

CANADIAN MEDICAL TOURISM: EXPANDING OPPORTUNITIES AND REDUCING LEGAL RISKS FOR AMERICAN HEALTHCARE PROVIDERS

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ABSTRACT: Medical tourism, growing worldwide, includes Canadians coming to the United States for medical treatment. For U.S. healthcare providers to take advantage of the potential economic benefits of cash-paying Canadian medical tourists, they must comply with U.S. federal and state laws governing fraud and abuse, including the federal Stark Law and Anti-Kickback Statute (AKS), and state-level analogs. These laws may restrict the ability of U.S. healthcare providers to compensate foreign medical tourism brokers, who play an important role in the growth of medical tourism by providing patients with assistance arranging travel and medical services. Using a hypothetical arrangement among U.S. healthcare providers and a Canadian medical practice that not only provides the typical broker services, but also serves to identify appropriate cases for referral from a medical perspective, this article demonstrates how to reduce or even eliminate potential fraud and abuse liability, while improving the quality of the experience for both patients and U.S. providers.

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Medical tourism has existed for millennia. In ancient times, people traveled to hot springs for healing.¹ In recent decades, increasing numbers of medical tourists from countries in the developed world—including the United States—have been traveling to numerous developing nations, such as Mexico, Thailand, and India, seeking lower cost medical procedures and treatments as well as procedures that may not be readily available or even legal in travelers' home

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1. Kate Pickert, *A Brief History of Medical Tourism*, TIME (Nov. 25, 2008), <http://content.time.com/time/health/article/0,8599,1861919,00.html>.

nations.² The literature about the legal issues arising from medical tourism to the developing world is extensive.³

Yet, there is also a long history of medical travel to developed nations, including the United States. Premier providers, such as Cleveland Clinic and Mayo Clinic, have consistently attracted wealthier residents of other countries, particularly those from other nations in the Americas,⁴ who are drawn to the world-class medicine provided at these institutions, many of which specifically devote personnel to assisting international patients with arranging every aspect of their care and treatment, even travel arrangements.⁵ Given the geographic proximity, it is not surprising that some Canadians are among those seeking medical care in the United States.

Despite generally higher prices in the United States than in many other nations, a number of Canadians have traveled to the United States for medical care in recent years,⁶ ostensibly motivated by lengthy wait times for nonemergency medical procedures and diagnostic tests in the Canadian national healthcare system.⁷ Medical tourism brokers or facilitators, which are typically “lay” owned or operated,⁸ whether located in Canada or elsewhere, offer medical tourists the gamut of services, ranging from solely travel package deals to those that include identifying physicians and hospitals and brokering all aspects of both

2. See *id.*; NEIL LUNT ET AL., MEDICAL TOURISM: TREATMENTS, MARKETS AND HEALTH SYSTEM IMPLICATIONS: A SCOPING REVIEW 14 (2011), <https://www.oecd.org/els/health-systems/48723982.pdf> (Estimates of the numbers of medical tourists worldwide range from 60,000–85,000 to 50 million individuals.); Kai Ruggeri et al., *Evidence on Global Medical Travel*, 93 BULL. WORLD HEALTH ORG. 785, 785–86, 786 tbl.1 (2015), <http://dx.doi.org/10.2471/BLT.14.146027> (noting the shortcomings of available data on medical travelers worldwide); I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1477 (2010) (discussing types of medical tourism).

3. See, e.g., Cohen, *supra* note 2; Nicolas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421 (2007).

4. Mayo Clinic has dedicated representative offices in Canada, Colombia, Ecuador, Guatemala, and Mexico. *Representative Offices*, MAYO CLINIC, <http://www.mayoclinic.org/departments-centers/international/representative-offices> [<https://perma.cc/3YWS-XNRF>] (last visited Jan. 19, 2017).

5. See, e.g., *International Services*, MAYO CLINIC, <http://www.mayoclinic.org/departments-centers/international> [<https://perma.cc/HH4T-NHVB>] (last visited Jan. 19, 2017); *International Patient Services*, CLEV. CLINIC, <http://my.clevelandclinic.org/patients-visitors/international> [<https://perma.cc/7EV4-X36A>] (last visited Jan. 19, 2017).

6. While the precise number of Canadians coming to the United States is uncertain, the number is a subset of the 52,000 Canadians estimated to have traveled in 2014 to all other countries, up from 41,838 in 2013. See BACCHUS BARUA & FEIXUE REN, LEAVING CANADA FOR MEDICAL CARE, 2015, FRASER RESEARCH BULLETIN 4 (2015), <https://www.fraserinstitute.org/sites/default/files/leaving-canada-for-medical-care-2015.pdf> [<https://perma.cc/G8AY-T9AT>].

7. 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); Bacchus Barua, *Waiting Your Turn: Wait Times for Health Care in Canada, 2015 Report*, FRASER INST. (Dec. 8, 2015), <https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2015-report> (Canadians waited an average of “10.4 weeks for a magnetic resonance imaging (MRI) scan” in 2015.).

8. We use the terms *lay owned* or *lay operated* to mean that the entity is not owned or operated by licensed healthcare professionals or healthcare entities.

the medical and the travel arrangements.⁹ U.S. providers have not generally embraced the notion of receiving healthcare business from other countries in the context of commercially brokered packages and deals.

Furthermore, American healthcare providers are understandably sensitive to the potential penalties associated with noncompliance with the myriad anti-kickback, self-referral, and fee-splitting laws at both the federal and state levels.¹⁰ As such, they may feel uncertain about the legality of expanding their business dealings to include physicians and other entities outside the United States, which would necessarily result in the need to reevaluate their existing compliance policies and programs with input from legal counsel. Indeed, while foreign-based brokers are likely to escape the grip of U.S. federal and state laws that brokered arrangements might implicate, U.S.-based physicians, hospitals, and other providers involved in such arrangements do not escape this risk and thus may be deterred from participating.

Aside from legal risk, U.S. providers are likely also to be concerned with limits on their financial return and inflexibility about the nature and structure of such referral arrangements. Perceived adverse impacts of inbound medical tourism on access to, and allocation of, limited healthcare resources in the destination nation raise additional concerns.¹¹ However, as discussed below, medical tourism to the United States does not necessarily adversely impact Americans' access to healthcare services and may indeed serve to increase access to certain technologies, procedures, and treatments. Even more importantly, medical tourism can increase revenues to U.S. physicians and hospitals as well as their local economies, with minimal potential for legal liability under U.S. fraud and abuse laws, provided the parties agree to a few relatively straightforward parameters.

To support our view of the positive impact of medical tourism with limited concerns for adverse U.S. medical regulatory repercussions, we begin by examining briefly the evolution of Canadian medical tourism to the United States (referred to herein as Inbound Medical Tourism) and the role of Canadian medical tourism brokers. We then set forth a hypothetical, mutually beneficial Inbound Medical Tourism arrangement among a U.S. medical group, a U.S. hospital, and a Canadian primary care physician practice that acts as the medical tourism broker, in lieu of utilizing a lay medical tourism broker, the reasons for which will unfold during our analysis.

9. See, e.g., Kail Penney et al., *Risk Communication and Informed Consent in the Medical Tourism Industry: A Thematic Content Analysis of Canadian Broker Websites*, 12 BMC MED. ETHICS, art. no. 17, 2011, at 1, 2; Lydia Gan & James Frederick, *Medical Tourism Facilitators: Patterns of Service Differentiation*, 17 J. VACATION MARKETING 165, 170 (2011).

10. In the authors' opinion, based on their experience as practicing healthcare attorneys, and Dr. Cochran's experience as a practicing physician.

11. 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); Regis et al., *supra* note 7, at 99–102.

After identifying the economic benefits that increased medical tourism may confer on the U.S. healthcare market and local economies, we turn to the applicable U.S. legal impediments that such arrangements may implicate. We determine that, while our hypothetical arrangement will not run afoul of the U.S. federal Stark Law and federal Anti-Kickback Statute (AKS), certain state-level anti-kickback and fee-splitting prohibitions impose the most substantial of the potential legal impediments on such Inbound Medical Tourism arrangements. Given these state restrictions, we suggest ways to structure these transactions in a manner designed to minimize this risk. We ultimately show that replacing the lay medical tourism broker with a Canadian primary care medical practice—serving as both the clearinghouse for identifying patients and as the broker for negotiating the arrangements—is critical for legal compliance purposes. Replacing the for-profit, lay-owned entity with a medical practice that does not seek to profit from the arrangement¹² serves critically to minimize inappropriate referrals and lowers the risk to the American providers under applicable legal impediments. Despite the ability to structure these arrangements to minimize risk under state laws, we also propose changes to the applicable laws to further eliminate risk from Inbound Medical Tourism ventures, without compromising the patient-protection goals of existing laws.

I. INBOUND MEDICAL TOURISM FROM CANADA

For a variety of reasons Canadian medical tourists look to other countries for care, in spite of essentially free universal publicly funded medical coverage and in spite of the availability of private insurance that some Canadians use to augment the public coverage provided through the country's Medicare program.¹³ Multiple researchers have speculated that the often lengthy wait times to receive many nonemergency procedures, ranging from MRIs to hip replacements, are a principal motivating factor for Canadian medical tourism.¹⁴ The

12. The Canadian practice in our hypothetical does not desire to profit directly from providing the services that would typically be provided by the for-profit broker; however, to the extent the practice's business for professional medical services grows because of its experience in medical tourism, the practice may profit indirectly.

13. Canadians do not pay out of pocket for Medicare-covered services, but only about 70 percent of financing for healthcare in Canada comes from Medicare and 30 percent comes from nonpublic, privately funded, or insurance-reimbursed sources. Karen Born & Andreas Laupacis, *Public and Private Payment for Health Care in Canada*, HEALTHY DEBATE (July 20, 2011), <http://healthydebate.ca/2011/07/topic/cost-of-care/publicprivate>. For example, Medicare does not pay for certain services, which may be complementary (meeting costs not covered by the public system such as the cost of prescription medicines, dental treatments, and copayments) or supplementary (adding more choice of provider or providing faster access to care). *Id.* Canadians must pay for those services out-of-pocket or through supplemental, private insurance. *Id.*; see Regis et al., *supra* note 7, at 74. The article explains that in a complex legal decision in 2005, the Supreme Court of Canada ruled that in some circumstances private insurance could be used to “jump the queue” for medically necessary Medicare-covered services. *Id.*

14. See, e.g., Steven J. Katz et al., *Phantoms in the Snow: Canadians' Use of Health Care Services in the United States*, 21 HEALTH AFFAIRS 19, 21–22 (2002); Milan Korcok, *Excess Demand Meets Excess Supply as Referral Companies Link Canadian Patients, US Hospitals*, 157 CANADIAN MED. ASS'N J. 767 (1997); Regis et al., *supra* note 7, at 74–75; Barua, *supra* note 7 (“[A]ssuming

expense of obtaining noncovered procedures, such as cosmetic and dental procedures, from private Canadian providers can also prompt some Canadians to seek care abroad.¹⁵ Further, certain cutting-edge or experimental procedures, such as Gamma Knife radiation and proton beam cancer treatments, are more widely available in the United States than in Canada,¹⁶ where provincial governments are sometimes unable financially to make the substantial investments in medical equipment needed to provide these services.¹⁷

While Canadians also travel to more distant destinations, including India and Thailand, given the opportunity and financial means, some Canadians prefer to stay closer to home and to seek care from their English-speaking neighbor with a reputation for a high standard of medical quality.¹⁸ A 2008 McKinsey study found that 40 percent of worldwide medical tourists traveled to obtain advanced medical technologies, with most patients reporting this travel motivation obtaining care in the United States.¹⁹ Mayo Clinic estimated that 18–20 percent of its roughly 8200 annual international patient registrations came from Canada in the late 1990s.²⁰

Estimates of the numbers of Canadians seeking medical care in the United States and other countries are not readily available. One study found only 2 percent of Canadian survey participants had previously traveled abroad to receive medical care, although 20 percent indicated they would consider traveling abroad for self-funded medical services.²¹ Given the relatively high cost of U.S. medical services and the inability of lower-income Canadians to afford them, it

that each person waits for only one procedure, 2.5% of Canadians are waiting for treatment in 2015.”).

15. Regis et al., *supra* note 7, at 86.

16. Katz et al., *supra* note 14, at 22.

17. See, e.g., *Donors Make It Happen: World Leading Gamma Knife Technology Is Coming to Edmonton Thanks to Donor Support*, UNIV. HOSP. FOUND., <https://www.universityhospitalfoundation.ab.ca/braincentre/gamma-knife> (last visited Jan. 19, 2017) (noting private donations were needed to establish Gamma Knife procedure availability in Edmonton); *Gamma Knife Surgery*, WINNIPEG REGIONAL HEALTH AUTHORITY, http://www.wrha.mb.ca/prog/surgery/gamma_knife/ (last visited Jan. 19, 2017) (asserting that Winnipeg has “Canada’s first and only [G]amma [K]nife and GKS program”).

18. Valorie A. Crooks et al., *What Is Known about the Patient’s Experience of Medical Tourism? A Scoping Review*, 10 BMC HEALTH SERVS. RES., art. no. 266, 2010, at 1, 5–6 (“The most frequently discussed pull factor [in the literature] was quality.”); see also Rory Johnston et al., “I Didn’t Even Know What I Was Looking for”: A Qualitative Study of the Decision-Making Processes of Canadian Medical Tourists, 8 GLOBALIZATION & HEALTH, art. no. 23, 2012, at 1, 6 fig.1 (Of study participants, the United States was the second most popular destination country for Canadian medical tourists.).

19. Tilman Ehrbeck et al., *Mapping the Market for Medical Travel*, MCKINSEY Q., Autumn 2008, at 80.

20. Korcok, *supra* note 14, at 769. Mayo Clinic now has numerous facilities outside the United States (although none are in Canada), which would reduce the need for patients from those countries to travel to the United States for care.

21. LISA PURDY & MARK FAM, DELOITTE, EVOLVING MEDICAL TOURISM IN CANADA: EXPLORING A NEW FRONTIER IN HEALTH CARE 6, <https://www2.deloitte.com/content/dam/Deloitte/ca/Documents/life-sciences-health-care/ca-en-health-care-life-sciences-evolving-medical-tourism-exploring-a-new-frontier.pdf>.

is not surprising that most Canadian medical tourists obtaining U.S. care are middle-aged (40-65) and have higher levels of income.²²

Notwithstanding the inconvenience and cost, Canadian medical tourism has grown significantly in the past several years.²³ For example, Ontario reported a 450 percent increase from 2001 to 2008 in the number of provincial citizens being reimbursed for medical treatment abroad, much of it in the United States.²⁴ At least a portion of the growth in Canadian medical tourism overall can be attributed to medical tourism brokers or facilitators, companies that connect medical tourists with providers abroad, assist with scheduling and coordinating pretreatment testing and transferring medical records, making travel arrangements, and sometimes arranging follow-up care back home in Canada.²⁵

Some Canadian facilitators also negotiate rates with U.S. providers, who may be willing to offer discounted fees that are still higher than many of their contracted rates with American health plans and insurance companies.²⁶ U.S. providers also may prefer to do business with these up-front cash-paying patients over insurance companies that may not pay for weeks or months.

While we have only limited empirical data about the prevalence of medical tourism brokers in Canada, one study estimated that approximately 50 medical tourism companies operated in Canada between 2006 and 2011, with seven providing assistance for travelers to the United States.²⁷ Another study noted that, of the ten medical tourism companies it identified, each worked with 1030 to 1335 clients per year.²⁸ Canadian medical tourism brokers can provide an invaluable service in a country that does not encourage, much less facilitate, patients to seek out medical tourism services. Many surveyed Canadian medical tourism patients noted their inability to even know what questions to ask when considering medical tourism, increasing their reliance on information from brokers.²⁹ Thus brokers can alleviate concerns and help patients locate their desired medical care, and the valuable functions they perform are an important component of Inbound Medical Tourism.

Neither the United States nor Canada directly regulates the medical tourism industry, despite calls to do so from multiple commentators.³⁰ One concern is

22. See Rory Johnston et al., *An Industry Perspective on Canadian Patients' Involvement in Medical Tourism: Implications for Public Health*, 11 BMC PUB. HEALTH, art. no. 416, 2011, at 1, 4.

23. *Id.* at 1.

24. Hopkins et al., *supra* note 11, at 188. Provincial governments may provide reimbursement when Canadian citizens receive certain forms of care abroad. However, the focus of this article is on medical tourism funded directly by the patients.

25. See Johnston et al., *supra* note 18, at 2. See generally Leigh Turner, *Canadian Medical Tourism Companies That Have Exited the Marketplace: Content Analysis of Websites Used to Market Transnational Medical Travel*, 7 GLOBALIZATION & HEALTH, art. no. 40, 2011, at 1 (discussing the expansion of the medical travel industry and the role of facilitating companies).

26. Korcok, *supra* note 14, at 768.

27. See Turner, *supra* note 25, at 1, 5.

28. Johnston et al., *supra* note 22, at 4.

29. See Johnston et al., *supra* note 18, at 8, 10.

30. See, e.g., Leigh Turner, *Quality in Health Care and Globalization of Health Services: Accreditation and Regulatory Oversight of Medical Tourism Companies*, 23 INT. J. QUAL. HEALTH CARE 1, 2 (2011); Roy G. Spece, Jr., *Medical Tourism: Protecting Patients from Conflicts of Interest in Broker's Fees Paid by Foreign Providers*, VI J. HEALTH & BIOMEDICAL L. 1 (2010); M. Neil

that the fees that foreign medical providers pay to lay-owned brokers may, without substantial safeguards, inappropriately encourage referrals and may be legally prohibited in the United States, as we discuss further below. One author estimated that these fees range from 8 to 15 percent of the total cost of care for the patient referred by the broker.³¹

While in some cases the patient pays the broker a comprehensive fee covering all care from which the broker takes its fee before passing along payments to medical providers, in other cases the patient may pay the medical provider(s) directly who then remit a fee to the broker.³² Each of these types of arrangements raises potentially differing legal risks under U.S. laws and regulations, making the structure of medical tourism arrangements critically important for minimizing the potential for legal liability. Indeed, our hypothetical, presented in the next Part, does not include a medical tourism broker that is owned and operated by lay persons. Rather, we see great utility from a practical perspective, and a reduction of the legal risk, in a model under which the referring physician practice provides or arranges for the services that would otherwise have been provided by a lay broker.

II. HYPOTHETICAL INBOUND MEDICAL TOURISM ARRANGEMENT

To better illustrate the potential U.S. legal impediments to Inbound Medical Tourism, we set forth a hypothetical arrangement among Canadian patients, a Canadian medical practice in lieu of a lay-owned broker, and U.S. medical providers (a large surgical practice and a hospital).

Dr. Betsy Kim, a Los Angeles-based general surgeon, leads a highly regarded fifteen-physician surgical medical group, called City of Angels Surgical Specialists, Inc. (CASS), which includes other general surgeons, as well as those specializing in organ transplantation, plastics and reconstructive surgery, and cardiac and orthopedic surgery. All the CASS surgeons are on the medical staff of, and hold academic appointments and leadership positions at, the prestigious University of Los Angeles Medical Center (ULAMC). CASS enjoys a solid reputation and an extensive network of referring colleagues.

Originally from Toronto, Canada, Betsy recently visited her extended family there. Her cousin Dave Kim, a family practitioner in a small practice on the outskirts of Toronto called Ontario Family Physicians (OFP), had anticipated Betsy's visit because he wanted to get her take on a new business idea. Dave told Betsy that his patients regularly need medically necessary, non-emergency surgical and endoscopic services, particularly joint replacement, cardiac, gastroenterological, and neurosurgical procedures, but because of the relative

Browne et al., *American Medical Tourism: Regulating a Cure that Can Damage Consumer Health*, 25 *LOY. CONSUMER L. REV.* 319, 324 (2013).

31. Spece, *supra* note 30, at 5.

32. *See id.* at 6, 16 (“usually foreign hospitals . . . pay broker’s fees”); Mark S. Kopson, *Medical Tourism: Implications for Providers and Plans*, 3:2 *J. HEALTH & LIFE SCI. L.* 147 (2010) (“[I]n many cases, the provider pays the facilitator a percentage of the provider’s fee for the medical care provided to the facilitator’s customer.”).

shortage of surgeons and hospitals in Canada's government-funded, single-payer system, patients regularly find themselves on long waitlists for most nonemergency procedures. Some opt to travel abroad at their own expense, even after paying taxes to the Canadian system, often to New York and to other north-eastern states, but to other countries as well. The waitlists have led to worsening of painful and debilitating conditions and complications that Dave believes could have been prevented with earlier intervention.

Aside from wanting faster service, Dave believes that Canadians go to the United States because medical costs in America, at least for some procedures, have come down in recent years compared to those in other developed-nation destinations such as the United Kingdom.³³ Dave also believes that his patients are attracted to U.S. hospitals that seem increasingly to have recognized the medical tourism market and that are willing to negotiate their rates. While the United States is still not usually the least costly option, particularly when compared to less developed-nation destinations, and indeed remains the most expensive option for many procedures, Dave believes that many Canadians trust the U.S. healthcare system and appreciate the common language, culture, and geographic proximity. Some U.S. hospitals and medical centers that have been specifically marketing their services to Canadians offer all-inclusive packages that cover the entire cost of the procedure, including physician, hospital and ancillary services, and in some cases, resources to make travel arrangements.³⁴

Alternatively, Dave explained that most of his patients have engaged the services of Canadian-based medical tourism brokers who organize every aspect of the journey abroad, including travel arrangements, and identify and schedule evaluations with the surgeons, negotiating prices and packages with travel agents, surgeons, anesthesiologists and hospitals.

Some of Dave's less wealthy patients have sought services in countries with substantially lower costs than those in the United States, and while most have been satisfied, some of them reported terrible experiences, including visa and entry-related problems, dangerously constructed and shoddily run hospitals, and questionably competent physicians and nurses. Some of Dave's patients even reported having been discharged with undiagnosed or untreated complications, some of whom end up in Canadian hospitals, sicker than they had been before the journey.

33. See, e.g., INT'L FED'N OF HEALTH PLANS 2015 COMPARATIVE PRICE REPORT: VARIATION IN MEDICAL AND HOSPITAL PRICES BY COUNTRY (2015), <http://static1.squarespace.com/static/518a3cfee4b0a77d03a62c98/t/57d3ca9529687f1a257e9e26/1473497751062/2015+Comparative+Price+Report+09.09.16.pdf> (showing U.K. average prices substantially higher than those in the United States for diagnostic angiograms and diagnostic colonoscopies).

34. See Andrea Downing Peck, *Hospitals in New York State and Throughout the United States Are Advertising to Attract the Growing Number of Medical Tourists from Canada*, DARK DAILY LABORATORY & PATHOLOGY NEWS (Jan. 27, 2016), <http://www.darkdaily.com/hospitals-in-new-york-state-and-throughout-the-united-states-are-advertising-to-attract-the-growing-number-of-medical-tourists-from-canada-127#axzz4NwBgBvkP>; see also *Cleveland Clinic and Mayo Clinic Compete for Medical Tourists*, INT'L MED. TRAVEL J., (Nov. 10, 2010), <https://www.imtj.com/news/cleveland-clinic-and-mayo-clinic-compete-medical-tourists/> (discussing Middle Eastern medical tourists).

Dave expressed concern that many patients sought medical tourism services without consulting with him or another physician and relied entirely on the lay medical tourism brokers and agencies which he views as nothing more than glorified travel agencies. Dave, too, is bothered that medical tourism does not appear to be an option for most of his less well-off patients. He believes that he could address those issues and otherwise make U.S. services more available to his patients by setting up an arrangement with reputable American providers with favorably discounted negotiated rates. Dave and his colleagues would identify patients and broker the arrangements themselves with the foreign surgeons and hospitals and eliminate the need for a third-party, lay-owned broker. OFP would either engage administrative staff to assist with the travel arrangements or subcontract that out to a travel agency. Dave asked whether Betsy and her partners would be interested in participating in such a venture, which he pitched as a source for business through the new revenue stream from Dave's and his colleague's referrals, including an expanded referral base from OFP and the practice's other colleagues in Toronto.

Betsy's only concern was whether Dave's practice saw enough potential medical tourists to justify the cost of setting up a business arrangement. Dave assured Betsy that, not only does his practice include numerous potential medical tourists, but that he learned in discussions with his network of physician colleagues that many of them face similar issues and would be interested in referring their patients to OFP for that specific service. Dave said, too, that many of his patients expressed concerns about using lay brokers for this type of travel and have said that they would much prefer for these arrangements to be made by their physicians. Acknowledging, as well, that travel arrangements are a bit outside the scope of a primary care practice, Dave feels that such services are directly related to ensuring quality care for his patients and that his colleagues believed that the expense of hiring or contracting with travel specialists, for whose services the patients would pay, would not adversely affect their bottom line or their reputation as clinicians.

Betsy told Dave that she was very excited about the proposed venture and believed that her colleagues would be too. She felt that ULAMC would also be quite interested in a potential new service line. Dave suggested that once Betsy's colleagues gave her the thumbs up, they start by meeting and establishing relationships with CASS and ULAMC, hopefully leading to agreements between and among them that set forth the terms and conditions of their respective services and fees, including mutually agreed to protocols for identifying and screening patients and matching them to the appropriate providers. As such, Dave's practice, rather than a lay-owned broker, would serve as the broker. Dave hopes that the business would at least cover his practice's costs, including compensation for his time spent managing the venture, but he explained to Betsy that his main motivator in pursuing the arrangement would be to help his patients get timely, high-quality surgery.

Betsy was very enthusiastic about her cousin's idea and thought that her partners and the ULAMC administration would be too. She explained to Dave that almost all of CASS's and ULAMC's patients' health plans and insurance

companies, particularly Medicare and Medicaid, pay the group and the hospital substantially less than their usual and customary fees, and that they would thus welcome the opportunity to serve privately paying patients, even at a discount, especially if the patients were required to pay for the services in advance.

Dave informed Betsy that he would prefer not to collect money from these patients because that would be a substantial additional burden on his small practice; thus, he proposed that patients would pay CASS directly one price for the full package of services, and CASS, which has much more sophisticated systems and expertise, would then allocate and remit the money to ULAMC for its services and the administrative fee to OFP for the administrative costs in paying its staff and arranging travel services.

III. POTENTIAL BENEFITS AND DRAWBACKS TO INBOUND MEDICAL TOURISM

Before discussing the legal issues inherent in an arrangement like the one in our hypothetical, we explain how such arrangements can not only financially benefit the U.S. medical providers, but also can benefit the local economies where the participating U.S. providers are located. We also briefly assess the potential drawbacks inherent in Inbound Medical Tourism, including potential harms to the U.S. population, concluding that the potential benefits outweigh the potential risks from an arrangement such as that in our hypothetical.

A. Potential Benefits of Inbound Medical Tourism to the United States

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, in some cases offsetting declining revenues from the providers' other sources, including private insurance programs and Medicare and Medicaid. One study estimated the value of inbound medical tourism in 2007 from all countries to be between \$491 million³⁵ and \$1.2 billion, resulting from between approximately 43,000 and 103,000 foreigners seeking medical care in the United States.³⁶ Thailand generated approximately \$850 million in additional revenue from treating an estimated 900,000 medical tourists in 2008.³⁷ Additional revenues from medical tourists could help to offset both unreimbursed emergency medical care provided by CASS and ULAMC, as well as the lower revenue they receive from other payors, particularly lower-paying government 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

35. All dollar amounts are in U.S. dollars unless otherwise noted.

36. Tricia J. Johnson & Andrew N. Garman, *Impact of Medical Travel on Imports and Exports of Medical Services*, 98 HEALTH POL'Y 171, 176 (2010).

37. Hopkins et al., *supra* note 11, at 192.

in the United States for some time to recover before returning home. These additional expenditures could as much as double the impact on the U.S. economy from inbound medical tourism.³⁸ When medical tourism-related expenditures are included, Thailand generated up to \$1.35 billion from medical tourism in 2007.³⁹

Commentators have touted medical tourism's positive economic impact on developing nations,⁴⁰ an impact which should correlate to Inbound Medical Tourism to the United States as well, perhaps even more strongly than in a developing nation such as India or Thailand. Medical tourism encourages medical facilities to invest in state-of-the-art medical equipment to attract medical tourists, equipment which is then at least potentially more readily available to the providing country's citizens.⁴¹ The increased revenue from medical tourism contributes to the demand for, and thus assists the country in retaining, all levels of skilled healthcare professionals, from highly trained physician specialists to ancillary services technicians.⁴²

Medical tourism may also reduce the excess capacity for some medical services in the United States. Excess capacity and underutilization may reduce recovery from investments in expensive equipment such as proton-beam machines and MRIs, thereby discouraging investment and growth.⁴³ Medical tourists serve both to absorb some of the excess capacity and to contribute to the return on physicians' and hospitals' investments in such technology and equipment.

B. Potential Drawbacks of Inbound Medical Tourism to the United States

Even if Inbound Medical Tourism to the United States helps to expand the market for American healthcare services and economically benefits the United States and local healthcare markets as described above, it does so not without at least calling into question some potential drawbacks, ethical and otherwise, predominantly those related to patients' access to, and the equitable allocation of, scarce healthcare resources. The United States historically has struggled, for many reasons, with providing its own citizens adequate access to care.⁴⁴ Compared to other developed nations, the United States has had a high percentage of

38. Johnson & Garman, *supra* note 36, at 176.

39. Chen & Flood, *supra* note 11, at 296.

40. See, e.g., Regis et al., *supra* note 7, at 102; Hopkins et al., *supra* note 11, at 191–92.

41. Rory Johnston et al., *What Is Known About the Effects of Medical Tourism in Destination and Departure Countries? A Scoping Review*, 9 INT'L J. EQUITY HEALTH 24, 30 (2010).

42. Regis et al., *supra* note 7, at 99.

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

44. KAREN DAVIS ET AL., MIRROR, MIRROR ON THE WALL: HOW THE PERFORMANCE OF THE U.S. HEALTH CARE SYSTEM COMPARES INTERNATIONALLY 7 (2014) ("The U.S. fails to achieve better health outcomes than the other countries, and . . . the U.S. is last or near last on dimensions of access, efficiency, and equity."); see also Aaron E. Carroll, *Why the U.S. Still Trails Many Wealthy Nations in Access to Care*, N.Y. TIMES (Oct. 24, 2016), https://www.nytimes.com/2016/10/25/upshot/why-the-us-still-trails-many-wealthy-nations-in-access-to-care.html?_r=0 (Despite beating last-place Canada, the United States was second-to-last in patients' beliefs that they could get a same-day or next-day appointment with their provider when sick.).

citizens who are uninsured or otherwise unable to pay.⁴⁵ Of those with acceptable insurance, many seek procedures for which the resources are limited and thus find themselves on the waitlist for such procedures just like Canadians.⁴⁶ A model like the hypothetical described in this article could potentially serve to favor Canadians with means by providing them with an opportunity to jump to the front of the line. Indeed, a number of commentators believe that medical tourism reduces access to healthcare for the destination country's poor.⁴⁷ Such comments, however, are usually made in the context of countries with already dramatic and clear disparities in access to healthcare between the rich and poor. In the context of the specific Inbound Medical Tourism model presented in this article, such disparities should be less problematic for several reasons.

First, as discussed above, 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. Certainly, while basic economics would seem to predict that CASS and ULAMC will be incentivized to show preference for booking OFP patients under very favorable, advanced and all-cash payment terms over local patients who pay later at likely lower rates,⁴⁸ the American providers are not likely to displace American patients for OFP patients because the differences in amounts collected are not likely to be so substantial that CASS and ULAMC will be incentivized to turn away U.S. patients in favor of OFP patients. Given that U.S. prices are already the highest for most medical tourism services compared to its competition in many other countries, CASS's and ULAMC's leverage for pricing will be limited to their appeal in providing quality, relatively nearby services, in an English-speaking environment. As such, the prices they negotiate with OFP are not likely to be so substantially below those offered to and collected from their U.S. patients. Further, particularly after the enactment of the Patient Protection and Affordable Care Act in 2010, substantially higher numbers of Americans are insured and thus able and willing purchasers to whom providers are less likely to deny services because of the provider's preference for Canadian medical tourists.

45. See *Social Protection: % of Total Population Covered*, OECD, <http://stats.oecd.org/Index.aspx?QueryId=29856> (last visited Nov. 26, 2016) (showing that the U.S. percentage of total population covered by public and private health insurance was 90.9 percent in 2015, ranking among the very lowest).

46. DAVIS ET AL., *supra* note 44, at 21 ex.A (showing that the United States ranked in the bottom half (6 out of 11) of countries studied for having waiting time of 4 months or more for elective/nonemergency surgery).

47. See, e.g., Rupa Chanda, *Trade in Health Services*, 80 BULL. WORLD HEALTH ORG. 158, 160 (2002) (Medical tourism threatens to "result in a dual market structure, by creating a higher-quality, expensive segment that caters to wealthy nationals and foreigners, and a much lower-quality, resource-constrained segment catering to the poor.").

48. Even with discounted, prenegotiated rates, OFP can still offer rates that are likely to result in greater net reimbursement compared to that received on behalf of local patients. Most of these local patients pay using government or private insurance, which generally pay less than the doctors' usual and customary fees.

Second, the disparities described above are less likely to arise in a model like this because the U.S. providers, such as CASS and ULAMC, are not likely to begin turning away patients and alienating their solid local network of referral physicians due to the preferred terms associated with the Canadian patients. Rather than simply turning down patients with moderately less favorable payment terms, U.S. providers will likely be just as incentivized to grow their businesses to provide more services to all by hiring more surgeons and opening up more operating rooms to meet the increased demand from Canadian and U.S. referral sources. Therefore, we think that Canadian displacement of U.S. patients should not be a material detriment to the proposed model.

Even if the model led to displacement of U.S. patients, such a result would likely only have a direct effect on the local market where medical tourists seek treatment. We would not anticipate huge numbers of medical tourists coming into any given local area. Further, any such displacement effect should be temporary and ultimately would be offset by the increase in technology and services that will arise out of the greater demand for them, as discussed above.⁴⁹ Additionally, notwithstanding any potential temporary displacement, the model will favorably impact morbidity and mortality related to delay in treatment for Canadians. In summary, we would expect that any displacement of American patients would be relatively insignificant and short-lived, and would 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 technology.

IV. APPLICABLE U.S. LEGAL REQUIREMENTS

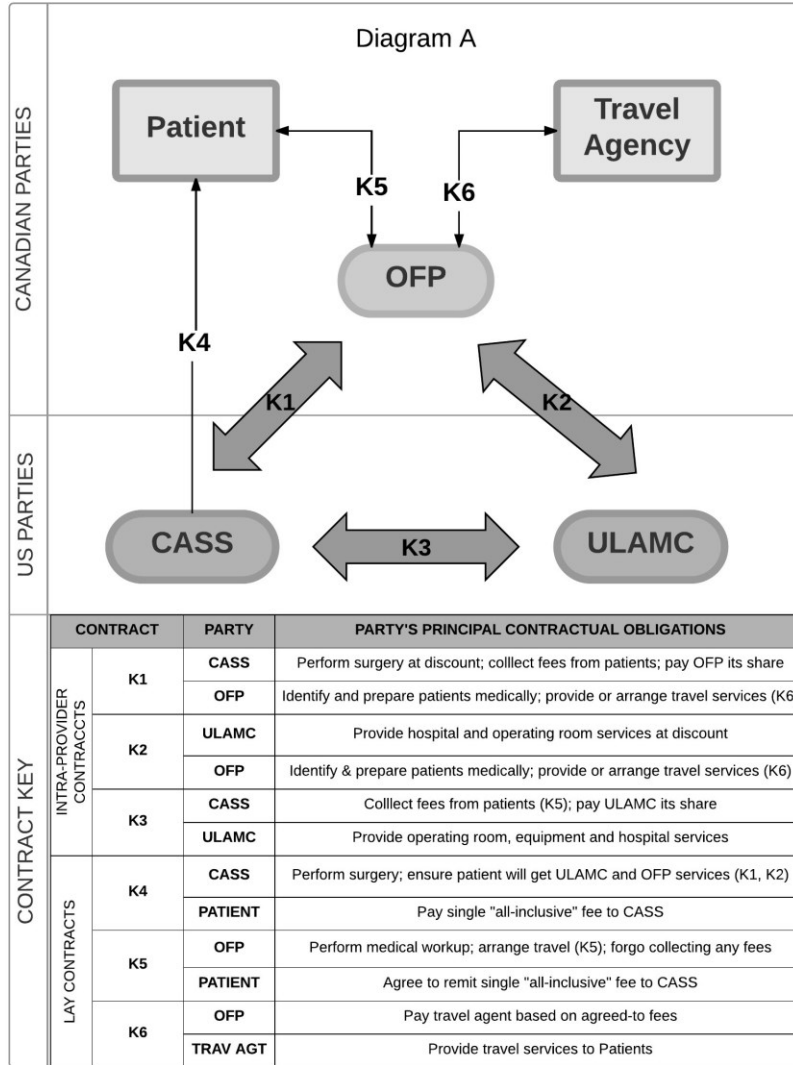
With access to and allocation of resources not presenting an insurmountable challenge to the proposed medical tourism model, and recognizing that Inbound Medical Tourism can provide significant economic benefits to providers and their communities, we now examine the legal hurdles that the model implicates and conclude that none in the U.S. federal scheme pose an absolute barrier. The proposed transactions involve varying degrees of risk under certain U.S. state laws, but we will explain how to structure the arrangement to minimize such risks.⁵⁰

We provide a diagram of the pertinent contractual relationships among the various parties under the model proposed in the hypothetical, referred to later as the “CASS Redistribution Model.” (See Figure 1.) Hereinafter, references to “K1,” “K2,” and so forth are references to the contracts shown on the diagram.

49. See discussion *supra* Section III.A.

50. Our focus in this article is on the impact of the fraud and abuse laws on Inbound Medical Tourism from Canada and on the means for minimizing such risk to encourage more U.S. providers to offer such services. However, we would be remiss in not at least acknowledging that U.S. providers are likely to raise concerns about how arrangements such as the one described in our hypothetical affect their negligence, particularly professional negligence, risk. This raises issues such as whether a Canadian plaintiff may sue a U.S. provider at all, what law would be applied to such a suit, and the relative burden placed on a plaintiff facing a lawsuit outside his home country. For a discussion of professional negligence in the medical tourism context, see Browne et al., *supra* note 30, at 324–47; Cohen, *supra* note 2, at 1494–1504.

Figure 1. Diagram of the CASS Redistribution Model



A. Federal Laws

Any arrangement that involves the referral of patients by one individual to another for healthcare services financed by American Medicare, Medicaid, or

certain other U.S. federal healthcare programs must pass scrutiny under the federal Stark Law and the AKS.⁵¹ The proposed hypothetical involves no such federally financed services because OFP patients referred to CASS and ULAMC under the arrangement (including those associated with K1, K2 and K4) are Canadian citizens who reside in Canada, and thus are not and cannot be beneficiaries of Medicare, Medicaid, or any other Federally Funded Healthcare Service.⁵² We thus can quickly conclude that the Stark Law and the AKS impose no prohibitions on Dave's and Betsy's proposed Inbound Medical Tourism model.⁵³

On the other hand, we cannot so readily dismiss certain analogous state laws⁵⁴ that apply to healthcare services funded by all sources, including the patients themselves. The remainder of this Part of the article will explore such laws. As we explain, the proposed model can nonetheless be structured to create minimal risk under those laws without diminishing the appeal of the arrangement to the parties involved or diminishing the benefit the transactions otherwise bring to the United States.

The parties could structure the arrangement to ensure no risk under state fraud and abuse laws if, for example, Dave and OFP merely referred their patients to CASS and ULAMC without any mutual covenants pertaining to fees, availability, or administrative obligations, such that CASS and ULAMC each simply billed its respective charges directly to, and collected from, the patients, with or without offering discounts or otherwise negotiating their fees. Such an arrangement would involve no exchange of money or other remuneration between OFP and CASS or between OFP and ULAMC and thus would not likely

51. The federal Anti-Kickback Statute prohibits improper inducements to refer business to providers for any or all services that Medicare, Medicaid and other federal health programs (such as the Veteran's Administration, CHAMPUS, and the Indian Health Services) pay for (hereafter, Federally Funded Healthcare Services). The Stark Law, on the other hand, prohibits certain referrals from physicians to providers of "Designated Health Services," which is a list of specifically defined and enumerated services, which is a relatively small subset of Federally Funded Healthcare Services.

52. For purposes of this analysis, we will not address whether a dual citizen of both the United States and Canada, residing in Canada, may be an American Medicare or Medicaid beneficiary.

53. We acknowledge that Dr. Kim and her CASS colleagues will be entering into a financial arrangement with ULAMC as one piece of the proposed model. Because CASS refers patients other than OFC patients to ULAMC, some of which are federal healthcare program beneficiaries, such arrangement must comply with Stark, the AKS, and other relevant federal fraud and abuse laws. Further, because ULAMC is a nonprofit institution, this arrangement must also comply with applicable federal and state tax-exemption laws with respect to transactions to which ULAMC is a party. For purposes of this article however, we make the assumption, without fear that it will not bear out, that the CASS-ULAMC relationship can and will be structured to comply with those laws and in a manner that does not have any substantial legal or practical impact on the other transactions described in this article.

54. See, e.g., CAL. BUS. & PROF. CODE §§ 650–657 (West, Westlaw through 2016 Regular Session laws). Many other states have similar laws that would need to be analyzed with respect to any transactions where the providers are located in that state. *But see infra* note 56. We also do not address Canadian federal or provincial laws that may be applicable to these arrangements. Because we conclude that the proposed model will pass scrutiny under California law, which is quite broad in terms of its applicability to relationships between and among providers and lay entities, we will assume without analysis that the relationship would also pass scrutiny under similar Canadian laws.

implicate the AKS or any state law analogs. However, because the model's success depends, at least in part, on CASS's and ULAMC's agreement to discount their fees for OFP's patients, and on the U.S. providers remaining available to provide the services and to work with OFP and its agents and employees in coordinating and scheduling the services, CASS and ULAMC each must enter into financial relationships with OFP, and thus each must pass muster under applicable California laws pertaining to financial arrangements involving healthcare providers.⁵⁵ Dave's proposal that the patients pay the full amount to CASS for the services (K4), after which CASS allocates and remits the appropriate amounts to ULAMC for the hospital services (K3) and to OFP for the administrative and travel services (K1), must also pass scrutiny under those laws. In summary, a triad of financial relationships must pass state-law muster—the relationships between OFP and CASS (K1), between OFP and ULAMC (K2), and between CASS and ULAMC (K3). We turn to that analysis now.

B. Applicable State Laws

Our proposed transaction could implicate two California statutes, the California Anti-Kickback Statute (CAKS) (Bus. and Prof. Code 650) and California's Health & Safety Code Section 445 (H&S 445), which we introduce and then apply to our hypothetical and proposed arrangement. The diagram in Figure 1 shows the relationships between the parties in the proposed model to assist the reader in following the ensuing analysis.

1. California's Anti-Kickback Statute⁵⁶

Unlike the federal AKS, which applies only to referrals for services reimbursed by federal government programs, including Medicare and Medicaid, the CAKS is broadly applicable to all healthcare services, regardless of payor source. It provides, in pertinent part:

[Except with respect to certain intermediate and long-term care referral agencies], the offer, delivery, receipt, or acceptance by any [licensed healthcare professional]⁵⁷ of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest,

55. CASS and ULAMC may or may not desire to enter into an agreement to set forth any terms that could be specific to the two in connection with the venture. Because any such arrangement would not, and indeed should not, include the exchange of remuneration, we need not analyze its compliance with California's Anti-Kickback law.

56. Laws covering kickbacks vary from state to state, but we exclusively focus on the California statute as a fifty-state survey of anti-kickback laws is beyond the scope of this article. As will become apparent in the remainder of this Section III.B, the applicable California laws prohibiting kickbacks in this context together constitute a very broad prohibition, making it valuable for analysis. While we cannot confirm without performing such a survey, we would predict that business arrangements passing muster under California's laws are likely to be allowed under other states' laws.

57. More specifically, the prohibition applies to "person licensed under [Division 5 of the Health and Safety Code ('Healing Arts')] or the Chiropractic Initiative Act." § 650(a) (Westlaw).

or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.⁵⁸

Aside from being broader than the AKS in its applicability to all referrals without regard to payor source,⁵⁹ the CAKS applies only when a licensed healthcare provider, such as a physician, dentist, or acupuncturist, is the inducer or the person induced (inducee), and in that respect is thus narrower than its federal counterpart.⁶⁰ The person receiving the referral can be “any person” who provides the service, meaning the inducer or anyone else.

2. California Health & Safety Code Section 445 (H&S 445)

In addition to implicating the CAKS, our hypothetical and proposed transaction also implicates H&S 445, which is similar to the CAKS:

No person, firm, partnership, association or corporation, or agent or employee thereof, shall for profit refer or recommend a person to a physician, hospital, health-related facility, or dispensary for any form of medical care or treatment of any ailment or physical condition.⁶¹

H&S 445 is narrower than the CAKS in its applicability to treatment referrals made only to physicians, hospitals, “health-related facilities” or dispensaries, while the CAKS applies to referrals for services by “any person.” On the other hand, H&S 445 is broader than the CAKS in that the inducee (the entity who profits) can be anyone, where the inducee under the CAKS must be a licensed healthcare professional. Under both statutes, the entity making the referral (referrer) and the inducer can be anyone.

The CAKS is also broader than H&S 445 in its prohibition on mere “offers” of inducement and its applicability when an inducee merely accepts the inducement, without regard to when, or even if, one of the things of value listed (the inducement) is actually delivered to the inducee. Under H&S 445 the referrer must “profit” from the referrer, meaning that the statute does not apply if the referrer merely accepts an offer of profit; arguably the inducer must have delivered the inducement to the referrer. Both statutes apply without regard to when,

58. *Id.*

59. Under the federal analog:

(1) Whoever knowingly and willfully solicits or receives any remuneration . . . in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a *Federal health care program*, or . . . in return for purchasing, leasing, ordering . . . any good, facility, service, or item for which payment may be made in whole or in part under a *Federal health care program*, shall be guilty of a felony and upon conviction thereof . . . and

(2) Whoever knowingly and willfully offers or pays any remuneration . . . to any person to induce such person—(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a *Federal health care program*, or (B) to purchase, lease, order . . . any good, facility, service, or item for which payment may be made in whole or in part under a *Federal health care program*, shall be guilty of a felony

42 U.S.C. § 1320a–7b(b) (2012) (emphasis added).

60. *See* § 650 (Westlaw).

61. CAL. HEALTH & SAFETY CODE § 445 (West, Westlaw through all 2016 Regular Session laws).

or even if, the service is provided. There are numerous possible combinations of entities and persons acting as inducers. For example, there are attempting inducers (i.e., inducees who have accepted but not received the inducement); inducers who have received the inducement; and referrers. Some combinations would be prohibited under the CAKS and not H&S 445. Additionally, some combinations would be prohibited by both. Thus we cannot make a general statement about whether compliance with one of the statutes ensures compliance with the other.

However, for purposes of analyzing our hypothetical scenario, our proposed structure will face the same negligible risk under both statutes because the two statutes prohibit the same conduct under the proposed arrangement (inducing improper referrals and being induced to make such referrals), as long as the parties to the proposed transaction do not change. More specifically, under the CAKS, the risk is that CASS and ULAMC will be in a position to induce OFP and its physicians (licensed healthcare professionals) to refer patients to anyone, including CASS and ULAMC. Under H&S 445, the risk is that anyone, including CASS and ULAMC, will be in a position to induce referrals to OFP and its physicians (who belong to the subset of “physicians, hospitals, health facilities” and the like).⁶² Hereinafter, we refer to the CAKS and H&S 445 together as the California Anti-Kickback Laws (CAKL).⁶³

3. Analysis of Proposed Arrangement under California Anti-Kickback Laws

The proposed Inbound Medical Tourism model entails the establishment of financial relationships between all three healthcare providers, between OFP and CASS (K1), between OFP and ULAMC (K2) and between CASS and ULAMC (K3), each of which includes compensation terms and each of which thus must not run afoul of the CAKL. Further, Dave’s proposal for the cash to flow from the patients to CASS (K4), which then redistributes ULAMC’s and OFP’s portions to them (K1 and K3), could be problematic under those laws, at least upon initial scrutiny, because that model—which we refer to hereinafter as the “CASS Redistribution Model”—requires one party (i.e., a provider, CASS), to redistribute the total sum of money to others, including a referral source, OFP. Any such redistribution of proceeds, while not per se prohibited, must be approached very carefully to avoid the appearance of improper “fee splitting,” which the

62. As explained earlier, *supra* Section IV.A.2, unlike H&S 445, CAKS also applies when inducers merely “offer” inducement and when inducees merely “accept” inducement, whereas under H&S 445, the parties are not in violation until the referrer has profited from the inducement. In that regard, our parties could face greater risk under CAKS because of the liability attaching at an earlier point in the process. However, we recommend our proposed structure with full recognition of those differences.

63. California law includes other statutes that prohibit kickbacks and remuneration for referrals, but our hypothetical’s proposed transactions would not implicate any of them; such laws typically apply when specific payor sources are involved, such as Medicaid or workers’ compensation benefits. *See, e.g.*, CAL. LAB. CODE § 139.3 (Deering, LexisNexis through all 2016 legislation and propositions) (prohibiting improperly induced referrals of patients in the workers’ compensation context).

CAKL both prohibit.⁶⁴ Even under the CASS Redistribution Model, however, the arrangement can be structured to incur minimal risk under those laws

The main goal of the OFP-CASS (K1) and OFP-ULAMC (K2) contracts is for CASS and ULAMC to promise to provide their respective services (surgery by CASS, hospitalization and ancillary services by ULAMC) to qualified OFP patients at prenegotiated rates and for OFP to ensure payment of fees in advance at such rates. Risk under the CAKL for both relationships would arise if any aspect of the compensation and services exchange could be construed as “compensation or inducement” (under the CAKS) or as “profit” (under H&S 445) for OFP’s referral of patients to CASS or to ULAMC, respectively. For example, the CASS Redistribution Model—under which CASS, after collecting the total-package fee from the patients, will pay OFP⁶⁵ directly a fixed amount for each patient referred or a fixed percentage of the fee that CASS charges each referred patient—appears, at least on its face, to be a classic fee-splitting arrangement, which is highly suggestive that the compensation serves to induce OFP to refer patients to CASS and possibly to ULAMC.

However, because payment from CASS to OFP under the proposed arrangement serves as compensation to OFP for performing certain specific services, services that most substantially benefit the patients rather than the two providers, CASS is merely passing through to OFP the portion of the patients’ fees for OFP’s services. As long as such portion is consistent with the fair-market value of OFP’s services, the payment is not simply a quid pro quo for OFP’s referrals and would not be improper under the CAKL, which do not prohibit a party from compensating another for services as long as the compensation does not also serve to incentivize the service provider to refer patients. The amount for such services can be a fixed amount or can be based on a fixed percentage of the providers’ charges to the patient as long as the amount paid is consistent with the fair-market value of the services.⁶⁶

Indeed, if the payment CASS remits to OFP were an amount equal to the fair-market value of the services that OFP provided to the patients only, and CASS were simply collecting such amount from the patients as a convenience to OFP, this would clearly not be an inducement for referrals, provided the value of CASS’s “collection and remittance” service is either negligible or included

64. Fee splitting, whereby a provider pays part of the fee collected from the patient or payor source to the person who referred the patient, is merely one specific form of a kickback. While neither of the CAKLs include the words “fee,” “split,” or derivatives or combinations of those words, those statutes nonetheless prohibit the act commonly referred to as fee splitting. *See* CAL. CORP. CODE § 13408.5 (Deering, LexisNexis through all 2016 legislation and propositions).

65. CASS also pays ULAMC its portion of the total fee, but because ULAMC is not a referral source to CASS, this particular aspect of fee splitting is not relevant to that payment.

66. Indeed, the CAKS specifically and affirmatively permits a party to compensate another for services based on a percentage of the paying party’s total gross revenues, as long as the amount is consistent with the fair-market value of the services. CAL. BUS. & PROF. CODE § 650(b) (West, Westlaw through all 2016 Regular Session laws) (“The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished . . . by the recipient to the payer.”).

in determining the amount remitted by CASS to OFP. In effect, CASS would not be paying any “compensation” to OFP, if compensation means payment for a service provided, and that aspect of the arrangement would not implicate the CAKL. CASS would simply be passing through from the patients to OFP an amount equal to OFP’s cost in providing the services to the patients, such as travel arrangements, fee-negotiations, communications with the U.S. providers on the patients’ behalf, the medical work up, and the like.

However, if the arrangement obligates OFP to provide any services at all to, or in favor of, CASS or ULAMC, which is likely to be the case, then the amount remitted from CASS to OFP must be determined to reflect the fair-market value of such services. For example, if OFP is obligated under the arrangement to act as the central scheduling coordinator for all of the patients under the arrangement, thus simplifying the work that CASS and ULAMC would otherwise do by scheduling the services directly with each patient, then such service, which has a certain value, must be considered in the remittance amount to OFP. Another example may be that OFP is obligated to screen all the patients for certain medical conditions or to perform a more extensive workup on the patients than CASS or ULAMC would require of local referring physicians. If OFP incurred costs for providing those services, such as in the case where the patients would not pay for them—as is likely in a single-payor system such as Canada’s—such would also be services for which CASS and ULAMC would need to compensate OFP.

Nonetheless, because the CASS Redistribution Model appears outwardly to constitute a traditional fee-splitting arrangement under which a physician sends a cut of each referred patient’s fee to the referral source, the arrangement could be structured to avoid that appearance by instead obligating OFP to collect the full amount from the patients, after which OFP distributes CASS’s and ULAMC’s portions to them (hence eliminating K4, and adding OFP’s redistribution obligations to K1 and K2). This “OFP Redistribution Model,” which shifts undesirably the administrative burden that Dave wanted to avoid back to OFP, would serve to remove CASS’s obligation to collect and then “split” and redistribute the fee to the referring provider. However, this approach is probably only slightly less likely to raise concerns under the CAKL, because simply shifting to the referral source, OFP, the obligation to collect and then split and redistribute the fee to the providers does very little to change the appearance that the total fee is being redistributed. Nonetheless, if structured to ensure that all payments made to each party are in amounts consistent with the fair-market value for the services provided by the recipient party, the OFP Redistribution Model would be at least as safe as the CASS Redistribution Model under the CAKL but without the unpleasant outward appearance of one provider splitting the fees and redistributing them to another provider and to a referral source. One party’s payment of amounts consistent with the fair-market value of the services provided by the party receiving the payment goes a long way to demonstrate that the arrangement is not an illegal kickback or fee split in disguise.⁶⁷

67. See Publication of OIG Special Fraud Alerts, 59 Fed. Reg. 242 (Dec. 19, 1994). In that alert the Office of Inspector General explained:

The cleanest approach legally, and the one most favorable from an administrative perspective for each of the three parties, would be for the patients to pay each of the three entities, CASS, ULAMC, and OFP, separately for their respective services. Such “Patient Direct Remittance Model,” however, would be much less appealing to the patients and thus may discourage them from seeking services under this model. Therefore, we think that because both the CASS Redistribution Model and the OFP Redistribution Model can be carefully structured and the fair-market value of the services can be adequately documented, as described above, they are not likely to create undue risk for liability and thus obviate the need to implement a Patient Direct Remittance Model.⁶⁸

Putting aside the nuances of the appearance of fee splitting among the parties, when analyzing the actual economics of the payments and services, regardless of the specifics of how the money flows, the risk under the CAKL is still not zero, however, because the mere difference between the two providers’ non-discounted rates and their discounted rates for OFP could be viewed as “compensation or inducement” for OFP to refer its patients to CASS and ULAMC. As long as OFP passes all of that savings on to its patients, however, and does not retain a portion of the discount to cover its costs for providing the services it provides under the arrangement, OFP would not itself profit from CASS’s and ULAMC’s discounts. Without any profit from the discounts, it is unlikely that the discounts would be viewed as “compensation or inducement” for OFP to refer its patients to CASS and ULAMC.

An astute reader will remember, too, that our hypothetical specifically states that CASS is interested in entering into the arrangement with OFP to obtain “an expanded referral base from OFP and the practice’s other colleagues in Toronto,”⁶⁹ which certainly sounds on its face like it could be problematic under the CAKL. However, provided that the parties ensure that the discount (which would be the relevant and improper remuneration under a CAKL analysis) is passed on entirely to the patients, and does not benefit Dave or OFP other than

Whenever a [provider] offers or gives to a source of referrals anything of value not paid for at fair market value, the inference may be made that the thing of value is offered to induce the referral of business. The same is true whenever a referral source solicits or receives anything of value from the [provider]. By “fair market value” we mean value for general commercial purposes. However, “fair market value” must reflect an arms-length transaction which has not been adjusted to include the additional value which one or both of the parties has attributed to the referral of business between them.

Id. § F.

68. Theoretically, even if the arrangement requires the patients to pay each of the three parties separately, either CASS or ULAMC could nonetheless game the arrangement to result in an improper incentive to OFP. For example, CASS or ULAMC could, in collusion with OFP, offer even more substantially discounted fees to OFP’s patients while simultaneously turning a blind eye to OFP’s increase in its service fee to patients. The net result would be greater total remuneration to OFP, no change in what the patient pays, and a net decrease in what CASS or ULAMC collect, for which they expect even more referrals from OFP. As such, the respective agreements should further safeguard the arrangement by including covenants that OFP will only charge and collect fees for its services from patients that are commensurate with the fair-market value for those services. As an additional precaution, OFP and ULAMC should consider including documentation in their files of OFP’s fair-market value analysis for the fees it charges to patients.

69. *See supra* Part II.

indirectly by incentivizing patients to seek out their services, we would not be concerned about the risk in that regard. Further, CASS's intent in providing the discount is to be able to offer better prices to Canadians, for whose business it would be competing with other, much less expensive nations.

The preceding analysis did not discuss in detail the relationship between OFP and ULAMC. We would anticipate that those parties will enter into a written agreement with each other to set forth the analogous terms and conditions relevant to the relationship between OFP and CASS (K2). If, for example, OFP provides similar services for ULAMC as those it provides to CASS, such as scheduling coordination, and if the arrangement is implemented under one of the two Redistribution Models, CASS or OFP will remit a portion of the fee collected from patients to ULAMC. Such terms must be memorialized in writing, and the financial components must pass muster under the CAKL. Pursuant to the same analysis as the relationship between OFP and CASS under the CASS Redistribution Model, the financial relationship between OFP and ULAMC should comply with the CAKL under the OFP Redistribution Model as long as the amount retained by OFP before paying ULAMC is consistent with the fair-market value for OFP's services. If the arrangement is structured to require the patients to pay all three providers separately, as under the Patient Direct Admittance Model, then OFP will make no payment to ULAMC, and we thus need not be concerned about the OFP-ULAMC relationship's compliance with the CAKL.⁷⁰

If a lay medical tourism broker were substituted for OFP in our hypothetical, the legal risk would be increased to the extent that the broker makes a profit rather than simply being compensated for the fair-market value of the services it is providing to the patients and CASS/ULAMC. Because typically lay brokers are for-profit entities and thus would seek to receive more than simply the fair-market value of their services with no markup, we advise providers seeking to reduce their potential liability under the CAKL to avoid these types of arrangements.

We need not further analyze the arrangements between OFP and the patients (K6) or between OFP and any subcontracted travel service (K5) under the CAKL because they do not involve patient referrals. Those contracts are necessary simply to effectuate the model from a business perspective, so that, for example, the patients become obligated to receive services from OFP in connection with the procedure and to pay CASS directly for the services provided by all three healthcare providers.

The CAKL are not the only potentially applicable state-level statutes, however. California also has an analogous statute to the federal Stark Law.

70. All three models—the CASS Redistribution Model, the OFP Redistribution Model, and the Patient Direct Remittance Model—are subject to the same theoretical limitation as that described in *supra* note 66, so long as the parties colluded to intentionally restructure the economics of the arrangement so that one party ends up receiving compensation that is greater than the fair-market value of the services such party provides, even if the patients pay the same as they would under a compliant model.

4. California's Self-Referral Prohibition

California's Physician Ownership and Referral Act (PORA), also known as the "Speier" Law, is the California analog to the Stark law and prohibits physicians from referring patients to any person for certain specific, mostly ancillary services, such as laboratory, diagnostic nuclear medicine, radiation oncology, and physical therapy services (PORA-Covered Services),⁷¹ if the physician or a member of the physician's immediate family has a financial interest with the person or in the entity that receives the referral.⁷² As with the CAKL, the California anti-kickback analogs to the federal AKS, PORA's prohibitions apply to referrals for services funded by any source, not just Medicare, Medicaid, or other federal programs. On the other hand, PORA is much narrower than the Stark Law in its applicability to referrals for a smaller subset of services, which, most notable for our purposes, excludes a physician's referrals to a hospital for any type of service, even those listed above, as long as the hospital simply "does not compensate the [physician] for the referral."⁷³

PORA only applies to referrals from physicians who are in a financial relationship with an entity to whom the physician refers patients for one or more of the enumerated services.⁷⁴ OFP will have a financial relationship with CASS, but that relationship will not be subject to PORA because OFP is referring its patients to CASS primarily for surgical services, which are not subject to PORA.

On the other hand, CASS may occasionally provide a PORA-Covered Service, and OFP's financial relationship with ULAMC will entail OFP's and CASS's referrals to ULAMC for hospital services, which undoubtedly will include ancillary services, such as laboratory and x-ray services, all of which are PORA-Covered Services. Even if we presume that the California agencies that enforce PORA would take the position that OFP physicians are subject to PORA, notwithstanding that they are not California "licensees" and notwithstanding their physical presence outside California,⁷⁵ the relationships between

71. The other PORA-Covered Services are: physical rehabilitation, psychometric testing, home infusion therapy and diagnostic imaging goods or services. CAL. BUS. & PROF. CODE § 650.01(a) (West, Westlaw through all 2016 Regular Session laws).

72. *Id.* § 650.02(a).

73. *Id.* § 650.02(c)(1).

74. *Id.* § 650.01(a) (making it "unlawful for a licensee to refer a person for [PORA-Covered Services] if the licensee or his or her immediate family has a financial interest with the person or in the entity that receives the referral").

75. We acknowledge that even if OFP remains insulated from prosecution under PORA, or if the referrals from OFP did run afoul of PORA, CASS and ULAMC could face direct liability under PORA because they are prohibited from seeking reimbursement for any services they provide pursuant to an improper referral from OFP. *Id.* § 650.01(d) ("No claim for payment shall be presented by an entity to any individual, third party payer, or other entity for a good or service furnished pursuant to a referral prohibited under this section."). Because we are structuring the arrangement to ensure compliance with PORA as if OFP were prosecutable under the statute, we are not concerned about its liability, except to the extent CASS and ULAMC should be aware of it. Notwithstanding whether OFP is insulated from prosecution under PORA for a misdemeanor (*see id.* § 650.01(g)), CASS and ULAMC also could theoretically be subject to scrutiny under PORA as aiders or abettors of the crime committed by OFP. We are not aware of any such prosecutions, successful or otherwise, but the attorneys for the parties to the transactions should inform their clients about this possibility.

OFP and CASS and between OFP and ULAMC will easily pass muster under PORA as long as they are structured such that no element of the remuneration exchanged serves to “compensate the physician for the referral.” As explained above, CASS and ULAMC will each be compensating OFP at fair-market value for a small amount of administrative services that OFP provides under the proposed arrangement. Aside from that, ULAMC’s principal obligation will be to provide services to OFP’s patients in return, under either of the Redistribution Models, for CASS’s or OFP’s obligation to pay ULAMC hospital in advance for the services at the agreed upon rate, and ULAMC’s obligations will be to provide the hospital services according to the terms set forth in the agreement.⁷⁶ Under the Patient Direct Remittance Model, OFP would not be receiving any compensation or anything else of value from a referring entity, other than the opportunity to develop a resource that will provide more affordable services to its patients. Thus, the arrangements carry little or no risk under PORA.⁷⁷

V. LEGAL CHANGES TO ENCOURAGE MEDICAL TOURISM

Perhaps the most administratively simple way to achieve the goals of the proposed Inbound Medical Tourism arrangement is for the patient to pay one fee to either CASS or ULAMC, which then compensates OFP for its services as the medical tourism broker. However, relevant state laws, in California and elsewhere, are likely to, at least initially, view such an arrangement with suspicion under existing state anti-kickback laws, as demonstrated above.

All risk under these state laws can be avoided by having the patient make separate payments to the two providers and the broker for their individual services, so long as OFP does not negotiate discounts from CASS or ULAMC for the OFP patients. This is the traditional referral model, where a medical provider refers its patients to a surgeon and a hospital with no contractual arrangement among these parties. However, such an arrangement does not always accomplish the provider’s goals. Here, Dave wants to negotiate a set discount for his patients to enable lower-income patients to obtain needed medical care in the United States. As discussed above, by ensuring that any fee OFP receives is based on the fair-market value of the services it is providing, and by passing along all of the discounts to its patients, the risk under relevant California laws can be minimized but not completely eliminated. The three Models we have set forth provide structures to accomplish this reduction in liability. However, U.S.

76. CASS and its California-licensed physicians are directly subject to PORA with respect to any referrals they make, to ULAMC or otherwise, for any PORA-Covered Services, and CASS will be making such referrals of OFP patients to ULAMC for laboratory, x-ray and other PORA-Covered Services during the admissions. However, as with any other financial relationship between CASS and ULAMC, such as any medical directorships or call coverage arrangements between them, they can easily be structured to avoid scrutiny under PORA, most typically under PORA’s personal services exception. *See id.* § 650.01(b)(6). PORA also provides an exception permitting physicians to refer patients to their own group practices. *See id.* § 650.02(f). As such, the CASS physicians will be able to refer OFP patients to either ULAMC or to CASS for laboratory, x-ray and other services that might otherwise be prohibited, without fear of noncompliance with PORA.

77. *But see supra* note 75.

providers would surely prefer to have potential liability for Inbound Medical Tourism eliminated, not simply reduced.

Before proposing changes to the existing law, we must consider the policy rationale for anti-kickback laws and self-referral prohibitions. Legislators and regulatory agencies are unlikely to enact any changes that run counter to these policies. While it may seem obvious, anti-kickback laws and self-referral prohibitions are designed to ensure that healthcare providers make only appropriate, nonfinancially incentivized referrals based solely on clinical considerations. If a provider receives a payment for making a referral, the fear is that the provider may be financially motivated to (1) refer a patient to a less-than-qualified provider or (2) refer a patient for services the patient does not truly need.⁷⁸ Preventing both protects patients.

Under our hypothetical scenario, OFP arguably could be financially incentivized to refer patients to CASS and ULAMC even if another provider would be more appropriate, given the written arrangements among these three parties. This is perhaps compounded by the family relationship between Dave and Betsy, but is lessened somewhat by the esteem in which CASS and ULAMC are held by their U.S. peers and in the additional work OFP is undertaking to facilitate the referrals. Arguably, OFP could actually face a disincentive to refer to CASS and ULAMC, given the additional work required to make the needed arrangements and the lack of profit to OFP from the arrangement under any of our three models.

Further, without some compensation for the time OFP will spend administering the referrals to CASS and ULAMC, OFP arguably will actually face a disincentive to negotiate the discounts that will enable more patients to receive care at CASS and ULAMC, leading to decreased access to such services. Furthermore, OFP will not be paid simply for referring patients, but instead will receive compensation for actual additional services it is performing on behalf of its patients, further lessening the concern.

In addition, because of the considerable cost to obtain medical services in the United States and because the patients have already been diagnosed with a condition for which they could seek care in Canada, the policy concern of incentivizing medically unnecessary referrals is lessened, as patients are unlikely to spend their own funds to obtain care unless they are dramatically impacted by their medical condition and in great need of medical care.

While the proposed arrangement can be structured to create minimal risk of liability under the California statutes, formally eliminating this risk would not be much of a stretch. As the federal AKS and Stark laws have done for such risk-prone relationships as medical directorships, California could create a

78. Spece, *supra* note 30, at 15. Spece recognized that these laws also prevent against (1) paying windfalls to referring physicians . . . (3) increasing the cost of care . . . (5) encouraging providers who pay referral fees to cut corners in their care to recoup the costs of referral fees; (6) commodifying patients and commercializing and debasing providers; (7) undercutting societal and individual patient trust in providers; and (8) creating poorer patient outcomes because of the attenuation of trust.

Id.

formal safe harbor under the CAKS, H&S 445 or both and a formal exception under PORA for medical tourism arrangements similar to those we have proposed, which, if followed, will absolutely protect the providers from liability under state law.

Such a safe harbor under the CAKL could be a standalone statement like the other CAKS safe harbors⁷⁹ and thus take the following form:

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

The PORA exception would be worded almost identically, except that, because the lead-in language for the PORA exceptions states that “[t]he prohibition of [PORA] shall not apply to or restrict any of the following,” we would simply delete the last phrase above, “shall not be deemed to violate this Section [650] [445],” to make the exception conform to the PORA grammatic structure. Legislators also could make a policy decision on whether to permit payment of a portion of the fee to any broker, or limit allowed direct payments to those made to other medical professionals or medical practices, as we have done in our hypothetical.

This proposed CAKL safe harbor and PORA exception would permit CASS or ULAMC to collect the entire fee from the patients in our hypothetical, and then pay OFP a reasonable fee based on the fair-market value of the services that OFP provides in administering the arrangement, without fear of legal liability or regulatory scrutiny in California.



U.S. medical providers seeking to provide medical care to foreign citizens face an uncertain regulatory environment at the state level, which undoubtedly discourages participation in the more innovative financial arrangements becoming common in medical tourism worldwide. We have exemplified an Inbound Medical Tourism arrangement using California law under which providers may significantly reduce, but not entirely eliminate, liability under the state equivalents of the federal AKS and Stark law. The referring physician or group under such arrangement acts as the medical tourism broker or facilitator. Such physician or group may even be compensated for its services, so long as the compensation is documented to reflect the fair-market value of the services, and the broker does not retain any discounts it negotiates with the service pro-

⁷⁹ CAKS provides certain safe harbors and exceptions; H&S 445 does not. § 650.02 (Westlaw); CAL. HEALTH & SAFETY CODE § 445 (West, Westlaw through all 2016 Regular Session laws).

viders but instead passes them along to the patients. This structure has the additional advantage of shifting responsibility for identifying appropriate cases for referral and for ensuring that the patients are properly prepared for surgery from a medical perspective from a lay broker to a physician.

State legislators and regulators should review the benefits that attracting additional medical tourists to U.S. hospitals can provide not only to the medical providers, but to the community at large, and consider whether the patient protection policy goals of laws restricting referrals and kickbacks can be maintained while providing a safe harbor permitting a wider range of financial arrangements with medical tourism brokers to encourage increased medical tourism. Encouraging medical tourists, particularly Canadians, to seek care in U.S. hospitals can be a win-win situation for medical providers and their communities, while perhaps serving also to incentivize the tourists' home countries to ameliorate the problems that led their citizens to seek care elsewhere.