



Legal Barriers to Implementing International Providers into Medical Provider Networks for Workers' Compensation

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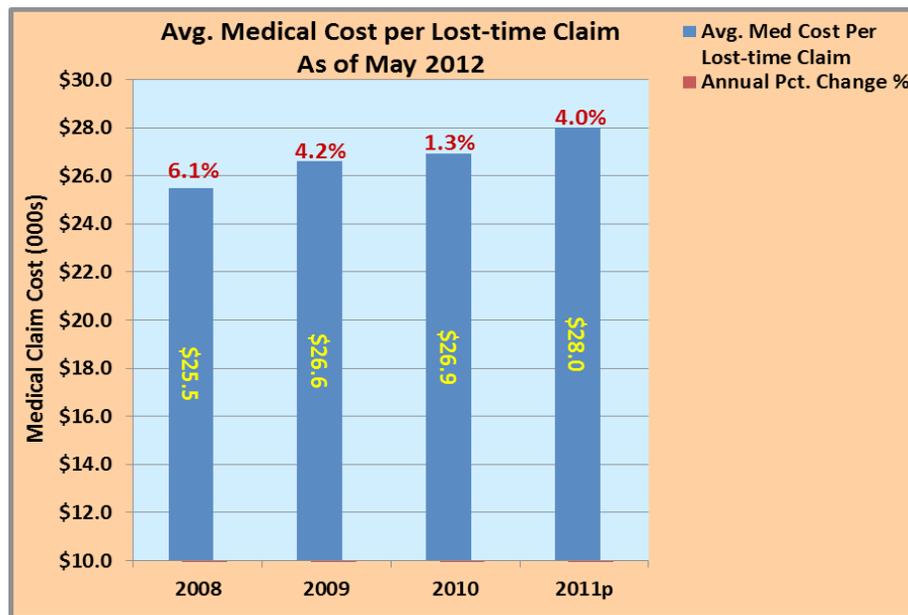


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INTRODUCTION

Throughout the debate leading to the enactment of the 2010 Affordable Care Act (ACA), one area of health care has been relegated to the sidelines; the rising cost of workers' compensation claims. One major factor for the increase of workers' compensation claims costs is the rise of medical costs associated with those claims. The average medical cost per loss time claim in workers' compensation in 2008 was \$26,000, and medical losses in that year represented 58% of all total losses.^{1,2} Since 2008, the average medical cost has risen steadily, increasing at a moderate rate³, as shown in Figure 1.

Figure 1 - WC Medical Claim Cost



2011p – Preliminary figure based on data valued 12/31/2011

1 Barry Llewellyn, (2009, September). *Workers' Compensation Medical Cost Issues*. Casualty Loss Reserve Seminar (presented at the meeting of the Casualty Actuary Society (CAS), Chicago, Illinois, September 14, 2009).

2 Dennis C. Mealy, (2009, May). *State of the Workers' Compensation Line*. (Presented at the meeting of the Annual Issues Symposium at the National Council on Compensation Insurance, Boca Raton, Florida, May 7, 2009). Figures shown in the 2009 report for 2008 were adjusted in later years, so that in the latest report, the average medical claim cost per lost-time claims in 2008 was \$255,000, as shown in Figure 1.

3 Dennis C. Mealy, (2012, May), *State of the Workers' Compensation Line*, (presented at the meeting of the Annual Issues Symposium at the National Council on Compensation Insurance, Boca Raton, Florida, May 10, 2012).



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In the past twenty years, from 1991 to 2010, the average medical cost per lost-time claim has gone from \$8,100 to \$26,900. In 2001 it increased to \$15,900, and by 2005 it had gone up to \$21,300. Given this trajectory, medical costs for workers' compensation will continue to rise, perhaps even reaching \$50,000, if medical costs cannot be controlled. With all the workers' compensation system calls for reform, one possible solution has yet to catch on; implementing international medical providers into workers' compensation.

Implementing international medical providers into the U.S. workers' compensation system sounds far-fetched; however, globalization is rapidly changing many industries around the world, and health care and workers' compensation should not be an exception to that change. A rapidly emerging segment of the global healthcare industry is medical tourism.⁴ Medical tourism refers to patients going abroad to seek low-cost treatment. As international travel becomes more affordable and less complicated, and the technology and standards of care have improved, medical tourism has become very popular.⁵

This development has led to the creation of commercial ventures that facilitate the process of providing medical services to their clients. The facilitators' role is to choose the best location, the best hospital and the best physicians to perform the treatment or procedures the patient requires. It began primarily as an individual practice.⁶ However, more group health plans are adding medical tourism into existing plans, or offering health plans that include medical tourism and implementing international provider networks into their plans.⁷

The desire to seek care abroad is motivated by a desire to seek health care that is lower cost, avoids long wait times, or provides services that are not available in one's own country.⁸ The skyrocketing cost of U.S. health care due largely in part to exorbitant administrative costs,

4 Laura Hopkins, Ronald Labonte, Vivien Runnels and Corinne Packer, "Medical tourism today: What is the state of existing knowledge?," *Journal of Public Health Policy*, 31, no. 12 (2010): 185.

5 Kristen Boyle, "A Permanent Vacation: Evaluating Medical Tourism's Place in the United States Healthcare System," *The Health Lawyer*, 20, no. 5 (2008): 4

6 Heather T. Williams, "Fighting Fire with Fire: Reforming the Health Care System Through a Market-Based Approach to Medical Tourism," *North Carolina Law Review*, 29 (2011): 615.

7 *Ibid*, 616.

8 Hopkins, et al., 185.



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the practice of defensive medicine, and weak preventative care, is a potent argument for seeking medical tourism.^{9,10} Countries that serve as locations for medical tourism also have lower labor costs,¹¹ and that translates into considerable savings for the patient.¹²

Just as many legal barriers exist to doing business overseas, the implementation of international medical providers into U.S. workers' compensation medical provider networks also presents many barriers. This article will attempt to examine a few legal and regulatory barriers currently preventing foreign medical providers from treating patients abroad for injuries resulting from work-related accidents. It is not intended to be a definitive discussion of the subject, but rather a starting point for further discussion. Currently there is no literature available on the subject of medical tourism and workers' compensation, but it is hoped that such literature will be forthcoming. At the conclusion, support for the hypothesis that the globalization of health care and the move towards medical tourism should include workers' compensation will be offered.

QUALITY AND MEDICAL TOURISM

Considerations of cost are one reason why patients go abroad for medical treatment. Patients also seek medical care abroad for the quality of care received at foreign hospitals, which is the primary concern of medical tourism critics.¹³ Fears of poor quality result from stereotypes regarding doctors and facilities in developing countries.¹⁴ The quality of care available at many of the common medical tourism destinations are comparable to that available to the average U.S. patient; also death rates and adverse outcomes for cardiac patients in Indian and Thai medical tourist hospitals are comparable to, and in some instances, lower than those at American hospitals.¹⁵

Typically, the effectiveness and safety of health care services delivered to patient popula-

9 Boyle, 42.

10 Williams, 613.

11 Ibid, 613.

12 Ibid, 613.

13 Ibid, 627.

14 Ibid, 628.

15 Ibid, 628.



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tions in the U.S. is how “quality of care” is measured. However, quality is generally difficult to measure or define.¹⁶ Also, comparing safety on a state or local level is practically impossible.¹⁷ Federal policy makes reporting adverse events at medical facilities voluntary, and few states require reports to be made public.¹⁸ Reports, where made, are usually incomplete as well.¹⁹

Apollo Hospital Group and Wockhardt Hospitals in India (affiliated with Harvard Medical School), and Bumrungrad International Hospital in Bangkok, provide a better level of care than most community hospitals in the U.S., according to Harvard Medical International, Inc. (now Partners Harvard Medical International).^{20,21} For at least one common procedure performed in the U.S. today, coronary artery bypass graft (CABG), the mortality rate for Apollo Hospital Group and Wockhardt Hospitals is <1%, whereas in several California hospitals, the mortality rate ranged from 2.1% to 13.8%.²²

The disclosure of recognized quality indicators, oftentimes not done in the U.S., is true for many hospitals overseas.^{23,24} However, those hospitals that compete on an international level do disclose quality indicators.^{25,26} U.S.-based hospitals such as Dartmouth Hitchcock Medical Center in NH and Cleveland Clinic in OH post quality indicators on their hospital websites.^{27,28} National University Hospital in Singapore discloses information that their quality compares favorably internationally.^{29,30} The Apollo Hospital Group in India, has devised a clinical excellence model to ensure its quality meets international health standards in all of their hospitals,^{31,32} other Indian hospitals are creating standards for reporting performance measures.^{33,34}

16 Ibid, 628.

17 Ibid, 629.

18 Ibid, 629.

19 Ibid, 629.

20 Devon M. Herrick, “Medical Tourism: Global Competition in Health Care”, (NCPA Policy Report No. 304, Dallas, Texas, 2007), 14.

21 Toro Longe, “The Ethical and Legal Complexity of Medical Tourism: Questions of International Justice, Economic Redistribution and Health Care Reform,” (master’s thesis, Loyola University of Chicago, 2010), 9.

22 Herrick, 13, Cardiac Surgery Mortality Chart, Figure IV.

23 Ibid, 14.

24 Longe, 10.

25 Herrick, 14.

26 Longe, 10.

27 Herrick, 14.

28 Longe, 10.

29 Herrick, 16.

30 Longe, 10.

31 Herrick, 16.

32 Longe, 10.

33 Herrick, 16.

34 Longe, 10.



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Perhaps the best example of this is Bumrungrad International Hospital in Thailand. Bumrungrad is a modern multispecialty hospital with 554 beds. Its main building was built in 1997 to conform to U.S. building and hospital standards. Bumrungrad tracks more than 500 quality and patient safety measures.³⁵ Over 100 of their doctors are board-certified by U.S. medical specialty groups, as they have been trained in the U.S. or the U.K.^{36,37} Many of them have licenses from Australia, Europe and Japan.³⁸ Bumrungrad is also accredited by the Joint Commission International.³⁹

The establishment of the Joint Commission International (JCI), the international arm of the Joint Commission has meant that the quality of hospitals overseas has been assessed by the Commission and that the health care offered at those hospitals conforms to 'international quality'. Countries such as Thailand and India, recognize the value of standardization and certification, and have established their own national accreditation bodies.⁴⁰ Therefore, the issue of quality of care at international hospitals that cater to medical tourism should not be a major factor, and will only improve as more nations comply with international standards, and their hospitals are equipped with the latest technology and most-highly skilled and trained medical providers.

Additionally, medical tourism will relieve the critical shortages in medical staff for physicians, specialists and nurses. In 2000, the demand for registered nurses exceeded the supply by more than 100,000, and by 2020 this shortage will increase to more than 200%.⁴¹ And as the Affordable Care Act kicks in in the next few years, the demand for services as more individuals are covered will put considerable strain on an already strapped health care system. This will affect quality in U.S. hospitals as the shortages become more acute.

Putting the issue of quality aside, another fact to consider is the number of people participating in medical tourism. An estimated 500,000 Americans traveled abroad for treatment

³⁵ Ibid, 9.

³⁶ Boyle, 44.

³⁷ Longe, 9.

³⁸ Ibid, 9.

³⁹ Ibid, 9.

⁴⁰ Leigh Turner, "First World Health Care at Third World Prices": Globalization, Bioethics and Medical Tourism", *BioSocieties* 2, (2007): 311.

⁴¹ Williams, 627.



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in 2005, the majority of them to Mexico and other Latin American countries. Americans were among the 250,000 foreign patients seeking care in Singapore, 500,000 in India, and as many as 1 million in Thailand. The impact of these numbers is considerable as medical tourism grossed approximately \$60 billion worldwide in 2006, and was estimated to rise to \$100 billion in 2010.⁴² Medical tourism is growing very rapidly and is expected to grow even more so in the coming decade.

MEDICAL TOURISM AND HEALTH CARE

Williams agrees with critics, that medical tourism is a trade-off for consumers, allowing them to opt-out of increased regulation in favor of fewer restrictions and greater cost savings. Factors unique to the medical tourism industry will help preserve the quality of patient care and insulate patients from the regulatory pitfalls critics fear. Williams points to the benefits of medical tourism as providing patients with substantial cost savings, due in part to lower labor costs overseas.⁴³

The cost savings in the context of inflated health care costs in the U.S. indicates why patients are driven abroad to seek medical care. How much of a cost savings medical tourism offers patients can be seen in how much hospitals charge for major surgical procedures such as cardiac surgery, partial hip replacement, knee replacement, and rhinoplasty. A hospital in India charges \$4,000 for cardiac surgery, compared to \$30,000 in the U.S. Hospitals in Argentina, Singapore or Thailand charge \$8,000 to \$12,000 for a partial hip replacement that would otherwise cost twice that much here. Singapore and Indian hospitals charge \$18,000 and \$12,000 respectively for knee replacement that normally cost \$30,000 in the U.S. Finally rhinoplasty that costs \$4,500 in the U.S. costs only \$850 in India.⁴⁴

⁴² Herrick, Executive Summary.

⁴³ Williams, 611.

⁴⁴ Herrick, 8.



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Though all patients can benefit, medical tourism's cost savings are more likely to benefit those with inadequate health insurance coverage.⁴⁵ Lower-middle-class individuals, who typically have sufficient means to pay for reduced-price care out-of-pocket, will benefit most from medical tourism.⁴⁶ This is a point to bear in mind with regard to workers' compensation, as many claimants are generally lower-middle-class.⁴⁷

Medical tourism disproportionately benefits uninsured or underinsured individuals,⁴⁸ but they are not the only ones benefitting from cost savings from medical tourism.⁴⁹ Self-insured employers and private insurance companies have begun integrating medical tourism into their policies. It is attractive to small businesses as well.⁵⁰ Medical tourism is expanding as self-insured employers and insurance companies have integrated medical tourism into their policies.⁵¹ For instance, Blue Ridge Paper Products of Canton, NC sought to send an employee overseas for gallbladder and shoulder surgery.⁵² They offered him 25% of the savings, but the United Steelworkers' prevented them from doing so and union workers were removed from the pilot program.^{53,54}

State governments, looking to save money anyway they can may accept medical tourism for their state employees. A bill introduced into the state legislature in West Virginia in 2006, (H. B. 4359), would have encouraged state employees covered by the Public Employees Insurance Agency (PEIA) to utilize Joint Commission International accredited foreign hospitals, receive travel reimbursements for themselves and a companion, and participate in the savings with a cash rebate.^{55,56} The bill is still pending in the House Banking and Insurance committee.⁵⁷

45 Williams, 614.

46 Ibid, 614.

47 Juan Du and J. Paul Leigh, "Incidence of Workers Compensation Indemnity Claims Across Socio-Demographic and Job Characteristics," *American Journal of Industrial Medicine*, 54 (2011): 758-770. The study suggests that low socioeconomic status was a predictor of reporting workers compensation claims, but did not include income levels; although it is possible to extrapolate from the data presented that the subjects were generally lower middle class or working class.

48 Williams, 614.

49 Ibid, 615.

50 Ibid, 615.

51 Ibid, 615.

52 Boyle, 43.

53 Ibid, 43.

54 Williams, 616.

55 Ibid, 44.

56 Nicolas P. Terry, "Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing," *Western New England Law Review*, 29, no. 29 (2007) 427.

57 West Virginia Legislature website, (2006), http://www.legis.state.wv.us/Bill_Status/bills_pend_com.cfm?year=2006&sessiontype=RS&btype=bill&abbr=BNI&chavar=H



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Large HMO's and health insurance companies have established plans to allow patients to obtain low-cost services overseas.⁵⁸ BlueShield and Health Net of California, United Group Programs of Boca Raton, and BlueCross and BlueShield of South Carolina have offered such plans for travel to Mexico and Thailand for treatment.⁵⁹ The effect of financial incentives on American's willingness to travel for medical care is evident in a 2007 nationwide telephone survey of a representative sample of 1,003 Americans in which 38% of uninsured and one-quarter of those with insurance would travel abroad for care if the savings exceeded \$10,000. One-quarter of uninsured, but only 10% of those with insurance would travel if savings were between \$1,000 and \$2,400. Fewer than 10% would travel to save \$500 to \$1,000, and no one would do so to save \$200 or less. This represented a potential market share of 20-40 percent for non-urgent major surgery.^{60,61}

Medical tourism is fast becoming a feature of American health—care. In the next few years, more and more Americans will be going overseas for medical care. It is only a matter of time before medical tourism's mark is felt on another arena of American health care workers' compensation.

WORKERS' COMPENSATION AND THE LEGAL BARRIERS TO MEDICAL TOURISM

The parallels to health care costs rising and workers' compensation medical costs are no coincidence, since workers' compensation is a subset of the health care system. The average workers' compensation medical cost per loss time claim (in which the worker has lost more than seven days from work) in 2008, as previously stated, was \$26,000, which is a 6% increase from 2007. In addition, medical costs in 2008 were 58% of all total claims.^{62,63} Approximately 40% of workers' compensation costs are associated with medical and rehabilitative treatment. In the 1980's and 1990's, medical costs for workers' compensation fluctuated, and in the last decade

⁵⁸ Williams, 616.

⁵⁹ Boyle, 44.

⁶⁰ Herrick, 2.

⁶¹ Arnold Milstein and Mark Smith, "Will the Surgical World Become Flat?," *Health Affairs*, 26, no. 1 (2007): 138.

⁶² See note 1.

⁶³ See note 2.



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rose again, and in 2002, totaled \$41.7 billion annually.⁶⁴

As with health care, states have experimented with different ways to reduce workers' compensation costs. Former California Governor Arnold Schwarzenegger made workers' compensation reform a part of his legislative program.⁶⁵ Some of the same strategies applied to health care have been tried with workers' compensation: utilization management of workers' compensation medical services, restricted networks of designated physicians, case management, mandatory treatment guidelines, and hospital payment regulations.⁶⁶ The introduction of DRG's for hospital payments and ICD-9 and CPT codes for provider payments for health care in the 1980's, also impacted workers' compensation, as insurance companies began to use them.

This has led some to believe that there is a place for medical tourism in workers' compensation.

Merrell: "...Can you see a role of medical tourism in workers' compensation injury?"

Ludwick: "I could, if it were a long-term issue. Many workers' comp issues are emergent, so that would take out the medical tourism aspect. However, if it was a long-range issue, I could see us involving workmen's comp issues into that, or problems."

Lazzaro: "I would support that. I don't know the incidence, for example, of some of the orthopedic procedures that are non-emergent, such as knee or hip replacement, which would fall under workmen's comp. But theoretically, a case could be made for that..."

Merrell: "I was thinking about it in terms of the chronic back injury and the repetitive action injuries and hernia that are in the workers' compensation area. An acute injury on the job would probably not be at issue but a work-associated problem with a potentially surgical solution might be a matter for medical tourism."⁶⁷

The savings from medical tourism mentioned in the Introduction are even more relevant to workers' compensation. As Lazzaro and Merrell discussed above, knee and hip replacement, as well as chronic back and repetitive action injuries and hernia are just some of the work-related injuries that can benefit from medical tourism. Table 1 lists three of the most common procedures performed and the costs of each in the U.S. and three countries that cater to medical tourists.⁶⁸

64 Facts in Brief, "Workers' Compensation Medical Care: Controlling Costs", University of Massachusetts, Worcester, (2002), www.umassmed.edu/uploaded_files/costs.pdf

65 California Healthcare Foundation, "Schwarzenegger Signs Workers' Compensation Reform Bill," *California Healthline*, (April 20, 2004), accessed February 22, 2011, <http://www.californiahealthline.org/articles/2004/4/20schwarzenegger-signs-workers-compensation-reform-bill.aspx?topic=insurance%20and%20uninsured#>

66 University of Massachusetts, Worcester, (2002).

67 Ronald C. Merrell, et al., Roundtable Discussion, Medical Tourism, *Telemedicine and e-Health*, (January/February 2008), 16, <http://www.lieberonline.com/doi/pdf/10.1089/tmi.2008.9995>

68 Herrick, Table 1, The Cost of Medical Procedures in Selected Countries (in U.S. dollars), 11.



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Table 1 - Cost Comparison of Common Procedures					
Procedure	U.S Retail Price*	U.S. Insurers' Cost*	India**	Thailand**	Singapore**
Hip Replacement	\$75,000	\$31,485	\$9,000	\$12,000	\$12,000
Knee Replacement	\$69,000	\$30,358	\$8,500	\$10,000	\$13,000
Spinal Fusion	\$108,127	\$43,576	\$5,300	\$7,000	\$9,000

*Retail and insurer costs are mid-point between high and low ranges.

**U.S. rates include one day hospitalization; international rates include airfare, hospital and hotel. Source⁶⁹

Given the data presented here, one could conclude that implementing medical tourism into workers' compensation is a logical solution to rising medical costs for workers' compensation, and should be seriously considered. However, there are legal barriers to accomplishing this.

One of the most obvious legal barriers to implementing medical tourism into workers' compensation are the provisions of State workers' compensation laws that establish who can provide medical care to injured workers. In four of the largest workers' compensation states, California, Florida, New York and Texas, medical providers must be licensed by the state to practice medicine.^{70,71,72,73} Florida's statutes have a provision to allow certain foreign-trained physicians to practice in the state, but do not mention treatment outside of the state.⁷⁴

On the other hand, two states, Oregon and Washington State, both have statutes or rules that allow workers to choose an attending doctor or physician in another country. Oregon's labor code states, "...The worker also may choose an attending doctor or physician in another country or in any other state or territory or possession of the United States with the prior approval of the insurer or self-insured employer."⁷⁵

69 Ibid, 11.
70 CA Labor Code, § 3209.3 (a) (2010).
71 FL Statutes, Title XXXI, Chap. 440.13, (1)(q) (2010).
72 NY Workers' Compensation Laws, Art. 2, § 13-b (2010).
73 TX Labor Code, Title 5, Subtitle A, Chap. 401, Subchapter B, § 401.011 (17) (2005).
74 FL Statutes, Title XXXII, Chap. 458.3124.
75 Oregon Labor Codes §656.245 (2)(a). <http://landru.leg.state.or.us/ors/656.html>



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The WA State Department of Labor and Industries has a page on their website that allows workers to find an attending practitioner in the U.S., Canada, Mexico and Other Countries. The webpage allows the worker to search for a U.S. physician by entering a zip code, miles, doctor or provider type, and specialty.⁷⁶ Workers seeking physicians in Canada, Mexico and Other Countries, such as England, Germany, Honduras, New Zealand, the Philippines, Spain, Thailand and Ukraine are directed to .pdf files that list selected doctors and their specialties and contact information.⁷⁷

Among some of the other barriers to medical tourism is the result of entrenched interest groups wishing to avoid competition with low-cost providers.^{78,79} Also, outdated federal and state laws intended to protect consumers, but only increase costs and reduce convenience.^{80,81} Additionally, state and federal regulations restrict public providers from outsourcing certain expensive medical procedures.^{82,83} Federal laws inhibit collaboration⁸⁴ and state licensing laws prevent certain medical tasks being performed by providers in other countries.^{85,86} Foreign physicians lack the authority to order tests, initiate therapies and to prescribe drugs that U.S. pharmacies are able to dispense.^{87,88}

Restrictions on the practice of medicine have been removed, and many still exist. Some laws, for example, make it illegal for a physician to consult with a patient online without an initial face-to-face meeting; it is illegal for a physician who is outside the state and who has examined the patient in person to continue treating via the Internet after the patient goes home; and it is illegal (in most states) for a physician outside that state to consult by phone with the patient residing in that state if the physician is not licensed to practice there.^{89,90}

⁷⁶ WA Dept. of Labor and Industries website, (2012), <http://www.lni.wa.gov/ClaimsIns/Claims/FindaDoc/>

⁷⁷ Ibid, see <http://www.lni.wa.gov/ClaimsIns/Claims/FindaDoc/FadMexico.pdf>, <http://www.lni.wa.gov/ClaimsIns/Claims/FindaDoc/FadCanada.pdf>, <http://www.lni.wa.gov/ClaimsIns/Claims/FindaDoc/FadOtherCountries.pdf>

⁷⁸ Herrick, 23.

⁷⁹ Longe, 21.

⁸⁰ Herrick, 23.

⁸¹ Longe, 21.

⁸² Herrick, 23.

⁸³ Longe, 21.

⁸⁴ Ibid, 21.

⁸⁵ Herrick, 24.

⁸⁶ Longe, 22.

⁸⁷ Herrick, 24.

⁸⁸ Longe, 21.

⁸⁹ Herrick, 24.

⁹⁰ Longe, 22.



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Other barriers or potential barriers, which are extremely important ones, also exist that must be addressed before medical tourism is accepted for workers' compensation. Issues regarding medical malpractice and liability laws overseas, patient privacy and medical record laws (including HIPAA), ERISA and the impact of PPACA have to be dealt with before medical tourism is a viable option not only for non-compensation patients, but for compensation patients as well. Some of these issues are spelled out below.

MEDICAL MALPRACTICE AND LIABILITY LAWS

One major criticism of medical tourism is the lack of legal remedy for patients claiming injury from medical malpractice.⁹¹ Medical malpractice and liability laws in foreign countries are not as strict as laws in the U.S.⁹² Awards for malpractice are generally not as generous either as those in the U.S.⁹³ Physicians overseas do not typically have the same amount of malpractice insurance as their American counterparts.⁹⁴ And the threshold for determining malpractice is higher outside the U.S.⁹⁵ Limited recourse through the court systems of many countries is a problem, and the right to sue may not exist for injured patients.⁹⁶ In India, even though the court system is similar to that in the U.S., medical malpractice awards are rare and never reach the multi-million dollar amount common in U.S. court systems.⁹⁷

Before recognizing a suit, an American court must have personal jurisdiction over a foreign provider.⁹⁸ The issue of personal jurisdiction over the foreign provider is a difficult burden for anyone initiating a suit.⁹⁹ U.S. courts are reluctant to assert personal jurisdiction over physicians who are not residents of the U.S. and do not practice in the forum state.¹⁰⁰ Minimum contacts sufficient to exercise personal jurisdiction could be difficult to establish over a physician who

91 Williams, 641.

92 Longe, 14.

93 Boyle, 46.

94 Longe, 14.

95 Ibid, 14.

96 Ibid, 14.

97 Boyle, 46.

98 Williams, 643.

99 Ibid, 643.

100 Ibid, 643.



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performed a harmful procedure outside of the forum state.¹⁰¹ If a U.S. court does find evidence to support personal jurisdiction, the case could be dismissed on the grounds of *forum no conveniens* (not suitable to the forum).¹⁰² If the case is not dismissed, then choice of law conflicts arises.^{103,104} If a court recognizes a valid claim against a defendant, it is likely the defendant will be successful challenging the location of the suit.¹⁰⁵ Most jurisdictions would apply the laws of the country where the malpractice occurred, decreasing the likelihood of a finding of malpractice, and a reduction of damages.¹⁰⁶

PATIENT PRIVACY AND MEDICAL RECORD LAWS (INCLUDING HIPAA)

In recent years, the U.S. health care industry has outsourced the processing and interpretation of x-rays and other medical records to countries such as India,¹⁰⁷ where the data entry costs are less than half of those in the U.S.¹⁰⁸ Half of the \$20 billion medical transcription industry is outsourced.¹⁰⁹ This is due to the fact that information technology is not a core competency of the health care industry and has proven itself to be a prime candidate for outsourcing. Other tasks such as billing, coding, data-clearing, claims processing, and electronic records data processing and storage also are outsourced.¹¹⁰

One example of a task that is outsourced to India, and that pertains to the workers' compensation industry is the outsourcing of the initial processing of medical bills for health care claims that are later determined to be workers compensation claims. A company this author had contact with in 2008, conducts subrogation recovery on those medical bills paid by their health care clients when injured workers present their employer's health care insurance card at time of treatment, and does not inform staff that he was injured on the job. The provider bills the health

¹⁰¹ Ibid, 643.

¹⁰² Boyle, 46.

¹⁰³ Ibid, 46.

¹⁰⁴ Williams, 644.

¹⁰⁵ Ibid, 644.

¹⁰⁶ Ibid, 644-645.

¹⁰⁷ Herrick, 19-20.

¹⁰⁸ Terry, 441.

¹⁰⁹ David Lazarus, "Outsourced UCSF Notes Highlight Privacy Risk: How one offshore worker sent tremor through medical system," *San Francisco Chronicle*, (San Francisco, CA), March 28, 2004. accessed from <http://www.mindlully.org/Reform/2004/Outsourced-Privacy-Risk28mar04.htm>

¹¹⁰ Terry, 441.



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insurer, rather than his employer's workers' compensation carrier. The subrogation company, working on a pilot project for the NYS Workers' Compensation Board under the Health Insurers' Match Program (HIMP), outsources the initial processing of the medical bills for health care claims to an office they have contracted with in Gurgaon, India.

Since much of the current business of medical tourism is conducted through facilitators, or medical tourism brokers, as mentioned in the Introduction, they must conform to national or state legislation that governs the privacy and confidentiality of medical records and patient information. The locations in which they are located should bind them to the laws of that jurisdiction, and therefore, they would have to conform to the Health Insurance Portability and Accountability Act (HIPAA) regarding privacy of medical records.¹¹¹

HIPAA privacy applies to a limited subset of health care entities.¹¹² Those "covered entities" include health plans, health care providers, and health care clearinghouses that process nonstandard information. "Business associates" of covered entities are organizations that perform certain functions or activities on behalf of, or provide certain services to, a covered entity. Examples of functions or activities include claims processing, data analysis, utilization review, and billing. Their services are limited to legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services.¹¹³

HIPAA rules are strict and health plans in the U.S. must follow them even for services provided abroad. However, they are not applicable to foreign hospitals and doctors. Business Associate agreements under HIPAA should be placed with offshore vendors, and vendors should have their contracts with hospitals and other providers conform to HIPAA standards.¹¹⁴

111 Leigh G. Turner, "Quality in health care and globalization of health services: accreditation and regulatory oversight of medical tourism companies," *International Journal for Quality in Health Care* 2011, 23, 1 (2010): 4. doi:10.1093/intqhc/mzq078 accessed from <http://intqhc.oxfordjournals.org.ezproxy.fau.edu/content/23/1/1.full.pdf+html?sid=457146b6-dfb0-4710-b2a7-eaf483ddb69>

112 Terry, 443.

113 U.S. Department of Health and Human Services, Office for Civil Rights. (2003). Summary of the HIPAA Privacy Rule (OCR Privacy Brief). Retrieved from <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>

114 Joseph Marlowe and Paul Sullivan, "Medical Tourism: The Ultimate Outsourcing," *Aon Consulting Forum*, March, (2007), 4. Retrieved from [https://infolinx.aon.com/InfoLinx/RTS/Rtsdbln.nsf/0455ef6bb6300d3185256a40005a1065/e3a8903cf47ff95586257441005522704/\\$FILE/mar07_forum_lead_article.pdf](https://infolinx.aon.com/InfoLinx/RTS/Rtsdbln.nsf/0455ef6bb6300d3185256a40005a1065/e3a8903cf47ff95586257441005522704/$FILE/mar07_forum_lead_article.pdf)



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The Employee Retirement Income Security Act (ERISA), enacted in 1974, is a federal law that imposes a set of minimum standards on employee benefit plans, including health insurance plans, and is intended to protect employees by ensuring basic fairness and financial stability to such plans.¹¹⁵ In considering integrating medical outsourcing, i.e., medical tourism, into employee benefit plans, a variety of factors motivates HMO and employee welfare plan administrators.¹¹⁶ Cost savings are one factor, as we have already seen. In determining to use medical outsourcing, HMO and plan administrators must remember their fiduciary duty under ERISA “to discharge their duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to plan participants...and to defray reasonable expenses of administering the plan”.¹¹⁷

Medical tourism has come under challenge that it violates the fiduciary duty imposed by ERISA. It is argued that ERISA is inconsistent with the concept of medical tourism because health insurance plans, employers, and health maintenance organizations (“HMO’s”) cannot authorize and pay for participants to engage in medical tourism without violating the ERISA fiduciary duty of loyalty.¹¹⁸ Authorization of medical tourism does not result in a *de jure* violation of ERISA requirements; it is argued that the benefits are so great that they overwhelm the sponsor’s ability to evaluate the dangers inherent in medical tourism.¹¹⁹ Yet, the very act of authorizing medical tourism produces a *de facto* violation of ERISA’s fiduciary duties some have argued.¹²⁰ Further it is argued, that medical tourism defeats ERISA’s public policy justification of ensuring equity in the distribution of employee health benefits.¹²¹ Medical tourism may actually promote ERISA’s goal of providing health care benefits more equitably, proponents counter.^{122,123}

115 Williams, 612 and 650.

116 Christopher J. Brady, “Offshore Gambling: Medical Outsourcing Versus ERISA’s Fiduciary Duty Requirements,” *Washington and Lee Law Review* 64, no. 3 (2007): 1105.

117 *Ibid.*, 1106.

118 Williams, 650.

119 *Ibid.*, 650.

120 *Ibid.*, 651.

121 *Ibid.*, 651.

122 Brady, 1105.

123 Williams, 652.



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This presents an inherent conflict between medical tourism and ERISA's fiduciary duty because the question arises as to whether the cost saving element qualifies the decision to implement medical tourism as "defraying reasonable expenses", or does the risk and potential profit to the plan, preclude the decision to outsource from being in the interest of the plan participants.¹²⁴

There are three arguments that proponents of medical outsourcing use in light of the fiduciary duty imposed by ERISA. The first argument is that the cost savings associated with medical tourism falls within the scope of ERISA's fiduciary duty because plan administrators are obligated to discharge their duties for "the exclusive purpose of...defraying reasonable expense of administering the plan." Second, the decision by the Supreme Court in *Pegram v Herdrich* bolsters the argument that medical tourism does not violate ERISA's fiduciary duty because it is characterized as a mixed medical and eligibility decision made by a physician, and is exempt from ERISA's coverage. Finally, proponents argue that the availability of medical tourism does not violate ERISA, it only imposes a fiduciary duty on those who exercise control over the management of a plan or its assets.¹²⁵

Before medical tourism can be implemented in workers' compensation, the conflict between the fiduciary duty imposed by ERISA and the benefits of medical tourism must be addressed so as to not prevent the cost savings from medical tourism to be lost to the workers' compensation industry.

IMPACT OF PPACA ON MEDICAL TOURISM

The Patient Protection and Affordable Care Act (PPACA) signed by President Obama in March 2010 will affect individuals, health care providers, insurers, and employers.¹²⁶ It represents a dramatic shift in U.S. health policy, and is designed to expand access to health insurance, reduce health care spending, expand federal fraud enforcement and transparency requirements,

¹²⁴ Brady, 1106.

¹²⁵ Ibid, 1106.

¹²⁶ Corinne M. Karuppan and Muthu Karuppan, "Changing Trends in Health Care Tourism," *The Health Care Manager* 29, no. 4 (2010): 351.



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and impose new taxes and fees on health industry sectors.¹²⁷ The political argument for PPACA equates coverage with access, and access to health care is dependent on the capacity of the health care system to absorb increased demand. Many of these changes will not take place until 2014, and there are hints that the “squeeze” on capacity may mean longer wait times for elective surgery. The new health care reform is seen by some as a push for insurers to include plans with medical travel options.¹²⁸

It is too early to tell what the impact of PPACA will be on the health care system of the U.S.; yet the effects of PPACA on the international health care community will be far-reaching and economically substantial. For the U.S., the influence of health reform will serve as an impetus towards accelerated globalization of the U.S. health care industry, and will encompass the export of patients abroad. Medical tourism is likely to experience explosive growth over the next three to five years due to the changes in the U.S. health care industry brought about by reform.¹²⁹ PPACA has already planted seeds for comparison shopping in health care, which will benefit both domestic and outbound medical tourism.¹³⁰

Much of the discussion so far has been focused on medical tourism from the standpoint of the health care side, which is understandable given the state of the health care system in this country. The laws and regulations imposed upon the health care system are equally incumbent on the workers' compensation system and present a formidable obstacle to implementing medical tourism. The laws in Oregon and Washington State would suggest that at least as far as these states are concerned, medical tourism in workers' compensation does not present a problem. However, in order for medical tourism to become a part of the workers' compensation system in the US, the laws previously mentioned and many other laws may need to be amended or repealed.

¹²⁷ Brad Beauvais, Matt Brooks and Suzanne Woods, “Gazing through the Looking Glass...Analysis of the Impact of the US Health Care Reform Bill on the International Health & Business Landscape,” (paper presented at the Seventeenth Annual South Dakota International Business Conference, Rapid City, SD, October 1, 2010), 51.

¹²⁸ Karuppan and Kauppan, 351.

¹²⁹ Beauvais, et al., 61.

¹³⁰ Karuppan and Karuppan, 357.



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WORKERS' COMPENSATION CASE LAW AND MEDICAL TOURISM

An exhaustive case law search resulted in identifying three cases that support or refute the implementing of medical tourism into the workers' compensation arena. However, these three cases do offer some insight into how courts might rule regarding the implementation of medical tourism in workers' compensation.

In *State Compensation Insurance Fund v. Workers' Compensation Appeals Board*¹³¹, a Mexican resident, working in California as a laborer, fell from a ladder in January 1975. He was treated by the Fund until February 1975. He received treatment from a Mexican provider in his hometown of Tijuana. The medical reports were prepared by both the treating physician and another doctor. The WCAB made an award ordering reimbursement for treatment, as well as for medical-legal costs. The State Fund petitioned for reconsideration to disallow reimbursement on the grounds that both physicians were not licensed under California law. The petition was denied, and the case was appealed.

The Court of Appeal affirmed the Board's award, citing that the definition of physician in the CA Labor Code¹³² does not exclude physicians licensed to practice in another country, and when medical treatment and reports are procured from physicians in accordance with Labor Code, § 4600¹³³, employers are responsible for reasonable expense of treatment and medical-legal costs. The court held that the definition of physicians in the statute was unreasonable in light of clear jurisdiction of the Board over extraterritorial injuries when the contract of hire was made in California.

The next case, also in California, was a case of domestic medical tourism, and has some relevance on implementing medical tourism for workers' compensation abroad because it involves the matter of distance. In *Braewood Convalescence Hospital et al. v. Workers' Compensation Appeals Board*¹³⁴, the applicant, Eugene Bolton, worked as a cook for the employer,

¹³¹ State Compensation Insurance Fund v. Workers' Compensation Appeals Board, 69 Cal. App.3d 884 (1977).

¹³² CA Lab Code, § 3209.3.

¹³³ CA Labor Code, § 4600.

¹³⁴ Braewood Convalescence Hospital et al. v. Workers' Compensation Appeals Board, 34 Cal.3d 159 (1983).



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Braewood Convalescent Hospital. He slipped and sustained injuries to his back and right elbow. He was overweight at the time of the accident, having weighed 422 pounds. His treating physician and two of the employer's physicians recommended he lose weight to facilitate his recovery from his injuries. On the recommendation of a friend, he enrolled in the Duke University obesity clinic in Durham, North Carolina in February 1979. He participated at the clinic for ten months and lost 175 pounds.

In November 1979, he returned to California because he could no longer afford to continue the program. He filed for reimbursement of his expenses at the clinic, which included medical, lodging, special diet and transportation costs. The Workers' Compensation Judge awarded him temporary disability prior to his enrollment at the clinic, the cost of the clinic, and his future participation in the program. Braewood sought reconsideration and challenged the award for past and future self-procured medical treatment. The WCAB granted reconsideration of the judge's failure to award temporary disability benefits during the time of his treatment at the clinic. After reconsideration, the WCAB affirmed the judge's award. On appeal, the employer contended that the WCAB erred in awarding reimbursement, temporary benefits and compensation for future treatment.

The Supreme Court of California affirmed the award of the WCAB by holding that, although the employer had a right to direct applicant to a specific weight-reduction program¹³⁵, such a right was lost as a result of employer's failure to act by identifying and offering an alternative program, thus the applicant acquired the right to choose for himself which program to undertake, and that the right of reimbursement was part and parcel of his proper exercise of the right to choose.¹³⁶ The evidence supported the WCAB's conclusion of reasonableness of location 3,000 miles from applicant's home, and thus the costs of attending were reimbursable. The applicant was entitled to the award of temporary disability for the period he participated in the program, and the recommendations of two physicians to lose weight were sufficient to support award for cost of future medical treatment.¹³⁷

¹³⁵ Cal Civ. Prac. Workers' Compensation, §2:29.

¹³⁶ CA. Labor Code, §4600.

¹³⁷ Braewood Convalescence Hospital et al. v. Workers' Compensation Appeals Board, 34 Cal.3d 159 (1983).



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The last case, *AMS Staff Leasing, Inc. v. Arreola*¹³⁸, involved an undocumented Mexican worker in Florida who was injured in January of 2005, when a vehicle struck him in the right leg as he was unloading trash from the back of a truck. He was hospitalized for a long period of time, and had twelve surgeries to repair the fracture. In August 2005, he was seen by an orthopedist in Dallas, who recommended additional surgery. Arreola, never got the surgery in the US, as he returned to Mexico in November, and did not have legal documents to return to the US.

In February 2006, Arreola's lawyer sent a letter to the counsel for the employer/carrier requesting authorization of one of three orthopedic doctors in Arreola's hometown of Jalisco. The employer/carrier did not offer him any medical care in Mexico and refused to authorize any Mexican physicians to treat him. In March 2006, the claimant went to a hospital in Jalisco and was assigned to an orthopedic surgeon. The surgeon's diagnosis was the same as the orthopedist in Dallas, and it was his opinion that Arreola's chances to return to work were poor. Arreola filed a Petition for Benefits seeking authorization for continued medical care in Mexico and for costs and attorney's fees. The employer/carrier defended the petition on the grounds there were no known orthopedic doctors in Mexico who qualified as a "physician" according to the workers' compensation statutes.

The Judge of Compensation Claims entered an order directing the employer/carrier to provide written authorization to the orthopedic surgeon in Mexico to provide Arreola "with ongoing care that is reasonable, and medically necessary, and related to the industrial accident." The judge also ordered the employer/carrier to pay for that care. In August 2006, the claimant filed another Petition of Benefits for Temporary Partial Disability (TPD) Benefits. He was awarded the benefits after a second hearing.

The employer/carrier challenged the two orders of the Judge for the TPD benefits and the continuing medical care in Mexico. The Court of Appeal ruled that state law did not preclude the foreign physician's treatment of the claimant in Mexico. They stated that Florida workers' com-

¹³⁸ *AMS Staff Leasing, Inc. v. Arreola*, 976 So.2d 612 (2008).



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pensation law contemplates coverage for non-citizens, and they cited an earlier case in which the court held that undocumented workers were entitled to workers' compensation coverage in Florida¹³⁹, and two later cases^{140,141} that held that "to construe the section 440.13(2)(a) in a manner that would limit authorized treatment for a claimant injured in Florida to a physician licensed in the State, or anywhere else in the US, would preclude workers (including illegal aliens) who return to their home country from receiving authorized remedial care for clearly compensable injuries."

The Court of Appeal in the Arreola case also stated that Florida law indicates that an injured worker is not prohibited from moving from his pre-injury residence in the state, and receiving treatment outside of the state. As the claimant was no longer living in Florida, the court held that this case was different from the *Decker v. City of West Palm Beach*¹⁴², *United Records & Tapes v. Deall*¹⁴³ and *Layne-Western Co. v. Cox*¹⁴⁴ cases that the defendants cited, in that Arreola was already living in Mexico when he requested medical treatment. Therefore, the trial court did not err in directing the employer/carrier to authorize treatment by a Mexican physician, and the trial court's decision was affirmed by the court.

139 Cenvill Dev. Corp. v. Canelo, 478 So.2d 1168 (Fla. 1st DCA 1985).

140 Safeharbor Employer Servs., Inc v. Velazquez, 860 So.2d 984 (Fla. 1st DCA 2003).

141 Gene's Harvesting v. Rodriguez, 421 So.2d 701 (Fla. 1st DCA 1982)

142 Decker v. City of West Palm Beach, 379 So.2d 955 (Fla. 1st DCA 1980).

143 United Records & Tapes v. Deall, 378 So.2d 99 (Fla. 1st DCA 1979).

144 Layne-Western Co. v. Cox, 497 So.2d 955 (Fla. 1st DCA 1986).



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CONCLUSION

Research into the legal barriers to implementing medical tourism into workers' compensation found nothing of any real substance that would prevent workers' compensation cases from benefiting from medical tourism. We have seen that there still remains several legal barriers to the implementation of medical tourism into workers' compensation. Various federal and state laws need to be changed, and the issues of medical malpractice and liability laws, patient privacy and medical record laws and HIPAA, as well as ERISA and the impact of PPACA must all be addressed. But it is my opinion that these barriers can and will be overcome, especially in light of case law that has broken down some of those barriers already for foreign workers. The cost savings that can be achieved and the quality of care that matches, and even surpasses that found in the U.S., is sufficient reason why medical tourism should be implemented.

However, those opposed to implementing medical tourism into workers' compensation would make the point that we cannot be certain of the quality of care and outcomes of medical procedures performed, especially in third world countries where the living conditions might not be ideal for recovery and healing. They may also add that the technology and skill level of the physicians are not on the same level as that found in the U.S. And finally they may be reluctant to spending money to fly a claimant and a companion to another country for what may seem to be a "medical vacation".

Yet, the creation of the Joint Commission International to assess the quality of foreign hospitals has brought about a higher standard of care. There are more physicians trained in the U.S. or in the U.K. in many of the countries catering to medical tourists, utilizing the latest technology and medical training available, as well as many of them being board-certified in various medical specialties. The costs for three of the most common procedures in India, Thailand and Singapore includes the cost of airfare, hospital and hotel, and is considerably cheaper than having the injured worker treated in the U.S.



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LEGAL CRITICISMS OF MEDICAL TOURISM AND WORKERS' COMPENSATION

There will still be objections to implementing medical tourism from the defendant community, (i.e., employers and their insurance carriers); however, the courts in both of the cases presented here ruled against the defendants in those cases. The defendants argued on the grounds that the physicians treating the plaintiffs in Mexico were not licensed in the states where the cases occurred, or in any other U.S. state. The court in *State Comp Ins. Fund* denied the defendant's petition to reconsider the WCAB award on the grounds that the definition of a physician did not exclude physicians licensed to practice in another country. The court in *AMS Staff Leasing, Inc.* ruled that state law did not preclude treatment by a foreign physician.

Defendants also stated that there were no known orthopedic doctors in Mexico who qualified as a "physician" as the term is used in the statutes. This argument about there not being any *known* orthopedic doctors is specious at best, given the fact that many doctors are being trained in the U.S. and are board-certified here as well.

It would appear that at least for the moment, the courts are willing to allow some measure of medical tourism in workers' compensation. How future courts will decide is unclear, but there is at least some precedent for ruling in favor of medical tourism. Another way in which medical tourism will be implemented is if workers' compensation carriers, realizing the benefits of medical tourism, push for it at the state and federal level. The evidence presented here has indicated that employers and insurance companies may not have a choice in the matter as the cost of health care rises and the process of reform taking place makes it obvious that the increased competition will offer medical tourism as viable option to lower costs.

The globalization of health care will necessitate the removal of all barriers to providing the best care possible at the lowest cost. The cost savings that are being realized by medical tourism as a part of the health care industry can be just as beneficial in workers' compensation. Therefore, medical tourism should be implemented into workers' compensation and the legal barriers should be modified.



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FOR MORE INFORMATION

MEDICAL TOURISM ASSOCIATION (MTA)

The Medical Tourism Association™ (Global Healthcare Association) is the first and only international non-profit trade association for the medical tourism and global healthcare industry made up of the top international hospitals, healthcare providers, medical travel facilitators, insurance companies, and other affiliated companies and members with the common goal of promoting the highest level of quality of healthcare to patients in a global environment. Our Association (Global Healthcare Association) promotes the interests of its healthcare provider and medical tourism facilitator members. The Medical Tourism Association™ (Global Healthcare Association) has three tenets: Transparency in Quality and Pricing, Communication and Education.

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The Medical Tourism Association™ has partnered with the International Healthcare Research Center on all future research projects. The International Healthcare Research Center, a 501(c)3 nonprofit research center, focuses on market research, trends and analysis and providing actionable intelligence for the Medical Tourism, International Healthcare and International Health Insurance Industry. The International Healthcare Research Center does its own independent research as well as partner with third party research organizations and educational institutions.

Types of Research

- International patient experiences & outcomes
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- Patient demographics
- Trends & analysis of international patient care
- Global health insurance research
- Hospital research
- Researching healthcare issues with local populations and understanding health, wellness and population health management that can positively affect the health and wellbeing of individuals

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