



United States-México Border Health Commission

Access to Health Care in the U.S.-México Border Region:
Challenges and Opportunities

A White Paper
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United States-México Border Health Commission

The mission of the United States-México Border Health Commission is to provide international leadership that optimizes health and quality of life along the U.S.-México border.



Providing Leadership on Border Health Issues to—

- Facilitate Identification, Study, and Research*
- Raise Awareness of Critical Border Health Issues*
- Promote Sustainable Partnerships for Action*
- Serve as an Information Portal*



EXECUTIVE SUMMARY

The United States-México Border Health Commission (BHC) acts as a lead entity in identifying challenges and opportunities for improving access to health care under two reforms: the United States' Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, P.L. 111-152) and México's System of Social Protection in Health, specifically its *Seguro Popular* program. While both reforms invest in prevention, health promotion, and improved access to health care, estimates presented in this paper indicate that several challenges to increasing access to health care in the U.S. border region remain.

The purpose of this paper is to identify how the BHC and its stakeholders can increase access to health care for populations living on the U.S. side of the border. This paper compares the key features of health reform in the United States and México in order to identify areas for leveraging cross-national public health efforts. It also examines the unique socioeconomic challenges affecting access to care in the border region and summarizes border state variation and enrollment gaps identified during the ACA's initial implementation phase.

CHALLENGES

The border region is characterized by high unemployment and poverty rates, factors associated with inequitable access to health care and poor health outcomes.

The following challenges contribute to disparities in access to health care among border populations:

- *High unemployment rates*

For two decades, the unemployment rate has been consistently higher among border counties (excluding San Diego County, California, and Pima County, Arizona) than throughout the border states and nationally. In 2008, unemployment in border counties dropped to 8.1%, the lowest in 20 years, but it increased by 3.6% in 2012. Research has consistently documented that type of employment and income are key determinants of high uninsurance rates among Latinos.

- *High poverty rates*

Latinos living in border counties are more likely to live in poverty than their state and national counterparts (31.8% vs. 23.4% nationally). Children under age 18 who live in border counties (excluding San Diego County, California) are more likely to live in poverty (37%) than children nationally (20%).

- *High rates of uninsured*

In 2012 and 2013, all four border states had lower rates of employment-based private insurance and the highest rates of uninsured, with Texas at 27%, New Mexico at 24%, California at 21%, and Arizona at 20%, as compared to the national average of 18%. In 2011, 29% of persons age 65 and under living in U.S. border counties (not including San Diego County, California) lacked health insurance coverage, as compared to 22.2% of their respective state counterparts and 17.3% nationally.

- *High rates of chronic disease*

Obesity and diabetes rates among border populations are higher than state prevalence rates and significantly higher than national averages. Latinos living with these types of chronic diseases are also more likely to be unaware of their status, which can be attributed to inadequate access to health care.

The generally low socioeconomic position of border residents, many of whom are Latino and uninsured, prevents border communities from achieving optimal health.

OPPORTUNITIES

The ACA presents new opportunities that can address these persistent disparities in access to health care. Opportunities include the establishment of the Health Insurance Marketplace (Marketplace), a cornerstone of the ACA that serves as a resource where individuals, families, and small businesses can learn about health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The ACA also provides for an expansion of Medicaid coverage for previously ineligible adults with incomes at or below 138% of the federal poverty level.

To leverage these and other opportunities available under the ACA, the following three options are recommended to increase health insurance coverage in the border region:

- *Expand outreach and education through trusted partner networks, academic institutions, community health centers, and community health workers (promotores) to assist enrollment in ACA-related efforts along the border.*

The BHC should facilitate closer coordination between federal, state and tribal governments, and local agencies and organizations as well as other private and public partnerships to develop a border clearinghouse or outreach and enrollment network that increases the availability of ACA information, promotion, and enrollment assistance. These coordinated efforts should ensure the public health workforce is trained in the National Culturally and Linguistically Appropriate Services Standards and that information is developed and disseminated in a culturally and linguistically appropriate manner.

In this way, the BHC and the following public health partners can collaborate as key leaders in filling the information gap:

- U. S. Department of Health and Human Services’ (HHS) and Other Federal Departments—The BHC should strengthen coordination between community health centers, the border state health departments’ offices of border health, and HHS regional offices along the border, to include the Centers for Medicare & Medicaid Services and the Administration for Children and Families, to train a cadre of community-based case managers who can conduct outreach and enroll children, their families, and adults without children into the Marketplace, Medicaid, and the Children’s Health Insurance Program. The Region IX Federal Regional Council partnership could augment BHC coordination by enhancing enrollment linkages through program efforts that focus on eliminating health disparities, maternal and child health, and environmental health. Other federal partners would include, but are not limited to, the Office of the Assistant Secretary for Health, Health Resources and Services Administration, and the Environmental Protection Agency, among other federal departments as well as other HHS operating divisions and regional offices focused on border health.
- Academic Institutions—Academic institutions and academic health centers in the border region should play a key role in training and educating their health provider workforce to raise awareness and increase health literacy among residents, including student populations, regarding ACA eligibility requirements and enrollment processes. The BHC can facilitate these efforts by bringing together academic partners and community leaders to improve communication, coordination, and collaboration among public and private sectors.
- Community Health Centers—The BHC should collaborate with new health center sites to increase access to comprehensive, affordable, high quality primary health care services in the communities that need it most.

- Community Health Workers (*Promotores*)—The BHC should coordinate efforts with federal, state, and local partners to increase engagement and collaboration with community health workers, known as *promotores* along the U.S.-México border, and other allied health professionals working in hard-to-reach areas, including *colonias*¹. In addition, funding mechanisms need to be expanded to cover the cost of *promotores* and other allied health professionals in their ACA outreach and enrollment roles.

- *Assist border states to strengthen public health systems by identifying ACA funding opportunities in support of continued outreach and education efforts.*

Hospitals, community health centers, AHCs, and other public health providers in the border region should work collectively to leverage federal funding under the ACA that can improve coordination and integration of care. The BHC can assist with identifying these and other funding opportunities to continue outreach, research, and health literacy activities.

- *Provide access to and analyze data necessary to better inform programmatic decisions.*

The BHC should partner with HHS to exchange border-specific enrollment data that can inform outreach efforts. Through data analysis, the BHC can evaluate the effectiveness of outreach and education efforts that took place during the ACA's initial enrollment phase—October 2013 through March 2014—in preparation for the next open enrollment. This would also assist state offices of border health and other public health partners to identify coverage gaps that can assist them with planning for subsequent enrollment phases, to include strengthening outreach and enrollment strategies.

The ACA creates new opportunities to promote population health and improve access to health care through its key features, including the Marketplace and the provision for state expansion of Medicaid eligibility. The BHC is positioned to play an instrumental part in leveraging these opportunities through continued collaboration with binational, national, tribal, state, and local partners in support of strengthening information dissemination to diverse and hard-to-reach communities; identifying ACA funding resources in support of outreach and education efforts in the border region; and providing access to and analyzing ACA border enrollment data to inform targeted outreach and enrollment strategies developed for the next open enrollment phase.

¹ *Colonias* are considered semi-rural subdivisions of substandard housing lacking basic physical infrastructure, potable water, sanitary sewage, and adequate roads (U.S. Department of Housing and Urban Development, 2014).

Introduction

In recognition of the need for an international commission to address border health challenges, the Secretary of Health and Human Services of the United States and the Secretary of Health of México signed an agreement in July 2000 to establish the United States-México Border Health Commission (BHC). Since its creation, the BHC's sole mission has been to provide international leadership that optimizes health and quality of life along the U.S.-México border.

One of the BHC's key priorities is to raise the visibility of border health issues that impact health care access. As part of the BHC's Healthy Border 2010 initiative, which is composed of common elements from the United States' Healthy People initiative and México's National Health Indicators, the Commission sought to promote maintaining at fewer than five percent the population lacking access to basic health services in México and reducing by 25% the population lacking access to a primary care provider in underserved areas of the United States (U.S.-México Border Health Commission [BHC], 2010b). In accordance with this priority, the BHC acts as a lead entity in identifying challenges and opportunities for improving access to health care under two reforms: the United States' Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, P.L. 111-152) and México's System of Social Protection in Health, specifically its *Seguro Popular* program (Knaul & Frenk, 2005).

The binational region comprises two sovereign nations; four U.S. states (Arizona, California, New Mexico, and Texas); six Mexican states (Baja California, Chihuahua, Coahuila, Nuevo León, Sonora, and Tamaulipas); 44 U.S. counties and 80 Mexican municipalities; 15 pairs of sister cities; and 26 U.S. federally recognized indigenous tribes (four in Arizona, 20 in California, and two in Texas), some of which maintain citizenship rights on both sides of the border (BHC, 2014). Since a high proportion of the uninsured resides in the border region, the decisions of state and tribal governments will significantly impact future coverage and access to health care for millions of uninsured children, adults, and families. As such, successful implementation of the ACA depends on intergovernmental collaborations, and the BHC is instrumental in securing committed leadership and increasing coordination across government programs and agencies.

The purpose of this paper is to identify how the BHC and its stakeholders can increase access to health care for populations living on the U.S. side of the border. This paper compares the key features of health reform in the United States and México in order to identify areas for leveraging cross-national public health efforts. It also examines the unique socioeconomic challenges affecting access to care in the border region and summarizes border state variation and enrollment gaps identified during the ACA's initial implementation phase. As a result, the following three action strategies are recommended to increase health insurance coverage: 1) expand outreach and education to assist enrollment efforts; 2) identify ACA funding opportunities to strengthen regional public health systems; and 3) provide access to and analyze data essential to making informed programmatic decisions.

Two Reforms, One Border

While the ACA and *Seguro Popular* both focus on expanding access to health care, the United States and México have taken different approaches to achieve similar goals of better health access and

outcomes, with improving insurance coverage representing an important component. México incorporated health care into their Constitution in 1917 as a basic human right and, more recently, modified their health system in 2004 to create a universal security program (Frenk, González-Pier, Gómez-Dantés, Lezana, & Knaul, 2006). Over the past several decades, the United States has pursued incremental approaches to cover the uninsured, including the inception of Medicaid and Medicare in 1965, the Nixon and Kennedy-Mills proposals in 1974, and the Clinton administration's 1993 health reform efforts (The Henry J. Kaiser Family Foundation [KFF], 2009b). Enactment of the ACA represents the most significant overhaul of the U.S. health care system since implementation of Medicare and Medicaid, relying on a combination of public and private approaches to expand coverage, control costs, and improve quality of care.

México: Seguro Popular (System of Social Protection in Health)

Background

Prior to México's health system reform in 2004, over 50% of the population was uninsured and lacked access to health care (Frenk, 2006). Other challenges included an inequitable distribution of public funds among population groups and between states and uneven coverage, with the majority of those insured covered by public insurance (Mexican Institute for Social Security, or IMSS) and only about a third of those covered by public funding (State Employee Social Security and Social Services Institute, or ISSSTE). These disparate inequities in health violated México's understanding of basic human rights and principles of equality, as well as its Constitution. These factors led the Mexican Congress to approve *Seguro Popular* in 2003 (González-Fagoaga, 2013).

Goals, Key Features, and Funding Mechanisms

In an effort to remedy these outcomes, *Seguro Popular* was launched as a pilot program in 2001 and fully implemented by 2004. By 2007, 20 million Mexican citizens were beneficiaries (Frenk, 2006; Frenk, Gómez-Dantés, & Knaul, 2009; González-Fagoaga, 2013). The major goals of Mexican health reform included the following: provide universal coverage to all; increase public spending in health so as to correct existing imbalances; reduce out-of-pocket costs and medical impoverishment; create an explicit package of basic health services; increase efficiency; and redistribute funds among states in a more equitable manner (see Table 1) (Frenk et al., 2006; Knaul & Frenk, 2005). The following are key reform features: 1) a package that is legally mandated to include ambulatory care and hospitalization for basic specialties, i.e., internal medicine, general surgery, obstetrics and gynecology, pediatrics, geriatrics; 2) investment in infrastructure, medical equipment, and human resources; 3) emphasis on preventive services; and 4) voluntary enrollment (Frenk et al., 2006).

Impact on Vulnerable Populations

As of December 2010, 40 of the 50 million uninsured have been enrolled in *Seguro Popular*, representing a decrease in the overall uninsured population from 50% in 2005 to 34% in 2010 (González-Fagoaga, 2013; Frenk et al., 2009). In addition, there has been an increase of health personnel and health facilities, leading to improvements in health indicators. Results from the *National Health Survey* found services increased for 11 indicators, including *Seguro Popular* participation rates for preventive screenings and services. Yet, while Mexican health care expenditures increased from 5.6% of the gross domestic product (GDP) in 2000 to 6.5% in 2006, they remain lower than the average for Latin American countries (6.9% of GDP). Funds for Protection against Catastrophic Expenditures (*Fondo de Protección contra Gastos Catastróficos*) is a fund that finances 18 more expensive

interventions, including treatment for breast and cervical cancer, pediatric cancer management, and Neonatal Intensive Care Unit treatment.

United States: Affordable Care Act

Background

The ACA, passed in 2010 and the country's most significant reform of the health care system since the passage of Medicare and Medicaid, relies on a combination of public and private approaches to expanding coverage, controlling costs, and improving quality of care. The ACA was enacted to address certain fundamental problems with the current health care system, including the growing numbers of uninsured, poor overall population health, poor or uneven quality of care, and rapidly rising health care costs (NCIOM, 2013).

Goals and Key Features

In response to these issues, the ACA includes changes that offer new opportunities for providing coverage to eligible uninsured U.S. residents by 2019, which included over 49.9 million Americans in 2010 (U.S. Census Bureau, 2011a). In addition to increasing health insurance coverage, goals include greater oversight of the private health insurance sector, improvement of the quality of health system performance through payment reforms, and a focus on prevention efforts.

Prior to the passage of the ACA, eligibility for Medicaid, a joint federal-state program, depended on income, state residence, family composition, age and/or disability, and usually covered children, pregnant women, parents of eligible children, seniors, and individuals with disabilities. The ACA now provides for an expansion of Medicaid coverage to all eligible individuals whose adjusted gross income is less than 138% of the federal poverty level (FPL), or \$32,913 for a family of four in 2014 (Centers for Medicare & Medicaid Services [CMS], 2014c). The federal government will cover the full cost of the newly eligible Medicaid population for the first three years (2014–2016) and then will support no less than 90% of the costs thereafter.

In addition, tax credits and subsidies are available to aid individual low- to middle-income Americans in the purchase of insurance through the Health Insurance Marketplace (Marketplace) as well as assist small businesses to provide employee health coverage. The Marketplace is a program where individuals and small businesses can compare insurance plans and purchase coverage.

The ACA also establishes the individual shared responsibility payment, also referred to as a penalty, that requires the uninsured to purchase health coverage in 2014 (Internal Revenue Service, 2014). Starting in January 2014, individuals and families must have health insurance coverage throughout most of the year, qualify for an exemption, or make the individual shared responsibility payment on their federal income tax returns in 2015.

Individuals are not responsible for the individual shared responsibility payment for the following reasons:

- Lack of coverage for less than three months
- Lack of access to coverage that costs no more than eight percent of the household income
- Maintenance of income below the tax filing threshold
- Recognition as part of a health care sharing ministry

- Recognition as part of a federally recognized tribe
- Recognition as part of a federally recognized religious sect with religious objections
- Incarceration
- Not lawfully present in the United States

Hardship exemptions can also be granted if individuals meet requirements that affect their ability to purchase coverage, some of which include homeless status; bankruptcy filed within the last six months; and Medicaid ineligibility due to residency in a state not expanding Medicaid, such as Texas (CMS, 2014b). An employer responsibility provision requiring employers to pay a penalty if they do not provide qualifying coverage to full-time employees will generally apply to larger firms with 100 or more full-time employees starting in 2015 and employers with 50 or more full-time employees starting in 2016 (U.S. Treasury Department, 2014).

All plans offered in the Marketplace must meet certain qualifications, including coverage of an essential benefits package. The essential benefits package includes ambulatory care, emergency care, hospitalization, maternal/newborn care, mental health/substance abuse disorders services, prescription drugs, habilitative/rehabilitative services, preventive/wellness services, chronic disease management, pediatric services, and laboratory services (CMS, 2014d). Private health plans are prohibited from discriminating on the basis of preexisting medical conditions and must establish limits on consumers' out-of-pocket costs for in-network services, as well as provide justifications for premium increases (CMS, 2014a).

Impact on Vulnerable Populations

While the ACA provides a pathway to expanded insurance coverage for U.S. citizens and most lawfully residing immigrants, it excludes those not lawfully present in the United States. Before implementation of the ACA, certain lawfully residing immigrants who had resided in the United States for less than five years were ineligible for Medicaid or the Children's Health Insurance Program (CHIP) unless a state had decided otherwise, and that restriction remains in place (subject to the exemptions and state flexibility mentioned below). Currently, only U.S. citizens and lawfully residing immigrants qualify for federal credits/subsidies in the Marketplace (income and citizenship status verification required) and are subject to the individual shared responsibility requirement. Individuals not lawfully residing in the United States are exempt from the individual shared responsibility requirement since they are not eligible for coverage in the Marketplace.

Federal immigrant eligibility restrictions in Medicaid include the five-year waiting period for most low-income, legal permanent residents, subject to exemptions (e.g., for refugees, asylees, victims of human trafficking, and others), and other state options. For example, states have the option to provide Medicaid and CHIP benefits to lawfully residing children and pregnant women without a waiting period. Deferred Action for Childhood Arrivals (DACA) recipients are ineligible for Medicaid, CHIP, and ACA benefits (National Immigration Law Center, 2012), but some states have chosen to offer DACA recipients options for coverage using state funds.

In addition to these immigrant eligibility issues, the law provides an opportunity for addressing health status and access disparities for other medically underserved populations, including certain racial and ethnic populations, through various provisions, such as the state expansion of Medicaid eligibility. Examples of vulnerable U.S. populations that could have improved access and better health outcomes include 19 million uninsured women; 407,000 people with HIV between 19 and 64

years of age who are in care and have incomes below 400% of the FPL; and lesbian, gay, bisexual, and transgender individuals (KFF, 2014a). Children who are already eligible for Medicaid are guaranteed access to essential services like dental care in underserved areas throughout the country, such as rural/frontier and border communities.

Regarding the border region, previous research has recommended dedicated resources be invested in the public health infrastructure in order to meet the needs of the population (McCarthy, 2000). Without additional investments in hospital facilities, health centers, and the health workforce, vulnerable border communities will likely continue to be underinsured and lack access to health care.

While reforms in both countries invest in prevention and health promotion, the impact of chronic conditions and infectious diseases on population health has already reached crisis proportions in the border region. For instance, in 2010, the prevalence of diabetes and obesity in border populations was higher than the national figures for each country. Among persons with diabetes who had a greater prevalence of obesity, 6 out of 10 U.S.-México border inhabitants with diabetes were obese, and 3 out of 10 were overweight. Among persons without diabetes, the proportion of the overweight population was higher among border inhabitants compared to the United States as a whole (41.2 % vs. 29.7%) (Diaz-Kennedy et al., 2010). Obesity prevalence among the U.S. border population with diabetes was higher than among the Mexican border population (57.5% vs. 45.5%). Obesity rates were higher among certain border state populations. Nuevo León, México (64.6%), and Arizona, United States (61.2%), had the highest prevalence of obesity, whereas Chihuahua, México (42.3%), and New Mexico, United States (40.1%), had the lowest (Diaz-Kennedy et al., 2010).

TABLE 1: Comparison of Health Reform Provisions in México’s System of Social Protection in Health and the U.S. Affordable Care Act (P.L. 111–148)

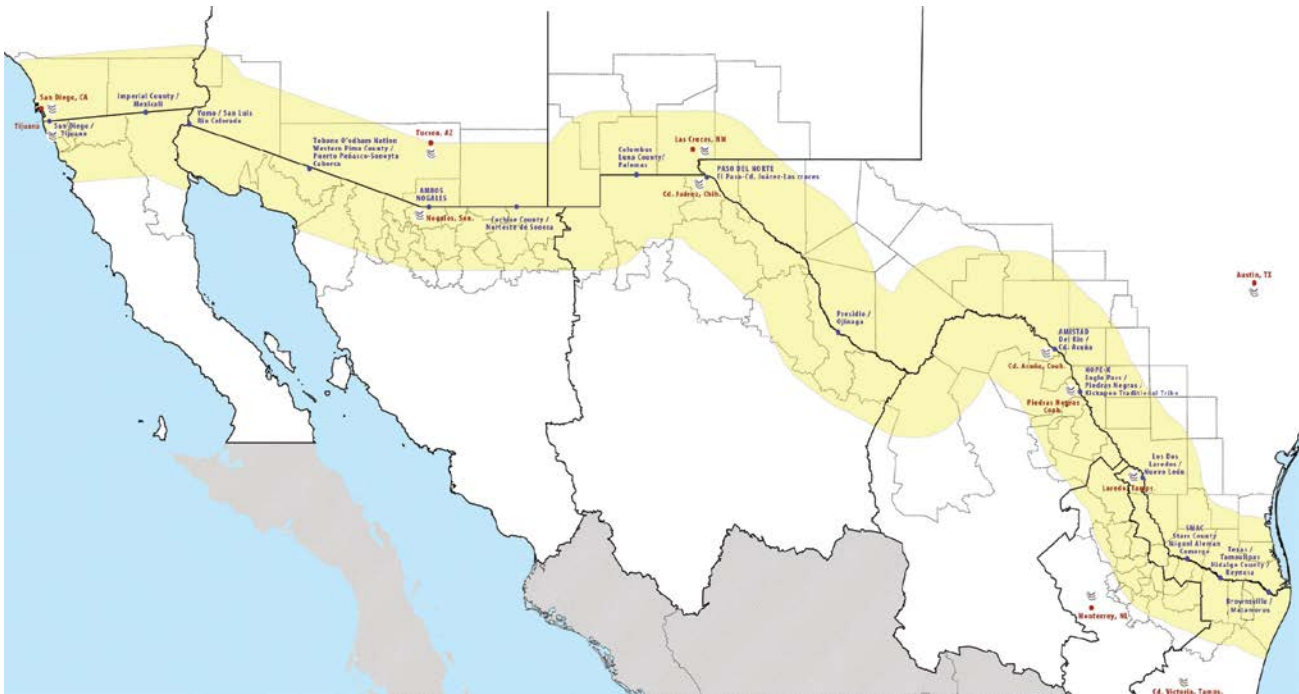
México: System of Social Protection in Health	United States: Affordable Care Act
Background	
<ul style="list-style-type: none"> • 50% of the population is uninsured, many of whom are migrant workers and female heads of household • High out-of-pocket costs, as indicated by the high proportion of uninsured people • Inequitable distribution of funds between poorer and wealthier states and between populations • Low health spending (% of gross domestic product [GDP]) compared to commensurate Latin American countries 	<ul style="list-style-type: none"> • 17.3% of population uninsured • Health spending accounts for 17% of the GDP • Increases in health spending outpace growth in other economy sectors • From 2000–2009, increases in health insurance premiums rose by 108%, while workers’ earnings rose by only 32%
Goals	
<ol style="list-style-type: none"> 1. Provide universal coverage for all 2. Increase health spending 3. Reduce out-of-pocket costs and medical impoverishment 4. Create an explicit package of basic health services 5. Increase efficiency 6. Redistribute funds between states more equitably 	<ol style="list-style-type: none"> 1. Expand coverage 2. Contain costs 3. Implement stricter regulations of private health insurance sector 4. Improve quality/health system performance 5. Emphasize prevention/wellness
Key Features	
<ul style="list-style-type: none"> • Creation of <i>Seguro Popular</i>, also known as the People’s Insurance, a publicly managed health insurance system • Enactment of voluntary enrollment • Establishment of an explicit basic health services package • Investment in infrastructure and health care facilities, medical equipment, and human resources • Emphasis on early detection/preventive services for specific age groups and sexes, i.e., HIV/AIDS, chronic conditions • Redefinition and expansion of public programs aimed at improving coverage, equity, and quality • Evidence-based policy enhancement through the establishment of a comprehensive information system on families and annual benchmark reports • Development of a comprehensive information system that identifies family contribution level and utilization/outcomes 	<ul style="list-style-type: none"> • Creation of the Health Insurance Marketplace (Marketplace) through which coverage can be purchased • Individual shared responsibility provision • Creation of an essential benefits package • Development of affordability provisions for low- and middle-income families • Expansion of Medicaid • Implementation of insurance market rules, intended to increase market fairness and insurance affordability • Establishment of payment reform provisions that reward quality of care and results rather than quantity of services toward a system that rewards quality of care and results • Advancement of health system reforms to contain costs and improve quality, primarily via comparative-effectiveness research and the development of payment and service delivery models
Impact on Vulnerable Populations	
<ul style="list-style-type: none"> • Increase in health coverage for low-income women, independent of employment status, with a focus on gender inequality focus by • Development of a basic essential health services package with an emphasis on preventive services, which can address health issues specific to women • Creation of the National Program on Women and Health that seeks to redress gender exclusion and discrimination 	<ul style="list-style-type: none"> • Restriction of access to coverage through the Marketplace to U.S. citizens and most lawfully residing immigrants • Expansion of funding to community health centers • Development of community-based integrated health care delivery systems for medically underserved communities through grant provisions

Sources: González-Fagoaga, 2013; KFF, 2010

Socioeconomic Profile of the Border Region

The border region is approximately 2,000 miles long and is defined as the area 100 kilometers (62 miles) north and south of the U.S.-México border (BHC, 2014). While this region shares environmental, social, economic, cultural, and epidemiological characteristics, each side operates under different legal, political, and health systems and policies.

FIGURE 1: U.S.-México Border Region

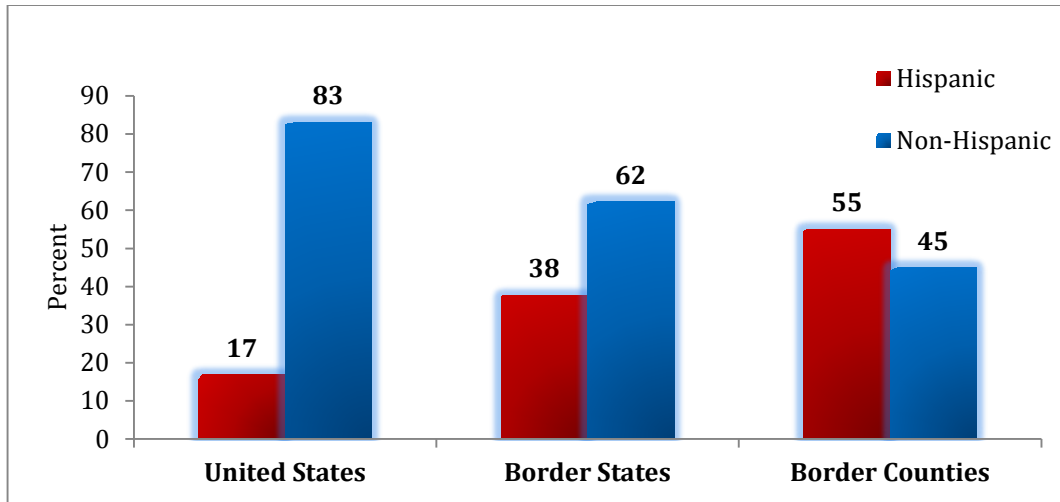


Source: U.S.-México Border Health Commission, 2014

More than 14 million people live in the U.S.-México border region, 53% on the U.S. side. If rapid population growth trends persist, the total population on both sides combined is expected to reach 20 million by 2020, more than twice the rate of the overall growth in each country (BHC, 2014).

In 2012, 55% of the U.S. border population was Latino, compared to 38% throughout the four U.S. border states and 17% nationally (see Figure 2). According to the *Pew Research Center's Hispanic Trends Project*, the 100 largest U.S. counties by Latino population contain 71% of all the nation's Hispanics. Half (52%) of those counties are in three states—California, Texas, and Florida (Brown & Lopez, 2013).

FIGURE 2: U.S. Border Population by Ethnicity, 2012

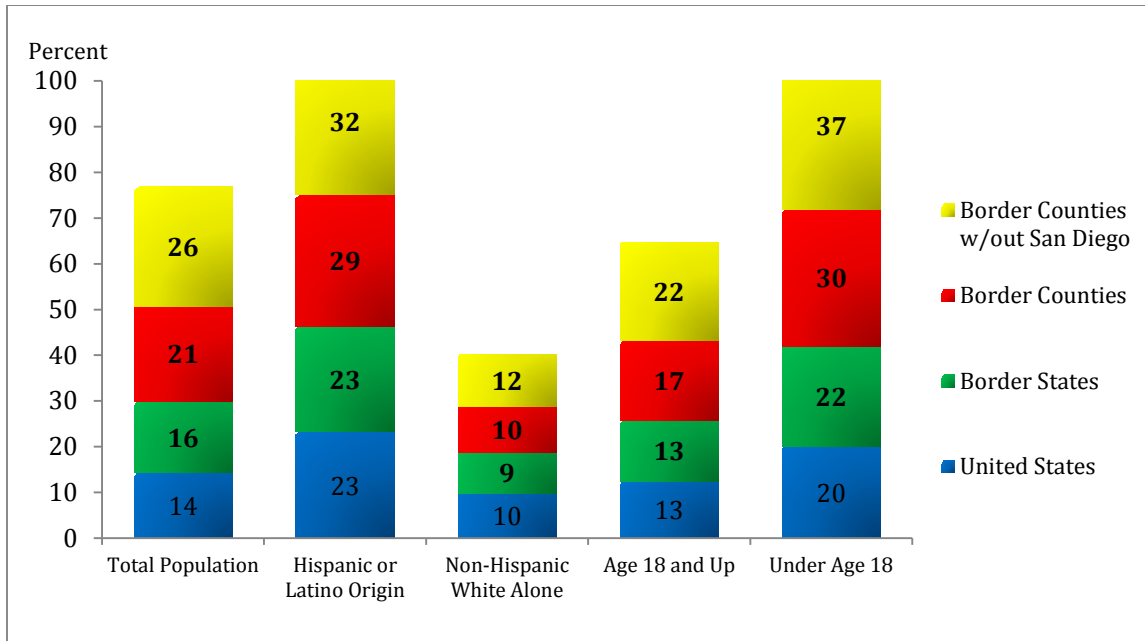


Source: Population Estimates, U.S. Census Bureau (Brown & Lopez, 2013)

The border region is characterized by high unemployment and poverty rates, which is associated with inadequate access to care and, therefore, poor health outcomes (Bastida, Brown, & Pagán, 2008). Consistently, the 44 U.S. border region counties experience higher health access disparities as compared to their respective state populations and the rest of the nation. The generally low socioeconomic position of border residents, many of whom are Latino and disproportionately represented among the uninsured, places them at further risk for poor health conditions (Cacari Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007).

It is well established that the higher one's income, the more access one has to quality health care (Marshall, Urrutia-Rojas, Mas, & Coggin, 2005). Figure 3 shows that Latinos living in border counties are more likely to live in poverty than their state and national counterparts (31.8% vs. 23.4% nationally). An income of \$23,550 or less for a family of four or \$11,490 for a single person household falls within 100% of the federal poverty guidelines (U.S. Department of Health and Human Services [HHS], 2013). Children under age 18 who live in border counties (excluding San Diego County, California) are more likely to live in poverty (37%) than children nationally (20%) (see Figure 3).

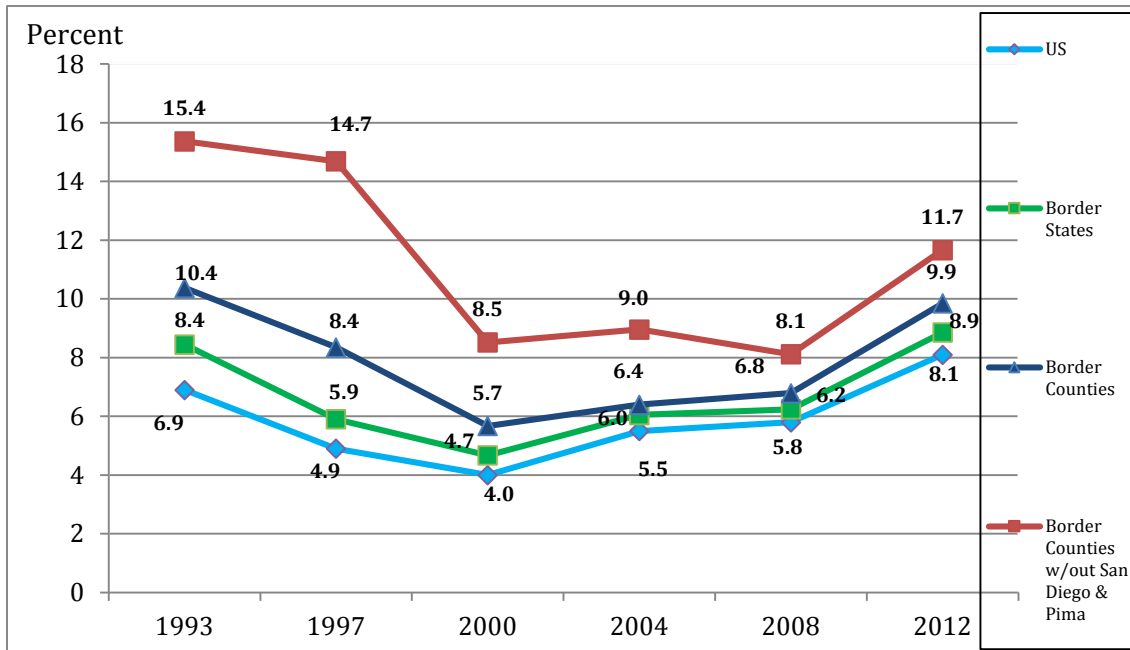
FIGURE 3: Persons Living Below Poverty in the United States and Border Region



Source: American Community Survey 5-Year Estimate, 2007–2011 (U.S. Census Bureau, 2012)

For two decades, the unemployment rate has been consistently higher among the border counties (excluding San Diego County, California, and Pima County, Arizona) than throughout the border states and nationally (see Figure 4). In 2008, unemployment in the border counties dropped to 8.1%, the lowest in 20 years, but it increased to 11.7 % in 2012. Research has consistently documented that type of employment and income are key determinants of the high rates of uninsurance among Latinos (see Figure 4). For example, Latinos who earn less than \$30,000 annually are over four times as likely to lack health insurance as those who earn more than \$50,000 annually (Brown & Lopez, 2013). Despite high participation in the labor force, Latinos are less likely to get employer-sponsored coverage (Shah & Carrasquillo, 2006). It is worth exploring the variables that contribute to this statistic, including whether types of employment play a contributing role, following the next enrollment phase.

FIGURE 4: U.S. Unemployment Rates, 1993–2012



Source: Local Area Unemployment Statistics (U.S. Department of Labor, 2014)

How Does the Affordable Care Act Impact the Uninsured in the Border Region?

The ACA created the Marketplace through which people can purchase insurance directly and offers new premium tax credits to help low- to moderate-income individuals afford coverage. In addition, the ACA provides states the option to expand Medicaid eligibility to millions more low-income adults. Since a high proportion of the uninsured resides in the border region, the decisions of state and tribal governments will significantly impact future coverage and access to health care for millions of uninsured children, adults, and families.

Uninsured Population in the Border Region

Insurance coverage for Latino communities varies by geographic area, with the largest proportion of uninsured residing in the border region. Differences in state labor markets, availability of employer-sponsored coverage, eligibility for public insurance, availability of charity care, and viability of the local safety net are some of the reasons for variations in coverage (Cacari Stone et al., 2007). These differences are magnified in border states, which is home to 31% of the *total* U.S. uninsured population (KFF, 2013c) (see Table 2).

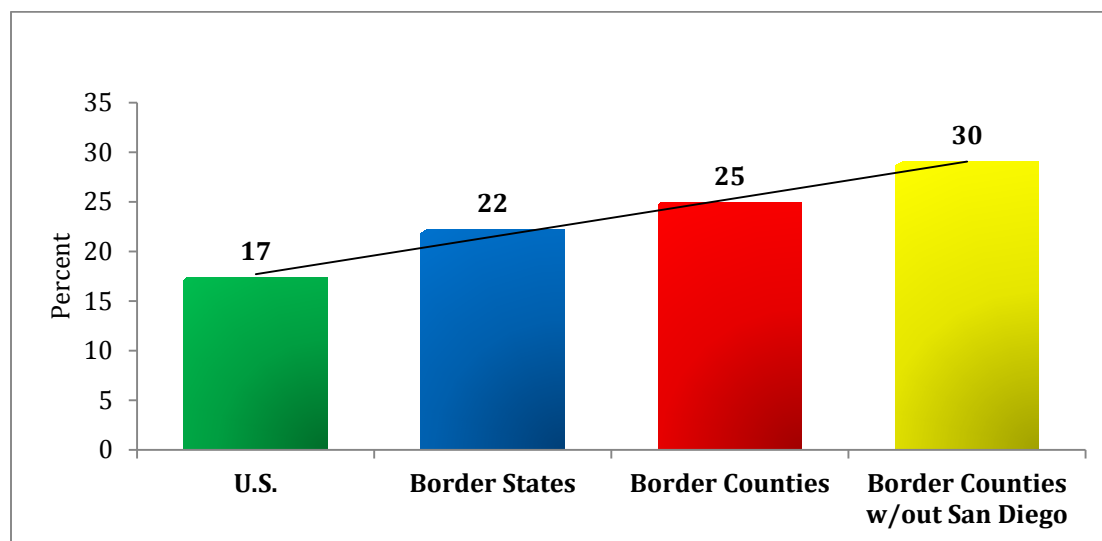
TABLE 2: Percent of the Total U.S. Uninsured Population by Border State

Uninsured (0–64) % of U.S. Total	
Arizona	2
California	15
New Mexico	1
Texas	13
Total	31%

Source: KFF, 2013c

In 2011, 30% of persons age 65 and under living in border counties (not including San Diego County, California) lacked health insurance coverage, as compared to 22.2% of their respective state counterparts and 17.3% nationally (see Figure 5).

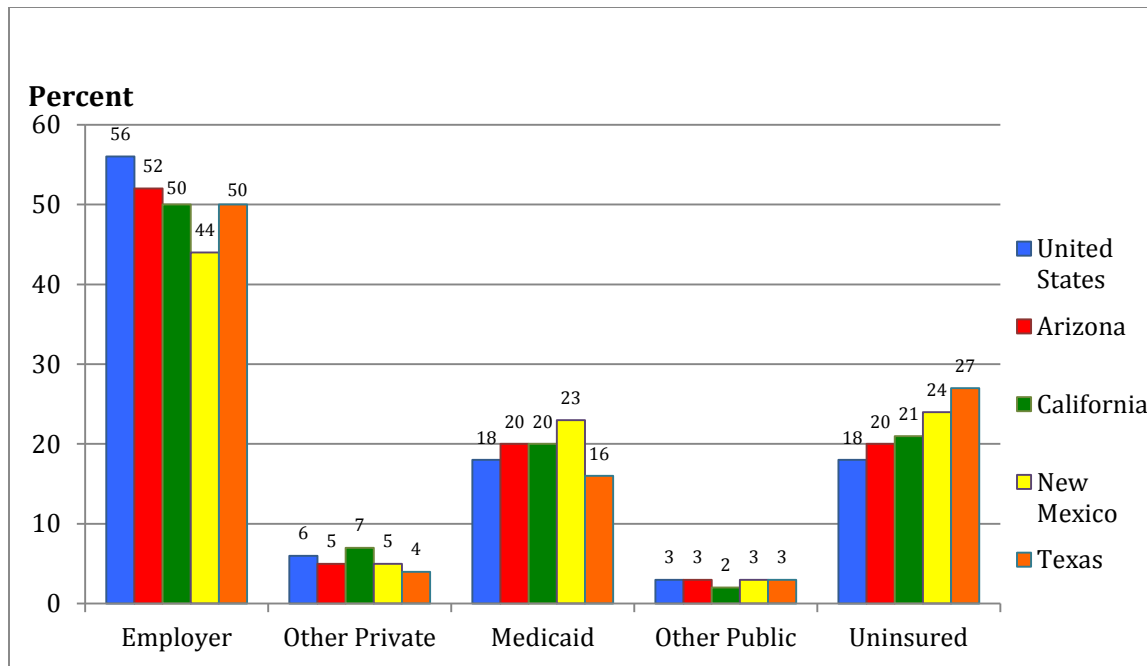
FIGURE 5: Uninsured Under Age 65, 2011



Source: Small Area Health Insurance Estimation, 2011 (U.S. Census Bureau, 2011b)

In 2012 and 2013, all four borders states had lower rates of employment-based private insurance and the highest rates of uninsured, with Texas at 27%, New Mexico at 24%, California at 21%, and Arizona at 20%, as compared to the U.S. average of 18%. New Mexico had the highest rate of Medicaid enrollees (23%) but the lowest rate of employer-sponsored insurance (44%). Among the four border states, Arizona had the highest employer-sponsored insurance coverage (52%), followed by California (50%) (see Figure 6) (KFF, 2014b).

FIGURE 6: Health Insurance Coverage of Nonelderly (ages 0–64), United States



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey (KFF, 2012b)

Health Insurance Marketplace

A cornerstone of the ACA, as mentioned earlier, is the establishment of the Health Insurance Marketplace (Marketplace), a new point of entry where individuals and small businesses can shop for and compare either public or private insurance coverage. Insurance plans in the Marketplace are offered by private companies and are required to cover the same essential health benefits described above under U.S. health reform features (KFF, 2013b).

The ACA provides for states to set up a Marketplace in each state by October 1, 2013, either by electing to form their own State-Based Marketplace (SBM); or opting out of doing so, in which case the federal government runs the state marketplace as a Federally-Facilitated Marketplace (FFM); or by partnering with the federal government to run a State Partnership Marketplace (SPM), where states assume primary responsibility for many functions of an FFM permanently or as they work toward running an SBM.

As of December 2013, 17 states, including California and New Mexico, had established an SBM; seven states were operating an SPM; and the remaining states, including Texas, defaulted to an FFM. As of May 1, 2014, the end of the first enrollment period, Marketplace enrollment surged to eight million (HHS, 2014). Table 3 shows the numbers of applicants, both eligible and enrolled, by state Marketplace type. It is important to note that marketplace enrollment in the four border states, thus far, is significantly lower than the estimated number of individuals who are eligible to enroll (see Table 3) (KFF, 2013e).

TABLE 3: Applicants (Eligible and Enrolled) by State Health Insurance Marketplace Type

Location	Marketplace Type	Total Number of Completed Applications	Total Number of Individuals Determined Eligible to Enroll in a Marketplace Plan	Total Number of Individuals Eligible to Enroll in a Marketplace Plan with Financial Assistance	Total Number of Individuals Determined or Assessed Eligible for Medicaid/CHIP by the Marketplace	Total Number of Individuals Who Selected a Marketplace Plan
United States		NA	NA	NA	814,502	372,488
Arizona	Federally-Facilitated	36,212	42,291	16,607	16,680	3,601
California	State-Based	250,838	225,897	158,435	181,817	107,087
New Mexico	State-Based	8,539	9,058	3,950	4,457	934
Texas	Federally-Facilitated	118,577	177,472	62,321	16,767	14,038
TOTAL		414,166	454,718	241,313	219,721	125,660

Source: State Marketplace Statistics (KFF, 2013e)

Under the ACA, persons with incomes that fall between 100% and 400% of the FPL (for a family of four in 2014, 100% FPL is \$23,550 and 400% FPL is \$94,200) may be eligible for tax credits that help with insurance premiums when they purchase coverage in the Marketplace. The Henry J. Kaiser Family Foundation (KFF) estimates that approximately 17 million people who are now uninsured or who buy insurance on their own (“nongroup purchasers”) will be eligible for premium tax credits in 2014 (KFF, 2013d).

According to the KFF:

The amount of tax credit that a person receives depends on their [*sic*] family income and the cost of health insurance where they live. The law establishes a maximum percentage of income that people within the 100 to 400 percent of poverty income range must pay for a benchmark plan where they live.... If the premium that a person or family faces for the benchmark plan in their area is higher than the maximum percent of income defined in the law for their income, they are eligible for a tax credit.... (KFF, 2013d)

Two of the border states—Texas and California—each have more than 1 million tax-credit-eligible residents (2013d).

The ACA also permanently reauthorized the federal Indian Health Care Improvement Act, which ensures the delivery and financing of health care for American Indians and Alaskan Natives (AI/ANs) by including them in the Marketplace and Medicaid expansions as well as modernization of the Indian Health Service (IHS) (CMS, 2011). These expansions are important to note since there are 26 federally recognized tribes in the border region. Historically, Medicaid has reimbursed a 100% match of state funds for Medicaid services provided through IHS and other facilities. However, a recent study completed for the Centers for Medicare & Medicaid Services Tribal Affairs Group

reported that approximately 29% of AI/ANs are currently uninsured, and so increasing health insurance among this population will be beneficial to these health facilities (CMS, 2011).

Additionally, in 2009, the typical Medicaid program enrolled only two percent of the AI/AN population. It is predicted that Medicaid AI/AN enrollment will increase to 61% under the ACA's Medicaid expansion, and those not eligible for Medicaid will be eligible for health insurance subsidies (CMS, 2011). The ability of urban AI/ANs to access either Medicaid or private insurance through the Marketplace will make greater financial resources available to provide treatment for urban AI/ANs and provide greater access to care for this population (Urban Indian Health Institute, 2011). Access to Medicaid and insurance provided through the Marketplace will reduce or eliminate financial barriers to health care as well as provide another source of revenue for nonprofit urban AI/ANs health care organizations, currently in desperate need of improved staffing and resources (Bly, 2013).

Table 4 shows the structure, plans, program and benefits, information technology capacity, consumer assistance, and outreach features of each of the border states' ACA-related activities (National Conference of State Legislatures, 2014). While New Mexico has opted for an SBM, its plan allows for the federal government to initially run the eligibility and enrollment system. Arizona and Texas identify the U.S. Department of Health and Human Services (HHS) as the responsible party for consulting with stakeholders and Native American tribes, while New Mexico has identified plans for a state-funded tribal outreach program and a targeted website for Native Americans. California and New Mexico have established nonpartisan oversight of their ACA-related initiatives, comprised of legislative and executive branch members as well as consumers and other stakeholders. While each state complies with the basic benefits package required by HHS, each has different processes for licensure and certification of insurers and their plans. The baseline capacities in information technology and pre-health reform efforts to strengthen outreach and enrollment strategies vary by state, indicating the need for stronger coordination within and across the border states to strengthen Marketplace efforts regardless of the Marketplace type (federal vs. state).

TABLE 4: Side-by-Side Comparison of U.S. Border States' Implementation Features under the ACA Leading to Open Enrollment, 2013

STATE	STRUCTURE	PLANS	PROGRAM & BENEFITS	INFORMATION TECHNOLOGY	CONSUMER ASSISTANCE & OUTREACH
Arizona	<ul style="list-style-type: none"> Federally-Facilitated Marketplace (FFM) Implementing Medicaid expansion in 2014 <p>The U.S. Department of Health and Human Services (HHS) will aid Arizona's Office of Health Insurance Exchanges in coordinating state implementation and analysis of the exchange under the Exchange Final Rule.</p>	<p>HHS will be responsible for—</p> <ul style="list-style-type: none"> Consulting with stakeholders and with Native American tribes Certifying, recertifying, and decertifying Qualified Health Plans (QHPs) Determining eligibility for the Health Insurance Marketplace (Marketplace) and for insurance affordability programs <p>Marketplace flexibility/variance will be based on local markets.</p>	<p>Benefit Benchmarks:</p> <ul style="list-style-type: none"> State Employee's Benefit Options Exclusive Provider Organization Plan, administered by United Healthcare Named <i>State of Arizona Self-Insured Plan</i>, to include plans for pediatric vision and dental coverage <p>HHS will grant licensure/certification to any entities that will match the benchmark provisions and abide by state laws.</p>	<p>HHS will be responsible for aiding in technical and enrollment assistance through an account manager who will also serve as a point of contact.</p>	<p>HHS will be responsible for customer support as well as in-person assistance and Navigator programs.</p> <p>HHS will run the www.healthcare.gov website.</p>
California	<ul style="list-style-type: none"> State-Based Marketplace (SBM) Named <i>Covered California</i> Implementing MediCal (Medicaid) expansion in 2014 <p>Quasi-governmental five-member board:</p> <ul style="list-style-type: none"> Secretary of California Health and Human Services Governor-appointed members (2) Senate appointed member Speaker assembly appointed member Supplemental Tribal Consultation Advisory Group 	<p>Standardized benefits and cost sharing clearinghouse for all participants in the Marketplace with—</p> <ul style="list-style-type: none"> All metal tiers being offered Bids for at least one Covered California Benefit plan Options to propose alternate to the Healthy Savings Account program <p>May sell stand-alone dental and vision plans.</p>	<ul style="list-style-type: none"> Proposed Subsidized Insurance for families between 139% and 200% of the federal poverty level (FPL) Proposed Bridge Plan to transition from MediCal to the Marketplace <p>Benefit Benchmark: Kaiser Small Group Health Maintenance Organization with the CHIP program for pediatric dental supplement</p>	<p>California Healthcare Eligibility, Enrollment, and Retention System County Service Centers</p> <p>Consortia-based Service Center Networks</p> <p>Enroll UX 2014</p>	

STATE	STRUCTURE	PLANS	PROGRAM & BENEFITS	INFORMATION TECHNOLOGY	CONSUMER ASSISTANCE & OUTREACH
New Mexico	<ul style="list-style-type: none"> • SBM • Named <i>New Mexico Health Insurance Exchange</i> (NMHIX) • Implementing expansion in 2014 <p>Non-profit Quasi-Governmental 13-member board to include—</p> <ul style="list-style-type: none"> • State Superintendent of Insurance • Secretary of Human Services • Health Insurance Issuer • Consumer Advocate • Healthcare Provider • Governor appointed members (3) • State legislative appointed members (4) <p>The federal government will initially run the eligibility system.</p>	<p>The New Mexico Department of Insurance will issue licenses for QHPs, which will include—</p> <ul style="list-style-type: none"> • Silver and Gold plans comparing state and vendor plans with three variations of the Silver level based on cost-sharing subsidies • Comparative pricing for vendor and state plans when providing all metal levels • Limited cost sharing plans for metal levels offered • Capacity to offer plans through the Marketplace and the Small Business Health Options Program • Dental and vision benefits. These benefits may also be offered as stand-alone plans not to exceed \$700 /single child or \$1400 /2+ children <p>Entities not in the Marketplace by 2014 cannot participate until 2016.</p>	<p>Benefit Benchmark:</p> <ul style="list-style-type: none"> • Lovelace Classic Preferred Provider Organization <p>Continued research will be conducted for the basic health program to facilitate development of a fiscal model.</p>	<p>NMHIX Exchange IT System will partner with the Medical Assistance Division and the Income Support Division of the NM Human Services Department.</p> <p>An Automated System Program and Eligibility Network (ASPEN)</p> <p>Medicaid Management Information System (MMIS)</p> <p>Enroll UX 2014</p>	<ul style="list-style-type: none"> • State funded Healthcare Guide and Navigator programs • Non-profit organization partnerships • State funded tribal outreach programs and Native American-targeted website • State funded advertising and marketing campaigns • State funded triage call centers 'New Mexico Health Insurance Alliance' • Insurance Web brokers beginning in 2015 <p>State Website: www.NMHIX.com</p>
Texas	<ul style="list-style-type: none"> • FFM • Not moving forward at this time <p>The U.S. Secretary of Health and Human Services will aid the Texas Department of Insurance and the Texas Health and Human Services Commission in establishing and operating the Marketplace under the Exchange Final Rule.</p>	<p>HHS will be responsible for—</p> <ul style="list-style-type: none"> • Consulting with stakeholders and Native American tribes • Certifying, recertifying, and decertifying QHPs • Determining eligibility for the marketplace and for insurance affordability programs 	<p>Benefits Benchmark will follow the Blue Cross Blue Shield of Texas Best Choices Preferred Provider Organization.</p> <p>HHS will grant licensure/certification to any entities that will match the benchmark provisions and abide by state laws.</p>	<p>HHS will be responsible for aiding in technical and enrollment assistance through an account manager who will also serve as a point of contact.</p>	<p>HHS will be responsible for customer support, in-person assistance, and Navigator programs.</p> <p>HHS will run the www.healthcare.gov website.</p>

Source: National Conference of State Legislatures, 2014

Medicaid Expansions, Financial Assistance, and Coverage Gaps Vary by State

In an effort to significantly reduce the number of uninsured, the ACA provided for the expansion of Medicaid coverage to an estimated 14 million adults who were not eligible and had incomes at or below 138% of the FPL—about \$32,500 for a family of four in 2013 (KFF, 2012a). While the ACA itself requires expansion of Medicaid in every state, the Supreme Court decision of June 28, 2012 (KFF, 2012a), prohibited HHS from taking enforcement actions against states that did not comply with the Medicaid expansion requirement, and states were, as a result, free not to do so, as a practical matter. As of September 2014, 28 states (including D.C.) were implementing the Medicaid expansion (KFF, 2014c). In states that have chosen not to implement the expansion, such as Texas, many uninsured adults who would have been newly eligible for Medicaid will likely remain uninsured (see Table 5) (KFF, 2014b).

These individuals fall into the coverage gap because “...[they] have incomes above the limited Medicaid eligibility levels in these states but do not earn enough to qualify for premium tax credits to purchase Marketplace coverage, which begins at 100% FPL” (KFF, 2013c). These gaps in coverage will have the greatest impact on the border region, where a high percent of the population lacks insurance coverage. Based on early-release estimates from the *National Health Interview Survey* (January-June 2013), in states moving forward with Medicaid expansion, adults aged 18–64 were more likely to have public coverage, less likely to be uninsured, and more likely to have private insurance than adults in states not moving forward with expansion (National Center for Health Statistics [NCHS], 2013). Among the states not moving forward with Medicaid expansion at this time, Texas has the highest uninsured rate for adults aged 18–64 years (29.6%) and among the second to lowest rates of public health plan coverage (12.7%) and private health insurance coverage (58.8%) (NCHS, 2013). Table 5 compares the number of individuals eligible for financial assistance by border state and highlights the impact of Texas’ decision not to expand Medicaid for over one million adults who fall into the coverage gap (KFF, 2014b).

However, states have expanded health coverage to children through Medicaid and CHIP, building on federal requirements for all states to cover children up to certain minimum levels, which as of January 1, 2014, will be 138% of the FPL for children of all ages (KFF, 2014d; KFF 2013c). Additionally, children aged 0–17 and adults aged 18–64 were less likely to be uninsured in those states moving forward with Medicaid expansion under the ACA (Arizona, California, and New Mexico), compared to states not moving forward with Medicaid expansion, such as Texas (NCHS, 2013).

TABLE 5: Eligibility for Financial Assistance, Tax Credits, Medicaid, and Coverage Gap with No Financial Assistance by Border State

ELIGIBILITY STATUS	NUMBER OF UNINSURED				
	CA	AZ	NM	TX	All Border States
		6,993,000	1,140,000	422,000	6,167,000
Ineligible for Financial Assistance • Includes those whose income is too high to be eligible for tax credits, who have affordable employer coverage, or who are not lawfully present in the United States	2,627,000	424,000	123,000	2,491,000	5,665,000
<i>Ineligible based on income or availability of employer coverage</i>	1,177,000	242,000	81,000	1,264,000	2,764,000
<i>Estimated persons not lawfully present in the United States</i>	1,449,000	182,000	42,000	1,226,000	2,899,000
Eligible for Tax Credits					
• People with incomes 100–400% of the federal poverty level who are eligible to buy coverage in the Marketplace and do not have other affordable coverage available	1,387,000	247,000	95,000	1,756,000	3,485,000
In the Coverage Gap with No Financial Assistance					
• Adults in states not expanding Medicaid under the ACA who do not qualify for assistance because they are ineligible for Medicaid and tax credits	0	0	0	1,046,000	1,046,000
Eligible for Medicaid/CHIP					
• Includes people eligible for Medicaid/CHIP who are not currently enrolled and those newly eligible under the ACA in states expanding Medicaid.	2,979,000	469,000	204,000	874,000	4,526,000
<i>Adults</i>	2,206,000	339,000	153,000	122,000	2,820,000
<i>Children</i>	772,000	130,000	51,000	752,000	1,705,000

Source: KFF, 2014b

Opportunities

Even with implementation of the ACA, there is likely to remain a significant number of uninsured residents living in the border region, which may result in continued sociodemographic risks linked to poor access to care; the growing prevalence of chronic conditions, including diabetes and obesity; variable health insurance coverage gaps; and unequal financial assistance and tax credits across states. To this end, the United States-México Border Health Commission (BHC) can lead the public and private sectors in increasing the outreach, enrollment efforts, information dissemination, and messaging to border residents as well as educating communities and decision-makers about the needs of border populations.

The following opportunities to increase access to health care were informed by various sources, including input from border region stakeholders and the BHC.

→ **Expand outreach and education through trusted partner networks, academic institutions, community health centers, and community health workers (*promotores*) to assist ACA-related enrollment efforts along the border.**

Information Dissemination and Messaging

For two decades, landmark reports and studies have called for national action to ensure that Latino populations receive health information earlier rather than later to avoid delayed care and unnecessary emergency room use (HHS, 1993). One of the many priorities called for has been the dissemination of health information via *centralized clearinghouses* to health care providers, patients, and the general population (HHS, 1993). The 2013 *Colorado Latino Health Care Survey* found that Latinos lack basic knowledge about the new health care law, and those surveyed indicated they received minimal information that was, overall, confusing and complicated (Barreto, Herrera Bortz, del Castillo, & Sanchez, 2013).

In an effort to address this information gap, there have been federal and state efforts to provide linguistically appropriate materials through expanded digital communication strategies to the nation's growing Latino population, including those who reside in hard-to-reach communities along the border. HHS launched the Spanish online enrollment tool *CuidadoDeSalud.gov* in early December 2013, a website designed to impact Spanish speakers, including those living in border states, with State Partnership Marketplaces and Federally-Facilitated Marketplaces. For those purchasing coverage through State-Based Marketplaces (SBM), over half of the SBM websites contain some materials or information in languages other than English (Gold, 2013a). For example, *Covered California's* website includes fact sheets on the Marketplace, changes in health coverage, financial eligibility, and small business tax credits in 13 languages and maintains a full Spanish version of the site (KFF, 2013e).

Just as HHS and the states are making progress through online access, the BHC has an opportunity to leverage current communication platforms in conjunction with more traditional approaches. For instance, the BHC can build on existing relationships and facilitate closer coordination between national organizations and local partnerships to develop a border clearinghouse or outreach and enrollment network. This type of system could assist with the next enrollment phase, scheduled to take place from late 2014 to early 2015, by increasing the availability of ACA information. Potential partners may include the Border Governors' Conference Health and Emergency Management Work Table; binational health councils and local community coalitions; offices of border health within the border state health departments; the Mexican Consulates' *Ventanillas de Salud* program; local school districts and universities; border associations of community health centers; and border counties and *colonias*'² development councils.

Additionally, the BHC and other public health partners have an opportunity to fill the information gap by establishing associations with private insurance carriers to take part in media outreach campaigns. This type of media-specific action plan has the potential to significantly impact Latino

² *Colonias* are considered semi-rural subdivisions of substandard housing lacking basic physical infrastructure, potable water, sanitary sewage, and adequate roads (U.S. Department of Housing and Urban Development, 2014).

enrollment, especially in vulnerable and underserved communities, as indicated by participants at the 2012 and 2013 regional stakeholder meetings of the BHC's Health Promotion and Prevention among Vulnerable Populations initiative. Local health professionals identified targeted media strategies as having the potential to significantly impact the border and indicated the following media sources as the most commonly utilized by vulnerable populations to access health information:

- Radio
- Television
- Word-of-mouth
- Newspaper
- Texting, Internet, Social Media
- Posters and Flyers

To illustrate, CMS successfully partnered with *Univision*, a popular Spanish-language media network, during the initial enrollment period to increase information dissemination through the network's award-winning health initiative *Salud Es Vida* (Health Is Life). These types of partnerships provide direct contact with nearly three-quarters of the Spanish-speaking television audience regularly tuned in to the network (Gold, 2013b), thereby significantly increasing access to critical information.

To further expand outreach and close the information gap, the BHC, federal and state agencies, community health centers, academic health centers (AHCs), binational health councils, and other community-based organizations could collaborate with *Univision* and other Spanish-language media networks by developing culturally and linguistically specific messages and media broadcasts targeted to border residents.

Targeted Outreach and Enrollment

Providing health reform materials in Spanish and delivering information via trusted messengers are critical strategies for improving access to insurance coverage for border residents. According to a recent study in Colorado, outreach strategies targeted to Latino populations between April and October 2013 increased awareness about the ACA (Barreto et al., 2013). The study assessed 300 Latino residents according to the following criteria: 1) knowledge of the new health care law, 2) exposure to outreach efforts, 3) responses to participation appeals, and 4) actual experiences with ACA enrollment. Among the general public, Latinos reported very low levels of knowledge about the ACA and indicated the new law is “confusing” and “complicated.” Among those who had attempted to access information or enroll, 57% reported that the system was easy to understand, as compared to 27% who experienced problems. Results from that study provided insight on appropriate terminology, messaging, messengers, and the use of information platforms designed to maximize the impact of outreach programs.

In another study that examined the effectiveness of a culturally centered outreach strategy utilized in Medicaid/CHIP implementation, parents reported that they needed better information about programs, eligibility, and the application process as well as a more efficient, user-friendly system (Flores et al., 2005).

A recent study examining large state variations in health insurance coverage rates suggests that states could emphasize different targeting and enrollment strategies based on information regarding whether they have high or low rates of people losing public or private health insurance and high or low percentages of newly uninsured people who remain uninsured for more than two years (Graves, 2013). Border states could focus particularly on reaching border county residents and members of tribes located in the border region, where the highest percent of uninsured reside, as these residents

may be eligible for subsidized plans in the Marketplace. These states could also concentrate on reducing the number of residents losing Medicaid eligibility due to temporary income fluctuations.

Community health centers and offices of border health located within the border state departments of health could collaborate with the state health reform/Medicaid offices in order to train a cadre of community-based case managers dedicated to reaching and enrolling Latino children and their families, as well as adults without children, into the Marketplace. A study on enrollment of Latino children into CHIP demonstrated that families working with trained case managers who assisted them in completing insurance applications; provided information on program eligibility; acted as family liaisons with Medicaid/CHIP; and assisted in maintaining coverage were significantly more likely to obtain health insurance (96% vs. 57%) and to remain continuously insured (78%) than families who were subjected to traditional Medicaid/CHIP office strategies (Flores et al., 2005).

Funding mechanisms should include the ability to cover the cost of allied health professionals and community health workers, known as *promotores* along the U.S.-México border, or Community Health Representatives (CHRs), specific to the Indian Health Care System, in their ACA outreach and enrollment roles. Highlighted as a program of excellence by the BHC, *promotores* and CHRs play a central role in linking vulnerable border populations with social and medical services and supports. The effectiveness of *promotores* and CHRs is attributed to their multiple roles: health educator, trusted advisor, advocate, and role model (Andrews, Felton, Wewers, & Heath, 2004). They are viewed as cultural brokers or intermediaries for marginalized or underserved communities experiencing barriers to resources, such as healthy food, medical services, health insurance, and protection from environmental exposures (Rhodes, Foley, Zometa, & Bloom, 2007). The 2013 *Latino Decisions* study also found that “Tapping into social networks for outreach will be key given the high number of Latinos who report that they would be more likely to enroll if encouraged by family members and friends” (Barreto et al., 2013). Additionally, Latino teachers and doctors are two other categories of trusted confidants who are perceived by Latinos to be critical in increasing the dissemination of information, outreach, and engagement with hard-to-reach border residents.

Finally, AHCs in the border region can play a key role in training and educating their health provider workforce and residents about the ACA and its eligibility requirements and enrollment processes. Busy health providers can also be oriented toward introducing residents to specially trained community-based case managers and community health workers/*promotores* for further linkages and express-lane-type eligibility in order to expedite enrollment in the ACA. To facilitate this, the BHC can work with partners, such as binational health councils, whose local and regional members serve as voices for border public health, to utilize them as liaisons between consumers and health advisors.

AHCs are key leaders in ensuring that the young uninsured population, also referred to as *young invincibles*, is enrolled in the Marketplace. For instance, the University of New Mexico, through its Community Engagement Center, is training students as *navigators*, an individual or organization trained and able to help consumers, small businesses, and their employees look for health coverage options through the Marketplace. These peer navigators are educating other college students on ACA benefits and options, including ways to inform their parents and families about their options. This type of an approach is also effective for English-speaking students whose parents and family members are limited English proficient.

→ Assist border states to strengthen public health systems by identifying ACA funding opportunities in support of continued outreach and education efforts.

ACA and *Seguro Popular* invest in prevention and health promotion to address the high prevalence of chronic health conditions, including diabetes and obesity. Hospitals, community health centers, academic teaching institutions, and other public health providers in the border region should work collectively to leverage federal funding to improve coordination and integration of care. The BHC can explore these and other funding opportunities and strategies, both private and public, to continue outreach, research, and health education activities that address these chronic health conditions.

The ACA provides financial incentives for safety-net providers, including community health centers, to grow their workforce; to develop accountable care organizations and medical health homes that are rewarded for improved patient care coordination and management of chronic conditions; and to develop innovations that are cost-effective and culturally and linguistically competent (Riley, Berenson, & Dermody, 2012). The BHC could assist federally qualified health centers located in border counties with identifying funding and grant opportunities for testing new innovations in service delivery (i.e., Center for Medicare and Medicaid Innovation) and enhancing the federal matches for Medicaid Health Homes.

→ Provide access to and analyze data necessary to better inform programmatic decisions.

Good policy and systems planning is based on good science and data. Most of the national data sets tracking the uninsured and utilization of health services include state-level variables that can be easily analyzed for patterns and can be found in the Centers for Disease Control and Prevention's (CDC) *National Center for Health Statistics*; the U.S. Census Bureau/Bureau of Labor Statistics' *Current Population Survey*; and the Agency for Healthcare Research and Quality's *Medical Expenditure Panel Survey*. However, sub-state variation to the county level and zip code are rarely available in public use data sets, except in the U.S. Census Bureau/Bureau of Labor Statistics' *Small Area Health Insurance Estimates* and *American Community Survey* as well as variables on coverage in the CDC's *Behavioral Risk Factor Surveillance System*. The Henry J. Kaiser Family Foundation is tracking the numbers and types of enrollees by state into the Marketplace, yet no one entity is collecting or analyzing data specifically focused on the border region.

Building on the efforts of the border health research network, the BHC could partner with HHS to exchange border-specific enrollment data to inform outreach efforts. This would provide BHC members, state offices of border health, and other public health stakeholders the opportunity to identify insurance coverage gaps, adequately plan for future enrollment phases, and strengthen outreach and enrollment strategies. However, potential challenges include existing enrollment data errors that need to be repaired by HHS and lack of communication linkages between consumers who sign up for coverage through the Marketplace and insurance companies.

The BHC can assess the education outreach and enrollment efforts that took place during the initial enrollment phase in October 2013 through March 2014. By assessing the needs of border communities, the BHC will be able to take a lead role in future enrollment efforts during the next enrollment periods. The assessment could include such factors as the characteristics of enrollees,

which options they enrolled in, the role of community health workers, and reasons uninsured residents opted not to enroll.

→ Other Strategies

Other previously considered policy options and system interventions should be reconsidered within the context of health reform in the border region, including cross-border service utilization and insurance coverage options as well as increased investments in growing the public health workforce.

Cross-border service utilization presents windows of opportunity to capitalize on the binational consumer trade, economic exchanges, and public health initiatives that have occurred for almost a century in the border region. Multiple *borderless* innovations have been piloted since the 1970s and have shown positive outcomes for improving health care access and increasing the quality of care. For example, since the 1990s, several organizations from both countries have been exploring options for binational health insurance. Binational health insurance has been implemented in California, allowing employers to purchase insurance coverage for their employees who either live in México or prefer to use health services in that country (Warner & Schneider, 2004; Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995).

The BHC, along with AHCs in the border states, should continue to explore options that increase the public health workforce capacity through recruitment and training of culturally and linguistically competent health care professionals. In order to raise the visibility of border health issues that impact health care access and to increase collaborative opportunities, BHC training in the form of leadership development could be expanded to include HHS and other federal regional partners who influence and manage community programs throughout the border region. The inequitable distribution of knowledgeable health professionals within and between countries poses an important obstacle to the achievement of optimal attainable health for all (Grobler et al., 2010). Along the U.S.-México border there is a significant shortage of health care professionals due to lack of incentives and meager salaries, which results in professionals seeking employment opportunities elsewhere (Landeck & Garza, 2002). Equally important are the medical and public health institutions that train and educate health professionals and deliver care. Access to preventive services would likely be improved with a greater supply of primary health care providers and culturally and linguistically appropriate services.

Conclusion

Improving access to health care can increase health and wellness within U.S.-México border populations. Both the United States and México have developed health reforms to address the need for increased health insurance coverage. As such, prevention and health promotion opportunities created under the ACA and *Seguro Popular* have the potential to provide coverage to millions of uninsured residents living in these vulnerable communities.

In support of its mission to provide international leadership that optimizes health and quality of life, the United States-México Border Health Commission will play an instrumental role in leveraging these opportunities to ensure all border residents have access to quality care that can help them achieve good health.

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