LAW & MEDICINE

Medical 'Adventures' Abroad

BY MILES J. ZAREMSKI, J.D.

Remember when the heads of state came to this country for medical care they couldn't get elsewhere? Potentates and prime ministers alike would visit facilities such as the Mayo Clinic and Cleveland Clinic because that was where the best medicine in the world was practiced. Of course, money was never an issue for them.

Even now, patients with cleft palate and other deformities come to this country—often as charity cases—for treatment unavailable in their native lands. But now the tide is beginning to turn. Increasingly, Americans are seeking health care in lands other than the United States.

The main reason? Saving money. A hip replacement in Mexico costs $12,000 compared with $43,000-$63,000 in the United States. Statistics indicate that more than 300,000 U.S. citizens sought treatment outside the borders in 2003 alone, with the McKinsey Quarterly (May 2008) projecting 60,000-85,000 inpatient visits per year overseas. Most of those who travel overseas for care are uninsured or underinsured.

Would-be overseas patients have a few issues to consider. First, what about insurance? Does it cover procedures overseas? In general, *caveat emptor*. Check your health plan before making reservations to go abroad.

Employers also have been looking into providing medical tourism as a benefit of employment. According to U.S. News & World Report, one North Carolina employer was prepared to have an employee undergo two medical procedures in India, but the company's union opposed subjecting him to medical care without appropriate safeguards and legal rights.

Though traveling abroad presents a myriad of issues—such as navigating a foreign locale, unfamiliarity with native customs, obtaining appropriate follow-up care, differences in licensure, privacy issues, and medical malpractice claims—Fredric J. Entin, a Chicago legal guru, reports that more employers are considering health care abroad for their employee health benefit plans offered as early as 2010. He adds that a complicating factor will be the formation of physician and hospital networks willing to provide preoperative and follow-up care. For this option to work, patients must have some sort of recourse if a serious medical error is made.

Should medical negligence occur, patients could very well be hard-pressed to pursue the kinds of remedies they might get in this country. Many countries—such as New Zealand, for example—have a "no fault" system of recovery, i.e., recovery that is limited according to a scale of what certain injuries are worth. Ila S. Rothschild, a respected health care attorney, notes that Thailand does not recognize claims for pain and suffering.

Requiring overseas doctors or hospitals to defend malpractice claims filed in the United States for acts of medical negligence overseas will be difficult or impossible. One considerable hurdle will be proving jurisdiction of an American court over medical care and treatment abroad by one or more defendants.

Even having entities advertising over the Internet in this country on behalf of foreign-based health care facilities is no guarantee that these sites submit themselves to being sued in an American court. Many such sites provide a disclaimer to acting under American law on behalf of any health care facility or physicians in another country. If an American is injured during treatment rendered in another country, the odds are that such an individual will not be able to recover stateside.

In the end, the popularity of medical tourism is slowly progressing, regardless of the risks and inherent problems. However, as Mr. Entin observes, the gatekeeper to medical tourism moving from its current model to one that allows patients due process will be setting up financial relationships and liability procedures similar to those in this country. Only time will tell if he is right. ■

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Contractors' Protests Halt RAC Rollout

The national rollout of Medicare's Recovery Audit Contractor program is on hold because of protests filed by two contractors who bid unsuccessfully to be part of the program.

The dispute will be reviewed by the Government Accountability Office (GAO) and a decision is expected next month. In the interim, officials at the Centers for Medicare and Medicaid Services imposed an automatic stay on any work by the four regional recovery audit contractors (RACs) recently selected by the agency.

The stay means that the agency has postponed most of its provider outreach efforts. However, the delay is temporary and not expected to result in any substantive changes to the program, according to CMS.

The RAC program is aimed at identifying and correcting improper payments—both over and under—made through the Medicare fee-for-service program. But the program has been unpopular with physicians, who say it adds administrative hassles and puts the burden on physicians to prove that payments they received were correct.

The RAC program was mandated by Congress as part of the Medicare Modernization Act.

—Mary Ellen Schneider