payments could not be made to ships and airplanes of American registry, regardless of whether they are physically located in American waters or airspace at the time services are rendered;²³⁵ or to DME supply companies that are already doing business within the United States, no matter if it sends its products beyond American boundaries.²³⁶

The argument that administering and monitoring claims originating from overseas poses too many practical difficulties is completely without merit in these particular situations. In fact, if Congress were truly concerned about such things as a minimum standard of care, linguistic and fiscal differences, and physical proximity, there should be an even greater incentive to pay for services in these two circumstances. Ships of American registry and DME suppliers located within the United States can be regulated by American accreditation standards just as any other health care provider operating within the United States. Moreover, the fiscal and linguistic differences are completely non-existent in these situations. Finally, any potential problems caused by physical distance also disappear in this context because DME companies doing business in the United States and ships of American registry are already located within the United States.

The concern that foreign providers do not satisfy American quality levels and standards of health care has also begun to break down in the face of recent trends towards globalization. Specifically, JCAHO recently announced a change in its long-standing policy of not accrediting foreign health care organizations²³⁷ and has now be-

233. See Arthur Higbee, *American Topics*, INT'L HERALD TRIB., Mar. 14, 1994, at 3 (arguing that "Americans overseas have never had access to Medicare . . . even though they have paid into the program for decades"); *U.S. House Creates Expatriate Task Force*, TULSA TRIB., Nov. 9, 1989, at A-16 (noting that hundreds of thousands of Americans receiving health services abroad "are denied Medicare benefits even though they have paid for them through their taxes").

234. See *supra* notes 137-52 and accompanying text.

235. See *supra* note 115 and accompanying text.

236. See *supra* notes 106-09 and accompanying text.

237. See J. Duncan Moore, Jr., *Going Global: JCAHO to Accredite Foreign Healthcare*

gun providing accreditation on a worldwide basis to any health care provider that requests its services.²³⁸ Whatever fears Congress initially had over the lack of appropriate health care standards in foreign countries are simply no longer valid in today's global marketplace.

Similarly indefensible in this context is the suggestion that the government would be handicapped in preventing the filing of fraudulent claims. Whatever merit this argument has regarding foreign-owned providers located in countries other than Canada or Mexico, it fails as applied to the two situations described above. One can hardly doubt that Congress possesses the authority to regulate ships of American registry and DME providers located within the United States.

The foreign exclusion is particularly troubling when compared with other general exclusions found in the Medicare statute. Most people would probably not consider it unfair to deny payment for such things as personal comfort items,²³⁹ purely elective cosmetic surgery,²⁴⁰ or any other service that is not "reasonable and necessary" for medical treatment²⁴¹ because these types of health care costs do not contribute to the improvement of a patient's condition. In stark contrast, the foreign exclusion denies *even medically necessary* services, as long as they are not provided within the United States.²⁴²

Finally, denying coverage to Medicare beneficiaries for services received overseas verges upon hypocrisy in the face of TRICARE. By virtue of TOP, military personnel and their dependents, including retirees and their spouses, may seek medical care—both emergency and non-emergency—from civilian health care providers in a host country and have the U.S. government help pay the bill. In addition, TRICARE beneficiaries can take advantage of an elaborate, international network of foreign producers who are willing to accept American patients and work with the American government to receive payment. Yet these same benefits are denied to civilian Americans traveling overseas, simply because they are Medicare, rather than TRICARE, beneficiaries. Moreover, TOP regulations ensure that the

Organizations, MOD. HEALTHCARE, Apr. 6, 1998, at 44.

238. *See id.*

239. *See* 42 U.S.C. § 1395y(a)(6) (1998).

240. *See id.* § 1395y(a)(10).

241. *Id.* § 1395y(a)(1)(A)–(E).

242. *See id.* § 1395y(a)(4) (excluding payment for "any expenses incurred" for services received outside the United States, except for the limited exceptions identified in section 1395f(f) (emphasis added)).

U.S. military is able to administer its foreign provider network, control fraud and abuse, process claims efficiently and accurately, and provide assistance to TRICARE beneficiaries and providers. In short, there appears to be no reason why the same TOP system, along with its administrative regulations and network of foreign providers, could not be utilized to provide coverage for medically necessary services received by Medicare patients while traveling abroad.

With these concerns in mind, this note proposes that the Medicare foreign exclusion be amended in two ways: first, to include payment for services received from any American-owned health care provider, regardless of where that provider is located or where the services are rendered; and, second, to include payment for emergency services received from a foreign provider while outside the United States for a limited period of time.

The first amendment would cure the two anomalies currently existing under the foreign exclusion: services provided by (1) a ship of American registry more than six hours from the closest American port and (2) a DME supplier located within the United States sending its products to a foreign address.²⁴³ Such an amendment could be accomplished by adding a paragraph like the following to the foreign exclusion exceptions found in 42 U.S.C. § 1395f(f):

Payment may also be made for any services furnished an individual who would otherwise be covered under Parts A or B of this chapter, regardless of whether the services are rendered within or outside the United States, so long as the provider of services is a corporation organized under the laws of any state, has its principal place of business within any state, or is registered to do business within the United States.

The second amendment would provide much needed health care protection for elderly travelers while on vacation in foreign lands. As already suggested, Congress should incorporate the same system that is already in place under the TRICARE Overseas Program to provide benefits for services received overseas under Medicare. That is, it should condition coverage under the proposed exception to the Medicare foreign exclusion upon the beneficiary receiving services from a TRICARE foreign network provider. From the government's perspective, the advantages of using the TOP provider network are obvious: it provides assurance that the foreign providers are not only legitimate, but are properly accredited and certified by the appropriate

243. See *supra* notes 106–15 and accompanying text.

authorities in the providers' home country, that the level of health care they provide satisfies American standards, and that they are already familiar with treating American patients, receiving payments from the U.S. government, and dealing with the government's procedures. And the provider network may be even more important to a Medicare beneficiary because it guarantees that certain foreign providers will be available and willing to care for an American patient in the case of an emergency while traveling overseas and that Medicare will pay for services rendered by those foreign providers. Before even leaving the United States for a trip abroad, a Medicare beneficiary would be able to obtain a list of network providers in the country(ies) of destination and plan the trip accordingly by knowing where to go in an emergency. Such peace of mind is invaluable to anyone traveling in a foreign country.

With the TRICARE Overseas Program, Congress also already has an effective administrative scheme that both it and the foreign providers are familiar with, allowing for a smoother and more efficient transition to provide Medicare benefits outside the United States. To take advantage of the collective expertise gained from working within this system, HCFA could contract with the TOP fiscal intermediary to process the new Medicare foreign claims. As noted earlier, the Department of Defense requires its TOP fiscal intermediary to have the capability of translating claims submitted in any foreign language, to issue payments in foreign currency, and to provide customer assistance to foreign providers. Moreover, this fiscal intermediary is well-acquainted with TOP's other claims processing guidelines and the various regulations for reviewing claims and recouping overpayments. Thus, because the TOP fiscal intermediary is adept at handling TRICARE foreign claims, and because of the similarity between TRICARE and Medicare, including the same overseas provider network, having this same fiscal intermediary handle the Medicare foreign claims should be a nearly seamless process for all concerned—the government, the beneficiaries, and the foreign providers.

In addition, to alleviate any fears that individuals who remain overseas for extended periods of time are no longer U.S. residents, Congress could impose a durational limit on emergency services re-

ceived overseas, similar to that used under SSI.²⁴⁴ Thus, Medicare eligible beneficiaries could claim any emergency services received outside the United States that began within the first thirty days from the date of their departure. Once patients remain overseas for more than thirty days, they would be deemed to have waived their Medicare coverage. Such a provision would also put potential travelers on notice that, if they plan on remaining outside the United States for more than a month, they will need to seek additional insurance. On the other hand, a thirty-day limit should provide senior travelers enough time to enjoy a long-awaited vacation without fear of losing their Medicare coverage.

As the nonemergency exclusion would primarily apply to American expatriates who decide to retire overseas, this part of the exclusion could remain intact because most such expatriates will already have given much thought to their health insurance needs before leaving the United States permanently.²⁴⁵ In fact, many will either purchase a private policy that covers them while living overseas or will be able to buy into the national health system of their adopting country.²⁴⁶

Exceptions to the Medicare foreign exclusion for emergency services received outside the United States are currently found at 42 U.S.C. § 1395f(f)(2). To enact this second proposed amendment, an additional paragraph should be inserted at the end of this section. Thus:

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual . . . by a hospital located outside the United States if—

(C) (i) the hospital is a member of the TRICARE Overseas Program provider network and (ii) the emergency which necessitated such inpatient hospital services occurred within the first thirty (30) consecutive days that the individual was outside the United States.

Of course, the Medicare statute would also need to be amended to incorporate TOP's various rules and regulations, including its procedures for processing foreign claims and its other procedures for monitoring foreign providers, but this should not pose a significant

244. See *supra* note 203 and accompanying text.

245. See Joseph D'allegro, *More Issues Must be Dealt with in Retiring Abroad*, NAT'L UNDERWRITER LIFE & HEALTH-FIN. SERVICES EDITION, Sept. 21, 1998, available in 1998 WL 20199185.

246. See *id.*

challenge. In addition, this amendment would necessarily affect the Foreign Travel Emergency benefit under Medigap policies and such policies would probably need to be revised to reflect this change in the Medicare statute.²⁴⁷

V. Conclusion

In the thirty-five years since Medicare has been on the books, a few minor exceptions to the foreign exclusion have been added, but the general exclusion of payment for services received overseas has remained intact. By exploring the substantive applications of this relatively obscure statute, it becomes clear that the policies underlying the exclusion as it now exists fail under closer scrutiny.

No one would doubt that monitoring the level of care and requiring certain standards of accreditation and certification of providers are legitimate, if not compelling, concerns of the government when paying for medical care received by American citizens in foreign countries. Along these same lines, the difficulty of preventing fraudulent claims and prosecuting offenders—both providers and beneficiaries alike—are equally satisfying justifications for denying benefits to American citizens who receive health care while outside the United States. And yet these same concerns have not stopped the government from establishing an effective and elaborate system to pay for medical costs provided in foreign countries to members of the armed forces and their dependents under TRICARE. It is inexplicable that Congress is willing to minimize the risks involved in sending payments to foreign providers for the military but not Medicare beneficiaries. If the TRICARE program works well enough to deliver quality civilian health care to military families serving in foreign nations that measures up to U.S. standards, it should certainly be adequate for Medicare patients vacationing in those same countries.

Perhaps fiscal concerns provide the best explanation as to why Congress has not authorized Medicare payments for services received overseas. It is possible that Congress feels obligated to provide medical benefits to foreign providers under TRICARE for military families

247. As noted earlier, the Medigap Foreign Travel Emergency benefit actually provides coverage up to the first 60 days that the beneficiary is outside the United States. See *supra* note 77 and accompanying text. Thus, this benefit under Medigap policies could still be retained to provide coverage for an additional 30 days beyond the initial 30 days of the proposed amendment.

because of the U.S. military presence in so many countries around the world. But this does not adequately explain why TRICARE benefits extend to military *retirees* and their spouses when they decide to remain overseas permanently. Moreover, this note's most substantial proposal—to provide Medicare coverage for emergency services received outside the United States only when the emergency occurred within the first thirty days that the individual was outside the United States—is rather limited in scope. As such, it would only modestly increase the Medicare budget. It is not an attempt to completely abandon the foreign exclusion and open the door for expanding total Medicare coverage worldwide or to let patients have procedures performed in the country of their choice. Instead, the purpose of this proposal is simply to allow Medicare beneficiaries to keep their Medicare benefits while vacationing outside the United States in the case of a medical emergency. Doing so would not appear to place a dramatic strain on Medicare expenditures, which have actually seen decreases in the last few years.²⁴⁸

Despite a judicial opinion to the contrary, the foreign exclusion does affect a Medicare beneficiary's right to travel abroad. Does it actually stop a beneficiary from traveling overseas in the same way that refusing to issue a passport does? Of course not. But health insurance coverage is critically important to older travelers. The fear that they might suffer an injury while visiting a strange land without health insurance, leaving them to finance a hefty hospital bill entirely by themselves, is unquestionably real and a valid cause for rethinking a trip abroad. It seems safe to assume that the Medicare foreign exclusion certainly discourages, if not altogether deters, some Medicare beneficiaries from traveling overseas and exercising their right to international travel.

Additionally, Medigap is hopelessly incapable of offering an efficient and economic alternative to an older traveler who wants only to purchase additional health insurance coverage while vacationing overseas. Medigap's greatest strength—its standardization of policies—is also its greatest weakness in this context. Because Medigap policies are so inflexible, they make it impossible for a Medicare beneficiary to purchase only one particular benefit. It is impractical for an individual to purchase a Medigap policy (assuming the enrollment

248. See *Health Care Spending Growth Rates Stay Low in 1998; Private Spending Outpaces Public*, *supra* note 151.

period has not already passed by) for only the Foreign Travel Emergency benefit if it also includes several other benefits for which the individual may have absolutely no use.

In the end, the Great Wall of Medicare lacks a rational foundation and is inconsistent with traditional notions of fairness. In light of other federal benefit programs that provide nearly identical or analogous benefits outside the United States, the foreign exclusion emerges not only as illogical, but almost hypocritical. The fact that the government sends Social Security payments to American citizens living abroad and provides medical coverage for military families stationed overseas under TRICARE makes it impossible to satisfactorily explain why Medicare flatly denies coverage for services provided outside North America. Similarly inexplicable is why Medicare prohibits payment to American-owned providers when their services are received or sent overseas. Finally, the foreign exclusion is a slap in the face to the millions of older workers who have paid into the Medicare system throughout their lifetime but are then denied Medicare coverage for medically necessary health care costs incurred while visiting another country.

To make sense out of the Medicare foreign exclusion and provide Medicare beneficiaries with necessary coverage while traveling abroad, two more exceptions should be added to the foreign exclusion: the first to pay for services received from an American-owned provider, no matter where the services are actually rendered, and the second to pay for emergency services received while outside the United States, up to a statutorily defined period of time (such as thirty days). Such an amendment would not only bring Medicare into line with other federal benefit programs, but would better serve the beneficiaries who have paid into the system over the years. It would allow these individuals to finally venture outside the Great Wall of Medicare and see what lies beyond.