

## **AN OVERVIEW OF THE IMPLICATIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT FOR LOW-INCOME HISPANICS IN TEXAS: A CASE FOR CROSS- BORDER HEALTH CARE MODELS**

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### **ABSTRACT**

Health reform, especially health reform in Texas, may not result in a system that allows access for all. This paper outlines how, in Texas, those remaining uninsured even after the implementation of the Patient Protection and Affordable Care Act will likely be low-income Hispanics. A solution is proposed in cross-border health models that utilize the inexpensive health care market in Mexico.

### **I. INTRODUCTION**

In 2010, President Obama signed the Patient Protection and Affordable Care Act (“ACA”) into law. Devised to provide quality, affordable care for all Americans,<sup>1</sup> the ACA aims to strengthen the health care system. However, aiming to control health care costs, the ACA contemplates a major overhaul of the health care system in the

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<sup>1</sup> Patient Protection and Affordable Health Care Act, 26 U.S.C. Title I (2011), *available at* <http://www.healthcare.gov/law/full/index.html>.

United States,<sup>2</sup> and has become one of the most polarizing government initiatives of its time.

Because the ACA will be implemented gradually, it is too soon to judge conclusively the effectiveness of the Act. However, it is estimated that 23 million Americans will remain uninsured after the ACA is enacted.<sup>3</sup> In Texas, implementation may be particularly challenging, and with respect to low-income Hispanics in Texas, nearly ineffective.

First, the insurance status quo for Hispanics in Texas is one of the worst in the nation.<sup>4</sup> Up to thirty-eight percent of Hispanics Texans are uninsured.<sup>5</sup> Further, the Texas health care system does not effectively address health issues that primarily affect Hispanics. In a study examining quality of health care offered by state, Texas performed “very weak” in both diabetes measures and preventative care measures,<sup>6</sup> health issues that disproportionately affect Latinos.<sup>7</sup>

The Supreme Court’s decision in *National Federation of Independent Business v. Sibelius*,<sup>8</sup> coupled with Texas Governor Rick Perry’s refusal to expand Medicaid or create a state insurance

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<sup>2</sup> *Reducing Costs, Protecting Consumers: The Affordable Care Act on the One Year Anniversary of the Patient’s Bill of Rights*, 1, 1, 12 (Sept. 23, 2011), available at

<http://www.healthcare.gov/law/resources/reports/patients-bill-of-rights09232011a.pdf>

<sup>3</sup> Robert Wood Johnson Found., *Health Policy: Health Insurance Coverage*, <http://www.rwjf.org/healthpolicy/coverage/fastfacts.jsp> (last visited Oct. 18, 2012).

<sup>4</sup> U.S. Dep’t of Health and Human Servs., *Best Performing States Across All Measures in Overall Health Care*, [http://statesnapshots.ahrq.gov/snaps11/overall\\_quality.jsp?menuId=5&state=TX&level=0&region=0&compGroup=N&compRegion=-1](http://statesnapshots.ahrq.gov/snaps11/overall_quality.jsp?menuId=5&state=TX&level=0&region=0&compGroup=N&compRegion=-1) (last visited Oct. 18, 2012).

<sup>5</sup> Kaiser Found., *Uninsured Rates for the Nonelderly by Race/Ethnicity, states (2009-2010)*, U.S. (2010), <http://statehealthfacts.org/comparable.jsp?ind=143&cat=3> (last visited Oct. 18, 2012).

<sup>6</sup> Agency for Healthcare Research and Quality, U.S. Dep’t of Health and Human Servs., *Texas: Dashboard on Health Care Quality Compared to All States*, <http://statesnapshots.ahrq.gov/snaps11/dashboard.jsp?menuId=4&state=TX&level=0> (last visited Oct. 18, 2012).

<sup>7</sup> Ctr. Am. Progress, *Texas Puts Latinos’ Health at Risk: How Opting Out of the Medicaid Expansion Will Affect the State’s Hispanics*, [http://www.americanprogress.org/issues/2012/07/texas\\_medicaid.html/](http://www.americanprogress.org/issues/2012/07/texas_medicaid.html/) (last visited Oct. 18, 2012).

<sup>8</sup> Nat’l Fed’n of Indep. Bus. v. Sibelius, 132 S. Ct. 2566, 2572, 183 L. Ed. 2d 450 (2012), (heard together with *Florida v. Dep’t of Health and Human Servs.*, 648 F.3d 1235 (11<sup>th</sup> Cir. 2011)).

exchange<sup>9</sup>, are particularly bad for Texas Hispanics. Further, the ACA has structural “glitches” that will likely disproportionately affect Hispanics. And most saliently, previous studies of health reforms already implemented in Massachusetts suggest Hispanics were the ethnic group most likely to remain uninsured even after the reforms.<sup>10</sup> This paper discusses how Hispanics may be excluded in Texas as well.

Including Hispanics into the reformed health care system will be a necessity if affordable care is to be achieved systemically. According to the Kaiser Foundation, “the adequacy of assistance will be a key determinant of how many people will gain coverage and whether or not lower income people will be able to use the health insurance they obtain.”<sup>11</sup> Affordability will affect compliance with the individual mandate, and without broad compliance, it would be difficult to maintain the proposed insurance reforms that depend on broad risk pools.<sup>12</sup> As such, including Hispanics in the Texas health system is necessary for the success of the ACA in Texas.

Previous studies of health reform suggest, “[w]ithout specialized tools. . .the widespread disparities in coverage and access to care in the current system may be reduced, but they are not likely to be eliminated.”<sup>13</sup> In considering the effects of the recent development in the ACA implementation, the pathologies of the ACA itself, and health reform initiatives in Massachusetts, cross-border health models (“CBHM”) could serve as one of these “specialized tool[s]” in Texas.

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<sup>9</sup> Manny Fernandez, *Texas Counties Fear Residents Will Pay the Price of Perry’s Medicaid Rebuff*, N.Y. TIMES, JULY 17, 2012, available at <http://www.nytimes.com/2012/07/18/us/texas-counties-fear-cost-of-medicaid-rebuff.html>.

<sup>10</sup> See James Maxwell et al., *Massachusetts’ Health Care Reform Increased Access to Care for Hispanics, But Disparities Remain*, 30 HEALTH AFFAIRS 1451, 1457 (2012).

<sup>11</sup> The Henry J. Kaiser Found., *Explaining Health Care Reform: Questions About Health Insurance Subsidies*, FOCUS ON HEALTH REFORM, July 2012, at 1, available at <http://www.kff.org/helathreform/upload/7962-02.pdf>.

<sup>12</sup> BOWEN GARRET ET AL., TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES PREMIUMS AND COST-SHARING SUBSIDIES UNDER HEALTH REFORM: IMPLICATIONS FOR COVERAGE, COSTS, AND AFFORDABILITY (Dec. 2009), available at [http://www.urban.org/uploadedpdf/411992\\_health\\_reform.pdf](http://www.urban.org/uploadedpdf/411992_health_reform.pdf).

<sup>13</sup> Maxwell et al., *supra* note 10, at 1458.

I do not purport to have identified all problems in the ACA implementation rubric as to the inclusion of Hispanics in the Texas health care system. As the ACA is implemented, it is my hope that these and other problem areas to be identified in the future will be addressed in order to best create a health system that allows greater access to all Americans.

## II. RECENT DEVELOPMENTS: MÁS MEDICAID?

On the last day of the 2011-2012 term, the United States Supreme Court decided *National Federation of Independent Business v. Sibelius*,<sup>14</sup> where the Court agreed to consider the constitutionality of both the individual mandate and the issue of Medicaid expansion. As a result, because the decision to expand Medicaid eligibility is now within each state's discretion, this creates uncertainty for millions of low-income Americans.<sup>15</sup>

As the ACA was originally designed, Medicaid eligibility was expanded to all people with incomes up to 133 percent of the poverty line—\$14,856 for individuals and \$30,657 for a family of four.<sup>16</sup> It was estimated that this expansion would extend coverage to 17 million Americans.<sup>17</sup>

The Court found the mandated Medicaid expansion unconstitutionally coercive as to the states. The Court ruled that this expansion created the existence of an entirely new program, and Congress was not allowed to condition the receipt of a state's existing federal Medicaid funds on its agreement to expand Medicaid

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<sup>14</sup> *Nat'l Fed'n of Indep. Bus. v. Sibelius*, 132 S. Ct. 2566, 2572, 183 L. Ed. 2d 450 (2012) (heard together with *Florida v. Dep't of Health & Human Servs.*, 648 F.3d 1235 (11<sup>th</sup> Cir. 2011)).

<sup>15</sup> Maura Calsyn & Emily Oshima Lee, *Interactive Map: Why the Supreme Court's Ruling on Medicaid Creates Uncertainty for Millions of Americans*, CENTER FOR AMERICAN PROGRESS, [http://www.americanprogress.org/issues/2012/07/medicaid\\_expansion\\_map.html](http://www.americanprogress.org/issues/2012/07/medicaid_expansion_map.html) (last visited Nov. 12, 2012).

<sup>16</sup> *Increased Access to Medicaid*, HEALTH CARE AND YOU, <http://www.healthcareandyou.org/what-is/more-americans/> (last visited Oct. 6, 2012).

<sup>17</sup> Douglass W. Elmendorf, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*, CONGRESSIONAL BUDGET OFFICE, (Mar. 30, 2011, 10:00 AM (EDT)), <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf>.

eligibility. Chief Justice Roberts joined by Justices Breyer, Kagan, Ginsburg and Sotomayor, held that the individual mandate is a constitutional exercise of Congress' power to levy taxes. Article I, Section 8 of the U.S. Constitution provides, "Congress shall have Power. . . to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States." The expansion of Medicaid was not so lucky.

While the Court has long recognized that Congress may attach conditions on the receipt of federal funds that it disburses under its spending power, the Court found this reason insufficient to uphold the expansion of Medicaid. In dicta in both *Charles C. Steward Machine Co. v. Davis*<sup>18</sup> and in *South Dakota v. Dole*,<sup>19</sup> the court suggested there could possibly be a case in which a financial inducement offered by Congress could pass the point at which permissible pressure on states to legislate according to Congress' policy objectives crosses the line and becomes unconstitutional coercion. The Court considered the expansion of Medicaid as crossing this line because states did not have adequate notice to voluntarily consent, and the Secretary could withhold all existing Medicaid funds for state non-compliance. The Court thus circumscribed the Secretary's enforcement authority, and left the rest of the ACA in tact.<sup>20</sup>

### **a. Texas on Track to Reject Medicaid Expansion**

Now states are free to reject the expansion without fear of losing any of their federal Medicaid funding. Though this decision has been highly criticized,<sup>21</sup> Texas appears to be on track to reject Medicaid expansion. Recently, Governor Rick Perry of Texas wrote a letter to Kathleen Sibelius stating that Texas would neither expand Medicaid

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<sup>18</sup> *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937).

<sup>19</sup> *S.D. v. Dole*, 483 U.S. 203, 210-11 (1987).

<sup>20</sup> Mary Beth Musumeci, *A Guide to the Supreme Court's Affordable Care Act Decision*, THE HENRY J. KAISER FAMILY FOUNDATION, (Jul. 2012) <http://www.kff.org/healthreform/upload/8332.pdf>.

<sup>21</sup> State Senator Rodney Ellis (D-Houston), *Ellis: Perry Affordable Care Act Plan Short-Sighted and Not the Final Word*, TEX. ST. SENATE, (Jul. 9, 2012), <http://www.senate.state.tx.us/75r/Senate/members/dist13/pr12/p070912a.htm>.

eligibility nor create a state exchange. Stating he “will not be party to socializing healthcare and bankrupting [Texas] in direct contradiction to [the] Constitution and [the] founding principles of limited government,” Governor Perry attacked the central pillars of the ACA.<sup>22</sup>

In Texas, Hispanics will likely be affected the most by this decision.<sup>23</sup> According to the 2010 United States Census Texas is home to 9.5 million Hispanics; roughly 19 percent of the Hispanic population in the United States.<sup>24</sup> Hispanics represent 37.6 percent of the entire Texas population.<sup>25</sup> Even though Hispanics are a dominant ethnicity in Texas, 37 percent of Hispanics go without health insurance as compared to 13.5 percent of whites.<sup>26</sup> It is estimated that Medicaid expansion would have allowed approximately 2 million uninsured Texans to gain access to the healthcare system.<sup>27</sup> Many of these would have been Hispanics.<sup>28</sup>

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<sup>22</sup> Michael Muskal, *Texas Rejects Two Pillars of New Federal Healthcare Overhaul*, L.A. TIMES (Jul. 9, 2012, 12:24 PM) available at <http://www.latimes.com/news/nation/nationnow/la-na-nn-texas-rejects-federal-healthcare-20120709,0,5870338.story>.

<sup>23</sup> Jennifer Witte, *Texas Puts Latinos' Health at Risk: How Opting Out of the Medicaid Expansion Will Affect the State's Hispanics*, CTR. FOR AM. PROGRESS (July 19, 2012), [http://www.americanprogress.org/issues/2012/07/texas\\_medicaid.html](http://www.americanprogress.org/issues/2012/07/texas_medicaid.html).

<sup>24</sup> Sharon R. Ennis et al., *The Hispanic Population: 2010*, 2010 CENSUS BRIEFS (May 2011), available at <http://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf>.

<sup>25</sup> *Id.* at 6.

<sup>26</sup> *The Uninsured in Texas*, TEX. MED. ASS'N, <http://www.texmed.org/templateprint.aspx?id=5517> (last visited Jun. 14, 2012).

<sup>27</sup> Anne Dunkelberg, *Texans Need Real Solutions to Our Health Care Needs*, CENTER FOR PUBLIC POLICY PRIORITIES (Jul. 9, 2012), available at [http://cphp.org/files/3/HC\\_2012\\_07\\_ST\\_Gov\\_Medicaid.pdf](http://cphp.org/files/3/HC_2012_07_ST_Gov_Medicaid.pdf).

<sup>28</sup> Witte, *supra* note 23.

## II. "GLITCHES"<sup>29</sup> IN THE ACA: ROUTES TO COVERAGE UNDER THE ACA & COST PROBLEMS FOR FAMILIES

As the ACA individual mandate was upheld by the Supreme Court, all U.S. citizens and legal immigrants will be required to maintain "minimum essential [health insurance] coverage"<sup>30</sup> Coverage may be attained through the private insurance market, newly formed state or federal health exchange markets, government assistance programs like Medicaid, or through an individual's employer.<sup>31</sup>

However, only a few of these routes to coverage are actually viable for uninsured Hispanics. As noted above, because of the recent Supreme Court decision and Texas' decision to not expand Medicaid eligibility, Medicaid may not be a coverage option for the previously uninsured.<sup>32</sup> Based on the large number of uninsured Hispanics pre-ACA, it is likely the barriers to the private market, such as affordability, will remain. As such, these individuals should seek coverage through the State exchanges or their employers. However, for Hispanics in Texas, these routes to coverage are not certain either.

The ACA imposes monetary penalties on the uninsured to encourage compliance with the Act's provisions. Specifically those who do not comply with the individual mandate must make a "[s]hared responsibility payment" to the Federal Government.<sup>33</sup> That payment, which the Supreme Court has labeled a tax, is calculated as a percentage of household income, subject to a floor based on a specified dollar amount and a ceiling based on the average annual premium the individual would have to pay for qualifying private health insurance.<sup>34</sup> The Act provides the penalty will be paid to the

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<sup>29</sup> See Editorial, *A Glitch in Health Care Reform*, N. Y. TIMES, Aug. 26, 2012, at SR10 available at [http://www.nytimes.com/2012/08/26/opinion/sunday/a-glitch-in-health-care-reform.html?\\_r=1&src=recg](http://www.nytimes.com/2012/08/26/opinion/sunday/a-glitch-in-health-care-reform.html?_r=1&src=recg).

<sup>30</sup> 26 U.S.C. § 5000A(a) (2010).

<sup>31</sup> 26 U.S.C. § 5000A(f).

<sup>32</sup> Witte, *supra* note 23.

<sup>33</sup> 26 U.S.C. § 5000A(b)(1).

<sup>34</sup> 26 U.S.C. § 5000A(c).

Internal Revenue Service with an individual's taxes and "shall be assessed and collected in the same manner" as tax penalties.<sup>35</sup> It is notable that some individuals who would be subject to the mandate are exempt from the penalty<sup>36</sup>—for example, those with incomes below a certain threshold<sup>37</sup> and members of Indian tribes.<sup>38</sup>

As such, individual non-compliance with the Act will be discouraged, but as the next section of this article develops, accessible routes to health coverage may not be available. This means the ACA non-compliance penalties may be imposed on those who never had a viable health care coverage route either before or after the ACA. Alternatively, if those who remain uninsured after the Act is implemented have incomes below the penalty assessment threshold, and they are thus not assessed the penalty, they may be less inclined to comply with the Act. Broad risks pools are essential to the success of the ACA.<sup>39</sup> Either outcome results in a systemic inefficiency.

#### **a. Employer**

One option for attaining health coverage is through an individual's employer; however, Hispanics working for small firms in Texas will not necessarily receive coverage via this route. Like the individual penalties for ACA non-compliance, some employers also will face monetary penalties in the event their employees are not covered a health plan. However, because the penalties structure for employer non-compliance is based on the size of that employer, small employers may not be hit with these penalties. Additionally, large employers are only required to offer coverage to full-time, non-seasonal employees. Full-time employment is thus another requisite

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<sup>35</sup> 26 U.S.C. § 5000A(g)(1).

<sup>36</sup> *Tax Penalties for Individuals Who Do Not Purchase Coverage*, AM. COLL. PHYSICIANS (2011), available at [http://www.acponline.org/advocacy/where\\_we\\_stand/access/internists\\_guide/vi6-tax-penalties-individuals-who-do-not-purchase-coverage.pdf](http://www.acponline.org/advocacy/where_we_stand/access/internists_guide/vi6-tax-penalties-individuals-who-do-not-purchase-coverage.pdf).

<sup>37</sup> 26 U.S.C. §5000A(e)(1)(A) ("Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act.").

<sup>38</sup> 26 U.S.C. § 5000A(e)(3).

<sup>39</sup> Bowen, *supra* note 12.



for government mandated, employer coverage.<sup>40</sup>

First, even before the ACA Hispanics finished second to last in holding jobs that typically furnish health care benefits.<sup>41</sup> Nationally, the most common types of employment for the Hispanic population include: sales and office work; employment in the service industry; production, transportation, and material moving; construction; and farming, fishing, and forestry.<sup>42</sup> Traditionally, these sectors infrequently offer health insurance to their employees<sup>43</sup>—this is particularly true among recent immigrants.<sup>44</sup>

While the ACA contemplates employer-provided coverage, an employer's obligation to provide insurance is different depending on the classification of that employer as small or large.<sup>45</sup> First, the ACA

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<sup>40</sup> Full time employment is another area in which Hispanics trail other ethnicities. See *Household Data Annual Averages*, BUREAU OF LABOR STATISTICS (2011), available at <http://www.bls.gov/cps/cpsaat08.pdf>.

<sup>41</sup> U. CAL., BERKELEY, ACCESS TO HEALTH CARE FOR LATINOS IN THE U.S. FACT SHEET 1, (2010), available at [http://www.binationalhealthweek.org/uploads/accesstohealthcare\\_factsheet.pdf](http://www.binationalhealthweek.org/uploads/accesstohealthcare_factsheet.pdf) (providing that Hispanics finished second to last in filling management professional and related occupations).

<sup>42</sup> PETER FRONCZEK & PATRICIA JOHNSON, U.S. CENSUS BUREAU, OCCUPATIONS: 2000 6-7 (2003), available at <http://www.census.gov/prod/2003pubs/c2kbr-25.pdf>.

<sup>43</sup> U. CAL., BERKLEY, ACCESS TO HEALTH CARE FOR LATINOS IN THE U.S. FACT SHEET (October 2010), available at [http://www.binationalhealthweek.org/uploads/accesstohealthcare\\_factsheet.pdf](http://www.binationalhealthweek.org/uploads/accesstohealthcare_factsheet.pdf) (“[S]ome of the major industries that provide significant employment opportunities for the U.S. Latino labor force include agricultural, manufacturing, construction, and service sectors which are not only low paying industries, but also less likely to provide health insurance coverage and other employer sponsored benefits for their employees.” (citing X. Castañeda et al., *Migration, health & work: Facts behind the myths*, THE HEALTH INITIATIVE OF THE AMERICAS (2007)).

<sup>44</sup> CLAUDIA L. SCHUR & JACOB FELDMAN, THE PROJECT HOPE CENTER FOR HEALTH AFFAIRS, RUNNING IN PLACE: HOW JOB CHARACTERISTICS, IMMIGRANT STATUS, AND FAMILY STRUCTURE KEEP HISPANICS UNINSURED 10 (2001), available at [http://web02.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2001/May/Running%20in%20Place%20%20How%20Job%20Characteristics%20%20Immigrant%20Status%20%20and%20Family%20Structure%20Keep%20Hispanics%20Uni/schur\\_running\\_453%20pdf.pdf](http://web02.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2001/May/Running%20in%20Place%20%20How%20Job%20Characteristics%20%20Immigrant%20Status%20%20and%20Family%20Structure%20Keep%20Hispanics%20Uni/schur_running_453%20pdf.pdf) (last visited Jan. 21, 2012); see also JOSH VALDEZ & ROBERT G. DE POSTADA, STRATEGIES FOR IMPROVING LATINO HEALTHCARE IN AMERICA, available at [http://www.borderhealth.org/files/res\\_642.pdf](http://www.borderhealth.org/files/res_642.pdf).

<sup>45</sup> LINDA J. BLUMBERG, TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES, *HOW WILL THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AFFECT SMALL, MEDIUM, AND LARGE BUSINESSES?*, 4 (Aug. 2010), available at <http://www.urban.org/UploadedPDF/412180-ppaca-businesses.pdf>.

does not impose new coverage requirements on small employers (fewer than 50 workers).<sup>46</sup> While coverage for employees is not required for a small business, it is encouraged.<sup>47</sup> A small business will be able to purchase health insurance plans through the state-based Small Business Health Options Program (SHOP), and will receive a tax credit of up to 35% (up to 25% for non-profits) to offset the costs of providing coverage to employees. This credit will increase in 2014 to 50% (35% for non-profits).<sup>48</sup>

The bulk of the employer burden under the ACA to provide coverage to employees falls on the large employer;<sup>49</sup> however, it is unlikely large employers will be substantially affected by ACA penalties as most large employers already offer health coverage to their employees. According to the Medical Expenditure Panel Survey-Insurance Component, 9 percent of employers with 100 or more workers offered insurance in 2009.<sup>50</sup> Large employers with 200 or more full-time workers that offer health care to their employees will be required to automatically enroll all *full-time* employees in a plan each year.<sup>51</sup>

However part-time employees should not hope to obtain government mandated coverage via their employer. The employer penalties are only initiated if at least one *full-time* employee<sup>52</sup> obtains coverage through an exchange and receives a premium credit.<sup>53</sup> Thus,

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<sup>46</sup> *Id.* at 1; see also 42 U.S.C. § 18024(b)(3) (2010).

<sup>47</sup> Blumberg, *supra* note 38, at 1.

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.* at 3.

<sup>52</sup> An individual working 30 hours or more per week. I.R.C § 4980H(c)(4) (West 2011). Part-time employees are factored into the employer classification calculation but essentially do not count as a full-employee. The hours worked by part-time employees are multiplied by the number of part-time employees and divided by 120. Thus, part-time employees do not count as full-employees in the small/large employer calculation, allowing a company who wishes to skirt the ACA employer-provided coverage mandate to employ only part-time workers.

<sup>53</sup> HINDA CHAIKIND & CHRIS L. PETERSON, CONG. RESEARCH SERV., R41159, SUMMARY OF POTENTIAL EMPLOYER PENALTIES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) 1 (2010) available at <http://www.ncsl.org/documents/health/>

Hispanics working part-time may not receive coverage through the employer-provided route. The same applies for seasonal workers.<sup>54</sup>

Health insurance may be out of reach for some—particularly low and moderate-income families—if they are not offered health benefits through their employer.<sup>55</sup> In Texas, people making moderate and low wages are much less likely to have job-based health insurance coverage than those earning more.<sup>56</sup> Further, as many Latinos tend to work for small businesses,<sup>57</sup> the structure of the ACA is especially troubling.

## b. Exchanges

“Exchanges” are insurance marketplaces that either a State or the Federal government creates in order to facilitate the purchase of coverage for both individuals and small businesses. It is not clear at this point whether all States will participate.<sup>58</sup> In Texas however, as of July 9, 2012, Texas has decided not to create an exchange.<sup>59</sup> As such, Texans who wish to purchase coverage via an exchange will be confined to the coverage offered in the Federal exchange marketplace. Some believe this is a detriment to both the individual

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EmployerPenalties.pdf.

<sup>54</sup> *Id.* at 2 (claiming that an employer will only be assessed a penalty for a seasonal worker receiving a premium credit if (1) the seasonal worker was working full-time when they received the credit, and (2) the employer is considered a large employer even without the seasonal worker).

<sup>55</sup> THE HENRY J. KASIER FOUND., *Focus on Health Reform* (2010), available at <http://www.kff.org/healthreform/upload/7962-02.pdf>.

<sup>56</sup> *The Uninsured in Texas*, TEX. MED. ASS'N, <http://www.texmed.org/template.aspx?id=5517> (last visited Oct. 19, 2012).

<sup>57</sup> Sandra Lilley, *Supreme Court decision can impact health insurance for millions, say Latino Advocates*, NBC LATINO (Jun. 27 2012, 10:30 PM), available at <http://nbclatino.com/2012/06/27/supreme-court-decision-can-impact-health-insurance-for-millions-say-latino-advocates/> (citing Jennifer Ng'andu, a health policy director of the National Council of La Raza, stating “[n]ine out of ten Latinos work in small businesses.”).

<sup>58</sup> *State Action Toward Creating Health Insurance Exchanges, as of September 27, 2012*, THE HENRY J. KAISER FAM. FOUND., <http://statehealthfacts.kff.org/comparemactable.jsp?ind=962&cat=17> (last visited October 13, 2012).

<sup>59</sup> Letter from Rick Perry, Governor of Texas, to the Honorable Kathleen Sebelius, Secretary, United States Department of Health and Human Services (July 9, 2012), available at <http://governor.state.tx.us/files/press-office/O-SebeliusKathleen201207090024.pdf>.

and the state.<sup>60</sup>

Offered only for purchase of coverage within an exchange, the ACA provides for advanceable, refundable premium assistance credits to limit the amount of money some individuals would pay for premiums.<sup>61</sup> The ACA makes premium credits available to those whose income exceeds 133 percent of the Federal Poverty Line ("FPL") but does not exceed 400 percent FPL.<sup>62</sup> Under PPACA, for example:

a family of three just above 133% of the federal poverty line (FPL)—that is, currently with annual income of \$24,352—would be required to pay 3% of its income toward premiums (\$824 annually, if the proposed premium subsidies were currently in effect). A family of three just under 400% FPL (\$73,240), where the premium subsidies end, would be required to pay no more than 9.5% of its income in premiums (\$6,958 annually, if the proposed premium subsidies were currently in effect).<sup>63</sup>

Without the extension of Medicaid eligibility, those earning below the FPL will not be eligible for subsidies.<sup>64</sup> Because Congress assumed these people would be eligible for Medicaid under the provisions in the ACA,<sup>65</sup> people in Texas who are below the federal poverty line without children (a requirement to be Medicaid eligible in Texas) will be severely disadvantaged.<sup>66</sup>

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<sup>60</sup> ERIC A. BOOTH & JIM DYER, TEXAS HEALTH EXCHANGE PLANNING SYMPOSIUM: PUBLIC INPUT AND PERSPECTIVES 6 (Mar. 10, 2011), available at <http://www.tdi.texas.gov/health/documents/symposiumreport.pdf>.

<sup>61</sup> Affordable Care Act, 26 U.S.C.A. § 36B (West 2011).

<sup>62</sup> *Id.*

<sup>63</sup> CHRIS L. PETERSON & THOMAS GABE, CONG. RESEARCH SERV., HEALTH INSURANCE PREMIUM CREDITS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) (2010), available at <http://www.ncsl.org/documents/health/HlthInsPremCredits.pdf>.

<sup>64</sup> Federal tax credits and subsidies will not be available for Texans with incomes below the FPL because the credits and subsidies are only available to people with incomes between 100 and 400 percent of the FPL. This means the uninsured above poverty could receive financial assistance, but those below poverty will not.

<sup>65</sup> Maura Calsyn & Emily Oshima Lee, *Interactive Map: Why the Supreme Court's Ruling on Medicaid Creates Uncertainty for Millions*, CTR. FOR AM. PROGRESS (July 5, 2012) [http://www.americanprogress.org/issues/2012/07/medicaid\\_expansion\\_map.html](http://www.americanprogress.org/issues/2012/07/medicaid_expansion_map.html)

<sup>66</sup> GENEVIEVE M. KENNY, ET AL., URBAN INST, OPTING OUT OF MEDICAID EXPANSION UNDER THE ACA: HOW MANY UNINSURED ADULTS WOULD NOT BE ELIGIBLE FOR MEDICAID? 1 (July 5, 2012), available at <http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the>

Further, even with the subsidies, the cost of insurance may still not be affordable for some low-income families.<sup>67</sup> These tax credits are to be given to those who would otherwise not have had access to affordable care. A premium contribution is deemed affordable when it does not exceed 9.5 percent of the worker's household income. However, as the New York Times recently noted, this calculation is based on individual coverage for the individual worker alone.<sup>68</sup> Family coverage is much more expensive. Citing a recent Kaiser survey,<sup>69</sup> it does not appear the expected premium contribution for low-income families (\$4,129) will be affordable to low-income workers.<sup>70</sup> As such, attaining coverage through the exchanges, especially for those seeking family coverage, may not be an option for low-income individuals.

### c. Implications

Though the ACA does attempt to provide affordable health care access, due to the ACA "glitches," many Hispanics may still be left out of the system. As the Texas Medical Association notes, those without coverage post-ACA will probably continue to "delay seeking needed primary care services and end up in the emergency room with a preventable condition (at a much higher cost to the community), and subsequently, are absent from work for extended periods contributing to a loss of productivity and increased cost to local employers and do not contribute to the tax base as substantially."<sup>71</sup> Even after the ACA is implemented, because of

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Medicaid-Expansion-Under-the-ACA.pdf.

<sup>67</sup> See JONATHAN GRUBER & IAN PERRY, THE COMMONWEALTH FUND, REALIZING HEALTH CARE REFORM'S POTENTIAL: WILL THE AFFORDABLE CARE ACT MAKE HEALTH INSURANCE AFFORDABLE? (April 2011), available at [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Apr/1493\\_Gruber\\_will\\_affordable\\_care\\_act\\_make\\_hlt\\_ins\\_affordable\\_reform\\_brief\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Apr/1493_Gruber_will_affordable_care_act_make_hlt_ins_affordable_reform_brief_v2.pdf).

<sup>68</sup> Editorial, *A Glitch in Health Care Reform*, N.Y. TIMES, Aug. 25, 2012, available at [http://www.nytimes.com/2012/08/26/opinion/sunday/a-glitch-in-health-care-reform.html?\\_r=1&src=recg](http://www.nytimes.com/2012/08/26/opinion/sunday/a-glitch-in-health-care-reform.html?_r=1&src=recg).

<sup>69</sup> THE KAISER FAM. FOUND. & HEALTH RES. & EDUC. TRUST, EMPLOYER HEALTH BENEFITS - 2011 ANNUAL SURVEY, available at <http://ehbs.kff.org/pdf/2011/8225.pdf>.

<sup>70</sup> Editorial, *supra* note 60.

<sup>71</sup> DAVID C. WARNER & PABLO B. SCHNEIDER, POLICY RESEARCH PROJECT ON CROSS-BORDER HEALTH INSURANCE, CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS 155 (2004),

these “glitches,” economic barriers to health access may exist for Hispanics in Texas. While only a forecast at this juncture, based on previous research, it appears these predictions may become reality.

### III. LEARNING FROM MASSACHUSETTS REFORM

While only projections can be made as to the success of health reform in Texas, reform in Massachusetts (“Chapter 58”) was fully implemented in 2006. As Chapter 58 subsequently served as a model for the ACA,<sup>72</sup> it is particularly relevant to projecting the success of the ACA elsewhere.

As a result of Chapter 58, Massachusetts has achieved the highest rate of health insurance coverage in the nation.<sup>73</sup> While Chapter 58 reduced the number of uninsured, coverage disparities remain between Hispanics and other ethnicities.<sup>74</sup> Even after the reform, one-third of Spanish-speaking Hispanics still did not have a personal provider.<sup>75</sup> While non-Hispanic whites and English-speaking Hispanics had similar rates of having a personal provider after Chapter 58, Spanish-speaking Hispanics had a significantly lower rate.<sup>76</sup> Ultimately cost and cultural difficulties were barriers to effective implementation of the Chapter 58 reforms as to Hispanics in Massachusetts.<sup>77</sup>

Interviews conducted<sup>78</sup> further explain why Massachusetts

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available at [http://www.utexas.edu/lbj/chasp/publications/downloads/Cross\\_Border\\_Health\\_Insurance.pdf](http://www.utexas.edu/lbj/chasp/publications/downloads/Cross_Border_Health_Insurance.pdf).

<sup>72</sup> James Maxwell et al., *Massachusetts’ Health Care Reform Increased Access to Care for Hispanics, but Disparities Remain*, 30 HEALTH AFF. 1451 (2011).

<sup>73</sup> *Id.* at 1451; see LEIGHTON KU, ET AL., HOW IS THE PRIMARY CARE SAFETY NET FARING IN MASSACHUSETTS? COMMUNITY HEALTH CENTERS IN THE MIDST OF HEALTH REFORM 1, 6, 8 (The Kasier Commission on Medicaid and the Uninsured 2009) available at <http://www.kff.org/healthreform/upload/7878.pdf> (tracking the effect Chapter 58 had on community health centers in Massachusetts).

<sup>74</sup> Maxwell, *supra* note 72, at 1452.

<sup>75</sup> *Id.* at 1455 (having a personal health care provider indicative of access to care).

<sup>76</sup> *Id.*; see Exhibit 3.

<sup>77</sup> *Id.* at 1453-56.

<sup>78</sup> *Id.* at 1452-53. To measure the effectiveness of Chapter 58 implementation, Maxwell studied data collected by a state-based telephone survey on health-related topics. Those

Hispanics continued to be less likely to have a regular source of care and why cost remained a significant barrier. Those interviewed cited difficulty in finding a provider with the appropriate language skills and cultural competence.<sup>79</sup> Additionally, low-income Hispanics with public coverage were disadvantaged in finding a provider because many providers began to only accept patients with private insurance.<sup>80</sup> In short, Chapter 58 implementation drove up the demand for physicians and care centers that could provide culturally sensitive care, and that demand outpaced the supply. Culturally sensitive providers in Massachusetts were difficult to find and had long waiting lists.<sup>81</sup>

Similar results have been found elsewhere.<sup>82</sup> It is estimated that up to “one-third of Latinos have difficulty communicating with their physicians.”<sup>83</sup> According to the Valdez/De Posada study, “[m]any have trouble reading and understanding written information in their doctors’ offices, omit medications, miss office appointments and rely on hospital emergency departments for their general healthcare.”<sup>84</sup>

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surveyed were among people ages 18 or older, conducted in English and Spanish, and oversampled cities with a high proportion of minority populations, especially Hispanic communities. The survey gathered information concerning compliance with the Massachusetts’ mandate for health insurance coverage, the process of obtaining coverage, perceptions of health insurance affordability, the meaning of insurance coverage, the difficulties in maintaining coverage, and the use of insurance once enrolled. The Chapter 58 study also collected data using focus groups and twenty in-depth interviews with newly insured Hispanics whose income was 150-300 percent of the federal poverty level. *Id.* at 1452-1453.

<sup>79</sup> *Id.* at 1456. (“Another challenge for Hispanics was finding a provider with whom they felt comfortable discussing sensitive health issues. Our focus-group participants reported that they would have preferred to see Spanish-speaking providers instead of relying on interpreters, but such providers were difficult to find and had long waiting lists.”).

<sup>80</sup> *Id.* (“One Spanish-speaking participant reported obtaining health insurance coverage but not using it because she could not find a provider...She said that the hospital she usually visited did not accept her new insurance, so she had to change providers. Then she had to wait for an appointment with her new primary care physician. Another Spanish-speaking woman complained that she had to wait four months to see her new physician...”).

<sup>81</sup> *Id.*

<sup>82</sup> See JOSH VALDEZ & ROBERT G. DE POSADA, STRATEGIES FOR IMPROVING LATINO HEALTHCARE IN AMERICA: REPORT OF THE LATINO HEALTHCARE TASKFORCE, available at [http://www.borderhealth.org/files/res\\_642.pdf](http://www.borderhealth.org/files/res_642.pdf).

<sup>83</sup> *Id.* at 18.

<sup>84</sup> *Id.* at 7.

Alternatively, when Spanish-speaking patients are served by Spanish speaking doctors, the patients “tend to ask more questions about their health, have higher levels of satisfaction and have better recall of their physician’s recommendations.”<sup>85</sup>

Finally, financial barriers existed even after enrollment in a health plan.<sup>86</sup> Even after obtaining coverage, Hispanics in the study reported reluctance to see their providers because of copayment fees and costs of medication. Some respondents noted confusion as to what was covered by the premium. According to the Maxwell study, “[t]he confusion about what costs are covered [by an insurance premium] may influence whether or not people decide to keep paying their insurance premiums.”<sup>87</sup>

#### IV. CROSS-BORDER HEALTH MODELS: A USEFUL TOOL

One possible solution to both the cost and cultural problems on the Texas health care horizon is crafting legislation to allow for cross-border health models (“CBHM”). Bustamente has noted, in California, where CBHM are legal, the future of these plans, “depend on whether [CBHM are] effective at actually offering better care for those who are currently underserved, even though they have insurance, and also whether it is effective at reducing costs.”<sup>88</sup> As noted above, in Texas, there may be more uninsureds, and it is likely these uninsureds will be Hispanics.

Previous studies suggest those with access to the Mexican health market utilize it when afforded the opportunity.<sup>89</sup> A 2003 study

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<sup>85</sup> *Id.*

<sup>86</sup> Maxwell, *supra* note 72, at 1456.

<sup>87</sup> *Id.*

<sup>88</sup> Lisa Zamosky, *Room for Growth in California’s Cross-Border Insurance*, CAL. HEALTHLINE (April 23, 2010), <http://www.californiahealthline.org/features/2010/room-for-growth-in-californias-crossborder-insurance.aspx#ixzz23kXn2tGr>.

<sup>89</sup> Arturo Vargas Bustamante, et al., *Willingness to Pay for Cross-Border Health Insurance Between the United States and Mexico*, 27 HEALTH AFFAIRS 169 (2008), available at <http://content.healthaffairs.org/content/27/1/169.full.html>; WARNER & SCHNEIDER, *supra* note 71.



tracked cross-border health usage in the El Paso Metropolitan Area.<sup>90</sup> The researchers concluded CBHM would be an economically and culturally useful addition to the chronically uninsured in the region.<sup>91</sup>

Though the vast number of uninsured Hispanics do not necessarily reside along the U.S./Mexico border,<sup>92</sup> El Paso, is one of the least insured major cities in the U.S.<sup>93</sup> In 2003, one of every three non-elderly residents living in El Paso was uninsured compared to one in seven nationwide.<sup>94</sup> In 2010, it was estimated that 28 percent of the population was uninsured.<sup>95</sup> Given that around 82 percent of El Paso is Hispanic,<sup>96</sup> it is thus likely the majority of these uninsured are from Hispanic descent.

Additionally, El Paso residents will not likely receive health care coverage from their employer. The 2000 report by the Commonwealth Fund and UCLA found that 67 percent of non-elderly U.S. residents in the 85 surveyed major metropolitan regions were covered by employer-based health insurance.<sup>97</sup> In El Paso County, on the other hand, just 49 percent of non-elderly residents had employer-based health insurance, ranking El Paso County last of the 85 metropolitan areas in the study for job-based health insurance coverage.<sup>98</sup> It has been estimated that 45 percent of the gainfully

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<sup>90</sup> WARNER & SCHNEIDER, *supra* note 71, at 106.

<sup>91</sup> *Id.* at 243-44.

<sup>92</sup> See *The Uninsured in Texas*, TEX. MED. ASS'N, <http://www.texmed.org/template.aspx?id=5517> (stating that "In Texas, 35 of the state's 254 counties account for 80 percent of the uninsured. A common misconception is that the uninsured are concentrated in the counties along the Texas - Mexico border. Texas' 28 largest cities, including Houston, Dallas, San Antonio, Austin, Ft. Worth and El Paso, had a greater percentage of their population without insurance than the collective United States").

<sup>93</sup> WARNER & SCHNEIDER, *supra* note 71, at 107.

<sup>94</sup> Karen Brandon & Jeff Zeleny, *Uninsured in America*, CHICAGO TRIBUNE, January 31, 2003, at 1, available at [http://articles.chicagotribune.com/2003/02/31/news/0301310394\\_1\\_universal-health-care-system-health-care](http://articles.chicagotribune.com/2003/02/31/news/0301310394_1_universal-health-care-system-health-care).

<sup>95</sup> *The Uninsured in Texas*, TEX. MED. ASS'N, <http://www.texmed.org/template.aspx?id=5517>.

<sup>96</sup> Diana Washington Diaz, *Hispanics Grow to 82 Percent of County Population*, EL PASO TIMES, Feb. 18, 2011, available at [http://www.elpasotimes.com/news/ci\\_17418626](http://www.elpasotimes.com/news/ci_17418626).

<sup>97</sup> WARNER & SCHNEIDER, *supra* note 71, at 107.

<sup>98</sup> *Id.*

employed population in El Paso was not offered health insurance coverage by their employers.<sup>99</sup> It is further estimated that 80 percent or more of those workers are Mexican or Mexican-American.<sup>100</sup>

As noted above, the health care reforms do not heavily encourage small employers to provide coverage to their employees, thus compounding what already was a coverage deficiency in the El Paso area. Pre-ACA, small employers in the region were not likely to provide coverage to their employees.<sup>101</sup> In a 1999, 636 businesses were surveyed, and only 52 offered a health insurance plan.<sup>102</sup> Traditional plans are particularly ineffective for those employees living in Juarez or employees who have undocumented children as they could not participate in a health plan even if one was offered.<sup>103</sup>

For all of the above, Warner and Schneider conclude El Paso could still be a viable market for cross-border products.<sup>104</sup> In fact, at the time of the study, limited cross-border insurance activity already existed in El Paso/Juarez. At the time of the study, at least one El Paso based TPA had 600 Mexican physicians in a 25-year-old network.<sup>105</sup> It is estimated that up to 20 percent of enrollees using the network opt to get care in Mexico.<sup>106</sup> In fact, Warner and Schneider found at least two hospitals in Juarez to already accept U.S. insurance.<sup>107</sup>

## V. BARRIERS: A VOCAL OPPOSITION

Though there is a demand for cross-border health models, there is a vocal opposition in some members of the El Paso medical community who express concern about the quality of health care in

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<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> *Id.* at 116.

<sup>102</sup> *Id.* at 116 citing FN 136.

<sup>103</sup> *Id.* citing footnote 137.

<sup>104</sup> WARNER AND SCHNEIDER, *supra* note 71, at 134.

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> *Id.* at 135.

Juarez and about the possibility of losing business to Mexican providers.<sup>108</sup> Opponents of these plans also claim this kind of international competition promotes a “race to the bottom.”<sup>109</sup> They claim that consumers will be attracted to the least costly plan even when their medical needs may require wider coverage.<sup>110</sup> Furthermore, many comparative studies have been conducted examining the quality of medical care between the United States and Mexico.<sup>111</sup> Some argue better care exists in the United States,<sup>112</sup> while others disagree.<sup>113</sup> How quality care is defined is thus open to interpretation on many fronts.

In 1999, Superior Health Plans, one of the largest HMOs in the El Paso area “felt there was a need for a cross-border product and a market that would be receptive to a cross-border plan.”<sup>114</sup> In response, two Texas legislators, Rep. Haggarty (R-El Paso) and Rep. Olivera (D-Brownsville), crafted a bill to explore the possibilities of a cross-border health product, however, it was not passed.<sup>115</sup> Additionally, the opposition to the Texas bill noted a cross-border plan in El Paso would reduce the number of patients receiving care in El Paso.<sup>116</sup> Aside from the projected financial loss to the doctors, the opposition noted this patient loss would in turn encourage doctors to practice in other areas, thus further decreasing access to care.<sup>117</sup>

With the advent of the ACA, if Texas ACA implementation

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<sup>108</sup> *Id.*

<sup>109</sup> Phil Galewitz & Lexi Verdon, *FAQ: Selling Health Insurance Across State Lines*, (Jan. 25, 2011), <http://www.kaiserhealthnews.org/Stories/2010/September/30/selling-insurance-across-state-lines.aspx>.

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> ELIZABETH DOCTEUR & ROBERT A. BERENSON, *TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES, HOW DOES THE QUALITY OF U.S. HEALTH CARE COMPARE INTERNATIONALLY?* (Aug. 2009), available at [http://www.urban.org/uploadedpdf/411947\\_ushealthcare\\_quality.pdf](http://www.urban.org/uploadedpdf/411947_ushealthcare_quality.pdf).

<sup>113</sup> Chris Hawley, *Mexico's Health Care Lures Americans*, USA TODAY, August 1, 2009, available at [http://www.usatoday.com/news/world/2009-08-31-mexico-health-care\\_N.htm](http://www.usatoday.com/news/world/2009-08-31-mexico-health-care_N.htm).

<sup>114</sup> WARNER & SCHNEIDER, *supra* note 71, at 117.

<sup>115</sup> *Id.*

<sup>116</sup> *Id.* at 118.

<sup>117</sup> *Id.*

follows Chapter 58 trends, the concern of patient loss to other markets may be moot. As seen in Chapter 58 reform, many doctors began taking only private insurance.<sup>118</sup> In implementing a CBHM in the El Paso area, it is likely El Paso will see an influx of doctors following suit. Thus, care may not even be offered to these Hispanics in this area post-ACA.

Regardless of these political positions, without authorization from the Texas state legislature, many cross-border products will remain illegal. Several reforms would be necessary.<sup>119</sup> First, Texas Insurance Code defines “physician” as a doctor who is licensed to practice medicine in Texas.<sup>120</sup> In California, the law does not hold Mexican health care providers to the same standards as California providers.<sup>121</sup> According to the Health Policy Monitor:

[t]he plans require that physicians be licensed in Mexico and meet any specialty board requirements. The companies regularly audit the services, and patients can make complaints through California regulators.<sup>122</sup>

According to the California Department of Managed Health Care, the office has received “few complaints about the plans.”<sup>123</sup>

If these reforms were implemented, a previous study suggests a market demand would be filled. At least one U.S. insurance company has expressed interest in selling a cross-border product in El Paso:

Centene seriously considered creating a cross-border product a few years ago and supported legislation to license cross-border plans in Texas; however, the company is unwilling to pursue cross-border products until their legality is clearly defined.<sup>124</sup>

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<sup>118</sup> Maxwell et al., *supra* note 10, at 1456.

<sup>119</sup> WARNER & SCHNEIDER, *supra* note 71, at 244.

<sup>120</sup> *Id.* (“the Texas Insurance Code (TIC) defines the term “physician” to mean only doctors who are licensed to practice medicine in Texas”).

<sup>121</sup> ANKE THERESE SCHULZ & CAROL MEDLIN, HEALTH POLICY MONITOR, CROSS-BORDER HEALTH CARE PLANS 4 (2006), available at <http://www.hpm.org/us/d7/4.pdf>.

<sup>122</sup> *Id.*

<sup>123</sup> WARNER AND SCHNEIDER, *supra* note 71, at 55.

<sup>124</sup> *Id.* at 135.

In short, there seems to be a demand for cross-border health products that the legislature has the tools to satisfy. With the advent of the ACA, and Texas' response to its implementation, cross-border products and other inventive health models may be necessary to include Texans in the health care system.

## VI. EXISTING CROSS-BORDER MODELS

Cross-border health products have been implemented in the United States. First, inter-state plans existed before and within the ACA. Secondly, cross-border programs are being explored to solve other implementation problems of the ACA.

### a. Cross-border Insurance Inter-State: A Model for International Implementation

Just as regional exchanges make sense in large metropolitan areas that cross state boundaries,<sup>125</sup> CBI plans also make sense for the same reasons. Residents may reside in one jurisdiction but work and obtain health insurance in another. As the private health insurance market stands today, insurers make adjustments in order to effectively capture these types of individuals. For example, there are two existing Blue Cross Blue Shield (BCBS) plans that operate in Kansas. The Kansas BCBS plan operates statewide with the exception of the Kansas City metropolitan area.<sup>126</sup> The Kansas City BCBS provides coverage only in the Kansas City, Missouri metropolitan area and is licensed in both Kansas and Missouri.<sup>127</sup>

In 2008 Rhode Island created a regional health insurance

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<sup>125</sup> LINDA J. BLUMBERG, TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES, MULTI-STATE HEALTH INSURANCE EXCHANGES, (April 2011), available at <http://www.rwjf.org/files/research/72109multistateexchanges201104.pdf>.

<sup>126</sup> *Company Info – Service Area*, BLUE CROSS BLUE SHIELD OF KANSAS, [http://www.bcbsks.com/AboutUs/CompanyInfo/service\\_area.htm](http://www.bcbsks.com/AboutUs/CompanyInfo/service_area.htm) (last visited Oct. 20, 2012).

<sup>127</sup> *See Provider Services – Glossary of Health Insurance Terms*, BLUE CROSS BLUE SHIELD OF KANSAS, <http://www.bcbsks.com/CustomerService/Providers/faqs/glossary/B.htm> (last visited Oct. 20, 2012).

market.<sup>128</sup> Wyoming followed suit in 2010 voicing the intent to create multi-state reciprocal agreements to lessen healthcare costs by doing away with duplicative legislation.<sup>129</sup> And finally, in 2011, Georgia signed into law Insurance HB 47 which allows for the sale of individual health coverage if, among other requirements, the plan is approved in another state and has a basic minimum of coverage.<sup>130</sup>

As such these types of plans are not unheard of, and in fact, the legislatures who have enacted inter-state plans acknowledge the inefficiencies of systems without this type of reciprocity. The same could be said for a system in the U.S. that fails to work in cooperation with a substantially less expensive Mexican healthcare market.

### **b. Salud Migrante**

In Texas, undocumented individuals are almost three times as likely to be uninsured as native U.S. citizens.<sup>131</sup> Immigrants, many of whom are Hispanics, often work in economic sectors less likely to offer health insurance than others, such as construction.<sup>132</sup> Due to the high number of undocumented immigrants in Texas, and because those seeking care in emergency rooms tend to be undocumented, it is unclear how effective the cost-cutting measures of the ACA will be in practice.

A CBHM called *Salud Migrante* may allow undocumented Mexicans access to care in the US. In 2008, it was proposed as a model for expanding binational health care coverage among uninsured Mexican immigrants residing in the United States.<sup>133</sup> Though only in the pilot program stages, *Salud Migrante* provides

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<sup>128</sup> Richard Cauchi and Katie Mason, National Conference of State Legislatures, *Allowing the Purchase of Health Insurance from Out-of-State Insurers*, <http://www.ncsl.org/issues-research/health/out-of-state-health-insurance-purchases.aspx> (last updated August 2012).

<sup>129</sup> *Id.*

<sup>130</sup> Ga. State Univ. Law Review, *Insurance HB 47*, 28 GA. ST. U. L. REV. 35, 35-36 (2002), available at <http://digitalarchive.gsu.edu/gsulr/vol28/iss1/4>.

<sup>131</sup> *The Uninsured in Texas*, TEX. MED. ASS'N (June 14, 2012, 4:18 PM), <http://www.texmed.org/template.aspx?ide=5517#financial>.

<sup>132</sup> *Id.*

<sup>133</sup> Arturo Vargas Bustamante et al., *United States-Mexico Cross-Border Health Insurance Initiatives: Salud Migrante and Medicare in Mexico*, 31 REV PANAM SALUD PUBLICA 74, 75 (2012), available at <http://www.scielosp.org/pdf/rpsp/v31n1/11.pdf>.

Mexican guest workers with ambulatory and emergency service coverage in the United States (through community clinics) and comprehensive health care coverage in Mexico (through the government-run health care program *Seguro Popular*).<sup>134</sup>

Most notably, the Plan provides this care at a cost of \$30 per worker per month assessed to the Mexican Government.<sup>135</sup> If *Salud Migrante* is successful, it could serve as a basic rubric for designing plans that allow U.S. citizens to receive their health care in Mexico as well.

### c. Medicare in Mexico

Another demographic that may be potentially disadvantaged by the ACA mandate are seniors retiring in Mexico. Medicare in Mexico is an initiative developed to address the concerns of this group. It is projected that up to 64% of the retired U.S. citizens living in Mexico return to the United States for medical treatment, and those who receive their medical treatments in Mexico assume all the costs for those health care services.<sup>136</sup> Under the individual mandate of the ACA, these individuals will essentially be paying double for health access: once in the United States and once again if receiving care in Mexico.

Under Medicare in Mexico, Mexican providers that qualified for Medicare certification would receive Medicare payments for services provided to program beneficiaries. It has been estimated the utilization of Mexican health services by Medicare enrollees, due to the expanded reimbursement system, would result in considerable savings to the Medicare program.<sup>137</sup>

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<sup>134</sup> *Id.*

<sup>135</sup> *Id.*

<sup>136</sup> *Id.* at 76.

<sup>137</sup> *Id.* (citing POLICY RESEARCH PROJECT ON MEDICARE IN MEXICO, LYNDON B. JOHNSON SCHOOL OF PUBLIC AFFAIRS, REP. NO. 156, MEDICARE IN MEXICO: INNOVATING FOR FAIRNESS AND COST SAVINGS (2007), available at [http://www.utexas.edu/lbj/chasp/publications/downloads/Warner\\_Medicare\\_in\\_Mexico.pdf](http://www.utexas.edu/lbj/chasp/publications/downloads/Warner_Medicare_in_Mexico.pdf)).

## V. CONCLUSION

Cross-border health models would be a creative addition to the ACA. Due to the systemic “glitches” in the ACA, many Hispanics may remain uninsured. The success of price control of the ACA depends on large risk pools.<sup>138</sup> In Texas, the failure to include Hispanics may be fatal to health cost control. As health care tends to cost less in Mexico, if Americans would agree to receive their care there, this may result in a considerable cost saving to the health system as a whole.<sup>139</sup> Previous study suggests there is a demand for cross-border health products.<sup>140</sup>

Additionally, CBHM may make access to culturally sensitive care more readily available for Hispanics. Previous study suggests Hispanics who cannot speak English tend to remain uninsured even after reforms.<sup>141</sup> CBHM may help lessen this disparity.

Ultimately CBHM, though potentially beneficial, may not be developed in Texas because of market concerns. On the other hand, programs like *Salud Migrante*, because they target low-income populations that are often uninsured, may not be met with staunch opposition because of the high cost of treating uninsured individuals with complex and expensive health care conditions is a serious financial burden for safety net hospitals in the United States.<sup>142</sup> As such, in those states with larger uninsured populations, programs like *Salud Migrante* may be welcomed by hospital administrators and local authorities.<sup>143</sup> If a cross-border component was included in the exchanges for example, and if that cross-border plan catered to the lower-income individuals who may be left out of health care reform, such a plan may be met with less opposition.

However, if these barriers can be surmounted, the operational

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<sup>138</sup> See Garrett, *supra* note 12, at 1.

<sup>139</sup> Bustamante, *supra* note 89, at 77.

<sup>140</sup> See *id.* at 75.

<sup>141</sup> *Id.*

<sup>142</sup> Kevin Sack, *Uninsured Immigrants; Public Hospitals' Warnings*, NEW YORK TIMES, Feb. 21 2012, available at <http://query.nytimes.com/gst/fullpage.html?res=9F0CEEDF143CF936A25752C0A9669D8B63>.

<sup>143</sup> Bustamante, *supra* note 89, at 77.



side of instituting cross-border care may be minimal. First, research conducted for Medicare in Mexico is establishing a standard for measuring Mexican health care provider networks. To date, several private Mexican health care facilities have initiated the process of becoming Medicare-certified.<sup>144</sup> This requires compliance with U.S. regulations regarding safety standards, licensure, and malpractice insurance. Using the Medicare-certification rubric, a similar certification criterion could be developed for the Medicaid program as well.

Ultimately, the ACA is designed to give Americans control over their health care.<sup>145</sup> To further this goal, CBHM could be an economically, and for some, a culturally relevant addition to the ACA that should not be overlooked.

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<sup>144</sup> *Id.* (citing Richard C. Morais, *Medicare in Mexico: American Retirees Push Congress to Allow Medicare Benefits in Mexico*, FORBES, Feb. 21, 2010, available at <http://www.forbes.com/2009/09/04/mexico-medicare-retirees-personal-finance-health-care.html>).

<sup>145</sup> *The Affordable Care Act, Section by Section Title I. Quality, Affordable Health Care for All Americans*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/full/index.html>.