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Health Law: Canadian Medical Tourism: Expanding Opportunities and Reducing Legal Risks for American Healthcare Providers

R. Gregory Cochran

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The term "medical tourism" commonly evokes an image of wealthy Americans going to Switzerland for cosmetic surgery or not-so-wealthy Americans going to Mexico or Canada for cheaper pharmaceutical products. But medical tourism from other countries, including Canadians coming to the U.S. for procedures, pharmaceuticals, and other treatments, is growing rapidly. U.S. healthcare providers have found this "Inbound Medical Tourism" market appealing economically because, among other reasons, these patients usually pay all cash in advance.

To facilitate this line of business in the Canadian market, U.S. providers sometimes establish relationships with "lay" for-profit Canadian medical-tourism brokers to provide patients with assistance arranging travel and coordinating the medical services. However, depending on the financial aspects of such arrangements, the broker's referrals to the U.S. providers may subject the providers to risk under U.S. fraud-and-abuse laws, including the federal Stark Law and Antikickback Statute (AKS), as well as their state-level analogs. U.S. providers may also experience great variability in the quality of screenings of patients and in the quality of communications with the Canadian primary-care medical practices.

This chapter demonstrates that, by eliminating lay Canadian medical-tourism brokers from the arrangements and shifting the responsibility for providing the traditional broker services to a primary-care medical practice that also identifies and screens the patients, U.S. providers can reduce or even eliminate much potential fraud and abuse liability. This model also improves the quality of the experience for patients because they need only interact with the Canadian medical practice for all the services. The U.S. providers also benefit by establishing ongoing relationships with a single Canadian medical practice, rather than with a broker whose clients are patients of countless physicians.

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1. Summarized and excerpted from R. Gregory Cochran & Alicia Corbett, *Canadian Medical Tourism: Expanding Opportunities and Reducing Legal Risks for American Healthcare Providers*, 57 JURIMETRICS J. 211 (2017).

In-Bound Canadian Medical Tourism from Canada

Despite generally higher prices in America than in many other nations, Canadians are among many who travel to the United States for medical care, seemingly motivated primarily by lengthy wait times for nonemergency medical procedures and diagnostic tests in the Canadian national healthcare system.[2] Premier providers in the United States, such as Cleveland Clinic and Mayo Clinic, have consistently attracted foreign residents, particularly those from other nations in the Americas. In addition to attracting patients with the world-class medicine they offer, these institutions also assist international patients with arranging travel and with every other aspect of their care and treatment. Canadian patients who seek care from U.S. physicians and hospitals who do not offer those medical tourism-related services often engage lay-owned or lay-operated medical-tourism brokers or facilitators,[3] who offer medical tourists the gamut of services, ranging from travel packages to identifying physicians and hospitals and brokering all aspects of both the medical and travel arrangements.[4]

For several reasons, U.S. providers generally have not embraced Inbound Medical Tourism. Some believe it adversely affects Americans' access to, and allocation of, limited healthcare resources.[5] However, medical tourism does not do so, and it may in fact serve to increase access to certain technologies, procedures, and treatments. Many U.S. providers are also concerned about the financial risk in such unfamiliar and relatively untested approach. However, if structured appropriately, Inbound Medical Tourism can increase revenues to U.S. physicians, hospitals, and their local economies.

Some U.S. providers are also deterred from engaging in these arrangements because of the generally recognized legal risk in establishing financial relationships with referral sources under the myriad federal and state healthcare fraud-and-abuse laws, including

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2. Catherine Regis et al., *Implementing Medical Travel in the Canadian Health Care System: Considerations for Policy Makers*, 20 HEALTH L.J. 73, 74, 83–84 (2013).

3. The terms *lay owned* or *lay operated* here mean that the entity is not owned or operated by licensed healthcare professionals or healthcare entities.

4. *See, e.g.*, Lydia Gan & James Frederick, *Medical Tourism Facilitators: Patterns of Service Differentiation*, 17 J. VACATION MARKETING 165, 170 (2011).

5. *See, e.g.*, Y. Y. Brandon Chen & Colleen M. Flood, *Medical Tourism's Impact on Health Care Equity and Access in Low- and Middle-Income Countries: Making the Case for Regulation*, 41 J.L. MED. & ETHICS 286 (2013); I. Glenn Cohen, *Medical Tourism, Access to Health Care, and Global Justice*, 52 VA. J. INT'L L. 1 (2011); Laura Hopkins et al., *Medical Tourism Today: What Is the State of Existing Knowledge?*, 31 J. PUB. HEALTH POL'Y 185, 192–94 (2010).

antikickback, self-referral, and fee-splitting laws. One concern is that any fees or other remuneration that U.S. medical providers pay to Canadian lay-owned brokers may, without implementing substantial safeguards, inappropriately encourage referrals and thus may be prohibited under U.S. federal or state laws, many of which call for potentially severe consequences for non-compliance.

It turns out that medical tourism arrangements between U.S. and Canadian providers will not run afoul of the most feared U.S. *federal* fraud-and-abuse laws—the Stark Law and AKS—even if a for-profit medical-tourism broker is involved, because such laws apply only to financial arrangements involving referrals for treatment and care of beneficiaries of the U.S. Medicare, Medicaid, or other federal healthcare payor programs, for which Canadians do not qualify. But certain *state* antikickback, self-referral, and fee-splitting prohibitions typically apply more broadly and are not limited in their applicability only to arrangements where the patients are Medicare, Medicaid, or other federal healthcare-program beneficiaries.

A U.S. provider's risk of running afoul of such laws is substantially reduced by replacing the for-profit, lay-owned entity with a Canadian medical practice that does not seek to profit from the arrangement to provide the broker's usual services. Further, proposed changes to applicable state fraud-and-abuse laws can essentially eliminate legal risk arising out of Inbound Medical Tourism ventures. Without compromising their patient-protection policy goals, such revised laws would assure potentially interested medical-tourism service providers that properly structured arrangements will be safer from a compliance perspective.

Benefits and Nonlegal Risks

The Inbound Medical Tourism model proposed here can financially benefit both the participating U.S. medical providers and the local economies where such providers are located. The model has potential drawbacks, including harms to the U.S. population, but the potential benefits outweigh the potential risks.

Using appropriately structured models, U.S. providers benefit from increasing medical tourism to their facilities and communities. Canadian medical tourists pay the U.S. providers in advance for care out-of-pocket, improving cash flow and revenue and, in some cases, offsetting declining revenues from the providers' other sources, including private and government insurance programs.

Medical tourists' expenditures on travel confer another economic benefit on the United States, particularly on the local area where the services are provided, especially when medical tourists bring companions or when they remain in the U.S. for some time to recover before returning home. Medical tourism may also reduce the excess capacity for some medical services in the U.S. Excess capacity and underutilization may reduce recovery from investments in expensive equipment such as MRIs, thereby discouraging investment and growth.[6] Medical tourists absorb some of that excess capacity, thereby improving the return on physicians' and hospitals' investments in such technology and equipment.

Indeed, medical tourism can reduce access to healthcare for the destination country's poor, particularly for countries with dramatic and clear disparities in access to healthcare between the rich and poor.[7] For several reasons, the Inbound Medical Tourism model proposed here would not create or accentuate class-based disparities in access to care. Inbound Medical Tourism may in many cases create a demand for certain procedures and technology to improve the economies of scale for implementing such procedures and technology, thus making them more available to a larger segment of the region's population. Further, the class-based disparities in access to care are less likely to arise in this model because the U.S. providers are not likely to begin turning away patients and alienating their solid local network of referral physicians because they prefer the terms associated with their Canadian patients.

Even if the model led to displacement of some U.S. patients, such displacement should be relatively insignificant and short-lived and would likely affect directly only the local market where medical tourists seek treatment. At the same time, such ventures should have a net immediate positive impact on health for the medical tourists and a net longer-term improvement on health for the local population because of improved access to more services and technology.

Applicable U.S. Laws

None of the U.S. federal fraud-and-abuse laws, such as the Stark Law and the AKS, poses a barrier to the Inbound Medical Tourism model proposed here. These laws pertain only to referrals of patients for

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6. *See* Robert S. Kaplan & Michael E. Porter, *How to Solve the Cost Crisis in Health Care*, 89 HARV. BUS. REV. 47, 59 (2011).

7. *See, e.g.*, Rupa Chanda, *Trade in Health Services*, 80 BULL. WORLD HEALTH ORG. 158, 160 (2002).

healthcare services financed by the U.S. federal Medicare, Medicaid, or certain other healthcare programs,[8] of which Canadian citizens who reside in Canada are not and cannot be beneficiaries.[9] These federal laws therefore impose no prohibitions on Canadian Inbound Medical Tourism.

State fraud-and-abuse laws, however, present some risk to the transactions necessary to effectuate the model because these state laws typically are more broadly applicable to all healthcare services, regardless of payor source. Examples of such laws include the California Antikickback Statute and Health & Safety Code § 445 (collectively, the California Antikickback Laws) and California's Physician Ownership and Referral Act ("PORA"). Providers may, however, implement certain safeguards to minimize such risks without substantially affecting the arrangement's economic or practical benefits.

The California Antikickback Laws present liability risk under the proposed model if any aspect of the compensation and services exchange could be construed as "compensation or inducement for" the practice's referral of patients to the surgical group or to the hospital, respectively.[10] From a business perspective, the parties would prefer not to ask patients to pay each provider separately, so the model presumes cash will flow from the patients to the U.S. surgical practice, which will then redistribute the Canadian medical practice's and the hospital's portions to them. This redistribution of proceeds, while not per se prohibited, must avoid the appearance of improper "fee-splitting," which the California Antikickback Laws explicitly prohibit. Structuring the arrangement so that the patients pay each of the three entities separately and maintaining documentation that such payments are consistent with the fair-market value of the services will substantially reduce risk for liability under these laws.

California's PORA, similar to the federal Stark law but not limited to beneficiaries of federal healthcare programs, prohibits physicians from referring patients to any provider of certain specified services ("PORA-Covered Services") if the physician or a member of his or her immediate family has a financial relationship with the provider that receives the referral.[11] PORA-Covered Services do not include surgical services, however, so a Canadian medical practice's financial relationship with a

8. Other federal health programs include the Veteran's Administration, CHAMPUS, and the Indian Health Services.

9. This analysis does not address whether a dual citizen of both the United States and Canada, residing in Canada, may be an American Medicare or Medicaid beneficiary.

10. CAL. BUS. & PROF. CODE § 650.

11. *Id.* § 650.02(a).

U.S. surgical practice will not be subject to PORA if the Canadian medical practice refers its patients to the U.S. surgical practice primarily for surgical services. Although such referrals undoubtedly will include some ancillary PORA-Covered Services, such as laboratory and x-ray services, PORA does not prohibit referrals even for PORA-Covered Services if the hospital "does not compensate the [physician] for the referral."[12] Thus, even if the California agencies that enforce PORA were to take the position that Canadian physicians are subject to PORA (notwithstanding that they are not California "licensees" and notwithstanding their physical presence outside California) their referrals to a U.S. surgical practice and those to the U.S. hospital will comply with PORA as long as none of the remuneration exchanged serves to compensate the physician for the referral.

Legal Changes to Encourage Medical Tourism

Ensuring that any fees are based on the fair-market value of the services provided will reduce but not eliminate the risk of liability under relevant state laws. To eliminate the risk, state laws should create a formal antikickback safe harbor and PORA exception for the kinds of medical-tourism arrangements proposed here. A safe harbor under the California Antikickback Laws could be a standalone statement like the other safe harbors under the California Antikickback Statute and thus could take the following form:

> An arrangement under which a provider remits a portion of a fee it collects from a patient to another provider or to a broker that arranges administrative and/or travel services for patients to travel to the provider, where such other provider or broker is located outside of California, and where such portion of such fee is consistent with fair market value for the services provided by the out-of-state provider or broker, and pursuant to a written arrangement between and among the parties, shall not be deemed to violate this Section [650] [445].

A PORA exception could be worded almost identically except to delete the phrase "shall not be deemed to violate this Section [650] [445]" to conform to PORA structure. Legislators also could make a policy decision on whether to permit payment of a portion of the fee to

12. *Id.* § 650.02(c)(1).

any broker or limit allowed payments to those made to other medical professionals or medical practices.

These statutory revisions would permit U.S. surgical practices or hospitals to collect the entire fee from the patient and in turn pay the Canadian medical practice a reasonable fee based on the fair-market value of the services provided by the Canadian medical practice in administering the arrangement, without fear of legal liability or regulatory scrutiny in California.

Conclusion

Although enabling medical tourists, particularly Canadians, to seek care in U.S. hospitals can be a win-win situation for providers and their communities, U.S. medical providers of services to medical tourists face an uncertain regulatory environment with respect to the state equivalents of the federal AKS and Stark Law. Providers may take certain steps to significantly reduce this liability risk. To eliminate the risk, state legislators and regulators should revise current laws to permit doctors and hospitals to enter into a wider range of medical-tourism arrangements. Lawmakers can do so without affecting the laws' patient-protection policy goals, and such changes may also incentivize the tourists' home countries to ameliorate the problems that led their citizens to seek care elsewhere.

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