

**IMPLEMENTING MEDICAL TOURISM REGULATION IN THE
FACE OF THE VOLUME SHOCK PROBLEM**

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* J.D. Candidate, 2016, Seton Hall University School of Law. To my brothers, Benjamin and Matthew, who will always be my pilots, my helmsman, my navigators. To my friends, who have offered their advice and companionship throughout my law school career. And to my parents, Margaret and Michael, who taught me everything.

I. INTRODUCTION

In 2013, Joy Guion, an employee at HSM Solutions, a diversified manufacturing company, traveled to Clinica Biblica, a hospital in San Jose, Costa Rica for gastric sleeve surgery.¹ The surgery, which would have cost approximately \$30,000 in the United States, cost only \$17,386 in Costa Rica.² This included the cost of in-patient stay in a “pristine room” in a “state-of-the-art hospital.”³ Even with insurance, Guion would have paid \$3,000 out of pocket in the United States.⁴ However, in Costa Rica, Guion pays nothing; the company foots the bill not only for the medical expense, but transportation and lodging as well.⁵ Guion is part of an ever-increasing wave of Americans who are electing to receive medical care internationally.⁶ Although the reasons many Americans, including Guion, travel abroad for medical care vary, the most powerful incentive, by far, is cost.⁷

U.S. patients continue to spend a disproportionately large percentage of their wealth on health care compared to those of other

¹ *Nightline: US Companies Look to ‘Medical Tourism’ to Cut Costs* (ABC television broadcast Oct. 10, 2013), available at <http://abcnews.go.com/Nightline/video/us-companies-medical-tourism-cut-costs-20427966>; *Ask a Patient: Americans Turn to Medical Tourism for Healthcare Relief*, MED. TOURISM MAG. (Sept. 12, 2014), available at <http://www.medicaltourismmag.com/blog/2014/09/ask-patient-americans-turn-medical-tourism-relief-bleeding-healthcare-system/>.

² *Medical Tourism Surgeries Pay Off Overseas for U.S. Employers*, MED. TOURISM MAG. (Oct. 1, 2013), available at <http://www.medicaltourismmag.com/news/2013/10/medical-tourism-surgeries-pay-off-overseas-for-u-s-employers/>.

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ Linda F. Powers, *Leveraging Medical Tourism*, THE SCIENTIST, Mar. 1, 2006, at 79, available at <http://www.the-scientist.com/?articles.view/articleNo/23768/title/Leveraging-Medical-Tourism/>. In 2004, Powers estimated that Thailand alone received over one million medical tourists from Australia, Europe, and the United States. *Id.* Powers went on to predict that in the “next five to seven years” medical tourism would increase six-fold to approximately six million by 2012. *Id.* See also Nathan Cortez, *Cross Border Health Care and the Hydraulics of Health Reform*, in THE GLOBALIZATION OF HEALTH CARE 65, 70 (I. Glenn Cohen, ed., 2013) (“[S]urvey results lend some credibility to the anecdotal evidence that U.S. patients increasingly travel for health care.”). But see Reenita Das, *Medical Tourism Gets a Facelift. . .and Perhaps a Pacemaker*, FORBES (Aug. 19, 2014, 2:48 PM), <http://www.forbes.com/sites/reenitadas/2014/08/19/medical-tourism-gets-a-facelift-and-perhaps-a-pacemaker/> (stating that in 2014 only 1.25 million Americans traveled overseas for medical care). While it is clear that medical tourism is increasing, it remains unclear the extent to which U.S. patients are actually going overseas.

⁷ 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, 613 (2011); Kerrie S. Howze, *Medical Tourism: Symptom or Cure?*, 41 GA. L. REV. 1013, 1017 (2007).

industrialized nations.⁸ As an illustrative example, the cost of a Caesarean section in the United States averages approximately \$15,041.⁹ In contrast, the cost of the same procedure in France or South Africa is \$6,441 and \$3,449, respectively.¹⁰ These estimates indicate U.S. patients could receive a 57% to 78% discount for the same treatment by going overseas. In fact, some research suggests that foreign care could undercut U.S. prices by up to 90%.¹¹ Data establishing the phenomenal cost savings available to U.S. patients by going overseas is overwhelming.¹²

In addition to tremendous cost savings, the factor that makes medical tourism stand out as an attractive and viable solution for the rising cost of health care is the distinct lack of legal and regulatory barriers.¹³ There are virtually no federal laws, state laws, or regulations purporting to oversee medical tourism.¹⁴ Indeed, Texas is the only state that has made any effort to place a legal or regulatory restriction on medical tourism.¹⁵ In 2007, the Texas Insurance Department promulgated a regulation that prohibits “[a] health benefit plan issuer [from issuing or offering for sale] a health benefit plan that *requires* an enrollee to travel to a foreign country to receive a particular health care service”¹⁶ However, the language

⁸ See, e.g., Susan Adler Channick, *Health Care Cost Containment: No Longer an Option but a Mandate*, 13 NEV. L. J. 792, 792–805 (2013) (explaining the unsustainable trajectory of U.S. health costs).

⁹ Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES, July 1, 2013, at A1, available at <http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html>.

¹⁰ *Id.*

¹¹ Christopher J. Brady, *Offshore Gambling: Medical Outsourcing Versus ERISA’s Fiduciary Duty Requirement*, 64 WASH. & LEE L. REV. 1073, 1107 (2007).

¹² See, e.g., Rosenthal, *supra* note 9 (comparing the cost of delivering a child in the United States to six other countries); Williams, *supra* note 7, at 613; Mohd Jamal Alsharif, Ronald Labonté & Zuxun Lu, *Patients Beyond Borders: A Study of Medical Tourists in Four Countries*, 10 GLOBAL SOC. POL’Y 315, 325 (2010); Thomas R. McLean, *The Global Market for Health Care: Economics and Regulation*, 26 WIS. INT’L L. J. 591, 596–97 (2008); Brady, *supra* note 11, at 1094.

¹³ See I. Glenn Cohen, *Medical Tourism, Access to Health Care, and Global Justice*, 52 VA. J. INT’L L. 1, 36 (2011) (“True, the U.S. government has not taken steps to prevent travel to India for medical procedures”); Angeleque Parsiyar, *Medical Tourism: The Commodification of Health Care in Latin America*, 15 LAW & BUS. REV. AM. 379, 397 (2009) (stating that there is currently no formal regulation of the medical tourist industry).

¹⁴ Cohen, *supra* note 13, at 36 (“In medical tourism by patients paying out of pocket, we do not have the U.S. government or international bodies directly creating push and pull factors.”); see also Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L. J. 71, 81–90 (2008) (describing recent trends that facilitate medical tourism).

¹⁵ TEX. INS. CODE ANN. § 1216.004 (West 2009).

¹⁶ *Id.* (emphasis added).

of the regulation only prohibits insurance companies or employers from requiring out of country care.¹⁷ Put differently, providing an overseas health care option concomitantly with domestic care is permissible.¹⁸ In the same vein, California is the only state to have officially sanctioned medical tourism.¹⁹

In the absence of legal limitations, various insurance company pilot programs incentivize patients to use medical tourism options.²⁰ Guion's case is hardly unique.²¹ As early as 2006, Blue Ridge, a self-insured manufacturer of paper products, offered to send one of its employees to India to undergo elective shoulder surgery to correct a rotator cuff injury and to have his gallbladder removed.²² The company stood to save approximately \$80,000 and offered to share \$10,000 of the savings with the employee.²³ In this respect, medical tourism is recognized as a "trade-off for consumers, allowing patients to *opt out of increased regulation* in favor of looser restrictions and greater cost savings."²⁴

Despite the undeniable cost savings, numerous scholars have theorized that medical tourism, if widespread, could result in

¹⁷ *Id.*

¹⁸ *Id.* As of this writing, the matter has never been litigated.

¹⁹ The California regulation states that a Mexican health plan may treat a California citizen provided that the Mexican health provider obtains proper state licensure. CAL. HEALTH & SAFETY CODE § 1351.2(a) (West 2008); Rebecca Bennie, *Medical Tourism: A Look at How Medical Outsourcing Can Reshape Health Care*, 49 TEX. INT'L L.J. 583, 597 n.145 (2014); see also Cortez, *supra* note 14, at 100 ("Three insurers in California pay for U.S. residents to obtain care in Mexico.") (citation omitted).

²⁰ For example, the Medical Tourism Association's website references a pilot program with the goal of "certifying medical tourism facilitators." Roy G. Spece, Jr. *Medical Tourism: Protecting Patients from Conflicts of Interest in Broker's Fees Paid by Foreign Providers*, 6 J. HEALTH & BIOMEDICAL L. 1, 16 n.73 (2010) (citation omitted); see also Brady, *supra* note 11, at 1103 (referencing the 2006 Blue Ridge Paper Products incident); MAGGI ANN GRACE, STATE OF THE HEART: A MEDICAL TOURIST'S TRUE STORY OF LIFESAVING SURGERY IN INDIA (2007) (referencing the mitral valve replacement of Howard Staab in New Delhi); Walecia Konrad, *Going Abroad to Find Affordable Health Care*, N.Y. TIMES, Mar. 20, 2009, at B6, available at <http://www.nytimes.com/2009/03/21/health/21patient.html>.

²¹ See *infra* notes 22–24, 26 and accompanying text.

²² Walecia Konrad, *Employers Make a Push for 'Medical Tourism'*, FORTUNE SMALL BUS. MAG., May 1, 2007, available at <http://money.cnn.com/magazines/fsb/fsbarchive/2007/05/01/100003808/>; Saritha Rai, *Union Disrupts Plan To Send Ailing Workers to India for Cheaper Medical Care*, N.Y. TIMES, Oct. 11, 2006, at C6, available at <http://www.nytimes.com/2006/10/11/business/worldbusiness/11health.html>.

²³ However, at the last minute, the United Steelworker's Union threatened to bring a lawsuit alleging that foreign surgical facilities would provide substandard medical care. McLean, *supra* note 12, at 600.

²⁴ See Williams, *supra* note 7, at 611 (emphasis added).

devastating effects to the global health care framework.²⁵ As a result of these potentially negative effects, these scholars have warned against wholesale adoption of medical tourism as a health access solution.²⁶ However, the warnings of the academic community, while troubling, have not been able to halt medical tourism's rapid expansion.²⁷ Medical tourism has already taken off as an increasingly important piece of the health care delivery puzzle.²⁸ In fact, since health care costs will remain high in the future, medical tourism will likely continue.²⁹ Arguably, it must continue in order

²⁵ See, e.g., Frank Pasquale, *Access to Medicine in an Era of Fractal Inequality*, 19 ANNALS HEALTH L. 269, 294–298 (2010) (suggesting that while medical tourism has the potential to dramatically reshape health delivery vis-à-vis cost, it also creates issues of access inequality); Nathan Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, 10 YALE J. HEALTH POL'Y L. & ETHICS 1, 41 (2010) (“Though medical tourism draws new revenues to Thailand, critics argue that it crowds out the medical care available to ordinary Thais.”); Tyler Grant, Note, *Made in America: Medical Tourism and Birth Tourism Leading to a Larger Base of Transient Citizenship*, 22 VA. J. SOC. POL'Y & L. 159, 170 (2015) (“As Taiwan-China relations improve, and the Taiwanese economy worsens, an increasing number of Taiwanese citizens are using their dual citizenships in the United States, Australia, and other countries to work abroad and then return to Taiwan for cheap medical treatment.”).

²⁶ See Cohen, *supra* note 13, at 6–7 (stating that medical tourism is limited by certain moral or “global justice” obligations of source countries towards destination countries); see also M. Neil Browne, Chelsea K. Brown & Facundo Bouzat, *American Medical Tourism: Regulating a Cure That Can Damage Consumer Health*, 25 LOY. CONSUMER L. REV. 319, 339–47 (2013) (stating that medical tourism is limited by the comparative health, legal, and regulatory risks incurred by overseas patients). This Note recognizes that the medical tourism industry is not yet fully mature, but evidence shows that issues of quality of care seem to be unfounded. See, e.g., Elisabeth Rosenthal, *In Need of a New Hip, but Priced Out of the U.S.*, N.Y. TIMES (Aug. 3, 2013), <http://www.nytimes.com/2013/08/04/health/for-medical-tourists-simple-math.html> (stating that while some tourists' destinations—the article studied Belgium—lack amenities, infection rates are lower than in the United States, possibly indicating a difference in quality); *Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the S. Spec. Comm. on Aging*, 109th Cong. 12–13 (2006) (statement of Magi Ann Grace).

²⁷ See Vadim Schick, *Data Privacy Concerns for U.S. Healthcare Enterprises' Overseas Ventures*, 4 J. HEALTH & LIFE SCI. L. 173, 175 (2011) (“In this regard, India's medical tourism sector is expected to grow 30 percent annually from 2009 to 2015”); Maria Lenhart, *Survey Sees Robust Growth for Medical Tourism*, TRAVEL MARKET REPORT (Apr. 4, 2013), <http://www.travelmarketreport.com/articles/Survey-Sees-Robust-Growth-for-Medical-Tourism> (“Sixty percent of respondents to the Medical Tourism Climate Survey 2013 reported growth in international patients during the past 12 months.”).

²⁸ McLean, *supra* note 12, at 599 (suggesting that the global market for medical tourism already has economic clout). See also Bennie, *supra* note 19, at 587.

²⁹ See, e.g., Elisabeth Rosenthal, *The \$2.7 Trillion Medical Bill*, N.Y. TIMES (June 1, 2013), <http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html> (stating that health care spending is “still expected to rise faster than the gross domestic product”).

to ensure access to health care.³⁰ The problem then becomes how medical tourism will scale to take advantage of its reduced costs, while recognizing the harm to the global health care framework.

This Note addresses the specific problem that medical tourism poses to the global health care framework. It then proposes a solution to that problem through a regulatory mechanism. Part II describes volume shock, a key danger of medical tourism to the global health framework, and a problem that could potentially destabilize the current medical tourism system causing service shortages to U.S. patients. Part III describes the proposed solution to this problem involving a two stage regulatory mechanism. This regulatory mechanism theorizes that *de minimis* regulation coupled with patient behavior can be used to internally self-regulate medical tourism. Specifically, the effect of moral hazard and patient trepidation may operate to limit patient volume without a tremendously complex regulatory scheme.³¹ Should *de minimis* regulation fail, Part III proposes various theories that could be helpful in determining the outer boundaries of a replacement regulatory scheme. Part IV offers a brief conclusion.

II. THE VOLUME SHOCK PROBLEM

Although medical tourism has been growing, there is no consensus regarding a marked negative effect to American patients or destination health delivery.³² Consequently, it may very well be that the recent observed growth of health tourism is simply a product of increasing globalization in a digital age, health care included.³³ If so, this Note is not objecting to globalization itself. Rather, this Note explores the concept of volume shock—a rapid increase in patient volume causing the failure of both global and

³⁰ Williams, *supra* note 7, at 611.

³¹ See discussion *infra* Part III(B).

³² 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, 287 (2013) (“[T]here appears to be consensus among academics that current understanding about medical tourism and its effects . . . largely derives from ‘theory, assumption or conjecture.’”); Pasquale, *supra* note 25, at 273 (“Medical tourism has dual effects . . . both diverting doctors away from indigenous populations and supplying capital that may build health infrastructure in those nations.”).

³³ See Cohen, *supra* note 13, at 7 (suggesting that medical tourism is part of a larger move toward the globalization of health care, but also including such phenomena as “brain drain,” medical outsourcing, research tourism, and parallel trade in approved pharmaceuticals). See generally, JOSEPH E. STIGLITZ, *MAKING GLOBALIZATION WORK* (1st ed. 2007) (discussing economic globalization and its effect on developing nations).

domestic health care frameworks—and to what extent it may be monitored and limited.

Previous scholarship has described the danger of medical tourism and its effect on the tripartite concerns of quality, cost, and access.³⁴ Certainly, these factors can be used to explain the medical tourism problem.³⁵ However, this Note uses the singular factor—patient volume—to discuss the effect of medical tourism on U.S. health care.

Medical tourism serves an increasingly important role as a relief valve for the U.S. health care economy.³⁶ Arguably, since at least 2006, medical tourism has provided an avenue of financial relief to those individuals otherwise priced out of the U.S. health system.³⁷ Medical tourism already provides a powerful alternative for obtaining cheap health care. Any corrective action to modify its current course should take into account its benefit to the U.S. public without adhering to an abstract notion of global justice.³⁸ However, there is a reason to curb medical tourism's expansion. As the popularity of medical tourism grows, the volume of patients will grow proportionately, presenting a threat to the U.S. health care

³⁴ The sources that describe these effects are numerous. They generally indicate that quality of care is more of a perceived issue than an actual issue. In fact, the quality of care received by individuals like Guion is often on par with or superior to the care received in the United States. See *Ask a Patient: Americans Turn to Medical Tourism for Healthcare Relief*, *supra* note 1. See also Cortez, *supra* note 14, at 82–86. As described above, cost of care in destination countries is usually significantly reduced. See *supra* notes 8–12 and accompanying text. Volume and volume shock as discussed in this Note has the most noticeable effect on health care access. See Cortez, *supra* note 14, at 108. Access is also perhaps the most difficult term to define in health law. Martin Gulliford et al., *What Does 'Access to Health Care' Mean?*, 7 J. HEALTH SERV. RESEARCH & POLICY 186, 186–88 (2002). However, while it is true that international care decreases geographic access, the significant reduction in cost results in an overall increase in access to care from a financial standpoint. For a more nuanced discussion of how medical tourism affects health care access, see Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71, 107–14 (2008).

³⁵ See, e.g., Cortez, *supra* note 14, at 108.

³⁶ See Rosenthal, *supra* note 26; Bennie, *supra* note 19, at 587 (“The allure of low-cost medical care to potential medical tourists is undeniable, especially to the uninsured and underinsured.”); Cortez, *supra* note 14, at 77 (“In India alone, the number of medical tourists visiting the country tripled between 2002 and 2006, and is expected to rise by 600% over the next few years.”).

³⁷ See Brady, *supra* note 11, at 1103 (discussing Blue Ridge Paper Products, the first widely publicized medical tourism case). Cf. Cortez, *supra* note 14, at 77 (suggesting that medical tourist data has been available since 2002).

³⁸ See Cohen, *supra* note 13 (discussing the effect of health tourism from a global justice perspective).

system.³⁹ Scholars have yet to articulate the parallel problem that medical tourism poses in the United States and other source countries.⁴⁰ The general substance of this problem follows.

Currently, a large portion of funding for community hospitals, especially emergency departments—the U.S. health safety net—comes from cross-subsidized specialty care.⁴¹ Although the phenomenon is complex, the general thrust is that revenue generated from specialty departments, such as neurology, cardiology, and orthopedic surgery is used to keep “unprofitable” but socially desirable services, namely emergency departments, afloat.⁴²

As the cost of health care rises, more people will be priced out of domestic private insurance.⁴³ Without domestic health care options, individuals who have been priced out will increasingly seek care overseas due to the attractive prices of medical tourism.⁴⁴ This Note posits that as the amount of patients seeking international solutions for medical care increases, the number of patients requiring domestic specialty care decreases. Less specialty care patients means less overall revenue for community hospitals, jeopardizing the cross-subsidization scheme of hospital emergency departments.⁴⁵ The potential for medical tourism to cause the

³⁹ See discussion *infra* Part II.

⁴⁰ See, e.g., Cohen, *supra* note 13; Chen & Flood, *supra* note 32, at 288–90 (discussing how health tourism may create increased competition for health resources between foreign patients and domestic patients but not discussing the effect to domestic—or source—health services).

⁴¹ See Erik J. Olson, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449 (1994) (“The emergency rooms of American hospitals have frequently become the principal suppliers of nonurgent primary care to the under- and uninsured.”). See also Elizabeth Weeks, *After the Catastrophe: Disaster Relief for Hospitals*, 85 N.C.L. REV. 223, 231 (2006) (footnote omitted).

⁴² See generally MICHAEL E. PORTER & ELIZABETH OLMSTED TEISBERG, *REDEFINING HEALTHCARE*, 65–66 (2006) (“Patients covered by the public sector are subsidized by private sector patients. Within the private sector, patients enrolled in large health plans are perversely subsidized by members of small groups, the uninsured, and out-of-network patients, who pay higher [than] even list prices.”). Guy David et al., *Do Hospitals Cross Subsidize?*, 37 J. HEALTH ECONOMICS 198 (2011), available at <http://www.nber.org/papers/w17300.pdf>; Suzanne Strothkamp, *Understanding the Physician-Owned Specialty Hospital Phenomenon: The Confluence of DRG Payment Methodology and Physician Self-Referral Laws*, 38 J. HEALTH L. 673, 677–82, 684–85 (2005).

⁴³ See Bennie, *supra* note 19, at 587 (“In the face of prohibitively high healthcare costs, Americans are traveling abroad for medical care by the hundreds of thousands . . .”).

⁴⁴ *Id.*

⁴⁵ This parallels the debate over the rise of single specialty hospitals in the late 1990s. See, e.g., Unmesh Kher, *The Hospital Wars*, TIME, Dec. 05, 2006; Mike J. Wyatt,

failure of domestic health delivery systems is the volume shock problem. In the worst case scenario, dwindling cross-subsidization will cause hospital emergency departments to close.⁴⁶

An effective medical tourism regulatory scheme must balance two competing interests. On the one hand, medical tourism can be used as a tool to increase the access of individuals to medically necessary (or eventually medically necessary) procedures.⁴⁷ On the other hand, medical tourism must be monitored so that action can be taken to avoid volume shock. This Note proposes a methodology to balance these opposing interests.

Before presenting any theory on regulatory structure, it is important to recognize that volume shock is peculiarly affected by a patient's ability to pay for care.⁴⁸ Thus, any discussion of where volume shock potentially originates must begin with a discussion of health insurance.⁴⁹ Essentially, three broad categories of individuals benefit from medical tourism.⁵⁰ At one extreme, there are those with insurance, either public or private, that will cover the cost of a procedure without any co-payment on the part of the consumer.⁵¹ These individuals are not addressed by this Note as they will invariably receive domestic treatment and therefore have little overall effect on total patient volume.

That leaves two types of individuals who receive medical care overseas.⁵² The first involves uninsured or underinsured

Leveling the Healing Field: Specialty Hospital Legal Reform as a Cure for an Ailing Health Care System, 46 WASHBURN L.J. 547 (2007).

⁴⁶ See generally David et al., *supra* note 42; Mona Al-Amin et al., *Specialty Hospital Market Proliferation: Strategic Implications for General Hospitals*, 35 HEALTH CARE MGMT. REV. 294, 298–99 (2010) (discussing the negative economic effect of single specialty hospitals on non-profit general hospitals with emergency departments).

⁴⁷ Cf. Cortez, *supra* note 14, at 108 (“[M]edical tourism should improve access to care for two significant populations: the uninsured and the underinsured.”).

⁴⁸ See, e.g., Rosenthal, *supra* note 26 (expanding on pricing problems and the reluctance of insurers to pay for procedures).

⁴⁹ *Id.*

⁵⁰ This is based loosely on the framework proposed by Kopson. See Mark S. Kopson, *Medical Tourism: Implications for Providers and Plans*, 3 J. HEALTH & LIFE SCI. L. 147, 159–62 (2010).

⁵¹ One such example of public health insurance is Medicare and Medicaid. According to a statistical brief by the Agency for Healthcare Research and Quality, Medicare pays for the cost of approximately 63.4% of all hip replacements; Medicaid pays for 6.8%. Combined, federal health programs pay for over 70% of all hip replacements in the U.S. CHAYA MERRILL & ANNE ELIXHAUSER, HOSPITAL STAYS INVOLVING MUSCULOSKELETAL PROCEDURES, at 9 (2007), available at <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb34.pdf> (based on data available from 2004).

⁵² Note that this model is an oversimplification: it assumes that income demographics are classifiable into discrete buckets, although the demographics of

individuals.⁵³ These individuals cannot afford domestic health insurance but may have the savings to obtain treatment abroad.⁵⁴ The second involves insured individuals being incentivized to take part in overseas treatment as part of their insurance plans: what this Note refers to as the incentivized insured.⁵⁵ This latter group poses the greatest threat to the global health framework because it has the potential to inflate patient volume tremendously.⁵⁶ These two groups can each be further divided into three sub-groups, giving a total of six groups.

Uninsured or underinsured individuals:

- seeking *purely* medically unnecessary care
- seeking eventually medically necessary care
- seeking medically necessary care

Insured individuals being incentivized to take part in medical tourism programs:

- seeking *purely* medically unnecessary care
- seeking eventually medically necessary care
- seeking medically necessary care

A. *Eliminating Types of Treatment from the Framework Analysis*

For uninsured or underinsured individuals seeking medically necessary care overseas the system should remain intact. Assuming that medical tourism ought to be used as a device to increase access to medically necessary health services, it is axiomatic to conclude that the law should not prohibit individuals from taking advantage of potentially lifesaving care.⁵⁷ In fact, this sort of care should be

income likely exist as a continuum. Further, this model fails to recognize the impact of medical tourism on undocumented immigrants, a conversation that is, regrettably, beyond the scope of this Note. However, it is useful for the purposes of illustration to consider how these groups affect the medical tourism economy.

⁵³ I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1473 (2010) (indicating the possibility of medical tourism growth from uninsured and underinsured patients).

⁵⁴ *Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the S. Spec. Comm. on Aging*, 109th Cong. 3–5 (2006) (testimony of Magi Ann Grace).

⁵⁵ See also Cohen, *supra* note 53, at 1473 (dubbing the same phenomenon “insurer-prompted medical tourism”). Cohen also demarcates treatment as invasive, diagnostic, or lifestyle. “Lifestyle” ostensibly includes “nutrition, weight reduction and anti-aging treatments” and in this case may be a subset of the type of treatment described in this Note as “medically unnecessary.” Cohen *supra* note 53, at 1479–80. It is unclear how treatment containing an invasive element and a lifestyle element, e.g., facelifts, are properly categorized under the framework established by Cohen.

⁵⁶ *Id.* at 1486.

⁵⁷ This is especially true if the care is preventative care or non-emergency care,

prioritized.⁵⁸ This is especially true where domestic markets have failed by pricing out their own consumers.⁵⁹

Since underinsured and uninsured patients lack sufficient insurance to cover a given procedure, they cannot obtain care domestically.⁶⁰ Where the individual can afford to have the procedure done overseas, it seems unduly restrictive to force the individual to wait until the procedure is medically necessary (and therefore covered by insurance) to obtain it. In these situations, patients seeking eventually medically necessary care face the same problem as patients seeking medically necessary care.⁶¹ Attempting to bar such care would deny access to health care that is obtainable.

Despite the connotation that uninsured and underinsured patients are less financially well off (compared to insured patients) and therefore more in need of health care coverage, medical tourism as a treatment option for these groups should not be absolute. The subgrouping above makes an important distinction between *purely* medically unnecessary care and *eventually* medically necessary care. Individuals who are uninsured or underinsured may still be less “deserving” of treatment if what they are seeking amounts to purely medically unnecessary care.⁶² This distinction is a way of triaging

which most medical tourism is. See Tony Hope, *Rationing and Life-Saving Treatments: Should Identifiable Patients Have Higher Priority?*, 27 J. MED. ETHICS 179, 183–84 (2001) (stating that preventative care is both ethically and financially more efficient than “rescue” care). Cf. Cortez, *supra* note 14, at 89 (stating that many medical tourists cannot receive emergency treatment overseas because they may be too frail or ill to travel).

⁵⁸ Cf. David et al., *supra* note 42, at 29–30 (espousing the benefits of community hospitals in providing socially desirable—though financially uncompensated—care). The priority of lifesaving care has been a hotly debated ethical issue. See, e.g., Eleanor D. Kinney, *Realizing the International Human Right to Health: The Challenge of For-Profit Health Care*, 113 W. VA. L. REV. 49, 56–57 (2010) (discussing the development of a rights-based approach or entitlement to health care).

⁵⁹ See Rosenthal, *supra* note 26 (presenting the case of Michael Shopenn, a 67 year old photographer and snowboarder priced out of the U.S. health system when insurance refused to cover his hip-replacement due to a pre-existing condition).

⁶⁰ See *supra* note 53.

⁶¹ Where treatment is integral to patient fitness, the only question that remains is when should that treatment be received? What are the ethical ramifications of allowing an individual to suffer while a diagnosis awaits approval for medical necessity? See Rosenthal, *supra* note 26 (“Mr. Shopenn . . . had been in such pain from arthritis that he could not stand long enough to make coffee, let alone work.”).

⁶² There is a tendency to view certain types of care—namely cosmetic—as less “deserving” of the type of attention that other non-cosmetic care receives. Cf. *Thomas v. Gen. Am. Life Ins. Co.*, 568 N.E.2d 937, 940 (Ill. 1991) (holding that an insurance company’s decision to refuse coverage of cosmetic surgery was not arbitrary and capricious); 26 U.S.C.A. § 213(d)(9)(A) (West 2011) (“The term ‘medical care’ does not include cosmetic surgery or other similar procedures, unless the surgery or

access to medical tourism procedures based on the type of treatment sought. Medically unnecessary care is usually thought of as care that is not essential for the purpose of treating affliction.⁶³ This Note challenges that existing definition of medically unnecessary.⁶⁴ Medically unnecessary care actually encompasses two distinct categories: pure medically unnecessary care and *eventually* medically necessary care.

The best way to illustrate this dichotomy is through a case study of lower extremity joint replacements (“LEJRs”), which include knee replacements and hip replacements: operations most likely to see a surge in demand.⁶⁵ A knee diagnosed with degenerative osteoarthritis may eventually require a total knee replacement (“TKR”).⁶⁶ The patient may choose to undergo the procedure preemptively, i.e., before it is explicitly required or indicated.⁶⁷ In this case, the issue of necessity becomes predicated on timing: should the knee be operated on now or later? Even when the procedure is undertaken in order to maintain a certain standard of living—a patient undergoes a preemptive TKR to continue playing tennis—it remains true that the procedure will be indicated or ordered eventually.⁶⁸ Advances in medical technology and the longevity of artificial implants means that a procedure done earlier will likely increase quality of life with no materially negative effect

procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.”).

⁶³ Liza Khan, *Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform*, 11 YALE J. HEALTH POL’Y L. & ETHICS 375, 399 (2011) (“Medically unnecessary interventions include, but are not limited to, procedures insurers conclude are cosmetic or experimental. The medical-necessity requirement is at once the broadest and least defined exclusion clause in most insurance plans.”).

⁶⁴ See *Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the S. Spec. Comm. on Aging*, 109th Cong. 14 (2006) (statement of Magi Ann Grace) available at <http://www.aging.senate.gov/imo/media/doc/hr159mg.pdf> (alleging that an insurance company would not pay for a removal of a tooth until it had been “impacted and abscessed”).

⁶⁵ See Rosenthal, *supra* note 26 (“With baby boomers determined to continue skiing, biking and running into their 60s and beyond, economists predict a surge in joint replacement surgeries . . .”).

⁶⁶ PEGGY A. HOUGLUM, THERAPEUTIC EXERCISE FOR MUSCULOSKELETAL INJURIES (3d ed. 2010), available at <http://www.humankinetics.com/excerpts/excerpts/total-knee-replacement-for-treatment-of-knee-osteoarthritis> (detailing total knee replacement treatment for knee osteoarthritis).

⁶⁷ See Elisabeth Rosenthal, *In Need of a New Hip, but Priced Out of the U.S.*, N.Y. TIMES (Aug. 3, 2013), <http://www.nytimes.com/2013/08/04/health/for-medical-tourists-simple-math.html>.

⁶⁸ Special thanks to Professor John Jacobi who first provided insight into this particular angle.

even if the procedure is undertaken before it is “medically necessary.”⁶⁹ The practical effect of distinguishing a treatment that is eventually medically necessary from one that is purely medically necessary is very close to zero. The mere fact that an individual has not yet been medically authorized to receive a procedure does not obviate the eventual need for such a procedure.⁷⁰ When a patient chooses to preemptively undergo a procedure before his or her fitness fails, it is said to be “eventually medically necessary.”⁷¹

This is in contrast to a procedure undertaken purely for aesthetic or cosmetic reasons.⁷² For example, procedures such as non-corrective rhinoplasty or breast augmentation are *purely* medically unnecessary.⁷³ While there is an argument that so long as the procedure is eventually undertaken the patient should remain a consumer of domestic health care, such an argument is tenuous. This is especially true because a majority of insurers (including Medicare and Medicaid) will not pay for procedures deemed medically unnecessary.⁷⁴

Returning to the example of LEJR, an insurance company will likely refuse to pay for the procedure even if it is eventually needed.⁷⁵ In fact, a CMS memo published in 2012 states that “[major joint replacement surgery: hip and knee] is reserved for patients whose symptoms have not responded to other treatments.”⁷⁶ However, an

⁶⁹ See Rosenthal, *supra* note 26 (“Some [artificial implants] use more durable materials so that a patient requiring a hip implant at age 40 or 50 might rely on it longer than the standard 20 years . . .”).

⁷⁰ *Id.*

⁷¹ See *infra* discussion accompanying Part II.

⁷² See *supra* note 62.

⁷³ Despite the advantages of using LEJR as an illustrative example, I cannot conceive of an LEJR being undertaken for cosmetic or aesthetic reasons.

⁷⁴ *Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing before the S. Spec. Comm. on Aging*, 109th Cong. 3 (2006) (statement of Magi Ann Grace) (“It is, of course, a mistake to say that our government does not provide [uninsured or underinsured] people with healthcare. We do. Only we do it in what may be the least efficient, the most expensive and least effective way possible: by refusing to provide any necessary care until a patient’s illness becomes a medical emergency.”).

⁷⁵ *Id.* See also Rosenthal, *supra* note 26 (stating that treatment for a joint replacement costing at least \$78,000, not including the surgeon’s fee, was denied by an insurance company because it was related to a pre-existing condition).

⁷⁶ Memorandum from the Ctr. for Medicare & Medicaid Servs. on Documenting Med. Necessity for Major Joint Replacement (Hip and Knee) (Sept. 17, 2012), available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1236.pdf> (“CMS recognizes that joint replacement surgery is reserved for patients whose symptoms have not responded to other treatments. To avoid denial of claims for major joint replacement surgery [hip and

individual electing to undergo an LEJR despite the contrary opinion of his or her insurance company may have the discretionary income to pay for at least part of the procedure out of pocket. A patient in this position may choose from two options.

The first option is to remain in the U.S. and receive treatment domestically. But this route is practically infeasible. The cost of a TKR in the United States is approximately \$25,398.⁷⁷ The cost of a total hip replacement (“THR”) is approximately \$26,489.⁷⁸ Given the tremendous cost of care, is it unlikely that domestic treatment without insurance will be a viable solution.⁷⁹

The second option is to go overseas, where the same treatment could cost thousands of dollars less.⁸⁰ In a 2013 report, the International Federation of Health Plans estimated that the cost of THR is \$8,010 in Spain, amounting to a savings of approximately 70%.⁸¹ The realistic option for individuals receiving medically unnecessary care is to go overseas, which adversely contributes to the total patient volume.

While eventually medically necessary care is subject to the same sort of supporting rationale as medically necessary care, it does not command the same level of exigency. Its priority of care is somewhat less than medically necessary care, although higher than that of cosmetic care.⁸² Regardless of priority and the associated ethical dilemmas, eventually medically necessary care may still be obtained as medically necessary care depending on time. If care is *eventually* medically necessary, the analysis should parallel medically necessary care: there should be no categorical bar on care

knee], the medical records should contain enough *detailed* information to support the determination that major joint replacement surgery was reasonable and necessary for the patient.”).

⁷⁷ INT’L FED’N OF HEALTH PLANS, 2013 COMPARATIVE PRICE REPORT: VARIATION IN MEDICAL AND HOSPITAL PRICES BY COUNTRY (2013). No significant change in price for TKR was found between the 2012 report and the 2013 report. *Id.*

⁷⁸ *Id.* at 21 (reporting that the price of a THR went down significantly from \$40,364 in 2012 to \$26,489 in 2013, over a 40% reduction in price). The cause of this decline and whether it has any effect on the future of medical tourism is unknown.

⁷⁹ See Williams, *supra* note 7, at 614 (stating that most individuals seeking medical tourism solutions are “lower-middle class”).

⁸⁰ See INT’L FED’N OF HEALTH PLANS, *supra* note 77.

⁸¹ *Id.*

⁸² See S. R. Mousavi, *The Ethics of Aesthetic Surgery*, J. CUTANEOUS & AESTHETIC SURGERY 38–40 (2010), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2890136/> (suggesting that cosmetic surgery is valued differently based on why it is being undertaken and stating that “[Ma]ny people” experience “real pain, discomfort, social handicap and suffering” due to aesthetic appearance, but others undergo cosmetic surgery for a “non-existent or minimal cosmetic ‘defect.’”).

deemed eventually medically necessary.

This Note treats “eventually medically necessary care” as equivalent to “medically necessary care” for the purposes of discussion. Due to the lack of empirical evidence on the effect of medical tourism, there is no clear rationale for separating the two.⁸³ As patient volume grows and the U.S. health care system contends with the possibility of volume shock, eventually medically necessary care may be triaged, reduced, or even eliminated based on its comparative exigency as compared to medically necessary care. But it is premature to make that determination now.

B. Restricting Access to Purely Unnecessary Care

In contrast to “medically necessary” and “eventually medically necessary care,” an argument can be made for restricting access to purely medically unnecessary care regardless of the patient’s insured status.⁸⁴ The guiding principle behind this argument is that medical tourism should be used as a release valve. Wherever possible, medical tourism should not be used to supplant domestic health services. Under this principle there are two rationales for curbing medical tourism for purely medically unnecessary care.

The first justification is utilitarian. Unlike medically necessary care, which is arguably essential to save, prolong, or improve quality of life, purely medically unnecessary care (or cosmetic care) is principally focused on enhancing appearance and improving aesthetics.⁸⁵ In that respect, purely medically unnecessary care is subject more heavily to the law of diminishing returns.⁸⁶ Whereas a sick person may benefit greatly in overall health from receiving

⁸³ See Cortez, *supra* note 6, at 70 (stating that current estimates of the frequency of medical tourism are unreliable). See also 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, 877–78 (2011) (citing industry studies varying wildly in their estimates of the total number medical tourist patients, from five thousand to six million, and noting that despite the variation in estimates, “most indicators point toward an unprecedented migration of U.S. patients”).

⁸⁴ See, e.g., Liza Khan, Note, *Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform*, 11 YALE J. HEALTH POL’Y L. & ETHICS 375, 390–91 (citing James P. Jacobson, *To Pay or Not To Pay, That is the Question: Coverage Disputes Between Health Plans and Members*, 29 HAMLIN J. PUB. L. & POL’Y 445, 448–49 (2007) (discussing exclusions for cosmetic and experimental treatments)).

⁸⁵ Christine Nardi, Note, *When Health Insurers Deny Coverage for Breast Reconstructive Surgery: Gender Meets Disability*, 1997 WIS. L. REV. 777, 783 n.34 (1997) (“Cosmetic surgery is defined as a procedure ‘performed to reshape normal structures of the body in order to improve the patient’s appearance and self-esteem.’”) (citations omitted).

⁸⁶ See Cohen, *supra* note 13, at 18–21.

medical treatment, even if that treatment is abroad, a healthy person seeking cosmetic surgery may not benefit to the same degree. In other words, the total utility of a procedure undertaken for pure cosmetic reasons is markedly less than a procedure undertaken for a medically necessary purpose.

Previous literature reveals a correlation between the number of medical tourism facilities specializing in a certain procedure and the external demand of that procedure.⁸⁷ Although it is true that this relationship is not causative, it is possible that an increase in medical tourism for a certain procedure is loosely related to the number of medical tourism destinations that provide that procedure. Assuming this assertion is true, increased demand for cosmetic surgery encourages the development of cosmetic surgery centers.⁸⁸ By the same token, increased demand for TKRs may promote the development of orthopedic surgery centers.⁸⁹ In this example, utility is maximized by establishing an orthopedic surgery center rather than a cosmetic surgery center because it allows indigenous people to avail themselves of a treatment solution that would be more likely to increase overall utility.⁹⁰

The second justification is normative. One goal of this Note is to examine a way to use medical tourism to increase access to medically necessary care. Allowing medical tourism for cosmetic surgery would do nothing to further this goal. For example, assume that there is a universal threshold for sufficient access to medically necessary procedures, i.e., the threshold for receiving “sufficient access” is equivalent across countries. Arguably, an individual accessing medical tourism services for cosmetic purposes has already met and exceeded the level of sufficient access to medically necessary care.⁹¹ On the other hand, the vast majority of poor

⁸⁷ Cohen, *supra* note 13, at 18–19.

⁸⁸ Laura Hopkins et al., *Medical Tourism Today: What Is the State of Existing Knowledge*, 31 J. PUB. HEALTH POL’Y 189, 194 (2010).

⁸⁹ *Id.* at 193 (suggesting that the commercial investment in medical tourism is likely what is causing the largest effect on tiered health care access); *see also* Cohen, *supra* note 13, at 9–10 (stating that the attractive option of providing cosmetic surgery to U.S. patients may attract destination physicians away from providing care to the indigenous poor). *Cf.* Rupa Chanda, *Trade in Health Services*, 80 BULL. OF THE WORLD HEALTH ORG. 158, 160 (2002) (stating that investment from corporate medical tourist facilities would most likely be diverted towards funding more “high-level technology” medical tourist ventures and not towards the public health sector).

⁹⁰ This assumes that the treatment will be available. But whether the price point will be feasible is largely a function of whether public and private services are linked. *See, e.g.*, Chanda, *supra* note 89, at 162.

⁹¹ *Cf.* Pasquale, *supra* note 25, at 305 (implying that cosmetic surgery might in fact

patients in destination countries do not have sufficient access to medically necessary care.⁹² Further, there has been no evidence that investing in medical tourism in general does anything to promote access to care by poorer indigenous individuals.⁹³ In fact, as suggested above, foreign investment in medical tourism facilities with specialties like cosmetic care may further reduce access of indigenous persons to medically necessary care.⁹⁴ In this case, allowing medical tourism for cosmetic care should be questioned because it does nothing to raise an indigenous population's threshold to sufficient access of medically necessary care.

If we assume that there is a threshold for health care access, it is likely that an individual seeking cosmetic treatment has already met that threshold for access to medically necessary care. On the other hand, a poor destination patient likely has *not* met that threshold for access. If we are to focus on raising the threshold of access, it seems to be a greater investment of resources to raise the access levels of individuals who are *below* the threshold of access rather than those who are at or have exceeded this threshold. In

be a diamond good: a good "valued not necessarily for [its] intrinsic beauty or worth but for [its] ability to show off one's wealth") (citing Richard Dusansky, Comment, *Diamonds Are a Government's Best Friend: Burden-Free Taxes on Goods Valued for Their Values*, 79 AM. ECON. REV. 1285, 1285 (1989) (discussing the economics of taxation on "diamond goods")).

⁹² China and India are representative of the medical tourism industry and the availability of health care access to indigenous populations. See Alsharif et al., *supra* note 12, at 319 (studying the effect of medical tourism on India, China, Jordan and the United Arab Emirates); see also IMS INSTITUTE FOR HEALTH CARE INFORMATICS, UNDERSTANDING HEALTH CARE ACCESS IN INDIA 24, 33–36 (2013) (stating that expensive private health care facilities significantly reduce overall access and affordability of health care in India); "Ticking Time Bombs": China's Health Care System Faces Issues of Access, Quality and Cost, WHARTON SCHOOL OF BUSINESS, <http://knowledge.wharton.upenn.edu/article/ticking-time-bombs-chinas-health-care-system-faces-issues-of-access-quality-and-cost/> (last visited June 20, 2015) (giving an anecdotal account of health care access issues in China); Juan Pablo Gutiérrez et al., *Effective Access to Health Care in Mexico*, 14 BMC HEALTH SERV. RES. 1, 8 (2014) (suggesting with 95% confidence that only 51.51% of Mexican citizens have access to effective health care).

⁹³ This trickle-down effect assumes that general investment in medical tourism will benefit the entire destination country and not only the destination facility. But this is unsubstantiated. In fact, there seems to be evidence to the contrary—that trickle-down economics is not effective in increasing medical tourism access to poorer individuals. See Debora Lipson, quoted in ABC Radio National Background Briefing on Medical Tourism, Feb. 20, 2005, at <http://www.abc.net.au/cgi-bin/common/printfriendly.pl?http://www.abc.net.au/rn/talks/bbing/stories/s1308505.htm> ("It's just not the case that [profits from medical tourism] are tapped and redirected to health services for the poor, it just does not happen."); see also STIGLITZ, *supra* note 33, at 23, 273 (stating that trickle-down economics has been repeatedly shown to be ineffective).

⁹⁴ Hopkins et al., *supra* note 88, at 194; see also *supra* text accompanying notes 87–89.

sum, the use of medical tourism to address medically necessary and eventually medically necessary health conditions should not be discouraged.

In brief summary, there are two different groups of persons seeking overseas care: (1) individuals who are uninsured or underinsured; and (2) the insurance incentivized. In addition, each group can be further separated into three sub-groups based on the type of care they are seeking. However based on the analysis above, it would be ethically difficult to refuse lifesaving treatment for uninsured or underinsured individuals.⁹⁵ In contrast, it is justifiable to remove cosmetic or purely medically unnecessary operations insofar as they: (1) do not markedly increase the volume of patients traveling abroad for medical tourism; and (2) because medically unnecessary care tends to raise utilitarian and normative issues.⁹⁶ We are left then with the question of how regulation can apply to limit volume shock from insurance incentivized individuals seeking medically necessary or eventually medically necessary care. Given this landscape, how can a regulatory environment be constructed to allow the growth of medical tourism, while simultaneously limiting damage to the global health care framework?

III. DESIGNING A REGULATORY SYSTEM IN THE FACE OF VOLUME SHOCK

Currently, because the detrimental impact of medical tourism to destination countries is unclear, there is no reason to categorically eliminate access to medical tourism services.⁹⁷ Medical tourism services can serve as a relief valve for priced out customers where domestic health care markets have failed.⁹⁸ However, this Note, along with previous literature, recognizes that medical tourism is also accompanied by numerous dangers.⁹⁹ Rampant medical tourism may lead to widespread failures of the global health care framework.¹⁰⁰

⁹⁵ See discussion *supra* Part II. *Florida v. United States*, 648 F.3d 1235, 1358 (11th Cir. 2011) (citing EMTALA, 42 U.S.C. § 1395dd) (“[N]early all hospitals are required by law to provide emergency services to anyone, regardless of ability to pay.”).

⁹⁶ See discussion *supra* Part II.

⁹⁷ See generally, Chen & Flood, *supra* note 32, at 287 n.14 (“[T]here appears to be consensus among academics that current understanding about medical tourism and its effects on LMICs [low- and middle-income countries] largely derives from ‘theory, assumption or conjecture.’”).

⁹⁸ See *supra* note 36–40.

⁹⁹ See Browne et al., *supra* note 26, at 325–46 (discussing dangers stemming from the lack of regulations in medical tourism overseas).

¹⁰⁰ See discussion *supra* Part II.

One solution to this threat is to create a regulatory mechanism that does not eradicate the practice of medical tourism, but instead actively minimizes the risk of volume shock by adjusting outbound patient volume. This part will describe a two stage regulatory system that attempts to accomplish this goal. This solution will be applied to the two categories of medical tourism beneficiaries enumerated above: (1) uninsured and underinsured patients and (2) patients being incentivized by insurance programs.¹⁰¹

The first stage is intended as an immediate patch: a temporary solution that may become permanent if no further intervention is necessary. The second stage is intended to address the long-term problem and consists of more invasive regulatory procedures. The mechanics of the second stage of the regulatory scheme are not constructed in this Note. Rather, various control mechanisms are suggested and the reader is invited to consider the contours of a more comprehensive regulatory solution.

A. *The Context of Medical Tourism Regulation*

In the first stage, the United States should adopt a self-interested philosophy by passively or prospectively applying regulation while not discouraging the use of medical tourism. As suggested above, the market has already embraced medical tourism as a release valve for the ever-increasing cost of health care.¹⁰² In fact, the utility of medical tourism, especially in its lower costs, arguably *cannot* be disregarded due to increasing reliance on foreign care.¹⁰³ Recognizing these substantial cost savings, the next obvious step is to encourage the use of medical tourism as a solution to the problem of cost in health care; however, this is precisely what health policymakers should avoid. Due to volume shock and the various externalities generated by significant reliance on foreign medical frameworks, medical tourism is *not a solution*.¹⁰⁴ Allowing insurance

¹⁰¹ See discussion *supra* Part II (discussing categorization of medical tourism beneficiaries based on insurance and treatment sought).

¹⁰² See discussion *supra* Part II, especially notes 36–39. Much existing literature has documented the expansion of the medical tourism market, suggesting that consumers have embraced medical tourism as a viable alternative to receiving domestic treatment. See, e.g., Thomas McLean, *The Global Market for Health Care: Economics and Regulation*, 26 WIS. INT'L L.J. 591, 596 (2008) (“Until this current crisis in health insurance affordability is resolved, it is likely to drive the expansion of the medical tourism market.”) (footnote omitted).

¹⁰³ See, e.g., Cohen *supra* note 53, at 1525 (stating that a ban on medical tourism for uninsured Americans would prevent access to nonemergency health care).

¹⁰⁴ Cohen *supra* note 53, at 1526.

companies to treat medical tourism as anything more than a temporary fix or alternative to care will create a tremendous flood of outward bound patients. The regulation this Note proposes seeks to limit volume shock by giving patients the option to choose between foreign and domestic care.

Currently, the main factor delaying volume shock is the federal government's reluctance to allow foreign health providers to administer federal health programs. Federal health programs prohibit approximately 41.1 million Medicare beneficiaries from receiving health care outside the United States.¹⁰⁵ The elderly people who receive Medicare benefits require a higher level of medical attention.¹⁰⁶ It follows that, as the population ages, this would create a huge demand for cheaply priced medical care.¹⁰⁷ However, because the federal government prohibits medical tourism as a treatment option under Medicare, the total outbound patient volume in foreign health systems remains insulated from this potential flood of patients.¹⁰⁸ This same line of reasoning can be applied to Medicaid beneficiaries—approximately 48.6 million

¹⁰⁵ CTRS. MEDICARE & MEDICAID SERVS., MEDICARE ENROLLMENT FOR AGED BENEFICIARIES: AS OF JULY 1, 2012 (2012), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/12Aged.pdf> (stating that the total number of Medicare beneficiaries is 41,116,359). *But see*, HENRY J. KAISER FAMILY FOUND., TOTAL NUMBER OF MEDICARE BENEFICIARIES (2012), available at <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/> (stating that the total number of Medicare beneficiaries in 2012 was 48,711,844). Statistics from U.S. territories have been removed to offer a better comparison with data generated by CMS.

¹⁰⁶ BARRY FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 534 (2013) (“The population of the United States is steadily aging, and older people, particularly those over 80, require a great deal of health care.”). *But see* Joseph White, *(How) is Aging a Health Policy Problem?*, 4 YALE J. HEALTH POL’Y L. & ETHICS 47, 48 (2004) (“[P]olicymakers and citizens need not worry about the implications of aging for medical costs. Aging of the population has some effect on health costs, but a much smaller effect than those factors that are both more susceptible to manipulation and pose less difficult ethical dilemmas.”).

¹⁰⁷ See Mark S. Kopson, *Medical Tourism: Implications for Providers and Plans*, 3 J. HEALTH & LIFE SCI. L. 147, 163–64 (2010) (describing Medicare beneficiaries as “members of the fastest growing portion of the U.S. population”); *see also* FURROW ET AL., *supra* note 106, at 534. While both Furrow et al. and White, talk about the effect of aging vis-à-vis cost, it is important to see that cost is not necessarily entirely coincidental with demand. The fact that services cost more, or less, than “our perception” is not related to the overall *demand* for services. *See* White, *supra* note 106, at 49.

¹⁰⁸ 42 C.F.R. § 411.9(a) (2015) states the basic rule that “Medicare does not pay for services furnished outside the United States.” Subsection 1 then defines “United States” as “the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, The Northern Mariana Islands, and for purposes of services rendered on board ship, the territorial waters adjoining the land areas of the United States.”

persons.¹⁰⁹

Federal health programs provide at least two self-regulatory checks on medical tourism. First, as discussed above, federal health programs literally prevent volume shock.¹¹⁰ Millions of persons receiving federal health benefits are incentivized *not* to receive care overseas because federal health programs simply do not pay for it.¹¹¹

Second, so long as federal health programs do not adopt medical tourism, its application in insurance plans will be stunted. A government sanction promoting the use of medical tourism as a solution to rising health costs would likely end the current model of medical tourism as a relief valve. Government sanction of such plans would bring medical tourism provisions out of experimental status and accelerate the industry towards unsustainability.¹¹² The sheer volume of patients under the Medicare/Medicaid umbrella illustrates the significant role that federal health programs have in controlling the potential outbound patient flood. An uncontrolled increase in the volume of medical tourism services would cause serious problems for the health framework that exists today. Therefore, while the United States should recognize the positive cost effect of medical tourism, official sanction to promote its use should be discouraged. Consequently, insurance companies will question the feasibility of adopting medical tourism in force in the absence of government sanction, further stemming patient volume from the incentivized insured.

¹⁰⁹ KAISER HEALTH NEWS, CENSUS BUREAU: AMERICANS ON MEDICAID STEADY AS POVERTY RISES (2011), *available at* <http://khn.org/morning-breakout/census-data-on-health-coverage/>.

¹¹⁰ *See supra* notes 105–09 and accompanying text.

¹¹¹ Whether federal health programs provide adequate incentive for patients to remain in the domestic health network is a matter that is open for interpretation.

¹¹² *See, e.g.,* Adam Teicholz & Glenn Cohen, *Some Insurance Companies Ask Their Customers to Cross the Border for Care: Is the Practice Going to Spread?*, NEW REPUBLIC (July 7, 2014), <http://www.newrepublic.com/article/118546/some-insurance-companies-ask-customers-cross-border-care> (suggesting that the practice of offering cross-border care is a relatively new phenomenon); *Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing before the S. Spec. Comm. on Aging*, 109th Cong. 18 (2006) (statement of Arnold Milstein, M.D.); Cortez, *supra* note 14, at 121 (“Several U.S. employers and insurers are beginning to *experiment* with cross-border health insurance coverage Yet, this momentum has stalled in at least one instance.”) (emphasis added) (citations omitted).

B. Making the Case for De Minimis Regulation

In order to limit volume, the United States should not take action that sanctions or appears to sanction private medical tourism. However, that is not to say that Congress must remain idle. Rather, a federal statute or regulation can be implemented to control the supply of patients while still refraining from a medical tourism endorsement. That is to say, policy makers should create barriers that prevent insurance companies from allowing U.S. patients to contribute, unchecked, to the overall volume of medical tourism patients.

This can be accomplished via federal regulation analogous to that adopted by the Texas legislature prohibiting insurers from providing medical tourism as the only available treatment option.¹¹³ Recall Texas Insurance Code § 1216.004, which states that no insurance provider may “require[] an enrollee to travel to a foreign country to receive a particular health care service.”¹¹⁴ Under Texas law, while an insurance company may include a provision allowing treatment to be provided overseas, a domestic alternative *must* be made available. Essentially, this gives insured patients the option to choose whether they will receive care domestically or abroad, ensuring that a foreign service does not supplant a domestic one.¹¹⁵ An analogous federal regulation might read as follows: “No state shall allow to be purchased or sold any health benefits plan that requires a beneficiary to travel to a foreign country to receive a particular health or medical procedure provided under that plan.” The rationale behind this implementation is threefold.

First, regulation that requires insurers to offer alternatives to foreign travel leaves the paradigm of medical tourism as a relief valve in place.¹¹⁶ As described previously, the current paradigm is not materially deficient.¹¹⁷ It allows private self-pay individuals to travel overseas for medical care and, indeed, many Americans have

¹¹³ TEX. INS. CODE ANN. § 1216.004 (West 2009).

¹¹⁴ *Id.*

¹¹⁵ It must be noted here that the effect of this regulation is principally on insurance incentivized patients. As discussed *supra* in Part II.A, it is unclear what effect, if any, this regulation will have on uninsured or underinsured patients.

¹¹⁶ See also McLean, *supra* note 12, at 597 (calling medical tourism, “[a] new paradigm for purchasing health care services”).

¹¹⁷ See *supra* Part III.A.

come to rely on foreign health services.¹¹⁸ Further, so long as insurers offer both foreign and domestic options to their patients, insurance incentivized individuals may take advantage of lower overseas rates.

Second, patient beliefs about medical tourism may self-regulate and operate to limit overall patient volume abroad without additional regulatory measures. As a cautionary aside, this possible self-regulation applies only to the incentivized insured and does not apply to uninsured or underinsured patients.¹¹⁹ For the uninsured or underinsured, the problem of price appears to be a non-issue.¹²⁰ Even if care is available both domestically and internationally, if those individuals cannot afford health insurance—or if they can afford the insurance, but the procedure is denied because it not medically necessary—they will receive the care overseas anyway, if at all.¹²¹ Insurance incentivized patient self-regulation may occur as a combination of two related components: (a) moral hazard, and (b) apprehension about overseas care.

In this context, moral hazard describes the tendency of individuals to overconsume health care precisely because they are insured.¹²² Since their inception, managed care organizations have taken steps to reduce moral hazard, which increases the burden on the health delivery system. Existing medical tourism plans have taken similar steps to decrease the possibility of moral hazard. For example, insurers in California offering cross-border plans use low premium, high deductible plans to “minimize moral hazard.”¹²³ Lower premiums “encourage patients to travel abroad in the first instance” while high deductibles “could discourage moral

¹¹⁸ See *supra* note 82, at 286 (“The number of patients travelling from the developed world to low- and middle-income countries (LMICs) for treatments has ballooned in recent years, primarily driven by difficulties with accessing affordable care at home.”).

¹¹⁹ As discussed *supra* in Part II.A, because underinsured and uninsured individuals: (a) may heavily rely on medical tourism as their primary source of non-emergency care and (b) are unaffected by insurance restrictions, self-regulation is unlikely to affect these patients.

¹²⁰ See Cohen, *supra* note 53, at 1480 (“The high cost of purchasing medical care out of pocket is an obvious reason for uninsured Americans to consider medical tourism, but it may play an important role for the underinsured as well.”).

¹²¹ After the passage of the ACA, there can be no denial of health treatment based on a pre-existing condition. 45 C.F.R. § 147.108 (2015) (stating that “a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion”). Therefore, the single largest remaining factor determining whether a health procedure is covered involves a usage determination.

¹²² Cortez, *supra* note 14, at 101.

¹²³ *Id.*

hazard."¹²⁴ However, this Note argues the opposite: that moral hazard, especially when coupled with pre-existing apprehension about overseas care, can *limit* travel for medical care. Most insurance companies do not offer cross-border coverage and, therefore, most insurance incentivized patients are left to their own devices.¹²⁵ When given the choice, individuals who have already paid premiums to receive care may be financially inclined to undergo treatment domestically. This is the precise definition of moral hazard.¹²⁶

Additionally, factors other than price play a noteworthy role in influencing where patients receive care.¹²⁷ Presumably, individuals remain apprehensive or uncomfortable with receiving care overseas.¹²⁸ Whether this concern arises from the fear of substandard quality of care or other concerns such as cultural, social, or linguistic barriers, it is clear that medical tourism remains (at this time) niche in part due to patient uncertainty.¹²⁹ When this issue is considered in conjunction with the effect of moral hazard, it appears that insurance incentivized patients may, in fact, be self-regulating.

It should be noted that self-regulation is only feasible in a band of values centered on an overseas care price point. Patients may favor a domestic health provider over a foreign health provider even if the comparative cost is higher, but only to a point. The extent of that tolerance is unclear.¹³⁰

The third rationale for the proposed regulation is that medical tourism exposes the U.S. health care market to competitively lower prices overseas.¹³¹ For example, in 2008, Hannaford Brothers, a grocery chain, offered its employees the option of traveling to

¹²⁴ Cortez, *supra* note 14, at 102. Professor Cortez writes that these schemes are to be met with some skepticism, stating that “[i]t is not clear whether we should be as optimistic as the World Bank that traditional insurance tools can effectively mitigate . . . moral hazard in overseas medical care, as these tools have arguably not worked well in the United States.”

¹²⁵ Most cross-border care is still experimental. *See supra* note 112.

¹²⁶ *See Cortez, supra* note 14, at 101.

¹²⁷ *See Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs: Hearing before the S. Spec. Comm. on Aging, 109th Cong. 19 (2006) (statement of Arnold Milstein, M.D.).*

¹²⁸ *See, e.g., Cohen, supra* note 53, at 1482 (suggesting that factors such as language, ethnic origin, cuisine, and religion effect patient comfort).

¹²⁹ But this discomfort is eroding. *See, e.g., Powers supra* note 6, at 79 (stating that the number of medical tourists visiting India alone tripled between 2002 and 2005).

¹³⁰ The flexibility of individuals and willingness to pay around a certain medical tourist price point has not been discussed in previous literature and is an excellent topic for future research on the subject.

¹³¹ *See Williams, supra* note 7, at 625.

Singapore for surgery, where the insurance company would cover the bill.¹³² Although no employees availed themselves of the service, Hannaford Brothers was contacted by a U.S. insurer “offering to provide . . . [Hannaford’s] employees with comparably priced operations in the U.S.”¹³³ Additionally, a West Virginia bill proposed in 2006 gave state employees treatment options overseas at JCI-accredited hospitals.¹³⁴ The bill proposed that employees availing themselves of the care would receive reimbursement for sick leave and a 20% rebate of the cost savings by the State.¹³⁵ The legislators intended the bill to “save the state money . . . and encourage more competition between West Virginia medical facilities.”¹³⁶

In conclusion, regulations that give patients the option to receive care overseas but do not limit patients to that option or demand that it be exercised may be the most effective and least invasive regulations available. Such regulations benefit from their relative simplicity, ease of implementation, and—other than possible right-to-travel issues—lack of material effect on experimentation into providing cross-border care solutions.¹³⁷ Further, self-regulation, preservation of medical tourism for at-risk populations who rely on the service, and the possibility of increased competition for domestic health providers all act to make this regulation extremely attractive.

¹³² Bruce Einhorn, *Hannaford’s Medical-Tourism Experiment*, BLOOMBERG BUSINESS (Nov. 9, 2008), <http://www.bloomberg.com/bw/stories/2008-11-09/hannafords-medical-tourism-experimentbusinessweek-business-news-stock-market-and-financial-advice>.

¹³³ *Id.*

¹³⁴ See also Williams, *supra* note 7, at 655–56.

¹³⁵ Kris Wise, *Bill Would Cover Surgeries Outside U.S.*, CHARLESTON DAILY MAIL, Feb. 3, 2006, at 7A.

¹³⁶ *Id.*

¹³⁷ Implementation of this type of regulation would be simple because it only affects providers who offer cross-border options. Additionally, the regulation only requires the review of managed care contracts—something that both state and federal insurance regulating bodies already do. See, e.g., 42 C.F.R. § 438.6 (2015) (stating that for federal medical assistance programs, “[t]he CMS Regional Office must review and approve all [managed care contracts]”); Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625, 626 (1999) (stating that in all places where federal regulation is absent, states are free to impose their own regulations, particularly with regard to insurance).

C. Broad Brushstrokes and the Future of Medical Tourism Regulation

This Note promotes a two-stage regulation mechanism. The first stage involves regulation that gives consumers a choice between domestic or foreign care.¹³⁸ This sort of passive *de minimis* regulation is simple to administer and can be quickly implemented. In contrast, the second stage of regulation is more extensive and complex and, because it is active, it should only come into effect as a result of some triggering condition. The triggering condition attempts to determine the point at which health care services being offered to medical tourists would otherwise become available to the destination country's poor. The reason for using this particular condition, which ostensibly focuses more on the demand for health services in the destination country rather than the state of the U.S. health care economy, is twofold.

First, medical tourism facilities currently have no proven negative effect on destination countries.¹³⁹ Although their positive effect is also questionable at this point, the only definitive conclusion is that medical tourism facilities have an unknown effect on destination countries.¹⁴⁰ This is because medical tourism facilities cater to a price point and to a service that indigenous patients cannot afford.¹⁴¹ Although current theorists fear a two-tiered health delivery system will be established in destination countries, it is unlikely that such a division exists at this time.¹⁴² It is even possible that a system promoting this type of stratification will never exist. The phenomenon of medical tourism may fade into irrelevance as the U.S. health economy undergoes major overhauls following the implementation of the ACA.¹⁴³ Alternatively,

¹³⁸ See discussion *supra* Part III.B, especially notes 113–15.

¹³⁹ See *supra* note 83.

¹⁴⁰ *Id.* at 877–78.

¹⁴¹ See Cohen, *supra* note 14, at 9 (stating that many indigenous patients are unlikely to be able to afford boutique treatments provided to medical tourists anyway).

¹⁴² Churnrurtai Kanchanachitra, et al., *Medical Tourism in Southeast Asia: Opportunities and Challenges*, in RISKS AND CHALLENGES IN MEDICAL TOURISM: UNDERSTANDING THE GLOBAL MARKET FOR HEALTH SERVICES 56, 76–79 (Jill R. Hodges, Leigh Turner & Ann Marie Kimball, eds., 2012).

¹⁴³ CONG. BUDGET OFFICE, INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT—CBO'S FEBRUARY 2014 BASELINE (2014), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-02-ACAtables.pdf> (suggesting that the ACA will reduce the total number of uninsured by approximately 25 million). See also *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2613 (2012) (citing 42 U.S.C. § 18091(2)(C) and (1) (2006 ed., Supp. IV)) (stating that the central aim of the ACA is to reduce the total number of uninsured Americans).

continued economic development in destination countries may create robust health systems to adequately cater to indigenous populations and medical tourists.¹⁴⁴

At this point, it is difficult to suggest that medical tourism creates a two-tiered system of health delivery since poor individuals would be unable to access health care regardless of the existence of medical tourism facilities.¹⁴⁵ For example, it is currently unlikely that medical tourism by U.S. patients in New Delhi would diminish access to those services utilized by poor Indian patients.¹⁴⁶ Therefore, the triggering condition of prospective regulation correctly focuses on the moment when health tourism actually begins to affect the viability of destination country health services.

Second, the Joint Commission International (“JCI”) is currently collecting data that informs this triggering condition.¹⁴⁷ As part of its certification process, JCI collects information on patient clinical records.¹⁴⁸ The JCI standard states that a hospital must “initiate[] and maintain[] a standardized clinical record for every patient assessed or treated and determine[] the record’s content, format, and location of entries.”¹⁴⁹ Further, the “clinical record [must] contain[] sufficient information to *identify the patient . . .* [and] to *justify the treatment.*”¹⁵⁰ Although the purpose of this Note is not to explain the information collection methods of the JCI, it is possible that information regarding hospital capacity, the nationality of treated patients, and the type of treatment they are receiving is already available through JCI records.¹⁵¹ Ideally, this data might be used to extrapolate an estimate or basis for indigenous demand for health

¹⁴⁴ See Kanchanachitra et al., *supra* note 142, at 76–79. (“[T]here are little definitive data on the extent to which the benefits of medical tourism, which at least initially accrue to private hospitals, eventually extend to the public sector.”). While tax incentives and other government efforts to promote medical tourism theoretically increase access of care to poorer patients, there is no consensus as to the actual effect. *Id.* The matter remains a topic of fierce debate.

¹⁴⁵ See Cohen, *supra* note 13, at 9 (“[M]edical tourism by American patients . . . would not necessarily diminish access for poor Indian patients (which would remain steady at virtually none).”).

¹⁴⁶ There is some danger that medical tourism limits access to indigenous middle-class and wealthy persons. See Cohen, *supra* note 13, at 9–10.

¹⁴⁷ See Williams, *supra* note 7, at 680.

¹⁴⁸ JOINT COMM’N INT’L, JOINT COMMISSION INTERNATIONAL ACCREDITATION STANDARDS FOR HOSPITALS 66 (5th ed., 2014), available at <http://www.jointcommissioninternational.org/assets/3/7/Hospital-5E-Standards-Only-Mar2014.pdf>.

¹⁴⁹ *Id.*

¹⁵⁰ *Id.* (emphasis added).

¹⁵¹ See Williams, *supra* note 7, at 640–42, 680.

services.¹⁵² Thus, the information necessary to create an effective regulatory triggering mechanism, and the regulatory system itself, might be available now in the data JCI currently collects.¹⁵³

The second stage regulatory mechanism operates under the following assumptions. First, at the time of this writing, medical tourism has been accepted as a relief valve for source health systems. Insurers and patients have already reaped the benefits of medical tourism and will be accustomed to its presence.¹⁵⁴ Therefore, complete removal of a medical tourism option is impracticable. Second, medical tourism as the sole option for patients will have been curbed or eliminated due to the effect of the stage one regulation.¹⁵⁵ This regulation would have hopefully allowed domestic markets to reclaim some volume of patients requiring eventually medically necessary services. Third, at the time phase two regulation is necessary, something must be done to limit the growth of medical tourism such that output bound patient volume remains at a level that will not upset the balance of the global health care framework. Two possible plans of action that adhere to the constraints above may prevent unsustainable medical tourism growth.

The first plan of action involves rationing medical tourism services. Rationing is often seen as a "dirty word" in the health care context.¹⁵⁶ However, rationing recognizes that medical services are limited by financial constraints.¹⁵⁷ Rationing care, especially in the private health insurance market, may be more tenable in the context of medical tourism because doing so constitutes rationing a supplemental health resource rather than a primary health resource. While the actual machinery of rationing care is beyond the ambit of this discussion, this Note envisions two types of rationing paradigms: rationing based on medical procedure and rationing based on volume.¹⁵⁸

¹⁵² For example, by looking at nationality of the patient and type of treatment received.

¹⁵³ There is an outstanding issue with privacy of patient data. However, this issue is beyond the scope of this Note.

¹⁵⁴ This is assuming that the phenomenon has room to expand, which evidence, at least on an anecdotal level, seems to support. See Cortez, *supra* note 14, at 108.

¹⁵⁵ See *supra* Part III.B.

¹⁵⁶ Peter Singer, *Why We Must Ration Health Care*, N.Y. TIMES (July 15, 2009), <http://www.nytimes.com/2009/07/19/magazine/19healthcare-t.html> ("In the current U.S. debate over health care reform, rationing has become a 'dirty word.'").

¹⁵⁷ *Id.*

¹⁵⁸ For more information on various rationing paradigms, see Leslie P. Scheunemann & Douglas B. White, *The Ethics and Reality of Rationing in Medicine*, 140

In the rationing based on medical procedure framework, private insurers may allow a medical tourism option only for medically necessary care. This method of rationing has already been practiced to some extent in Europe. Currently, Medicare and Medicaid already provide guidelines on what constitutes medically necessary care.¹⁵⁹ It would not be a substantial deviation to apply those guidelines to rationing medical care. The current CMS guidelines on medical necessity for orthopedic implants could be used to determine eligibility for medical tourism to receive such an implant.¹⁶⁰ This sort of rationing *does* eliminate eventually medically necessary care, but it is needed to prevent volume shock.

In the rationing based on volume framework, rationing medical care would be centered on the number of people who are permitted to obtain a certain procedure. While rationing based on medical procedure is theoretically limitless, rationing based on volume sets a numerical cap on the number of individuals who can actually obtain certain treatment. Rationing based on volume is especially controversial because it poses the same question that medical tourism is intended to solve: how can individuals obtain medically necessary care if they do not meet the quota? Additionally, adopting rationing *ex post*—after medical tourism is allowed to flourish—is atavistic. It amounts to a regression from being able to offer certain medical services via exploitation of the global health market to being unable to offer such services. However, the complexity of this matter is beyond the scope of this Note.

Both types of rationing involve difficult value based determinations that must weigh cost versus quality of life. For example, a decision to forgo a certain medical procedure due to its low incident rate could doom patients with rare diseases when rationing is based strictly on what type of medical procedures are provided.¹⁶¹ Rationing based on volume presents an equally

CHEST J. 1625, 1626–27 (2011).

¹⁵⁹ See HOUGLUM, *supra* note 66.

¹⁶⁰ *Id.*

¹⁶¹ See Singer, *supra* note 156. The article describes Britain's National Institute for Health and Clinical Excellence's (NICE) recommendation against the use of Pfizer's drug Sutent for patients with advanced kidney cancer. The cost for the drug exceeded the £30,000 (or \$49,000) cost of extending life for one year. Six months later, NICE reversed its decision after Pfizer agreed to administer the first round of treatment free for the National Health Service, making the treatment more cost effective. See Henry Scowcroft, *NICE Recommends Sutent (sunitinib) for Advanced Kidney Cancer*, CANCER RESEARCH UK (Feb. 4, 2009), <http://scienceblog.cancerresearchuk.org/2009/02/04/nice-recommends-sutent-sunitinib-for-advanced-kidney-cancer/>.

uncomfortable situation where a lottery system is used to determine priority.¹⁶² While these ethical questions remain unanswered, they are important considerations in deciding what path the United States should take if stage two regulation becomes necessary.

The second plan of action to prevent unsustainable medical tourism growth should use rationing based on medical procedure. In other words, private insurers may allow a medical tourism option only for medically necessary care. As stated above, the usage of the term medically necessary should continue to follow Medicare and Medicaid guidelines. One implementation of this plan involves imposing taxes on the use of medical tourism.¹⁶³ Imposing a tax on medical tourism must be done according to some sort of procedure triage—operations that are medically necessary should incur the least amount of tax, with *eventually* medically necessary procedures taxed at a middle tier, and cosmetic care taxed most heavily. Imposing different tax levels on specific types of medical tourism will limit undesirable behavior while still allowing the procedures to be undertaken where medically necessary.¹⁶⁴

IV. CONCLUSION

There is no substitute for widespread national health care reform. Medical tourism acts in a temporary capacity as a relief valve for costly health care in the U.S.¹⁶⁵ However, medical tourism is not intended to be the panacea. Hopefully, by phasing in regulation, medical tourism will be allowed to relieve financial pressure on patients in the United States as long as it is possible. This has the added benefit of exposing the American health care system to foreign pressure to aid in overall cost reduction. Despite these perceived benefits, all the proposed regulatory devices are predicated on the need for more data. Principally, the key data point missing for these regulations and their effective implementation is information on the number of Americans who

¹⁶² See Scheunemann & White, *supra* note 158, at 1628.

¹⁶³ For a more detailed discussion of how tax law may be used to influence medical tourism, see I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1513–16 (2010).

¹⁶⁴ Cigarette taxes are a good example of using tax policy to regulate certain undesirable behavior. For example, a Thai study performed in 2009 showed that increasing taxes for cigarettes reduced smoking at least 48%. See Mondha Kengganpanich, Lakkhana Termsirikulchai & Sarunya Benjakul, *The Impact of Cigarette Tax Increase on Smoking Behavior of Daily Smokers*, 92 J. MED. ASSOC. THAI. S46, S48 (Supp. 7) (2009).

¹⁶⁵ See *supra* notes 36–40.

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will travel abroad and for what treatment or procedure. Finally, empirical data on the effect of medical tourism in destination countries, including patient nationality and medical procedure, would be invaluable in ensuring a better analysis of the global landscape of medical tourism.

There are numerous uncertainties about medical tourism that make it difficult to predict what its likely effects will be. It is possible that these anticipated issues will never materialize. However, that does not alleviate the need to err on the side of caution in order to best prevent both domestic and international problems from arising. At this point, the next step should be to implement a regulatory scheme that allows *de minimis* control of patient volume and the continuation of research regarding what an elaborate and complete regulatory solution should aim to achieve.