
EMBRACING THE NEW GEOGRAPHY OF HEALTH CARE: A NOVEL WAY TO COVER THOSE LEFT OUT OF HEALTH REFORM

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ABSTRACT

Even after landmark health reform in 2010, our health care system will not achieve universal coverage. The Patient Protection and Affordable Care Act is expected to leave twenty-three million people uninsured after a decade. And until several major provisions take effect in 2014, fifty million people will remain uninsured. This Article argues that cross-border health insurance plans that utilize foreign medical providers are a surprisingly feasible alternative for the residually uninsured. Cross-border plans can be much less expensive than traditional, domestic-only plans. And they might appeal to immigrants and others that are neither eligible for public plans nor able to afford private ones.

The Article begins by evaluating the 2010 health reform legislation and the populations that it leaves out. I then reveal how gaps in our health care system are being filled by foreign medical providers. Three major constituents of the U.S. health care system now utilize foreign providers:

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patients travel as “medical tourists” when they cannot afford care domestically; insurers outsource high-margin procedures to foreign hospitals; and somewhat perversely, some U.S. hospitals facing extraordinary expenses repatriate immigrants to their native countries in a form of international “patient dumping.” These trends reflect what I call the “new geography” of health care.

The Article demonstrates how cross-border plans might appeal both to immigrants and to the nonimmigrant middle class that cannot afford traditional insurance. I explain how cross-border plans operate and propose various solutions to the legal and practical impediments that presently discourage such arrangements. For example, the Article applies “new governance” theories to recommend how to impose quality standards on foreign providers that otherwise reside beyond the jurisdiction of domestic regulators.

This Article also confronts an underlying normative question: How much should we relax or reconfigure our standards to make health care more accessible? I argue that if a significant portion of residents cannot afford health care in the United States—and if we are not prepared to provide it publicly as most other countries do—then we should reimagine current laws that contemplate only domestic care and create a legal framework that allows patients to seek it elsewhere.

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I. INTRODUCTION

In March 2010, Congress enacted the most significant health care legislation in nearly fifty years.¹ The Patient Protection and Affordable Care Act (“the Affordable Care Act” or “the Act”)² is expected to expand access to insurance greatly through an intricate and controversial series of mandates, subsidies, tax credits, public program expansions, and insurance market reforms. Forecasters predict that the law will lower the number of uninsured from fifty-four million to twenty-three million over the next decade, reducing the percentage of uninsured from nineteen to eight.³ This

1. Forty-five years prior, Congress passed the Social Security Amendments of 1965, creating Medicare and Medicaid. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C.).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified in scattered sections of 26 and 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified at 42 U.S.C. § 1305).

3. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, House

undoubtedly would represent a major achievement, particularly for a health care system that has gained international notoriety for simultaneously spending almost twice as much as any other system while leaving over fifty million uninsured.⁴ But even after health reform is fully implemented, twenty-three million will remain uninsured, “about one-third of whom would be unauthorized immigrants.”⁵ And in the more immediate future, before several major provisions take effect in 2014, roughly fifty million residents will remain uninsured.⁶ How might these populations access health insurance?

This Article proposes a relatively novel way to make health insurance accessible to those who remain uninsured after reform. I explain how cross-border insurance—plans that cover domestic medical providers but also encourage patients to visit foreign providers—is a surprisingly feasible alternative for many patients who cannot access traditional public or private insurance. Cross-border plans are documented to be much less expensive than traditional plans, and may appeal to immigrants and others who already look outside the United States for health care. To these patients, the choice may be between cross-border insurance or none at all.

This proposal assimilates various trends that reveal the harsh realities of our health care system. Over the past decade, foreign medical providers have emerged as an important safety valve for three major constituents of the U.S. health care system: patients, insurers, and hospitals. Patients are venturing overseas as so-called “medical tourists” when they cannot afford care domestically. Insurers are contracting with foreign hospitals to outsource certain expensive treatments. And even U.S. hospitals providing uncompensated care to immigrants have begun “repatriating” those who they suspect are here unlawfully⁷ to hospitals and clinics abroad.⁸ The

Speaker, U.S. House of Representatives 9, app. tbl.4 (Mar. 20, 2010) [hereinafter CBO letter], available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>. These figures account for the “nonelderly” population not eligible for Medicare.

4. See *id.*; CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA C. SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 22, 23 tbl.8 (2010); ORG. FOR ECON. COOPERATION & DEV., OECD HEALTH AT A GLANCE 2009: OECD INDICATORS (2009), available at <http://www.oecd.org/health/healthataglance>; WORLD HEALTH ORG., SPENDING ON HEALTH: A GLOBAL OVERVIEW (2007), available at <http://www.who.int/mediacentre/factsheets/fs319/en/index.html>.

5. CBO Letter, *supra* note 3, at 9.

6. *Id.* at app. tbl.4.

7. Because there are dozens of different immigration statuses, I use the phrase “immigrants” to refer both to those who are lawfully present and those who are not. I use “authorized immigrants” to refer to those who are lawfully present, pursuant to the Immigration and Nationality Act, 8 U.S.C. § 1101 (2006). I use “unauthorized immigrants” to denote immigrants who do not reside in the United States with the express permission of the U.S. government. For a discussion of the social and legal

federal government neither regulates nor monitors these trends. This Article explains how we can use cross-border insurance not only to cover some uninsured populations, but also to fill the regulatory void in which medical tourism, outsourcing, and repatriation have emerged.

This Article proceeds in five parts. Part II explains who will remain uninsured after health reform, both in the immediate and distant futures, and discusses how these populations access care in the United States. Part III examines how a combination of opportunism, creativity, and desperation has led U.S. patients, insurers, and hospitals to rely on foreign medical providers. Parts IV and V then outline precisely how cross-border insurance can offer an alternative to those who remain uninsured after reform, sketching out the legal mechanics and responding to commonly cited concerns about cross-border care.

Part IV.A outlines why cross-border insurance is a feasible alternative. And Part IV.B describes how states can create a very basic legal framework to encourage cross-border insurance. This framework would (1) legally authorize insurers to utilize foreign providers, (2) give insurers flexibility to design plans that actually appeal to the uninsured, (3) specify minimum coverage requirements, (4) identify regulatory proxies for ensuring quality care, and (5) address other legal hurdles that presently discourage cross-border care. This framework incorporates lessons from the only two states that have formally addressed cross-border insurance: California, which in 1998 legalized cross-border plans for a narrow population;⁹ and Texas, which in 2007 banned such plans altogether.¹⁰ This framework builds on California's experience and addresses the concerns animating the ban in Texas. Part IV.B.6 addresses the normative ambiguities of cross-border insurance.

Part V then envisions ways that states can leverage alternative regulatory methods to impose standards on cross-border plans and ensure quality care overseas, which is the most frequently cited concern. It explains why "new governance" is particularly well suited for addressing phenomena like cross-border health care that reside beyond the purview of domestic regulators.¹¹ Part V then examines how new governance is

valence of various terminologies, see Kevin R. Johnson, "Aliens" and the U.S. Immigration Laws: *The Social and Legal Construction of Nonpersons*, 28 U. MIAMI INTER-AM. L. REV. 263, 276-79 (1997).

8. As noted in *infra* Part III.C, hospitals have repatriated not only unauthorized immigrants, but also authorized immigrants.

9. CAL. HEALTH & SAFETY CODE §§ 1345, 1351.2 (West 2008).

10. TEX. INS. CODE ANN. art. 1216.004 (West 2010).

11. For a definition of "new governance," see *infra* Part V.A. Louise Trubek and Tamara Hervey

already being used in the cross-border industry (for example, international hospital accreditation has become a de facto industry standard), before recommending additional methods to ensure quality care, such as conditioning insurance reimbursement on meeting quality criteria, using international networks to develop best practices, and mobilizing the recent proliferation of border health initiatives to educate immigrants about the value of insurance.¹²

Part VI concludes by addressing the proposal's limitations—for example, cross-border insurance will not cover everyone left out of health reform—and argues that despite these limitations, cross-border plans are perhaps the only alternative for some uninsured residents, short of a system that provides genuine universal coverage.

Throughout, the Article confronts a fundamental normative question: How much should we reconfigure our standards to make health care more accessible? If our laws are designed to regulate domestic care and do not contemplate foreign care, to what extent should we relax or reimagine these laws? I argue that if a significant portion of residents cannot afford health care in the United States—and if we are not prepared to provide it publicly—we should help patients seek it elsewhere. Even after health reform, our system will not achieve universal coverage, a result that is hard to justify for a nation with our resources. Cross-border insurance certainly is not the first-best option here. But as others grappling with the residual uninsured have noted, “if there were ever an occasion to avoid the ideal becoming the enemy of the good, surely this is it.”¹³

In this vein, my proposal is very much animated by the blunt reality that our health care and immigration systems do not provide all care at all times to all people, regardless of one's immigration status or ability to pay. Given these realities, cross-border insurance may represent our best option for covering many of those who remain uninsured.

have been early proponents of applying new governance to health care. *See generally* Tamara Hervey & Louise Trubek, *Freedom to Provide Health Care Services Within the EU: An Opportunity for a Transformative Directive*, 13 COLUM. J. EUR. L. 623 (2007).

12. *See, e.g.*, Margaret A. Laws, *Foundation Approaches to U.S.-Mexico Border and Binational Health Funding*, 21 HEALTH AFF. 271, 275 (2002).

13. Mark A. Hall, *After Insurance Reform: An Adequate Safety Net Can Bring Us to Universal Coverage*, HASTINGS CENTER REP., Nov.-Dec. 2009, at 9, 10, available at <http://www.tseed.com/aslme/conference/forSystemUse/papers/051.pdf>.

II. WHO ARE THE UNINSURED AND HOW DO THEY ACCESS CARE?

To understand how foreign providers have become a safety valve for our health care system, it is important to understand who is uninsured in the United States, who will remain so after health reform, and how they access care. A brief analysis suggests that cross-border insurance might be a viable alternative for a significant portion of them.

A. WHO IS UNINSURED NOW?

Fifty million U.S. residents currently lack health insurance, representing 17 percent of the nonelderly population.¹⁴ And as many as eighty-two million may be uninsured at some point during a two-year span—roughly a third of the nonelderly population.¹⁵ Despite general perceptions, the uninsured are not a cohesive, monolithic identity group, but are diverse demographically and even economically.¹⁶

Demographically, the uninsured span every age, race, and citizenship status.¹⁷ Yet some categories claim more uninsured than others. One in three Hispanics lacks insurance compared to about one in ten non-Hispanic whites.¹⁸ The young are more likely to be uninsured than the old.¹⁹ The South and West have markedly higher numbers of uninsured than the Northeast and Midwest.²⁰ The foreign born are almost three times more likely to be uninsured than the native born.²¹ And of the foreign born, noncitizens are more than twice as likely to be uninsured than naturalized

14. See CBO Letter, *supra* note 3, at 9, app. tbl.4. The latest official data estimated that in 2008, 46.3 million U.S. residents lacked health insurance. Less than 2 percent of the Medicare population aged sixty-five and older lacked insurance. DENAVAS-WALT, PROCTOR & SMITH, *supra* note 4, at 23 tbl.8. Before health reform, experts predicted that roughly fifty-six million people would be uninsured by 2013. Todd Gilmer & Richard Kronick, *It's the Premiums, Stupid: Projections of the Uninsured Through 2013*, 24 HEALTH AFF. W5-143, W5-143 (Apr. 5, 2005), <http://content.healthaffairs.org/content/early/2005/04/05/hlthaff.w5.143.full.pdf>.

15. Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 540 (2006) (citing a Families USA study which found that eighty-two million residents were uninsured at some point during 2002 and 2003).

16. *Id.* at 540-42; I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1524 (2010); Nan D. Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. 1, 58 (2008).

17. See DENAVAS-WALT, PROCTOR & SMITH, *supra* note 4, at 23 tbl.8.

18. *Id.*

19. *Id.*

20. *Id.*

21. See *id.*

citizens.²² So even though the uninsured are diverse demographically, some patterns do emerge.

The uninsured are also unexpectedly diverse economically. More than 9 percent live in households that earn \$75,000 or more annually, and 25 percent live in households that earn at least \$50,000.²³ Sixty-nine percent were employed during the year²⁴—although many work part-time, for themselves, in temporary jobs, or for employers that do not offer insurance.²⁵ But again, patterns emerge. Most of the uninsured have low or very low incomes, below or near the poverty line.²⁶ Therefore, although the uninsured are demographically and economically diverse, some populations tend to lack insurance more than others.

In addition to the fifty million uninsured, another twenty-five million are “underinsured” because they bear out-of-pocket expenses and cost-sharing obligations that are excessive relative to their incomes.²⁷ This population is also rising, partly reflecting the trend of insurers pushing costs onto the insured.²⁸ Together, the un- and underinsured total nearly seventy-five million—roughly 42 percent of the U.S. adult population.²⁹ Thus, a surprisingly large number of U.S. residents must rely on so-called “safety net” programs that offer free or very low-cost care.³⁰

Further complicating this picture, immigrants access care in complex ways, caught in the hydraulics between perhaps our two most dysfunctional systems, immigration and health care.³¹ Both unauthorized and authorized immigrants struggle to access care. Many are not offered health insurance

22. *See id.*

23. *See id.*

24. *See id.*

25. Jost, *supra* note 15, at 540–41.

26. *Id.* at 541; DENAVAS-WALT, PROCTOR & SMITH, *supra* note 4, at 23 tbl.8.

27. Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, 27 HEALTH AFF. w298, w298–99 (June 10, 2008), <http://content.healthaffairs.org/content/27/4/w298.full.pdf>.

28. *Id.* at w298.

29. *Id.* at w301 (exhibit 1) (noting that out of 177 million U.S. adults, roughly 74.7 million either lacked insurance or were underinsured during the year 2007).

30. These patients tend to be some of the most vulnerable. A disproportionate number of the chronically ill, the mentally ill, the disabled, substance abusers, and those with communicable diseases rely on “safety net programs,” defined as “providers that organize and deliver a significant level of health care . . . to uninsured, Medicaid, and other vulnerable patients.” INST. OF MED., *AMERICA’S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED* 3, 49–54, 180–98 (Marion Ein Lewin & Stuart Altman eds., 2000). Other vulnerable populations, such as the elderly, low-income children, and pregnant women, also tend to rely on the safety net. Raymond J. Baxter & Robert E. Mechanic, *The Status of Local Health Care Safety Nets*, 16 HEALTH AFF. 7, 9 (1997).

31. *See* Deborah Sontag, *Deported, by U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, at A1.

because they work part-time jobs or for industries or smaller companies that tend not to offer any.³² Others are reluctant to buy insurance because of their immigration status, or because they simply cannot afford it.³³ And a growing proportion of immigrants are undocumented, uninsured, or both.³⁴ Unsurprisingly, immigrants tend to rely on safety net providers more than nonimmigrants,³⁵ and the demand for free or discounted care tends to be higher in areas with large immigrant populations.³⁶ Immigrants also tend to reside in medically underserved areas for which providers in Mexico or other countries might be more accessible, economically if not also geographically.³⁷

Some of these difficulties derive from benign neglect, but some reflect official policy. In 1996, Congress sharply limited immigrant access to Medicaid and most other public health benefits by making unauthorized “aliens” completely ineligible, and by requiring five- or even ten-year waiting periods for “qualified aliens.”³⁸ Therefore, Congress has exacerbated the problem and even cut new holes in our health care system for many immigrants. Given these gaps, it is not surprising that foreign providers have emerged as an alternate source of care.

B. WHO WILL REMAIN UNINSURED AFTER HEALTH REFORM?

Over the next decade, the landmark Affordable Care Act is predicted to reduce the number of uninsured from fifty-four million to twenty-three

32. See Laura Sullivan, *Latinos in California and Texas and Access to Health Care*, in CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS 1, 7 (Policy Research Project on Cross-Border Health Ins. ed., 2004), available at http://www.utexas.edu/lbj/chasp/publications/downloads/Cross_Border_Health_Insurance.pdf (focusing on the Latino immigrant population).

33. *Id.* See also Laws, *supra* note 12, at 271 (“A large percentage of border residents and migrants live at or below the poverty level, are uninsured, and lack access to health care providers.”).

34. Marion E. Lewin & Raymond J. Baxter, *America’s Health Care Safety Net: Revisiting the 2000 IOM Report*, 26 HEALTH AFF. 1490, 1491 (2007).

35. INST. OF MED., *supra* note 30, at 49–51.

36. Baxter & Mechanic, *supra* note 30, at 13.

37. See Sullivan, *supra* note 32, at 4 (noting, for example, that Southern California is a key destination for Mexican immigrants to California).

38. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, §§ 401–404, 110 Stat. 2105, 2261–67 (codified as amended at 8 U.S.C. §§ 1611–1614 (2006)). This Act prohibits unauthorized “aliens” from enrolling in Medicaid and other public benefit programs, and created a five-year waiting period for “qualified aliens.” *Id.* Those who must file an affidavit of support agreeing that the applicant will not become a public charge must wait ten years to qualify. *Id.* § 421, 110 Stat. at 2270 (codified as amended at 8 U.S.C. § 1631). Note also that states and cities may use their own money to care for unauthorized aliens beyond what is allowed by Medicaid, as California and New York City do. See Richard Wolf, *Rising Health Care Costs Put Focus on Illegal Immigrants*, USA TODAY, Jan. 21, 2008, http://www.usatoday.com/news/washington/2008-01-21-immigrant-healthcare_N.htm.

million, “about one-third of whom would be unauthorized immigrants.”³⁹ Yet over the next four years—before several major provisions take effect in 2014—roughly fifty million U.S. residents will remain uninsured,⁴⁰ and potentially more given the prolonged recession and lingering high unemployment. As I demonstrate below, cross-border insurance might be a surprisingly feasible alternative for some of the uninsured.

So who will remain uninsured? That is, who will not be among the estimated thirty-two million that will obtain coverage after health reform’s medley of mandates, subsidies, tax credits, public program expansions, and insurance market reforms take effect? It may be helpful to describe who stands to benefit from health reform before describing the residuum. Those who should benefit from reform are primarily those who will be required to obtain health insurance under the controversial new personal mandate.⁴¹ Most of the Act’s provisions are designed to make insurance more affordable to this population who, beginning in 2014, must either purchase insurance or pay a tax penalty.⁴² This population will access insurance in a number of ways under the Act.

First, around twenty-four million residents are expected to purchase individual policies via new state-created health benefit “exchanges.”⁴³ These exchanges are designed to provide a competitive insurance marketplace for individuals who are not offered employer-sponsored insurance and are not eligible for public programs like Medicaid.⁴⁴ The Act is designed to liberate and stimulate the individual insurance market, notorious for being more expensive and less generous with benefits than group plans.⁴⁵ The Act, however, does not require states to establish these exchanges until 2014.⁴⁶ Moreover, the Act expressly limits access to the exchanges to “citizens and lawful residents”; those who do not fall into either category “may not be covered.”⁴⁷ Thus, unauthorized immigrants may not purchase insurance in the new exchanges, even without the benefit

39. CBO Letter, *supra* note 3, at 9, app. tbl.4.

40. *Id.* at app. tbl.4.

41. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501, 124 Stat. 119, 242–49 (2010) (to be codified at 42 U.S.C. § 18091).

42. *Id.* § 1501(b), 24 Stat. at 242.

43. CBO Letter, *supra* note 3, at 9.

44. Patient Protection and Affordable Care Act §§ 1311–1324, 124 Stat. at 173–99. Policies offered in the exchanges must meet criteria for a “qualified health plan” and provide an essential benefits package. *Id.* §§ 1301–1302, 124 Stat. at 162–68.

45. Roland McDevitt et al., *Group Insurance: A Better Deal for Most People Than Individual Plans*, 29 HEALTH AFF. 156, 162–63 (2010).

46. Patient Protection and Affordable Care Act § 1311(b)(1), 124 Stat. at 173.

47. *Id.* § 1312(f), 124 Stat. at 183–84.

of federal subsidies or tax credits.

Second, the Act significantly expands eligibility for Medicaid and the State Children's Health Insurance Program ("CHIP").⁴⁸ Without reform, Medicaid and CHIP enrollment was expected to drop from forty million to thirty-five million by 2019.⁴⁹ But after reform, enrollment is expected to rise to fifty-six million.⁵⁰ Beginning in 2014, the Act expands eligibility to those with incomes up to 133 percent of the federal poverty line given their household's size, and determines eligibility primarily by income.⁵¹ Currently, states set income eligibility requirements that are markedly lower, and attach several nonincome criteria that significantly limit eligibility largely to "children and some parents, pregnant women, those who are permanently and totally disabled, and the elderly."⁵² Thus, until 2014, Medicaid will continue to cover less than half of those with incomes at or below the poverty line.⁵³ The new law seeks to cover substantially more than that—turning Medicaid into a genuine insurance program for the poor. But again, unauthorized immigrants are not eligible for Medicaid and CHIP, and even many authorized immigrants must wait several years to become eligible.⁵⁴

Third, the Act will increase access to private, employer-sponsored insurance for some and reduce it for others. Over the next decade, employers are projected to cover an additional six to seven million who would not be covered under current law because the individual mandate will increase employee demand for coverage.⁵⁵ But at the same time, between eight and nine million are predicted to lose coverage from employers who elect to pay a fee rather than offer coverage—primarily "smaller employers and employers that predominantly employ lower-wage workers."⁵⁶ Moreover, between one and two million who currently have employer-sponsored insurance would likely purchase individual policies in the state exchanges, although they generally would be ineligible for cost-sharing subsidies.⁵⁷ Thus, the net number of people insured through their

48. See *infra* note 110 and accompanying text.

49. CBO Letter, *supra* note 3, at 9, app. tbl.4.

50. *Id.*

51. Patient Protection and Affordable Care Act § 2001, 124 Stat. at 271–79.

52. Sidney D. Watson, *Commercialization of Medicaid*, 45 ST. LOUIS U. L.J. 53, 57 (2001). See also KAISER FAMILY FOUND., KAISER COMM'N ON MEDICAID AND THE UNINSURED 1–2 (2011), available at <http://www.kff.org/medicaid/upload/7993-02.pdf>.

53. Watson, *supra* note 52, at 57 & n.26.

54. See *supra* note 38 and accompanying text.

55. CBO Letter, *supra* note 3, at 10, app. tbl.4.

56. *Id.* at 10.

57. *Id.*

employers in 2019 is expected to be about three million less than it is now.⁵⁸ Overall, the effect on access to private, employer-sponsored insurance is hard to predict. But many smaller employers and those who tend to employ lower-wage employees are predicted to drop coverage,⁵⁹ which affects certain populations more than others.

Finally, the Act creates alternatives to the controversial “public option” that drafters excised during the legislative process.⁶⁰ For example, the Act creates local, member-run, nonprofit insurance “cooperatives” that are intended to compete with private plans in the new exchanges.⁶¹ Likewise, the Act allows the U.S. Office of Personnel Management to contract with insurers to offer multistate plans in each exchange.⁶² There is considerable speculation whether these will serve as meaningful alternatives that will force private insurers to offer better policies at lower prices. But what is not speculative is that these will not be alternatives available to unauthorized immigrants.⁶³

Indeed, Congress took pains to clarify that health reform will not help those who are not lawfully present. In short, the Affordable Care Act explicitly prohibits those who are not “lawfully present” from (1) accessing temporary high-risk pools for those with preexisting conditions,⁶⁴ (2) enrolling in special state-created plans for low-income individuals not eligible for Medicaid;⁶⁵ (3) enrolling in new health care cooperatives;⁶⁶ (4) receiving cost-sharing subsidies or premium tax credits to purchase health insurance;⁶⁷ and (5) purchasing policies in the newly created exchanges, even without the benefit of government subsidies or credits.⁶⁸

58. *Id.*

59. *See id.*

60. The House legislation contained a government-run “public health insurance option.” Affordable Health Care for America Act, H.R. 3962, 111th Cong. §§ 321–331 (2009). The public option was not included in the Senate bill (H.R. 3590) and was not a part of the final health reform legislation.

61. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1322, 124 Stat. 119, 187–92 (2010) (referring to the Consumer Operated and Oriented Plan, or “CO-OP”).

62. *Id.* §§ 1334, 10104(q), 124 Stat. at 902–06.

63. *Id.* § 1312(f)(3), 124 Stat. at 184. Even if Congress had passed a public option, the likelihood is close to nil that it would have been available to unauthorized immigrants.

64. *Id.* § 1101(d)(3), 124 Stat. at 142.

65. *Id.* § 1331(e)(1)(A)–(B), 124 Stat. at 202–03.

66. *Id.* § 1322, 124 Stat. at 187–92.

67. *See, e.g., id.* § 1401, 124 Stat. at 213–20 (amending I.R.C. § 36B(c)(1)(B) (2006), limiting tax credits to aliens lawfully present); *id.* § 1402(e)(1)(A), 124 Stat. at 223 (stating that no cost-sharing reductions shall apply to individuals not lawfully present); *id.* § 1412(d), 124 Stat. at 233 (“Nothing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.”).

68. *Id.* § 1312(f)(3), 124 Stat. at 184. Note that those not lawfully present are generally exempt

Although critics claim these requirements will not be enforced, the Act specifically calls for the U.S. Department of Health and Human Services (“HHS”) to determine whether individuals are “eligible,” which includes ascertaining whether they are lawfully present.⁶⁹ Exchange applicants must provide information about their citizenship or immigration status,⁷⁰ which will be verified by the Department of Homeland Security and cross-checked against other agency databases.⁷¹

Congress was much more charitable toward immigrants who are lawfully present. Health reform treats the lawfully present similarly to U.S. citizens and nationals, in that they generally are subject to the individual mandate,⁷² eligible to purchase plans in the exchanges,⁷³ and eligible to receive premium tax credits and cost-sharing subsidies.⁷⁴ The Medicaid gap, however, largely remains for authorized immigrants. Reform did not alter the immigration-related eligibility rules for means-tested programs like Medicaid, so lawfully present immigrants that are required to maintain insurance under the new personal mandate still might not be eligible for Medicaid for five years or longer.

To partially compensate, the new law makes two special accommodations. First, “aliens lawfully present” who have incomes below 100% of the federal poverty line, but who are not eligible for Medicaid in their state “by reason of such alien status,” may enroll in alternative plans created by states to cover low-income individuals who also are not eligible for Medicaid.⁷⁵ Second, such aliens are also eligible to receive premium tax credits and cost-sharing subsidies at levels equivalent to those who have incomes equal to 100% of the federal poverty line.⁷⁶ So legal immigrants not eligible for Medicaid whose household incomes are below 100% of the poverty line generally will have their premiums capped at 2% of their income pursuant to the tax credit, and will have out-of-pocket cost-sharing

from the individual insurance mandate, *id.* § 1501, 124 Stat. at 242–49 (amending I.R.C. § 5000A(d)(3)), although other classes of immigrants are not, *see* RUTH ELLEN WASEM, CONG. RESEARCH SERV., R40889, NONCITIZEN ELIGIBILITY AND VERIFICATION ISSUES IN THE HEALTH CARE REFORM LEGISLATION 3 tbl.1 (2010).

69. Patient Protection and Affordable Care Act § 1411, 124 Stat. at 224–31.

70. *Id.* § 1411(b)(2), 124 Stat. at 224.

71. *Id.* § 1411(c)(2), 124 Stat. at 226.

72. *Id.* § 1501(b), 124 Stat. at 244–49.

73. *Id.* § 1312(f)(3), 124 Stat. at 184; *id.* § 1411, 124 Stat. at 224–31.

74. *Id.* § 1401, 124 Stat. at 213–20 (amending I.R.C. § 36B(e)(2) (2006)); *id.* § 1402(e)(2), 124 Stat. at 220–23.

75. *Id.* § 1401(c)(1)(B), 124 Stat. at 215–16.

76. *Id.* § 1401(c)(1)(B)(ii), 124 Stat. at 216.

subsidized by two-thirds.⁷⁷ But insurance may still be too expensive even with these credits and subsidies. And immigrants above 100% but below 133% of the federal poverty line will qualify for cost-sharing subsidies but not tax credits, because tax credits begin at 133% of the federal poverty line⁷⁸—a possibly unintended gap.

In sum, of the twenty-three million who will remain uninsured in ten years, some will simply fall through the cracks, and others (particularly unauthorized immigrants) will remain uninsured as a matter of design. Although unauthorized immigrants are not subject to the new personal mandate,⁷⁹ neither do they benefit from reforms designed to make insurance more accessible to those who are. Moreover, until 2014—before the mandates, exchanges, and Medicaid expansions take effect—roughly fifty million U.S. residents will remain uninsured, and possibly more given lingering high unemployment during this prolonged recession.

C. HOW DO THE UNINSURED ACCESS CARE?

To understand how foreign providers have become an alternate source of care, we must first understand how the un- and underinsured access care in the United States. Those without adequate insurance generally rely on our health care safety net, loosely defined as “providers that organize and deliver a significant level of health care . . . to uninsured, Medicaid, and other vulnerable patients.”⁸⁰

The core safety net consists of public and nonprofit providers that care for patients regardless of their ability to pay—either because the providers are legally required or have made it their mission to do so.⁸¹ For example, roughly one thousand federally funded community health centers care for medically underserved populations like the homeless, public housing residents, and migrant workers;⁸² around 1300 public hospitals offer more

77. *Id.* § 1401, 124 Stat. at 213–20 (amending I.R.C. § 36B(b)(3)(A)); *id.* § 1402(c)(1), 124 Stat. at 221.

78. *Id.* § 1401, 124 Stat. at 213–20. Generally, the sliding scales for tax credits begin at 133 percent of the poverty line, assuming those below it will enroll in Medicaid under the new income criteria.

79. *Id.* § 1501(b), 124 Stat. at 244–49 adds Section 5000A(d)(3) to the Internal Revenue Code, which defines “applicable individuals” who are required to “maintain minimum essential coverage” as excluding “individuals not lawfully present.”

80. INST. OF MED., *supra* note 30, at 3. *See also* Bruce Siegel, Marsha Regenstien & Peter Shin, *Health Reform and the Safety Net: Big Opportunities; Major Risks*, 32 J.L. MED. & ETHICS 426, 426 (2004).

81. INST. OF MED., *supra* note 30, at 3–4.

82. Stephen L. Isaacs & Paul Jellinek, *Is There a (Volunteer) Doctor in the House? Free Clinics*

specialized treatments, particularly in large urban areas;⁸³ academic hospitals and affiliated medical schools also provide specialized care for a large volume of indigent patients;⁸⁴ and 3000 local health departments care for vulnerable patients, particularly those with special health needs.⁸⁵ Another layer of specialty providers—free clinics, family planning centers, and school-based programs—crop up periodically to fill holes left by the larger safety net programs.⁸⁶

This public and nonprofit core is flanked by an even more scattered periphery of private providers. For example, private practitioners offer a substantial proportion of medical care to the uninsured in some communities, and emerging local referral networks send uninsured patients from community health centers and clinics to private specialists that treat them for free.⁸⁷ Pharmaceutical companies have long been a source of free and discounted drugs for low-income patients by distributing free samples, and more recently by operating patient assistance programs.⁸⁸ Retail clinics like Wal-Mart and Walgreen have emerged as a unique alternative for the un- and underinsured because they satisfy a growing demand for immediately accessible low-cost care, accepting only out-of-pocket payments rather than insurance reimbursement.⁸⁹ Thus, the private sector

and Volunteer Physician Referral Networks in the United States, 26 HEALTH AFF. 871, 872 (2007); Siegel, Regenstein & Shin, *supra* note 80, at 426–27. See also 42 U.S.C. § 254b (2006).

83. INST. OF MED., *supra* note 30, at 4, 55–59; Randall R. Bovbjerg & Frank C. Ullman, *Health Insurance and Health Access: Reengineering Local Safety Nets*, 22 J. LEGAL MED. 247, 251–52 (2001); Isaacs & Jellinek, *supra* note 82, at 872; Siegel, Regenstein & Shin, *supra* note 80, at 427.

84. Baxter & Mechanic, *supra* note 30, at 20. Note that some remain uneasy with indigent patients bearing the brunt of physician training at these facilities. See, e.g., ATUL GAWANDE, *COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE* 31–33 (2002).

85. INST. OF MED., *supra* note 30, at 4, 63–65; Isaacs & Jellinek, *supra* note 82, at 872.

86. INST. OF MED., *supra* note 30, at 4, 69; Lawrence D. Brown, *The Amazing Noncollapsing U.S. Health Care System—Is Reform Finally at Hand?*, 358 NEW ENG. J. MED. 325, 325 (2008); Isaacs & Jellinek, *supra* note 82, at 872.

87. INST. OF MED., *supra* note 30, at 6, 67–68. Between 1996 and 2005, the number of private physicians providing charity care dropped from 76 percent to 68 percent despite growing demand. Isaacs & Jellinek, *supra* note 82, at 871. The Institute of Medicine also found that “physicians have been increasingly less willing to treat uninsured patients.” Lewin & Baxter, *supra* note 34, at 1492. Such care remains an underappreciated part of the safety net, as roughly four out of five uninsured or Medicaid patients receive primary care in a physician’s office. Thus, almost any decline in physicians providing charity care represents a genuine decrease in the overall quantity of safety net services available. Isaacs & Jellinek, *supra* note 82, at 871–72.

88. Publication of OIG Special Advisory Bulletin on Patient Assistance Programs for Medicare Part D Enrollees, 70 Fed. Reg. 70,623, 70,624 (Nov. 22, 2005). In 2004, the pharmaceutical industry gave away \$16.4 billion worth of free drug samples. Sarah L. Cutrona et al., *Characteristics of Recipients of Free Prescription Drug Samples: A Nationally Representative Analysis*, 98 AM. J. PUB. HEALTH 284, 284 (2008). Observers note, however, that few samples flow to low-income patients, concluding that “free drug samples serve as a marketing tool, not as a safety net.” *Id.* at 284.

89. See William M. Sage, *Might the Fact that 90% of Americans Live Within 15 Miles of a Wal-*

also provides a range of basic and specialty care to those without adequate insurance.

Finally, emergency departments serve as a true provider of last resort. Federal law requires them to screen all patients and stabilize those with emergent conditions.⁹⁰ Because emergency departments cannot turn away patients, they “are the only providers who offer immediate care for the full range of medical and surgical conditions to any individual, of any age, regardless of his or her ability to pay.”⁹¹ Therefore, emergency care may be “the only type of health care to which access is guaranteed by law in this country”⁹² and the closest thing to a national health care entitlement that we have.⁹³

Together, this loose constellation of public, nonprofit, and private safety net providers cares for the un- and underinsured. But this safety net is weak and vulnerable, leaving gaps that foreign providers increasingly fill.

Our domestic safety net is severely fragmented and lacks any

Mart Help Achieve Universal Health Care?, 55 KAN. L. REV. 1233 (2007). In 2009, the Walgreen pharmacy chain announced that it would offer free clinic services to unemployed and uninsured customers until the end of the year. Walgreen runs 341 clinics around the country that provide a range of primary care, as well as services that uninsured patients might otherwise seek from emergency rooms or urgent care centers. Walgreen reports that the clinics treated 1.2 million patients between November 2005 and May 2007, 30 percent of whom were uninsured. *Walgreen Giving Free Care to Jobless and Uninsured*, ASSOCIATED PRESS, Mar. 31, 2009.

90. Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2006). EMTALA requires emergency departments to stabilize patients regardless of their immigration status. To some, EMTALA encourages immigration to the United States by offering a public benefit. ALISON M. SISKIN, CONG. RESEARCH SERV., RL 31630, FEDERAL FUNDING FOR UNAUTHORIZED ALIENS’ EMERGENCY MEDICAL EXPENSES 13 (2004), available at <http://www.policyarchive.org/handle/10207/bitstreams/1544.pdf>. To others, it creates a perverse financial anomaly in which hospitals can obtain federal funds for providing expensive emergency care but not routine preventative care. Morgan Greenspon, *The Emergency Medical Treatment and Active Labor Act and Sources of Funding*, 17 ANNALS HEALTH L. 309, 312–13 (2008) (noting, for example, that EMTALA reimburses emergency labor but not prenatal care). Although EMTALA applies only to hospitals that receive Medicare funding, hospitals generally must accept Medicare and state-sponsored health insurance to survive, and thus, it applies to virtually all hospitals with emergency departments. *Id.* at 311–12.

91. Lynne D. Richardson & Ula Hwang, *America’s Health Care Safety Net: Intact or Unraveling?*, 8 ACAD. EMERGENCY MED. 1056, 1057 (2001). See also Siegel, Regenstein & Shin, *supra* note 80, at 427.

92. Richardson & Hwang, *supra* note 91, at 1056. Note, however, that some states require local governments to provide health care to indigent residents. For example, Texas counties must provide at least basic care to indigent residents. TEX. HEALTH & SAFETY CODE ANN. § 61.022 (West 2010); CAROL KEETON STRAYHORN, OFFICE OF THE TEX. COMPTROLLER, UNDOCUMENTED IMMIGRANTS IN TEXAS: A FINANCIAL ANALYSIS OF THE IMPACT TO THE STATE BUDGET AND ECONOMY 10 (2006), available at <http://www.window.state.tx.us/specialrpt/undocumented/undocumented.pdf>.

93. Bovbjerg & Ullman, *supra* note 83, at 251–52.

discernible organization, due partly to multiple sources of financing and partly to the reality that providers are part of the safety net “typically [as] a matter of mission and location rather than legal obligation.”⁹⁴ Although some laws require some providers to offer uncompensated care (usually as a matter of tax, nonprofit, or emergency medical law), there is no general legal obligation to do so.⁹⁵ Moreover, no single entity is responsible for overseeing or coordinating safety net care.

A correlated problem is that our safety net is financially vulnerable. Most safety net providers rely on a multitude of funding sources that come and go. Medicaid—the largest means-tested health care program in the United States—constitutes the “financial underpinning of the safety net.”⁹⁶ But safety net providers also rely to varying degrees on funding from Medicaid, federal and state grants and subsidies, and a wide array of private charity.⁹⁷ Shortfalls in any one source can threaten a provider’s financial viability. And some providers seem virtually destined to go bankrupt. For example, public hospitals often “treat Medicaid and Medicare patients for less than cost; provide trauma units and AIDS clinics that consistently lose money; and provide medical care to the uninsured, often for free.”⁹⁸ Not surprisingly, many public hospitals report net operating losses.⁹⁹ Indeed, the Institute of Medicine found that safety net providers of all kinds struggle financially.¹⁰⁰

Finally, our safety net is also highly localized, varying dramatically depending on each community’s unique local circumstances and blend of funding.¹⁰¹ Care itself is provided locally by public hospitals, academic medical centers, community clinics, and office-based physicians.¹⁰² And while federal and state programs focus on their own beneficiaries, cities and counties that run public hospitals are left to deal with the remainder.¹⁰³

94. *Id.* at 252 (internal punctuation omitted).

95. *Id.*

96. INST. OF MED., *supra* note 30, at 5.

97. Siegel, Regenstein & Shin, *supra* note 80, at 427.

98. Stuart H. Altman, David Shactman & Efrat Eilat, *Could U.S. Hospitals Go The Way of U.S. Airlines?*, 25 HEALTH AFF. 11, 11, 20–21 n.1 (2006) (including not only public hospitals, but also profit and not-for-profit hospitals).

99. Amy Yarbrough Landry & Robert J. Landry III, *Factors Associated with Hospital Bankruptcies: A Political and Economic Framework*, 54 J. HEALTHCARE MGMT. 252, 253 (2009) (noting that forty-two acute care hospitals filed for bankruptcy between 2000 and 2006); Lewin & Baxter, *supra* note 34, at 1491.

100. Lewin & Baxter, *supra* note 34, at 1491.

101. Baxter & Mechanic, *supra* note 30, at 12; Brown, *supra* note 86, at 325; Siegel, Regenstein & Shin, *supra* note 80, at 426.

102. Bovbjerg & Ullman, *supra* note 83, at 247–48.

103. *Id.* at 256–57.

Moreover, the financial viability of local safety net providers is determined not only by the number of un- and underinsured that demand care, but also by the number of insureds that can cross-subsidize this care.¹⁰⁴ Thus, the safety net in southern Texas might look very different from the safety net in northern Minnesota.¹⁰⁵ Fortunately, some well-functioning local safety nets have proven to be cost-effective alternatives to universal insurance coverage in various localities.¹⁰⁶ But not everyone is lucky enough to live in such an area.

In many ways, the safety net's defining traits—fragmentation and local variation—reflect our broader health care system.¹⁰⁷ Like our safety net, our health care system is highly fragmented.¹⁰⁸ In fact, much like our health care system, calling our safety net a “system” is being charitable—some more accurately describe it as a “nonsystem” or an “incoherent pastiche.”¹⁰⁹ Moreover, when holes in the safety net appear, we try to patch them by creating even more programs, only adding to the fragmentation.¹¹⁰ This patching and repatching helps explain how foreign providers have become a necessary safety valve. The un- and underinsured simply cannot always rely on domestic safety net providers, and some have begun to look elsewhere.

III. THE NEW GEOGRAPHY OF HEALTH CARE

Foreign medical providers have become a safety valve for three major constituents of the U.S. health care system: patients, insurers, and hospitals.

104. *Id.* at 252–53.

105. *Id.* at 253 (comparing safety net providers in Texas, where 26 percent are uninsured, to those in Minnesota, where 8 percent are uninsured).

106. Mark Hall has studied how some local safety nets are serving as cost-effective alternatives to universal insurance coverage. *See, e.g.*, MARK A. HALL, ROBERT WOOD JOHNSON FOUND., THE COSTS AND ADEQUACY OF SAFETY NET ACCESS FOR THE UNINSURED (2010), available at <http://www.rwjf.org/healthpolicy/product.jsp?id=49869> (reporting on the health care safety nets in San Antonio, Texas; Denver, Colorado; Boston, Massachusetts; Asheville, North Carolina; Flint, Michigan; Exeter and Portsmouth, New Hampshire; and South Coastal Maine); Hall, *supra* note 13, at 9.

107. Indeed, some view our safety net as one part of a tripartite health care system, along with the public and private sectors. George J. Annas, *Health Care Reform in America: Beyond Ideology*, 5 *IND. HEALTH L. REV.* 441, 448 (2008).

108. Brown, *supra* note 86, at 326. *See also* THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (Einer R. Elhauge ed., 2010) (discussing the meaning, causes, and solutions to this fragmentation).

109. Brown, *supra* note 86, at 325.

110. For example, when it became apparent that many families with children were uninsured and did not qualify for Medicaid, Congress created CHIP. State Children's Health Insurance Program, 42 U.S.C. §§ 1397aa–jj (2006), added by Balanced Budget Act of 1997, Pub. L. No. 103-33, §§ 4901–4923, 111 Stat. 251, 552–75.

Together, their reliance on foreign providers is not only a symptom of what ails our health care system, but also may be a potential solution.

A. PATIENT MOBILITY

In the last few years, providers in a dozen or so low- and middle-income countries have become alternatives for some U.S. patients by offering medical care of comparable quality for a fraction of the U.S. price—usually 50–90 percent less than what U.S. counterparts charge.¹¹¹ Hospitals in countries like India, Thailand, and Mexico have become a valid option for Western patients with varied backgrounds, financial means, and medical needs.¹¹² For example, in one of the earliest and most publicized cases, a medical tourist testified at a 2006 Senate hearing that a patient she traveled with spent \$6700 for life-prolonging heart surgery in India because U.S. providers would have charged the patient anywhere from \$50,000 to \$200,000.¹¹³ Similar stories abound.¹¹⁴ In 2006, two economists demonstrated that patients could save considerable amounts by leaving the United States for various procedures, even when factoring in travel expenses.¹¹⁵ Indeed, a burgeoning industry has emerged to connect patients with foreign providers,¹¹⁶ seeking to capture obvious gains from trade.¹¹⁷ Thus, in a relatively short time, foreign providers have become a safety valve for the most expensive health care system in the world.

No one, however, really knows how many patients leave the United States for medical care. Despite several attempts to measure the market and map its trajectory, the data remains frustratingly incomplete and unreliable. Estimates from both industry and foreign government sources seem

111. See, e.g., Aaditya Mattoo & Randeep Rathindran, *How Health Insurance Inhibits Trade in Health Care*, 25 HEALTH AFF. 358, 361 ex..1 (2006).

112. See Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71, 79–82 (2008).

113. *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the Senate Special Committee on Aging*, 109th Cong. 9, 13 (2006) (written statement of Maggi Ann Grace) [hereinafter *Senate Hearing*].

114. A basic search for the phrases “medical tourism” or “medical tourist” in the “All News” database of Westlaw yields 5305 results over the last three years.

115. Mattoo & Rathindran, *supra* note 111, at 359, 361–62.

116. For example, the 4th Annual World Medical Tourism & Global Healthcare Congress is expected to register up to 2000 attendees and up to 140 exhibitors and sponsors. See *Medical Tourism Conference*, MED. TOURISM ASS’N, <http://www.medicaltourismassociation.com/en/medicaltourism-conference.html> (last visited Apr. 22, 2011).

117. Mattoo & Rathindran, *supra* note 111, at 358 (estimating that the United States could save \$1.4 billion per year if only 10 percent of patients seeking one of fifteen medical procedures traveled abroad).

inflated, sometimes wildly so.¹¹⁸ Even two mainstream consulting firms produced radically disparate estimates: McKinsey & Company calculated that only 5000–10,000 Americans leave the country each year for inpatient procedures, while Deloitte calculated that 750,000 U.S. patients traveled overseas in 2007 for both inpatient and outpatient procedures, predicting that by 2010 the number would rise to six million.¹¹⁹ Between these extremes, most indicators point toward an unprecedented migration of U.S. patients.

We also lack reliable data describing who travels and why, making it difficult to ascertain which medical tourists would otherwise rely on domestic safety net programs. But again, emerging evidence suggests that certain populations that rely on safety net providers are also more likely to visit foreign providers, including (1) the un- and underinsured; (2) those with high-deductible and other consumer-directed health plans that impose high cost-sharing obligations (some of whom might be considered to be underinsured as well); and (3) immigrants, including both the authorized and unauthorized.¹²⁰

The un- and underinsured are the most logical candidates to utilize foreign providers because they are more likely than the adequately insured to have sufficient financial incentives and perhaps also be in desperate medical need.¹²¹ The un- and underinsured include several subpopulations that might rely on foreign providers precisely because they have fallen

118. Ian Youngman, *How Many American Medical Tourists Are There?*, INT'L MED. TRAVEL J. (2009), <http://www.imtjonline.com/articles/2009/how-many-americans-go-abroad-for-treatment-30016> (noting that within a two-year period, the estimates of medical tourists ranged from 150,000 to one million). See also Ian Youngman, *Medical Tourism Statistics: Why McKinsey Has Got It Wrong*, INT'L MED. TRAVEL J. (2009), <http://www.imtjonline.com/articles/2009/mckinsey-wrong-medical-travel> [hereinafter Youngman, *Why McKinsey Has Got It Wrong*] (noting that past estimates show “agencies, experts, politicians and hospitals . . . make ludicrous estimates of actual or potential numbers”).

119. Tilman Ehrbeck, Ceani Guevara & Paul D. Mango, *Mapping the Market for Medical Travel*, MCKINSEY Q., May 2008, at 2, 3, 6; DELOITTE CTR. FOR HEALTH SOLUTIONS, MEDICAL TOURISM: CONSUMERS IN SEARCH OF VALUE 4 (2008), [http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_MedicalTourismStudy\(3\).pdf](http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_MedicalTourismStudy(3).pdf). Like other estimates in this field, the McKinsey and Deloitte estimates are flawed. McKinsey's estimate excludes both outpatients and patients traveling in largely “contiguous geographies,” even though outpatients likely constitute a large percentage of medical tourists, and travel within contiguous geographies includes a significant number of patients traveling between the United States, Canada, and Mexico. Youngman, *Why McKinsey Has Got It Wrong*, *supra* note 118. At the same time, Deloitte recently shaved its prediction that five or six million Americans would travel for care in 2010 to 1.6 million people. Tom Murphy, *Health Insurers Explore Savings in Overseas Care*, ASSOCIATED PRESS, Aug. 23, 2009.

120. Note that for purposes of this analysis, I exclude patients traveling overseas for elective cosmetic procedures and those traveling primarily for procedures or technologies not allowed in the United States.

121. See Cohen, *supra* note 16, at 1479–81; Cortez, *supra* note 112, at 81–82.

through the cracks in our domestic safety net. For example, many uninsured patients earn too much to qualify for means-tested programs like Medicaid.¹²² Roughly 80 percent of the uninsured are either employed or live with someone who is,¹²³ and in 2009, approximately 25 percent of the uninsured lived in households that earned more than \$50,000.¹²⁴ Many of these patients either choose not to purchase or cannot afford private insurance, which in 2008 cost the average family \$12,298.¹²⁵ As I note above, health reform will gradually narrow these gaps in coverage but will not completely eliminate them. So foreign providers have become and will remain a viable alternative.

Foreign providers have also become an option for patients who are too young to qualify for Medicare, our public insurance program for those ages sixty-five and older.¹²⁶ Pre-Medicare patients struggle on two fronts: employers are significantly reducing retiree health benefits, and it is often prohibitively expensive for patients approaching Medicare age to purchase quality individual insurance in the private market.¹²⁷ As a result, some have called for Congress to extend Medicare benefits to early retirees,¹²⁸ and the White House recently announced that it would begin subsidizing medical bills for pre-Medicare retirees who rely on employer-sponsored

122. Criteria for Medicaid eligibility are difficult to generalize because, until several provisions in the Affordable Care Act take effect in 2014, each state continues to set its own requirements, and different income and resource limits apply to different beneficiary categories and family sizes. In general, states cap eligibility at a certain percentage of the Federal Poverty Level. For example, the income threshold for a working parent in a family of four in California is 106 percent of the Federal Poverty Level, which translates to an annual income of \$23,373. See *Medicaid Income and Resource Guidelines*, U.S. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.hhs.gov/MedicaidEligibility/07_IncomeandResourceGuidelines.asp (last visited Apr. 20, 2011); *Income Thresholds for Jobless and Working Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL), 2009*, KAISER FAMILY FOUND., <http://www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4> (last visited Apr. 20, 2011). Note that the Affordable Care Act will increase Medicaid eligibility to 133 percent of the Federal Poverty Level beginning in 2014. See *supra* note 78 and accompanying text.

123. Jost, *supra* note 15, at 540.

124. See DENAVAS-WALT, PROCTOR & SMITH, *supra* note 4, at 23 tbl.8.

125. Cathy Schoen, Jennifer L. Nicholson & Sheila D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes*, COMMONWEALTH FUND, Aug. 20, 2009, at 3 fig.1, available at http://www.commonwealthfund.org/~media/Files/Publications/Data%20Brief/2009/Aug/1313_Schoen_paying_the_price_db_v3_resorted_tables.pdf.

126. 42 U.S.C. § 426(a)(1) (2006).

127. See generally Richard L. Kaplan, Nicholas J. Powers & Jordan Zucker, *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL'Y L. & ETHICS 287 (2009) (examining health insurance in retirement, a source of retirement anxiety that has not received as much attention as Social Security).

128. *Id.* at 342–54.

insurance.¹²⁹

Evidence suggests that foreign hospitals often perform surgeries required by older populations, such as knee and hip replacements and various forms of heart surgery.¹³⁰ Moreover, even those covered by Medicare increasingly demand surgery overseas, particularly in Mexico.¹³¹ Thus, foreign providers appeal to precisely those patients that have fallen through the cracks in our safety net, often because the providers tend to offer more expensive and specialized services than those offered by local safety net providers.

Foreign providers have also become attractive to insured patients. Increasingly, insurers are offering “consumer directed health plans” that require patients to bear higher premiums and deductibles, under the theory that patients will better utilize care when spending their own money.¹³² Industry watchers speculate that as more insurers offer such plans—which often require patients to spend upwards of \$5000-\$10,000 out-of-pocket—more patients will try to save money by using foreign providers.¹³³ For example, many patients already travel for dental procedures precisely because dental plans often require high out-of-pocket cost sharing.¹³⁴ Along these lines, insured patients also utilize foreign providers when their domestic policies do not cover certain procedures. Foreign providers are already popular for “dental care and cosmetic surgery because few have health insurance that covers those services.”¹³⁵

Evidence also suggests that U.S. patients are becoming less reluctant to seek care overseas. A 2006 survey showed that 10–35 percent of U.S. residents polled who had a sick family member would be willing to travel

129. Robert Pear, *Some Retirees Will Receive Aid to Pay Health Bills*, N.Y. TIMES, May 4, 2010, at A14.

130. Shawn Rhea, *Still Packing Their Bags; Health Reform Won't Drastically Alter the Economics of Medical Tourism, but Patients and Providers Can Expect New Opportunities, At Home and Abroad*, 39 MOD. HEALTHCARE 28, 29 (2009).

131. LYNDON B. JOHNSON SCH. OF PUB. AFFAIRS, MEDICARE IN MEXICO: INNOVATING FOR FAIRNESS AND COST SAVINGS, Policy Research Project Report No. 156, at 12 (David C. Warner, Project Dir., 2007), available at http://www.utexas.edu/lbj/chasp/publications/downloads/Warner_Medicare_in_Mexico.pdf.

132. See TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 133–38 (2007).

133. Murphy, *supra* note 119; DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 119, at 4–5 (noting that higher cost-sharing and responsibility for managing health savings accounts might encourage discount shopping).

134. Murphy, *supra* note 119 (noting that under a plan offered by BlueCross BlueShield of South Carolina, a patient paid \$2800 for a dental procedure in Costa Rica instead of the \$10,000 it would have cost in the United States).

135. Cohen, *supra* note 16, at 1480 n.45.

overseas for major, nonemergency surgery, depending on how much they could save.¹³⁶ And a 2009 poll of 5050 U.S. adults showed that 29 percent would consider going abroad for a “major medical problem,” with the percentage rising to 40 percent assuming “equal quality and significantly cheaper cost.”¹³⁷

Finally, immigrants living in the United States increasingly rely on foreign providers, particularly those in Mexico, Costa Rica, and other Latin American countries.¹³⁸ Researchers estimate that, during one year, 952,000 California residents traveled to Mexico for medical care, dental care, or prescription drugs, roughly half of whom were Mexican immigrants.¹³⁹ Providers in Mexico have long attracted U.S. residents,¹⁴⁰ not only because they offer an economical alternative for uninsured, low-income populations, and patients who prefer Spanish-speaking providers,¹⁴¹ but also because they are much closer to the United States than providers in Asia.¹⁴²

Foreign providers often fill a unique gap in our safety net. Most of the

136. Arnold Milstein & Mark Smith, *Will the Surgical World Become Flat?*, 26 HEALTH AFF. 137, 138–40 (2007). The survey posed the following question to 148 households with “sicker” family members:

How much savings do you think would cause the sicker person (in your household) to agree to obtain major, nonemergency surgery at a very good hospital outside the United States (for example, in Thailand, India, or Mexico) by a good surgeon who was trained in the United States, England, or Canada and speaks English or the patient’s language?

Id. at 140.

137. Christopher Khoury, *Americans Consider Crossing Borders for Medical Care*, GALLUP (May 18, 2009), <http://www.gallup.com/poll/118423/americans-consider-crossing-borders-medical-care.aspx>. Unsurprisingly, Gallup found that respondents lacking health insurance were more willing to travel overseas than those with insurance. *Id.*

138. Ian Youngman, *Where Do American Medical Tourists Go Abroad for Treatment?*, INT’L MED. TRAVEL J. (2009), <http://www.imtjonline.com/articles/2009/where-do-americans-go-abroad>.

139. Steven P. Wallace, Carolyn Mendez-Luck & Xóchitl Castañeda, *Heading South: Why Mexican Immigrants in California Seek Health Services in Mexico*, 47 MED. CARE 662, 662 (2009) (using California Health Interview Survey data from 2001).

140. MILICA Z. BOOKMAN & KARLA R. BOOKMAN, MEDICAL TOURISM IN DEVELOPING COUNTRIES 49 (2007); Núria Homedes & Antonio Ugalde, *Globalization and Health at the United States-Mexico Border*, 93 AM. J. PUB. HEALTH 2016, 2016–17 (2003); Alfredo Corchado & Laurence Iliff, *Good Care, Low Prices Lure Patients to Mexico*, DALLAS MORNING NEWS, July 28, 2007, at 1A (describing the emerging trend of U.S. residents traveling to Mexico for medical services).

141. Cortez, *supra* note 112, at 101; MARISSA PAULA WALKER & ROBERT GUERRERO, ARIZONA-MEXICO COMM’N, CROSS-BORDER HEALTH INSURANCE INITIATIVES IN CALIFORNIA, TEXAS AND ARIZONA 5, 8 (2003), available at <http://econdev.web.arizona.edu/pubs/az-mexico/pubs/Cross-Border Insurance.pdf>.

142. See BOOKMAN & BOOKMAN, *supra* note 140, at 58 (noting that proximity is an important factor for elderly and ill patients traveling from the United States and Canada to Mexico); Corchado & Iliff, *supra* note 140 (noting that basic surgical procedures are 40 percent less expensive in Mexico than in the United States); Kelly Arthur Garrett, *Prices of Medical Services Are at Least 30% Lower in Mexico than in U.S.*, EL UNIVERSAL (Mex.), Dec. 27, 2004, available at 2004 WLNR 14869899.

un- and underinsured can access at least some level of basic services in the United States, but this population often does not have reliable access to “specialists, inpatient care, high-tech procedures, or a regimen of prescription drugs.”¹⁴³ These are precisely the products and services that patients seek in foreign countries.

B. INSURER OUTSOURCING

Insurers are the second major constituent of our health care system now experimenting with low-cost foreign providers. Employers and third-party insurers of all sizes are garnering national media attention for outsourcing expensive surgeries, adding foreign providers to their networks, or for creating true cross-border plans.¹⁴⁴ These companies seem to be driven by one of two motivations—the need to cut spending and preserve health benefits for existing beneficiaries, or the desire to market new insurance products to populations that cannot afford traditional private insurance.

The four largest commercial insurers in the United States (UnitedHealth, WellPoint, Aetna, and Humana) have either introduced medical tourism pilot programs or are considering it.¹⁴⁵ Moreover, BlueCross BlueShield of South Carolina contracted with a hospital in Bangkok, Thailand to perform certain surgeries,¹⁴⁶ and Cigna published a podcast on the topic.¹⁴⁷

In general, smaller employers and insurers have been even more adventurous experimenting with foreign providers. For example, around two hundred U.S. employers offer a network of foreign providers through BasicPlus Health Insurance, which sells group plans and contracts with

143. Brown, *supra* note 86, at 326.

144. See, e.g., Janet Fullwood, *Booming Trend is Standard Operating Procedure*, MIAMI HERALD, Nov. 2, 2008, at J4 (discussing BlueCross BlueShield of South Carolina); Roni Caryn Rabin, *Insurer Offers Option for Surgery in India*, N.Y. TIMES (Nov. 21, 2008), <http://www.nytimes.com/2008/11/21/health/21abroad.html> (discussing Wellpoint).

145. Murphy, *supra* note 119; *Fortune 500 2010: Industry: Health Care: Insurance and Managed Care*, FORTUNE, May 3, 2010, available at <http://money.cnn.com/magazines/fortune/fortune500/2010/industries/223/index.html>.

146. *BlueCross BlueShield and BlueChoice HealthPlan Pioneer Global Healthcare Alternative*, BUS. WIRE, Feb. 8, 2007, available at <http://www.businesswire.com/news/home/20070208005660/en/BlueCross-BlueShield-BlueChoice-HealthPlan-Pioneer-Global-Healthcare>. BlueCross BlueShield has also negotiated with hospitals in Costa Rica and other countries. Bruce Einhorn, *Medical Travel is Going to Be Part of the Solution*, BLOOMBERG BUS. WK., Mar. 17, 2008, available at http://www.businessweek.com/globalbiz/content/mar2008/gb20080312_835774.htm.

147. *Cigna International Expatriate Benefits Podcast Library, Medical Tourism*, CIGNA, http://cignaexpats.com/producer_resources/podcasts/MedicalTourism.mp3.

medical tourism facilitator Companion Global Healthcare.¹⁴⁸ As of 2006, United Group Programs, a third-party insurance administrator, had contracted to outsource surgeries for at least forty U.S. companies.¹⁴⁹ Blue Ridge Paper Products, a self-insured company in North Carolina, generated national media attention in 2006 when it contracted to send patients to India for certain surgeries.¹⁵⁰ And in 2008, the New England grocery store chain Hannaford Brothers contracted with Aetna to outsource knee and hip surgeries to Singapore, although it has yet to send anyone overseas.¹⁵¹ These smaller insurers have been particularly hard-pressed to cut health expenses, so we might view outsourcing along with high-deductible plans and health savings accounts as one more effort to preserve benefits in an increasingly expensive health care system.

Finally, some insurers are experimenting with true cross-border plans that rely more heavily on foreign providers. For example, health maintenance organizations (“HMOs”) in California like Health Net, Blue Shield, and Mexican-insurer SIMNSA offer plans to California residents willing to be treated in Mexico.¹⁵² These plans generally cost 40–50

148. Ian Youngman, *What Happened to Those 2008 Medical Tourism Forecasts?*, INT’L MED. TRAVEL J. (2009), <http://www.imtjonline.com/articles/2009/what-happened-to-those-2008-medical-tourism-forecasts-30002>; Press Release, Companion Global Healthcare, Inc., Insurance Company Global Network Option in Limited Benefit Plans (June 4, 2008), available at <http://www.companionglobalhealthcare.com/news.aspx?article=36>.

149. Joe Cochrane, *Medical Meccas: Beyond the Beaches*, NEWSWEEK INT’L, Oct. 30, 2006, at 1.

150. *Senate Hearing*, *supra* note 113, at 29–32 (oral testimony of Bonnie Grissom Blackley, Corporate Benefits Director, Blue Ridge Paper Products Inc.). Nevertheless, Blue Ridge Paper Products canceled plans to send one of its employees to India after protests by the United Steelworkers Union. Saritha Rai, *Union Disrupts Plan to Send Ailing Workers to India for Cheaper Medical Care*, N.Y. TIMES, Oct. 11, 2006, at C6.

151. Youngman, *supra* note 148. Some believe Hannaford’s experience is instructive—local providers have responded to price competition from abroad. *Id.* (noting that domestic hospitals are “offering discounted packages to counter the foreign competition”); Nicolas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421, 462 (2007) (“Western insurers and policymakers likely will use the threat of overseas fulfillment as a bargaining tool with domestic health care providers.”). See also H.B. 2841, 78th Leg., Reg. Sess. (W. Va. 2007) (proposing a bill to incentivize public employees in West Virginia to utilize Joint Commission International-accredited hospitals overseas); H.B. 4711, 77th Leg., Reg. Sess. (W. Va. 2006) (same); H.B. 4359, 77th Leg., Reg. Sess. (W. Va. 2006) (same); Kris Wise, *Bill Would Cover Surgeries Outside U.S.*, CHARLESTON DAILY MAIL (W. Va.), Feb. 3, 2006, at 7A.

Indeed, industry watchers are now observing increased “intra-bound” medical tourism within the United States. Joanne Wojcik, *Employers Consider Short-Haul Medical Tourism*, BUS. INS., Aug. 24, 2009, at 1 (noting that some domestic providers charge up to 75 percent less than local prices because they receive compensation up front and negotiate on a case-by-case basis); Ian Youngman, *The Hottest Medical Tourism Location for Americans Traveling for Treatment*, INT’L MED. TRAVEL J. (2009), <http://www.imtjonline.com/articles/2009/location-for-americans-travelling-for-treatment>.

152. Policy Research Project on Cross-Border Health Insurance has published a comprehensive analysis of these plans. CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32. See

percent less than those that utilize U.S. providers only,¹⁵³ and therefore attract immigrants and potentially other populations that might otherwise rely on safety net providers. In Part IV, I argue that we can use precisely this type of cross-border insurance to help cover these populations and patch the holes in our domestic safety net.

C. MEDICAL REPATRIATION

Foreign providers have become a perverse form of safety net for several U.S. hospitals that are sending suspected immigrant patients back to their countries of origin. This phenomenon has been coined “medical repatriation,” but has also been referred to more pejoratively as “international patient dumping” and even “medical rendition.”¹⁵⁴ Media reports suggest that U.S. hospitals repatriate hundreds of suspected immigrants each year to countries like Mexico, Guatemala, China, Lithuania, and Poland.¹⁵⁵

In the typical scenario, an immigrant presents to an emergency room in serious condition.¹⁵⁶ The hospital screens and stabilizes the patient regardless of his or her immigration status, as required by the Emergency Medical Treatment and Active Labor Act (“EMTALA”).¹⁵⁷ Some patients, however, require long-term care that the hospital is not equipped to provide, such as neurological rehabilitation, around-the-clock nursing care, or perhaps simply ongoing kidney dialysis.¹⁵⁸ Thus, the hospital begins searching for a nursing home, rehab center, or other long-term care facility—or even a family member or charity—that is willing to care for the patient.¹⁵⁹ But often no family is present in the United States, and long-term care facilities are usually reluctant to accept uninsured immigrants who do not qualify for Medicaid or other programs that might reimburse at least part of their expenses.¹⁶⁰ Thus, left with potentially massive

also Cortez, *supra* note 112, at 99–100; Ly Tran, Note, *Sick and Tired of the Knox-Keene Act: The Equal Protection Right of Non-Mexican Californians to Enroll in Mexico-Based HMO Plans*, 14 SW. J. L. & TRADE AM. 357, 357–63 (2008).

153. Tran, *supra* note 152, at 358; Sonya Geis, *Passport to Health Care at Lower Cost to Patient; California HMOs Send Some Enrollees to Mexico*, WASH. POST, Nov. 6, 2005, at A03.

154. Sontag, *supra* note 31.

155. *Id.*; Joseph Wolpin, *Medical Repatriation of Alien Patients*, 37 J.L. MED. & ETHICS 152, 152 (2009); Deborah Sontag, *Deported in Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 9, 2008, at A1.

156. Sontag, *supra* note 31; Sontag, *supra* note 155.

157. 42 U.S.C. § 1395dd (2006). See *supra* note 90 for a brief description of EMTALA.

158. Sontag, *supra* note 31.

159. *Id.*

160. Wolpin, *supra* note 155, at 152–53. Note that Medicaid does pay hospitals treating immigrants for emergencies, but does not cover all expenses or extend beyond emergency treatment.

uncompensated expenses, the hospital takes the dramatic step of arranging with a commercial airline service or ambulance to transport the patient back to his or her suspected country of origin.¹⁶¹ The most highly publicized case to date followed precisely this pattern.¹⁶² But its path through the legal system failed to clarify the legal boundaries of this practice and what, if any, legal rights patients or their families might exercise.¹⁶³

As with medical tourism and other cross-border health trends, no government entities track medical repatriation and no federal or state laws seem to address it. Thus, medical repatriation has been incubated in a legal void, outside the purview of regulators or oversight mechanisms that might

Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 allotted \$250 million for treating immigrants, but it expired in 2008. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011, 117 Stat. 2066, 2432 (codified as amended at 42 U.S.C. § 1395dd). Proposed legislation to extend these payments to 2012 has stalled. See Border Health Care Relief Act of 2009, H.R. 1639, 111th Cong. (2009) (referred to the Committee on Energy and Commerce).

161. Sontag, *supra* note 31. California company MexCare helps U.S. hospitals repatriate unfunded Latin American nationals to a “network of over 50 hospitals, dialysis treatment centers, and physicians in Latin America.” *Services, About Us*, MEXCARE, <http://mexcare.com/services-mexcare.html> (last visited Apr. 20, 2011). MexCare calls itself the “‘liaison’ between the American and the Latin American healthcare systems,” *id.* (follow “Procedures” hyperlink), but contracts only with private hospitals in foreign countries, see Press Release, MexCare, The New York Times Gets It Wrong! (Aug. 15, 2008), available at <http://mexcare.com/press-release-mexcare.html>.

162. In 2000, Luis Alberto Jiménez, a gardener from Guatemala, suffered traumatic brain damage while riding in a car struck by a drunk driver in Florida. Jiménez was treated by Martin Memorial Hospital, which spent \$1.5 million caring for him over several years, only \$80,000 of which was reimbursed by Medicaid. Unable to find a rehabilitation center that would accept him, the hospital intervened in his guardianship hearing and obtained a court order allowing the hospital to transfer him to a facility in Guatemala. Jiménez’s guardian appealed the ruling and attempted to stay the transfer. But before the district court could rule on the stay, Martin Memorial spent \$30,000 for an air ambulance and transported Jiménez to Guatemala’s sole public rehabilitation hospital, which does not provide services to rehabilitate traumatic brain injuries. *Montejo ex rel. Jimenez v. Martin Mem’l Med. Ctr., Inc.*, 874 So. 2d 654, 655–57 (Fla. Dist. Ct. App. 2004); Sontag, *supra* note 31.

163. In 2004, a Florida appeals court invalidated the district court’s order, noting that there were Medicare and the hospital’s own discharge rules requiring the hospital to demonstrate that the facility in Guatemala could meet Jiménez’s medical needs, and finding that “there was no substantial competent evidence to support” his discharge. *Montejo*, 874 So. 2d at 657–58. See also 42 C.F.R. § 482.21(b)(2); 59 Fed. Reg. 64,149 (1994). The court also noted that the trial court lacked subject matter jurisdiction to effectively deport Jiménez because only the federal government can order deportations. *Montejo*, 874 So. 2d at 656–58. But by this time, Jiménez had already been transferred from the rehabilitation hospital in Guatemala, and was being cared for in a one-room house by his elderly mother, where he received “no medical care or medication.” Sontag, *supra* note 31. In 2006, the Florida appeals court allowed Jiménez’s guardian to proceed with a claim that transporting Jiménez to Guatemala constituted false imprisonment. *Montejo ex rel. Jimenez v. Martin Mem’l Med. Ctr., Inc.*, 935 So. 2d 1266, 1272 (Fla. Dist. Ct. App. 2006). The jury, however, rejected this claim. Melissa E. Holsman, *Jury Finds for Martin Memorial in Immigrant’s Deportation Case*, TCPALM (July 27, 2009), <http://www.tcpalm.com/news/2009/jul/27/jury-favor-martin-memorial-immigrant-deportation-c>.

protect patients. The practice has generated a slew of controversy, ranging from litigation to media scrutiny to investigations by medical societies.¹⁶⁴ In 2008, the California Medical Association denounced the practice, and the American Medical Association (“AMA”) commissioned a study to examine it.¹⁶⁵ Some call medical repatriation “inhumane” or even a “death sentence.”¹⁶⁶

How did we get here? The cumulative flaws of our health care and immigration systems have combined to create “a *de facto* regulatory framework” in which hospitals find it necessary and even prudent to repatriate immigrant patients.¹⁶⁷ On the health side, EMTALA requires hospitals to provide “appropriate” treatment to emergency patients, and precludes hospitals from transferring them if it would materially deteriorate their condition.¹⁶⁸ Hospitals may only transfer patients to an appropriate facility “that can meet the patient’s medical needs on a post-discharge basis.”¹⁶⁹ The federal government reimburses hospitals for emergency care provided to immigrants, but some of this funding has expired, and even with it, the funding was inadequate.¹⁷⁰ Moreover, federal funding stops once a hospital stabilizes the patient.¹⁷¹ Thus, the federal government does

164. Wolpin, *supra* note 155, at 152–55.

165. California Medical Association House of Delegates, Adopted Res. 105a-08, *Forced Deportation of Patients* (2008); American Medical Association House of Delegates, Proposed Res. 4 (1-08), *Forced Repatriation of Immigrants by Hospitals* 89–95 (2008), available at <http://www.ama-assn.org/ama1/pub/upload/mm/38/i-09-ceja-reports.pdf>.

166. Sontag, *supra* note 31. Other countries are not immune. In the United Kingdom, *The Lancet* called the deportation of a Ghanaian woman who later died of cancer an “atrocious barbarism.” Editorial, *Migrant Health: What Are Doctors’ Leaders Doing?*, 371 LANCET 178, 178 (2008).

167. Wolpin, *supra* note 155, at 152.

168. 42 U.S.C. §§ 1395dd(a), (e)(3)(A) (2006).

169. Medicare and Medicaid Programs; Revisions to Conditions of Participation for Hospitals, 59 Fed. Reg. 64,141, 64,149 (Dec. 13, 1994) (to be codified at 42 C.F.R. pts. 405–82); 42 C.F.R. § 482.43 (2010).

170. Kit Johnson, *Patients Without Borders: Extralegal Deportation by Hospitals*, 78 U. CIN. L. REV. 657, 662 (2009) (noting that the University of California San Diego Trauma Center spends on average \$18,000 treating each migrant injured by the border fence, but is reimbursed only \$4000 by the federal government).

171. 42 U.S.C. § 1320b-7(f) (requiring that immigrants, regardless of their immigration status, are not cut off from receiving medical care for “emergency medical condition[s]”). See also *id.* § 1320b-7(d). Note, however, that courts have interpreted this provision differently. See, e.g., *Greenery Rehab. Grp., Inc. v. Hammon*, 150 F.3d 226 (2d Cir. 1998) (holding that when the patient was stabilized, the emergency medical condition had ended); *Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Syst. Admin.*, 75 P.3d 91, 98 (Ariz. 2003) (“[T]he focus must be on whether the patient’s current medical condition—whether it is the initial injury that led to admission, a condition directly resulting from that injury, or a wholly separate condition—is a non-chronic condition presently manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical treatment could result in one of the three adverse consequences listed in [the statute.]”); *Szewczyk v. Dep’t of Soc. Servs.*, 881 A.2d 259 (Conn. 2005) (holding that the stabilization of an injury is not

not reimburse long-term care expenses for immigrants, which can leave hospitals caring for immigrants with long-term needs indefinitely.¹⁷²

On the immigration side, our immigration laws make it extremely difficult for immigrants to access care. Unauthorized immigrants are not eligible for most public programs,¹⁷³ and in 1996, Congress made even authorized immigrants ineligible for Medicaid and CHIP for at least five years after entering the United States—which often extends to ten years due to the vagaries of immigration law.¹⁷⁴ Moreover, very few immigrants have a realistic path to legal residency that would increase their chance of receiving public or private health benefits.

Thus, the intersection of our health care and immigration laws has created a gaping hole in the safety net by excluding most immigrants from public, means-tested health insurance programs. And out of some combination of opportunism, necessity, and desperation, U.S. patients, insurers, and even hospitals now rely to varying degrees on low-cost foreign providers. Foreign providers have become a safety net for our health care system.

IV. IS CROSS-BORDER INSURANCE THE ANSWER?

Can foreign medical providers compensate for the deficiencies of our domestic system? Can they offer an affordable alternative for those who remain uninsured after health reform? And can we ensure that cross-border plans do not devolve into junk plans that offer poor coverage and low quality care to marginalized populations?

This part proposes how providers can accomplish each, pivoting on the following three elements. First, we should allow health insurers to experiment with cross-border plans that actually appeal to those who are not offered and cannot afford traditional insurance. Second, states should create a very basic legal framework that resolves various legal and logistical ambiguities, and ensures that cross-border plans meet minimum quality and financial criteria. And third, I argue in Part V that because

dispositive as to whether an emergency medical condition still exists); *Diaz v. Div. of Soc. Servs.*, 628 S.E.2d 1, 5 (N.C. 2006) (“The Second Circuit’s analysis in *Greenery* follows the plain meaning of 42 U.S.C. § 1396b, and our holding is consistent with both the statute and *Greenery*.”).

172. Sontag, *supra* note 31.

173. 8 U.S.C. § 1611 (2006) (noting that “aliens” are “not eligible for any Federal public benefit” except for emergency care under EMTALA, immunizations, and so forth). Note that immigrants do benefit from public spending given to emergency departments, federally qualified health centers, and other safety net programs, as noted in *supra* Part II.C.

174. 8 U.S.C. §§ 1611, 1613.

cross-border care largely resides beyond the purview of domestic regulators, we should use several tools of new governance to regulate both the cross-border insurance market and the quality of care offered in it. Parts IV and V thus outline the proposal, examine its legal and regulatory mechanics, and offer both theoretical and doctrinal support.

A. UNFORTUNATE REALITIES

Although cross-border insurance is a relatively novel and feasible way to insure those left out of reform, I emphasize that it is not the ideal solution. Two unfortunate realities animate this proposal. First, despite landmark health reform in 2010, the Affordable Care Act will leave twenty-three million without insurance after ten years, and roughly fifty million more will remain uninsured until several major provisions take effect in 2014.¹⁷⁵ The second reality is that very few expect these reforms to markedly lower the cost of medical care,¹⁷⁶ particularly to prices that might diminish the appeal of foreign providers. In short, health reform will not cover everyone and will not eliminate foreign providers as an economical alternative. As others trying to tackle the problem of the postreform uninsured have noted, the perfect should not be the enemy of the good.¹⁷⁷

As such, cross-border insurance represents a unique chance to expand coverage to two very different uninsured populations—immigrants and the nonimmigrant middle class. As explained above, cross-border insurance should appeal to immigrants who are less likely to be offered public or private insurance and who generally struggle to access care. Health reform does not pretend to insure unauthorized immigrants, and, in fact, the law goes out of its way to exclude them from receiving federal support. Cross-border insurance not only would appeal to this population, but also would incorporate the growing network of foreign providers that more and more immigrants already use for care.¹⁷⁸ These plans would also be economical, as cross-border plans in California are estimated to be 25–60 percent less expensive than plans that utilize only domestic providers.¹⁷⁹

175. CBO Letter, *supra* note 3, at 9, app. tbl.4.

176. The reforms in the Affordable Care Act that might reduce the costs of medical care are several years from being fully implemented and scaled up.

177. Hall, *supra* note 13, at 10.

178. CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at xix (noting that there has long been “a large and thriving informal market for dental, vision, and medical services” along the U.S.-Mexico border).

179. See Rachel C. Maguire, *SIMNSA and Salud con Health Net*, in CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at 49, 57 (citing estimates from SIMNSA); Phillip

Cross-border insurance may also offer a low-cost alternative to nonimmigrant middle class patients who must now obtain insurance under the individual mandate but might be unable to afford it. As noted above, many un- and underinsured are too young for Medicare and earn too much for Medicaid.¹⁸⁰ Some middle-class patients may not be offered health insurance by employers because they work in temporary or part-time jobs, or for small employers, or in certain industries that do not offer health insurance.¹⁸¹ Although health reform now requires these employers to “play or pay”—to offer creditable coverage or pay a fee—smaller employers and employers who employ low-wage workers are expected to “pay,” and eight to nine million people are expected to lose employer-sponsored insurance.¹⁸²

Moreover, individual policies may still be too expensive after health reform, despite cost-sharing subsidies, premium tax credits, and other stopgap measures designed to reduce costs. Though most observers have been reluctant to endorse foreign providers as a solution for the uninsured,¹⁸³ cross-border insurance provides a distinct opportunity to craft a low-cost option that appeals precisely to these populations. In fact, as noted above, some nonimmigrant middle class patients are already gravitating toward foreign providers. Thus, cross-border insurance may be one of the more economical ways to cover patients who remain uninsured after reform.

B. CREATING A BASIC LEGAL FRAMEWORK

Most states will need to create a basic legal framework to encourage cross-border insurance. This framework should (1) explicitly authorize state-licensed insurers to utilize foreign providers, eliminating any legal ambiguities that might be interpreted to prohibit or deter it; (2) give companies flexibility in designing such plans; (3) specify any minimum coverage requirements; (4) encourage regulatory proxies that ensure quality care; and (5) address other hurdles that discourage cross-border insurance,

Savio, *Blue Shield Access Baja*, in *CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS*, *supra* note 32, at 35, 41 (citing estimates from Blue Shield’s Access Baja plan); Kelly Shanahan, *Western Growers Association*, in *CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS*, *supra* note 32, at 67, 73–74 (citing estimates from the Western Growers Association (“WGA”). Although California law requires that enrollees be legally present and employed in the United States, there is evidence that undocumented immigrants enroll in some of these plans. Maguire, *supra*, at 57.

180. See *supra* text accompanying notes 121–29.

181. Jost, *supra* note 15, at 540–41.

182. CBO Letter, *supra* note 3, at 10.

183. See Cohen, *supra* note 16, at 1525–26; Cortez, *supra* note 112, at 121.

such as legal recourse for malpractice committed abroad.

The idea of cross-border insurance is not entirely new, and my proposal necessarily builds on earlier ones. For example, California demonstrates how states can regulate cross-border plans by requiring them to maintain a state license and consent to California law and jurisdiction.¹⁸⁴ The dozen or so insurers that have added foreign providers to their networks show how insurers can leverage network access to encourage quality care. The California-Mexico Health Initiative's "Strategy for Binational Health Insurance" shows how plans could cover preventative and ambulatory care in the United States and Mexico while requiring hospitalization in Mexico.¹⁸⁵ Economists have demonstrated that portable health insurance can be cost effective even when paying for travel costs.¹⁸⁶ Eleanor Kinney has proposed that North American Free Trade Agreement ("NAFTA") countries use portable health insurance to protect individuals traveling as a result of economic integration.¹⁸⁷ And Europe's experience in this area demonstrates how states can confront their limited jurisdiction over cross-border care.¹⁸⁸ In addition to the legal scholars studying medical tourism, these predecessors have considered how to maximize the benefit-risk differential when using foreign providers.

Before detailing my proposal, it is worth noting that the only two states formally to consider cross-border insurance reached opposite conclusions. California legitimized cross-border health insurance in the late 1990s, amidst concerns that patients were vulnerable in the unregulated market.¹⁸⁹ Conversely, after studying cross-border insurance for a few years, Texas recently banned companies from issuing any insurance policy that "requires an enrollee to travel to a foreign country" for care,¹⁹⁰

184. See CAL. HEALTH & SAFETY CODE § 1351.2 (West 2008) (describing California's arrangement allowing Mexican prepaid health plans to operate health care service plans in California).

185. CALIFORNIA-MEXICO HEALTH INITIATIVE, PROPOSED CALIFORNIA STRATEGY FOR BINATIONAL HEALTH INSURANCE 1 [hereinafter CMHI], available at <http://www.ucop.edu/cmhi/documents/binationalinsurpro.pdf>.

186. Mattoo & Rathindran, *supra* note 111, at 361–62. See also CMHI, *supra* note 185, at 1.

187. Eleanor D. Kinney, *Health Care Financing and Delivery in the United States, Mexico, and Canada: Establishing Intentional Principles for Sound Integration*, 26 WIS. INT'L L.J. 934, 963 (2008).

188. See generally Wolf Sauter, *The Proposed Patient Mobility Directive and the Reform of Cross-Border Healthcare in the EU* (Tilberg L. & Econ. Ctr., Discussion Paper No. 2008-034, 2008), available at <http://ssrn.com/abstract=1277110> (discussing the European Commission's Proposal for a Directive on patients' rights in cross-border health care).

189. 1998 Cal. Legis. Serv. Ch. 1025 (S.B. No. 1658) (West) (codified as amended at CAL. HEALTH & SAFETY CODE §§ 1345, 1351.2); CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at xix.

190. S.B. No. 1391, 80th Leg., Reg. Sess. (Tex. 2007) (codified at TEX. INS. CODE ANN. art. 1215 (West 2009), amended as § 1216). The statute states that "A health benefit plan issuer may not issue or

responding to thinly veiled protectionist concerns voiced by Texas providers. These two laboratories of democracy present two contradictory precedents. My proposal tries to embrace the innovations in California and overcome some of the concerns in Texas.

Given these precedents, my proposal calls for states to pass legislation containing the five basic elements laid out above.

1. Authorizing Cross-Border Plans

State legislatures should begin by explicitly authorizing cross-border plans and creating exceptions to any statutory or regulatory provisions that could be interpreted to prohibit them. The statute need not be long or complex—the authorizing statute in California occupies only one section of the California Health and Safety Code, stating simply that health plans operating lawfully in Mexico may sell plans in California after obtaining a license.¹⁹¹

Authorizing cross-border plans in states like Texas, however, would be more complicated.¹⁹² In addition to the 2007 Texas law that prohibits cross-border plans,¹⁹³ the Texas legislature would also have to amend several laws that functionally preclude HMOs and other plans from utilizing foreign providers.¹⁹⁴ Despite similar complexities in other states, I recommend that the authorizing legislation be as simple as possible to ensure compliance¹⁹⁵ and that insurers be given wide latitude to craft low-cost plans that actually appeal to the uninsured. Authorizing legislation

offer for sale in this state a health benefit plan that requires an enrollee to travel to a foreign country to receive a particular health care service under the health benefit plan.” TEX. INS. CODE ANN. art. 1216.004. The legislative history states that this prohibition applies to plans that “require” out-of-country care or offer a “discount on the amount an enrollee is required to pay to receive a particular health care service under the plan.” S.B. 1391, 80th Leg., Reg. Sess.

191. CAL. HEALTH & SAFETY CODE § 1351.2. Note, however, that dozens of other sections of the Knox-Keene Health Care Service Plan Act of 1975 also govern these plans. *See id.* §§ 1340–1399. But California shows how states can authorize cross-border plans without extensive amendments to existing law.

192. *See, e.g.,* Yael Cohen & Adam Lenert, *Texas Legislation and Regulation, in* CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at 79, 79–90.

193. TEX. INS. CODE ANN. art. 1216.

194. *See* Cohen & Lenert, *supra* note 192, at 80–83 (describing regulations on HMOs, including the HMO Act, Chapter 982, and Chapter 3).

195. I borrow this basic tenet from the proposal suggested by Hervey and Trubek to govern cross-border care in Europe. Hervey & Trubek, *supra* note 11, at 636 (“The first component would articulate the formal substantive legal rule in highly abstract and simple terms.”). David Zaring also notes that communicating simple and broadly worded core principles can help proselytize these standards. David Zaring, *Informal Procedure, Hard and Soft, in International Administration*, 5 CHI. J. INT’L L. 547, 580–85 (2005).

could even specify the ends desired rather than the means to achieve them,¹⁹⁶ for example by requiring plans to ensure that foreign providers offer medical care of comparable quality to U.S. providers. Finally, the legislation should require companies offering cross-border plans to be authorized to sell insurance in that state, which in most states would require insurers to meet various financial solvency requirements and be subject to state jurisdiction.¹⁹⁷

Notably, the new health reform law may allow states to play a more active role than even my proposal envisions. The Affordable Care Act allows states to create “alternative programs” for low-income individuals not eligible for Medicare or Medicaid, in lieu of offering such coverage through an exchange.¹⁹⁸ Although the plan must provide “essential health benefits,”¹⁹⁹ the language of the Act does not explicitly prohibit cross-border plans (although it does not seem to contemplate them either). Note, however, that states may enroll only “eligible individuals,” which excludes unauthorized immigrants.²⁰⁰ But the Act explicitly encourages “innovation,”²⁰¹ and cross-border plans would certainly supply it.

2. Giving Flexibility to Design Plans

Because we do not yet know what plans will actually appeal to the uninsured, states should give insurers some flexibility to design plans. Cross-border plans may be structured as HMO plans, preferred provider organization (“PPO”) plans, self-funded Employment Retirement Income Security Act (“ERISA”) plans, multiple employer welfare arrangements (“MEWAs,” a type of ERISA plan),²⁰² or one of several nontraditional plans, such as a plan organized through nonprofits like religious

196. See Anne-Marie Slaughter & William Burke-White, *The Future of International Law Is Domestic (or, the European Way of Law)*, 47 HARV. INT’L L.J. 327, 332 (2006) (noting how “the EU Council of Ministers and the EU Commission issue directives that specify ends rather than means” and that this European way of law is how international law should function).

197. See, e.g., CAL. HEALTH & SAFETY CODE §§ 1351.2(a)(3), (6)–(10) (West 2008).

198. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1331, 124 Stat. 119, 199–203 (2010).

199. *Id.* § 1302(b)(2), 124 Stat. at 164. Moreover, HHS must certify that plans meet the Act’s benefits requirements under criteria yet to be determined by regulation. *Id.*

200. *Id.* § 1331(b)(1), (e)(1)(A), 124 Stat. at 200, 202.

201. *Id.* § 1331(c)(2)(A), 124 Stat. at 200. Section 1332 also provides a “waiver for state innovation,” but it does not apply until 2017. *Id.* § 1332, 124 Stat. at 203–05.

202. MEWAs are a subset of ERISA plans that are self-funded plans offered by groups of employers in a bona fide trade, industrial, or professional organization. 29 U.S.C. § 1002(40)(A) (2006). Notably, self-funded plans and MEWAs are exempt from various provisions in the new health reform law governing qualified plans offered in state exchanges. Patient Protection and Affordable Care Act § 1301(b)(1)(B), 124 Stat. at 163.

congregations or even more innovative types of microinsurance.²⁰³ In California, insurers generally structure their cross-border plans as HMOs that incorporate providers in Mexico into their networks, although the Western Growers Association (“WGA”) also offers a self-funded ERISA plan.²⁰⁴

Each design presents its own complexities. Cross-border HMO and PPO plans would be subject to the most state regulation and thus would require states to do more carving. For example, some states require that providers in PPO networks be accessible within certain geographical distances, and some also limit the financial incentives PPOs use to distinguish preferred from nonpreferred providers by requiring a cost differential no greater than 20–25 percent.²⁰⁵ States would have to amend these requirements to accommodate cross-border plans that typically utilize providers hundreds or even thousands of miles away, and that typically offer savings much greater than the current differential. Federal HMO laws also impose certain accessibility requirements that may implicate cross-border arrangements.²⁰⁶ The benefit of using an HMO design is that insurers could use primary care gatekeepers in the United States to ensure that care overseas is medically appropriate. By contrast, self-funded ERISA plans are subject to minimal, if any, state regulation and thus offer not only more flexibility, but also substantially lower rates.²⁰⁷ Finally, plans of most forms can simply attach riders that cover care in foreign countries, as the

203. E.g., Adam Lenert & Kelly Shanahan, *Conclusions, in* CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at 238, 246–47 (describing proposals for nontraditional plans in Texas). See also David M. Dror et al., *Microinsurance: Innovations in Low-Cost Health Insurance*, 28 HEALTH AFF. 1788, 1788, 1797 (2009) (discussing how low-cost health insurance based on community, cooperative, or other self-help arrangements in India have fared). The California-Mexico Health Initiative’s proposal calls for binational insurance offered through employers, or via Mexican hometown associations consisting of migrants from the same towns in Mexico. CMHI, *supra* note 185, at 2.

204. See Maguire, *supra* note 179, at 58–59 (discussing how Salud con Health Net incorporates providers in Mexico into HMO plans in fifteen states across the U.S.); Savio, *supra* note 179, at 36–38 (discussing the incorporation of providers in Mexico and California HMOs); Shanahan, *supra* note 179, at 67–70 (discussing health insurance packages offered by the WGA); CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at xxi (discussing the WGA).

205. Cohen, *supra* note 16, at 1563 (discussing PPO statutes that “establish maximum fixed disparities in co-pays”).

206. *Id.* at 1557 (citing 42 U.S.C. §§ 300e(b)(4), (c)(6) (2006)).

207. Adam Lenert & Yael Cohen, *California Legislation and Regulation, in* CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at 19, 28; Lenert & Shanahan, *supra* note 203, at 246. Note, however, that states do impose some requirements on ERISA plans. For example, California requires ERISA plans to be certified by the state, and they are subject to state regulatory standards consistent with ERISA. CAL. INS. CODE §§ 742.20–742.43 (West 2005).

WGA does.²⁰⁸

Regardless of the design, I recommend that most plans contract with both domestic and foreign providers, creating a de facto cross-border provider network.²⁰⁹ The bottom line is that states should grant insurers latitude to design low-cost plans that actually appeal to the uninsured.²¹⁰

3. Specifying Minimum Coverage Requirements

States should also enumerate minimum coverage requirements for cross-border plans, which will require states to consider both routine and novel questions. States routinely decide what should be covered by imposing mandates that require insurers to cover certain tests or procedures.²¹¹ But most states have never considered where these benefits should be provided, or whether insurers may incentivize or even require beneficiaries to seek care in another country.

On the first question—what should be covered—states should give insurers flexibility to deviate from state-mandated coverage minimums so long as they clearly disclose and explain such deviations. Cross-border plans might cover (1) only basic, primary care; (2) only catastrophic care; or (3) some combination of primary, specialty, and catastrophic care.²¹²

States should consider whether to require coverage for emergency and urgent care, though I generally recommend that they do. On the one hand, plans that cover only emergency care would likely cover such care in the United States, which could undermine the financial rationale of cross-border plans—California insurers have expressed concern that nonimmigrants are purchasing cross-border plans solely to cover emergency care in the United States, with no intention of seeking care in Mexico.²¹³ On the other hand, plans that do not cover emergency or urgent

208. Shanahan, *supra* note 179, at 70–74 (discussing an optional rider program known as the “Mexico Panel”).

209. These are sometimes called “dual networks” because they include both domestic and foreign providers. Maguire, *supra* note 179, at 49.

210. States can tinker with the requirements that apply to each design, for example by requiring more protections for patients in cross-border HMO plans or mandatory plans. For a discussion on how to tailor requirements to plans, see Cohen, *supra* note 16, at 1556–59 (suggesting HMO models are more worrisome than PPO models).

211. *Id.* at 1557.

212. See Cesar Martinez, Luis de la Mora & Laura Spagnolo, *Dallas-Fort Worth Area Case Study, in CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS*, *supra* note 32, at 197, 205.

213. Maguire, *supra* note 179, at 54; Savio, *supra* note 179, at 39–40. Additionally, states should consider the criteria for transferring emergency or urgent care patients to foreign hospitals. Mexican citizens might be covered by catastrophic health insurance coverage for tertiary services in Mexico, as requested by former President Vicente Fox in 2004. CMHI, *supra* note 185, at 2 (quoting former

care in the United States would not address the medical repatriation problem. For example, the California-Mexico Health Initiative's proposal does not specify coverage for emergency care, and anticipates that hospitalization "will continue to be provided through the existing safety net system in California."²¹⁴ It would be difficult, however, to justify not covering domestic emergency and urgent care as a normative matter.²¹⁵

Another wrinkle is that states should give insurers flexibility to cover travel expenses, particularly to regions like Southeast Asia for which travel expenses are high but provider discounts are even higher.²¹⁶

Finally, to rebut concerns that cross-border plans will be coercive, or will crowd out plans that utilize only domestic providers, states might consider requiring that if employers offer cross-border plans, they must also offer at least one domestic plan that meets state-mandated coverage requirements.²¹⁷ Even if price differentials are so high that the choice is illusory, the price differentials may pressure domestic providers to compete for patients and lower their rates.

On the second question—where should care be provided—states should require plans to cover emergency care in the United States. For example, California law requires that cross-border plans cover emergency and urgent care in California, and that all other care must be provided in Mexico.²¹⁸ The cross-border plans in California seem to ignore the latter requirement. Blue Shield's plan offers most services in Mexico but reserves some for California due to "lack of necessary facilities" and other "cultural standards" in Mexico.²¹⁹ Health Net's plans allow the insured to choose between receiving services primarily, but not exclusively, in the Los

President Vicente Fox during Binational Health Week, Oct. 11, 2004).

214. CMHI, *supra* note 185, at 1.

215. See Cohen, *supra* note 16, at 1560.

216. See Mattoo & Rathindran, *supra* note 111, at 361–63; CMHI, *supra* note 185, at 1 (proposing that binational plans cover transportation costs to Mexican facilities).

217. Cohen, *supra* note 16, at 1549.

218. CAL. HEALTH & SAFETY CODE § 1351.2(a)(2), (4) (West 2008). See also Cohen & Lenert, *supra* note 192, at 85 (describing a proposed cross-border health care bill that would require emergency care coverage to extend to Texas and other U.S. states); Maguire, *supra* note 179, at 50, 52–53 (describing how the licensed plans in California divide emergency, urgent, primary, and specialty care between U.S. and Mexican providers).

219. CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at xx. Blue Shield relies on General de Salud to manage its provider network in Mexico, which includes three Mexican hospitals. General de Salud contracts directly with physicians and ensures their credentials and the quality of care they provide, and receives a capitated payment from Blue Shield based on the number of customers served, reimbursing Mexican providers directly. The Blue Shield Access Baja plan operates like an HMO, with primary care gatekeepers needed for referrals to specialists. Savio, *supra* note 179, at 36–42.

Angeles or Mexico service areas.²²⁰ The WGA also uses a network of primary and specialty providers in both countries.²²¹ Only SIMNSA provides all but emergency and urgent care in Mexico.²²² States could decide whether primary, urgent, and specialty care must be provided domestically or abroad, or states could simply leave these decisions to insurers, given that we do not yet know which combinations will appeal to the uninsured. Other insurers around the country have designed plans that simply outsource a menu of high-cost individual procedures that are conducive to travel.²²³ Again, states should grant insurers some flexibility to identify plans that will actually appeal to the uninsured.

States may also wish to confront the extent to which insurers should be able to encourage or even require beneficiaries to seek care overseas. As

220. Salud con Health Net is a “binational partnership between Health Net, Hispanic Physicians, Tenet HealthSystems in LA county, and SIMNSA in Mexico.” Maguire, *supra* note 179, at 58. Health Net contracts with U.S. providers who agree to lower reimbursement rates to be included in the network. Health Net offers a full-network plan with access to Health Net’s broad network in California, and a narrow-network plan that limits access to eight hospitals in Mexico (including SIMNSA’s network) and seven in Los Angeles county. *Id.* at 58–59; SALUD CON HEALTH NET, <http://www.saludconhealthnet.com> (last visited Apr. 24, 2011).

221. The WGA draws members from agricultural businesses in California and Arizona. Beginning in 1972, it began offering optional cross-border care through self-funded ERISA MEWAs, aimed primarily at seasonal migrant workers, utilizing an extensive provider network in Mexico that now includes at least ninety specialist providers and ten hospitals. The WGA contracts directly with doctors, clinics, hospitals, and pharmacies in Mexico, and contracts with several U.S. insurers for care in the United States. The WGA offers traditional indemnity and HMO and PPO plans, to which an additional cross-border “Mexico Panel” rider can be attached. As an ERISA MEWA that does not offer precipitated HMO plans, the WGA plans are regulated primarily by the U.S. Department of Labor rather than the California Department of Managed Health Care. Shanahan, *supra* note 179, at 67–71. *See also Health Insurance, WESTERN GROWERS*, <http://www.wga.com/default.php?id=701> (last visited Apr. 24, 2011).

222. Maguire, *supra* note 179, at 50, 53. SIMNSA is a Mexican insurer that operates in California by contracting with U.S. companies. For example, it contracts with two provider networks (HealthSouth and the Community Care Network) to offer emergency and urgent care in the United States; it contracts with International Healthcare Inc. to perform administrative functions; and it reinsures its coverage with AIG to reduce its financial liabilities. CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at xxi; Maguire, *supra* note 179, at 50–53.

223. *See* Cohen, *supra* note 16, at 1515–16; Mattoo & Rathindran, *supra* note 111, at 360–61. For example, Aaditya Mattoo and Randeep Rathindran choose for price comparison purposes fifteen medical procedures that (1) treat non-acute conditions, (2) allow patients to travel without major pain or inconvenience, (3) are fairly simple with low complication rates, (4) require minimal follow-up treatment on site, (5) generate minimal laboratory and pathology reports, and (6) result in minimal immobility after the procedure. Procedures that qualified included knee surgery, shoulder arthroplasty, hernia repair, and glaucoma procedures, among others. New options are emerging. *Id.* For example, Sekure Healthcare offers a broad provider network in Mexico to employer plans. *See Coverage in Mexico, SEKURE HEALTHCARE*, <http://www.mysekure.com/incl/Ciudades-de-Mexico2.pdf> (last visited Apr. 24, 2011).

Glenn Cohen notes, insurers can frame incentives differently.²²⁴ For example, an insurer may provide rebates *ex post* for using foreign providers, with domestic providers serving as a more expensive default; a plan may charge additional copayments *ex ante* if patients use domestic instead of foreign providers for certain procedures; or, a plan may simply require patients to use foreign providers for certain procedures, and refuse to cover those procedures domestically.²²⁵ Insurers may conjure up variations that use positive or negative incentives or both to guide patients to lower-cost foreign providers.

Again, I recommend that states grant insurers wide latitude to experiment here. The industry does not yet know which incentive structures patients will tolerate, and which ones will be cost effective. For example, cross-border insurers in California worry that they will lose money if patients can choose U.S. instead of Mexican hospitals.²²⁶ Thus, insurers should be able to offer plans with more aggressive incentives, so long as they adequately explain where patients must seek care.²²⁷ Finally, though many will undoubtedly bristle at requiring patients to use foreign providers, it is debatable whether U.S. patients have a normative entitlement to receive all types of care at all times in the United States.²²⁸ This proposal takes the U.S. health care system as it is, not perhaps as it should be—even after health reform.

4. Identifying Regulatory Proxies to Ensure Quality Care

Part V describes in detail how we can use principles of new governance to “regulate” cross-border plans. Briefly, state legislation can require insurers to use regulatory proxies that ensure quality care overseas. For example, states can require that cross-border insurers contract only with foreign physicians that possess credentials equivalent to their U.S. counterparts, such as maintaining a license to practice and obtaining any necessary specialty certifications. Similarly, states can require that insurers utilize only foreign hospitals that are accredited domestically or even by Joint Commission International (“JCI”).²²⁹ Again, states can be as broad or

224. Cohen, *supra* note 16, at 1547–50.

225. *See id.*

226. Cf. Jennie Kerr, Stacey Pogue & Kim Tucker, *El Paso Case Study, in* CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at 97, 119 (discussing a similar worry of Texas insurers).

227. Note that states might consider applying laws that cap the cost incentives between network and nonnetwork providers in PPOs to cross-border plans. *See, e.g.*, Cohen, *supra* note 16, at 1563.

228. *Id.* at 1548–49.

229. *See infra* notes 287–304 and accompanying text.

specific as they wish—a simple statutory clause requiring foreign providers to meet all applicable regulatory criteria in their jurisdictions might suffice, though more assertive channeling devices are probably warranted here.²³⁰ The benefit of most of these proxies is that they already exist. States need not regulate from scratch. Indeed, my proposal pivots on the ability of nongovernmental entities to regulate quality on their own. This is a hallmark of the new governance framework and something that groups are already doing, as I discuss below.

5. Addressing Legal Recourse and Other Barriers

Legal uncertainty remains a barrier to cross-border care. The medical tourism literature examines in detail who might be liable, in which jurisdictions, and under which legal theories if a U.S. patient is injured by a foreign provider.²³¹ Rather than rehashing these analyses, I will simply note that states should say something about liability and jurisdiction in order for cross-border insurance to succeed. For example, California law requires cross-border insurers to consent to California law and jurisdiction, and make grievance procedures available in the United States.²³² I recommend other states do the same (though other proposals diverge on this point).²³³ Note, however, that because Mexican providers are independent contractors under the California plans and may not be subject to U.S. jurisdiction, it remains unclear whether U.S. residents would have legal recourse in the United States for malpractice committed in Mexico.²³⁴ The California plans often ask patients to acknowledge this point.²³⁵

Fortunately, states have several options here. Briefly, states may (1) impose vicarious strict liability on cross-border insurers; (2) require payors to purchase malpractice or complications insurance; (3) invalidate

230. See Cohen, *supra* note 16, at 1515–23.

231. See, e.g., *id.* at 1494–1504; Cortez, *supra* note 112, at 106–07, 121–23; Nathan Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, 10 YALE J. HEALTH POL'Y L. & ETHICS 1 (2010) (discussing patients seeking redress in the United States and foreign jurisdictions); Terry, *supra* note 151, at 457–61; Philip Mirrer-Singer, Note, *Medical Malpractice Overseas: The Legal Uncertainty Surrounding Medical Tourism*, 70 LAW & CONTEMP. PROBS. 211 (2007).

232. CAL. HEALTH & SAFETY CODE § 1351.2(a)(9)–(10) (West 2008); CAL. CODE REGS. tit. 28, § 1300.68 (2008).

233. For example, the CMHI's proposal for binational insurance notes that legal and regulatory standards between the United States and Mexico would “continue to be separate,” and that “US providers will NOT be responsible for the quality of services in Mexico.” CMHI, *supra* note 185, at 2.

234. See Cortez, *supra* note 231, at 67–77.

235. See, e.g., *Access Baja HMO, Medical Care in Mexico*, BLUE SHIELD OF CALIFORNIA, <https://www.blueshieldca.com/producer/largegroups/products/medical/baja/medical.jhtml> (last visited Apr. 24, 2011).

by statute any liability waivers the plans might use; (4) prohibit plans from using foreign providers that do not consent to U.S. jurisdiction or alternative dispute resolution; (5) require cross-border insurers to cover necessary follow-up care by domestic providers;²³⁶ or (6) simply require plans to disclose that patients may not have legal recourse against foreign providers in the United States and may have to rely on foreign complaint mechanisms in which it can be exceedingly difficult to recover satisfactory compensation.²³⁷ Any of these mechanisms would help reduce the legal uncertainty that daunts cross-border plans.²³⁸

6. The Normative Ambiguities of Cross-Border Insurance

Together, the five elements of this proposal raise an overarching normative question: Should states relax minimum standards to improve access to affordable care?²³⁹ If existing laws do not anticipate cross-border care, to what extent should states change their laws to accommodate it? How much should states deviate from their existing requirements, and would these deviations jeopardize the minimum standards for ensuring access to quality care that we otherwise can accept?

Another risk of embracing cross-border insurance is that it might further segment our health care system, separating those who can afford care in the United States from those who cannot. If insurers have too much discretion or insufficient oversight, they might market junk policies that offer inferior coverage and quality to marginalized groups like low-income patients and immigrants. How far should we stretch our standards to insure these groups? Will insurers be able to cream-skim and charge more to patients too sick and frail to travel overseas, or perhaps try to send sicker patients overseas in response to pay-for-performance or other quality incentives?

Moreover, there is some precedent for relaxing standards to expand

236. Cohen, *supra* note 16, at 1560; Cortez, *supra* note 112, at 122; Cortez, *supra* note 231, at 80.

237. See, e.g., Cohen, *supra* note 16, at 1517–20; Cortez, *supra* note 231, at 85–89; Cortez, *supra* note 112, at 118–19.

238. Note, however, that some new governance theorists believe it is crucial for domestic courts or at least alternative dispute resolution to serve as a backstop. Slaughter & Burke-White, *supra* note 196, at 341 (“The political benefits of adjudicating matters domestically rather than giving jurisdiction to an international tribunal over which domestic officials have little or no control creates new incentives to act locally.”).

239. Glenn Cohen frames the issue slightly differently in terms of lower quality care rather than lower regulatory standards governing that care: “We also need a theory that tells us when we should allow individuals to choose care of lesser quality to achieve cost savings . . .” Cohen, *supra* note 16, at 1491.

access to affordable care. In 2004, Texas revised its Insurance Code to authorize new “consumer choice” plans, exempting these plans from some minimum benefit requirements, such as mental health care, in vitro fertilization, and care for hearing impairment.²⁴⁰ The legislature’s intent was to make available “more affordable and flexible” health plans.²⁴¹ Yael Cohen and Adam Lenert emphasized how this law established a possible precedent for cross-border plans:

For the first time, [Texas law] created a two-tier health care system that acknowledges that not everyone can afford the type of health insurance plans that meet all of the state’s mandates for the highest quality of services. The ideology behind the law is that a less extensive coverage plan is necessary in order to reach the large numbers of uninsured that could not afford the traditional health insurance plans.²⁴²

In 2009, Texas companies offering these “consumer choice” plans reported cost savings averaging between 5 and 10 percent.²⁴³ Although these plans do not suddenly make health insurance affordable to all uninsured Texans, they may represent the first step in recognizing that “some care is better than no care,” giving legal legitimacy to a two-tiered health insurance system.²⁴⁴

This normative quandary also evokes the ever-present question of “value for money” in health care.²⁴⁵ Lower-income patients (and particularly immigrants) may have a different conception of value and quality, and may be more willing to seek health care outside the United States. This proposal asks us to consider whether value, quality, or “performance” should be an individualized decision made by patients or a collective one.²⁴⁶ In a pluralistic society, it is difficult to imagine one-size-fits all judgments of value and quality that satisfy us all. Moreover, the U.S. health care system already discriminates among patients based on their

240. 28 TEX. ADMIN. CODE § 21.3501 (2010); TEX. INS. CODE ANN. art. 1507.001 (West 2009); *Approved SB 541 Consumer Choice Plans as of April 29, 2010*, TEX. DEPT. OF INS., http://www.tdi.state.tx.us/health/documents/lhccplst_73004.pdf [hereinafter *S.B. 541 Consumer Choice Plans*].

241. S.B. 541, 78th Leg., Reg. Sess. (Tex. 2003).

242. Cohen & Lenert, *supra* note 192, at 90. A related normative question is whether states should differentiate standards for Mexican citizens and American citizens. The Texas Department of Insurance raised this possibility when considering binational health plans. *Id.* at 84.

243. See *S.B. 541 Consumer Choice Plans*, *supra* note 240.

244. Cohen & Lenert, *supra* note 192, at 90. See also *id.* at 92.

245. William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 509 (2008).

246. *Id.* at 509, 513, 516 (citing the United States’ negative experience with managed care during the 1980s and 1990s as “America’s inability to engage affordable access to basic medical care as a collective issue”).

ability to pay, and health reform does little to change this. If our health care system as currently constructed does not offer affordable care domestically, it is difficult to make the normative argument that foreign providers should not be allowed to fill these gaps. Indeed, others have made parallel arguments in other contexts (although these arguments generally propose relaxed quality standards).²⁴⁷

I argue that while this proposal would require us to expand our conception of how health care can be delivered, it would not require us to relax our standards *per se*. On the one hand, it would require us to relax our geographic preconceptions of health care that envision patients accessing virtually all care relatively close to home. States would need to reconceive laws and regulations that accommodate only this domestic framework. On the other hand, the proposal considers relaxing geographic rather than quality standards. And it would provide considerably more regulation to cross-border phenomena like medical tourism, outsourcing, and repatriation that remain largely unregulated.

V. REGULATING QUALITY OVERSEAS VIA NEW GOVERNANCE

Because government oversight of the cross-border market will probably remain minimal, this proposal relies on theories of new governance to regulate cross-border plans and the quality of care they provide. Examples include insurers leaning on foreign providers to adopt U.S.-inspired quality standards as a condition of payment, or nongovernment initiatives to develop industry standards and best practices. But before explaining how to apply new governance here, it is worth discussing what new governance is and why it is well suited to this area. This part offers theoretical support for relying on alternative forms of regulation, given the low likelihood of traditional regulation.

247. David A. Hyman, *Accountable Managed Care: Should We Be Careful What We Wish For?*, 32 U. MICH. J.L. REFORM 785, 803 (1999) (“[G]iven the choice between unaccountable but affordable insurance coverage and accountable insurance coverage which is unaffordable for some percentage of those currently insured, why are we so quick to conclude that the latter should be not just the default term, but a mandatory minimum?”); David A. Hyman, *Professional Responsibility, Legal Malpractice, and the Eternal Triangle: Will Lawyers or Insurers Call the Shots?*, 4 CONN. INS. L.J. 353, 394 n.177 (1997) (“Given the choice between something and nothing, most people would have little difficulty choosing the former, but our legal system and ethical framework directly and intentionally precludes that option.”); John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 VA. L. REV. 439, 487 (1991) (“By embracing the chimera of equality between the rich and poor, [tort law] effectively disables health care providers from offering reasonable, low-cost care to large numbers of the medically indigent.”).

A. WHY NEW GOVERNANCE?

New governance generally represents alternative regulatory initiatives that deemphasize traditional command and control regulation—typically expressed through binding “hard law” and enforced through formal sanctions—and instead emphasize a flexible approach that employs some combination of the following: voluntary cooperation; public-private partnerships; networks; decentralization; information gathering and dissemination; and the use of nonbinding “soft law” such as guidelines, standards, and best practices.²⁴⁸ International forms have emerged, sometimes labeled “Transnational New Governance.”²⁴⁹ New governance theories generally unite around shifting away from traditional government regulation where it is impractical or ineffective.

New governance offers several commonly cited benefits over traditional regulation, including greater responsiveness, customization, cost-effectiveness, and even higher levels of compliance.²⁵⁰ In addition to these general advantages, new governance should be particularly useful for regulating cross-border phenomena like medical tourism, outsourcing, and repatriation that are virtually unregulated and probably will remain so. Like some other international markets, the cross-border market largely operates without government oversight, in a sort of Hobbesian state of nature.²⁵¹ New governance is filling regulatory voids in a variety of markets, particularly “in those areas that have experienced the most private-sector

248. E.g., Kenneth W. Abbott & Duncan Snidal, *Strengthening International Regulation Through Transnational New Governance: Overcoming the Orchestration Deficit*, 42 VAND. J. TRANSNAT'L L. 501, 507–09 (2009); John D. Blum, *New Governance and Health Care Regulation*, 2 ASIAN J. WTO & INT'L HEALTH L. & POL'Y 125, 126 (2007); Scott Burris, Michael Kempa & Clifford Shearing, *Changes in Governance: A Cross-Disciplinary Review of Current Scholarship*, 41 AKRON L. REV. 1, 3–4 (2008); Benedict Kingsbury, Nico Krisch & Richard B. Stewart, *The Emergence of Global Administrative Law*, 68 LAW & CONTEMP. PROBS. 15, 16 (2005) (“[V]arious transnational systems of regulation or regulatory cooperation have been established through international treaties and more informal intergovernmental networks of cooperation . . .”); Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 MINN. L. REV. 342, 345–47 (2004); Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 137, 146–50 (2006). See also Daniel C. Esty, *Good Governance at the Supranational Scale: Globalizing Administrative Law*, 115 YALE L.J. 1490, 1497–98 (2006).

249. Abbott & Snidal, *supra* note 248, at 509–10.

250. Blum, *supra* note 248, at 127–28; John Braithwaite, *Responsive Regulation and Developing Economies*, 34 WORLD DEV. 884, 886–88 (2006).

251. See Harold Hongju Koh, *Transnational Legal Process*, 75 NEB. L. REV. 181, 192 (1996) (noting that nonstate actors interact “in a system of international commercial transactions that operates largely without governmental intervention”). The one narrow exception is a discrete trio of cross-border insurers overseen by California regulators. See *infra* Part V.B.5.

globalization,” such as banking and securities.²⁵² The emergence of cross-border phenomena like medical tourism and repatriation has been accompanied by similar calls for voluntary international cooperation.²⁵³

New governance is most useful when traditional regulation is neither likely nor feasible. It is doubtful that the federal government will regulate cross-border health care in the near future. States are more likely to intervene, as demonstrated in California and Texas, but state regulation will be more piecemeal and subject to greater enforcement constraints.²⁵⁴ For example, the one narrow segment of cross-border care that is regulated in California is overseen by the Department of Managed Health Care, which is understaffed and overwhelmed with these responsibilities.²⁵⁵

Traditional regulation is also unlikely because foreign providers generally reside beyond the purview of domestic regulators.²⁵⁶ As with other transnational markets, cross-border care suffers from “a lack of domestic governance capacity, a lack of domestic will to act, and new problems that exceed the ordinary ability of states to address.”²⁵⁷ New governance offers useful theories to fill these voids. For example, the California Department of Managed Health Care relies on private insurers to regulate the quality of care offered by foreign providers, supporting the precept that states can “deliberately shar[e] power as a means of exercising it.”²⁵⁸ The European Union has also embraced new governance in areas like employment, education, and health, in which top-down regulation arguably has failed.²⁵⁹

There are, however, strong arguments that alternative methods of regulation are not ideal for this type of market. As Jody Freeman notes in the context of privatizing public contracts,

252. Jonathan R. Macey, *Regulatory Globalization as a Response to Regulatory Competition*, 52 EMORY L.J. 1353, 1357 (2003).

253. Cortez, *supra* note 112, at 127–31; Hervey & Trubek, *supra* note 11, at 627.

254. Moreover, state regulation of cross-border health care might run afoul of the Foreign Commerce Clause, U.S. CONST. art. I, § 8, cl. 3. For one of the only in-depth treatments of the boundaries of this clause, see Anthony J. Colangelo, *The Foreign Commerce Clause*, 96 VA. L. REV. 949 (2010).

255. Lenert & Cohen, *supra* note 207, at 26–27. The Department of Managed Health Care must conduct regular financial and medical audits, review quarterly and annual reports, approve certain changes to licensed plans, and manage other regulatory and oversight responsibilities. *Id.*

256. Cortez, *supra* note 231, at 9–14.

257. Slaughter & Burke-White, *supra* note 196, at 333.

258. Burris, Kempa & Shearing, *supra* note 248, at 4.

259. Hervey & Trubek, *supra* note 11, at 627 (noting that new governance offers “‘bottom up’ solutions to complex social problems, where ‘top down’ regulation has either failed to deliver, or where it is constitutionally unavailable”); Lobel, *supra* note 248, at 386.

The argument for publicization is strongest in instances when services are highly contentious, value-laden, and hard to specify, and when providers enjoy significant discretion; when services affect vulnerable populations with few exit options and little political clout; and/or when the motivation for privatization is explicitly ideological or clearly corrupt.²⁶⁰

Although cross-border insurance meets many of these criteria, new governance is still worth pursuing for a number of reasons.

First and foremost, new governance is not new to the health industry. Health care is one of the most heavily regulated industries in the United States, and its regulations are “both voluminous and costly.”²⁶¹ As Rand Rosenblatt notes, the U.S. health sector has relied at various historical points on more traditional regulation, but we have transitioned into a new phase characterized by nonconventional forms.²⁶² Moreover, new governance accommodates two key traditions in U.S. health care: the longstanding preference of having physicians regulated by peers, or at least by nongovernment bodies;²⁶³ and the traditional responsibility of states.²⁶⁴ Health care “has historically drawn heavily on self-regulatory structures, and thus, governance mechanisms that involve the relevant actors in norm setting ‘from within,’ rather than the imposition of norms ‘from above.’”²⁶⁵ Indeed, scholars like Tamara Hervey and Louise Trubek have begun to apply these lessons to cross-border care.

New governance is also useful for cross-border health care because domestic regulators have limited jurisdiction over problems of international scope.²⁶⁶ Its precepts hold theoretical appeal because more cooperative approaches “comport with deep-seated intuitions about how globalization

260. Jody Freeman, *Extending Public Law Norms Through Privatization*, 116 HARV. L. REV. 1285, 1291 (2003).

261. Blum, *supra* note 248, at 128.

262. Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 193 (2004). *See also* Trubek, *supra* note 248, at 147–48.

263. Sage, *supra* note 245, at 498–99. Indeed, the most influential account of the history of American medicine characterizes it as the ongoing quest of physicians to resist regulation by corporate or government entities. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 3–9 (1982).

264. Several states have experimented with new governance techniques that integrate patients and community input into quality of care initiatives. Trubek, *supra* note 248, at 143–44.

265. Hervey & Trubek, *supra* note 11, at 627 (footnote omitted).

266. *See, e.g.*, Abbott & Snidal, *supra* note 248, at 509–11; Kingsbury, Krisch & Stewart, *supra* note 248, at 53–54; Harold Hongju Koh, Review Essay, *Why Do Nations Obey International Law?*, 106 YALE L.J. 2599, 2604 (1997); David Zaring, *Best Practices*, 81 N.Y.U. L. REV. 294, 299, 318–21 (2006) (discussing how, in general, new governance’s popularity stems from globalization).

really works.”²⁶⁷ But new governance also holds a practical appeal because it can scale down transnational problems by allowing interested parties from different jurisdictions to cooperate.²⁶⁸ And perhaps more importantly, new governance allows us to spread regulatory principles to countries with limited capacity to regulate themselves—what Kal Raustiala terms “regulatory gospel.”²⁶⁹ Thus, new governance appeals here because cross-border health care phenomena are transnational and foreign providers generally reside beyond the jurisdiction of U.S. regulators.

Related to the preceding point, most foreign providers that attract U.S. patients are located in developing countries that lack the internal capacity to regulate effectively. These countries not only have less governmental capacity to regulate, but also have less social infrastructure and civil society to account for these deficiencies.²⁷⁰ New governance “mobilizes cheaper forms of social control” and allows developing countries to rely on foreign regulators who have an incentive to enforce legal norms there.²⁷¹ Thus, new governance can help counter “weak enforcement capabilities” in developing countries.²⁷² It can help assure U.S. patients and insurers that rely on foreign providers that these providers meet acceptable standards.

Moreover, like other young industries that struggle for legitimacy, the cross-border health industry should prefer new governance not only to traditional regulation, but also to zero regulation. Providers and facilitators can use new governance to respond to reputational concerns and growing public apprehension that medical tourism and related phenomena are unregulated.²⁷³ The industry also benefits because new governance asks the private sector to contribute to technical standards that govern the industry

267. Anne-Marie Slaughter & David Zaring, *Networking Goes International: An Update*, 2 ANN. REV. L. SOC. SCI. 211, 218 (2006).

268. Lobel, *supra* note 248, at 382–83.

269. Kal Raustiala, *The Architecture of International Cooperation: Transgovernmental Networks and the Future of International Law*, 43 VA. J. INT’L L. 1, 32 (2002) (quoting Interviews with SEC officials, SEC Headquarters, in Washington, D.C. (Apr. 2000)). For example, the U.S. Securities and Exchange Commission (“SEC”) has long spread “the ‘regulatory gospel’ of U.S. securities law” around the world to help it influence conduct beyond its jurisdiction. *Id.* See also Macey, *supra* note 252, at 1356 (noting that agencies might seek to “export” regulatory powers and principles to other countries to avoid regulatory arbitrage by regulated parties seeking more favorable regulatory environments).

270. See Braithwaite, *supra* note 250, at 884–86. Developing countries, however, are not monolithic. For example, “Some larger developing societies such as India have strong democratic states with substantial, sophisticated bureaucracies and courts.” *Id.* at 896.

271. *Id.* at 884. See also *id.* at 891 (regulation of intellectual property piracy); *id.* at 896 (U.S. Food and Drug Administration (“FDA”) regulation of foreign clinical trials).

272. *Id.* at 888.

273. See Abbott & Snidal, *supra* note 248, at 504.

and perform other “arguably public functions.”²⁷⁴ In the health industry, private providers and insurers already formulate health policy by making decisions about coverage and quality.²⁷⁵ This is particularly true in the cross-border industry. Insurers that use foreign providers are making important coverage and quality decisions. As I explain below, the industry is already establishing standards and best practices, and is verifying compliance with these new requirements. My proposal thus implements Nan Hunter’s suggestion that because the primary concern of health law is managing risk, we should use insurance as a “technology” to practice new governance.²⁷⁶

Finally, new governance is typically easier and less costly to implement than traditional regulation, which requires formal legislation or rulemaking.²⁷⁷ It makes use of relatively modest levers to ensure that the governance is effective and legitimate.²⁷⁸ For example, payors in the cross-border industry have begun to require that foreign hospitals be accredited by JCI, and this has become a powerful de facto industry standard without consuming public resources.²⁷⁹

In short, new governance holds particular promise for unregulated, international phenomena like cross-border health care that involve actors in developing countries that reside beyond the purview of U.S. regulators. It may not be preferable to traditional regulation, but traditional regulation is unlikely and inherently limited given the market’s transnational scope.

B. HOW NEW GOVERNANCE CAN REGULATE CROSS-BORDER CARE

New governance allows us to respond to phenomena like medical tourism, outsourcing, and repatriation that are plagued by pervasive uncertainty, particularly the lingering suspicion that U.S. patients will receive lower quality care in developing countries.²⁸⁰ These concerns are animated first by the lack of credible information on quality; second, by doubts that foreign jurisdictions employ the same caliber of professional

274. Freeman, *supra* note 260, at 1289. *See also* Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 663–64 (2000); Errol Meidinger, *Competitive Supragovernmental Regulation: How Could It Be Democratic?*, 8 CHI. J. INT’L L. 513, 515 (2008) (citing examples of nonstate regulatory programs).

275. Hunter, *supra* note 16, at 44.

276. *Id.* at 1, 8.

277. Zaring, *supra* note 266, at 299–300.

278. Abbott & Snidal, *supra* note 248, at 511.

279. *See infra* Part V.B.1.

280. *See, e.g.*, Cohen, *supra* note 16, at 1490; Cortez, *supra* note 112, at 102–06; Lenert & Shanahan, *supra* note 203, at 247; Terry, *supra* note 151, at 454–55.

credentialing, hospital accreditation, and interlocking judicial and regulatory oversight used in the United States;²⁸¹ and third, by the suspicion that as cross-border care becomes more commonplace and lucrative, lower quality providers will enter the market.²⁸² A final aggravation is our perceived inability to influence the quality of care overseas, either ex ante (such as through regulation) or ex post (such as through litigation or regulatory enforcement).

I use the following four methods of new governance to address these concerns. First, the cross-border industry and its patrons can generate quality standards and other forms of “soft law” for foreign providers. Second, insurers and other payors can leverage coverage and reimbursement to require that foreign providers meet these standards. Third, emerging networks surrounding cross-border care can help develop and enforce these standards. And fourth, these tools can generate credible information about the quality of foreign providers, which would benefit both the industry and its patrons. This section concludes by discussing why this proposal is a hybrid form of new governance, relying as it does on at least minimal government regulation and hard law as a backstop.

1. Regulating Quality Through Industry Standards and Soft Law

The primary benefit of new governance is that it can introduce standards, best practices, and other forms of soft law to industries that would otherwise lack them. Indeed, the cross-border health industry already practices this type of new governance. Private, voluntary programs are generating industry standards and verifying compliance with them.

The best example is international hospital accreditation, which is becoming a de facto prerequisite for hospitals that attract foreign clientele.²⁸³ At least four organizations have established such standards, including: JCI, an arm of the major U.S. hospital accreditor; QHA Trent, originally developed to accredit hospitals and clinics for Britain’s National Health Service;²⁸⁴ the Australian Council on Healthcare Standards International, which accredits foreign hospitals based on Australian standards;²⁸⁵ and the International Organization for Standardization, which

281. See, e.g., Cohen, *supra* note 16, at 1489.

282. *Id.* at 1492–93.

283. See Cortez, *supra* note 112, at 83–84.

284. See QHA TRENT, <http://www.qha-international.co.uk> (last visited Apr. 22, 2011).

285. See ACHSI *Around the World*, AUSTL. COUNCIL ON HEALTHCARE STANDARDS INT’L, <http://www.achs.org.au/ACHSIaroundtheworld> (last visited Apr. 22, 2011).

certifies that international hospitals meet quality management standards.²⁸⁶

The most well-known of these is JCI, which has accredited roughly 275 facilities in thirty-five foreign countries.²⁸⁷ JCI accreditation parallels the process by which its domestic parent, the Joint Commission on Accreditation of Healthcare Organizations (“Joint Commission”), accredits U.S. hospitals.²⁸⁸ JCI visits foreign hospitals to determine whether they satisfy six overarching International Patient Safety Goals. For example, a hospital must “Improve the Safety of High-Alert Medications” and “Reduce the Risk of Health Care-Associated Infections.”²⁸⁹ JCI evaluates whether a hospital satisfies these goals by assessing whether it complies with more than one hundred standards, which JCI further reduces into several “measurable elements.”²⁹⁰

For example, an overarching patient safety goal requires hospitals to “Identify Patients Correctly.”²⁹¹ A corresponding standard requires that “[p]atients are admitted to receive inpatient care or registered for outpatient services based on their identified health care needs and the organization’s mission and resources.”²⁹² JCI surveyors measure compliance with this standard by evaluating seven “[m]easurable [e]lements,” such as “[p]atients are accepted only if the organization can provide the necessary services and the appropriate outpatient or inpatient setting for care,” and “[p]olicies identify which screening and diagnostic tests are standard before admission.”²⁹³

Hospitals must meet a minimum score on each of one hundred-plus standards, as well as minimum aggregate scores for each category; otherwise, JCI gives the facility additional time to demonstrate

286. See *About ISO*, INT’L ORG. FOR STANDARDIZATION, <http://www.iso.org/iso/about.htm> (last visited Apr. 22, 2011).

287. See *JCI Accredited Organizations*, JOINT COMM’N INT’L, <http://www.jointcommissioninternational.org/JCI-Accredited-Organizations> (last visited Apr. 22, 2011).

288. Cortez, *supra* note 112, at 83–84. Although accreditation is voluntary in the United States, most U.S. hospitals seek Joint Commission accreditation because it satisfies conditions for participating in the Medicare and Medicaid programs. See 42 C.F.R. § 488.5 (2010). Like its parent, JCI has been criticized for potential financial conflicts of interest. Cohen, *supra* note 16, at 1508, 1516–17; Cortez, *supra* note 112, at 125–26.

289. JOINT COMM’N INT’L, ACCREDITATION STANDARDS FOR HOSPITALS (3d ed., 2007), http://www.jointcommissioninternational.org/common/pdfs/jcia/Standards_Only-Hosp_3rd_ed.pdf.

290. *Id.*

291. *Id.*

292. *Id.*

293. *Standards, Intents, and Measurable Elements, Admission to the Organization*, JOINT COMM’N INT’L 41, http://www.jointcommissioninternational.org/common/pdfs/jcia/Standard-Intent-MEs_Hospital_3rd_ed.pdf.

compliance.²⁹⁴ The survey itself can take several weeks and the entire accreditation process can take two to three years.²⁹⁵ This voluntary process is designed to signal that the foreign hospital meets certain recognized international quality standards.

Hospital accreditation represents new governance in many ways. Like other industries, the cross-border health industry is using accreditation to proselytize international standards in “competitive, non-harmonious environments” that “could hardly be less centralized.”²⁹⁶ Moreover, JCI and other accreditors are primarily private actors that both prescribe and standardize behavior,²⁹⁷ generating industry norms and best practices. The standards represent a form of soft law or private regulation.²⁹⁸ And even though accreditation standards do not formally bind,²⁹⁹ they have become de facto standards that require compliance as a practical matter. This type of soft law may have as much impact on industry practices as traditional laws.³⁰⁰

Finally, consistent with new governance, these accreditation schemes rely on significant reputational and financial pressures to monitor and report compliance.³⁰¹ Hospitals market their accreditation to signal that they meet international standards, and the proliferation of hospitals seeking

294. *Accreditation Decision Rules*, JOINT COMM’N INT’L 1 (Jan. 1, 2009), <http://www.jointcommissioninternational.org/common/pdfs/fpdfs/pubs/pdfs/JCI%20ezine/JCIA%202009%20Hosp%20Accreditation%20Decision%20Rules.pdf>.

295. See *JCI Accreditation Process Time Line*, JOINT COMM’N INT’L, <http://www.jointcommissioninternational.org/Accreditation-and-Certification/JCI-Accreditation-Process-Timeline> (last visited Apr. 22, 2011) (advising applicants to begin preparing for the JCI accreditation survey twelve to twenty-four months in advance of the actual survey).

296. Zaring, *supra* note 266, at 313. See also Zaring, *supra* note 195, at 551, 580–85. JCI and the Joint Commission also collaborate with the World Health Organization’s (“WHO’s”) patient safety programs, the Collaborative Center for Patient Safety Solutions and the World Alliance for Patient Safety. WHO COLLABORATING CTR. FOR PATIENT SAFETY SOLUTIONS, <http://www.ccforspatientsafety.org> (last visited Apr. 24, 2011); *World Alliance for Patient Safety*, WHO COLLABORATING CTR. FOR PATIENT SAFETY SOLUTIONS, <http://www.ccforspatientsafety.org/World-Alliance-for-Patient-Safety> (last visited Apr. 24, 2011). Indeed, the WHO program is a prototypical form of new governance, as it “coordinates efforts to spread [patient safety] solutions as broadly as possible internationally through its work with ministries of health, patient safety experts, national agencies on patient safety, health care professional associations, and consumer organizations.” *WHO Redesignates JCI*, JOINT COMM’N INT’L, <http://www.jointcommissioninternational.org/WHO-Redesignates-JCI> (last visited Apr. 24, 2011).

297. See Abbott & Snidal, *supra* note 248, at 505 n.15 (citing Stepan Wood, *Voluntary Environmental Codes and Sustainability*, in ENVIRONMENTAL LAW FOR SUSTAINABILITY 229, 230 (Benjamin J. Richardson & Stepan Wood eds., 2006)).

298. Abbott & Snidal, *supra* note 248, at 506 & n.26.

299. See Trubek, *supra* note 248, at 149.

300. *Id.* at 149–50; Lobel, *supra* note 248, at 388–89.

301. See Hervey & Trubek, *supra* note 11, at 638.

accreditation demonstrates its value.³⁰² In fact, other segments of the cross-border health industry are trying to replicate this model.³⁰³

States can require that cross-border plans use only accredited facilities, or simply rely on reputational concerns to drive this trend. And as I note elsewhere, states could provide some much-needed oversight of JCI to counterbalance financial conflicts of interest.³⁰⁴

2. Regulating Quality Through Insurers

State laws authorizing cross-border insurance can rely on insurers to “regulate” the quality of foreign providers. Insurers and others that pay for cross-border care can leverage their purchasing power to require that foreign providers satisfy specified standards, such as hospital accreditation, physician licensing, and other quality-related criteria. Glenn Cohen and I both have recommended that payors channel patients to high-quality providers by using JCI accreditation and other proxies as “indicia of quality.”³⁰⁵ Many payors seem to be using these levers on their own, but states should still require them.

The new governance literature sometimes refers to this as supply chain leveraging.³⁰⁶ Public and private insurers frequently condition coverage and reimbursement on suppliers meeting specified criteria. Like companies in other industries, foreign hospitals would “commit themselves to traditionally public goals as the price of access to lucrative opportunities.”³⁰⁷ Access to U.S. patients may allow organizations like JCI to induce compliance with U.S.-inspired standards.³⁰⁸ Again, foreign providers will comply with these voluntary standards not out of legal

302. Virtually every accredited hospital advertises its JCI accreditation on its website. Cortez, *supra* note 112, at 86. Between 2005 and 2007, JCI had accredited over eighty hospitals. *Id.* at 83 & n.91. Today, JCI has accredited over 300 hospitals. *About Joint Commission International*, JOINT COMM’N INT’L, <http://www.jointcommissioninternational.org/about-jci> (last visited Apr. 24, 2011).

303. The Medical Tourism Association (“MTA”) has created a facilitator certification program meant to signal that companies that arrange for patient travel meet certain minimum industry standards. Although the MTA has only certified four companies as of February 2011, it serves a similar purpose as JCI accreditation. See Cortez, *supra* note 231, at 78–80; *Medical Tourism Association Facilitator Certification*, MED. TOURISM ASS’N, http://www.medicaltourismassociation.com/en/prod_2_medical-tourism-association-facilitator-certification.html (last visited Apr. 24, 2011); *List of Certified Medical Tourism Facilitator Companies*, MED. TOURISM ASS’N, <http://www.medicaltourismassociation.com/en/certified-facilitators.html> (last visited Apr. 24, 2011).

304. Cortez, *supra* note 112, at 125–26.

305. Cohen, *supra* note 16, at 1516–17. See also Cortez, *supra* note 112, at 118–27.

306. Meidinger, *supra* note 274, at 516 (noting that supply chains are often transnational networks, themselves subject to different jurisdictions).

307. Freeman, *supra* note 260, at 1285.

308. See Slaughter & Zaring, *supra* note 267, at 213–14.

obligation, but out of economic motivation.³⁰⁹

The best example in the health industry is Medicare, which reimburses hospitals only if they satisfy various “Conditions of Participation” that touch on everything from hospital quality controls to staff requirements.³¹⁰ And public insurers continue to experiment with contract-based incentives. The Centers for Medicare and Medicaid Services (“CMS”) implemented pilot programs requiring hospitals to adhere to pay-for-performance criteria as a condition of reimbursement.³¹¹ CMS also requires hospitals to maintain quality assessment and performance improvement programs to reduce medical errors, delegating significant discretion to individual hospitals to implement these broad requirements.³¹² And Medicaid attaches conditions to contracts with hospitals and managed care organizations.³¹³ These Medicare and Medicaid criteria are backstopped by the threat that a hospital will not be reimbursed.³¹⁴ Thus, contracting “may extend public norms to private actors and lead to ‘re-regulation’ rather than deregulation.”³¹⁵

Cross-border payors have already embraced these devices. The California Department of Managed Health Care relies on private plans to ensure that providers in Mexico offer quality care, recognizing that the state might not be able to exercise jurisdiction over foreign providers directly.³¹⁶ Although California law relies to some extent on Mexican hospital and physician standards,³¹⁷ acknowledging that these standards necessarily differ from those in the United States, it also relies on insurers themselves to regulate foreign providers.³¹⁸

309. Trubek, *supra* note 248, at 149–50.

310. 42 C.F.R. pt. 482 (2010). Note that the Medicare program allows hospitals to satisfy most Conditions of Participation by receiving accreditation by the Joint Commission. Accredited hospitals will be “deemed” to satisfy all but a few conditions. *Id.* § 488.5.

311. Revision to Hospital Inpatient Prospective Payment Systems, 71 Fed. Reg. 47,870, 48,046, 48,102–03 (Aug. 18, 2006) (to be codified at 42 C.F.R. pt. 409, 410, 412, 413, 414, 424, 485, 489, and 505); Trubek, *supra* note 248, at 166. CMS implemented this pilot under Section 5001(b) of the Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5001(b), 120 Stat. 4, 29, which encourages such programs.

312. Medicare and Medicaid Programs; Hospital Conditions of Participation: Quality Assessment and Performance Improvement, 42 C.F.R. pt. 482; Blum, *supra* note 248, at 131–32.

313. See James W. Fossett, *Managed Care and Devolution*, in *MEDICAID AND DEVOLUTION* 106, 122–23 (Frank J. Thompson & John J. Dilulio Jr. eds., 1998).

314. Blum, *supra* note 248, at 132. See also 68 Fed. Reg. 3435, 3443, 3446 (Jan. 24, 2003).

315. Freeman, *supra* note 260, at 1286 (footnote omitted).

316. Lenert & Cohen, *supra* note 207, at 20.

317. CAL. HEALTH & SAFETY CODE § 1351.2(a)(1) (West 2008) (requiring plans and medical directors overseeing care in Mexico to be lawfully licensed in Mexico).

318. Lenert & Cohen, *supra* note 207, at 19–20.

States should consider the following precedents from California's cross-border insurers. First, the California plans require that Mexican physicians (1) have graduated from medical school; (2) are members in good standing with a professional medical association; (3) have a valid license to practice, including board certification for specialists; (4) are registered with the Mexican Secretary of Health to prescribe drugs; (5) have clinical privileges in good standing at a network hospital; and (6) have malpractice insurance.³¹⁹

States or insurers could also use access to U.S. patients as a carrot to encourage foreign providers to adopt adequate practice standards. For example, insurers sometimes require providers to use clinical practice guidelines ("CPGs") and other protocols for specific ailments.³²⁰ In the United States, the public and private sectors have collaborated to produce over two thousand CPGs over the past decade.³²¹ Similarly, insurers and other payors for cross-border care can require that foreign providers adhere to certain practice standards.

Insurers can also impose requirements on foreign hospitals. California's cross-border plans generally require foreign hospitals to be accredited by the Mexican government and be members of the National Hospital Association.³²² As such, hospitals in these cross-border insurance networks may be audited by multiple oversight bodies, such as the California Department of Managed Health Care, the Mexican Secretary of Health, and the insurance companies themselves.³²³

State laws authorizing cross-border plans should consider a combination of these requirements and encourage insurers to generate more "indicia of quality."³²⁴ Or, states that do not wish to get into the business of setting standards for foreign providers might simply delegate to insurers the duty to regulate the quality of care overseas. The experience of the WGA is

319. Maguire, *supra* note 179, at 55–56 (discussing SIMNSA and Health Net); Savio, *supra* note 179, at 36–37 (discussing Blue Shield); Shanahan, *supra* note 179, at 72 (discussing the WGA).

320. Hunter, *supra* note 16, at 15–16.

321. *Id.* at 15 (citing Lars Noah, *Medicine's Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community*, 44 ARIZ. L. REV. 373, 417–18 (2002)).

322. See Maguire, *supra* note 179, at 55–56; Savio, *supra* note 179, at 37–38; Shanahan, *supra* note 179, at 72.

323. Maguire, *supra* note 179, at 55–56; Shanahan, *supra* note 179, at 72. BlueShield established requirements for Mexican hospitals that require them to meet minimum standards for measuring patient outcomes, credentialing, maintaining medical records, and managing facilities. Savio, *supra* note 179, at 36, 38, 42–44. The California insurers generally work with Mexico-based companies to monitor quality of care—Blue Shield works with General de Salud and Health Net relies on SIMNSA. *Id.* at 43; Maguire, *supra* note 179, at 49.

324. Cohen, *supra* note 16, at 1516.

particularly instructive here. As a self-funded ERISA plan, the WGA had to establish and monitor quality standards itself, without relying on state regulation.³²⁵ The WGA has developed its own quality control standards and checklists for both U.S. and Mexican providers, and frequently inspects facilities for compliance.³²⁶ Membership in the WGA's lucrative network gives Mexican providers significant incentives to provide quality care.³²⁷ Thus, the WGA generally requires that services provided in Mexico meet the company's own quality standards as a condition of payment, and frequently visits facilities to audit for quality.³²⁸ The WGA has declined to renew contracts with Mexican facilities that did not meet its standards.³²⁹ This counters a potential asymmetry by which providers in Mexico might access lucrative U.S. markets without complying with more onerous U.S. regulations.³³⁰

3. Regulating Quality Through Transnational Networks

We should also rely on emerging transnational networks to “regulate” cross-border plans, as well as phenomena like medical tourism, outsourcing, and repatriation. Network cooperation has long been a hallmark of new governance,³³¹ and it offers several potential benefits here. Networks can create epistemic communities of those with special expertise and competence,³³² which can generate standards and police compliance with them.³³³ Domestic regulators are collaborating in a wide variety of

325. Shanahan, *supra* note 179, at 71–72.

326. *Id.*

327. *See id.*

328. *Id.* at 72.

329. *Id.*

330. *See* Macey, *supra* note 252, at 1360–61 (noting how foreign securities issuers used American Depository Receipts to market their securities to U.S. investors without being subject to SEC regulation, which was “a clever means for foreign issuers to avoid the reach of U.S. securities law”).

331. *See* Hervey & Trubek, *supra* note 11, at 639 (noting that participation from the “main necessary stakeholders” is required). A consensus is emerging that traditional state-centered governance is ceding ground to a more polycentric form of distributed governance. *See, e.g.*, Braithwaite, *supra* note 250, at 890; Burris, Kempa & Shearing, *supra* note 248, at 12–13, 25–27; Slaughter & Burke-White, *supra* note 196, at 334–35.

332. Koh, *supra* note 266, at 2648 n.246 (noting Peter Haas’s definition of epistemic community as a “network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area” (quoting Peter M. Haas, *Introduction: Epistemic Communities and International Policy Coordination*, 46 INT’L ORG. 1, 3 (1992))); Slaughter & Zaring, *supra* note 267, at 214.

333. Network governance occurs via repeated interactions—the more actors from different jurisdictions interact, the more they will internalize international norms domestically. Koh, *supra* note 251, at 199, 203–05; Koh, *supra* note 266, at 2602–03. Thus, we should encourage the cross-border industry and its patrons to interact “in forums capable of generating norms.” Koh, *supra* note 251, at 206.

areas, including antitrust regulation, aviation, consumer protection, criminal justice, education, environmental protection, financial regulation, food and drug regulation, human rights, information technology, labor rights, public health, tax, telecommunications, and transportation.³³⁴ These collaborations are useful because they can generate and encourage compliance with standards that otherwise might not exist. With cross-border care, the goal is to avoid a race to the bottom between jurisdictions competing for patients.³³⁵ Fortunately, there already exists a fairly robust series of networks and collaborations that touch on various aspects of cross-border health care, including binational insurance and border health initiatives with Mexico. Five categories of networks and collaborations are particularly promising here.

a. Industry Networks

The cross-border industry is beginning to coalesce around several transnational networks. Trade groups like the Medical Tourism Association (“MTA”) provide a forum for companies to interact.³³⁶ Association members include hospitals, clinics, medical tourism facilitators, government agencies, and related businesses from nearly every major continent.³³⁷ Several industry periodicals have emerged that analyze cross-border trends.³³⁸ Accreditors like JCI act like de facto network nodes by

334. Slaughter & Zaring, *supra* note 267, at 215–16 (listing industries); Zaring, *supra* note 266, at 319–20 (same); Zaring, *supra* note 195, at 549–50 (same). *See also* Lobel, *supra* note 248, at 345 (noting that a new governance model is instigating change in a variety of fields, and listing examples); Meidinger, *supra* note 274, at 530 (listing supragovernmental regulatory standards); Joseph J. Norton, *The Modern Genre of Infrastructural Law Reform: The Legal and Practical Realities—The Case of Banking Reform in Thailand*, 55 SMU L. REV. 235, 238 (2002) (noting how the international financial community developed consensus standards). Cooperation in these areas has been “driven by the basic need of government officials in one country to interact with their counterparts in another to regulate increasingly mobile and global private actors.” Slaughter & Zaring, *supra* note 267, at 215. *See also* ANNE-MARIE SLAUGHTER, A NEW WORLD ORDER 261–71 (2004). In fact, federal agencies like the SEC and Federal Reserve Board are seen by many as “international lawmakers” given their international reach and cooperation with foreign regulators. Zaring, *supra* note 266, at 318. Harmonization between jurisdictions will help avoid “regulatory arbitrage” between jurisdictions and forum shopping by patients and providers. *Id.* at 300–01; Macey, *supra* note 252, at 1353–54, 1362.

335. Eleanor Kinney has expressed concern that economic integration between the U.S. and Mexican health care sectors could “precipitate[] a race to the bottom in terms of providing accessible, high quality health care at an affordable cost.” Kinney, *supra* note 187, at 958. But as Anne-Marie Slaughter and David Zaring note, international networks can provide “an alternative to the paradigm of a regulatory race to the top or bottom.” Slaughter & Zaring, *supra* note 267, at 217.

336. *See About the MTA*, MED. TOURISM ASS’N, <http://www.medicaltourismassociation.com/en/about-the-MTA.html> (last visited Apr. 24, 2011).

337. *Id.*

338. *See, e.g.*, INT’L MED. TRAVEL J., <http://www.imtjonline.com/welcome> (last visited Apr. 24, 2011).

not only applying relatively uniform standards to hospitals in different jurisdictions, but also by factoring local practices into accreditation standards.³³⁹ In California, insurers like Health Net tend to have “strong relationship[s]” with the Mexican government.³⁴⁰ Each of these collaborations can help generate pseudoregulatory norms.

b. Professional Medical Networks

Professional medical societies have addressed cross-border trends, and could provide much-needed expertise to develop industry standards. The AMA published the “first ever guidance on medical tourism,”³⁴¹ calling for “employers, insurance companies, and other entities that facilitate or incentivize medical care outside the U.S.” to follow nine rules.³⁴² The AMA and the California Medical Association both have debated medical repatriation, with the latter publicly condemning it.³⁴³ The National Hispanic Medical Association organized a forum on binational health insurance at the U.S. Senate, attended by regulators from the United States and Mexico.³⁴⁴ These organizations have an obvious interest in cross-border trends and should continue to contribute to emerging norms and standards here.

c. Hospital Networks

Several flagship U.S. hospitals and medical schools have formalized relationships with foreign hospitals that attract international clientele. Harvard, Johns Hopkins, Cornell, Columbia, and Duke have relationships with hospitals in several countries, including Brazil, Chile, India, and Singapore.³⁴⁵ World-renowned hospitals like the Cleveland Clinic and the Memorial Sloan-Kettering Cancer Center also have international

339. JCI uses Regional Advisory Councils “to facilitate JCI’s awareness and understanding of important regional health care quality, patient safety, health financing, and health policy issues, and cultural needs and requirements.” *Regional Advisory Councils*, JOINT COMM’N INTL, <http://www.jointcommissioninternational.org/Regional-Advisory-Councils> (last visited Apr. 24, 2011) [hereinafter JCI, *Regional Advisory Councils*].

340. Maguire, *supra* note 179, at 59.

341. “AMA Provides First Ever Guidance on Medical Tourism,” MED. NEWS TODAY (June 17, 2008), <http://www.medicalnewstoday.com/articles/111577.php>.

342. *New AMA Guidelines on Medical Tourism*, AM. MED. ASS’N, <http://www.ama-assn.org/ama1/pub/upload/mm/31/medicaltourism.pdf> [hereinafter *AMA Guidelines*].

343. See *supra* note 165 and accompanying text.

344. CMHI, *supra* note 185, at 2; *Forum Seeks to Increase Insured, Expand Cross-Border Health Coverage*, HISPANICBUSINESS.COM (Feb. 2, 2005), http://www.hispanicbusiness.com/news/2005/2/7/forum_seeks_to_increase_insured_expand.htm.

345. DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 119, at 16–17. These relationships vary, however, in how much the collaborators actually collaborate.

partnerships.³⁴⁶ Foreign hospitals proudly fly these flags, demonstrating that their hospitals meet Western standards. And like professional medical societies, U.S. hospitals and medical schools have an obvious stake in cross-border phenomena. Again, we should use these networks to influence emerging industry standards.

d. Public-Private Networks

Since the mid-1990s there has been a significant increase in collaboration among the U.S.-Mexico border health programs.³⁴⁷ These collaborations can contribute significant expertise to cross-border networks.³⁴⁸ The most notable of these is the Cross-Border Health Insurance Initiative,³⁴⁹ which “brought together private insurers, government officials, and health leaders from both sides of the border” to discuss access to affordable cross-border insurance.³⁵⁰ The Initiative wrote issue briefs and solicited competitive proposals for how to design and market cross-border plans.³⁵¹ This work has paved the way for later public-private collaborations in the United States and Mexico, producing “an information substructure and a network of relationships” that have enabled more concentrated work on border and migrant health.³⁵² Indeed, the Initiative is perhaps the best example of a transnational network in this area, and states and insurers should rely on its work.

States and insurers should also utilize other border health programs. For example, the California-Mexico Health Initiative (“CMHI”) at the University of California, Berkeley is a genuine public-private network, including “Mexican consulates, community clinics, county health services, community-based organizations, hometown associations, boards of

346. *Id.*

347. *See* Laws, *supra* note 12, at 271–73. Foundations focusing on border health issues have proliferated, including the Border Health Initiative and Alliance Healthcare Foundation. *Id.* at 273–74.

348. These public-private partnerships might embody the principles of “democratic experimentalism” endorsed by Michael Dorf and Charles Sabel, which emphasize the use of guidelines, benchmarking, and best practices implemented through public-private cooperation. Michael C. Dorf & Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 COLUM. L. REV. 267, 350, 354 (1998). Hybrid approaches combining traditional state regulation and decentralized governance among private actors holds particular appeal for cross-border health care. Hervey & Trubek, *supra* note 11, at 627–28.

349. The Initiative was formed in 1998 by the California Health Care Foundation, the Mexican Health Foundation, the Academy for International Health Studies, and Healthcare Redesign International. Laws, *supra* note 12, at 276.

350. *Id.*

351. *Id.*

352. *Id.*

supervisors, legislators, and funding agencies.”³⁵³ As noted above, the CMHI has worked on access to insurance for migrant workers, publishing a “Proposed California Strategy for Binational Health Insurance” that contemplates affordable binational plans.³⁵⁴ In Texas, the Paso del Norte Health Foundation is formulating programs that might complement the programs in California.³⁵⁵ These programs can become quasi-regulators in their own right by using a variety of pressure points, such as “naming and shaming, restorative justice, consumer boycotts, strikes, and litigation.”³⁵⁶

e. Government Networks

Finally, we can rely on the long accumulation of government-sponsored border health programs.³⁵⁷ In 1996, the U.S. Health Resources and Services Administration (“HRSA”) created the Border Health Initiative to address primary care and public health along the border.³⁵⁸ That same year, HHS and Mexico’s Secretary of Health formed a health care working group called the U.S.-Mexico Bi-National Commission (“BNC”) to collaborate on public health, including migrant health.³⁵⁹ The BNC has sponsored meetings and professional exchanges, and developed treatment standards for common diseases.³⁶⁰ A separate U.S-Mexico Border Health Commission—chaired by the HHS secretary and including the director of each border state’s department of public health—was “the first ever created between the United States and another country to specifically address health issues.”³⁶¹ The Commission’s goals are to institutionalize domestic thinking on border health issues and to “create an effective venue for binational discussion” of public health issues along the border.³⁶² Again, each of these collaborations could contribute expertise to cross-border networks.

Yet, despite this impressive range of collaborations, there is potential

353. Martinez, Mora & Spagnolo, *supra* note 212, at 222. *See also* Laws, *supra* note 12, at 275.

354. *See* CMHI, *supra* note 185.

355. Paso del Norte focuses on disease prevention and health promotion in west Texas, southern New Mexico, and Ciudad Juárez, Mexico. Laws, *supra* note 12, at 273.

356. Braithwaite, *supra* note 250, at 888. *See also* Kingsbury, Krisch & Stewart, *supra* note 248, at 35 (presenting examples of global institutions and networks that have established “greater procedural transparency and participation”).

357. Government-sponsored border health programs date back to the 1940s. Laws, *supra* note 12, at 271.

358. *Id.* at 271–72.

359. *Id.* at 272.

360. *Id.*

361. *Id.*

362. *Id.* The USMBHC published its “Healthy Border 2010 Program Objectives” to identify and mitigate the most significant public health threats affecting the border region. *Id.*

for more streamlined and centralized cooperation. As it stands, this constellation of collaborations might be overwhelming. Government entities in both Mexico and the United States should formalize their collaborations and create a model for similar collaborations with other jurisdictions that draw U.S. patients, serving as a central repository for other collaborations.

There are several candidates for spearheading centralized cooperation in Mexico. The Secretary of Health licenses private insurers that offer HMO-style prepaid plans, setting standards for patient rights and safety, and inspecting the plans for compliance.³⁶³ Mexico's General Health Council certifies public and private hospitals based on standards set by the Mexican Commission on Hospital Certification, and operates an additional, voluntary certification system.³⁶⁴

There are also several candidates for collaboration in the United States. On the federal level, HRSA, CMS, the Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Services Administration all have contributed to border health programs.³⁶⁵ The Food and Drug Administration ("FDA") also has an interest in reimportation of prescription drugs across the Mexican and Canadian borders.³⁶⁶ On the state level, each of the border states runs border health programs,³⁶⁷ and most have studied cross-border insurance. The Texas Senate convened a committee to study binational health insurance after the legislature rejected

363. Mexico's private health insurers are known as "Instituciones de Seguros Especializadas en Salud" ("ISES"), or Insurance Institutions Specializing in Health Care. The Secretary of Health is "La Secretaria de Salud." Lenert & Cohen, *supra* note 207, at 25–26; CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at app. C; SECRETARÍA DE SALUD, http://portal.salud.gob.mx/index_eng.html (last visited Apr. 24, 2011).

364. The voluntary program is called the National Program of Medical Services Facilities Certification. The standards govern facilities, equipment, and other physical operations. These national regulations are known as "normas" (this one being the Norma Oficial Mexicana de Certificacion de Hospitales y Consultorios). The General Health Council relies on a committee that includes representatives from several official organizations, such as the Secretary of Health, the National Autonomous University of Mexico, and the membership associations representing physicians, surgeons, nurses, and hospitals. Facilities must be recertified every three years. Cesar Martinez, *Certification of Hospitals and in Mexico and Credentialing of Mexican Physicians*, in CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at app. E; Kerr, Pogue & Tucker, *supra* note 226, at 126.

365. Laws, *supra* note 12, at 272.

366. See, e.g., *Imported Drugs Raise Safety Concerns*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/Drugs/ResourcesForYou/Consumers/ucm143561.htm> (last updated May 1, 2009) ("The list of safety risks is long, but the principal problems involve the use of prescription drugs without a physician's supervision and the danger of buying drugs of unknown origin and quality.").

367. Laws, *supra* note 12, at 272.

bills that would have authorized such plans,³⁶⁸ and the Texas Department of Insurance has met with its counterpart in Mexico.³⁶⁹ Similarly, the Arizona-Mexico Commission has studied cross-border health insurance.³⁷⁰ And as noted above, California's Department of Managed Health Care already regulates a segment of cross-border plans. Cross-border networks should continue to rely on these collaborations and their work. Further, collaborations with Mexican regulators could create a model for working with other jurisdictions that host U.S. patients.

4. Generating Credible Information

Another key tenet of new governance is generating credible information, and the methods above can help generate credible information about cross-border care, particularly regarding the quality of foreign providers. Counterintuitively, there is both a glut and a dearth of information here: a glut of suspect information supplied by the industry that promises care of equal or superior quality to that in the United States, and a dearth of reliable information from objective sources that could test these claims. Although American observers praise foreign hospitals for publishing voluminous price and quality data compared to their U.S. counterparts,³⁷¹ there are very few ways to validate this data, so it is far from clear whether the value of this data correlates at all to its volume. This credibility gap warps the calculus for patients and payors considering overseas care, complicating an already complex decision and probably deterring some from pursuing care overseas at all.

As most of us can attest, "A plenitude of information leads to a poverty of attention."³⁷² Given the overabundance of industry-supplied information in the cross-border market, there is great value not only in testing the industry's claims and generating credible information, but also in making this information accessible to purchasers.³⁷³ This function is

368. See *Interim Committee on Binational Health Benefit Plan Coverage*, TEX. ST. SENATE, <http://www.senate.state.tx.us/75r/senate/commit/c1000/c1000.htm> (last visited Apr. 24, 2011); REPORT OF THE INTERIM COMMITTEE ON BINATIONAL HEALTH BENEFIT PLAN COVERAGE (2003), available at <http://www.senate.state.tx.us/75r/senate/commit/c1000/downloads/binational.pdf>; Cohen & Lenert, *supra* note 192, at 84–87.

369. Cohen & Lenert, *supra* note 192, at 84.

370. See WALKER & GUERRERO, *supra* note 141, at 1.

371. E.g., DEVON M. HERRICK, NAT'L CTR. FOR POL'Y ANALYSIS, POLICY REPORT NO. 304, MEDICAL TOURISM: GLOBAL COMPETITION IN HEALTH CARE 10–11 (2007), available at <http://www.ncpa.org/pdfs/st304.pdf>. See also Cortez, *supra* note 112, at 85–86.

372. Robert O. Keohane & Joseph S. Nye, Jr., *Power and Interdependence in the Information Age*, 77 FOREIGN AFF. 81, 89 (1998).

373. See Slaughter & Zaring, *supra* note 267, at 220.

particularly important “in an age of information overload.”³⁷⁴

Although virtually every facet of cross-border care deserves more searching examination, the quality of foreign care remains a major blind spot. Public and private “regulators” should prioritize collecting and publishing quality data, such as surgical success and failure rates that are defined by standardized endpoints.³⁷⁵ High-performing hospitals could then market themselves as centers of excellence for certain procedures—which many already do based on unverified data—and low-performing hospitals would have more incentive to improve their outcomes.³⁷⁶ The movement toward evidence-based medicine provides several models. For example, states, insurers, and accreditors might require foreign providers to report “never events”—a defined list of preventable adverse events that should never occur.³⁷⁷ Publishing this information would be critical to invoking the pressure points new governance supplies, such as public shaming.³⁷⁸

But who should collect this information, and how? Insurers can gather quality information from foreign providers as a condition of doing business, though it is uncertain whether insurers would publish this information without states requiring it.³⁷⁹ If states did require publication, the states could aggregate and disseminate the information.³⁸⁰ Alternatively, some of the networks discussed above could aggregate and publish the data. For example, JCI could aggregate quality data from hospitals and use it to calibrate its accreditation standards. Trade groups like the MTA could do the same. State regulators could even use industry data to generate state-sanctioned guidelines.³⁸¹ Given the glut of

374. *Id.*

375. See Cortez, *supra* note 112, at 120, 125; Hervey & Trubek, *supra* note 11, at 639.

376. Hervey & Trubek, *supra* note 11, at 639.

377. Blum, *supra* note 248, at 131. In fact, “Minnesota became the first of several states to require that the list of 27 adverse events measures developed by the National Quality Forum (NQF), referred to as ‘never events,’ be reported to the Minnesota Department of Health.” *Id.*

378. Trubek, *supra* note 248, at 150–51, 163–64; Zaring, *supra* note 195, at 557 (noting how the Basle Committee on Banking Supervision has used press releases to announce its purpose and activities, in a departure from more conventional notices and activities).

379. Disclosure by facilitators and providers in the cross-border market meets the spirit of informed consent law, which is being used increasingly to address information asymmetries between health care purchasers and providers, in part by requiring disclosure of performance and outcome data. Hunter, *supra* note 16, at 21 & nn.101–02.

380. Similarly, several states have pharmaceutical marketing reporting laws. Companies submit information that the state then discloses to the public in aggregate form. See, e.g., *Disclosures of Marketing Expenditures for Prescription Drugs, Biological Products and Medical Devices*, OFFICE OF THE ATT’Y GEN. OF VT., <http://www.atg.state.vt.us/issues/pharmaceutical-manufacturer-payment-disclosure.php> (last visited May 10, 2011) (including a link to the “Previous Years Pharmaceutical Public Data” as required by 18 VT. STAT. ANN. tit. 18 §§ 4631(a), 4632 (2010)).

381. See, e.g., Zaring, *supra* note 266, at 308 (noting that the Environmental Protection Agency

information here, the groups that do aggregate and distribute credible information would wield significant influence over industry practices.³⁸²

Generating reliable information is itself a goal, and new governance is well suited to it.³⁸³ Using information gathering as a regulatory tool has always been attractive to politicians and regulators looking for less burdensome regulatory alternatives.³⁸⁴ Not only should credible information enable patients and insurers to make more informed decisions, but it should also generate public goods like transparency that will allow us to make better collective decisions about the quality of overseas care.³⁸⁵ In this vein, involving the many government and nonprofit organizations focused on border health can balance the individualistic concerns of patients, providers, and insurers.

5. The Government Backstop

As much as new governance suits the cross-border industry, this proposal does not rely solely on voluntary cooperation and nonbinding standards. Hard law supplies a useful starting point and backstop. State laws can buttress private regulation and intervene when it fails.³⁸⁶ The government can play a number of roles here—legislator, funder, monitor, sanctioner, orchestrator, and educator.³⁸⁷ State regulators can also contribute to private standards, enhancing the accountability of the entire scheme and lending it the imprimatur of the state, even if nongovernment parties are the primary actors.³⁸⁸ For example, a state law requiring JCI accreditation for foreign hospitals would put an official stamp on an otherwise nongovernmental process.

Government regulators frequently rely on new governance, for example by setting performance standards that are implemented by decentralized, local actors.³⁸⁹ In the health industry, several state laws now require drug and device companies to comply with voluntary industry

takes this approach under the Clean Water Act).

382. See Keohane & Nye, *supra* note 372, at 89 (“Editors, filters, interpreters, and cue-givers become more in demand, and this is a source of power.”).

383. Burris, Kempa & Shearing, *supra* note 248, at 32–33; Trubek, *supra* note 248, at 151.

384. Sage, *supra* note 245, at 508 (“The fact that information-based regulation is essentially off-budget enhances its political attractiveness.”).

385. *Id.* at 516–19.

386. Abbott & Snidal, *supra* note 248, at 544–45; Meidinger, *supra* note 274, at 528 (“[S]upragovernmental regulatory programs are accountable to states in multiple ways.”).

387. Trubek, *supra* note 248, at 160.

388. Abbott & Snidal, *supra* note 248, at 558.

389. See Dorf & Sabel, *supra* note 348, at 430, 436–37.

codes of conduct, transforming de facto requirements into de jure ones.³⁹⁰ Regulators have considered similar proposals in the cross-border industry—proposed bills in West Virginia would have given state employees an incentive to have surgeries overseas, but only at JCI-accredited hospitals.³⁹¹ Thus, private certification can serve as a proxy for compliance with state law,³⁹² or states may adopt or endorse private standards.

States should follow California's example, which demonstrates the complementary roles for hard and soft law. California law requires cross-border plans to review continuously "the quality of care"³⁹³ and the "performance of medical personnel,"³⁹⁴ among other things, and the Department of Managed Health Care can revoke an insurer's license if it fails to oversee the quality of care in its provider network.³⁹⁵ Before California applied these laws, the unregulated cross-border insurance market generally provided "cheap services" for "cheap costs."³⁹⁶ Hard law legitimated this market.³⁹⁷ California law even legitimated cross-border

390. See, e.g., CAL. HEALTH & SAFETY CODE § 119402 (West 2008) (incorporating the Pharmaceutical Research and Manufacturers of America ("PhRMA") Code on Interactions with Health Care Professionals); MASS. GEN. LAWS ch. 111N, § 2 (2010) (requiring the Massachusetts Department of Public Health to issue a code of conduct "no less restrictive" than the PhRMA Code and the Advanced Medical Technology Association Code); NEV. REV. STAT. § 639.570 (2009) (citing the PhRMA Code as satisfying a drug manufacturer's new obligation to adopt a written code of conduct).

391. H.B. 2841, 78th Leg., Reg. Sess. (W. Va. 2007); H.B. 4711, 77th Leg., Reg. Sess. (W. Va. 2006); H.B. 4359, 77th Leg., Reg. Sess. (W. Va. 2006).

392. Meidinger, *supra* note 274, at 519. Indeed, if nongovernment certification programs interact with state regulators, these standards can coalesce. Even courts may adopt privately generated standards, for example, by embracing private standards as the standard of care in tort cases. *Id.* at 520. States can combine reliance on voluntary standards with oversight of the organizations that promulgate them, representing a form of metaregulation. Abbott & Snidal, *supra* note 248, at 566. Elsewhere, I have suggested government oversight of JCI. Cortez, *supra* note 112, at 125–26. For more, see Bronwen Morgan, *Regulating the Regulators: Meta-Regulation as a Strategy for Reinventing Government in Australia*, 1 PUB. MGMT. 50 (1999) (discussing the structure of the Australian metaregulatory regime and discussing the ability of metaregulation to create more efficient systems).

393. CAL. HEALTH & SAFETY CODE § 1370.

394. *Id.*

395. *Id.* § 1351.2(a).

396. Maguire, *supra* note 179, at 49 (quoting Ernesto Dominguez Garcia, Subdirector Operativo in Tijuana for Seguros Comercial America). See also Lenert & Cohen, *supra* note 207, at 21 ("[T]he companies that were selling cross-border insurance products were not licensed, tracked, or accounted for by a regulator in California, nor by any Mexican regulatory entity."). Although Texas law does not permit cross-border plans under Texas Insurance Code § 1216.004, prior legislation would have relied on Mexican laws and regulations to govern Mexican providers, and the Texas Department of Insurance has contemplated conditioning cross-border insurance licensure in Texas on compliance with Mexican regulatory requirements. TEX. INS. CODE ANN. art. 1216.004 (West 2010); Cohen & Lenert, *supra* note 192, at 81, 84, 86.

397. Having a controlled, regulated market can also be an asset internationally. For example, there

ERISA plans that are largely subject to federal rather than state oversight—the WGA lobbied California to require ERISA plans to obtain a state Certificate of Compliance to give the WGA plan credibility among the fraudulent or underfunded plans in the market.³⁹⁸ More recently, several private groups in California, including labor unions and the hotel, restaurant, and construction industries, have lobbied for regulation of cross-border plans.³⁹⁹

Nevertheless, cross-border insurance can thrive even without hard law or government regulation. For example, the WGA has had to regulate its foreign provider network itself because, as a self-funded ERISA plan, it cannot rely on state regulation and ERISA does not concern itself with minimum coverage requirements or the quality of care.⁴⁰⁰ Thus, although I recommend that states use hard law as a backstop, cross-border care might be feasible without it.

VI. LIMITATIONS OF THE PROPOSAL

Cross-border insurance is not a panacea. It will not cover all those who remain uninsured after health reform. Nor will it eliminate concerns that health care in developing countries is of lower quality, or not regulated adequately, or both. Moreover, because the proposal relies on new governance, it is also susceptible to criticisms that it suffers from democratic and accountability deficits. These limitations are real. And they remind us that cross-border insurance is not the ideal solution for covering those who remain uninsured after health reform. But given current political realities, particularly regarding immigrants, this proposal is worth pursuing even with its limitations.

A. HOLES IN THE SAFETY NET WILL PERSIST

Foreign providers cannot patch every hole in the U.S. health care system. Cross-border insurance will not cover all twenty-three million residents that will remain uninsured after health reform, something that even the most ardent advocates for cross-border insurance recognize.⁴⁰¹

is a demand for U.S. capital markets not only because of the resources available in the United States, but also in part because SEC regulation has been successful. *See* Macey, *supra* note 252, at 1362.

398. Shanahan, *supra* note 179, at 69, 71.

399. Lenert & Cohen, *supra* note 207, at 22; Maguire, *supra* note 179, at 49.

400. *See* Shanahan, *supra* note 179, at 67, 71–72. In fact, the WGA might serve as a useful regulatory node, not only due to its foreign network, but also because it serves as an appointed agent of several U.S. insurers, including Aetna and Health Net. *See id.* at 68.

401. *See* Lenert & Shanahan, *supra* note 203, at 239.

Low-cost cross-border insurance may still be too expensive for some. The average annual cost of the cross-border plans in California for a family of three is \$4300,⁴⁰² which may be unaffordable for many migrant workers and other unauthorized immigrants. At some point, low-cost insurance competes with out-of-pocket, fee-for-service care.⁴⁰³ And unauthorized immigrants are often reluctant to enroll in health insurance plans “because of fear of revealing their immigration status, lack of education, and lack of information.”⁴⁰⁴ Insurers must educate consumers in the lowest-cost market on the value of insurance.⁴⁰⁵ Thus, states and nonprofit networks will be important here, as they can provide unbiased information not tainted by a financial interest to enroll customers.

Cross-border plans also are not practical for everyone. They may not be practical for expensive chronic treatments, such as kidney dialysis or treatment for mental illness. Moreover, proximity matters. Most patients would prefer not to travel to Asia for surgery. And some patients simply cannot, due to medical conditions or limited mobility or a host of other reasons. Even plans that utilize providers in Mexico confront this reality—cross-border plans in California have reported declining enrollment for residents farther away from the Mexico border.⁴⁰⁶ In fact, California may be unique geographically in that it enjoys a large population near the border.⁴⁰⁷ Even states like Texas do not enjoy the same border population.

Cross-border insurance also further complicates the insurance market. Uninsured patients would have to make difficult tradeoffs between public plans (if eligible), private plans that utilize only domestic providers, and cross-border plans that use foreign providers. Cross-border insurance adds another layer of complexity: in addition to choosing between plans that offer varying premiums, deductibles, and benefits, patients also would have to consider whether they would be willing to leave the country for care, and under what circumstances. Insurance products that encourage foreign care will further complicate both purchasing and utilization decisions by patients, which is a real concern.⁴⁰⁸ Moreover, it is not clear whether

402. CMHI, *supra* note 185, at 4.

403. CROSS-BORDER HEALTH INSURANCE: OPTIONS FOR TEXAS, *supra* note 32, at xxiv.

404. Martinez, de la Mora & Spagnolo, *supra* note 212, at 218. *See also* Maguire, *supra* note 179, at 58–59.

405. Lenert & Shanahan, *supra* note 203, at 249–50; Maguire, *supra* note 179, at 58–59; Savio, *supra* note 179, at 41.

406. Maguire, *supra* note 179, at 57. *See also* Martinez, de la Mora & Spagnolo, *supra* note 212, at 221.

407. Martinez, de la Mora & Spagnolo, *supra* note 212, at 221.

408. *See* Cohen, *supra* note 16, at 1552 (citing a New York state study showing that despite

patients can or want to make these decisions.⁴⁰⁹ Thus, convincing patients to enroll and educating them on the tradeoffs they are making may require significant outreach.

Perhaps most importantly, some immigrants may be reluctant to leave the United States for care if doing so would jeopardize pending applications for legal residency or if they could not reenter. Unauthorized immigrants, in particular, will need an avenue for legal reentry, which probably requires comprehensive federal immigration reform—yet another extraordinary hurdle.

Finally, cross-border insurance may exacerbate existing problems with our domestic safety net. It will further fragment both the safety net and the insurance market. Cross-border plans may make it even more difficult for physicians to coordinate care, particularly when a patient receives primary care in one country and specialty care in another. And cross-border insurance may have the perverse effect of undermining future political efforts to cover the remaining uninsured.

Again, these limitations are real. But they are not insurmountable, nor do they mean that cross-border plans will not be a viable low-cost alternative for a significant number of uninsured residents. For many, the choice will be between cross-border insurance and no insurance at all. Moreover, because the United States attracts low-income immigrants from developing countries who cannot afford traditional insurance, we might use innovations from these countries to offer affordable health insurance. For example, insurers in some developing countries are experimenting with private “microinsurance” that is proving to be a viable alternative to paying out-of-pocket for care as needed.⁴¹⁰ Several features of my proposal parallel the practices used by microinsurance.

“heroic efforts to educate patients” on insurance plan choices, most still misunderstood the basic plans).

409. See, e.g., JOST, *supra* note 132, at 31, 90, 92–96 (recognizing the importance of freedom of choice but pointing out limitations on such freedom, including insufficient information gathering, manipulation of tastes and preferences, and irrational consumer behavior); Cortez, *supra* note 231, at 87 (discussing the prohibition of liability waivers and the issues surrounding liability standards in medical tourism); Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 649–51 (2008) (noting the effects of illness on a patient when making choices as a consumer); Carl E. Schneider & Mark A. Hall, *The Patient Life: Can Consumers Direct Health Care?*, 35 AM. J.L. & MED. 7, 11–13, 19–26 (2009) (discussing consumerism and the availability of information to patients).

410. “Microinsurance” is “low-cost health insurance based on a community or cooperative model.” Dror et al., *supra* note 203, at 1788.

B. REGULATORY AND NORM DIFFERENTIALS WILL PERSIST

This proposal relies on the ability of public regulators, private insurers, and a host of other collaborators to convince foreign providers to meet U.S. quality standards, largely without using the threat of formal legal sanctions. Even if these efforts succeed, they will not completely eliminate the discrepancies in how health care is practiced and regulated in developing countries. As I have demonstrated elsewhere, legal differentials will remain embedded—countries like India, Thailand, and Mexico have legal systems that differ dramatically from ours.⁴¹¹ Indeed, California was originally motivated to regulate cross-border plans in part by the concern that American citizens would have to rely on Mexico's legal system to resolve complaints.⁴¹² Even geographically linked countries like the United States and Mexico differ enough socially, politically, and legally that cooperation faces inherent obstacles.⁴¹³ As Kinney notes, "Mexico has the health care sector of a developing country," and "[t]he legal infrastructure for each country's health sector is quite different."⁴¹⁴ Other countries in the cross-border market are just as heterogeneous with the United States, and new governance tends to be most effective when the parties are relatively homogeneous.⁴¹⁵ Developing countries may resist perceived efforts to regulate their hospitals and physicians from afar. In short, the countries that supply and demand cross-border health care may not share common histories, religions, or cultures, which tend to facilitate cooperation.⁴¹⁶

Note, however, that most destination countries are generally liberal states that observe international law and norms.⁴¹⁷ And although parties' interests may diverge, most in the cross-border industry share the long-term interest that cross-border care be safe and legitimate. It is not necessary for destination countries to cater their legal and regulatory systems to U.S.

411. See generally Cortez, *supra* note 231 (discussing the legal recourse available to patients who choose to travel to India, Thailand, Mexico, or Singapore for medical treatment).

412. Cal. Bill Analysis, S.B. 1658, Assemb. Floor, Reg. Sess., at 2 (1998); Lenert & Cohen, *supra* note 207, at 23.

413. See Laurence R. Helfer & Anne-Marie Slaughter, *Toward a Theory of Effective Supranational Adjudication*, 107 YALE L.J. 273, 276–77 (1997).

414. Kinney, *supra* note 187, at 947–48.

415. Slaughter & Zaring, *supra* note 267, at 217–19 (noting that transatlantic networks are generally easier to implement than north-south ones). Networks among wealthy, established liberal democracies with strong commitments to the rule of law are naturally more robust than networks comprised of more heterogeneous members. Helfer & Slaughter, *supra* note 413, at 276–77, 335–36.

416. See Helfer & Slaughter, *supra* note 413, at 335.

417. See Anne-Marie Slaughter, *International Law in a World of Liberal States*, 6 EUR. J. INT'L L. 503, 509, 529 n.57 (1995) (defining "liberal states" as those with a representative government and a market economy).

standards; I simply call for foreign providers that do target U.S. patients to observe emerging industry standards. We can never fully harmonize health care or its regulation. But we can try to guide international standards to protect U.S. patients. And new governance holds the best hope for regulating cross-border care between countries with widely divergent legal and regulatory regimes.⁴¹⁸ Moreover, softer regulation can be more suitable in areas “where there is intense disagreement among decision-making authorities.”⁴¹⁹ New governance is an appropriate response to legal pluralism and viewpoint pluralism, as noted in other areas.⁴²⁰

Another potential criticism of this proposal is that it largely lacks the legal power to compel and coerce foreign providers,⁴²¹ which virtually ensures that legal and norm differentials will persist. Thus, foreign providers and ministries seeking to protect their domestic providers may ignore or disregard nonbinding standards and norms when it suits them. The very process of interaction, however, should encourage foreign providers to internalize these nonbinding standards.⁴²² And even with traditional regulation, “actual enforcement . . . is weak” and regulators do not have the resources or wherewithal to enforce every requirement all of the time.⁴²³ “Partial-industry regulation” can be better than nothing at all.⁴²⁴ Thus, more flexible noncoercive regulation may be the best approach for the cross-border market, particularly if it is enforced by contractual arrangements.

A more fundamental potential criticism of the proposal is that economic integration between developed and developing countries is often used as a lever “to force the legal and economic systems of stronger countries, such as the U.S., onto weaker countries,”⁴²⁵ as a form of

418. See Hervey & Trubek, *supra* note 11, at 645; Lobel, *supra* note 248, at 379–81.

419. Lobel, *supra* note 248, at 394.

420. *Id.* at 424 (describing how new governance would address the need for “intergovernmental coordination and continuous experimentation, learning and adjustment” within environmental regulation).

421. See, e.g., Koh, *supra* note 266, at 2603, 2645–59 (describing how “transnational legal process promotes the interaction, interpretation, and internalization of international legal norms,” causing nations to obey international rules, despite the lack of enforcement of such rules). As Louis Henkin famously noted “almost all nations observe almost all principles of international law and almost all of their obligations almost all of the time.” LOUIS HENKIN, *HOW NATIONS BEHAVE: LAW AND FOREIGN POLICY* 47 (2d ed. 1979) (emphasis omitted).

422. Koh, *supra* note 251, at 203–05.

423. Lobel, *supra* note 248, at 392.

424. Ian Ayres & John Braithwaite, *Partial-Industry Regulation: A Monopsony Standard for Consumer Protection*, 80 CALIF. L. REV. 13, 14 (1992) (“[I]n some situations ‘partial-industry’ regulation may be superior to all-or-nothing regulatory policies.”).

425. Kinney, *supra* note 187, at 957 (citing Mark B. Baker, *No Country Left Behind: The*

developed-country imperialism.⁴²⁶ Regulatory export is not always welcomed by its recipients. Thus, the quality standards that emerge should ensure that developing countries have a voice in the process.⁴²⁷ Indeed, cross-border health networks should effectively integrate developing country regulatory expertise—as JCI claims to do with international accreditation standards.⁴²⁸ Nevertheless, on a fundamental level my proposal would impose U.S.-inspired standards on foreign providers mainly in developing countries. Thus, it is imperative that foreign providers contribute to the standards.⁴²⁹

C. DEMOCRATIC AND ACCOUNTABILITY DEFICITS WILL PERSIST

Because this proposal relies on alternative methods of regulation, it is similarly susceptible to criticisms that it will regulate conduct without being accountable to voters in any traditional way, a critique often framed as a democratic or accountability deficit.⁴³⁰ Participation in new governance schemes is rarely democratic in the traditional sense called for by liberal democratic theory.⁴³¹ Soft law guidelines and standards usually are not reviewable by courts.⁴³² And international collaborations of putative experts are not subject to formal checks and balances.⁴³³ Their informality and lack of public-mindedness can make them susceptible to capture, allowing the industry to manipulate the network for its own ends, perhaps by ratcheting down or diluting standards.⁴³⁴ Indeed, particularly in

Exporting of U.S. Legal Norms Under the Guise of Economic Integration, 19 EMORY INT'L L. REV. 1321 (2005)).

426. These relationships may include parties with unequal bargaining power, which allows wealthy advanced states to impose standards unilaterally on weaker and poorer states. Slaughter & Zaring, *supra* note 267, at 221. They are also criticized as having a Western or liberal bias, and being “imperialistic.” Esty, *supra* note 248, at 1541.

427. Burris, Kempa & Shearing, *supra* note 248, at 28. *See also* Slaughter & Burke-White, *supra* note 196, at 336 (“It should not be assumed that regulatory expertise flows only from developed to developing countries.”).

428. JCI, *Regional Advisory Councils*, *supra* note 339.

429. This approach may even be preferable because regulators in the United States will not be as concerned about the effects policies may have on foreign jurisdictions. *See* Meidinger, *supra* note 274, at 528 (“[S]tates have few institutional incentives to consider the effects of their policies on noncitizens outside their boundaries.”).

430. *See, e.g.*, Esty, *supra* note 248, at 1507–08; Kingsbury, Krisch & Stewart, *supra* note 248, at 16; Zaring, *supra* note 195, at 597–600.

431. *See* Abbott & Snidal, *supra* note 248, at 555–56.

432. Hervey & Trubek, *supra* note 11, at 640.

433. *See* Kingsbury, Krisch & Stewart, *supra* note 248, at 58.

434. Esty, *supra* note 248, at 1507; Slaughter & Zaring, *supra* note 267, at 221 (“[I]nformal harmonization is subject to many of the familiar problems of public choice, such as capture and unrepresentative agency action.”).

international industries, corporate power has “seize[d] an increasing number of the levers of governability away from public authorities.”⁴³⁵ Although the ideal of new governance is democratic experimentalism, some forms may be closer to “managed tokenism.”⁴³⁶ These types of failures—capture and a lack of accountability—can be particularly corrosive.⁴³⁷

These criticisms are valid but can be overcome. First, decentralization can mitigate against capture. A multiplicity of public and private “regulators,” some of whom have countervailing interests, should protect against capture by the industry.⁴³⁸ For example, the Texas bills that would have legalized cross-border plans were defeated in large part by the Texas Medical Association and other local providers over concerns that they would lose market share to less expensive Mexican providers.⁴³⁹ As such, U.S. hospitals and physicians can serve as a powerful counterweight to the cross-border industry, as demonstrated by the AMA’s guidelines on medical tourism.⁴⁴⁰

Second, as Hunter argues, using insurance as a conduit for regulation can help counter the “huge democracy deficit” created by our system of employer-based health insurance that delegates important decisions to private, corporate parties.⁴⁴¹ Cross-border insurance can be used as a form of self-governance in the “pragmatic spirit of democratic experimentalism.”⁴⁴² Insurers should thus engage their customers on whether to offer cross-border options in insurance plans, which will invite discourse between insurers and the insured.⁴⁴³ Indeed, soliciting broad participation will come closer to the ideal enunciated by William Sage that health policy should be driven by broader, more collective “regulatory”

435. Burris, Kempa & Shearing, *supra* note 248, at 19.

436. Meidinger, *supra* note 274, at 534.

437. Esty, *supra* note 248, at 1524–25.

438. Abbott & Snidal, *supra* note 248, at 553–54; Braithwaite, *supra* note 250, at 885.

439. See Cohen & Lenert, *supra* note 192, at 88. Proponents of cross-border care believe that the Texas Medical Association (“TMA”) “will always take a hard-line approach against cross-border care.” *Id.* The TMA argued that Texas physicians would rather care for uninsured patients for free than send them to a Mexican health care system that they believe has few standards regarding access, quality, and care. *Id.* at 89. Even in California, the medical community generally opposes cross-border insurance. Lenert & Cohen, *supra* note 207, at 23.

440. *AMA Guidelines*, *supra* note 342.

441. Hunter, *supra* note 16, at 45–46, 60. In particular, Hunter argues that the Supreme Court’s ERISA preemption decisions have delegated decisionmaking responsibility to private insurers, creating “a charter of corporate sovereignty.” *Id.* at 60.

442. *Id.* at 46.

443. *Id.* at 49–51 (noting that such a process invites the parties to contemplate their moral and social obligations).

interests rather than individualized “relational” self-interest.⁴⁴⁴ Finally, scholars have proposed countless ways to enhance public participation and accountability with alternative forms of regulation.⁴⁴⁵ Perhaps the sole missing ingredient here is the lack of activist patient groups with a stake in cross-border care.⁴⁴⁶ But again, U.S. providers might serve as a proxy for patient interests.

Another rebuttal is that when evaluating options for addressing cross-border care, “the appropriate counterfactual is not hypothetical representative democracy or ‘ideal speech’ deliberation, but the prevailing regulatory setting.”⁴⁴⁷ Here, the appropriate counterfactual may be traditional regulation (which again is not particularly feasible, given the market’s international dimensions), or more likely, no regulation at all. Cross-border insurance can serve as a conduit for employing alternative methods of regulation where regulation otherwise would not exist. Some regulation, even if it is not comprehensive or perfect, is often better than no regulation at all.⁴⁴⁸

A final political consequence relates to our health care system itself. If we accept cross-border insurance as a solution for the residual uninsured, it may temper calls for universal coverage or even lend political legitimacy to arguments against it under the rationale that these populations can “still get care.”⁴⁴⁹ Just as the “social mythology surrounding the safety net lends the

444. Sage, *supra* note 245, at 500–01 (arguing that health policy is too often driven by “relational duties” in which legal obligations are structured with individual parties in mind, rather than “regulatory duties” that serve broader, more abstract goals, casting the distinction as “[a]n obligation to further the interest of a something rather than a someone”).

445. For example, standard-setting organizations like JCI might consider stakeholder advisory councils, notice and comment procedures, or other consultative procedures. See Abbott & Snidal, *supra* note 248, at 554–55. And alternative mechanisms of creating accountability are often “backed by pressures from markets and from peers, by financial controls, and by public reputational dynamics.” Kingsbury, Krisch & Stewart *supra* note 248, at 58. Iterative, repeat dealings create reputational incentives, which are perhaps even more powerful than the threat of sanctions. Koh, *supra* note 266, at 2601, 2639.

446. Activist groups can be an important force in “challenging the acceptability of existing institutional arrangements and offering alternatives.” Meidinger, *supra* note 274, at 516. They can also publicize noncompliance. *Id.* at 525.

447. Abbott & Snidal, *supra* note 248, at 557 (footnote omitted).

448. Ayres & Braithwaite, *supra* note 424, at 14; Koh, *supra* note 266, at 2603 (noting that despite well-known shortcomings with international rules, they are nonetheless obeyed).

449. Brown, *supra* note 86, at 326 (quoting a statement from George W. Bush while he was president). Similar arguments have been made regarding our domestic safety net. *Id.* at 325. In fact, President Bush also remarked “people have access to health care in America . . . After all, you just go to an emergency room.” Dan Froomkin, *Mock the Press*, WASH. POST (July 11, 2007, 1:14 PM), <http://www.washingtonpost.com/wp-dyn/content/blog/2007/07/11/BL2007071101146.html>.

system an eerie stability,⁴⁵⁰ so too might cross-border insurance and other stopgap measures deflate calls for universal coverage.⁴⁵¹ Thus, while this proposal may cover many uninsured in the short-term, it could undermine longer-term efforts.

VII. CONCLUSION

Cross-border insurance is a relatively novel and surprisingly feasible way to cover those who remain uninsured after health reform, particularly immigrants who are not offered or cannot afford public or private insurance. It appeals intuitively not only because our polity seems unwilling to provide truly universal coverage or extend public coverage to most immigrants, but also because foreign providers have already emerged as a safety valve for U.S. patients, insurers, and even hospitals. At the same time, using cross-border insurance as a stopgap to cover vulnerable populations might also offend our basic intuition that people living in the United States should be able to access affordable care here. In this vein, my proposal is very much animated by the blunt reality that our health care and immigration systems will not provide all care at all times to all people, regardless of their immigration status or ability to pay. This Article accepts these realities and proposes a way to embrace the new geography of health care.

450. Brown, *supra* note 86, at 326. See also Annas, *supra* note 107, at 448.

451. E.g., Hall, *supra* note 13, at 10.

