MEDICARE IN MEXICO

Innovating for Fairness and Cost Savings

PROJECT DIRECTOR
DAVID C. WARNER

Lyndon B. Johnson School of Public Affairs
The University of Texas at Austin
Policy Research Project Report

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Project Directed by

David C. Warner

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AARO	The Association of Americans Resident Overseas
AARP	American Association of Retired Persons
ABC	American British Cowdray Medical Center
ACA	American Citizens Abroad
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CIFRHS	La Comisión Interinstitucional para la Formación de Recursos Humanos para la Salud (Interinstitutional Commission for the Formation of Human Resources for Health)
CMS	Centers for Medicare and Medicaid Services
COMAEM	Consejo Mexicano para la Acreditación de la Educación Médica (Mexican Council for the Accreditation of Medical Education)
CONAPO	Consejo Nacional de Población (National Council of Population; México)
DIF	Sistema Nacional para el Desarrollo Integral de la Familia (National System for the Integral Development of the Family)
DOD	U.S. Department of Defense
EU	European Union
FDA	U.S. Food and Drug Administration
FMP	Foreign Medical Program
HMO	Health Maintenance Organizations
IMSS	Instituto Mexicano del Seguro Social (Mexican Social Security Institute)
INAMI	Instituto Nacional de Migración (National Migration Institute)
INEGI	Instituto Nacional de Estadística, Geografía e Informática (National Institute of Statistics, Geography and Data Processing)
IPUMS	Integrated Public Use Microdata Series
ISSSTE	Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (Social Security System for Mexican Government Employees)

JCAHO	Joint Commission on Accreditation of Health Care Organizations
JCI	Joint Commission International
LCS	Lake Chapala Society
LPR	Lawful Permanent Resident
MA-PD	Medicare Advantage Prescription Drug (MA-PD) Plan
MMA	Medicare Modernization Act of 2003
MPI	Migration Policy Institute
MSA	Medical Savings Account
MTF	Military Treatment Facility
NOM	Norma Oficial Mexicana (Mexican Government Regulations)
PCM	Primary Care Manager
PDP	Stand-alone Prescription Drug Plan
PFFS	Private Fee-for-Service Plan
PPO	Preferred Provider Organizations
SS	Secretaría de Salud (Health Secretariat)
TMA	TRICARE Management Activity Office
TMA PI	TRICARE Management Activity Office Program Integrity
TOP TFL	TRICARE Overseas Program TRICARE for Life
TSC	TRICARE Service Center
USCIS	U.S. Citizenship and Immigration Services
USD	U.S. Dollar
VA	U.S. Department of Veterans Affairs
WPS	Wisconsin Physicians Service

Foreward

The Lyndon B. Johnson School of Public Affairs has established interdisciplinary research on policy problems as the core of its educational program. A major part of this program is the nine-month policy research project, in the course of which two or more faculty members from different disciplines direct the research of a small group of graduate students of diverse backgrounds on a policy issue of concern to a government or nonprofit agency. This "client orientation" brings the students face to face with administrators, legislators, and other officials active in the policy process and demonstrates that research in a policy environment demands special talents. It also illuminates the occasional difficulties of relating research findings to the world of political realities.

This publication presents the results of a policy research project conducted during the 2006-2007 academic year that examined the availability of health coverage for U.S. retirees in Mexico. The project surveyed more than 1,000 retirees in Mexico, and students visited five retirement locations in Mexico. The students also researched Medicare and TRICARE and developed information on licensure of hospitals and physicians in Mexico and on immigration rules and limitations. In addition to presenting this research, this volume also includes the proceedings of a day-long conference held in Austin, Texas, on March 30, 2007, which included health care providers, retirees, regulators, and insurers. The primary funder of this project was the Foundation for Insurance Regulatory Studies in Texas. The conference also received significant funding from the Health Education Training Centers Alliance of Texas, and the Texas Tech University Health Sciences Center at El Paso (as part of a federal grant from the Health Resources and Services Administration).

The curriculum of the LBJ School is intended not only to develop effective public servants but also to produce research that will enlighten and inform those already engaged in the policy process. The project that resulted in this report has helped to accomplish the first task; it is our hope that the report itself will contribute to the second.

Finally, it should be noted that neither the LBJ School nor The University of Texas at Austin necessarily endorses the views or findings of this report.

James Steinberg
Dean

Acknowledgments

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The policy research project benefited from visits by Jim Arriola, President of Sekure Health, Monty Page of Secure Horizons, and Alan Ross, MD, Columbia University. We also benefited from background work done by research assistants Phillip Savio, Rachel Maguire, Kelly Shanahan, and Kim Tucker in the two years prior to the beginning of the class. Glen Johnson of the Department of Veterans Affairs was helpful in providing information. Similarly, a number of people were extraordinarily helpful in helping us with some of our field trips and in obtaining data and information. Trino Zepeda, MD, introduced us to a number of physicians and hospitals in Guadalajara and got us to these meetings. Elizabeth Van Wombeck supported our efforts in Lake Chapala and introduced us to a number of key residents. Charlie Smith, President of the Lake Chapala Society, helped us to reach a number of residents for our survey. In the visit to the greater Vallarta area David Collins introduced our researchers to several key people, and Terry Kimball and Nicole Martin of Prudential California Realty in Puerto Vallarta were very helpful. Richard Kiy, Executive Director of the International Community Foundation, provided valuable contacts in Baja California Sur.

In Austin, Hector Morales, MD, chair of the Mexican center advisory board at the Lozano Long Institute of Latin American Studies, helped with the conference and provided expert advice. Candy Sandefur tirelessly helped to organize the student trips, the reimbursement of speakers at the conference, and many of the details that made the project work. Debbie Bunch and Kelly Bolinger of the LBJ School Office of Conferences and Training helped organize and support the conference. Teresa Hines was very helpful in helping with the application for funding from the HETCAT. Caren Troutman filmed the conference. And Lauren Jahnke was as always a vigilant, punctilious, and helpful editor of both the chapters and the conference proceedings.

Chapter 1. Introduction

This volume contains the proceedings of a one-day conference held in Austin, Texas, on March 30, 2007, as well as background research focused on the health care needs of Americans retired in Mexico and factors related to the feasibility and value of extending Medicare benefits to U.S. retirees in Mexico. The background research was conducted over the 2006-2007 academic year as part of a Policy Research Project at the LBJ School of Public Affairs by a research team of graduate students led by Dr. David Warner. Much of the work builds on earlier research directed by Dr. Warner on care received by Americans in Mexico,[1] on the likely impact of NAFTA on trade in medical services,[2] on options for developing a Medicare waiver for coverage for beneficiaries in Mexico,[3] and on developing cross-border health insurance initiatives.[4]

A number of factors contributed to the decision to undertake this project, including the rapid development of a modern private hospital sector in Mexico, an increasing number of Medicare beneficiaries choosing to relocate to Mexico, a growing number of homes being purchased in Mexico by U.S. residents, a rapidly growing Mexican-origin population in the U.S., and an accelerating appreciation of the imminence of an aged baby boom population. The conference brought together participants with a broad familiarity with these developments.

Chapter 2 presents three views of the population that has moved to Mexico or is contemplating such a move. Alex Gunter, a member of the research team whose work also appears in Chapter 7, presents retiree demographics and trends that can be obtained from official documents. He concludes that the official numbers are likely to be overly conservative for a number of reasons. Erin Daley presents the results of an online survey of nearly 1,000 Americans who live at least part-time in Mexico with regard to their characteristics, health coverage, and where they seek medical care. She presents the survey in more detail in Chapter 11, and the survey itself can be found in Appendix C and the results in Appendix D. David Collins, who is overseeing the development of an assisted living project in Nuevo Vallarta, describes the rationale for the project and the kinds of people who are attracted to retiring there. Several participants subsequently pointed out that due to changes in availability of mortgages in Mexico that large numbers of U.S. residents, both Mexican-origin and not, had begun to purchase property there. The message of this chapter is that medical care is important to retirees in Mexico and it may be sufficient for some to be located close to an airport with frequent departures to the U.S., and for many the availability of Medicare at least for emergencies in Mexico would provide a good deal of reassurance.

Chapter 3 presents the panel that addressed the issue of emerging trends in quality assurance for care delivered in Mexican hospitals. Dr. Enrique Ruelas, the Surgeon General of Mexico, described steps that Mexico has taken to improve quality in hospitals over the last eight years. John Zipprich, general counsel for CHRISTUS Health, described the five hospitals that CHRISTUS has developed with partners in Mexico as

well as several projects that are underway. He stressed the high quality of care provided in their CHRISTUS Muguerza Alta Especialidad facility, which is expected to become the first hospital in Mexico to be certified by the Joint Commission International in the summer of 2007. He emphasized the potential cost savings from using these facilities relative to care in the U.S. Dr. Mark Engleman, who founded the AmeriMed hospital group to provide emergency care in tourist areas in Mexico, described his experience and some of the quality and transparency issues that he believes will have to be dealt with before Medicare could pay in Mexico. Finally, Michael Ford described his experiences in trying to assure high quality care when developing hospitals abroad as president of Tenet Healthcare International. He expressed the view that free enterprise is what is most likely to drive the development of health care in Mexico in response to the growth of the Mexican middle class and that it is unlikely that Medicare would certify a hospital in Mexico under the certification process we are currently using in the U.S.

The third panel included Russell Bennett of Pacific care, Jim Arriola of Sekure Healthcare, and Pablo Schneider, who developed a Blue Cross subsidiary to compete in Mexico. They all discussed various aspects of developing cross-border health insurance products and provided some assurance that such projects might be feasible. Finally, Lawrence Meagher, the CEO of the ABC Medical Centers in Mexico City, described how that facility has become affiliated with Methodist Hospital in Houston and how they are benchmarking their clinical results to the same benchmarks as Methodist. ABC also intends to become certified by the Joint Commission International shortly. These panels were followed by a keynote address by Sidney Weintraub, who is the holder of the William E. Simon chair in Political Economy at the Center for Strategic and International Studies in Washington, D.C. He discussed a number of the economic and social challenges facing Mexico in the coming six years and identified some of the initiatives he believes the government should undertake. One of the implicit conclusions that might be drawn from this analysis is that it is in the interest of both the U.S. and Mexico to create jobs in Mexico to reduce the rate of immigration of workers from Mexico to the U.S. And if these jobs will also enhance the retirement options for U.S. residents and lead to reductions in the cost of Medicare and social services, it would appear to be an initiative that makes sense in a number of ways.

In the afternoon there were breakout sessions and there is a summary of each of these in Chapter 6. These sessions were devoted to exploring options for Medicare coverage in Mexico, strategies for implementing such initiatives, and identifying additional research that might be required.

Additional background research was done by members of the research team to provide further data on Medicare and the rationale for coverage abroad including the model developed by the EU, the delivery system in Mexico, regulations relating to immigration and benefits in both the U.S. and Mexico, the experience of TRICARE in covering care abroad, and the growth of private hospitals in Mexico and the structure of medical education and specialty certification in Mexico. These are all presented in Part II (Chapters 7-15) of this volume. In addition, the team conducted field research in five areas of Mexico: Baja California Sur, Lake Chapala, Cuernavaca, San Miguel de

Allende, and the greater Vallarta area. These visits, which are summarized in Chapter 12, include data collected through interviews with retirees, consular officials, developers, community leaders, medical staff, hospital administrators, and others, and are focused on providing estimates on the number of retirees in each community as well as the level of health care available.

In Chapter 13 we summarize the very different experiences of four people who have used or planned to use the Mexican medical system in one way or another. These testimonies provide the rationale for why people choose to retire to Mexico and also help to identify some of the very real problems that they face when Medicare is not portable. These short case studies provide very concrete reasons for retiring to Mexico, including trading $5,000 a year in property taxes for $100 a year to having the ability to afford personal care when Alzheimer's develops for one member of a couple. One case study reveals the nightmarish experience of someone in a very serious medical condition who had to be smuggled onto a plane to get back to the U.S., where he received life-saving care paid for by Medicare.

As several of the students have stated in this report, there are a number of good reasons why some experimentation should be permitted to determine the costs and benefits of making Medicare coverage portable. It will be far easier now to conduct such Medicare experiments when the numbers are fairly small rather than five or ten years from now when the numbers of retirees and people seeking care will be much larger. And due to NAFTA, proximity, and the growing interdependence between the U.S. and Mexico, such an experiment can probably be uniquely justified.

Notes

[1] David Warner and Kevin Reed, Project Directors, *Health Care Across the Border*, U.S.-Mexico Policy Report no. 4 (LBJ School of Public Affairs, The University of Texas at Austin, 1993).

[2] David Warner, Project Director, *NAFTA and Trade in Medical Services*, U.S.-Mexico Policy Report no. 7 (LBJ School of Public Affairs, The University of Texas at Austin, 1997).

[3] David Warner, Project Director, *Getting What You Paid For: Medicare Coverage for Retired Beneficiaries in Mexico*, U.S.- Mexico Policy Report no. 10 (LBJ School of Public Affairs, The University of Texas at Austin, 1999).

[4] David Warner and Pablo Schneider, Project Directors, *Cross Border Health Insurance: Options for Texas*, U.S.-Mexico Policy Report no. 12 (LBJ School of Public Affairs, The University of Texas at Austin, 2004).

Section I. Conference Proceedings

Chapter 2. Panel 1: Moving South: U.S. Retirees in Mexico

David Warner: This is a policy research project (PRP) in which seven students have done most of the research. Jennifer Nading, one of these students, will introduce Dean Steinberg. Jennifer was born in Nebraska and went to junior high and high school in Cameron County in South Texas. She's a 2006 graduate of Texas A&M University. She has gone on three separate trips to Mexico in the last four months gathering information about various retirement communities as part of our research.

Jennifer Nading: Dean James Steinberg received his bachelor's degree from Harvard and his J.D. Degree from Yale Law School. His extensive list of achievements includes a senior analyst position at Rand, and serving as the Chief of Staff of the U.S. State Department and Director of the State Department Policy Planning staff. He also held the position of Deputy National Security Advisor to President Clinton, during which he also served as the President's personal representative to the G8 Summit of 1998 and 1999. Dean Steinberg is also the author of numerous books and chapters on foreign policy and national security topics. Prior to becoming the Dean of the LBJ School of Public Affairs, Dean Steinberg was the Vice President and Director of the Foreign Policy Studies at the Brookings Institution in Washington, D.C., from 2001 to 2005.

James Steinberg: Good morning everybody. This is a remarkable conference. I'm particularly pleased about this PRP, first of all because the kind of work our students are doing in tackling real-world problems and working with those of you who are out there trying to handle these problems is really at the core of what we are trying to do here at the LBJ School, which is prepare leaders to tackle the big policy questions of the future. There is really no better way to get that experience than working with a distinguished mentor like David Warner and people out in the field who are actually grappling with these problems. I am very proud of our students. I am very committed to this part of our program so it is a very great honor for me to have a chance to say a word to you this morning.

The second reason that I am particularly pleased to be here is that the work that this PRP is doing represents what I think is really on the cutting edge of what is becoming increasingly the characteristic of policy problems here in the United States, which is to recognize that there is simply no longer a meaningful line between domestic and international issues. What happens here in our community affects the world, and conversely, what happens in the world around us effects people in this community. So understanding this deep level of interdependence that we are now experiencing in this globalized world, particularly in a state which has such an extensive interaction across the border with our neighbor to the south, is really at the heart of the kinds of ways that we are beginning to try to re-think the way we examine issues here at the LBJ School, and so this is a particularly clear example of this. We have been working on a number of issues, whether they have been environmental, health, or education, all of which have to be seen in this context of a much more interdependent world. I think it's quite telling that the

issues that we are seeing today and how our populations and societies interact across the border are affected by decisions made by governments on either side of the border. This really is the quintessential policy problem of the 21st century.

You will see this during the course of the day in terms of the different kinds of populations from the United States who decide to move to Mexico and look at the kinds of questions about what implications there are for them in terms of their choices for their social safety-net and how that effects the choices made back here in terms of provision benefits to our own people, whether it ranges from issues of coverage to issues of quality, and this is an issue that we have been looking at in the LBJ School for over a decade. We have a remarkable group of speakers today including the Secretary of the Mexican National Health Council and the Vice President of the CHRISTUS Health Systems, which is a Catholic Health and Hospital System in Texas, Louisiana and other states. And it is a great honor to have Sidney Weintraub as our keynote speaker at lunch-time, who is a very distinguished emeritus professor here and has had a remarkable career in public policy. So again I want to welcome you. I know that this is going to be a very productive and interesting conference. It's also part of a broadening commitment at our school for our work on health policy. Thanks again to David Warner who has been such a leader in this field.

David Warner: Michelle Lalonde, who will introduce the first panel, is a native of Cleveland, Ohio. She went to Ohio State University. She worked in the Peace Corps in Africa and AmeriCorps prior to coming to the LBJ School.

Michelle Lalonde: Good morning. I would like to begin by introducing the first panel of the conference entitled "Moving South: U.S. Retirees in Mexico." The panelists are Alex Gunter, Erin Daley, and David Collins. Alex Gunter graduated from the University of Texas in 2006 with a Bachelor's Degree in Economics. After some traveling around Turkey and elsewhere, he entered the LBJ School. He will be discussing the projected and current demographics of American retirees in Mexico. Erin Daley graduated from Wake Forest University in 2002 with a B.A. in Spanish and then she did a graduate program in Community Development at the Universidad Autónoma de Querétaro, and she is now a Master's student at the LBJ School as well as the Lozano Long Institute of Latin American Studies. She will describe the survey we have conducted of U.S. retirees in Mexico and their insurance coverage and health care needs. Mr. David Collins earned his Bachelor's degree in English Literature and Languages from St. Anslem College and did his graduate studies at George Washington University in D.C. and the Wharton School at the University of Pennsylvania. He was a founder and board member of the American Retirement Villas, which is one of the largest assisted living companies in the United States. He also introduced this company into Europe. He is now the managing partner of Active Living International and he will be speaking on the vision of the future of retirement in Mexico.

Alex Gunter: I will go over some of the numbers and figures related to American retirees in Mexico and look at projections, then I will discuss the different sources of data and some of the difficulties of estimating retirees in Mexico who are eligible for

Medicare now and in the future. I will also discuss the potential future impact of baby boomers and also the aging of the growing number of Mexican immigrants in the U.S.

We encountered some challenges in finding sources that were reliable and accurate. Particularly, the U.S. Census does not take into account Americans living abroad. The U.S. Department of State in 1999 made an estimate of Americans abroad. The purpose was for evacuation or security and as a result, the numbers were usually two to three times larger than what the census showed. The Mexican Census, on the other hand, looks at country of birth and not citizenship, and that makes it difficult when we are trying separate U.S.-born retirees moving to Mexico from a Mexican-born population that has lived in the United States for a long time, some of them obtaining U.S. citizenship and then deciding to go back, at least for much of the year. This group is identified as Mexican in the Mexican census even though they may be U.S. citizens receiving Social Security. Also, the Mexican Census shows residents, so many American retirees that are snowbirds, or reside part-time in Mexico, often on a visitor visa, are not taken into account.

The U.S. Department of State estimated in 1999 just over one million U.S. citizens were living in Mexico, which is a little bit different from the U.S.-born moving to Mexico. The 2000 Mexican Census estimates 358,000 U.S. citizens. That also is not entirely a clear picture because it includes children who were born in the U.S. but whose parents have returned to Mexico with one or more of their children.

The Migration Policy Institute used data from a 10 percent sample of the Mexican Census that said the number of U.S.-born residents of Mexico over the age of 55 had increased from 24,900 to 28,247. But based on our field work and trips to Puerto Vallarta, Lake Chapala, Baja California Sur, Cuernavaca, and San Miguel de Allende, the numbers of American-born retirees in Mexico are clearly much larger that that. Since 2000, there have been continued and increasing rates of growth that we have seen just from our fieldwork. It is important to look at the numbers and the growth rate of Mexican émigrés to the United States. In 2002, the U.S. Census Bureau estimated 9.9 million and in 2005 the Pew Hispanic Center puts it at 11 million persons who were born in Mexico in the United States. The Mexico National Population Council projects that net immigration to the U.S. will continue at between 3.5 million and 5 million per decade. In addition to the baby boomers, which will result in an increased number of U.S. retirees deciding to go to Mexico, there will be large numbers of Mexican-born Americans deciding also to retire to Mexico.

The issue of exploring affordable retirement and Medicare options is pressing given that the first of the baby boomers will turn 65 in 2011, at which point the growth of the senior population will begin to increase dramatically, doubling to 71.5 million in 2030 from 35 million in 2000. The period of most rapid growth of the senior population, from 2010 through 2030, will see a 78 percent increase in the 65 and older population compared to an 18 percent increase in the total population.

The most alarming consequences will be on the Medicare and Social Security trust funds. Medicare costs, as a percentage of GDP, will increase most dramatically with the baby

boomer growth between 2010 and 2030, resulting from higher utilization as well as rising costs of medical care. In 2005, the cost of Medicare as a percentage of GDP was at 2.7 percent, and in 2080 it is projected to reach 11 percent of GDP. What does that mean? Rising costs will outstrip the income going into these funds. An analysis of the income and cost rates as a percentage of taxable payroll helps to illustrate when this will occur. According to the 2007 Annual Report by the Social Security and Medicare Boards of Trustees, 2011 will be the first year that outgo exceeds income (including interest), and by 2019 the HI trust fund assets will be exhausted.

It would appear that it would make a great deal of sense to test alternatives arrangements for coverage now when the numbers of retirees abroad are smaller rather than later when the costs will be much higher.

Erin Daley: As Michelle mentioned, I am going to be presenting the results of a survey that we've been conducting of American retirees in Mexico. These are the preliminary results of the survey that is still up on the web—it's a web-based survey. This will help you get an idea of where we are so far. The survey has 45 questions. We put it up on the web in January and it will probably last until early to mid-April. So far, the information I am presenting is based on 960 valid responses that we have had to date from all over Mexico.

I am going to start off with some demographic information regarding the survey respondents and then get a little bit more into the questions relating to their health care. It was about half men and half women that have responded to the survey—slightly more men. As far as age, we had about one-third who were under 65, so not yet at Medicare age, but another two-thirds over 65, and the average age was 67 so most in their 60s and 70s. We had an age range from 31 to 101 years old. Regarding marital status, about 62 percent were married, 17 percent divorced, 9 percent widowed, 12 percent single, and several who did not respond to this question. As far as the number of individuals in the household, the majority are living in two-person households, with another large group living just one person in the household, and only about 3 or 4 percent having more than one or two individuals living in the household.

To get some information on where the individuals were coming from, we asked in which U.S. state they had resided most recently. California and Texas were named the most, which wasn't a surprise but what was interesting is that we did get responses from individuals who lived in 48 states and Washington, D.C. So people are definitely coming from all over the U.S. to retire to Mexico. This was our first question on the survey. In order to fill out the survey an individual had to be living in Mexico at least one month out of the year and so we asked how many months out of the year they were living in Mexico. About three quarters are living there most of the year, 10 to 12 months, and then a pretty small percentage of those who filled out the survey were just there one, two, or three months. Some were living there about half the year as well.

As far as amount of time they have been living in Mexico, it was really all over the place. We had some individuals who had been there under three years, even just a few months, and then people who had been there over 13 years, even up to 20 or 30 years.

Next we have some questions related to where they live in Mexico, and I broke this down by the state that they live in because there is a lot of variety in terms of the individual communities. The vast majority of those who responded to our survey live in the state of Jalisco. That is mainly because there are several major retiree communities there, especially the community near Guadalajara in Lake Chapala and Ajijic with a pretty large community. We received a lot of responses from that area and also the area around Puerto Vallarta. Some of the other communities where we got a lot of responses were Guanajuato, 15 percent—that was mainly from the community of San Miguel de Allende—and the state of Sinaloa, mainly from the community of Mazatlán. In Sonora, there are several different communities on the coast there and in Morelos, it was the community of Cuernavaca. We got responses from 20 of the 32 Mexican states. In some cases, just one or two U.S. retirees are currently living in that state and in some cases, several hundred or thousands. We got a pretty wide representation across the country as well.

We also asked, "What is the primary reason you are living in Mexico?" Overwhelmingly the response was the cost of living in Mexico. Forty-five percent stated that, and other than that, climate was a really important reason for living in Mexico. Continuing with the cost of living, we asked questions about their annual income. About half the people earned more than $35,000 per year and about half earned less. That was important for us to know how many were living in their household as you'll remember most are living in two-person households, so you can get a sense for what their income is and how they are able to live in Mexico on those incomes.

Audience Member: In your question about the level of income that residents in the state had, did you differentiate between earned income and a fixed income, pension versus wages?

Erin Daley: No. We did have a question in terms of what types of retirement benefits they received. We just asked what the annual income for the household was and that was all. Then we wanted to know how long individuals had been retired and how long they had worked in the United States—only 9 percent are not currently retired, and 91 percent have been retired for varying numbers of years. Then we asked how long they had worked in the United States. This is impressive in that 63 percent had worked in the United States for 31 years or more. We are talking about people who had put a lot of money into the Medicare system. You can see for those who have worked under 10 years, it's only about 5 or 6 percent.

We also asked at what age they were planning to return to the United States; 88 percent are not planning on returning. Of those that are planning to return, we asked them why, and this was an open ended question so we got a lot of different responses, but overwhelmingly health and family were the two major reasons that everybody said why they would return. Seventy-two percent of the individuals who answered this question mentioned something related to health and 19 percent mentioned Medicare specifically, but many mentioned health coverage and things like that that would be related to Medicare without mentioning it by name.

I will now get more into some of the questions related to their medical care in Mexico. We asked individuals if they have an established source of care both in Mexico and the United States. It is pretty similar, about half and half in both countries. We also asked if in the event of a future serious illness, they would they return to the United States. Sixty-four percent said yes, and then we asked why, and 77 percent said coverage in the United States, which includes Medicare. For the most part, that is the reason they would return to the United States for their care. Then we asked how they paid for medical care both in Mexico and the United States. The major difference is that in Mexico, a lot of people are using cash to pay for their care, whereas in the United States that goes down to about 30 percent using cash. About 55 percent of the respondents are using Medicare in the United States. A slightly larger amount is using private insurance in the U.S. as well. A small percentage of the individuals surveyed used IMSS, the Mexican public health insurance program. In the "other" category, we have some who used the Veteran's Administration (VA) and some other ways of paying for their care but for the most part, Medicare is the most significant within the United States.

We asked what kind of Medicare coverage they currently had. About 60 percent said they have Part A coverage, the traditional Medicare. About 50 percent have Part B. Smaller amounts have Part C, Medicare Advantage, or Part D, prescription drug coverage. Then we wanted to get a sense of how individual behavior would change if they did have some sort of Medicare coverage in Mexico, and we asked two different questions for that. The first was what percentage of your hospital service is currently consumed in Mexico. The largest numbers of responses were in the 0 to 20 percent group, people who are consuming very little of their hospital service in Mexico, and the 81 to 100 percent group, people who are consuming most of their hospital services in Mexico, with little in between. Then we asked if Medicare Part A were available in Mexico, what percentage of your hospital care would be consumed in Mexico. The percentage of people who would consume very little drops down quite significantly and the percentage of those who would consume most of their care in Mexico goes up quite significantly. So we are seeing that if Medicare Part A were available in Mexico, a lot more people would be consuming most of their hospital services in Mexico.

We asked a similar question regarding physician services. It's basically the same pattern here; it's a little bit less marked but we asked what percentage of physician services are currently being consumed in Mexico and then what percentage would be consumed if Medicare Part B were available in Mexico. Many more people would consume most of their physician services in Mexico if Medicare Part B were available. Our last question on the survey was just an open-ended question, if any individuals had anything else to share about health care in Mexico or the United States. Overwhelmingly, these are the four most common comments that we got. The quality of care is excellent in Mexico, that care is much less expensive, that there is a greater attention to patients, and they enjoy the fact that there is a lot less paperwork. We did get a few comments that the quality of care is not so good but most thought the care was very good.

In conclusion, what we have seen is that most U.S. retirees in Mexico feel pretty comfortable with the quality of care in the country. However, many continue to return to

the United States to receive Medicare coverage for their care, and many more retirees would stay in Mexico for their health care needs if they would be covered by Medicare.

Audience Member: Is one of your conclusions that Americans in Mexico view the quality of Mexican medical care as high? Did you all have any questions that got into that?

Erin Daley: No. What we have seen in our visits to the communities is that there seems to be a divide. Some people think that the care is fabulous and they would stay in Mexico for everything and some people think that would not stay in Mexico for anything. I think that would have been an interesting question to ask in our survey. We only got that information through the open-ended question.

Audience Member: Was that divide generational?

Erin Daley: Not that I have observed. It depends certainly on the community. There are really great facilities in certain areas and less so in other areas, but I think it is individual preference in a lot of cases too.

Audience Member: Did you ask about frequency back and forth for medical care in the U.S.?

Erin Daley: We actually got at that a little bit. It's the preliminary results and we will be posting the final comprehensive results for the entire survey on our website.

Audience Member: I saw that your research was focused on the northern and central parts of Mexico. However, you do have a large number of Americans living in the south of Mexico. Is there any reason why you could not continue your research down there?

Erin Daley: In the case of our survey, we posted it on the web and distributed it through our contacts and some of the communities we were aware of so, we got a few responses from the Cancun area and a few from Chiapas and from Oaxaca. We certainly made an effort to make it go everywhere.

Janice Finder: Did your survey give you any information about the relative savings in health care in Mexico opposed to the U.S.?

Erin Daley: With our research that we have done in the communities we have seen a huge difference, and I think it will come out in some of the other presentations today that the cost of health care is much lower. I don't know if we asked any specific dollar amounts. It will be in the final survey results, but I don't think we touched on that.

Audience Member: You posted your survey online. Did you also get a feel of how retirees are using the Internet not only for getting health information but also getting in touch with their physicians and hospitals back in the U.S.?

Erin Daley: That is another great question. We did ask how frequently they accessed the Internet to get health information but I don't have that information off the top of my head. We didn't ask specifically about communicating with doctors.

David Collins: Good morning, it's nice to be with you today. The company that I was involved with, ARV Assisted Living, is no longer in existence. That company was at one time the nation's largest assisted living company. In 2003, we sold it to Lazard Freres. The business that I am in today is not assisted living but it is more working with people over the age of 50 who are looking at the opportunity to be able to live the kind of a lifestyle that they have always dreamed of and perhaps in a place where the cost of living is less and the opportunities are greater, and we have formed a consulting company, Active Living International. One of the companies that we have consulted for is a Spanish company called Sensara that I have invested in. That is how I am associated with this particular project.

For our work, we looked at the overall senior market in America. We looked at it in terms of numbers, and the students have done a wonderful job in trying to encapsulate what those numbers are, and we looked at the characteristics that we would need for our business. That is, what is the retirement age, and of course today, worldwide retirement has changed significantly. More people are retiring at an earlier age of 60. In the United States, it's only 20 percent but in Europe, particularly in the Netherlands for example, 80 percent of the population enters retirement at age 60. If you go back to 1900, 70 percent of men over 60 were still working but by 2000 it was the other way around—70 percent of working men were retired. In the world on average, the retirement age was 58.

I watched the Ken Dychtwald presentation on PBS recently that was really quite well done, and one of the things he talked about was the Bismarck Age. When the Chancellor decided he needed to keep his men in the military longer, he came up with a retirement plan. He put the retirement plan in effect so that when his generals wanted to retire at age 65, they would get significant benefits. The life span for men at the time was age 59. It made no sense then, and, of course, it makes no sense today. By the year 2025, more than 800 million people in the world will be over 65. In the year 2046, the first of the baby boomers will turn 100. The number of the persons aged 60 years or older will have increased to 1.9 billion by 2050. Between 2000 and 2050 the age dependency ratio changed pretty dramatically.

We started our assisted living business in 1980 and had about 100 communities across the United States during that time. When we started our business, the average age in assisted living was 62. The consumer and the customer were two different people. The customer was the oldest daughter or the wife of the oldest son. It was a three-generation world. Today in assisted living, the average age is 87 and the oldest daughter or the wife of the oldest son may be in her 70s, and now that we are in a nuclear society where families move away from each other because they can quickly reassemble, job opportunities span the globe, so we don't have the same support system for seniors that we once had. This will significantly increase the burden on workers, on younger people to be able to provide

the capital and the support for an aging population. The burden will be 50 percent larger in 2025 than it was just a few years ago.

So, why Mexico? Mexico benefits from the same factors that North Americans experience relative to retiree migration. North Americans have been going to Mexico for years and the dynamics relative to the number of people turning 50 are quite compelling. The 50-plus cohort has been a primary source for increasing demand and that 50-plus cohort has more money today, they are more maneuverable, they move around much more than my parents would ever have thought of and they are able to do it. So the empty nest syndrome comes into play and baby boomers moving into new homes reflect the fastest growing segment of the home-building market. We know that first time homebuyers really get a boost when mortgage rates and aggressive lending put a lot of people into homes earlier and perhaps with less security than ever before. The baby boomers have really fueled the market. Their annual income is enormous. It is two trillion dollars. They control more than seven trillion dollars in wealth and they own 77 percent of all the financial assets in America.

We got a telephone call one day from Cemex, the large cement company headquartered in Monterrey. They said that they would like to know if there is a market in Mexico for 10,000 units of 50-plus housing in the pipeline within five years. We said we don't know but we know how to do the study. We did a study, which involved looking at three cities: Cancun, Los Cabos, and Puerto Vallarta. We looked at those cities because those are the most popular cities that Americans travel to and our study was designed to determine the market dimensions. The reason that Cemex wanted the study was that they want their developers, contractors, and customers, the people who buy their products, to know about these markets and know how they are going to expand and know where the markets come from.

We did the first study, which led to a second, a road map study of how it would happen, where it would be, and what timing to expect. We have done other studies for different companies in Mexico as a result of that work. Our response to Cemex as a summary was that, yes, there is a market 10,000 units of 50-plus housing in the pipeline. Not within five years, but now. We said that Cancun was a hotel market; it was probably five years away. We concluded that Los Cabos is a market right now but it is a very expensive market and Puerto Vallarta was probably the most likely market to begin the process of attracting American investors, builders, and developers for American and Canadian buyers. The study found a lower cost of living, lower property taxes, and the conviction that Mexico will absolutely be the next land boom. Obviously, the effects of 9/11, the terrorist activities in the Middle East, and problems that exist around the world make Mexico a much more accessible and traditional market, which we think that Americans are going to like and will for generations. English and Spanish in many of these communities exist side-by-side, not that the Americans are learning Spanish but most service providers speak English. Over one million Americans already have bought a second home in Mexico and it is the number one destination abroad for Canadian and American buyers. Canadian buyers are very important to this market and represent a disproportionate number of buyers.

We asked Cemex if we could share the study with the group in Spain that I have been active with and am on their board. The review by Sensara resulted in a project of 250 luxury condos in Nuevo Vallarta modeled after a 50-plus community we developed in Spain. That had the same kind of marketing emphasis, people moving from the cold north to warmer weather. The development was well-done and won three National Association of Homebuilders awards, so we decided to do the same in Mexico—building the 250 homes in Nuevo Vallarta in Paradise Village.

The amenities will be what Americans are used to here in the United States. We think that there are two very big markets. One of the markets will be second and third-generation Mexican families who are very accustomed to the same kinds of quality that other Americans find in their homes, which is what they want when they go to Mexico. The developer will offer the amenities that are familiar to people in the United States and the community will be designed with friendships and visits by grandchildren in mind. One of the residents has to be 50-plus but the owner can be any age. It's a Del Webb Sun City kind of community.

One of the important questions that buyers ask is "what about access to health care"? We think that access to health care is not about trauma care or emergency care, which is generally excellent, but we think that access to one's own doctor and records is the key. Sensara is 15 minutes from the airport and there are 15,000 non-stop flights a year from the United States to Puerto Vallarta. There are 50,000 non-stop flights a year from the United States to various destinations in Mexico. Access to health care today for many people will be the opportunity to get to the airport, get on a plane, have a two and a half or three hour flight back to their doctor, back to their Medicare benefits in the United States. Dr. Mark Englemen started AmeriMed, and it was one of the reasons that we decided on our location there, because people could get excellent emergency care. But still, as a selling point, access to health care is "how do I get to the airport." When it comes to sales, people want to see the common names that are familiar so developers offer names that Americans know such as Prudential, First American Title, and Morgan Stanley. Americans are finding familiar names in Mexico and are finding that it's not as foreign as it once might have seemed, and with cheap and frequent flights that there are plenty of opportunities.

I like what Vicente Fox said in March 2006. He said that he is absolutely convinced that by 2010 the United States will have a great demand for laborers and workers to sustain its economy and to sustain its population of retirees and pensioners. The president said in that very year Mexico would need its young people to help its own economy and to attend to its retirees.

Michelle Lalonde: We would like to open it up to questions now.

Audience Member: Did you consider the role of drugs and drug traffic in your projections? I don't mean drug purchasing—I mean the drug cartels and the security of Americans who are thinking about retiring to a country that is far more insecure than a couple years ago.

David Collins: In our work, we looked at what we believed to be the safest areas in Mexico. We looked at Cancún, Los Cabos, and Puerto Vallarta—actually Nuevo Vallarta in Nayarit. Because we looked at those areas, we did look at security and our conclusion is that the crime rate and the value of security would attract Americans and that in those areas, we could say to Americans that security is recognized as being important and is enforced. Problems that are read about in other Mexican cities don't exist so broadly in those areas and I believe that there is a very strong local effort to ensure that tourism is not negatively affected, and I can tell you in our experience over the last year the subject has not come up once, not even once from an American buyer as regards to drug cartels or anything like that. They have certainly asked questions about security.

Chapter 3. Panel 2: Health Care in Mexico: Assuring Quality and Supply

David Warner: Chairing the second panel will be Karla Vargas, a member of the Policy Research Project. Karla is a native of Dallas County and a graduate of the University of Texas. She is a student in the LBJ School and UT Law School joint program.

Karla Vargas: Good morning everyone, welcome to the second panel. The bios of the speakers are in the packet so I will briefly introduce them. Our first speaker is Dr. Enrique Ruelas, who is the Secretary of the National Health Council, a position that oversees the accreditation of health facilities. He was a pioneer in introducing hospital certification to the private sector in Mexico as Deputy Minister of Health.

The second speaker is John Zipprich, who is General Counsel and Senior Vice President of CHRISTUS Health. He has been a leader in developing joint ventures in Mexico for CHRISTUS. The third speaker is Dr. Mark Engelman, who has established a number of hospitals in Mexico, especially for resort and retirement communities. Finally, we have Michael Ford, who is the former President of Tenet Healthcare International. We have a uniquely qualified panel to address these important issues.

Enrique Ruelas: Good morning and thank you. I am pretty aware of the concern about the quality of care in Mexican hospitals so what I would like to do is to talk about the efforts that we have done in Mexico for the past eight years. It was in 1999 that we started the accreditation system for hospitals and other health care facilities in Mexico. However, I would like to focus attention now on the period from 2002 to 2006 and then I will let you know what has happened since and what I think will happen in the next years.

In 2000 the Mexican government launched a major initiative, a comprehensive nationwide strategy called the National Crusade for the Quality of Care. Utilizing the term "crusade" as it is defined in the dictionary means it is a huge effort aimed at a high objective. We tried to bring all actors in the health care field together to work on behalf of improving quality of care.

Let me give you some figures of what we did during the six years from 2000 to 2006 through this National Crusade for The Quality of Care. We implemented the measurement of 17 quality indicators, including technical quality and interpersonal quality. Let me give you some examples: for hospitals, infections; for primary care facilities, the care of diabetes, hypertension, diarrhea, pneumonia, the main health care problems in the country. By the end of 2006, about 8,000 units of the public sector were reporting to a common public information system on these indicators. These 8,000 units account for about 50 percent of all health care units of the public sector in Mexico. Some private units were also reporting, very few of them, but they also added to the information system. Of course, we included patient satisfaction as one of the indicators that were measured continuously through this system.

We added an innovation in the system with a strategy we called citizen endorsement. This meant that groups in the society voluntarily were checking some indicators in the health care units. They were trained basically with a check list where they were able to go into the units, either a hospital or a primary care facility, and see that the personnel were kind, the facilities were clean, all the things that patients or a community person would measure by just looking at the facility. At the end of 2006, about 2,000 groups in Mexico were working as citizen endorsement groups measuring all these indicators and reporting. They make agreements with the directors and CEOs of the facilities to improve what they need to improve. Then we implemented about 600 quality improvement cycles in different kinds of facilities in the country and for doing all this, about 40,000 people in the health care system were trained on quality improvement tools and concepts.

One of the aspects of the whole national crusade was accreditation, and there was a major change by making accreditation compulsory for the services provided by the Ministry of Health. In Mexico, we have two major social insurance schemes, the Mexican Institute for Social Security and the Institute for Social Security for Civil Servants. In 2003, a major change was made in the law to create a new social insurance scheme for the rest of the people in the country, mainly the poorest. Now there are three major insurance schemes. For this third one, we made accreditation compulsory so units would have to provide services for the popular insurance, which is the name of this third social insurance scheme, so they have to be accredited in order to provide services. For the rest, accreditation is voluntary.

The other thing that we did during the past six years was to include an initiative for patient safety. As you know, this is a major concern world wide and we include indicators within the accreditation system and training for many hospitals and people in the field on patient safety. What has happened with accreditation and will happen with accreditation in the next few years?

The first thing that I would like to talk about is who is in charge of accreditation in Mexico. There is a commission equivalent to the Joint Commission here in the states. That commission reports to the National Health Council, which is equivalent to the Surgeon General's Office in the United States, with additional responsibilities such as the definition of health care policy and the strategic coordination of public health care students. In addition to that, the National Health Council is responsible for the accreditation of health care facilities. I took office as Secretary of the National Health Council in January 2007. Regarding accreditation, one of the first things that I did was to get in touch with Joint Commission International in order for us to harmonize the standards of the Mexican accreditation system with the Joint Commission standards. That will mean that some hospitals in Mexico will want to be accredited with those standards. Not all hospitals will be able to meet those standards but we want to offer them the possibility in a joint effort with Joint Commission to be accredited with harmonized standards.

For the rest of the hospitals that would not be able to accomplish those standards, we will have to develop different levels of standards that will assure quality at the level that they are able to provide services. That means that the standards won't be lowered in the sense that they will be first class and second class and third class hospitals. If a hospital is mainly providing obstetrics, which is the case of many of our tiny hospitals, they will have to do that very well. They won't be able to achieve the standards of the Joint Commission because they are very comprehensive but they will have to meet some standards for obstetric care, and they won't have any choice if they want to be accredited. So what I am seeing is that we are going to offer a top level of accreditation with standards very similar to the U.S. standards and we will have to open other alternatives to other hospitals to be accredited and to make sure that they are doing what they do in the best possible way. We are introducing more patient safety standards.

The third thing we are doing is asking for accreditation by the International Society for Quality Health Care for the Mexican accreditation system. The International Society provides the service and we have already asked for that accreditation so the Mexican process is accredited as well as the standards harmonized with the U.S. and with Canada.

I would like to conclude by saying that there is a strong commitment of the government in Mexico to improve the quality of care. We have made many efforts in the past six years. We will keep doing them, but I do wonder, even though the awareness on quality in the Mexican health care system has increased dramatically in the last seven or eight years, and the efforts that we have done have been huge, my question is how much people care about an accredited hospital. Is that going to make any difference in which hospital a person chooses? I don't know. I know that this is a question everywhere. I am convinced that it helps but I am not sure it will affect how people pick a hospital. And, I would also like to know about the impact of accreditation on payers.

John Zipprich: Good morning. When retirees are searching the globe thinking about the best place to retire with good medical services, they might not think that the best destination is not the most expensive or the furthest away, but our neighbor, Mexico. What I would like to talk about today is Grupo CHRISTUS Muguerza, where I have had the honor to serve with my Mexican collaborators, including serving as the first gringo President of the Grupo. When CHRISTUS Health became associated with the Muguerza family in 2001, our collective goal and direction was to establish clinical quality, service excellence, and community service in Mexico and build on the great tradition of CHRISTUS Muguerza. We are currently working in or constructing facilities in five Mexican states.

I would like to focus today on Monterrey, which is Mexico's third-largest city and gateway for commerce. Picking up on the comments about airports, we have direct service to many places in the U.S. as well as other Mexican cities. Monterrey is a nice spot for retirees from other Mexican states who might want to go to Monterrey for health care service. There is a great domestic flight service to Monterrey.

In focusing on the Monterrey facilities, I am going to talk about clinical quality, service excellence, and community service. The premier facility that we have with our group,

our flagship hospital, is CHRISTUS Muguerza Alta Especialidad. It has 188 beds and ten operating rooms and what you will find in Alta Especialidad is high level, what we call third level, services. We are also able to do transplants in that facility, substantial neurosurgery, and it is really a leader in technology in Latin America and many U.S. hospitals. I was on a flight coming back from Monterrey one day when someone sitting next to me was talking about going to the Houston medical center. I happened to know the hospital where they were going to have a particular test. I knew that CHRISTUS Muguerza Alta Especialidad had much better equipment than that particular hospital but they were actually going to the U.S. for medical travel. If it had been me, knowing the equipment we have in Monterrey, I would have had that test in Monterrey. I have had exams in Monterrey because I knew the equipment and the quality of the physicians was much better.

I also want to point out that we have 140 medical residents. There is a physicians-in-training program within our facility. We have about 20 percent of our doctors at CHRISTUS Muguerza with international certifications, either double-boarded in the United States or have French, German, Spanish, or other certifications as well. We have the only College of American Physicians certified hospital laboratory in Mexico. We have nursing schools affiliated with our Monterrey facility, particularly with CHRISTUS Muguerza Conchita. Conchita was originally a maternity hospital in Monterrey created at the same time as the Muguerza hospital in the 1930s. Now Conchita is a general hospital that specializes in OB/GYN but also has bariatrics and a strong pediatrics program. It became a part of CHRISTUS Muguerza in 2003.

Our newest facility in Monterrey is CHRISTUS Muguerza Sur. If you are on the national highway to Mexico City you will see it. It's right across from Mormon temple. It is a great facility and is designed to 21st century standards. It started with 50 beds, with expansion capacity to 200. We opened in May 2006. It's really a new medical community developing in a growth area in the south of Monterrey. We are very proud of this facility, not only its design but also the opportunity that it offers for the future.

Besides what we are offering in Monterrey, our other facilities are in Saltillo and Chihuahua. We are constructing a short stay and ambulatory facility in Reynosa and in Tuxtla Gutierrez in Chiapas. We have developed plans that will match markets with a combination of what we have in Monterrey in Sur. These plans we hope to spread throughout the country.

One of the things that I would like to talk about is our infrastructure. This slide shows the total number of units that we have within the Monterrey community and it spreads out through a number of services (see Table 3.1). This is just some demographic information with regard to our infrastructure.

Table 3.1
CHRISTUS Muguerza Monterrey

DESCRIPTION	CMAE	CONCHITA	SUR	Total CHRISTUS MUGUERZA Monterrey
Beds	188	124	50	**362**
Operating rooms	10	5	4	**19**
Shock-Trauma rooms	2	2	2	**6**
Labor and delivery rooms	4	4	2	**10**
Underwater birth labor and delivery rooms	-	1	-	**1**
Cesarean delivery rooms	2	5	2	**9**
Intensive Care cubicles	14	4	6	**24**
Intermediate Care rooms	10	12	-	**22**
Neonatal Intensive Care cubicles	14	25	5	**44**
CT	2	1	1	**4**
Magnetic Resonance	1	-	1	**2**
Endoscopy	3	2	2	**7**
ER cubicles	16	6	9	**31**
Regular rooms	134	73	37	**244**
Junior Suites	10	8	2	**20**
Suites	6	2	-	**8**

I want to talk about our plans for excellence. Throughout the CHRISTUS facilities, we are on a journey to excellence that includes our service quality—that's how we deliver the services to meet the expectations of the patients. This is part of the consumer trend that is world-wide. Also, critical is the satisfaction of our associates or collaborators and our doctors. Our scores in our Mexican facilities are some of the highest in the CHRISTUS Health System overall. It is very unusual to see doctors at close to 90 percent satisfied with hospital and hospital administration. The physicians in the audience know that is very difficult to achieve. It is very difficult to achieve 96 percent satisfaction of patients within our facilities in the U.S.A. It is difficult in the midst of tremendous change to still have 90-plus percent of your workers saying they are satisfied with the changes that are being made. We are very good at monitoring this and achieving great results. This data is from September 2006 and our latest survey points actually are higher than these scores. We are very comfortable that we are meeting our service excellence deliveries. When we do our quick surveys at the end of the hospital stay, we receive between 90 and 95 percent satisfaction. We are very comfortable trying to address the patient needs and doing it in a way that they find acceptable in service delivery.

We are also looking at clinical quality measures. We are looking at typical things that you would see in the U.S.A. The benchmarking is against our own facilities, since Mexico hospital benchmarking is possible. But we are working with some other Mexican hospitals to see if we can benchmark some of our indicators. Many U.S. facilities would be very excited if you could have waiting time for x-rays of 15 minutes or less as we do. One of our facilities had a 25 minute wait and we said that is unacceptable. Many places in the U.S. would consider 25 minutes acceptable. Our time for delivery of clinical results of pathology from the time of the blood draw to the time you get the results is approximately 20 minutes. Those results should be back to the floor and we are able to meet that in most cases. We have high standards for what we are expecting on our clinical processes and clinical excellence is one of our goals we are going to benchmark.

We have high-quality equipment, including magnetic resonance and a 64 slice CT scanner. One of our hospital administrators from the U.S. was visiting one of our facilities and said, "Gosh, I wish I had that MRI machine." We are a GE Beta site for all of Latin America for equipment. We have the typical equipment you would expect in very good hospitals.

I would like to point out one thing about our cath lab experience in Alta Especialidad. For more than four years now, our diagnostic tool was not invasive angiography but digital angiography. The first diagnosis you make is not by cutting through the leg and going up, instead it was using digital means to do it. The physician that initiated this modality was also doing a joint study with Johns Hopkins and Stanford. Two U.S. doctors were visiting down in Mexico; one had chest pains and was probably under stress because of career change. The other did not have any symptoms but he said he would go along and have this test with the other doctor. It turned out the one with the chest pain was fine, and the other person was asymptomatic yet actually had some heart lesions that he would not have known about had he not undergone that test. He would never have undergone angiography because of the risk factors when asymptomatic.

Our hospital laboratory at Alta Especialidad is CAP certified as I mentioned. We have a full range of surgical services and again, we are benchmarking these services and qualifying our doctors for practice, as also happens in the U.S.A., but from a Mexican cultural perspective. To pick up on what Enrique was talking about regarding documentation for the Joint Commission, we are under going that process, and we hope to have our Joint Commission International certification for the Alta Especialidad Hospital by the end of the summer.

In Mexican culture, as people know, there is not the obsession with documentation that we have in the United States. In the U.S.A., you didn't do it if you can't show a piece of paper to document that you did it. That's our U.S. cultural standard. We have to prove it by a piece of paper. It's interesting how we have that concept. It is a very significant cultural change to try and add the JCI documentation process in Mexico. Our people do the clinical processes and document the results, but it is done in a different way. Joint Commission for Healthcare International standards puts a much different pressure on the documentation part to prove that you in fact did it. That is a real challenge for us and all

Mexican facilities to be able to document in that fashion, as required by the U.S. standard. That's some education that will go on with the Joint Commission.

Regarding the facility, I really like our Third Floor South rooms because you can see the beautiful mountains in Monterey from your window. We have a concierge-like process that we call Amigo Muguerza. You have someone who is able to follow you and address all your needs within the hospital stay, so you have one person that you can count on and go to if you are having some issues. It's a great service that I think patients really like.

Now let's look at global drivers. Retirees have the same interest that others have in terms of looking at where they want to live. One issue that I think retirees find important, as pointed out by the first panel, is health care. It may not be the primary; you might want a great place to golf. But are you going to think about health care as part of that decision. You want high quality medical care, you want modern hospital facilities and infrastructure, you may want some world class tourism opportunities and you want cost advantages to the patient.

Mexico is well positioned in people strength in terms of productivity, quality, cost, and English-speaking skills. We think it matches with India and the Philippines if you are looking at a global market for where health care could be. We think that Mexico is obviously a destination, particularly when we are working with medical tourism companies that want to bring patient cost advantages. Mexico and certainly Monterrey offer distinct advantages because if you have a hip replacement in India or Thailand at excellent facilities, you have a different flight pattern to come back home than from Monterrey. Monterrey has a big draw in terms of international interests in the city as Monterrey is going to be hosting the second international forum of cultures this year.

We also think the CHRISTUS Muguerza hospitals in Monterrey are well positioned internationally. The State of Nuevo Leon is also interested in seeing medical care develop within Monterrey, not only for Mexico, as a destination medical center, but also we think it has some international opportunities because of the quality of our care. We think that our technological innovation is very important; we think we are well positioned from a technological stand point. We have 70-plus years of medical services and a commitment to innovation. We have services in almost in every field of medical specialization, and we have a state-of-the-art telemedicine system that I want to mention. We link our facilities through telemedicine. We can have in a community service clinic in Tampamolon, which is in the state of San Luis Potosi, a link from the indigenous people's clinic with an opportunity for the patient to be seen by video camera transmitted back to our medical residency program and our specialists in Monterrey. This offers help for diagnosis in a difficult place to reach. We can also link by telemedicine so that if necessary, we can transmit back to U.S. doctors. We have invested over $100 million in the last four years in facilities, technology, and equipment. We have national and international patients who come to Monterey and are able to receive world class medical care delivered with warmth and compassion.

A little side story on the warmth and compassion: After hurricane Rita, which happened after Katrina, we ended up with 5,000 special needs patients in Alexandria, Louisiana.

They were in school gymnasiums and those kinds of places. A plane load of our Mexican doctors and nurses came up and wanted to help. They did great service. Some English skills were okay, some were like my Spanish skills, they could communicate but it wasn't so pretty. But they were great. When they left, a U.S. doctor came to see a patient and the patient asked, "Where are those Mexican doctors?" The U.S. doctor said, "I am here to help you." The patient said, "But those Mexican doctors touched us. They touched us." And that's a telling challenge for our U.S. medical delivery system. Maybe their English skills weren't so good, but they added that warmth and compassion. For someone like myself who has had the pleasure of working in Mexico for six years and to be able to see that warmth and compassion, it's a very different health care delivery system. What I tell our Mexican physicians when they come to the United States to our meetings is that they should not adopt the commodity and competition attitude that is part of the U.S. care delivery model. They have to keep what is important to the Mexican culture, the relationship-building and that kind of attention, which is something I think retirees to Mexico would appreciate.

This slide shows significant cost savings in Mexico (see Table 3.2). We have representatives from ING, one of our insurance partners, MetLife, Generale, New York Life that we have agreements with, so we are able to look at cost comparisons. This slide is just a sample pulled about the cost of care, and you can compare Mexico with other potential tourist destinations for medical travel. The cost comparisons are very positive, particularly when you get state-of-the-art good care delivered with warmth and compassion and you can get it one, two, three, and four hours away from U.S. cities, as opposed to 16 or 18 hours away. We are not necessarily talking about the cosmetic procedures and other kinds of elective procedures where you want to go to Cancun or Los Cabos and have time on the beach and have some cosmetic surgery; we are talking about other kinds of care here. This slide shows the kind of care retirees might need.

Table 3.2
CHRISTUS Muguerza and Other Countries, Approximate Prices of Procedures in U.S. Dollars

Procedure	U.S. Retail Cost	India	Thailand	Singapore	CM-Mexico
Heart Bypass	122,000-176,000	10,000	12,000-13,000	17,000-20,000	19,000-23,000
Angioplasty	57,000-82,000	11,000	13,000	13,000	10,000-12,000
Hip Replacement	43,000-63,000	9,000	12,000	12,900	12,000-13,000
Knee Replacement	40,000-58,000	8,500	9,000-10,000	11,000-13,000	10,000-11,000
Gastric Bypass	48,000-69,000	11,000	15,000	15,000	13,000

I particularly want to point to our service to the underserved. Eighty percent of our patients in Monterrey are insurance patients; 20 percent are self-pay. In Mexico, self-pay generally means that you *do* pay as opposed to the United States, where you know that self-pay often means that you do not pay. We have clinics for the poor that respect the dignity of people without insurance, people who are living in *colonias* within Monterrey, living with the indigenous people in the Tampamolon region, people who have crops in the indigenous regions but don't necessarily have pesos. We are able to serve 130,000 a year in our clinics for the poor, and we are able to serve those poor people with a subsidy of about four dollars per patient. In other words, that means that the people themselves are able to pay 60 to 80 percent of their own care. There is no other clinic that I'm aware of in the U.S. that is able to say that they recoup from the poor people they serve 60 to 80 percent of their operating cost of care. It is a very efficient model. Just because we are serving people who can pay, we are not forgetting the people who can't pay.

To conclude, we can offer retirees and medical tourists in Mexico high quality medical care that is paying attention to service quality, service excellence, and clinical quality. We are benchmarking, we are measuring, and in the Mexican certification exam, CHRISTUS Muguerza received the highest score in all of Mexico. We can offer quality and cost advantages to patients and organizations. What David asked me to do is talk about quality, and I think we can offer that in Mexico.

Mark Engelman: I would like to say how much I appreciate the invitation to speak here and be a part of this. I have been involved in Mexican health care for 15 years. Obviously, Medicare has been a discussion and coverage of Medicare in Mexico and I am sure in other parts of the world. Mexico has been a discussion for a long time.

First, I have a comment on Dr. Ruelas' comment about certification and quality: one issue is that the perception of quality isn't always the measurement of quality, that's the problem. When you are working in other countries, just because the doctor speaks English doesn't mean that is the best doctor, and so it's an ongoing issue.

I want to talk about the topic of Medicare in Mexico in as practical terms as I can. First I will briefly tell you about my background. I come from a medical background; my father was a doctor and a professor at Ohio State and he believed that practicing medicine was the best thing you could possibly do with your life—having nothing to do with economics, just taking care of sick people. He passed that down to me and I feel exactly the same way. As far as I am concerned, it's the greatest thing you could do. I ended up training in internal medicine and fell in love with emergency medicine when it was just becoming a specialty. I was one of the pioneers of emergency medicine, including advanced cardiac life support, CPR, paramedic programs, and the board certification of emergency medicine. I became the chairman at St. Joseph's in Phoenix, which is a 600-bed teaching hospital that also had the largest and most prestigious private neurological and neurosurgical teaching program and facilities in the world.

The hospital was a Catholic hospital and the mission of the nuns was to take care of sick people. If they had money you took care of them and if they didn't have money you took care of them—that was the mission and if you worked for that hospital you either went

along with the mission or you didn't have a job. Because it was a Catholic hospital it had a large Hispanic population (in Phoenix that means mostly Mexican), and we took care of the wealthiest Mexicans and we took care of the migrant farm workers as well. That is when I really fell in love with Mexico, by meeting the families. I hadn't spent much time there but I met the people and I fell in love with the country through the people. I ended up with a house south of San Diego near Rosarito years ago, and saved a little girl's life who got thrown through the windshield of a car and broke many facial bones. She was transported to the local hospital where they didn't have the equipment or the know-how and ended up having to make a hole in her windpipe with a knife and a spoon, and then had to use a straw and so forth. It was primitive, but we saved her life. I got back home and my Dad was visiting my house there and asked me where I had been all night. I told him and he said that was amazing and maybe that would be an interesting thing to do—to look at emergency services in Mexico.

This was in about 1990. I put the word out that I was sort of interested in looking at emergency service in resort communities. Grupo Situr, which at that time was the premiere tourism group in Mexico, about a $4 billion company just before the peso got devalued in 1994, contacted me. They figured out that health care is an infrastructure piece in the retirement and resort communities in Mexico. It was like a bridge, like a pool. Whatever it is you have to be able to offer health care services in the hotels particularly, but if you are going to sell property to people who are going to move to Mexico, they are going to ask about health care services.

We signed a letter of intent to put up 15 urgent care centers in various locations in Mexico. It ended up that they went under because of the peso devaluation, but we continued to move forward and put in an emergency outpatient facility in Puerto Vallarta in 1996 with the idea that everyone, at least Americans and probably Canadians, who got sick with any kind of significant illness would absolutely want to be flown back to the United States. We weren't going to do any inpatient care and we were going to try to cooperate with the local hospitals and be the experts in emergency medicine and then we would transfer the patients.

My model of health care was a very formal model. In the hospital at St. Joseph's, the doctors all wore long white coats with a shirt and tie with their nametags and it was very, I think elite is the term, but very Mayo Clinic-type, "proper" medicine. When you are in the resort communities, in the large communities, Mexico City, Monterrey, Guadalajara, I think medicine is very formal, but the further away you get, the more you go to the beaches, the less formal it becomes. But the people who want the medicine want a doctor in a long white coat and a shirt and tie. The medicine should remain formal even though you are living in a retirement community.

It turned out that we moved into becoming boutique hospitals with 100 percent bilingual doctors and nurses and using the highest standards that we could possibly put in—not dissimilar from those in the United States. I founded that company and we moved on and started a hospital in Cancun and one in Cabo San Lucas, and that was the hospital group called AmeriMed. Recently I sold my share of AmeriMed, which I don't have anything

to do with anymore for reasons having to do with mission and management. I have started my own company that is an expanded company that now provides consulting services for second and third-world countries, for medical services for developers, and also for other types of medical services including owning and developing hospitals. So that is how I got here.

The issue now is the issue of Medicare in Mexico, and the way I like to do these things is to try and simplify them: essentially look at who the stakeholders are in these various things and see if the stakeholders are ever going to be able to get together. I think, ultimately, Medicare, or some form of Medicare or something like Medicare, will end up coming to Mexico and other parts of the world. But to get there I think you have to figure out how you manage all the stakeholders. First of all, it's no great mystery; it's obvious that there is a huge desire to have Medicare cover care in Mexico. The developers want it, Mexico wants it, the retirees want it, and the medical establishment of Mexico wants it. It's great business for them; it's more people who stay in Mexico and don't get flown back to the United States.

Why isn't it there? This is just my theory. I took care of a lot of pretty famous people, including some United States Senators, and I would ask them how do you guys figure out what you are going to do in terms of laws? They said we never figure out anything. People bring us problems and complaints and then we pass laws, and that is how we come up with the laws. Why am I bringing that up, fraud and abuse? Stark laws in the United States. I practiced medicine; I watched my father practice medicine that was the old medicine. I started when it was the old fee-for-service medicine. Gradually managed care came in and the laws became stricter. The laws of the United States for fraud and abuse are tough but they didn't happen by accident. It was not unusual in my father's day for fee-splitting, referral fees, owning your own labs and x-ray and sending people there for tests they didn't need and so forth. So did I see this as a pain in the rear end to fill out all the forms? Yes. Was it good for patient care? Yes. Going to someplace that doesn't have it, I can see how much better in terms of control it is when you do have it than when you don't have it. So I am an advocate of fraud and abuse laws. I think it's a great idea. Now you have fraud and abuse laws, so if people screw up they get fined and then they go to jail.

How else can you control things in the United States? JCAHO. If you want Medicare patients, you have to pass JCAHO. In fact, up until I learned about international JCAHO, I thought it was a government agency. I'll bet if you asked a lot of the people in the hospital business, they are convinced it is a government agency. It's not. It's a private group, which is why they have expanded to international health care. In those days we used to spend two years getting ready to pass JCAHO because if you don't get Medicare patients, you don't survive in the United States. It wasn't just an exercise; it was quality control, relationships with the patients, infection rate, and so forth. All of which are great for medicine as far as I am concerned, and all are essential to good quality health care.

That's the legal side. Now you have Medicare. I just turned 60, and I can tell you that my medical premium that I pay every month, and I am a healthy guy, is expensive. I

can't wait for Medicare. That is the greatest deal that ever happened as far as I am concerned. That is why everybody wants it. It's a great deal when you turn 65.

Number one: Medicare has a mandate. Medicare has to cover certain people. So that is their mission. But the bigger issue is the financial situation with Medicare. How are they going to pay for it? How are all these people going to get covered—and it's huge. From Medicare's standpoint, I can see one side of Medicare that says if we cover care in Mexico, the cost would be less, so it would be great. The other side of Medicare says look at all the people going down to Mexico, maybe they won't come back and we won't have to pay for them at all. It would be great. We are not going to pay for them in Mexico. We are just going to let them go to Mexico and, good luck and God bless you and if you get back home and you have paid your premium, you're covered.

In their circumstance, it may be a good thing not to pay in Mexico. Until you get your arms around that and figure out if it's a good thing or a bad thing, then that is relevant to this discussion I think. The other thing is fraud and abuse. Do you honestly think that your American Express Gold Card that has doctors all over the world has ever gone down and visited any of those doctors that are in that network? I can tell, because I am there, and the answer is no. They need to have thorough certification and credentialing, which is difficult, before Medicare ever even considers remotely going down to Mexico. And I happen to think it will be a private health care group, not Medicare, that pays directly, that sells that as a health care product to retirees like they manage health care in the United States for people on Medicare.

That will be another product. I don't see Medicare ever directly paying. I think they will pay through another managed health care group. You have to get your arms around certification and your arms around credentialing because without Stark laws and without JCAHO, it is rife with fraud and abuse and believe me, I have been there, and I have seen it. It's not from the country, it's from the people, it's from this doctor or this doctor or this hospital or this hospital. That has to be controlled before Medicare will consider covering everybody in Mexico. To me what you have is a stakeholder here, a stakeholder there, and these stakeholders and these areas of fraud and abuse. The areas of finance, the areas of coverage, and the areas of administration have to be worked out in some fashion and when they are worked out, if they are worked out, they'll have Medicare coverage. From a person who has the scars on both sides of the border, it's my outlook on things.

Michael Ford: When I met Dr. Warner, we talked about health care in general and he was interested in my career. I spent a long time trying to develop private hospitals in foreign locations and I think I was successful at it, and I would like to point out that never did we develop a private hospital in a foreign location for expatriates. We were always interested in developing the hospital to serve the local community, the citizens of the country where we were doing development. We never gave any consideration whatsoever to retirees or to the number of expatriates who lived there. The demographics that drove us were the development of the middle class in that particular foreign location. Could we erect a facility that would attract local people to come to it?

I think anybody who tries to develop a hospital that is just going to serve expatriates is not going to have a very successful hospital, and I suspect that they will not get the type of business return they are looking for. I also agree that, unless we can change things through some kind of think tank endeavor, Medicare probably is never going to certify a hospital in Mexico under the certification process that we are currently using in the United States. They just aren't going to do it. I don't believe they are interested in doing it. People I have talked to just think that it will not happen. The model of perhaps developing an insurance scheme that might lead to a demonstration project that might give Medicare some incentive to make a change is possible.

I would like to talk a little bit about quality. One of the things that has come up is the idea of medical tourism, which leads me to the comment about quality. When we developed our hospitals in foreign locations, we made a very important effort to try to adapt ourselves to that environment, and we knew we had to get a license from the local authorities to operate the hospital. We thought that we would gradually put in the type of quality things that were important, not necessarily to the American environment, but to the environment there—things that we thought were creative.

We looked at credentialing of physicians and how that was done. We tried to make sure that our hospitals credentialed our doctors in a non-political fashion, that we used the kinds of things that we would use in the United States. We involved communities; we formed community boards. We took important people in the community and put them on the board of the hospital and let them become involved in the way that the hospital was operated. Eventually, we looked at trying to become accredited in some form, either through ISO 9000 or through the Joint Commission for Healthcare International. Was it important to the local community? I don't think so. I think it was important to us because we wanted to be able to say that we are good. You can say "I am good" but it really helps if someone else, independent from you says, yes, I think you are good.

That is kind of the purpose of this Joint Commission, and maybe it's not through anybody's fault, but there is not a single hospital in Mexico that is currently certified by the Joint Commission for Healthcare International. I do not know whether there are some ISO 9000 certified hospitals in Mexico. Should they strive to do that? Is that going to ensure quality in Mexico, which was one of the topics of our panel? I don't know. I think it is something that needs to be looked at and I think that is something that apparently the government is going to actively pursue, try to find a way to partner and develop some things with the people in the United States through the Mexican government.

Medical tourism is now the reverse in our country. People are leaving the United States to go and get their health care in foreign locations because it is a heck of a lot cheaper. I talked to a gentleman, Dr. Milstein, who is a consultant with Mercer Health, and he feels in the next couple of years, someone is going to put together a program that will actually put this medical tourism to the test. He actually thinks it could be a union, although the unions seem to be dead against exporting health care to foreign locations. We know the American Medical Association is against it, they don't want it, and probably if you talk to

economics people they would say it's more exporting of jobs. The fact is that our costs in this country are running away and it has become an increasing burden.

Should we look at letting people go abroad and find ways for them to receive their health care? I will mention this because Dr. Milstein thought they were important in considering a study as to whether or not you should get people to get their health care in a foreign location. He said does some international body certify them? Do they have a certificate that says that they are accredited? He didn't use the word "equivalent" but I think that it could be added in the interest of Mexico, you could perhaps create an equivalency. That would be one of the criteria. What are the verifiable outcomes of this particular hospital that is being considered? This is an important thing for insurers and it should be an important thing for patients. What are they doing, let's take something routine, a hip replacement. How do they do it? What are their best practices and how do they compare with something that I might want to have done? If they don't gather these statistics, it is likely the patient might not want to choose that particular location. Are the physicians accredited according to some Western standard? We always have the burden of saying if they are not a U.S. Board Certified surgeon or physician, they are not any good. Well, we all know that's not true, but we have to figure out exactly what is meant by that.

Do they have a low mortality and complication rate? These again are quality issues. The last one that he brought up was, does it have any affiliation with any U.S. hospital. I think he was trying to allude to the fact that many hospitals abroad are seeking advice from well-known international hospitals. Johns Hopkins has one, and I think Larry's ABC Hospital has an affiliation with the Methodist System in Houston. Are these good things, are these going to be particular requirements? I throw these out mostly as things I hope that will get you to ask questions. Again, I'll repeat, I think that free enterprise is going to drive the development of health care in Mexico, not retirees. Free enterprise created by the Mexican economy, created by the Mexican people, and growth of their middle class, which I think is the private sectors. We want to see the private sector grow and it will grow if the middle class grows. The portability of Medicare, while an interesting topic, and I hope to discuss it later today, how we are going to at least get at least one demonstration project organized and get the government interested in that, I don't think we are going to get any hospitals in Mexico certified by Medicare under the current way we are doing things. So what are we going to do? I think that is probably a topic for the break-out session.

Karla Vargas: I would like to thank our panelists, and now we will open up the floor for questions.

Audience Member: I am Eduardo Sanchez with the School of Public Health at the University of Texas Health Science Center in Houston. I had the pleasure of working with Dr. Ruelas as a member of the U.S. Mexico Border Health Commission. A lot of the focus was on hospitals but the fact is that it's chronic diseases that are affecting most people in the United States and in Mexico. Whether we are talking about U.S. retirees in Mexico or Mexicans visiting the United States, it is what role you see and what work is

going on to go beyond the use of technology. Telemedicine is great and obviously connections within the CHRISTUS hospital from hospital to hospital to electronic health records, whether we are talking about folks who can afford care as opposed to folks who may not be able to afford it, is important. What do you see as being the role of electronic health records, so that if you are a retiree in Mexico, and maybe there is a slow progress in getting hospital certification for Medicare, how can we at least work on making sure that when a patient arrives back in the United States, there is a complete medical record that can serve that patient? In turn, when that individual returns to Mexico, there is a complete medical record there that can assure the continuity of care, the coordination of care irrespective of where that person is.

Michael Ford: I don't think anybody has developed an electronic medical record that really is as portable as you might want it to be. I know there is a lot of work being done on it. It would help to help people going back in forth and certainly, I've worked with projects that have worked on it but we have been unsuccessful in really getting it done. I am not aware of anyone who has that. Perhaps Methodist—do you have an electronic medical record that you are happy with that people can take with them?

Janice Finder: We have electronic medical records. The second question is that are all people all the time happy with it? Not all the time, but it's the best thing we have seen so far.

John Zipprich: I might comment on one part. From my experience in working with a number of hospitals throughout Mexico—some we have, some we've looked at, and some we consult with—there is not the level of electronic record keeping that you would see in the U.S. U.S. hospitals are struggling with developing the right kind of electronic medical record that will link in with the doctor's office and be unified. That is a struggle that we are still trying to work on and government is saying that they are going to put money for it. The best thing that we have been able to do is within our clinic program. In that program, for example, the first neighborhood that we started with was a colonia of about 100,000 people. We had 90,000 in our database and we were able to keep their records electronically because we have that closed system within that neighborhood. We have been able to do that for that community, but we can't always transport those records if any of those people need hospital care. We can't transport it, for example, if they are going to the Universitario Hospital, because they do not have the linkage of the systems, so I think that is a problem. It is a greater problem in Mexico than it is in the U.S. but after we make our mistakes here in the U.S., we might then be able to transport the right technologies to other countries once we get it developed.

Enrique Ruelas: I would like to add that it is not only a technical problem but one of reliability as well. I wonder whether an American doctor would rely on the report of a Mexican doctor and whether a patient would have to go through the whole process again because the studies were not reliable according to the perception from the other side.

John Zipprich: I can comment on the reliability. I had an exam of a fungus, it's a minor thing, my toe—nothing came out with our CAP certified lab in Mexico, and I could get it tested in the United States but going to the Internet and using my password to

see my results, I saw it was nothing. So I went to my doctor in the U.S., and she says we need to send a toe scraping to Methodist lab. I said I have already done this and it was low cost to me. She says no, we really need to do this again, as she didn't trust the Mexican lab, though I had complete trust in it. I spent $123 of my own money—I don't know how much the insurance paid—plus another consulting fee to the pathologist who really didn't do much for the fee that he got. Of course, the results were zero—no fungus. That is the example of trust. I could get my doctor access to that electronically but there was a lack of trust of those results. That is a cultural thing we are going to have to get U.S. doctors to accept. Regarding ABC and CHRISTUS Muguerza hospitals for example, are there other hospital that would not have the same standards? Sure. But can we get quality care in Mexico? Can you get quality care in Mexico with good lab results that you can rely on? Absolutely.

Mark Engelman: The practical circumstance is that you've got hospitalized patients—I am talking about retirees now. You have hospitalized patients and then you have the 95 to 98 percent of the people who have ongoing care who don't go to the hospital. That is a big deal to me. That is something that we are working on for developers, which is preventative health care, taking care of chronic medical conditions, how is that information kept, is it 100 percent bilingual? Less than the electronic record is the quality of the record and the consistency of how it is taken care of. You can have an acute catastrophic health care incident that happens from time to time, but that is not the majority of what goes on with retirees. The majority is chronic conditions like hypertension and high cholesterol. There are regular day-to-day things that need to be monitored. How do you put that in so that people have a system that has a certain amount that's paid so they get consistent health care that they can bring back in an electronic record or bring it back in written record, but consistent with U.S. standards and certainly bilingual.

Hector Morales: I am a local surgeon and am also a consultant with the Veterans Administration system, and they have a very good electronic record. We take care of people throughout the country without any difficulty whatsoever. Their system works very well, so there is an example of an electronic system that is working.

Mark Engelman: The VA system is supposed to be the best system.

Jacobo Kuperstoch: I believe that certification is vital. Certification of hospitals, physicians, nurses, and of health professionals in general, and perhaps the United States will open more to an international certification that will allow people to practice certified in the two countries. And today, I think that everybody knows that we have a dramatic shortage of nurses. Nurses cannot practice because they are not certified. Something that will be very useful is to standardize the certification of physicians and other health professionals so that they can practice in both countries.

Karla Vargas: We would like to thank our panel.

Chapter 4. Panel 3: Administering Cross-Border Medical Insurance

David Warner: I'd like to introduce another member of the PRP, Juan Martinez, who is going to introduce the chairperson of the next panel. Juan is a native of Puebla and has his degree from the Tech in Monterey. He worked for three and a half years for the Mexican version of the IRS in Mexico City prior to coming to the LBJ School.

Juan Martinez: I want to introduce Dr. Hector Morales, who is the chairman of the Advisory Committee of the Mexican center at the Lozano Long Institute for Latin American Studies at UT Austin. The Lozano Long Institute is jointly sponsoring this conference. Dr. Morales is a surgeon here in Austin who has been certified and recertified by the American Board of Surgery and Advanced Cardiovascular Technology. He has held a number of important posts at the hospital and the Travis County Medical Society, and was chairman of the Board of the Central Texas Medical Foundation for ten years. He is licensed to practice in both the U.S. and in Mexico and is uniquely qualified to chair this panel.

Hector Morales: Thank you. We have four distinguished speakers today. The first speaker will be Russell Bennett; Mr. Bennett is Vice President of Latino Health Solutions at United Health Care. Mr. Bennett lived in Mexico for 30 years. He has served as the founding Executive Director of the United States Mexico Border Health Commission, U.S. Section. He has had an extensive career with Sharp Healthcare and as an international business consultant. His work in leading the transformation of Pacific Care, a United Healthcare company, to serve the growing Hispanic market is profiled in the book "Marketing to Hispanics" by Tracy L. Soto, published by Kaplan Publishing.

The second speaker will be Jim Arriola, who serves as a CEO and President of Sekure Healthcare. He's a co-founder of Sekure Healthcare, a health care service company primarily focused on providing health care coverage to California's uninsured workforce. He helped Blue Shield of California organize the first California-based cross-border HMO Plan. Mr. Arriola has been appointed by the California Department of Health Services to serve on the advisory group of the California Office of Bi-National Border Health. He graduated from the United States Military Academy of West Point and has served on active duty in the United States Army for 12 years, reaching the rank of Major.

Our third speaker will be Lawrence Meagher. Mr. Meagher is Director General (CEO) the American British Cowdray Medical Center, known as ABC. This is a general acute care teaching and research hospital that is affiliated with the National University of Mexico Medical School as well as leading medical schools in the country. From 1991 to 2003, Mr. Meagher was the president and chief executive officer of the International Hospital Corporation based in Dallas, Texas. He has been Vice President and founding director of international services for Baylor University Medical Center, and Executive Vice President and Chief Operating Officer for the Baptist Health Enterprises. Mr.

Meagher has a B.A. in history and political sciences from the Wheeling Jesuit University and an M.P.H. from Yale University School of Medicine.

Our fourth speaker will be Pablo Schneider. Pablo Schneider is Executive Vice President of Business Development of Fusion Mobile, a wireless company focused on United States, Hispanic, and border markets. He was previously vice president of Latin Affairs for a group of Delta Dental Insurance companies and was responsible for initiatives in Hispanic Border and Mexico markets. He was the president of the ACTI joint venture between Blue Cross and Blue Shield plans in the border region and was responsible as a senior executive for the development and implementation of Blue Cross and Blue Shield Hispanic Border and Mexico initiatives. He was also co-director of the LBJ School project that resulted in the book *Cross Border Health Insurance: Options for Texas*.

Russell Bennett: Thanks. Before anything else I wanted to make sure that we appropriately recognized Dr. Ruelas, who is not only all the wonderful things that were said in his bio but he's actually Mexico's Surgeon General. So Dr. Ruelas, we're honored to have you here with us and thank you for your words. We've heard some excellent speeches this morning and I've certainly learned a lot on the real estate side and in terms of some of the wonderful things that are being done in Mexico in health care and how the level of health care, both on the certification side as well as for care delivery and patient satisfaction, are increasing month to month and year to year.

Dr. Warner asked me to speak today about several topics. I'm with United Health Care, which is one of the largest health care carriers in the United States. I'm on the commercial side of the business, that is, I work with employer-paid insurance, not strictly on the Medicare side, but I do help them with some of their Latino business and some of their Latino issues. As a Medicare carrier we have probably over a million Medicare Advantage members through our Ovation Subsidiary and one of our largest customers, perhaps the largest customer our company has, is AARP. So David asked me to speak about whether U.S. health insurance companies could be the intermediaries for Medicare to pay claims in Mexico. You heard Dr. Mark Engelman talk about that fact that if and when Medicare pays in Mexico it probably wouldn't do it directly, it would probably do it through existing intermediaries that they already have experience with.

I'd also like to talk about some of the near-term prospects for Medicare to address paying claims outside the U.S., because I think that Congress is otherwise engaged right now and we may not see action on that topic as fast as we would all like to see it. So for that reason I will also talk about a couple of alternative insurance product solutions for U.S. retirees in Mexico and I would caution you that these are not products that we're developing yet, but they're ideas, and they're ideas for anyone who would like to develop them. Then I would tell you a little bit about one of the products that we have today that begins to build towards eventual cross-border coverage in Mexico, with some of the "foundational" steps that we need to take in order to be able to develop cross-border coverage as we move forward.

So, can U.S. health insurance companies be intermediaries for Medicare and for payment to Mexican health care providers? I'd say administratively, yes it can be done. It can be

done most probably in joint venture companies with Mexican insurers. I think that favorable experience in paying commercial claims in Mexico over time could set a precedent in order to be able to pay Medicare claims, that is, if we can show a few years of experience paying commercial claims, whether it's our company or whether it is done by any of the other companies in our insurance space, we will then be able to go to Medicare and say look, we've done this successfully, we've addressed the potential issues of fraud and abuse, we've addressed all the different issues that you want to know about, and now we can be an intermediary on your behalf. The Mexican health care delivery system has advanced greatly, and that is evidenced by the talk that Mr. Zipprich gave about CHRISTUS Muguerza, and evidenced by what Larry Meagher does and will tell you about at ABC hospital, and what he has done with the CIMA hospitals over the last few years creating a whole network, and it is evidenced also by the Angeles Group that's building 14 first-class hospitals around Mexico. The health care delivery system has really advanced, but I must say that private medical insurance still lags behind. Private medical insurance in Mexico has not kept pace with the growth of the delivery system, because health insurance in Mexico is still primarily "major medical" and there is really a limited supply of prepaid primary care.

Now, another point that I think is important in terms of whether we can be intermediaries or in some way serve Medicare in that capacity is that Medicare providers are very highly regulated in the United States and there's no reason to believe that there's going to be less regulation if and when they begin to pay in Mexico. They are not going to find it acceptable or satisfactory to say "just because we're paying outside the country, we're going to require less regulation" and the caveat there is that regulation adds administrative costs, so even though we see that costs are substantially better in Mexico than they are in the United States, that cost difference could be eroded when you overlay the need for additional regulations.

So, what are the near-term prospects, in my mind, for Medicare to address paying claims outside the U.S.? Just a brief overview: there are now 43 million elderly and/or disabled people on Medicare in the United States, and approximately 19 percent of those are under a product called Medicare Advantage provided not only in our Ovations Subsidiary and our Secure Horizons brand, but by many other companies around the United States. Medicare Advantage had really gone downhill in terms of growth for several years, because costs were outpacing the reimbursement that insurance companies were getting from the government. With the Medicare Modernization Act of a couple of years ago and the establishment of Part D drug coverage, Medicare Advantage has once again grown and I think it's about 6 million people, or 19 percent of 43 million that are in Medicare Advantage.

Medicare Advantage is an HMO plan where private insurers (mostly HMO plans) receive a per capita payment from the government, and then take on the responsibility of providing care, not only the same care that you get in traditional Medicare but additional care that you can get with the savings achieved with coordinated or managed care. Now traditional Medicare, that is "fee for service Medicare" where the Medicare beneficiary has to pay a co-payment or a co-insurance and then Medicare pays the rest, is still over 81

percent of the total, and in my mind, once we can get Medicare to pay in Mexico, and that may be quite a few years down the pike, I think that they will pay for traditional Medicare, not for Medicare Advantages services. But Congress has other immediate priorities to debate regarding Medicare and if you searched for "Medicare Advantage debate" in the Internet right now you would find a series of articles that talk about this debate. For example, representative Pete Stark from California and others are saying that Medicare Advantage is costing the government more per person than traditional Medicare, and the other side of the position is that Medicare Advantage is providing more than traditional Medicare, but until they resolve that debate and until they squeeze a certain amount of costs or find out that they can't squeeze that cost out of Medicare Advantage, I very much doubt that they will take up the debate of cross-border payment or out of U.S. payment.

So at least for the next few months, at least through November through the next election cycle, this debate may consume all the attention that we would like to see focused on cross-border provider payment, so again that's a caveat that I think we need to be aware of. As much as we would like Medicare to pay abroad and pay in Mexico we have to be patient. There's a website you can go to called "Protect Your Advantage" and it's from Blue Cross Blue Shield, BCBS Association, and what they're doing is exactly what Dr. Engelman mentioned. He talked about speaking with senators and saying "how do you make laws" or "how do you plan what legislation you're going to propose," and really what happens with our legislators in many cases is that people begin to put pressure on them, to bring things to their attention, to get initiatives and laws proposed based on the fact that there is enough of a grass-roots demand for something, and basically what this website tells you is that Medicare Advantage is at a critical crossroads.

There's this debate in Congress, and it is encouraging people to write to their Congress people about the importance of preserving Medicare Advantage. I think that one of the ways that we would all have to think about getting Congress to act on changing the Medicare regulations, in order for Medicare to begin to pay abroad, is to start with things such as letter-writing campaigns and informing legislators that there is a need for this. In order to get policy changed in the United States in favor of one thing or in favor of another, you really have to have a critical mass of people that are interested in it, not just the academics, but also the voters who are actually going to be able to say they are interested in this topic.

What are some alternatives if we can't get Medicare to step up to the plate very quickly? I think that there are some alternative insurance product solutions or ideas that U.S. retirees could look at. Smaller companies with varied levels of success have tried some of these before, but I think it's only when the larger companies try it that it may work. The time may be right for it now or in the next couple of years. It might involve some commercial managed care products that would provide prepaid primary care and urgent or emergency care in Mexico that's not tied to Medicare (we're not asking Medicare to make any payments), and then care coordination or transportation back to the U.S. for major medical procedures. As David Collins was saying, you have to be near the airport where you can be transported back or transport yourself back to the United States,

perhaps to a designated center of excellence, when a patient wants to use their traditional Medicare coverage. The point is they've already paid for it (through Medicare) and buying another insurance policy in Mexico that's "all inclusive" would be double-paying, so what makes sense is to pay for the care that is not covered, pay for that in Mexico, and then to transport yourself to the United States and use your Medicare if and when you need it.

Another class of products might be commercial indemnity products that provide a fixed payment or reimbursement amounts for designated services and that would perhaps be the same payment whether the service is utilized in Mexico or in the U.S. My guess is that Jim Arriola will tell us about some products of that type that he has developed. Now we know that many U.S. retirees in Mexico utilize the IMSS for primary and urgent care. I think that came out in the study that the students presented. Or, alternatively, they pay cash for medicine or non-covered items and then they return to the U.S. to use Medicare-covered services when necessary, so essentially the first option I talked about is what's happening already. It's just that it's not happening in an organized, insured, fashion but rather in a more haphazard out-of-pocket fashion.

I'd like to just tell you about starting the cross-border product development process. As I've mentioned before, if we demonstrate success in developing commercial products with cross-border features we may be able to apply the lessons learned to future government products. We are starting in my division with employer-paid products, one which we called Plan Bienstar or a "well-being plan," which is a California HMO product. It's available in five counties with a total Hispanic population of 8.3 million people, and it's built around Hispanic-focused services and multi-specialty clinics. It has a series of directories and guides that educate people on how to use the plan. Also, one of the things that we do is look through the list of doctors that tell us during the credentialing process that they have Spanish-speaking offices, and we go out and survey them and say: you're saying that you have a Spanish-speaking office, but is it the receptionist, the nursing staff, or the medical staff who speaks Spanish? And, according to this series of definitions, do those professionals speak Spanish at a one-star, two-star, or three-star level, where three-star is educated in medical Spanish, and where one star is "where does it hurt and how long has it hurt." I think that those are very important steps that we need to take on the U.S. side and that could ultimately translate to things that we need to do on the Mexican side. Again, Dr. Engelman said quality is not necessarily just a doctor who speaks your language, but the doctor who is providing the care with all the quality and cultural understanding.

We've created the ability to quote our products along side a Mexican company that's licensed in California called SIMNSA, which was developed to provide quality health care coverage for that growing segment of the U.S. work force that prefers to access health care services in Mexico. Right now they have health care services rendered by a network of more than 200 doctors and specialists in Baja California, and we're going to see how that goes over the next couple of years and use that experience to develop products if and when Medicare approves the payment abroad.

If you look at the total population of California, 13 million people or over 35 percent Hispanic, in the five counties that we've selected for Plan Bienestar, 8.3 million people are Hispanic in those areas. An average of about 42 percent of the people in Southern California are Hispanic and if you look at L.A. alone it's getting close to 50 percent. So that is where we feel that we have the biggest opportunity for Latino-focused products and perhaps for cross-border products, at least in phase one and then ultimately moving through Texas and Arizona and other places. Thank you very much.

Jim Arriola: Good morning, it's an honor to be here; there are a lot of giants here who have done a great deal of work. And there are some folks who will be giants no doubt, and who are going to be able to do some great things, and I'm awed to be in this company. I'm not a physician, I'm not a care-giver, but I've been focusing for the last 12 years or so on access to care, economic access to care. As you know in the United States, we basically have a third-party payer system, and not to get too technical but basically there are three key factors, or roles. You have the patients, we all know who those are; you have the providers, the hospitals, doctors, and others; then you have this other category called the payers, carriers, or insurance companies. As was mentioned many times before we live in a very regulated industry—insurance and health care are very regulated—and many years ago when regulators came around to develop the laws and rules because of issues of quality and pride and other things, they did it with a paradigm involving a closed system, where the assumption was that the consumers, the patients, would get all their care inside this geographic region and the laws for all the parties, for the providers as well as the insurers, the payers, would all conform to these laws.

But consumer demand doesn't necessarily confine itself to a geographic entity, and in the United States insurance and the practice of medicine is decentralized down at the state level, so potentially you have 50 different states with different rules. You have hundreds of insurance companies and self-funded entities as well as the federal government and many agencies, and it's not consistent. You can call it a system but it's not really a system, it is just a collection of a lot of various programs put together. For the consumer who wants to get services, it's trying at best, especially when you're trying to get or use your coverage outside of the geographic boundaries, and now the cost of health care and a whole bunch of other issues has made it more difficult.

My focus has been this notion of cross-border insurance. Basically what that means is the financing or the delivery of health care from one place to the other and primarily in Mexico. Imagine if you don't have access to health care or access to payment for health care, that's going to put a big crunch in your lifestyle, and I've been involved in helping break through some of the regulatory barriers to provide health care insurance to folks outside of their normal closed system where they really want it or need it. To me it's one of the biggest rushes to help people's quality of life and see them get health insurance where they previously haven't had it. So that is what motivates me. I've had a chance to work at Blue Shield of California where we developed it. I learned first-hand all the challenges from the regulatory, the liability, and the malpractice and insurance sides to try to create something. We were able to create something where people in San Diego County were able to get their service in Tijuana and it was a huge jump there.

On the quality side, and it's very important because of Medicare, JCAHO is imposed upon all the insurers. If a hospital is not JCAHO accredited then Medicare is usually not going to pay. In fact all the insurance companies adopted this same thing, so it's a necessary requirement, but in Mexico and other places JCAHO doesn't really exist. So it is important to convince American insurance companies that determine where the payments could be to adapt to the other place where the consumer demand is going.

So in that context I wanted to share what we've been doing because I think it lends itself to a mechanism that might be able to be used in being able to cross the border and expand coverage. At Sekure Healthcare, we're a small company but we have an immense vision and we've been able to do a lot of things. I just want to highlight some of the key issues. The fact that the cost of health care is expensive because of the rules and the regulations makes it is very difficult to have access to both the U.S. and Mexico. It's usually either one or the other. Regarding transportability of care for dependents, we know that a number of workers here in the U.S. have dependents in Mexico, and especially if there's any guest worker program, that's something that there are not any products out there that are going to be able to address the family. That is what we're focused on. How can we get something out because the demand is out there. What we've been looking at is what is the market need, what's the price point that employers are willing to pay because we know that the cost is getting higher.

What's happening in the industry is that companies are not paying 100 percent of the coverage for their workers. They're paying less and less, as a result there are more uninsured. The typical paradigm of using what's called major medical that conforms to a lot of the state laws that specify what you have to do with mandated benefits, and where it has to be delivered, and how it has to be delivered, makes it very rigid and very expensive and difficult to meet the consumer demands that are outside the envelope. What we've been able to do after a long, long time is work with a new platform, something that's been around for a long time. Pablo Schneider has been working on it, this concept or notion of limited benefits; they're available in just about all 50 states and it's something that's a lot more portable, and we've found that it is an excellent vehicle. What we've been able to do is package a lot of different services and coverages together in a package and sell it to employers, but also make it so the benefits can be accessed in the U.S. and Mexico.

We've looked at the needs of a lot of the migrant workers and low wage earners, and I think a lot of it is applicable to U.S. retirees in Mexico, being able to get not just the health care services but the telephone—the telephone is one of the most underutilized tools that could help facilitate medicine or health care. Why do people have to go to the hospital to find out what's wrong when in some cases being able to have access to a doctor or a nurse or somebody might prevent a visit, especially when you're looking at all the unreimbursed emergency room visits.

If a system like that was available, I think that would be good, but who can you call if you don't have health insurance? There are a few benevolent organizations that offer that. So what we're looking at is trying to design something that is able to serve the need

of one family in two worlds, and it brings the notion of what we call transportability of employee benefits in the industry. I think this is something that there's a need for and you're going to see more and more companies doing it, starting first with the small companies, and then as the innovations and the trends spread and they figure out how to do it, I think the larger companies are going to get more involved. The idea is being able to have workers send their private, not government, but private health care benefits to allow their families to obtain their benefits in both countries. Once that happens, and it's the financing aspect of it, then all the great providers that are trying to work on the quality of care are going to be able to provide those services, and it's going to help reduce the expense to a lot of folks. But the idea is really where workers in the U.S. can have their benefits sent to Mexico, or the worker themselves can go. Not everything has to go there but it provides a lot more flexibility and we think that it's going to help improve the quality of life for a lot of folks.

What we've been able to do is break through this cross-border paradigm where it's just available on the border, and have been able to work with and develop networks in Mexico. We now have contracts with providers in about 300 cities in Mexico. Some providers are located in the big cities but some of them are also in the little pueblitos where there might be a few doctors; the idea is to be able to have a network. What we've been successful at is with the insurance partner that we're working with where they've agreed to pay claims in Mexico using our networks, so it's not just the emergency care but it's routine care, the hospital, and the other services that are covered. It's a huge achievement for us and I think this is just one out of hundreds of insurance companies. You have to go one by one by one.

I think as the results are going to be known on how good it is and what it's helping, and obviously the insurance companies want to do it because they can differentiate themselves from others. They're going to increase market share and sell more policies, so that's kind of what's in it and I think that would be the impetus for why anybody would want to get involved—to be able to better serve the consumer demand, because if you can't serve the consumer demand, you're going to find yourself out of business. We think that the model that we have has a lot of applicability as far as guest workers, part-timers not just in Mexico but also in the U.S. The whole notion of limited benefits I think lends itself to be used for guest worker programs.

I think some of the lessons we've learned lend themselves to having Medicare in Mexico. Mexico has a different system, not just the language, but this whole billing the third-party carrier system hasn't developed in Mexico because it a very different system. But for a U.S. company to be able to take the way that things are done in Mexico, several million dollars of IT changes have to happen. If the market's not that big, then the companies are not going to incur the investment to go through. What we've been able to do is find some very low tech ways of being able to get the claims and the services into the U.S. systems so the U.S. payers can recognize it, something that most Mexican providers don't have a notion of, how the U.S. system works. So I think the little, innovative, low tech methods are going to have a lot of applicability.

What folks are trying to do here is just incredible because the quality of life is going to be enhanced for a lot of folks, especially for the retirees who are living in Mexico. We saw some of what the studies have indicated as far as the trends that are going on down there. For folks who are going to be on fixed pension or retirement income, it could make a big difference in their lifestyle, and really it's kind of freedom of choice. Medicare is a federal benefit and although you can get Social Security anywhere, you can only get Medicare right now in the United States, so if there is a consumer demand hopefully intermediaries could develop programs to allow that to happen. I just wanted to share what we're doing as I think it's pretty innovative. I'm happy to talk to anybody that's interested in trying to do things or has ideas, and I think it's through this collaboration that more advances can be made.

Lawrence Meagher: Good morning everybody, and first and foremost a thanks to David Warner and his group of students for inviting me. It's an honor to be here in a room with so many people involved in the subject at hand, some of whom we have worked with before and some of whom we'll certainly hope to work with in the future.

I want to tell you a little about our institution and how it might be a player in what we're talking about today. The ABC Medical Center, and that stands for American British Cowdray, is an institution that dates back to 1886 and was founded by the American community in Mexico City, the American Benevolent Society that still operates today in Mexico City. It is there to help Americans who are in need. I imagine back in those days they were involved in the mining industry, and railroads, and rough and tough kinds of stuff. Today they do investment banking and nice safe jobs, but the American Benevolent Society in their wisdom in 1886 founded the hospital. One of the first donors to it was ex-President U.S. Grant, and they located on what was then the outskirts of Mexico City, which is now the middle of Mexico City. It operated successfully, initially taking care of Americans, but very quickly it was seen by the Mexican community as a high quality institution and gained a great reputation, and it went from foreign providers, most of them Europeans physicians trained in France and Germany, to a Mexican medical staff.

The British side is interesting because Wheatman Pierson Lord Cowdray, who made himself in today's numbers sort of the Bill Gates of the Western hemisphere by developing railroads and ports and all kinds of ambitious projects, was the founder of the Eagle Oil Company in Mexico, and he was a man of very good timing because he sold that to Shell before Mexico nationalized the oil industry. And he sold off the railroads to the Mexican government before the Panama Canal opened. He donated a million pounds and built the Cowdray sanatarium, which sits today on the property that is occupied by the Camino Real hotel in Mexico City, right across from Chapultepec Park. The institutions merged in 1941 and became known as the American British Cowdray Hospital, and continued operating on that site for many years.

There are some of us here in the room who remember that place well—it was an elegant facility designed by a British architect in London who had never been to Mexico. He'd also designed a hospital in New Delhi and he thought they are about the same latitude so

this must be a tropical climate. When I was a child growing up in Mexico City, my father used to say if they don't kill you in the operating room you'll freeze to death in recovery. It was designed for a tropical climate but the ABC grew in stature and grew in recognition in the country, and in 1964 we moved to the current location of the principal hospital, and in 2004 we opened a new facility.

During those years we grew in many ways, and let me just speak to two years, one of them was 1980 when I first became the CEO Director General of the ABC Hospital. I held that position for six years, then went on to do other things, and then came back in 2003. The 1970s and 1980s saw the consolidation of the hospital as a quality institution. In the 1970s, the first residency training program was established at the ABC; it was in critical care medicine and it was the first residency training program in Mexico at that time. The school operated a school of nursing, which was a degree granting school of nursing, and as a result of the intense involvement of the ABC and most of the health care community and the polio crisis of the early 1950s, it also supported a school of physical therapy. So the hospital was involved in teaching, it was involved in clinical care, and in the 1980s we began introducing concepts from American medicine and we reorganized the medical staff in the traditional mode and way of a U.S. hospital. The hospital formed peer review committees that did certification of physicians with the requirement that everybody in the institution be board-certified in their area of practice, be it board-certified in the Mexican system or board-certified internationally. Many of the physicians in those days were foreign-trained, but much less so today, I think both because it isn't required and because it's more difficult to accomplish that. Most of the physicians today who go abroad for their training go to Europe or Canada rather than the U.S., although we still have physicians coming back from the U.S.

The medical staff is organized into not only the credentialing process but also morbidity and modality committees, and into departments that had regular meetings. Grand rounds were established as a weekly event. The hospital participated in clinical research and generally the individual physicians participated in clinical research and also were involved in some other interesting projects. One of them that was very significant in Mexico and I think often forgotten by everyone down there was a joint project between UNAM, the National University, Harvard Medical School, and the ABC, where Dr. Eduardo Palazuelos, who later became the health secretary of the City of Mexico, worked on a long term-study reviewing blood lead levels of young women through pregnancy and through delivery of their children. The data were so impactful that the government finally eliminated lead from gasoline, and for those of you who knew Mexico City in the 1980s versus today, you can see the tremendous change in the reduction of air pollution. Obviously, other factors have taken place and wood burning stoves and many of the old industrial plants located in the city have now disappeared as well.

The ABC began in those days looking at quality directed at our market, which by the way is 99 percent Mexican patrons. We are often seen as the institution that takes care of foreigners in Mexico and it may be true that we have more expats as patients, but as a fraction of our total patient volume it's almost nothing. We have relationships with most of the major embassies in the U.S. and take care of their employees and their

beneficiaries. In 1981 after returning from Canada, Dr. Enrique Ruelas became the first external consultant on quality at the ABC hospital, helping us develop some of these items that we're talking about, and when I reflect back on it, it was like shoveling sand against the tide because we didn't make a great deal of progress but we did establish a concept that we wanted to take a look a quality. We went to Chicago and asked the Joint Commission if they published their book in Spanish and they said no but we will soon, and I think it took 20 years before they finally did it, so we took the book in English and we circulated it to the medical staff leadership and said this is going to be our Bible, and we began to install things that looked at quality.

Jumping forward to the years 2000 to 2002, the hospital grew naturally, the level of technology increased tremendously, and we put in place additional real solid, quality programs. We decided we had to do something other than try to do it in a home grown fashion, and so in November 2006 we signed a six-year agreement with Methodist Hospital in Houston. We have tried other partnerships—in the 1980s we had a partnership with Baylor University Medical Center in Dallas, but it was really a collegial relationship. It was friendly, we used their name, they used our name, but it didn't do a lot beyond give the opportunity for some physician exchanges and educational exchanges of that nature. The relationship with Methodist is an all-embracing relationship. It's taking the ABC Hospital and restructuring the whole way we do business.

We're going from a traditionally organized departmental system to a service line concept. We're going to wind up having nine or ten SVUs or service line components in the institution, and each will have an administrative and a clinical director. Benchmarking is the bottom line in this. We will participate as soon as we complete the transition, and I will speak a little bit about that, to a system where we can benchmark against U.S. institutions. Methodist belongs to University Healthcare Consortium, which is 97 universities with 150 hospitals in the database, and as soon as we get our coding straightened out and we get our documentation compatible, which should be April or May at the latest, we will be benchmarking against 150 of the top hospitals in the U.S. on objective criteria having to do with mortality, morbidity, errors, falls with harm, all of those things that form the basis for measuring the quality in the U.S. institution. I think Methodist is a leader in this country. We've attended meetings of their board committee on quality, which is chaired by a federal judge, and they have a number of highly involved, educated directors serving in that capacity. You see the degree of professionalism in their involvement.

So that's where we are today. What does all this have to do with Medicare reimbursement for U.S. citizens? I don't know that I'm as pessimistic as Mike Ford is about this happening, but I think that you do have to put in place mechanisms which can objectively speak to the quality of the institution. It's not just saying you are good; today I think we have a way of establishing that.

Final word about two issues: number one is I think that there's a major issue here in that there are many Mexicans retiring in the United States today who are torn about where they're going to spend their retirement years. They would like to go back to Mexico and

be in their villages, their cities with their families, but they don't want to give up their Medicare benefit, their health care benefit. They can take their Social Security checks with them, that's not a problem, but I think that the numbers there may be more significant than just those Americans going to Mexico to retire, and it's becoming an issue that's been written up in the New York Times in the last year a couple of times.

The other issue is that the ABC, I think, is providing leadership in Mexico in developing ongoing open dialogue with the health insurance industry of Mexico. There's hardly a week or two that goes by that we don't have formal meetings with these organizations understanding that the synergy is there. They can't write policies without us and we certainly can't continue to operate the hospital without them. We're not 80 percent third-party paid but we're over 60 percent third-party paid, and so we think that establishment of that relationship is something that is necessary and it's proving fruitful to us. There isn't a day that doesn't go by that we are not presenting claims to BUPA, which has taken over Amadex and the Dutch international insurance program. Many Mexicans purchase that coverage, and much of the international community in Mexico does as well. They pay our claims, they pay them quickly and they pay them for the most part without any argument, and they would much rather quite frankly pay those claims than see those patients fly to Miami or to Houston, or to other parts of the U.S. Thank you very much.

Pablo Schneider: It's a real pleasure to have the opportunity to make some closing remarks. In the early 1990s in San Diego I was working in health care and working with Medicare and Medicaid recipients and visiting with them about their health care services. The beneficiaries kept saying that they were crossing the border into Mexico for services even though they had full coverage on the U.S. side, and when it happened once or twice I thought that that was kind of a novelty, but after I was told that dozens and dozens of times by the consumers that they were crossing to the South, it indicated that there was a bigger trend and a bigger movement happening, and so that led me to Dr. Warner's health care across the border book in 1993. Then that lead to the NAFTA and trade in health services project in 1997, and then in 1999 the expanding Medicare into Mexico project. It's a real pleasure to see some of the students here who have worked on these projects. That lead to the 2004 cross-border health insurance options project that I had the pleasure of working on with Dave, so I just wanted to thank you for your leadership and your mentorship through so many years in this field of improving health services.

If you take a step back and you think about what's needed in order to expand Medicare into Mexico, you really need four or five things. One is for CMS to agree to it, which is a big issue. Two, you need an insurer like United who has experience in Medicare HMOs who could do a Medicare Plus Choice program, and you need an intermediary like Sekure Health Care, who has the expertise on both sides and the ability to intermediate between the U.S. requirement and the Mexican reality and delivery. Then on the Mexican side you need high-quality providers like ABC, Angeles, and many others represented here, so it really is a nice fit. Then of course in the context of improving the infrastructure in Mexico and improving quality, we have Enrique Ruelas as well, so it's a very nice fit in terms of exactly what would be needed to expand to make Medicare portable into Mexico.

A couple of issues on CMS (the Center for Medicare and Medicaid Services): if you make it portable into Mexico what about the whole rest of the world for Medicare beneficiaries? Perhaps there is a geographic argument that since Mexico and Canada are contiguous that it would be a significant improvement for the Medicare beneficiaries that live in Mexico to go ahead and expand coverage given their current service usage. You have the Mexican health system versus the airport, that's kind of the continuum, 100 percent in Mexico for all services, a mix in the middle with some on each side, or just going to the airport back to the U.S. So looking at the situation, there are many parallels and precedents in the private sector that are improving the infrastructure of health care financing delivery that will make Medicare portability into Mexico more feasible. You have the self-funded programs of Western Growers going across the border, Access Baja, Health Net, and Sekure Care working with those various carriers in the U.S., United on the insurers side. On the provider side you look at what's happening with quality what's happening with ABC, with Angeles, with Muguerza, with CIMA—there's really significant improvement from prior years in that infrastructure. We also have the specific things that Enrique is working on: certification, credentialing, and quality.

So the bridge between the delivery side and the financing side is really information systems, and there is major U.S. software being adapted and implemented in Mexico and Mexico City, so there are some systems that are moving forward in terms of their sophistication to be able to manage a cross-border or a Medicare portable kind of program. Jim's solution is more low tech, where he actually intermediates rather than trying to spend a million dollars per modification to a big U.S. system in English, so he has more low tech ways of solving that kind of systems issue. Then on the financing side Larry mentioned coding claims: how can the providers comply with all of those administrative requirements? So finally in that continuum of contrasting the complete 100 percent Mexico health care delivery and the Mexican health system and 100 percent getting on the airplane and flying back to the U.S., it's very interesting in this survey that this PRP did that the established source of medical care is a huge issue in access. So established source of medical care is almost 50/50 in the retirees, 50 percent have an established source in Mexico and do not have an established source in the U.S., and 50 percent have an established source in the U.S. but not in Mexico.

The second key thing is how they pay for it: 85 percent are using cash to pay in Mexico, so that means the 50 percent that would use Mexico anyway plus another 30 percent of the people who would get on the airplane are using cash for something in Mexico. Then the third issue which is key from the survey is hospitalization; 60 percent said they would stay in Mexico and 40 percent said they would get on the airplane, but if it was serious it's the opposite, about 36 to 40 percent would stay in Mexico and 60 percent would get on the airplane. So in closing I would just like to say that it's really remarkable the advancements that have been made in with those parallels and precedents, both in the private sector as well as in the public sector with the quality crusade. Many things have been happening in Mexico where the level of infrastructure is improving to the point where at least you could make a case that it would be viable to make Medicare portable into Mexico. Thank you.

Hector Morales: Thanks to the panelists for a great presentation. I'm going to have a quick comment before I ask to take any questions. Jim mentioned something about taking care of people over the telephone, and this brings up an issue that has not been mentioned this morning and that is the legal issue in medicine, if you take care of patients over the telephone then the liability increases tremendously, and there are other factors that also need to be considered because the cultural differences are significant when it comes to taking care of people on both sides. Any questions?

David Stamp: I'm David Stamp from Texas State University and I live in Mexico. One of the problems I've run across with Mexican insurers, in particular private insurers, is that they have age limits. Very few will cover people past age 65 and almost nobody past 70, and this is the age at which most retirees are going into Mexico. Is there any comment you might have on that issue?

Pablo Schneider: Are you talking about the domestic Mexican policies like you would buy from a Mexican insurance company that would allow you to go back to the U.S?

David Stamp: It would allow you to have coverage in Mexico or might have coverage in both Mexico and the U.S.

Pablo Schneider: There are international insurance companies like Larry mentioned and there are a few others out there that are actively selling that international coverage so that's one thing you might do. Part two is I look at it as almost a holdover from the major med sort of mentality where they set the dials pretty tight in terms of the administrative rules because it's really not designed as the primary coverage for the person because in Mexico in the private sector people mainly pay cash, and then if they buy private insurance they're going to use it as a sort of higher end coverage if something catastrophic happens as opposed to comprehensive coverage, first dollar coverage. That would be more of an IMSS kind of coverage, so I think it's more of the mentality of the major medical kind of administrative rules rather than some intentional exclusion, and then the other part is that in Mexico the system is really developed in the context of governmental coverage as well. So if the insurance companies are used to the people having IMSS or ISSSTE or something else then they're not trying to serve the retiree population.

Russell Bennett: I totally agree with what Pablo was saying, it's a very good analysis, the only thing I would add is an example: my parents live in Mexico and they're in their mid-80s. They live in Cuernavaca and for years they have purchased annually the IMSS coverage and they're covered by traditional Medicare because if you want to be covered by Medicare Advantage and by Medicare HMOs, there are limitations as to how long you can be outside the country each year. Different plans I think have different limitations, but you can be out maybe six months, maybe nine months, maybe three months, so if you lived in Mexico or outside the United States all year long, or most of the year, you would not be able to be covered by a Medicare HMO, so you would revert to having traditional Medicare. But traditional Medicare is only good, as all Medicare, in the United States, and so what many American retirees are doing, and retirees from other countries, is to buy a policy that costs, I don't know, between $250 and $600 a year at the IMSS and in

most of the cities that I know of where there is a large number of U.S. retirees, the IMSS clinics are very good for primary and urgent care, and they don't have an age limit.

David Warner: But they exclude preexisting conditions?

Russell Bennett: Yeah, there is some preexisting conditions limit, but other than that they're providing good care, regular doctor visits, and then for preexisting conditions or those non-covered services you end up paying cash, with the system being much less costly than paying cash in the United States.

Pablo Schneider: One quick observation, when I was working with Medicare recipients in San Diego a lot of them were living in Baja and they'd come over, sign up, go live in Baja and just come back whenever they wanted services, and technically, I guess, as long as they came back once every 90 days, then they were maintaining some kind of residency, but basically what they were doing was going around the system in order to still get the full coverage but still live in Baja. As long as they were close enough to do that they'd cross the border to get care if they could through their Medicare HMO. I suppose if Medicare ever found out they might make them go back on regular Medicare, but they enjoyed that full coverage right there on the border, so they single handedly took Medicare portability into Mexico on an individual basis.

Chapter 5. Keynote Speech: NAFTA, Interdependence between the U.S. and Mexico, and Trade in Services

David Warner: To introduce our keynote speaker today is Marina Zolezzi, the final member of our research group. Marina Zolezzi is a native of Brownsville, Texas. She is a graduate of St. Mary's University in San Antonio where she had joint majors in business and Spanish. She worked for two years for the Department of the Treasury in Philadelphia, and started at the LBJ School in September.

Marina Zolezzi: Good afternoon, I'm pleased to present to you our keynote speaker, Dr. Sidney Weintraub. Sidney Weintraub holds the William E. Simon chair in Political Economy at the Center for Strategic and International Studies. He's also Professor Emeritus at the Lyndon B. Johnson School of Public Affairs, where he was Dean Rusk Professor from 1976 to 1994 when he joined CSIS. A member of the U.S. Foreign Service from 1949 to 1975, Dr. Weintraub held the post of Deputy Assistant Secretary of State for International Finance and Development from 1969 to 1974, and Assistant Administrator of the U.S. Agency for International Development in 1975. He was also a Senior Fellow at the Brookings Institution. His book *Energy Cooperation in the Western Hemisphere: Benefits and Impediments* is expected to be published by CSIS next week. Other recent books are *Issues in International Political Economy: Constructive Irreverence*, *Free Trade in the Americas: Economic and Political Issues for Governance and Firms*, *NAFTA's Impact on North America: The First Decade*, *Financial Decision Making in Mexico: To Bet a Nation*, and *Development and Democracy in the Southern Cone: Imperatives for U.S. Policies in South America.* Dr. Weintraub has also published numerous articles in newspaper and journals. He received his Ph.D. in Economics from the American University as well as an M.A. in Economics from Yale University.

Sidney Weintraub: Thank you. I'm not going to talk about health care—I am going to talk about Mexico, what's going on, what the economy is like, what the future may be. If there are Mexicans here who disagree with me, please speak up after I finish talking. With the group here I don't have to spend much time commenting on whether Mexico is important to the United States, and vice versa. There are many ways to look at the nature of their mutual importance but it is obviously one of the important relationships that each of the two countries has, maybe in Mexico's case *the* most important relationship. The numbers on trade and other issues will come up in the presentation. On issues other than those of war and peace, Mexico is probably the most important country affecting the United States. When there's turmoil here in the United States, there's going to be turmoil in Mexico. When we grow rapidly Mexico will export more. If Mexico has problems of one kind or another, we in the United States will be affected, perhaps less immediately than Mexico is affected by our problems because about 80 to 85 percent of Mexico's exports come to the United States. For us the percentage is much lower, about 12 or 13 percent. It is an asymmetrical relationship. There are other aspects of that relationship that I will note.

Mexico is right next door and that geography is not going to change, and we have to remember that as we fashion our policies. The U.S.'s trade with Mexico is substantial. Mexico is now our third-largest trading partner after Canada and China. The U.S. also has large trade deficits with these countries.

Mexico receives a good deal of foreign direct investment and most of this comes from the United States. The amount is increasing and the inward investment flow is quite important to the Mexican economy. NAFTA was formed in part to stimulate trade between the two countries and it has certainly done that, but NAFTA was also designed to stimulate Mexican receipt of foreign direct investment. Mexico needs that capital because the country is not saving enough, and NAFTA has helped Mexico receive this investment.

I've often heard people criticize NAFTA because the agreement has not helped Mexico to grow at a high enough rate. I've never understood the comment because NAFTA was not expected to be a panacea. I'll come to other elements of economic growth policy, but the two basic parts of NAFTA are to promote trade between the two countries, and that has been successful, and to promote investment into Mexico, and that has been successful.

I will talk now and again later about migration. We track legal permanent immigrants from Mexico into the United States as well as naturalizations, but an interesting part of migration is to note what's been happening with respect to unauthorized migration from Mexico into the United States. In recent years this has been about 400,000 to 500,000 a year. The figure is large. There was some mention of guest workers by earlier speakers. The United States does have a number of specialized guest worker programs, but we don't have a general temporary worker program with Mexico.

I will shift my comments to Mexican vulnerabilities. This is where the main changes are necessary. Mexico collects about 11 percent of GDP in taxes. That figure may not mean much to you if you are not an economist, but that percentage is low even by Latin America standards. The figure for the United States is around 20 percent. Tax collections in Brazil, which may be overtaxed, are about 38 percent of its GDP. Remember that Mexican tax collections are about 11 percent of GDP, and government expenditures are normally about 18-20 percent of GDP. That means that Mexico really can't finance its budget from its tax collections.

The other main source of revenue for the federal government is from Petroleos Mexicanos, or Pemex, the Mexican national oil company, and Pemex contributes about one third or so to the Mexican federal budget. This makes Pemex highly vulnerable. In most recent years, Pemex actually ran a loss in its net position. The loss came about mainly because the government taxes on Pemex come right from the top of the company's gross revenue in order to finance the central government budget. Consequently, Pemex is short of money for its own activities. Pemex has been able to do little exploration for finding new oil, and on top of that production is declining in Mexico's most important old oil fields. The most important oil field in Mexico, in fact the second largest oil field in the world, is Cantarell. Its production is declining at a rapid

rate, by as much as 25 percent over the past year. At current rates of production, Mexico's oil proven reserves will last only about 11 years, unless Mexico finds new sources. That is not happening because Mexico is not doing enough exploration for new oil fields.

The United States now gets about two-thirds of its new oil from the deep waters of the Gulf of Mexico. Pemex is hardly exploring in the deep waters of the Gulf of Mexico because each exploration can cost $100 million or more and Pemex doesn't have the money. There's a graph in the book I just edited on oil cooperation in the western hemisphere that shows the two parts of the Gulf of Mexico, the part that the United States owns the part that Mexico owns. There is a little black dot for each drilling in the two parts. The U.S. part is all black with dots and the Mexican part is just about all white with practically no dots.

As I think all of you know, Mexico does not permit private equity investment in oil. Pemex has a monopoly over all exploration and all oil production in Mexico and that is built into the constitution. The idea of a government monopoly over oil is deeply embedded in the Mexican psyche ever since the expropriation of oil in 1938. Those of you who know Mexico City are aware of the large monument to oil expropriation on the Reforma, Mexico City's prominent avenue. It has been impossible to change the constitution to permit private investment. Mexico is willing to sign contracts with private oil companies and others for services, not equity.

Okay, what does one do in that situation? That's one of the Mexico's deep vulnerabilities. The government needs much of the money that Pemex brings in to finance the budget because tax collections are insufficient. Another way to get the money for the exploration is to allow private companies to enter into joint ventures with Pemex. That does not appear to be allowed under the constitution and, as far as I can see, the only real solution in the next few years is to get lucky and find something big. That is hardly a prudent way to run oil policy.

It's worth comparing Pemex to the Brazilian national oil company, whose abbreviation is Petrobras. The structure of Petrobras is very different from that of Pemex. Petrobras sells private shares; indeed there are more private shares outstanding in Petrobras than there are shares that the government owns. The government controls policy by having separate voting shares and here the government has a slight majority and can control policy. The reason the structure is useful is that because Petrobras has to satisfy private shareholders and maximize their profits in order to be able to operate, and to explore for and produce oil and gas. Pemex doesn't have to satisfy any private shareholders.

Another vulnerability of the Mexican economic structure is its labor employment policy. Most economists, Mexican as well as foreigners, argue that the law is too rigid. If an employer hires a full-time employee the benefits are quite high, and there is nothing necessarily wrong with that; if an employer finds it necessary to fire an employee, he must pay compensation based on the number of years that person has worked. The labor unions like that, but the employers under those conditions defend themselves; they try not to hire people formally. They hire them for part-time work or they use them informally

and this means that Mexico has much informal employment. There are more people in Mexico who do not contribute to IMSS or any other Social Security system than those who do, thus showing the informal economy is larger than the formal economy for employment. The informal economy is big, very big. These people do not show up as unemployed, but as part of the labor system, but without the formality that provides benefits and pensions.

Mexico's population is now quite young, especially compared with that of the United States. The United States already has an older population and it's aging even more. However, if one takes into account all current demographic projections for 2050, Mexico's age/quantity population chart will look much like that of the United States in 2050 as Mexico's population ages, and that will bring many problems. The way demographers look at it is that Mexico has about 30 years in which to take advantage of the excess population and build up the economy, and the basic problem is that Mexico is not doing that. In other words demography will play a big role in Mexico's future, and this is obviously a relevant point for all that we have been talking about in just about all our discussions. An older population affects health care costs.

Another weakness is in Mexico's educational structure. Most economists agree that Mexico's education system is weak. Relatively few people complete high school and college in comparison with comparable countries. That means that Mexico will have to devote much money for education, especially if the country is going to alter production techniques to become more competitive internationally. Mexico is already trying to do this in its maquiladora, or assembly plants, to compete with China. Mexico has learned over the past several years that the country cannot compete with China and many other countries on the basis of low wages because wages are even lower in other places in the world. The solution is to upgrade education. I am not talking here about people who go to universities, but rather about people who just complete that basic portion of their secondary education and are able to handle more complex machinery.

Many Mexicans live in poverty. In addition, Mexico is an unequal society. Every recent president promised to lower poverty rates, with only modest success. This failure, together with the large inequalities that exist in the country, was probably the main reason for the very good showing of Andrés Manuel López Obrador (AMLO) in the last presidential election. The only sure way that countries have found to reduce poverty is to grow faster, to grow at a reasonable rate year after year. Chile was able to reduce poverty from about 40 percent to 20 percent between 1985 and 2000 because the country grew year-in and year-out by about 6 or 7 percent a year. This did not reduce inequality, but the steady growth reduced poverty.

Mexico has an anti-poverty program that I am sure is known to Mexicans at this meeting, even if not to Americans here. This program used to be called Progresa and is now known as Oportunidades, and from what I know it is probably one of the best welfare programs in the world. The program deals with health care at the same time it focuses on education and food. The three aspects are combined in one program. I don't want to go

into the elements of the program and how it is administered now, but it is really an important operation for dealing with poverty in Mexico.

Unfortunately, Mexico's economic growth rates have not been all that high in recent years. Recall the point I made earlier—that high economic growth, year-in and year-out, is the best way to reduce poverty.

I have often asked myself what are the most important contributions the United States could make if it wanted to help Mexico grow faster and at a regular pace over the years. My conclusion is that the most important thing that we can do is to run our own economy well and not be protectionist because the more our economy grows, the more we suck in imports from Mexico. We don't have to take any special action, we just have to properly run the U.S. economy. About 80 to 85 percent of Mexico's exports are sent to the United States. These exports amount to about a third of Mexico's gross domestic product, and this one-third is determined as much by U.S. GDP growth as by anything else. Mexico is now our third most important trading partner, after Canada and China. However, China's exports to the United States are growing much faster than Mexico's.

I would like to return here to a discussion of immigration and how the United States is going about establishing immigration policy. I think that everybody knows that the number of border patrol agents hired for the Mexico-U.S. border has increased substantially in recent years. Large further increases in the size of the border patrol are in store. In addition, during the past few years there has been a program to increase internal surveillance of workers who are in the United States without proper papers. The 1986 Immigration Reform and Control Act (IRCA) was a bargain with two key provisions, one to legalize or give regular status to unauthorized immigrants who had been in the United States for a number of years, and the second part of the bargain was that the U.S. government would punish employers who knowingly hired undocumented workers. Well, we did legalize several million people. This was done in a sloppy way, but that part of the bargain was kept. That led to further immigration because those immigrants already in the United States then brought their families.

However, the second part of the bargain reached in 1986 was not kept. For the most part, the U.S. government did not punish employers who hired unauthorized immigrants. It was evident in the legislation itself that there was no disposition to punish employers because the Congress refused to authorize foolproof identification cards that employers could use to effectively determine whether the person they were hiring was properly in the United States. Instead, the IDs used were drivers' licenses, birth certificates, and other papers that are easily forged. Indeed, what the 1986 legislation did was to stimulate a large forgery industry in these kinds of papers, something that all those who followed the crafting of the legislation knew at the time would happen.

President Bush is now talking about new immigration legislation. The system of enforcement after 1986 was to try to stop unauthorized entry at the border, but once inside the country, there was little enforcement—the unauthorized immigrants once in the United States were more or less home free. During the past few years, with new legislative proposals being made, the Department of Homeland Security has been

arresting people on site where they are working. There is now recognition that internal enforcement is necessary to curtail the number of unauthorized workers in the United States. That may make a difference. About 40 percent of the roughly 12 million persons here without proper documents are visa overstayers and not clandestine border-crossers.

There has been more migration from Mexico to the United States during the last 15 years than ever before. In other words, immigration from Mexico went up after NAFTA came into effect in 1994. One of the reasons for this, the main reason I think, is that the opportunities for employment in Mexico have not been good. In addition, wages in Mexico in comparable activities, such as manufacturing, are about 15 percent of U.S. wages. Once a migration pattern is under way, sister communities between those in Mexico and the new ones in the United States build up and kinships relations give Mexican migrants a place to go. Once clandestine migration starts, it is hard to stop. Generally the migration will not stop until Mexicans are reasonably convinced that Mexico will grow regularly and provide the means to raise a family, put children through school, and provide economic opportunity at home.

I have been discussing impediments to economic growth in Mexico. These include insufficient tax collections, an inadequate educational structure, failures to find new sources of energy, inadequate job creation and others—all these together stimulate emigration.

Mexico's new president, Felipe Calderón, has started out quite well in making clear that he understands what needs to be done. However, the migration issue is complicated and I have no idea what will happen this year in the U.S. Congress. The conservative wing of the Republican party does not want to give legal status to the 12 million people (about 60 percent of them are Mexicans) who are in the United States without proper papers. They are opposed to what they call "amnesty." Amnesty is a strong word because any legislation for regularizing these people would impose many conditions and take at least a decade to fulfill. The unauthorized immigrants work in agriculture, construction, restaurants, hotels, cleaning offices, and in homes. There is still no consensus in the United States as to how immigration should be handled.

One argument made by many analysts is that NAFTA stimulated emigration from Mexico by helping to augment U.S. exports of staple Mexican food products, corn and beans in particular. But the data tell a different story. The proportion of people in Mexico who live in rural areas is about 18 to 19 percent of the total. Most of these are agricultural workers. They contribute about 3 to 4 percent of Mexico's GDP. This means that most of them are poor, very poor. They are not very productive. If you are at all intelligent and working in the countryside, then you know that your children will not get a good education and you and your family are not even eating well. If you are intelligent and can move, you get out of there and go someplace else. That's what they are doing. If there are lots of jobs being created in the cities of Mexico or in regional development areas, that's one place the migrants could go. That might happen, if they can stay in the same region and work both in agriculture and in a nearby location to earn additional money. It has happened in other countries. What is actually happening is

different: based on the combination of low job creation year after year, great poverty (and most of Mexico's poverty is in rural areas, not in the cities), the migrants just keep moving to the United States.

I find this a logical outcome for those young people trying to earn some money and have a family. I am bothered by the contention that Mexico has failed because people are leaving the farms. Of course people are leaving the farms because they live there in poverty. When agriculture is successful, people also leave farms. What is the agricultural population of the United States now? Four percent or something like that. In other words, what is happening is logical. What is taking place is often blamed on NAFTA and it really should be blamed on agricultural poverty and the lack of non-agricultural opportunity, and it has been that way in Mexico long before NAFTA.

The starting point of my comments was that the relationship between the two countries is one of the most important for the United States and certainly the most important for Mexico. NAFTA did lead to big increases in exports of Mexican goods and services. U.S. exports to Mexico have also gone up. However, this increase in trade in both directions was not accompanied by effective macro and structural policies in Mexico. By structural policy I have in mind things like education, an effective tax system, a system of justice that people depend on, a labor employment system that does not discourage the hiring of people for full-time work. These structural problems have not been effectively addressed in the last 15 years.

Much of U.S. policy is focused on the symptoms of these shortcomings, namely, on the migration phenomenon. Mexico must itself focus on the underlying causes stimulating emigration. We can help Mexico by growing our economy at a steady, high rate. I think we should also do what the European Union does in providing assistance from the richer parts to the poorer parts of the European Union. NAFTA does not include this kind of financial assistance, but I think it would help if we provided such assistance to Mexico. I would extract a condition from Mexico if such assistance could be provided. My condition would be that they collect more taxes so that the U.S. taxpayer does not substitute for the Mexican taxpayer. Neither side is now willing to take on such a bargain—more U.S. aid and higher Mexican tax collections—but I make this suggestion to let it marinate over the years. It may one day become ready for implementation.

During the administration of Vicente Fox, most of the debate that took place within Mexico centered on political parties trying to advance their own positions. President Fox was not adept at working out compromises. The current President, Felipe Calderón, was raised in a political family. You can even argue he was raised to one day be president of Mexico. He knows the political system, he served in the congress, he was minister of energy—in sum, he knows the political structure well. Just a week or so ago, Calderón successfully obtained legislation to alter the public pension system and demonstrated that he is skillful in working out a compromise on a complex political issue. The hope of most Mexicans is that perhaps Calderón will be able to work out changes on other structural issues which most Mexicans know have to take place. This is the first year of his six-year term of office and he must build up his popularity. That gives him five more

years for key compromises with other political parties on energy, education, job-creation, tax collections, and a more equitable system of justice. I wish him well.

Gus Cardenes: I am a lecturer of economics, retired executive of a major corporation, and currently the president of AARP of Texas, and I have a question. We talked about some of the challenges that Mexico is facing, but what are the solutions?

Dr. Weintraub: I thought they were implicit in what I was saying, but let me go through them. I've made some back-of-the-envelope calculations as to how much it is costing Mexico in GDP growth by not having the structural corrections I discussed and I came to a figure of about two percentage points a year; this is not exact. If Mexico could grow about 6 percent a year, a lot of the problems would look very different in ten years. It would be quite a different Mexico. In other words, you could bring poverty way down, you could get more job creation, you could probably collect more taxes, but that wouldn't be enough. In other words the structural changes that I went through, I think, are the most critical problems that Mexico faces—other than one other, namely, the level of violence and lawlessness on the streets of some of the big cities. That's the one I think that most politicians are most concerned about.

When I first decided to go to Mexico City a long, long time ago, I never really had a worry about where I walked. I don't think that Mexicans are violent people, I've never found them that way, but there is a lot of violence now and I think this impedes economic growth. The lack of security adds to all the structural shortcomings. If the educational structure were improved, this would make a difference. The benefits won't all take place at once, but a sounder educational structure could be the impetus for other critical improvements. If the employment law were changed, this might lead employers to hire more people. In the six years of the Fox administration, employers didn't begin to hire enough extra people until the last year. If the government collected all the taxes that were due and didn't have to rely on Pemex for financing the budget, Pemex might become the kind of company that it could be. I don't care that Pemex is a public company. Many people in the United States talk about the privatization of Pemex, but nobody in Mexico is seriously suggesting that—instead what they're talking about is that Pemex should be willing to enter joint ventures with other companies. If Pemex were able to do what other national oil companies in Latin America do, particularly Petrobras, this could make a tremendous difference in Mexico's energy future.

If Mexico were able to correct some or all of its structural impediments—and what is holding the country back is its politics—these are the kinds of solutions I am talking about. Making these changes will not easy but they are not impossible. Other countries have done these things. Those are the solutions.

Chapter 6. Workshop Summaries and Closing Remarks

(Note: This chapter contains the workshop summaries presented at the conference followed by detailed descriptions of each workshop written after the conference.)

David Warner: We had at least two students who were working as reporters in each of the break-out sessions and one of each of those will be giving a summary of the discussion in that group. I think we should go through all three in the order that they are on the program, and then go through questions and discussion on the issues. Jennifer will be first for the research workshop.

Jennifer Nading: In the first break-out section we discussed areas of future research, what more do we need to do to get more accurate information to take this a little bit further, and so we had discussed essentially getting more information on the affected population such as people who would retire to Mexico if Medicare were available for them. Some of the recommendations were to contact more of the home town associations within the U.S. to find those who were born in Mexico but have lived in the U.S. and who would want to potentially retire back in Mexico, so that's an option, and then to get a better grasp of those U.S. citizens who would like to go to Mexico or aren't there but would like to go if Medicare were offered. Someone suggested that we put an ad in things such as the AARP magazine or investment periodicals to get at a larger population.

We also felt that it was important to find the answers to several questions, one of them being to evaluate how much retirees are paying for health care now in general and then figure out how it's changing demographically in each state and location to track how much money retirees are spending in Mexico on health care. The first part is just looking more in-depth at populations that we haven't studied yet, and we also want to look at the cost-effectiveness of the program of Medicare in Mexico, how much money would they potentially save, what would the administrative costs be, and that would go into trying to set up a demonstration in Mexico. Then we want to look at other countries or entities that cover people abroad such as the EU and TRICARE for Life and how they prevent fraud and how they operate their business. We want to get a better estimate of how many people are now living in Mexico and as Alex mentioned in his demographic piece, it's been a struggle to find concrete numbers—we've looked at the consulates, the immigration services, INEGI—and it all seems to be incomplete, so I think a key portion of this now would be to figure out how to get more accurate numbers.

Michelle Lalonde: Our break-out group talked about the short and long-terms initiatives and what we can really do to make this happen. We had a very diverse group, with a couple of members from AARP, insurance people, real estate developers, students and former students, and hospitals.

Some of the drawbacks or challenges that we were looking at were the fact that this isn't a priority for AARP, and their main priority is the legislation going through Congress at the moment to fix Medicare Part D and to give them bargaining power in the Part D plan.

Another issue with it is that not enough people are really affected by this, if you look at how many Medicare beneficiaries there are and then how many we're talking about in Mexico; it's a very small percentage, so that was one of the challenges we were talking about is the number might not be big enough to adequately sell. Another challenge is that Medicare itself right now is concerned about going under, so they're not concerned about spreading their coverage because we have the baby boomers coming up and they're concerned about how they're going to cover all of the baby boomers. Another thing is the climate of the United States right now and with the current spending that's going into another foreign country in particular, are U.S. citizens and the United States Congress going to be receptive to the idea of sending more American dollars to other countries when these other things are happening? So those are some of the drawbacks that we were looking at.

We talked about the things that we need before we can develop real models, and one of the things that we said we needed was to make people aware and make Congress aware that it's a consumer-driven initiative, and that it has to be, that people need to make their representatives and senators aware of the problem. It can't be something that's talked about in academic circles only, it has to be something that's carried to the legislators because they're the ones who change it. The other thing we need, as was mentioned, is better numbers. We talked about how inaccurate we know that the numbers are that are out there and that we need to get better ones, and we talked about some methods for doing that. There was an example of how there's a new visa in Thailand that's a retirement visa, and how they're tracking retired people there, so we were talking about passport laws changing or different visa requirements, because currently a major problem in tracking Americans in Mexico is that there's no requirement of documentation, so it's pretty hard to track. So those are some of the things that we need to adequately put in place, and now I'm going to discuss the ideas.

We talked about a lot of different places where we can draw our models from and one of them that was mentioned was Panama, with the big American presence there, and how you follow through on the promises for medical care for people there. Another one of course was TRICARE, and another one was the issues that the EU has faced in their cross-border health initiatives as the borders have totally opened up in Europe. So those were some of the models that we looked at in coming up with our ideas. One of the ideas that we came up with was a Medicare Part E, and Part E would involve an optional system where you would pay into it and where maybe for an extra $30 a month premium or something like that, then you could also get coverage in Mexico. That way people are paying for their coverage in Mexico, which probably makes it sell a little bit better if people have to pay into it, and that way the people in the U.S. aren't paying for other people to be covered in Mexico. One of the things we talked about was modeling it after the dental plans. Many of the Medicare Advantage plans offer dental plans, which isn't covered in traditional Medicare, so if we could model the way they set up those extra dental plans and just make it an international plan instead of a dental plan then maybe that could work.

We also talked about a couple of things that the people had decided wouldn't work like an opting-out system if you could buy out your Medicare when you wanted to, but people thought that that wouldn't work. Another thing that came up was a reimbursement system rather than a direct pay system but people also thought that that wouldn't work, so what we really have come to is that in whatever initiative or whatever plan we come up with to pursue this that it needs to be really heavy on the number of people that are affected by it and the cost-benefit analysis. We need to keep in mind that while we need the personal face to sell to Congress, we also need the numbers to sell to businesses because ultimately it's probably going to be sold to insurance companies rather than to Congress so we need to have strong cost-benefit analysis and make this worth people's while, and then also show that it affects a large enough number of people that people ought to care about it.

Alex Gunter: In the third workshop we looked at public policy strategy to advance the issues and I think in terms of strategy the main thing we were looking at was what route to take, such as fairness—people have been paying for 30 years into it so they should be able to use their Medicare in Mexico. Or the cost savings advantage and to look at the savings. We were talking a little bit about the cost of the third-party insurers and how it could probably be significant even more than just administrative costs, if it were administered directly by Medicare. Going back and getting some more data and analyzing it, such as if we had about five years of digitized data from the ABC hospitals, to do a cost study and see how much are those savings after you add things on top of it. Considering that if Americans in Mexico are paying out-of-pocket cash for small things and coming to the U.S. for the major surgeries, would it be better from a cost standpoint for Medicare to say we're saving money by not having to pay the Americans in Mexico, so with the larger operations that Americans are coming back to the U.S. for and the small kind of regular visits that Americans are just paying out-of-pocket in Mexico, to see which is larger, because it might turn out that not doing anything is saving more money. So we were trying to decide between the fairness and the cost issue.

For the timing of approaching Congress, does it hurt more to wait or not to wait in terms of starting to introduce it to Congresspeople, in particular committees that have the most interest. We tried to identify a few of our allies if we could get the AARP or the home builders behind us and to expect push back probably from labor unions and trial lawyers. Even with some of the issues that are pressing that are high priority and are center stage, those are not all being addressed very successfully, so even if the question of the cost savings or the fairness were to be raised, whether anything could get done is an entirely different question. We looked last at giving CMS the authority to conduct international experiments, and from a strategy standpoint by trying to start small with an experiment or just a waiver in the eyes of opponents might be that they would want to stop at that point rather than saying we know where you're going with this, so these are all a lot of the issues that we were discussing. Primarily from the strategic standpoint it was to go get a little bit more data and decide whether the fairness route would work better or the cost savings route.

We discussed a couple of other challenges, talking about a question of legal systems in other countries as well as the Joint Commission International being different from the Joint Commission in the U.S. in terms of the standards—the Joint Commission International realized that when dealing outside of the U.S. you have to be a little bit more flexible and lower standards for some of the things. We also discussed whether certifications and credentialing is going to be an issue, so these are all just things that we thought of, but primarily we talked about some of the allies and political timing of this, so it kind of comes down to the fairness versus cost and trying to decide which one would be the best approach to take to get results.

David Warner: Before we take questions let me make it clear that this class will be finished in May, and we will produce the background papers and the written conference proceedings, and we'll put that out as a publication. We'll also have a video of this conference that should be up soon on the LBJ School web site. I will continue to stay interested in this topic, and there may be some other possibilities to push forward, but just realize that we don't have a permanent group here that is going forward, so we're trying to energize you in terms of what sorts of initiatives you think are appropriate in putting together some teamwork.

Russell Bennett: I just wanted to say to the group of students and to David Warner what an excellent job you've done, not only from the academic side and studying this issue but bringing together a really outstanding group of people to be here. I think we're oversubscribed, there were not enough chairs at the board, so congratulations.

David Warner: Thank you and let me say that we only had seven students—typically we have 12 to 15 in a PRP—so basically everybody has had to be prepared to travel on a moment's notice, and at the same time everybody's doing their own research and backing up in a number of different ways. Katie?

Katie Updike: Do you foresee having some economic estimate of what the cost would be to Medicare?

David Warner: I think you could do back-of-the envelope things, but beyond that the problem is there are a number of different approaches. You could design a waiver program that maybe you'd restrict to the Chapala area and then even there maybe you randomly assign who would get it and get everybody to agree that you can monitor how much they spent off their Medicare over the next year. That would be one way to do it, I mean that would be kind of a random approach, and there are a lot of speculative things, because a lot of the savings would not necessarily be directly to the Medicare program. For instance there are a number of people who are of Mexican origin who are older and living in the U.S. who would prefer to retire to Mexico who have a support system there, who have housing there, who would return to Mexico if they had their Medicare. They may be in poor health but stay in the U.S. and end up having to go to a nursing home or requiring quite a bit of expense, so from the U.S. government's point of view it definitely would probably be cheaper, but all the savings wouldn't be recognized in the Medicare program. So I guess you'd have to make a number of different assumptions as to whether the Medicare program was going to save money or not.

Katie Updike: But do you foresee the school doing that kind of work, whether it's back-of-the-envelope or speculative with a lot of assumptions.

David Warner: We did some of that back in 1999 in that project, but I don't necessarily foresee doing it how.

Sidney Weintraub: In our group one of the things we discussed about Medicare is that if there were co-pays of the amount, there would be less usage, and that would also hold true in Mexico, and I guess if you have a lower cost in Mexico that would have to be considered, the idea of a co-pay in order to cut down the small things.

David Warner: Sure. And you could require people to contribute to Part B and then maybe make an additional fee and then maybe it could apply. There are a number of different arrangements, or you could do it just for emergency services. Right now if you have Medicare Advantage, many of those plans will cover you in Mexico if it's an emergency and you haven't been out of the U.S. more than 60 days and you permanently live in the U.S. That's because a lot of these Advantage plans, for a small additional premium, more or less give you Medigap coverage in addition to Medicare coverage, but if you don't have a U.S. address you don't get that kind of a benefit.

Thank you. I think it's been great. When we first decided to have this conference we were not sure we would have this many people. It was a diverse group and it worked out very well. Thank you very much.

Detailed Summaries of the Three Break-out Sessions

Areas for Future Research

by Erin Daley and Jennifer Nading

Facilitated by: David Warner. LBJ School

Participants: Luis Azarcoya, Ed Bennett, Russell Bennett, Erin Daley, Eddie Geisel, Nuria Homedes, Amin Iftekhar, Jennifer Nading, Heather Stieglitz, Antonio Ugalde

This break-out session focused on areas for future research looked at what additional information is needed in order to analyze alternative policies for covering U.S. retirees abroad and explored ways to gather this information. The major areas of research identified include the following: further research on the populations that would be affected if Medicare coverage were to be extended to Mexico, ways to analyze the cost-effectiveness of different initiatives, and existing programs that allow for medical coverage outside of national borders.

There are two major populations that can be considered the affected populations of a policy allowing for Medicare to cover care outside the United States. The first

population is Medicare-eligible retirees currently living in Mexico. These individuals include both U.S.-born and Mexican-born U.S. citizens who worked sufficient time in the United States to qualify. The second affected population includes those who are currently living in the United States and are interested in retiring to Mexico, but are not willing to do so at present due to the lack of portability of Medicare to Mexico. While the first population has been studied to some extent through the research conducted in this Policy Research Project as well as previous projects, there is still further work to be done. For example, there is limited information on Mexican nationals who are eligible for Medicare but are living in Mexico. In order to get a better sense of the impact of extending Medicare benefits to eligible individuals living in Mexico, it would be necessary to gather some of the same information on these individuals as we have gathered on those of U.S. origin. Additionally, there are questions that have not been researched in depth regarding those who are currently retired in Mexico, including how much they are currently spending on health care in Mexico, both out-of-pocket expenses and expenses covered through their health insurance. It would also be important to look at trends in health care spending among retirees in Mexico as well as geographical differences between states and communities.

There is limited information on those who are not currently retired in Mexico, but would likely retire in Mexico if Medicare coverage were available to them there. Thus, it is necessary to conduct much more research on this affected population in order to get a better idea of the size of this cohort, what it would take for them to make the decision to retire to Mexico and what their health care needs are. Mexican hometown associations, such as Casa Guanajuato in Dallas or the Zacatecas Association in California as well as other organized groups comprised of a large number of Mexican nationals such as the United Farmworkers, may be an important way to get in touch with Mexicans who would like to retire to Mexico, whereas the AARP magazine and other investment periodicals may be a way to find other U.S. citizens interested in retiring to Mexico. Recent changes in Mexico now allow for U.S. citizens interested in buying a second home to arrange for a mortgage through Mexican lending institutions. The numbers of persons who are doing that is growing rapidly and many of these people are in their 50s and planning to retire to Mexico eventually.

Determining the cost-effectiveness of extending Medicare benefits to Mexico is the second important area where further research is needed. While it is widely known that medical care in Mexico is much less expensive compared to costs in the U.S., what is not clear is whether a net cost-savings would result to the Medicare program if coverage were extended to Mexico. Some of the areas of research necessary to acquire this information include studying what the administrative costs associated with extending Medicare benefits to Mexico would be and what services/procedures retirees would continue to receive in the United States even if Medicare coverage were available in Mexico. Furthermore even if it were not directly cost effective from Medicare's point of view, the fact that such coverage might permit people to remain in Mexico could well save significant funds for Medicaid and housing and other social programs.

Finally, before taking on such a project, it would be important to analyze how current programs both for U.S. retirees and retirees of other countries that allow for portability of health care coverage are working. An example to research would be the case of the European Union in which EU citizens may receive care in any EU country and that country will be reimbursed by the individual's country of origin. Another important case would be the relatively recent establishment of the TRICARE for Life program in which beneficiaries may be reimbursed for care received anywhere in the world. Prior to 1999 TRICARE beneficiaries had to return to the U.S. after turning 65 since Medicare became the primary payor.

In addition to these broad areas of research, it was suggested that research be conducted on how Medicare could pay into the IMSS system. Some participants believed that Medicare should pay into IMSS rather than trying to develop a system to work with private insurance. They believe that using private insurance would have the negative effect of spreading many of the dysfunctional parts of the U.S. system to the Mexican health system.

Short-Term and Long-Term Initiatives to Enhance Coverage in Mexico

by Michelle Lalonde and Marina Zolezzi

Facilitated by: Rachel Maguire, Institute for the Future

Participants: Jim Arriola, P. Gus Cardenas, John Christian, Erez Cohen, Janice Finder, Michael Ford, Michael Henry, Jacobo Kupersztoch, Michelle Lalonde, Oscar Luna, Jayme Meyer, Derly Rivera, Reymundo Rodriguez, Katie Updike, John Zipprich, Marina Zolezzi

In this break-out session, the participants discussed the initiatives needed now and in the future to extend Medicare coverage to Mexico and other foreign countries. Participants examined the feasibility of developing improved bi-national delivery systems for care. Participants also looked at how the Medicare Advantage program could be expanded and the feasibility of a research and demonstration project in Mexico. Current successes and challenges in the administration of international health coverage were discussed. The group was very diverse with representatives from industries/organizations such as investment banking, real estate development, insurance, AARP, hospitals, retirees, and students.

Initiatives to Enhance Coverage in Mexico/Feasible Options

Develop Demonstration Project: The overall consensus of the participants in this session expressed that using traditional Medicare will not work for a research and demonstration project in Mexico. Some form of expansion of the Medicare Advantage program seemed to be the most reasonable option for enhancing coverage in Mexico. It was expressed that the U.S. consumer would be the driving force behind pushing a research and demonstration project due to the high costs in care, not Medicare.

Options

Another offer under Part C: The insurance company would collect the premiums and be the provider for Medicare recipients who want exclusive coverage in Mexico. This option would not involve Medicare in terms of administering the program or dealing with fraud and abuse.

If we were to use this option, a couple of questions remain:

- Is this a good deal for the insurance companies?
- What would happen to the U.S. retirees enrolled in this new 'option' who want to go back to the U.S. for their Medicare? Could they possibly reenroll when the next open enrollment is available? Or, for an additional premium, would coverage in both countries be possible?
- Knowing that the federal government pays premiums based on age and risk we need to determine how much premiums would have to be collected in order for the project to be worthwhile.

Create a new category, for example category X: Another option is to create a new category for U.S. retirees abroad. This category would need to entice insurers to build a network. There may have to be some sort of quality proxy of providers established before Medicare can go for a demonstration project. For example, a quality proxy can include being recognized by the Joint Commission International. It was recommended to use private insurers instead of getting the Mexican government involved. AARP mentioned that they were instrumental in supporting the additional category to Medicare, regarding the prescription drug plan, Part D. In addition, they mentioned that getting Part D was "hard to pull off."

Provide emergency care for more than the current limited benefit days: Many Medigap plans and Advantage Plans that also cover extended benefits will cover emergency care that occurs during a trip outside the United States of no more than 60 days. If that length of time were extended, additional retirees could be covered.

Recommendations for Analyzing the Viable Options in Extending Coverage in Mexico

- There are some HMOs that have Medicare risk contractors (not straight Medicare) that offer other products such as dental for an additional premium. It was recommended to analyze all the Medicare approved products (outside of traditional Medicare) in order to define what they are and their costs. Since Medicare risk contractors have additional benefits that are approved and are outside the traditional Medicare package (such as home health) it would be worthwhile to have all the offerings outside of Medicare "wrapped up" together. The closer you can "wrap up" the new package to the currently approved products that are outside of Medicare, the easier it will be to get a demonstration passed.

One could contact an organization such as AARP to see if they are interested in this package being portable to Mexico.

- Since the U.S. spends about 16.4 percent of its GDP on health care while other developed nations spend about half that, the university should look into researching and writing more about the current health care systems worldwide in order to track the flow of health care services and people between countries.

- Since the numbers of retirees in Mexico is a crucial number for pushing a research and demonstration project, it was suggested that we look into Thailand's strategy in providing retirement visas. Through a retirement visa system, one could obtain accurate numbers in regards to the number of foreign retirees living in a country. If the Mexican government can offer retirement visas, one can count on accurate numbers for U.S. retirees residing in Mexico.

- Have AARP or another organization develop some sort of position paper showing interest on the portability of Medicare benefits in Mexico. AARP would then invite proposals to different Medicare intermediaries and select three to four interesting options that can be taken to craft legislation for a model program. It is suggested to do this on a small scale (for example Mexico vs. worldwide).

- Analyze models such as the Department of the Defense's TRICARE for Life and VA's Foreign Medical Program.

Challenges to Progress

The discussion was very frank in terms of the challenges that proponents of extending Medicare coverage outside of U.S. borders will encounter. The main challenges that were identified are as follows:

Medicare almost broke: The Medicare system is on the verge of bankruptcy.

Overseas Medicare not a priority: Expansion of Medicare Coverage is not a priority for AARP. Their main priority now is dealing with the Part D issues. Trying to get Congress to accept Part D was like "pulling teeth without anesthesia." However, someday it may be a priority if it becomes a priority for AARP's membership. The government is concerned with how to handle the impending baby boomer retirement boom.

Not enough people affected: The number of U.S. retirees living in Mexico is very small relative to the number of beneficiaries of Medicare. There are 43 million Medicare beneficiaries in the U.S. and the Mexican government only recognizes 28,000 in Mexico. Consumer demand is not very high. In order to do a demonstration project, an insurance company would have to invest quite a bit of money and won't do so unless there is high demand. Along the same lines is the issue of retirees living all over Mexico. It will be much more difficult for a carrier to develop a demonstration project and prove a cost benefit with retirees living all over Mexico instead of just one area.

Physician certification: Currently Medicare pays only physicians licensed to practice in the United States or its possessions. An intermediary would have to find a way to adequately certify providers.

Political climate: Current U.S. interest is not to spend our money in another country, especially now with the money being poured into the Iraq war.

Ammunition Needed

While discussing these challenges, the group came up with suggestions of the ammunition that will be needed to accomplish the goal of extending Medicare.

Campaigning: Raising awareness with state and local representatives is essential to build support. Since legislation has to be passed to change Medicare, constituents must make their opinions know to their representatives. Letters and emails to representatives and also to groups such as the AARP are essential to getting the word out and building interest. The current situation will not change unless that change is driven by U.S. consumers.

Accurate numbers: More accurate numbers of the retirees living in Mexico are needed to truly address the issue. The numbers have to be more than are being given or real estate would not be booming the way it is.

Cost/benefit analysis: If the approach is to be taken that a carrier would handle the administration of Medicare benefits in Mexico rather than Medicare itself administering them, it will be essential to show a cost benefit. Insurance companies are in the business primarily to make money and will not take on the expense of a demonstration project unless it can be reasonably shown that it would pay in the end.

Public Policy Strategies to Advance the Issues

by Francis Dummer Fisher, Alex Gunter, Juan Ignacio Martinez, and Karla Vargas

Facilitator: Francis Dummer Fisher, Research Fellow, LBJ School of Public Affairs

Participants: Larry Meagher, Joseph Annis, Sidney Weintraub, Alex Gunter, Juan Martinez, Karla Vargas

Introduction

The group that convened to discuss public policy strategies on the issue of Medicare in Mexico held a frank discussion that touched on several of the perceived challenges, identified two strategic approaches, and suggested caution on any optimism that changes needed to move the issue forward might soon be approved.

Challenges

One of the first issues addressed was the need to have concrete cost saving data that could be presented to Congress. As a basis for a cost study one of the participants suggested using records from ABC Hospitals that were already in digital form and extend over the last five years.

A possible outcome from a comprehensive cost study might be that extending Medicare to beneficiaries residing in Mexico might increase, instead of reduce, costs to the program. While major medical procedures on Medicare beneficiaries might still largely be performed in the United States, Medicare would have to pick up the cost of covering more routine care within Mexico, expenses that are currently paid for by the beneficiaries themselves. In addition, the administrative costs of intermediaries such as insurance groups might further reduce any cost advantage. Thus, an extension of Medicare beyond the border might result in an increase in total Medicare spending, despite the established lower cost of medical care in Mexico.

Another challenge lies in credentialing hospitals and physicians, given the cultural differences and differences in the legal systems of the United States and Mexico. Noted for instance was the litigious culture of the United States and its well developed record-keeping. Such cultural differences are reflected in credentialing procedures. In response to the realities of the world beyond the United States, the Joint Commission International guidelines are less specific than are the Joint Commission (American) guidelines. Despite moving toward an improved certification process in Mexico and rising levels of medical care quality, additional steps to align credentialing and administrative regulations in Mexico to the levels found in the United States may require a long and perhaps difficult process of reconciling different cultural and legal norms.

Strategies

Two basic strategic directions were identified. One is to present the issue as an economic issue, if and when it can be determined that significant cost savings exist. The second would present the problem as an issue of fairness to the American retirees who have paid into Medicare and whose access to benefits is denied solely because they live and seek medical care in Mexico. The workshop's notion was that after administrative costs and a detailed cost study were examined it could turn out that presenting the issue as one of fairness might be the better strategy. This may entail waiting for a political climate favorable to the fairness approach. Attempting to use timing advantageously, however, might not work because timing always seems to be wrong for one reason or another.

From an economic standpoint, with the wave of baby boomers set to begin retiring in the next 10 to 15 years, the message should be the sooner Congress begins looking at options and experimenting with cost saving solutions, the better. Even if savings by extending Medicare to Mexico could not be assured in advance of a study, an experiment to explore that possibility would be warranted. Congress needs options down the road to deal with the issue of Medicare and the massive onslaught of retiring baby boomers.

Strategies to approach representatives in Congress and lobby them require either better evidence of concrete cost savings or a formulated fairness approach with the demonstrated backing of key supporters such as the AARP, homebuilders, and groups representing Americans abroad. Finding ways to visit with members of Congress, particularly those on committees or in coalitions that may represent Americans living abroad, would be a logical first step. Again, the emphasis would need to be on Congress, merely giving CMS the power to waive regulations so it could design and conduct experiments in extending Medicare payments to beneficiaries living in Mexico.

Moving Forward

The two options for pursuing this issue are to present it as an economic relief on the Medicare system, highlighting cost savings to the government and appealing to the budget-minded concerns of Congress, or to frame the issue as one of fairness to beneficiaries in Mexico unable to receive the Medicare benefits they have paid already paid for in the course of their working years. The first option could be pursued by undertaking a more rigorous cost study that not only compares fees and charges between Mexico and the U.S., including those for common procedures and routine care, but also identifies administrative costs and costs associated with intermediaries such as third-party insurers. The second option requires a greater reach for those groups of persons who would benefit from a change, and the identification of political allies sensitive to the issue of fairness to Medicare beneficiaries living abroad. Both options could be pursued at the same time.

Section II. Background Papers

Chapter 7. Retiree Demographics and Projections

by Alex Gunter

Americans are increasingly looking south of the border when choosing where to spend their retirement years. Attracted by the lower cost of living and warmer climate, among other factors, American retirees are heading to areas in Mexico such as San Miguel de Allende, Chapala, Guadalajara, Puerto Vallarta, and Los Cabos. This migratory trend is set to continue well into the future and will be accelerated as the baby boom generation begins to retire in 2010. Vast numbers of Americans will begin seeking affordable retirement options, so it is imperative to begin testing models of retirement and possibilities under Medicare today.

American Retirees in Mexico

The number of American retirees currently living in Mexico appears to be well above 100,000, but beyond that it is difficult to know with any precision how many reside there part or all of each year, primarily because the U.S. Census Bureau does not keep track of this group and existing figures are imperfect. The U.S. Department of State used to keep rough estimates of the number U.S. citizens in Mexico and other central and Latin American countries in case of evacuation, and these were usually many times larger than host government census figures. Discontinued in 1999 due to security concerns, the last estimate for Mexico put the number at 1,036,300 for that year.[1]

The remaining primary source is the Mexican Census, which brings with it a unique set of limitations. First is that classification is by place of birth, rather than citizenship. Many Mexican-born U.S. citizens and permanent residents live in Mexico much of the year but are recorded as being of Mexican origin in the Mexican census. The attraction of Mexico for so many Mexican-origin Medicare beneficiaries is the ability to return to the town or area in which they were born, be near friends and relatives, take advantage of living in property they may have purchased or inherited, and be able to live on their Social Security checks. On the other hand, the number for U.S.-born foreigners living in Mexico includes a large number of offspring who have one or both parents that are Mexican-born, and have returned to live with their family in Mexico.

The second problem is that the figures do not include the large numbers of American retirees that go down on visitor visas and reside some of the year in Mexico and the rest in the U.S. These “snowbirds” often keep two homes and use their time in the U.S. to visit family and get medical care covered by Medicare. And since most beneficiaries now receive their Social Security check electronically at their U.S. banks, it is no longer possible to use this indicator to determine residence. Due to these limitations the figure for U.S.-born seniors residing in Mexico is both much smaller than the actual number of American retirees living at least part-time in Mexico and includes U.S.-born Mexican offspring.

Table 7.1
U.S.-Born People Residing in Mexico, 1990 and 2000

Year	Total Population	U.S.-Born	U.S.-Born aged 55 and over
1990	81,249,645	194,619	24,090
2000	97,014,732	358,614	28,247

Adapted from: Migration Policy Institute, *America's Emigrants: U.S. Retirement to Mexico and Canada* (Washington, D.C., 2006), p. 24.

Therefore, while the actual numbers for Americans over the age of 55 is much larger, the Mexican census figures show an 84 percent increase, from 194,619 in 1990 to 358,614 in 2000, for total U.S.-born, and a 17 percent increase in the number of seniors 55 and older during the same period, from 24,090 to 28,247. Our field research to six retiree communities indicated that in the areas we visited alone there were at least 28,000 American retirees, which did not include many other areas with high numbers of U.S. retirees. In addition, our research pointed to growth in the last five years alone that will be well over 17 percent for the decade ending in 2010.

The growth is evidenced by the number of real estate developments being undertaken in areas such as the greater Vallarta area and the Baja peninsula. One example of a recently completed 150-unit luxury retirement community is Sensara Vallarta, in Nuevo Vallarta.[2] Along with the construction of new housing and residential communities is the increasing availability of financing, which is relatively new in Mexico. According to one real estate agency, seven million North Americans travel to Mexico every year, and as many as 400,000 Americans and Canadians have purchased property either as vacation getaways or second homes.[3]

While we believe the census figures to be very low, one of the strengths of the Mexican national census is that it breaks down the numbers of U.S.-born seniors by location within Mexico. Between 1990 and 2000 some of the areas with the highest growth rates of U.S.-born senior residents were Chapala, 581.4 percent; Los Cabos, 308.3 percent; and San Miguel de Allende at 47.7 percent.[4]

An important point to keep in mind is the difference between returnees and retirees. Returnees may have been born in the U.S. or Mexico to one or more Mexican-born parents, and decide to go back to Mexico to live with family. American retirees with no family in Mexico generally are attracted to areas like Chapala, Los Cabos, and San Miguel de Allende. Because many of the Mexican-origin returnees have worked possibly their whole lives in the U.S. and may have attained citizenship, a good number of these people are Medicare beneficiaries as well.[5]

On a webpage dated February 2007 the Department of State writes of the number of Americans in Mexico that "more than a half-million American citizens live in Mexico."[6] As a result we believe there may be between 100,000 and 200,000 retirees living at least six months out of the year in Mexico, if not today, certainly by 2010.

Mexican-Born Population in the U.S.

The Mexican-origin component of Medicare beneficiaries retiring to Mexico demands a closer look at the migration patterns and projections of Mexicans coming in to the U.S. The U.S. Census information on Mexican-born foreigners in the U.S. was 4,298,014 in 1990 and 9,177,487 in 2000, more than double over the ten-year period.[7] For a more recent figure, the Pew Hispanic Center puts the number of foreign-born from Mexico at 10,993,851 in 2005, or 30.7 percent of all foreign-born people in the U.S.[8]

The Mexican government projects that mass immigration to the United States will continue at between 3.5 and 5 million people per decade until at least 2030.[9]

Mexico's National Population Council (CONAPO), a branch of the Ministry of the Interior, issued a report in November 2001 on migration to the United States through 2030. The report projected that immigration will cause the Mexican-born population in the U.S. to at least double by 2030, reaching 16 to 18 million, regardless of economic conditions in Mexico.[10] The result is a projection of Mexican-seniors in the U.S. of 18 percent in 2030, up from 6 percent of the total 65 and older population in 2003.[11]

A large percentage of the migrants to the U.S. are between the ages of 15 and 35, resulting in the future in a growing population of Mexican-born foreigners that will have worked in the U.S., contributed to Medicare, and possibly attained citizenship. When they become beneficiaries, they may return to Mexico to live a substantial part of the year. Today this population could be as big a group as the U.S.-origin retirees, and the growth indicates that it will keep up with if not surpass the growth rates of U.S.-born retirees moving to Mexico.

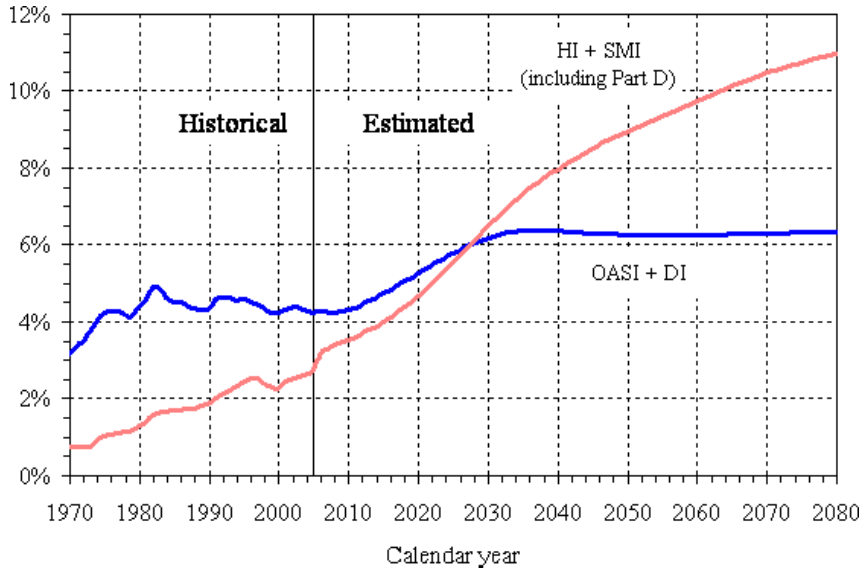
Baby Boomers and Medicare

The issue of exploring affordable retirement and Medicare options is pressing given that the first of the baby boomers will turn 65 in 2011, at which point the growth of the senior population will begin to increase dramatically, doubling to 71.5 million in 2030 from 35 million in 2000.[12] The period of most rapid growth of the senior population, from 2010 through 2030, will see a 78 percent increase in the 65 and older population compared to an 18 percent increase in the total population. That will amount to a 2.9 percent annual average growth rate from 2010 through 2030, before settling at 0.7% from 2030 through 2050. By 2040 the age structure will be unprecedented in U.S. history in terms of the proportion of old and very old cohorts to the other younger cohorts.[13]

The most alarming consequences will be on the Medicare and Social Security trust funds. Medicare costs, as a percentage of GDP, will increase most dramatically with the baby boomer growth between 2010 and 2030, resulting from higher utilization as well as rising

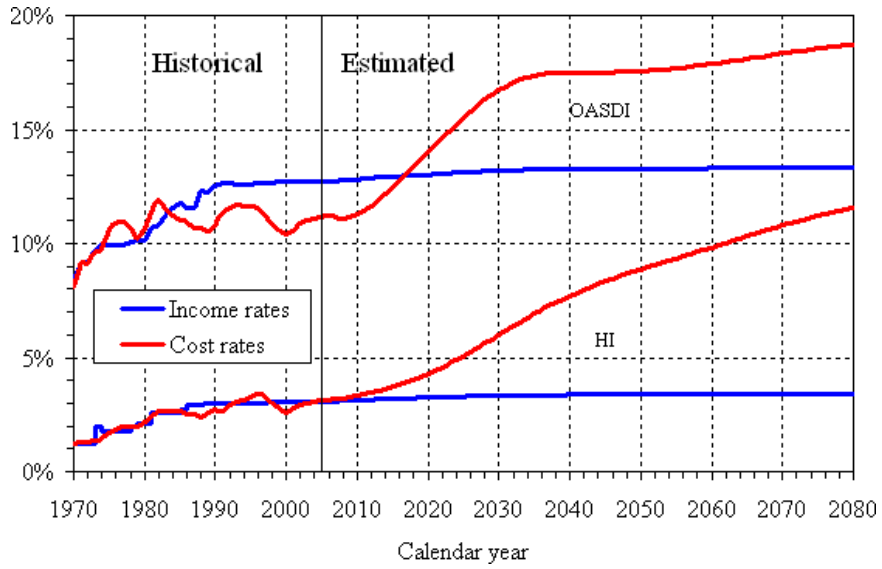
costs of medical care. In 2005 the cost of Medicare as a percentage of GDP was at 2.7 percent, and in 2080 it is projected to reach 11 percent of GDP (see Figure 7.1).[14] What does it mean? Rising costs will outstrip the income going into these funds. An analysis of the income and cost rates as a percentage of taxable payroll helps to illustrate when this will occur.[15] According to the 2007 Annual Report by the Social Security and Medicare Boards of Trustees, 2011 will be the first year that outgo exceeds income (including interest), and by 2019 the Hospital Insurance (HI) trust fund assets will be exhausted. Income comes from the payroll tax, and since the payroll tax rate is not likely to change the income curve is flatter. The slower increase in beneficiaries also explains the flat curve seen in Figure 7.2. (SMI stands for Supplemental Medical Insurance, OASI is Old-Age and Survivors Insurance, DI is Disability Insurance, and OASDI is Old-Age, Survivors, and Disability Insurance.)

Figure 7.1
Social Security and Medicare Cost as a Percentage of GDP



Source: Social Security and Medicare Board of Trustees, *Status on Social Security and Medicare Programs.* Online. Available: http://www.ssa.gov/OACT/TRSUM/trsummary.html. Accessed: March 20, 2007.

Figure 7.2
Income and Cost Rates (Percentage of Taxable Payroll)



Source: Social Security and Medicare Board of Trustees, *Status on Social Security and Medicare Programs.* Online. Available: http://www.ssa.gov/OACT/TRSUM/trsummary.html. Accessed: March 20, 2007.

The need to begin discussing solutions, such as extending Medicare benefits to American retirees in Mexico, is urgent. The Board of Trustees to Social Security and Medicare frames the issue well:

> The financial difficulties facing Social Security and Medicare pose enormous, but not insurmountable, challenges. The sooner these challenges are addressed, the more varied and less disruptive their solutions can be. We urge the public to engage in informed discussion and policymakers to think creatively about the changing needs and preferences of working and retired Americans. Such a national conversation and timely political action are essential to ensure that Social Security and Medicare continue to play a critical role in the lives of all Americans.[16]

Notes

[1] Migration Policy Institute, *America's Emigrants: U.S. Retirement to Mexico and Canada* (Washington, D.C., 2006), p. 24.

[2] Speech by David Collins, CEO of Active Living International, at The Future of Healthcare for U.S. Retirees in Mexico Conference, The University of Texas at Austin, Austin, Texas, March 30, 2007.

[3] Ricardo Barraza & Asociados Bienes Raices Real Estate*, Financing Options in Mexico*. Online. Available: http://www.ricardobarraza.com/financing_options_inmexico.htm. Accessed: April 29, 2007.

[4] Migration Policy Institute, *America's Emigrants,* p. 28.

[5] Ibid., p. 27.

[6] U.S. Department of State, *Mexico* (February 2007). Online. Available: http://www.state.gov/r/pa/ei/bgn/35749.htm. Accessed: April 11, 2007.

[7] Migration Information Source, *The Foreign Born from Mexico in the United States.* Online. Available: http://www.migrationinformation.org/feature/display.cfm?ID=163. Accessed: April 11, 2007.

[8] Pew Hispanic Center. *Foreign born at mid decade, Pew Hispanic Center tabulations for 2005 American Community Survey.* Online. Available: http://pewhispanic.org/reports/foreignborn/. Accessed: April 11, 2007.

[9] Center for Immigration Studies, *Another 50 years of Mass Mexican Immigration.* Online. Available: http://www.cis.org/articles/2002/back202.html. Accessed: April 11, 2007.

[10] Ibid.

[11] U.S. Census Bureau, *65+ in the United States* (Washington, D.C., December 2005), p. 6.

[12] Ibid., p. 12.

[13] U.S. Census Bureau, *65+ in the United States*, p. 16.

[14] Social Security and Medicare Board of Trustees, *Status on Social Security and Medicare Programs.* Online. Available: http://www.ssa.gov/OACT/TRSUM/trsummary.html. Accessed: March 20, 2007.

[15] Ibid.

[16] Ibid.

Chapter 8. Navigating Medicare

by Michelle L. Lalonde

Medicare Basics

Since the legislation providing Medicare and Medicaid was signed into law by President Lyndon B. Johnson in 1965,[1] Medicare has been a great benefit yet also greatly confusing and sometimes frustrating for retired Americans. And it has only become more beneficial and more confusing. Traditional Parts A and B have been joined by Medicare Advantage Plans (Part C), Part D, and Medicare Medical Savings Accounts, creating better coverage but also more potentially puzzling policies. This section will briefly cover each of these parts of Medicare.

Medicare Part A

Along with Part B, this is the original Medicare plan. Part A covers most inpatient care in hospitals including critical access hospitals. The hospital portion of care is usually completely covered after satisfying a $992 deductible per stay. There is a limited skilled nursing facility benefit subsequent to a covered hospital stay. Hospice care and home health care are also covered under Part A. Inpatient mental health care in a psychiatric hospital is covered on a 190-day lifetime limited basis as is all blood received at a hospital or skilled nursing facility during a stay already covered by Part A. All Americans aged 65 or older and those who are disabled or who have returned to work after being disabled are eligible for Part A coverage. People who have paid, or have had a spouse pay, Medicare taxes for ten years while working are eligible for premium-free Part A. Most of the others who are eligible must purchase it at up to $410 per month (2007 rates). Generally, when buying Part A coverage, Part B is a required purchase.[2]

Medicare Part B

Part B covers most physician, outpatient, and diagnostic services and is optional (unless you must purchase Part A). Most of the services covered are medically necessary but some preventative services are also covered. Unlike Part A, Part B is not free if Medicare taxes have been paid. A premium must be paid each month in addition to a yearly deductible of $131 that must be met before Medicare coverage begins. Beginning on January 1, 2007, Part B premiums are based on income. In 2007, premiums range from $93.50 per month to $161.40 per month for an individual, depending on yearly income. There are late enrollment costs associated with Part B, meaning that if you do not sign up when you first become eligible, the premium will go up by 10 percent for each full year Part B could have been purchased but was not. For instance, individuals with annual incomes of less than $80,000 would pay $93.50 if they enroll as soon as they are eligible. However, if they enroll one full year after they become eligible the monthly premium would become $102.85, and subsequent percentage increases in premium would be

computed from that base. TRICARE recipients must enroll in Part B in order to keep their coverage (see Chapter 15 for more information). Enrollment rights and requirements for Part B can be affected if the individual or spouse are still working and have employee group coverage.[3]

Part A and B benefits cover limited medical services outside of the United States. This includes when traveling between Alaska and the continental United States through the most direct route through Canada, emergency situations when a patient is in the United States but the nearest hospital is not, and in some cases Medicare will cover the "services on board a ship within the territorial waters adjoining the land areas of the United States."[4] All other medical expenses incurred abroad are not covered by traditional Medicare.

Medigap

Some Medicare beneficiaries purchase Medigap policies to help pay for pharmaceuticals, coinsurance, co-payments, or deductibles that would otherwise be the responsibility of the individual under the original Medicare plan. Depending on the state, individuals can choose from 12 different Medigap plans (plans A through L) that all follow federal and state laws. Medigap policies are listed as "Medicare Supplement Insurance" and each plan provides different benefits. New Medigap plans do not include prescription drug coverage although many older ones do. Individuals with new Medigap policies would need to purchase the Medicare Prescription Drug Plan (Part D) to cover prescription drug costs. Those who already have prescription drug coverage under their Medigap plan and wish to use Part D must have the prescription coverage removed from their policy. Additionally, Medigap plans only cover one individual. The spouse of the individual is not covered unless an additional plan has been purchased. People who have a Medicare Advantage Plan cannot use a Medigap policy.

Part C: Medicare Advantage Plans

In 1997, Medicare began offering more alternatives to the original Medicare plan; the Medicare Advantage plans may be more than the managed care plans established initially under Part C. These plans include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Private Fee-for-Service plans, Medicare Special Needs plans, and Medicare Medical Savings Account (MSA) plans. To be eligible for these plans, the individual must be enrolled in Parts A and B and Medigap cannot be used.[5] These plans are run by private insurance companies but are approved by Medicare. The plans cover all of Medicare Parts A and B and may offer extra benefits, sometimes including Part D prescription drug coverage. Usually these plans have a network of doctors that must be used and often referrals are required for specialists. The plans are paid a monthly capitation rate per employee depending on demographic and medical characteristics of the enrollee as well as the county of residence. With Medicare Advantage plans, coverage can continue out of the service area of the plan for emergencies and urgently needed care. Table 8.1 illustrates the differences between the three main Medicare Advantage Plans. In particular many advantage plans which offer enhanced benefits replacing Medigap plans incorporate a feature some Medigap plans

have had which is coverage of emergency care during a trip out of the country of not more than six weeks duration. This permits coverage for emergency care for some retirees who spend part of the year in Mexico but who live in the U.S. for more than six months of the year and are eligible to enroll in a Medicare Advantage plan.

Table 8.1
Comparison of Three Types of Medicare Advantage Plans

	Preferred Provider Organization (PPO) Plan	Health Maintenance Organization (HMO) Plan	Private Fee-for-Service Plan (PFFS)
Are prescription drugs covered?	In most cases; the cost for coverage will be included in the premium	In most cases; the cost for coverage will be included in the premium	Sometimes
Does the enrollee need to choose a primary care doctor?	No	Yes; in most cases, a primary care doctor must refer you to any other health care provider	No
Can health care be obtained from any doctor or hospital?	Yes; PPOs have network doctors and hospitals, out-of-network doctors can be used, usually for a higher cost	No; unless in the case of an emergency, care and services must be received from doctors or hospitals in the plan's network	In most cases; any Medicare approved doctor or hospital that accepts the plan's payment terms for covered services can be used.
Referral required from a primary care physician before seeing a specialist?	No	In most cases; women don't need a referral for a yearly screening mammogram or an in-network pap test and pelvic exam	No
Other information	• Regional PPOs limit your out-of-pocket costs but may have a higher yearly deductible and/or premium than other PPOs • Extra benefits are often offered for an extra premium	• Obtaining care outside the network may incur full costs for the care • It is essential to follow plan rules • Extra benefits are often offered for an extra premium	PFFS plans are different from the Original Medicare Plan; PFFS plans are offered by private companies; the private company, rather than Medicare, decides how much it will pay and what the beneficiary will pay; extra benefits are often offered for an extra premium

Adapted from: Centers for Medicare and Medicaid Services, *Medicare & You*. Online. Available: http://www.medicare.gov/publications/pubs/pdf/10050.pdf. Accessed: February 13, 2007.

Medicare Special Needs plans are for people with chronic diseases and other special health needs such as living in an institution (nursing home) or having a disabling condition. They are also meant for people who qualify for both Medicare and Medicaid. This category of Medicare Advantage Plans must cover Parts A, B, and D. People on the Special Needs plan receive help in the management of their care and the coordination of doctors, services, community resources, Medicare, Medicaid and others.[6]

There are two parts to the Medicare Medical Savings Account (MSA) plan: the account and the high-deductible health insurance policy. The money held in the savings account can be withdrawn tax-free if used for qualified medical expenses and is able to earn interest and dividends. Individuals purchase Medicare MSA plans from a Medicare approved insurance company, set up the MSA at the banking institution of their choice, and register the account with Medicare. Enrollment in Medicare MSA is for one year at a time. Every month, money is deposited into this account by Medicare. Medicare also pays the premium for the policy to the insurance company. All policies must offer basic Medicare benefits, though they are permitted to offer more as well.

Medicare MSAs are not the best option for everyone, especially those who require extensive medical care. One of the qualifications for a Medicare MSA is living in the United States no less than 183 days per year.[7]

Medicare Part D: Prescription Drug Insurance

Part D was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect in January 2006. Part D is offered through two types of private plans: stand-alone prescription drug plans (PDPs) for people getting other Medicare benefits through the fee-for-service program, and Medicare Advantage prescription drug (MA-PD) plans, such as HMOs or PPOs, that cover drugs and other Medicare benefits. Drug plans are optional to most beneficiaries unless they are dual-eligible for Medicaid or certain other low-income programs.

To enroll in Part D, the beneficiary must pay a monthly premium. These premiums will vary by plan, which drugs the beneficiary uses, and whether or not the beneficiary receives help paying Part D premiums.[8] Monthly premiums vary from about $11 per month to $100 per month, with the higher premium plans generally offering some coverage in the gap.[9] Although Part D is optional, currently, deciding not to enroll when you are eligible and then enrolling later will result in a penalty. However, bills (H.R. 1310 and H.R. 1521) were introduced in March 2007 to remove the penalty for late enrollment in Medicare Part D.[10]

Part D plans must offer either a statutorily defined standard benefit or an alternative that is equal in value ("actuarially equivalent"). Plans can also offer enhanced benefits. The standard benefit in 2006 has a $250 deductible and coinsurance of 25 percent after the deductible up to a coverage limit of $2,250 in total drug costs, followed by a gap in coverage where enrollees pay 100 percent of the costs of their drugs (the so-called "donut hole"). The beneficiary then pays $3,600 out-of-pocket (estimates vary) before the plan kicks in again and pays 95 percent of drug costs for catastrophic coverage for the rest of

the year. Table 8.2 shows nine of the most common types of prescription medications taken by seniors and their costs.

Table 8.2
Cost and Dosage of Nine Common Prescription Drugs for Seniors

Drug Name	Therapeutic Category	Estimated Yearly Cost (based on recommended dosages)*	Generic Available?
Aricept	Alzheimer's treatment	$1973.04	NO
Isosorbide mononitrate	Anti-Anginal Agent (treatment of chest pain)	$169.14	YES
Zoloft	Anti-depressant	$1087.56	YES
Celebrex	Anti-Inflammatory	$1222.20	NO
Plavix	Anti-platelet Agent (prevent sluggish bloodflow)	$2113.68	NO
Metoprolol tartrate	Beta Blocker (blood pressure)	$466.86	YES
Norvasc	Calcium Channel Blocker (blood pressure)	$670.20	NO
Digitek	Cardiac Glycoside (heart strengthening)	$27.48	YES
Lipitor	Lipid-Lowing Agent (high cholesterol)	$924.60	NO
Furosemide	Loop Diuretic (treatment of congestive heart failure	$171.12	YES
Klor-Con M 20	Potassium Replacement (used with heart drugs and diuretics)	$311.42	NO
Evista	Osteoporosis	$1027.68	NO

Adapted from: FamiliesUSA, The Voice for Health Care Consumers. *Coverage Through the "Doughnut Hole" Becomes Scarcer in 2007*. Online. Available at: http://www.familiesusa.org/assets/pdfs/medicare-donut-hole-nov-2006.pdf. Accessed: March 28, 2007.

Note: Prices are average prices taken from Destination Rx and are applied to the minimum dosage of the prescription drugs for the retired age range. Adapted from: Healthcare.com, *Guide to Prescription Drugs/ Encyclopedia of Medicine*. Online. Available: http://www.healthsquare.com/drugmain.htm. Accessed: February 20, 2007. (Destination Rx, *Prescription Drug Finder*. Online. Available: http://www.destinationrx.com/PRESCRIPTIONS/drugSearch.aspx?drugName=. Accessed: February 20, 2007.)

It is quite easy for moderately ill beneficiaries to fall into the donut hole. For instance, a patient who has already had a heart attack might be on an anti-platelet, diuretic,

potassium, anti-anginal, and cardiac glycoside totaling $2792.84 for the year. Total cost to the patient for the year will be $1191.59 with $392.84 coming directly out-of-pocket towards the end of the year after the beneficiary enters the donut hole. Costs for any other medication would increase the out-of-pocket cost for the patient, say if they were to get a cold or if they had arthritis or osteoporosis. Falling into the donut hole is much easier than getting out and most beneficiaries who are not critically ill do not. However, some Part D plans include limited coverage in the gap, generally for generic drugs.[11]

Standard Part D benefit amounts will be updated annually with the growth in per capita Part D spending; amounts for 2007 will increase by 7 percent over 2006 levels.[12] Despite claims that the premiums for Part D plans are becoming less expensive, out-of-pocket costs due to the donut hole are expected to rise in the coming year as is illustrated in Table 8.3.

Table 8.3
2006 and 2007 Comparison: Standard Costs and Out-of-Pocket Thresholds

Standard Benefit, 2006	Standard Benefit, 2007
You pay the first **$250** (Deductible)	You pay the first **$265** (Deductible)
You pay 25% of the next **$2,000** (25% of $2,000 = $500) (Initial Benefit Period)	You pay 25% of the next **$2,135** (25% of $2,135 = $533.75) (Initial Benefit Period)
Donut hole "threshold" = $2,250 What you and the plan have spent ($250 + $2,000 = $2,250)	**Donut hole "threshold" = $2,400** What you and the plan have spent ($265 + $2,135 = $2,400)
You pay 100% of the next **$2,850** (The "donut hole")	You pay 100% of the next **$3,051.25** (The "donut hole")
"Catastrophic Coverage" Begins after you have spent **$3,600:** Your out-of-pocket spending requirement ($250 + $500 + $2850 = $3,600) OR, put another way: Total spending (you and the plan) to trigger Catastrophic Coverage = **$5,100** ($250 + $2,000 + $2,850 = $5,100)	**"Catastrophic Coverage"** Begins after you have spent **$3,850**: Your out-of-pocket spending requirement ($265 + $533.75 + $3051.25 = $3,850) OR, put another way: Total spending (you and the plan) to trigger Catastrophic Coverage = **$5,451.25** ($265 + $2,135 + $3051.25 = $5,451.25)
Minimum cost-sharing in Catastrophic Coverage period: $2 (generic); $5 (brand)	Minimum cost-sharing in Catastrophic Coverage period: $2.15 (generic); $5.35 (brand)

Adapted from: Center for Medicare Advocacy, Inc. *Part D by the Numbers*. Online. Available: http://www.medicareadvocacy.org/PartD_06_11.09.BytheNumbers.htm. Accessed: March 28, 2007.

Current Legislation

During the first session of the 110th Congress, Senators and Representatives do not seem to be shying away from Medicare as an issue. Since, the new Congress took office, no less than 90 bills have been introduced or are at some stage in the bills approval process. In addition to the bills listed in each area, others have been introduced dealing with End-of-Life Care, rehabilitation services, laboratory services, physical therapy, long-term hospitalization, Puerto Rican reimbursement, and rural health services, to name a few.[13]

On April 23, 2007, trustees said that Social Security and Medicare would last one year longer than projected the year before; Social Security until 2041 and Medicare until 2019. The report also addressed the impending problems for both systems as 78 million baby boomers get ready to retire. It also triggered a funding warning for the first time that will require the president to propose remedial action to Congress early next year to address the Medicare problems, though Congress will have no obligation to act on the recommendations. The warning mechanism went into effect with the passage of the prescription drug benefits in 2003 and requires the president to propose action "any time two consecutive trustees reports conclude that the amount of general revenue needed to finance Medicare will top 45 percent of the program's outlays. The trustees first made that determination last year."[14] The new report also estimates that Medicare will begin spending more in benefits payouts than it is collecting in taxes this year. According to Treasury Secretary Henry Paulson, the new report illustrates the need for Social Security and Medicare reform saying, "If we do not take action soon to reform Social Security and Medicare, the coming demographic bulge will jeopardize the programs' ability to support people who depend on them. Reform is needed and time is of the essence."[15]

Lessons from around the Globe

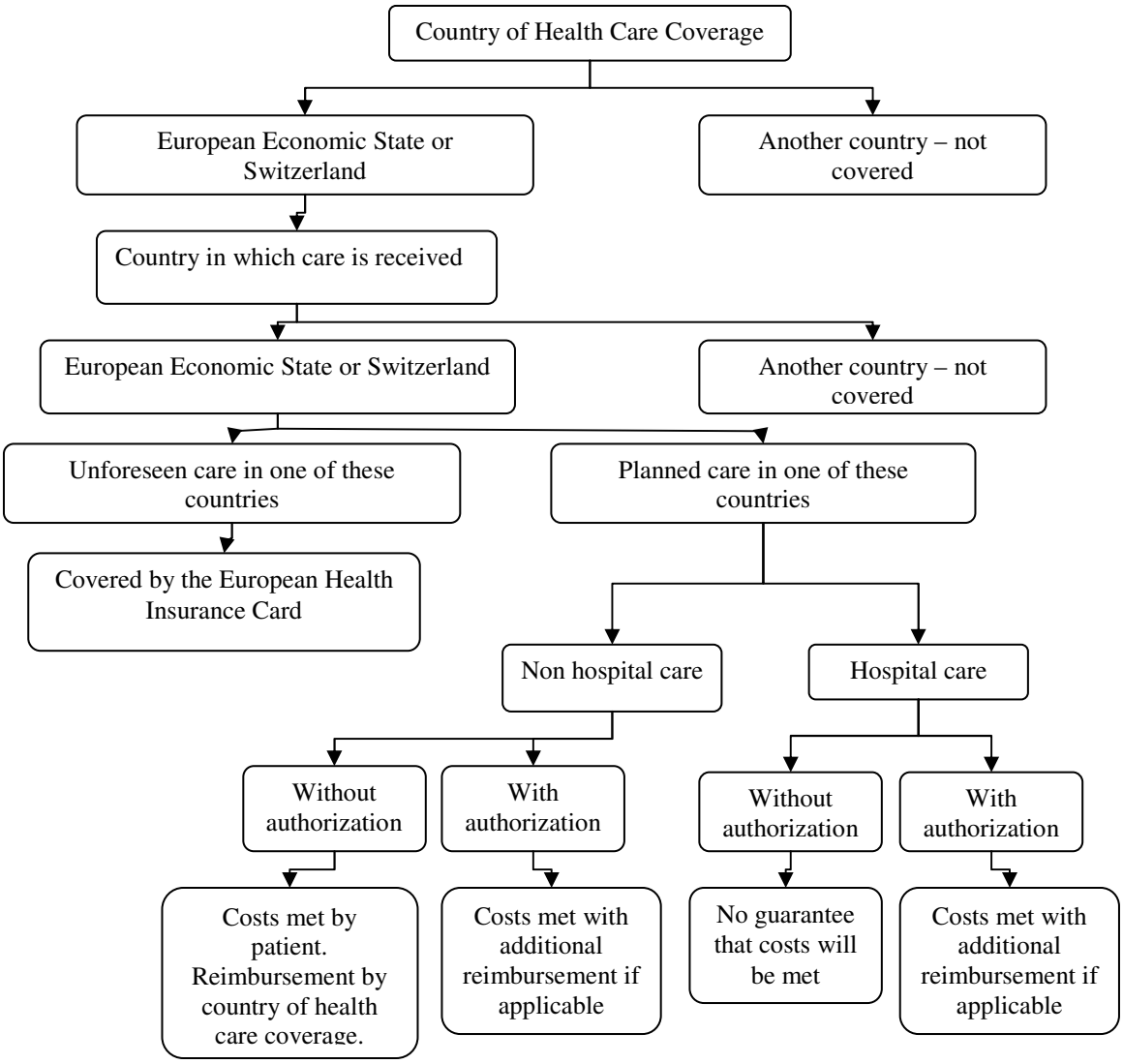
The idea of cross-border health coverage for citizens of different countries while on holiday, on business, or while residing in another country is not new. As the European Union (EU) further integrates, health care has been an inevitable topic of concern and one from which North America might gain some insight. EU Health and Consumer Protection Commissioner Markos Kyprianou believes that access to health care in other member states is a right for every citizen of an EU country. Furthermore, he asserts that, "The health care that patients need is sometimes best provided in another EU country." Last year the EU's high court ruled that patients have rights to cross-border health care under EU law. Now, 25 EU governments are working to establish rules to carry out the order.[16]

In early February 2007, the EU launched a website detailing how member state citizens can obtain medical treatment abroad. Unforeseen treatment of a covered citizen of one member state can be covered in any other member state under the European Health Insurance Card, which was progressively introduced from 2004 to 2005 and became fully established as of January 1, 2006, replacing the E 111 card. Like the introduction of the Euro, this two-year period allowed for a more smooth transition to the new policy. Participating states are Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark,

Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom.[17] Laws in the host countries dictate the provider available in the health care scheme and visitors must use those providers in order to be covered. Using the card helps member state beneficiaries gain access to health care and receive treatment without charge or if there is an upfront charge, receive reimbursement quickly after returning home. The European Health Insurance Card is not meant to cover planned treatment. In fact, it only covers medical treatment "which becomes medically necessary during a stay in the territory of another member state, taking into account the nature of the benefits and the expected length of the stay."[18]

To receive planned treatment in another member state, there are five questions, the answers to which will determine if the procedure will be covered. They are: 1) in which country do you have health insurance? 2) where are you planning to get treatment? 3) is the treatment unforeseen? 4) is this treatment covered by the legislation of the state where you have your health insurance? and 5) is it hospital treatment?[19] Figure 8.1 illustrates the flow of obtaining planned medical treatment in the EU. Usually in the case of planned treatment there are two options for care: hospital and non-hospital treatment. If it is a treatment requiring hospitalization, it will almost always require authorization from the beneficiaries' health insurance. Costs are covered under the terms of the country of treatment. If there is a gap between what the treatment costs in the country of treatment and what the beneficiary would have paid in their own country, they will be reimbursed for the difference. Without authorization, treatment costs are not automatically covered though upon returning home, a beneficiary can still file for reimbursement. This does not mean that the claim will necessarily be accepted. The same method of authorization can be used for non-hospital treatment to guarantee coverage. Citizens of member states can, however, choose to have the procedure and then file for reimbursement after returning home.[20]

Figure 8.1
Flowchart of How Planned Treatment is Handled within Participating EU Member States



Adapted from: European Commission, *Assumption of Costs for Health Care Abroad*. Online. Available: http://ec.europa.eu/employment_social/social_security_schemes/healthcare/e112/pdf/schema_en.pdf. Accessed: April 10, 2007.

As a resident of one member state, one is entitled to these health services in other member states. However, once a person becomes a permanent resident of another state, they are no longer covered under these rules and might be required to buy in to the national health system of the resident state, or purchase International Health Insurance.

Options for Extending Medicare

Extending Medicare coverage to Mexico will not be simple. There are many challenges that must be overcome in order to implement any kind of change, whether it be a demonstration project, a waiver, or a reimbursement system. Medicare's current financial situation is one of those challenges. The Medicare system is on the verge of bankruptcy. Though predictions vary slightly, most forecasters agree that Medicare has the capacity to fully operate until 2018.[21] Another challenge is the relatively low priority of the issue. The Center for Medicare and Medicaid Services (CMS) is trying to plan for the retirement of the baby boom generation. Meanwhile, AARP is focused on prescription drug benefits. As a top member of the organization's Austin chapter confirmed at a recent conference, their main priority now is dealing with the Part D issues. Trying to get Congress to accept Part D was like "pulling teeth without anesthesia."[22] In order for the extension of Medicare overseas to be a priority for AARP, it must be a priority for its members, and it is up to the members to make that priority known.

One of the reasons Medicare coverage in Mexico or other countries has not become important to AARP, CMS, or Congress is that currently relatively few people retire abroad. Medicare covers more than 40 million retired Americans. Probably less than 150,000 of these are residing in Mexico at least six months of the year. However, Mexican retirement is becoming more popular for both American-born and Mexican-born U.S. citizens. The ability to obtain mortgages in Mexico for property purchases has expanded the demand for second homes and ultimately retirement homes in the popular areas. Additionally, as the baby boom generation begins to retire, we are bound to see increased numbers of retirees everywhere (see Chapter 9 on demographics and projections), including Mexico. Though hard numbers do not exist, it is widely agreed that the number of Americans retired in Mexico will only increase in the coming years, and will increase substantially. Now is the time to experiment with new coverage in Mexico while the numbers are relatively modest to see what innovations will work and which will not. Other challenges in extending Medicare include the certification of doctors and hospitals, the true cost savings to Medicare, and the current political climate in the U.S. Even so, it is essential to begin work on a small demonstration of how Medicare coverage can work in Mexico. This will be even more salient as growing numbers of Mexican-origin U.S. citizens attain retirement age and would like to return to their home communities where they can live more comfortably and independently if only their medical care was covered as it would be in the U.S.

There are a number of options that would be possible either under the broad 1122 waiver authority given under the Social Security Act or through limited regulations and trade-offs that might be possible. The following are a small subset of what might be possible; in some cases Congressional authority might be required for CMS to undertake such an innovation in others it might not be needed.

Emergency Coverage

Medicare could cover emergency care in Mexico not only for travelers but for retirees who live there if they have Part A and Part B coverage and are also signed up for Part D. This is the biggest concern of most retirees to whom we talked—they can handle routine care out-of-pocket and a non-emergency procedure for which they can return to the U.S. but, for an emergency, they are afraid they will be stuck with a huge bill from a local hospital. With the use of emergency care on the rise, extending that care for retirees and snowbirds in Mexico should be cost effective for CMS since it would likely be cheaper in Mexico (especially if there were preferred providers and the extra part B and D premiums from beneficiaries who are unlikely to use the services would more than cover the cost of such care). Visits to emergency departments in the U.S. by Medicare patients grew substantially from 2000 to 2004 increasing from 12.1 million to 15.7 million visits.[23] Recent cost estimates for emergency care in the U.S. range from the low end $126 for non-trauma to $192 for trauma to the high end $295 for non-trauma to $412 for trauma.[24] Accordingly, emergency care cost for Medicare patients can reasonably estimated between $1.98 billion to $6.5 billion per year. Since Medicare does not pay commercial rates, their costs for emergency care can be estimated at about 80 percent of the commercial cost or $1.6 billion to $5.2 billion. The additional cost savings in Mexico from 50 to 70 percent will cut Medicare's already reduced emergency costs. Assuming that Americans retired in Mexico use emergency health care services as well as their domestic counterparts, this could mean substantial savings for Medicare. Although the population of U.S. retirees in Mexico has not yet grown to its full potential, saving on the emergency costs of .05 percent of Medicare enrollees would save Medicare between $39.6 million and $129.4 million.

Medicare Advantage Plans

Permit advantage plans to enroll beneficiaries who live in Mexico on an experimental basis. Ideally, several companies who are already providers of Advantage plans could design what they think would be the most feasible model for extending some Part C coverage to Mexico. Some constraints they might consider would be a minimum percentage requirement of services received in Mexico, different additional premiums, and the services covered.

Pharmacy and Physician Care

For those who continue Part B and Part D, permit the inclusion of Mexican pharmacies in the network and also cover physician care at some level. This would of course include certifying some pharmacies and physicians (most likely those at prominent hospitals) as Medicare providers. While this is a challenge, it is not impossible. The Mexican system of certifying hospitals and physicians has improved greatly and the standards of patient care in most of the new hospitals we visited in Mexico seemed high. A direct billing agreement between Medicare and a Mexican hospital might also raise some concerns about fraud. While it is true that this might be an avenue for increased Medicare fraud, there are insurance companies such as IHI (International Health Insurance danmark a/s) who have found ways around such fraud by requiring *facturas* for each service rendered.

A *factura* is an official record of that transaction for tax purposes and the physician will pay income tax on the amount of the *factura*. Obviously, most physicians will want to avoid paying additional income tax on services not rendered. IHI is not the only insurance company offering insurance to expatriates and Mexican nationals in Mexico. Companies such as Aetna, Blue Cross Blue Shield Association, Sigma Assistel, and KAISER Permanente are just a few of the many insurance companies who have found ways to provide health care coverage to people of all nationalities in Mexico.

Medicaid

For low-income retirees abroad, permit some Medicaid coverage as well—perhaps an all federal low cash payment for those who require nursing home care as a way to permit them to remain in place rather than having to return to the U.S. The cost to the U.S. government for indigent retirees abroad can be quite large. The Consular Agent in Nuevo Vallarta spoke of the frequent calls the Consulate receives from hospitals when their American patients cannot pay. One example of this was of a gentleman who broke his hip—it had been two months and he had no money, so he could not get to the U.S. to take advantage of his Medicaid. His retirement in Mexico is, in large part, to be able to live off his $450 per month social security check. He had been given a loan once before to get back to the U.S. for medical treatment, but the government has had trouble collecting repayment. The gentleman is now back in Mexico and in need of health or monetary assistance again.[25] Had he been able to use even a limited amount of his Medicaid benefits in Mexico, the loans would not be necessary, nor would the staff of the Consular Agency and even Consulate General be tied up in these matters.

Medical Savings Accounts

Permit Medical Savings Accounts for those who live in Mexico. If individuals living in Mexico for more than six months each year were allowed to hold Medicare Medical Savings Accounts, they could use the money in those accounts for qualified medical care in Mexico. Medicare MSAs are more useful to people living in Mexico because the savings will go much farther there than in the U.S. The same individuals in the U.S. who might not choose a Medicare MSA could find it useful in Mexico even if they are a person with high health care needs. The actual MSA could still be held in an American bank and accessed by the beneficiary remotely. This option also requires that doctors be certified through Medicare. However, as already discussed, it is not out of the realm of possibility.

Additional Premium

Develop an additional Medicare option that would allow, for an extra monthly premium, use of Medicare outside the United States. The additional premium would keep the already taxed Medicare system from carrying an additional financial burden. As with most insurance plans, it will be purchased more than used. U.S. retirees who like to travel once or twice a year might find the additional $25 monthly premium, for example, worth it to know that if they do leave the country, they will be covered. Those retirees living part or full-time in another country would still be paying their Part B and possibly

Part D premiums but would also be contributing the extra premium. While some might think it unfair to pay an additional premium for the Medicare coverage for which they have already paid, the burden on Medicare cannot be overlooked. Regardless of which option is used for a pilot program, there will be something of an initial administrative cost to Medicare. It will be lower when using insurance companies to administer the new options and collect premiums but Medicare is still responsible for certifying physicians and oversight. One way to pilot this might be to certify one hospital in each of the major Mexican cities and allow MSAs to be used for payment at those hospitals only. If the demonstration were to be more global, Medicare could certify a hospital in the capital, or another large city, in each of the major countries where Americans retire. The cost would be less if it were part of the options offered by Medicare since when used in many cases it would replace higher cost procedures in the U.S. When it is part of Medigap the individual premium would reflect the value to that person and the risk from someone who would pay that premium without taking into account these offsetting savings.

As more and more Americans choose to live their retirement years abroad to enjoy more temperate weather or a lower cost of living, it is vital that we begin amending retirement benefits for these beneficiaries. Similarly, we must be mindful of the upcoming threat posed by the baby boomers' retirement. It will take creative solutions to modify Medicare to accommodate these new challenges. The potential solutions listed here are not exhaustive. The attendance and enthusiasm at our recent conference on the topic of extending Medicare coverage to Mexico made it clear that there are many stakeholders in the area who are willing and able to work together to develop viable solutions.

Notes

[1] SeniorJournal.com Senior Citizens News and Features Daily on Web, *Brief History of the Medicare Program.* Online. Available: http://www.seniorjournal.com/NEWS/2000%20Files/Aug%2000/FTR-08-04-00MedCarHistry.htm. Accessed: March 8, 2007.

[2] Centers for Medicare and Medicaid Services (CMS), Medicare & You, *Section 2: What is Medicare Part A*, p. 7-8. Online. Available: http://www.medicare.gov/publications/pubs/pdf/10050.pdf. Accessed: February 13, 2007.

[3] CMS, Medicare & You, *Section 2: What is Medicare Part B*, p. 10-11. Online. Available: http://www.medicare.gov/publications/pubs/pdf/10050.pdf. Accessed: February 13, 2007.

[4] CMS, Medicare & You, *Section 2: What's Covered*, p. 19. Online. Available: http://www.medicare.gov/publications/pubs/pdf/10050.pdf. Accessed: February 13, 2007.

[5] Medicare.gov, The Official Site for People with Medicare, *Plan Choices;Overview*. Online. Available: http://www.medicare.gov/Choices/Overview.asp. Accessed: November 13, 2006.

[6] CMS, Medicare & You, *Medicare Advantage Plans (Part C).* p. 33. Online. Available: http://www.medicare.gov/publications/pubs/pdf/10050.pdf. Accessed: February 13, 2007.

[7] Health Care Financing Administration, *Your Guide to Medicare Medical Savings Accounts* (1998), Online. Available: http://library.findlaw.com/1998/Sep/1/126201.pdf. Accessed: March 20, 2007.

[8] CMS, Medicare & You, *Medicare Prescription Drug Coverage (Part D).* p. 43-56. Online. Available: http://www.medicare.gov/publications/pubs/pdf/10050.pdf. Accessed: February 13, 2007.

[9] Ibid.

[10] GovTrack.us, Independently Tracking the United States Congress, *Bill Search*. Online. Available: http://www.govtrack.us/congress/billsearch.xpd. Accessed: April 2, 2007.

[11] CMS, Medicare & You, *Medicare Prescription Drug Coverage (Part D)* (online).

[12] The Henry J. Kaiser Family Foundation, *Medicare: Prescription Drugs.* Online. Available: http://www.kff.org/medicare/index.cfm. Accessed: November 3, 2006.

[13] GovTrack.us, *Bill Search*. (online).

[14] MSNBC, *Good News for Social Security, Medicare: Trustees extend both funds' depletion dates by a year*. Online. Available: http://www.msnbc.msn.com/id/18268874/. Accessed: April 23, 2007.

[15] Ibid.

[16] "EU to Draft Ground Rules on Cross-border Health Care for Patients." Associated Press (September 5, 2006), p. 1. Online. Available: Lexis Nexis Academic Universe, http://web.lexis-

nexis.com.ezproxy.lib.utexas.edu/universe/document?_m=22cc1577cc22b04a923e86845df9c4b1&_docnum=1&wchp=dGLbVzz-zSkVA&_md5=cc8eaa127ac232acc77d853b90e4256f. Accessed: April 10, 2007.

[17] European Commission, *The European Health Insurance Card*. Online. Available: http://ec.europa.eu/employment_social/healthcard/*citoyens*_en.htm#4c. Accessed: April 10, 2007.

[18] Ibid.

[19] Ibid.

[20] European Commission, *Planned Treatment*. Online. Available: http://ec.europa.eu/employment_social/social_security_schemes/healthcare/e112/conditions_en.htm#. Accessed: April 10, 2007.

[21] Amy Goldstein, "Medicare Will go Broke by 2018, Trustees Report," *The Washington Post* (May 2, 2006). Online. Available: http://www.washingtonpost.com/wp-dyn/content/article/2006/05/01/AR2006050101448_pf.html. Accessed: April 9, 2007.

[22] Statement by Oscar Luna, Associate State Director AARP, Texas, in Short and Long-Term Initiatives Breakout Session at The Future of Health Care for Retirees in Mexico, March 30, 2007.

[23] Solucient Center for Healthcare Improvement, *Trends in Medicare Emergency Department Utilization, 2000-2004.* Online. Available: http://www.solucient.com/docs/100TopEDTrends_06.pdf. Accessed: April 24, 2007.

[24] Health Policy and Clinical Practice Editorial, *Calculating the Cost of Emergency Care*. Online. Available: http://www.usc.edu/schools/sppd/research/healthresearch/images/pdf_reportspapers/calculating%20the%20cost%20of%20emergency%20care.pdf. Accessed: April 24, 2007.

[25] Interview by Alex Gunter and Michelle Lalonde with Kelly Trainor de O, U.S. Consular Agent, Nuevo Vallarta, Mexico, January 12, 2007.

Chapter 9. Health Care Providers in Mexico

by Juan I. Martinez Valdez

Extending Medicare into Mexico requires not only quality assurance, but also an assurance of compliance with international medical norms. This chapter outlines quality regulations and standards for Mexican hospitals. It also lists the certified private hospitals in Mexico, as well as the hospitals that cater to American-born residents or foreign tourists, and outlines the standards these hospitals must follow in order to offer specific services.

Mexican Hospital Industry

Mexican hospitals can either be public or private. The private hospitals can be for profit or nonprofit entities. Public hospitals are state-run entities established by either the federal government, the state government or by the city government, as is the case in Mexico City.

There is a public system of federal and state hospitals found throughout Mexico that includes the *Instituto Mexicano del Seguro Social* (IMSS), the *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (ISSSTE), and the *Sistema Nacional para el Desarrollo Integral de la Familia* (DIF) and each state hospital. IMSS is a medical system created in 1946 to provide medical care to the growing blue collar workers in the early industrialization of Mexico. The IMSS system operates many hospitals throughout the country and also operates one federal specialization center in Mexico City. In order to receive coverage under IMSS, an individual must have formal employment in Mexico and/or have worked in a formal setting for a number of years before retiring. In the beginning, it was in charge of medical care, pension and disabilities, but it soon expanded in response to the changing needs of the population and began to offer day care for children and nursing homes for retirees. In 2005, the creation of the *Seguro Popular* increased the size of the population that can seek treatment at the IMSS hospitals and clinics increasing the waiting time for appointments and the availability of some drugs.

Payment for the services IMSS provides is shared by employees, employers and the federal government. These contributions are managed in a general trust fund that pays for all IMSS services including medical care, retirement and disability. In 1996 the Mexican congress authorized a reform to the pension system by allowing employees to open individual savings accounts, thus decreasing the general pool of funds that contributed to the IMSS trust. Actuarial projections have shown that the IMSS trust will be exhausted in five to 10 years. For these reasons, IMSS has been under political pressure as it does not have sufficient funds to supply the necessary drugs and medical supplies to hospitals and clinics. IMSS' inability to reform its employees pension system has also exacerbated the problem.

Mexico's private hospital industry is extremely fragmented as a large number of small hospitals and clinics have only a local presence in one or limited areas. In June 2001, the Ministry of Health's Executive Report states that more than 4,000 private hospitals exist in the country, but 90 percent of them have fewer than 20 beds and most are dedicated to obstetric services.[1] A few companies do exist however, that have hospitals in various states throughout the country. Additionally, the Red Cross hospitals located in each state capital operate independently from one another and are not incorporated. For this reason, it is currently difficult to apply one general standard to these hospitals as they all provide different services, vary greatly in staff size and access to the latest medical equipment also varies from one hospital to the next. For the purposes of our research, this industry fragmentation and the lack of clear categorization makes it difficult to compare the services these hospitals provide. Furthermore, competition among the hospitals deters many from disclosing detailed information regarding their services, staff experience, and available technology.

Hospital Groups with a Regional Presence

Grupo Angeles, which operates 17 hospitals throughout Mexico, is the largest hospital group in the country. It was created in 1986 when Hospital Humana was sold to the Vazquez Rana family and it has recently been growing rapidly. It has several hospitals certified by the *Consejo de Salubridad General*, a state agency that ensures hospitals are complying with federal standards. Additionally, *Grupo Angeles* will soon begin the process of obtaining certification by the Joint Commission International for some of its hospitals, an agency that ensures hospital compliance with international medical norms. *Grupo Angeles* hospitals are primarily found in Mexico's larger cities as well as in some smaller cities. It provides a wide range of specialized health care second only to the federal government institutions (IMSS).[2]

Star Medical is the hospital group with the second largest number of hospitals In Mexico. It offers services in eight cities including Morelia, Puebla, San Luis Potosi, Ciudad Juarez, and Mexico City. Although it provides general services in all of its facilities, some specialized services can be found in a few locations. This group has been increasing its available funds through capital investments made available by *Grupo Financiero Inbursa* and *Impulsora del Desarrollo y el Empleo en América Latina* (IDEAL) and thus expects to grow. Additionally, it also expects to increase the number of hospitals certified by the *Consejo de Salubridad General*.[3]

The following four hospital groups all have or had American investors.

CHRISTUS Muguerza is a joint venture between the CHRISTUS Group and the Muguerza family of Monterrey. The Muguerza hospital group was founded in the 1930s in Monterrey and has been recognized for the high quality of the services it provides. Since 2001, it is part of the joint venture with CHRISTUS Health. This group has three hospitals in Monterrey, one in Saltillo, and one in Chihuahua. Each one of the CHRISTUS Muguerza[4] hospitals has been certified by the *Consejo de Salubridad General* and it is the hospital group that is furthest along in the process of obtaining the Joint Commission International (JCI) certification (see below).[5]

International Hospital Corporation has developed and operates the *Centro Internacional de Medicina* (Cima) hospitals in Mexico. It started with CIMA Hermosillo hospitals in a joint venture with local physicians and investors and has growth to Monterrey and Chihuahua. Another hospital is scheduled to start operations in Puebla City in 2007. It also has operations in Costa Rica and Brazil.[6]

The American British Cowdray Medical Center (ABC) is a hospital group founded in Mexico City in 1941 when the American Hospital and Cowdray hospital merged. In 2004, they signed an agreement with the Methodist Hospital in Houston and, as a result, it has committed to obtaining Joint Commission International certification by 2009. Additionally, this group operated with only one hospital from its creation until 2005 when its second hospital, Santa Fe Hospital, began operations. ABC is recognized as top quality since it boasts state of the art equipment in both locations. Both facilities have been certified by the *Consejo de Salubridad General*.[7]

AmeriMed hospitals are mostly located in tourist locations such as Puerto Vallarta and Los Cabos. This hospital group primarily caters to health for tourists. AmeriMed hospitals have yet to be certified by the *Consejo de Salubridad General*.[8]

Health Care Regulation

Health care regulation in Mexico is governed by the Mexican legal system. *The Ley General de Salud*, or General Health Law, is a federal law that governs the actions of any medical institution, including hospitals and medical schools, as well as individual physician activities in Mexico. Specifically, the law stipulates the limitations and regulatory responsibilities of the *Secretaría de Salud*, the federal agency created to oversee compliance of the aforementioned entities to federal health regulation standards. The *Secretaría* ensures overall compliance with the *Ley General de Salud* by creating the infrastructure necessary to ensure all medical facilities and physicians in the country are meeting at least minimal regulatory standards. Thus, the *Secretaría* is aided by three things, the *Norma Oficial Mexicana* (secondary laws that further detail the requirements that all medical institutions in Mexico must comply with), the *Consejo General de Salubridad*, and the Medical Boards. Through these entities, the *Secretaría* is able to delegate different responsibilities to each agency and thus ensure multiple oversights into the medical activities in Mexico.[9]

Mandatory Regulations as Specified by the *Norma Oficial Mexicana*

The federal standards, *Norma Oficial Mexicana* (NOM), are specific to each medical procedure in order to ensure quality, thus, all hospitals in Mexico must comply with the NOM related to the services they provide. The title of each NOM is composed of a sequential number, the agency responsible for the regulation, and the year when it becomes mandatory. It can also contain a short description on the activity that is regulated.[10]

All health care NOMs are listed on the *Secretaría de Salud* webpage at www.salud.gov.mx, where they can be located by their code names.

Table 9.1 presents the Health Care NOMs as of December 2006.[11]

Table 9.1
Mexican Federal Standards for Health Care (Norma Oficial Mexicana)

Area	Code and Complete Name
Anesthesiology	*NOM 170-SSA1-1998. Norma Oficial Mexicana para la Práctica de Anestesiología*
Laboratory	*NOM-166-SSA1-1997. Norma Oficial Mexicana. Para la Organización y Funcionamiento de los Laboratorios Clínicos.*
Clinic file	*NOM-168-SSA1-1998. Norma Oficial Mexicana. Del Expediente Clínico.*
X-Ray	X ray diagnostic protection and safety regulations *NOM-157-SSA1-1996 Norma Oficial Mexicana, Salud Ambiental. Protección y Seguridad Radiológica en el Diagnóstico Médico con Rayos X.* Sanitary liabilities to X rays centers. *NOM-146-SSA1-1996. Norma Oficial Mexicana. Salud Ambiental. Responsabilidades Sanitarias en establecimientos de Diagnóstico Médico con Rayos X.* Technical requirements for X rays centers. *NOM-156-SSA1-1996. Norma Oficial Mexicana. Salud Ambiental. Requisitos Técnicos para las Instalaciones en Establecimientos de Diagnostico Medico con Rayos X.* Technical specifications for X rays centers. *NOM-158-SSA1-1996. Norma Oficial Mexicana. Salud Ambiental. Especificaciones Técnicas para Equipos de Diagnóstico Médico con Rayos X.*
Ambulatory Surgery	*NOM-178-SSA1-1998. Norma Oficial Mexicana. Que establece los requisitos mínimos de infraestructura y equipamiento de establecimientos para la atención médica de pacientes ambulatorios.*
Specialized Medical Services	*NOM-197-SSA1-2000. Norma Oficial Mexicana que establece los requisitos mínimos de infraestructura y equipamiento de hospitales y consultorios de atención médica especializada.*
Access and Architecture Requirements for Handicap Transit	*NOM-001-SSA2-1993. Norma Oficial Mexicana que Establece los Requisitos Arquitectónicos para Facilitar el Acceso, Transito y Permanencia de los Discapacitados a los Establecimientos de Atención Médica del Sistema Nacional de Salud.*
Radiotherapy	*NOM-002-SSA2-1993. Norma Oficial Mexicana. Para la Organización, Funcionamiento e Ingeniería Sanitaria del Servicio de Radioterapia.*
Hazardous Waste Disposition	Blood and blood components disposition regulations *NOM-003-SSA2-1993. Norma Oficial Mexicana para la Disposición de Sangre Humana y sus Componentes con Fines Terapéuticos.* Other bio hazard hospital waste. *NOM-087-ECOL-SSA1-2002. Norma Oficial Mexicana - Protección ambiental - Salud ambiental - Residuos peligrosos biológico-infecciosos - Clasificación y especificaciones de manejo.*
Epidemiology and Prevention and Control of Hospital Endemic Infections	*NOM-026-SSA2-1998. Norma Oficial Mexicana para la Vigilancia Epidemiológica, Prevención y Control de las Infecciones Nosocomiales.*

Source: Secretaria de Salud, *Normas.* Online. Available: http://www.salud.gob.mx. Accessed: December 10, 2007.

Voluntary Regulations for Private Hospitals

Mexican law allows hospitals to obtain further quality certification by the *Consejo de Salubridad General*. It is a voluntary process that involves the verification of the administrative processes, infrastructure of the hospitals, and compliance with the *Norma Oficial Mexicana* that pertains to the service provided.

The certification was originally designed to provide a standard for public hospitals and its reach was subsequently extended to private hospitals shortly after its inception. The main focus of the certification is on standardizing the processes among hospitals to provide a quality standard in all public hospitals and is the government's last step towards a national mandatory standard of quality.

The certification process is divided into two main sections. The first section requires a self-evaluation of the hospital care, of the administrative support processes, and of compliance with the NOMS. The criteria and user guide for this self evaluation is provided by *the Consejo de Salubridad General* in the web page "Certificación" at http://www.csg.gob.mx/progr_cert2.htm. The second part of the process consists of an evaluation by a third party to ensure that all the information recorded and documented in the first section is accurate and that the hospital is able to maintain the quality of its services. The hospital must prove that all of the services they provide adhere to all applicable *Normas Oficiales Mexicanas*. [12]

When the certification process is completed, the *Consejo General de Salubridad* issues a certificate and lists the hospital as one of its certified hospitals on its webpage. These hospitals can be found on the "Certificación" page in the "*Hospitales certificados*" link, and in Table 9.2.

The aforementioned certification process is expected to become mandatory for both public and private hospital sometime during the presidential term of Felipe Calderon Hinojosa, 2006-2012.

Emergency Care

Emergency care in Mexico is required by law in all hospitals, private or public. Although even private hospitals cannot refuse a patient emergency services, it is not uncommon for them to ask for proof of a patient's ability to pay for the required treatment. In these cases, Medicare beneficiaries might be forced to pay out-of-pocket and then be reimbursed by their insurer. Despite this inconvenience, receiving emergency medical services in a Mexican private hospital will provide immediate attention to patients, and at probably a much lower cost than hospitals in the U.S.

Certification by the Joint Commission International

The Joint Commission International is part of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and provides quality standards for non-U.S. hospitals. Currently, the four-year process of compliance and certification with JCI is a

voluntary process, but it can serve as a point of reference with which to compare the Mexican medical system with that of the United States.[13]

Some differences exist between the focus of JCI standards versus those of the Mexican *Consejo de Salubridad General*. For example, JCI emphasizes the quality of patient care with a different set of tools and skills than those used by the *Consejo de Salubridad General* certification process.

Non U.S. hospitals can apply to the following certification programs:

- International Standards for Hospitals;
- International Standards for Clinical Laboratories;
- International Standards for the Care Continuum; or
- International Standards for Medical Transport Organizations.

In 2002, the state government of Nuevo Leon started a program to promote the certification of private hospitals by JCI, since then, some major hospitals in Nuevo Leon have started to work on certification.[14]

Several hospitals stated that they are undergoing JCI certification, but there is no public information on the commission's website about the current status of the certification process of any Mexican hospital. JCI's webpage only lists Brazil and Bermuda as countries who have JCI-accredited hospitals in the Americas, so although there exists a system with which to compare country specific hospitals and medical systems on an international scale, it is still in its early stages and has yet to expand its reach.

Table 9.2
Private Hospitals Certified by the *Consejo de Salubridad General*

As of October 13, 2006, this is the list of the certified private hospitals published on the website of the *Consejo General de Salubridad*.

Hospital	**City**	**State**	**Valid until**
Central Médico Quirúrgica de Aguascalientes	Aguascalientes	Aguascalientes	19-Jun-08
Beneficencia Española de la Laguna	Torreón	Coahuila	15-Oct-07
Unidad Médica Quirúrgica de Colima S.A de C.V.	Colima	Colima	8-Dec-08
Centro Médico de Especialidades de Ciudad Juárez, S.A. de C.V.	Cd. Juárez	Chihuahua	18-Mar-07

Clínica del Centro, S.A. de C.V.	Chihuahua	Chihuahua	3-Oct-06
Clínica del Parque, S.A. de C.V.	Chihuahua	Chihuahua	18-Oct-06
Hospital Cima de Chihuahua	Chihuahua	Chihuahua	8-Dec-08
Servicios Hospitalarios Ambulatorios S.A. de C.V.	Chihuahua	Chihuahua	27-Apr-09
Operadora San Ángel Inn, S.A. de C.V	Álvaro Obregon	Distrito Federal	28-Jul-09
Hospital Cedros S.A. de C.V.	Álvaro Obregón	Distrito Federal	3-Feb-07
Hospital The American British Cowdray Medical Center I.A.P	Álvaro Obregón	Distrito Federal	9-Dec-07
Hospital Infantil Privado, S.A. de C.V.	Benito Juárez	Distrito Federal	17-Mar-08
The American British Cowdray medical Center I.A.P.	Cuajimalpa	Distrito Federal	28-Jul-09
Clínica Lóndres (Servicio Médico Social, S.A. de C.V.)	Cuauhtémoc	Distrito Federal	27-Apr-08
Hospimed S.A. de C.V. (Hospital Santelena)	Cuauhtémoc	Distrito Federal	7-Sep-08
Hospital Mariajosé	Cuauhtémoc	Distrito Federal	8-Dec-08
Hospital Metropolitano, S.A. de C.V. Grupo Ángeles	Cuauhtémoc	Distrito Federal	27-Apr-08
Hospital Santa Fe, S.A. de C.V.	Cuauhtémoc	Distrito Federal	8-Dec-08
Hospital Torre Médica, S.A. de C.V.	Cuauhtémoc	Distrito Federal	22-May-06
Inter, Hosp., S.A. de C.V., Centro Médico Dalinde,	Cuauhtémoc	Distrito Federal	20-Oct-08
Nuevo Sanatorio Durango, S.A. de C.V.	Cuauhtémoc	Distrito Federal	15-Oct-07
Sanatorio Trinidad S.A. de C.V.	Cuauhtémoc	Distrito Federal	19-Nov-09
Sanatorio y Servicios Médicos Obregón, S.A. de C.V.	Cuauhtémoc	Distrito Federal	9-Dec-07
Hospital MIG S.A. de C.V.	Gustavo A. Madero	Distrito Federal	22-May-06
Hospital Ángeles del Pedregal S.A. de C.V.	Magdalena Contreras	Distrito Federal	7-Sep-08
Asociación Gineco-Obstétrica, S.A. de C.V (Hospital Ángeles México)	Miguel Hidalgo	Distrito Federal	7-Sep-08
Hospital Santa Teresa Institución Gineco - Obstétrica, S.A. de C.V.	Miguel Hidalgo	Distrito Federal	30-Jul-07
Hospital Sociedad de Beneficencia Española I.A.P.	Miguel Hidalgo	Distrito Federal	9-Dec-07
Hospitales Nacionales, S.A. de C.V. (Hospital Mocel) Gpo. Ángeles	Miguel Hidalgo	Distrito Federal	27-Apr-08
Médica Sur, S.A. de C.V.	Tlalpan	Distrito Federal	17-Mar-08
Centro de Atención Medica Integral, S.A. de C.V. Hospital CAMI.	Venustiano Carranza	Distrito Federal	9-Dec-07
Hospital Aranda de la Parra, S.A. de C.V.	León	Guanajuato	10-Jun-06

Hospital del Bajio, S.A. de C.V. (Hospital Ángeles León)	León	Guanajuato	7-Sep-08
Hospital La Luz / Sanatorio Santa Fe de León, S.A. de C.V.	León	Guanajuato	12-Nov-07
Hospital Bernardette, S.A. de C.V.	Guadalajara	Jalisco	1-Apr-08
Hospital Country 2000	Guadalajara	Jalisco	7-Sep-08
Hospital de la Santísima Trinidad	Guadalajara	Jalisco	27-Apr-08
Hospital del Carmen, S.A. de C.V.	Guadalajara	Jalisco	7-May-07
Hospital México Americano, S.C.	Guadalajara	Jalisco	17-Mar-08
Hospital San Javier S.A. de C.V.	Guadalajara	Jalisco	7-Sep-08
Sanatorio San Francisco de Asís, S.A. de C.V.	Guadalajara	Jalisco	18-Mar-07
Hospital Vicentita S.A. de C.V.	Tepatitlán de Morelos	Jalisco	8-Dec-08
Hospital Ángeles del Pedregal S.A. de C.V. Sucursal Lomas	Huixquilucan	México	27-Apr-08
Centro Médico de Toluca, S.A. de C.V.	Metepec	México	2-Dec-07
Coorporativo Hospital Satélite, S.A. de C.V.	Naucalpan	México	9-Dec-07
Institución Gineco-Obstétrica y de Perinatología, S.A. de C.V.	Naucalpan	México	17-Mar-08
Sanatorio Florencia S.A de C.V.	Toluca	México	25-Mar-06
Hospital Star Médica Morelia	Morelia	Michoacán	27-Apr-09
Clínica Hospital San José, S.A. de C.V.	Zamora	Michoacán	20-Sep-06
Hospital Bellavista de Cuernavaca S.A. de C.V.	Cuernavaca	Morelos	12-Feb-08
Sanatorio Henri Dunant, A.C.	Cuernavaca	Morelos	7-Jan-07
Hospital Santa Engracia, S.A. de C.V.	Garza García	Nuevo León	23-Oct-07
Clínica Cuauhtémoc y Famosa	Monterrey	Nuevo León	8-Dec-08
Clínica Vitro, A.C.	Monterrey	Nuevo León	9-Dec-07
CHRISTUS Muguerza, S.A. de C.V.	Monterrey	Nuevo León	7-Sep-08
Hospital de Ginecología y Obstetricia, S.A. de C.V.	Monterrey	Nuevo León	1-Mar-07
Hospital San José de Monterrey, S.A. de C.V	Monterrey	Nuevo León	1-Feb-08
Hospital y Clínica, OCA, S.A. de C.V.	Monterrey	Nuevo León	9-Dec-07
Hospital Dinámica, S.A. de C.V. (Hospital Clínica Nova)	San Nicolás de los Garza	Nuevo León	27-Apr-08
Fundación Tamariz Oropeza Hospital Betania	Puebla	Puebla	25-Mar-06
Hospital Sociedad Española de Beneficencia de Puebla	Puebla	Puebla	9-Dec-07
Clínica Díaz Infante S.A. de C.V.	San Luis Potosí	San Luis Potosí	7-Sep-08
Promotora de Servicios Médicos, S.A. de C.V. Hospital de Nuestra Señora de la Salud	San Luis Potosí	San Luis Potosí	8-Dec-08
Sociedad de Beneficencia Española, A.C.	San Luis Potosí	San Luis Potosí	7-Sep-08

Hospital Privado de Hermosillo S.A. de C.V.	Hermosillo	Sonora	28-Jul-09
Sanatorio Covadonga Servicios Médicos de Oriente S.A de C.V.	Córdoba	Veracruz	15-Oct-07
Sanatorio Orizaba Servicios Médicos S.A. de C.V.	Orizaba	Veracruz	15-Oct-07

Adapted from: Consejo de Salubridad General, *Certificacion de Hospitales/ Hospitales Certificados*. Online. Available: http://www.csg.gob.mx/progr_cert2.htm. Accessed: March 10, 2007.

Notes

[1] Secretaria de Salud, *Síntesis Ejecutiva No. 10, Unidades privadas con servicio de hospitalización, México 2001*. Online. Available: http://www.salud.gob.mx/unidades/dgied/sinais/publicaciones/publicaciones.htm. Accesed: October 10, 2006.

[2] Grupo Angeles Salud, *Quienes somos*. Online. Available: http://www.mediks.com/gass/www/index.php. Accessed: February 18, 2007.

[3] Email from Mayra Itzvett Bolanos Arizmendi, Spokesperson, Grupo Star Medica, to Juan Martinez Valdez, March 10, 2007.

[4] John Zipprich, "Medical Travel, CHRISTUS Muguerza in the Global Market" (paper presented at a conference on "The Future of Health Care for U.S. Retirees in Mexico - Health Care in Mexico: Assuring Quality and Supply," at the LBJ School of Public Affairs at the University of Texas at Austin, March 2007), p, 33.

[5] Grupo CHRISTUS Muguerza, *Quienes Somos*. Online. Available: http://www.christusmuguerza.com.mx/cm/modules/xfsection/article.php?hospital=Grupo&articleid=299. Accessed: February 10, 2007.

[6] Centro Internacional de Medicina, *Quienes somo / historia*. Online. Available: http://www.cimahermosillo.com/index3.php?idpag=14. Accessed: February 20, 2007.

[7] American British Cowdray Hospital, *Corporativo ABC / historia*. Online. Available: http://www3.abchospital.com/domino/abchospital/WebPageABC.nsf/VwAuxContPub/H4.4_1?OpenDocument. Accessed: February 20, 2007.

[8] Amerimed American Hospitals, *About us*. Online. Available: http://www.amerimed-hospitals.com/about_us. Accessed: February 18, 2007.

[9] Presidencia de la Republica, *Decreto por el que se reforma la Ley General de Salud* (Diario Oficial de la Federacion, February 7, 1984, last reform June 6, 2006), pp. 1-3.

[10] Secretaria de Salud, *Normas.* Online. Available: http://www.salud.gob.mx/. Accessed: December 10, 2006.

[11] Secretaria de Salud, *Normas.* Online. Available: http://www.salud.gob.mx/. Accessed: December 10, 2006.

[12] Consejo de Salubridad General, *Certificacion de Hospitales*. Online. Available: http://www.csg.gob.mx/progr_cert2.htm. Accessed: March 10, 2007.

[13] Joint Commission International, *Accreditation / International Standards*. Online. Available: http://www.jointcommissioninternational.com/22758/. Accessed: November 24, 2007.

[14] Nuevo Leon Competitivo, *Programa Regional de Competitividad e Innovacion.* Cecic (Nuevo Leon, 2004), pp. 397-403.

Chapter 10. Medical Schools and the Specialty Accreditation of Physicians

by Juan I. Martinez Valdez

Medical Schools in Mexico

The *Secretaría de Salud* (Ministry of Health) and the *Secretaría de Educación Pública* (Ministry of Public Education) are the federal agencies designated to monitor the overall regulation and certification process of medical schools in Mexico. These two entities govern the actions of the Sub-Secretary of Professions and the Autonomous University of Mexico, the two agencies which actually conduct the evaluations in order to assess whether or not a medical school is adhering to federal standards. All medical schools must be registered and approved by both institutions in order to have the legal accreditation necessary to provide its students an approved curriculum.

Due to the increase in the number of individuals applying to medical school, there has been a surge in the number of medical schools in Mexico over the last 10 years. Almost all states in Mexico have a state university that houses a medical school, but the increased demand for a medical education has exceeded the available positions. Private investors have seized the opportunity and have thus created several schools around the country with wide variations in facilities and quality.[1]

In 2001, the *Consejo de Salubridad General* delegated the task of ensuring one standard of quality throughout all the medical schools in the country.to the *Consejo Mexicano para la Acreditación de la Educación Médica* (COMAEM). COMAEM attempts to ensure entities from all sectors of the medical profession are represented and thus, it is comprised of members of the federal government, mostly from the Ministry of Health, and by directives of the public and private universities housing medical schools. The COMAEM has published the process that guides the criteria used for school accreditation and it is the entity that determines whether or not a medical school will receive accreditation.[2]

The accreditation process has the following steps:

1. Self evaluation: The medical school has to answer a standard questionnaire regarding the facilities, the faculty and the study programs. The medical school must also gather evidence of the information they provide such as the record of faculty, the licenses from local agencies and course detail information.

2. Verification: A commission of the COMAEM will verify the information provided by the school and evaluate the evidence provided according to the established criteria.

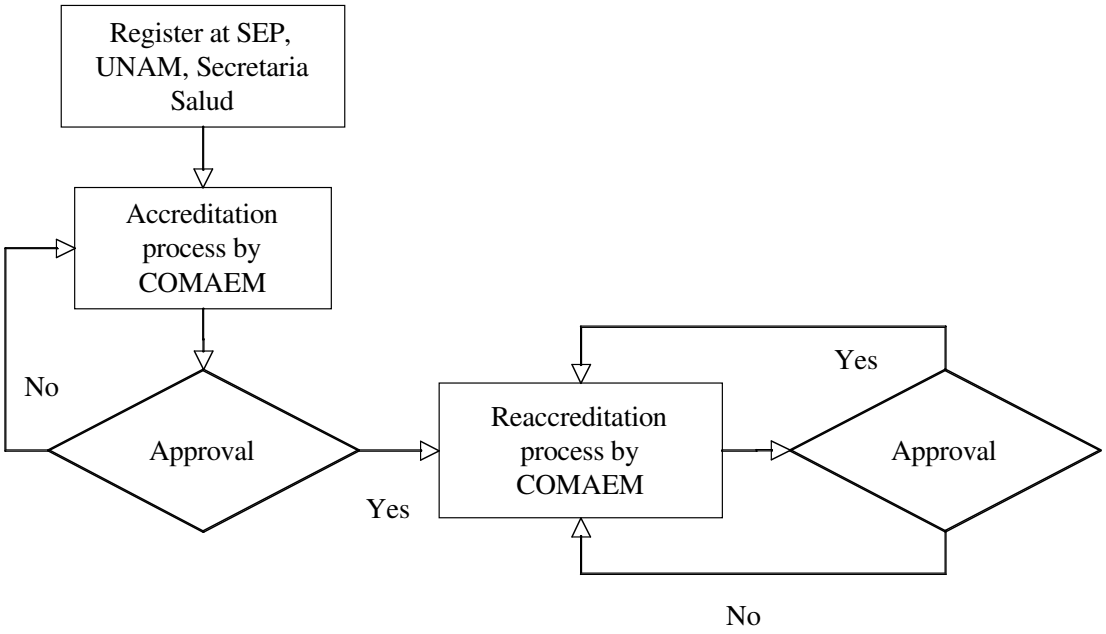
3. Report: Once all the information is evaluated, the COMAEM will report whether or not the medical school will receive accreditation. The report is mailed to the school and published on COMAEM's website http://www.comaem.org.mx.

The accreditation process is valid for five years and after that the medical school must again undergo the process in order to maintain accreditation.[3]

It is of no benefit for students to enroll and/or graduate from a medical school that has not been accredited by COMAEM since they will not be allowed to apply for any of the specialization tests and thus, cannot advance in their careers. Although many students disagree with this policy, the *Consejo General de Salubridad, Secretaría de Salud* and the medical boards are all standing firm in their support of this measure. These entities prefer to focus on the long-term effect of providing some standardization process that ensures high-quality education and training for practicing physicians throughout the country.

Figure 10.1 outlines the aforementioned process to register a new school in Mexico:

Figure 10.1
Medical School Accreditation



Adapted from: Consejo Mexicano para la Acreditacion de la Educacion Medica, *Proceso de acreditacion.* Online. Available: http://www.comaem.org.mx/ProcAcreditacion.html. Accessed: October 14, 2006.

Physicians Specialty Accreditation

The *Ley General de Salud*'s Title 4 statute entitled "*Recursos Humanos para los Servicios de Salud*" (Human Resources for Health Services), Chapter I - II, which includes Articles 78 to 95, contains all the regulations regarding medical education and specializations given to the *Secretaría de Salud*. The *Secretaría* then delegates some of these powers to other institutions such as the *Consejo Normativo para las Especialidades Medicas* and the *Academia Mexicana de Medicina*.[4]

For a physician wanting to obtain a specialization, it is required that the student complete his or her education at an accredited medical school as well as the required *Servicio Social*, or general residency program in hospitals designated by the *Secretaría de Salud*. All medical students in Mexico, regardless of whether or not they wish to specialize in one area, must complete a social service component providing medical services, preferably to underserved populations.

To be eligible for a specialty program, all students must take a standardized test created and regulated by the *Comisión Interinstitucional para Formación de Recursos Humanos para la Salud* (CIFRHS), a federal agency that coordinates the training and education for all medical specialties. Specialty programs are extremely competitive and only about 22 percent of applicants are admitted into these programs each year. Once admitted, the overall score on the standardized test limits the specialty programs that a student may enroll in, and the students that score highest will be admitted into the top rated specialty programs and institutions in Mexico.[5]

The standardized test consists of 700 questions that are divided into two sets. The first set tests a student's knowledge of medical concepts and is worth 90 percent of the final grade. The second set explores the ability to understand medical writing in English and provides the other 10 percent of the final grade. This second part ensures that the students willing to attend U.S. universities or who will take care of U.S. patients may serve their patients with fewer language barriers. Each standardized test is different depending on the specialty the student is applying for, thus, there are currently nine different versions of the test being administered.[6]

For the 2006 exam, the CIRFH reported the results as show in Table 10.1.

Table 10.1
Applicants and Availability by Specialty

Specialty	Applicants	Available Places
Anatomic Pathology (Anatomia patologica)	180	78
Anesthesiology (Anestesiologia)	1,497	515
Quality of Medical Care (Calidad en la atención clinica)	32	10
General Surgeon (Cirugia General)	3,676	539
Audiology, Communication and Phoniatry (Audiologia, comunicacion y foniatria)	91	25
Epidemiology (Epidemiologia)	80	37
Medical Genetic (Genetica Medica)	94	24
Gynecology and Obstetrics (Ginecologia y obstetricia)	3,384	520
Sport and Physical medicine (Medicina de la actividad fisica y deportiva)	59	12
Rehabilitation (Medicina de Rehabilitacion)	489	71
Work Medicine (Medicina del Trabajo)	238	58
Family Medicine (Medicina Familiar)	1,972	920
Integral Medicine (Medicina Integrada)	200	203
Internal Medicine (Medicina Interna)	3,623	721
Forensic Medicine (Medicina legal)	90	10
Radiation Therapy (Medicina Nuclear)	49	12
Ophthalmology (Oftalmologia)	775	140
Orthopedics (Ortopedia)	1,301	269
Otolaryngology (Otorrinolaringologia)	557	79
Clinic Pathology (Patologia clinica)	60	26
Pediatrics (Pediatria)	3,010	640
Psychiatry (Psiquiatria)	462	132
Radiology (Radiologia e Imagen)	809	208
Public Health (Publica)	75	13
Urgent Care (Urgencias medicas)	953	215
Total	**23,050**	**5,477**

Adapted from: Comision Interinstitucional para la Formacion de Recursos Humanos para la Salud, *Informe 2006 XXX ENARM*. Online. Available: http://enarm.cifrhs.org.mx/ 11.Informes ENARM, Informe 2006 XXX ENARM. Accessed: March 20, 2007.

Once a student is successfully admitted into a specialty program, he must work in a residency program at a designated hospital while continuing his medical studies. Residency programs have an average duration of two years, but some specialties require more time.

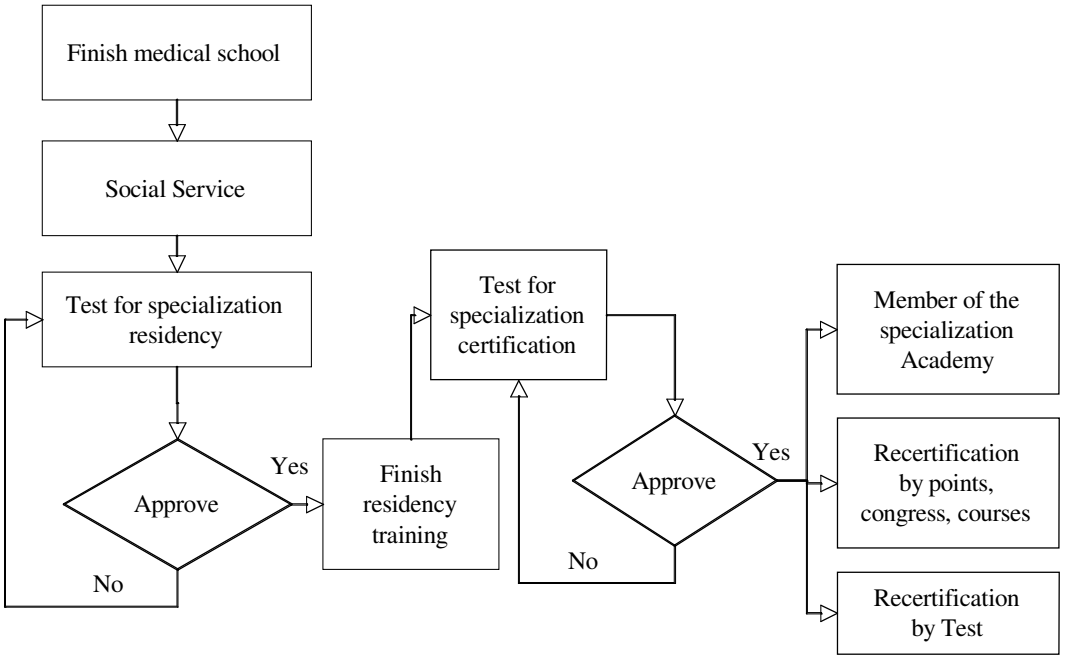
When the residency program is completed, a student must then take the test administered by the respective Specialty Council. The test must be approved by the *Comité Normativo Nacional de las Especialidades Médicas* (National Council of Medical Specialties), a mix of public and private agencies that ensures all students specializing in a medical area meet minimum standards. When approved, students receive their Certification by their

respective Specialty Counsel and become part of the *Academia Médica*, or Academy of Medicine. Students receive their diploma certification and their information is posted on the online directory at http://www.certificacionespecialistas.org.mx. This directory provides links for each specialty and almost all have the updated directory of the accredited physicians in alphabetical order. As of 2006, there were 81,792 certified physicians with a specialization, as recorded by the *Consejo Nacional de Especialidades Médicas*.[7]

Even if a medical student passes this test, goes through the abovementioned process, and begins practicing medicine, he must be recertified at least every five years, if not sooner, as dictated by his specialty requirements, to ensure each physician is up to date with the latest advances in medicine. The recertification process can be done in two different ways.[8] The first way for a physician to be recertified is simply to take the initial certification test that students just entering their specialty profession are taking. The second way is for a physician to attend a required number of training sessions, either in Mexico or abroad, to ensure he is current with all the advances in his area of specialty. Each Specialty Council gives the training sessions a certain number of points, depending on the breadth and scope of the session, and requires each physician to receive a minimum total number of points for all the sessions they attend in order to qualify for recertification. So, as can be seen, Mexico does have a system in place to ensure high-quality physicians who are up-to-date with the latest advances in their areas of medical expertise.

The aforementioned process is shown in Figure 10.2.

Figure 10.2
Specialization Process



Adapted from: Consejo Nacional de especialidades Medicans (CONACEM), *Talleres/ Recertificacion.* Online. Available: http://www.certificacionespecialistas.org.mx. Accessed: March 17, 2007.

Notes

[1] Guillermo Soberon, "The Expansion of Medical Education in Mexico and Initiatives in Accreditation", *Health Workforce Weed: Opportunities for U.S. Mexico Collaboration*, 2003 Proceedings and Background Papers, Center for Health and Social Policy, The LBJ School and Regional Center for Health Workforce Studies (San Antonio, December 2003), pp. 5-13.

[2] Presidencia de la Republica, *Decreto por el que se reforma el Segundo parrafo del articulo 81 de la Ley General de Salud* (Diario Oficial de la Federacion, October 22, 2003), p. 1.

[3] Consejo Mexicano para la Acreditacion de la Educacion Medica, *Proceso de acreditacion.* Online. Available: http://www.comaem.org.mx/ProcAcreditacion.html. Accessed: October 14, 2006.

[4] Presidencia de la Republica, Decreto por el que se reforma la *Ley General de Salud* (Diario Oficial de la Federacion, February 7, 1984, last reform June 6, 2006), pp. 30-33.

[5] Presidencia de la Republica, *Acuerdo por el que se crea la Comisión Interinstitucional para la Formación de Recursos Humanos para la Salud*. (Diario Oficial de la Federacion, October 19, 1983), pp. 1-4.

[6] Comision Interinstitcional para la Formacion de Recursos Humanos para la Salud, *Informe 2006 XXX ENARM*. Online. Available: http://enarm.cifrhs.org.mx/ 11.Informes ENARM, Informe 2006 XXX ENARM. Accessed: March 20, 2007.

[7] Consejo Nacional de Especialidades Medicans (CONACEM), *Articulos / Que son los consejos?* Online. Available: http://www.certificacionespecialistas.org.mx. Accessed: March 17, 2007.

[8] Consejo Nacional de Especialidades Medicans (CONACEM), *Talleres / Recertificacion.* Online. Available: http://www.certificacionespecialistas.org.mx. Accessed: March 17, 2007.

Chapter 11. Survey Findings

by Erin Daley

Introduction

As limited data is available on the U.S. retiree population in Mexico and their medical needs, the Policy Research Project class conducted an online survey from January 24, 2007, to April 6, 2007, in which U.S. retirees living in Mexico were asked to answer 45 questions relating to their retirement and the health care they receive in the United States and Mexico. Because of the lack of data on Americans retired in Mexico, it was not possible to conduct the survey with a random and representative sample. Nonetheless, efforts were made to advertise the survey to U.S. retirees throughout Mexico. In order to access potential respondents, the survey website was listed on the project website, electronic bulletin boards used by Americans living in Mexico, electronic newsletters, and in English newspapers in retiree communities in Mexico. Additionally, flyers with information on how to access the survey were left in the retiree communities of San Miguel de Allende, Cuernavaca, Los Barriles, and Cabo San Lucas. Lastly, e-mails were sent directly to approximately 400 individual retirees as well as over 20 e-mail listservs designed for Americans living in Mexico to share information.

We received a total of 1,025 valid responses from retirees originating in 48 U.S. states in addition to Washington, D.C., and living in 21 of the 32 Mexican states including Mexico City (see Table 11.1). The states of Jalisco, Guanajuato, and Sinaloa together made up for nearly 75 percent of survey responses with the communities of San Miguel de Allende, Mazatlán, and the area around Lake Chapala as the most represented in the survey.

On average, approximately 5 or 6 percent of respondents did not respond to each individual question on the survey. Thus, the percentages shown in this chapter represent the percentage of those who answered a given question. For more complete data on the exact survey questions and responses, please see Appendices C and D.

Respondent Demographics

Fifty-five percent of survey respondents who provided information on their sex were male and 45 percent were female. Their ages ranged from 31 to 101 years old, with an average age of 67. Slightly less than one-third of survey respondents were under 65 at the time of the survey. Most respondents were married and living in a two-person household and approximately half had incomes of $35,000 per year or less (see Table 11.3 for a breakdown of income by city of residence in Mexico). Nearly all (98 percent) of respondents providing information about their country of citizenship were U.S. citizens. Only a small percentage of the U.S. citizens had dual citizenship with Mexico or with another country.

Questions on Retirement

Of the survey respondents who answered the questions related to retirement, 91 percent were currently retired and 65 percent had worked in the United States for 31 years or more. Only 6 percent had worked in the U.S. for ten years or less, making them ineligible for Medicare on their own. Of those who were retired, slightly more than half (53 percent) of the respondents had been retired six years or more and slightly less than half (47 percent) had been retired for five years or less. With regards to their retirement income, 13 percent reported not receiving any type of retirement benefits, while 77 percent receive Social Security payments and 30 percent receive a pension from private employment. Other types of retirement benefits respondents reported receiving include benefits from the Veterans Administration, military retirement, teacher's or other state retirement benefits, and Individual Retirement Accounts (IRAs). Fifty-seven percent currently had coverage under Medicare part A, 46 percent under part B, 6 percent under part C, and 13 percent under part D. Thirty-one percent did not have any type of Medicare coverage.

Table 11.1
Respondents by State of Residence in Mexico

State	Number of Respondents	Percent of Total Respondents
Baja California Norte	12	1.2
Baja California Sur	31	3.0
Chiapas	1	0.1
Colima	2	0.2
Mexico City	27	2.6
Guanajuato	147	14.3
Guerrero	2	0.2
Jalisco	499	48.7
Michoacán	19	1.9
Morelos	45	4.4
Nayarit	1	0.1
Nuevo Leon	1	0.1
Oaxaca	19	1.9
Puebla	1	0.1
Querétaro	3	0.3
Quintana Roo	20	2.0
Sinaloa	117	11.4
Sonora	57	5.6
Veracruz	4	0.4
Yucatán	9	0.9
Zacatecas	2	0.2

No Response	2	0.2
Invalid Response	4	0.4
Total	1,025	100

Note: Because of the variety of communities in which retirees live, we have organized the responses by the state where the community is located. However, the original survey asked respondents to name the community where they lived. In the case of Puerto Vallarta, the survey option was stated as "Puerto Vallarta and vicinity." While Puerto Vallarta is located in the state of Jalisco and most retirees in the area live within the state of Jalisco, there are some retiree communities in the vicinity of Puerto Vallarta that are located in the state of Nayarit. All the responses of "Puerto Vallarta and vicinity" have been coded as Jalisco.

Table 11.2
Respondents by City of Residence in Mexico

City	Number of Respondents	Percent of Total Respondents
Alamos, Sonora	26	2.5
Cuernavaca, Morelos	41	4.0
Guadalajara, Jalisco	20	2.0
La Paz, Baja California Sur	22	2.1
Lake Chapala & vicinity, Jalisco	402	39.2
Mazatlán, Sinaloa	116	11.3
Mexico City, DF	27	2.6
Oaxaca, Oaxaca	18	1.8
Playa del Carmen, Quintana Roo	15	1.5
Puerto Vallarta and vicinity, Jalisco	66	6.4
San Carlos/Guaymas, Sonora	29	2.8
San Miguel de Allende, Guanajuato	137	13.4
Other	100	9.8
Invalid response	4	.4
No response	2	0.2
Total	1025	100.0

Note: The communities represented in the category of "Other" include the following: Akumal, Bajamar, Cancún, Chelem, Chuburna Puerto, Cozumel, East Cape, El Ranchito Salvador, Ensenada, Guanajuato, Ixtapa, Jalapa, Jerez, Kino Bay, La Ribera, Loreto, Los Barriles, Los Cabos, Manzanillo, Melaque, Mérida, Mineral de Pozos, Monterrey, Morelia, Pátzcuaro, Puebla, Puerto Escondido, Querétaro, Rosarito, San Antonio Tlayacapan, San Crisanto, San Cristóbal, San Felipe, San Juan Cosala, San Luis de la Paz, San Luis Soyatlán, Santa Clara del Cobre, Sayula, Teacapan, Tepic, Tepoztlán, Tequisquiapan, Tlachichilco, Tuxpan, and Zacatecas.

Table 11.3
Respondents' Annual Income by City of Residence in Mexico

City of Residence in Mexico	Respondents providing data on income	Under $15,000	$15,001-$25,000	$25,001-$35,000	$35,001-$45,000	Over $45,000	Total
Alamos, Sonora	25	12%	12%	16%	28%	32%	100%
Cuernavaca, Morelos	37	16%	16%	19%	8%	41%	100%
Guadalajara, Jalisco	17	12%	29%	18%	6%	35%	100%
La Paz, Baja California Sur	20	20%	5%	40%	10%	25%	100%
Lake Chapala and vicinity, Jalisco	372	11%	21%	20%	12%	36%	100%
Mazatlán, Sinaloa	103	9%	21%	21%	20%	28%	100%
Mexico City, Distrito Federal	21	10%	10%	10%	5%	67%	100%
Oaxaca, Oaxaca	15	13%	33%	7%	7%	40%	100%
Playa del Carmen, Quintana Roo	24	13%	4%	13%	8%	63%	100%
Puerto Vallarta and vicinity, Jalisco	61	10%	16%	20%	8%	46%	100%
San Carlos/ Guaymas, Sonora	26	19%	19%	15%	12%	35%	100%
San Miguel de Allende, Guanajuato	128	14%	22%	13%	14%	37%	100%
Other	86	14%	36%	20%	17%	13%	100%

In order to respond to the survey, respondents were required to live in Mexico at least one month out of the year. Nonetheless, only 4 percent spent 1-3 months per year in Mexico, while 73 percent lived in Mexico most of the year (10-12 months). The amount of time respondents had been living in Mexico varied greatly, although many respondents had begun living in Mexico fairly recently. Thirty-nine percent reported having lived in Mexico for three years or less, while 15 percent have lived in Mexico for 13 years or more. The most important reason respondents stated for living in Mexico was cost of living (44 percent), followed by climate (32 percent).

When asked at what age they planned to return to the United States permanently, respondents overwhelmingly (86 percent) stated that they did not plan to return to the United States permanently. However, in a follow-up question in which those who were planning to return to the United States were asked why, several comments indicated that those who were not planning to return recognized that it may be economically or logistically necessary to return to the United States if their health deteriorated. Among those who stated their reasons for planning to return to the United States, the most

common response was health, which was mentioned by 71 percent of respondents as a reason. Twenty percent of respondents mentioned Medicare specifically. The second most common response was family, which was mentioned by 31 percent of respondents.

Questions on Health

When asked whether they had an established source of care in Mexico or in the United States, 48 percent reported having an established source of care in Mexico, while a slightly higher percentage (56 percent) reported having an established source of care in the United States. Respondents were also asked how many total days they had spent in inpatient care in a Mexican or a U.S. hospital and how many times they had visited a doctor in Mexico or the U.S. over the past three years. Respondents had spent slightly more time in a Mexican hospital than in a U.S. hospital (20 percent had spent at least one day in a Mexican hospital while only 17 percent had spent at least one day in a U.S. hospital) and had visited a doctor in Mexico slightly more than in the United States (39 percent had visited a doctor in Mexico six or more times whereas only 27 percent had visited a doctor in the U.S. six or more times). See Figures 11.1 and 11.2.

Figure 11.1
Total Days in a Hospital in Mexico or the U.S. in the Past Three Years

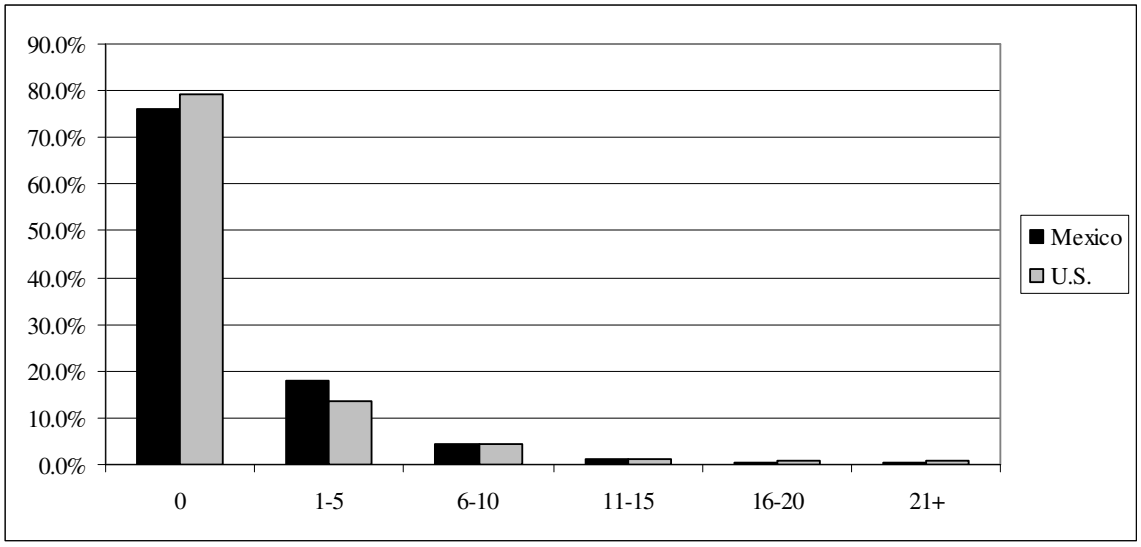
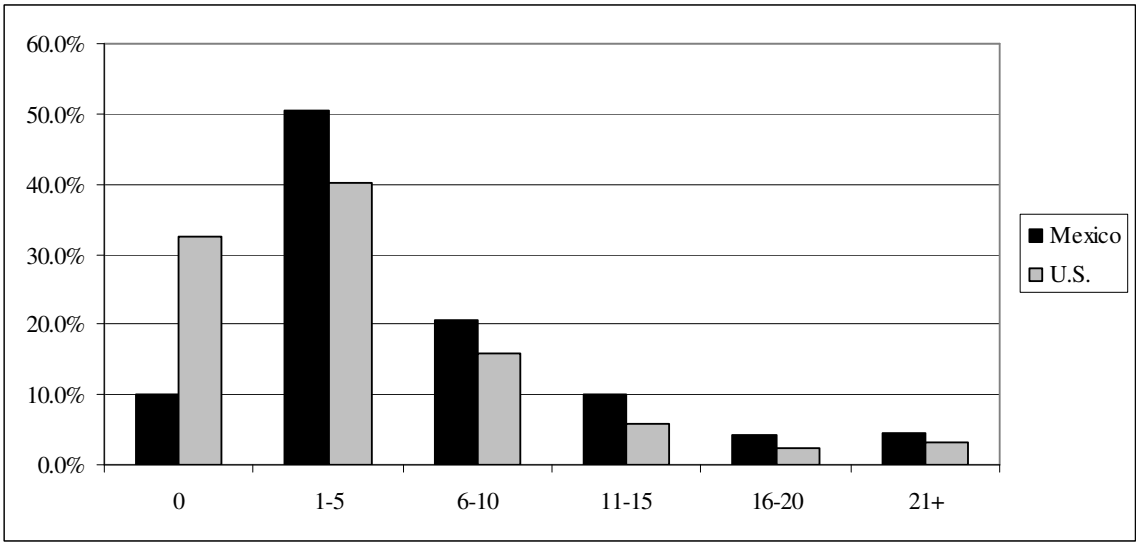


Figure 11.2
Total Visits to a Doctor in Mexico or the U.S. in the Past Three Years



Respondents were also asked where they would seek treatment in the event they needed to be hospitalized. Of those responding to this question, 59 percent said Mexico, while 32 percent said the U.S. and 9 percent marked "other." Of those marking other, many commented that it would depend on factors such as where s/he was at the time as well as what type of health problem s/he was suffering. However, when asked if they would return to the United States in the event of a serious illness, 66 percent said yes, while only 34 percent said no, indicating that fewer individuals would remain in Mexico if their need was more long-term. Sixty-eight percent of male respondents reported that they would return to the United States for care while only 61 percent of female respondents reported that they would do so. Respondents over 65 were more likely to report that they would return to the United States for care than those under 65 (see Figure 11.3). Similarly, those who had traditional Medicare coverage (Part A) were more likely to report that they would return to the United States for health care services than those without Part A coverage. Seventy-five percent of those with Part A coverage report that they would return while only 44 percent of those without Part A coverage report that they would return. Of those who said they would return to the United States, the most important reason (reported by 78 percent of respondents) was coverage in the United States, including Medicare coverage. Table 11.4 presents data on the percentage of respondents who say they would return to the United States in the event of a serious illness by state of residence in Mexico.

Figure 11.3
Percent of Respondents Who Would Return to the U.S. for Care by Age

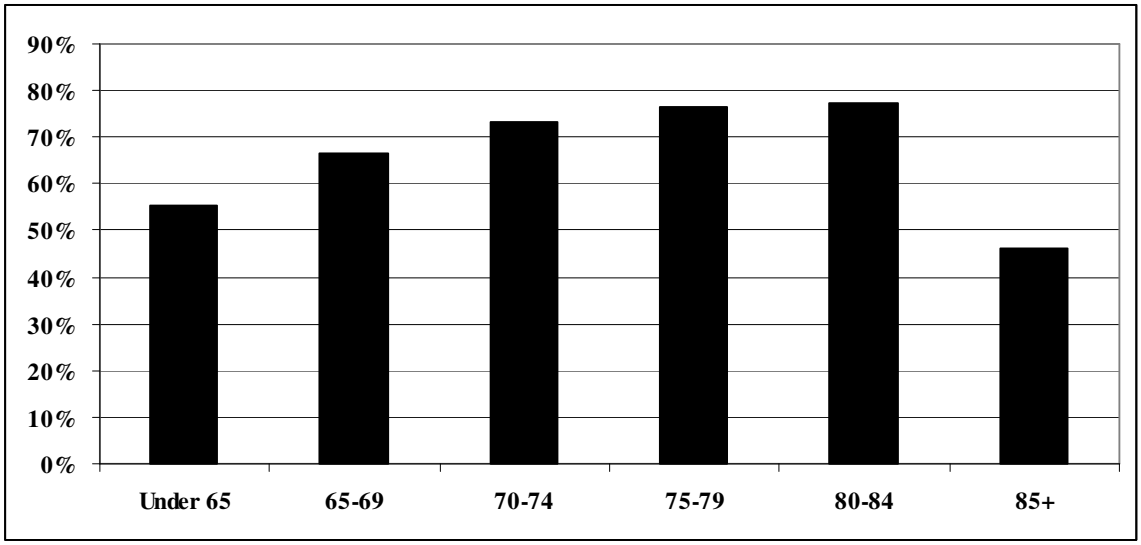


Table 11.4
Respondents Who Would Return to the U.S. for Care by State of Residence in Mexico

	Respondents providing data on whether they would return to the U.S. in the event of serious illness	Yes	No	Total
Baja California Sur	30	77%	23%	100%
Mexico City	24	67%	33%	100%
Guanajuato	140	72%	28%	100%
Jalisco	475	61%	39%	100%
Morelos	41	61%	39%	100%
Sinaloa	107	65%	35%	100%
Sonora	54	80%	20%	100%
Other	91	71%	29%	100%

In order to ascertain how retiree behavior would change with respect to where they seek their health care if Medicare benefits were available, they were asked how much of their hospital services and physician services are currently consumed in Mexico and how much they would consume in Mexico if Medicare Parts A and B were available in Mexico respectively. In both cases, respondents indicated that they would consume a

significantly greater proportion of their health care in Mexico if Medicare were available (see Figures 11.4 and 11.5).

Figure 11.4
Percentage of Required Physician Services Consumed in Mexico

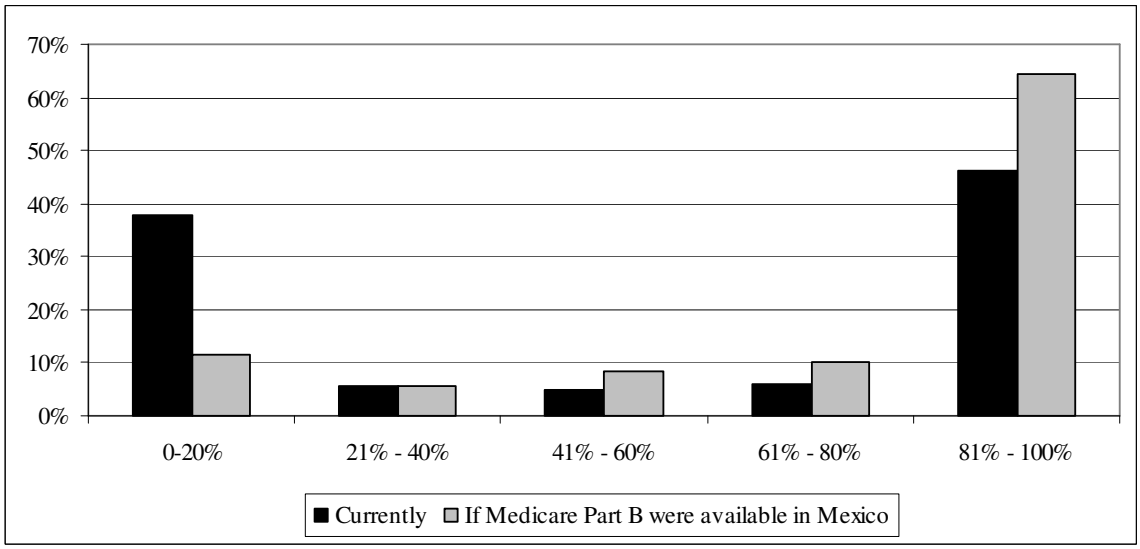
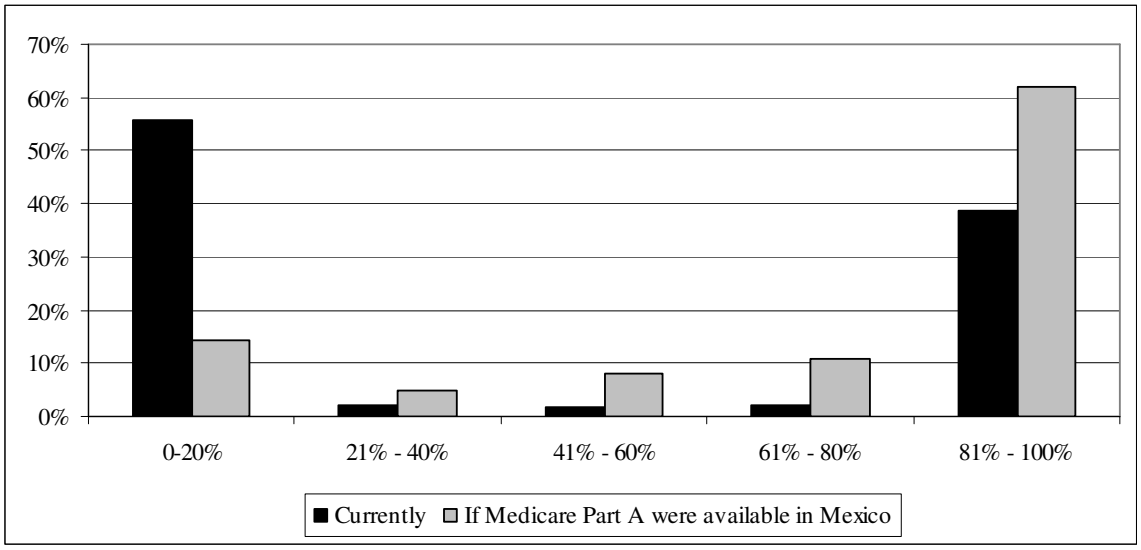


Figure 11.5
Percentage of Required Hospital Services Consumed in Mexico



While the survey did not contain any questions expressly addressing how retirees felt about the quality of health care in Mexico, this issue was addressed by many respondents in the open-ended questions. In particular, in one survey question that asked respondents to provide any additional information they would like regarding their experiences with health care in Mexico, approximately 60 percent addressed issues of quality. Of these responses, 98 percent expressed the view that quality of care in Mexico was adequate, good or excellent, while only 2 percent expressed the view that the quality of care in Mexico was poor. It is important to note, however, that many of the comments specified a location within Mexico where they had had good experiences with care. In addition to comments directly addressing the quality of care, many respondents were pleased at the level of personal attention they received from doctors in Mexico, citing the practice of making house calls and the ability to make appointments without having to wait a long time to see the doctor as major advantages to receiving health care in Mexico. Many respondents also commented on the lower cost of care in Mexico. Figure 11.6 presents a sample of responses to this open-ended question. (See Appendix D for a full list of these responses.)

Figure 11.6
Comments Regarding Care in Mexico

- I have found that medical care in Mexico is comparable to that in the United States and the nursing care is even better than in the U.S. And I am comparing Mexico against world-class Manhattan hospitals in New York City.
- I feel very good about the level of care I receive here and the expertise of the doctors. I feel they spend more time with me and care about me personally.
- I have had four surgeries in Mexican hospitals. The hospitals, doctors, and care were excellent... better than I would receive in the States and much cheaper.
- Mexican medical care is more personal and more satisfying. The doctors even give you their home phone number and will come to your home if you are unable to travel. And, it is so much cheaper.
- My husband was in Hospiten Hospital in Cancun for a week and received excellent care. All of their equipment is new. I am a nurse and know that he would not have received any better care in the U.S.
- My Mexican doctor spends 30 minutes (not rushed) with me and charges $15. If Medicare was available, the red tape would drive up costs.
- Overall, I have been very impressed with the health care in Mexico. Even though I am no longer on a health insurance plan, I often find that the care here costs less than my insurance copays in the U.S.
- You get what you pay for in Mexico—good care is expensive. In the U.S. all care is expensive.
- I believe that routine care in San Miguel de Allende is better than routine care in Cleveland, Ohio. Physicians here take time to really talk with you and explore alternatives. They also make house calls.
- Medical care is excellent in Mexico and much cheaper than in the U.S. We'd save money by paying the bill in Mexico rather than the higher U.S. rates. Covering retirees in Mexico seems to be a no-brainer!
- The medical care I have received in Mexico City has been outstanding, and much less expensive than in the U.S. I had successful surgery on a herniated disk at Hospital Angeles in Mexico City in 2003.

Conclusions

While Americans retired in Mexico are a heterogeneous group living in varied communities across the country, this survey indicates that most Americans living in Mexico are pleased with the health care services they receive. However, many continue to return to the United States for care due primarily to insurance and Medicare coverage that can only be used in the United States. If Medicare benefits were available to retirees living in Mexico, it is likely that many retirees would seek health services in Mexico that they currently seek in the United States.

MEXICO

1. Los Cabos, Baja California Sur
2. Los Barriles, Baja California Sur
3. Puerto Vallarta, Jalisco
4. Guadalajara and Lake Chapala, Jalisco
5. San Miguel de Allende, Guanajuato
6. Cuernavaca. Morelos

Chapter 12. Retiree Communities in Mexico

Compiled by Jennifer Nading

Introduction

The U.S. Department of State estimates that there are over one million U.S. retirees residing in Mexico and this number is increasing each year.[1] Many choose Mexico as their new residence due to the country's climate, cost of living, and relaxed lifestyle. Whether they seek the city life filled with art and its amenities or they prefer a smaller town along the coast, there are a number of locations in Mexico that offer a variety of communities for U.S. retirees and expatriates. Although we were unable to complete field research for each major locale, we have collected information pertaining to retiree living for a number of these communities including Puerto Vallarta, Guadalajara, Lake Chapala, Cuernavaca, San Miguel de Allende, and regions of Baja California Sur (Cabo San Lucas, San José del Cabo, and Los Barriles).

Nuevo Vallarta, Nayarit, and Puerto Vallarta, Jalisco

by Alex Gunter and Michelle Lalonde

Puerto Vallarta and Nuevo Vallarta are located on the Banderas Bay in the heart of Mexico's Pacific coastline in the states of Jalisco and Nayarit. Residents of Puerto Vallarta enjoy a tropical climate year-round with average temperatures of 80 degrees Fahrenheit.[2] The total population for the municipality of Puerto Vallarta is 220,368.[3] Estimates from the U.S. Consular Agent in Nuevo Vallarta put 6,000 Americans as registered residents.[4] It is widely believed that the number of Americans residing in Puerto Vallarta would be increased if "snowbirds" were counted. This is the term used to refer to people who live part of the year in the United States and the rest of the time in Mexico. The hot summer in the greater Vallarta region and cold winters in the northern parts of the United States results in many retirees owning two homes and spending the winters in Mexico and the summer in the U.S. Many American retirees begin as snowbirds and later buy property and retire full-time to the Greater Vallarta area. The U.S. Consular Agent believes that there are an additional 6,000 Americans who are part-time residents and not registered with the Consulate.[5]

The number of Americans choosing to retire to Puerto Vallarta is increasing, as evidenced by the growth in real estate developments and upgrades to medical facilities over the last five years. While millions of North Americans travel to Mexico each year, it is estimated that 400,000 have purchased second homes there.[6] As some retirees in Puerto Vallarta told us, buying a second home or timeshare for a few years was the first step to eventual retirement in Mexico. Though property prices have gone up a bit, property taxes are still quite low, making retirement in Mexico a good option for any senior but especially those looking to stretch their dollar. In the March/April 2004 issue of AARP's magazine, Barry Golson reported that, "For 600 bucks a month, retirees in

Mexico can live in a three-bedroom home, with a gardener. For a cool thousand...well, you won't believe it."[7]

Virtual Vallarta reports that the past three years have seen steady growth in the region to the extent that developers, realtors, and buyers are having a difficult time keeping up. In the nearby Village of Chacala the intense rush of construction and developments is likened to the Westward Expansion of the United States, according to a recent Washington Times article. In it, Mindy Christie, a retired teacher from Modesto, California, draws the likeness saying, "I compare it to the Wild West, only instead of Conestoga wagons, the settlers are coming in RVs." Mrs. Christie and her husband, also a teacher, are currently renting in Chacala on a budget of $2,500 per month.[8] New Mexican laws protecting foreign investment have also fueled the development. One of several companies selling title insurance to foreign investors, Stewart International, reports having insured $3 billion to $4 billion worth of property in Mexico in 2001, mostly for American and Canadian buyers.[9] Chief Executive of Stewart International Michael Skalka assures investors that, "Buying property in Mexico is safe, with competent legal counsel and title insurance."[10] Overall real estate sales in Banderas Bay seem to be upwards of USD $550 million, a significant increase from USD $400 million in 2004. Growth in sales should be anticipated in part due to the new financing options available for home purchases in Mexico. In December 2006, GMAC International Mortgage announced that it would offer 30-year fixed-rate mortgages for second and retirement homes in Mexico at 8.75 percent, the first lender to do so.[11]

One of the many communities sprouting up along the coast is the Sensara Vallarta, just north of Puerto Vallarta. Designed for "active adult living," Sensara Vallarta will offer 250 adult homes. The project is being run by Active Living International, a specialized consulting and management group focused on developing active style retirement communities, paying special attention to international projects.[12] After a careful feasibility study conducted for CEMEX, a Mexican cement company, Active Living was able to identify the Greater Vallarta area as an ideal location for a retirement community. The main draws to the area, according to David P. Collins, Managing Partner and Director of Active Living International, are the fact that Vallarta is easily accessible with more than 15,000 flights a year at affordable rates, and the affordability of developing there in the range of the target buyers.[13] The Front Porch Development Company, California's largest non-profit provider of senior living communities, is working with Mexican based Grupo Krone to develop a similar retirement community in an adjoining area called Luma.[14]

It is clear that the real estate and development industries believe that the growth potential for American and Canadian owners is large enough in the Greater Vallarta Area to invest large amounts of money into homes and communities catering to their investor's lifestyles. The large number of these communities that are directed towards senior citizens are also a good indication of the retirement growth expected in the area.

Health Care in Greater Vallarta

Health Care in the Greater Vallarta area has developed with the increase in tourism and migration to the area. Many new American-style hospitals have sprouted up in recent years and renovations of older hospitals are underway.

Puerto Vallarta has a public IMSS hospital. In addition there are several private hospitals and some smaller clinics. Americans interviewed in the area said that care is just as good in Mexico, if not better than in the United States. In fact, some believe that the care is better due to the personal attention of the doctors, an element of medical care often missing in the United States.[15] According to Kelsey Magnus, an American real estate agent who has been living in Mexico for many years, many people choose which hospital to attend based on language: if they are comfortable with Spanish, a less expensive hospital will do, but if they do not speak Spanish, they must pay extra to go to a bilingual hospital.[16] The major private hospitals in the area are Cornerstone, AmeriMed, Medasist, and CMQ. Prudential California Realty (Vallarta Division) offers new buyers in the Vallarta area a list of these hospitals, the insurance they accept, and their average fees.

Cornerstone Hospital

Cornerstone Hospital is a new facility, built in 2005. Pamela Thompson, Patient Services Coordinator/International Service at Cornerstone, estimates that 50 percent of the hospital's patients are American.[17] An initial tour of the facility showed it to be a clean, inviting facility with friendly staff. It has a Level Four Emergency Room, 20 private rooms, a 10-bed pre-op/recovery room, a five-bed nursery with neonatal, pharmacy, radiology, a laboratory, a dental unit, and a cafeteria. They offer almost all services including MRI, CAT scans, mammograms, cardiac catheters, angioplasty, chemotherapy, pacemakers, dialysis, and plastic surgery. Although the hospital is capable of doing many of these procedures, the doctors and equipment used often must come from Guadalajara. This means that with only a few exceptions, surgeries must be scheduled and organized ahead of time and emergency surgery is not available. Thompson also said that the top reasons Americans visit the hospital are 1) food poisoning, 2) gastroenteritis, 3) cardiac issues, and 4) plastic surgery.[18]

Cornerstone is an open hospital, meaning that most physicians, with the exception of emergency room doctors, are not on staff. They rent space from the hospital, which owns all the equipment. Most major insurance policies and travel policies are accepted and Cornerstone is now (as of January 2007) working with TRICARE for U.S. veterans.[19] Patients are billed separately for the hospital and for the doctor. The average medical consultation fee is $400.00 Mexican pesos, or USD $36.40, and the average dental consultation and cleaning fee is the same.[20]

AmeriMed Hospital

This is a well-equipped, inviting facility. In the waiting room, doctors can be found coming out to get their patients and sitting and talking with patients one on one. Furthermore, the staff is said to be completely bilingual, combining Mexican and

international medical standards. AmeriMed claims specialized care in emergency medicine, having an onsite staff of specialists in the field of emergency medicine, critical care medicine, internal medicine, general surgery, cardio-thoracic and vascular surgery, and an on-call staff of specialists in neurology, neurosurgery, cardiology, ENT, ophthalmology, dermatology, pediatrics, gynecology, trauma, and orthopedics, all of them available 24/7. Facilities such as orthopedics, x-ray, ultrasound, CAT scan, laboratory, and operating room are available, in addition to laparoscopic and arthroscopic equipment, shock room, trauma room, and an intensive care unit.[21]

Dr. Roberto Garcia Graullera, the Medical Director of AmeriMed Puerto Vallarta, is responsible for determining that all physicians at AmeriMed are emergency care certified. On staff there are two ER doctors, one general physician, one thoracic and cardio physician, and the medical director. In 2006, the AmeriMed Puerto Vallarta had a total of 6,739 patients, with Americans making up 22 percent of this figure.[22] The only procedures that they are unable to do on-site are angiograms, cardiology procedures, and neurology procedures.[23]

According to the information distributed by Prudential California Realty (Vallarta Division), AmeriMed is able to accept a wide variety of insurance including RBC Insurance, Assured Assistance, World Access, World Access Canada, One World Assistance, and Worldwide Mediclaim. They are also the preferred provider for Blue Cross Blue Shield Insurance through World Access and World Access Canada. Recently, they signed an agreement with Ambassador Care in Washington, D.C., to provide the medical services for Medicare insurance as of 2007.[24]

The average medical consultation fee is about $350.00 Mexican pesos. The average dental fees are $500.00 Mexican pesos.[25]

AmeriMed is currently constructing an additional hospital in Puerto Vallarta, which is expected to open in 2008. This new facility will have a total of 29 beds, an operating room, and four exam rooms. The hospital's services and technology will include a laboratory, X-ray, CT scan, ultrasound, fluoroscopy, mammography, MRI, catheter lab, and dialysis.[26]

Medasist Hospital

Medasist Hospital accepts medical policies from One World Assist, World Access Canada, World Wide Mediclaim, Travel Guard International; Managed Care of America, International SOS, Medex Assistance Corporation, CIGNA International, World Access Inc., BUPA International, Global Excel Management, AETNA Inc., CanAssistance Canada, Assured Assistance Inc., RBC, Global Medical Management Inc., AMEDEX Insurance Company, Carnival Cruise Line Pride, MEDSAVE International Insurance, and International Medical Group MG.

Consultation fees are from $400.00 Mexican pesos. No dental treatment is available.

CMQ Hospital

Fully specialized, equipped, and staffed with bilingual personnel, CMQ hospital has contracts and agreements with American, Canadian, and European health insurance companies including Aetna, RBC Insurance, Blue Cross Blue Shield Association, Sigma Assistel, Worldwide Assistance, Universal Assistance, Desjardins, MCARE, WTPAssist, TOUR*MED Assurance-Voyage, Mondial Assistance, BCAA, GlobalExcel, TRIP ASSURED, CanAssistance, BlueCard Worldwide, WORLD ACCESS, OneWorldASSIST, AXA Assistance, ACA Assurance, TIC travel insurance, MEDEX, KAISER Permanente, TD Insurance, InterGlobal Allianz, GNP, Zurich, VITAmerdica, and several others.

CMQ Hospital's emergency and trauma departments claim a commitment to excellence. The hospital boasts of the high quality of their board-certified physicians. The experience of the emergency service teams at CMQ, who are capable of diagnosing and managing life-threatening conditions, are also vital to the success of CMQ.

On average, a medical consultation fee is $400.00 Mexican pesos, with no dental service available.

Retiree Perspective

The Americans we interviewed in the Greater Vallarta area generally feel quite comfortable with health care in Mexico. They recognize the cost-saving benefits and use Mexican health care as much as possible. Two retirees interviewed in Puerto Vallarta indicated that insurance is the limiting factor to how much Americans use medical care services in Mexico. In one case, the retiree and her husband get all care in the United States with the exception of minor illness because they only carry Medicare with supplemental Blue Cross Blue Shield. Routine doctor visits are scheduled to coincide with holidays and other trips to the United States to save time and money on travel. The other carries a private international insurance, International Health Insurance (IHI), and received all of her care in Mexico.[27] Coverage through IHI includes worldwide coverage with complete freedom of choice concerning specialists and hospitals; full coverage regardless of job, leisure interests and sports activities; coverage of chronic conditions in full if diagnosed after enrollment or if accepted by IHI; coverage of accidents resulting from terrorist acts; and guaranteed renewal of the policy for life, regardless of age and state of health.[28]

Another important concern to Americans receiving medical care in Mexico is prescription medications. While pharmacists can be found widely in Mexico, they may not accept insurance and they also may not carry the needed medications. David Lord of Veterans Affairs in Puerto Vallarta claims that the Veterans Administration cannot ship prescription medications to eligible veterans in Mexico due to the *aduana* (customs) charge of 50 percent at the border.[29]

An additional challenge is the lack of home health care services and assisted living facilities.

Retirees in Puerto Vallarta

In addition to the U.S. Consular Agent's estimates of roughly 6,000 snowbirds on top of the 6,000 American retirees that are registered with the local government as residents,[30] the 45 and older American population was estimated to be around 15,000 to 20,000.[31] Of the American retiree population in the Puerto Vallarta region, one estimate put the percentage of American snowbirds closer to 75 percent than 50 percent.[32] These snowbirds leave Puerto Vallarta during the summer months, from June through October, when temperatures reach into the 90s (Fahrenheit).[33]

The increasing availability of better medical care combined with the real estate developments has attracted American and Canadian expatriates and retirees. The English-speaking community is very active in the Puerto Vallarta region. There are two English-language newspapers in the region, *Vallarta Today* and the *Vallarta Tribune*. Both cater to the existing expatriate community as well as new arrivals, with directories for organizations and important contacts along with news articles, advertisements, and maps for local restaurants, shops, real estate, and other businesses.

Among the organizations listed in these publications is the *International Friendship Club*, the largest group with primarily senior American and Canadian expatriates. Various other charitable and social organizations exist, as listed in *Vallarta Tribune's* Directories section on the back pages.[34]

American retirees come to Puerto Vallarta for many reasons, but once they arrive they integrate well with the local community. Retirees become involved in charitable organizations and make efforts to learn Spanish. Some abandon any desire to return to the United States while others continue to make routine visits back home to visit family, friends, and their doctors.[35]

Lake Chapala, Jalisco

by Karla Vargas

Lake Chapala is Mexico's largest natural lake and is about 55 miles long and 15 miles wide.[36] The area is known for its biodiversity and is home to hundreds of plant and animal species, many of which are not found anywhere else. With an average temperature of 67.82 degrees Fahrenheit, the "lakeshore climate is one of the best in the world according to a National Geographic survey."[37] The area's natural beauty and its close proximity to Guadalajara (45 minutes), Mexico's second-largest city, makes the Lake Chapala region an ideal setting for retirees. These retirees mostly live in the more populated towns of Chapala and Ajijic, but these populations are extending to the surrounding towns including San Antonio, San Juan Cosala, Jocotepec, and San Cristobal. As of 2005, the Lake Chapala region had an approximate total population of 45,345 people.[38] The number of Americans living in the region is increasing and estimates vary widely, mainly due to the fact that most Americans do not register with the U.S. Embassy. The Migration Policy Institute states that there are 3,407 U.S.-born seniors in the towns surrounding Lake Chapala.[39] The Lake Chapala Society (LCS), an

organization consisting of foreigners retired in the Lake Chapala region, has a membership of about 3,000 mostly Canadians and Americans scattered throughout the many small towns that make up the region.

Health Care in the Lake Chapala Area

Due to its close proximity to Guadalajara, most Lake Chapala residents go to hospitals in Guadalajara if they need more extensive medical treatment. The Lake Chapala region itself does not have a hospital, but residents can receive medical services through several other options. Some doctors in the area make house calls for ill patients at a fraction of the cost that such a service would be in the U.S. In addition, residents also visit local pharmacies, many of which have nurses on staff to diagnose and treat minor illnesses. The main problem for residents in this region arises when major and/or emergency treatment is necessary. Residents must travel the 45 minutes to reach a fully equipped hospital in Guadalajara if the need arises; the lack of an efficient ambulance response team further exacerbates the situation.

Nursing homes are common in the tranquil towns surrounding Lake Chapala. Since nursing home care in the United States is so expensive, many retirees see the nursing home care in Mexico as a great alternative. Three nursing homes in the area are owned and operated by a nurse, who, prior to opening these homes, worked at Hospital del Carmen. For the past 16 years, the owner has been operating these nursing homes that serve mostly foreign seniors, many of them American, but also many from Canada, Germany, and Holland. The nursing homes are fully staffed with nurses and nurse's aides that have been trained by the Red Cross for six months before caring for the 24-28 residents housed in the three homes. Seniors are usually admitted to a home on a sliding scale, depending on how much they can pay and how much care they need. An average senior at the home usually pays between $1,000-$1,300 per month and all residents pay cash since the homes do not yet accept private insurance, since they have no experience with it.[40] Residents in these nursing homes have varying needs ranging from cancer and Alzheimer's disease to retirees who are still able to function relatively independently but need supervision. All three of the nursing homes are certified by the Mexican *Secretaría de Salud*, and *Consejo de Salubridad General*, a governmental entity that routinely inspects these facilities to ensure proper care is given to residents and that protocol is followed.[41]

Retirees in the Lake Chapala Area

Americans living in the Lake Chapala region enjoy the tranquility and activities that the area provides. The weather in the Chapala region lends itself to many outdoor activities that provide a high quality of life for all of its residents. When Americans want to be in a fast-paced city, they travel to Guadalajara to visit museums, the theater, and to enjoy what Mexico's second-largest city has to offer. Most Americans are members of LCS, and the organization provides a community for expatriates to adjust to life in a foreign country by facilitating their integration into Mexican culture through learning and interaction. LCS also provides foreigners a physical space to get together and enjoy outdoor activities, such as the lush tropical garden LCS members maintain. On these

same grounds, LCS has a library and bookstore for its members. Aside from these LCS member-specific activities, LCS also provides scholarships to Mexican students through fundraisers and donations, sponsors community events, provides English classes to local residents, and provides many events and social services for the American retirees in the area.[42]

Guadalajara, Jalisco

by Marina Zolezzi

Guadalajara is the capital city of Jalisco, Mexico. The city is located in the central region of Jalisco. In 2005, Guadalajara's population was reported to be about 1,600,940.[43] The population for Guadalajara's metropolitan region is about 4,100,000, making it the second most populated metropolitan region in Mexico.[44] The metropolitan area of Guadalajara includes the municipalities of Guadalajara, Zapopan, Tlaquepaque, and Tonalá. Guadalajara enjoys temperate climate with an average temperature of 67 degrees Fahrenheit.[45] Guadalajara is known for its cultural wealth, beautiful architecture (both historic and modern), renowned universities, and commercial development. The capital city is home to numerous hospitals, clinics, and physicians. The city's combined features not only attract tourism but provide a viable option for many foreigners to retire.

The U.S. Embassy in Guadalajara estimates that there are about 50,000 resident U.S. citizens in the Guadalajara metropolitan area.[46] Lake Chapala, an area that is home to many U.S. retirees, is within a short driving distance from Guadalajara. Many retirees from the Lake Chapala region depend on the health care facilities available in Guadalajara.

Health Care in Guadalajara

Guadalajara has many certified and well-established hospitals. The hospitals in the Guadalajara metropolitan area that are certified by the Mexican *Secretaría de Salud* are Hospital Bernardette, Hospital Country 2000, Hospital de la Santísima Trinidad, Hospital Ángeles del Carmen, Hospital México Americano, Hospital San Javier, and Sanatario San Francisco de Asís.[47] Other hospitals in the Guadalajara metropolitan area include Hospital Real San José, Hospital Puerta de Hierro, Hospital Santa María Chapalita, Hospital Jardines de Guadalupe, Hospital Americas, and Hospital Terranova.[48] The following is a brief description of three hospitals: Hospital Angeles del Carmen, Hospital Puerta de Hierro, and Hospital Mexico-Americano, which have been frequented by Americans for their health care needs due to their advanced technology and English-speaking physicians.

Hospital Ángeles del Carmen

Hospital del Carmen was started in the 1940s as a maternity hospital.[49] The hospital was purchased by Grupo Ángeles in September 1999 and is known today as Hospital Ángeles del Carmen.[50] At least 90 percent of the doctors within Hospital Ángeles del Carmen are board-certified.[51] Some of these physicians also work part-time at other health facilities, such as in the IMSS hospitals.[52] According to the doctors interviewed from Hospital

Angeles del Carmen, U.S. retirees that are treated at their hospital are often recommended by other retirees within their communities.[53] The main medical treatment received by U.S. retirees from Hospital Angeles del Carmen include hip, knee, and gallbladder surgeries, hernia repairs, peptic ulcers, and carcinoma treatment.[54]

The average cost for a private consultation in Hospital Angeles del Carmen is USD $45.00 per patient.[55] The doctors mentioned that the hospital is willing to negotiate hospital rates with the insurance companies. The hospital does accept TRICARE however, it was noted that TRICARE payments have been problematic because of the recent decrease in the amounts that have been provided by TRICARE for each patient's medical needs.[56] The doctors believe that about 6-7 percent of the population in Mexico are privately insured and that there has been an increase in the use of private insurance from the following companies: MetLife, Seguros Monterrey New York Life, Grupo Nacional Provincial, Best Meridian, and Blue Cross Blue Shield Insurance Co.[57] They also added that expatriates with limited coverage usually plan to return to the United States for major medical treatment.

Hospital México-Americano

Hospital México-Americano was started by an American, Dr. Edward Lamar Cole, with the help of the National Baptist Convention, in the late 1950s.[58] Hospital México-Americano is certified by the Mexican *Secretaría de Salud*; the hospital was in the process of obtaining the ISO 9001, maintained by the International Organization for Standardization.[59] According to Dr. Jose Luis Solis Davila, Sub-Medical Director for Hospital México-Americano, the hospital is the vanguard for neurology and cardiology.[60] The hospital has 81 beds, 12 intensive care beds, MRI capacity, and provides advanced trauma support. Hospital Mexico-Americano has a special program with automobile insurance companies for automobile accident victims.[61] The hospital has treated U.S. veterans, individuals referred by the U.S. consulate in Guadalajara, and U.S. retirees. The most common insurance company used by the hospital's foreign patients is Blue Cross Blue Shield.[62] The hospital also accepts payments from the VA's Foreign Medical Program. Hospital Mexico-Americano has maintained a close relationship with the Baylor Hospital in Dallas, Texas, and has worked with them for training and development purposes.[63]

Hospital Puerta de Hierro

Hospital Puerta de Hierro is one of the newest hospitals in Guadalajara; its original outpatient center opened in 2004.[64] The hospital was founded by a group of ophthalmologists with an outpatient surgery center and their corresponding medical offices. Due to the increase in demand for the care that was provided at the outpatient center, the hospital was created and opened in 2006.[65] The physicians' offices are condos, many of which have been sold to the physicians who work there. The hospital is housed in two separate towers having 210 offices, 12 surgical rooms, 130 beds, catheter labs, and imaging centers.[66] Hospital Puerta de Hierro currently has about 320 doctors on its medical staff, including ophthalmologists, gynecologists, and pediatricians. The hospital has performed 17,500 surgeries.[67] Ophthalmology accounts for a high

proportion of total care since the inpatient facility has only recently opened. Hospital Puerta de Hierro has about $15 million of medical equipment.[68] The hospital maintains a working relationship with the Universidad Autónoma de Guadalajara.

In regards to hospital funding, the hospital receives 90 percent of its payments through private pay and 10 percent from IMSS and ISSSTE contracts. Of all private care, it was estimated that about 30 percent consisted of insurance payments and 70 percent consisted of out-of-pocket payments. Regarding inpatient care, the percentages are reversed with 30 percent consisting of out-of-pocket payments and 70 percent consisting of insurance payments.[69] The hospital has worked with 25 insurance companies, some of which include Blue Cross Blue Shield and TRICARE. According to the doctors from Hospital Puerta de Hierro, Chapala residents have used Blue Cross Blue Shield and TRICARE (which the hospital reluctantly accepts). The two entities take about four to six months to pay, leaving the hospital with the burden to cover the expenses until reimbursement is provided.[70] The hospital administrators are willing to provide a discount on the price of certain procedures depending on the volume of patients under an insurance entity; the more patients there are under one specific insurance entity, the higher the discount a patient would receive.[71]

Retirees in Guadalajara

As previously mentioned, the U.S. Embassy in Guadalajara estimates that there are about 50,000 resident U.S. citizens in the Guadalajara metropolitan area.[72] In 2000, over one-fifth of the U.S.-born seniors in Mexico resided in the state of Jalisco.[73] Estimates of U.S. retirees in Guadalajara are difficult to obtain because of two main factors: first, there are many U.S.-born children of Mexican migrants who either returned to Guadalajara as children or as adults and secondly, there has been a trend of U.S. retirees moving from Guadalajara to the Lake Chapala region.

There are many U.S. organizations and entities that cater to U.S. citizens in Guadalajara. The U.S. Consulate General, American Services Unit-Federal Benefits Unit, provides numerous services for those living or traveling in the states of Jalisco, Aguascalientes, Colima, Nayarit, Zacatecas, Sinaloa, and Baja California Sur.[74] One of the main tasks for the Federal Benefits Unit is to enroll or cancel Medicare Part B for eligible beneficiaries. Yet most of their work, about 85 percent, deals with Social Security.[75] Guadalajara also has communal organizations, such as the American Society of Jalisco (AMSOC), which caters to expatriates. It has been communicated, by word of mouth, that many are switching from the American Society of Jalisco to the Lake Chapala Society, which boasts about 3,000 members.

Cuernavaca, Morelos

by Erin Daley

Cuernavaca is the state capital of the small state of Morelos, located just south of Mexico City in the center of the country. The population in 2005 was approximately 350,000,[76] of which a small portion is U.S. retirees. While the government of Morelos requests that

foreigners living in the state register with the state government, few do so, making it difficult to estimate how many U.S. retirees are living in the area full or part-time.[77] Nonetheless, the Mexican *Instituto Nacional de Estadística, Geografía e Informática* estimated that in 2000, there were just over 5,000 persons living in the state of Morelos who were born in the United States.[78] Official estimates on the number of U.S. retirees in Cuernavaca put the number at around a few hundred.[79] Known as the "City of Eternal Spring," Cuernavaca's climate is what attracts many of the foreigners living there to this particular location. With an average temperature of 73 degrees Fahrenheit, the city has a pleasant climate year-round. Additionally, at just an hour away from Mexico City, Cuernavaca is also a convenient location for U.S. retirees as international travel from this area of the country is easy.

Health Care in Cuernavaca

How individuals get their care in Cuernavaca, as in other parts of Mexico, depends a lot on their insurance coverage. Many expatriates have health insurance coverage through BUPA, a private insurance company based in the United Kingdom.[80] Others have coverage through other private insurance companies or through the U.S. Veterans Administration. Many, however, use Medicare as their primary coverage for major medical care, traveling regularly to the United States for medical needs. In addition, some Americans have paid into an HMO-style health insurance plan that covers care only in the state of Morelos called MEDCROSS.[81]

With respect to hospital facilities, in addition to the public IMSS hospital, Cuernavaca has several large private hospitals as well as smaller clinics. The largest and most highly regarded hospitals include the Hospital Inovamed, A.C., and the Sanatorio Henri Dunant, A.C.[82] Hospital Inovamed has 25 beds in private rooms as well as three intensive care beds. Its services include urgent care, operating room, intensive care, radiology, tomography, nursery, ultrasound, pharmacy, and a clinical laboratory.[83] Inovamed offers on-site specialists in areas such as internal medicine, intensive care, cardiology, general surgery, and anesthesiology.[84] The Sanatorio Henri Dunant has 22 beds for hospitalized patients as well as eight beds for those undergoing minor procedures requiring a short-term stay at the hospital.[85] Its services include urgent care, operating room, intensive care, radiology, tomography, nursery, ultrasound, clinical laboratory, and pharmacy.[86] It also offers a blood bank, MRI, gamagraphy, arthroscopy, lithotripsy, laparoscopy, and a hyperbaric chamber.[87] The Sanatorio Henri Dunant is certified by the Mexican *Secretaría de Salud* as is the Hospital Bellavista de Cuernavaca.[88] The Hospital Bellavista offers the following services: 24-hour urgent care, operating room, nursery, intensive care, clinical laboratory, radiology, ultrasound, pharmacy, and specialists in a wide variety of areas.[89]

Many doctors in Cuernavaca speak English, although not always enough English to clearly deal with the most complicated health problems.[90] Nonetheless, one doctor in the city reports having as many as 500 current patients from the United States.[91] For major health problems in Cuernavaca, especially cardiac problems, many individuals go to Mexico City, an hour away.[92] Mexico City is home to some of the most advanced

hospitals in the country such as the ABC Hospital and Hospital Los Ángeles, which have a good reputation for providing high-quality care.

Retirees in Cuernavaca

In contrast to some of the other U.S. retiree communities in Mexico, there is no large club or organization uniting the American community in Cuernavaca, making it challenging to get accurate estimates on the number and characteristics of retirees. The Newcomers Club in Cuernavaca is an organization made up of approximately 140 Americans, most of whom are of retirement age.[93] There are also some informally compiled lists of foreigners in the area including an e-mail listserv with approximately 350 members and a telephone directory of approximately 400 members.[94] Both lists only include those individuals wishing to participate and thus, are likely to be an incomplete list of U.S. retirees in Cuernavaca.

San Miguel de Allende, Guanajuato

by Jennifer Nading

San Miguel de Allende, Mexico, is a small town located in the central state of Guanajuato. The population is estimated to be around 139,000,[95] however this number does not completely reflect the number of foreign residents who live in the city. The municipal government estimates that there are approximately 9,000-10,000 foreign residents. Although the local government believes that approximately 75 percent of these foreign residents are U.S. expatriates, all of the above numbers are disputed because Mexican authorities do not keep an official count of San Miguel's foreign population.[96] It becomes difficult to determine such information because most foreign residents do not register for FM3 visas (temporary residence) or FM2 visas (permanent residence).[97] The city attracts a large number of foreigners and this trend can be attributed largely to the climate. The average temperature is between 54 and 64 degrees Fahrenheit. During the coldest times of the year (December and January) the average temperature is between 39 and 64 degrees Fahrenheit and during the warmest times of the year (summer months) the temperature ranges from 54 to 93 degrees Fahrenheit. [98]

Health Care in San Miguel de Allende

The private hospital that serves the city is Hospital de la Fé. This hospital offers many services including internal medicine, anesthesiology, general surgery, gynecology, neurosurgery, pediatrics, ophthalmology, plastic surgery, urology, orthopedics, and general medicine. Available technologies include x-rays, laparoscopy, and a dialysis unit.[99] There is also a public hospital, Instituto Mexicano de Seguro Social (IMSS) and multiple small clinics. There are many doctors in San Miguel who speak English, which is helpful for the English-speaking residents and tourists in the city.[100] U.S. residents in San Miguel who choose not to obtain medical care in the city travel to major hospitals such as Hospital Ángeles that are located in Querétaro, San Luis Potosi, and Mexico City.[101]

In regards to health insurance, expatriates we interviewed had various health plans, and the majority had some type of health care safety net in Mexico. Examples of the health care coverage include Blue Cross Blue Shield coverage as part of a pension plan, TRICARE Overseas, AIG (a private U.S. insurance company that offers world wide coverage), and BUPA (a private UK insurance company that offers world wide coverage).[102]

Retirees in San Miguel de Allende

In addition to the demographic information provided earlier in the chapter, Bob Latta, a real estate agent who rents and sells to American retirees and expatriates in San Miguel, provided us with the following information. Based on the business that he conducts in the area, Mr. Latta estimates that there are 100,000 people living in San Miguel, and that there are roughly 7,000 U.S. retirees living in the city full-time and 10,000 who visit the city at some time during the year and rent houses. By these calculations, Americans make up 5-7 percent of the city's total population. Mr. Latta, along with other real estate agents in the area, present data concerning the number of expatriates residing in the city to the municipality leaders. This is largely because those who work in the real estate business have a better handle on how many U.S. retirees and visitors San Miguel has at any given time than does the municipal government.[103]

San Miguel was described by a few of its U.S. retiree residents as a college campus, with expatriates' social lives centered around groups with similar interests such as golf, charities, and volunteer work. [104] In addition, there are a number of organizations and networks that U.S. retirees and expatriates can enjoy in San Miguel such as the Lions Club, Republicans Abroad, and Democrats Abroad.[105]

There are two main mail stops in the city where expatriates pay a monthly or yearly fee to use the Internet and pick up their mail: La Conexión and Border Crossings. These businesses also provide a setting at which expatriates can converse with one another over coffee, or learn about what is going on in the community. [106] In addition, the English-language newspaper, *Atención*, keeps the American community abreast with community activity and news, sports scores, and literature reviews, among other topics.[107]

Baja California Sur

by Erin Daley and Jennifer Nading

Baja California Sur occupies the southern half of the Baja peninsula, south of the state of California in the United States. With an average annual temperature of about 74 degrees Fahrenheit, foreigners are attracted to retirement in the Baja peninsula due to its warm climate throughout the winter months and the oceanfront properties along the Pacific coast and the coast of the Sea of Cortes. In 2005, the state's population was reported to be 512,170, of which a small portion is U.S. retirees.[108]

Retired Americans in Baja California Sur live in a variety of areas ranging from some of the most expensive areas in Mexico located around Los Cabos to slightly more affordable communities in the East Cape region and the state capital of La Paz. Of the five

municipalities in the state, La Paz and Los Cabos are the largest with 219,596 and 164,162 residents respectively in 2005.[109] These municipalities also have high growth rates and have the largest number of Americans residing within their boundaries.[110] The *Instituto Nacional de Migración* (INAMI) estimated that approximately 4,500 Americans were residing in the municipality of La Paz in April of 2006, which includes the city of La Paz as well as outlying areas that include much of the East Cape.[111] In the East Cape, the largest retiree community is in Los Barriles, with an estimated 3,000 Americans living there for part or all of the year.[112] A growing number of Americans is also retiring to La Paz.[113] With respect to Los Cabos, INAMI estimated that approximately 6,100 Americans were residing in Los Cabos, which includes primarily the cities of San José de Los Cabos and Cabo San Lucas.[114] The other three municipalities of Baja California Sur are significantly smaller, with a small number of American residents. Nonetheless, the area around Loreto, a municipality registering only 11,839 residents in 2005, is estimated to have about 1,000 American residents, according to INAMI. [115]

Baja California Sur is the least populated state in Mexico in regards to both the number of inhabitants and the population density. [116] However, it has the third-highest growth rate in Mexico.[117] Areas that are growing the fastest in the state are Los Cabos (the southern tip of the Baja peninsula) and La Paz.[118] While the Mexican census data showed that Loreto had 0 percent population growth from 2000 to 2005 (in contrast to Los Cabos and La Paz, registering 8.1 and 1.9 percent growth respectively), there is some evidence that the American community in the area is growing rather quickly. In Los Cabos, a significant percentage of the growth rate is due to high migration into the state. Approximately 47 percent of those migrating to Los Cabos were born in other Mexican states and considerable amounts were foreign-born retirees.[119] In 2000, it was estimated that the population of Los Cabos would nearly double within seven years and in 2006 it had greatly exceeded this projection.[120] La Paz and Loreto are expected to follow a similar population growth pattern.[121] Due to the significantly larger numbers of American retirees currently living in the southern-most part of Baja California Sur, our research focused on the communities of Los Cabos and the East Cape, located in the municipalities of Los Cabos and La Paz.

Health Care in Baja California Sur

In comparison to some of the other retirement communities we have visited in Mexico, the southern Baja peninsula has less care available and there are no hospitals in the state that are certified by the Mexican *Secretaría de Salud*.[122] Most Americans with serious medical problems prefer to seek care outside of Baja California Sur due to their insurance or Medicare coverage, familiarity with the United States, and the lack of services available in the lower Baja peninsula.[123] For example, there are no facilities in Los Cabos that have the technology for radiation therapy to treat cancer patients.[124] In the Los Cabos area, the most comprehensive care is available in Cabo San Lucas. In addition to the public IMSS hospital, Cabo San Lucas has several private hospitals and smaller clinics. The hospitals seeing the largest number of Americans include AmeriMed and Hospital de Especialidades Baja Medical Response.[125]

The AmeriMed hospital in Cabo San Lucas is part of the AmeriMed group, which is a unique group of hospitals in that their principal aim is to serve Americans in Mexico. While the hospitals began with a focus on emergency care, they are beginning to provide a greater amount of general care.[126] This hospital caters its services to the needs of Americans as much as possible by requiring all doctors to speak English and encouraging other staff to learn or improve their English through classes offered by AmeriMed for its staff. [127] They also provide receipts in English with CPT codes in order to facilitate reimbursement.[128] In 2006, AmeriMed served 4,898 patients, of which approximately 41 percent were from the United States, including both tourists and residents.[129] This nine-bed facility has an emergency room, operating room, two ICU beds, laboratory, X-ray, CT scan, ultrasound, fluroscopy, MRI, catheter lab, and dialysis.[130] It is the only hospital in Los Cabos with ER specialists in the hospital 24 hours a day and is also the only hospital with both MRI equipment and a catheter lab.[131]

Hospital de Especialidades and Baja Medical Response (BMR) is the other medical facility in Cabo San Lucas that aims to serve Americans, but is significantly less frequented, with less than 10 percent of its patients being from the United States. [132] The hospital has a wide variety of services to provide care for its patients including 12 beds, an emergency room, an intensive care unit, a delivery room, neonatal ward, a laboratory, radiology and X-ray equipment, hemodialysis, mammography, colonoscopies, laparoscopic surgery, and a pharmacy. [133]

In San José del Cabo, the medical facilities are more limited than in Cabo San Lucas. The hospital that is currently most frequented by Americans is Médica de los Cabos.[134] Approximately 30 percent of the patients at Médica de los Cabos are from the United States.[135] Additionally, AmeriMed is building a hospital in San José del Cabo, which will open in the summer of 2007. This new facility will have 21 total beds including 13 hospital beds.[136] It will also offer more services than the current AmeriMed facility in Cabo San Lucas, including two operating rooms, four recovery beds, and mammography capabilities.[137]

Health Care in the East Cape is even more limited than in Los Cabos. For hospital services, the most accessible facilities for residents of the East Cape are in Los Cabos or in La Paz. However, many prefer to travel to the United States for their care. The most significant health facility for Americans in the East Cape area is the recently opened AmeriMed Clinic in Los Barriles. The clinic is the only facility in the city offering x-ray, pharmacy, and laboratory facilities all in one place. The clinic also can provide ambulance service to the AmeriMed facilities in Cabo San Lucas, located about an hour away.[138]

Table 12.1
Sample Prices for AmeriMed in Cabo San Lucas

Item	Price in Pesos	Price in Dollars
Private room per day	$5,804.64	$529.21
ICU Room	$23,218.57	$2,116.82
EKG	$738.77	$67.35
Hemodialysis	$4,362.05	$397.69
Urinalysis	$252.00	$22.97
Glucose blood test	$186.90	$17.04
X-ray of pelvis	$702.20	$64.02
MRI of lumbar spine with contrast	$15,318.45	$1,396.57
Ultrasound of abdomen	$4,347.68	$396.38

Adapted from: AmeriMed Hospital, *Most Common Services*, Cabo San Lucas, Mexico, March 23, 2007 (handout).

Note: Currency conversion done using Oanda.com, *FXConverter results—Currency converter for 164 currencies*. Online. Available: http://www.oanda.com/convert/classic. Accessed: April 8, 2007.

Retirees in Baja California Sur

There are no official estimates on the number of retirees in Baja California Sur. In contrast to some of the other U.S. retiree communities in Mexico, there is no large club or organization uniting the American community in Los Cabos, making it challenging to get accurate estimates. The Tomatoes is a large social group for women, with about 300 members,[139] and other groups of Americans tend to be focused around volunteer activities or industry.[140,141]

In contrast, the large U.S. retiree community in Los Barriles is much more organized, with numerous social and civic groups. Popular groups for Americans include the Rotary Club and the East Cape Guild. While there are Americans throughout the East Cape, the community in Los Barriles is the largest, at about 3,000 members, making up approximately 60 percent of the population of the town.[142] Most American retirees live in the area from October to May as the area becomes quite hot in the summer months.[143]

Notes

[1] The Migration Policy Institute, *America's Immigrants: U.S. Retirement Migration to Panama and Mexico.* Online. Available: http://www.migrationpolicy.org/pubs/americas_emigrants.pdf. Accessed: April 22, 2007.

[2] PuertoVallarta.net, *Fast Facts*. Online. Available: http://www.puertovallarta.net/fast_facts/index.php. Accessed: February 22, 2007.

[3] Instituto Nacional de Estadística, Geografía e Informática (INEGI), *Localidades y>su población por municipio según tamaño de localidad*, 2005. Online. Available: http://www.inegi.gob.mx/est/contenidos/espanol/sistemas/conteo2005/datos/14/excel/cpv14_pob_1_1.xls. Accessed: March 1, 2007.

[4] Interview by Michelle Lalonde and Alex Gunter with Kelly Trainor de O, U.S. Consular Agent, Nuevo Vallarta, Mexico, January 12, 2007.

[5] Ibid.

[6] Banderas News, *Financing Options*. Online. Available: http://banderasnews.com/real-estate/financing.htm. Accessed: April 16, 2007.

[7]"La Vida Cheapo," *AARP, The Magazine* (March-April 2004), p. 1. Online. Available: http://www.aarpmagazine.org/travel/Articles/a2004-01-21-mag-mexico.html. Accessed: April 16, 2007.

[8] "Mexico's Pacific Coast Beckons Retirees," *The Washington Times* (April 1, 2007). Online. Available: http://washingtontimes.com/specialreport/20070401-010932-4162r_page2.htm. Accessed: April 16, 2007.

[9] Ibid.

[10] Ibid.

[11] Ibid.

[12] Active Living International, *What We Do*. Online. Available: http://activelivinginternational.com/whatwedo.aspx. Accessed: April 16, 2007.

[13] "Access Makes Puerto Vallarta a Perfect Snowbird Perch," *The Herald* (February 18, 2007), p. 2. Online. Available. Accessed: April 16, 2007.

[14] "First American Beachfront Active Adult Community Going Up on Mexico's Pacific Coast," *Banderas News...* Online. Available: http://banderasnews.com/0703/re-luma.htm. Accessed: April 16, 2007.

[15] Interview by Michelle Lalonde and Alex Gunter with Tere Kimball, Broker, and Nicole Martin, Assistant to Tere Kimball, Puerto Vallarta, Mexico, January 11, 2007.

[16] Interview by Michelle Lalonde and Alex Gunter with Kelsey Magnus, resident of Puerto Vallarta, Real Estate Broker, Puerto Vallarta, Mexico, January 12, 2007.

[17] Interview with Pamela Thompson, Patient Services Coordinator/International Services, Cornerstone Hospital, Puerto Vallarta, Mexico, January 12, 2007.

[18] Ibid.

[19] Ibid.

[20] Kimball and Martin interview; Conversion done using Oanda.com, *FXConverter results—currency converter for 164 currencies*. Online. Available: http://www.oanda.com/convert/classic. Accessed: April 17, 2007.

[21] Kimball and Martin interview.

[22] AmeriMed Puerto Vallarta, S.A.DE.C.V, *Estadística Total de Procedencia de pacientes*, Puerto Vallarta, Mexico, February 29, 2007 (handout).

[23] Interview by Michelle Lalonde and Alex Gunter with Dr. Roberto Garcia Graullera, Medical Director, AmeriMed Hospital, Puerto Vallarta, Mexico, January 13, 2007.

[24] Kimball and Martin interview.

[25] Ibid.

[26] AmeriMed Hospital, *Your Partners in Health,* Cabo San Lucas, Mexico, March 24 2007 (handout).

[27] Interview by Michelle Lalonde and Alex Gunter with Chickie Alter and Liz Miller, U.S. retirees living in Mexico, Puerto Vallarta, Mexico, January 13, 2007.

[28] International Health Insurance danmark a/s, *International Health Insurance for Individuals.* Online. Available: http://www.ihi.com/english/individual/1.asp. Accessed March 8, 2007.

[29] Interview by Michelle Lalonde and Alex Gunter with David Lord, Veterans Administration Representative, Puerto Vallarta, Mexico, January 13, 2007.

[17] Kimball and Martin interview.

[30] Interview with Kelly Trainor de O, U.S. Consular Agent, Nuevo Vallarta, Mexico, January 12, 2007.

[31] Kimball and Martin interview.

[32] Interview with Pamela Thompson, Patient Services Coordinator/International Services, Cornerstone Hospital, Puerto Vallarta, Mexico, January 12, 2007.

[33] Si-Mexico, *Vacations Begin Here*. Online. Available: http://www.si-mexico.com/temps/vallarta_temps.htm. Accessed March 11, 2007.

[34] Ibid.

[35] Alter and Miller interview.

[36] Global Nature Fund, *Mexico's Largest Lake on the Verge of Collapse?* Online. Available: http://www.livinglakes.org/news/chapala0307.htm. Accessed: February 26, 2007.

[37] Mexico Connect, *Can Mexico's Largest Lake Be Saved?* Online. Available: http://www.mexconnect.com/mex_/travel/tonysarticles/tblagunasaved.html. Accessed: February 26, 2007.

[38] Instituto Nacional de Estadistica, Geografia e Informatica, *Conteo de Poblacion y Vivienda:Resultados Definitivos, 2005*. Online. Available: http://www.inegi.gob.mx/est/contenidos/espanol/sistemas/conteo2005/default.asp?c=6790. Accessed: February 26, 2007.

[39] Migration Policy Institute, *America's Emigrants, U.S. Retirement Migration to Mexico and Panama*. Online. Available: http://www.migrationpolicy.org/pubs/americas_emigrants.pdf. Accessed: April 16, 2007.

[40] Interview by Jennifer Nading, Marina Zolezzi, Karla Vargas with Alicia, Owner, Alicia's Convalescent Homes, Ajijic, Jalisco, Mexico, October 8, 2006.

[41] Ibid.

[42] Lake Chapala Society. *History of the Lake Chapala Society*. Online. Available: http://www.lakechapalasociety.org. Accessed: February 27, 2007.

[43] Instituto Nacional de Estadística Geografía e Informática (INEGI), *Población total por municipio según grandes grupos de edad, 2005*. Online. Available: http://www.inegi.gob.mx/est/contenidos/espanol/sistemas/conteo2005/datos/14/excel/cpv14_pob_1_1.xls Accessed: February 21, 2007.

[44] Ibid.

[45] Vive Guadalajara Turismo, *Ayuntamiento de Guadalajara 2004-2006.* Online. Available: http://vive.guadalajara.gob.mx/defaultE.asp?Descripcion=guadalajara. Accessed: February 22, 2007.

[46] United States Consulate General Guadalajara, *Living in Guadalajara*. Online. Available: http://www.usembassy-mexico.gov/guadalajara/Geliving.htm. Accessed: February 22, 2007.

[47] Secretaría de Salud, *Consejo de Salubridad General, Programa Nacional de Certificación de Establecimientos de Atención Médica, Unidades Hospitalarias Certificadas por Entidad Federativa, Municipio, Prestador de Servicios y Vencimiento de Certificación, Actualización al 29 de noviembre de 2006.* Online. Available: http://www.salud.gob.mx/unidades/csg/CERT_HOSP/HOSPITALES/hosp_cert_29nov06.xls. Accessed: March 1, 2007.

[48] Interview by David C. Warner, Jennifer Nading, and Marina Zolezzi with Dr. Jose Trinidad Zepeda, Pediatric Surgeon; Dr. Eloy Medina Ruiz, Internal Medicine; Dr. Jorge Alvaro Gonzalez, Traumotology and Orthopedics; Dr. Hector Mejia Michel, General Surgeon; Dr. Enrique Frutos, Cardiology; Dr. Ernesto

Delgado Mercado, General Surgeon; and Dr. Alfredo Avila Abundis, Anatomical Pathology; Hospital Angeles del Carmen, Guadalajara, Jalisco, Mexico, October 5, 2006.

[49] Hospital Angeles del Carmen, *History*. Online. Available: http://www.hospitalangelesdelcarmen.com/new/historia_i.php. Accessed: March 1, 2007.

[50] Ibid.

[51] Zepeda et al. interviews.

[52] Ibid.

[53] Ibid.

[54] Ibid.

[55] Ibid.

[56] Ibid.

[57] Ibid.

[58] Hospital México Americano, *Historia*. Online. Available: http://www.hmexamer.com.mx/index.php?option=com_content&task=view&id=18&Itemid=77. Accessed: March 1, 2007.

[59] Interview by David C. Warner, Jennifer Nading, Karla Vargas, and Marina Zolezzi with Dr. Jose Luis Solis Davila, Sub-Medical Director; LEM Karol Gomez Acosta, Marketing; and Isabel Ibarra, Insurance Specialist, Hospital México Americano, Guadalajara, Jalisco, Mexico, October 6, 2006.

[60] Ibid.

[61] Ibid.

[62] Ibid.

[63] Ibid.

[64] Interview by David C. Warner and Karla Vargas with several doctors from Hospital Puerta de Hierro, Zapopan, Jalisco, Mexico, October 6, 2006.

[65] Ibid.

[66] Ibid.

[67] Ibid.

[68] Ibid.

[69] Ibid.

[70] Ibid.

[71] Ibid.

[72] United States Consulate General Guadalajara, *Living in Guadalajara*. Online. Available: http://www.usembassy-mexico.gov/guadalajara/Geliving.htm. Accessed: February 22, 2007.

[73] Migration Policy Institute, *America's Emigrants, U.S. Retirement Migration to Mexico and Panama*. Online. Available: http://www.migrationpolicy.org/pubs/americas_emigrants.pdf. Accessed: March 1, 2007.

[74] Interview by Jennifer Nading and Marina Zolezzi with Ravi Candidai, American Services Unit; Carlos Jug, Federal Benefits Unit, Guadalajara, Mexico, October 6, 2006.

[75] Ibid.

[76] Instituto Nacional de Estadística, Geografía e Informática, *Población total por municipio según grandes grupos de edad, 2005*. Online. Available: http://www.inegi.gob.mx/est/contenidos/espanol/rutinas/ept.asp?t=mpob93&c=3839&e=17. Accessed February 14, 2007.

[77] Interview by Erin Daley and Jennifer Nading with Andie Grater, President, Newcomers Club of Cuernavaca, Cuernavaca, Morelos, Mexico, February 1, 2007.

[78] Sergio Aguayo Quezada, *Almanaque México-Estados Unidos* (Mexico City: Fondo de Cultura Económica, 2005), p. 189.

[79] Migration Policy Institute, *America's Emigrants, U.S. Retirement Migration to Mexico and Panama*. Online. Available: http://www.migrationpolicy.org/pubs/americas_emigrants.pdf. Accessed: February 27, 2007.

[80] Grater interview.

[81] Ibid.

[82] Interview by Erin Daley and Jennifer Nading with Leon Golub, Doctor of Internal Medicine, Grupo Médico Río Mayo, Cuernavaca, Morelos, Mexico, February 1, 2007.

[83] Hospital Inovamed, *Hospital Inovamed.* Online. Available: http://www.hospitalinovamed.com.mx. Accessed: April 18, 2007.

[84] Ibid.

[85] Sanatorio Henri Dunant, *Sanatorio Henri Dunant.* Online. Available: http://www.henridunant.com.mx. Accessed: April 18, 2007.

[86] Ibid.

[87] Ibid.

[88] Secretaría de Salud, *Consejo de Salubridad General, Programa Nacional de Certificación de Establecimientos de Atención Médica, Unidades Hospitalarias Certificadas por Entidad Federativa, Municipio, Prestador de Servicios y Vencimiento de Certificación, Actualización al 29 de noviembre de 2006.* Online. Available: http://www.salud.gob.mx/unidades/csg/CERT_HOSP/HOSPITALES/ hosp_cert_29nov06.xls. Accessed: February 20, 2007.

[89] Hospital Bellavista, *Servicios*, Online. Available: http://www.hospitalbellavista.com. Accessed: April 11, 2007.

[90] Grater interview.

[91] Golub interview.

[92] Grater interview; Golub interview.

[93] Grater interview.

[94] The Purple Book Committee (Oliver Araiz and volunteers), *The Purple Book: Directory of Foreign Residents in the State of Morelos* (Cuernavaca, Morelos, 2006), pp. 7-69; and Yahoo! Groups, *CuernAds-Cuernavaca Community*. Online. Available: http://groups.yahoo.com/group/CuernAds/. Accessed: February 28, 2007.

[95] Instituto Nacional de Estadística Geografía e Informática, *Población total por municipio según grandes grupos de edad, 2005*. Online. Available: www.inegi.gob.mx/est/contenidos/espanol/rutinas/ept.asp?t= mpob93&c=3839&e=17. Accessed: February 18, 2007.

[96] Wikipedia, *San Miguel de Allende.* Online. Available: http://en.wikipedia.org/wiki/San_Miguel_de_ Allende. Accessed: February 18, 2007.

[97] Class presentation by Erin Daley, Graduate Student, at the Lyndon B. Johnson School of Public Affairs, Austin, Texas, October, 2006.

[98] ABC Realty, *San Miguel.* Online. Available: http://www.abcrealty.com/San_Miguel.htm. Accessed: February 17, 2007.

[99] All about San Miguel de Allende, Mexico, *Medical Services in San Miguel*. Online. Available: http://www.internetsanmiguel.com/hospitals.html. Accessed: February 17, 2007.

[100] Interview by Erin Daley and Jennifer Nading with Ellen Geary, President, Lions Club International San Miguel, San Miguel de Allende, Guanajuato, Mexico, February 3, 2007.

[101] Interview by Erin Daley and Jennifer Nading with Cindy Strong, Resident of San Miguel de Allende, Guanajuato, Mexico, February 3, 2007; Interview with Bob Latta, Real Estate Agent, San Miguel de Allende, Guanajuato, Mexico, February 3, 2007.

[102] Interview by Erin Daley and Jennifer Nading with Jack Jennings, Resident of San Miguel de Allende, Guanajuato, Mexico, February 3, 2007; Strong interview; Latta interview.

[103] Latta interview.

[104] Latta interview; Jennings interview

[105] Strong interview, Latta interview; Jennings interview.

[106] Geary interview; Latta interview; Jennings interview.

[107] Atencion San Miguel, *This Week's Issue*. Online. Available: http://www.atencionsanmiguel.org/index.php?engnewspaper. Accessed: March 1, 2007.

[108] Instituto Nacional de Estadística, Geografía e Informática, *Población total según sexo, 2005*. Online. Available: http://www.inegi.gob.mx/est/contenidos/espanol/rutinas/ept.asp?t=mpob91&c=3837&e=03. Accessed March 26, 2007.

[109] Ibid.

[110] Interview by Erin Daley and Jennifer Nading with Michael Houston, Consular Agent, Consular Agency of the United States of America, Cabo San Lucas, Baja California Sur, Mexico, March 23, 2007.

[111] Instituto Nacional de Migración, *Extranjeros Residentes en el Estado de Baja California Sur Por Nacionalidad y Subdelegación,* Cabo San Lucas, Mexico, April 2006 (handout).

[112] Interview by Erin Daley and Jennifer Nading with Charlene Wenger, Clinic Manager, AmeriMed, Los Barriles, Baja California Sur, Mexico, March 24, 2007.

[113] Houston interview.

[114] Instituto Nacional de Migración, *Extranjeros Residentes en el Estado de Baja California Sur Por Nacionalidad y Subdelegación,* Cabo San Lucas, Mexico, April 2006 (handout).

[115] Ibid.

[116] International Community Foundation, *Baja California Sur's Community-Based Opportunities and Needs.* Online. Available: http://www.icfdn.org/publications/na2006/index.htm. Accessed: April 10, 2007.

[117] Ibid.

[118] Ibid.

[119] Ibid.

[120] International Community Foundation, *Baja California Sur's Community-Based Opportunities and Needs.* Online. Available: http://www.icfdn.org/publications/na2006/index.htm. Accessed: April 10, 2007; Solutions Abroad, *Los Cabos*. Online. Available: http://www.solutionsabroad.com/cabos.asp?city=8. Accessed: April 10, 2007

[121] International Community Foundation, *Baja California Sur's Community-Based Opportunities and Needs.* Online. Available: http://www.icfdn.org/publications/na2006/index.htm. Accessed: April 10, 2007.

[122] Secretaría de Salud, *Consejo de Salubridad General, Programa Nacional de Certificación de Establecimientos de Atención Médica, Unidades Hospitalarias Certificadas por Entidad Federativa, Municipio, Prestador de Servicios y Vencimiento de Certificación, Actualización al 29 de noviembre de 2006.* Online. Available: http://www.salud.gob.mx/unidades/csg/CERT_HOSP/HOSPITALES/ hosp_cert_29nov06.xls. Accessed: February 20, 2007.

[123] Houston interview.

[124] Interview by Erin Daley and Jennifer Nading with Ana Trelles, Chief Operating Officer, AmeriMed. Cabo San Lucas, Baja California Sur, Mexico, March 23, 2007.

[125] Trelles interview.

[126] Ibid.

[127] Ibid.

[128] Ibid.

[129] Hospital AmeriMed Cabo San Lucas, S.A. DE C.V., *Estadística Total de Procedencia de Pacientes*, Cabo San Lucas, Mexico, February 10, 2007 (handout).

[130] AmeriMed American Hospitals, *Your Partners in Health,* Cabo San Lucas, Mexico, March 2007, p. 3.

[131] Hospital AmeriMed Cabo San Lucas, S.A. DE C.V., *Estadística Total de Procedencia de Pacientes*, Cabo San Lucas, Mexico, February 10, 2007 (handout).

[132] Interview by Erin Daley and Jennifer Nading with Erika Ruiz Contreras, Public Relations and Marketing, Hospital de Especialidades. Cabo San Lucas, Baja California Sur, Mexico, March 23, 2007.

[133] Hospital de Especialidades and Baja Medical Response, *Anexo I,* Cabo San Lucas, Mexico, March 23, 2007 (handout).

[134] Trelles interview.

[135] Interview by Erin Daley and Jennifer Nading with Dr. Marco Antonio Plascencia, MD, Médico de Guardia, Médica de los Cabos. San José del Cabo, Baja California Sur, Mexico, March 24, 2007.

[136] AmeriMed American Hospitals, *Your Partners in Health,* Cabo San Lucas, Mexico, March 2007, p. 3.

[137] Ibid.

[138] Wenger interview.

[139] Yahoo! Groups, *Los Cabos Tomatoes.* Online. Available: http://groups.yahoo.com/group/loscabostomatoes/. Accessed: March 26, 2007.

[140] Ibid.

[141] Interview by Erin Daley and Jennifer Nading with Julie Walden, Cabo Linda Real Estate Sales, Cabo San Lucas, Baja California Sur, Mexico, March 23, 2007.

[142] Wenger interview.

[143] Ibid.

Chapter 13. Case Studies of Individual U.S. Retirees in Mexico

Case Study 1: When You Visit a Doctor in Mexico, You Feel as Though you Matter

We decided to retire to Mexico because we wanted to experience a new culture and Mexico is close to the U.S. Additionally, the area in which we live (Ajijic) contains a large expatriate community and this has made for an easier transition.

Retirement has become a very busy life here, there are so many opportunities to volunteer and expand one's interests—we simply don't have enough time to get old. The knowledge and talents that senior citizens bring to the community are much appreciated.

I am a retired registered nurse and have always been very particular when choosing medical care. What I have found in Mexico is medical care that is up-to-date coupled with a caring factor that used to be present in the practice of medicine in the U.S. When you visit a physician, you feel as though you matter—you feel respected, listened to, valued, and well cared for. I know of a woman who had a hip replacement and her physician personally drove her home in his SUV to ensure she made it home safely.

The IMSS hospitals provide fewer amenities than do U.S. hospitals. For example, the family of each patient goes to the hospital to do personal care for patients, not nurses. Patients must also take with them their own wash cloths, towels, and soap, and there are not typically phones or televisions in the rooms. However, friends who have used these services tell me the care, food, and overall cleanliness of these facilities are good. The majority of people I know go to Guadalajara if they need to see a specialist or be admitted into a hospital. The private hospitals in Guadalajara are as modern as any hospital in the U.S. and do provide most of the same services. My personal physician has all the modern equipment for diagnostics, medication updates, new procedures, and the like that are available in the U.S. at a fraction of the cost.

Are we going to stay here? Probably not forever. But, in the meantime it's a good place to be. But it would be better if Medicare could provide services for its expatriate enrollees.

Source: Edited e-mail correspondence from retiree in Lake Chapala, Mexico, to Jennifer Nading, March 12, 2007.

Case Study 2: I Went Through Hell to Save a Loved One's Life

My grandfather lives in Puerto Vallarta, Mexico. He is 84 years old and in perfect health. In January 2007, he fell and hit his head while cleaning the floor of his home and was found a few days later in his room. He was rushed to the hospital where doctors determined that he was bleeding from the outer part of his brain and the only way he would live is if they performed surgery to drain the blood that was causing the pressure in his brain. Doctors said they needed $12,000 dollars before they would start the emergency surgery. They contacted me to let me know about the situation and I collected the surgery fee and wired it to Puerto Vallarta. My grandfather was fine the first day after surgery, yet soon fell unconscious again. My uncle called and told me that grandpa was not doing well and that the doctors wanted to open up his skull to find out what the problem was. This surgery was going to cost more than the first one.

I begged my uncle to bring him back to the U.S. because he had benefits and better care here in the U.S. However, my uncle said he couldn't do this because my grandfather was in critical condition and almost ready to pass. I decided that I would go get him and bring him back to the states. I purchased our tickets and I got on the first plane out and flew all night to get to Puerto Vallarta. I rushed to the hospital. My grandfather looked like a corpse and had tubes coming out of his head with surgical gloves at each end where the blood would drain into. He had no machinery monitoring his condition at all. I argued with the doctors, nurses, and paramedics. They did not want me to take him out in his condition and said that the airlines would not accept someone in his condition on the plane. I insisted that I was going to do it anyway; I didn't care what they had to say after seeing the condition he was in. I knew that if I didn't try he would die anyway, so I had the nurses remove the IV and empty out his catheter. I taped and wrapped his catheter around his leg, I shaved him, and got him dressed and left.

When we got to the airport, I put him in a wheel chair and wrapped a small blanket around his neck to prop his head up and put a baseball cap on his head to cover up the wounds. To get my grandfather through immigration, I shook him very hard to wake him up and told him to open his eyes and he did. That lasted long enough for him to get through immigration. As the plane started to move I started crying because I was so relieved to be on the way to the U.S. with my grandfather. Even though I was happy to be on our way I was still very scared. I started panicking when I noticed that my grandfather was heating up and that I couldn't do anything for him. Every so often the stewardess would stop and ask what was wrong with my grandpa, and I would say that I sedated him because he was afraid of flying and he had Alzheimer's disease. Approximately 30 minutes before our arrival to San Francisco, I beeped the stewardess and told her to please ask the pilot to have an ambulance waiting for us when we arrived. As soon as we landed paramedics and firemen rushed my grandpa to the hospital. The paramedics told me that if the plane had been in the air one more hour my grandpa would have died.

As soon as we arrived at the hospital, the doctors started treating him immediately. The neurologist told me that he had never seen anything like the procedure that was done to

my grandfather's head and he was concerned and that he would get an infection (meningitis). The doctors were not concerned about the bleeding in my grandpa's brain, which was the original problem, but about the procedure done in Mexico.

All in all, my grandpa stayed at Stanford Hospital for 11 days, fought meningitis, and did not need any type of brain surgery, but was cured with medication only. He is perfectly fine mentally and owes no money to the hospital, thanks to Medicare. He is now back in Puerto Vallarta to finish living the rest of his life there. If he had his Medicare benefits in Mexico, I could have taken him to another hospital in any part of Mexico (Mexico City or Guadalajara) instead of having to go through hell to get him back to the U.S. to save his life. I wouldn't want anybody else having to go through what I went through to save a loved one.

Source: Edited e-mail correspondence from the granddaughter of a retiree living in Puerto Vallarta, Mexico, to Jennifer Nading, March 28, 2007.

Case Study 3: The Good Life Is Possible In Mexico

Cost of living and climate were the main factors behind our move to Mexico. I think that a friend of mine said it best when I told her that we were moving to Mexico. She said, "It isn't just the cost of living—you like to live well!" And that is probably one of the other factors in making a decision to move to Mexico. This is probably a key incentive for many who make this move. You can live very well on a lot less here in Mexico. The good life is possible here.

The property taxes on our house in Mexico are $50 a year versus $5,000 a year in Texas. Additionally, we don't need homeowners insurance here and our car insurance is $240 a year. Manicures are $7, pedicures are $9, my haircut is $3, and a massage is $20. So you tell me why this is better than the U.S.

Another attraction to Mexico is the close proximity to Texas and the rest of the U.S.-Mexico border. You can drive to the border if you wish and if you fly you can be in Houston in just two hours. There are new locations for retirees, like Panama and Argentina, but these have a distance problem and the cost of transportation back to the states.

With the above being said, there is a glaring problem which we all face in making this our choice for a retirement location—medical needs. Since Medicare is not an option here, we struggle with different scenarios hoping to find the answer. So far, we really don't feel comfortable with the options that we have here in Mexico, which are the following:

1. **Purchase a medical insurance policy here in Mexico**. Each medical event brings a deductible payment and once you are over the age of 65 the cost per month goes up to around $450 per couple a month. That is a lot for those on a fixed income. The companies also will not cover any pre-existing conditions and most people our age have something that is considered to be pre-existing. We hear of companies who decide that even if you don't have a pre-existing condition they determine that your claim is from a pre-existing problem and refuse payment.

2. **Purchase a medical evacuation policy**. This is a good answer for getting us back to the U.S. in the event that we can be stabilized enough to make the trip in order to use Medicare. The problem is that you have to be able to afford to pay for lodging, a rental car, and food. It may be weeks before you are ready to return due to pre-op appointments or rehabilitation therapy. So you may be able to use Medicare, but you have a hefty bill to pay for the above necessities.

3. **Use IMSS**. This is okay and I believe it is probably the best solution. However, you hear some good stories and at the same time you hear horror stories. This is kind of scary as you really are not sure about who will be assisting you in surgery and doing other procedures.

Probably, of all the questions about retiring in Mexico, the question of medical care is the greatest. If it were a perfect world I could live with being covered by Medicare in Mexico for emergencies only, as the everyday small medical problems can be handled easily out-of-pocket. It makes no sense to deny us Medicare since the emergency and catastrophic problems could be handled here at such a lower cost to the U.S. government. If fraud is a concern, why is TRICARE allowed to be used here? How do they handle fraud?

So, will we stay in Mexico? For the time being we will remain here. But, we foresee that we will probably be forced to move back to the states in a couple of years. My husband has heart problems that will probably require us to move back, as we live in fear that he will need heart surgery and we don't know that we are *really* ready to depend upon IMSS. Would you be?

Should we move back to the U.S. we will most likely move to the Bryan/College Station area. Scott and White offers a very good Medicare Plus Choice type plan and there is a hospital and doctors that will accept it. So many towns, like Austin and Houston, are becoming poor destinations for seniors because the doctors in these locations are not willing to accept new Medicare patients. On the other hand Bryan/College Station is in a great location, handy to Austin and Houston, and it offers great services to its seniors.

Source: Edited e-mail correspondence from retiree in Lake Chapala, Mexico, to Jennifer Nading, January 30, 2007.

Case Study 4: Quality of Life and Fairness

I am 68 years old and my husband is 73. April 2007 marks the fourth year we have been living on the western coast of Mexico. Before retiring in Mexico, we used to live in the Midwest, where I was an interior designer and art consultant and my husband was an attorney. When we bought our house in Mexico, we would divide our time between Mexico and the Midwest. I was fully retired at this point, but my husband continued to travel between the two places for work. We decided to move to Mexico's western coast because the quality of life is better and life overall is much more affordable. In Mexico, we have a much more active lifestyle that also helps keep us healthy. Here I go swimming and/or train with a personal trainer every day, for only about $10 a day. My husband is also very active, as he plays golf and works out with a trainer every day. We are both as healthy as we have ever been and we enjoy a quality of life that we could not afford living in the United States.

My husband never had much need for medical care, but I have had many complications throughout my life that have resulted in my undergoing 12 surgeries thus far. All of these procedures have been done in the United States and my primary doctors are all still in the United States. Due to this, I have learned to take care of myself throughout the years, but this care resulted in too many expenses in the U.S. In Mexico, I have been able to do much more with my preventive care and have had a much better overall quality of life. The weather in Mexico's western coast is extremely agreeable, especially with my arthritis. Additionally, I was diagnosed with spinal stenosis, so I currently receive a massage and have acupuncture once a week—this care comes at a much lower cost here than it ever would in the United States, even though this is a cost that comes from my own pocket.

Up until now, we have been traveling to the Midwest every few months and I always schedule appointments with my doctors whenever we go. Even though it has sometimes been difficult to wait for our trips to the U.S. for a doctor's appointment, we are covered in the U.S. through Medicare and Blue Cross Blue Shield. While I am in Mexico, I keep in touch with my doctors through email, updating them on any changes in symptoms I might have. I see doctors in Mexico for minor maladies, usually at a minimal cost. I currently have an internist in Mexico that I see but this is all I can really afford since he only charges about $40 a visit, plus any other incidental fees. One example of the difficulties with the way I have been receiving health care is that lately I have been having a lot of pain with my Achilles and have been unable to see a doctor. I would have no problem seeing an orthopedist in Mexico, except that this condition is likely to require x-rays and subsequent surgery—all of which would have to come out of my own pocket. For this reason, I prefer to wait and endure the pain for another month until we go to the U.S. and I can see a doctor there, knowing that these services will be paid through Medicare coverage.

All of this will soon change, however, for two main reasons. First, my husband was recently diagnosed with Alzheimer's and we are thus adjusting to the changes this will bring to our lives. My husband has since fully retired and we are in the process of selling

our apartment in the United States and will thus have less of an incentive to travel to the U.S. as often as we currently do. This will in turn limit our access to health care in the United States since we will now travel to the U.S. only 2-3 times a year.

Since my husband's diagnosis, we have both taken steps to make sure we're prepared when he begins to deteriorate. Here, we have a gardener that we are teaching to drive our car so he can drive my husband around when Alzheimer's limits his ability to do so; in the U.S., we would not be able to afford this. We do have an insurance policy for senior care that will cover the costs of my husband's senior care—care that is much less expensive in Mexico than in the United States. Here, my husband can be fully taken care of and he is in an environment that is very enjoyable to him, but for other medical expenses, neither of us have coverage. If we were in the United States, I could not afford this care for my husband.

Once you're 65, you can't get insurance in Mexico, so we have no access to coverage at this point. This is a difficult position to be in, especially knowing that I am fully covered in the United States by a system that I paid into my entire life. If I had the benefits that I am eligible for extended to Mexico, I would use all of the facilities here in Mexico without hesitation. They have great facilities and doctors here at a reduced price. For example, a colonoscopy in Mexico is about $300, whereas the same procedure in the Midwest is about $3,600. I wouldn't hesitate to have a colonoscopy in Mexico. It's a shame that I've invested so much all these years into the Medicare system and now, because we've chosen an easier lifestyle, we essentially pay double the cost. I would like to have access to my Medicare benefits here in Mexico, and I would be content with paying out of pocket and then sending a *factura* or detailed bill of the cost to Medicare and be reimbursed, to decrease any probability of corruption.

There are reasons people move down to Mexico such as the quality of life, the climate, and the cost of living. Now as the baby boomers are retiring and many of them are also choosing to move down to Mexico after retirement, there will be a much higher demand for extending their benefits to Mexico. The world is smaller and people have many more choices today as to where they choose to retire.

Source: Telephone interview conducted by Karla Vargas with an American retiree on the western coast of Mexico, April 10, 2007.

Chapter 14. Legal Considerations in Mexico and the United States Affecting Medicare and Social Security Benefits for Eligible Retirees

by Erin Daley

Introduction

In looking at the option of extending Medicare benefits to retirees living abroad in Mexico, there are two principal populations that could benefit from this possibility: (1) United States citizens, and (2) Mexican citizens with Lawful Permanent Resident status in the United States. In order to understand the feasibility of extending Medicare benefits to eligible retirees living in Mexico, it is important to understand the legal factors in both the United States and Mexico that could affect the desirability and feasibility of this option for both of these groups. This chapter explores United States laws related to immigration that may affect access to Social Security and Medicare benefits for non-citizen retirees as well as Mexican immigration laws relevant to United States citizens retiring to Mexico.

United States Legal Considerations

The three major immigration categories employed by United States Citizenship and Immigration Services (USCIS) are the following: (1) Non-immigrant, (2) Lawful Permanent Resident (and Conditional Resident), and (3) Citizen.[1] Both United States citizens and Lawful Permanent Residents have the right to receive Social Security and Medicare benefits provided they have worked in the United States for 40 quarters.[2] Non-immigrants, or visitors, include those coming to the United States temporarily such as tourists, business visitors, students, and temporary workers.[3] These visitors have no entitlement to Social Security or Medicare.

Lawful Permanent Residents (LPR) are those immigrants holding a "green card" or lawful permanent resident card which allows them several rights.[4] Among other things, these rights generally include living and working permanently anywhere in the U.S., applying for naturalization once eligible, requesting an immigrant visa for one's spouse and unmarried children to live in the U.S., getting Social Security, Supplemental Security Income, and Medicare benefits, if eligible, owning property in the U.S., and traveling outside the U.S. under certain conditions.[5]

Lawful Permanent Residents have the responsibility to maintain their status as United States residents. Those who leave the United States for extended periods, or who cannot show their intent to live permanently in the U.S., may lose their permanent resident status.[6] For this reason, USCIS advises these residents to apply for a re-entry permit before leaving the U.S. if they think they will be out of the U.S. for more than 12 months.[7] This permit is valid for up to two years and shows that the person is returning

from a temporary visit abroad. If the resident does not return to the U.S. before his/her re-entry permit expires or did not apply for a re-entry permit before leaving the U.S. and has been outside the U.S. for more than 12 months, s/he may be able to get a special immigrant Returning Resident visa overseas from the Department of State.[8] Nonetheless, this option only affords a Lawful Permanent Resident a temporary solution for relatively short trips and does not allow him/her to spend indefinite time abroad. Thus, retiring abroad for a Lawful Permanent Resident is not a viable option if s/he wishes to maintain LPR status.

Social Security coverage abroad depends upon the citizenship of the beneficiary as well as in which country s/he is living. For a Mexican citizen, coverage will not lapse for the primary beneficiary when living abroad unless s/he is living in Cuba, North Korea, Cambodia, Vietnam, or some parts of the former Soviet Union.[9] However, coverage for the dependents of a Mexican citizen who is a Lawful Permanent Resident in the United States has more restrictions. With few exceptions, the dependent must have been living in the United States for at least five years during which the family relationship on which benefits are based must have existed.[10] Another important way that Social Security works for individuals residing abroad is through Social Security Totalization Agreements. These agreements coordinate U.S. Social Security benefits with comparable programs of other countries. While totalization agreements are now in place between the United States and 21 other countries, no such agreement is currently in place between the United States and Mexico, meaning that workers may be required to pay Social Security taxes to both countries on the same earnings.[11] While an agreement was signed in 2004 by the United States Social Security Commissioner and the Director General of the Mexican Social Security Institute, it must be submitted for review by Congress both in the United States and Mexico.[12]

Medicare eligibility is dependent upon Social Security eligibility. Therefore, the requirements listed above apply. However, it is important to note that, unlike Social Security, Medicare benefits only apply to care received in the United States.[13] United States immigration law states that a Lawful Permanent Resident living abroad for longer than six months (with some exceptions) will lose his/her status as a resident in the United States.[14] Thus, presumably, if this individual attempts to return to the United States to receive Medicare benefits after having been outside the U.S. for longer than six months, s/he may not be allowed to enter the country and thus, would be unable to access Medicare benefits.

A subcategory of LPR is a Conditional Resident. Individuals are granted status as Conditional Residents when they have been married to their U.S. citizen spouse for less than two years when residence status is granted.[15] Also, this individual's child may be a Conditional Resident and some immigrant investors may be considered Conditional Residents.[16] A Conditional Resident has the same rights and responsibilities as a permanent resident, but must file a petition to remove the conditions on residence within two years of the date s/he was granted conditional permanent resident status.[17] If s/he does not do so, s/he will lose his/her immigration status.

A special type of LPR includes those living outside of the United States but close to the border. LPRs may live in Canada or Mexico without losing their status if they commute regularly to employment in the United States. These individuals are considered special immigrants under the Immigration and Naturalization Act and are referred to as "alien commuters."[18] Alien commuters include those who commute daily into the United States to work and those who enter just during a particular time of year to do seasonal work. An alien commuter's time in this status does not count towards the time needed for a Lawful Permanent Resident to be eligible to apply for naturalization.[19] However, alien commuters are required to pay Federal Insurance Contributions Act (FICA) taxes on their earnings in the United States, thus contributing to both Social Security and Medicare.[20]

United States citizens include both those granted citizenship by birth and those who have been naturalized. Naturalization requires a period of continuous residence and physical presence in the United States, an ability to read, write, and speak English, knowledge and understanding of United States history and government, an attachment to the principles of the United States Constitution, and giving up allegiance to any other country.[21] Both United States-born citizens and naturalized citizens have the same rights and have considerably more freedom than Lawful Permanent Residents with respect to where they choose to reside. Although earlier immigration law stated that naturalized citizens could lose their citizenship by remaining outside the United States for a long period of time or by setting up a permanent residence abroad one year after naturalization, today all United States citizens have the right to enter and leave the country as they wish for the amount of time that they wish without losing their citizenship.[22] There are only two ways that citizenship may be lost. The first way is denaturalization, which is the revocation of naturalization for individuals who were not qualified for naturalization when it was granted.[23] The second way citizenship may be lost applies both to United States-born citizens and naturalized citizens and is known as expatriation.[24] For expatriation to occur, an individual must voluntarily abandon his or her citizenship either by formally stating so to the Department of State or by engaging in certain types of activities "with the intention of relinquishing United States nationality."[25]

Mexican Immigration Laws

The three broad immigration categories used by the Mexican *Instituto Nacional de Migración* (National Immigration Institute), or INAMI, are *no inmigrante* (non-immigrant), *inmigrante* (immigrant), and *inmigrado* (immigrated).[26] With some exceptions, the category of *no inmigrante* is similar to the category of non-immigrant in the United States and the categories of *inmigrante* and *inmigrado* correspond roughly to the categories of Conditional Resident and Lawful Permanent Resident, respectively.[27] While all immigration procedures related to these statuses are handled by INAMI, the Mexican *Secretaría de Relaciones Exteriores* (Foreign Relations Secretariat) handles naturalization procedures.[28]

A United States citizen can enter Mexico as a non-immigrant under various types of visa categories including *turista* (tourist), *transmigrante* (transmigrant), *visitante* (visitor), *ministro de culto* (religious minister), *asiliado politico* (political asylee), *refugiado*

(refugee), *estudiante* (student), *visitante distinguido* (distinguished visitor), *visitante local* (local visitor), *visitante provisional* (provisional visitor), and *corresponsal* (correspondent).[29] The most likely category for a United States citizen entering Mexico under this visa for retirement purposes is as a tourist. As a tourist, the individual must not engage in any paid work and may be granted permission to stay in the country for a maximum of six months, with no possibility of extension.[30] Thus, any retired person in Mexico under this immigration status would have to make semi-annual visits to the United States at a minimum in order to avoid violating Mexican immigration law.

Another possibility for retired United States immigrants to enter Mexico as a non-immigrant would be under the status of visitor. The immigration category of visitor is further subdivided into *visitante rentista* (person of independent means), *visitante de negocios o inversionista* (business or investment visitor), *visitante técnico o científico* (technical or scientific visitor), *visitante artista o deportista* (artist or athletic visitor), *visitante observador de derechos humanos o procesos electorales* (observer of human rights or electoral processes), *visitante cargo de confianza* (visitor in a position of confidence), *visitante consejero* (adviser), and *visitante profesional* (professional visitor).[31] While a few visitor categories could potentially fill a temporary immigration need for some U.S. citizens, entry under these categories requires that the visitor engage in specific activities and visitors under each of these categories are only permitted to stay in Mexico for a maximum of one year. The non-immigrant category of transmigrant allows for a maximum of a 30-day stay when passing through the country and the other non-immigrant categories have very narrow focuses and are not likely to apply to many United States retirees in Mexico.[32] Thus, the non-immigrant visa is not a viable option for retired United States citizens wishing to live continuously in Mexico and maintain a legal immigration status.

The immigration category of immigrant in Mexico allows foreigners to stay in Mexico for up to five years with annual extensions.[33] This status applies to foreigners who are legally admitted to the country for the purposes of residing in it as well as non-immigrants already in Mexico who change their status to immigrant at a regional office of the INAMI. There are several possible ways to obtain immigrant status in Mexico, which include: *rentista* (person of independent means), *inversionista* (investor), *profesional* (professional), *cargo de confianza* (position of confidence), *científico* (scientist), *técnico* (technical or specialized worker), *familiares* (family-based immigration), *artistas y deportistas* (artists and athletes), and *asimilados* (assimilated).[34]

Most retired United States citizens who want to obtain the status of immigrant in Mexico would most likely only be eligible as a *rentista*. This immigration category applies to a foreigner who lives in Mexico permanently with income from another country. The Mexican government sets a minimum monthly income necessary in order to qualify for this immigration category. The INAMI website currently contradicts itself, stating both 250 and 400 times the daily minimum wage in Mexico City as the required minimum monthly income to qualify as an immigrant under the status of *rentista*.[35] As of January 1, 2006, this wage was set at 48.67 Mexican pesos (approximately USD$4.42), so an individual wishing to obtain the immigrant status under this category would need to

receive between USD$1,105 and USD$1,768 per month.[36] The requirement for additional family members is half the requirement for the first member, so if INAMI uses the rate of 250 times the daily minimum wage, a married couple would need to have income at 375 times the daily minimum wage (roughly USD$1,657 per month), and if INAMI uses the rate of 400 times the minimum wage, a married couple would need to have income at 600 times the daily minimum wage (roughly USD$2,652 per month). The rate required may also be reduced to 50 percent of the above listed rates if the individual or couple owns their own home in Mexico.[37]

Any person who has obtained immigrant status in Mexico and has lived in the country for five years may apply for the immigration status of immigrated. An immigrated person is a foreigner who has obtained the right to live permanently in the country.[38] Similar to the status of Legal Permanent Resident in the United States, however, this status can be lost if an individual spends significant time abroad. Although an immigrated person may come and go freely, if s/he spends more than three consecutive years abroad or more than five years abroad in any ten-year period, s/he will lose his/her immigration status.[39]

It is important to mention that many U.S. citizens retired in Mexico refer to their legal status in Mexico with respect to the immigration document they are granted as opposed to the more specific categories mentioned above. One of the most common immigration documents held by U.S. citizens in Mexico is the FMT, or tourist visa, which corresponds to the non-immigrant visa category of tourist.[40] The FM3 visa is another type of non-immigrant visa, which covers several different types of non-immigrant activities such as visitor (and its subcategories mentioned above), religious minister, political asylee, refugee, student, and correspondent.[41] Lastly, the FM2 visa is an immigrant visa, which can be granted under several different subcategories as well.[42]

Foreigners may also apply for Mexican citizenship after having lived for five consecutive years in Mexico under an FM2 visa by presenting an application to the *Secretaría de Relaciones Exteriores* (Foreign Relations Secretariat). In order to obtain citizenship, the individual must also demonstrate knowledge of the Spanish language as well as Mexican history.[43]

Conclusion

In summary, according to both Mexican and United States laws, retiring in Mexico is a viable option for United States citizens. They do not lose their legal right to any of the privileges they are granted as citizens and also may be eligible for immigrant and subsequently immigrated status in Mexico, depending on their monthly income. However, this is not a viable option for United States Lawful Permanent Residents wishing to maintain their immigration status in the United States. The only option for Lawful Permanent Residents wishing to retire to Mexico and maintain their right to live and work in the United States is to first apply for naturalization, which would afford them the right to move freely between the United States and Mexico.

Notes

[1] United States Citizenship and Immigrations Services, *United States Department of Homeland Security*. Online. Available: http://www.uscis.gov. Accessed: September 8, 2006.

[2] United States Social Security Administration. *Social Security Online.* Online. Available: http://www.ssa.gov. Accessed: December 4, 2006.

[3] Ibid.

[4] United States Citizenship and Immigration Services, *Welcome to the United States: A Guide for New Immigrants*. Online. Available: http://www.uscis.gov/graphics/citizenship/M-618.pdf. Accessed: September 8, 2006.

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] United States Social Security Administration, *Your Payments While You are Outside the United States*. Online. Available: http://www.ssa.gov/pubs/10137.pdf. Accessed: December 4, 2006.

[10] Ibid.

[11] United States Social Security Administration, *Social Security Online* (online).

[12] Ibid.

[13] United States Department of State, *Bureau of Consular Affairs.* Online. Available: http://travel.state.gov. Accessed: December 4, 2006.

[14] United States Citizenship and Immigration Services, *Welcome to the United States: A Guide for New Immigrants* (online).

[15] Ibid.

[16] Ibid.

[17] Ibid.

[18] Code of Federal Regulations, ch. 8, sec. 211.5. Online. Available: http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?YEAR=current&TITLE=8&PART=211&SECTION=5&SUBPART=&TYPE=TEXT. Accessed: March 6, 2007.

[19] Code of Federal Regulations, ch. 8, sec. 211.5. (online).

[20] United States Social Security Administration, *Social Security Rulings and Acquiescence Rulings On Federal Old-Age, Survivors, Disability, Supplemental Security Income, and Black Lung Benefits, SSR 86-11c.* Online. Available: http://www.ssa.gov/OP_Home/rulings/oasi/45/SSR86-11-oasi-45.html. Accessed: December 5, 2006.

[21] The Immigrant Legal Resource Center, *Naturalization and United States Citizenship: The Essential Legal Guide*, 2004 edition, San Francisco, CA, 2004.

[22] Ibid.

[23] Ibid.

[24] Ibid.

[25] U.S. Code, title 8, ch. 12, sec. 1481. Online. Available: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+8USC1481. Accessed: March 6, 2007.

[26] Instituto Nacional de Migración, *Secretaría de Gobernación, Instituto Nacional de Migración*. Online. Available: http://www.inami.gob.mx. Accessed: September 8, 2006.

[27] Ibid.

[28] Secretaría de Relaciones Exteriores de México. *Nacionalidad y Naturalización*. Online. Available: http://www.sre.gob.mx/tramites/nacionalidad/default.htm. Accessed: September 10, 2006.

[29] Instituto Nacional de Migración, *Servicios Migratorios, Calidades y Características Migratorias, No Inmigrante.* Online. Available: http://www.inami.gob.mx/paginas/211000.htm. Accessed: September 8, 2006.

[30] Ibid.

[31] Ibid.

[32] Ibid.

[33] Instituto Nacional de Migración, *Servicios Migratorios, Calidades y Características Migratorias, Inmigrante.* Online. Available: http://www.inami.gob.mx/paginas/212000.htm. Accessed: September 8, 2006.

[34] Ibid.

[35] Instituto Nacional de Migración, *Servicios Migratorios, Calidades y Características Migratorias, Inmigrante* (online); and Instituto Nacional de Migración, *Servicios Migratorios, Trámites y Requisitos,*

Internación en la Calidad Migratoria de Inmigrante, Rentista. Online. Available: http://www.inami.gob.mx/paginas/tramitesrequisitos/221210.htm. Accessed: September 8, 2006.

[36] Comisión Nacional de los Salarios Mínimos, Secretaría del Trabajo y Previsión Social. Online. Available: http:www.conasami.gob.mx. Accessed: September 10, 2006.

[37] Instituto Nacional de Migración, *Servicios Migratorios, Trámites y Requisitos, Internación en la Calidad Migratoria de Inmigrante, Rentista* (online).

[38] Instituto Nacional de Migración, *Servicios Migratorios, Calidades y Características Migratorias, Inmigrado.* Online. Available: http://www.inami.gob.mx/paginas/213000.htm. Accessed: September 8, 2006.

[39] Instituto Nacional de Migración, *Marco Jurídico y Organizacional, Manual de Trámites Migratorios,* Online. Available: http://www.inami.gob.mx/paginas/leyes/manualtramitesmigratorios/126000_l_mtm_ 08secc03.htm. Accessed: September 8, 2006.

[40] Instituto Nacional de Migración, *Secretaría de Gobernación, Instituto Nacional de Migración* (online).

[41] Ibid.

[42] Ibid.

[43] Secretaría de Relaciones Exteriores de México. *Ley de Nacionalidad.* Online. Available: http://www.sre.gob.mx/tramites/nacionalidad/leynacionalidad.htm. Accessed: September 10, 2006.

Chapter 15. Health Benefits Abroad: TRICARE and the Foreign Medical Program

by Marina M. Zolezzi

Introduction

In looking to analyze the portability of Medicare benefits to eligible retirees in Mexico, it is important to understand the structure and current experiences of the existing health care programs that provide services to eligible U.S. beneficiaries in Mexico. TRICARE for Life Overseas (TOP TFL) and the Foreign Medical Program (FMP) are two programs that provide health care to eligible beneficiaries residing in Mexico. Research in these programs could help determine the feasibility of creating an administrative network that would pay for and provide Medicare benefits for Americans in Mexico.

Department of Defense: TRICARE

TRICARE, formerly known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), is a military health care program provided by the U.S. Department of Defense for members of the U.S. uniformed services, military retirees, their families, and survivors.[1] Members of the following seven U.S. uniformed services groups are covered by TRICARE: Army, Air Force, Navy, Marine Corps, Coast Guard, Public Health Service, and the National and Oceanic and Atmospheric Administration.[2]

TRICARE provides medical care through one of its three following programs: TRICARE Standard, TRICARE Extra, and TRICARE Prime. TRICARE Standard is a fee-for-service plan that allows recipients to use any civilian health care provider that is TRICARE certified or authorized.[3] Although enrollment is not necessary to participate in the Standard program, beneficiaries are responsible for their annual deductibles and cost shares associated with the care.[4] Under this program the beneficiary may be responsible for filing his/her own claim(s). TRICARE Standard benefits are available outside of the U.S.[5]

TRICARE Extra is an option that is available for TRICARE Standard beneficiaries which comes into effect when a TRICARE Standard beneficiary chooses to select a TRICARE in-network provider for care.[6] TRICARE Extra is a Preferred Provider Network plan; it features care providers who are part of an organized network. This process minimizes costs as the beneficiary's co-payment for an in-network provider appointment is 5 percent less than what it would have been with an out-of-network provider that is TRICARE certified or authorized. Under this program, the network provider files the claim on behalf of the beneficiary. Enrollment is not necessary to participate in the TRICARE Extra program but beneficiaries are responsible for their annual deductibles and cost shares associated with the care.[7]

TRICARE Prime is a health maintenance organization-style plan. Beneficiaries are required to enroll in order to participate in the TRICARE Prime program (there is a fee for enrollment for non-active duty members).[8] Under this program, beneficiaries must also choose a Primary Care Manager (PCM) and request referrals and authorizations for specialty care.[9] Most TRICARE Prime beneficiaries receive care at a Military Treatment Facility (MTF). TRICARE prime benefits are available outside of the U.S.[10]

Coverage by TRICARE is divided into the following four regions: North, South, West (in the U.S.), and Overseas.[11] The TRICARE Overseas offices are divided into three main regions which include TRICARE Pacific, TRICARE Europe (includes Africa and the Middle East), and TRICARE Latin America/Canada.[12] The TRICARE program options that are delivered overseas include TRICARE Prime (not available for retirees and their families living abroad), TRICARE Global Remote Overseas (Prime benefits available in designated remote overseas areas), TRICARE Standard, and TRICARE for Life Overseas.[13] TRICARE Standard covers military retirees who are not eligible for Medicare (such as those under age 65).[14] Before TRICARE for Life was established, retirees who were living abroad and covered under TRICARE would lose their coverage once they were eligible for Medicare Part A. For the purpose of this analysis, the TRICARE for Life Overseas program, which is a TFL program under the TRICARE Overseas Program Standard, would be the most relevant option to a discussion of Medicare in Mexico. The TRICARE for Life program began in 2001 and is funded by the DOD Medicare Eligible Retiree Health Care Fund, which is funded by annual appropriation contributions and general revenues from the U.S. Treasury.[15]

TRICARE for Life Overseas

TRICARE for Life Overseas, or TOP TFL, is a type of coverage available worldwide to TRICARE and Medicare-eligible (dual-eligible) beneficiaries residing abroad. In order to receive TOP TFL benefits, dual-eligible beneficiaries must pay Medicare Part B premiums.[16] Since Medicare does not provide medical care outside the United States (with a few exceptions) TRICARE becomes the primary source of health benefits for eligible retirees located abroad.[17] In the United States and areas outside the United States where Medicare is available (such as Guam and Puerto Rico), TRICARE would act as the secondary source of health benefits after Medicare.[18]

Eligibility

TFL Overseas is available to all TRICARE and Medicare dual-eligible Uniformed Services beneficiaries (regardless of age due to end-stage renal disease or disability) including:[19]

- Dual-eligible uniformed service retirees (including retired guard members and reservists);
- Dual-eligible family members and widows/widowers (with the exception of dependent parents and parents-in-law);

- Dual-eligible Medal of Honor recipients and their family members; and
- Dual-eligible unremarried former spouses.

In order to be eligible for TOP TFL, one must belong to one of the categories previously mentioned and provide proof of purchase of Medicare Part B (Medicare Card), as well as a valid Uniformed Services identification card.[20]

TOP TFL Costs

The TFL overseas program provides the same coverage as the TRICARE Standard program. In the TRICARE Standard program, beneficiaries are responsible for paying cost shares and annual deductibles. The deductible is based on a fiscal year which runs from October 1 through September 30.[21] The following table displays health care costs outside of the United States and its territories (given it is outside a MTF).[22]

Table 15.1
TRICARE 2006 Health Care Coverage Outside U.S. and Military Treatment Facilities

	Medicare Pays	TRICARE Pays	Beneficiary Pays
Inpatient Care	Nothing	75%	25% of TRICARE Allowable Charges plus 25% of professional fees
Outpatient Care	Nothing	75%	25% of TRICARE allowable charges after annual deductible has been met ($150/person and $300/family)

Adapted from: Office of the Assistant Secretary of Defense- Health Affairs, and the TRICARE Management Activity, United States Department of Defense, *TRICARE for Life, 2006 Health Care Coverage: Who Pays?* Online. Available: http://www.tricare.mil/tfl/tflcostmatrix_b.html. Accessed: September 10, 2006.

It is important to note that TRICARE has a $3,000 per fiscal year "catastrophic cap" (maximum out-of-pocket expenses). After this maximum out-of-pocket cap is reached the beneficiary under TOP TFL is not required to pay any additional deductible or cost share needed for allowable health services for the rest of the fiscal period.[23] TRICARE's schedule of allowable charges does not apply to overseas retirees and TOP TFL reimburses based on the actual cost of services. It is important to note though, the schedule of allowable charges is currently being edited and may include rates overseas.[24]

TOP TFL Access to Health Care

For coverage under TOP TFL, beneficiaries may seek care from a qualified host nation provider without the requirement of obtaining prior authorization or a referral.[25] According to Chapter 12, Section 4.1 of the TRICARE Policy Manual 6010.54-M: TRICARE Overseas Program, the definition of a host nation provider is "an overseas hospital or individual licensed to practice or deliver health care overseas." [26]

TOP TFL Claims

In the TOP TFL (a fee-for-service plan) the beneficiaries are responsible for paying upfront for their care, usually in host nation currency, unless the provider is willing to submit a claim on behalf of the patient. Beneficiaries are also responsible for filing their own claims with the TRICARE Overseas Claims Processor, the Wisconsin Physicians Service (WPS), unless the provider is submitting the claim.

Claims are submitted to the following address:[27]

TRICARE Overseas
P.O. Box 7985
Madison, WI 53707-7985

The beneficiary is reimbursed minus the 25 percent outpatient cost-share or minus the appropriate inpatient cost-share pending successful completion of the following requirements:

- Must submit DD Form 2642- Patient's Request for Medical Payment along with medical receipts (itemized bill with provider's billing letterhead) to the TRICARE Overseas claim processor.

- Pay annual deductible.

- Benefit costs that are being claimed for reimbursement must be identified in the TRICARE Standard Handbook (medically necessary care and provided at an "appropriate level of care").[28]

Since WPS has experience with handling international claims, this organization can provide a model for developing a reimbursement system for a research and demonstration project related to Medicare portability to Mexico.

In regards to the dispute process, TRICARE does not get involved in disputes between doctors and beneficiaries. The legal framework within the respective host country handles disputes between doctors and beneficiaries.[29] If additional information is needed to determine whether a procedure is medically necessary, WPS will request additional information from the provider. The provider will have between two to three months to submit the documentation.[30] If the beneficiary paid out of pocket, the beneficiary has the responsibility to follow up with the provider to submit all necessary documentation in

order to receive reimbursement from WPS. The beneficiary can appeal the decision up to three times before it is sent for a final review to the TRICARE Management Activity Office (TMA) in Colorado.[31]

Fraud

The TRICARE Management Activity Program Integrity (TMA PI) office is responsible for "all anti-fraud activities worldwide for the Defense Health Program."[32] This office focuses on the prevention, detection, investigation, and control of TRICARE fraud, waste, and program abuse.[33] For example, during the year 2004, TRICARE was able to recover $6,000,000 from judgments related to fraudulent activities.[34] The TRICARE Fraud and Abuse website provides information such as fraud news and data on providers who have been sanctioned. The TMA PI office would be a great example to reference for a Medicare in Mexico demonstration project, in that it provides an existing structure for preventing and detecting overseas fraudulent activities.

TRICARE in Mexico

TRICARE coverage is available to U.S. eligible retirees in Mexico, thus, this program provides information regarding the framework that would be needed when extending Medicare benefits to Mexico. A resident of San Miguel de Allende commented in a prior LBJ School research project, "I have never understood why Medicare A and B are not available to U.S. residents in Mexico. CHAMPUS (now TRICARE) is able to provide reimbursement worldwide-why not Medicare?"[35] It is popular to question why programs such as TRICARE extend benefits to U.S. eligible retirees in Mexico while Medicare does not. An analysis of the TRICARE benefits, costs, processes, and experiences in Mexico will provide an understanding of how the program currently functions in Mexico.

TRICARE for Recipients in Mexico

In Mexico, the TOP TFL beneficiaries are free to choose where to seek health care services as long as the provider is a host nation provider. The U.S. military does not have MTFs in Mexico, therefore, there are no established set of network providers. Puerto Rico and Cuba are the only two MTF country locations representing the Latin America/Canada region.[36] In addition, there are no TRICARE Service Centers in Mexico (TSCs are located in Cuba and Puerto Rico for the Latin America Area).[37] Therefore, beneficiaries must research health care providers within their area. In many communities where there are large groups of U.S. retirees, the most prevalent way of finding health care providers is through the recommendations provided by the retiree community. The U.S. embassy is another source for U.S. retirees searching for information regarding health care services provided in Mexico.

Recipients using TRICARE for Life benefits in Mexico must follow the same TOP TFL requirements previously mentioned regarding claims process and cost table requirements. Beneficiaries in Mexico are responsible for paying upfront for their care and are responsible for submitting their own claims unless the provider in Mexico is willing to

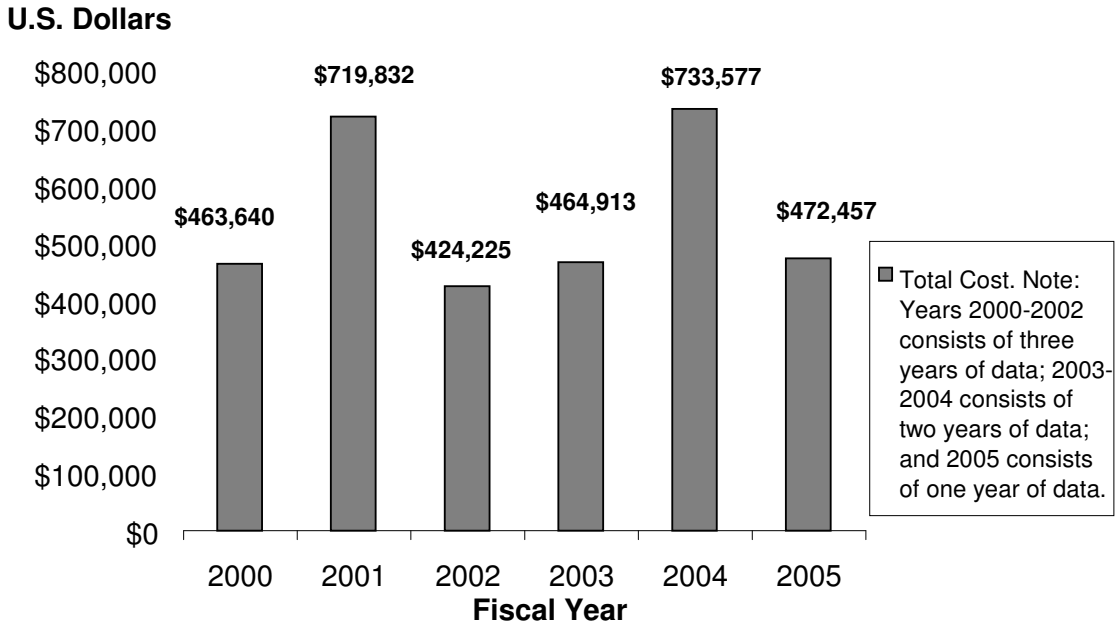
submit a claim on behalf of the patient. All TRICARE overseas claims are handled by the WPS therefore; claims from Mexico are processed in the U.S.

TRICARE Program in Mexico

In 2004, TRICARE received a total of 502 claims from retirees and dependents of retirees/deceased in Mexico. Of these claims, the government paid $715,701 and the retirees and dependents of retirees/deceased paid $17,876.[38] In 2000, before the TRICARE for Life program was implemented, TRICARE received a total of 330 claims from retirees and dependents of retirees/deceased in Mexico costing the government $450,210 and the beneficiaries $13,430. During the fiscal year 2001, with TOP TFL in place, TRICARE received a total of 447 claims from retirees and dependents of retirees/deceased in Mexico costing the government $711,199 and the beneficiaries $8,633. From 2000 to 2004, on average TRICARE received 416 claims annually from retirees and dependents of retirees/deceased. Within the 2000 to 2004 timeframe, the average yearly cost for the government was $549,962 and the average yearly cost for the beneficiaries was $11,276.[39] (See Figure 15.1).

.1

Figure 15.1
Government and Beneficiary Costs for Retirees and Dependents of Retirees/Deceased in Mexico, TRICARE Program



Adapted from: TRICARE Management Activity Report Center, *Foreign Country Reports:2000- 2005*. Online. Available: http://199.211.83.250/. Accessed: September 21, 2006.

In general, services including health care are cheaper in Mexico compared to the same health care services provided in the U.S. Due to the lower costs of receiving health care in Mexico, TRICARE saves money because the program pays less to reimburse a patient in Mexico than it would in the U.S. Since there are no MTFs and TSCs in Mexico, and the health care services are cheaper in Mexico, the overall cost of extending TRICARE coverage in Mexico is relatively low.

The possibility of fraud remains when extending benefits abroad. Regarding overseas fraud, the TRICARE Fraud and Abuse website indicates that any fraudulent activities should be reported to the Humana Military Healthcare Services located in Kentucky.[40] Since claims in Mexico are cheaper than those from the U.S., major cases of fraud should be easy to detect. There is currently no accessible data regarding TRICARE fraud cases in Mexico. Some measures have been taken regarding fraud in Latin America. For example, some countries in Latin America have been required to adhere to the allowable charge schedule implemented in Puerto Rico.[41] This action is used as a temporary measure during the investigation of the fraud. There is the possibility that TOP TFL will move towards a country-specific schedule of charges.

Experiences with TRICARE in Mexico

Interviews conducted in Guadalajara and Chapala, Jalisco, during October 2006 indicated that doctors and facilities showed some concerns regarding reimbursements from TRICARE. Some of the hospitals reluctantly accept TRICARE because it was expressed that the time it took for them to be reimbursed was lengthy, leaving the hospital with the financial burden to cover the expenses in the meantime.[42] Another concern was that the doctors and hospitals have recently seen a decrease in the reimbursement amount for each patient. Although these concerns are present, a number of retirees heavily depend on the TRICARE program to pay for their medical care in Mexico. According to the Medicare in Mexico LBJ School of Public Affairs survey, about 2 percent of the 1,025 U.S. retiree respondents depend on TRICARE to pay for their medical care in Mexico.[43]

TRICARE Conclusion

TRICARE is one of the existing health care programs for eligible U.S. retirees in Mexico. TRICARE's operation allows for this program to be an excellent model in framing an administrative network for extending Medicare benefits in Mexico. There are limits in replicating the TRICARE model such as the absence of service centers, the absence of network providers in Mexico, and the relatively small size (compared to Medicare) of the program itself. Yet, TRICARE's overseas procedures, WPS's experience in processing and reimbursing claims from Mexico, and the established TRICARE Management

Activity Program Integrity (TMA PI) office responsible for preventing and controlling fraud are excellent resources that could be used for developing a demonstration project.

Department of Veteran Affairs: Foreign Medical Program

The Foreign Medical Program is a program created by the Department of Veteran Affairs in order to provide health care benefits to U.S. veterans with VA-rated service-connected conditions who are residing or traveling abroad.[44] There are countries that are excluded from the program, such as North Korea, Cuba, and Iraq.[45] All abroad services are provided by the FMP office located in Denver, Colorado, including application processing, verification of eligibility, authorization of benefits, and claims processing.[46] A separate office located in White River Junction, Vermont, handles claims from U.S. veterans in Canada.[47] Research in this program could help determine the feasibility of creating a structure that would pay for and provide Medicare benefits for Americans in Mexico.

Foreign Medical Program Organization

Cost Shares and Deductibles

In general, if the care is medically necessary and it is VA service-connected condition, the care is covered fully by the Foreign Medical Program (with a few exceptions).[48] Before receiving benefits for service-connected disabilities, beneficiaries need to obtain prior authorization from the FMP office in order to obtain a letter of authorization identifying the VA-rates service-connected conditions. Treatment received by the beneficiary needs to fall under the accepted medical procedures approved by the VA and the U.S. medical communities.[49] Only prescription medicines approved for use by the U.S. Food and Drug Administration (FDA) are covered under FMP. The approved prescription medicines must be prescribed for the use of a service-connected condition.[50]

Regional Offices and Access to Health Care

There are VA regional offices that are responsible for establishing service-connected conditions. The office that represents veterans in Mexico, South and Central America, and the Caribbean is located in Houston, Texas.[51] Beneficiaries may select a provider of their choice, but it is recommended that they check with the U.S. embassy to find providers accepting FMP.[52]

Claims Process and Payment

According to the Foreign Medical Program, either a provider or a beneficiary can submit a claim for reimbursement. When a beneficiary submits a claim, he/she needs to provide information such as the VA Claim Number, Provider's information, Discharge Summary, Itemized Statement of Charges, and other information. Requirements for submitting a claim are described in FMP fact sheet 1-30.[53] All claims and reimbursements are processed by the Foreign Medical Program, a division within the VA Health Administration Center, thus there are no fiscal intermediaries. It is recommended by the

FMP office that the providers produce their documentation in English in order to facilitate the claims process.

Payments made for FMP are made using U.S. Treasury checks in U.S. currency. Currency is taken at the exchange rate based on the day services were rendered or in the case of hospitalization, the discharge date.[54] FMP does not pay for the cost beneficiaries incur when converting the U.S. Treasury check into their respective country's currency.[55] According to the FMP Fact Sheet for providers, FMP pays 95 percent of the claims received within a period of 45 working days.[56]

Cost to Run FMP

During the 2006 fiscal year, $10.27 million dollars in costs were associated with running the FMP Program.[57] As of January 2007, there were 16,751 beneficiaries enrolled in the FMP Program representing about 139 countries (number reflects both those living and traveling abroad).[58]

In regards to the volume of claims, during the 2006 fiscal year, there was an average monthly number of claims worldwide equaling to 1,225. During the 2005 fiscal year, the average monthly number of claims worldwide was 800.[59] The following are average payments made for each type of claim during the 2006 fiscal year:[60]

- Average payment for an inpatient claim: $4,898.00.
- Average payment for an outpatient claim: $239.00.
- Average payment for a pharmaceutical claim: $124.00.

The top countries with the highest volume of claims include Germany, Panama, Mexico, Australia, and Costa Rica.[61]

Fraud

FMP uses their judgment to detect fraudulent cases.[62] Past claims for similar services within a country, are used as guidelines for payment levels. If there is a suspicion of fraud, FMP will hold the claim and not pay it until the issue is resolved.[63] Fraudulent activities against FMP generally arise from third-party billers.[64]

FMP in Mexico

An analysis of the FMP costs, processes, and experiences in Mexico will provide an understanding of how the program specifically functions in Mexico. Mexico falls within the top three countries under the FMP program with the highest volume of claims.[65] During Mexico's entire history under the FMP program (January 1995 to January 2007), there were a total of 13,035 veterans filing claims for a total of $1,638,807.40.[66] During 2006, there were 55 separate users who filed claims in Mexico (both living and traveling in Mexico). From January 2006 to January 2007, the number of claims from Mexico paid by the FMP was 1,336 for $232,012.79.[67] According to the Medicare in Mexico

LBJ School of Public Affairs survey, about 1.4 percent of the 1,025 U.S. retiree respondents depend on the Foreign Medical Program to pay for their medical care in Mexico.[68]

In Mexico, FMP beneficiaries are generally free to choose where to seek health care services. Hospitals such as México-Americano and the Mexican Military Hospital in Guadalajara, Jalisco, treat veterans using the FMP.[69] The Mexican Military Hospital is an example where billing can be done from the provider directly to the FMP.[70]

Similarly to TRICARE, the overall costs of running the FMP program in Mexico is relatively low since there are no centers representing the FMP in Mexico and all claims are handled in the United States. In addition, health care services in Mexico are generally cheaper than those provided in the United States. Therefore, the VA saves money because the program pays less for providing care to a patient in Mexico than providing care to a patient in the United States.

FMP Conclusion

FMP is another existing health care program available for eligible U.S. retirees in Mexico. Like TRICARE, there are limits in replicating the FMP model such as the absence of service centers in Mexico, the absence of network providers in Mexico, and the relatively small size (compared to Medicare) of the program itself. Yet, FMP's presence worldwide proves to be an excellent resource that could be used when putting together a demonstration project.

Conclusion

TRICARE for Life Overseas (TOP TFL) and the Foreign Medical Program (FMP) are two programs that provide health care to eligible beneficiaries residing in Mexico. Research in these programs could help determine the feasibility of creating an administrative network that would pay for and provide Medicare benefits for Americans in Mexico. Those involved in putting together a research and demonstration project could discover a lot from not only the obstacles faced by TRICARE and FMP but from their accomplishments as well.

Notes

[1] Office of the Assistant Secretary of Defense, Health Affairs (OASD, HA) and the TRICARE Management Activity (TMA), United States Department of Defense, *TRICARE Handbook: Chapter 3*. Online. Available: http://www.tricare.mil/tricarehandbook/results.cfm?tn=0&cn=3. Accessed: September 10, 2006.

[2] OASD, HA, and TMA, *Fact Sheets: TRICARE Eligibility*. Online. Available: http://www.tricare.mil/factsheets/viewfactsheet.cfm?id=174. Accessed: September 10, 2006.

[3] OASD, HA, and TMA, *TRICARE Standard*. Online. Available: http://www.tricare.mil/TRICAREStandard/default.cfm. Accessed: September 10, 2006.

[4] Ibid.

[5] OASD, HA, and TMA, *TRICARE Overseas Program (TOP) Standard*. Online. Available: http://www.tricare.mil/TRICAREStandard/std-top.cfm. Accessed: September 10, 2006.

[6] OASD, HA, and TMA, *TRICARE Extra Summarized*. Online. Available: http://www.tricare.mil/tricareextra/default.cfm. Accessed: September 10, 2006.

[7] Ibid.

[8] OASD, HA, and TMA, *TRICARE Prime*. Online. Available: http://www.tricare.mil/tricareprime/default.cfm. Accessed: September 10, 2006.

[9] Ibid.

[10] Ibid.

[11] OASD, HA, and TMA, *Homepage*. Online. Available: http://www.tricare.mil/mhshome.aspx. Accessed: September 10, 2006.

[12] OASD, HA, and TMA, *Fact Sheets: TRICARE Overseas Program (TOP) Standard*. Online. Available: http://www.tricare.mil/Factsheets/viewfactsheet.cfm?id=342. Accessed: September 10, 2006.

[13] OASD, HA, and TMA, *TRICARE Overseas*. Online. Available: http://www.tricare.mil/overseas/index.cfm. Accessed: September 10, 2006.

[14] OASD, HA, and TMA, *Retirees*. Online. Available: http://www.tricare.mil/retirees/retireesunder65.cfm. Accessed: March 2, 2007.

[15] OASD, HA, and TMA, *TRICARE for Life*. Online. Available: http://www.tricare.mil/tfl/default.cfm. Accessed: February 6, 2007.

[16] OASD, HA, and TMA, *TFL Overseas Program*. Online. Available: http://www.tricare.mil/tfl/top.cfm. Accessed: September 10, 2006.

[17] Ibid.

[18] Ibid.

[19] OASD, HA, and TMA, *TRICARE for Life* (online).

[20] OASD, HA, and TMA, *TRICARE for Life Brochure*. Online. Available: http://www.tricare.mil/tricaresmart/product.aspx?id=100&CID=0&RID=3. Accessed: September 10, 2006.

[21] OASD, HA, and TMA, *TOP TFL Costs*. Online. Available: http://www.tricare.mil/tfl/cost-fees.cfm. Accessed: September 10, 2006.

[22] OASD, HA, and TMA, *TOP TFL Costs, 2006 Health Care Coverage: Who Pays?* Online. Available: http://www.tricare.mil/tfl/tflcostmatrix_b.html. Accessed: September 10, 2006.

[23] Ibid.

[24] Phillip Savio, "TRICARE Fact Sheet," Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, 2006 (research), pp. 1-5.

[25] OASD, HA, and TMA, *TFL Overseas Program Accessing Health Care*. Online. Available: http://www.tricare.mil/tfl/top_tfl_access.cfm. Accessed: September 10, 2006.

[26] OASD, HA, and TMA, *TRICARE Manuals: TRICARE Policy Manual 6010.54-M*. Online. Available: http://manuals.TRICARE.osd.mil/. Accessed: September 10, 2006.

[27] OASD, HA, and TMA, *TFL Overseas Program Claims*. Online. Available: http://www.tricare.mil/tfl/top-claims.cfm. Accessed: September 10, 2006.

[28] OASD, HA, and TMA, *TFL Overseas Program Claims* (online).

[29] Savio, "TRICARE Fact Sheet," p. 4.

[30] Ibid.

[31] Ibid.

[32] OASD, HA, and TMA, *TRICARE Program Integrity and Operational Report: January 1, 2005-December 31, 2005*. Online. Available: http://www.tricare.mil/fraud/AnnualFraudReport/Document/EOY%20Report%202005_WebFinal.pdf. Accessed: October 10, 2006.

[33] Ibid.

[34] Ibid.

[35] Lyndon B. Johnson School of Public Affairs, *Getting What you Paid For: Extending Medicare Benefits to Eligible Beneficiaries in Mexico*, U.S.-Mexico Policy Report, no. 10 (Austin, Tex., 1999), Chapter 2, p. 15.

[36] OASD, HA, and TMA, *MTF Locator*. Online. Available. http://www.tricare.mil/mtf/. Accessed: September 19, 2006.

[37] OASD, HA, and TMA, *TRICARE Service Centers*. Online. Available. http://www.tricare.mil/tlac/TLAC_tsc.cfm. Accessed: September 19, 2006.

[38] TRICARE Management Activity Report Center, *Foreign Country Reports: 2004*. Online. Available: http://199.211.83.250/. Accessed: September 21, 2006.

[39] TRICARE Management Activity Report Center, *Foreign Country Reports: 2000-2004* (online).

[40] OASD, HA, and TMA, *Reporting Fraud for Region: Overseas*. Online. Available: http://www.tricare.mil/fraud/index.cfm?fuseaction=ReportingFraud.showOneRegionMap&regionMapNodeID=12. Accessed: September 19, 2006.

[41] Savio, "TRICARE Fact Sheet," p. 2.

[42] Interviews by David Warner, Ph.D., and Karla Vargas with Hospital Puerta de Hierro, Guadalajara, Jalisco, Mexico, October 5, 2006.

[43] Lyndon B. Johnson School of Public Affairs, student surveys of U.S. retirees in Mexico, 2006-2007. (See Appendix D for survey results.)

[44] Foreign Medical Program (FMP), U.S. Department of Veterans Affairs, *Foreign Medical Program*. Online. Available: http://www.va.gov/hac/forbeneficiaries/fmp/fmp.asp. Accessed: September 19, 2006.

[45] Telephone interview with Glenn A. Johnson, Chief of Communications, Department of Veterans Affairs-Health Administration Center, Denver, Colorado, January 25, 2007.

[46] FMP, U.S. Department of Veterans Affairs, *Foreign Medical Program* (online).

[47] Johnson telephone interview.

[48] FMP, U.S. Department of Veterans Affairs, *Foreign Medical Program* (online).

[49] Johnson telephone interview.

[50] FMP, U.S. Department of Veterans Affairs, *FMP: Frequently Asked Questions*. Online. Available: http://www.va.gov/hac/forbeneficiaries/fmp/FAQs.asp. Accessed: September 19, 2006.

[51] FMP, U.S. Department of Veterans Affairs, *Foreign Medical Program* (online).

[52] FMP, U.S. Department of Veterans Affairs, *Foreign Medical Program: Fact Sheet 01-05*. Online. Available: http://www.va.gov/hac/factsheets/fmp/FactSheet01-05.pdf. Accessed: September 19, 2006.

[53] FMP, U.S. Department of Veterans Affairs, *Foreign Medical Program: Fact Sheet 01-30: How to File a Claim*. Online. Available: http://www.va.gov/hac/factsheets/fmp/FactSheet01-30.pdf. Accessed: September 19, 2006.

[54] FMP, U.S. Department of Veterans Affairs, *FMP: Frequently Asked Questions* (online).

[55] Johnson telephone interview.

[56] FMP, U.S. Department of Veterans Affairs, *Foreign Medical Program: Fact Sheet 01-17: For Outpatient Providers and Office Managers*. Online. Available: http://www.va.gov/hac/factsheets/fmp/FactSheet01-30.pdf. Accessed: September 19, 2006.

[57] Johnson telephone interview.

[58] Ibid.

[59] Ibid.

[60] Ibid.

[61] Ibid.

[62] Ibid.

[63] Ibid.

[64] Ibid.

[65] Ibid.

[66] Email from Glenn A. Johnson, Chief of Communications, Department of Veterans Affairs- Health Administration Center, "FMP Facts," to Marina M. Zolezzi, January 25, 2007.

[67] Johnson email.

[68] Lyndon B. Johnson School of Public Affairs, student surveys of U.S. retirees in Mexico, 2006-2007. (See Appendix D for survey results.)

[69] Interviews by David Warner, Ph.D., Jennifer Nading, Karla Vargas, and Marina Zolezzi with Isabel Ibarra, Foreign Insurance Specialist, Hospital Mexico-Americano, Guadalajara, Jalisco, Mexico, October 5, 2006.

[70] Email from David Lord, Purple Heart Recipient and Representative for Veterans in Mexico, "Veterans in Mexico," to Marina M. Zolezzi, November 21, 2006.

Appendix A. Conference Agenda

The Future of Health Care for U.S. Retirees in Mexico
March 30, 2007

Time: 8:15 am – 4:30 pm
Where: Doubletree Club Hotel
1617 IH-35 North, Austin, TX 78702
(512) 479-4000

Agenda

7:30 – 8:00 Registration

8:15 – 8:30 Welcome: James Steinberg, Dean, LBJ School of Public Affairs

8:30 – 9:30 Panel 1: Moving South: U.S. Retirees in Mexico

- **Chair: Michelle Lalonde**, Student, LBJ School
- Retiree Demographics and Projections – **Alex Gunter**, Student, LBJ School
- A Survey of U.S. Retirees and their Healthcare Needs – **Erin Daley**, Student, LBJ School
- A Vision of the Future of Retirement in Mexico – **David Collins**, Managing Partner and Director, Active Living International

9:30 – 10:30 Panel 2: Healthcare in Mexico: Assuring Quality and Supply

- **Chair: Karla Vargas**, Student, LBJ School
- **Enrique Ruelas, MD**, Secretary of the Mexican National Health Council
- **Mark R. Engelman, MD**, Founder and CEO, One World International Hospitals and Founder, AmeriMed American Hospitals
- **John L. Zipprich**, General Counsel and Senior Vice President, CHRISTUS Health
- **Michael Ford**, Former President, Tenet Healthcare International

10:30 – 10:45 Break

10:45 – 12:00 Panel 3: Administering Cross-Border Medical Insurance

- **Chair: Hector E. Morales, MD**, Chair, Advisory Committee of the Mexican Center at LLILAS, University of Texas at Austin

- **Jim Arriola**, President & CEO, Sekure Healthcare
- **Lawrence V. Meagher**, Director General (CEO), The American British Cowdray (ABC) Medical Center, I.A.P.
- **Russell A. Bennett**, Vice President, Latino Health Solutions, UnitedHealthcare
- **Pablo Schneider**, Former President, ACTI, Blue Cross Blue Shield of Mexico

12:00 – 1:30 Lunch / Keynote Speaker: NAFTA, Interdependence between the U.S. and Mexico and Trade in Services

- **Sidney Weintraub**, William E. Simon Chair in Political Economy, Center for Strategic and International Studies, Washington, D.C.

1:45 – 3:00 Workshops (Concurrent Sessions):

- **Areas for Future Research** (Location: Oak Wood)

Participants in this session will address the following question: What additional information would be helpful in analyzing alternative policies regarding health coverage for American retirees abroad? ***Dr. David Warner****, Professor of Public Affairs-LBJ School, will be the facilitator for this session. Some possible initiatives would include surveying specific groups in the U.S. (i.e. current and future Medicare beneficiaries who were originally from Mexico regarding their intentions in retirement and the impact having coverage would make), doing particular analysis, (i.e. simulating the impact of such coverage on cost, access, and quality to the Medicare program), examining current developments in Medicare (medical savings accounts, broader benefits under Advantage plans, combined Medicare/Medicaid experiments), analyzing the impact of such a program on Mexican development, and choices available to U.S. seniors.*

- **Short and Long-term Initiatives to Enhance Coverage in Mexico** (Location: Univ. Hall A)

Participants in this session will examine the feasibility of developing improved bi-national delivery systems for care. ***Rachel Maguire****, from the Institute for the Future (San Francisco), will be the facilitator for this session. This workshop will also look at how the Medicare Advantage program could be expanded and the feasibility of a research and demonstration project in Mexico (in one part of Mexico or in Mexico and several other countries). Current successes and challenges in the administration of international health coverage will be discussed. Conference participants who are interested in the discussion of feasible solutions to the challenge of healthcare coverage in Mexico are encouraged to participate in this session.*

- **Public Policy Strategies to Advance these Issues** (Location: Univ. Hall B)

Participants in this session will discuss strategies that might be appropriate to help achieve the goal of extending Medicare benefits to eligible beneficiaries in Mexico, as well as to map the steps necessary to achieve this goal. ***Francis D. Fisher****, Research Fellow-LBJ School, will be the facilitator for this session. The group will identify additional supporters and issues that will need to be addressed in order to alleviate the concerns of various entities. There will be discussion of alternative approaches to Congress and CMS and ways in which various stakeholders might be involved. This group will be asked to develop a hypothetical timetable for when particular activities might be initiated.*

3:00 – 3:15 Break

3:15 – 4:30 Workshop Summary and Closing Remarks

Appendix B. Conference Presenters

Jim Arriola

Jim Arriola serves as the CEO and President of Sekure Healthcare. He is the co-founder of Sekure Healthcare, a healthcare service company primarily focused on providing healthcare coverage to California's uninsured workforce. With over 20 years of management and business experience, Mr. Arriola has led the development and operations of pioneering healthcare insurance products to better serve Latino and Mexican immigrant consumers. He has led Blue Shield of California's program to becoming the first California-based, cross-border HMO Plan. Mr. Arriola has been appointed by the California Department of Health Services to serve on the Advisory Group for the California Office of Bi-national Border Health. He is also the founder of Latino Health Resources, a consulting agency that specializes in Latino healthcare matters. Mr. Arriola graduated from the United States Military Academy at West Point. He has served on active duty in the U.S. Army for 12 years, reaching the rank of Major. Mr. Arriola also has two Master degrees, an MS in Human Resources Management from Chapman University and an MBA from National University. He previously served on the Board of Directors of the San Diego County Hispanic Chamber of Commerce.

Russell A. Bennett

Russell A. Bennett is Vice President of Latino Health Solutions at UnitedHealthcare (UHC). Mr. Bennett lived in Mexico for 30 years. He served as the founding executive director of the United States-Mexico Border Health Commission, U.S. Section. Prior to that, he was the director of international and multicultural services for Sharp HealthCare in San Diego and was also the spokesman for the company on international and multicultural issues. Mr. Bennett created and produced the health education program on television titled ¡Salud para Usted! (Health for You!), which provided health information for community members. Mr. Bennett has been an international business consultant to management and boards of directors of companies working with Mexico and Latin America. He has taught leadership courses in both English and Spanish. Mr. Bennett has been Board Member and supporter of the American Heart Association and the American Cancer Society. Mr. Bennett's work in leading the transformation of PacifiCare, a UnitedHealthcare company, to serve the growing Hispanic market is profiled in the book "Marketing to Hispanics" by Terry J. Soto, published in 2006 by Kaplan Publishing. He has a BA in Economics, an MBA, and has earned the distinction of Certified Health Insurance Executive (CHIE) from the Executive Leadership Program of America's Health Insurance Plans (AHIP).

David Collins

David Collins is the Managing Partner of Active Living International. Mr. Collins was a founder and Board Member of American Retirement Villas (ARV), one of the largest

assisted living companies in the United States, acquired by Lazard Freres in 2003. The Active Living concept was introduced to Europe by Mr. Collins and Sensara Partners of Malaga, Spain, in 2004. Their 150-unit project has been called the "Best Retirement Development" in Europe by *The London Daily Telegraph*. A frequent speaker on the subject of Active Living as vacation retirement or second home lifestyles, he has addressed audiences throughout the world on subjects having to do with real estate, health care, and assisted living as it relates to baby boomers and seniors. In January 2007 he was named as one of the top 50 executives in the Active Adult business in the United States. Mr. Collins has served on numerous public and private boards. He served for many years as a member of the board of The Philharmonic Society of Orange County and currently is Vice Chair for Development and member of the audit committee of the Orange County Center for the Performing Arts. He has been a member of the Institute of Directors, London, and serves on the advisory Board of the Center for Unconventional Security Affairs at the University of California, Irvine (UCI). Mr. Collins earned his Bachelor's Degree with a double major in English Literature and Languages from St. Anselm College, followed by graduate studies at George Washington University in Washington, D.C., and at The Wharton School, University of Pennsylvania.

Mark R. Engelman, MD

Dr. Mark R. Engelman is the founder of One World International Hospitals (2006). He had also founded AmeriMed American Hospitals (1994), which are located in Puerto Vallarta, Cancun, and Cabo San Lucas, Mexico. Dr. Engelman was an internal medicine resident at St. Joseph's Hospital and Medical Center in Phoenix, Arizona. He began his medical career in Emergency Medicine and served from 1975 to 1996 as the Medical Director and Chairman for the Department of Emergency Services at the St. Joseph's Hospital and Medical Center and the Barrow Neurological Institute. Dr. Engelman is board certified by the College of Emergency Medicine, and is a fellow of the College of Emergency Medicine. He has held several professional memberships some of which include The American Heart Association, AZ Boys and Girls Club, and The American College of Emergency Physicians. Dr. Engelman has been active in lecturing and teaching locally and nationally. Dr. Engelman earned his BS degree from the Ohio State University and his Doctor of Medicine degree from the Ohio State University College of Medicine.

Michael H. Ford

Michael H. Ford is the former President of Tenet Healthcare International. He was involved exclusively for more than 20 years in the development and operation of private hospitals in overseas environments including Singapore, Thailand, Australia, Spain, United Kingdom, and Malaysia. Within Tenet Healthcare International, Mr. Ford was the Senior Vice President of Health System Development, President and Chief Operating Officer, and previously Senior Vice President of the International Hospital Division, Vice President of the United Kingdom and Far East Operations, Vice President of the Saudi Arabian Operations, and Vice President of Human Resources. An international businessman and health care executive, Mr. Ford was the Senior Vice President of

International Development for International Hospital Corporation and was an Industrial Relations Manager for Arabian American Oil Company. Mr. Ford has been an advisor and consultant to public sector officials and private sector executives involved with health care policy and delivery systems. Some of his previous consulting positions, specializing in international and domestic development include Bumrungrad Hospital PLC based in Thailand, MedCompliance in Miami, Global Care Solutions in Thailand, Broadlane in Dallas, and International Hospital Corporation in Dallas. Mr. Ford is a graduate of the University of San Francisco.

Lawrence V. Meagher, Jr.

Lawrence V. Meagher, Jr., is the Director General (CEO) of The American British Cowdray (ABC) Medical Center, I.A.P. The flagship is a general acute care teaching and research hospital. ABC is affiliated with the National University of Mexico Medical School, and other leading medical schools in the country. From 1991-2003, Mr. Meagher was the President and Chief Executive Officer of International Hospital Corporation based in Dallas, Texas. He was the co-founder of the privately held hospital development and management company, International Hospital Corporation, with subsidiary holding companies in Mexico, Central America, and Brazil. Mr. Meagher had been Vice President and Founding Director for International Services at the Baylor University Medical Center, Executive Vice President and Chief Operating Officer for the Baptist Health Enterprises, and Director General (CEO 1980-1986) for the American British Cowdray Hospital in Mexico City. In addition, he has served as Assistant Administrator for two New England Hospitals and had been Executive Director of two chapters of the American Heart Association in Pennsylvania and Connecticut. Mr. Meagher holds a B.A. in History and Political Science from the Wheeling Jesuit University and a MPH from the Hospital and Health Care Administration at the Yale University School of Medicine, Department of Public Health and Epidemiology.

Hector E. Morales, MD

Dr. Hector Morales is Chair of the Advisory Committee of the Mexican Center at the Teresa Lozano Long Institute of Latin American Studies at the University of Texas at Austin. He is a member of numerous associations, some of which include the American College of Surgeons, American Medical Association, Texas Surgical Society, and the International College of Surgeons. Dr. Morales has held several positions in Austin, Texas, including Chairman of the Surgical Department at Holy Cross Hospital and St. David's Hospital, member of the Executive Committee at Holy Cross Hospital, Brackenridge Hospital, and St. David's Hospital, and Chief of Staff at Holy Cross Hospital. He has also served as President for the Austin Surgical Society and Travis County Medical Society, a surgical consultant of the Veterans Administration System, Chairman of the Advisory Council on Surgical Assistants to the Texas Board of Medical Examiners, Chairman of Quality Control of Medical Care at the Corner Stone Hospital System, and Chairman of the Board of Trustees of the Central Texas Medical Foundation for 10 years. Dr. Morales has written scientific papers that have been published in the U.S. and Europe and has been a speaker for medical, surgical, educational, and control of

medical care quality topics in the U.S., Mexico, and Europe. Dr. Morales graduated from the University of San Luis Potosi, Medical School, in Mexico, where he later served as a professor of surgery and anatomy. He performed his residency in general and vascular surgery in New York City, Washington, D.C., Utrecht, Holland, and Detroit, Michigan. Dr. Morales is certified and re-certified by the American Board of Surgery and Advanced Cardiovascular Technology.

Enrique Ruelas, MD

Dr. Enrique Ruelas is the Secretary of the National Health Council, a position which has under its control the Mexican Commission for Accreditation of Health Care Facilities. Previous to this, he was the Deputy Minister of Health, in charge of quality and innovation. Dr. Ruelas was President of the International Society for Quality in Health Care (ISQua), Executive President of QUALIMED, and was the President of the Mexican Association of Hospitals. He also founded and was President of the Mexican Society of Health Quality Assurance (SOMECASA). Dr. Ruelas is a member of the National Academy of Medicine and the Mexican Academy of Surgery. He has been involved in numerous conferences regarding the quality of health care in Latin America, Mexico, United States, Canada, Europe, and Australia. Dr. Ruelas has also published many articles regarding quality of care in both national and international magazines. He graduated with honors from the Universidad La Salle, Medical School, in Mexico. Dr. Ruelas has a Masters in Public Administration from Centro de Investigación y Docencia Económicas in Mexico, and a Masters in Health Administration from the University of Toronto, Canada.

Pablo Schneider

Pablo Schneider is Executive Vice President of Business Development of Fusion Mobile, a wireless company focused on U.S. Hispanic and border markets. He was previously Vice President of Latin Affairs (2004-2006) for a group of Delta Dental insurance companies and was responsible for initiatives in Hispanic, border, and Mexico markets. Mr. Schneider was President of ACTI (1997-2001), a joint venture between Blue Cross and Blue Shield Plans in the border region, and was responsible as a senior executive for the development and implementation of Blue Cross and Blue Shield Hispanic, border, and Mexico initiatives. One of his previous corporate positions included Senior Marketing Executive for the largest Medicaid HMO in the San Diego region. Mr. Schneider has served in numerous leadership activities such as being a member of the Thunderbird Global Council, Chairman of the Perfect Attendance Foundation, Founder of the Amigo Gatherings, and an Advisor to the National Association of Corporate Directors. He is also an advisor to the Hispanic Alliance for Progress Institute and Latino Leaders Magazine. Mr. Schneider has served as a speaker to the National Society of Hispanic MBAs (in which he is a lifetime member), the University of Texas, the LBJ School of Public Affairs, and the Thunderbird, Garvin School of International Management. He earned his undergraduate and graduate degrees with honors in Business Administration and Management from San Diego State University and has completed executive programs at the Harvard Business School and Thunderbird. He also co-

directed a project that resulted in the book *Cross-Border Insurance: Options for Texas*, published by the LBJ School at University of Texas at Austin.

Sidney Weintraub

Sidney Weintraub holds the William E. Simon Chair in Political Economy at the Center for Strategic and International Studies. He is also Professor Emeritus at the Lyndon B. Johnson School of Public Affairs of the University of Texas at Austin, where he was Dean Rusk Professor from 1976 to 1994, when he joined CSIS. A member of the U.S. Foreign Service from 1949 to 1975, Dr. Weintraub held the post of deputy assistant secretary of state for international finance and development from 1969 to 1974 and assistant administrator of the U.S. Agency for International Development in 1975. He was also a senior fellow at the Brookings Institution. His book *Energy Cooperation in the Western Hemisphere: Benefits and Impediments* is expected to be published by CSIS Press in March 2007. Other recent books are *Issues in International Political Economy: Constructive Irreverence* (CSIS, 2004), *Free Trade in the Americas: Economic and Political Issues for Governance and Firms* (Edward Elgar Publishing, 2004), *NAFTA's Impact on North America: The First Decade* (CSIS, 2004), *Financial Decision-Making in Mexico: To Bet a Nation* (Pittsburgh, 2000), and *Development and Democracy in the Southern Cone: Imperatives for U.S. Policy in South America* (CSIS, 2000). Dr. Weintraub has published numerous articles in newspapers and journals. He received his Ph.D. in economics from the American University as well as an MA in economics from Yale University.

John L. Zipprich II

John Zipprich is General Counsel and Senior Vice President for CHRISTUS Health; he is responsible for Legal and Governance Services and serves on the Senior Leadership Team. Previously he served in the same capacities for Sisters of Charity of the Incarnate Word, Houston, Texas, for almost 18 years. Mr. Zipprich is on the board and past President (2002-2004) of CHRISTUS Muguerza S.A. de C.V. and serves on the board of CHRISTUS Muguerza Saltillo, S.A. de C.V. He is also President and serves on the boards of CHRISTUS Muguerza Monterrey, S.A. de C.V., CHRISTUS Muguerza Conchita, S.A. de C.V., and CHRISTUS Muguerza Sur, S.A. de C.V. He is a member of the Board of Servicios Comunitarios Adelaida Lafon de Muguerza A.C., a Mexican community service corporation currently providing clinic and health services in Monterrey and San Luis Potosi. Mr. Zipprich is a graduate of the University of Notre Dame and its Law School. He has served as board member of nonprofit hospitals, foundations, civic associations, and a theater group. He has served on the Board of Associated Catholic Charities and was a member and past Chair of the Diocesan AIDS Council. Mr. Zipprich served from 1982 to 1997 as Commissioner and Vice Chair of the Housing Authority of the City of Houston. He is a member of the Advisory Board of the Congregation of the Incarnate Word and Blessed Sacrament and is counsel for The Congregation of the Sisters of Charity of the Incarnate Word. He has lectured, participated in videos, and written on nonprofit and health care organizations.

Appendix C. Survey Questions

1. Approximately how many months a year do you reside in Mexico?
   - ☐ 0 *(if 0, will be ineligible to complete survey)*
   - ☐ 1-3
   - ☐ 4-6
   - ☐ 7-9
   - ☐ 10-12

2. For how many years have you lived in Mexico for at least three months a year?
   - ☐ 0-3
   - ☐ 4-6
   - ☐ 7-9
   - ☐ 10-12
   - ☐ 13+

3. In what city do you reside in Mexico?
   - ☐ Cuernavaca
   - ☐ Ensenada
   - ☐ Guadalajara
   - ☐ La Paz
   - ☐ Lake Chapala
   - ☐ Loreto
   - ☐ Los Cabos
   - ☐ Puerto Peñasco
   - ☐ Puerto Vallarta & vicinity
   - ☐ Rosarito
   - ☐ San Miguel de Allende
   - ☐ Tijuana
   - ☐ Other (please specify) _____

4. What is your primary reason for living in Mexico?
   - ☐ Cost of living
   - ☐ Family
   - ☐ Business
   - ☐ Climate
   - ☐ Social
   - ☐ Other (please specify) _____

5. At what age do you plan to return to the United States permanently?
   - ☐ Before age 60
   - ☐ 60-65
   - ☐ 66-70
   - ☐ 71-75
   - ☐ 76+

☐ I do not plan to return to the United States permanently

6. If you plan to return to the United States permanently, why? _____

7. What retirement benefits do you currently receive?
   ☐ Social Security benefits
   ☐ Veterans Administration benefits
   ☐ Civil Service benefits
   ☐ Military retirement
   ☐ Pension from private employment
   ☐ Other (please specify) _____
   ☐ None

8. Do you currently have an established source of medical care in Mexico?
   ☐ Yes
   ☐ No

9. If yes, please specify the following:
   Specialty of Physician: _____
   Name of Clinic/Hospital: _____
   City:_____

10. Do you currently have an established source of medical care in the United States?
    ☐ Yes
    ☐ No

11. In the event you needed to be hospitalized, where would you seek treatment?
    ☐ Mexico
    ☐ United States
    ☐ Other (please specify) _____

12. How do you pay for your medical care in Mexico? (Mark all that apply)
    ☐ Cash
    ☐ IMSS
    ☐ Private insurance
    ☐ Foreign Medical Program (VA)
    ☐ Tricare
    ☐ Other (please specify) _____
    ☐ I do not seek care in Mexico

13. Do you have insurance to cover emergency evacuation?
    ☐ Yes
    ☐ No

14. How do you pay for your medical care in the U.S.? (Mark all that apply)
    ☐ Cash

☐ Tricare
☐ Medicare
☐ Private insurance (including Medigap)
☐ Other (please specify) _____

15. Approximately how many days total did you spend in inpatient care in a Mexican hospital over the past three years?
☐ 0
☐ 1-5
☐ 6-10
☐ 11-15
☐ 16-20
☐ 21+

16. Approximately how many days total did you spend in inpatient care in a United States hospital over the past three years?
☐ 0
☐ 1-5
☐ 6-10
☐ 11-15
☐ 16-20
☐ 21+

17. Approximately how many times did you visit a doctor in Mexico over the past three years?
☐ 0
☐ 1-5
☐ 6-10
☐ 11-15
☐ 16-20
☐ 21+

18. Approximately how many times did you visit a doctor in the United States over the past three years?
☐ 0
☐ 1-5
☐ 6-10
☐ 11-15
☐ 16-20
☐ 21+

19. What was the primary reason you returned to the U.S. to receive health care services?
☐ Coverage in the U.S. (including Medicare and/or private insurance)
☐ Familiarity with U.S. system (including having no established source of care in Mexico)

☐ Lack of adequate medical care in Mexico (including the need for specialized treatment)
☐ Family
☐ Other (please specify) _____

20. What health services were sought during your last visit to a provider in the U.S.?
☐ Diagnostic
☐ Dental
☐ Routine medical examination
☐ Medical (please specify) _____
☐ Surgical (please specify) _____
☐ Emergency treatment (please specify)_____
☐ Other (please specify) _____

21. What health services were sought during your last visit to a provider in Mexico?
☐ Diagnostic
☐ Dental
☐ Routine medical examination
☐ Medical (please specify) _____
☐ Surgical (please specify) _____
☐ Emergency treatment (please specify)_____
☐ Other (please specify) _____

22. In the future, in the event of serious illness, would you return to the U.S. for health care services?
☐ Yes
☐ No

23. If yes, why?
☐ Coverage in the U.S. (including Medicare and/or private insurance)
☐ Familiarity with U.S. system (including having no established source of care in Mexico)
☐ Lack of adequate medical care in Mexico (including the need for specialized treatment)
☐ Family
☐ Other (please specify) _____

24. Please mark the situation below that best describes your eligibility for Social Security benefits from the United States
☐ I am currently eligible
☐ I will be eligible when I turn 62
☐ I will never be eligible

25. Under which of the following Medicare categories do you have coverage? (mark all that apply)
☐ Part A (hospital insurance; "traditional Medicare")
☐ Part B (medical insurance)

- ☐ Part C (Medicare Advantage)
- ☐ Part D (pharmaceutical coverage)
- ☐ None of the above
- ☐ Unsure

26. Currently, what percentage of your physician services is consumed in Mexico during a year?
    - ☐ 0% - 20%
    - ☐ 21% - 40%
    - ☐ 41% - 60%
    - ☐ 61% - 80%
    - ☐ 81% - 100%

27. Currently, what percentage of your required hospital services is consumed in Mexico during a year?
    - ☐ 0% - 20%
    - ☐ 21% - 40%
    - ☐ 41% - 60%
    - ☐ 61% - 80%
    - ☐ 81% - 100%

28. If you were given access to your Medicare Part B benefits in Mexico, what percentage of your physician services would be consumed in Mexico during a year?
    - ☐ 0% - 20%
    - ☐ 21% - 40%
    - ☐ 41% - 60%
    - ☐ 61% - 80%
    - ☐ 81% - 100%

29. If you were given access to your Medicare Part A benefits in Mexico, what percentage of your required hospital services would be consumed in Mexico during a year?
    - ☐ 0% - 20%
    - ☐ 21% - 40%
    - ☐ 41% - 60%
    - ☐ 61% - 80%
    - ☐ 81% - 100%

30. How often do you use the internet to access health information?
    - ☐ Never
    - ☐ Sometimes
    - ☐ Frequently

31. In what year were you born? _____

32. In what country were you born?
- ☐ United States
- ☐ Mexico
- ☐ Canada
- ☐ Other (please specify) _____

33. Sex
- ☐ Male
- ☐ Female

34. Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

35. Including yourself, how many people are in your household?
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5+

36. Are you currently retired?
- ☐ Yes
- ☐ No

37. How long have you been retired?
- ☐ Less than 1 year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ 11+ years
- ☐ Not retired

38. Occupation (if retired, please indicate previous occupation): _____

39. How many years did you work in the United States?
- ☐ Less than 1 year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ 11-15 years
- ☐ 16-20 years
- ☐ 21-25 years
- ☐ 26-30 years
- ☐ 31+ years

40. What is your country of citizenship:

- ☐ United States
- ☐ Mexico
- ☐ Canada
- ☐ Dual citizen (US-Mexico)
- ☐ Other (please specify) _____

41. What type of visa do you hold in Mexico?
    - ☐ FMT (tourist)
    - ☐ FM3 (nonimmigrant)
    - ☐ FM2 (immigrant)
    - ☐ NA

42. In what year did you last reside in the U.S.? _____

43. In which U.S. state did you most recently reside? _____

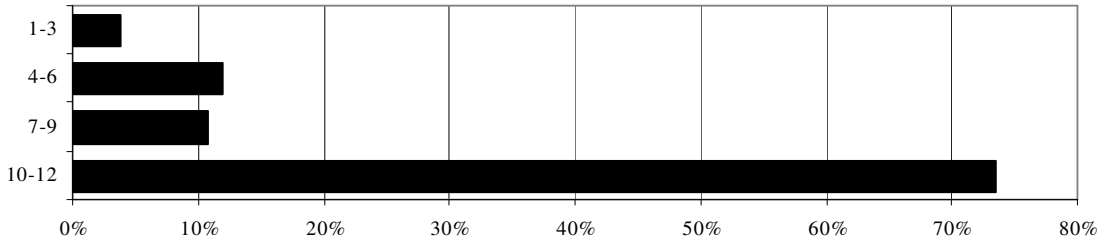
44. Please indicate your current annual household income in U.S. Dollars:
    - ☐ Less than $15,000
    - ☐ $15,001 - $25,000
    - ☐ $25,001-$35,000
    - ☐ $35,001-$45,000
    - ☐ Over $45,000

45. What additional comments do you have regarding the medical care you receive in the United States and/or Mexico? (Please specify which country the response is for) _____

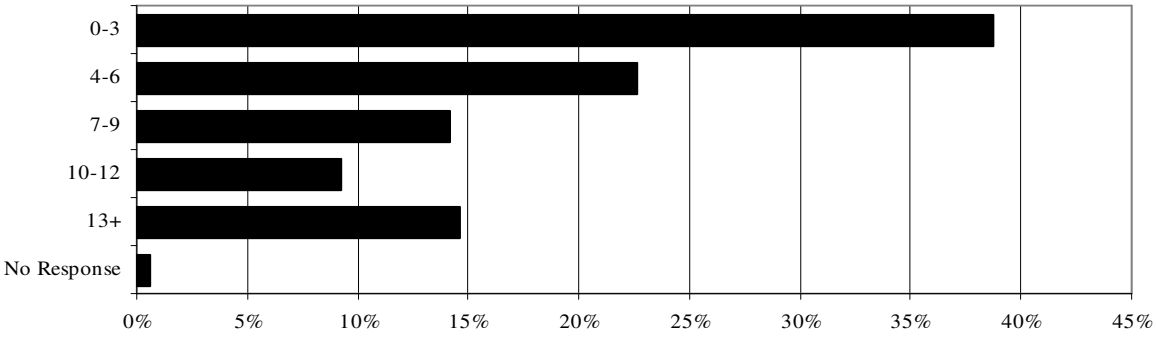
Appendix D. Survey Results

This appendix provides the responses to an online survey conducted from January 24, 2007, to April 6, 2007, with U.S. retirees in Mexico. During this period a total of 1,025 valid responses were received. For more information on the survey implementation and results, please see Section II, Chapter 11.

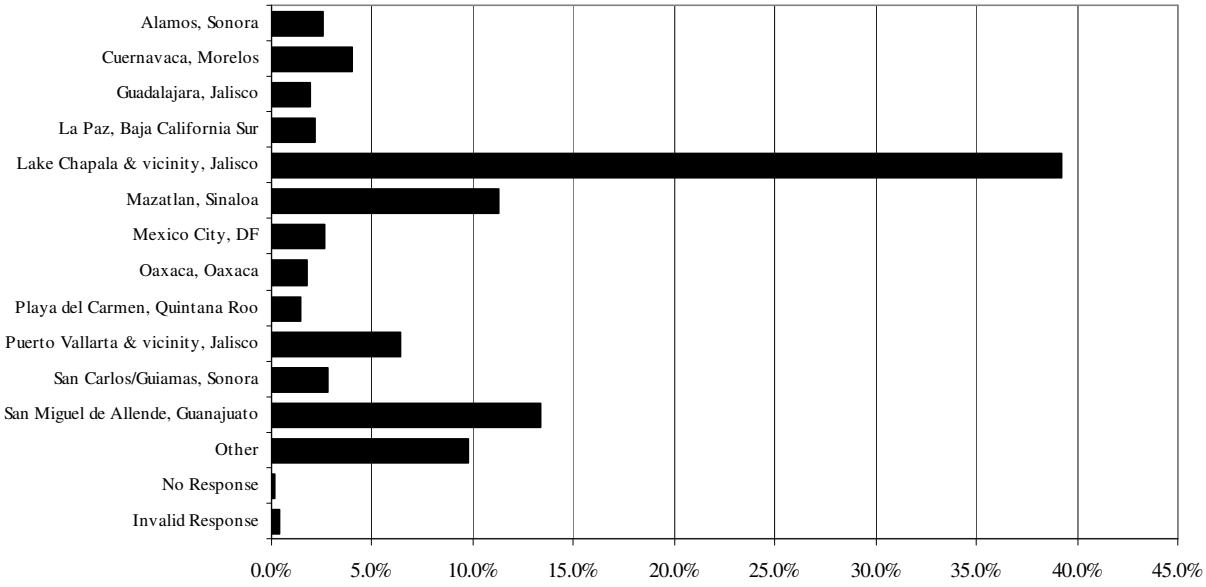
1. Approximately how many months a year do you reside in Mexico?



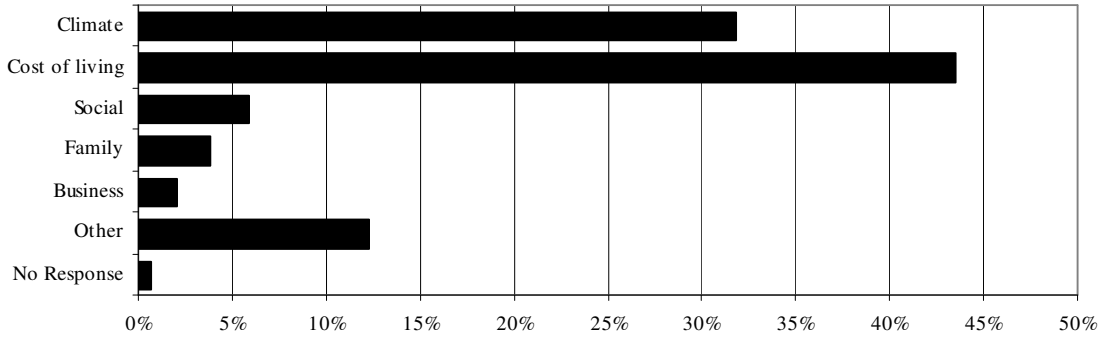
2. For how many years have you lived in Mexico for at least three months a year?



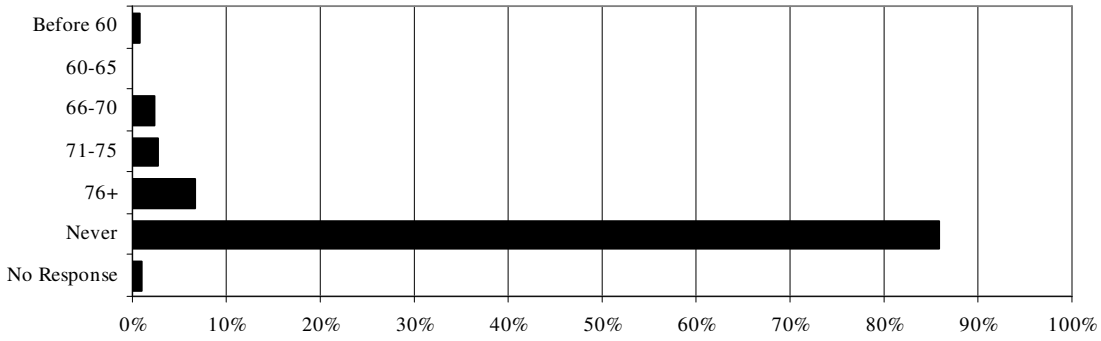
3. In what city do you reside in Mexico?



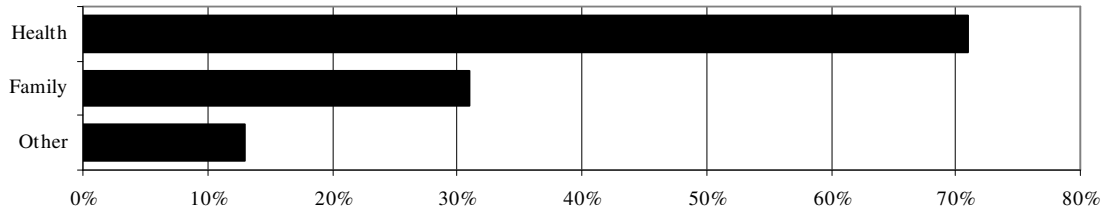
4. What is your primary reason for living in Mexico?



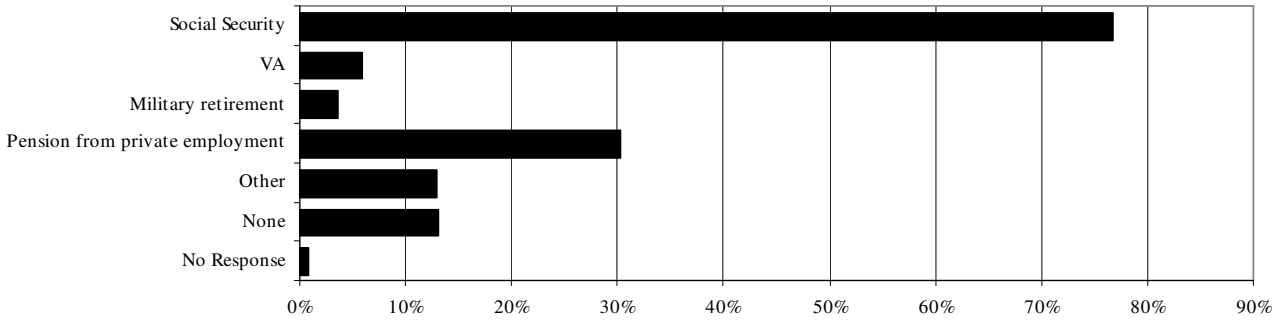
5. At what age do you plan to return to the United States permanently?



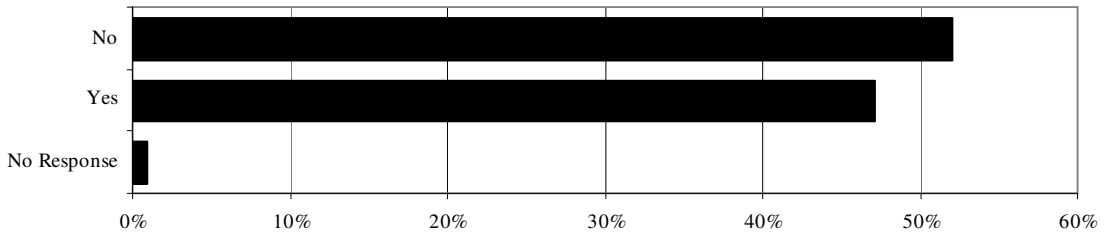
6. If you plan to return to the United States permanently, why? (open-ended)



7. What retirement benefits do you currently receive?

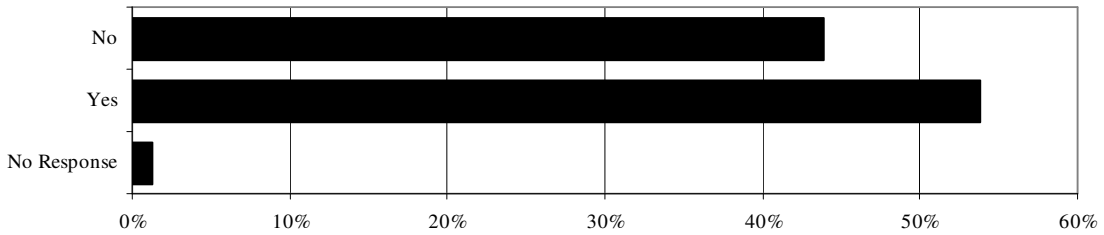


8. Do you currently have an established source of medical care in Mexico?

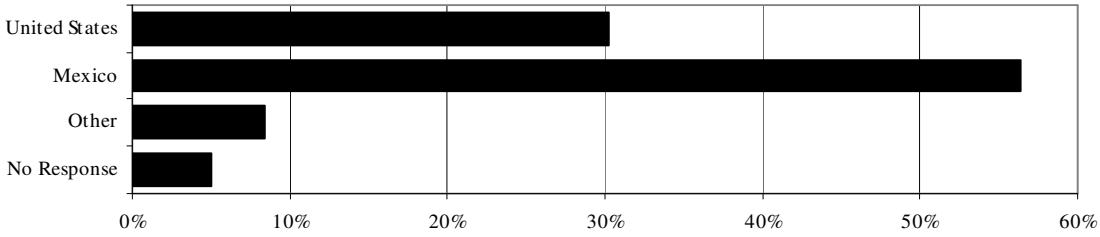


9. This question asked participants who answered "yes" in the previous question to provide information on the specialty of the physicians they visit in Mexico as well as the clinic name and city. Due to the wide variety of responses received, this information is not provided here.

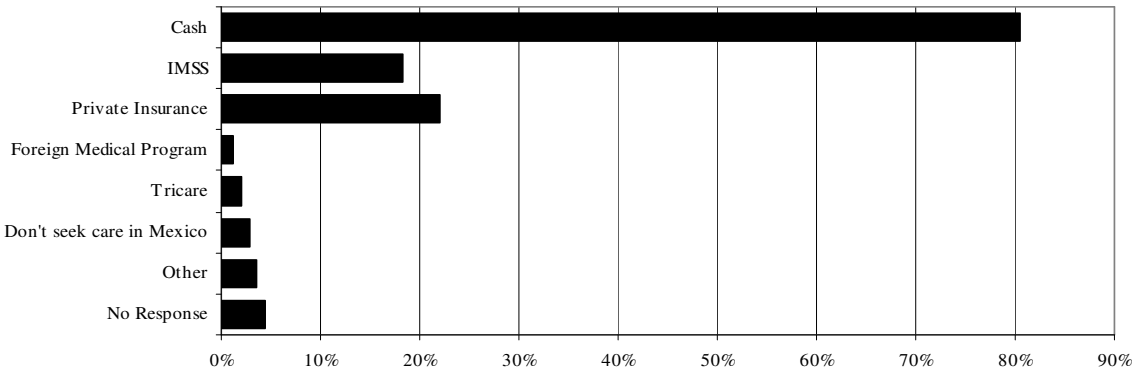
10. Do you currently have an established source of medical care in the United States?



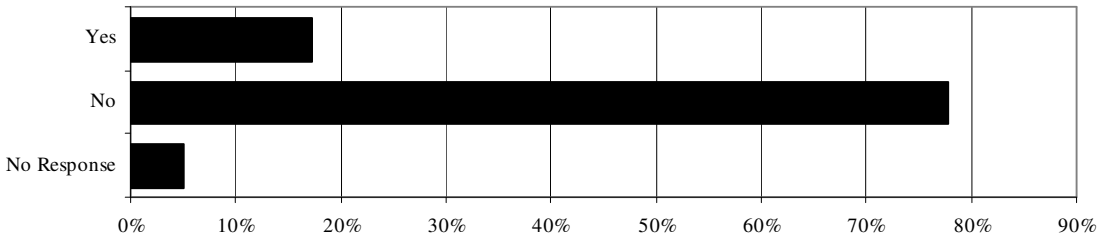
11. In the event you needed to be hospitalized, where would you seek treatment?



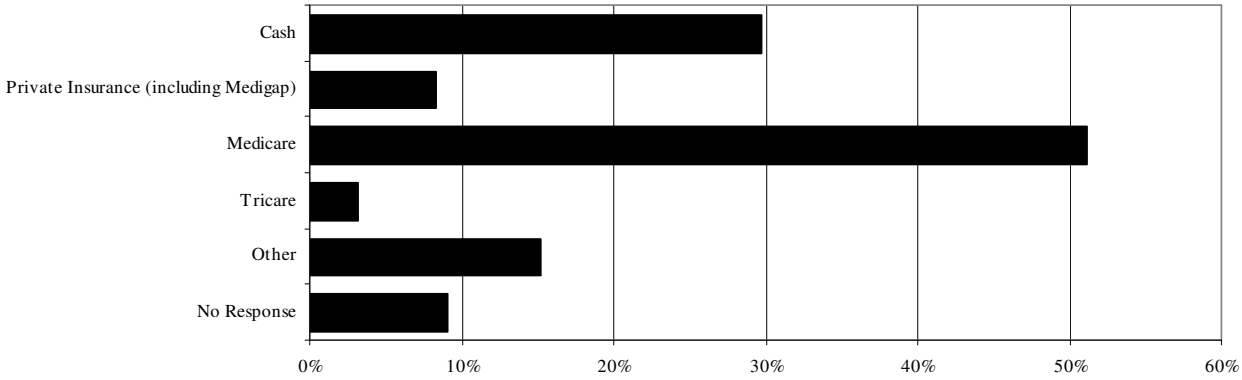
12. How do you pay for your medical care in Mexico?



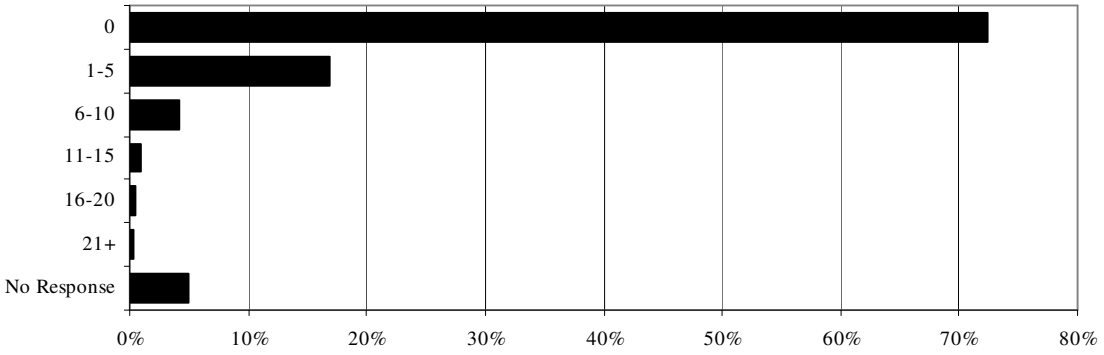
13. Do you have insurance to cover emergency evacuation?



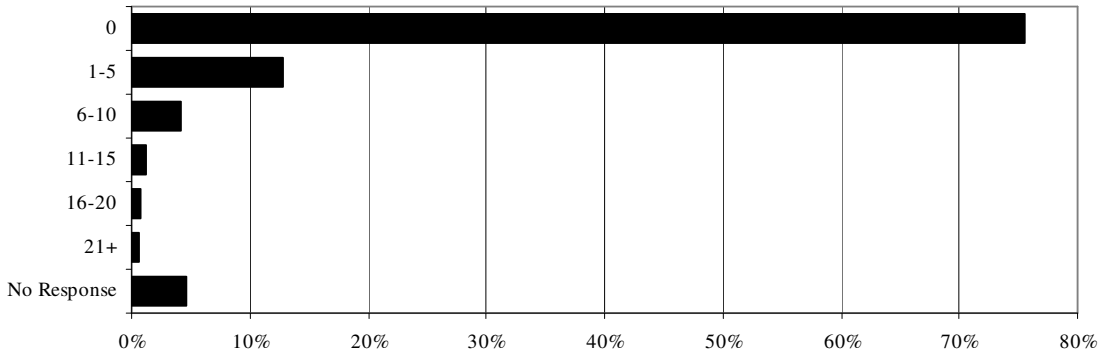
14. How do you pay for your medical care in the U.S.?



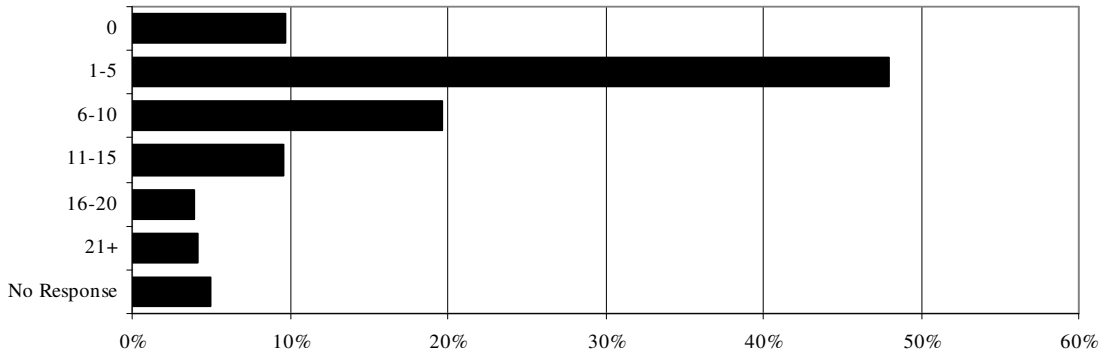
15. Approximately how many days total did you spend in inpatient care in a Mexican hospital over the past three years?



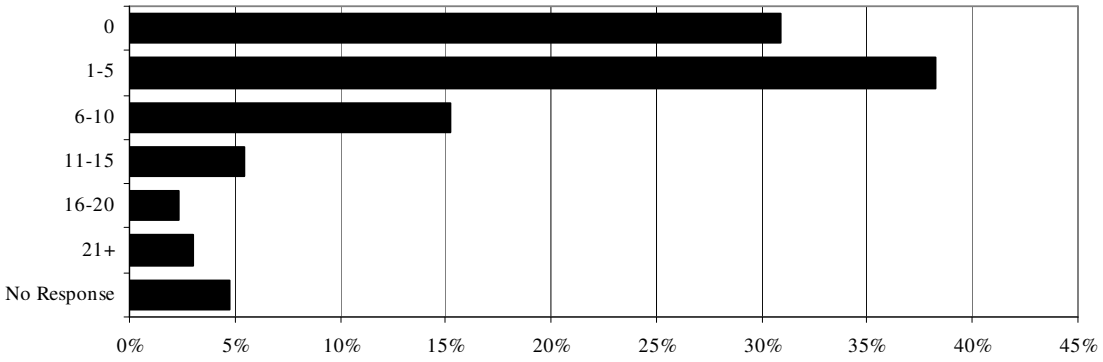
16. Approximately how many days total did you spend in inpatient care in a United States hospital over the past three years?



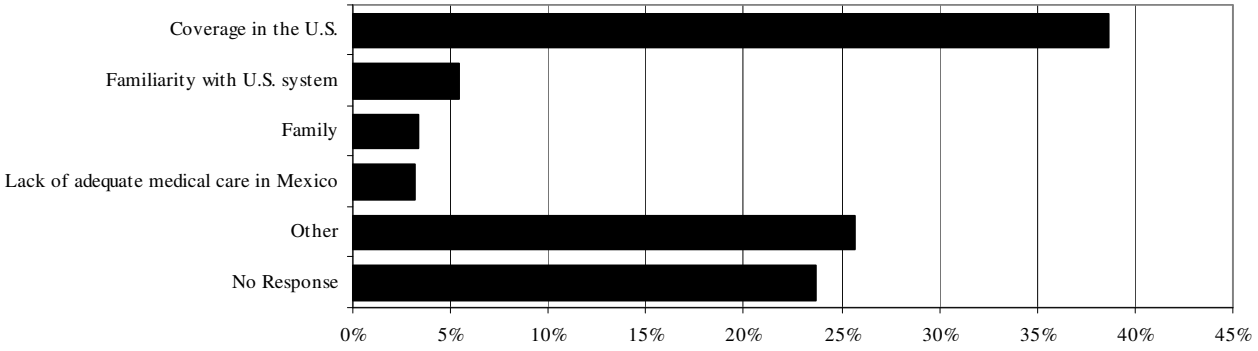
17. Approximately how many times did you visit a doctor in Mexico over the past three years?



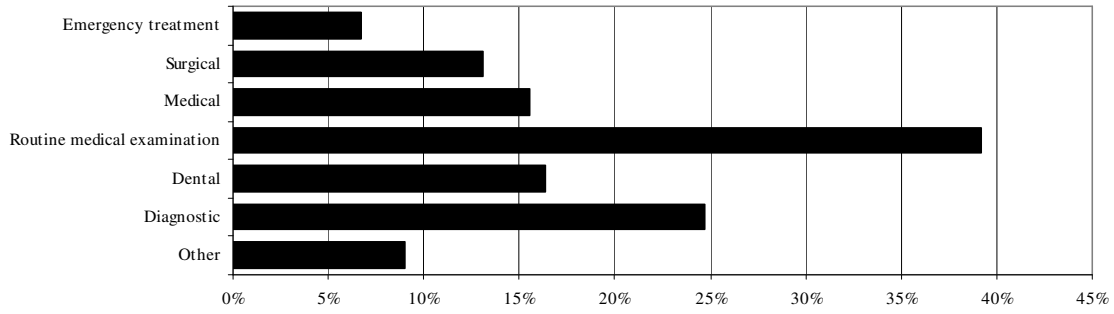
18. Approximately how many times did you visit a doctor in the United States over the past three years?



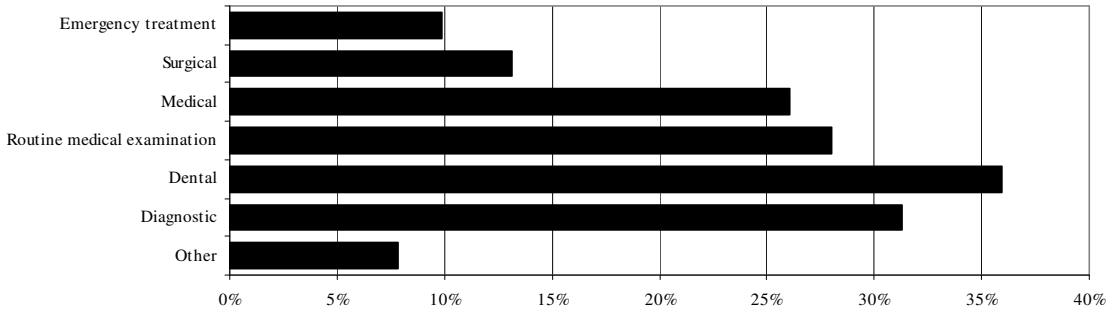
19. What was the primary reason you returned to the U.S. to receive health care services?



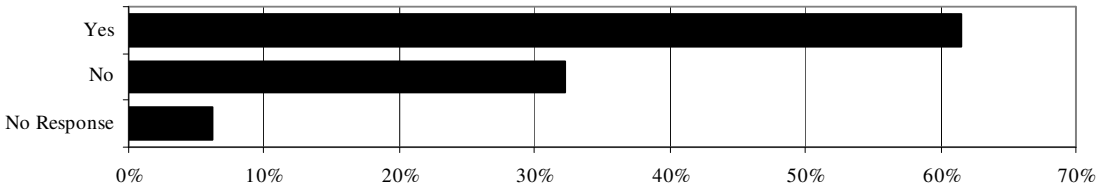
20. What health services were sought during your last visit to a provider in the U.S.?



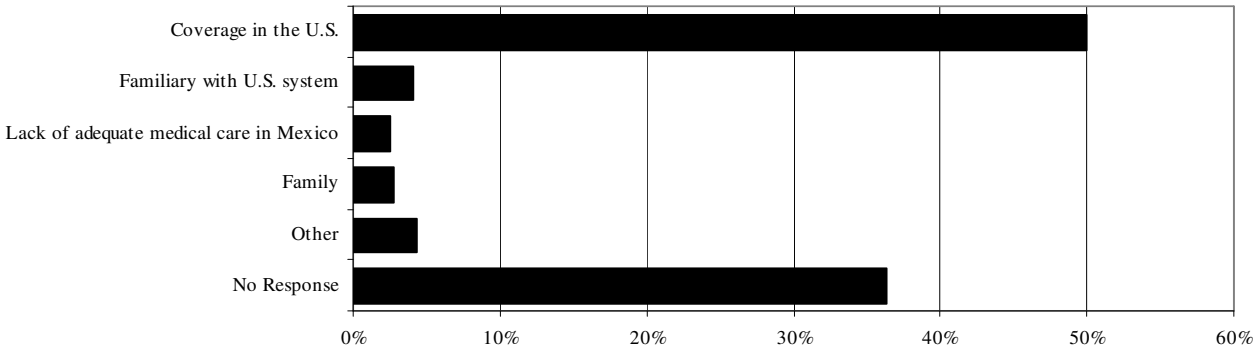
21. What health services were sought during your last visit to a provider in Mexico?



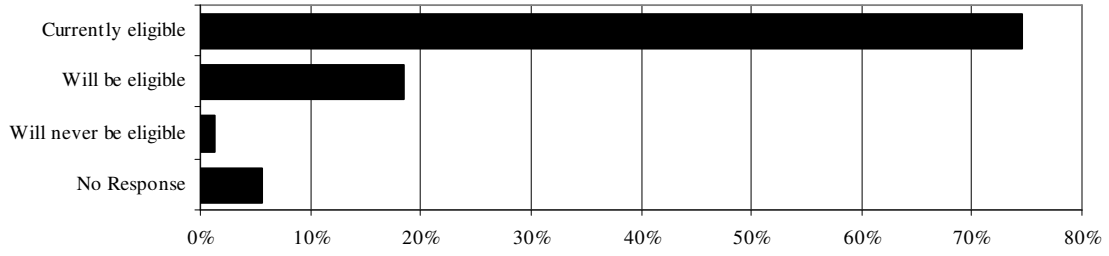
22. In the future, in the event of serious illness, would you return to the U.S. for health care services?



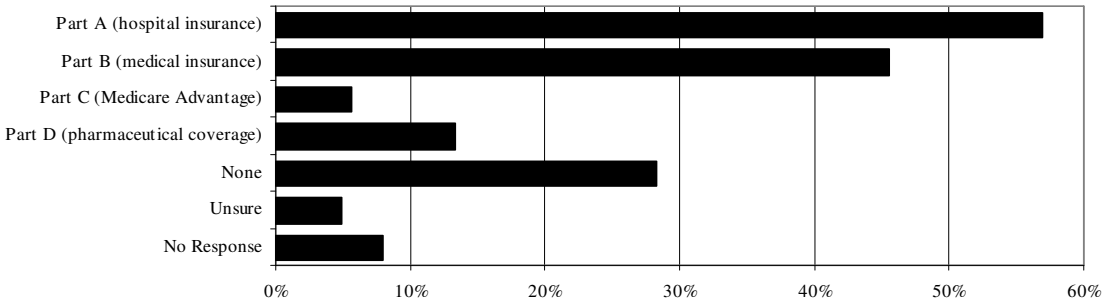
23. If yes, why?



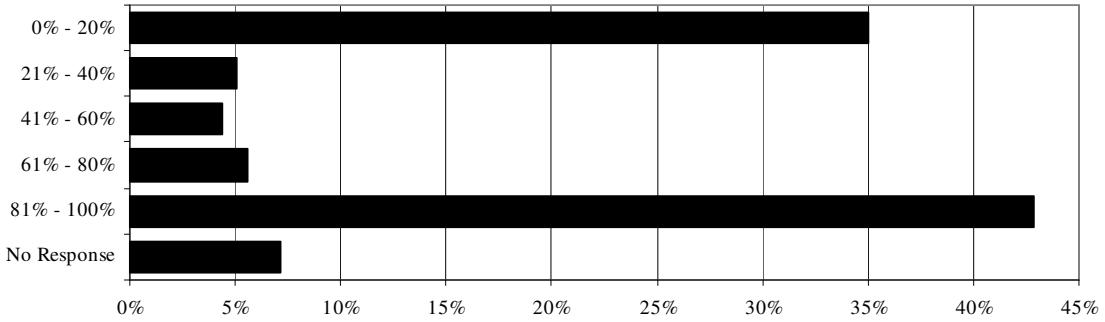
24. Please mark the situation below that best describes your eligibility for Social Security benefits from the United States.



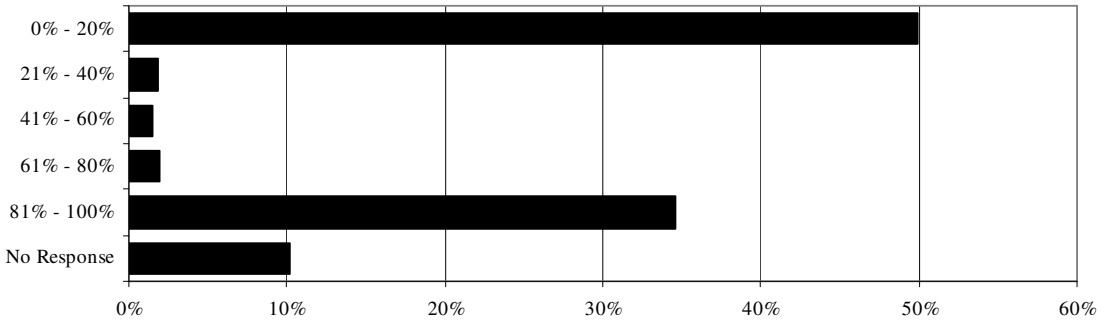
25. Under which of the following Medicare categories do you have coverage?



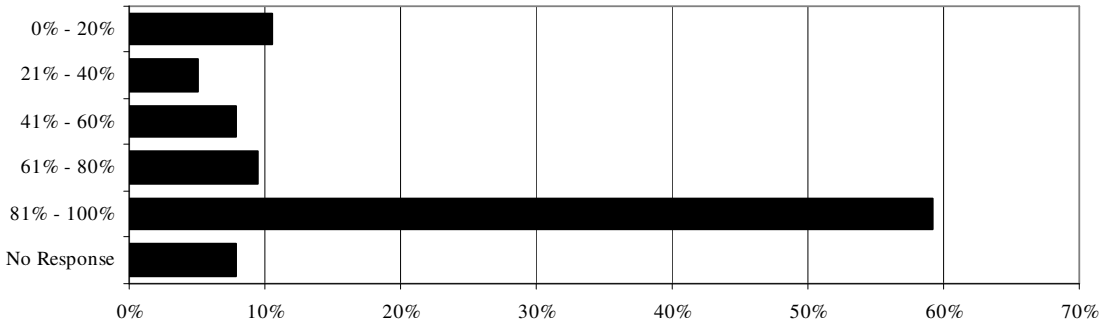
26. Currently, what percentage of your physician services is consumed in Mexico during a year?



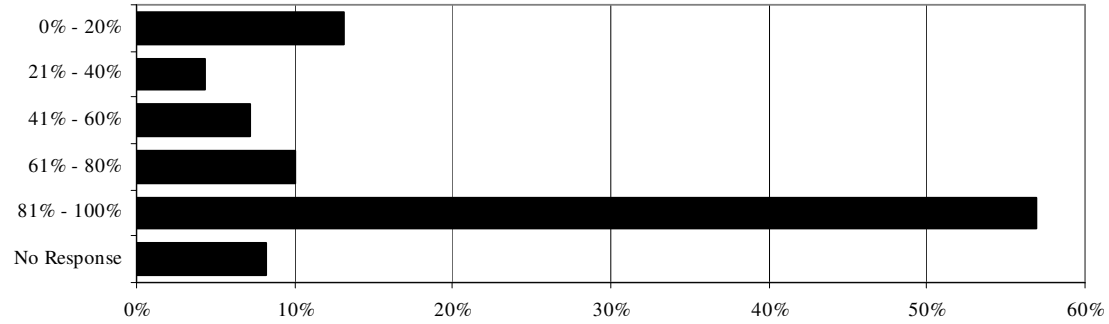
27. Currently, what percentage of your required hospital services is consumed in Mexico during a year?



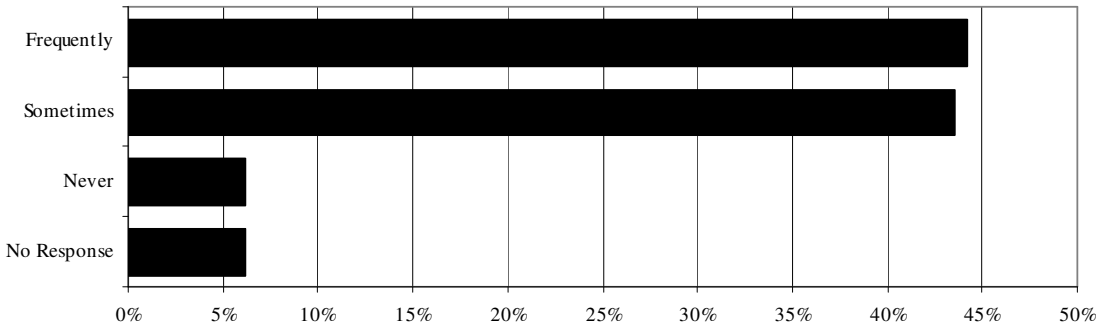
28. If you were given access to your Medicare Part B benefits in Mexico, what percentage of your physician services would be consumed in Mexico during a year?



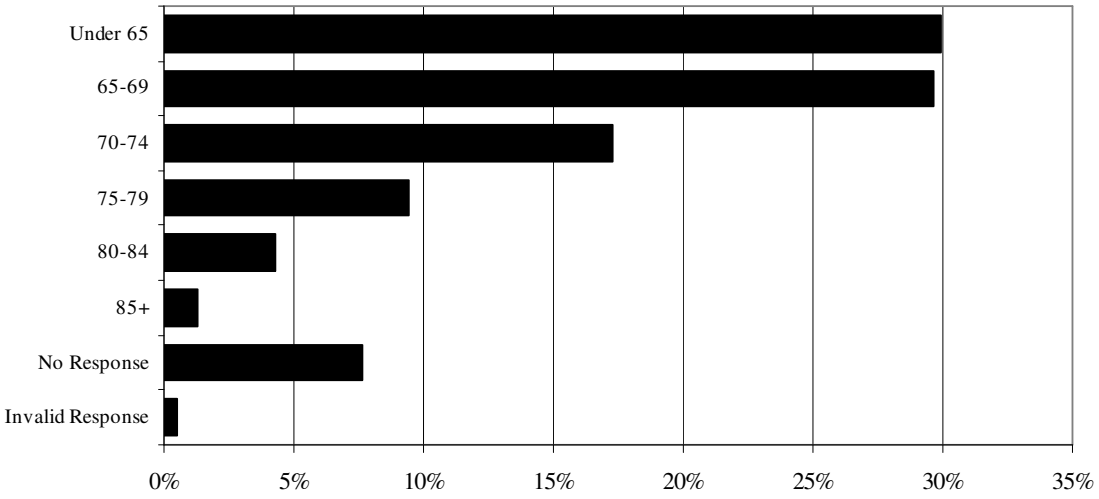
29. If you were given access to your Medicare Part A benefits in Mexico, what percentage of your required hospital services would be consumed in Mexico during a year?



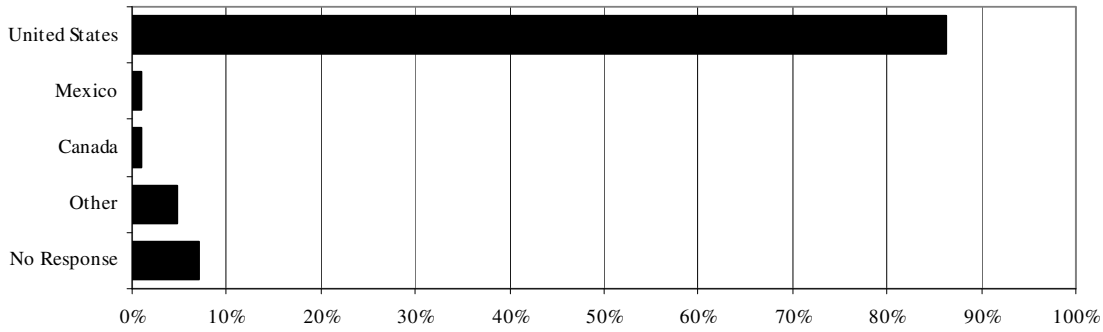
30. How often do you use the internet to access health information?



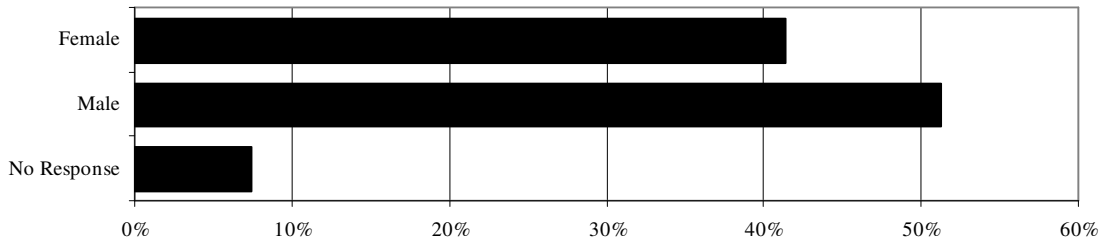
31. Age



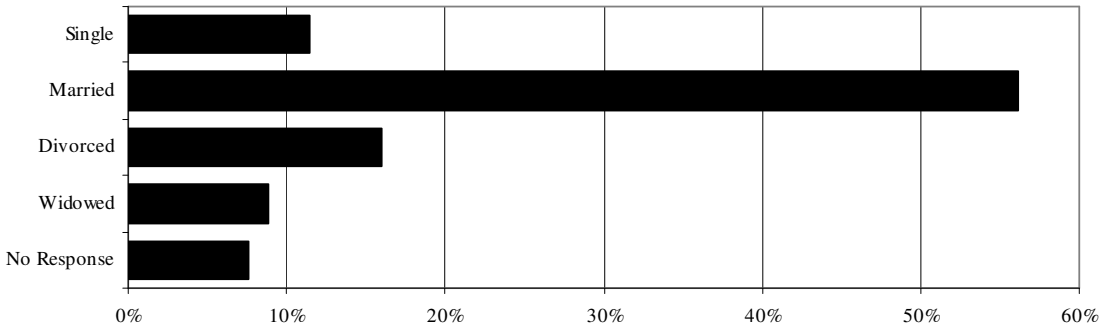
32. In what country were you born?



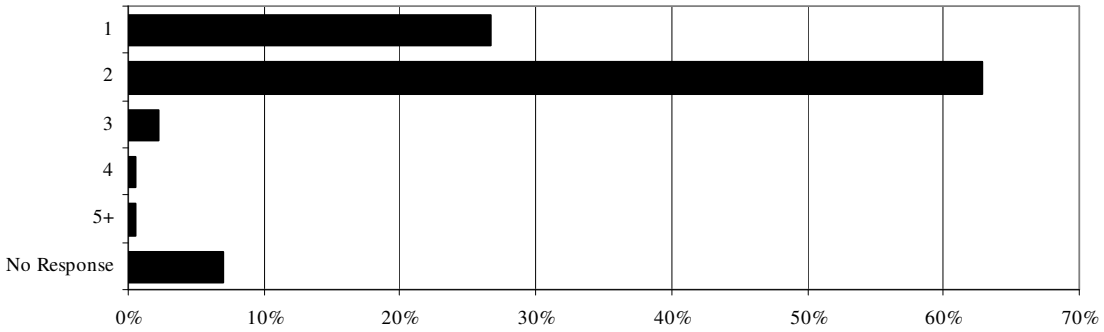
33. Sex



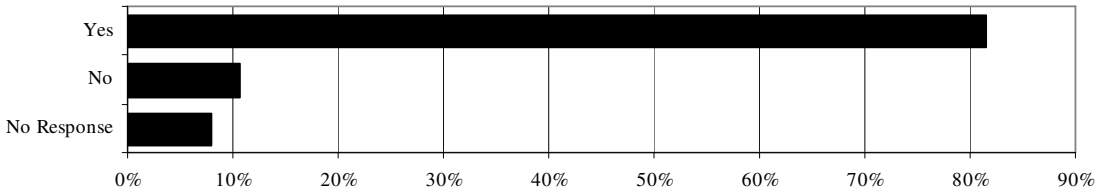
34. Marital Status



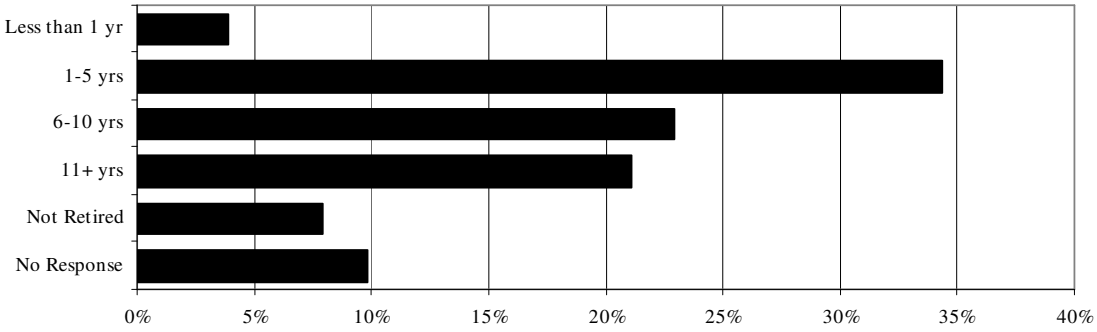
35. Including yourself, how many people are in your household?



36. Are you currently retired?

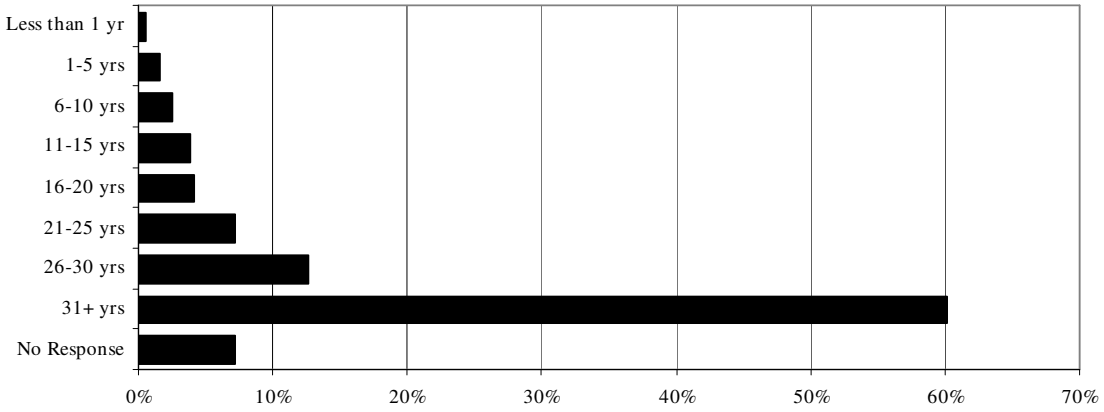


37. How long have you been retired?

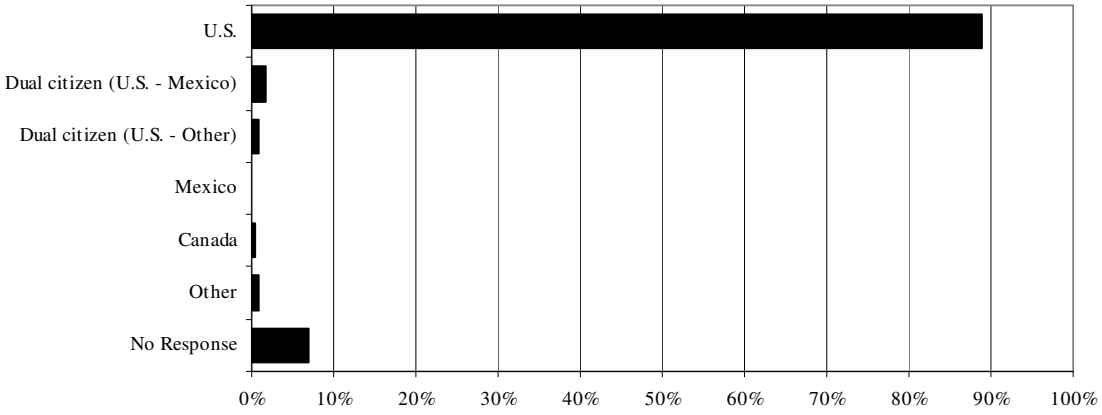


38. This question asked participants to provide information on their current or previous occupation. Due to the wide variety of responses received, this information is not provided here.

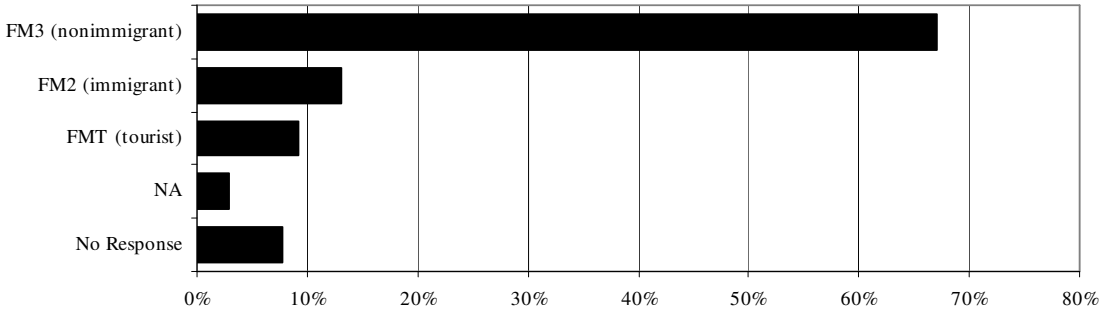
39. How many years did you work in the United States?



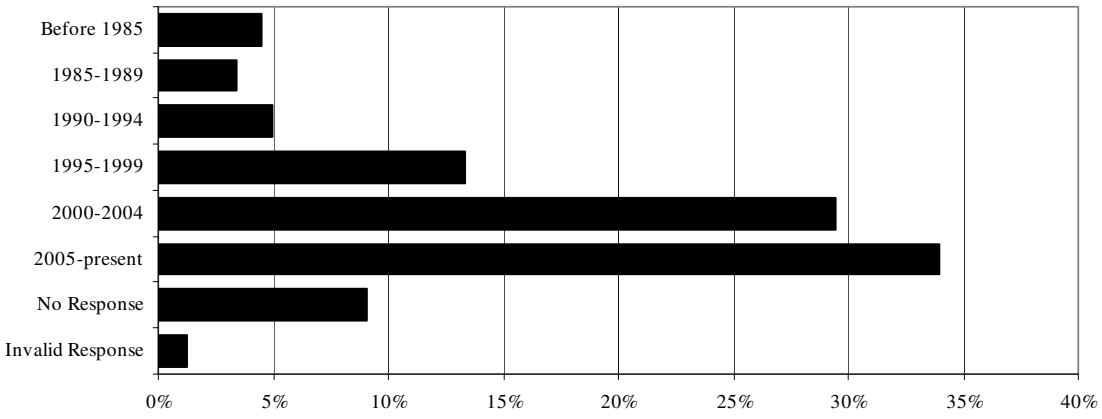
40. What is your country of citizenship?



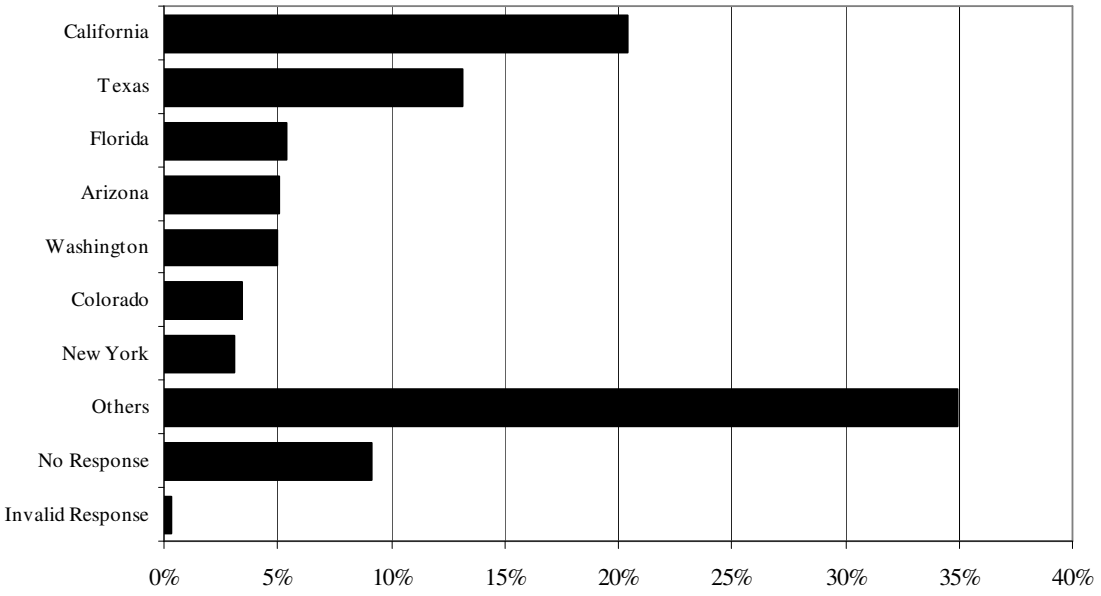
41. What type of visa do you hold in Mexico?



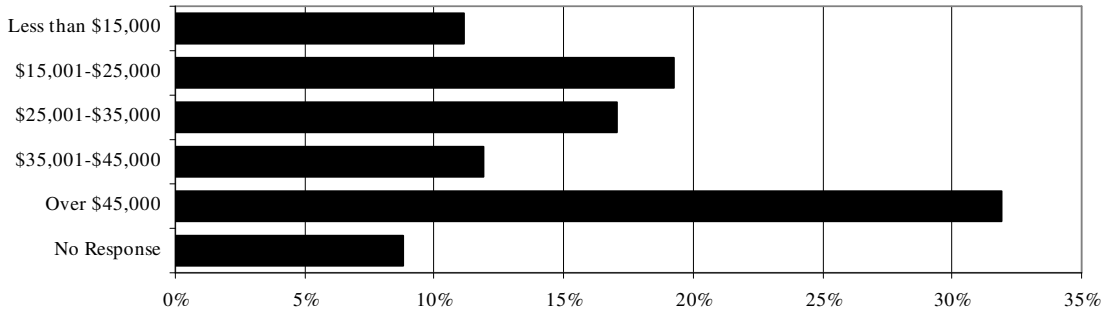
42. In what year did you last reside in the United States?



43. In which U.S. state did you most recently reside?



44. Please indicate your current annual household income in U.S. Dollars:



45. What additional comments do you have regarding the medical care you receive in the United States and/or Mexico?

Note: To improve ease of reading, the comments received in response to question 45 have been edited slightly to remove abbreviations and fix grammatical errors. When two or more comments were identical, the number in parenthesis after the comment indicates how many individuals made the comment.

- Adequate—both.
- Adequate care available in Mexico.
- Air Evac most needed for foreigners.
- All medical and dental care in Mexico is better and cheaper than in the U.S.
- Although not always as high tech as in the U.S., Mexican physicians are far more patient oriented. They take time to listen, discuss with you, ask questions and actually diagnose.
- America is superior, but Mexico is good, just expensive for Americans on my new income.
- Better in Mexico.
- Better medical care in Mexico, but not all hospitals have the latest equipment.
- Better medical care in Mexico.
- Both countries have excellent care but could not afford to use Mexican care without Medicare insurance.
- Both have been excellent, but I speak Spanish and have many friends who are doctors, which helps in both places.
- Both have been excellent.
- BOTH provide excellent care...
- Both U.S. and Mexico offer excellent care.
- Cannot afford care in U.S.
- Can't afford excessive U.S. care.
- Care appears adequate in Mexico.
- Care in Mexico has been excellent, but it is getting much more expensive.
- Care in Mexico is excellent but our Medicare and Medigap insurance does not apply so we are limited due to our income level.
- Care in Mexico is excellent. (3)
- Care in Mexico is good but without insurance can become expensive.
- Care in Mexico is good. It should be covered under Medicare.
- Care in Mexico is just as good and a lot less expensive than in the U.S.
- Care in Mexico is much more caring. Some of their procedures are advanced of the U.S. Obtaining medication is so much simpler. No time consuming waits for refill permission. More respect for us.
- Care in Mexico is superb and not as costly as the U.S., but would like to be reimbursed by my U.S. insurance.
- Care in Mexico seems to be good and affordable.
- Care in U.S. and Mexico is excellent-less expensive in Mexico and more accessible in Mexico.
- Care is attentive and accurate.

- Care is good in Mexico....cost is difficult to deal with on a fixed income.
- Care is still personalized in Mexico.
- Complicated due to no coverage in Mexico. Frequently delay care due to cost of travel.
- Cost of health care in U.S. is prohibitive. Many types of care in Mexico are adequate or better, and affordable. Tricky diagnostic questions can be a problem in Mexico but care is more personal and affordable.
- Cost to Medicare would be less if care was provided in Mexico.
- Cost will be a factor in my choosing Mexico over U.S. when I am there full time. I will prefer to be treated there.
- Could not answer questions 28 and 29. Who knows? I have not needed medical care; I use natural/non-allopathic products (Mexico).
- Dental work, the best I have ever had, in MEXICO.
- Dentists and doctors spend more time with you in Mexico. I was misdiagnosed in the U.S. I received proper care here in Mexico.
- Doctors generally are very good and very caring, and even do house calls in Mexico.
- Equal.
- Even if I had Medicare, it is too costly to go to the U.S. for normal medical care, unless special care is needed. But if I am in the U.S. and fall sick, how do I pay for treatment without Medicare?
- Everything needed is in Guadalajara.
- Everything was good.
- Excellent care in Mexico. (2)
- Excellent care is available in Mexico but proximity is a factor.
- Excellent here in Mexico, but as I age, I probably can't afford major problems unless I return to the U.S. and am covered by Medicare.
- Excellent in both countries. (2)
- Excellent in Mexico.
- Excellent medical care in Mexico. (2)
- Excellent medical care is available in Mexico. Access to Medicare benefits in Mexico for which I paid dearly into the system for so many years would be wonderful! Thank you for doing this survey.
- Excellent personalized care in Mexico.
- Excellent quality health care in Mexico.
- Excellent services in both countries.
- Excellent, our doctor even does home visits, which is wonderful for a stroke survivor.
- Excellent.
- Except for specialized high-level care, the medical care in Mexico is far superior to U.S. care.
- Expense of travel to U.S. for twice annual medical services is high. Medical care in Mexico is well regarded, but I cannot afford to accept care here. Specifically my wife has various serious ailments.
- Expensive in U.S.
- For most care Mexico is excellent. (2)

- Fortunately, I have no health problems!
- General care is good in Mexico but I would return to U.S. for any surgery or complex diagnosis.
- Good care in Mexico and reasonable.
- Good care in Mexico, but need to travel for some things.
- Good dental care in Mexico.
- Good healthcare is available in Mexico.
- Good in both countries. (2)
- Good in Mexico.
- Good inexpensive care in Mexico.
- Good medical care in Mexico. Doctors take time with you, cost is reasonable. However, I would like to have Medicare as without any U.S. insurance I will not return or travel to U.S.
- Good medical care, but would like very much to be covered in Mexico by Medicare.
- Great care in Mexico coupled with a caring manner and personalized service.
- Great care in Mexico. Better hands on physicians, better diagnosticians, with less equipment.
- Have had good care in Mexico for a broken ankle bone and high blood pressure episode only.
- Having Medicare available in Mexico would give us more options for the next 10 years.
- Health care in Mexico is good and a good value. The U.S. government would save much money by extending my future medical benefits to me in Mexico.
- HMC would benefit greatly were Mexico services encouraged.
- Hospital care in Mexico is far more attentive than in the U.S.
- I am appalled by rising costs of medical care and prescribed medications in the United States, and they are going up in Mexico as well.
- I am comfortable with both.
- I am comfortable with the health care in Mexico. I would only return to the states because of Medicare. I also like the fact that the doctors in Mexico don't push the pills.
- I am crippled, so I need services here in Mexico because traveling by air has become almost impossible for me alone.
- I am healthy, but fear the overbooking of medical people if I ever needed someone.
- I am permanently disabled because of an auto accident and my doctors in both countries communicate with each other frequently. The cost without Medicare-Medicaid is what is difficult for me.
- I am very involved in American Community activities in Mexico, a member in the American Benevolent Society, which helps aging Americans here and see a very strong need for Medicare payments in Mexico.
- I am very satisfied, at this point, with the level of care in Mexico. Doctors seem to be more knowledgeable, caring and efficient. I cannot speak to hospital care at this point have not had any experience.

- I believe that routine care in San Miguel de Allende is better than routine care in Cleveland Ohio. Physicians here take time to really talk with you and explore alternatives. They make house calls.
- I cannot afford U.S. Medicare payment deductions from my social security pension.
- I feel very good about the level of care I receive here and the expertise of the doctors. I feel they spend more with me and care about me personally.
- I find medical care in Mexico is highly professional.
- I find medical care in Mexico superior to medical care in the U.S. because of accessibility and an attitude of true caring of physicians here.
- I find that the care in Mexico is adequate.
- I find the medical care in Mexico better and much faster to secure appointments—usually same day.
- I find the medical care in Mexico to be equal to or superior to that found in most doctor's offices and/or hospitals in the U.S. Mexican doctors are more caring of their patients!
- I find the medical treatment in Mexico very good. I find the medical charges in the U.S. to be overcharging Medicare and it will break Medicare.
- I fortunately have access to doctors in California and don't feel the doctors here have good diagnostic skills.
- I go to the U.S. for care simply because I am covered by Medicare and the VA. However, the care I receive here in Mexico is very good. If I had the choice, I would prefer to receive care in Mexico.
- I got excellent medical care in Mexico, and very inexpensively.
- I had a triple A operation in 2001 that was covered by my employers insurance. Other than that I have not been ill or missed a day's work in over 35 years. I still work 65 to 75 hours per week.
- I have Blue Cross through retirement and paid partly by Medicare and ex-employer, but I cannot use it.
- I have declined Medicare. Therefore I receive no care from the U.S.
- I have found medical care in Mexico to be excellent.
- I have found that medical care in Mexico is comparable to that in the U.S. and the nursing care is even better than in the U.S. And I am comparing Mexico against world-class Manhattan hospitals in New York City.
- I have friends in Mexico who have needed serious health care here and they are extremely happy with the quality of care and are amazed at how low the prices are.
- I have had four surgeries in Mexican hospitals. The hospitals, doctors and care were excellent…better than I would receive in the States and much cheaper.
- I have had good care in Mexico. I have had good care in Arizona.
- I have insurance here but I usually go to a private doctor and pay myself.
- I have medical insurance through the State of Washington as a retired teacher. However this insurance, which I pay almost $400 for per month, only covers me in emergencies in Mexico, where I live.
- I have mixed feelings about the medical care in both countries...

- I have not yet accessed Mexican medical care, but have been told it is excellent, including in local clinics. My previous care in the U.S. has been good.
- I have received excellent care in Mexico but using expensive private insurance.
- I have received excellent care in Mexico.
- I have received excellent medical care in Mexico.
- I like my doctor contacts very much in the U.S. The doctors that I know here in Puerto Vallarta are very personable, friendly and educated. I consider the medical care in Puerto Vallarta to be of high quality.
- I love the caring, non-litigious way medical care is given in Mexico.
- I paid for it, why am I not entitled to the benefits in Mexico?
- I paid Social Security all of my life in the U.S. and now cannot collect here in Mexico for medical and prescription drugs. It is totally unfair. Medical expenses and prescription costs are lower in Mexico.
- I receive excellent care in Mexico.
- I receive good care in both countries, but believe the U.S. could save money by honoring Medicare in Mexico. I would still go to the U.S. if I could not find the proper specialist in Mexico for some reason.
- I return to the U.S. for health care with doctors who have a proven track record with me and for procedures which would be financially prohibitive if I couldn't use my Medicare. I also need to have prescriptions.
- I strongly believe that 'expats' should be eligible for Medicare in Mexico.
- I suspect major work should be done in the states because of lack of Medicare in Mexico.
- I think it is insane to restrict benefits by national boundary. I only want what I paid for or give me back my contribution!
- I think it is unfair to not have a system that allows reimbursement through Medicare for services in Mexico.
- I think medicine is a crap shoot in both U.S. and Mexico; doctors in Mexico are just as good as in the U.S.
- I think the U.S. Government could save a lot of money.
- I use the VA in the U.S.
- I would be satisfied to seek care in Mexico if I had the coverage, however, if I needed surgery I would have to return to the U.S.
- I would feel more secure having the funds to receive medical care in Mexico, although for a very serious situation I would return to the U.S.
- I would have routine procedures done in Mexico if they were covered by Medicare Parts A and B.
- I would like to be able to receive certain care in the U.S. with my Medicare benefits.
- I would like to get Medicare in Mexico.
- I would like to have Medicare pay for doctors and/or hospital coverage in Mexico.
- I would live in Mexico for longer periods of time if my medical costs were covered.
- I would move to Mexico permanently or for at least six months a year, if medical insurance/coverage were extended to Mexico.

- I would prefer to have medical insurance in the U.S. but cannot afford it.
- I would prefer to have my medical care in Mexico as travel to the U.S. for medical issues is expensive.
- I'd love to have Medicare in Mexico for major and ER. I have no place to stay in the U.S. and delays to get care are bad in the U.S. I'll have to have all medical care here, but can't afford it.
- If I could get 100% of my medical care covered in Mexico, it would cost the Medicare system about one fifth of what they pay now for the care I get in the U.S.
- If I had coverage here and started to use the system I might find it better than I think and use it more.
- If I had medical insurance coverage in Mexico I would obtain all my treatment in Mexico.
- If Part D was available to use here it would be wonderful and we would sign up for that. Now we have AARP and rely on friends or our trips back for medications.
- In general, medical care in Mexico is excellent, and costs considerably less than in the U.S.
- In Mexico—good. In the U.S.—better.
- In Mexico I am able to get blood tests for my thyroid disease easier and cheaper.
- In Mexico I talk to doctors that have time and interest in my health care. They advise, offer choices and are able to approach medicine without interference from insurance companies or fear of being sued.
- In Mexico medical care is excellent.
- In Mexico the care is excellent but not as advanced as in the U.S. The VA system serves me for more state of the art procedures.
- In Mexico the care is very good.
- In Mexico the medical care is excellent and less expensive.
- In Mexico, doctors tend to have a wait and see approach. They don't immediately send you for expensive tests but first see if your own immune system will heal the problem. U.S. doctors fear malpractice.
- In Mexico, medical care is excellent where I live, but the cost of major hospitalization without insurance is still too high, even though the overall cost of health care here is low in comparison to the U.S.
- In Mexico, we pay cash for doctor/dentist visits. Much more reasonable fees than in the U.S.
- In the U.S. it is very good.
- In the U.S., I can only go to the VA and their care is very, very lacking. I can get better care here or in Guadalajara but IMSS won't pay for much for another two years or so...
- In U.S. tort reform is necessary to reduce costs, single payer system. In Mexico costs are dramatically less, care is excellent, over the counter drugs are widely available and cheap.
- It is difficult to get to the U.S. for medical care.
- It is difficult to receive care with IMSS because of the number of patients they insure. Other physicians are expensive.

- It is expensive for me to use my Medicare benefits. It requires a plane ticket, rental car and hotel stay.
- It is far better here in Mexico.
- It would be a great help to be able on occasion to use Medicare benefits in Mexico.
- It would be cheaper for me to have services done here in Mexico.
- It would be very beneficial to have Medicare benefits here in Mexico. It is not feasible to be returning to the U.S. for surgeries, etc. Medical care in Guadalajara is excellent but not as cheap as it was.
- It would certainly be less expensive to provide Medicare coverage in foreign countries, but of course the AMA would frown on that, wouldn't they?
- It would really help us financially.
- It would serve the U.S. taxpayers very well to have Medicare benefits allowed in foreign countries. The care we have received in Mexico is excellent. Doctors and hospital were superior.
- It's ridiculous that we have to lie about where we live to get care through Social Security that we've paid into all our lives!
- I've never used my coverage.
- Let's get it in Mexico.
- Level of care is superior in Mexico.
- Medical care and supplies are much cheaper in Mexico.
- Medical care for poor people in Mexico is poor.
- Medical care here in Mexico is considerably cheaper than in the U.S. and much more personal. Providers take time to understand your issues and concerns.
- Medical care in both countries is excellent.
- Medical care in Mexico cost substantially less than care in the U.S.
- Medical care in Mexico far exceeds the care in the U.S. I can't afford to commute to the U.S. for care and would much prefer to be treated in Mexico.
- Medical care in Mexico has been improving steadily.
- Medical care in Mexico is adequate, but I have a difficult time getting reimbursed from the VA.
- Medical care in Mexico is better than in the U.S. in all areas.
- Medical care in Mexico is excellent and cheap, paying for my health care in Mexico would be a bargain for Medicare.
- Medical care in Mexico is excellent. I prefer the attention I get here to what I hear about in the U.S. I would not like to have to get medical care in the U.S. because of a lack of social security here.
- Medical care in Mexico is excellent. (2)
- Medical care in Mexico is fairly good but rapidly getting very expensive.
- Medical care in Mexico is fine.
- Medical care in Mexico is good. (2)
- Medical care in Mexico is great and inexpensive.
- Medical care in Mexico is great.
- Medical care in Mexico is less expensive.
- Medical care in Mexico is more efficient, caring and cost effective.
- Medical care in Mexico is much more personal.

- Medical care in Mexico is superb.
- Medical care in Mexico is very good and considerably less expensive. I would use it 100% if it were covered by Medicare.
- Medical care in Mexico is very good and less expensive than it would be in the U.S.
- Medical care in Mexico is very good. If I had insurance coverage here I would use it more often.
- Medical care in Mexico requires cash prepayment except for at certain public clinics. Private care is expensive.
- Medical care in the U.S. is run by insurance companies. It stinks. It is expensive and uncaring.
- Medical care in the U.S. is terrible.
- Medical care in the U.S. is too impersonal and the patient is treated piecemeal instead of as a whole person. It is not that way in Mexico.
- Medical care in the U.S. is too over priced compared to Mexico.
- Medical care in the United States has been great for me, however, my health care would be much better if it covered Mexico.
- Medical care is excellent in Mexico and much cheaper than in the U.S. We'd save money by paying the bill in Mexico, rather than the higher U.S. rates. Covering retirees in Mexico seems to be a no brainer!
- Medical care is excellent in Mexico.
- Medical care is excellent in the larger Mexican hospitals such as Los Angeles (Queretaro) and both Los Angeles and ABC Hospitals in Mexico City. Local doctors mostly graduated from the U.S. Mayo Clinic.
- Medical care is good in San Miguel.
- Medical care is less expensive in Mexico and would save Medicare money in the long run.
- Medical care received in Mexico is fine. It has seen me through two operations and one heart attack.
- Medicare should be available to U.S. citizens wherever we reside.
- Medicare should be extended no matter where a U.S. citizen resides. The IRS wants to tax a citizen no matter where he resides.
- Medicare would pay much less for providing good care, if it would cover care that was provided to recipients when they are in Mexico.
- Mexican care excellent so far.
- Mexican care has been excellent.
- Mexican care has proven to be excellent although I have heard and witnessed horror stories of others.
- Mexican care is better in many respects, besides cost.
- Mexican care is better.
- Mexican care is generally excellent and I believe Medicare should cover me here. It would cost everybody a lot less than me going back to New York City for anything!
- Mexican care is personal and superb without making you feel like a 'number'.
- Mexican care is very caring and personal with outstanding facilities and doctors and it is reasonably priced.

- Mexican care is very good and relatively inexpensive.
- Mexican doctors are interested in their patients instead of keeping the lawyers at bay.
- Mexican doctors are very good and cost less!
- Mexican doctors care about their patients.
- Mexican doctors have time to spend with you and they seem to be just as qualified.
- Mexican health care in Mazatlan is very good and I would use it more if Medicare would cover it.
- Mexican healthcare is equally good, less expensive and much more personal.
- Mexican healthcare is very competent.
- Mexican healthcare so far is quite adequate, up-to-date, easy. (2)
- Mexican medical care appears to be as good as the U.S. but at a far more reasonable price. The doctors even make house calls.
- Mexican medical care is excellent and it costs less than 50% of the costs for similar treatments in the U.S.
- Mexican medical care is excellent. (2)
- Mexican medical care is far better than I ever expected!
- Mexican medical care is more personal and more satisfying. The doctors even give you their home phone number and will come to your home if you are unable to travel. And, it is so much cheaper.
- Mexican medical care is much less expensive and much more personal. Medicare would likely save money by allowing members to get treatment in Mexico.
- Mexican medical services are excellent and, if available through Medicare, would save the government money overall.
- Mexican medical, dental and ophthalmologist care has been excellent.
- Mexican physicians and hospitals are better than most U.S.
- Mexico - adequate.
- Mexico - as good as in the U.S.
- Mexico - as good or better and much more thorough.
- Mexico - better care at a much lower price.
- Mexico - better than the U.S.
- Mexico - better than the U.S. by a very long shot!
- Mexico - care is excellent and a much better value for the money. Doctors are caring and hospitals are excellent.
- Mexico - care is good.
- Mexico - CIMA Hospital in Hermosillo is state-of-the-art and I am very happy with their services.
- Mexico - dental care is superb, medical care is subject to the quality you can afford; doctor's office visits are generally cheaper: no book keeping staff because no ov coverage on insurance.
- Mexico - dental services in Mexico are outstanding! I have had outpatient surgery in Mexico with a wonderful surgeon.

- Mexico - doctors and dentist seem to care more about their patients. They will call you at home to find out how you are doing. The cost for all medical procedures is much less.
- Mexico - doctors are care givers not money makers.
- Mexico - doctors spend more time with patients and are more caring.
- Mexico - emergency care only. I would go to the U.S. if able.
- Mexico - emergency only.
- Mexico - equal but less expensive.
- Mexico - equal or superior so far.
- Mexico - excellent care and immediate with caring doctors who had great bedside manners!
- Mexico - excellent care.
- Mexico - excellent doctors.
- Mexico - excellent medical care.
- Mexico - excellent treatment, far less expensive than U.S.
- Mexico - excellent. (5)
- Mexico - fabulous!
- Mexico - fast, cheap, competent, and accessible.
- Mexico - good and cheap $15.
- Mexico - good care but expensive, though cheaper than the U.S. Spent $13,000+ in 2005, $8,400+ in 2006.
- Mexico - good care.
- Mexico - good.
- Mexico - good/inexpensive.
- Mexico - great.
- Mexico - had major dental surgery: mini implants that I could not have afforded in the U.S. It was fabulous work. If I had access to affordable dental care in the U.S., I would not have needed this work.
- Mexico - have seldom sought medical care in Mexico, but the few occasions have been inexpensive and very satisfactory.
- Mexico - I am very impressed with what is available and the quality of service.
- Mexico - I feel very good about the level of care I receive here and the expertise of the doctors. I feel they spend more time with me and care about me personally.
- Mexico - I find the health care and hospital care to be excellent. The Doctors are available at all times, willing to make house calls when necessary, and fees are very reasonable.
- Mexico - I get medical and hospital services at an excellent hospital for half the cost as the U.S.
- Mexico - I have had an opportunity to see what medical care is like here and it is much better than the U.S. Doctors will spend as much time as necessary to discuss any problems you may have.
- Mexico - I have had four surgeries in hospitals. The hospitals, doctors and care were excellent....better than I would receive in the states...and much cheaper...$100,000 vs. $4000.

- Mexico - I have had one major illness since I have resided in Mexico. Care in San Miguel was poor but it was excellent in nearby Querétaro.
- Mexico - I have nothing but exceptional care from doctors as well as hospitals in Mexico.
- Mexico - I want health insurance here.
- Mexico - I'm very careful.
- Mexico - inadequate for anything but the simplest common problems unless the rare excellent expert can be located. There is zero regard for prescription conflicts amongst local doctors and no warnings about side effects.
- Mexico - inexpensive.
- Mexico - it is excellent!
- Mexico - it is much easier to manage your own care, find the doctor you need, and take an active role in your care.
- Mexico - it would save the U.S. money to pay for treatment in Mexico.
- Mexico - language barrier is a big problem.
- Mexico - medical care is far superior than the United States.
- Mexico - more caring and personal. U.S. - better average technology (but Mexico is catching up fast)!
- Mexico - more one to one attention and care.
- Mexico - more personal attention from the doctors.
- Mexico - more personalized.
- Mexico - my general practitioner and ophthalmologist seem as competent as any doctor I have had in the U.S. Their fees are less than the deductible on U.S. health insurance.
- Mexico - not impressed with doctors here.
- Mexico - OK; U.S. - too costly.
- Mexico - outstanding.
- Mexico - professional and inexpensive.
- Mexico - quality care, more personal, much less expensive.
- Mexico - quality is excellent and inexpensive; U.S. is very expensive, but Medicare pays.
- Mexico - relationship with doctor is not impersonal!
- Mexico - satisfactory.
- Mexico - some excellent medical care is available. However, one has to ask a lot of questions and make sure one has a competent doctor, just as one should in the U.S.
- Mexico - the doctors really care about you.
- Mexico - the licensed doctor was very informative and capable and spent more time than an American doctor does.
- Mexico - there is a lack of monitoring of both doctors and hospitals by the government, such as JCAHO in U.S. as well as national and state reviews.
- Mexico - treatment only as a last resort.
- Mexico - under-rated. Cost, service, availability (non-IMSS) is superior to U.S.; for all but most cutting edge technology (which most of us never need), expertise equal to U.S. Ergo, Mexico better in most aspects.
- Mexico - very adequate.

- Mexico - very comfortable with quality of service, equipment. U.S. too much unnecessary diagnostic testing.
- Mexico - very competent, less complication, less paperwork.
- Mexico - very good, but need Medicare.
- Mexico - very good. (2)
- Mexico - very pleased with medical care at a fraction of the U.S. price; I can't afford U.S. medical care.
- Mexico (in Puerto Vallarta and Guadalajara) - excellent.
- Mexico does not have the technical services that are affordable.
- Mexico has an excellent health care system in IMSS I would not return to the U.S. for any medical treatment.
- Mexico has better care.
- Mexico has capable doctors. I would be happy and confident to be able use their care and facilities.
- Mexico has excellent doctors.
- Mexico has excellent health care and it is far less expensive than in the U.S.
- Mexico has excellent hospitals.
- Mexico has excellent medical care available and it is less costly than U.S. The U.S. government would save money by letting us be treated in Mexico.
- Mexico has excellent medical care.
- Mexico has good cheap medical care. (2)
- Mexico has great medical coverage. My medivac insurance is to get me back to Mexico.
- Mexico has medical care equivalent to the U.S. for less cost.
- Mexico has prompt, personal attention.
- Mexico has quality health care.
- Mexico has some very good medical centers which I would attend if I had Medicare coverage.
- Mexico has very acceptable medical and dental care.
- Mexico has wonderful, caring, medical care. It is a little short on the newest equipment, but the humanity of the staffing makes up for it.
- Mexico health care is fine. I just can't afford it. I'm using all my savings up.
- Mexico healthcare services are good! Doctors are good, speak English, and make house calls. Two retired hospital administrators and one retired nurse all say hospital care is better in Mexico: the way it used to be in the U.S.
- Mexico is better and cheaper.
- Mexico is better than the U.S.
- Mexico is better, less expensive, more self-guided.
- Mexico is fast catching up with the U.S. for quality medical care. But they're much better for overall patient care by both the physician and nursing staffs. Doctors in Mexico never rush during an exam, etc.
- Mexico is fine if you locate a good general practitioner and back up the services with a specialist if needed. I am healthy enough.
- Mexico is great and relatively inexpensive.
- Mexico is great for fractures and suturing....for a brain abscess, I'm not so sure.

- Mexico is just more convenient and I have already earned Medicare and it would save the U.S. money to provide coverage here rather than having to return to the states.
- Mexico is my choice for medical care.
- Mexico is spotty and there is no recourse for malpractice.
- Mexico is very satisfactory.
- Mexico like the U.S. has some very good and capable doctors. Like in the U.S. you must find the doctors best for your needs. The U.S. doctors seem always more busy and have less time for the patient.
- Mexico medical care is excellent but our private insurance is extremely high since U.S. Medicare does not apply here.
- Mexico medical care is very much patient-oriented.
- Mexico Medicare is the best.
- Mexico needs more specialized doctors.
- Mexico provides a much more nurturing environment. The Mexican doctors help rather than overmedicate and move you out.
- Mexico's physicians take time to listen to their patients. A generalization, to be sure, but true in our experience.
- More immediate care in Mexico. Doctors in California do not have time for in depth consultations and charge high costs due to malpractice insurance and cost of living.
- Much better care in Mexico, and it is affordable.
- Much cheaper in Mexico and good.
- Much of the care in Mexico is excellent. A new technology or handling of a particular problem might be better there. Mostly we need our earned Medicare to support lower cost care here.
- My dental care is received in Mexico, examinations for physicals in the U.S. I currently am very healthy for my age.
- My experience in Mexico is limited, but I have a good impression.
- My experience with medical care in Mexico has been for my wife. The care and services were better than anything we experienced in the U.S., all of which was in the private health care system in Mexico.
- My experience with the Mexican doctor and pharmacy were great.
- My health care in Mexico is affordable and adequate for my current needs. I have confidence in private physicians in Mexico. However, I paid over $62,000 into Medicare in my working career.
- My husband was in Hospiten Hospital in Cancun for a week and received excellent care. All of their equipment is new. I am a nurse and know that he would not have received any better care in the U.S.
- My Mexican doctor spends 30 minutes (not rushed) with me and charges $15. If Medicare was available, the red tape would drive up costs.
- Need good medical services in Alamos.
- Our care in Mexico has been excellent. There are a few procedures they don't perform here (such as the SynVisc). The biggest problem is not being able to use my Medicare.
- Our care in Mexico has been superior to that in the U.S. and cheaper.

- Our medical care is Mexico is exceptional. It would be wonderful to have Medicare coverage here. It would save the U.S. taxpayers money compared to the cost I would incur for the same services in U.S.
- Overall I am happy with Mexican medical care, but concerned about hospital care and costs without Medicare.
- Overall, I have been very impressed with the healthcare in Mexico. Even though I am no longer on a health insurance plan, I often find that the care here costs less than my insurance copays in the U.S.
- Personal care is better in Mexico. Technical care is better in U.S.
- Personal service is more available and affordable in Mexico. Latest technologies and hi-tech machinery are better in the U.S. Also some medications not allowed distribution in Mexico.
- Please get us Medicare in Mexico! I can't afford to live in the U.S. and worry about medical all the time.
- Prefer Mexico's access to prescription drugs.
- Prefer U.S.
- Private Mexican medical care is inexpensive, personal, and adequate. U.S. medical care is expensive, impersonal, and too high tech.
- Puerto Vallarta has very good medical but I prefer the U.S. because of language.
- Quality of service is good in Mexico, but I wish I could receive Medicare coverage here.
- Save U.S. money by honoring Medicare in Mexico.
- Seems to be excellent, according to my wife, very good diagnosticians.
- Should be covered in Mexico! Paid for it!
- Since I do not have medical coverage and am not eligible for Medicare, I would seek my health care in Mexico.
- Standard of care in U.S. is generally higher, and much more expensive. I am fortunate to have good insurance. I am not fluent in Spanish, and feel more comfortable with U.S. doctors/nurses for best care.
- Strong preference for care in Mexico - more personalized and doctor has/takes time.
- Surprised how good it is in Mexico.
- The care in Mexico was good, but for something serious (such as the aneurysm), we would go to the states.
- The care is just as good in Mexico as the U.S. and about 70 percent less.
- The care I've received so far in Mexico is equal to that I received in the U.S.
- The cost of medical care in the U.S. will bring serious changes in the not too distant future.
- The health care in Mexico is excellent. I wish my insurance company would honor billing from the local hospitals so I could continue to receive my care from here.
- The language barrier is the biggest problem with Mexican medical care. I am learning Spanish to overcome that.
- The medical care here is similar to that in the U.S. For emergencies, however, I do not have a lot of faith.

- The medical care I have received in Mexico City has been outstanding, and much less expensive than in the U.S. I had successful surgery on a herniated disk at Hospital Angeles in Mexico City in 2003.
- The medical care I receive in Mexico is excellent. I have a heart problem with medications not available in Mexico and must return for prescriptions. Return trips run $200 USD each four times a year.
- The medical care in both countries is fine, however, in cases of emergencies, if we had Medicare coverage in Mexico, it would be more convenient and economical as traveling would be unnecessary.
- The medical care in Mexico is much more personal.
- The medical/hospital/dental care is excellent here in Mexico. It is also much cheaper than the United States.
- The U.S. care is excellent. There is excellent medical care in Guadalajara, near where we are retired that we would use if it were paid by Medicare.
- The U.S. needs to provide cheaper health care that is fully covered by Medicare scale; care in Mexico is lower cost because less frills and salaries.
- There are very good medical facilities in many of the major Mexican cities. There could be some that are certified by Medicare as well as the physician groups that refer to those hospitals.
- To be able to access Medicare A and B benefits in Mexico would be of great benefit to me.
- To the U.S. - Please help Americans living in Mexico who must travel to the U.S. for medical care because Medicare and gap coverage doesn't pay for services rendered in Mexico. You would save money.
- Too expensive in the states, especially nursing homes.
- Too far to go back to U.S.
- Top care in Mexico.
- TRICARE was not there when I needed it. I just hope I never need Medicare. I still carry my Blue Cross because I don't feel that I can trust Medicare.
- U.S. - disappointing.
- U.S. - efficient; Mexico - caring but confused.
- U.S. - excellent care; Mexico - adequate care but very expensive.
- U.S. - excellent.
- U.S. - excellent; Mexico - my physician is very attentive and my titanium hip replacement surgery and post-op rehab, was also excellent.
- U.S. - excellent; Mexico - very good.
- U.S. - fine.
- U.S. - I am in the process of probably signing up for the Medicare additional health insurance. Because I am not living there, I'm trying to decide if it makes sense to do it.
- U.S. - I have a metastasized colon cancer that is being treated with Avastin. This treatment would not be covered in Mexico.
- U.S. - I keep U.S. coverage in case for some unexpected reason I should have to return to the United States to live.

- U.S. - it is unfair after contributing the maximum in taxes from 1961 to 2003 that I do not have coverage. Actually, in Mexico the costs are much below what they are in the U.S.
- U.S. - lousy; Mexico - great.
- U.S. - medical care is much too expensive for us. We had a Medicare supplement policy which increased annually and the cost became prohibitive for us.
- U.S. - Medicare in Mexico will greatly help.
- U.S. - outrageously expensive; Mexico - affordable, better bedside manner.
- U.S. - satisfied.
- U.S. - still good care from specialists. With general practitioners, mediocre and depersonalized compared to when I lived there. Emergency room: only experience since 1980 was essentially malpractice.
- U.S. - too expensive.
- U.S. - unnecessary pre-op testing causing five-week delay for an overnight low risk surgery. Mexico - fast, inexpensive, medical service at 1/4 the U.S. price.
- U.S. - VA is a waste of time. I have received no (zero) treatment for anything. Tests yes, treatment no.
- U.S. care is adequate.
- U.S. care is on downward trajectory.
- U.S. has been excellent and I have been quite healthy.
- U.S. is outrageously expensive.
- U.S. is too expensive.
- U.S. several friends could use help in Mexico.
- Unable to afford Medicare (U.S.) or IMSS (Mexico).
- Uneven quality in both countries.
- United States - familiar with the system and have had the same cardiologist for twenty years, do not like the managed care system; Mexico - not familiar with the system, do not have a cardiologist.
- Very difficult to find adequate medical insurance in Mexico.
- Very disappointed with care in the U.S. Our care in Mexico has always been far and above what we receive in the U.S., and for a fraction of cost.
- Very expensive in the U.S.
- Very good in both countries. (2)
- Very good in both places.
- Very good in Mexico, but no insurance or Medicare.
- Very good in Mexico.
- Very good in U.S. and Mexico.
- Very good medical is available here in Mexico and I plan to use it completely after my husband fully retires. If I was seriously ill I'd go back to the U.S. while I have insurance coverage.
- Very good-Mexico.
- Very satisfied (Mexico) in the U.S. it was so so via VA.
- Very satisfied with quality of care in Mexico.
- Very satisfied with the medical care in Mexico.

- Very unhappy with present medical care in U.S. Most of the physicians have M. Deities (rather than M.D.,s) and don't treat us with respect.
- We are full time RVers and would spend much more time in Mexico if Medicare was available in Mexico.
- We have found Mexican medical care excellent.
- We lie about our time in Mexico because by law we can't be out of the state for more than six months if we receive Medigap.
- We live in Mexico, pay U.S. taxes, and would love to be able to receive Medicare benefits when eligible here in Mexico.
- We love the doctors in Mexico.
- We moved to Mexico only two months ago. We have had limited opportunities to seek medical services here and we are still making decisions about health insurance and service options.
- We prefer Mexican doctors.
- We really need our Medicare here in Mexico. We are in trouble without it.
- We were happy with the emergency care in Mexico and the heart cath in Houston.
- We would love to be able to use Mexican doctors more frequently and to use our medical insurance to pay. Medical care here is quite good, and it would save both our insurer and us a lot of money.
- When we use it, I expect excellent care in Mexico.
- Why can't I use service in Mexico which cost less and have Medicare cover them.
- Without the help of Medicare B private insurance is extremely costly and almost useless even though I must carry Medicare B to have the insurance valid.
- Wonderful care here in Mexico at cheaper rates, but would like coverage from Medicare since my insurance here excludes my prior heart condition.
- Would be wonderful to have Medicare here.
- Would certainly use it if available. For serious problems that allowed travel to the U.S. would do so.
- Would get medical treatment in Mexico if covered.
- Would like current Social Security coverage honored in Mexico.
- Would like Medicare to cover medical and hospital in Mexico.
- Would use more medical services in Mexico if I had coverage here.
- You get what you pay for in Mexico—good care is expensive. In the U.S. all care is expensive.