

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - A-08

Subject: Medical Care Outside the United States
(Resolutions 711 and 732, A-07)

Presented by: Georgia A. Tuttle, MD, Chair

Referred to: Reference Committee G
(H. Christopher Alexander, III, MD, Chair)

1 At the 2007 Annual Meeting, the House of Delegates referred Resolutions 711 and 732 (A-07) to
2 the Board of Trustees. Resolution 711, introduced by the New York Delegation, calls for the AMA
3 to “seek legislation to prevent insurance companies from incentivizing subscribers in this country
4 to have to go overseas for medical treatment that could be provided locally.”

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6 Resolution 732 (A-07), introduced by the Organized Medical Staff Section (OMSS), calls for the
7 AMA to: “(1) work with the National Association of Insurance Commissioners and other
8 interested parties to examine international medical liability issues; (2) work with the Joint
9 Commission, the Physician Consortium for Performance Improvement, and the World Medical
10 Association to develop standards in the area of international quality of medical care; (3) encourage
11 development of a separate CPT code for the post-operative care of surgical patients treated outside
12 of the US; (4) develop model state legislation obliging companies that facilitate travel for medical
13 care outside the US to: (a) require that the patient sign a form acknowledging that they have been
14 informed of the differences in standards of care across countries; (b) provide for HIPAA-compliant
15 transfer of the patient’s medical record; (c) arrange follow-up care prior to sending the patient
16 outside of the US; (d) ensure that seeing a physician outside the US is always voluntary; and (e)
17 make facility outcomes data, physician licensing and outcomes data, and the patient’s rights to
18 legal recourse, if any, transparent to the patient prior to care delivery.”

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20 The Board of Trustees referred these items to the Council on Medical Service for a report back to
21 the House at the 2008 Annual Meeting. This report describes medical care outside of the US,
22 discusses advantages and disadvantages of such care, highlights price and cost information,
23 summarizes relevant AMA policy, and presents a set of guiding principles that could serve as a
24 framework for promoting patient safety for Americans traveling for medical care outside of the US.

25 26 BACKGROUND

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28 Travel for medical care outside of the US for the purpose of medical treatment is gaining public
29 attention. In the last year, a new trade organization, the Medical Tourism Association, has
30 emerged, along with an online resource www.PlanetHospital.com, which acts as an intermediary
31 that helps patients find international health care providers. Accrediting bodies are broadening their
32 standards to apply to medical care outside the US. In 2007, the Colorado and West Virginia state
33 legislatures introduced bills that would require the insurance companies for state employees to
34 cover medical procedures in overseas hospitals, including travel expenses, and hotel stays for the
35 recovering patient and a travel companion. In addition, some US corporations are investigating the
36 best places to outsource elective surgery for their covered employees.

1 A growing number of foreign hospitals and clinics are owned, managed or affiliated with
2 prestigious American universities or health care systems, including the Cleveland and Mayo
3 Clinics, and Johns Hopkins, Duke, Harvard, and Tufts Universities. The so-called “co-branding”
4 of US hospitals such as Harvard Medical International’s endorsement of Wockhart Hospital in
5 India, Johns Hopkins’ endorsement of Singapore’s Joint Commission International (JCI)-accredited
6 International Medical Center, and the Cleveland Clinic’s partnership in Abu Dhabi, will likely
7 increase the appeal of hospitals abroad.

8
9 In 2006, an estimated 150,000 Americans received medical care overseas, according to Josef
10 Woodman, author of *Patients Beyond Borders: Everybody’s Guide to Affordable, World-Class*
11 *Medical Tourism*. Nearly half of the procedures were for medically necessary surgeries.
12 Procedures performed overseas can cost less than 20% of the price for the same procedure in the
13 US.

14
15 For decades, some in the US have traveled to Mexico for minor surgeries or to Canada for
16 prescription drugs at reduced prices. More recently, international hospitals offering significant
17 savings for major medical care have been attracting US patients needing major cardiac and
18 orthopedic procedures. The impact on the US health care market remains negligible, accounting
19 for less than 2% of US spending on non-cosmetic health care (*New England Journal of Medicine*,
20 “America’s New Refugees-Seeking Affordable Surgery Offshore,” October 2006). Similar
21 research indicated that offshore surgery is unlikely to reduce US health spending by more than 1-2
22 percent in the near-term (Mattoo and Rathindran, *Health Affairs*, Volume 25, No. 2, 2006).

23 24 RESOLUTION 711 (A-07)

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26 Resolution 711 (A-07) is concerned with health plan incentives to seek medical treatment in
27 another country. The Council identified two insurers that provide financial incentives for the
28 provision of health care services in other countries. Since 2000, Blue Shield of California has
29 offered an HMO plan, Access Baja, which covers health care in the Mexican municipalities of
30 Tijuana or Mexicali, Baja California, or in the US within a 50-mile radius from the US-Mexico
31 border crossing points at San Ysidro and Calexico, CA. Premiums for Access Baja are less than
32 two-thirds the cost of alternative Blue Shield of California plans.

33
34 In 2007, Blue Cross and Blue Shield of South Carolina created the subsidiary Companion Global
35 Healthcare (Companion), to help US patients plan trips to Thailand’s Bumrungrad International
36 Hospital where they can access discounted care. When a patient receives care at the hospital, the
37 patient pays the Bumrungrad hospital directly at the rate negotiated between Companion and the
38 hospital. Companion also covers two follow-up visits in South Carolina upon return to the US.

39
40 Florida’s United Group Programs (UGP), which offers administrative services for employee health
41 benefit plans of self-insured employers, has begun promoting surgeries in a Thai hospital as an
42 option for its employer clients. So-called “mini-medical” plans, which cap payment for surgery at
43 \$3,000 and hospital stays at \$1000, are also being offered by UGP in combination with medical
44 tourism.

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46 A 2006 telephone survey of households with sicker family members found that 20-40 percent of
47 respondents said that they would agree to obtain major, non-urgent surgery at a very good hospital
48 outside the US by a good surgeon who was trained in the US, England or Canada and speaks

1 English or the patient's language, if offered an incentive of \$10,000 (Arnold Milstein and Mark
2 Smith, *Health Affairs*, January/February 2007).

3
4 RESOLUTION 732 (A-07)

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6 With respect to the proposed directives in referred Resolution 732 (A-07), the National Association
7 of Insurance Commissioners (NAIC) was contacted to determine whether it had examined the issue
8 of international medical liability. At the time that this report was written, the NAIC had not
9 initiated a study on the issue of international medical liability.

10
11 The second resolve of Resolution 732 (A-07) asked the AMA to work with The Joint Commission.
12 AMA Trustee Joseph M. Heyman, MD, is a member of the Board of Directors of Joint
13 Commission Resources (JCR), which is a not-for-profit affiliate of The Joint Commission and
14 which is charged with providing direction and guidance to Joint Commission International (JCI).
15 JCI accreditation programs are based on an international set of standards comparable to US
16 domestic standards, which have been characterized by international consensus, quality
17 management and patient safety, but do not reflect US laws and regulations. Dr. Heyman also
18 serves on JCR's Globalization of Health Services Task Force and JCR's Accreditation Committee,
19 which has responsibility for monitoring aggregate data and compliance of health care organizations
20 with JCI standards.

21
22 In January 2008, JCI revised its accreditation standards for hospitals in its manual *Joint*
23 *Commission International Accreditation Standards for Hospitals*. This third edition of the JCI
24 hospital accreditation standards contain chapters to address high-risk areas such as anesthesia and
25 surgical care, medication management, and the management of communication and information.
26 International patient safety goals were implemented in 2007, and incorporated in the hospital
27 standards for 2008. JCI accreditation standards also address the care of patients after discharge to
28 ensure the continuity of care that patients receive. In August 2007, JCI received accreditation by
29 the International Society for Quality in Health Care (ISQua). ISQua is a non-profit, independent
30 organization comprised of leading quality health care providers and agencies in more than 70
31 countries. More than 170 hospitals in 31 countries are accredited by the JCI.

32
33 The second resolve of Resolution 732 (A-07) also asked that the AMA work with the Physician
34 Consortium for Performance Improvement (PCPI), and the World Medical Association (WMA) to
35 develop standards in the area of international quality of medical care. In 2005, the World Health
36 Organization (WHO) partnered with The Joint Commission and JCI to eliminate medical errors
37 worldwide and improve patient safety as part of the WHO Alliance for Patient Safety. The PCPI
38 has not developed standards in the area of international quality of medical care. Similarly, the
39 WMA Policy Handbook contains no policy on medical travel or medical tourism.

40
41 The third resolve of Resolution 732 (A-07) asks that the AMA encourage development of a
42 separate CPT code for the post-operative care of surgical patients treated outside the US. AMA
43 Policy D-475.997 (AMA Policy Database) encourages the public to learn about the need to
44 coordinate post-operative care, particularly when the patient lives a significant distance from where
45 the surgical procedures were performed. In addition, Policy D-70.955 encourages private payers to
46 recognize CPT codes, and follow guidelines and conventions as they relate to appending
47 appropriate CPT modifiers 54, 55, and 56 to describe the segment of pre-operative, surgical or
48 post-operative care performed during the global period of a procedure when more than one
49 physician delivers a specific segment of the care. Accordingly, the development of a new and

1 separate CPT code does not appear warranted, although the Council agrees that prior to travel,
 2 follow-up care should be coordinated and financing should be arranged to ensure continuity of care
 3 for patients.

4
 5 The fourth resolve of Resolution 732 (A-07) calls for model state legislation requiring companies
 6 that facilitate travel for medical care outside of the US to adhere to various regulations. Strict and
 7 mandatory professional licensure requirements may not be required outside the US, and US has
 8 more robust security and privacy regulations than the international community. However, it is
 9 unclear the extent to which state insurance laws could be used to regulate travel for medical care
 10 outside the US in accordance with the protections set forth in Resolution 732 (A-07). For example,
 11 AMA legal counsel advises that there may be commerce clause limitations on the ability of states
 12 to impose limitations on insurers, employers or other entities that facilitate medical tourism if such
 13 laws or regulations result in undue burdens on interstate commerce.

14
 15 The Governing Council of the Organized Medical Staff Section, the sponsor of Resolution 732
 16 (A-07), met in December 2007, and agreed that the AMA should, at a minimum, recommend that
 17 managed care companies be required to outsource to JCI-accredited hospitals in instances where
 18 they are incentivizing plan enrollees to seek care overseas. The Council agrees with this
 19 suggestion, and believes that other internationally recognized accrediting bodies should be included
 20 in this policy statement.

21
 22 THE PRICE OF CARE WITHIN AND OUTSIDE OF THE US

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 24 A May 2006 *Time* magazine article, “Outsourcing Your Heart,” compared a US insurer’s
 25 negotiated rate to the prices of one surgical tourism agency. The US insurer’s rate included at least
 26 one day of hospitalization. The surgical tourism agency’s rates were presented as package prices
 27 for treatment in India, Thailand and Singapore, and included airfare, hospital, and hotel room. The
 28 *Time* Magazine comparison appears in the following table:

29
 30 COMPARISON OF THE PRICE OF CARE FOR SELECT PROCEDURES IN THE US, INDIA,
 31 THAILAND AND SINGAPORE

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33 Procedure	US Insurer’s Price	US Retail Price	India	Thailand	Singapore
34 Angioplasty	\$26K - \$37 K	\$57K - \$83K	\$11K	\$13K	\$13K
35 Gastric Bypass	\$28K - \$40K	\$48K - \$69K	\$11K	\$15K	\$15K
36 Heart Bypass	\$55K - \$79K	\$122K - \$177K	\$10K	\$12K	\$20K
37 Hip Replacement	\$18K - \$26K	\$44K - \$63K	\$9K	\$12K	\$12K
38 Knee Replacement	\$18K - \$25K	\$41K - \$59K	\$8.5K	\$10K	\$13K
39 Spinal Fusion	\$25K - \$37K	\$63K - \$91K	\$5.5K	\$7K	\$9K

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 41 Source: *Time*, May 21, 2006.

42
 43 Prices for treatment are lower in foreign hospitals for a number of reasons. First and foremost,
 44 labor wages for physicians and other health care workers in countries such as India and Thailand
 45 are significantly lower, prices sought by global suppliers of medical devices and other health care
 46 products are lower, and there is substantially less involvement by third party payers. There are also
 47 lower malpractice litigation costs and less cost-shifting from covered patients to those without
 48 health insurance.

1 COST OF HEALTH CARE IN THE US

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3 The emergence of medical travel for health care outside the US is a response to many aspects of the
4 US health care system, but typically it is linked to rising costs of health care in the US. At the 2007
5 Annual Meeting, the House of Delegates adopted the recommendations of Council on Medical
6 Service Report 8, which outlined four broad strategies to address rising health care costs, including
7 making health care delivery more efficient and reducing non-clinical health care system costs that
8 do not contribute to patient care (Policy H-155.960).

9

10 The US health care system is impacted by inconsistent price transparency, excessive regulatory
11 costs, excessive costs associated with medical liability; and relies on uncompensated physician
12 charity care and cross-subsidization of hospital services. Third-party payment has become the
13 primary mechanism for financing even routine, predictable health care, as well as large,
14 unpredictable expenses. Health insurance protects against the unpredictability of medical
15 expenses, but also insulates patients from the true costs of health care.

16

17 RELEVANT AMA POLICY

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19 AMA policy supports the monitoring of developments on US international trade agreements that
20 involve the provision of medical services (Policy D-505.998[1]). Concurrently, the American
21 public is encouraged to become better informed about the need to coordinate postoperative care,
22 especially in cases where the site of recovery is a significant distance from where the initial surgery
23 was performed (Policy D-475.997). Several policies call for properly structured financial
24 incentives, and proper collection and use of electronic medical records that are in compliance with
25 HIPAA Privacy and Security Rules (Policies H-285.951 and H-315.973). Other policies strongly
26 encourage public and private payers to recognize CPT codes and appropriately use CPT modifiers
27 to describe the provision of postoperative care (Policies D-70.955 and D-475.997).

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29 DISCUSSION

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31 Travel for medical care outside the US is an emerging development, but it is too early to determine
32 whether the risks outweigh the advantages. Long-standing AMA policy on pluralism supports the
33 ability of patients to choose their treatment settings and providers. Travel outside the US for
34 medical care is encouraged by bankruptcy rules, and by rising rates of uninsurance in the US.
35 Potential communication barriers are being addressed with the increasing availability of English-
36 speaking surgeons in other countries who are educated on the most recent quality standards. The
37 co-branding of hospitals and clinics and incentives offered by employers and insurers will likely
38 increase the appeal of medical care outside the US.

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40 The risks of seeking care outside the US can be significant. International quality standards are less
41 rigorous than those in the US, patients may experience difficulty assessing physician credentials,
42 and there may be little legal recourse for poor outcomes. Seeking health care overseas, particularly
43 with long flights following surgery, also carries the potential risk of developing complications,
44 such as a pulmonary embolism. Other potential health risks may arise with the combination of
45 travel for surgery and vacation activities. In addition, if key inefficiencies in the US system
46 continue, such as excessive regulation and unchecked medical liability, the effect of the trend for
47 seeking medical care outside the US may potentially erode the ability of the US health care system
48 to provide quality care, particularly in areas where access to health care is limited.

1 The Council suggests advocating a series of key principles to guide patients, employers, insurers,
2 and those third parties responsible for coordinating travel outside of the US. It is imperative that
3 travel for medical care outside the US be voluntary. In order to make an informed choice, patients
4 need to understand their potential health and legal risks. Patients should also be provided access to
5 information about their physician and facility. Care should be coordinated in the US in order to
6 ensure that optimal care is provided to patients, and postoperative care should be covered once the
7 patient returns to the US. Furthermore, regarding privacy, security, and confidentiality, the transfer
8 of medical records to and from the US should be consistent with HIPAA guidelines.
9

10 Despite significant risks, medical care outside the US provides many advantages and the
11 opportunity to learn from international competition. Pursuant to Policy D-505.998[1], the AMA
12 will continue to monitor this issue for new developments that may impact physicians and patients.
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14 RECOMMENDATIONS

15
16 The Council on Medical Service recommends that the following be adopted in lieu of Resolutions
17 711 (A-07) and 732 (A-07), and that the remainder of this report be filed:
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- 19 1. That our American Medical Association amend Policy D-475.997[2], by insertion to read as
20 follows: Our AMA strongly encourages the American public to become better informed about
21 the need to coordinate both preoperative and postoperative care, especially in cases where the
22 patient's site of recovery is a significant distance from where the initial surgery was performed.
23 (Modify HOD Policy)
24
- 25 2. That our AMA advocate that employers, insurance companies, and other entities that facilitate
26 or incentivize medical care outside the US adhere to the following principles:
 - 27 (a) Medical care outside of the US must be voluntary.
 - 28 (b) Financial incentives to travel outside the US for medical care should not inappropriately
29 limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict
30 treatment or referral options.
 - 31 (c) Patients should only be referred for medical care to institutions that have been accredited
32 by recognized international accrediting bodies (e.g., the Joint Commission International or
33 the International Society for Quality in Health Care).
 - 34 (d) Prior to travel, local follow-up care should be coordinated and financing should be
35 arranged to ensure continuity of care when patients return from medical care outside the
36 US.
 - 37 (e) Coverage for travel outside the US for medical care must include the costs of necessary
38 follow-up care upon return to the US.
 - 39 (f) Patients should be informed of their rights and legal recourse prior to agreeing to travel
40 outside the US for medical care.
 - 41 (g) Access to physician licensing and outcome data, as well as facility accreditation and
42 outcomes data, should be arranged for patients seeking medical care outside the US.
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- 1 (h) The transfer of patient medical records to and from facilities outside the US should be
2 consistent with HIPAA guidelines.
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- 4 (i) Patients choosing to travel outside the US for medical care should be provided with
5 information about the potential risks of combining surgical procedures with long
6 flights and vacation activities. (New HOD Policy)
7
- 8 3. That our AMA reaffirm and publicize policy D-70.955, which encourages private payers to
9 recognize CPT codes and follow guidelines and conventions as they relate to appending
10 appropriate CPT modifiers 54, 55 and 56 to describe the segment of pre-operative, surgical, or
11 post-operative care performed during the global period of a procedure when more than one
12 physician delivers a specific segment of the care. (Directive to Take Action)
13
- 14 4. That our AMA advocate the development of model state legislation, which encompasses our
15 nine AMA principles in Recommendation 2 and which can be used to regulate insurance
16 companies and any other business that refers patients for non-local care. (Directive to Take
17 Action)

Fiscal Note: Staff cost estimated to be less than \$500 to implement.

References for this report are available from the AMA Division of Socioeconomic Policy Development.