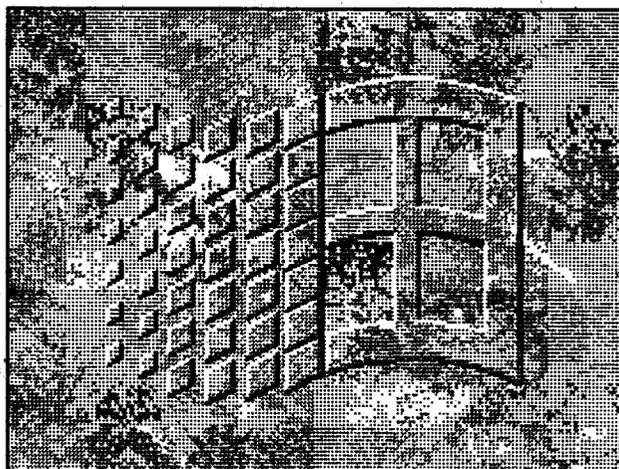


**A LOOK INTO THE
FUTURE:**

**HOW NAFTA AND US
HEALTH CARE REFORM
AFFECT HEALTH CARE
IN MEXICO AND THE
CARIBBEAN**



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Abstract

A LOOK INTO THE FUTURE: HOW NAFTA AND US HEALTH CARE REFORM AFFECT HEALTH CARE IN MEXICO AND THE CARIBBEAN

Giving every American health care that can never be taken away was President Clinton's rallying cry that fired off the long-awaited battle for universal health care. The USA, Canada and Mexico are, ostensibly, seeking to achieve greater levels of economic efficiency and effectiveness in the production and delivery of goods and services. Higher standards of living, the opening of markets and the reduction of migration of Mexicans entering the USA are principal stated objectives of the North American Free Trade Agreement (NAFTA) (Jones-Hendrickson, 1993). Improved health care has always been clearly linked to a higher standard of living. On the other hand, illegal immigrants have clearly placed a burden on health care services especially in emergency rooms where the services are the most costly and least efficient in promoting continuity of care and improved health status. Therefore it would seem obvious that NAFTA would shift the flow of migration back to Mexico and away from the USA as new economies are created in Mexico. We will argue in this paper that the newly proposed health care reform poses a series of new problems that may in fact continue to create enormous logistical problems for companies considering establishing businesses in Mexico. We will argue that health care reform may continue to encourage employees, whether Mexican or American, to continue to opt for migration into the U.S. A. We will argue that the availability of health care is a major determinant of where people choose to live especially if their contribution to the cost of the care is sizeable.

INTRODUCTION

The man who ran for change has been bold and aggressive on issues that had their origin many administrations ago. President Clinton achieved what other U.S. Presidents couldn't even get on the agenda. The health care reform proposal that is on the lips of every American and has all industries and entities that buy, sell or provide health care scrambling to be heard by Hilary Clinton, the wife of the President and the key player in health care reform, was started in the Truman Administration. The North American Free Trade Agreement (NAFTA) which joins Mexico with the United States and Canada in the world's largest trade zone had its origins in the Carter Administration. It has been successively refined and reintroduced under different names in each successive administration. U.S. President Bill Clinton has made it a reality. Mexico's President, Carlos Salinas de Gortari, has made NAFTA the centerpiece of his sweeping economic reforms. Canada's Prime Minister, Jean Chretien, although in favor of NAFTA, wants better rules on what constitutes a subsidy and what sort of sanction should be imposed for trade violations. But, all in all, the three leaders are united in creating a huge economic market encompassing 363 million people and \$6.7 trillion.

When there is talk of NAFTA , the areas considered are agriculture, automobiles, banking, energy, trucking, textiles, patent and copyright protection, environmental

regulations, tariffs and immigration. We would like to focus on immigration as it relates to health.

NAFTA states that the general immigration laws would be unchanged. Only limitations on the movement of business executives and professionals would be reduced. Ross Perot, leading the opposition to NAFTA, warns that companies will accelerate moving jobs to Mexico and U.S. wages will drop. In 1990, the per capita income in the U.S. was \$21,790 with a per capita health expenditure of \$2,763 or 12.7% of the gross national product (GNP). The per capita income in Mexico was \$2490 with a per capital health expenditure of \$89 or 3.2% of the GNP. The USA's per capita health expenditure was more than the total per capita income of each Mexican. (**World Development Report 1993**).

For the Caribbean, the measures needed in NAFTA to give Caribbean nations equal treatment with Mexico were left out when the US. House of Representatives approved the agreement on November 17, 1993. With Mexican imports entering duty-free status under NAFTA, the Caribbean share of the dollar could diminish and in turn increase the number of unemployed or underemployed. The per capita income in the Caribbean varies from as low as \$370 in Haiti to a middle-income economy like Jamaica of \$1500 to a high-income economy of the U.S. Virgin Islands of \$11,000.

A drop in wages in the U.S.A. has the same effect in the Caribbean. Wage reduction

has far-reaching effects on health care. Putting aside income reduction, which in and of itself has an effect on health, coupling the present Mexican expenditure vs. the USA expenditure on health and the income disparity between per capita income in Mexico versus the USA. NAFTA has a special relationship to the proposed American Health Security Act.

THE AMERICAN HEALTH SECURITY ACT (ASHA)

The American Health Security Act (ASHA) promises security, responsibility, savings, quality choice and simplicity. We will limit our discussion of the ASHA only to those areas that impact on perceived changes as a result of NAFTA.

Before discussing ASHA and NAFTA, it is important that we discuss some of the specifics of frequently used terms. Health alliances, health plan, and comprehensive or defined benefit package will be discussed throughout the paper.

Health Alliances

Health alliances are meant to act as conduits between health plans and individual purchasers of health insurance coverage. The alliances contract with health plans to provide the required benefit package. They provide a simplified uniform means for individuals to choose between plans.

There are several 'musts' and some 'mays' for all alliances. Alliances must contract with a plan unless the plan's premium exceeds the weighted-average premium by more than 20%, its quality is poor, or it discriminates. The alliance must use a risk-adjustment mechanism to account for enrollment variations across plans. The alliance must establish provider advisory boards. The alliance must enroll all eligible individuals and have annual open enrollment periods. The alliance must publish consumer information on cost, providers, access restrictions and quality of plans. The alliance must offer at least one fee-for-services plan, but may limit its number to three through competitive bidding.

The alliance may be a nonprofit corporation or state agency, but nonprofit's board must equally consist of consumer and employers whose selection is determined by the state. After collective provider negotiations, the Alliance may set a provider fee schedule for each fee-for-service plan and providers may not balance bill. Balance bill means that the provider would attempt to collect the difference between his/her regular charge from the portion not paid by the fee schedule. This balance billing would not be allowed. States may impose prospective budgeting on fee-for-service plans. The alliance may not bear insurance risk.

Alliances are permitted to adopt varying arrangements with health plans for providing work-related medical benefits, including negotiating per case capitation payments.

Health Plans

Health plans provide coverage for the nationally guaranteed comprehensive benefit package through contracts with regional or corporate alliances. Again, here there are several 'musts' and 'mays'. Health plans must be state certified. Health plans must accept all eligible individuals, have an open enrollment period, and may not cancel/reduce benefits even for enrollee nonpayment. Pre-existing condition limits and disease-specific exclusions are prohibited. The plans must provide the alliance with extensive information on cost, quality, provider availability, utilization review, consumer rights, and plan responsibilities. ASHA also states that all US citizens and legal residents **must** enroll in a health insurance plan. Plans may be purchase through a state/regional health alliance. Large employers (more than 5000 employees) may provide coverage through its own alliance. Out-of-service-area emergency/urgent care when required is paid on the alliance's fee-for-service payment schedule.

As we focus on occupational health care, health plans will provide treatment for individuals with work-related injuries covered under workers' compensation insurance.

To obtain state certification, a health plan must demonstrate its ability to provide or arrange for comprehensive medical benefits for work related-injuries and illnesses, including rehabilitation and long-term care services. Health plans must employ or enter into contract with specialist in industrial medicine and occupational therapy.

Health alliances are responsible for coordinating access to specialized health providers or centers of excellence in industrial medicine and occupational therapy. An alliance

may designate as subcontractors health care professionals and institutions that provide specialized services for the treatment of work-related injuries and illnesses on behalf of all health plans serving the alliance region. Individuals enrolled in health plans within the alliance will receive treatment for work-related injuries or illnesses from their health plans, although emergency treatment may be obtained from any provider. State laws regarding choice of provider for workers' compensation cases are overridden in the ASHA with respect to individuals covered through health alliances. Exception may be necessary in cases of disputes.

Defined Benefit Package

The new health security card will entitle each holder to a nationally defined comprehensive benefit package. The national defined benefit package includes:

- comprehensive medical care inclusive of hospital services;
- emergency services and services of physicians and other health professionals;
- clinical preventive services based on a periodicity schedule;
- 30 days/episode and 60 days/yr inpatient mental health/substance abuse with 30 visits/yr psychotherapy;
- family planning; pregnancy-related care;
- hospice; home health care;
- extended care services; ambulance services;
- outpatient laboratory and diagnostic services; outpatient prescription drugs and

biologicals; outpatient rehab services;
durable medical equipment and prosthetic/orthotic devices;
vision/hearing care;
preventive dental care for children;
and health education classes.

For the first time, all Americans would be guaranteed no-cost physical exams and all childhood immunizations. Most preventive services would be provided at no cost to the consumer. In addition to the regularly covered items like hospital care, also covered would be classes that encourage the reduction of behavioral risk factors and promote health activities including smoking cessation, nutritional counseling, stress management and physical training classes. An annual exam would be a lot more than the laying on of hands. It would be a chance to make sure that the patient is getting all the counseling about risk prevention that causes over 80% of our present preventable illnesses.

ASHA will change the payment of health care significantly. Employees will pay 20% of weighted average-cost alliance health plans, depending on its cost. Self-employed and unemployed will pay 100%, but anyone below 150% of poverty will receive federal premium assistance from the alliance. Undocumented ~aliens~ will not be eligible for the alliance health plans, but federal aid to institutions for their care will continue. States will address migrant worker issues. These provisions will, de facto, limit

choice of providers for occupational illnesses to whomever are the providers in the plan, yet it will define the dollar contribution of the employee to the plan without defining the dollar contribution to workmen's compensation by the employer. It is understood that workers' compensation will reimburse the plan, yet the administrator of the plan is permitted to negotiate fees that vary from the fee-for-service rate schedule with workers' compensation insurers and employers. If all care is covered by the plan, why is there a need for workmen's compensation separate and beyond the employer's contribution of the 80% to the plan? If the plan is reimbursed, why isn't the reimbursement equal to the expenditure by the plan? Since emergency care can be obtained from any provider and since emergency care gives freedom of choice, will more care be labelled ~emergency~?

ANALYSIS

Exhibit 1 details the trail of coverage, the redistribution of funds, who pays what, what is covered, and what's not covered as per the White House documents in September, 1993 when ASHA was released. However, ASHA is silent on the issue of whether or not the nationally defined comprehensive benefit package of U.S. based companies, which have a mixture of U.S. citizens and employees who are not U.S. citizens, is applicable to all. But the ASHA is clear on the employer requirement. ASHA states that all employers must pay 80% of weighted-average plan premium for all employees, with pro rata contribution for part-time employees under 30 hours a week. Caps exist on the employer's contribution not to exceed 7.9% of payroll and for small

employers (less than 50 employees between 3.5% and 6.5% depending on the employee's average annual wage." Coupling these requirements of ASHA suggests that U.S. based companies will have a responsibility to insure all its employees are covered. No distinction is made between employees that are U.S. citizens and employees that are non-U.S. citizens in the Act although the ASHA states only citizens and legal residents will hold a card. Unions often require health care benefits for all their members. Will Mexicans work under a Mexican labor law and U.S. citizens under the collective bargaining agreement for U.S. companies? If the same Union collective bargaining agreement is not applicable, then we have a double standard within the same company. If so, will this double standard press the U.S. labor union machinery to interact or interfere, as some may see it, in the laws of Mexico to insure all employees receive equal benefits? Jack Sheehan, Assistant to the President, United Steelworkers of America in a recent interview with me indicated that the Unions did just that in Canada recently. Apparently the National Labor Relations Act of 1935, better known as the Wagner Act, requires equity. How is equity determined? Is it based on U.S. companies standards for its U.S. citizens or is it based on the community standard of the specific country? If a double standard exists, what does that say in reference to disease transmission for communicable diseases that can be prevented by proper immunization and health care?

Will there be one plan for U.S. citizens and an another or none for non-US. citizens?

Will certain benefits that would clearly improve the health status of the Mexican worker

be deleted from the package or will all elements of the above stated defined benefit package be applicable? Will services not available in Mexico be guaranteed for the Mexican worker? Will services not available in Mexico be guaranteed for U.S. citizens while resident in Mexico? Will U.S. companies have to expend additional dollars to set up preferred provider systems utilizing the best of Mexican health care providers for company purposes or flying in their own health care providers at an additional cost to the company to meet the requirements of ASHA for employees accustomed to a higher standard of health care? Will U.S. citizens with acute problems, where care is unavailable in Mexico, have to be transported by expensive air ambulance to a U.S. based hospital for a service that is part of the defined benefit plan? The cost of air ambulance ranges from approximately \$3000.00 for a 50 mile flight to \$16,000.00 for a three and a half hour flight. The ASHA requires that the plan pay for the cost of emergency/urgent care when required. Who will determine the necessity of the expenditure? Will it be a medical decision of the treating physician, a plan's officer decision or an alliance decision? If alliances exceed their targeted budget in two out of three years, which cannot be adjusted other than by Congress, they will be terminated. Alliances of the border states of California, Arizona, and Texas, and the Caribbean entities of the Commonwealth of Puerto Rico and the territory of the U.S. Virgin Islands will be in jeopardy from the beginning because of their peculiar situation and the built-in increased need for services. We fear that the border states and the territories will exceed the nation's per capita based premium set by the national board and therefore will have to be terminated. Who then will be available for insuring

care? Will we be faced with yet another insurance crisis as exists due to the devastation effects of Hurricane Hugo and Hurricane Andrew? After these natural disasters, basic insurance was unaffordable, even for the well-to-do middle class. What will be the overall health of these states? The Northwestern National Life State Health Rankings considers 17 areas that measure disease, lifestyle, access to health care, occupational safety, disability, and mortality. Presently the southern states are ranked the least healthy states **[FP Update, Dec 22, 1993 p.7]**. Will the southern states suffer disproportionately more to their detriment because of NAFTA and ASHA?

How will border states pay for undocumented workers and migrant workers when the federal government reduces its participation and leadership in providing care for these individuals? States will have to address migrant workers health care benefits. Are the border states prepared financially for this event and if not, what will happen to the quality of the care these workers receive when quality is a stated goal of the ASHA?.

Medicaid defines an eligible person as one whose income is \$5,500.00 per person with an additional \$1,000.00 allowed for each additional person in the household **[Source: USVI Medical Assistance Program, March 8, 1994]**. Although not under Medicaid, any illegal immigrant has access to the U.S. health care system in many ways but most importantly in emergency rooms which are the most expensive avenue of care. Will illegal immigrants at the border states have more access to care than citizens of the U.S. who live in the Caribbean?

ASHA significantly changes the workers' compensation/auto injury practices. Under the ASHA, health plans and auto insurance policies will be reimbursed at a negotiated fee-for-service alliance schedule with no copayments. The state will continue to determine workers' compensation benefits. The state freedom-of-choice provider laws will be pre-empted. These provisions seem to allow workers to be treated by whomever is designated by the plan. This approach will save dollars but appears to be in direct contradiction to the freedom-of-choice concept, one of the basic tenets of the ASHA.

Many industries presently require workers with job-related injuries to see a designated "company physician" to assess the problem and to dialogue with Workmen's Compensation. Some workers object to the usurpation of their rights to see their own physician and in turn see their physician of choice with the understanding that, although workmen's compensation will not reimburse the company for the expenditure, the private insurance held by the individual will cover the cost. Although this general situation applies whether there was a NAFTA or not, with American workers and especially the more skilled workers being assigned outside the U.S.A., when injuries occur these workers will no longer have the option of choosing to see their own physician. Will this discourage professionals and highly skilled workers from assignments in Mexico? Will the companies have to provide some additional extraordinary coverage? A case in point: Worker A is an engineer brought to Mexico to assist in the construction of a new textile plant. Worker A sustains a second

degree burn of approximately 9.9% of his body. He is taken to the nearest emergency facility and the physician, assigned by workmen's compensation, determines that his burn is under 10% and does not meet the criterion to allow him to be transported to a burn center in the U.S.A. Worker A is in severe pain and demands that he be flown immediately to a burn facility for care. If he is transported to the burn facility, who pays? Does Worker A pay out of pocket since the workers' compensation rules now specify a protocol that limits Worker A from accessing the burn center? Does Worker A's company pay since it is job-related? If Worker A is not flown out and succumbs to his injury, is it a wrongful death because the patient failed to get optimum care?

We all know the draft of ASHA is excellent. But the devil may be in the details as it relates to NAFTA. President Clinton sprinkled his 53-minute address on September 22, 1993 with anecdotes of nightmares from the current health system, laying out his rationale for the biggest social initiative for the USA since the New Deal. The President said the current health system is "too uncertain, too expensive, too bureaucratic and too wasteful." ASHA is the product of eight months of active work. ASHA is based on the premise that it can extend health coverage to all and at the same time shrink the nation's \$900 billion medical bill. But NAFTA, places all the adjectives used by President Clinton for the present health care system right back onto ASHA- too many present uncertainties, potential increased expense, increased bureaucracy and increase waste. It is difficult to say if NAFTA will be good or not good to ASHA. It is too early to judge. There are too many unanswered questions.

Complex and likely to change-yes. Nothing is set in concrete yet, but we know enough that we raise significant questions. Is the passage of NAFTA a thunder-storm cloud hanging over ASHA? We will have to watch and wait. Behind every cloud, it is said, there is a silver lining. We will wait and see if NAFTA is the silver lining of ASHA or if NAFTA will be the thunderstorm of ASHA deluging it with rains of mammoth fiscal and logistical problems.

References:

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2. James, M. USVI Medical Assistance Program, (telephone conversation March, 1994)
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4. Pompa, F. "To You and Your Health". The Daily News 1993, September 23.
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6. Investing in Health-World Development Indicators. World Development Report 1993, p.210-211.

TO YOU AND YOUR HEALTH



Only U.S. citizens or legal U.S. residents will be covered under the new health care plan. Citizens covered by Medicare, the Indian Health Service, the Department of Veterans

Affairs, and the Department of Defense will continue the plans they have. Here is a look at how the new system will function:

How premiums are divided:

Employee



depending on average wage.

Self-employed workers pay total premium but are allowed a 100 percent tax-deduction.

Employers spend up to 7.9 percent of annual payroll on workers' premiums. Companies with fewer than 50 workers pay between 3.5-7.9 percent of payroll,

Families and individuals whose incomes are 150 percent of the poverty level are eligible for subsidies to help pay their share.

What's covered

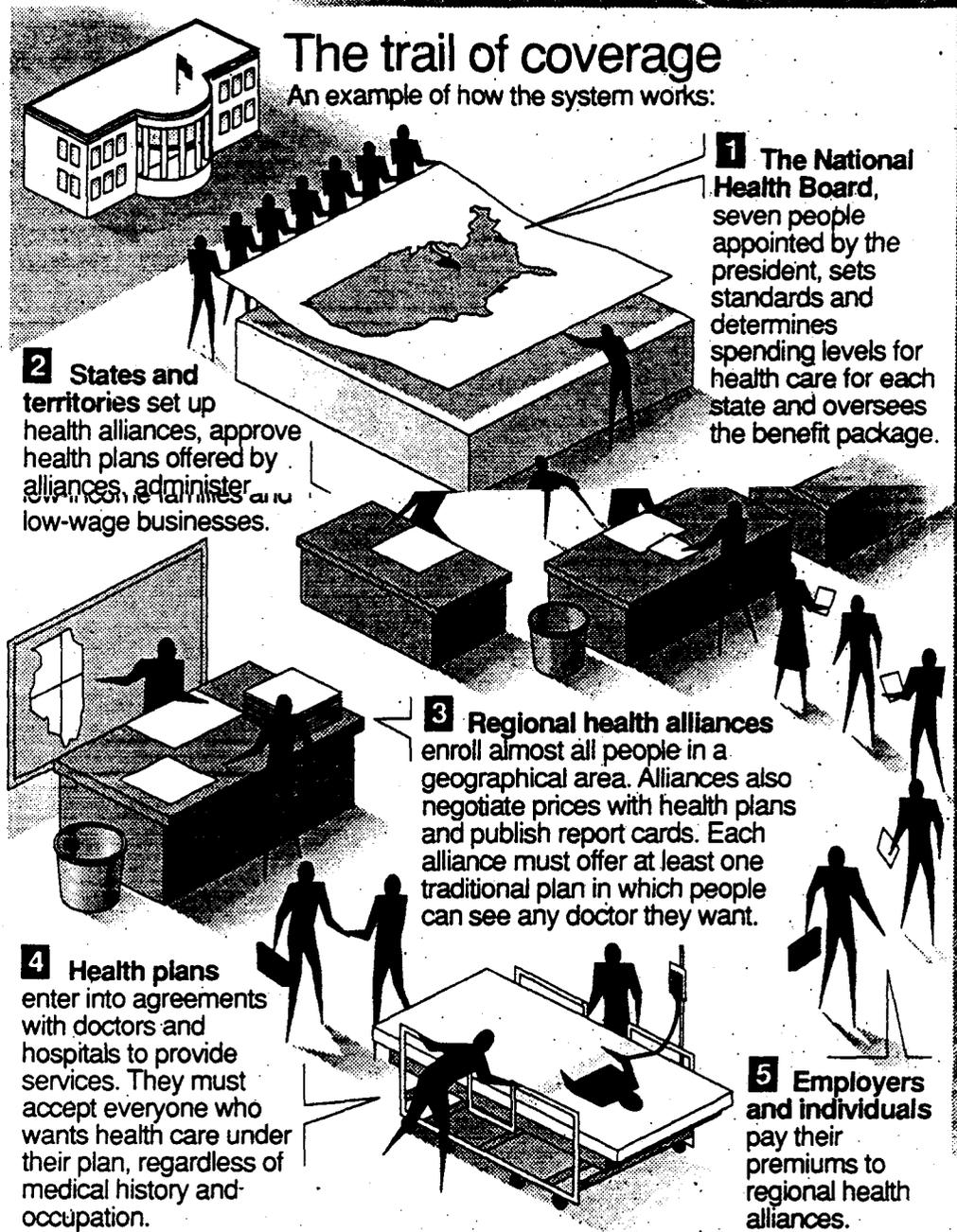
The standard national benefits package includes:

- Hospital services
- Emergency services
- Doctors' visits
- Preventive care*
- Prescription drugs
- Mental health and substance abuse
- Pregnancy-related services
- Hospice and home health care
- Outpatient care
- Physical rehabilitation and durable medical equipment
- Vision and hearing care

*Includes mammograms, Pap smears, cholesterol test and immunizations.

What's not covered

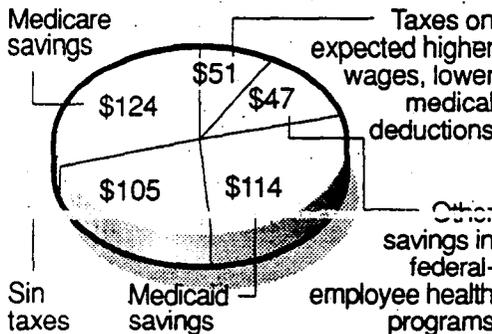
- Adult dental care*
 - Adult eyeglasses and contact lenses
 - In vitro fertilization
 - Private hospital rooms
 - Cosmetic surgery
 - Orthodontia
- *to be added after the year 2000.



Redistributing the funds

A breakdown of the \$441 billion allotment, in billions of dollars, through the year 2000:

Where the money comes from



Where the money goes

