

Redefining Medical Tourism: A Legal and Qualitative Analysis of International Medical Travel  
from the United States

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**Abstract**

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International medical travel from the United States occurs when a patient travels to a foreign country for prearranged health care services such as a new knee or a cardiac valve. This dissertation provides further insight into this phenomenon in two key areas. First, a systematic review of the multidisciplinary literature was completed to better understand how the international travel of patients for medical care has been defined. These data were then used to propose criteria for clearer terminology, which is important if international medical travel is to be more readily accepted as part of the U.S. health care delivery system, or for future regulatory efforts. Second, key informant interviews were conducted to better understand self-funded employers' use of international medical travel benefits. This research provides a framework for future legal and regulatory efforts in international medical travel.

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## **Chapter One: Introduction**

American patients are traveling internationally to access specific, prearranged acute health care services such as orthopedic, cardiac, and bariatric surgeries. Such patients are often called medical tourists in the legal, medical, and social science literature. Outbound U.S. medical tourists purposely leave their domestic health care system to access medical services in a foreign country; they are not tourists who experience an unexpected illness or injury while traveling.

U.S. patients traveling for health care is not a new phenomenon; patients travel within the U.S. to Centers of Excellence, and outside of the U.S. for care not covered by their health plans. What *is* new are U.S. self-funded employers incentivizing employees to engage in medical tourism. In an effort to lower their health care expenditures, some self-funded employers are broadening their health care benefits to include international medical travel. With lower or nonexistent copayments, caretaker provisions, sharing of cost savings, and other incentives, public and private employers are now incentivizing employees to travel great distances for health care.

Medical tourism provides a unique lens through which to examine the globalization of health care as it impacts the U.S. health care system. By purposefully moving the patient for health care services, medical tourism demonstrates some of the possibilities of global health care. Similar to outsourcing certain tasks, such as reading x-ray images or billing for medical services, outsourcing specific surgeries or other health care services may be a less costly alternative with at least equivalent quality. By examining the legal context for medical tourism, this dissertation provides a framework for future legal and regulatory analysis of the phenomenon.

## **I. Background**

### A. Self-funded Employer Sponsored Medical Tourism

By traveling, patients may escape the high prices and fragmented health care often encountered in the U.S. health care system. Patients might choose to travel outside of the U.S. for health care because of the potential cost savings, the incentives offered by an employer, for cultural reasons, or other reasons. While anyone may choose to travel outside of the U.S. for health care, this research focuses on self-funded employers offering an option to travel outside the U.S. specifically for health care.

Publicized employer encouragement of international medical tourism began in 2006 when Blue Ridge Paper Products, Inc. added an international medical tourism option to its employee benefit plan. Blue Ridge, a 100-year old company based in North Carolina, offered incentives to encourage employees to have non-emergency surgeries in India. These incentives included international airfare, extra sick-time leave, and a \$10,000 bonus.<sup>1</sup> United Steelworkers' Union, to which employees of Blue Ridge belonged, threatened to seek a temporary injunction stopping Blue Ridge from sending union employees abroad, alleging that the care abroad would be substandard and thus jeopardize the union member's life.<sup>2</sup> Media coverage of this issue stressed

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<sup>1</sup> Levi Burkett, *Medical Tourism Concerns, Benefits and the American Legal Perspective*, 28 J. Legal Med. 223, 223 (2007).

<sup>2</sup> Thomas R. McLean, *The Global Market for Health Care: Economics and Regulation*, 26 WIS. INT'L L.J. 591, 600 (2008).

the economic advantage gained by the employer and questioned the employer's ethics.<sup>3</sup> Within a month of introducing an international medical tourism option, Blue Ridge withdrew the option.<sup>4</sup>

Blue Ridge's short-lived initial attempt at incentivizing employees to travel to India for health care may have encouraged other employers to proceed very cautiously so as to avoid negative media coverage, but they still began to explore and implement similar benefits. Karuppan (2014) reported surveying U.S. human resource professionals with decision-making responsibilities for medical benefits and finding that almost 17% of respondents offered outbound medical travel options to their employees.<sup>5</sup> The precise number of U.S. employees and eligible beneficiaries that use an employer-sponsored benefit to travel abroad for health care services is unknown because there is no established tracking mechanism, nor is there any reporting requirement. It is evident, however, that some employers are offering this type of benefit and, at least for some self-funded employers, the number of employees using the benefit is increasing over time.

Many types of employers self-insure in an effort to save money and achieve stability with respect to ever-changing health insurance premiums. Three in five covered workers are in self-funded health plans.<sup>6</sup> If more employers choose to self-fund,<sup>7</sup> that may increase the number of employers offering a medical tourism option as part of their health benefit plan.

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<sup>3</sup> *Id.*

<sup>4</sup> Burkett, *supra* note 1, at 245.

<sup>5</sup> Corrine Marie Karuppan, *Employer-Based Coverage and Medical Travel Options: Lessons for Healthcare Managers*, 59 J. HEALTHCARE MGMT. 210, 215 (2014).

<sup>6</sup> The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2014 Annual Survey*, at 174 (2014), <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

<sup>7</sup> See Karen M. Kroll, *More law firms find saving, stability through self-insurance*, A.B.A. J., 1 (Mar. 2016) (describing how law firms are becoming more interested in self-funding; historically less than 50% of national law firms self-funded but recent data suggest approximately 65% are now self-funded.)

Savings alone are an insufficient driver for self-funded employers to pursue medical tourism; the quality of health care services is also important.<sup>8</sup> Many employers rely on the Joint Commission International (JCI) accreditation as an assurance of quality. Currently, approximately 500 hospitals worldwide have JCI accreditation, and this number is reported to be growing at about 20% per year.<sup>9</sup> The U.S. relies on the Joint Commission for accreditation but other countries may rely on different accrediting bodies such as QHA Trent, the Australian Council on Healthcare Standards International, or the International Organization for Standardization. Americans traveling for health care using an employer-sponsored benefit may only consider receiving services at a JCI accredited foreign hospital, perpetuating its use as an indicator of quality and perhaps unnecessarily narrowing their global options for care.

## B. Benefits and Barriers to U.S. Outbound Medical Tourism

A key benefit for participating employees and eligible beneficiaries willing to travel internationally for health care is access to quality health care at no out-of-pocket cost. These patients may still choose to obtain health care at a local health care facility, but will bear more of the costs for the local procedure (such as co-payments and deductibles). Additionally, employers often incentivize participation in medical tourism. Typically, travel expenses for the employee, or eligible beneficiary, and a caregiver companion are covered, and additional recovery time at a

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<sup>8</sup> Jennifer Conley, *Medicare and Medical Tourism: Saving Medicare with a Global Approach to Coverage*, 21 ELDER L.J. 183, 197 (2013) (describing some of the complications of quality determinations in foreign countries because only some providers/facilities are likely to treat medical tourists and these providers/facilities may have quality ratings superior to other providers/facilities). Valorie A. Crooks, et al., *Ethical and legal implications of the risks of medical tourism patients: a qualitative study of Canadian health and safety representatives' perspectives*, BMJ Open (2013), <http://bmjopen.bmj.com> (questioning whether patients are able to make informed decisions based on existing quality data).

<sup>9</sup> Jan Peter Ozga, *Global health care benefits employers, employees*, Emp. Benefit News (Apr. 4, 2014) (2014 WLNR 9150844).

local hotel or resort is included. Moreover, some employers will share part of the overall cost savings with the patient (usually a percentage amount up to a specific dollar amount such as \$10,000), often depositing it in the employee's retirement account.

In addition to accessing care more affordably, some employees have clearly enjoyed the cultural and travel appeal of receiving care abroad. For instance, Bruce Ryan, a construction manager at Blue Lake Rancheria in Northern California, opted to use his employer's medical tourism benefit to travel to Toulouse, France, for his rotator cuff surgery.<sup>10</sup> In addition to touring the Pyrenees Mountains, Ryan raved about the meals he had in Toulouse while he was recovering: "The food in Toulouse was out-of-this world. We ate like royalty."<sup>11</sup>

There are also barriers to U.S. outbound medical tourism. Traveling for health care is not for everyone. Patients might be fearful of traveling away from home and family for health care, and some medical tourism destinations might be dangerous. For instance, the CDC recently warned Americans about the risks of medical tourism after 21 patients undergoing cosmetic surgeries in the Dominican Republic contracted serious mycobacteria infections.<sup>12</sup> Patients may also worry about possible language barriers. Since many physicians practicing in foreign hospitals were trained in the U.S. or the U.K.,<sup>13</sup> the language concern might be the easiest to overcome.

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<sup>10</sup> Renee-Marie Stephano, *Medical Tourism: Pièce de Résistance for Self-Funding U.S. Employers*, MED. TOURISM MAG., (July 17, 2014), <http://www.medicaltourismmag.com>.

<sup>11</sup> *Id.*

<sup>12</sup> David Schnabel et al., *Multistate U.S. Outbreak of Rapidly Growing Mycobacterial Infections Associated with Medical Tourism to the Dominican Republic 2013-14*, 22 EMERGING INFECTIOUS DISEASES 8, (Aug. 2016).

<sup>13</sup> See Irving Stackpole, *Why Have U.S Employers Failed to Adopt Medical Tourism?* INT'L MED. TRAVEL J., (June 7, 2016), <https://www.imtj.com>.

Two other potential barriers may be more challenging to overcome. First, implementing the Patient Protection and Affordable Care Act (ACA) is the primary focus of many insurers, including self-funded employers who want to avoid potential penalties and fines.<sup>14</sup> By capturing the attention of employers, the ACA may have temporarily slowed the growth of international medical tourism, because the need to comply with the ACA likely outweighed any interest in exploring innovative coverage options. Second, for some self-funded employers offering an international medical tourism option, the uptake by employees was very low. Sometimes incentives are not sufficient to encourage an employee to travel abroad for health care. For instance, in 2008 Hannaford Brothers, a Maine based supermarket, partnered with Aetna to offer employees the option of traveling to Singapore for hip or knee replacements.<sup>15</sup> The incentives included paying the insurance co-payment of approximately \$2,500, and the travel expenses for the employee and a companion.<sup>16</sup> Still, no employees opted to use this benefit. Media coverage of this option led to New England providers offering similarly priced care, and so employees chose the domestic option.<sup>17</sup>

Finally, as the academic literature discusses, there may be ethical concerns for home and destination countries, which may be barriers for outbound medical tourism. These concerns include possible negative impacts on access to health care and health equity in home and destination countries; the potential to undermine the value of the public provision of health care as a social good; and, the risk of creating new costs for health care systems and insurers if

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<sup>14</sup> *Id.* Large employers may face a penalty under the employer shared responsibility provisions, or “play-or-pay mandate” of the ACA. IRC § 4980H (2011). See Kathryn L. Moore, *The Pay or Play Penalty Under the Affordable Care Act: Emerging Issues*, 47 CREIGHTON L. REV. 611 (2014)(providing overview of the play-or-pay mandate).

<sup>15</sup> Franklin Chou, *Note: Implementing Medical Tourism Regulation in the Face of the Volume Shock Problem*, 40 SETON HALL LEGIS. J. 187 (2015).

<sup>16</sup> Katharine Q. Seelye, *Looking Abroad for Health Savings*, Nov. 7, 2009, <http://prescriptions.blogs.nytimes.com/2009/11/07/looking-abroad-for-health-savings>.

<sup>17</sup> *Id.*

complications from treatment abroad require extensive follow-up in the home country.<sup>18</sup> However, such ethical dimensions are beyond the scope of this research.

### C. U.S. Outbound Medical Tourism: A Disruptive Innovation or an Alternate Health Care Delivery Model

Medical tourism may be a disruptive innovation, when a small company with fewer resources challenges an established business.<sup>19</sup> A key factor behind disruptive innovation is “customers who demand products and services that provide more value and are more affordable than the current ones.”<sup>20</sup> As Garman et al. suggest, medical tourism might become a disruptive innovation if it spreads more widely to new markets, such as employer-sponsored insurance, or other insurance schemes, eventually disrupting established service providers.<sup>21</sup> The three barriers to true disruption, as described by Lee and Lansky, are: 1) the fee-for-service payment system encourages innovations that increase revenue based on more complexity, higher prices, and greater volume; 2) the regulatory regime limits innovation by restricting the delivery of services to the existing paradigm; and, 3) patients lack the information and financial incentives to seek higher value.<sup>22</sup> Medical tourism may overcome these barriers by: 1) emphasizing value-based care; 2) adding a new type of service delivery, travel for health care, to the existing health

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<sup>18</sup> See Jeremy Snyder et al., *Perceptions of the Ethics of Medical Tourism: Comparing Patient and Academic Perspectives*, 5 PUB. HEALTH ETHICS 1, at 38-46 (2012)(providing background summary of ethical considerations raised in the academic literature).

<sup>19</sup> See Clayton M. Christensen et al., *What is Disruptive Innovation?* 93 HARVARD BUS. REV. 44 (2015) (clarifying the classic disruption theory evolution and utility).

<sup>20</sup> Peter V. Lee & David Lansky, *Making Space For Disruption: Putting Patients at the Center of Health Care*, 27 HEALTH AFF. 1345 (2008).

<sup>21</sup> See Karuppan, *supra* note 5 (discussing Garman et al.’s seminar presentation on medical tourism: niche market or disruptive innovation?).

<sup>22</sup> Lee & Lansky, *supra* note 20 at 1347.

care delivery system; and, 3) providing a mechanism for better informing and incentivizing patients.

Outbound U.S. medical tourism could emerge from the shadow and become a more mainstream component of the U.S. health care delivery system. Telemedicine, another way of increasing the globalization of health care services, is an example of a growing alternate health care delivery model. With respect to travel, it is the opposite of international medical tourism in that one of telemedicine's attractions is the lack of travel time required to access a physician.<sup>23</sup>

#### D. Research Boundaries and Definitions

This research focuses on U.S. outbound medical travel offered by a self-funded employer as part of a health benefit plan. As such it emphasizes medical care often covered by a health benefit plan, not care that is typically paid for out-of-pocket, such as cosmetic surgery. Moreover, it underplays certain types of medical travel, such as for surrogacy and organ transplantation. While U.S. patients may travel for such types of care, they are usually paying out-of-pocket and may be even more secretive because of ethical concerns. Finally, although there are some limited discussions of domestic medical travel, that is not a major component of the research.

Three pertinent definitions for this document are:

1) U.S. outbound medical travel: U.S. residents who specifically travel outside the U.S. for pre-arranged medical services. These patients may either pay out-of-pocket for the services, or they

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<sup>23</sup> Caroline M. Poma, *Telemedicine: A Therapeutic Prescription for our Health Care System Contaminated by Old Economy Rules and Regulations*, 17 N.C. J.L. & TECH. ON. 74, 79 (2016).

may be covered by a health benefit plan. As discussed in Chapter Two, Terminology, medical tourism is a catch-all phrase often used as a type of shorthand, as it was in this introductory chapter.

2) International medical travel: This term is synonymous with U.S. outbound medical travel when referring to a U.S. patient who is crossing an international boundary specifically for pre-arranged medical services. International is used to differentiate from domestic medical travel, which would be limited to travel within the U.S. for pre-arranged medical services.

3) Medical travel facilitators: As Snyder, Crooks, Wright, and Johnston describe in Hodges, Turner, and Kimball's book, *Risks and Challenges in Medical Tourism*, medical travel facilitators are "private agents who broker medical travel and foreign care arrangements between patients and destination facilities but are not employed by these facilities."<sup>24</sup>

## II. Research Overview

Medical tourism has been described as a volatile immature market with pockets of growth.<sup>25</sup> This qualitative research aims to provide further insight into this nascent market in two areas. First, a systematic review of the multidisciplinary literature was completed to better understand how the international travel of patients for medical care has been defined. These data were then

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<sup>24</sup> Snyder, J., et al., *Medical Tourism Facilitators: Ethical Concerns about Roles and Responsibilities*, in *RISKS AND CHALLENGES IN MEDICAL TOURISM: UNDERSTANDING THE GLOBAL MARKET FOR HEALTH SERVICES* 279-295 (J. Hodges, L. Turner, & A. Kimball (eds.)) (2012).

<sup>25</sup> Keith Pollard, *When Will Medical Tourism Reach the Tipping Point* (Part 1), *INT'L MED. TRAVEL J.*, <http://imtj-blog> (July 9, 2015).

used to propose criteria for clearer terminology, at least for U.S. outbound medical travel. Second, key informant interviews were conducted to better understand self-funded employers' use of an international medical travel benefit. The research questions for this part of the research are:

- 1) Why are select public and private self-funded U.S. employers including an international medical travel option in their health care benefits options?
- 2) How are select public and private self-funded U.S. employers changing their health care benefit plans to offer international medical travel options and incentivizing their employees and eligible beneficiaries to participate in this option?

#### A. Significance of Research

By focusing on the terminology for this type of outbound medical travel and the experiences of some self-funded employers incentivizing their employees to travel internationally for medical care, this research contributes to two components of the scholarly literature. First, it demonstrates how the literature's use of terminology is confusing and conflicting and provides recommendations for moving toward definitional clarity. Second, it discovers some unexpected insights into self-funded employers' experiences with incentivizing international medical travel and may be significant when considering further expansion of this type of benefit, particularly from the payer and regulator perspectives. Together, modifying the terminology used to describe

this phenomenon and making such an international medical travel benefit available to more Americans could make it a larger part of the U.S. health care delivery system.

## B. Organization of Dissertation

The dissertation has six chapters. Chapter Two, Terminology, describes the systematic review of the literature regarding three specific terms often used in defining the international travel of patients for medical care: medical tourism, medical travel, and medical outsourcing. The findings of the systematic literature review are analyzed by comparing them with existing typology models and making a recommendation for moving toward definitional clarity.

Chapter Three, Current Legal Framework for U.S. International Medical Travel, details medical tourism's benefits, barriers, and rationale for employer interest in offering an international medical travel benefit to employees and eligible beneficiaries and explores how a limited legal framework for outbound medical travel permits it to exist, albeit in an environment of legal uncertainty. This chapter also examines potential employer, employee, and beneficiary protections that can help successfully navigate existing legal ambiguity

Chapter Four, Qualitative Methodology, posits the research questions and describes the research methodology used to answer these questions. It includes a description of the data collection process and concludes with an explanation of the data analysis from which the themes and patterns were derived.

Chapter Five, Findings, presents the findings from the qualitative case studies. And, Chapter Six, Conclusions, discusses additional interpretations of the research data, recommendations for possible next steps regarding expansion of international medical travel benefits and regulatory considerations. This chapter also describes the research limitations and provides examples of future research studies on this topic.

## Chapter Two: Terminology

### I. Introduction

Medical tourism is an elastic term conveying movement of people seeking or providing health care services away from their homes. Such flexibility in terminology may be useful in describing and discussing a changing and emerging phenomenon. Medical tourism has long been under the radar of the U.S. health care delivery system; for many years it was occurring but the numbers were small, often used by the uninsured or by patients seeking non-covered services such as cosmetic surgery. As such, it could be considered a fad.<sup>26</sup> It was less important whether it was called medical tourism, medical travel, medical outsourcing, or some other term. The phenomenon was too small to warrant careful attention to the terminology choices. It was sufficient for authors to acknowledge the difficulties with the term and then use it as a type of shorthand.

But now, as employers encourage the use of an employer-sponsored travel health plan benefit and medical tourism is defined in state statute, it is time to clarify terminology. Although this research focuses on U.S. outbound medical travel, it is noteworthy that Rhode Island, when enacting a law encouraging domestic medical tourism into the state, became the first state to define domestic medical tourism in statute.<sup>27</sup> While Rhode Island's novel law addresses domestic medical tourism, not international medical tourism, as the globalization of health care

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<sup>26</sup> See McLean, *supra* note 2 (explaining that critics consider medical tourism as a fad). Merriam-Webster defines fad as "something (such as an interest or fashion) that is very popular for a short time" available at <http://Merriam-Webster.com>.

<sup>27</sup> R.I. GEN. LAWS § 23-93-1 (2014) (defining domestic medical tourism as "the practice of patients traveling to states other than their residence for the provision of health care services").

continues, it is foreseeable that future regulatory efforts may expand beyond domestic medical tourism. The inclusion of domestic medical tourism in state statute draws attention to the potential significance of new terminology in state law. Rhode Island's statutory language may be copied by other states. Alternatively, states may opt for different terminology or definitions, creating different, or similar terms, with different meanings, increasing potential confusion or misunderstanding of terminology. Vague and conflicting terminology can hinder public discourse on travel for health care. Stakeholders (e.g., regulators, health care facilities, industry organizations, countries, medical travel facilitators, certification organizations, and providers) can also use imprecise terminology to further their specific interests and positions.

Legislation may be the most pressing reason why terminology consensus would be beneficial. The lack of consensus on a more precise definition or typology may encourage stakeholders to use terminology to promote their own perspective, further reducing clarity. For instance, medical tourism may be used to emphasize the market nature of health care or a patient-centered approach to health care. With respect to the market side, medical tourism "reveals the shape that medicine takes when it is commodified, subjected to international competition, and subsumed within a global market economy."<sup>28</sup> With respect to patient-centered care, medical tourism may be an appropriate marketing term because it may reduce patient fears regarding post-surgical debilitation and focus patient attention on the positive side of recovery.<sup>29</sup> Another reason for moving toward consensus is to better position the phenomena of traveling for health care as a larger component of the health care delivery system. Without a clear and universally-understood

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<sup>28</sup> Leigh L. Turner, *Medical tourism and the global marketplace in health services: U.S. patients, international hospitals, and the search for affordable health care*, 40 INT'L. J. HEALTH SERVICES 443, 444 (2010).

<sup>29</sup> Elisa J. Sobo et al., *Selling medical travel to US patient-consumers: the cultural appeal of website marketing messages*, 18 ANTHROPOLOGY & MED. 119, 131-2 (2011). See also Laura Hopkins et al., *Medical Tourism Today: What is the state of existing knowledge?*, 31 J. PUB. HEALTH POL'Y 185, 185 (2010).

definition, medical tourism is not likely to be a familiar or standard component of health plan coverage. The medical tourism label may decrease uptake of the benefit by an eligible patient, or at least, add to hesitancy of health plans to offer such benefits.

This chapter proposes criteria for more clear terminology. A systematic review of the multi-disciplinary literature was completed to better understand how the international travel of patients for health care has been defined. Section II of this chapter explains the use of medical tourism as a shorthand term, medical tourism typologies, and the growing use of systematic reviews in studying medical tourism. Section III describes the research methodology of the systematic literature review. The findings of the review are provided in Section IV. Section V applies the findings to existing categories, and Section VI analyzes the findings from the perspective of U.S. outbound medical travel, the focus of this dissertation.

## **II. Existing Terminology Landscape**

### A. Medical Tourism as Shorthand

Other scholars have grappled with the terminology and typology issues surrounding medical tourism. At the very least, many scholars have defined medical tourism and in doing so, have acknowledged some of the term's shortcomings.<sup>30</sup> Some scholars use the term medical tourism

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<sup>30</sup> See e.g. Christabelle Sethna & Marion Doull, *Accidental Tourists: Canadian Women, Abortion Tourism, and Travel*, 41 WOMEN'S STUD. 457, 457 (2012) (describing medical tourism as a complex phenomenon with a contested term); Regan Bergmark et al., *Mexican Immigrants Living Far From the Border May Return to Mexico for Health Services*, 12 J. IMMIGRANT & MINORITY HEALTH 610, 614 (2010) (explaining that medical tourism is not a sufficient term for such a significant form of health seeking behavior).

simply because it is commonly used.<sup>31</sup> For example, Nathan Cortez, a law professor and one of the leading legal scholars on the legal and ethical implications of medical tourism, uses medical tourism “because it reflects the dominant nomenclature.”<sup>32</sup> Some scholars, however, reject the term medical tourism and call for what they perceive as more neutral terms such “international medical travel” or “cross-border medical travel” depending on whether the travel is outside their home country or in a neighboring country.<sup>33</sup> According to Dalstrom, medical tourism trivializes patients traveling for health care, focusing more on tourism than on the patient’s need for medical care.<sup>34</sup> A more neutral term of either international medical travel or cross-border medical travel would better separate the pleasure of tourism from need for health care.<sup>35</sup>

## B. Medical Tourism Typologies

Editors of two contemporary medical tourism books briefly address their employment of the term medical tourism. In each case, once the decision to use the term is made, the editors then divide the broad term into smaller categories. For instance, Hodges, Turner, and Kimball, editors of the book “Risks and Challenges in Medical Tourism,” define medical tourism “as the practice of traveling, primarily across international borders, with the intent to access medical care, including dental services, screenings, and exams,” although they permit contributing

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<sup>31</sup> I. Glenn Cohen, *How to Regulate Medical Tourism (and Why It Matters for Bioethics)*, 12 DEVELOPING WORLD BIOETHICS 9, 9, n1 (2012) (using medical tourism “in part because it is the common term used in public reporting on the subject.” Cohen also asserts that he does not “mean to be pejorative or make normative judgments with the usage.”).

<sup>32</sup> Nathan Cortez, *Recalibrating the legal risks of cross-border health care*, 10 YALE J. HEALTH POL’Y L. & ETHICS 1, 2 (2010). See also Hodges et al., *supra* note 23 at 6.

<sup>33</sup> See Matthew Dalstrom, *Medical travel facilitators: connecting patients and providers in a globalized world*, 20 Anthropology & Med. 24, 27 (2013).

<sup>34</sup> *Id.* at 26.

<sup>35</sup> *Id.* at 27.

authors to use alternative terms and definitions.<sup>36</sup> These editors further explain that medical tourism “is a contested concept used in at least four distinct ways.”<sup>37</sup> These four ways are: 1) health care providers traveling to provide brief episodes of care in under-resourced areas; 2) patients traveling abroad to receive free care from publicly funded health care systems; 3) patients who travel solely for health care; and, 4) patients who travel for health care and participate in tourist activities.<sup>38</sup> Another renowned legal scholar, Glenn Cohen, uses the term medical tourism because “it is the most common one employed in this nascent literature.”<sup>39</sup> In his book, “Patients with Passports,” Cohen divides medical tourism into three types depending on: 1) the legal status of the health care services; 2) the payer type (patients paying out-of-pocket, patients whose medical tourism is covered by private insurance, and patients whose medical tourism is covered by public insurers); and, 3) the direction of patient flow (North-North, South-South, North-South, and South-North).<sup>40</sup>

Other scholars have also proposed typologies related to medical tourism. For instance, Glinos et al., suggests a typology of cross-border patient mobility, defined as the “movement of a patient traveling to another country to seek planned health care.”<sup>41</sup> In 2010, this type of patient travel for health care was gaining attention at the international level, particularly in the European Union (EU) where Member States had been exploring creating a new legal framework for patients traveling within the EU.<sup>42</sup> Glinos et al. found that patients traveling internationally for health

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<sup>36</sup> Hodges et al., *supra* note 24 at 6-7.

<sup>37</sup> *Id.* at 6.

<sup>38</sup> *Id.*

<sup>39</sup> I. Glenn Cohen, PATIENTS WITH PASSPORTS XV (2015).

<sup>40</sup> *Id.* at 2.

<sup>41</sup> Irene A. Glinos, et al., *A typology of cross-border patient mobility*, 16 HEALTH & PLACE 1145, 1153-1154 (2010). These authors intentionally do not use medical tourism which “insinuates leisurely travelling and does not capture the seriousness of most patient mobility.” (*Id.* at 1145-1146.)

<sup>42</sup> *Id.* at 1146. The next year, in 2011, the EU adopted a directive on cross-border health care clarifying the rights of

care could be divided by type of patient motivation (availability, affordability, familiarity, and perceived quality) and type of payer (out-of-pocket, and covered by a funding body).<sup>43</sup> By combining these two dimensions of their typology, they created a matrix of possible patient scenarios depending on patient motivation type and payer type. Their classification permits greater specificity for why a patient is traveling abroad for health care and who is paying for such care. For example, a patient travels to another country because she is more familiar with that country's health care system and receives care for which she pays out-of-pocket.<sup>44</sup> For these scholars, patient mobility is a broader, more nuanced, more diverse phenomenon than medical tourism.<sup>45</sup> Moreover, their typology is from the perspective of the patient demand side rather than the industry supply side of the equation.<sup>46</sup>

Sobo, an anthropologist, advocates for creating an anthropologically informed taxonomy of medical travel types.<sup>47</sup> Some of Sobo's suggested divisions include patients traveling for complementary or alternative care, as opposed to patients traveling for biomedicine, as well as qualitative differences in types of health care such as organ transplants, face lifts, and infertility treatment.<sup>48</sup> Sobo calls for the different types of medical travel to be teased apart and no longer lumped together.<sup>49</sup>

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EU patients seeking health care in a member state. *Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border health care*, 2011. Individual countries had until Oct 25, 2013 to pass their own laws implementing the directive. See also Tomas Mainil, et al., *Transnational health care: From a global terminology towards transnational health region development*, 108 HEALTH POL'Y 37 (2012) (describing a typology of twelve types of international patients based on the criteria of geographical distance, cultural distance and searching efforts, public/private/no cover and private/public provision of health services).

<sup>43</sup> Gilnos et al., *supra* note 41 at 1147.

<sup>44</sup> *Id.* at 1151.

<sup>45</sup> *Id.* at 1146.

<sup>46</sup> *Id.* at 1146.

<sup>47</sup> Elisa J. Sobo, *Medical Travel: What it Means, Why it Matters*, 28 MED. ANTHROPOLOGY: CROSS-CULTURAL STUD. HEALTH & ILLNESS 326, 331 (2009).

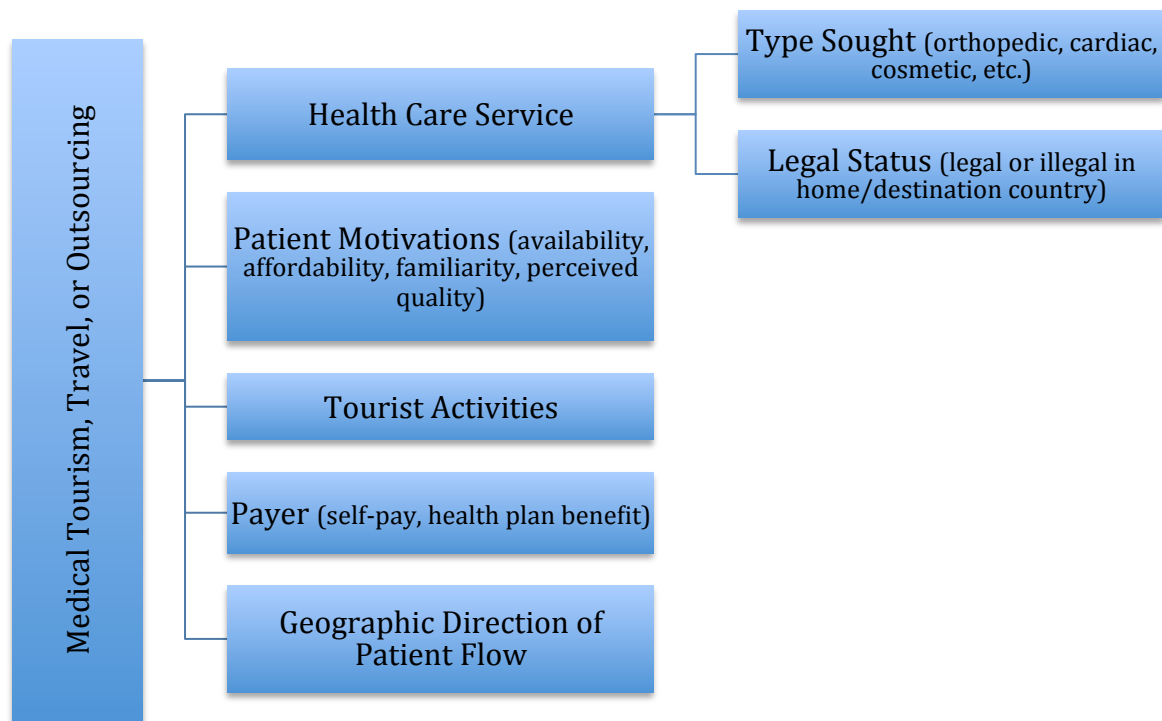
<sup>48</sup> *Id.* at 332.

<sup>49</sup> *Id.*

Medical outsourcing is another term used to describe this phenomenon in the literature. Medical outsourcing connotes an economic factor and cost can be a significant component of international travel for health care. Outsourcing can be defined as a cost-saving strategy that reduces costs by using outside suppliers, in this case health care providers in another country.

Based on the typologies indicated by these authors, Figure 1 summarizes possible classification factors for medical tourism. These suggested typologies are based on theory and not on existing usage.

Figure 1. Existing Possible Classification Factors for Medical Tourism or Travel



### C. Existing Systematic Literature Reviews

A small number of scholars have examined and coded parts of the medical tourism literature but not related to definitions of medical tourism or other associated terms. Edel's dissertation research included examining 150 articles identified through a Google search ending in 2009.<sup>50</sup> He hand coded these articles for: 1) intended audience; 2) author's affiliation/research field; 3) reference to quality of care; 4) reference to cost savings; 5) type of medical care; 6) inclusion of patient interview; and, 7) general evaluation of medical tourism. Edel found that authors and audiences could be divided into three groups: 1) business interests (marketing); 2) social scientific interests (academic researcher or journalist emphasizing medicine aspect); and 3) other interests (entertainment media).<sup>51</sup> Crooks et al. also completed a scoping review of patient's experience with medical tourism using a focused search and analysis of academic and media databases.<sup>52</sup> (Valorie Crooks is an Associate Professor at Simon Fraser University and a leading member of the University's Medical Tourism Research Group.) In her article, a scoping review is defined as "a knowledge synthesis technique that is most commonly used when: it is difficult to identify a narrow review question; studies in the reviewed sources are likely to have employed a range of data collection and analysis techniques; no prior synthesis has been undertaken on the topic; and a quality assessment of reviewed sources is not going to be conducted."<sup>53</sup> Methodologically, this scoping review appears similar to a systematic literature review. Select databases were searched for keywords; inclusion and exclusion criteria were applied; title and

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<sup>50</sup> Gareth Alexander Feodor Edel, *Navigating Choice: Medical Tourism, Travel, & Care in the New Global Biomedicine* (2014)(Ph.D. dissertation, Rensselaer Polytechnic Institute), <http://ProQuest.com>.

<sup>51</sup> *Id.* at 150-151.

<sup>52</sup> Valorie A. Crooks et al., *What is known about the patient's experience of medical tourism? A scoping review*, 10 *BMC HEALTH SERVICES RES.* (2010), <http://biomedcentral.com> (indicating that the list of the 216 articles included in the scoping review is on file with the lead author).

<sup>53</sup> *Id.*

abstract reviews completed; included texts reviewed in full; and themes were identified from the data. These same authors, led by Johnston, conducted a similar scoping review of the effects of medical tourism in destination and departure countries.<sup>54</sup> Lunt and Carrera also reviewed literature in two databases, OVIDSP and Web of Science and SSI Proceedings, for out-of-pocket payments by medical tourists, preferably those middle-aged or older.<sup>55</sup> (Neil Lunt, a Reader in Social Policy at the University of York, has researched and published extensively on medical tourism.) More recently, Lunt et al. completed a study of inbound and outbound medical travelers from the United Kingdom.<sup>56</sup> Lunt et al., conducted a systematic literature review with the goals of better understanding: patient motivation, the medical tourism industry, the volume of medical tourism and the effects of medical tourism on originating health systems.<sup>57</sup> In their systemic literature review, Lunt et al. searched the databases: MedLine, Web of Science, EMBASE, Global Health, Health Management Information Consortium, and EconLit, using the search terms “health tourism,” “medical tourism,” “medicine, tourism, and health,” and “tourism and medicine.” The results of this review included a breakdown of issues such as fertility, cosmetic, risks in health outcomes, and recipient country health care system, as well as industry categories such as providers and facilitators.

These systematic literature reviews by other scholars and researchers indicate that this type of research methodology is a viable, and perhaps growing, approach useful in generating robust answers to research questions. These authors’ contributions to the field of medical tourism,

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<sup>54</sup> Rory Johnston et al., *What is known about the effects of medical tourism in destination and departure countries? A scoping review*, 9 INT’L J. EQUITY HEALTH 24 (2010), <http://equityhealthj.com> (indicating that the list of the 203 articles included in the scoping review is on file with the lead author).

<sup>55</sup> Neil Lunt & Percivil Carrera, *Medical tourism: Assessing the evidence on treatment abroad*, 66 MATURITAS 27 (2010).

<sup>56</sup> Neil Lunt et al., *Implications for the NHS of inward and outward medical tourism: a policy and economic analysis using literature review and mixed-methods approaches*, HEALTH SERVICES & DELIVERY RES. 2 (2) (Jan. 2014).

<sup>57</sup> *Id.*

however, do not address how the medical tourism phenomenon is defined in the literature. Edel's research emphasized who is writing about the phenomenon and how this impacts the discourse on medical tourism. Crooks and Johnston's articles provide access to literature review data focusing on patient experiences and the effects of medical tourism in different countries. Like Lunt and Carrera's research, these articles and data do not provide a systematic review of how the medical tourism phenomenon is defined in the literature nor do they provide a workable framework to help stakeholders define medical tourism. This chapter provides such a systematic review, and it begins to bridge the gap between terminology, as used by contributors to the literature, and typologies derived from theory more than actual usage.

### **III. Research Methodology**

With the goal of answering the research question of how the literature defines the U.S. outbound international travel for health care and how these definitions may impact future legislation and possible increased utilization by health plans, a systematic literature review was completed. As a systematic review, this research provides a synthesis,<sup>58</sup> not a quantitative combination of the data or a meta-analysis.<sup>59,60</sup>

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<sup>58</sup> See Caroline Young, *Medico-Legal Research Using Evidence-Based Medicine*, 102 LAW LIBR. J. 449, 460 (2010).

<sup>59</sup> Lisa A. Bero, *Evaluating Systematic Reviews and Meta-Analyses*, 14 J.L. & POL'Y 569 (2006) (describing that a systematic review will not necessarily result in a meta-analysis, but a high quality meta-analysis will start as a systematic review).

<sup>60</sup> Diana B. Petitti, *META-ANALYSIS, DECISION ANALYSIS, AND COST-EFFECTIVENESS ANALYSIS*, 4-5 (2nd ed. 2000) (providing a brief history of meta-analysis and the statistical techniques used for combining data in the agricultural data of the 1930s, before the term meta-analysis was coined).

## A. Term Selection

In order to identify the search terms to use in the systematic review, the literature was scanned to identify key words relevant to the research question.<sup>61</sup> Medical tourism has been noted as emerging “from the broader notion of health tourism, but with an emphasis on clinical, surgical, and hospital provision.”<sup>62</sup> This description reflects a common connotation of the term in which patients travel for some form of clinical care as opposed to a broader category of patients traveling for spa treatment and other wellness services. Because this research focuses on medical care, and not more general wellness travel, medical tourism was included as a search term while health tourism was not. U.S. outbound travel for health care existed in the literature as medical tourism, medical travel, and medical outsourcing, so these terms were used in the literature search.

## B. Literature Search

Academic Search Complete,<sup>63</sup> or EBSCO, Web of Science,<sup>64</sup> PubMed,<sup>65</sup> and, Westlaw Next<sup>66, 67</sup>

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<sup>61</sup> The literature referred to here includes all multidisciplinary journals and legal secondary sources described in footnotes 62-65.

<sup>62</sup> Percivil Carrera & Neil Lunt, *A European perspective on medical tourism: the need for a knowledge base*, 40 INT’L. J. HEALTH SERVICES 469, 470 (2010).

<sup>63</sup> EBSCO (Academic Search Complete) is a database of multidisciplinary academic journals available through University of Washington Libraries. Materials date back to 1887. It contains over 13,800 indexed and abstracted journals, 9,000 full-text journals, and full text for more than 7,8000 peer-reviewed journals. Searches were limited to English full texts.

<sup>64</sup> Web of Science Core Collection is a database of scholarly literature in the sciences, social sciences, arts, and humanities and examine proceedings of international conferences, symposia, seminars, colloquia, workshops, and conventions. Available through University of Washington Libraries. Includes: Science Citation Index Expanded (1900-present); Social Sciences Citation Index (1975-present); Arts & Humanities Citation Index (1975-present). Searches were limited to “Articles” under “Document type.”

<sup>65</sup> PubMed contains citations for biomedical literature from MEDLINE, life science journals, and online books. PubMed is a free resource that is developed and maintained by the National Institutes of Health. Articles were filtered by English language.

<sup>66</sup> Westlaw Next legal database was queried for cases (All States and All Federal) and secondary sources (Law reviews and journals).

were queried using the search terms “medical tourism,” “medical travel,” and “medical outsourcing,” all in combination with “United States.” These searches had no restriction on the earliest date of publication and had an end date of April 2, 2015.

Using the “United States” as part of the search terms narrowed the results from any country to, at least, a reference to, or comparison with, the U.S. Without the U.S. qualifier, the data were too large to be manageable. For instance, a search for “medical tourism” in PubMed yielded 776 articles while the same search with the addition of the “United States” yielded 149 articles.<sup>68</sup> Also for purposes of manageability, the 559 news articles extracted in the original search from WestlawNext were not included.

### C. Exclusion Criteria

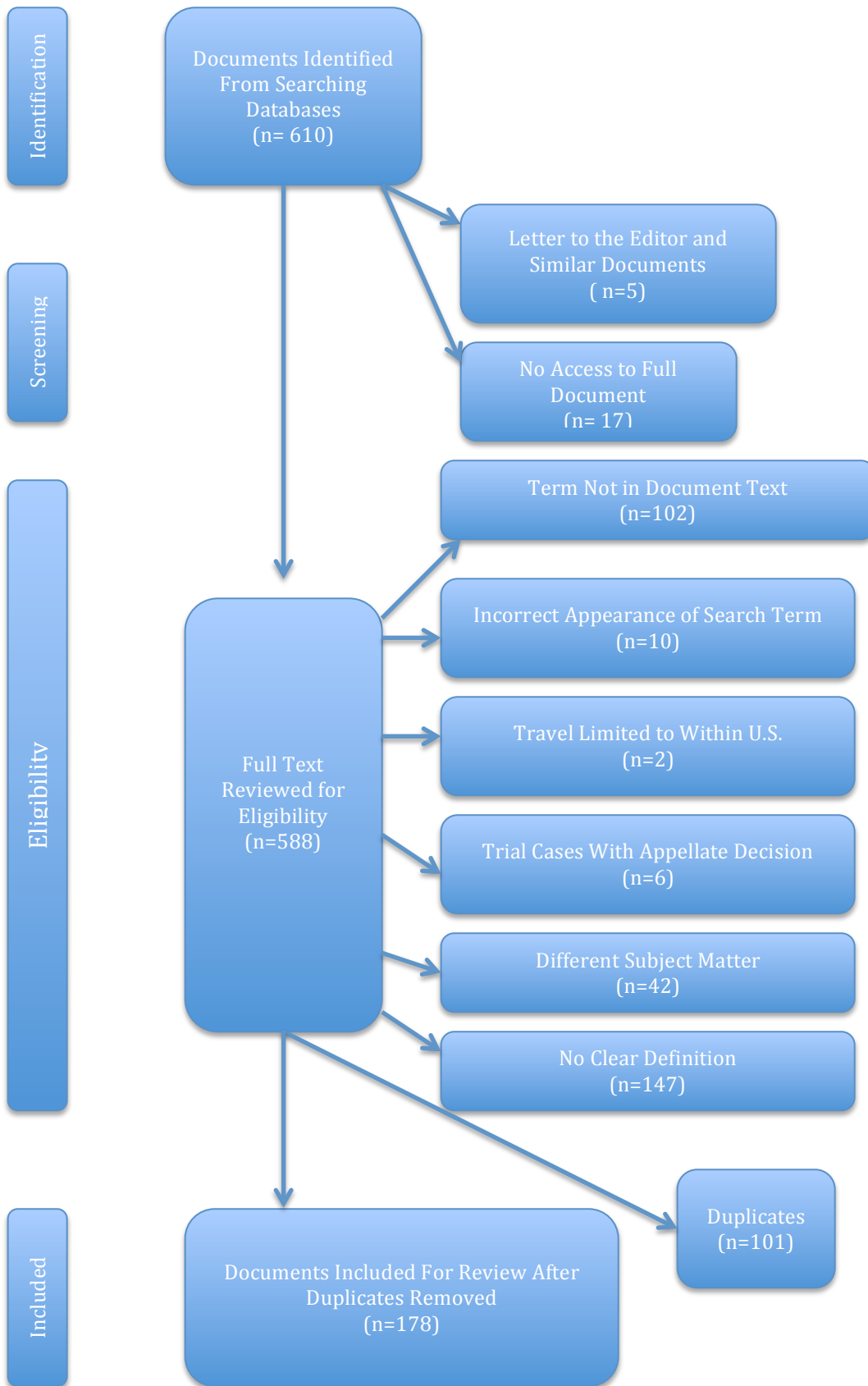
Because the title, and often, the abstract did not provide an indication of any terminology definitions, the full text of each document was reviewed. Excel was used to store and organize the data. Information included in the Excel worksheets included the document’s citation, as well as any statement regarding the destination country, procedure sought, and definition of search terms. Figure 2 depicts the exclusion criteria applied to the documents retrieved from searching the databases.

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<sup>67</sup> Reasons for which documents were considered non-relevant include: articles not accessible through the on-line database subscription; articles not using the term in the text of the article, only in the title or the footnotes, and articles that contained search term errors such as “medical, travel.”

<sup>68</sup> The search to demonstrate this comparison generating these numbers was run on July 27, 2015.

Figure 2. Flow Chart for Systematic Review

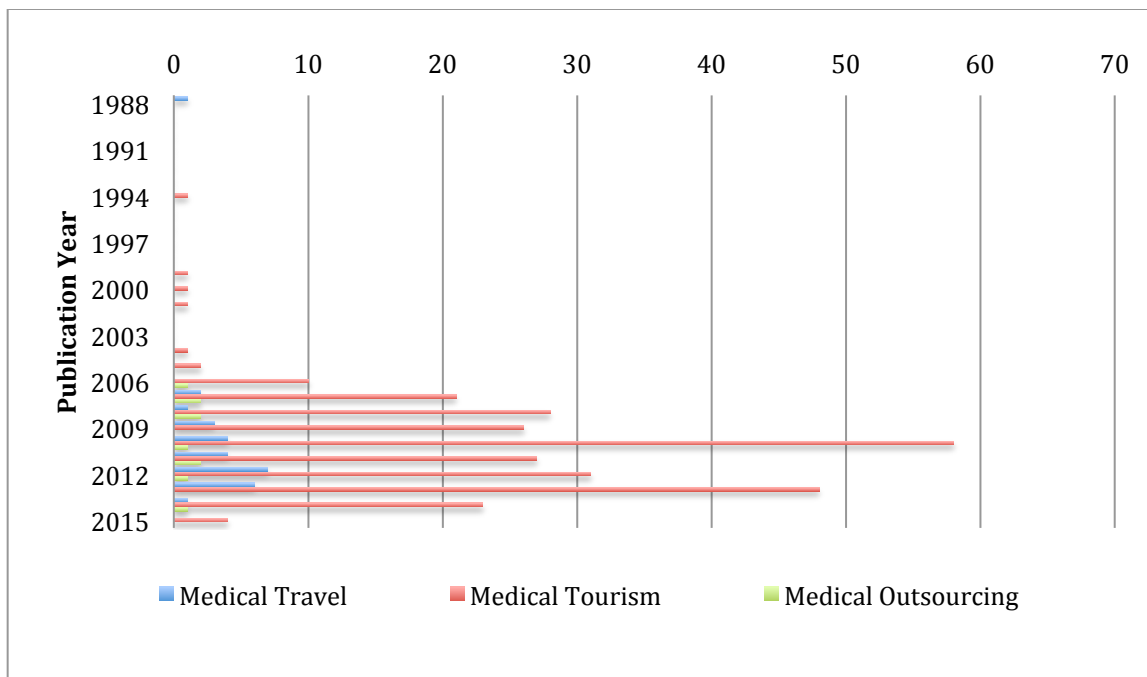


## IV. Findings

### A. Prevalence of Terms Over Time

Medical tourism, medical travel, and medical outsourcing have different usage patterns over time. (Figure 3)

Figure 3. Publication Years and Terminology Usage



Medical tourism usage peaks in 2010, with broad use in the literature from 2007 to 2014. While medical travel is first defined in the reviewed literature in 1988, the term has been used more often beginning in 2007. Medical outsourcing appears as a defined term in the literature during much of the same time as medical travel, but it is not used as frequently. As the next subsection

discusses, medical travel and medical outsourcing are both considered by some authors to have originated from medical tourism.

## B. No Consensus on Terminology Definitions

Because there is no consensus on defining terms, authors have discretion as to how to define any terms he or she employs in writing. Authors can also choose to use terms without defining them. In fact, of the 284 medical tourism included articles, the term was used with no clear definition in half of the articles.

With no consensus the use of terms varies by author and may generate confusion among readers. For instance, medical tourism can refer to patients seeking health care or as health professionals traveling to deliver healthcare, often in a country poorer than their own.<sup>69</sup> Medical travel can be intentionally used to stress the neutrality, accuracy, and universality of medical travel compared to medical tourism.<sup>70</sup> Medical travel and medical tourism can also be used as synonyms.<sup>71</sup> The

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<sup>69</sup> Stephen Bezručka, *Medical tourism as medical harm to the Third World: Why? For whom?* 11 WILDERNESS & ENV'T MED. 77, 77 (2000) (defining medical tourism as "short-term overseas work in poor countries by clinical professionals from rich countries"). See also Christie M. Reed, *Medical tourism*, 92 MED. CLINICS N. AM. 1433, 1433 (2008); Christie M. Reed, *Hot topic: medical tourism*, 30 PLASTIC SURGICAL NURSING 187 (2010) (defining medical tourism as both traveling to obtain health care abroad and travel by health care professionals to provide care).

<sup>70</sup> Matthew D. Dalstrom, *Winter Texans and the Recreation of the American Medical Experience in Mexico*, 31 MED. ANTHROPOLOGY: CROSS-CULTURAL STUD. HEALTH & ILLNESS 162 (2012); Aren Aizura, *Feminine Transformations: Gender Reassignment Surgical Tourism in Thailand*, 29 MED. ANTHROPOLOGY 424 (2010); Dalstrom, *supra* note 33; Sobo et al., *supra* note 47; Sobo, *supra* note 29.

<sup>71</sup> Two of the 29 analyzed medical travel articles failed to provide a clear definition. Sarah Horton, *Medical Returns as Class Transformation: Situating Migrants' Medical Returns within a Framework of Transnationalism*, 32 MED. ANTHROPOLOGY: CROSS-CULTURAL STUD. HEALTH & ILLNESS 417 (2013); Sarah Horton & Stephanie Cole, *Medical Returns: Seeking Health Care in Mexico*, 72 SOC. SCI. & MED. 1846 (2011). Ormonde defines medical travel and medical tourism as "traveling from one's home country to another country for the purpose of receiving medical care," making no distinction between the two terms. Mariana E. Ormonde, *Debunking the Myth of the "Anchor Baby": Why Proposed Legislation Limiting Birthright Citizenship is not a Means of Controlling Unauthorized Immigration*, 17 ROGER WILLIAMS U.L. REV. 861, 878 (2012). Rhea uses medical travel and medical tourism to refer to travel to the United States for care. Shawn Rhea, *Tourism Trap*, 39 MOD. HEALTHCARE 0017

American Medical Association (AMA) 2007 report on medical travel uses these two terms as synonyms and add a third term, medical outsourcing, into the mix, using all three terms without distinction. Finally, “medical outsourcing” can also be synonymous with “medical tourism” when it refers to a patient traveling internationally for healthcare treatment.<sup>72</sup> Alternatively, Brady asserts that while medical outsourcing finds its roots in medical tourism, medical outsourcing is different because it focuses on non-cosmetic procedures.<sup>73</sup>

### C. When Defined, Four Categories of Definitions Emerge

Analysis of the included documents highlights four definitional categories for medical tourism, medical travel, and medical outsourcing. These four broad classifications are: 1) crossing a border; 2) medical treatment type; 3) healthcare services combined with a vacation or a holiday; and, 4) patients traveling from developed to developing countries. Table 1 provides examples of these classifications and their source documents.

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(2009). York deploys medical travel and medical tourism for patients seeking medical treatment outside of the United States. Diane York, *Medical tourism: the trend toward outsourcing medical procedures to foreign countries*, 28 J. CONTINUING EDUC. HEALTH PROF. 99 (2008).

<sup>72</sup> E.g., Brian J. McKinnon & Nishant Bhatt, *Cochlear Implants and Medical Tourism*, 11 COCHLEAR IMPLANTS INT’L 125 (2010); Jennifer Spellman & Jeanne Varrichio, *Bad Reputation?: The Potential Negative Impact of Outsourcing on the Legal Profession*, 29 HOFSTRA LAB. & EMP. L.J. 575 (2012). See also Jenifer B. Boyd et al., *Emerging trends in the outsourcing of medical and surgical care*, 146 ARCHIVES SURGERY 107 (2011) (using medical outsourcing, medical travel, and medical tourism without clear distinctions). The biomedical literature also uses the term to refer to a health care provider engaging outside third parties to provide medical services. Sanjiv N. Singh & Robert M. Wachter, *Perspectives on medical outsourcing and telemedicine – rough edges in a flat world?* 358 NEW ENGL J. MED. 1622 (2008).

<sup>73</sup> Christopher J. Brady, *Offshore Gambling: Medical Outsourcing Versus ERISA’s Fiduciary Duty Requirement*, 64 WASH. & LEE L. REV. 1073, 1091-2 (2007).

TABLE 1: Examples of Definitional Categories and Source Types

<b>Definitional Categories</b>	<b>Examples</b>	<b>Type of Source</b>
International border crossing	1) “Outside of one’s home country” (medical tourism) 2) “Outside of a patient’s usual country of residence” (medical outsourcing) 3) “Going abroad for medical care” (medical travel)	1) Peer-reviewed journal 2) Law review article 3) Peer-reviewed journal
Medical treatment type	1) Traveling abroad for organ transplant (medical tourism) 2) Low-cost alternatives to non-cosmetic procedures (medical outsourcing) 3) Traveling abroad for cosmetic or bariatric surgery (medical travel)	1) Peer-reviewed journal 2) Law review article 3) Peer-reviewed journal
Health care services plus vacation/holiday	1) Linking leisure travel, fun, and relaxation with medical interventions (medical tourism) 2) [No example for medical outsourcing] 3) [No example for medical travel]	1) Peer-reviewed journal
Travel from developed to developing country	1) Patients from wealthy nations traveling to poor countries for medical care (medical tourism) 2) [No example for medical outsourcing] 3) Patients traveling from developed to developing nations for healthcare that is comparable in quality but cheaper in price (medical travel)	1) Peer-reviewed journal 3) Law review article

There are also some less frequently used distinctions such as the level of patient involvement in seeking healthcare outside their local geography, whether the therapy sought was legitimate or illegitimate, and the prevalence of technology in the healthcare component, which also provide the basis for some authors’ terminology distinctions. For instance, Craig distinguishes medical

tourism from medical outsourcing based on the level of client activity.<sup>74</sup> Under Craig's definitional distinction, medical tourism requires an individual patient to take action while medical outsourcing occurs when an agency is involved.<sup>75</sup> For example, a patient in Oregon that surfs the web and chooses Toulouse, France for a surgical procedure is a medical tourist; while another patient in Oregon who goes to SUT Royal Hospital, India, for coronary bypass surgery with IndUSHealth, a company providing corporate medical travel administration services, is a medical traveler.

In some instances, medical travel is considered a legitimate activity, in contrast to medical tourism. For instance, as Hyun denotes, "medical travel for unproven stem cell-based therapies," is "a phenomenon otherwise known as "stem cell tourism."<sup>76</sup> It is "very difficult to discern the differences between problematic stem cell tourism and acceptable medical travel for innovative therapies."<sup>77</sup>

Often medical outsourcing arises from technological advances and the ability to carve out select components of healthcare treatment that can be sent to other countries such as teleradiology and medical transcription.<sup>78</sup> In fact, some researchers assert that America's involvement in medical outsourcing "began with telemedicine, which includes electronic delivery of medical services such as x-ray readings, insurance interpretations, and videoconference consultations."<sup>79</sup> In other

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<sup>74</sup> K. Craig & L. Beichl, *Globalization of healthcare: case management in a 21<sup>st</sup>-century world*, 14 PROF. CASE MGMT. 235 (2009).

<sup>75</sup> *Id.* at 235-236.

<sup>76</sup> I. Hyun, *Allowing innovative stem cell-based therapies outside of clinical trials: ethical and policy challenges*, 38 J. L. MED. & ETHICS 277, 277 (2010).

<sup>77</sup> *Id.* at 277.

<sup>78</sup> Vivek Nayar, *Teleradiology: Images of an Improved Standard of Medical Care?* 35 RUTGERS COMPUTER & TECH. L.J. 104 (2008).

<sup>79</sup> Boyd et al., *supra* note 72 at 107.

instances, technology may be the driving factor influencing what is looked at more favorably. Siegal stresses that regardless of whether physical medical travel is allowed, tele-travel should be permissible.<sup>80</sup>

### *1. Border crossing:*

Border crossings are often central to the phenomenon of patients traveling for healthcare.<sup>81</sup> Medical tourism and medical travel may be distinguished by whether or not an international border was crossed. Medical tourism may occur if the patient travels outside her home country for healthcare<sup>82</sup> while medical travel may occur if the patient travels for healthcare but remains within her country's borders.<sup>83</sup> For example, if a patient, living in Virginia, travels to Costa Rica for bariatric surgery, she is a medical tourist. The same patient traveling from Virginia to Rhode Island for spinal surgery may be a medical traveler.

Many authors define medical tourism relative to patient movement across a border, such as outbound/inbound medical tourism<sup>84</sup> and cross-border health care.<sup>85</sup> Commonly, unless "domestic" precedes medical tourism, the term refers to patients traveling internationally for treatment.<sup>86</sup> Medical travel authors also make distinctions based on the type of border crossed by

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<sup>80</sup> Gil Siegal, *Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web*, 17 VA. J.L. & TECH. 1(2012).

<sup>81</sup> At least 177 of the articles analyzed implied or stated that a border was crossed by a patient seeking health care.

<sup>82</sup> See e.g. Shawn Rhea, *Still Packing Their Bags*, 39 MOD. HEALTHCARE 0028 (2009) (outbound medical travel is also known as medical tourism).

<sup>83</sup> Richard Mark Kirkner, *The forces that feed medical travel*, 19 MANAGED CARE 30 (2010).

<sup>84</sup> Alex Hung, *Inbound medical tourism and visa reform*, 35 HOUS. J. INT'L L. 103, 106 (2013).

<sup>85</sup> Cortez, *supra* note 32.

<sup>86</sup> E.g. Art Murray, *Creating the Future through Disruptive Innovation*, 23 KM WORLD 16 (2014); David Conley & Alberto Coustasse, *Medical Tourism and International Healthcare Options*, 21 INSIGHTS CHANGING WORLD J. 125 (2013); Michael Guiry & David G. Vequist, *Traveling Abroad for Medical Care: US Medical Tourists' Expectations*

traveling patients. For instance, “outbound medical travel” occurs when U.S. patients go abroad for medical care and “inbound medical travel” occurs when patients travel to a domestic healthcare facility outside their geographic area.<sup>87</sup> Some authors, such as Karuppan, also add on additional distinctions based on the price of care. Karuppan, in a 2011 qualitative study of medical travelers, defined medical travel as “flying to a foreign country to purchase medical services at a substantially lower price than that offered by domestic providers.”<sup>88</sup>

Cross-border care is another term that has been carved out and described as “an offshoot of the more widely reported phenomenon of medical travel or medical tourism.<sup>89</sup>” Glinos et al. emphasize cross-border patient mobility as a “wider, more diverse and more nuanced phenomenon than” medical tourism.<sup>90</sup> While medical tourism is predicated on travel exclusively for receiving medical care, cross-border care might include the incidental need for healthcare arising while an individual is traveling.<sup>91</sup> Based on this distinction, an American patient who pre-arranges her total knee replacement in Thailand before flying to Bangkok is a medical tourist. The same American who trips and falls on a business trip to India, chipping her tooth, participates in cross-border care when her tooth is repaired in India before returning home.

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*and Perceptions of Service Quality*, 28 HEALTH MARKETING Q. 253 (2011); Prema Nakra, *Could Medical Tourism Aid Healthcare Delivery?* 45 FUTURIST 23 (2011); Kurt C. Gunter et al., *Cell Therapy Medical Tourism: Time For Action*, 12 CYTOTHERAPY 965 (2010); IG Cohen, *Medical Tourism: the view from ten thousand feet*, 40 HASTINGS CENTER REP. 11 (2010); Stanley M. Bergman, *US-India Business Relations*, 2 VITAL SPEECHES INT’L 239 (2010); Kristen Boyle, *A permanent vacation: examining medical tourism’s place in the U.S. healthcare system*, 20 HEALTH LAW. 42 (2008).

<sup>87</sup> Karuppan, *supra* note 5 at 210-211.

<sup>88</sup> Corinne M. Karuppan & Muthu Karuppan, *Who are the medical travelers and what do they want? A qualitative study*, 28 HEALTH MARK Q. 116 (2011).

<sup>89</sup> Kimberly M. Mutcherson, *Welcome to the Wild West: Protecting Access to Cross Border Fertility Care in the United States*, 22 CORNELL J.L. & PUB. POL’Y 349, 355 (2012).

<sup>90</sup> Glinos et al., *supra* note 41 at 1146.

<sup>91</sup> Federico de Montalvo, *A European Common Framework for Health: A Reap Possibility or an Improbably Myth? Lessons for the Future Healthcare System in the United States*, 14 DEPAUL J. HEALTH CARE L. 189 (2012).

## 2. Medical treatment type:

Numerous authors specify individual health related types of tourism by adding tourism to a specific medical treatment type such as: reproductive tourism;<sup>92</sup> death tourism;<sup>93</sup> surgical tourism;<sup>94</sup> electronic medical tourism;<sup>95</sup> transplant tourism;<sup>96</sup> stem cell tourism;<sup>97</sup> and fertility tourism.<sup>98</sup> Cohen coined the term *circumvention tourism* distinguishing certain medical tourists based on their traveling to access healthcare services legally available in one jurisdiction but not in another.<sup>99</sup> While, *circumvention tourism* may have its foundations in differences among legal frameworks, ultimately the patient travels in order to obtain a particular type of medical

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<sup>92</sup> E.g., Lisa C. Ikemoto, *Reproductive Tourism: Equality Concerns in the Global Market for Fertility Services*, 27 LAW & INEQ. 277 (2009); J. Brad Reich & Dawn Swink, *You Can't Put the Genie Back in the Bottle: Potential Rights and Obligations of Egg Donors in the Cyberprocreation Era*, 20 ALB. L.J. SCI. & TECH. 1 (2010); J. Brad Reich & Dawn Swink, *Outsourcing Human Reproduction: Embryos & Surrogacy Services in the Cyberprocreation Era*, 14 J. HEALTH CARE L. & POL'Y 241 (2011) (reproductive tourism is part of medical tourism). Marcia C. Inhorn, *Diasporic dreaming: return reproductive tourism to the Middle East*, 23 REPRODUCTIVE BIOMEDICINE 582 (2011) (explaining that reproductive tourism is gradually being replaced by cross-border reproductive care but, Inhorn uses the term to emphasize return reproductive tourism undertaken by expatriate populations).

<sup>93</sup> Rohith Srinivase, *Exploring the Potential for American Death Tourism*, 13 MICH. STATE U.J. MED. & L. 91 (2009).

<sup>94</sup> Aizura, *supra* note 70.

<sup>95</sup> Siegal, *supra* note 80 (coining the term electronic medical tourism and distinguishing it from the medical tourism that occurs in the physical world).

<sup>96</sup> E.g. I Glenn Cohen, *Transplant Tourism: The Ethics and Regulation of International Markets for Organs*, 41 J.L. MED. & ETHICS 269 (2013); Robert Ainley, *Organ Transploitation: A Model Law Approach to Combat Human Trafficking and Transplant Tourism*, 13 OR. REV. INT'L L. 427 (2011); Kiran Sheffrin, *Establishing an International Organ Exchange Through the General Agreement on Trade In Services*, 38 BROOK. J. INT'L L. 829 (2013); Erica D. Roberts, *When the Storehouse is Empty, Unconscionable Contracts Abound: Why Transplant Tourism Should Not Be Ignored*, 52 HOW. L.J. 747 (2009); Raneer Kooshie Lal Panjabi, *The Sum of a Human's Parts: Global Organ Trafficking in the Twenty-First Century*, 28 PACE ENVTL. L. REV. 1 (2010); Sheelagh McGuinness et al., *A Complex Web of Questions*, 22 CAMBRIDGE Q. HEALTH ETHICS 4 (2013); Nasrollah Ghahramani et al., *Paid donation: a global view*, 19 ADVANCED CHRONIC KIDNEY DISEASE 262 (2012); Michael P. Jaycox, *Coercion, autonomy, and the preferential option for the poor in the ethics of organ transplantation*, 12 DEVELOPING WORLD BIOETHICS 135 (2012).

<sup>97</sup> E.g. G.K. Crozier & Kyle Thomsen, *Stem cell tourism and the role of health professional organizations*, 10 AM. J. BIOETHICS 36 (2010); Arthur Caplan & Bruce Levine, *Hope, hype and help: ethically assessing the growing market in stem cell therapies*, 10 AM. J. BIOETHICS 24 (2010); Zubin Master et al., *What's Missing? Discussing Stem Cell Translational Research in Educational Information on Stem Cell 'Tourism'*, 41 J.L. MED. & ETHICS 254 (2013) (noting that the term "stem cell tourism" may not be ideal because it may minimize the gravity of the situation, and doesn't necessarily involve travel. Master uses the term, however, as it has "emerged as the term of art to describe this controversial topic." at 254)

<sup>98</sup> Charles P. Kindregan & Danielle White, *International Fertility Tourism: The Potential for Stateless Children in Cross-Border Commercial Surrogacy Arrangements*, 36 SUFFOLK TRANSNAT'L L. REV. 527 (2013).

<sup>99</sup> I. Glenn Cohen, *Circumvention Tourism*, 97 CORNELL L. REV. 1309 (2012).

treatment. Fahrenkrog discusses a similar issue where differences in regulating preimplantation genetic diagnosis among countries lead to medical tourism.<sup>100</sup> Here, the patient simply avoids the regulations in his or her home country by traveling to a more permissive jurisdiction for the desired treatment.

### 3. *Holiday or vacation components:*

Medical travel and medical tourism are also distinguished based on the holiday or vacation component associated with the patient's travels. Per Karuppan, "[w]hen medical travel also includes a vacation component, it is referred to as medical tourism."<sup>101</sup> The vacation/luxury component of medical tourism is visible in Browne's description of "attractive costs and luxurious accommodations,"<sup>102</sup> Klaus' highlight of surgical vacations created by packaging luxury with low cost surgery,<sup>103</sup> and Gabry's reference to medical treatments at "exotic locations."<sup>104</sup> Turner also implies a difference between medical tourism, healthcare plus a holiday, and medical travel lacking the holiday component.<sup>105</sup> In a creative effort to create balance in terminology, one author purposefully uses medical tourism and medical travel interchangeably to "balance the discursive ubiquity of the term 'medical tourism' in Indian

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<sup>100</sup> Aaron R. Fahrenkrog, *A Comparison of International Regulation of Preimplantation Genetic Diagnosis and a Regulatory Suggestion for the United States*, 15 *TRANSNAT'L L. & CONTEMP. PROBS.* 757 (2006).

<sup>101</sup> Karuppan, *supra* note 5, at 211.

<sup>102</sup> M. Neil Browne et al., *American Medical Tourism: Regulating A Cure That Can Damage Consumer Health*, 25 *LOY. CONSUMER PROTECTION J.* 319, 320-21 (2013).

<sup>103</sup> Michael Klaus, *Outsourcing Vital Operations: What if U.S. Health Care Costs Drive Patients Overseas For Surgery?* 9 *QUINNIPIAC HEALTH L.J.* 219 (2006).

<sup>104</sup> Leora I. Gabry, *Procreating Without Pregnancy: Surrogacy and the Need For a Comprehensive Regulatory Scheme*, 45 *COLUM. J.L. & SOC. PROBS.* 415, 439 (2012).

<sup>105</sup> Turner, *supra* note 28.

media with the term ‘medical travel’ used in social science scholarship.”<sup>106</sup>

Medical tourism “offers the promise of escape and repair”<sup>107</sup> which might include a fun trip.<sup>108</sup>

As Patients without Borders described, “the plan was simple: woo tourists ... to come for medical procedures and help them arrange sightseeing trips while they are there.”<sup>109</sup> Doing this

can improve the destination economy beyond the medical sectors (a market perspective).

Linking care with tourist activities is also described as easing “foreign patients into a new cultural environment and to occupy[ing] them during the pre-and post-operative periods”<sup>110</sup> (a

patient-centered perspective). Yet for many patients, traveling for healthcare is not likely to focus on sightseeing, rather these patients will define their travel to the hospital grounds and

nearby vicinity. As Karrupan’s patient interview data indicate, although medical travel and medical tourism are often used interchangeably, tourism is not very important to the patient,

although it might be more important to any accompanying family members.<sup>111</sup> Dalstrom, who

clearly states that he does not like the term medical tourism, asserts that while medical tourism is a popular term it trivializes the practice because tourism is not usually the driving force behind

patients traveling for healthcare.<sup>112</sup> In patient interviews, Solomon noted that most patients

indicated that the vacation element of medical travel was irrelevant if not ridiculous.<sup>113</sup>

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<sup>106</sup> Harris Solomon, *Affective Journeys: The emotional structuring of medical tourism in India*, 18 ANTHROPOLOGY & MED. 105, 115 (2011).

<sup>107</sup> *Id.* at 114.

<sup>108</sup> Melissa Knopper, *Medical tourism promotes R&R*, 18 CLINICIAN REV. 8 (2008).

<sup>109</sup> Mary Cuddehe, *Patients Without Borders*, 240 NEW REPUBLIC 16, 16 (2009).

<sup>110</sup> Hopkins et al., *supra* note 29, at 185.

<sup>111</sup> Karuppan & Karuppan, *supra* note 88.

<sup>112</sup> Dalstrom, *supra* note 33 at 26.

<sup>113</sup> Solomon, *supra* note 106 at 115.

Because individual patients seek care, there will likely be individual variation regarding any vacation/holiday component of medical travel, and some of this variation may reflect the type of medical care being sought. For instance, patients seeking in-vitro fertilization therapy may have the time and be healthy enough to sightsee.<sup>114</sup> Although some patients studied by Whittaker did not participate in tourist activities, some made a half-hearted attempt to “see a crocodile and elephant show,” and others visited local attractions and spas, much like any other tourist.<sup>115</sup>

#### 4. *Direction of Travel Relative to Countries' Development Status:*

The development status of the home and destination country is also a factor in terminology choices. Medical travel can describe travel, in any direction, between a developed and a developing country.<sup>116, 117</sup> While travel from a developed to a developing country has been described as an “unambiguous way of differentiating the recent phenomenon of medical tourism from the traditional model of international medical travel,”<sup>118</sup> it appears ambiguous. In the included articles, most authors use medical tourism to refer to a patient traveling from a developed to developing country,<sup>119</sup> which is the growing phenomenon being studied in this research.

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<sup>114</sup> Andrea Whittaker & Amy Speier, *Cycling overseas: care, commodification, and stratification in cross-border reproductive travel*, 29 MED. ANTHROPOLOGY: CROSS-CULTURAL STUDIES HEALTH & ILLNESS 363, 370 (2010).

<sup>115</sup> *Id.* at 370-71.

<sup>116</sup> See e.g. Y.Y. Brandon Chen & Colleen M. Flood, *Medical Tourism's Impact on Health Care Equity and Access in Low-and Middle-Income Countries: Making the Case for Regulation*, 41 J.L. MED. & ETHICS 286 (2013) (medical travel can be from developed or developing countries with patient seeking care in Western facilities).

<sup>117</sup> Mutcherson, *supra* note 89 at 367.

<sup>118</sup> Michael D. Horowitz et al., *Medical tourism: globalization of the healthcare marketplace*, 9 MEDSCAPE GENERAL MED. 33 (2007) (noting that medical tourism “does not accurately reflect the reality of the patient’s situation or the advanced medical care provided in these destination” at 33.)

<sup>119</sup> See e.g. Akke K. van der Bij & Johann D. Pitout, *The role of international travel in the worldwide spread of multiresistant Enterobacteriaceae*, 67 J. ANTIMICROBIAL CHEMOTHERAPY 2090, 2090 (2012) (patients traveling in this direction in order to avoid long wait times and take advantage of lower costs); Reed, *supra* note 69 at 1433 (patients seek care abroad, often in less developed countries); Sara Darbandi et al., *Studying the place of Iran in*

## V. Applying Findings to Existing Classifications

As noted in Figure 1, existing classification factors for medical tourism or travel include health care services, patient motivation, tourist activities, payer, and the geographical flow of patients. The systematic review identified similar categories used in the multi-disciplinary literature: border crossing, medical treatment type, holiday or vacation component, and direction of travel relative to countries' developmental status. Based on the literature, the classification factors for the international travel for health care services (including medical tourism, medical travel, and medical outsourcing) are depicted in Figure 4.

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*the World for Medical Tourism in Infertility Fields*, 12 IRANIAN J. REPRODUCTIVE MED. 69 (2014); Zahra Meghani, *A robust, particularist ethical assessment of medical tourism*, 11 DEVELOPING WORLD BIOETHICS 16 (2011) (patients from wealthy nations such as America, traveling to poorer countries for surgical procedures they can not afford in the U.S); Heather T. Williams, *Fighting Fire with Fire: Reforming the Health Care System Through a Market-Based Approach to Medical Tourism*, 89 N.C. L. REV. 607, 608 (2011); Chen & Flood, *supra* note 116.

Figure 4. Classification Factors for International Travel for Health Care Services From Systematic Review

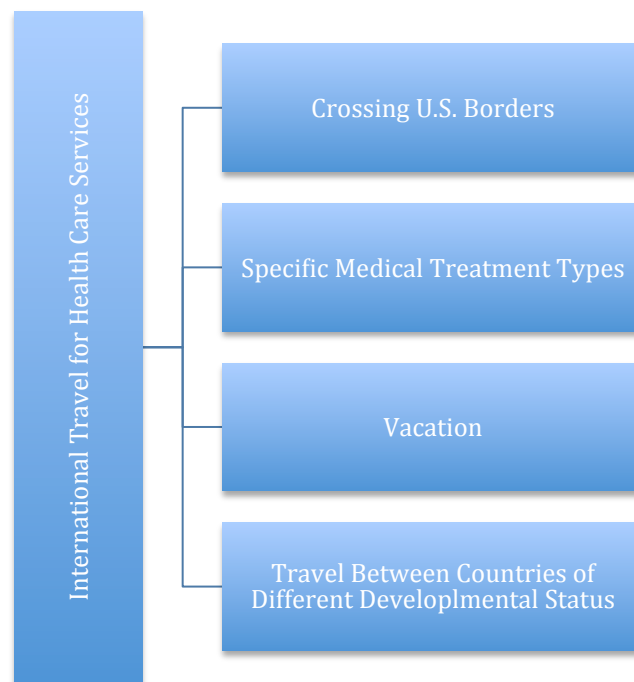


Figure 4, from the systematic review, is similar to Figure 1, from the theoretical literature in two ways. First, the category of specific medical treatment types is similar to the type of health care service sought. Second, the vacation group is like the tourist activities category. The two figures differ in other ways. Figure 4 includes crossing U.S. borders, which was not in Figure 1. The reason for this is that Figure 4 has a U.S. perspective, which many of the typologies contributing to Figure 1 lacked. Also, Figure 4 includes travel between countries of different developmental status. This is related to, but has a different nuance from Figure 1's geographic flow of patients, referring to patients moving North-North, South-South, North-South, and South-North.

## **VI. Synthesis and Recommendations Regarding Classifications for U.S. Outbound Travel for Health Care**

### A. Existing Terminology and Definitions Fail to Provide Needed Clarity

The choice of any of the terms medical tourism, medical travel, or medical outsourcing may indicate nothing beyond the flavor of the day, or it may reflect an author's chosen approach or bias toward the subject matter.

Border crossing distinctions may be useful to describe patients traveling across various jurisdictional boundaries for healthcare, whether they are international, border, or domestic borders. This distinction is illusory, however, because it fails to make any meaningful distinction between patients traveling for healthcare. Simply by crossing an international border, a patient does not become more of a tourist than a traveler. Once a patient has left his or her local geographical area, the same opportunities for new experiences increase, as do basic tourist expenses, including transportation, lodging, food, and sightseeing.

For the vacation category, the link between fun, and travel, and medical care is critical.<sup>120</sup> Overall, the vacation component may be more of a marketing tool, a catch phrase designed to attract mobile patients, occluding the more serious financial and medical catalysts of traveling for healthcare services. The vacation part can be the hook or pull factor that ultimately entices the patient to seek care at a new location. Using fun and vacations as a marketing tool to attract

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<sup>120</sup> See Christine N. Buzinde & Careen Yarnal, *Therapeutic landscapes and postcolonial theory: a theoretical approach to medical tourism*, 74 SOC. SCI. MED. 783 (2012).

patients may be helpful when attempting to attract patients from an international population. As Bergmark has asserted, the term “medical tourism does not adequately encompass this significant form of health seeking behavior” from the patients perspective.<sup>121</sup> There are many factors such as patient personality and expectations, patient health status, economic status and more, that may impact her desire and ability to participate in a vacation or holiday when primarily traveling for purposes of healthcare. The vacation component does not add specificity to the terminology.

The relationship of travel for health care services and the developmental status of countries does not seem capable of adding clarity to the terminology. While a patient may travel between a less developed country and a more developed country when seeking health care, distinguishing the direction does not add clarity. It may, however, add stigma.

The expanding number of “tourism’s” based on specific medical interventions and treatments may represent the most useful distinction already in the literature. While distinctions based on medical specialization are likely to increase as patients travel for more types of medical care, it does provide specific and precise information.

#### B. Recommendations for Moving Toward Definitional Clarity

While consensus over terminology will take time and active discussion, this subsection makes recommendations aimed at standardizing terminology. Based on the discussion below, a U.S. patient who leaves the U.S. for a hip replacement is an international medical traveler for

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<sup>121</sup> Bergmark, et al., *supra* note 30 at 614.

orthopedic surgery. The key components of this terminology are: 1) a patient; 2) leaving the U.S.; 3) for an identified type of health care service.

*1. Use “International Medical Travel” for Services Covered by Health Plans: Not Tourism*

The term medical tourism has outlived its usefulness as a catch-all term. This is particularly true for services covered by health plans. In an era where patient outcomes and quality of care are emphasized, tourism is out of place when referring to many of the health care services patients access by traveling such as cardiac and orthopedic surgeries. By eliminating the use of tourism, the association of health care and tourism is severed. Medical outsourcing has had limited usage (see Figure 3) in the literature and likely has too negative of a connotation to help add neutral clearness to a terminology discussion. Others have called for improved classifications. Dalstrom suggested that more neutral terms are “international medical travel,” if the patient travels beyond his or her country’s boundaries, and “cross border medical travel,” if the patient travels to a neighboring country.<sup>122</sup>

For U.S. outbound travelers for health care, “international medical travel” provides a single umbrella term for patients leaving the U.S. With only two borders, the U.S. does not gain from also using cross border medical travel. Rather, “international medical travel” encompasses both types of travel, and it permits a clear demarcation from domestic medical travel, where a U.S. patient crosses state lines for health care but remains within the U.S.

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<sup>122</sup> Dalstrom, *supra* note 33 at 27 (using more neutral terms separates the fun part of tourism from the medical care component, shifting the emphasis to the health care services).

## *2. “International Medical Travel” Applies to Patients: Not Providers*

With a migration to the use of travel instead of tourism, a clear line needs to be drawn around who is traveling. Medical tourism can refer to patients or providers that receive or provide care outside their local geographies. Lack of clarity is only perpetuated when it is not clear who is traveling, the patient or the provider. Both patients and providers can, and do, travel to receive or provide health care services, however, “international medical travel” should be limited to patients to avoid misunderstandings.

## *3. Create Specificity By Adding the Health Care Service Type*

“International medical travel” alone is still vague. Including the health care service type such as orthopedic, cardiac, or bariatric can provide increased specificity. This proposition is supported by Sobo’s call for distinguishing the specific types of medical travel. For instance, a U.S. patient may choose to travel to India for cardiac surgery. At the most fundamental level, this means a U.S. patient left the U.S. for a cardiac surgical procedure.

## **VI. Chapter Summary**

If courts and legislators are to rule on, or regulate, this phenomenon of patients traveling abroad for healthcare, then consensus on terminology will aid in providing a bases for such decision-making and regulating. If this phenomenon aims to become better incorporated in the U.S. health care delivery system, then clear terminology that resonates with existing language will be

helpful. Such terminology should strive for neutrality, clarity, and specificity. “International medical travel” for specific health care services provides a starting point for building terminology consensus.

### **Chapter Three: Current Legal Framework for U.S. Outbound Medical Travel**

In an effort to lower health benefit plan expenditures, some employers are broadening their health care benefits to include international medical travel. With lower or nonexistent copayments, caretaker provisions, sharing of cost savings, and other incentives, public and private self-funded employers are incentivizing employees and beneficiaries to travel abroad for health care. Based on health insurance coverage status, international medical travelers may be characterized as: 1) Uninsured; 2) Employees or beneficiaries of self-funded employers seeking health care treatment covered by their health plan; 3) Employees or beneficiaries of self-funded employers using their medical tourism option for health care treatment not covered by their health plan; or, 4) Fully insured with a high deductible plan.<sup>123</sup> This chapter focuses on the second category: employees or eligible beneficiaries of self-funded employers utilizing an international medical travel option.

This chapter analyzes the existing legal framework and protective measures available for employers and employees opting to offer or participate in an international medical travel option. Specifically, Section I provides further background on U.S. outbound medical travel and rationale for employer interest in offering an international medical travel benefit to employees and eligible beneficiaries. Section II explores how a limited legal framework for outbound medical travel permits it to exist, albeit in an environment of legal uncertainty. Section III examines potential employer, employee, and beneficiary protections that can help successful navigation of existing legal ambiguity.

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<sup>123</sup> See Mark S. Kopson, *Medical Tourism: Implications for Providers and Plans*, 3 J. HEALTH & LIFE SCI. L. 147, 159 (2010) (breaking down medical tourists according to uninsured, employees of self-funded employers, and fully insured with high-deductible plans).

## I. Introduction

You have osteoarthritis in your right knee and need a total knee replacement. You've lost weight, modified your activities, and taken nonsteroidal-anti-inflammatory medicines for the past decade. Your activity levels are still severely limited, and your level of pain is high. As an employee of a large Seattle company, you are relieved that the procedure will be covered by your employer-sponsored health insurance plan. However, your knee replacement will only be covered at no cost to you if you travel to the Bumrungrad International Hospital in Bangkok, Thailand. If you want your surgery to be done at your local hospital, you will have to pay 20% of the costs, about \$12,800.<sup>124</sup> You weigh your options, and you leave your community, home, and most of your family, and travel to Thailand for the surgery.

This is one example of how employees may be incentivized to travel abroad for health care services. The U.S. health care system is changing from fee-for-service to value based reimbursement, emphasizing cost and outcomes. Employers are actively embracing this change by literally moving one of the central components of the health care system--the patient. For their part, some patients are also willing to pack their suitcase and receive their health care in a foreign country. Health care was predominantly a local service, dependent on the patient living in close proximity to the physician and health care facility.<sup>125</sup> With the rise of globalization, and significant differences in cost of care depending on location (although not necessarily with a difference in quality), the market for patients willing to travel for health care is ripe for expansion.

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<sup>124</sup> 20% of \$64,000. See Walter Eisner, *CMS Lifts Veil from Hospital Charges*, ORTHOPEDICS THIS WEEK, at 12, 2013.

<sup>125</sup> See McLean, *supra* note 2.

The international medical travel industry is growing as demonstrated by the specialized Internet medical tourism web sites, industry associations, and certification programs for medical travel companies. Approximately 50 countries participate in the medical travel industry.<sup>126</sup> In 2012, medical travel was estimated to gross about \$100 billion.<sup>127</sup> Some developing and emerging countries are focusing on medical travel as an economic development driver.<sup>128</sup> These are primarily lower and middle-income countries where the exchange rate facilitates economic competition.<sup>129</sup> Sectors of developed countries, such as the self-funded U.S. employers, are capitalizing on this medical travel industry as a cost savings, incentivizing their employees to travel for specific medical services.

Employers are changing their health care benefits strategies and incentivizing employees and beneficiaries to engage in medical travel by offering particular medical procedures at little, if any, out-of-pocket cost to the employee or beneficiary. Out-of-pocket costs are likely more important to insured patients than the total price of any given health care service.<sup>130</sup> Out-of-pocket costs include co-payments, coinsurance payments, and deductible payments made by patients.<sup>131</sup> Typically, under an international medical travel benefit, co-payments and deductibles are waived; travel expenses for the medical traveler and a caregiver companion are

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<sup>126</sup> Anchama NaRanong & Viroj NaRanong, *The Effects of Medical Tourism: Thailand's Experience*, 89 BULL. WORLD HEALTH ORG. 336, 337 (2011).

<sup>127</sup> Deloitte Center for Health Solutions, *Medical Tourism Consumers in Search of Value*, 6. Estimates of the value of medical tourism and the number of patients participating varies in the literature, perhaps because of differences in definitions, and should be relied upon with caution. See Johnston, et al., *supra* note 54.

<sup>128</sup> Puteri Nemie J. Kassim, *Medicine Beyond Borders: The Legal and Ethical Challenges*, 28 MED. & L. 439, 450 (2009). But in order for developing countries to reap the most benefit from such an economic driver, medical tourism must be based on a solid legal regulatory framework.

<sup>129</sup> See Johnston, *supra* note 54.

<sup>130</sup> Spending on Shoppable Services in Health Care, Health Care Cost Institute, Issue Brief #11, 2-3 (March 2016), <http://www.healthcostinstitute.org/issue-brief-shoppable-services.pdf>.

<sup>131</sup> *Id.* at 3 (noting that deductible payments provide unique incentives for patients because they may choose low priced providers while satisfying their deductible but demonstrate less price sensitivity once reaching their deductible).

also usually covered. Covered individuals may still choose to obtain care at a local facility, but he or she will bear more of the financial burden for the local procedure. Moreover, international medical travelers often stay at a local hotel or resort, at no extra cost, after discharge from the hospital and before flying home. The experience of self-funded employers will be valuable in informing any future legal and public policy responses.

#### A. U.S. Outbound Medical Travel

A global marketplace exists for health care. Providers and facilities are marketing to patients around the globe. The projected patient flow, from local clinic to local hospital, may be disrupted as patients choose to receive care in a foreign country. An emerging phenomenon, international medical travel's possible role and longevity within the U.S. health care benefits structure and thus, more broadly, the U.S. health care system, are not yet known. Scholars are divided between advocating for including international medical travel within the U.S. health care system,<sup>132</sup> and elaborating upon the possible risks<sup>133</sup> with the goal of limiting such travel. This research does not aim to resolve this debate; rather, after a brief discussion, it proceeds under the premise that international medical travel will remain an option to U.S. patients. Because of their early adoption, the self-funded employer experience with international medical travel merits further analysis as a contemporary example of the benefits and barriers of including an international medical travel option within a U.S. health benefit plan.

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<sup>132</sup> Kerrie S. Howze, *Note, Medical Tourism: Symptom or Cure?*, 41 GA. L. REV. 1013, (2007).; Boyle, *supra* note 86; Williams, *supra* 119; Rebecca Bennie, *Medical Tourism: A Look at How Medical Outsourcing Can Reshape Health Care*, 49 TEX. INT'L L.J. 583 (2014); Stephen Samlan, *Medical Tourism: Opportunity To Control Escalating Health Care Costs In The United States?* 20 ANNALS HEALTH L. ADVANCE DIRECTIVE 136 (2010).

<sup>133</sup> See Kenneth A. Young, *Of Poops & Parasites: Unethical FDA Overregulation*, 69 FOOD & DRUG L.J. 555 (2014); Elizabeth Pugliese, *Organ Trafficking and the TVPA: Why One Word Makes a Difference in Int'l Enforcement Efforts*, 24 J. CONTEMP. HEALTH L. & POL'Y 181 (2007); McLean *supra* note 2.

Proponents and opponents to international medical travel, at least in part, both use economic arguments to support their positions. Proponents argue that the U.S. health care market should have learned from the Asian automobile industry that the demand for foreign services would likely grow for quality services.<sup>134</sup> International medical travel may constitute “a market substitute for high priced care.”<sup>135</sup> Medical travel services are “shoppable.”<sup>136</sup> Because they are known, necessary, and non-urgent, they can be researched in advance, providers compete to provide these services, and available data exist regarding prices and quality.<sup>137</sup> It is difficult not to be persuaded by the potential economic savings, particularly if foreign quality equals or exceeds that in the U.S. As the U.S. continues grappling with high and often variable prices for health care, it is economically appealing to permit, and even encourage, patients to travel for necessary non-urgent health care.

Opponents of international medical travel often raise concerns of the potential risks of “foreign, and often unsupervised, treatment.”<sup>138</sup> For some health care services, such as organ transplants, there is support for medical travel to be illegal.<sup>139</sup> Arguably, American medical jobs could be protected if patients were cared for within the U.S. borders. As McLean asserts, stopping international medical travel could be another good reason for the U.S. to adopt universal health care.<sup>140</sup>

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<sup>134</sup> McLean *supra* note 2.

<sup>135</sup> William P. Kratzke, *Tax Subsidies, Third-Party-Payments, and Cross-Subsidization: America's Distorted Health Care Markets*, 40 U. MEM. L. REV. 279, 384 (2009).

<sup>136</sup> Health Care Cost Institute, *supra* note 130.

<sup>137</sup> *Id.* at 1.

<sup>138</sup> Young, *supra* note 133.

<sup>139</sup> Pugliese, *supra* note 133

<sup>140</sup> See McLean *supra* note 2.

Regardless of which side one takes in this debate, there are potentially large financial implications to the U.S. once its citizens pack their suitcases and travel abroad for health care. As the patient travels, so do the health care dollars associated with treating that patient. While the price for treatment in a foreign country may be lower than the price for similar treatment within the U.S., those health care dollars are leaving the U.S. health care system and entering the global marketplace. The savings are significant enough for self-funded employers to include international medical travel within health benefit plans; it remains to be seen how providers will respond if and when, enough health care dollars leave the U.S. health care system with medical travelers.

### *1. International Medical Travel Is A Hybrid Industry With Potential For Growth*

International medical travel is a hybrid, overlapping the trade and health policy spheres.<sup>141</sup> It can encourage foreign investment in health care infrastructure and provide a foreign revenue stream. Tourism is the world's largest industry.<sup>142</sup> Health care is becoming a global industry with international hospital chains and an emerging global contract research industry.<sup>143</sup> Moreover, international standards are developing for medical education, hospital accreditation, and pharmaceuticals and medical devices,<sup>144</sup> all part of the medical tourism industry. The combination of health services with tourism is often lucrative, increasing consumption of both

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<sup>141</sup> Nicola S. Pocock & Kai Hong Phua, *Medical tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia*, 7 GLOBALIZATION AND HEALTH 10 (2011).

<sup>142</sup> Kassim, *supra* note 128.

<sup>143</sup> Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71, 89 (2008).

<sup>144</sup> See Nathan Cortez, *International Health Care Convergence: The Benefits and Burdens of Market-Driven Standardization*, 26 WIS. INT'L L.J. 646 (2008) (discussing standardization efforts which are beyond the scope of this article). Moreover, trade agreements may be used by countries to establish minimum quality standards. See Williams, *supra* note 119, at 657.

types of services. For instance, in India, where comparable treatment costs about one eighth to one fifth of those in the West, the amount of revenue brought in by medical tourists for hotels, food, and shopping can equal that spent on health care.<sup>145</sup> And, in Thailand, medical tourists spend about 33.3% of the cost of their medical care on associated non-medical charges.<sup>146</sup> With increasing globalization of health care, it is likely that more patients, including Americans,<sup>147</sup> will follow this growing global market, seeking medical services they desire, regardless of geographic or jurisdictional boundaries.

## B. Employers and International Medical Travel

Traveling for medical care is not a new phenomenon. In the 20<sup>th</sup> century wealthy patients traveled from less developed to developed nations to access high-quality facilities and well-trained personnel.<sup>148</sup> More recently, patients have been traveling from developed countries, like the U.S., to less developed countries, such as Thailand and India, for health care services.<sup>149</sup> Americans also travel within the U.S., often to receive care at Centers-of-Excellence (facilities

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<sup>145</sup> Basanth K & Binu Ann Kuriachan, *Medical Tourism & Health Care Hosting*, 12 INTEGRAL LIBERATION 1, 33-35 (2008).

<sup>146</sup> Anchama NaRanong & Viroj NaRanong, *supra* note 126, at 337.

<sup>147</sup> It is estimated that 750,000 Americans travelled overseas for health care in 2007 and that in 2012 this number reached 1.6 million. Matthias Helble, *The Movement of Patients Across Borders: Challenges and Opportunities for Public Health*, 89 BULL WORLD HEALTH ORG. 68 (2011). Some U.S. employers are offering insurance plans for employees who prefer to receive their health care services in a bordering country, such as Californians who seek care in Mexico. Access Baja HMO and Dependent Plan.

<https://www.blueshieldca.com/producer/largegroups/products/medical/baja/eligibility.sp>. See Deloitte Center for Health Solutions, *Medical Tourism: Update and Implications 2009*, at 5. [http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us\\_chs\\_MedicalTourism\\_111209\\_web.pdf](http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_MedicalTourism_111209_web.pdf), (discussing other insurers providing health benefits at foreign medical sites. Large insurers are also conducting pilot programs as they explore the possibility of including medical tourism options in their health plans.) Nancy Hatch Woodward, *Medical Tourism: Expand Health Benefits, Save Money*, 20 INT'L. H.R. J. ART 2 (2011). Such insurance efforts are driven by cost and an effort to reduce expenditures.

<sup>148</sup> Neil Lunt et al., *Medical Tourism: Treatments, Markets and Health System Implications: A Scoping Review*, OECD, Directorate for Employment, Labour and Social Affairs. <http://www.oecd.org/dataoecd/51/11/48723982.pdf>.

<sup>149</sup> *Id.*

specializing in particular procedures in order to reduce cost and improve quality)<sup>150</sup>. What is new are U.S. employers incentivizing employees to engage in international medical travel as part of their health benefit plans.

### *1. Health Care Price Variability In The U.S. Impacts Employers*

Rising health care costs in the U.S. create economic strains on employers and employees.<sup>151</sup> Employer sponsored health care has been a major component of the U.S. health care system since World War II. A Medical Tourism Association survey indicates that 95% of U.S. employers consider health care benefits an important part of their compensation package.<sup>152</sup> Even employers committed to providing health care benefits are often daunted by the high costs. To alleviate financial strain, employers have begun offering employees an international medical travel option in an effort to reduce health care expenditures. For employers trying to remain competitive in an era of expanding health care charges, international medical travel can be a viable option, lowering employer and employee health care costs.

International medical travel also helps employers avoid existing health care cost variability within the U.S. Cooper et al.'s recent study analyzed variations in health care spending and

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<sup>150</sup> Centers-of-excellence generally refer to facilities that demonstrate superior clinical outcomes for specialized procedures such as organ transplants. Health plans and employers are carrying this principle to more common procedures such as total knee and hip replacements. See James C. Robinson and Kimberly MacPherson, *Payers Test Reference Pricing and Centers of Excellence to Steer Patients to Low-Price and High-Quality Providers*, 31 HEALTH AFFAIRS 9, 2028 (2012)(discussing centers-of-excellence contracting).

<sup>151</sup> William Willis, Alberto Coustasse, *Medical Tourism: Comparing Coronary Bypass Surgery in the U.S. and Abroad*, In proceedings of the Business and Health Administration Association Annual Conference 2014, at 208, Chicago, IL.

<sup>152</sup> Medical Tourism Association, *Medical Tourism and Obamacare: Self-Funding Employers in Search of Benefits to the Affordable Care Act*, <http://www.medicaltourismmag.com/medical-tourism-and-obamacare-self-funding-employers-in-search-of-benefits-to-the-affordable-care-act/>.

hospital price variation across the U.S.<sup>153</sup> Cooper et al. use actual transaction prices paid for individual claims by employer-sponsored insurance by three of the largest U.S. insurers.<sup>154</sup> These authors found that hospital negotiated prices varied by a factor of 8 or more across the nation.<sup>155</sup> For instance, the mean hospital procedural price for a knee replacement ranges from \$14,581 in St. Louis, Missouri, to \$34,720 in Fort Worth, Texas. Unlike most consumer services, a higher price paid for health care services does not necessarily translate into receiving a higher quality of health care services.<sup>156</sup> This disconnection between price and quality may further encourage self-funded employers to seek out lower costing care associated with high quality outcomes in foreign countries.

## *2. Self-Funded Employers Have Increased Flexibility to Offer An International Medical Travel Benefit*

Employers' health benefit plans may be fully insured or self-insured.<sup>157</sup> For a fully insured employer health benefit plan, the employer purchases coverage from a state regulated insurer. Here, the insurer bears the financial risk for any health insurance claims made by the employees, not the employer.<sup>158</sup> Any cost savings resulting from where an employee's health care services are received primarily benefits the insurer. Neither the employer nor the employee experiences direct reductions in their health care expenditures if an employee seeks to have surgery at a lower

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<sup>153</sup> Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, (Dec. 2015), [http://www.healthcarepricingproject.org/sites/default/files/pricing\\_variation\\_manuscript\\_0.pdf](http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf).

<sup>154</sup> *Id.*

<sup>155</sup> *Id.* at 34.

<sup>156</sup> *See Id.* at 22. *See also* Melinda Beck, *How to Bring the Price of Health Care Into the Open*, WSJ online, updated February 23, 2014.

<sup>157</sup> Bernadette Fernandez, *Health Insurance: A Primer*, Congressional Research Service, 7-5700. February 16, 2012, at 4.

<sup>158</sup> *E.g.*, Amalia R. Miller et al., *Financing of Employer Sponsored Health Insurance Plans Before and After Health Reform: What Consumers Don't Know Won't Hurt Them?*, 36 INT'L REV. L. & ECON. 36, 39 (2013).

cost facility. For example, an employee or beneficiary needing a total knee replacement, with coverage under a fully insured employer health benefit plan, may not pay less for her health care because her surgery was performed at a less costly facility, nor will her employer see a direct reduction in that year's health care expenditures. Any cost related incentive must, therefore, already exist within the insurance health plan's structure of benefits.

Self-funded or self-insured plans, on the other hand, place the financial risk for employees' health care costs more squarely on the employer. These employers are not purchasing health care insurance; rather, they are paying for the health care benefits directly. Employees may be unaware that their employer pays for health care claims, not an insurance company. Employers often contract with a third-party administrator (TPA), which often is an insurance company, for administrative services such as processing claims and other associated paperwork.<sup>159</sup> Because of this arrangement, employees may not realize that their employer self-funds their health care benefits, mistakenly considering the TPA as their insurance company.

Self-funded employers, however, do not bear all the risk in providing health care benefits because they can, and often do, purchase stop-loss coverage to mitigate their risk above a certain threshold.<sup>160</sup> Sixty percent of individuals covered by self-funded employer health benefit plans

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<sup>159</sup> E.g., Amy B. Monahan, Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935, 1965 (2013).

<sup>160</sup> Adam V. Russo, *Will Self-Funding Drown or Soar in 2014?*, 21 EMPLOYER'S GUIDE TO SELF-INSURING HEALTH BENEFITS NEWSL. 2 (February, 2014). Cf. Monahan & Schwarcz, *supra* note 159 (recommending that the small-group insurance market's stability be strengthened not only through state regulation of stop-loss insurance but also by designing small-group coverage so that it is more attractive than self-insuring). See also Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 27, 78 (2011) (discussing that federal court cases holding that self-insured plans do not lose their self-insured status by purchasing stop-loss insurance).

are further protected by stop-loss insurance.<sup>161</sup> Stop loss coverage may either cap the total amount of claims paid per employee, or it may cap the total amount the employer pays for all claims during the plan year.<sup>162</sup> In 2015, 92% of employees in self-funded health benefit plans were in plans that had stop-loss insurance limiting the total amount of claims paid per employee.<sup>163</sup> Within this category of per employee stop –loss claims coverage, stop-loss insurance begins paying for claims when a certain dollar amount is reached. Generally, this dollar amount differs depending on the employer’s size. Employers with less than 200 employees typically have a stop-loss plan that begins at \$210,000 while employers with more than 200 employees often have a stop-loss plan beginning at \$340,000.<sup>164</sup> Regardless of the exact dollar amount when the stop-loss insurance attaches, this type of insurance functions to shift risk above this amount from the employer to the stop-loss insurer. The self-insuring employer continues to bear risk for those health benefit claims filed below the attachment point of the stop-loss policy.<sup>165</sup>

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<sup>161</sup> Kaiser Family Foundation, *2015 Employer Health Benefits Survey*, <http://files.kff.org/attachment/report-2015-employer-health-benefits-survey>.

<sup>162</sup> *Id.*

<sup>163</sup> *Id.* (this 92% includes stop-loss insurance plans that limit the per employee claims and plans that limit the employer’s total spending and per employee spending).

<sup>164</sup> *Id.*

<sup>165</sup> *Eg.*, Monahan & Schwarcz, *supra* note 159 at 1966 (noting that self-insuring employers may retain additional liability for claims if the stop-loss insurer does not reimburse the employer due to insolvency, a material misrepresentation in the application, or an applicable policy exclusion).

#### a. Self-funded Employers Avoid State Insurance Laws

Employers may choose to self-insure to avoid state laws governing health insurance plans.<sup>166</sup> Under the Employee Retirement Income Security Act of 1974 (ERISA),<sup>167</sup> self-funded health benefit plans are not subject to state law reserve requirements, mandated benefits, premium taxes, and consumer protection regulations. Free from these laws, self-funded employers tend to be creative with their offerings and pricing methodologies.<sup>168</sup> One way in which self-funded employers demonstrate creativity in health benefit plan options is by including a benefit covering international travel for health care. This type of option may also provide one method for an employer to tailor its health care benefits to better fit the needs of its employee population.

#### b. Most Covered Employees Are in Self-funded Health Plans

Most people in the U.S. with employer sponsored health care benefits are in self-funded plans.<sup>169</sup> According to Kaiser Family Foundation's 2015 Annual Report, 63% of all covered employees are in a self-funded plan.<sup>170</sup> Self-funding often appeals to companies with at least 200 employees because the employer can spread the risk over a larger pool of employees and other covered persons such as an employee's dependents.<sup>171</sup> Moreover, larger employers are better able to predict their risk and usually have greater financial reserves if needed to absorb additional

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<sup>166</sup> *E.g.*, Miller et al., *supra* note 158 (studying impact of regulatory arbitrage on consumers when employers self-insure health plans and asserting that the significance of regulatory arbitrage may increase for small firms under the 2010 Patient Protection and Affordable Care Act).

<sup>167</sup> Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829.

<sup>168</sup> Russo, *supra* note 160.

<sup>169</sup> *E.g.*, Miller et al., *supra* note 158 at 37 (authors' analysis of Kaiser/HRET Annual Survey of Employer Health Benefits, 2006-2010).

<sup>170</sup> Kaiser Family Foundation, *supra*, note 161.

<sup>171</sup> Kaiser Family Foundation, *supra* note 161 (83% of covered workers in a firm with 200 or more employees are in a partially or fully self-funded plan as compared with 17% in small firms).

medical claims.<sup>172</sup> The larger the firm size, the greater the percentage of employees are covered by a self-funded plan. Firms with 1,000 to 4,999 employees had 82% of employees covered by a self-funded plan while firms with 5,000 or more employees had 94% of employees covered by a self-funded plan in 2015.<sup>173</sup>

## **II. Limited U.S. Law Applies to Employer Sponsored International Medical Travel Benefits**

ERISA and the Patient Protection and Affordable Care Act (ACA)<sup>174</sup> are the two primary federal statutes governing employer sponsored international medical travel benefits. Neither of these laws prohibits self-funded employers from including an international medical travel option as part of their health benefit plans. ERISA permits self-funded employer health benefit plans to include an international medical travel option but does require satisfaction of a fiduciary duty to act “solely in the interest of the participants and beneficiaries.”<sup>175</sup> The ACA also does not impede self-funded employers from offering an international medical travel benefit or encouraging employees to utilize such a benefit. Perhaps the ACA’s greatest impact on traveling for medical care is diverting much of the health care market’s and insurance market’s energy and attention away from continued exploration of creative options such as international medical travel as the industries committed themselves to focusing on compliance after enactment. Moreover, very little case law exists addressing medical travel of any type, and none specifically

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<sup>172</sup> Monahan & Schwarcz, *supra* note 159 at 1966.

<sup>173</sup> Kaiser Family Foundation, *supra* note 161.

<sup>174</sup> See generally ACA, Pub. L. No. 111-148, 124 Stat. 119 (2010). These are not the only federal state statutes affecting health plans. Others include: The Americans with Disabilities Act, the Health Insurance Portability and Accountability Act, and the Consolidated Omnibus Budget Reconciliation Act.

<sup>175</sup> 29 U.S.C. § 1104(a)(1).

ruling on employer sponsored international medical travel. With no case law on point and limited boundaries placed on employer sponsored international medical travel benefits by federal statutes, this type of travel occurs in an uncertain legal environment.

#### A. Existing Federal Statutory Framework Places Limited Boundaries On Employer Sponsored International Medical Travel

##### *I. ERISA*

ERISA was enacted following reports of private pension system abuses.<sup>176</sup> Although it therefore focuses on pension plans, it also applies to welfare benefit plans, including health plan benefits.<sup>177</sup> ERISA establishes two types of employee benefit plans: employee pension plans and employee welfare benefit plans.<sup>178</sup> The latter, employee welfare benefit plans, is relevant to international medical travel.<sup>179</sup> ERISA protects interstate commerce and beneficiaries by setting minimum standards for employee welfare benefit plans, including health insurance plans.<sup>180</sup> ERISA is very broad in its coverage, applying to most private employer plans, except for government plans, church plans, plans maintained solely for the purpose of complying with

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<sup>176</sup> Bernadette Fernandez, *Health Insurance: A Primer*, Congressional Research Service, 7-5700. (February 16, 2012.) ERISA was originally designed to “safeguard participants and beneficiaries against pension plan bankruptcy.” *Overview of ERISA, Executive Legal Summary* 302 (2015).

<sup>177</sup> Fernandez, *supra* note 176. ERISA also encourages employers to sponsor benefit plans and minimizes potential conflicts with state laws. Marea B. Tumber, *The ACA’s 2017 State Innovation Waiver: Is ERISA a Roadblock to Meaningful Health care Reform?*, 10 U. MASS. L. REV. 388 (2015).

<sup>178</sup> 29 U.S.C. §1002 §§ 3(1) & 3(2).

<sup>179</sup> 29 U.S.C. §1002 § 3(1).

<sup>180</sup> 29 U.S.C. § 1001(b). ERISA’s standards apply to employee welfare benefit plans, which include “medical, surgical, or hospital care benefits.” 29 U.S.C. § 1002(1).

applicable worker's compensation laws or unemployment compensation or disability insurance laws, and plans maintained outside of the U.S. primarily for nonresident aliens.<sup>181</sup>

When ERISA was enacted, Congress included a broad preemption clause under which ERISA supersedes "any and all State laws" that "relate to" employee benefit plans.<sup>182</sup> This preemption clause permits self-funded employers to avoid being subject to the insurance laws of individual states. Thus, such employers have greater flexibility to be innovative and experimental by including options for their employees such as international medical travel.

*1. By Offering an International Medical Travel Option, Self-funded Employers Do Not, Per Se, Violate ERISA's Fiduciary Duty*

While self-funded employee health-plans avoid state insurance laws, employers offering international medical travel benefits still must comply with ERISA's fiduciary duty.<sup>183</sup> ERISA imposes fiduciary responsibilities on persons with discretionary authority or discretionary control regarding the management of an employee welfare benefit plan,<sup>184</sup> such as plan administrators and plan trustees.<sup>185</sup> If the fiduciary duty is breached, then a plan beneficiary or participant, among others, may bring a civil action.<sup>186</sup> This fiduciary duty does not ban self-funded employers from authorizing international medical travel options in their health benefit plans. Rather, it puts restraints on such employers to satisfy a prudent person standard of care in

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<sup>181</sup> 29 U.S.C. § 1003(b).

<sup>182</sup> 29 U.S.C. § 1144 (a).

<sup>183</sup> Kopson, *supra* note 123 at 179.

<sup>184</sup> 29 U.S.C. § 1002(21)(A) defines fiduciary. See Brady, *supra* note 73 (discussing fiduciary responsibility and duty under ERISA).

<sup>185</sup> 29 U.S.C. § 1002(16)(A).

<sup>186</sup> 29 U.S.C. § 1132(a) (listing persons eligible to bring a civil action for breach of fiduciary duty under ERISA).

discharging their duties “with respect to a plan solely in the interest of the participants and beneficiaries” and acting for the exclusive purposes of providing benefits to the plan participants and reasonably defraying the plan’s administrative expenses.<sup>187</sup> The fundamental issues raised by this fiduciary duty when applied to international medical travel options are: 1) whether the cost savings that may be recognized by the employer qualify as the defrayment of reasonable expenses; or, 2) whether the risks and likely financial profit for the plan mean that the decision is not in the sole interests of the plan participants.<sup>188</sup>

Christopher Brady analyzes employer sponsored international medical travel through the lens of ERISA’s fiduciary duty, ultimately determining that offering a medical tourism option to plan participants violates ERISA’s fiduciary duty requirement.<sup>189</sup> On one hand, Brady explores the arguments that outbound medical travel does not violate ERISA’s fiduciary duty. Here, the large health care savings an employer may recognize fits within the fiduciary duty to defray health benefit plan expenses as long as the plan administrator acts within the sole interest of the plan beneficiaries; thus, not violating ERISA’s fiduciary duty.<sup>190</sup> This rationale is based on the legislative intent of ERISA, arguably emphasizing cost control in managing employee benefit plans over discharge of benefits.<sup>191</sup> Additional arguments for why international medical travel options do not violate ERISA’s fiduciary duty include: (1) international medical travel is a mixed treatment and eligibility decision to which the fiduciary standards do not apply; and (2) because

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<sup>187</sup> 29 U.S.C. § 1104(a)(1) (describing the prudent man standard of care). *See also* Kopson, *supra* note 123 at 179; and Brady, *supra* note 73 (discussing medical tourism and medical outsourcing within the limitations of ERISA’s fiduciary duty). *See also*, Williams, *supra* note 119 at 650.

<sup>188</sup> Brady, *supra* note 73.

<sup>189</sup> *See* Brady, *supra* note 73 (Brady refers to outbound medical tourism as medical outsourcing, defined as “treatments or surgeries that have been planned in advance to take place outside of a patient’s usual country of residence.”).

<sup>190</sup> *Id.* at 1107.

<sup>191</sup> *Id.*

the patient is the decision-maker in choosing health care treatment abroad, there can be no breach of a fiduciary duty because the plan administrator is not the decision-maker.<sup>192</sup>

On the other hand, Brady posits that the central argument for international medical travel options violating ERISA's fiduciary duty focuses on the potential large financial savings unduly influencing plan administrators.<sup>193</sup> By responding to this undue influence, and offering an international medical travel option, as part of the health plan benefit plan participants are exposed to the risks of receiving health care abroad.<sup>194</sup> Brady argues that while no single part of international medical travel violates ERISA, the combined impact of medical tourism "on plan participants amounts to a de facto violation of a plan administrator's fiduciary duty and the policy goals of ERISA."<sup>195</sup> Brady calls for Congress to clearly resolve this issue of whether an international medical travel benefit does or does not violate ERISA's fiduciary duty. Specifically, Brady recommends that Congress enact federal legislation requiring the distribution of savings from international medical travel between the employer and the plan participants and establish a fund, also from the international medical travel savings, dedicated to providing follow-up or corrective care in the U.S. following any negligence abroad.<sup>196</sup>

Brady's solution and underlying position that an international medical travel option violates ERISA's fiduciary duty, fails under further analysis. First, Congress is unlikely to address the issue of an international medical travel option in the near future in the absence of reliable data or a health care or public policy crises involving such a travel option. Beyond a few hearings, little

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<sup>192</sup> *Id.* at 1108-9.

<sup>193</sup> *Id.* at 1110.

<sup>194</sup> *Id.* at 1110.

<sup>195</sup> *Id.* at 1109-10.

<sup>196</sup> *Id.* at 1112.

federal attention has been paid to international medical travel. In 2006, a U.S. Senate hearing examined whether outbound medical travel could reduce health care costs.<sup>197</sup> Dr. Arnold Milstein testified that large U.S. employers were exploring incentivizing international medical travel for employees for 3 reasons: lower cost; evidence of quality of care provided by accreditation; and a sense of fiduciary responsibility.<sup>198</sup> In more recent House of Representative hearings, medical tourism is referenced in terms of a U.S. hospital recruiting foreign patients, such as Canadians, who participate in package prices and have the ability to compare prices and quality.<sup>199</sup> There is no indication at this time that Congress would be willing to take legislative action on international medical travel, particularly when most of the health care and insurance sectors are still focused on adjusting to the new regulatory environment under the ACA.

Furthermore, the argument that any cost savings most likely falls within the employers' fiduciary duty, provided the international medical travel option is in the best interests of the health benefit plans participants, appears to be a supportable legal premise. As discussed below, there are practical strategies plan administrators may take to increase the likelihood that including international medical travel options in a health benefit plan will not be found by the courts to violate ERISA's fiduciary duty. Moreover, Brady's assertion that forcing participants to choose between expensive health care in the U.S., with access to malpractice liability remedies, and less expensive foreign care, often lacking access to comparable malpractice remedies, violates

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<sup>197</sup> S. Hrg. 109-659; *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?*; Special Committee on Aging, United States Senate, June 27, 2006.

<sup>198</sup> *Id.*

<sup>199</sup> Serial No. 112-159 (House Hrg.); *Examining the Impact of Obamacare on Job Creators and the Economy*; Committee on Oversight and Government Reforms; July 10, 2012; at 93; (Serial No. 113-20 (House Hrg. .)); *Examining the Lack of Transparency and Consumer-Driven Market Forces in U.S. Health Care*; Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reforms; April 25, 2013; at 12; (Serial No. 113-83 (House Hrg.)); *The Roll Out of Health care.gov: the Limitations of Big Government*; Committee on Oversight and Government Reform; December 4, 2013 at 82.

ERISA's goals of equitable distribution and minimum standards of care fails in the face of the quality of care provided to outbound medical travelers by providers in foreign countries. Brady premises this choice of health care between domestic and foreign care as arising out of a "medical emergency."<sup>200</sup> The majority of international medical travel definitions do not include treatment sought during a medical emergency. Rather, outbound medical travel applies only in instances of non-emergent care. The choice between domestic and foreign care does not arise when a plan participant suffers an acute myocardial infarction, or heart attack, because international medical travel does not cover such medical emergencies. Treatment for an acute myocardial infarction occurs at a domestic emergency department. A medically necessary, but not emergent procedure, such as cardiac valve replacement is characteristic of the types of health care that plan participants might choose to have performed by a foreign provider.

Furthermore, Mark Kopson's practice tips for self-funded employers wanting to include an international medical travel option but not violate ERISA's fiduciary duty provide useful guidance. Specifically, Kopson suggests that plan sponsors, at a minimum:

1. "Ensure that the inclusion of a medical tourism benefit is implemented in the best interests of the plan's participants and not merely to reduce the employer/sponsor's overall benefit costs;
2. Act prudently in the selection of plan service providers; and
3. Provide participants with adequate and accurate information."<sup>201</sup>

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<sup>200</sup> Brady, *supra* note 73 at 1111.

<sup>201</sup> Kopson, *supra* note 123 at 179-180.

The challenge, however, may lie in how fully any health benefit plan administrator can satisfy these objectives. Each requirement is analyzed more fully in Section III.

## 2. ACA

Signed into law in 2010, the ACA is a national effort to implement broad reforms to the U.S. health care system.<sup>202</sup> The three main goals of the ACA are reducing the number of uninsured, increasing health care quality, and reducing health care spending.<sup>203</sup> Some of the key changes under the ACA include facilitating the purchase of health insurance through exchanges, mandating that most Americans obtain health insurance, and enhancing consumer protections.<sup>204</sup> The two areas where the ACA is most likely to impact international medical travel are by potentially encouraging additional employers, specifically small employers, to self-fund,<sup>205</sup> and by employers retaining an international medical travel benefit within a plan grandfathered under the ACA.<sup>206</sup>

Historically, self-funding is attractive to large employers whose size makes them better able to accept the risk of unpredictable medical claims.<sup>207</sup> However, to avoid some of the ACA's provisions, small employers may be tempted to self-insure.<sup>208</sup> According to Kaiser Family

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<sup>202</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>203</sup> Tumber, *supra* note 177.

<sup>204</sup> Rachel Hansen & Rebecca Newman, *Health Care: Access After Health Care Reform*, 16 GEO. J. GENDER & L. 191, 195 (2015).

<sup>205</sup> Jost, *supra* note 160 at 30; Miller et al., *supra* note 158; Monahan & Schwarcz, *supra* note 159 at 1967.

<sup>206</sup> ACA § 1251(a)(1), (2) codified at 42 U.S.C. 18011.

<sup>207</sup> Monahan & Schwarcz, *supra* note 159 at 1966.

<sup>208</sup> See Monahan & Schwarcz, *supra* note 159 at 1967 (specifying that after 2014 self-insuring permits small employers avoid the ACA's requirements of coverage including essential health benefits, participating in risk-adjustment programs, compliance with medical-loss ratios, having premium increases be reviewed, and not exceeding deductibles of \$2,000 per individual and \$4,000 per family.); Jost, *supra* note 160 at 29. For employers

Foundation's 2015 Employer Health Benefits Survey, the percentage of covered workers employed by an employer with 1 to 199 employees in self-funded plans increased slightly from 13% in 2011 to 17% in 2015.<sup>209</sup> This is not a large percentage increase since small-employers are not as a voluminous group opting to self-fund. Even this slight increase may be indicative of a growing trend. More time is needed to fully determine any increase in employers deciding to self-fund.

Additionally, the uncertainty of the ACA's stability, plus the continued adjustment and emphasis of compliance with the ACA's ongoing implementation, suggests that employers may be less inclined to make major changes and more inclined to weather out this era of change and uncertainty. Finally, the grandfathered coverage option under the ACA may apply to self-insured employers with a grandfathered plan that includes an international medical travel benefit. The ACA permits grandfathered plans to remain exempt from many of the ACA reforms including coverage of the essential health benefits.<sup>210</sup> Such an employer may choose to maintain its international medical travel benefit if no longer offering it might alter its grandfathered status.

#### B. U.S. Case Law Is Not Yet Developed Enough To Provide Guidance

While a small number of U.S. cases incidentally address international medical travel, only *Gatte v Ready For A Change, LLC*, makes a direct ruling on the appropriate forum for jurisdiction –

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considering avoiding some of the ACA's requirements by opting to self-fund, purchasing stop loss insurance may help them make the transition to self-funding without taking on too high a risk of large claims. Lucia et al., *Post-Affordable Care Act Trends in Health Coverage for Small Businesses: Views from the Market*, (September 2015), Robert Wood Johnson Foundation and Urban Institute, at 6.

<sup>209</sup> Kaiser Family Foundation, *supra* note 161.

<sup>210</sup> 42 U.S.C. 18022.

Mexico, not Louisiana. In the other U.S. cases, neither the act of medical tourism, nor any patient outcome from medical tourism, was a root issue before the courts. For example, *In re Plaza Resort* addressed bankruptcy issues involving a hotel used for medical tourism.<sup>211</sup> The *First Metlife* court addressed whether Zilkha, an ophthalmic surgeon licensed to practice in Brazil, had an insurable interest in the life of her business partner, Bosniak, an ophthalmic surgeon licensed to practice in New York.<sup>212</sup> Here, the court described in a footnote how Brazil had a large number of plastic surgeons and that there was evidence that the two surgeons in this case were aware of the “advent of medical tourism,” defined as the “practice of patients traveling from North America and Europe, especially to Brazil for medical treatments and in particular for plastic surgery procedures.”<sup>213</sup> More recently, the court in *Florida Van*, a trademark case, indicated that medical tourism was synonymous with medical travel.<sup>214</sup>

In *Gatte v Ready For A Change, LLC*, a Louisiana resident contacted Ready 4 A Change, a medical tourism business based in Minnesota, after seeing its website.<sup>215</sup> One of the co-owners of Ready 4 A Change, Judy Dohm, a Minnesota resident, communicated with Phillip Gatte via telephone and email, ultimately arranging for Gatte to travel to Cancun, Mexico, for bariatric surgery.<sup>216</sup> Ready 4 A Change and Dohm recommended the physician and hospital for Gatte’s

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<sup>211</sup> *In re Plaza Resort at Palmas Inc.*, 469 B.R. 398 (1<sup>st</sup> Cir. 2012).

<sup>212</sup> *First Metlife Investors Ins. Co. v. Zilkha*, 2009 WL 2999607 2009.

<sup>213</sup> *Id.* fn 3.

<sup>214</sup> The court based its reasoning on tour and tourism being synonyms of travel, as well as the fact that medical travel has been commonly used to refer to services for people with special medical needs. *Florida Van’s* reasoning is surprising because courts have used the term medical travel for almost fifty years. But most use the term in reference to tax issues, workers compensation, premises liability, prison health care, and employment issues, not for patients traveling for health care. *Florida Van Rentals, Inc. v. Auto Mobility Sales, Inc.* 85 F. Supp.3d 1300 (2015).

<sup>215</sup> *Gatte v. Ready For A Change, LLC*, 2015 WL 1649942, 1 (2015).

<sup>216</sup> *Id.*

surgery.<sup>217</sup> Unfortunately, Gatte died from surgical complications (blood clots and an embolism) before being released from the Cancun facility.<sup>218</sup>

Gatte's wife and son brought personal injury and wrongful death actions in Louisiana State District Court against Ready 4 A Change.<sup>219</sup> Defendants filed a Motion to Dismiss on Forum Non Conveniens grounds, which the court granted.<sup>220</sup> The court reasoned that an alternate forum existed – Mexico – and the defendants agreed to submit to jurisdiction there.<sup>221</sup> Moreover, when the court considered the availability of an adequate remedy in Mexico, it considered the private and public interest factors and found that the private interest factors favored dismissal.<sup>222</sup> These private interest factors included: ease of access to proof in Mexico; it would cost less to obtain the testimony of witnesses in Mexico since most of the witnesses are located in Mexico; and, the hospital where Gatte's death occurred could only be viewed in Mexico. Also, although it would be more expeditious to try the case in Louisiana where originally filed, the plaintiffs did not submit evidence that a trial in Louisiana would be more practical than in Mexico.<sup>223</sup> Essentially, this case is a foreign medical malpractice case that the U.S. court considers appropriate for determination by a Mexican court. While a single case, it is noteworthy that the U.S. court dismissed the suit so that it could be refiled in Mexico, possibly establishing precedent that other courts will follow.

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<sup>217</sup> *Id.*

<sup>218</sup> *Id.*

<sup>219</sup> *Id.*

<sup>220</sup> *Id.*

<sup>221</sup> *Id.* at 1 -2.

<sup>222</sup> *Id.* at 2-3.

<sup>223</sup> *Id.* at 2.

### C. Professional Guidelines Provide Slight Guidance But Are Not Binding

In 2008, the American Medical Association (AMA) adopted guidelines for “employers, insurance companies, and other entities that facilitate or incentivize medical care outside the U.S.”<sup>224</sup> These guidelines recommend that: medical care outside the U.S. is voluntary; financial incentives to travel outside the U.S. for care should not inappropriately restrict treatment or referral options; financial incentives should only apply to care received at institutions accredited by recognized international accrediting bodies; local follow-up care should ensure continuity of care and be included in the coverage for travel outside the U.S. for care; patients should be informed of legal rights before traveling outside the U.S.; patients should have access to physician licensing and outcomes data as well as facility accreditation and outcomes data; the transfer of medical records should be consistent with HIPAA; and, patients should be informed of the potential risks of combining surgical procedures with long flights and vacation activities.<sup>225</sup> At the time these guidelines were adopted, some AMA delegates sought legislation or regulations preventing employers and insurers from incentivizing potential medical travelers with five-star hotels, cash payments, and other perks. Ultimately, such proposals were not included in the guidelines.<sup>226</sup>

While the AMA guidelines are frequently cited, other professional organizations, such as the American College of Surgeons (ACS), have also adopted statements on medical tourism.<sup>227</sup> This

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<sup>224</sup> H-450.937, *Medical Care Outside the United States*, American Medical Association (CMS Rep. 1.A-08)

<sup>225</sup> *Id.*

<sup>226</sup> Karen Caffarini, *AMA meeting: Guidelines target safety of medical tourists*; amednews.com; (July 7, 2008).

<sup>227</sup> Statement on Medical and Surgical Tourism; American College of Surgeons; (April 1, 2009). The American Society for Aesthetic Plastic Surgery has also published guidelines for patients considering medical tourism. Guidelines for Patients Seeking Cosmetic Procedures Abroad, <http://www.surgery.org/consumers/consumer->

statement is similar to the AMA's with respect to: encouraging patients to receive care at an internationally accredited institution; coordination and reimbursement of follow up care at home; and informing patients of the risks of international flights and vacation activities when combined with health care procedures. The ACS also encourages patients to "consider the medical, social, cultural, and legal implications of seeking medical treatment abroad" and states that there should be a viable means of recovery for malpractice damages in place. Additionally, the ACS opposes insurers making a mandatory referral to a foreign health care institution unless such a provision is clearly stated in the insurance contract and accepted by the subscriber. The existence of these guidelines is noteworthy as evidence of knowledge about medical tourism and organizational positioning with respect to medical tourism. However, ultimately such guidelines are advisory and not legally binding.

### **III. Potential Employer and Employee Protections**

Employers and employees can protect their individual interests while facilitating their common interests of high quality low cost health care. By acting in the best interests of the plan's participants, selecting providers prudently, and providing sufficient and accurate information, employers can use international medical travel to reduce their health benefit costs and increase employee access to affordable quality care. Employees and other health plan beneficiaries should make an informed decision to become medical travelers and should avail themselves of additional insurance products that can reduce their risk of financial exposure in the event of a bad

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resources/consumer-tips/guidelines-for-patients-seeking-cosmetic-procedures-abroad. These guidelines, however, are beyond the scope of my research focus because insurance coverage generally does not include plastic surgery.

medical outcome. International medical travel will never be for everyone, but for willing employers and employees, it can be a valuable tool for achieving joint goals.

A. Employers Should Act in the Best Interest of the Plan's Participants, Select Providers Prudently, and Provide Participants with Sufficient and Accurate Information

*1. An International Medical Travel Option Should Be In The Best Interests of the Plan's Participants, Not Merely A Means To Reduce Health Care Expenditures*

Basic economic and financial sustainability goals support self-funded employers acting aggressively to reduce health benefit costs. If offering a self-funded health plan participant an option of traveling to Thailand for a total knee replacement is less costly for the health plan, and therefore the self-funded employer, then the employer should make that international medical travel offer. An international medical travel offer alone, however, may not result in any employees or beneficiaries choosing to accept this offer. Participants' possible lack of knowledge about the international medical travel offer or a reluctance to travel away from home and family for health care services are some of the factors that may result in health plan participants not engaging in international medical travel. One means of encouraging health plan participants to more seriously consider and possibly decide to travel internationally for health care services, is to incentivize international medical travel. Many self-funded employers do incentivize participation in this benefit. These incentives may include: no co-payment, no deductible, covering the costs of a companion traveling with the health plan participant, four-star hotel accommodation, and sharing a percentage of the overall cost savings with the employee as

an additional contribution to the employee's retirement plan. Reducing overall health plan benefits costs, alone, is not sufficient, the international medical travel benefit must be in the participant's best interest.

For a participant whose health care need, such as a total knee replacement, is eligible for coverage under her health benefit plan the best interest requirement may be satisfied by facilitating access to care at a lower out-of-pocket cost to the participant. Here, the surgery in Thailand is in the best interest of the plan participant because she receives the needed total knee replacement while benefiting financially from the employer offered incentives. International medical travel may also be in the best interests of the health plan participant if she is able to have protected recovery time before flying home and returning to the workplace.

## *2. International Medical Travel Providers Should Be Prudently Selected*

Quality of care is a critical component of health care, regardless of where such care is accessed. As such employers should include quality of care assessments as a major component of their selection of international health care providers. Courts, however, may look beyond quality assessment to how employers selected the specific providers offered as international medical travel options to health benefit plan participants. Ultimately, in order to satisfy prudent provider selection, employers may need to demonstrate reliable quality assessment.

In the U.S., one proxy for quality of care is accreditation by the Joint Commission (JC). Established in 1951, the JC is America's oldest accrediting body in health care.<sup>228</sup> Federal programs, such as Medicare, permit accreditation through the JC's deemed status survey to satisfy the Centers for Medicare and Medicaid Services' Conditions of Participation.<sup>229</sup> Accreditation by a private accrediting organization thus serves as a substitute for direct public regulation of providers participating in a federal program. The JC also has an international component, the Joint Commission International (JCI) that provides quality assurance outside of the U.S. by accrediting international facilities.<sup>230</sup> Currently, there are 768 accredited organizations in 64 countries.<sup>231</sup> Many of these facilities are engaged in medical travel, including recruitment and treatment of U.S. patients.

The JCI promotes accreditation, in part, so as to "boost medical tourism."<sup>232</sup> Noted scholars, Glenn Cohen and Nathan Cortez, have both recommended that payers specifically funnel patients to providers with a track record of providing quality services by "using JCI accreditation and other proxies as 'indicia of quality.'"<sup>233</sup> The JCI is well known and used by influential

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<sup>228</sup> *Facts About the Joint Commission*, [www://www.jointcommission.org/facts\\_about\\_the\\_joint\\_commission](http://www.jointcommission.org/facts_about_the_joint_commission).

<sup>229</sup> See Timothy Stoltzfus Jost, *Medicare and the Joint Commission on Accreditation of Health care Organizations: A Healthy Relationship?*, 57 LAW & CONTEMP. PROBS. 15-46 (1994) (discussing the Joint Commission's effective monopoly in hospital accreditation and why the various interests to which the Joint Commission must be responsive (including hospitals, physicians, and federal and state governments) makes it better able to ensure health care quality).

<sup>230</sup> Heather T. Williams, *supra* note 119 at 665 (discussing the JCI as an example of voluntary industry self-regulation). For Williams, JCI has an incentive to accredit only high quality facilities if it is to maintain its status as a world leader of hospital accreditation. And as suggested by Cortez, state law regulating insurance could require that foreign providers be JCI accredited. Nathan Cortez, *Embracing the New Geography of Health Care: A Novel Way to Cover Those Left Out of Health Reform*, 84 S. Cal. L. Rev. 859 at 910 (2011)

<sup>231</sup> JCI-Accredited Organizations. <http://www.jointcommissioninternational.org/about-jci/jci-accredited-organizations/>

<sup>232</sup> JCI Promotes Health Care Transformation in India: The focus is on building highly reliable organizations (February 10, 2015), <http://www.jointcommissioninternational.org/jci-promotes-health-care-transformation-in-india-the-focus-is-on-building-highly-reliable-organizations/>

<sup>233</sup> Nathan Cortez, *Embracing the New Geography of Health Care: A Novel Way to Cover Those Left Out of Health Reform*, 84 S. CAL. L. REV. 859, 910 (2011).

international organizations such as the World Health Organization who works with the JCI to promote safety standards through its Collaborating Center.<sup>234</sup> As a U.S. based nonprofit organization with international recognition, the JCI is well poised to be a benchmark of quality of care for American employers and patients. By utilizing JCI accreditation, foreign providers are encouraged to comply with U.S. quality standards that can provide valuable protections for outbound U.S. patients.<sup>235</sup> Such compliance may be beneficial for foreign providers who want to attract U.S. patients but may not be as desirable for providers targeting non-American international patients.

U.S. self-funded health benefit plans may be most likely to rely on JCI accreditation because of its familiarity in the U.S. but unless there are legal requirements that such plans use JCI accreditation, plans may opt to rely on other international accrediting organizations. With increasing globalization, it is not surprising that there are other organizations, besides JCI, accrediting international hospitals. Certain accrediting bodies are prominent in different geographical regions.<sup>236</sup> For instance, QHA Trent is prominent in the United Kingdom and the European Union, while the Australian Council on Health care Standards International is prominent in Australia.<sup>237</sup> Moreover, the International Organization for Standardization certifies

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<sup>234</sup> Who is JCI? [www.jointcommissioninternational.org](http://www.jointcommissioninternational.org). WORLD HEALTH ORGANIZATION PARTNERS WITH JOINT COMMISSION AND JOINT COMMISSION INTERNATIONAL TO ELIMINATE MEDICAL ERRORS WORLDWIDE [http://www.who.int/patientsafety/newsalert/WHO\\_final.pdf](http://www.who.int/patientsafety/newsalert/WHO_final.pdf)

<sup>235</sup> See Cortez, *supra* note 233 at 902 (discussing the benefits of self-regulation across international boundaries, or what Cortez refers to as “new governance”).

<sup>236</sup> Tamara L. Hill, *The Spread of Antibiotic-Resistant Bacteria Through Medical Tourism and Transmission Prevention Under the International Health Regulations*, 12 CHI. J. INT’L L. 273, 281 (2011).

<sup>237</sup> The Australian Council on Health care Standards International also works with organizations in Hong Kong, the Middle East, India, and New Zealand. Our Members [www.achs.org.au/achs-members/our-members](http://www.achs.org.au/achs-members/our-members).

hospitals internationally.<sup>238</sup> Expanding access to international providers accredited by organizations other than the JCI may be important for self-funded health benefit plans wanting to access international providers whose marketing plan does not concentrate on U.S. patients. No U.S. law dictates a specific type of provider accreditation, such as JCI, to be in place before U.S. outbound medical tourists travel for health care services. Thus, self-funded employer health benefit plans have discretion in how they choose to assess international providers, particularly regarding quality of care.<sup>239</sup> Plans may still want to include such providers because of geographic location (closer proximity to the U.S.) or in order to appeal to specific employee demographics. For example, currently a U.S. employer with a large Hispanic employee population may opt to offer international medical travel to Costa Rican facilities rather than Indian facilities. By selecting Costa Rican facilities, the employer may further incentivize employees to travel for health care services. As the U.S. reduces travel and other restrictions with Cuba, such self-funded employers may also include Cuba in international medical travel options. Geographic proximity, tourist interest, and highly trained Cuban health professionals, make Cuba a likely destination for U.S. outbound medical travelers.

In addition to quality of care assessments, the mechanics of how a health benefit plan administrator selects international providers and makes them available to plan participants may also indicate whether the providers were prudently selected. Three of the basic approaches health plan administrators could use in selecting international providers are: 1) provide numerous choices provided to the participant on a case-by-case basis; 2) contract with foreign

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<sup>238</sup> Hill, *supra* note 236 at 281. Cortez, *supra* note 235 at 907.

<sup>239</sup> For purposes of this article, provider is used to refer not only the health care provider, such as a physician, providing the health care service, but also the health care facility itself, such as the hospital or surgical center. Liabilities may attach to each of these providers if an adverse outcome occurs.

providers and offer participants a limited menu of provider options; and, 3) contract with an intermediary that provides a defined list of providers to participants. These specific implementation mechanisms, while all arguably achieving a floor of prudent provider selection, differ in the level of an employer's direct involvement in such selection. This involvement in provider selection, and associated risk, may affect the successfulness of potential liability claims brought against an employer or health benefit plan following an adverse outcome abroad.

First, health benefit plan administrators may independently provide a number of international provider choices to a plan participant considering medical tourism based on the participant's specific health care need. This approach requires plan administrators to invest a large amount of time and effort into researching providers. The duty to select providers prudently then lies more firmly with the plan administrators. This approach may be most attractive to health benefit plan administrators with fewer participants interested in international medical travel and a high level of confidence in evaluating foreign providers. In many aspects, this independent selection is reminiscent of an uninsured patient researching medical travel options on the Internet, except that the health plan administrator is likely to have more health care knowledge and expertise.

Second, health benefit plan administrators may also contract with a foreign, country-specific facilitator to provide access to providers in that country. For instance, a U.S. health benefit plan administrator may contract with Costa Rica Medical Tourism and offer plan participants specific access to Costa Rican providers. This approach may be beneficial but future lawsuits may depend on contract law. While Costa Rica Medical Tourism indicates on its website that it contracts with JCI accredited hospitals in Costa Rica, it also states in its disclaimer: "selection of

the medical institution/facility and attending physician is the sole responsibility of the patient and patients are required to do their due diligence.” Health benefit plan administrators choosing to contract with such a facilitator are relying on the JCI accreditation as a proxy for quality of care. In the event of an adverse event occurring to a plan participant receiving care in Costa Rica, it is unclear if such reliance on JCI accreditation is sufficient to establish that the employer selected providers prudently.

Third, plan administrators may contract with a U.S. based operator or facilitator, with an international provider network. Such organizations include subsidiaries of U.S. insurance companies or independent companies. For example, BlueCross BlueShield of South Carolina formed Companion Global Health care, Inc., as a wholly owned subsidiary to provide international medical travel services. Existing BlueCross BlueShield of South Carolina members can access Companion Global Health Care’s international network of hospitals at reduced rates.<sup>240</sup> Participants can find information about international medical travel under their on-line member discounts listing.<sup>241</sup> Through Companion Global Health care, BlueCross BlueShield of South Carolina members can access this added-value discount program, which BlueCross specifies is offered to members in addition to, but not included in, the services and benefits that its policies cover.<sup>242</sup> Companion Global Health care also offers medical tourism services to self-insured employers.

Examples of such operators and medical travel facilitators include: Companion Global Health care, Inc., IndUSHealth, and Satori World Medical. These medical travel facilitator’s

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<sup>240</sup> Companion Global Health Care. [www.companionglobalhealthcare.com/news](http://www.companionglobalhealthcare.com/news).

<sup>241</sup> BlueCross Blue Shield of South Carolina. [www.southcarolinablues.com](http://www.southcarolinablues.com).

<sup>242</sup> *Id.*

responsibilities often include selecting providers and assessing provider quality. Again, because there are no legal requirements governing this process, the extent of assessing provider quality may differ among medical travel companies. For example, Companion Global Health care, Inc. hospitals have all earned accreditation from the JCI and go through their “extensive credentialing process.”<sup>243</sup> On the other hand, Satori World Medical’s quality assessment includes: JCI accredited hospitals, “continuous quality monitoring systems,” interviewing hospital management teams, touring and evaluating clinical facilities, and on-site due diligence visits by Satori’s Chief Medical Officer.<sup>244</sup> As U.S. outbound medical travel exists within a very limited legal framework, it is likely that future courts will be asked to determine whether health benefit plan administrators prudently selected providers.<sup>245</sup> Quality of care assessments combined with the implementation of offering an international medical travel benefit will contribute significantly to this legal determination.

### *3. Self-funded Employer Health Benefit Plan Participants Utilizing An International Medical Travel Benefit Should Be Provided with Sufficient and Accurate Information*

Providing health plan participants with adequate and accurate information may be the most difficult of these three employer actions to satisfy. Ideally, price transparency will result in patients selecting lower-priced health care services from high-quality providers.<sup>246</sup> Detailed information may be available about a foreign provider’s quality assessment, price of care,

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<sup>243</sup> Companion Global Health Care, *supra* note 240.

<sup>244</sup> Satori World Medical, [www.satoriworldmedical.com/quality-assurance](http://www.satoriworldmedical.com/quality-assurance).

<sup>245</sup> There have been no cases to date on this issue. Moreover, although U.S. employers cannot directly impose any licensing requirements on foreign providers treating American patients, they can require and verify that such providers are licensed and credentialed in their home country.

<sup>246</sup> Health Care Cost Institute, *supra* note 130. (focusing on price transparency lowering health care spending because patients choose low-cost services while keeping quality constant).

English proficiency, staff to patient ratio, and other aspects of patient care about an international provider. That same information, however, may not be available for a domestic provider. Although the U.S. health care system is moving toward greater transparency, a patient covered by a self-funded employer sponsored health benefit plan may not have access to comparable information for local and international options.<sup>247</sup>

Muzaurieta argues that U.S. international medical travel legislation should emphasize increasing information available to potential medical travelers but not limiting patient options or choices.<sup>248</sup> He further asserts that future decision-making research can be used to draft legislation ensuring that patient information is accessible and accurate.<sup>249</sup> Indeed, additional research on medical traveler's decision-making process is necessary for a more complete understanding of the relevant factors and relative weight given such factors. Such knowledge could be very useful to policy makers, health care professionals, and other stakeholders involved in medical travel. It could facilitate key interventions and policies directed at critical decision-making factors in international medical travel, with the goal of nudging potential medical travelers into particular decision pathways. While Muzaurieta's goal of accessible and accurate patient information is admirable, it may be better located within the general U.S. health care transparency environment rather than focused on international medical travel. Specifically, for U.S. outbound medical travelers to have accessible and accurate information such data would have to be available and comparable for health care services within the U.S. and internationally. However, a global

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<sup>247</sup> *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. \_\_\_\_ (2016).

<sup>248</sup> Joseph L. Muzaurieta, *Surgeries and Safaris: Creating Effective Legislation Through a Comparative Look at the Policy Implications, Benefits, and Risks of Medical Tourism for the American Patient*, 29 TEMP. INT'L & COMP. L.J. 115, at 121 (2015).

<sup>249</sup> *Id.* at 121.

network of accessible health care services information, updated in real-time, or close to it, is not feasible in the near future.

Even if international medical travelers could access accurate provider, facility, and related information, it is not clear that they would use such information. First, depending on how the information is conveyed, medical travelers may not readily interpret the information. For example, survey research indicates that patients may not understand provider quality report cards.<sup>250</sup> Secondly, medical travelers and other patients may ignore such information, choosing instead to rely on other information, such as word-of-mouth, in their decision-making process.<sup>251</sup> As Shaller posits, the three main factors influencing patient engagement with quality data are the patient's emotional state, the patient's capacity to interpret multiple measures of quality, and the patient's need for external trusted sources, all of which interact with each other.<sup>252</sup> Moreover, patients', including medical travelers', perspectives on quality of care may differ from health care providers.<sup>253</sup>

If international medical travelers cannot access complete and ideal information, sufficient and accurate information can still be provided. Health benefit plans or medical travel facilitators can provide information needed for a potential medical traveler to decide whether or not to travel

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<sup>250</sup> Kolstad & Chernew, *Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services*, MEDICAL CARE RESEARCH & REV., Supplement to Volume 66 No 1, 15 (February 2009).

<sup>251</sup> Shaller et al., *Context-based Strategies for Engaging Consumers with Public Reports about Health Care Providers*, MEDICAL CARE RESEARCH & REV., Supplement to 2014 Volume 71(5), 17S-37S.

<sup>252</sup> *Id.* at 20S-23S (concluding that the form and nature of quality reports needs to better match patients' circumstances by being more attentive to patients' emotional and cognitive abilities in making health care decisions and by incorporating multiple report designs targeting different patients with different engagement styles).

<sup>253</sup> See Khaled Mohammed et al., *Creating a Patient-Centered Health Care Delivery System: A Systematic Review of Health Care Quality From the Patient Perspective*, 31 Am. J. of Medical Quality 12 (2016)(identifying 10 dimensions of patient perceptions of quality: communication, health care access, shared decision making, clinical quality/provider knowledge and skills, physical environment, patient education, electronic medical record, pain control, discharge process, and preventive services).

internationally for health care. This information should include information about the risks and benefits of the sought-after health care service, the details of what is paid for and included by the medical tourism option, the quality information available for international care, any cost and quality information available regarding domestic care, and any travel alerts or other relevant information from the U.S. State Department for the international countries of interest to the potential medical traveler.

## B. Employees and Their Beneficiaries Should Make Informed Decisions to use an International Medical Travel Benefit and Seek Out Additional Insurance Coverage Options

### *1. Making An Informed Decision To Travel Internationally For Health Care*

Medical travelers, willing to travel to a foreign country specifically for health care, should decide whether or not to use a medical tourism benefit with a full understanding of the potential health, financial, and legal ramifications. The incentives offered by an employer should not be so great that the medical traveler feels compelled to travel abroad. Rather, the benefits and drawbacks should be balanced between local and international options.

As part of making an informed decision to engage in international medical travel, the patient should give informed consent for the procedure he or she is preparing to travel internationally to access. It is important that the informed consent discussion occur while the medical tourist is still in the U.S. and more readily able to consider the risks, in particular, presented by the surgery or treatment. Once a medical tourist decides to leave the U.S. for health care, engages in all the

necessary travel preparations (getting a passport and visa if needed, packing, and notifying family, friends, and co-workers) and traveling, possibly through many time zones, the medical tourist is fairly committed to receiving the health care service prompting their international journey. Upon arriving in a foreign country and entering that country's health care system, it may be more difficult for the medical tourist to provide true informed consent. By that time, the economic incentives and personal commitment to continue with the surgery or treatment may outweigh any concerns about the risks. The foreign provider may still choose to engage in another informed consent discussion, in person, once the medical tourist arrives at the foreign facility. This discussion may better function as a reminder and means of further establishing a provider-patient relationship, than a true informed consent process.

## *2. Additional Insurance Coverage Options*

Traditional travel insurance excludes traveling specifically for health care. New policies, however, have been developed that cover travel related risks as well as medical complications risks and other risks. For instance, Global Protective Solutions' Individual and Companion Travel Accident Insurance covers complications arising within 180 days of the traveled for medical procedure.<sup>254</sup> Complications can arise regardless of whether or not negligence occurs.<sup>255</sup> If additional treatment is necessary, such treatment can occur in the destination or source country.<sup>256</sup> This policy also covers travel accident/injury/illness occurring within 30 days.<sup>257</sup> In

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<sup>254</sup> Individual and Companion Travel Insurance, [www.globalprotectivesolutions.com/individual-and-companion-travel-accident-insurance](http://www.globalprotectivesolutions.com/individual-and-companion-travel-accident-insurance).

<sup>255</sup> Tracy Simons, Medical Tourism Congress, September 2014 [www.globalprotectivesolutions.com/frequently-asked-questions](http://www.globalprotectivesolutions.com/frequently-asked-questions) (noting that these insurance policies aim to make the medical tourist whole again, reducing the risk of legal recourse against the employer or health benefit plan).

<sup>256</sup> *Id.* (the original surgeon care following a complication may be covered if necessary and prudent).

<sup>257</sup> *Id.*

addition, the patient's travel companion can also be covered for travel accident/injury/illness, further limiting the risks of encouraging travel for health care. If the employer or medical tourism facilitator does not include complications insurance as part of its package, information about complications insurance (what it covers, how much it costs) should also be provided to the medical traveler.

#### **IV. Chapter Conclusion**

U.S. outbound medical travel provides an opportunity for self-funded employers to reduce their health benefit plan costs while providing access to quality health care services. Employees and eligible beneficiaries also benefit from international medical travel because of lower, or nonexistent, out-of-pocket expenses.

The existing legal framework governing international medical travel creates uncertainty for both employers and employees. By taking the protective actions discussed in this article, both parties can clarify their responsibilities and risks in international medical travel.

## **Chapter Four: Qualitative Methodology**

As discussed in Chapter One, expanding provider networks internationally and incentivizing travel abroad for health care services has the potential to disrupt the U.S. health care delivery system. In doing so, this type of travel may introduce risks to patients and employers, possibly requiring regulatory oversight. The economic impacts of this phenomenon may be significant for the patients, employers, foreign and domestic providers, and others. Some self-funded employers are incorporating international medical travel options into their health benefit plans. Little is known about why and how these employers include such options. In this study, key informants are interviewed in order to better understand employers' use of an international travel benefit. Research contributing to this topic is important to better assess potential legal and policy issues arising from this emerging phenomenon.

This qualitative study explores why and how self-funded employers modify their health care benefit plans to include an international medical travel option. This chapter proposes the research questions and describes the research methodology used to answer these questions. It includes a description of the data collection process. The chapter concludes with the methods of data analysis from which themes and patterns were derived (see Chapter Five).

Qualitative research methods are well suited to investigate why and how self-funded employers alter their health care benefit plans to offer an international medical travel option. This is

inductive research, intended to use specific data from case studies to help form a more general theory.<sup>258</sup> The research questions posed by this study are:

- 1) Why are select public and private self-funded U.S. employers including an international medical travel option in their health care benefits options?
- 2) How are select public and private self-funded U.S. employers changing their health care benefit plans to offer international medical travel options and incentivize their employees and eligible beneficiaries to participate in this option?

## I. Case Studies

Based on the research questions, why and how do certain private and public self-funded U.S. employers structure their health care benefits to include international medical travel and incentivize their employees and eligible beneficiaries to participate in this benefit, case studies were selected as an appropriate data collection method. Case studies involve “the study of a case within a real-life, contemporary context or setting.”<sup>259</sup> Thus, they are a fitting means of better understanding of an, as yet, emerging phenomenon. This is a collective case study where multiple case studies are selected to illustrate an issue.<sup>260</sup> An advantage of case studies is that they permit the researcher to focus on the unique character of each unit of study or case.<sup>261</sup>

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<sup>258</sup> Michael G. Pratt, *For The Lack of a Boilerplate: Tips on Writing Up (And Reviewing) Qualitative Research*, 52 ACAD. MGMT. J. 856, 859 (2009).

<sup>259</sup> John W. Creswell, *Qualitative Inquiry & Research Design, Choosing Among Five Approaches* 97 (SAGE Publications) (3<sup>rd</sup> edition 2014).

<sup>260</sup> *Id.* at 99.

<sup>261</sup> *Present-Status Perspectives—Qualitative*, 33-41 In R. Murray Thomas (Ed.), *Blending Qualitative & Quantitative Research Methods in Theses and Dissertations*. (SAGE Publications) (2003).

Self-funded employers, brokers, and facilitators, including international medical travel within a health benefit plan are, in many ways, unique case studies. Each of these entities has its own narrative regarding how they began offering international medical travel and what their experiences with it have been. However, more generalizable information may be gathered from the motivation behind offering this benefit and encouraging its use among employees. Using several case studies, rich in information, permits greater insight into the motivations of both employers and their employees.

The unit of analysis for the case studies is the self-funded employer, broker, or facilitator promoting international medical travel for self-funded employer plan participants.<sup>262</sup> This unit may include interviews of one or more individuals representing that entity. Analyzing these entities provides information specific to these organizations, which are currently encouraging international medical travel health plan benefits. These entities were chosen as the unit of analysis for the case studies because they are some of the key drivers for this phenomenon, at least from the demand side of the equation.

Context is a significant part of case studies.<sup>263</sup> The case study method is enriched by consideration of different evidence such as documents, observations, and interviews.<sup>264</sup> Overall, case findings will be more reliable if based on a variety of information sources.<sup>265</sup> For this research, additional information about employer communications with employees regarding the existence of an international medical travel benefit and employee experiences with this type of

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<sup>262</sup> Creswell, *supra* note 259 at 294.

<sup>263</sup> Robert K. Yin, *Applications of Case Study Research*, Applied Research Methods Series, Volume 3, (Sage Publications) (1993).

<sup>264</sup> Robert K. Yin, *Case Study Research, Design and Methods*, (Sage Publications) (2<sup>nd</sup> ed. 1994).

<sup>265</sup> Robert K. Yin, *Case Study Research* (Sage Publications) (5<sup>th</sup> ed. 2014).

benefit can be found by combing the internet. This is not surprising since this phenomenon relates to globalization and thus electronic communication efforts to inform potential patients may be a useful mechanism. This study collected information from:

1. Key informant interviews;
2. Employer-provided health benefit plan information;
3. Published articles discussing an employers' international medical travel benefit; and,
4. Employer and employee on-line videos (YouTube) discussing international travel for health care.

All of the data from the different sources became part of the case study database. Having multiple data types permitted: 1) limited triangulation; 2) clarification; and, 3) supplementation of key informant information.

## **II. Study Design**

### A. Semi-structured Key Informant Interviews

Semi-structured interviews were used for this research to explore the experiences of self-funded employers in establishing and implementing an international medical travel benefit option.<sup>266</sup>

Because semi-structured interviews use a guide for key discussion topics, they allow greater

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<sup>266</sup> See Allison Tong et al., *Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups*, 19 INT'L J. QUALITY IN HEALTH CARE 349-357 (2007).

flexibility than structured interviews.<sup>267</sup> This flexibility is important in an area such as self-funded employer sponsored international medical travel where information is limited.<sup>268</sup> Moreover, this approach is less likely to place preconceptions on the employers and more likely to highlight their experiences and decision-making processes.

According to Dunn and other researchers, there are four main reasons research interviews are used.<sup>269</sup> First, they can fill a gap in existing knowledge. Second, they can be used to investigate complex behaviors and motivations. Third, they can be used to collect a wide range of information about a given issue. Fourth, interviews demonstrate respect for the participant. Key informant interviews are an appropriate research tool used when particular individuals are likely to provide needed information on a select topic.<sup>270</sup> It is the knowledge of the individuals that is sought, and such knowledge may not be available from other sources.<sup>271</sup> Key informant interviews can provide in-depth information and context for a particular issue.

In this study, where possible stigma or concern about potential adverse media attention or political consequences limited publically available data, key informant interviews are one of the primary options for data collection. Due to the diverse geographical locations of the interview participants, in-person interviews were not feasible for this research. All interviews were completed by telephone.

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<sup>267</sup> Kevin Dunn, *Interviewing Qualitative Research Methods in Geography*, (Oxford Univ. Press) (2<sup>nd</sup> ed. 2005).

<sup>268</sup> *Id.* at 111.

<sup>269</sup> *Id.* at 102.

<sup>270</sup> Yuri Lee & Mami Wakabayashi, *Key informant interview on antimicrobial resistance (AMR) in some countries in the western pacific region*, 9 GLOBALIZATION & HEALTH 34 (2013).

<sup>271</sup> *Id.*

## B. Participant Selection

Participants were originally selected through nonrandom purposeful sampling. Purposive sampling involves participants with experience of the phenomenon under study.<sup>272</sup> Participants in this research were required to have knowledge of medical travel obtained through their employment responsibilities. Employers were identified through scholarly articles, media accounts, and other announcements of their participation in offering a medical travel option to their employees. Additionally, select associations and organizations that work with employers on the issue of medical tourism were also identified. For example, Companion Global Healthcare, Inc. (a U.S.-based medical travel facilitator), was identified as a participant. This participant could purposefully inform an understanding of why and how employers modify their health benefits to include outbound medical travel because they work directly with employers providing this benefit.

Difficulties in successfully accessing identified self-funded employers amenable to being interviewed on this subject required that the sampling strategy to be modified. It is not unusual that sampling strategies are changed during a study.<sup>273</sup> Here, only a few employers contacted for this research were willing to be interviewed. Because of the lack of responses from additional interviewees, snowball and opportunistic sampling were also used. Snowball sampling, identifying participants of interest from experts, was also used.<sup>274</sup> For instance, an interviewee, contacted by telephone, declined to participate but suggested that the marketing representative the interviewee's human resources department worked with regarding international medical travel benefits might be amenable to participating. Opportunistic sampling, following new leads

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<sup>272</sup> Creswell, *supra* note 259 at 155.

<sup>273</sup> *Id.* at 156.

<sup>274</sup> *Id.* at 158.

and taking advantage of the unexpected, was also used in a limited fashion.<sup>275</sup> A webinar on medical tourism revealed the work of a broker who was then interviewed. Additionally, two University of Washington School of Pharmacy professors recommended contacting the CEO of a Washington Pharmacy Benefit Manager.

Once identified, introductory contact was made with participants via email, telephone, or both. The introductory email text was tailored specifically for the participant. Each email typically contained an introduction of the researcher and her institutional affiliation, a brief statement that the researcher was interviewing stakeholders in medical travel, a request for an interview, an estimate of the time expected for such an interview, and contact information for the researcher. Appendix 1 contains an example of an email interview request used in this study. These emails were sent directly to a participants email if an email address for the participant could be identified. If an email address was not discovered, a request was sent through the contact page of the participants' organization. If the participant could be identified by name, the researcher requested that the contact page message be forwarded to the specific participant. If a specific individual was not identified, the researcher requested that the message be forwarded to the appropriate person in the Human Resources Department. In some cases, where email did not generate a response, the researcher phoned the participant. Appendix 2 contains the participants (de-identified) contacted during this research.

Overall, 27 entities were contacted to request an interview for research purposes. Twelve participants responded to the interview request. Participants fell into two primary categories: 1) those that responded very quickly and were willing to participate in the research, or 2) those that

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<sup>275</sup> *Id.*

would not respond regardless of the different methods used to contact them such as company websites, direct emails, and telephone calls. Participants willing to be interviewed received representative questions (Appendix 3) and a consent form (Appendix 4) via email. Four different examples of responses not resulting in any interview were also noted. First, one entity (Patient Information Organization 1) responded that the founder's schedule did not permit time for such an interview. Second, another respondent, a broker, (Broker 1) agreed to be interviewed but was ill at the time of the request and so offered to reply by email. Although this individual returned the completed informed consent form, several follow-up emails failed to engage him in answering any questions. Third, one leader at a medical travel administration organization (Facilitator 2) indicated his agreement to talk with the researcher when requested by his client, but never responded to any follow-up requests. Attempts to talk to another individual in a leadership role at that same organization resulted in being forwarded back to the original nonresponsive person. And fourth, one employer (Employer 12(domestic)) often reported in the media to offer domestic medical travel options to its employees, responded to indicated that they were considering the research request. After a few phone calls, it became apparent they would not participate.

Identified key informant interviewees were not necessarily willing to be interviewed on the topic of this study. Because this phenomenon exists, in many instances, under-the-radar, employers may not want to broadly publicize their use or interest in encouraging employees to travel abroad for health care.<sup>276</sup> Individuals may have been more reticent to discuss international medical

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<sup>276</sup> This reticence is not unlike some U.S. hospitals that are reportedly guarded regarding releasing information about the number of medical travelers from foreign countries that they treat. Conference notes from: David Christian, Vice President of Government Affairs, Florida Chamber of Commerce, Case Study: Initiative to Establish Florida as a Medical Tourism Destination, September 23, 2014, 9<sup>th</sup> World Medical Tourism & Global Healthcare Congress.

travel benefits because they are innovative but not fully integrated into our health care delivery system.

### **III. Data Collection**

#### **A. Interview Guide**

Prior to conducting any interviews, an interview guide was developed. This guide was provided to participants prior to any actual interview, so that participants had an opportunity to familiarize themselves with the questions. The intent was that by seeing that no sensitive information was requested, such as outcome metrics or financial data, more individuals would be willing to be interviewed.

Ideally, preliminary interviews would have been completed to test the interview guide. Changes could then have been made prior to interviewing the actual research participants. That was not possible because of the limited number of potential participants. Preliminary interviews to fine-tune the interview guide were not possible because such interviews would have detracted from the number of interviews included in this research. Rather, the researcher relied upon previous interview experiences from public policy and clinical risk management work and experiential learning from a graduate geography course in advanced qualitative methods, to aid in developing a sufficient interview guide. Regardless, even with the small number of interviews completed, both the iterative process and the differing levels of information publicly available about each participant's international medical travel benefit caused the researcher to fine-tune the questions

prior to each scheduled interview. The most significant changes to the interview guide occurred with the transition from individual self-funded employers to other organizations working with self-funded employers. (See Appendix 3 for an example of an employer interview guide and a facilitator interview guide.)

The interview guide included both background queries and questions specific to international travel for health care. The two to three background questions were opening questions to clarify information such as the participant's role in the organization and length of experience. The next nine to twelve questions were more specific to international travel for health care. For the employer participants, these questions related to when and how the organization implemented an international travel benefit, how they chose any intermediary for this type of benefit, what the organization hoped to achieve with this benefit, whether these goals were satisfied, the importance of quality and how this was assessed, what legal concerns they encountered, what incentives were offered to employees and how these incentives were chosen, and what future trends the participant anticipated regarding international medical travel. The final element was an open-ended question to determine if there was anything else that the participant wanted to discuss about the subject matter.

Having received the question guide prior to the interview did not bias any answers. Rather, the researcher observed that participants primarily answered the questions having given no indication that they had reviewed the interview guideline. The exception to this was a participant who researched the answer to a question she did not know (Employer 7). She, therefore,

provided a more complete response than if the question had been posed for the first time during the interview.

Table 2 demonstrates the types of questions, examples of the questions, and the types of data and benefits expected from the questions.<sup>277</sup>

TABLE 2 Overview of interview question types, examples and expected data and benefits

<b>Type of Question</b>	<b>Examples</b>	<b>Types of Data and Benefits</b>
Descriptive knowledge	What is your role in determining employee health benefits? When was this type of benefit implemented?	Details on individual responsibilities and engagement with employee health benefits. Easy, beginning questions.
Storytelling	How did you go about establishing a benefit option of covering international travel for healthcare services –what was your process like?	Narrative identifies types of information sources used, such as a broker, collective group, or other source. Encourages sustained input from the participant.
Opinion	Do you think other employers will include such options in their benefits package? What trends do you expect to see for international travel by U.S. employees for healthcare in the next 5 to 10 years?	Thoughts, impressions, insights; potentially advocacy.
Decision-making	How did you determine what incentives you would offer employees? Have these incentives worked as expected?	Identifies factors in defining incentives. Encourages reflection.

<sup>277</sup> This table is modified from Box 6.3, Primary Question Types, in Dunn, *supra* note 267 at 106.

## B. Researcher's Position in the Interview Process

In all interviews, the researcher was the interviewer. Prior to this study, the researcher knew none of the interviewees.

## C. Recording and Transcribing Interviews

As described in the informed consent form, participants were informed that the interview would be recorded. At the beginning of each interview, the researcher orally asked if the participant was willing to have the conversation recorded. The NoNotes.com call recording platform was used to tape the telephone interviews. After each call ended, NoNotes.com sent an email indicating that the recording was available for downloading. Once downloaded, the researcher transcribed each audiotape within 24 hours of the interview. Only one participant declined to be taped stating that he preferred not to be taped because "*it is not always clear who is on the other end of a telephone call*" (Employer 8). And one interview was not recorded due to a technical failure of the platform to record (Employer 7). In that instance, the researcher suspects that because the call encountered difficulty going through a switchboard and being transferred to a conference line, the recording software was inadvertently disconnected. For all interviews, the researcher made notes during the interviews. These notes were particularly valuable when technology failed. When a recording was not available, regardless of the reason, the researcher's handwritten notes were typed up immediately after the interview concluded.

#### D. Human Subjects Division Research Exemption and Ethics

The University of Washington Human Subjects Division reviewed and determined that this research qualified for exempt status. The exempt status period was approved from October 22, 2014 to October 21, 2019. All interviews for this research were conducted within that time frame.

Voluntary written consent to participate in this study was obtained prior to any interviews. Along with the interview guide, each participant received an informed consent form prior to the scheduled interview (See Appendix 4). Each participant was requested to complete the form and return it to the researcher. All but one participant did so. That participant did not sign the form but did indicate his consent to participate and to be recorded before any additional questions were posed.

### **IV. Analysis of Data**

#### A. Strategy for Analysis of Semi-Structured Interview Data

Once the interview data collection was complete, thematic coding was used to analyze the data. In general, “[c]oding generates new ideas and gathers materials by topic.”<sup>278</sup> As Meghan Cope discusses, coding these data is a means of identifying and organizing the content and themes.<sup>279</sup> For this study, interview transcripts were read carefully multiple times and emerging patterns and

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<sup>278</sup> Lyn Richards, *Handling Qualitative Data A Practical Guide* 103 (3<sup>rd</sup> ed. Sage 2015).

<sup>279</sup> Meghan Cope, *Coding Qualitative Data*. In I. Hay, Ed., *Qualitative Research Methods in Human Geography* 281-294 (Oxford Univ. Press) (3<sup>rd</sup> ed. 2010).

concepts were marked. After further review, codes were assigned to the marked passages. A codebook (Appendix 5) was developed and used to finalize the coding.

### B. Strategy for Analysis of Other Information

Per Yin, triangulating data aids in ensuring the accuracy of results.<sup>280</sup> Multiple sources of documentation help to prevent misconception while providing additional meaning to the primary data.<sup>281</sup> The additional sources of information, listed in Subsection I of this Chapter, were included in the case study database and analyzed for complementary and dissimilar information from that provided by the key informants.

## **VI. Chapter Conclusion**

Case studies were used in this research to answer the research questions:

- 1) Why are select public and private self-funded U.S. employers including an international medical travel option in their health care benefits options?
- 2) How are select public and private self-funded U.S. employers changing their health care benefit plans to offer international medical travel options and incentivize their employees and eligible beneficiaries to participate in this option?

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<sup>280</sup> Robert K. Yin, *Case Study Research Design and Methods*, Applied Social Research Methods Series, Volume 5, (SAGE)(4<sup>th</sup> ed. 2009).

<sup>281</sup> R.E. Stake, *Qualitative case studies*, in N.K. Denzin and Y.S. Lincoln (eds.), *The Sage handbook of qualitative research* (Sage)(3<sup>rd</sup> ed. 2005).

Six case studies were completed and analyzed using thematic coding to extract themes from the data. These themes are described in Chapter Five.

## **Chapter Five: Findings**

Before conducting the key informant interviews, it was hypothesized that: 1) Employers were motivated to offer an international medical travel benefit to employees because it was a less expensive means of providing access to health care; 2) Employers could use incentives to increase employee participation in an international medical travel benefit; and, 3) Employers offering such a benefit would be motivated to limit their liability exposure from employees who used the benefit and suffered a bad outcome. The interview questions were written with this conceptual framework in mind. As discussed in this Chapter, the data yielded some unexpected insights not fully aligned with these hypotheses.

This Chapter presents the findings from the qualitative multiple case studies. The quotations noted in this Chapter are the opinions of the key informants, not necessarily facts. This information provides a firsthand account of key informant perspectives. Demographic and contextual information is provided, followed by the two overarching themes identified in the case studies: (1) Employers use international medical travel benefits as a cost saving measure; (2) Liability concerns are not a barrier. Sub-themes of these themes are also identified in this chapter. These themes help to better understand why and how some self-funded employers have incorporated this type of benefit into their benefits packages.

## I. Study Demographic Data

Of the sample, all case study employer participants were responsible for overseeing the health plan for their entity. In doing so, these participants held positions such as Risk Manager (Employer 14), Human Resources Manager (Employer 3), Director of Benefits (Employer 8), and City Manager (Employer 7). Participants served in their current positions from 10 years (Employer 3) to 25 years (Employer 8). The gender for this sample was 75% male and 25% female.

## II. Context of Employer Case Studies

All the self-funded employers in this research incorporated an international medical travel benefit in the benefits package offered to their employees. Figure 5 demonstrates when each employer began offering this type of benefit.

Figure 5: When Case Study Employers Began Offering International Medical Travel Benefits



Spread across the U.S., two of these employers are headquartered in the south, one is in the west, and one is in the mid-west. Some of these entities' employees may work at a location different from the headquarters. Half of these employers are located in rural areas, and the other half in

urban areas. These employers range from a family owned manufacturing businesses started in 1944 (Employer 8) to a recently established Native American Tribal Casino created in 2003 (Employer 3). Table 4 provides background information about each employer as well as information specific to international medical travel.

Table 4: Case Study Employer Background Information

Case Study	Type of Employer	Region of U.S.	Urban or Rural	Number of Employees	Date Began Offering International Medical Travel Benefit	Approximate Total Number of International Medical Travelers
Employer 8	Manufacturing	South	Urban	2,500	2006	500
Employer 3	Casino and hotel	West	Rural	200	2009	4
Employer 14	Manufacturing	Midwest	Rural	2,475	2010/11	2
Employer 7	Local government	South	Urban	1,477	2012	8

#### A. Choosing a Medical Travel Facilitator

Every employer interviewed chose an international medical travel facilitator to aid in the mechanics of offering an international medical travel benefit. The private employers interviewed each chose a facilitator based on specific criteria. For instance, Employer 8 chose a facilitator, IndUSHealth, Inc.,<sup>282</sup> based on trust. When Employer 3 began their international medical travel option they looked “*for a facilitator that was credible, had some credibility behind them. And ... chose Companion Global Healthcare.*” Employer 14 selected Satori World Medical because “*the other companies we talked to didn’t really have any experience.*”

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<sup>282</sup> IndUSHealth, Inc., calls itself a medical travel program administrator, which for purposes of this research is equivalent to a facilitator.

Employer 7, a public employer, also selected Satori World Medical. But unlike the private employers, Employer 7 was part of a state-specific Public Employee Benefits Alliance (PEBA) which was responsible for selecting Satori World Medical. PEBA works to achieve economies of scale for the alliance of political subdivisions seeking to develop strategies to manage the rising costs of health care benefits.<sup>283</sup> Moreover, unlike the private employers that used their discretion in determining how many facilitators to contact and consider, PEBA used a request for proposals (RFP) process to select Satori World Medical as the International Provider Network. After PEBA entered into a contract with Satori World Medical, members of PEBA, such as Employer 7, decided whether to offer the international travel benefit to their employees.

While the concerns of private and public employers considering offering an international medical travel benefit, such as quality, pricing, and breadth of client services, are likely similar, public employers may have heightened public impression concerns, including their choice of a facilitator. For instance, the City of Hartford canceled its contract with Satori after learning that the founder, president, and chief executive officer (CEO), Steven Lash, had been convicted of fraud and sentenced to 51 months in prison.<sup>284</sup> The City of Hartford had a large Hispanic workforce and anticipated that many employees would take advantage of being able to receive care in Puerto Rico through Satori's global network.<sup>285</sup> After a local journalist wrote about the contract with Satori and included information about the CEO's fraudulent behavior, the City of Hartford told Satori to "terminate all services immediately."<sup>286</sup> While in 2011 the City of Hartford indicated that they were still interested medical tourism and might consider contracting

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<sup>283</sup> Public Employee Benefit Alliance, [www.buypeba.org](http://www.buypeba.org).

<sup>284</sup> Vanessa De La Torre, *Hartford Cancels "Medical Tourism" Contract*, Hartford Courant, Sept. 13, 2011.

<sup>285</sup> Renee-Marie Stephano, *Due Diligence in Facilitation*, Medical Tourism Magazine, Sept. 29, 2011.

<sup>286</sup> De La Torre, *supra* note 284.

with a different company, there is no publically available document indicating that the City made another attempt at offering a medical tourism benefit. As Employer 7 described “*there was a problem with [Satori’s] CEO, who spent about 30 months in the federal pen. But we didn’t have concerns, although other employers did. We researched it and it was in the past and there were two sides of the story.*” Although Employer 7 considers the benefit to have been successful and would like to offer it again, their current network does not permit them to contract with an outside organization.

Employer 8 took the additional step of traveling to a foreign facility before offering it as an option to employees. The Director of Benefits traveled to each country for a comprehensive physical exam. He “*used the physical to test it out first*” (Employer 8). Later, after the international travel benefit was implemented and employees had been using it for several years, the Director of Benefits reassessed the destination country choice based on travel time. After measuring the time it took to get from the employer’s headquarters to the foreign facility, he determined that it was “*too tough to travel that far*” (Employer 8). He investigated closer destinations and repeated the physical examination to experience an example of the care first-hand.

### **III. Themes from Data**

Two primary themes, each with sub-themes, were identified from the case study databases. These themes and sub-themes are:

- (1) Employers use international medical travel benefits as a cost savings measure

- a) Once incentives for an international medical travel benefit are established they are not likely to change;
- b) A positive employee experience can act as a catalyst for uptake in accessing the international medical travel benefit; and,
- c) Potential fear of poor quality care abroad does not match employee experience.

(2) Liability concerns are not considered a barrier by participating employers

- a) Directing employees abroad brings is no different, liability wise, than directing employees to domestic providers; and,
- b) Limited protections are in place if something goes wrong.

Each of these themes, as well as the sub-themes, is discussed in detail below.

#### A. Theme 1: Employers use international medical travel benefits as a cost savings measure

Every case study employer indicated that they offer international medical travel benefits as a cost savings measure. As Employer 14 explained, *“health care is so expensive – it is our second or third expense. It is a very high expense so we are constantly looking at ways to save money, and I would assume that every employer is too”* (Employer 14). Employer 8 indicated that the reasons for their global program were: *“1) quality; and, 2) lower cost.”* Employer 3 exclaimed that the goal was to *“reduce our overall claims expenses.... simple, money”* (Employer 3). Per Employer 7, *“[w]e offered it to save us and the employees money.... This also allows us to offer services not covered by our health plan”* (Employer 7).

For at least some of these case-study employers, it was important to them that they knew the total cost of treatment before the patient left the U.S. and that the care included follow-up care so that the employee returned ready to rejoin the workforce. For Employer 14, the benefit represented a: “[h]uge savings because unlike the U.S. when you have any procedure done overseas, you know exactly what you are going to pay for it. They give you a quote and it [includes] facility, doctor, anesthesiologist, physical therapy, everything – it is all inclusive so you know exactly what you are going to pay for any one procedure before any one leaves the country to have it done” (Employer 14). Employer 8 noted that the international medical care received by their employees included “everything, even rehab, so the patient does not leave until they are ready, as opposed to [domestic care where they do the procedure] and ship them back shortly thereafter for follow-up care at home” (Employer 8).

Employees, or other covered lives, utilized the international medical travel benefits offered by these employers to travel for surgeries at no out-of-pocket costs to themselves. Table 5 illustrates the types of surgeries, destination countries, and relative costs of these procedures in the foreign country and the U.S.

Table 5: Examples of Procedures Covered by Case Study Employers

Employer	Example of International Destination	Example Procedure	Estimated Procedure Cost at US Residence	Estimated Patient Out-of-Pocket Expenses at US Residence	Reported Total Cost at International Destination	Reported Cost to Patient at International Destination
8	Costa Rica	Knee Replacement	\$33,575 <sup>287</sup> - \$59,000 <sup>288</sup>	\$3,000	\$23,531	0
3	France	Rotator Cuff Repair	\$34,300 <sup>289</sup>	\$7,000 <sup>290</sup>	~<\$22,000 <sup>291</sup>	0
14	India	Hip Resurfacing	\$12,883 - \$34,355 <sup>292</sup>	\$5,000 - \$10,000	\$21,362	0
7	Canada	Gastric Bypass Surgery	\$17,490 <sup>293</sup> - \$21,218 <sup>294</sup>	\$5,000	\$14,000- \$24,000 <sup>295</sup>	0

Broker 2 and Facilitator 8 also indicated that a driving factor in creating and offering international travel benefits is cost savings. Broker 2 thinks that there is nothing else left to limit health care expenditures except for medical tourism. “[E]verybody has gone through all the tools at their disposal to save costs on their medical spending. The consumer driven health care stuff hasn’t worked, Obamacare hasn’t worked.... You can’t juggle deductibles and copayments anymore.” Facilitator 8, when speaking about traveling for specialty pharmaceuticals, indicated that with cost escalations come alternative solutions such as this – it is “just the simple economics of it.”

<sup>287</sup> A Study of Cost Variations for Knee and Hip Replacement Surgeries in the U.S., BlueCross BlueShield, Jan. 21, 2015, [www.bcbs.com/healthofamerica/BCBS\\_BHI\\_Report-Jan-\\_21\\_Final.pdf](http://www.bcbs.com/healthofamerica/BCBS_BHI_Report-Jan-_21_Final.pdf) (noting the average cost of a knee replacement in Charlotte-Gastonia, N.C.).

<sup>288</sup> Renee-Marie Stephano, *No Kidding: Overseas Medical Tourism Is Well Worth Trip*, Health Law Gurus, Oct. 27, 2014, [www.healthlawgurus.com](http://www.healthlawgurus.com).

<sup>289</sup> Computed from \$12,000 savings reported to be about 35% of cost in the U.S. Renee-Marie Stephano, *Medical Tourism: Piece de Resistance for Self-Funding U.S. Employers*, Medical Tourism Magazine, July 17, 2014, [www.medicaltourismmag.com](http://www.medicaltourismmag.com).

<sup>290</sup> Based on estimated \$7,000 of deductibles and co-pays that were waived. Renee- Stephano, *supra* note 289.

<sup>291</sup> If Blue Lake Rancheria reportedly saved \$12,000 then the cost of the procedure plus, transportation, lodging, meals, etc., would likely total to approximately \$22,000.

<sup>292</sup> KJ Bozic, et al., *Do the Potential Benefits of Metal-on-Metal Hip Resurfacing Justify the Increased Cost & Risk of Complications?* 468 Clin. Orthop. Relat. Res. 2301-2312, 2305 (2010).

<sup>293</sup> Gastric Bypass Surgery Cost by State: 2015, Bariatric Surgery Source, [www.bariatric-surgery-source.com](http://www.bariatric-surgery-source.com).

<sup>294</sup> Average Cost of Gastric Bypass Surgery, Gastric Bypass, How Much?, Insurance and Costs, Dec. 22, 2015, [www.obesitycoverage.com/insurance-and-costs/how-much/average-laparoscopic-gastric-bypass-prices](http://www.obesitycoverage.com/insurance-and-costs/how-much/average-laparoscopic-gastric-bypass-prices).

<sup>295</sup> Bariatric Surgery in Canada, Canadian Institute for Health Information, May 2014, [www.secure.cihi.ca/free\\_products/Bariatric\\_Surgery\\_in\\_Canada\\_EN.pdf](http://www.secure.cihi.ca/free_products/Bariatric_Surgery_in_Canada_EN.pdf).

The Executive Director of the TML MultiState Intergovernmental Employee Benefits, explained that Texans may be hesitant to support health care dollars leaving the state, but the savings may be too substantial to ignore.<sup>296</sup> For example, for individuals traveling for health care within the U.S., discounts of up to 50% may be available, with a 40% additional discount for international care.

Employer use of an international medical travel benefit may arise from an interest in lowering health care expenditures, but may also function as a recruiting and retention tool. Medical travel can serve as a “*cost reduction, ...a recruiting tool, ...a recruiting retention tool* (Broker 2). This same concept was reiterated by Employer 8 who stated “the global benefit is a good way to recruit people” (Employer 8). Once implemented, employers may learn from participating employees that the patient experience in a foreign facility may be perceived as more personalized than care received at home. For instance, Employer 7 noted that an employee opting to receive dental care in Mexico made “*friends with the staff there ....[and found it] hard to say goodbye to his friends on his last visit*” (Employer 7). This same employer explained that the number of health care workers per patient in other countries is often higher than in the U.S. so the patient may experience more personalized service. (Employer 7)

*1. Sub-theme: Once incentives for an international medical travel benefit are established they are not likely to change*

All case study employers offer incentives for their international medical travel benefit. These incentives all include waiving any co-pay and deductible, plus travel and accommodation for the

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<sup>296</sup> Telephone conversation with the Executive Director, February 2, 2016.

employee and a companion. Two private employers share a percentage of the cost savings with the employee. Table 6 depicts the incentives offered by these employers.

Table 6: Incentives Offered by Case Study Employers for International Medical Travel Benefit

Case Study	Co-pay & Deductible Incentives	Travel & Accommodation Incentives	Share of Cost Savings Incentives
Employer 8	Waived	-Covered for employee and companion -May include 4-star hotel, personal concierge and local driver <sup>297</sup>	20% of company savings up to \$20,000 <sup>298</sup>
Employer 3	Waived	-Covered for employee and companion -May include sightseeing tour, eating “like royalty” <sup>299</sup>	2009 – 2010 no sharing of savings 2011 to present 10% of savings shared
Employer 14	Waived	-Airfare and accommodation covered for employee and companion -Meal allowance	None
Employer 7	Waived	- Covered for employee and companion - \$500 credit card for incidentals - May include 4-star hotel	None

Case study employers initially determined their incentives and only one employer, Employer 3, later increased the incentives. For Employer 14, the owner determined the incentives that would be offered. *Our owner just said their deductible is waived, they don’t pay anything for the trip, for the airfare, or for the hotel, for the spouse to go”* (Employer 14). And although Satori

<sup>297</sup> Byron Pitts & Nikki Battiste, *As More Americans Have Surgeries Overseas, US Companies Consider “Medical Tourism” a Health Care Option*, Sept. 30, 2013, [www.abcnews.go.com](http://www.abcnews.go.com).

<sup>298</sup> David G. Vequist, *The Best Money Saving Strategy Most Texas CEOs Aren’t Using*, Oct. 18, 2014, Texas CEO Magazine.

<sup>299</sup> Stephano, *supra* note 289.

suggested that Employer 14's incentives be increased, there was no *"upper management buy-in for that"* (Employer 14).

Employer 7, on the other hand, chose to adopt the incentives as suggested by Satori. The sales presentation slides by Satori contained recommended incentives and Employer 7 *"used [them] just as Satori sold it to us. We didn't change anything."* While only Employer 7, in Table 3, includes cash for incidentals, per Broker 2, higher case incentives may be used by other, non-case study employers. For example, Broker 2 explained that one employer offers \$2,500 spending cash while another offers \$6,000 spending cash.

*2. Sub-theme 2: A positive employee experience may act as a catalyst for uptake in accessing the international medical travel benefit*

Without uptake of the benefit, there is no cost savings. Employees who have always received their employee-sponsored health care locally and never considered leaving the U.S. for health care may view an international medical travel benefit skeptically, or worse. An enthusiastic employee can help persuade other employees to stop looking at an employer, newly offering such a benefit, as if the employer were creating an outlandish barrier to health care and begin to view the employer more as a partner in accessing health care. For example, when an international medical travel benefit was published at Employer 8's employee meetings, employees looked at the employer representatives like they were *"monsters"* (Employer 8). But at the final employee meeting of the year, one employee said he needed his knee fixed and he was going to India. (Employer 8) The employer reported that other employees began to use the

benefit based on the first employee's success story, not based on the information provided by the employer. Essentially, *"other employees have followed him, not us, him"* (Employer 8). Employers may trust that employees' utilization of an international medical travel benefit will support their decision to implement the benefit. When other employees follow, this may further support their decision.

Employers may encounter resistance to using an international medical travel benefit. While early employee travelers may be able to draw attention to the benefit, employers must have an effective means of disseminating information about the benefit to the employees. For example, Employer 3 includes information about the international medical travel benefit in its company newsletter. But, as Employer 3 states, *"probably a lot of times [that] goes in the waste paper basket...[so]..there is still a lack of an educational piece"* (Employer 3). Moreover, Employer 3 realizes that *"if we kind of prime the pump"* with employees telling their experiences or easing people in by using the dental benefit, then employees may be more apt to consider traveling for medical care (Employer 3). Shortly after Employer 3's *"first major"* international medical traveler went abroad for orthopedic surgery and described her positive experience, two more employees opted for treatment abroad, which the employer attributed to the first employee's explanation.

Sometimes an interested employee can provide the impetus for an employer to implement an international travel benefit that it had considered but not yet made available. As Employer 14 explained, the company had considered offering an international medical benefit but had not yet implemented it. Because of uncertainty in employee interest and possible fears associated with

going overseas for a medical procedure, Employer 14 “*kept it on the back burner*” until one of their sales employees approached the company about options for treatment overseas. This employee already traveled internationally as part of his job responsibilities and needed an orthopedic procedure. With no U.S. physician in the company’s network who could perform the procedure and expertise outside the U.S., the employee’s inquiry “*jump started*” Employer 14’s international medical travel benefit. After considering 3 to 4 companies providing facilitator services, Satori World Medical was chosen and the benefit was started. This employee allowed Satori to videotape him on his journey,<sup>300</sup> which was shown to the other employees. Shortly after learning of the first employee’s positive experience, another employee decided to use the benefit to have a similar procedure done. But such success stories were not able to eradicate some of the perceived concerns of the employees and their families. Located in a rural Midwest area, Employer 14 “*had a lot of interest – we had a lot of people call that were interested. And they would get so far and then they would back out. And a lot of it was you take a travel companion with you and a lot of the spouses did not want to go out of the country. So that part has been a challenge because our people are a little uneasy.*”

Because of her administrative position, an employee working for Employer 7 knew that an international medical travel benefit was going to be offered before the public announcement was made. With this knowledge she was able to begin planning her international treatment. After she returned from receiving treatment abroad, her story was published internally with Employer 7 as well as externally in a published article.<sup>301</sup> Employer 7 acknowledged that when employees tell their stories it is very powerful. They believe that as more stories get heard, people are more

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<sup>300</sup> US Patient Gets Affordable Birmingham Hip Resurfacing Surgery in India, [www.youtube.com/watch?v=7KgfMcpZQ6Y](http://www.youtube.com/watch?v=7KgfMcpZQ6Y).

<sup>301</sup> David Levine, *Medical Tourism Saves Government Money*, Governing, July 2012, [www.governing.com](http://www.governing.com).

likely to become interested. In 2012 Employer 7 reported one employee traveled for health care, and the next year, after hearing about her positive experience, seven more employees opted to use the benefit.

### *3. Subtheme 3: Potential fear of poor quality care abroad does not match employee experience.*

Case study employers acknowledge that potential patients fear receiving poorer quality care in an international facility than in a domestic facility. This fear, however, does not align with international medical travel experiences in these case studies. Moreover, as described by Employer 3, who participated in a Robert Wood Johnson grant to align forces for quality asserted, it is also difficult to get quality information in the US because *“some of the physicians aren't doing that great of a job and they don't want to air their dirty laundry”* (Employer 3). Although Employer 7 states that there *“is a fear of bad quality”* abroad, they clarified that, from their perspective, there was no difference in resolving an adverse event or unexpected outcome in the U.S. or another country. If an employee or eligible beneficiary experiences a complication in Thailand, then *“it is the same as if that happened [in the U.S.], you fix it”* (Employer 7).

These case study employers report that employees using the international medical travel benefit indicated that they were satisfied with the quality of care received internationally. This satisfaction ranges from recognition that the physician was a *“world expert”* (Employer 7) to experiencing fewer complications in employees and eligible beneficiaries receiving care internationally. Employer 8 stated that the employees traveling abroad for medical care encountered *“zero infections”* (Employer 8). This is in stark contrast to the healthcare-associated

infection rates in U.S. hospitals which, while decreasing, remain a “major, yet often preventable, threat to patient safety.”<sup>302</sup> Employer 8 also relayed a comparison between two employees that received similar orthopedic surgeries, one in Costa Rica and one in the U.S.: The employee who traveled to Costa Rica did not recover as expected after her surgery; her pain increased and she lost bladder control. The international facility treated her for another week, including another surgery. They followed up with her until she was well. The employee who underwent a similar procedure in the U.S. is still standing to work because she is too uncomfortable to sit down. The U.S. facility asserts that the outcome is not related to the surgery. For this employer, international medical travel “*is unlike [the U.S.] where the patient doesn’t get better*” (Employer 8).

One innovative employer, Employer 8, takes the additional step of flying the foreign treating physicians to the U.S. to follow up with their patients every six months. Because the employer’s business spans different geographical locations, the foreign physicians travel to those locations with the highest concentrations of patients. Per, the employer, these visits work “well for all parties –[they are] wonderful” (Employer 8).

#### B. Liability concerns are not considered a barrier by participating employers

None of the employer case studies identified a specific liability concern associated with offering an international medical travel benefit. Employer 8 did not have any legal concerns. Moreover, the benefit is optional so it is the employee’s choice (Employer 8). Employer 14 also failed to identify any specific legal concerns troubling her company. She explained that their in-house

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<sup>302</sup> HAI Data and Statistics, Centers for Disease Control and Prevention, [www.cdc.gov/hai/surveillance](http://www.cdc.gov/hai/surveillance).

counsel “*worked with Satori to tweak the contract. And then we worked with our TPA and stop-loss carrier to make sure that they were okay*” (Employer 14). Ultimately, 2 or 3 attorneys for Employer 14 worked on the benefit. Employer 7 had “*no legal concerns*” and were “*not aware of anything that came up*” (Employer 7). Employer 7 indicated that they did not foresee any legal concerns with offering the benefit again in the future, but that “*if they did it again they would be more aggressive in getting employee stories out*” (Employer 7). While Employer 3 also did not refer to a specific liability concern, it did acknowledge a few lingering concerns that something could go wrong, and an employee could come back and “*sue [the Human Resource Manager], the health plan, and the [employer]*” (Employer 3).

A few factors helped to alleviate Employer 3’s concerns regarding possible legal liabilities. First, the employer is a domestic, federally recognized Native American tribe with “*quasi-domestic national status*” (Employer 3). If someone wanted to sue the Human Resource Manager or the tribe, “*they would have to go to our tribal court and start there first*” (Employer 3). Second, Employer 3 considers the information provided to employees utilizing this international benefit to be part of any “*back up*” defense (Employer 3). Anyone using this benefit is informed of the known risks, from *WebMD* or maybe the Mayo Clinic, and given the CDC guidelines. Employer 3 would also give the patient information from the State Department about the destination country. Ultimately, the Human Resource Manager exclaims if “*I’m doing what a reasonable person would do to reduce that level of risk or making sure that person is making a well-informed independent decision then it is their decision...not mine*” (Employer 3).

Facilitator 8 was the exception to these employers' lack of specific liability concerns. When asked whether employers he works with raise liability concerns his single word response was “*absolutely*” (Facilitator 8). Upon follow-up questioning about what the concerns were, he indicated that there was a “*range of liability, both from the employee standpoint, the corporate standpoint, [and] from a labor law perspective*” (Facilitator 8). As Facilitator 8 explained, because a health plan was being changed, legal issues arose, but these issues are not insurmountable. At least not from a “*practicality standpoint but from a perception standpoint ... I believe...there are x percentage of employers ... that will never go down this path simply because of what they believe is their exposure*” (Facilitator 8). Additionally, he was not aware of any legal actions against any of his client employers based on an international health care benefit.

*1. Sub-theme: Directing employees abroad is no different, liability wise, than directing employees to domestic providers*

Employer 8 noted that their health plan already included preferred provider organizations throughout the U.S. The company was already engaged in directing employees and beneficiaries to facilities and providers in the U.S. As Employer 8 discussed, providing an opportunity to receive health care in a foreign country is no different. In fact, Employer 8 experienced fewer complications with care received in abroad. Employer 14 explained that in the last year her company “*dropped all of our networks...[and] went with reference based pricing...that ...opened up the field where our employees can treat anywhere they want*” (Employer 14). Broker 2 had a similar perspective as these employers. First, he stated, under ERISA, “*there is*

*no liability anyways” (Broker 2). Second, it is “no different than any other service like ... Teladoc...we offer Teladoc too” (Broker 2).*

## *2. Sub-theme: Limited protections are in place if something goes wrong*

The interviewed employers have limited insurance protections in place if something were to go wrong when an employee used their international medical travel benefit. Employer 8 does not have a stop-loss policy covering procedures outside the U.S., nor does the company purchase or offer employees complication insurance. Employees with Employer 3 have the option of including complications insurance in their overall package price but are not required to get it. Employer 14 has stop-loss insurance, but does not purchase additional policies. Employer 7 opted for the additional stop-loss insurance for complications that Satori World Medical offered.

## **IV. Discussion of Findings**

These employer case studies yielded some unanticipated information. The themes from the data suggest some additional elements that are further explored in this subsection:

- 1) Employer frustration with the domestic health care delivery system
- 2) Employees’ willingness to rely on the anecdotes of employees that have participated in an international medical travel benefit rather than on information provided by the employer about the benefit
- 3) Participating employers’ lack of concern about potential liability arising from incentivizing an employee to travel internationally for medical care.

## A. Employer frustration with the domestic health care delivery system

These case-study employers are frustrated with the domestic health care delivery system. In trying to provide a meaningful health care benefit for their employees, they are stymied by issues of cost, quality, and fragmentation.

### *I. Cost*

The data that employers engage in incentivizing international medical travel to save money are not surprising (see Section III A of this Chapter). One case-study employer stated that health care is the company's second or third overall expense and so the company is always looking at ways to save money on health care (Employer 14). Once an employee opts for international care, the employer knows their costs and does not risk being further nicked-and-dimed. If there is an unexpected outcome requiring additional care while in a foreign country this care is generally provided at that location. This can relieve the employee from the administrative burden of finding additional treating providers and completing and cascade of new paperwork. For care received in the U.S., such comprehensive pricing and transparency is elusive. While employers may utilize claims history data to determine a price estimate for a given medical service provided locally, there may be additional charges incurred by any particular patient.

Achieving health care cost transparency and using the information to lower health care costs in the U.S. are challenging tasks. Transparency “implies the concepts of openness, communication,

and accountability in providing information to patients.”<sup>303</sup> In part, health care facilities provide this information, often including customer satisfaction ratings, quality information and price, to consumers in order to compete for their business.<sup>304</sup> Employers may also provide information in an effort to help employees better understand the cost of health care. But these tools do not always yield the anticipated result of lowering health care expenditures. For example, a recent study by Desai et al. concluded that employees at two large companies offering a price transparency tool did not spend less on health care.<sup>305</sup> Even with the tool providing employees about their out-of-pocket costs for services from different providers, only a small percentage of employees used the tool.<sup>306</sup> Still, for those employees that do factor in cost when choosing where to have a medical procedure performed, bundled price transparency, often available outside the U.S., may be one reason to travel abroad for health care.

Until the U.S. achieves greater health care cost transparency, international medical travel may be enticing to employers and employees seeking accurate knowledge of costs before the service is rendered. Even if the U.S. gains greater health care cost transparency, it may only draw more attention to the price discrepancies between domestic and international care. Such visibility may stimulate further interest in international medical travel.

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<sup>303</sup> Sandra J. Winterhalter, *Economic Factors Converge: Force Hospitals to Review Pricing Strategies*, 37 J. HEALTH CARE FIN. 15 (2011).

<sup>304</sup> *Id.*

<sup>305</sup> Sunita Desai et al., *Association Between Availability of a Price Transparency Tool and Outpatient Spending*, 315 JAMA 1874 (2016).

<sup>306</sup> *Id.*

## 2. *Quality*

The case-study employers perceived the quality of care received by their employees internationally as good as or perhaps better than comparable care in the U.S. This may be, in part, because the international hospitals and providers want medical travelers to have good outcomes so that the hospitals, and providers do not lose foreign patients and revenue.

## 3. *Fragmentation*

Inherent in these case-study employers' discussions of the bundled costs of international care is annoyance with the fragmentation of services in the U.S. Compared to the more holistic approach encountered abroad by their employees, the U.S. health care delivery's division into separate provider and facility fees is highlighted. The U.S. health care finance system is moving toward outcomes-based financing, and health care teamwork is stressed in health professionals' education, training, and practice.<sup>307</sup> Yet the U.S. health care system remains deeply fragmented, contributing to Employer 8's experience with two similarly situated employees discussed above in Subsection III A 3. The employee who opted for the international medical travel benefit received a package of care services that resulted in a good clinical outcome while the domestically treated employee encountered a fragmented system that left her still striving for a better outcome and having to do so on her own.

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<sup>307</sup> *E.g.*, Team STEPPS, [www.ahrq.gov](http://www.ahrq.gov).

B. Employees' willingness to rely on the anecdotes of employees who have participated in an international medical travel benefit rather than on information provided by the employer about the benefit

Employees that engage in international medical travel and describe their experiences to other employees may encourage other employees to consider and possibly choose such a benefit. Each of the case-study employers stated that the increase in interest or uptake in the benefit after the first employee returned and described his or her experience to colleagues was related to this employee-employee communication. This communication from employees is important to the case-study employers, more so than any announcements or information provided by the employer. Returning employees may catalyze interest and uptake in international medical travel among other employees while also reinforcing the usefulness of an international medical travel benefit to their employer. The employer, noting the positive feedback from their employees, may assume that the quality of care received is good because the returning employees are satisfied.

The employees' perception of quality of care abroad is based on subjective factors, just like it is for care received locally. Regardless of location, patients' abilities to discern the quality of health care services tend to rely on subjective factors such as experience and satisfaction.<sup>308</sup>

Because of the subjective nature of patients' quality determinations, they may not align with

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<sup>308</sup> See Kristin Madison, *Patients as "Regulators"? Patients' Evolving Influence Over Health Care Delivery*, 31 J. LEGAL MED. 9 (2010) Symposium Article, (discussing patients' increasing influence within the health care delivery system, in part through reported patient surveys of how patients perceived provider communications and cleanliness and whether they would recommend a provider or facility to a friend or family member).

more objective clinical measures of outcome quality.<sup>309</sup> It may be that many of the employees who have already used these benefits are those who appreciated being able to access needed health care without incurring large expenses. Traveling to a foreign country may have added to their overall satisfaction, not been viewed as a detriment. The combination of needed medical treatment at no cost to them, a perception of high quality and personalized services, and protected recovery time (time to recover more fully before flying home, which may be spent in resort accommodations) may predispose these employees from voicing any concerns with their care.

It may be human nature that employees give increased weight to information provided by fellow employees, rather than employer provided information, when making a decision regarding an international medical travel benefit. And based on their experiences, these case-study employers indicated a strong interest in further using early adopters to help spread information and potentially generate additional interest in the benefit. Employee experiences may be a valuable tool for engaging other employees, but employers should be cautious in relying solely on employee experiences. Early adopter experiences may provide valuable context for employees considering international medical travel. In addition to its subjective nature, it may also be a double-edged sword. A negative employee experience, if communicated to other employees, may taint the benefit and create a barrier to its use. To help counterbalance this risk and to provide more complete information, employers should make balanced information available, of which employee subjective descriptions may be a part, along with more objective information.

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<sup>309</sup> See Lisa L. Dahm, *Healthcare Systems and Quality of Care: Do International Measurement Standards Exist?*, 20 TEMP. INT'L & COMP. L.J. 395 (2006) (analyzing quality from the patient's perspective, describing existing and potential outcomes-based measurement tools and quality indicators).

C. Participating employers' lack of concern about potential liability arising from incentivizing an employee to travel internationally for medical care

It is also interesting that these case-study employers did not indicate significant concern about any potential liability arising from incentivizing employees to use an international medical travel benefit. Karrupan's research finds that although employers may fear potential liability from offering this option, employers that do so view liability as a weak deterrent.<sup>310</sup> Part of this lack of demonstrable concern may be because the employers are self-funded and thus have more freedom to offer such benefits than traditional employers offering state-regulated insurance benefits. The ability to offer it, combined with positive experiences and outcomes to date, may lull employers into continuing with the benefit as-is without considering steps to further protect themselves from liability.

One area where employers could better protect themselves from liability risks regarding offering an international medical benefit is in implementing a risk management program for non-medical travel risks. Employers should think beyond liability risks based on actions, such as failure to comply with ERISA's fiduciary duty. They should also consider liability risks for bad events that could occur when an employee was abroad for health care, unrelated to the provision of care. For example, an employee could be kidnapped (in hopes of ransom payments) while abroad for care, or the target of terrorism (such as being in a facility known to cater to foreign, particularly American, patients). Depending on the facts of the situation, an employee might be able to successfully assert a claim against an employer. Employers should evaluate their tracking,

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<sup>310</sup> Karuppan, *supra* note 5 at 218.

security measures, and any emergency evacuation plans in place for their employees using an international medical travel benefit.

## **Chapter Six: Conclusions**

### **I. Introduction**

This research begins to examine the role of U.S. outbound medical travel within the U.S. health care delivery system. International medical travel will likely remain a viable means for U.S. residents to access care and potentially expand. Outbound medical travel is a deceptively large subject. In addition to the basic elements of our domestic health care delivery system (including access, finance, liability, patient-provider relationships, informed consent, privacy, and ethics), it adds international travel and receiving health care in a foreign facility, experiences new to many Americans.<sup>311</sup> This research: 1) synthesizes existing literature to recommend specific definitions related to medical tourism for use by future researchers and policy makers; 2) reviews the existing legal framework and identifies gaps and areas for regulating risk; and 3) provides an in-depth assessment of the decision-making process invoked by employers offering an international medical travel benefit.

### **II. Further Interpretations of Research Data**

#### A. Terminology

A systematic review of the literature demonstrates a lack of clarity in the use of the terms “medical tourism,” “medical travel,” and “medical outsourcing.” Medical tourism is a

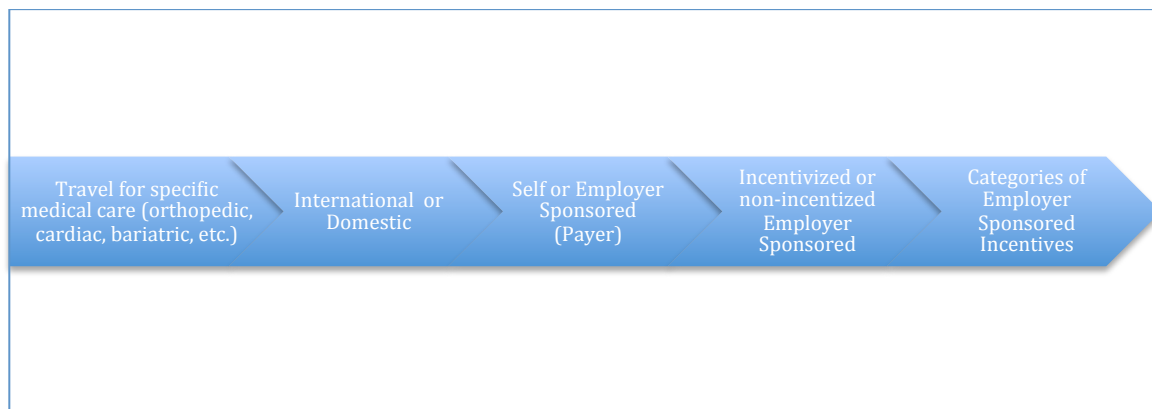
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<sup>311</sup> In 2015, approximately 39 percent of Americans had a valid passport based on a U.S. population on December 31, 2015 of 322,755,353 and 125,907,176 valid passports. U.S. and World Population Clock, U. S. Census Bureau, [www.census.gov/popclock/](http://www.census.gov/popclock/) (2016); Passport statistics, U.S. Dep’t of State, [www.travel.state.gov/content/passports/en/passports/statistics](http://www.travel.state.gov/content/passports/en/passports/statistics) (2016).

stigmatizing term in the context of medical care. It may have been a useful term to capture the attention of patients seeking elective surgeries (often cosmetic) and encourage them to combine exotic travel with surgery, like “surgical safaris.” But for patients seeking access to orthopedic, cardiac and other specialty care as a covered employment benefit, medical tourism as a term fails to represent a legitimate part of the U.S. health care delivery system. Medical outsourcing also falls short as it connotes a negative offshoring of American patients. Neither medical tourism nor medical outsourcing is an ideal choice for a medical benefit covered by a health plan.

Medical travel is a preferable term because it is more descriptive and neutral. Although it could serve as an umbrella term, it is too general a phrase to encompass all the nuances created by U.S. outbound international medical travel. At the least, the type of health care service, orthopedic, bariatric, etc., needs to be denoted. Incentives may also need to be included in future characterizations. As additional consideration is given to the terminology issue, it is conceivable that an identification key could be developed, as modeled in Figure 6.

Figure 6: Model of Medical Travel Identification Key



Potential legislation and additional insurance coverage of international medical travel are strong reasons supporting terminology clarification. Such terminology refinement may be achieved at the state or federal level.<sup>312</sup> Federal legislation with parallel state legislation could be the most explicit and efficient approach. Currently, however, there is no indication of sufficient political will to address this issue at the federal level. States such as Rhode Island are beginning to define and regulate domestic medical travel. Although states lack the ability to establish federal law, they and state-regulated payers are well situated to initiate a discussion of terminology options and begin including definitions in state insurance regulations. Such a dialogue could lay the groundwork for improved national consensus of terms. In fact, such state-led action could be similar to telemedicine, where state governments have led the way in introducing and enacting telemedicine legislation.<sup>313</sup>

## B. Case-Studies

Price may be an important trigger causing self-funded employers to implement an international medical travel benefit. Other factors such as employee satisfaction, recruitment and retention may help persuade employers to continue to offer such a benefit even if domestic providers begin to offer more competitively priced alternatives. This may be even more relevant with specific employee populations such as the high technology sector or millennials. These populations may embrace international medical travel, in part, because of experience with

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<sup>312</sup> Although state law has primacy with respect to state regulated health benefit plans, federal law governs ERISA plans.

<sup>313</sup> Nate M. Lacktman, *Five Telemedicine Trends Transforming Health Care In 2016*, 18 J. HEALTH CARE COMPLIANCE 43, 57 (2016).

internet research and a more global outlook.<sup>314</sup> They are likely to be more familiar with concept of traveling abroad for health care and not be averse to considering it.<sup>315</sup> Their trust in online services may also be greater because of purchasing products through Amazon, sharing genetic information through 21 & Me, and posting photographs on Instagram.

### C. Overall – Where Does Outbound International Medical Travel Fit in the U.S. Health Care Delivery System?

With enactment of the ACA, the U.S. is moving more toward integrated, value-based care. The ACA attempts to lessen the U.S. health care delivery system's fragmentation by promoting integrated delivery mechanisms such as medical homes and accountable care organizations (ACOs).<sup>316</sup> It also emphasizes value-based purchasing, including bundled payments, and pay-for-performance.<sup>317</sup> These efforts, like many others, strive to better align health care price, quality, and access. The low price and high quality goal is particularly difficult to achieve. Some measures, such as bundled payments, may be successful for one element, such as price, and not another, such as quality. For instance, a recent RAND study by Hussey et al., analyzed 58 studies in the literature and determined that bundled payments might effectively contain costs without having a major effect on quality of care.<sup>318</sup>

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<sup>314</sup> See Jason Hidalgo, *Here's how millennials could change healthcare*, Reno Gazette-J. (Feb. 7, 2016).

<sup>315</sup> See Chelsea, *Hack the Cost of Healthcare with Medical Tourism*, www.brokemillennial.com, (March 31, 2015)(describing health care services received in India and comparing costs to those in the U.S.).

<sup>316</sup> Richard S. Saver, *Envisioning the Future Health Care System*, 15 HOUS. J. HEALTH L. & POL'Y 1, 3 (2015).

<sup>317</sup> Barry Liss, *The Patient Protection and Affordable Care Act Six Years Later*, 299 APR N.J. LAW 41, 43 (2016).

<sup>318</sup> Hussey PS, Mulcahy AW, Schnyer C, Schneider EC, *Bundled Payment: Effects on Health Care Spending and Quality. Closing the Quality Gap: Revisiting the State of the Science*, Evidence Report/Technology Assessment No. 208. (Prepared by the RAND Evidence-based Practice Center under Contract No. 290-2007-10062-I.) AHRQ Publication No. 12-E007-EF. Rockville, MD: Agency for Healthcare Research and Quality, (August 2012) www.effectivehealthcare.ahrq.gov.

International medical travel may be an innovative means of aligning price, quality and access. For it to be economically efficient to incentivize an employee to travel abroad for health care, the entire package (including health care services, travel, and accommodation) must cost less than the same health care services provided locally. Employers offering an international medical travel benefit have experience with bundled prices for health care services provided abroad. It remains to be demonstrated whether these bundled payments, like the studies analyzed by Hussey et al., fail to have a major effect on the quality of care. It is probable that the foreign facilities and providers are striving for a high quality of care so as to further encourage other American patients to also travel for health care. Some of these bundled services, like knee or hip replacements, may represent the proverbial “low-hanging fruit” of bundled payments. Even so, these specific bundled treatments may be niches that facilitate and begin to establish international medical travel as a viable component of the U.S. health care delivery system.

Americans typically have a firm belief in the direct connection between price and quality, which is not necessarily true for health care.<sup>319,320</sup> International travel for specific health care services could highlight the lack of a strong connection.

As clinical quality indicators (such as patient safety data, clinical outcome data, compliance with clinical best practice guidelines, etc.) become available for international medical travel there may be further impetus to expand the use of international medical travel in the U.S. health care

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<sup>319</sup> Susan Adler Channick, *The ACA, Provider Mergers And Hospital Pricing: Experimenting With Smart, Lower-Cost Health Insurance Options*, 6 WM. & MARY POL'Y REV. 95, 129 (2015).

<sup>320</sup> *But see* Kathryn A. Phillips et al., *Most Americans Do Not Believe That There is an Association Between Health Care Prices and Quality of Care*, 35 HEALTH AFFAIRS 647 (2016) (describing a national survey examining whether health care consumers perceive that price and quality are associated and concluding that 58-71 percent of Americans do not think that price and quality are associated).

delivery system, if the indicators are comparable to, or exceed, locally provided medical care data.

Alternatively, the U.S. health care delivery system might adapt to an outward flow of health care dollars caused by international medical travel by reducing costs for domestic care. Domestic costs might decrease as providers and facilities strive to remain competitive with respect to their domestic patient population and the health care dollars that population represents.

### **III. Key Areas for Expansion and Regulation**

While it is premature to foresee the extent to which international medical travel will become part of the U.S. health care delivery system, focus can be placed on: 1) potential expansion beyond self-funded employer benefits; and, 2) future regulatory considerations.

#### A. Expansion Beyond Self-Funded Employer Benefits

By removing geographical boundaries, international medical travel increases patient options for where health care services are received. Employees with an international medical travel benefit can opt into a global market. Currently used by self-funded employers, this benefit could be expanded to other plans such as plans offered on the ACA marketplace or plans providing supplemental Medicare coverage. While it is unlikely that ACA marketplace plans will target international medical travel, particularly in light of the 2016 Presidential election and calls for

repeal of the ACA, Medicare Supplement Insurance (Medigap) plans may be more likely to include international medical travel benefits.

Medigap policies are sold by private companies to fill the gap and help provide coverage for some of the health care costs that the traditional Medicare does not cover such as copayments, deductibles, and some health care services.<sup>321</sup> One type of health care service that may be covered by a Medigap policy is medically necessary emergency medical treatment when traveling outside of the U.S.<sup>322</sup> Medigap plans pay for 80% of the billed charges once the annual \$250 deductible has been satisfied. While such plans currently have a lifetime limit of \$50,000, this limit could be removed or at least raised.

Medigap plans are the one of the most likely plans to be modified to cover medically necessary non-emergency medical treatment outside of the U.S. Offering the Medigap population an option to have non-emergent medical treatments abroad is reasonable because this population includes individuals seeking medical coverage while traveling. Many senior citizens want to enjoy their retirement by traveling abroad. While Medigap policies may currently help such citizens pay for medically necessary emergency care while traveling abroad, this same population may be interested in traveling abroad for the primary purpose of receiving certain medical procedures such as joint replacements. If Medigap covered even select non-emergency foreign medical care, such as the knee and hip replacements, some senior citizens might be willing to travel abroad for their care. They might have an interest in traveling abroad, and be willing to combine a trip with medical care. Moreover, the financial incentive of paying 20% of

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<sup>321</sup> *What's Medicare Supplement Insurance (Medigap)?*, Medicare.gov, [www.medicare.gov/supplement-other-insurance/medigap/whats-medigap](http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap).

<sup>322</sup> *Medigap & Travel*, Medicare.gov, [www.medicare.gov/supplement-other-insurance/medigap-and-travel](http://www.medicare.gov/supplement-other-insurance/medigap-and-travel).

a significantly less costly procedure performed abroad rather than in the U.S. may be persuasive to part of the Medigap population. If so, this type of expansion of international medical travel benefits could aid in lowering U.S. health care expenditures.

## B. Regulatory Considerations

Future regulations may either primarily promote or limit U.S. outbound medical travel. Regulations could also permit such travel while establishing employee or patient protections. These protective types of regulations may be a good starting point because they can allow continued exploration of this type of travel while providing some fundamental patient protections. One example of a protective regulation is a limitation on incentives. Federal law could prohibit coercive incentives. Employers could include information regarding offered incentives in their annual report on Form 5500.<sup>323</sup> The information on these forms could be used by federal agencies enforcing the law.

Incentives may be useful because they encourage employees to consider and possibly engage in international medical travel at less of a cost than comparable domestic care. However, if incentives are too strong than an employee may feel compelled to use the international medical travel benefit. Thus, any incentives should be carefully balanced to encourage employees to voluntarily utilize the benefit while not being too coercive. The law should protect the weakest party, or the employee-patient.

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<sup>323</sup> Form 5500 Series, Depart. of Licensing, [www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500](http://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500).

Incentives were the first issue that state legislatures considered regarding international medical travel. These early state legislative attempts strove to define mandatory incentives for public employees. While these legislative attempts failed, the incentives specified in these bills closely resemble the current incentives that some self-funded employers are offering their employees.

For example, bills introduced in West Virginia and Colorado were very similar and demonstrated an early interest by state legislatures to use medical outsourcing as a means of controlling increasing healthcare costs. Moreover, these early attempts at state legislation incentivizing international medical tourism may still be indicative of necessary legislative action. One benefit of legislation authorizing and defining mandatory incentives is reducing the fear that an employer may have that, by incentivizing their employees to travel for healthcare, they are increasing their liability exposure.<sup>324</sup>

In 2006, the West Virginia Legislature considered a bill aimed at reducing the state's costs for medical care for its covered employees.<sup>325</sup> This bill required that covered employees be incentivized to travel internationally for health care. In this instance, the state is acting like any private employer trying to reduce costs. The Joint Commission International must have accredited the foreign facility, and the cost of the health care service must be less in the foreign facility than in the U.S. This bill focused on potential cost savings, requiring the cost savings to be equal to or greater than the sum of the incentives. This bill also required that the incentives include:

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<sup>324</sup> See Samlan, *supra* note 132 at 146 (discussing how private insurers incentivizing patients to travel internationally for health care might benefit from legislation authorizing the use of incentives).

<sup>325</sup> West Virginia, H.B. 4359(2006).

1. Waiver of all co-payments and deductible payments; 2. Payment of cost of round trip air fares for the covered employee and one companion; 3. Lodging expenses in the foreign country for the companion for the length of the treatment or procedure; 4. Lodging expenses in the foreign country for the covered employee and the companion for not more than seven days of convalescence after the treatment or procedure; 5. Payment to the covered employees hiring agency for seven days of paid sick leave which are not counted against the employees accrued sick leave; and 6. Rebate not more than twenty percent of the cost savings directly to the covered employee.<sup>326</sup>

This would have provided a rich incentive package. However, by placing a strict limit on the number of convalescence days paid for in the foreign country, the bill might have had unexpected consequences related to flying home before medically appropriate or potentially increasing the risk of flight induced complications such as deep vein thrombosis. Ultimately, this bill died in committee.<sup>327</sup>

The next year, a bill was introduced in Colorado that would have required an incentive program be established for state employees covered under a state self-insured group benefit plan who chose to obtain medical care in a foreign health care facility.<sup>328</sup> This bill was very similar to that introduced the year before in West Virginia, including the same types of incentives contained in the West Virginia bill. This bill also was not enacted; rather it was postponed indefinitely.<sup>329</sup>

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<sup>326</sup> *Id.*

<sup>327</sup> One of the co-sponsors of the bill determined that such a medical tourism system as encouraged by this bill would “work better for private insurance firms.” See Boyle *supra* note 86 at 44.

<sup>328</sup> Colorado, HB 07-1143 (2007).

<sup>329</sup> House Committee on Business Affairs and Labor, Final Bill Summary for HB 07-1143 (2007).

The incentives in these bills are very similar to many of the incentives currently being used by self-funded employers. While these similarities may be the result of chance, it may also be that these bills provided a ready-made set of incentives that were adopted by self-funded employers, brokers, and facilitators. Although there is nothing inherently wrong with such an adoption, it may still be useful to reexamine and carefully tailor current incentives to encourage but not coerce.

Drivers of regulation limiting international medical travel include: competition and protectionism, and risk of bad outcomes. The threat of competition from foreign providers may cause domestic providers to seek regulations restricting the use of international medical travel based on patient safety concerns. Domestic providers could use evidence of increased usage and publicized bad outcomes as rationale for limiting such travel for medical care. If the U.S. attempted to halt the flow of outbound international medical travel, it would not be the first country to try this. Nigeria plans to halt outbound medical tourism from Nigeria by building internal health care infrastructure, providing universal health insurance, and discouraging Nigerians from seeking treatment abroad for ailments that can be treated domestically.<sup>330</sup>

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<sup>330</sup> *Nigeria Plans to Block Outbound Medical Tourism*, INT'L MED. TRAVEL J. (16 March 2016).

## IV. Limitations of Research

### A. Terminology

#### *1. Systematic Literature Review*

By analyzing a wide variety of literature sources, including legal, biomedical, social sciences, and other multidisciplinary scholarly journals, this research is more comprehensive than if limited to legal or other narrower sources. Also, explicit exclusion criteria, specified in the systematic literature review flow chart, makes the research less susceptible to researcher bias and more open to replication and refinement. Still, there are limitations to this type of review, including: risk of including “poor” articles because a quality determination is not made,<sup>331</sup> risk of including multiple articles by the same author or group of authors that reiterate the same information<sup>332</sup>

Systematic literature reviews are primarily used to analyze medical and scientific information.<sup>333</sup>

The focus was term definitions, not study data. Here, including a wide variety of literature also helped mitigate potential database limitations. For instance, unlike legal database searches that

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<sup>331</sup> See Jeremy A. Blumenthal, *Meta-Analysis: A Primer for Legal Scholars*, 80 TEMP. L. REV. 201, 214-15 (2007) (discussing objections to a meta-analytic approach).

<sup>332</sup> *Id.* at 216.

<sup>333</sup> Lisa A. Bero, *Evaluating Systematic Reviews and Meta-Analyses*, 14 J.L. & POL’Y 569, 570 (2006). Systematic literature reviews are also being used more frequently in legal research. See The Journals Editorial Staff, *A National Survey of Medical Error Reporting Laws*, 9 YALE J. HEALTH POL’Y, L. & ETHICS 201 (2009)(reporting research based on systematic literature reviews of state statutes and regulations).

include the article's text, PubMed searches only capture the search terms in the title, abstract, or Mesh<sup>334</sup> terms assigned to the article.

## 2. *Search Terms and Restrictions*

For this research, Academic Search Complete, or EBSCO, Web of Science, PubMed, and Westlaw Next were queried using the search terms “medical tourism,” “medical travel,” and “medical outsourcing,” all in combination with “United States.” Because the “United States” was included in this query, articles lacking that term were not retrieved. Thus, articles with the same terms but no reference to the United States were excluded. For instance, Tomas Mainil et al.'s article suggesting a global terminology for trans-national health care, but focusing on the European Union, was not retrieved.<sup>335</sup> Moreover, this systematic literature review restricted the search to English language articles only due to research language limitations. However, the definitions from the included articles often repeated themselves, and thus, the search most likely included the most common definitions.

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<sup>334</sup> MeSH is an acronym for Medical Subject Headings. On average, articles are assigned fifteen subject headings. See Young, *supra* note 58 (discussing the MeSH system in detail).

<sup>335</sup> Tomas Mainil et al., *supra* note 42 (specifying that cross-border health care is founded on the demand side while medical tourism is built on the supply-side perspective).

## B. Case Studies

### *1. Sample Size*

One limitation of this research is the small sample size limiting the study's generalizability. As indicated by Yin, however, the strength of case studies may not lie in supporting broad generalizations, but in providing data regarding an existing phenomenon in a real-world setting.<sup>336</sup> Although a small number of individuals were interviewed for this study, the information gained from these interviews is valuable even if limited to first insights into this topic.

Furthermore, this research targeted specific individuals, primarily self-funded employers incentivizing employees to use an international medical travel benefit. This was a hard-to-reach population that was generally unwilling to discuss their experiences offering this benefit. They may not want others in their community, including local hospitals and providers, to know that they include this health care option. Overall, employer reticence to be interviewed as well as time constraints prohibited saturation from being reached. While a small sample size is not ideal, this research process sheds light on how to restructure any future research efforts in this area. Moreover, this research focuses on employer experiences and additional research is needed regarding patient perspectives.

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<sup>336</sup> Yin, *supra* note 265.

## **V. Examples of Future Studies**

As an emerging phenomenon, there is much to study about outbound U.S. international medical travel. This topic is ideal for legal and economic analyses. To complement this employer-focused research, additional qualitative studies could be done looking at the employee and patient side of the medical travel experience. Law and society research could be done on the issue of outbound U.S. international medical travel for specialty pharmaceuticals. Each of these studies is discussed in more detail below.

### A. Law and Economics Research

Looking at U.S. outbound international medical travel from a law and economics perspective of promoting economic efficiency could provide useful information for developing public policy. Insights could be gained from looking at the global flow of resources, risks, and benefits of U.S. outbound international medical travel. Specifically, a single medical procedure, such as a total knee replacement, performed locally in the U.S. could be compared with the same procedure performed in other countries, such as Mexico and India.

A cost analysis could be completed from the payer perspective as well as from the societal perspective. A model could be developed using data on clinical adverse events, direct medical costs, direct non-medical costs, and indirect costs. Three of the most prevalent adverse events associated with total knee replacements include: venous thromboembolic events (VTEs), surgical site infections (early infections, EI), and early failure of the prosthetic requiring

revision.<sup>337</sup> Direct non-medical costs (including lodging, transportation, passport, and meal costs) and indirect costs (including patient and companion time off work) could be calculated and included in the model. Ideally, quality-adjusted life year data could also be included in the analysis.<sup>338</sup>

Such an analysis could aid in providing data for payers, patients and families, and society. Potential policy implications from such an analysis may include strategies for better informing and educating patients about weighing the potential risk and benefits of traveling for health care services. Data could be developed to aid in patient, payer, and other stakeholder's ability to determine the cost associated with a specific amount of risk of an adverse event.

## B Multi-Method Research on the Employee and Patient Experience

The research in this study focuses on self-funded employers but multi-method research is also needed on the employee and patient experience with incentivized international medical travel. Two main areas that could be studied are: 1) patient decision-making regarding medical travel (including patients who have seriously considered medical travel even if they did not participate in it); and, 2) patient experience. These data could be useful in better understanding the value of medical travel to patients.

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<sup>337</sup> See Lazaros Poultsides, *In-hospital Surgical Site Infections After Primary Hip & Knee Arthroplasty-Incidence and Risk Factors*, *www.J. of Arthroplasty* (8 Nov. 2012); S. Ridgeway & JT Moskal, *Early Instability with Mobile-bearing Total Knee Arthroplasty: a series of 25 cases*, 19 *J. OF ARTHROPLASTY* 686 (2004); Carl T. Talmo et al., *Perioperative Complications Following Total Joint Replacement*, 28 *CLIN. GERIATRIC MED.* 471 (2012); Geoffrey Tsaras et al., *Incidence, Secular Trends, & Outcomes of Prosthetic Joint Infection: A Population-Based Study, Olmsted County, Minnesota 1969-2007*, 33 *INFECTION CONTROL HOSPITAL EPIDEMIOLOGY* 1207 (2012); F. Vekemen et al., *In-hospital Risk of Venous Thromboembolism and Bleeding and Associated Costs for Patients Undergoing Total Hip or Knee Arthroplasty*, 15 *J. MED. ECON.* 644 (2012).

<sup>338</sup> See Pirjo Rasanen et al., *Effectiveness of hip or knee replacement surgery in terms of quality-adjusted life years and costs*, 78 *ACTA ORTHOPAEDICA* 108 (2007)(providing a model for calculating knee replacement QALYs).

The literature highlights existing gaps in knowledge about medical travelers including: what shapes decision-making for medical travelers,<sup>339</sup> what information is valued by medical travelers,<sup>340</sup> and the use and impact of destination facility websites on the behavior of medical travelers.<sup>341</sup> Lunt, Hardy, and Mannion, in an article on medical tourism and web-based medical information, specifically call for research on patient decision-making.<sup>342</sup> Crooks et al.'s (Canadian researchers) scoping review highlights that most information about medical tourists' experiences is not based on empirical research but on speculative and anecdotal sources.<sup>343</sup> More recently, Johnston, Crooks, and Snyder began to examine Canadian medical tourists' decision-making process.<sup>344</sup>

In this Canadian study, thirty-two Canadians who had sought surgical treatments abroad were interviewed using semi-structured phone interviews. Three themes emerged from the participants' descriptions of the decision-making process: information sources consulted; motivations, considerations, and timing of accessing care; and personal and professional supports drawn upon during the decision-making process. The study indicated that Canadian medical tourists used the Internet to gain access to information; often relying on the advice of previous medical tourists, perhaps because of the limited availability of unbiased information sources. The primary motivations to pursue surgery abroad were: availability of the procedure elsewhere and not in Canada; wait-listing when the procedure was available in Canada; combined wait-listing and availability where wait-listing prompted a search for alternatives; and cost. The

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<sup>339</sup> Lunt & Carrera, *supra* note 55.

<sup>340</sup> *Id.*

<sup>341</sup> Neil Lunt, Mariann Hardey, Russell Mannion, *Nip, tuck, and click: medical tourism and the emergence of web-based health information*, 4 OPEN MED. INFORM. J. 1 (2010) .

<sup>342</sup> *Id.*

<sup>343</sup> Crooks, et al., *supra* note 52.

<sup>344</sup> R. Johnston, V.A. Crooks, J. Snyder, "I didn't even know what I was looking for . . .": A qualitative study of the decision-making processes of Canadian medical tourists, 8 Globalization & Health 23 (2012).

majority of participants reported consideration of anecdotal accounts from former medical tourists. These included reading on-line accounts and speaking directly to previous medical tourists. Participants also reported that the opinions of friends and family had little impact on the outcome of the decision-making process; however, this remains hypothetical because none reported being seriously challenged by those in their support network. The participants reported a range of interactions with their domestic providers from not discussing it at all with their provider, consulting their provider for medical records needed by the destination physicians, to being encouraged to consider medical tourism by their physician before they themselves had considered it. These authors emphasize that future research needs to focus on the interaction of different motivators on patients considering traveling abroad for health care services, rather than accepting the often touted single motivator for potential medical tourists in a given nation, such as wait times in Canada.

There is little research on American medical travelers, and Canadian and American medical travelers may differ in their decision-making process, in part because of the differences in their health care systems<sup>345</sup> and the different expectations those systems engender. Qualitative research on this issue could fill existing gaps in the literature. One possible hypothesis is that U.S. patients' decision-making processes are influenced by AIR: Access, Information, and Relationships; but the patients' weighting of AIR factors are dominated by the strength of home and destination country incentives.

Additionally, once a patient decides to travel for medical care, there is little non-anecdotal information about what the patient experiences. Here, multi-methods could be used to both

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<sup>345</sup> In Canada, most medically necessary health care is publicly funded.

gather qualitative data on the nature of the patient experience, as well as quantitative data on factors such as the average time (of the procedure, the recovery, the follow-up care, and the length of time away from work,), adverse events or complications, and any resulting legal claims. These data will help provide a foundation for legal and public policy frameworks addressing American participation in medical travel.

### C. Law and Society Research

Law and Society Research emphasizes law on the books in comparison with law in reality. Employers incentivizing employees to travel internationally for specialty pharmaceuticals could be studied. Specifically, the study should look at programs and incentives related to the newer hepatitis C pharmaceuticals. Hepatitis C virus (HCV) is the most common chronic blood-borne infection in the United States.<sup>346</sup> The CDC estimates that 3.2 million Americans are infected. Annual HCV deaths now surpass deaths from HIV/AIDS. The costs, from 2010-2019, due to premature mortality and lost productivity from HCV are estimated to be \$75 billion.

While anyone can contract HCV, more than 75% of infected adults are baby boomers, born from 1945-1965.<sup>347</sup> Although the reason that this generation has such high rates of HCV is not completely understood, it is thought that they became infected in the 1970-80s when HCV infection rates were the highest. HCV is primarily spread through contact with blood from an infected person, so baby boomers could have contracted it from contaminated blood products

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<sup>346</sup> Hepatitis C, 2010 STD Treatment Guidelines, [www.cdc.gov/std/treatment/2010/hepC.htm](http://www.cdc.gov/std/treatment/2010/hepC.htm).

<sup>347</sup> Hepatitis C: Why Baby Boomers Should Get Tested, [www.cdc.gov/knowmorehepatitis/media/pdfs/factsheet-boomers.pdf](http://www.cdc.gov/knowmorehepatitis/media/pdfs/factsheet-boomers.pdf).

before widespread screening and universal precautions were adopted. Others may have gotten it from illicit injection drug use.

Chronic HCV is a long-term illness that can lead to cirrhosis or liver cancer. HCV is the leading reason for liver transplants in the U.S. Since December 2013, new pharmaceuticals have become available that are much more effective and more readily tolerated than previous drugs. These drugs exhibit high levels of sustained viral response meaning there is no measurable virus in the patient's blood, which is a proxy for cure. Specifically, Sovaldi, Harvoni, and Epclusa, manufactured by Gilead, and Viekera Pak, manufactured by AbbVie, are now available for U.S. patients with HCV. All of these drugs have very high cure rates, and the most recent two are one-a-day pills are unique in that they do not have to be taken with peg-interferon, a drug that is so toxic that many HCV patients have historically been unable to complete therapy. These revolutionary, new, highly-effective drugs come with a large price tag of approximately \$63,000 to \$160,000, depending on genotypes and length of treatment.

The costs of these HCV drugs are much less in foreign countries. For example, Sovaldi is reported to cost \$57,000 in the United Kingdom, \$55,000 in Canada, \$840 in India and Brazil, \$900 in Kenya and Myanmar, as compared with \$84,000 in the U.S. The Medical Tourism Association is actively encouraging the employers they work with to send their HCV infected employees abroad for treatment with the new drugs.<sup>348</sup> While their focus may place more weight on the tourism aspect (go on a safari and get the new drugs), the option of traveling abroad for these drugs is also of interest to self-funded employers. One of the case-study employers was in the process of trying to set up an option for employees to travel abroad for HCV drugs

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<sup>348</sup> Hepatitis C: Saving 90% + Through Medical Tourism, Medical Tourism Association presentation Aug. 5, 2014.

(Employer 8). Because of the recent changes in these drugs this option was a bit of a “*moving target*” (Employer 8). Another case-study employer was “looking at specialty drugs overseas” and waiting to hear from their facilitator (Employer 14). HCV is a prevalent infectious-disease with a high-cost, highly effective therapy – making access and distribution of the drugs a timely and pressing concern for health care policymakers, health plans, employers, patients, and others. This research on international medical travel for novel new pharmaceuticals may demonstrate the extent of this type of travel and the likelihood of this type of travel spurring further interest in international medical travel of other medical types (e.g. orthopedics, cardiac).

## **VI. Conclusions**

As U.S. health care finance and delivery change, and globalization increases, consideration should be given to how Americans access medical care. International medical travel is one option currently available to self-funded employers wanting to reduce their medical care expenditures. As such it may continue to exist, primarily under the radar. If it is to become a viable option for a larger U.S. patient population, it must be further integrated into the health care delivery system. Eliminating the “medical tourism” label and incorporating it into additional health care insurance plans, such as Medigap, are preliminary steps that could help achieve this goal.

Appendix 1: Sample email sent to prospective interviewees

My name is Tanya Karwaki and I am a Ph.D. Candidate at the University of Washington. As part of my dissertation, I am interviewing stakeholders in medical travel. I expect my dissertation will provide a clearer explanation of the current interest in, and any concerns with, this type of patient movement for health care.

If possible, I would greatly appreciate being able to interview you about Employer 1's experience working with self-funded employers to offer a surgical benefit.

Thank you in advance for considering my request. Interviews usually take about 30 minutes via phone. If you have any questions, or would like to schedule an interview, please do not hesitate to contact me at [tkarwaki@uw.edu](mailto:tkarwaki@uw.edu).

Sincerely,  
Tanya Karwaki

Appendix 2: Requested Interviews

<b>Organization</b>	<b>Interviewee's Name/ Title</b>	<b>Method of Interview Request</b>	<b>Dates of Request(s)/Any Responses</b>	<b>Interview Date</b>
Employer 1	N/A	Company Website	1/25/16	
Employer 2	N/A	Company Website	4/8/16	
<b>Employer 3</b>	<b>HR Manager</b>	<b>Company Website</b>	<b>7/8/16</b>	<b>7/16/15</b>
Employer 4	N/A	Company Website	1/25/16	
Employer 5 (domestic)*	N/A	University Relations Website	4/5/16	
Employer 6	President	Direct Email	3/30/16	
<b>Employer 7 (public)**</b>	<b>City Manager</b>	<b>City Website</b>	<b>1/11/16</b>	<b>1/19/16</b>
<b>Facilitator 1</b>	<b>Management Team Member</b>	<b>Company Website</b>	<b>4/3/16</b>	<b>4/28/16</b>
Broker 1	Director International Marketing	Company Website	2/16/16 (Agreed to interview, signed consent, after a few emails did not respond)	
Trade Association 1	N/A	Company Website	4/19/16	
<b>Employer 8</b>	<b>Director of Benefits</b>	<b>Company Website</b>	<b>7/23/15 &amp; 8/6/15</b>	<b>8/10/15</b>
Employer 9	Director Risk Management	Company Website	1/11/16 & 1/18/16	
Employer 10	N/A	Organizational Website	1/25/16	
Facilitator 2	Founder CEO & Founder President	Direct Emails	8/10/15, 1/11/16, 1/18/16 & 4/11/16 (client introduction; no response)	
Employer 11	CEO	Direct Email	1/25/16	
Employer 12 (domestic)*	Group Benefits Analyst	Company Website; Customer Service Phone Number	3/30/16, 4/5/16, & 4/13/16	
Employer 13 (public)**	N/A	Company Website	1/25/16	

<b>Organization</b>	<b>Interviewee's Name/ Title</b>	<b>Method of Interview Request</b>	<b>Dates of Request(s)/Any Responses</b>	<b>Interview Date</b>
Pharmacy Benefit Manager 1	CEO	Direct Email	4/12/16 & 5/2/16 (CEO reached out to contacts and did not find any leads)	
<b>Employer 14</b>	<b>Health &amp; Wellness Manager</b>	<b>Direct Email</b>	<b>7/24/15</b>	<b>8/6/15</b>
Employer 15 (public)**	N/A	County Website; Phoned HR Department	1/11/16, 1/18/16, & 2/16/16	
Patient Information Organization 1	Founder	Organization Website	1/18/16 (declined to be interviewed)	
State Provider of Health Benefits to Public Employees 1	Marketing Representative	Direct Email	4/5/16	
Employer 16 (public)**	HR Manager	Phoned HR Department	2/17/16 & 4/5/16 (HR Manager stated that no employee had taken advantage of benefit; declined to be interviewed and recommended Marketing Representative at State Provider of Health Benefits to Public Employees 1)	
Employer 17 (domestic)*	N/A	Company Website	3/10/16	
<b>Broker 2</b>	<b>Broker</b>	<b>Direct Emails</b>	<b>4/19/16,</b>	<b>4/29/16</b>

\* Employers publically known to offer domestic medical travel benefits to employees.

\*\* Public employers. All other employers are private.

## Appendix 3: Representative Questions

### Questions for Interview with Private Employer

#### Background:

- 1) What is your professional position and how long have you held it?
- 2) What is your role in determining employee health benefits?
- 3) By what mechanism does your company self-fund their employee health benefits – Third-party administrator or ?
- 4) How does your company evaluate new health benefit options?

#### Specific to international travel for healthcare:

- 1) When did your company implement this type of benefit?
- 2) What process did you use for establishing a benefit option of covering international travel for healthcare services?
- 3) If you are using an intermediary for this type of benefit, who is it and why did you choose it?
- 4) Had you considered offering this option before and chosen not to at that time? Why?
- 5) What does your company hope to achieve by including this option in your benefits package?
- 6) Do you have evidence of satisfying your goals?
- 7) How important was quality of healthcare services to your decision and how did you assess quality?
- 8) What, if any, legal concerns have you encountered with including traveling outside of the U.S for healthcare as part of your benefits package?
- 9) If you were to expand this option, do you foresee any legal or policy barriers?
- 10) How did you determine what incentives you would offer employees? Have these incentives worked as expected?
- 11) Do you think other employers will include such options in their benefits package?
- 12) What trends do you expect to see for international travel by U.S. employees for healthcare in the next 5 to 10 years?
- 13) Is there anything else that was not asked but that you consider important?

### Questions for Interview with Facilitator Organization

#### Background:

- 1) What is your professional position and how long have you held it?
- 2) What is your role in your company?

#### Specific to travel for healthcare:

- 1) How does your company work with health plans and self-funded employers to provide medical travel opportunities? If the plan or employer offers incentives for medical travel, does your company assist in recommending specific incentives?
- 2) When medical travel is a covered health care benefit, how is it usually structured? Is it a rider?

- 3) Does your company tailor options for specific employers – for instance, if the employer is interested in international or domestic networks? Do you help employers determine which type of network may be more appropriate for their employees? If so, what are the key factors considered?
- 4) Are most of your employers in the private sector or the public sector?
- 5) Do many of your employers indicate to your company that they have liability concerns? Do many of your employers purchase employer liability insurance or travel insurance policies?
- 6) I noticed on the website that drug tourism for HCV medications is available in the Cayman Islands. Is this a growing area for medical travel that is gaining traction among employers?
- 7) How do you anticipate Satori's bankruptcy will impact outbound US medical tourism? Does it provide new market share opportunities and/or is it likely to make employers more skeptical of the industry?
- 8) What, if any, legal concerns have you encountered as a facilitator?
- 9) What trends do you expect to see for US outbound medical travel in the next 5 to 10 years?
- 10) Is there anything else that was not asked but that you consider important?

Appendix 4: Code Book

<b>Code</b>	<b>Subcode</b>	<b>Definition</b>	<b>When to Use</b>	<b>Example of Quotes</b>
Media		Media coverage of international medical travel	When reference to radio, book, article and other media sources	"I heard a little bit on NPR radio . . . I read that there was a book . . . Patients Beyond Borders;" (Employer 3) "the AARP magazine came out with a picture of a patient in front of the Taj Mahal." (Employer 8)
Cost savings		Savings related to international medical travel	When reference to cost savings	"simple, money;" (Employer 3) "huge savings;" (Employer 14) "save us and the employees money." (Employer 7)
Trust or experience regarding facilitator		Trust and experience as criteria for choosing particular international medical travel facilitator	Trust, experience, or related term associated with choice of facilitator	"the other companies we talked to didn't really have any experience;" (Employer 14) "we, I, looked out for a facilitator that was credible, had some credibility behind them." (Employer 3)
Incentives		Tangible benefits received when opting for international medical travel	Copays, cash back and other types of tangible benefits received if choosing international medical travel	"we waived the copay and we would pay for the companion, but [in] 2011, maybe 2012, we changed that a little bit where we would share 10% of our savings with the patient." (Employer 3)
Benefit uptake		Employees and eligible dependents opting to use international medical travel benefit	Mechanism, method, or individual influencing benefit uptake	"We also realize that if we kind of prime the pump with some people talking about it, or use the dental, maybe they'll be more apt to venture off and consider medical treatment." (Employer 3)
Liability	Protections	Legal concerns associated with offering international medical travel benefit. Any protections to safeguard against liability risks	Employer concerns of liability. Insurance policies and possible defenses to liability claims.	"We had no legal concerns;" (Employer 7) "stop-loss we purchase;" (Employer 14)

<b>Code</b>	<b>Subcode</b>	<b>Definition</b>	<b>When to Use</b>	<b>Example of Quotes</b>
Competition		US acknowledgement or response to international competition for patients	US actions taken in response to patients leaving the US for healthcare	"The US is realizing they are losing business ... let [local providers] do this for you;" (Employer 8)
Comparison to US medicine		International healthcare experiences compared to domestic experiences	Illustrated differences between healthcare received in US and abroad	"When you get care internationally it is a different experience...In other countries the number of secondary people is higher. Unlike here where if you scream you might get somebody to come into your room." (Employer 7)
Individualism		Employers distinguishing themselves as individual actors in offering international medical travel	Reference to individual action taken by one employer but not by others in community	"Other cities/counties say their local hospital will shoot me/ counsel won't allow it. But we just did it because it was the right thing to do." (Employer 7)
Quality		Quality concerns either in domestic or foreign facility	Reference to quality in US or in foreign facility/provider	Foreign provider was a "world expert." (Employer 7) "We have fewer complications [abroad]. Employees come back and say what is wrong with our system." (Employer 8) It is difficult to get quality information in the US because "some of the physicians aren't doing that great of a job and they don't want to air their dirty laundry." (Employer 3)